Consumer Subcommittee of the MAAC

April 24, 2024

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

DHS representatives present: Sally Kozak, OMAP Deputy Secretary; Gwen Zander, OMAP Managed Care Bureau Director; Carl Feldman, OIM Policy Director; Montrell Fletcher, OLTL Executive Assistant.

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

>> SONIA BROOKINS: Good afternoon. Welcome to the Consumer Subcommittee. My name is Sonia Brookins, I'm the chair of the Consumer Subcommittee.
Kyle, you can take over now, please. Thank you.
>> KYLE FISHER: Thank you. Are there any introductions the Department wants to start the meeting with?
>> SALLY KOZAK: I don't think so. We have our usual cast of folks on and they will introduce themselves each as they talk. If that works for you, Kyle.
>> KYLE FISHER: Okay. Thank you. Kyle Fisher here, PHLP, counsel to the Consumer Subcommittee. Thank you for joining us for this April meeting of the committee.
We will go through brief introductions, do attendance for members of the committee.
We heard from the chair. Do we have the vice chair, Minta Livengood on the call?
>> MINTA LIVENGOOD: Yes, this is Minta Livengood.
>> KYLE FISHER: Excellent. Thank you.
Do we have Marsha White-Mathis?
>> MARSHA WHITE-MATHIS: I'm on. Can you hear me?
>> KYLE FISHER: We can. Thank you.
Do we have Liz Healey?
>> LIZ HEALEY: I'm on, Kyle.
>> KYLE FISHER: Good. Thank you. Do we have Lauren Henderson?
>> LAUREN HENDERSON: Present.
>> KYLE FISHER: And Meghann Luczkowski?
>> MEGHANN LUCZKOWSKI: Hi, this is Meghann.
>> KYLE FISHER: Welcome. Do we have Jamie Scali?
Do we have Lauren Hatcher?
Victoria Gardner? I do expect those three to join us shortly.
Anyone I am missing? Okay. Very good.

And do we have Danna?
>> DANNA CASSERLY: Yes, I'm here. Thank you.
>> KYLE FISHER: And do we have Amy?
>> AMY LOWENSTEIN: Yes, I'm here as well. Thanks.
>> KYLE FISHER: Very good. I'm happy to hand it back to you.

- **OMAP Report**

>> SALLY KOZAK: Thanks, everybody. Good afternoon. I have a few overall updates for you. And Gwen Zander from the bureau of managed care is on to talk about health choices issues that folks have been asking about.
Let me do the couple of pieces that I have first.
So ambulance rates. A lot of folks have been asking about this. As you know, there was legislation requiring us to increase ambulance rates. We had to submit the state plan to Centers for Medicare and Medicaid Services. We just got the approval back on April 16th to allow us to pay for ground mileage for every loaded mile. And to increase fees for ambulance services that are the greater of the highest Medicare rates published in the ambulance fee schedule public use file for calendar year 2023 or the current Medicaid ambulance fees as updated by our most recent bulletin of 262207.
These increases will be retroactive to January 1st, 2024. And just so folks know, we will automatically reprocess those claims in fee for service. We are currently serving our MCOs to see what they're going to do or if the ambulance providers will have to resubmit them.
On the 18th, after approval, we issued bulletin titled ambulance services letting providers know about the new rates that will be in effect. And I think that's everything on ambulance rate updates. Unless anybody has any questions about that.
>> KYLE FISHER: None from me. Thank you.
>> SALLY KOZAK: Okay. The enrollment assistance procurement. We are seeking an applicant to provide enrollment outreach and educational services to the health choices physical health program consumers and to CHIP consumers. That RFP started on 3/6/23. And responses are due back -- were due back yesterday, 4/23/24. If anybody is interested in looking at it, it's RFA number 1123.
Okay. Dental benefit limit exception. I know many folks watched the budget hearing. One of the conversations that occurred was around dental benefits. And at that time, it was expressed by one of the representatives that there appeared to be a lack of awareness among dental providers that we had streamlined the dental benefit limit exception process.
In response to that, we committed to re-issuing information related to the dental BLE. So on April 24th, we re-issued bulletin 082101, which is titled dental benefit exception process update.
We also issued a quick tip reminding providers of the bulletin. That's number 273.

And Dr. Shamloo, our chief dental officer, he is going out and meeting people and reminding providers about the streamlined BLE process. So all of that is in the works. So hopefully awareness of that will increase and continue to help ensure that people have access to dental care.
>> KYLE FISHER: It's Kyle.
>> SALLY KOZAK: Go ahead.
>> KYLE FISHER: Just a quick note on that. I think it's welcome news. I will note that we have had conversation around the data and managed care plans showing changes in their approval rates since they have implemented the streamlined process. And there continues to be challenges there, apart from the one plan whose rates markedly increased.
I guess one related note hopefully with the education campaign the department is doing, dentists will know to include relevant diagnosis information for their patients who diagnoses like diabetes, throat cancer, pregnancy would allow the streamlined process to occur. It's not clear that the MCOs are doing --
[indiscernible]
>> SALLY KOZAK: Yeah. And Dr. Shamloo meets regularly with the dental directors at each of the plans, as well as with the dental benefits manager. That's been a focus of almost every conversation they have. So yes, we are working on making sure people clearly understand the expectations around the streamlining of that process.
>> KYLE FISHER: Okay.
>> SALLY KOZAK: Okay. And then the last thing I have for you is the final rule on MA/CHIP eligibility, which was released on the 27th. And it governed eligibility for Medicaid and children's health insurance, or the CHIP program. These new eligibility rules will take effect on June 6th of this year. Although I will caution that some pieces of the rule have longer implementation time lines between 12 and 36 months from the date it was issued. So from June 6th -- or the day it took effect, June 6th.
The rule focused on eligibility is one of three rules that were released. The other two were released yesterday. The managed care final rule, as well as the nursing home staffing rule.
To go back to the eligibility rule, it has the primary goal of making it easier for folks who are eligible for Medicaid or CHIP to complete a determination and enroll in these programs and to retain their MA and CHIP benefits so long as they remain eligible.
It removes barriers for families trying to secure health care coverage for their children, particularly in the CHIP program, it requires us to eliminate the premium lockout periods and encouraging other mechanisms for addressing timely payment of premiums, such as frequent reminders, multiple payment options, pursuing past due premiums.
For the CHIP program, it prohibits a waiting period and annual lifetime limits of any CHIP benefits.
CMS has extended the time frames for reconsideration of an application and re-determination, as well as the time frames for returning requested verifications. We now must give individuals a minimum of 90 days to submit information for reconsideration. And

we must give a minimum of 30 days for applicants to provide verification of changes in circumstances.
The new rule also requires us to improve transitions between Medicaid and CHIP so that when we determine an individual ineligible for Medicaid but eligible for CHIP or the separate CHIP agency, which we don't have so it doesn't really apply, determines that the child is eligible for Medicaid, that we must accept each of those determinations seamlessly between the programs. That would have been true before we transitioned CHIP to OIM eligibility.
I think that's the update on the eligibility rule.
As I said, the managed care rule and the nursing facility staffing rules just came out Tuesday. So we are just now starting to take a look at them.
Questions?
>> KYLE FISHER: I don't think so, Sally. I know the questions around the transition from Medicaid to CHIP is on the agenda later. I don't have any questions related to this recently released. Thank you.
>> SALLY KOZAK: Okay. Yeah, the recent IT transition we did with that where we put all of the CHIP eligibility through OIM actually makes us compliant with that piece of it. So we're a little bit ahead on that one.
>> KYLE FISHER: Thanks.
>> SALLY KOZAK: Okay. If there's no immediate questions on anything that I just presented, I will go ahead and turn it over to Gwen. If other questions arise, I will be on the rest of the call.
So Gwen?

- **HealthChoices Issues**
  - **MCO/Hospital Contract Terminations**

>> GWENDOLYN ZANDER: Thank you, Sally. I serve as the director for the bureau of managed care operations in OMAP.
And I have got a couple of updates for you today or topics to go over.
The first one pertains to MCO and hospital contract negotiations and terminations.
This is a continuation of the discussion that we began at last month's meeting related to aMER health and keystone First, their contact with the Children's Hospital of Philadelphia, CHOP.
That contract is currently due to expire on June 30th, which means that both CHOP and Vista are working hard to renegotiate in hopes of getting a new contract in place for July 1st. Of course, because that date is coming up, there have been some notifications made by CHOP to their patients, their Amerihealth and Keystone First patients about the termination of the contract.
The MCO, Vista, Keystone, and Amerihealth have not notified their members that use

CHOP services. That is because the MCO is required to send that notification to their members 30 days in advance of a termination. It's really our belief that 30 days advance notice coupled with the 60-day continuity of care period after a contract termination is enough time for folks to decide whether they would like to transfer their care to another in network provider or select a new MCO that does have their current provider in the network.
Notification ahead of that time we think can be a little bit confusing and sometimes panic inducing, especially when negotiations are underway, as they are right now. Both entities continue to negotiate in earnest and in good faith.
So we are hopeful as a department that this contract will not come to an end. But in the event that it does, Keystone and Amerihealth will be sending out notices to their members that use services through CHOP at the end of May letting them know about the termination and advising them about the 60-day continuity of care period. They would have an opportunity to, like I said, either transfer their care to a new provider or select a new plan. Any MCO or any patient of CHOP that would like to transfer to a new MCO would need to do that by the 13th of June to make that effective for a July 1 start date.
So all of that will be communicated in the member notices that go out, like I said, at the end of May.
But as I also said, we are really, really hopeful that it doesn't come to this for all the reasons that we discussed last month.
So that's the update that I have right now on CHOP and Vista. And that is the only MCO and hospital contract termination that we are tracking in the short term right now.
Any questions from the Subcommittee members or council about that?
>> KYLE FISHER: Thank you. We did have a good conversation around this earlier this morning. I think fair to say the consumers are certainly hopeful and optimistic this did not come to pass and the contract is renewed and no one's care is interrupted.
One question mark going to the last piece you noted, this is dating rules for MCO plan change. Keystone is making its mailings the end of next month. So impacted families should have them by the beginning of June depending on mailing delays, into June.
The 13th is the normal dating rule for that to be effective July 1st.
Would the Department consider extending that at all? Is there a possibility of extending that date so families have more time to evaluate their options before going into --
>> GWENDOLYN ZANDER: I don't know that we have the ability to extend that. I will have to -- Sally, we can have that conversation and speak to the folks that operate the system. I'm not sure whether that is possible. But we can look into it.
>> KYLE FISHER: I guess a related concern going back to the continuity, and I appreciate you reiterating there is a 60-day continuity period. Would families need to request continuity, request approval from Keystone they are in fact in an ongoing course of treatment that would allow them to take advantage of that? Or is that something that can be applied as a blanket buffer period for all?

>> GWENDOLYN ZANDER: That is not something that families need to request. If they have open authorizations, if they're currently assigned to a CHOP affiliated PCP, for example, that continuity of care requirement kicks in automatically with no need for a consumer to request anything in particular.
>> KYLE FISHER: Okay. That's reassuring. I think we weren't certain of that. And we weren't certain if someone needed to have a pre-existing appointment scheduled. But it sounds like if you're assigned to an impacted doctor, essentially if you're getting this notice, you should have the ability to take advantage of that 60 days.
>> SALLY KOZAK: That's correct. That is the requirement for the MCO.
>> KYLE FISHER: Any other committee members have questions on this topic?
>> MEGHANN LUCZKOWSKI: This is Meghann Luczkowski. No other questions. Just sort of reiterating Kyle and Gwen's points. We're remaining optimistic and keeping a close eye. We appreciate the Department being on top of continuing to share the information that they have.
And looking forward -- hopefully, we don't have to talk about it next month. But maybe we do. And just keeping everybody's frame of mind in terms of how we can mitigate the fallout for members and maybe ways that we can revisit some of the existing time lines and things like that.
And then also just we're sort of thinking about how enrollnow.net and that system can be proactive and helpful. Not things we need to discuss today, but things on our mind if we have to talk about them further. We're all just keeping our fingers crossed.
>> GWENDOLYN ZANDER: Thanks, Meghann. Any recommendations you have for us at any time, please share them. Like you said, if this is still a topic for next month, it will definitely be a good time to talk about what those recommendations are for communications and processes to minimize member impact and family impact. We certainly share that goal.
>> MEGHANN LUCZKOWSKI: I will reach out offline if I hear anything that would be useful.
>> SALLY KOZAK: Go ahead, Kyle.
>> KYLE FISHER: With respect to recommendations and a topic for further conversation, Maximus potentially having a complex case unit that staff who are able to work with families who may have six or eight or more providers, many of whom are not CHOP providers, to help them coordinate. If this is going forward and a family needs to change their MO to remain with -- MCO to remain with the CHOP provider, how do we keep the same home health agency and provider, et cetera. I don't know that that is within the purview of what the enrollment brokers are typically helping families with. If there's the ability to have a more targeted customer service unit to help families with more complicated cases, I think that would go a long ways.
>> GWENDOLYN ZANDER: Thanks for that suggestion, Kyle. We will take that back and look into feasibility.
Sally, I think you had more to say?
>> SALLY KOZAK: No. The only thing that I was going to add was that just as a reminder for

folks, and I fully appreciate that every situation has its own uniqueness, so to speak, but this is not the first time that we have had a large termination from the network. And it's not the first time that we as a department have had to transition and enroll this large number of folks. And it's also not the first time that we have had to deal with this with particularly complex children.
So I just want to assure everybody that we have learned lessons from the past that we are incorporating as we move currently through the existing situation. But just as a reminder that this is not our first time through this type of situation.

- **Shift Care Prior Authorization & Appeal Data**

>> GWENDOLYN ZANDER: Thanks, Sally. Any further remarks on the CHOP and Vista contract before I move into the next topic?
All right. I think we can move ahead the slides here. For the next several minutes, I am going to be talking to you about shift care denial and overturn rates in the physical health choices programs. So reminder, we're only talking about the pediatric population here. When we say shift care, there are two types of services that are included under that umbrella. Private duty skilled nursing, as well as home health aid services.
And so I was asked by the subcommittee to come up with data to talk about just the number of authorization requests that are denied and then of those that are denied, what gets appealed and what subsequently gets overturned on appeal.
So I will warn you before I get going, I have a lot of slides here. A lot of numbers. I'm going to do my absolute best to take it step by step and keep this as easy to follow as I possibly can for you.
So before I dig into the data about the denials, appeals, and overturns, I thought it would be helpful to do a couple of slides to give you context about the universe of these services. So what you can see on this chart is that we are looking at the percent of shift care members that are covered by each MCO compared to the percent of overall health choices members that are covered by the MCO. This is statewide and based on just data from the month of February 2024. So it's a snapshot of a point in time.
The reason I thought this would be helpful is as we look at the numbers, you can keep in mind how large of a share of shift care members each MCO has. So when you're seeing trends and rates, you can think is this an MCO that has a small share of shift care members or a large share?
So that's where you're looking at that column that says percent of shift care members, ACPA, 5%. GEISINGER, 20%. Keystone first, 28. United, 2%. And UPMC, 22%. You can get a feel for the intrusion of how many total members receiving shift care services are enrolled with each plan.
And then you can compare that to the last column here that shows you the overall share of health choices members broken out by plan.

I thought that this was kind of interesting context just because, for example, Geisinger has over 21% of all shift care members, yet they only cover 11% of all health choices members. You see a disproportionate prevalence compared to the overall market share.
Again, this was meant to kind of set the table so that when you're looking at the future slides you have context about how big of a player each MCO is.
If we go to the next slide.
Here we have the denial rates. And this is for comparison of all prior authorizations as compared to home health aid services and compared to skilled nursing services.
This is over the full year of 2023. So it's not broken out by quarter or anything. It's a full year of data. So when you're looking at those blue columns, that's the denial rate for all prior authorization requests.
And then you can compare that to the orange column that shows you how many home health aid prior authorization requests were denied. And then the gray one is how many skilled nursing prior authorization requests were denied.
So you can see it's really kind of a mixed bag here. We have got some MCOs where home health aid authorization requests are more likely to be denied than the overall Prior Auth requests. You have others where the reverse is true.
You can see one that really stands out I think is Geisinger. The fact you see 0 denial rates for home health aid and skilled nursing authorization. We did verify that data and we do believe that that is correct. Geisinger does not appear to in 2023 did not appear to deny requests for home health aid and skilled nursing services.
I will share that I think the reason that we believe that is is because of some processes that Geisinger had in place in 2023 related to the Prior Auth request process where they were requiring that a home health agency had to already be identified in order for an authorization request to be submitted.
We have been working with G eisinger to update that process to allow for submission of authorization requests when a staffing agency has not yet been identified. We'll be interested to see whether that impacts the denial rates because involvement of an assigned agency does seem to help with the submission of all the required documentation to get things denied or to get things approved, excuse me.
I would also share Geisinger talked to us about the process they used to work with the prescribing provider and agency to make sure that all information is included so that think don't have to deny.
So I did want to just mention that because it is a bit of an outlier, something that stood out to me when I was looking at this chart. But this is just to give you some context about how home health and skilled nursing services, the rates of denials compared to all services across the MCO.
>> LIZ HEALEY: This is Liz. I have a quick question. Are these when there's a new request for a new service? Or does this -- is this for re-determinations of existing service or a mix of both?

>> GWENDOLYN ZANDER: This includes all authorization requests. It could be a first time request or a re-authorization request.
>> LIZ HEALEY: Thank you.
>> GWENDOLYN ZANDER: All right. On the next slide, we're going to start looking at this broken out by quarter. So I know this is a little bit of a busy chart to look at. And again, this is one where I'm trying to offer context. This is the Prior Auth denial rate broken out by quarter. What I really wanted to show you on this slide here is that it's a pretty flat line across all MCOs across quarters, which means that the denial rate doesn't really change from quarter to quarter when we're looking at all services all together.
Again, this is all prior authorizations. So this could be dental, it could be medical surgical, it could be pharmacy, shift care, anything. So really the point of this is just to show you that over time throughout calendar year 2023, we didn't see a ton of change in denial rates across all Prior Auth requests.
If we go to the next slide, what you're going to see is we did notice a change in the denial rates for home health aid services. So this is particularly interesting to us because in quarter two of 2023, that is when we issued the Ops memo that clarified that legally responsible relatives may be paid as home health aids. As well as when we provided additional information to the MCOs about what they should be considering when they are making coverage decisions for shift care services.
So I was really pleased to see that there appears to have been an impact in that change in policy and in the updated guidance that we provided.
Q3 is when we offered a training for MCO staff to further explain this. And so what you can see is just if you're looking at the red numbers here that are highlighted, that's the overall health choices program average. You can see a pretty big difference between Q2 and Q4 from 17.6% of home health aid Prior Auth requests being denied to 8.5% of those requests being denied.
So this was pretty interesting to us and what the subcommittee wanted to know is whether that change in policy and whether the enhanced explanations of instructions to the MCOs made a difference in coverage rates. And I think that we can conclude just from this data that it appears to have had an impact.
The next slide shows the same thing -- go ahead, Kyle.
>> KYLE FISHER: Thanks. If I can jump in.
That slide was really interesting. And we also talked about issuance of that guidance in the second quarter and the department's training in the third quarter. And it looks like there was a pretty clear correlation to the denial rates falling then, which is certainly positive to see.
And I want to extend a thank you. I know you and your team put a lot of time and effort into this, both pulling of the data and also illustrating it in these charts in a way that we're not looking at just spread sheets of numbers. We really appreciate that and the department's commitment to really monitoring the plans and ensuring they are executing

the policies the way they're supposed to.
One question was the home health aid denials here. It was clear that a couple of the plans had much higher denial rates than the others. And we talked about sort of the Geisinger scenario at the bottom of this chart.
What do you make of some plans or Vista having rates here that are three times higher than the state average?
>> GWENDOLYN ZANDER: It's a concern. Of course we noticed that as well. And I think that it's also particularly noteworthy given the share that especially Keystone First has of shift care members in our program.
So while we want to acknowledge the progress that has been made in decreasing those denial rates, we do still certainly recognize that those are significantly higher.
So we have been engaged in what we call denial audits of each of the MCOs. But we have been trying to make our reviews of those denials proportionate to the share of denials that an MCO issued. For example, instead of looking at the same number of cases across all MCOs, really trying to focus our attention on those ones that are issuing a lot of denials.
So we have been going through them, samples of them of course, we can't review every single one. But using them as learning opportunities to continue to work with the MCOs and make sure that they're considering the right things, that they're applying the guidance correctly, that all of their processes are where they need to be.
So it's going to just be an ongoing process to see what we can go to get the numbers more consistent with other MCOs.
>> MEGHANN LUCZKOWSKI: It's Meghann. Sorry, Kyle. Did you want to say something?
>> KYLE FISHER: No, go ahead.
>> MEGHANN LUCZKOWSKI: Just to sort of a data question to be sure we're clear what we're looking -- what the ingredients are.
Do you know if the denials would include, for instance, in a continuation of services for shift care, often times what a member would consider a denial, a plan would consider approved other than requested. So maybe the service was approved, but it wasn't the amount of hours or level of flexibility, et cetera.
Would that be captured in denials? And are we sure that -- if it is captured in denials, if it's captured in denials across plans? Are they all reporting that in the same way?
>> GWENDOLYN ZANDER: I want to go back and double check the data definitions before I answer you. We will take that as a follow-up to see how approved other than requested was reflected in numerators across plans. Thanks, Meghann.
>> MEGHANN LUCZKOWSKI: Great. I appreciate that. I know that's probably a tricky question. If we could get clarification, I think that would be helpful in mitigating the numbers too.
>> GWENDOLYN ZANDER: We'll follow up on that.
>> MEGHANN LUCZKOWSKI: Thanks.
>> GWENDOLYN ZANDER: So then if it's all right, I would like to move to the next slide. We

have the same information, but instead of looking at home health aid denials, here we're looking at the skilled nursing denials, again, over the quarters throughout 2023.
Sorry for the slightly wacky formatting here.
Again, you're seeing a similar trend here from Q2 to Q4, we have seen a decrease, a pretty marked decrease in the denial rates for skilled nursing requests here.
So pretty similar to what you saw on the other slide. The distribution from plan to plan, it's a little more concentrated here, a little more consistent. So that's something for us to use as a bit of a clue as well when we're working with those MCOs to determine whether they are applying the guidance correctly and considering all the right things is to look at the difference in their processes between skilled nursing and home health aid requests to see why they may be approving more skilled nursing requests as opposed to home health aid requests.
We'll continue to dig into this. But again, I think it's encouraging to see the direction of the numbers have gone over the last couple of quarters.
Any questions on this one?
All right. Then we can go ahead to the next slide.
Now we're getting away from just the denial rates and we're going to start talking about overturn rates when something is appealed.
So this chart shows you the overturn rates by appeal type. So you have got grievances, expedited grievances, external reviews, and fair hearings. This is across quarters. Again, this is for all Prior Auth denial overturn rates.
So you can see that the overturn rates are pretty consistent within each category across quarters. Not a ton of variation there. And you can see that on fair hearing, not a very high overturn rate. But on, for example, expedited grievance, pretty high overturn rate. So this is just to give you some context, again, for all Prior Auth overturn rates before we dig into looking at the overturn rates for home health aid and shift care services or skilled nursing, excuse me.
So on the next slide, this one I think I probably won't spend a lot of time talking about these ones. But I want you to know that you have access to the raw data for those who are interested in it. I know I myself when I look at charts that are showing me percentages, I like to know percent of what for context. I thought there might be some of you who are similar to me in that way and wanted to provide this data.
>> KYLE FISHER: Just a note on that one, and I agree we shouldn't spend a lot of time on it. Some of the numbers suggested that we could be apples and oranges. For instance, the high mark total Prior Auth numbers seem disproportionately large. And I know data integrity is always difficult with a project like this having the plans and ensuring the plans are submitting the same responses or understanding the responses in the same way. But we can circle back to you on this, some of the numbers seem a little surprising.
>> GWENDOLYN ZANDER: We agree. And we're continuing to work through validation. I had to make a decision about whether to display what we had or whether to suppress

numbers that I wasn't completely confident with. But we're going to keep working on this. And we will reissue corrected slides if needed.
>> MEGHANN LUCZKOWSKI: I'm going to interject for one minute. This is Meghann. I appreciate the transparency. I think that this is -- what you just said, you're not 100% confident that maybe the -- they were reported in the same way, but you're sharing it. And we appreciate that and can revisit it. And also bless your heart for making all this.
>> GWENDOLYN ZANDER: I used to live in Tennessee. Thanks, Meghann.
>> MEGHANN LUCZKOWSKI: This is such -- this is a labor of love here. We can see it. So thank you.
>> GWENDOLYN ZANDER: Of course. I will extend the thanks to my wonderful team who really put in, as you can imagine, some hours to try to put this together. But we will keep working on it and get it finessed and to a place where we can call it done.
In the interest of time, I will kind of keep moving along. And I may skip a couple of these slides. This chart, for example, again, these are just the raw numbers that support some of the graphs that you will see here soon. I think we can keep moving.
We'll keep moving.
Here we go. Okay.
So these are grievances for all Prior Auths broken out my MCO showing the overturn rate and the disposition. So like you kind of noted, the raw numbers are a bit strange. For example, when I look at United here, this one gives me some question marks because I have to wonder how a plan that has about 5% or less of our health choices membership across the state had this many grievances filed. But this is kind of intended to just show you whether grievances were overturned, partially overturned, upheld, or withdrawn or dismissed.
So I think this is a bit of a noisy slide, but you can see that there's an interesting break down between what's overturned and what's upheld here. So there's a little chart over on the side meant to give you just kind of the key take aways, the overturn rate for all grievances. And you can just see how that varies across MCOs.
Again, this is for all Prior Auth. So this is another kind of table setting slide with the rates going anywhere from just under 7.5% that get overturned to over 35% that get overturned on a grievance.
And it is noteworthy to us that the MCOs with the highest overturn rates are also the MCOs with the highest denial rates. And again, that's true for all Prior Auths. So just something to notice here.
On the next slide, we get into expedited grievances. So again, I'm not going to spend a ton of time on this. I wanted to explain how you can look at the slide and what you can draw from it and what you can see here is the expedited grievances are more likely to be overturned than regular grievances. So that was interesting to us as well.
On the next slide, we look at all Prior Auths. Again, this is not just specific to shift care. But denial overturn rates. And so you can see how it goes from the different types of

grievances in orange. Expedited grievances in gray. External review in yellow. And fair hearings in blue. I notice that expedited grievances, you can definitely see that some of those gray columns are pretty large. So the overturn rate for expedited grievances appears to be quite high for several MCOs. Where as we noted earlier in the presentation, the fair hearing overturn rate tends to be lower.
I do want to note it's important to remember the context of denominators here. 0% of 0 is 0. So if there were not any fair hearings, then that would be the reason that you would see nothing there.
So we can move on to the next slide here.
This one is while we were last looking at all prior authorizations, this one shows you home health aid. And again, I want to caution you that 100% of 3, if the denominator was only 3 and you saw all three of them overturned that it's going to look like 100% even if it was a small number. That's just something to keep in mind when you're looking at these things that it may be an issue of small numbers kind of making the data look a little bit noisy.
The next slide has the same information for skilled nursing. And so yeah, same notes just about some of those large percentages as a result of small denominators.
We can keep going.
>> KYLE FISHER: Just a couple of quick comments. We're getting some background noise. Please mute if you're not speaking. Thanks.
The expedited grievance data was somewhat shocking, surprisingly high. One piece that was a little alarming was the number of appeals that were either withdrawn or approved administratively for some of the MCOs. And I guess we would flag that as another for potential investigation. Some of those numbers were I think on the skilled nursing slide in particular, slide nine, were surprisingly high.
>> GWENDOLYN ZANDER: Thanks for flagging that, Kyle. We'll go back and look further.
>> MEGHANN LUCZKOWSKI: This is Meghann. I would just say for expedited grievances, I would guess, my educated guess would be that would inherently be overturned and have a higher likelihood of being overturned than other grievances. If they're approved for an expedited process, they're emergent in some way and there's proof that that is something that should not have been denied. If that makes sense. It wouldn't shock me from a data perspective to see expedited grievances overturned at a higher rate.
And I might have read the slide wrong, but I was surprised to see the external reviews were at 0% for a couple of plans for overturns. That would be another thing I would look deeper into.
>> GWENDOLYN ZANDER: Thanks. I'm taking notes of all of these things. I appreciate it.
So I think that actually brought me to the end of the slides. So am I right, folks driving the slides? I think I am at the end. I know I had until 1:50.
>> ELISE GREGORY: That is the last slide.
>> GWENDOLYN ZANDER: Thanks. I'm cutting in just under the end of time here.
Any final questions or comments? I guess my parting observations would be I have

mentioned some of the limitations and some of the things that we need to still verify. We'll certainly do that and can reissue corrective slides if needed.
Overall, pretty heartened to see the impact that policy changes and further training in 2023 had. And yeah, some more things for us to sleuth into.
So thank you. We really appreciate your gratitude for this. But we also appreciate you helping us find things that are important to you to be monitoring closely. This was a positive exercise for us as well.
>> KYLE FISHER: Thank you so much. Interesting data and important data. We appreciate your team putting so much time into this and presenting it publicly in the way you have.
I think one other piece we talked about and I think you may have seen this in the MACPAC recommendations issued recently is increased transparency on these issues. I know we had conversation earlier, especially in the context of the Keystone and CHOP conversations with families wondering if I'm changing plans, where should I go? And what plans are going to improve the services I already have in place? And data along the lines of what you just showed, the denial rate, the appeal overturn rates from the MCOs I think will be really valuable for all of the Medicaid families out there asking these questions.
I know the MACPAR reports are posted publicly. I suspect you appreciate that they're not the easiest to sleuth through. So I think if the Department could give some thought to how this type of data might be posted in a way that's accessible to consumers, we think that type of transparency would be --
[indiscernible]
>> GWENDOLYN ZANDER: Thanks, Kyle. We will be reviewing the recommendations and giving thought to what we can do to adopt some of those, the ones that we think add value. And certainly hear you that this is something that would be valuable to consumers.
>> MEGHANN LUCZKOWSKI: Yeah. This is Meghann. I will reiterate what Kyle said on the boots on the ground level. Those are the things that members are really interested in knowing. These are the things that we're by and large hearing members concerned about. Just trying to figure out -- it's the kind of questions they ask each other. We have all these providers, but the big thing is nursing. Who is most likely to approve our nursing? Who is going to be the easiest to get the DME supplies we need?
So just that consumer-driven accessible level of information. Or even what plans are on corrective action, knowing which plans have been maybe in hot water for one thing or another. It's very, very valuable information when we're talking about consumer choice and education. It's something to think about.
>> GWENDOLYN ZANDER: Thanks, Meghann.
>> LIZ HEALEY: I absolutely agree. I really think that having this information be accessible to families, especially thinking that some families need to be making a choice soon, this would be critical in helping them select a plan to best support their son or daughter.
>> GWENDOLYN ZANDER: Thank you all for your patience with me as I walked us through those very dense slides. Much appreciated. And I'm happy to hear from any of you with

further questions you have or more observations as you keep sifting through the data.
>> ELISE GREGORY: We had one question in the chat.
>> GWENDOLYN ZANDER: Of course.
>> ELISE GREGORY: It's from Michelle Cohen. Is the state required to track reasons for denials?
>> GWENDOLYN ZANDER: I will have to take that back. I don't believe that we do track that. But I need to confirm that with my staff.
>> ELISE GREGORY: There are no more questions in the chat at this time.
>> MEGHANN LUCZKOWSKI: Thanks so much, Gwen. We do appreciate the level of detail and your patience with presenting it for us. And your willingness to continuously just engage in conversation and it is, you're right, it's been -- while there's still work to do, it's promising to see that some of the guidances and updated policies that the department put out looks like it's moving the needle. It's appreciated.
>> KYLE FISHER: I will second that. I think the data also gives us a sense of a scale, the enormity of the issue looking at raw data showing hundreds of thousands of denials. And sort of the task that you and your team have in monitoring this program is very much appreciated the work you're putting in here.
Okay. I think we have OIM up next.

- **OIM Report**
  - **Unwinding Updates**

>> CARL FELDMAN: Good afternoon. This is Carl Feldman. Can you hear me?
>> KYLE FISHER: We can. Thanks for joining us.
>> CARL FELDMAN: Yes. All right. I have a series of questions that were asked --
>> KYLE FISHER: Carl, I'm sorry, your audio faded out. I don't know if the microphone is further away now.
>> CARL FELDMAN: Test, test, test. How is this?
>> KYLE FISHER: Much better.
>> CARL FELDMAN: All right. This series of questions that we'll try and answer for you today starting with kind of general update on unwinding.
I think that the important thing to know about the unwinding today is that we're very close to having completed renewal actions for all individuals with the renewal due date within the unwinding period. So those were renewals going from April of 2023 until March of 2024. The State has set aside until mid-June to ensure that we have all of the renewal processing associated with those unwinding renewals to be completed. But we expect to hopefully be done if not on time, a little earlier than that.
We think that the remaining figure is down around about 60,000 renewals to take care of. It might be the case that the last 5% or so takes longer. We don't really know.
But overall, we're very satisfied with the pace. And we are happy that we have some

additional kind of space and time to ensure that we can get everything done that we need to get done.
I think that that is the general unwinding update.
Do you have questions about that? Or shall I move on to the requests that you had around the Pitt study?
>> KYLE FISHER: You have a particular request around children's data and some of the items around that. I don't know if any of the committee members have questions about the wrapup of the unwinding?
Doesn't sound like it. Thank you.

- **Disenrollment & Ex Parte Review Surveys**

>> CARL FELDMAN: Okay. You asked us about a Pitt study that we are doing on an analysis of closures. And we are going to have information about that to share in the next month. The study solicits participation of people who experienced a closure over the course of the unwinding period by text and by phone. We're still trying to add more people into the survey that we're conducting. It asks how they get their information, what they understand about why they were disenrolled. It segments them by cohorts into if they were individuals that returned to coverage or not.
And we think that this will be useful and instructive in trying to determine how to make changes into the future around our policies and our ways of communicating with clients. So that's the intent of the survey. It's really to learn about how people understand what is happening to them and whether that can tell us something about how we need to communicate with them.
So that's the study side of it.
I think you have also asked about our analysis of closures and manual ex parte reviews. We have been conducting an ad hoc evaluation of about 50 cases monthly to determine if the manual ex parte reviews that workers are conducting are being done appropriately. As you have heard me say, our policy on ex parte has changed pretty significantly over the course of the unwinding period. And honestly, will probably continue to change and evolve as we move toward full compliance with CMS's required compliance deadline of April of 2026.
The review has shown that pretty much when we take errors, there's typically fewer than ten, and those errors are most frequently a failure of the worker to upload the ex parte checklist to imaging and have that available in the case record.
There is a smaller portion of cases that are closed incorrectly every month. So for example, for the month of February out of 50 cases, only two cases were closed incorrectly.
Given the scope of the changes that have occurred related to ex parte policy, we think that overall this is a good indication that workers are being diligent and attempting to follow the policy and for the most part not making inappropriate closures.
>> KYLE FISHER: A question related to the Pitt study, just to go back one topic here. Can you

tell us again when you expect results from that, to be able to release anything? And what was the sample size of the participants?
>> CARL FELDMAN: We expect results in the month of May. Next month, we expect to have results. And I don't know what the sample size is. But I will take a note to find out. I know that they're still adding people because they want a larger sample.
>> KYLE FISHER: Okay. Encouraging that the department is looking into how it can do all of these things better. Obviously, the ex parte mitigation plans has gotten a lot of attention recently. We are pleased to hear that you're looking more broadly of all of the procedural terminations and outreach to impacted members to see what might make a difference and improve the process going forward.

- **MAWD**

>> CARL FELDMAN: I will move on to discuss our MAWD activities recently. So you asked about the MAWD outreach to individuals who have lost their eligibility who might be MAWD eligible. If you remember, we initiated doing an analysis of this population to see who was potentially MAWD eligible, but not opened in MAWD. And so far as we could tell, not reviewed for MAWD. With those that had home and community-based services because you could receive waiver with MAWD. And that action is complete.
And then there are the individuals who are not receiving waiver, but that doesn't change the importance, I'm sure, of their coverage to their daily life. And there are around 2,000 individuals for whom we're doing outreach for in that category. And this will be handled through a letter sent to them giving them information about their potential MAWD eligibility and the willingness of the department to reopen them in MAWD if they provide us everything necessary for MAWD eligibility and they are willing to consent to the premium associated with the MAWD program. That will be in the form of a letter.
>> KYLE FISHER: Carl, can you explain how the 2,000 or so were identified?
>> CARL FELDMAN: It is individuals who have a certified disability and closed for having earned income. So the idea is they closed because they were making enough -- they were making money that made them not eligible for the benefit. And they have a certified disability. So in theory, this is the group of people that is more likely to be MAWD eligible. Though not necessarily. There might be a resource issue or something else.
>> KYLE FISHER: I'm assumed you separate identified the population under 65.
>> CARL FELDMAN: We made sure that we targeted the appropriate age range.
>> KYLE FISHER: Okay. I think very encouraging. I think you know this is not a population that we had as a committee focused on. We had sort of identified the waiver population of lost benefits. We appreciate DHS's outreach on this. Hopefully many of the past recipients who received this will understand and be able to come back on to these benefits of this program.
When were those letters being mailed? Or have they been mailed?

>> KYLE FISHER: Do you have a time frame?
>> CARL FELDMAN: I do not know when the mail will be able to go for this. It's part of a kind of hierarchy of messages that we're sending to people terminated since April of last year.
>> CARL FELDMAN: Everyone who is terminated since April of last year up until I believe February, beginning of February.terminated and then made their way back on to Medicaid?
To see if there were people who -- well, I mean I guess I
>> CARL FELDMAN: We didn't exclude anyone.
>> AMY: Okay.
>> CARL FELDMAN: If they -- I think this was in the
>> AMY: Okay. These are the people not on Medicaid currently at all?
>> CARL FELDMAN: This list of people is people not on Medicaid. Yes.
>> AMY: Okay.
>> LIZ HEALEY: This is Liz. I have -- will you mail them in a way that you're going to know whether they received it or not? Are there several different designations you can use. One is the post office has to tell you that it was undeliverable or return receipt requested. So that you know that these people in fact got your message?
>> CARL FELDMAN: I think that our mailings like this are done first class.
>> MARSHA WHITE-MATHIS: I have a question. Can you hear me?
Yes. So the mail is not deliverable and it comes back to the State, what happens to that mail and to the names on the letters that got returned?
>> CARL FELDMAN: It's a mix of what happens depending on what the mailing is, where the return address is, when we receive it. So for example, if there's a piece of mail that was sent out that has as the return address the CAO and it's something like a notice or even a renewal packet, you can read our end of COVID PHE ofs memo which provides detailed instructions about what the CAO needs to do when they receive that return mail.
Unfortunately, a lot of the time that we receive return mail it comes pretty significantly later than it was initially sent out, well beyond the time period for which the response was needed.
So in that instance, I don't have it in front of me, but if you read the policy, it describes what to do.
Mailings such as this where there is not a requirement that the person respond have return addresses to the headquarters office in Harrisburg, mostly because we don't want to drive negative actions based on that returned mail that was not necessary.
So for example, if we get return mail for someone and you follow the procedures in the Ops memo, it might result in someone's eligibility being brought into question. So for that reason, we are judicious about what we set as a return mail address.
So this is a nonessential mailing. And I think that we have the headquarters address as the return address. So if we receive this return mail, we're going to shred it.
>> MARSHA WHITE-MATHIS: Thank you for explaining that.
>> CARL FELDMAN: So you had specific questions about the HCVS group that we can go

into. Specifically you asked did the people in the HCBS group cover individuals whose closed since the unwinding began, including prior to the data run. The number included the recipients between the age of 16 and 65 whose benefits were closed since the unwinding began.
Only you asked about people who appear to be properly closed because of potentially resource issues. And were those with resources advised they remain closed due to resources. And people whose benefits were closed due to resources received the appropriate closure for resources notice in the first place. There's nothing additional to say to them.
You asked about people on MA but not on HCBS. How many are in a nursing facility category? And none of them are showing to be in a nursing facility.
There are ten on base funding. There were 16 individuals that are on MA, but not HCBS or base funding. And the reason that we did not do anything additional with these cases was we had information to show that MAWD had been reviewed.
>> KYLE FISHER: Just to pause on that. So for individuals who are on MA, but no longer on waiver, I'm not fully following that. No outreach was done to them because you already believe they had been screened for MAWD?
>> CARL FELDMAN: We believe the policy was followed. Yes.
>> MINTA LIVENGOOD: This is Minta Livengood. Kyle, can you say something?
>> KYLE FISHER: Go ahead.
>> MINTA LIVENGOOD: I have a question. People that's 50 and older that is mail determined ineligible for Medicaid but has medical issues, they are not being informed about MAWD. They are being informed about Pennie. But MAWD would be a better route for the person because even though they're not eligible for Medicaid, it's because they're a little bit over the guidelines for Medicaid versus -- and they do have medical issues. They are not being notified of that.
>> CARL FELDMAN: Thanks, Minta. I think you have identified the crux of the issue and the reason the consumer subcommittee was interested in this and the PHOP is interested in this. Which is that MAWD is not necessarily widely known among the MA population.
I will say it does have some specific eligibility criteria that make it not the same as normal eligibility. There is a premium that someone needs to pay to receive their MAWD coverage. That's one big difference. You have to be receiving earned income. So you have to be working is another one.
And then also the MAWD program requires that not just that you may have any medical issue, but that you have a medical issue which rises to the level of a certified disability by the SSI standards, which is a higher threshold than what I think some people might see as a disability. Not that I would dispute that they have one, but that's the standard set out by the program.
>> MINTA LIVENGOOD: Also there's a process of if they're sustaining medications that would prevent them from working and they are working, this person is working, if they're

sustaining medication and they do not receive that medication, they would definitely be not working. The health issues -- so I do know that is a process. But -- and as for a lot of assets, the person didn't have it, I am working with this person to get them all the paperwork that's needed to prove their disability. They have applied for disability, but have not been approved for disability. Which they received a good many years ago. But was taken off because they managed to maintain their health by taking their medication. considered to be certified disabled up to the SSI standard. But it isn't a guarantee every time.
>> KYLE FISHER: Go ahead, Amy.
>> AMY: I wanted to circle back -- I'm sorry, Liz.
>> LIZ HEALEY: I have a quick question. I believe with MAWD, one of the other differences between MAWD and regular medical assistance in addition to having to pay a premium is there's a higher resource limit. Isn't that true?
>> CARL FELDMAN: I mean, there is a higher resource limit for MAWD. I was just mentioning that those three differences are differences I think that often are why MAWD stands separate from the rest of the medical assistance categories that we offer. The higher resource threshold is a benefit to the client, of course. Whereas in the case of the premium, the fact that they have to have that earned income, that narrows the population who might be eligible and the certified disability also narrows who might be able to receive this too.
>> LIZ HEALEY: I was just wondering. When you said that there was a group of people determined ineligible and one of the reasons you gave was they were overresourced. Well,
>> CARL FELDMAN: MAWD still has a resource threshold. And some people are not eligible for it because of that reason.
>> LIZ HEALEY: Thank you.
>> AMY: I wanted to circle back to the ten people on base funding and the 16 on regular Medicaid.
Is there any follow-up being done for the people who Medicaid.
>> CARL FELDMAN: I mean, they were contacted -- well, this is the group that was not contacted. I don't know
>> AMY: Why weren't they contacted?
>> CARL FELDMAN: I mean, they're getting base services from their county. We can continue to look into it. But that's why it was handled that way.
>> AMY: I think the point was to find out why people lost waiver. Getting base funding is not even close to being able to get waiver services. It seems they should have also been contacted to see if they were interested in MAWD. Because they are essentially people terminated from waiver who might have been MAWD eligible.
And I had the same question about the 16 on Medicaid, but not on waiver. You said they were properly reviewed for MAWD. I don't understand why they are on Medicaid and not waiver.

>> CARL FELDMAN: Maybe they're no longer functionally eligible for waiver, something like that.
>> AMY: 16 is a lot of people. Can there be functional eligibility reason, there's no reason they wouldn't be on waiver right now.
>> CARL FELDMAN: I wouldn't say that. But we definitely can continue to look into it.
>> AMY: I can't think of any reason someone would be eligible for Medicaid and not -- because remember these people -- and not waiver. Because the limit -- I mean, maybe there was a resource limit. I don't know. I think those need to be looked at.
The last question I had quickly was I wanted to confirm that DHS looked at everybody who is in HCBS category and potentially eligible for MAWD, not just people in CHC waiver. So it could have been someone in
>> CARL FELDMAN: I will confirm this for you. I think that we did look at it beyond CHC specifically. This came up in the last meeting and we said so. But let me double
>> AMY: Thank you. I think those 26 people are who I think a little bit more information is needed and a little more follow-up to find out why they're not on waiver.
>> CARL FELDMAN: We'll continue to review those cases.
>> AMY: Thank you.
>> CARL FELDMAN: The next thing that you asked about was -- review terminations since the original 78 were identified. Yes, that's what we discussed with the additional 2,000 for whom the outreach letter will be sent to them.
And then regarding preventing inappropriate terminations from continuing, we're doing a training for caseworkers on MAWD. And we have requested system enhancements for MAWD. And at this time, it's not prioritized for implementation.
>> KYLE FISHER: When we first started talking about it, I think the HCBS and MAWD population, the outreach some of the system struggles with allowing these cases or these two benefits to be authorized simultaneously. I thought there had been a system enhancement scheduled for this spring or this month. Is that incorrect? Or was that something just bumped back because of competing priorities? Can you speak to the time frame for it now?
>> CARL FELDMAN: I don't -- I think that we -- we have had changes that we would like to do on this for a while. We don't have anything that was released for the spring for this. And I think we certainly said before there are things that we would like to get and we would like to get them at the time that we discussed it, I think we said in the spring. But that's not what was possible.
>> KYLE FISHER: Is there an updated time frame for when they might go through?
>> CARL FELDMAN: We would like to get them on our next available set of change requests. But I can't say that they will ultimately be prioritized.

- **Children Data & CHIP Transfers**

>> KYLE FISHER: Okay. I think last item we had, and appreciate your time this afternoon, pertains to terminations for children under 21 and transitions.
>> CARL FELDMAN: Yes. So you requested the total number of children under 21 who had their MA closed during the unwinding. I don't think that that's information that we currently have for the same reason we wouldn't be able to tell you who was determined ineligible and who is closed procedurally.
>> KYLE FISHER: I guess could you elaborate on that, Carl? Obviously, the department is posting some month by month numbers of children under 21 who had benefits closed.
>> CARL FELDMAN: I think the best thing that I would direct you to is the final monthly unwinding renewals outcomes. You can see break downs in that by age cohort, by gender, by ethnicity, and by county. I think that would be the most useful thing to correspond to what you're asking for.
But I don't think it's exactly what you're asking for.
>> KYLE FISHER: And are you unable to aggregate the numbers because you think there's duplication and some of these children may have re-enrolled and may have been terminated again?
>> CARL FELDMAN: It's not a report we have. It's not something that we can make available to you immediately.
>> LIZ HEALEY: This is Liz. I don't know if Gwen Zander is still on. But Nicole Harris -- because one of the questions was how many children actually lost health insurance. That would mean knowing how many who may have lost medical assistance but transitioned on to CHIP.
And Nicole Harris a month or so ago told me that they were tracking that information.
>> CARL FELDMAN: They are tracking what information?
>> LIZ HEALEY: Number of children who lost medical assistance and went on CHIP.
>> CARL FELDMAN: That's good. I don't have that available to share with you. It's not something that I'm familiar with. I think that the final unwinding information would probably be the most useful information here. And if you were to scroll to that, what you would find is that for individuals age 0 to 20, the number and percent that remained eligible month over month, you could do the math I think to get the information that you're looking for for the months available, which is currently only posted through November of 2023.
But the rest of the months should be posted there. And that would give you -- especially to the question of how many lost coverage and stayed without coverage. I think that would actually be pretty much what you're looking for. That's what this is showing. So I haven't done the math on that. But it's a public website. And you can just table it up.
>> SALLY KOZAK: So this is Sally, Liz. They're trying to unmute Nicole. She's on the other side. I believe what she can share with you is the number of children that came over to MA

-- or to CHIP from MA, which is different than the number of children that technically lost MA eligibility.
>> NICOLE HARRIS: Hi, Sally, it's Nicole. You are right. That's the number, how many kids transitioned from MA to the CHIP program. I don't have the number of how many kids lost MA eligibility throughout the unwinding.
>> CARL FELDMAN: Yeah. I think the final unwinding outcome is the best to answer the question how many last coverage. That really kind of tells the totals there. It's just that I'm a little frustrated to see that we only have posted until November. But the same thing is available on the Federal reports if you look at the updated Federal report. And I think that should go further. And then the final month of reporting would have been for March. So as long as that's posted, you should be able to do the math and just add that up.
>> LIZ HEALEY: And where is that posted?
>> CARL FELDMAN: On DHS.PA.gov. And on the right hand side, there's a panel, the one that says federal unwinding reports. That's what I think I would direct you to.
It looks like the CMS refresh is only showing until December right now. So we still have additional months that we need to add.
Actually, sorry, you have to use the final unwinding reports, which means we definitely need to make sure that's updated. The Federal one doesn't segment by age. But our update of it does segment by age.
>> LIZ HEALEY: Okay.
>> KYLE FISHER: Sounded like Nicole, if we can go back, you do have data available? Can you share the number of children who transitioned on to CHIP from Medicaid in the unwinding?
>> NICOLE HARRIS: Yep. We can pull that number. We do it by month. If you would like to see -- tell me how many months you would like to see, and we can give you a total if that's what I would like.
>> LIZ HEALEY: I think since the beginning of the unwinding would be really helpful. Thank you.
>> NICOLE HARRIS: We will work on that.
>> LIZ HEALEY: Okay. Thank you.
>> CARL FELDMAN: The next question asked was how many returned to MA within four months of closure. That's not a figure that we have available to share. Or at all.
How many were reopened in MA as a part of ex parte mitigation activity? We do have this information. There were 21,323 that were reopened.
>> LIZ HEALEY: Children?
>> CARL FELDMAN: Yes, children. I think the total -- the denominator there was 47,000. So about half. A little under half.
We talked about CHIP.
And then I think you asked how many had TPO at the time of the MA closure, and that's not information that we have.

>> KYLE FISHER: I don't know if the committee members have more questions on this topic that Carl might be able to answer?
>> LIZ HEALEY: I think we can try and do the math from the website and we'll see whether we come back with more questions after that. If we can get through the calculations. Thank you, Carl.
>> CARL FELDMAN: Yes. And we'll take a note to try and get as many months as we have available posted too. It's helpful in pointing out to me that we don't have everything online yet that we should have online.
>> KYLE FISHER: Okay. I think that closes the OIM section. Thanks for your time this afternoon.
>> CARL FELDMAN: Have a good afternoon.
>> KYLE FISHER: All right. I think we have OLTL. Do we have the deputy secretary, Juliet?

- **OLTL Report**
  - **CHC Waiver Renewal**
  - **PAS Direct Care Worker Rate Studies**
  - **PAS Direct Care Worker Matching System/ Directory**

>> MONTRELL FLETCHER: Juliet had a conflict. So you get me.
Good afternoon, this is Montrell Fletcher, executive assistant in the office of long-term living. I will be covering the OLTL updates today.
As you can see on the agenda, we have our procurement update. The committee was interested in hearing about the past direct care worker rate study. We'll also be covering the PAS direct care worker matching system, slash, directory.
The recommendations for improving the self-direction in community health choices report that was recently released.
And then a quick cover of the dental benefit limit exceptions.
Next slide.
And one more.
So as you can see, this is our general slide. As of today, we don't have any updates on the CHC RFA, agency with choice, as well as the IEB procurement. As of today, all of those updates remain the same. And any updates that we do have will be posted to E-marketplace.
Next slide.
All right. So I'm sure most of you are aware, but the general assembly directed OLTL and DHS to do worker rate studies. So for this year, we will begin working -- well, actually, we have already begun, but just looking at rates in general. So we'll begin with the 2015 fee development assumptions. And we have been working very closely with our actuary Mercer to do a crosswalk to program service description changes and update the current wage information.

So I know the question has been asked how much engagement will we have with stakeholders. And I think Juliet has been pretty clear in we want to get this completed, but we will have some stakeholder engagement, but not the lengthy engagement process that we would typically want to have.
So next up, you can see the time line. So like I said, we have already begun these discussions. And tentatively, we are looking to engage stakeholders in May of this year. So within a couple of weeks.
Coming up in June, we will launch a provider survey spanning from June to July. We'll have a follow-up stakeholder session. And then from there, Mercer will provide my preliminary market based rate ranges for the services identified. In hopes to have this be impacted for the July 31, 2024, fiscal year.
Next slide.
And this slide just covers the -- I'm sorry, was there a question?
>> KYLE FISHER: Lauren, did you have a question for Montrell? That might have been inadvertent.
I actually have a question since we paused. The study you just covered, is it encompassing CHC rates? Or only the fee for service programs?
>> MONTRELL FLETCHER: That is a good question. I believe it is for the fee for service. And as you can see, we are going to be covering adult day -- so the service categories that we'll be covering will include adult day, structured Res Hab. Personal assistance, employment, and training services. And -- yeah, structured day habilitation. So we're not going to focus on all 32 waiver services, but only the ones reflected here on the slide.
Next slide.
All right. And the committee -- sorry, one second.
The committee was curious about the PAS direct care worker matching system. And just as a quick update, we have the requirements outlined in the draft CHC agreement. And just to let you all know the process for procuring a vendor is strictly within the hands of the CHC MCOs and OLTL has no involvement in any vendor selection. Or that vendor selection process.
Next up, we have recommendations for improving self-direction in community health choices. This was a project assembled to identify challenges experienced by stakeholders. And the work group that was put together we're looking at potential reasons for the decrease in utilization of the self-direction program.
So what they did was they looked at the decreases and then came up with recommendations for potentially increasing enrollment in the self-direction program.
So the work group consisted of CLEs, common law employers, direct care workers, service coordinators, representatives from both Tempus and HHA. The CHC MCOs, and service authorization vendors. As well as two leaders from each of the CHC-MCOs and three representatives from the service employees international union, SEIU, and five representatives from OLTL.

So the work group was pretty extensive. And had representation from all areas.
Just briefly, the work group did meet and have six meetings to gather feedback from its members. And the work group walked through steps required to enroll in self-direction and identify multiple barriers that serve to make self-direction challenging. These barriers were grouped into the following categories, which were direct care workers, technology barriers, education and outreach materials, CLE support, CHC-MCO barriers, Tempus barriers, and other miscellaneous barriers.
I won't bore you with going through the whole report, but as you can see, it's been released. You can view it at your leisure.
Next slide.
And lastly, this was a last question that the committee had around any dental benefit limit exceptions for OLTL. So as you can see, CHC dental supplement manual, the supplement manual for 2024 didn't have any changes in the benefit period compared to 2023. And at this point in time, CHC does not include any dental BLEs.
And I believe -- go ahead.
>> KYLE FISHER: Thanks. On that last piece, I'm not sure I fully understand what you mean by that. Dental BLEs are available to CHC members, right? This is part of the state plan. Are you saying none of the CHC-MCOs are offering any additional benefits at the moment?
>> MONTRELL FLETCHER: Yes, I believe that was the case. But I will certainly take that back and provide some additional clarification.
>> KYLE FISHER: Okay. Thank you.
Committee members? I know Montrell covered a fair amount there.
Montrell, I believe you covered at the outset a couple of different rate studies, with the second one the department is under taking a list of a dozen or more waiver services. My question around whether these pertain to the fee for service waivers or CHC, is that true for both the rate studies that they're limited to OBRA, Act 150, other programs? Or is it one or the other?
>> MONTRELL FLETCHER: I think the other one is rates in general. And seeing how they impact the program. So we are working with Mercer on both. It's just that one is a wage study and the other is more of a rate study.
>> KYLE FISHER: Any of the consumers have questions?
It's a rare meeting. We may have wrapped up before 3:00.
>> ELISE GREGORY: There is one question in the chat, Kyle.
Is there a deadline to make decisions regarding awarding the contracts for CHC-MCOs? That's from Elizabeth R.
>> MONTRELL FLETCHER: Unfortunately, I cannot answer that question as we're in a blackout period.
>> ELISE GREGORY: There are no more questions in the chat at this time.
>> KYLE FISHER: Okay. Thank you, Montrell, for your time this afternoon. We moved quickly here.

>> MONTRELL FLETCHER: Thank you all.
>> KYLE FISHER: All right. I know our chair is on, Sonia, any comments? Any additional items from your end before we close?
Okay. All right. So for everyone, our next meeting is going to be in person May 22nd. Elise, please correct me if I'm off on the date there.
>> ELISE GREGORY: That is the correct date, Kyle.
>> KYLE FISHER: Okay. And building and room?
>> ELISE GREGORY: It's the Keystone building. And it is the Forest Room. It's on the first floor when you get to the Atrium. Look for the learning center.
>> KYLE FISHER: Thank you very much. Okay. Thank you, everyone, on the department side for your presentations this afternoon. We certainly appreciate it. Thank you consumers. And audience members for attending. I believe this meeting is adjourned.
>> LIZ HEALEY: Do we need a motion to adjourn?
>> MARSHA WHITE-MATHIS: I make the motion.
>> LIZ HEALEY: I will second. This is Liz. I will second it.

The meeting adjourned at 3:45pm.