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Date: 11/4/2026

Event: Long-Term Services and Supports Subcommittee Meeting

>>MATT SEELEY: I guess I can just keep talking. Anybody else want to talk.
>>PAM WALZ: Hi I'm here you can talk.
>>MATT SEELEY: I'm like really annoyed today. These agencies. Maybe we should start naming the agencies on these calls. What do you think about that Juliet?
>> NATALIA GOMEZ: I think it is more than just the agency Matt.
>>MATT SEELEY: Oh I know you are right Natalia. But the agency is a very low hanging fruit.
>>PAM WALZ: I'm sorry among other things Owen can't go out. I hope he is okay.
>>MATT SEELEY: You know, he will make do. He has had some -- it is not good for him. I don't want to make excuses. It is not going to be good for him. But,we are working on that on the side. 10 o'clock.
Good everyone. My name is Matt Seeley I'm the chair of the LTSS oh I can look at my phone screen I don't know the rest of the thing but today is November 4th. The day after election day congratulations everyone. And we are here for the November 4th, LTSS meeting. Thank you that is really small though. With that, I will pass it over to Pam.
>>PAM WALZ: Okay. Great. Can everybody hear me? Matt you can hear me.
>>MATT SEELEY: Yes.
>>PAM WALZ: Okay. Great. Just to begin with, and this is Pam Walz. This meeting is being recorded. Your participation in this meeting is your consent to being recorded and with that I will start the attendance. I know Matt is here. Abigail Foster.
>> ABIGAIL FOSTER: Good morning.
>> PAM WALZ: Ali Kronley.
>> ALI KRONLEY: Good morning I'm here.
>> PAM WALZ: Andrea Costello. Is Austin Coley here for Anna Warheit? Yes. Carol Marfisi I think I saw an e-mail she couldn't attend today. Carol?
Neil Brady?
>> NEIL BRADY: Good morning everyone.
>> PAM WALZ: Good morning. George Fernandez? Jay Harner?
>> JAY HARNER: Good morning.
>> PAM WALZ: Good morning. Kathy Cubit.
>> KATHY CUBIT: Good morning this is Kathy.
>> PAM WALZ: Hi Kathy. Laura Lyons? Linda Litton? Lloyd Wertz? Lynn Weidner?
>> LYNN WEIDNER: Good morning I'm here.
>> JULIET MARSALA: I see Lloyd on the people list.
>> PAM WALZ: Okay. Great. Chell Garrett?
>> CHELL GARRETT: Hi this is Chell.
>> PAM WALZ Hi. Okay. Padraig Tangney
>> PADRAIG TANGNEY: Yes I'm here good morning.
>> PAM WALZ: Could you remind me how to pronounce your first name.
>> PADRAIG TANGNEY: It is “PAW DRAG” Padraig. If you are close it is good enough don't worry about it.

>> PAM WALZ: Okay. Natalia Gomez.
>> NATALIA GOMEZ: Here.
>> PAM WALZ: Rebecca MacTaggart? Ryan Johnson.
>> RYAN JOHNSON: Present.
>> PAM WALZ: Anyone else who is a member joined since I read your name? Okay. Thank you housekeeping talking points. Again, this meeting is being recorded your participation in this meeting is your consent to being recorded. This meeting is being conducted as a webinar with remote streaming. To comply with logistical agreement, we will end promptly at 1:00 p.m. Remote captioning is available at every meeting. The CART captioning link is on the agenda and in the chat. It is very important for only one person to speak at a time. Please state your name before commenting and speak slowly and clearly so the captionist may capture conversations and identify speakers. Please keep your questions and comments concise to allow time for everyone to be heard. Webinar attendees may submit questions and comments into the questions box or use the raise hand feature to be put in queue to speak live.
Time is allotted on the meeting agenda for two public comment periods. Please remember to state your name to assist the captionist in identifying the speakers. If you have questions or comments, please send them to the resource account e-mail found at the bottom of the agenda meeting. Thanks and I will turn it back over to Matt.
>>MATT SEELEY: And I will turn it therefore to Juliet.
>>JULIET MARSALA: Thanks Matt and Pam. I hope everyone can hear me okay. Good morning.
>>MATT SEELEY: Yeah, you are fine.
>>JULIET MARSALA: Thank you for joining us virtually. We have an important agenda today. And for everyone's awareness, Secretary Arkoosh, if her schedule allows, will be joining us virtually. She is very interested in listening in and hearing the discussions and the topics and public comments related to LTSS sustainability. I hope her schedule allows her to join us at a later time.
Okay. So today, on the updates agenda, we will talk a little bit about HR1 and eligibility changes, Act 150, the EVV compliance monitoring, go over some general updates and announcements and some framing for the long-term services and supports sustainability.
So if we go to -- the next slide so HR1 eligibility changes act 150 commune managed care organizations the department of aging and act 150 service coordination entities to track and facilitate the transitions of participants impacted by the HR1 changes that went into effect and impacted them in October.
As an update to the team and for folks who may not be aware HR1 changed some temporary protection statuses for individuals in our community healthchoices program. There were also thousands of individuals that will -- that were impacted also on the healthchoices side.
So, where we are today, prior to the date of impact, the CHC-MCOs completed out reach to each of the impacted participants by letter and phone to provide notification on the impact on home and community-based services due to the eligibility change of their temporary protected status or immigration status REGTD. They assisted with identifying alternate resources and assisted with referrals to the PAID and the local area on aging depending on age.
We held a webinar on October 8, 2026, for the Act 150 service coordination entities. The providers to share information on the changes occurring, answer questions on the transitioning of participant that is are eligible for Act 150. We wanted to do our best to make it as seamless a transition as we could and provide additional weekly e-mail communication.
So from the enrollment as of the end of October, now, please note this is data that has not been

through the data integrity and compliance. So these numbers are also very fluid, but I will share to the best of our knowledge as of October 30th, where we stood with Act 150 enrollment.
So there have been 33 individuals enrolled in Act 150. 23 individuals still are active with the county assistance office in an appeal status. 98 individuals were still in process with their Act 150 application. There are 30 individuals that were determined ineligible that may or may not be in an active appeal process. So, those are sort of the high level numbers that we have been tracking for Act 150.
We have reached out to the Bureau of Hearings and Appeals to get some data with regards to the appeals related to this population and again this is not gone through our data integrity process, but it was shared that 136 individuals had appealed timely and there were at the time of our asking, 18 appeals that were submitted untimely.
We continue to monitor this group. We have reached out to the Department of Aging. They are working with their triple A's to track status of individuals and calls to our PA Link line. I do not have data to share but wanted to share with this group what I had with regards to our efforts to connect folks to alternate services.
Understanding that we would not have the possibility to kind of match their current services as they became ineligible for community healthchoices because there aren't no other alternatives to the extent of service that is community healthchoices provides. But certainly making every effort we can to connect them with community resources and other resources they might be eligible for.
All right. Let's go to the next slide.
So, participants as I had mentioned under the age of 60, they were provided information on the Act 150 program. The referrals were submitted to the PA independent enrollment broker and if the individual expressed they were interested in applying and want that had information. Of course it is always the participant's choice. Participants 60 years of age and older were provided information on their local area agency on aging as a resource and also to the PA Link from the aging disability resource centers.
To assist with facilitating the continued care the community healthchoices, managed health care organizations provided participant windshield their person centered service plans.
So that information could be shared timely which is critical for services to move forward.
Okay.
Go to the next slide.
All right. Folks should have seen some updates related to the electronic visit verification and compliance monitoring. So, in accordance with the medical assistance bulletin 59-25-03 we have moved forward with enforcing EVV noncompliance fee for service providers whose EVV manual entry percentages exceed 15 percent for two consecutive quarters. We talked about this a lot in the calendar year 2025 with the implementation of January 2026 and now the enforcement has begun.
So, on October 22, 2026, OLTL issued statements of finding to noncompliant fee for service providers agencies are expected to respond and complete a corrective action plan. There were 102 OLTL FSS providers who received a statement of findings. Agencies' CAPs are due no later than November 12, 2026. And then we will evaluate and follow up with approval or provide some additional direction to the corrective action plans that we receive. Agencies who have statements of findings, will have three months to implement remediation activities to improve the manual and entry percentages.
And so we will be anticipating improvement and evaluating that improvement with data from quarter one of 2027.

And then just for a reminder for our providers enrolled in community healthchoices.The managed care organizations are responsible for monitoring compliance in addition they may have other requirements in their provider agreements with you. So, please reference your contracts and agreements with your CHC-MCOs for what you need to adhere to okay. Next slide.
For electronic visit verification compliance monitoring the data is being shared here with regards to percentage compliance. In the commune TEUGT healths managed care organizations agencies we saw a 91 percent compliance and CHC-MCO self-directed model there was a 71 percent compliance percentage in the OLTL fee fer service agency model there was 82 percent compliance 82 percent of the providers were compliant and OLTL self-direction program 60 percent of the CLE and DCW EVV visit verifications were compliant and if you look at the programs for manual visits data for quarter two of 2026 you will see the opposite percentages and those match up to 100 percent.
All right. So this data is not broken down by providers this is the actual visits as a whole in aggregate for quarter 2. So it is not 82 percent of providers but 82 percent of visits met compliance.
If we go to the next slide --.
Okay. So OLTL released a ListServ on October 22, 2026, pertaining to OBRA and Act 150 service coordinator training summits the OLTL is conducting training summits for all OBRA and act 150 service coordinators in November 2026 and January 2027 every OBRA Act 150 service coordinator within service coordination agencies is required to attend one of the SC training summits.
So the topics to be covered will include their responsibilities on boarding transferring and terminating participants.
Person-centered service planning individual service plan. All the services available through the waiver. And I know we had received input from various parties about ensuring supported employment. What's covered. It will be covered through services available through the waivers because all five of those related services are part of HCBS program and services. Also review the care management instrument service authorization forms participant review tool and the critical incident management requirements and responsibilities.
So going to the next slide. For some additional updates and announcements OLTL released a ListServ on October 22nd -- sorry this is a continuation.
So, the first training summit took place on November 2nd. The second is scheduled for January 6th. There are registration links in the power point sent out previously and will be sent out afterwards if you have any questions related to the service coordination training summit that is required for service coordinators serving OBRA and Act 150 programs please contact the enrollment unit at this e-mail.
All right.
And an the diagnosisal announcement.
There are almost 300 individuals that have joined us today and I am very grateful for the high participation in the LTSS subcommittee meetings. I would like to share the Office of Long-Term Living is recruiting for additional members of the LTSS subcommittee membership. We would like to recruit for current vacancies and future vacancies. As you know on the LTSS subcommittee we have instituted term limits. So individuals will have opportunities to serve in this leadership and advisory role on going. We currently have a program participant vacancy. Two vacancies for either program participants and care givers.
Nominations and letters of interest or questions regarding joining the LTSS subcommittee

membership should be submitted to RA-PWLTSSSUBMAAC@pa.gov and our team will connect you with all of the requirements needed to submit an application for consideration.
All right.
So, I want to as we mentioned in the last meeting talk about the LTSS services and sustainability. And the reasons why this conversation and this discussion is so important and as I mentioned in the last meeting. It is not tied to HR1. HR1 impacts and the $20 billion of federal funding across the nation that is anticipated to have impact to all states really does impact state budgets. But; you know, it does not necessarily directly tie to OLTL. In fact it doesn't necessarily tie directly tie to Medicaid budget because state representatives can decide what they want to do with our budget and how they wish to address it. There isn't a direct tie. Certainly there is impact. Certainly there is significant concern our budget for states are made up on values that the states want to put forward there is population growth and I want to show you the trend that I was referencing in our last meeting call. So what you have here in this first table is the populations served for 2023.
This was the year I joined the Office of Long-Term Living team. You will see it broken out into categories: you will see the CHC-HCBS duals and the CHC-HCBS non-duals those are numbers of individuals that are receiving services and also see the categories of the CHC long-term care duals and long term care non-duals those are individuals who also meet nursing facility clinical eligibility that are served in our nursing facilities you will see the percentage total of the population which an is important to take into account and you will see the ineligible. These are our dually eligible Medicare and Medicaid individuals that do not require HCBS or long-term care service that is are served -- their physical health services are provided through HCBS programs. And you will see the total which is 412,000 individuals.
When we go to this next slide what you will see is the change in population over the past three years through September 2026 we are not all the way Through 2026 so you see a partial at this time.
What you will notice here is that the community healthchoices HCBS duals percentage has jumped up 8.4 percent of the total population. So, that is quite significant. And, you know, is about 30,000 individuals more than are eligible for HCBS service that is are dually eligible.
You will also notice in the CHC-HCBS non-duals there is an increase of individuals served it went from little under 10,000 visuals it went from 34,000 up to 44,451. Which is a percentage increase of 3.2 percent.
Or a little less -- you will also see in in the community healthchoices long-term care duals category there was a slight increase of 0.5 percent of individuals served in nursing facilities, that is a little over 500 individuals. And CHC long-term care non-duals you will see again a slight increase of 0.1 percent of population served in totality that is over 40,000 new individuals served and a higher acuity than our CHC nursing facility in eligible population can which saw a decrease of 20 percent over all. So what you see here and this is where folks kind of get hung up a little bit. When you total all of the numbers of individuals served in a participant count. You will see over all the program decreased in 2023, we were serving 412,000 individuals. In 2026, we are serving 398,000 individuals.
So, you know, that is a change a decrease of total number served but really where you see the cost trend increasing is because we are serving 40,000 plus more individuals in higher acuity populations that require HCBS services or nursing facility services.
So, that increase which is in double digits -- increasing by double digits, is where you see the cost increase for community healthchoices program. Even if we didn't change anything within the program, serving additional 40,000 individuals increases the cost of the program and the

need for additional funding to maintain the program year over year. So I know a lot of folks were wanting to know what is sort of the root cause for the increase funding needs. That is the acuity change of the population. We go to the next slide and see the data kind of in different ways with regards to kind of we had a lot of questions or some questions come to us related to sustainability strategies and what we have been doing to maintain the cost curve as best we can. I think many of you have seen this on the data dash month over month. This is a number we track. We have in the same years been increasing our success in serving individuals in the community rather than in nursing facilities that in and of itself need LTSS balancing does a lot to kind of lesson the cost curve because as you know it costs less to serve people with HCBS than it does to serve them in a nursing facility.

As you can see over the same years, we have been increasing that balance and increasing the percentage of individuals served in HCBS settings from the end of 2022 at 74.3 percent to December 2025 at 78.6 percent. That has been doing a lot to kind of maintain or lesson the growth of the cost within CHC. It hasn't zeroed it out but it has slowed it. We go to the next slide. This is another way to look at some of the data, you know, in different ways to kind of look at the population and the settings that they are served in. I'm not going to spend too much time on this. As you saw, it is sort of another way of looking at prior data and summaries in different ways. So we wanted to share this data as one of the primary drivers for increasing cost year over year within community health choices. We can go to the next slide. You know, one of the things that is important to note with regards to the discussion on LTSS sustainability is that -- and we have gotten questions on this certainly so I wanted to answer them. Questions about anticipated timelines, questions about when we would be implementing potential changes.

So, we are going to talk a little bit about this further on in the agenda. I wanted to share as I shared in our last meeting these discussions are in preparation of potential need. If we do not get sort of new revenue within the commonwealth to be able to provide additional support for programs such as the Office of Long-Term Living. They must administer the program with the appropriated funds we are provided with.

These conversations are in anticipation of funding which we are not aware of for potentially fiscal year 2028 which is when the states will feel the most impact on budget constraints related to federal changes.

So, there isn't a finalized plan. We are evaluating options because it is prudent to do so we have had offers of support which we appreciate with regard to requesting individual meetings with the office of long term living to kind of solution for the question of LTSS sustainability for many interested parties. What I will say is that the LTSS subcommittee is the advisory committee for the Office of Long-Term Living it is the place where our public stake holders can participate, can hear in a very transparent manner suggestions, recommendations that are coming from our stake holder groups. So while I appreciate the offer of individual meetings with parties, I would recommend and encourage folks to bring those ideas, those thoughts forward to the LTSS subcommittee for discussion. And the reason for that is to kind of maintain transparency in these discussions, provide opportunities for our participants who are directly impacted to participate in those discussions as we look to the future of LTSS programs and its sustainably moving forward. I think it is really important the participant voice is included in that and they are part of the process that being said the Office of Long-Term Living for folks awareness does have many set stakeholder meetings where certainly LTSS sustainability can be included on the agenda. we are not looking to form the specialized work group on this topic because we have the LTSS subcommittee but we also do have participants and advocate call as stakeholders. We have an HCBS provider call with our provider stakeholders. We have a nursing facility call

with our nursing facility stakeholders and our certainly our managed care organization monthly calls. Those are certainly other avenues in which interested parties can put forward the topic of LTSS sustainability.
With everything going on in the office of long-term living, we do not have the resources to hold many individual meetings with certain providers or organizations so we are really encouraging folks to utilize and maximize the channels that are already in place for engagement and feedback with the Office of Long-Term Living. With that, I will pause for questions.
>>MATT SEELEY: And I will not allow you to have them. I believe we are having an HR1 session now. So Pam and Lloyd I will pass it to you.
>>PAM WALZ: Okay. So we have -- this is Pam Walz we did not have another HR 1 stakeholder call since our last LTSS, so we don't have a lot to report. Within piece of news that I can report which is separate from the stakeholder calls but just a piece of news about HR 1 implementation generally is that the lawsuit in Massachusetts versus Oz got a court decision this during the past month. This is a lawsuit that was challenged by a number of different states including Pennsylvania. Again, CMS challenging the interim final rule which had narrowed the definition of medical frailty as an exception to the work requirements. One of the exclusions for people is if they are medically frail and the interim final rule added another component that had to be met to that -- not so that people would have to have a condition that met the definition of medical frailty plus they would have to be able to show that, that condition impacted their ability to work or volunteer or otherwise comply. That's not in the statute and so -- and the district court held that it was not -- that, that part of the interim final rule is not in compliance with the final statute and struck it down so what we are waiting to see in part is whether thereby an appeal. Will this decision stand?
That is some good news for the implementation of the work requirements. It probably won't have a lot of immediate impact because we don't know yet whether the DHSS will appeal and what the outcome of that will be it is likely states won't immediately change course on preparations they are making to implement work requirements with the requirements in the interim final role. Just as a reminder these we are talking about apply to the expansion population of Medicaid and not to, you know, community healthchoices and the other categories of Medicaid that are based on disability or age. So, that's what I have to add. Lloyd do you have anything to add?
>>LLOYD WERTZ: I do, yeah and first of all just a wild cheer to Governor first of all for winning re-election but for being part of the winning side of this lawsuit he noted where it was incorrectly being applied and did something about it along with maybe Maryland and New York and we got that decision from the federal level staying the implementation of that resolution.
At this point, the work group is seeking questions. Seeking questions from the people who attend it, and, you know, how much info can we get and share, and I think the best thing we can do as representatives of the LTSS on the HR 1 work group would be to amess questions we can bring to that meeting and hopefully be able to pose and I don't expect we will get answers at that meeting but we will get in answers in the follow up to the meeting I believe and we would appreciate those from this group either directly immediately now or at a later time. I can tell you some of the ones I have amassed thus far. It seems county assistance offices closing early on Thursday across the commonwealth? Why? What's the deal.
Why can there only be one e-mail address used in the compass application? Seems to me you ought to be with that level of sophistication, you ought to be able to accept and respond to more than one e-mail so you are sure the individual is receiving information but also that the individual helping him, the enrollee, complete it would be certainly positive. Excuse me. There is

a question about how the early application process for those who are being released from DOC institutions is being implemented. How will this impact those individuals preparing for reentry. But how can we make sure that they are going to have medical assistance from day one of bettering the community.
Another question is it possible to create a general health day where the CAO, the county assistance office staff or members of the staff can be available to answer questions on this whole process of application. Reapplication meaning work requirements what are the medical frailty rules and things like that there is also a question about how we might be able to solicit greater collaboration from hospital social workers because they are in the weeds on all of this and have been for a number of years. Are we able to get them to create a bit of a work sheet or participate in training for folks in the community who are offering those and I have two more. There is hope for the training of individuals within the provider network and will this be created so that the providers are aware of what it is they are trying to meet relative to work requirements and the other issues we mentioned earlier before the 1127 hard line implementation date which is barreling down the tracks. Although it was placed between the election and in the beginning of -- starting the beginning of the year they didn't escape that. Now there is a need for us to know what providers need to gather and be able to use to help their consumers and I have a new one this morning on another meeting I was on that started at 9:00. Do we know the definition of an immigrant that would be taken on our off the medical assistance program. Does that just include people with green cards. How is that determined? And what is that implementation?
So if you have questions other than the ones I have just kind of ticked off there. Can you share them with us? Whether it is in the chat or directly verbally in this meeting so we can then take them to the meeting next Friday. Friday the 13th of the work group.
>>JULIET MARSALA: I would also say Lloyd folks can send them to the LTSS resource account and we will be sure to get them to you as well. That's always open.
>>LLOYD WERTZ: That's good I was afraid I had put everybody to sleep.
>>MATT SEELEY: Thank you Lloyd, thank you Pam. Do we have any questions for public comment? I don't see any committee members with their hands up.
>>SPEAKER: I see no committee members. Well I see Pam has her hand up.
>>MATT SEELEY: Go ahead Pam.
>>PAM WALZ: This is a question for Juliet. Going back to your presentation on act 150, I want to share some concerns that we have based on what we are seeing and also about the numbers you were reporting.
First of all, really concerned it looks like about half of those who are applying for Act 150 are being found ineligible. I think the major reason seems to be people are being found not able to handle their financial or legal affairs or otherwise self-direct. And I just want to share the concerns that we have. We have a number of clients who have been -- who are rev few agrees and lost federal MA and applied for act 150 and have been denied and on that basis to our surprise because they don't seem to be people who are unable to handle their own finances. We would like to know how this is being determined. You know, what the process has been up until now to determine this for Act 150 applicants and how it is being done for this particular group if it is different. It looks to us from our client's cases as though part of it is on the Act 150 there are two questions do you handle your own financial affairs? Do you handle your own legal affairs and we are seeing among our clients particularly the women answering none of those questions not because they are not able to, but because their husbands handle those affairs in their households. That seems to be a data point being used along with the answer on the fed as

to whether people have a cognitive impairment. Some of these were found to have moderate cognitive impairment. The fed was -- that item on the fed was not design today determine whether people are able to handle their financial and legal affairs and so, we are worried that it is flagging and overly broad group of people and finding them not eligible so, that's actually the first of two concerns I have about the Act 150 process and maybe I will give you a chance to respond to that.
>>JULIET MARSALA: Two things on that. Certainly it is concerning if there is a cultural bias here. That is one I think being raised is the understanding of that question. We can certainly take that back and review that with the team to ensure that they are making sure there is full understanding of what that question is getting at. With regards to ability versus preference right?
>>PAM WALZ: Right.
>>JULIET MARSALA: And then the cognitive impairments. I'm not prepared to talk about the specifics of that but will absolutely take that back as well. I believe this was also brought up in the consumer sub meeting and think our team is awaiting for cases so we can drill down and take a look at them. I understand they are most likely in the appeal process currently and if those appeals were timely, that we would be working to expedite as we can.
>> PAM WALZ: One question we have we have a number of these appeals and this is a new type of appeal to us and for some of them, we are wondering if there is anyone at OLTL that we can bring these cases to, to discuss? Rather than waiting for a hearing. We get you examples and would like to try to resolve this.
>>JULIET MARSALA: Certainly, similar to how we have in the past. The Erin Slabonik would be the person to send all of those to.
>>PAM WALZ: That's really great. The second thing I would like to quickly raise about that is we are concerned there is a significant number of people who have lost federal Medicaid who have not yet applied for Act 150 and among our many, many clients we have 60 of these cases in the past month. A number of them. A significant number of them have not heard from their CHC service coordinators about Act 150 or received any outreach at all. So we are the first ones telling them about that. You know, I don't know if the outreach is missing some of them or imperfect or some of this is a language issue, but we again, would urge the department to use the process that is in the operations memorandum about transitions for people losing federal MA. We are worried there are people being lost in this process.
>>JULIET MARSALA: Um, yeah I hear you on that. Could you also if they are [word?] Send me a list of individual that is purport to not having ever heard about act 150.
>>PAM WALZ: Sure.
>>JULIET MARSALA: I certainly would like my team to crosswalk that. Those individuals to the reports we receive from the CHCMCOs because we were tracking weekly reports. So I am interested in evaluating that as well.
>>SPEAKER: Okay.
>>MATT SEELEY: Thank you. I see there is two questions. Three questions.
>>SPEAKER: Natalia had left a question in chat.
>>MATT SEELEY: Does someone -- can someone mute.
>>PAM WALZ: I'm so sorry, that's me.
>>MATT SEELEY: Okay. Sorry.
>>PAULA STUM: Natalia Gomez do you want to ask your question, please.
>>NATALIA GOMEZ: When the numbers were being provided with the visit. Does those findings or those numbers including the issues care givers are including in the HH ex-change plus application there a lot of care giver that is have not been able to clock in or out when they

were doing a lot of these transferring to these application and what some of the agencies are doing is saying they will not get paid even though it is not the care giver's fault for not clocking in or out.
>>JULIET MARSALA: I appreciate you raising that up. I was not aware of the issues HHA exchange plus. Certainly will look into them. You raise a very, very good point.
And that is one where -- two things. One if it is an issue with an application a provider can note that on their corrective action plan if that is a root cause of they are falling out of compliance with the 15 percent manual edit entry.
So, they can address it through the corrective action plan and note it as an anomaly if that is indeed what occurred for that particular provider agency. The second point you bring up is one I find highly concerning.
If there is an issue with EVV, that does not provide providers with an excuse to not to pay their employees if their employees worked for them.
Providers need to follow labor laws that are in place at federal and state and local levels which means if an employee is working, regardless if EVV which EVV is a compliance check to billable service that is are provided under Medicaid. EVV is not in and of itself your time sheet. You know? Providers need to account for the time their employees work for them as an employer.
If an employee checks in early, starts working earlier then what is billable that is still an employee working for a provider agency. Providers need to manage the time of their employees and pay them for their time worked. EVV is a compliance tool. So, providers really need to understand the difference between EVV and time worked. Two different things.
And I know that there have been trade associations for example PHA I think put out a free training about, you know, provider's responsibilities to labor laws. I just want to call that out.
If an employer knows an employee has worked. An employer needs to pay their employee. That is the law and they should follow that.
>>MATT SEELEY: I wish somebody could -- this is mad I wish someone could do a deep dive on that because I have to believe there is a lot of care givers out there maybe even listening on the call that don't want to be care givers because they are not paid by their provider.
>>JULIET MARSALA: Yeah, you know, the department of labor is looking into this. They actually launched a proactive auditing and investigation on this and other issues related to home care. The home care industry. You know, 40 percent of wage complaints that the department of labor received were tied to the home care and home health industry.
And, you know, it is important to note that, you know, the majority of provider agencies are doing quality efforts in this area, but certainly it is an issue raised up and is a special focus area that we are partnering with the department of labor so to your point, we are doing work in this area.
>>MATT SEELEY: Well I mean I'm not pointing a finger at the department but some of these providers I will use myself as an example and tag on to Natalia there are people that have worked shifts for me and because of the EVV thing typically in the past I would have to sign a -- I forget what they call it. Like a document sign thing to verify the individual from the hours and I don't even get those anymore. They don't -- it is nothing. I don't have to sign anything anymore. Whether the person was EVVed or not. It is a little concerning.
>>JULIET MARSALA: Well I know some vendors who do EVV also have a sort of payroll application piece that goes with it.
>>MATT SEELEY: Right but you have to sign that thing. The consumer has to sign that thing and it usually comes in a PDF you have to sign your name and acknowledge the hours. I don't even get those anymore.

>>NATALIA GOMEZ: To that point, I don't think none of the agencies are using that anymore Matt. They only use those when they do the time sheet sign in and I'm going to take this moment to publicly express I have been making a lot of noise in this field regarding what some agencies are doing and very interestingly enough, I was accused -- very interestingly enough someone anonymously called the fraud hot line. The person who was supposed to be doing this investigation questioned me how can I be working if I was -- if I need to be nursing home eligible to receive these services. Apparently that disappeared and no one got back to me what was the result of that investigation and last week I get a call that my fostering mom there was a report at APS there was no foundation about it.
So my question is am I being retaliated against by agencies that I'm opening up my mouth by the irregular laities I am finding out here in the field. Everything is presented as smooth sailing and that's not what is happening out in the field.
You know, workers are being told -- care givers are being told they cannot accompany us to the appointments, and they can want sign or clock out from doctor's offices, from et cetera, et cetera. I don't remember getting anything saying that cannot be done.
>>MATT SEELEY: Thank you, Natalia. We only have four more minutes. Paula are there quick questions or comments.
>>SPEAKER: I have Kathy on the line. Kathy Hertzog you are unmute first degree you would like to ask your question.
>>KATHY HERTZOG: I would like to address the fact that there is a very limited time for public comment on these meetings and that public comment frequently gets cut off before we have a chance to even type our question or get a word in. Also, with EVV compliance, we have issues with the software not working. We also have issues where somebody is on both agency model and self-directed model and the times occasionally overlap when there is a change between one shift and another shift.
And, I want to make sure that both the agency and the individual self-directed employee get paid for that time because I have been told numerous times from various sources if it is over lapping even by a single minute, that somebody isn't going to be reimbursed and that is absolutely a bad thing and that leads to problems and then that leads to manual entries which then leads to noncompliance. The new software is a pain in the butt to use because there is lots of craziness that has been added to it. You have to clock out and see things multiple times which again adds to the clocking out time frame. I don't think people understand how long it takes to clock out when you have a person like myself that has a lot of things that need to be checked off and depending on your phone to being touched and tapped and all of this stuff. That takes forever. You have to keep tapping and tapping and tapping to get things to click in. Like I said you have to resave and resave to get it going.
Other issues include the GPS is off. Like grossly off many times. So it looks like we are not where we are supposed to be and so forth and so on. That's a lot of really important issues there. And, I think that we need to have some additional time to look at those things and to get some of that cut back. I don't know -- there is nothing in the law anywhere that requires all of these tasks being checked on and checked off and all of that stuff. Somebody has to look at some of that reducing sop of that because takes a large amount of time people are trying to clock in and clock out. It is really crazy because it is just too much.
>>MATT SEELEY: Thank you, Kathy. I think Kathy brings up a good point about the public comments. I think it is labeled as public for a reason.
But with that, we will take our 10-minute break.
[10-minute break. Return at 11:10 a.m.]

>>MATT SEELEY: All right. 11:10 on to you Juliet.
>>JULIET MARSALA: Thank you, Matt. I appreciate it. All right. So, as many saw on the agenda today, we have changed up the public comment area and so now we are working into dedicated public comments on the topic of LTSS sustainability. As we talked about in the prior meeting in October, we wanted to set aside some considerable time today in this meeting to focus on LTSS sustainability, the areas in which we discussed last meeting, and we wanted to open it up with dedicated time to receive public comments related to LTSS sustainability from our stakeholders. We have over 250 individuals with us today, so, opening it up to the stakeholder group with regards to think about LTSS sustainability and priorities. Anyone would like to raise their hand to submit a public comment. Brenda? We can have Brenda Dare unmute yourself.
>>BRENDA DARE: There we go. It took a second for me to turn on the mic. I would say across the board in terms of sustainability for myself and the people I support you need to look whether service coordination is appropriately assigned and utilized. I think a lot of time is wasted when folks can't get a hold of their service coordinators and their case loads are inappropriately assigned for geography. People aren't able to receive assistance from their service coordinators in a timely manner and that ends up causing delays in how services are administered or in resolving problems I think there is a real disconnect between the intention of service coordination and what is happening on the ground.
>>JULIET MARSALA: Thank you, I appreciate you raising that up.
Kathy Hertzog.
>>KATHY HERTZOG: Hi this is Kathy Hertzog. I would like to see people that are high need users not getting clipped off because of the extra hours that some of of us need and use because our medical conditions have changed over the years I would like to see the Commonwealth of Pennsylvania actually make a law that puts home and community-based services first and nursing home placement second or as a last resort only for those that are absolutely positively in need of it. I think that would be a significant step forward. That would codify it so we are not at risk of nursing home placement due to federal cuts and things like that as far as other stuff, I'm not exactly sure, but we need to start looking at services that are pretty much wasted or unused properly I know seem people get meal programs and their meals are absolutely destroyed because, you know, they are left at the door and they have no way to bring them in there is a lot of different things like that, that could be looked at. Transportation for one is an extremely bad situation every since Midge (sp?) Care came into play. There is a bonus [indiscernible] however we now have the drastic problem that none of us know if we are going to get a ride until 6:00 p.m. the night before the ride is scheduled.
So we don't have the ability to actually schedule back up rides because we never know if we are going to get them in fact in certain areas and certain times I almost missed board meetings because they have other people scheduled ahead of me and they call me up while I'm waiting outside for my ride to pick me up now and tell me oh, you know, they are going to be like an hour late and I have already scheduled my trip an hour early so I can be there on time. This whole broker thing and crazy system that is in place now is completely dysfunctional.
It is absolutely absurd. I won't even use the system anymore unless I absolutely positively have to I'm paying out of pocket right now to use my local shared ride system which I use today be allow today use previously under the previous set up. I use today be able to get a certain amount in my budget buy my bus ticket and be able to do it. That's the other thing people should have greater choice in the types of transportation services they can access. We shouldn't just be required to have one set thing. There needs to be a menu across the board

because I know that my transportation services would be a lot less cost to the Commonwealth of Pennsylvania if I could choose to use the transit systems I would like to use. The cost would be greatly reduced.
So, that's all can I think of right now. Thank you very much.
>>JULIET MARSALA: Thank you Kathy. I was remiss in also noting we have about 3 minutes per comment but certainly the channels of also e-mailing the resource account, writing in chat, are always open. Thank you Kathy.
>>MATT SEELEY: Please be as succinct as possible to allow others to talk Susan.
>>SUSAN TACHAU: Thank you for this opportunity I'm susan tacah (sp?) The commonwealth has a great opportunity now to help make these long-term services and supports sustainable by increasing the wages for direct care workers. In home nursers and aids and other things.
It needs a commitment by the commonwealth that people deserve the right to be able to live and thrive in the community and looking at direct care worker salaries is critical thinking about how to improve community health choices, OBRA (sp?) To perhaps have advanced services for people that are more complicated and also looking at some of the services available in ODP such as remote supports that can also potentially if desired and appropriate be a cost savings.
I I think it is critically important that the commonwealth show this commitment and we as care givers and/or people with disabilities are not asked how would we cut our own service that is are allowing us to be in the community. Thank you very much.
>>JULIET MARSALA: Thank you Susan and you bring up a good point remote supports are available in community health choices under telecare so that's an opportunity to increase the education you know, the terminology is maybe a little different with regards to calling it enabling technologies and assistive technology but there are certainly pathways. That's a great opportunity and something tangible we can really focus on right now. So really appreciate you bringing those and other points up. Thank you. Kristine Luke.
>>CHRISTINE LUKE: Going to the points Brenda and Kathy have stated as somebody has worked within the service coordination field. I was advocating extremely hard for some of my clients that were having a lot of transportation issues. I was sitting on the phone with their insurance company as well as reaching out to the transportation side and it is kind of like a ping-pong ball. No one wants to take accountable or ownership. I set one of them set up medically necessary appointments only for her to call me the day of her appointment that no one came to pick her up or cancelled on her.
As well as, when I would get my new case load, you know, being told by some of the participants that I was their 5th or 6th service coordinator and they haven't heard anything. They were reaching out to their service coordinator the number and no one ever called them back. I think a little bit more transparency and a little bit more, you know, if you are in a role of service coordinator actually do the job. You know? Help the participants I don't you are supposed to be helping because it is not what is going on in the service coordination role.
Thank you.
>>JULIET MARSALA: Thank you so much. Appreciate you sharing your experience. That's very helpful.
Shona.
>>SHONA EAKIN: So, we have a group at voices for independence watching with Shona Aiken. This is going to be Kelly Barrett speaking.
>>KELLY BARRETT: Hi this is Kelly I wanted to talk about two things so I think investment in the direct care work force is critical for LTSS sustainability because having good reliable direct care workers that are paid well for what they do and the care they give will decrease

hospitalizations that are a high cost item as well as transition into nursing facilities because of a lack of care.
Also it disappoints me that we have to talk about sustainability of services when governor Shaperio is constantly posting on Facebook about how Pennsylvanians with disabilities are going to be able to remain in their own homes.
So that message is coming from top down it seems.
And then I also wanted to talk about the mention of assistive tech for remote services that would be great although myself included I recently had an assistive tech request to my MCO and it was denied because I was told that my PAS services are sufficient enough and cover the need for the assistive technology sew the MCOs may be countering options that may help sustainability in the long term. Thank you.
>>JULIET MARSALA: Thank you Kelly and thank you Shona for having a listening session and ensuring people have access and the ability to comment. Thank you Natalia.
>>MATT SEELEY: Did I get the impression there was more people in the room that wanted to speak.
>>JULIET MARSALA: I don't think so but we can check in. They lowered their hand.
>>MATT SEELEY: Sorry.
>>JULIET MARSALA: Natalia.
>>NATALIA GOMEZ: I think there is too many hands in the pot and if an assessment or evaluation is done, for instance, IEP enrollment with this CHC program is repetitive. They don't really follow through.
They do in home assessment. But the participant or applicant is the one responsible for submitting the application to the CAO offices. They are the ones supposed to get all of these documentations done and on top of that they added a component for the home visit supposedly to address any of those documentations that the applicant was not able to obtain during that first visit and they still don't get the documents on the same visit. How much does it cost DHS to pay these contractors. I'm going to follow with the service coordination. When you hear the word service coordination you are expecting this person to coordinate or help you coordinate your services in order for you to tap them. But when mistakes and errors are made after error after error for instance in my case in June something was recommended and we in October and because of miscon education and too many people are not reading or seeing the in home assessment and miscommunication from service coordination to the PCPs and so on a hole delay of services are done.
Not to mention I'm not going to talk about the transportation we know it is a given and as I mentioned in previous meetings, how much does it cost for these training sessions to be done? How can we cut there?
Where is the this stand for the independent living? Is it cheaper for independent living than CHCBS or nursing homes? Where do we monitor and do this and everybody falls at least myself I have been in a black hole for 5 TKWRAOERs and trying to obtain home modification. I had no idea there was a home mod and everything falls in different the participant plan of care is supposed to participant center once that in home assessment is done and once things are taken behind us we don't know nothing. With very to harass people to find out these things and what is going on. So duplication of services and how good are they being duplicated? Do they meet what they are intend today meet? Can some of these steps to get into CHC I countered there is more than 7 steps. More than 7 with a whole bunch of different agency that is are involved and you are ex-specificing with cognition issue or someone with dimension diagnosis or someone with age -- seniors that they are being expected to understand every step of the

way and which agency they are dealing with. For instance, a lot of the contractors. A lot of these MCOs have contractor that is do not service our areas and then you have to go to multiple providers to get things. How -- not to mention the fact that everybody has become very come place sent. My brain is a little tired today.
But, everybody has become okay dealing with informal support or allowing the agencies to use the terminology yes, I understand. We want to be cared by someone we feel comfortable with or might know. But that should not be the rule of thumb.
Everybody claims there is a huge shortage in direct care workers nationwide but it is because the service providing agencies have been allowed to practice certain thing that is is not beneficial for the participant so a lot of transparency is needed. A lot of accountable is needed. You know, everybody mentions about being able to go into your send e-mails and e-mail address when we don't have the time to do our comments, but many people are not savvy. Computer or technology savvy. They don't know how to navigate the system on top of that.
>>JULIET MARSALA: Natalia -- sorry I really appreciate all of your comments, and I'm sorry to kind of cut them a little short but I also.
>>NATALIA GOMEZ: [Indiscernible].
>>JULIET MARSALA: I also want to be mindful of you know, the time we have and other folks. With regards to your issues around home modifications I will certainly have my team follow up on that specifically as well as the delays you mentioned. But you bring up so many good points about many areas of opportunities across the system.
I do appreciate that. I want to be mindful of the time.
We are going to go to the next commenters. Michael Cessareno.
>>MICHAEL CESARINO: Yes when it comes to transportation our service coordinators can't even see when we book a ride. They have no control over that once it is booked. They can't even see if it is capped or anything. We really need to get on with that. We really need our service coordinators need to be able to do more also. Like other people said. We are expected to get all of the paper work together and make sure all of the [word?] Are done and what if we do like me I cognitive delay going on but a lot of people do and that's a big problem. Yeah, we need. If we are going to employ these contractors they need to be able to do what they need to do and not be oh an I don't know. You should have the same data base as [word?] I don't know the service coordinators they don't have enough help themselves.
That's all I got. Thanks guys.
>>JULIET MARSALA: Thanks Michael I appreciate your comment.
>>MATT SEELEY: Can we understand that comment. Is the issue there is a lot of middlemen in between or I don't have a better analogy or whatever.
>>SPEAKER: Yes.
>>MATT SEELEY: Yes is that what you are saying I don't you have too many partners on the field just to book a trip.
>>SPEAKER: Yes yeah.
>>MATT SEELEY: All right. Thank you.
I'm sorry there was another question then Paula.
>>JULIET MARSALA: So it is Juliet.
>>MATT SEELEY: I'm sorry.
>>JULIET MARSALA: We have Shona Akin's group.
>>SHONA EAKIN: Good morning this is Shona Akin I wanted to follow up on a comment made earlier and something we are seeing locally, there is several things I would like to say first when you mentioned earlier Juliet there was 40,000 -- there was an increase in 40,000 people going

to higher cost level of care part of me wonders if -- because what we are seeing here is used to be the barrier tote the get out of institutions was housing. Now we are seeing barrier to get out of institution remain in the community is the lack of the direct care workers. People can't find workers to get them out of nursing homes fast or to keep them in the community. So I think that is something we really need to look at and I would like to know if that number was dissected at all to find out why people are going to the higher level cost of care. My next comment is I want to follow up on something that other commenters have brought up and that is that we do need to give home and community-based services a level playing field the only [word?] We have in Pennsylvania is truly nursing home placement and home and community-based services are optional. You have said that 100 times Juliet and I think that we need your support and help to advocate with our legislature or whomever you feel we need to, to create legislation to make home and community-based service the first option and nursing facility placement the second option.

Thirdly and I brought this up many times allowing people to use their local area transit provider for transportation is going to save the Commonwealth a ton of money. It makes no sense in northwestern Pennsylvania that transportation providers come from two hours away to provide a two mile trip and then drive two hours away to go home.

And lastly, my final comment is there are 32 services added to CHC in addition to personal PAS and I wonder if we dissect the types of service that is the people are using and we keep the ones that people are using most often and we eliminate some of them, what kind of cost savings would we see. Kathy brought up the meals and the fact people can't bring them in the house and that is true. But there are still other people that don't want them and are getting them and are giving them away to people they know, you know, and not even using them the way they were intended to be used.

So I just think there needs to be investigation of the 32 services offered and see if there is a way to provide cost savings in those. Thank you.

>>JULIET MARSALA: Thank you Shonan really appreciate all of your comments. Before we move away to the LTSS subcommittee discussion, I wanted to go to some of the comments that were put in the chat so folks can be aware of them.

Kate Blaker says why does it take an inordinate amount of DNE this is not my comment but the SC told the person one service at a time a specialized bet is needed a wheelchair is needed and plus more issues.

Jeff submitted a question what services is OLTL paying under both [indiscernible] service programs that could be examined for cost effectiveness and utilization.

So we can certainly take a look at that area.

Lisa Tessler states I appreciate the information about changes versus long term care. Can you show us how much funding is dedicated for each group and have increases reflected those percentages?

So, Lisa we will follow up answering your question in the FAQ's after the LTSS subcommittee but you can look at the funding that is dedicated certainly in appropriations but we will certainly get back to you an that question.

Paul Remar has submitted a comment. The importance of promoting participant health safety and independence. I would like to raise a concern regarding the distinction between providing participants with prepared meals versus groceries while participant choice is essential how are we evaluating whether grocery deliveries are meeting the nutritional and functional needs of participants particularly those who have cognitive impairments physical limitations or difficulty safety preparing and storing foods providing raw meet or other ingredients to someone who

may be unable to safely cook. Handle or store those items could introduce additional health and safety risks.
My question is how are we ensuring those services are evaluated based not simply on whether food was delivered but whether the participant can safely utilize what is being provided especially when our broader goals including preventing avoidable hospitalizations. Thank you for your comment on that and raising that up Paul.
Um -- Jeff Iseman asked about the missed shifts -- let's see here.
So he noted we hear about 11,200 shifts are missed each month. I'm not sure Jeff if you can share where you get that number from for OLTL, HCBS programs what happens to those funds not utilized as far as the state budget goes? Jeff to answer that question, the community health choices managed care organizations they get a [word?] Payment. If there is a missed shift with CHC-MCOs that does not effect their cap payment. With the exception that if the CHC-MCOs fall below their agreement requirement, they are subject to potential sanctions penalties fines and other corrective actions. In the fee for service program. Funds remain in their allocated line throughout the budget period. So they remain in the fee for service program. Certainly our budgets are estimated in state budgeting if we do not utilize what is allocated within those budget lines then they are returned back to the general fund.
But it is not a sort of tie in one shift equals one shift going to the general fund. It is really looked at in the full year of expenses.
Okay.
So --
>>MATT SEELEY: Can I follow up on that?
>>JULIET MARSALA: Yeah.
>>MATT SEELEY: Are you saying then -- these are my words that if a shift is missed, there is really no recourse on an MCO they move on to the next shift.
>>JULIET MARSALA: That's -- that's pretty simplified but not.
>>MATT SEELEY: But not wrong, but not wrong.
>>JULIET MARSALA: Um, so in terms of the financing with regards to a sort of one shift missed does that one shift have a finance implication a one to one. The answer would be no because they are paid by capation payment.
>>MATT SEELEY: But there is no -- there is no disincentive to avoid a shift.
>>JULIET MARSALA: With sanctions and penalties and corrective action plans not to mention if individuals experience missed shifts and wind up in the hospital that could increase an MCO's cost. There are --
>>MATT SEELEY: Let me just make a statement. Let me just make a statement here since we are into LTSS time. If I'm stuck in bed and I'm forced to go to the hospital -- actually I'm stuck in bed right now I don't have a care giver. What time did we start? 10 o'clock?
Yeah still no care giver. So my -- let's pretend I'm with an MCO I'm not but an MCO doesn't care about this shift. They are worrying about the next shift. It is really no harm, no foul to them. They are worried what did you all at at the end there what practical effect does that have on the MCO's that would be my question and then we can move into our LTSS sustainability discussions.
>>JULIET MARSALA: Let's unpack that a little bit further F. You are with an agency the CHCMCOs monitor their agency missed shifts certainly an agency not performing well within a provider's network might be at risk no longer being in that network. There is lots of steps in between.
>>MATT SEELEY: Does that accountable go upstream at all?

>>JULIET MARSALA: Yes.
>>MATT SEELEY: It doesn't seem so that's kind of my point.
>>JULIET MARSALA: Yeah what I'm hearing you say that it may be --
>>MATT SEELEY: The low hanging fruit. Like that is what I was trying to say earlier in the call the low hanging fruit. There are 14,000 agencies but none of them have any staff and I heard someone make a comment I don't think it was at this meeting there was a fear of a lot of services becoming paper service they were available on paper but not in reality.
>>JULIET MARSALA: Yeah, I would say I don't think there are 14,000 maybe 1400. I get what you mean. There is certainly a surplus of home care agencies and more home care agencies doesn't equal more direct care workers.
>>MATT SEELEY: No.
>>JULIET MARSALA: I absolutely agree with you on that 100 percent.
So Matt kind of at this stage, we do have additional folks that might want to provide comments or we can go to the LTSS --
>>MATT SEELEY: I'm actually curious did the secretary ever join us.
>>JULIET MARSALA: Yes.
>>MATT SEELEY: Hello secretary Arkoosh.
>>JULIET MARSALA: Yes, we did see her join.
>>MATT SEELEY: I'm sorry I'm on my phone so I can't really tell.
>>JULIET MARSALA: Yes, I know I'm sorry Matt. I know that's not the preferred venue. But yes the secretary has joined us and has been listening to our public comments. Okay. So, moving into the LTSS sustainability discussion in terms of looking at different things that we had talked about and we had brought up in the last meeting some sort of big bucket items regarding LTSS sustainability.
So, can folks still hear me?
>>SPEAKER: We can hear you Juliet.
>>JULIET MARSALA: Okay. My mic icon has disappeared. So hopefully this continues.
Um, so we talked about some big areas in which other states have addressed systemically sustainability within their programs. And, you know, there has been a lot that OLTL has been doing over the years to kind of -- our focus has been on quality and often times when we see increases in quality we do see increases in sustainability and lowered cost.
And, we received some questions about what OLTL has been doing over the years to kind of maintain LTSS sustainability and sort of what were the sort of cost savings associated with it even though that wasn't the sort of main goal.
And so, bringing up some of them for your awareness to know that this is a constant issue again where we have looked at quality first, one has been the women's health initiatives that all three CHC MCO's have taken part in to, you know, some extent with, you know, leadership and collaboration with our medical director and our quality team and their medical directors. We have seen, you know, really great results including one of the women's health initiative programs reducing secondary stroke by 30 percent which is came up in the last quality review meeting what the CHC MCOs that sort of health outcomes type initiative of going upstream, you know, has an impact of cost avoidance because when individuals have a first stroke they are highly likely to have a second stroke. Putting in these health supports, health education supports and things of that nature has really helped reduce the occurrence of secondary strokes which then saves additional hospitalization cost which then saves the need for increased services.
So there are programs like that, that have been implemented across CHC including fall

prevention. Fall prevention is another program related to health outcomes that has really helped and again the cost avoidance. If we can prevent falls then we prevent additional need for additional LTSS services. Those are some services our team have been working with dual special needs plans to align services through their supplemental benefit allowances. They have been working towards offer personal emergency response systems through the D-SNP Plans. And again, that is to sort of increase that integration of service and quality of services allow them to be available to more participants even though NFI in addition to NFCE.
So again, main focus on that because that has been in development for a while does have some cost savings anticipated in terms of saving approximately 20 to $30 million. These are examples of what we have been doing in OLTL. When we look at again going back to the numbers in terms of LTSS sustainability with regards to changes in acuity of population needing to serve more with the current funding levels that we have. That's where we need to look at things that are more globally systemic potential options. Last meeting I brought up some states look at the level of care determination and evaluate whether or not that needs to be re-evaluated. Most folks look to -- we have heard across the nation that Pennsylvania has some of the most kind of robust and level of care determination in terms of in comparison to our sister states that is in laymen's term easier to get services in Pennsylvania than other places. To looking at potentially level of care determination. We talked about the states are looking at have tiers of personal assistance services. We put everything in one bucket but perhaps tiering it is something to look at in terms of tiering it by acuity or tiering it by kind of need type such as ADLs activities of daily living. IDLs, coaching, et cetera is another area to look at.
Increasing, you know, the integration of our dual special needs population. You know, going from Medicaid first and ensuring there is alignment may be another area because if our MCO plans can really integrate health services and LTSS services in all one stream with the same care coordinator that could have a lot of improvements in health outcomes which then potentially can improve health. Those were just, you know, open it up and talk about some of those things. But, I will now turn it over to the subcommittee to hear your thoughts on the different topics and things you would like to discuss, put forward at this time. So Matt or others?
>>MATT SEELEY: Anyone have any thoughts. Go ahead.
>>LLOYD WERTZ: Lloyd Wertz here and I put a question in the question so disregard that. It would seem to me we can spend a whole lot of time thinking about service that is should be not sustainable going forward if we have to and find out that the services we have considered are very, very low cost and have some positive impact versus services that are very high cost and it might not have quite that same positive impact. I'm wondering if the OLTL has any capacity to estimate the value of a reduced level of specific services in order to sustain the LTSS program going forward?
>>JULIET MARSALA: Um, yeah I mean we certainly can. What we do know is, you know, that many of the 33 other services have much lower utilization than personal assistance services. So, we continuously evaluate all of the services with each waiver application and things of that nature. The cost versus value is an interesting question. That can certainly be modelled many different ways. We can absolutely continue to do that.
I can say personal assistance services is the main driver of LTSS services. We actually believe if there was more utilization of assistive technology or enabling technology such as Susan's point to augment not to replace but augment direct care worker services that that could actually kind of help with the cost containment. We haven't seen as much adoption of enabling technology or assistive technology that we would like.
>>LLOYD WERTZ: That's good to know if we are aware -- if we can be made aware and debate

internally what those types of services are, and how they might positively impact sustainability I think that would be good to know rather than come to the table with here is a basket of things we think we should cut back on and find out they are not being used much at all or cost very, very little.
>>JULIET MARSALA: Yeah.
>>MATT SEELEY: Any other comments from committee members?
>>PAM WALZ: This is Pam Walz to follow up on what Lloyd just said I think another type of service that we don't see a lot -- we don't see included in service plans really kind of at all is physical therapy and occupational therapy. Which of course are also available under Medicare. And, I have to say this idea actually comes from Pam [name?] At Pennsylvania health care project. If we had more robust use for people who have mobility impairments, that could improve their functioning. And reduce PAS need. We really just don't see a lot of people who are getting home community-based services getting much in the way of physical therapy and occupational therapy. In the extent it is paid for by Medicare it is a place to look at better alignment and integration with Medicare.
>>JULIET MARSALA: Thanks Pam.
>>SPEAKER: I guess --.
>>JULIET MARSALA: Patrick Taniey (sp?)
>>PADRAIG TANGENY: Do we know how Pennsylvania compares to sister states in terms of the percentage of participant who is are getting PAS services and the amount of per par it is pant that are approved in Pennsylvania versus other states?
>>JULIET MARSALA: I don't know if we have the specific personal is sis taint services state by state comparison. There is no apples to apples comparison.
Because each state defines their HCBS services slightly so that creates sort of a challenge. I can say with regards to HCBS spend per person Pennsylvania is over all spend historically has been considerably higher than other states. I can have my team kind of go back if it is helpful for the LTSS committee kind of share potential -- like the Kyser family foundation. Backpack they have done studies on HCBS spend across the states and, you know, I don't know of any that have been published recently that I can refer to but we can certainly take that back. Historically Pennsylvania's spend per person has been considerably higher than peers.
>>SPEAKER: Okay. Thank you for your help today any other data points around spend per service line or just over all trending that we can look at as a group to help answer this sustainability question we don't know what particularly is driving it or if we have another view of it, it may shape possible policy solutions moving forward.
>>JULIET MARSALA: Absolutely. We certainly can. And you know, in addition I should point out this is why we are looking forward to the state of the work force survey that OLTL will be doing that all of our providers will be required to participate in. That will give us that direct care worker area so the apples to apples comparisons across the state as well.
So definitely to your point, we will look to see what we can provide to the committee.
Kathy Cubit.
>>SPEAKER: Thank you this is Kathy Cubit. I also wanted to put in a plug under utilized services is adult day. But I'm glad to hear OLTL doing more with the DSNIPS to provide some of the supplemental benefits and would encourage I don't know if you are already monitoring or able to do for the NFI more for the NFI population because we know from national studies that often people don't utilize or are not getting those supplemental benefits to help preventing them from needing LTSS in the future. Another area working with the DSNIPS if there is a way to be more aggressive in preventing people from being discharged from hospitals to nursing homes

by having services set up at home day one as Pam mentioned physical therapy, you know, all of the different services, equipment that is needed and if an individual does need to go to a nursing home for short term stay to have the MCH to monitor to make sure they are getting the PT or other care they need. What often happens a short term stay ends up becoming a long-term stay.
So if there is work that could be done around and focus in on that area, that may help with sustainability.
I would also quickly suggest that there be better identification of veterans and the spouses of veterans and better integrating with veteran benefits knowing there will be shortages of funds but thank you for the opportunity to comment.
>>JULIET MARSALA: Thank you Kathy. Okay.
Um this is still continuing with the subcommittee I'm going to go to Pam Walz.
>>PAM WALZ: Hi I'm really just coming back to say 100 percent what Kathy just said.
We see all the time people who are in nursing homes and they came for a short term stay. They never really got the therapy they needed and/or when it was time for them to go home, the coordination between the MCO and the nursing home didn't happen. The social workers and the nursing home didn't do what they needed to do in order to help the person go home and they end up stuck for years in a nursing home.
And, they don't want to be there, they don't -- they often don't really need to be there, but the service coordination is not happening from the MCO's end. The social work support from the nursing home isn't really happening and the person didn't really get what they needed when they came in and never got back to their baseline the way they might have.
That very much and then the other related thing I would say is I have some real questions about how nursing home transition how successfully it is working currently. We have to do a lot of advocacy on behalf of our clients to get them into nursing home transition with their MCOs. The service coordinators haven't, our nursing facility clients don't know who their service coordinators are and it hasn't been offered to them when we do try to connect them, we have terrible trouble trying to connect to the service coordinators and sometimes they say they are going to do something but nothing really happens and so a robust nursing home transition program is really important for helping people who want to get out of nursing homes who could be served outside of nursing homes to get out into the community where there would be cost savings.
>>JULIET MARSALA: Thank you Pam. I appreciate you bringing that up. That is a focus for us that nursing home transition and I certainly would be interested in hearing more and hearing more cases and connecting with you further on your experiences with regards to individuals not receiving nursing home transition services within our programs. That's a special area of focus for us. We have pay per performance metrics to address that as well.
We will certainly connect further on that. Thank you for raising that.
>>SPEAKER: Will do.
>>JULIET MARSALA: Patrick Tagney.
>>PADRAIG TAGNEY: This may be out of scope for the discussion of the subcommittee it is my understanding that part of the CFC program was to help with sustainability of the program and you know, since we are having this discussion I don't know if that goal has been reached or if it was ever within scope within the CHC program. So should part of this subcommittee get the effective ens of the MCO's since they have taken over this program or is it strictly our purview to look at the services and service utilization?
>>JULIET MARSALA: Yeah.

>>MATT SEELEY: Great question.
>>JULIET MARSALA: Certainly happy.
>>MATT SEELEY: Great question.
>>JULIET MARSALA: We have an independent researcher that has been researching the impact of the CHC managed care organizations in addition that has been part of the implementation of CHC. It is certainly I think my team may need to help me out here in terms of you know the report of the impacts. I believe there was one some years ago that was reported out from OLTL that we can circulate.
>>MATT SEELEY: You cut out Juliet. Juliet?
Can anyone hear me?
>>SPEAKER: Can I hear you I think we just lost Juliet.
>>MATT SEELEY: Oh Patrick I think we are waiting for Juliet to get her connection back I think it is interesting a good portion I think it is in senate is discussing that exact issue. The Pennsylvania senate that is.
>>SPEAKER: Oh I wasn't aware of that thank you Matt.
>>MATT SEELEY: I'm sure people on this call know much more about it than I do.
>>PAM WALZ: Matt can you see when Pennsylvania senate is considering this could you --
>>MATT SEELEY: Oh I didn't mean to put out some kind of a conspiracy theory. No, no. In my other job, I work for the SILK and we do advocacy and whatnot and we have rumblings about the state senate has been looking at CHC.
>>PAM WALZ: Thanks.
>>MATT SEELEY: I don't know anything more than that. There is nothing here.
>>PAM WALZ: Yep rumblings are interesting to hear about.
>>MATT SEELEY: Yep. Paula did we lose Juliet?
>>SPEAKER: We did lose Juliet, however she is coming back in so Let's just give it a minute or two.
>>MATT SEELEY: We could always just direct everything at the secretary.
That wasn't me that was laughing.
>>SPEAKER: [Indiscernible].
>>MATT SEELEY: I was.
>>SPEAKER: Good afternoon this is Jen [indiscernible] PHATD to your question I think I can fill in a little bit of what Juliet was saying until she gets back. Just from an evaluation prospective in terms of you asking. Let me make sure I have your question right. You are asking if there has been an evaluation of whether --
>>MATT SEELEY: No that was Patrick's question. Patrick asked a question of Juliet. I'm not going to reframe it go ahead if you want to ask it again.
>>SPEAKER: Yeah, thanks Matt. The question was more for the scope of what the subcommittee is responsible for looking at or helping surrounding sustainability. It is the question of what roles the MCO's have played in promoting sustainability or not promoting sustainability of the CHC program as our understanding that was their initial role coming into management program on behalf of the office of long-term living. So should [indiscernible] measures of CHC success in meeting that mission or is it not in scope of what we should be discussioning?
>>SPEAKER: I got it. And I don't know if Juliet hopped back on, but I think she was starting to talk about our independent evaluation which we had to do at the beginning of the program when we renewed the program at the first time. It is a federal requirement that requires all new MLTSS programs to conduct an independent evaluation to ensure we are meeting the goal that

is were set forth. There would be -- there is another one coming due. It is on our website. I'm not sure if it is totally answering your question.
>>MATT SEELEY: July put in the question there are quarterly and annual reports. They are the independent assess sorry of our CHC program the report is on the web we can have them present to the committee.
>>SPEAKER: Yep, that's perfect thank you Jill. I wanted to hop in and put that out there. I think that is what Juliet was trying to communicate. Thanks Matt.
>>JULIET MARSALA: Thank you. It was. I'm back. I switched to my phone I'm so sorry I cut out in the middle of my answer. Can folks hear me okay.
>>SPEAKER: Yes.
>>JULIET MARSALA: Fantastic. All right.
Okay.
I guess anything else from additional subcommittee members?
If there are no other comments from other committee members I know Natalia has more she wanted to say and she has been chatting quite a bit. Natalia do you have anything to add.
>>SPEAKER: I don't want to take -- I see there is two hands raised. I don't know if they are --
>>MATT SEELEY: You don't have to, I just wanted to give you the opportunity.
>>JULIET MARSALA: Natalia as a committee member it is your time. The hands raised may be raised for the additional public comment period at 12:30.
>>SPEAKER: As a participant that has been going through quite a lot of issues trying to tap into the services I agree with what is being said. Some transparency something has to be evaluated as to how the MCOs what are the MCO's doing to make this program and the service ins this program rightfully and legally sustainable.? As a participant who has been jumping through serious hurdles over the past five years I hope and pray for the future individual that is will benefit from these services they could be a little smoother or a little bit more ironed out. I believe that if re-evaluation can be done I found it interesting Juliet that you mentioned that is PAS side is one of the highest of the services while in my area, I have seen service providing agencies do -- I consider it or I see it and this is my opinion as predatory approaches to seniors and what they sell these seniors is do we need a home attendant? I can help you get it. Nothing else -- if you were to do an inquiry to a huge number of participants, especially those who are seniors who also have language access issues, if they know what services are provided to these community home based services or to the 3D OLTL for that matter the majority of them will tell you oh I can get a home attendant. And in fact, being part of this subcommittee I have learned so much services that are supposedly available for us participants especially those of us like myself and plenty of others who are bed bound or that the mobility is very restricted. It shouldn't take over five years for you to be fighting up and down with an MC orb or CHC provider to obtain service that is are advertised. If you see DHC and the MCOs advertisement when they PR molt or advertise about these services, they make it sound like we get accepted into CHC and we are going to be getting all of these services. No one tells us that we have to be battling everyone -- everyone and everything that you need to tap into and I believe or I see it -- I don't know how many other participants are in this meeting whether through Zoom or in person through this webinar that can atest to the fact that everything is very beautiful someone mentioned services are beautiful on paper. But the reality of our life and especially those who do not have family members or anyone to advocate for them, there are services that we have no idea that we were able to or that we could try to. If transparency or like Matt mentioned or other individuals have been mentioning hold them accountable. Those that are being given the money or the funds to be administered on our behalf is I think a very key point to explore and

see where sustainability can be done. I myself -- I myself unfortunately can identify that I will say and I will see it as false advertisement because we don't get or we don't tap and if I feel like the service coordinators are expected to be working 24/7 but getting paid for an 8-hour shift. When you have a service coordinator that has to drive almost two hours to come and see you and then almost two hours to go back that's almost half of her day hours. And, how is, you know, sustainability -- we mentioned -- I believe there is so much repetition so much repetitious and so much obstacles in the way for providers who want to provide sincerely and truthful services and then all of the other obstacles that are put into place that make the pay out a little bit more exorbitant if someone has to spend two hours of traveling. Four hours of traveling and then not to mention when contractors are way out of your service areas.
Like someone -- my thoughts are not so clear today and when I was reading what I was going to read out it made even less sense. I'm trying to make an effort because my cognition is compromised today. I do not want to sound repetitious and I notice in some of the work groups a lot of the things that are being being expressed about obstacles for certain services. I can see more the point of view of the MCOs of the real sincere contractors who want to do the right thing for the participant that is have proven that they are medically necessary service they are looking for. Not what I want, not what I desire because the world doesn't ring around what I want. What I want is a lot of things unfortunately. I didn't want my life to change the way it did and my independence to be taken away but it is very difficult and I know that as administrators as the Secretary Arkoosh is probably listening. There is a lot of things being mentioned and I have heard individual that is say to me oh you should be glad these services or you are dealing with this program now. It was even worse before and it seems that if changes were made to make it better, as a participant fighting for over 5 years for services I don't see where the betterness was done. I am very proud I was chosen to be part of this committee. I am very proud to see that the administration is looking for the inputs and the suggestions of those of us who are in the turmoil of these services and I thank you from the bottom of my heart that you are displaying this display of personal interest on behalf of the those of us who receive these services and I -- I'm very glad that there is hope that down the road serious issues in the transportation department, in the [word?] The PAS and not to mention specialty services can be probably made a little bit better for those of us who need it.
>>MATT SEELEY: Thank you Natalia.
>>JULIET MARSALA: Thank you Natalia if I also may Matt I want to thank you Natalia for your time and participation in the subcommittee because it is a lot of time and your willingness to share is greatly valued.
>>MATT SEELEY: Now that we are all warm and fuzzy --
>>JULIET MARSALA: I did, you know, want to bring up thinking about sort of what Lloyd and David Gates had shared in the past meeting, you know, for our stake holders and our members is the recognition that we have new members of the general assembly that will be transitioning into their roles in, you know, the new year and they may not have any awareness of home and community based services and so, I think one of the opportunities for the LTSS subcommittee and others would be to educate them on the importance of your services and the program so you have a clearer understanding of what it is that we do which is a lot.
I did raise that up. I am surprised Lloyd hasn't raised it up yet but didn't want to steal your thunder Lloyd but wanted to make a point as we were talking about LTSS and tangible thing that is are needed.
>>MATT SEELEY: Lloyd is gone.
>>JULIET MARSALA: Lloyd is gone? Oh no.

>>MATT SEELEY: I don't think all the warm and fuzzies were too much.
>>JULIET MARSALA: Have to make sure you let Lloyd know I did his plug.
>>MATT SEELEY: Uh-huh. Just for everybody on the call. I guess, you know, don't have a lot to say today I looked at this today a little bit differently than you all did. I decided to keep my mouth shut. But, to Juliet's point she just made there about talking to some of these new representatives and senators and whatnot and talking about what it is like to be disabled and some of these services. I'm kind of reminded of some of the high ranking officials in the administration that could also use the same kind of teaching because I remember certain members of the administration visited a center for independent living which I am very found of. And they didn't seem to understand the difference between certain services and I'm sure we can get Shona on the line to talk about that but we will skip that for today's purposes. That's my contribution to that. There is a question. I don't know what that link means.
>>SPEAKER: It is just a link to the reports previously mentioned. But Jay has his hand up from the committee.
>>MATT SEELEY: Go ahead Jay.
>>JAY HARNER: I was in a meeting on Friday where we were discussing ODP versus PAS. And that pay scale is so far out of whack with the assistance that we need, you know, 12 to $14 versus $31 for some individuals.
If we could get individuals in administration to come into these meetings. If they don't realize why the discrepancy is. I know we give our personal stories I feel terrible for Matt I'm sorry you are in bed today. I have lost two direct care worker ins the past two weeks with no notice I'm a quadriplegic like Matt and I am dealing with it too.
>>MATT SEELEY: Jay please everyone listening today it is the point of me getting on this call and doing this from bed was not for sympathy it was to -- no, no. Jay. So everyone else knows we do what we do anyway. You know, just like anybody else out there that works Jay I know you are just like me you do your best to show up for work.
>>SPEAKER: Well, part of it is $13 an hour versus 20 to 25 or $31 an hour makes a huge difference in the work force. If we can get that information to the people in charge and describe the difference, you know, they want to pat themselves on the back for again, I understand ODP and those other programs they need funding as well. But the discrepancy and the demand and what is needed in this state to keep individuals out of the nursing home and in the community needs to be heard more and more. If we could get them to come in and listen. It is not a sob story it is the truth and reality of things. Thank you.
>>MATT SEELEY: I agree. I wish the secretary had said something today. I do if you are still on I wish you would say something. There is a question. Natalie not to [indiscernible] if they have to provide more PAS hours.
>>MATT SEELEY: I don't know enough about the ODP system to make comments about that.
>>SPEAKER: I think are you referencing agencies not paying over time? And adjusting a pay rate down if they provide more PAS hours?
>>SPEAKER: Yes.
>>JULIET MARSALA: That's what you are referencing.
>>SPEAKER: Yes agencies will hire a care giver let's say for $15 an hour. If she is working let's say two hours of OT they don't have a problem. They keep them with the same pay rate. But the minute those OT hours increase more than 6 additional hours, they adjust the pay rate to the direct care worker down and then they tell them to pay them -- yeah, when they only work two hours of OT they pay them their time and a half. But then when they are working six to eight hours maybe ten more hours of OT then they adjust the rate and then they tell the workers oh

no you are getting paid the same thing. No you are not. If you are paying me $15 an hour and I'm getting $22.50 I don't know how my math is for those two hours and now you downgrade it or adjust my rate to $13 an hour to pay me the time and a half, you are not paying me $22 an hour.
>>JULIET MARSALA: Yeah okay.
>>SPEAKER: And that is a huge practice that a lot of the -- some agencies -- some aSKWREUs are doing. And I always ask the question, if this is something legal that they can actually do, then why don't all the agencies implement this rate adjustment? And the poor care workers that don't know how to interpret that and then I take their pay stub and show them you are not getting paid the same thing you were getting paid before. On the contrary, you are losing 4 to $5 an hour and that is a huge impact in direct care worker's lives. A lot of them can barely make ends meet. You know, when I started in this services, I was doing self-directing with PPO. The pay was $10 and I live in an area where there is a lot of logistic -- not the mention the data centers that are coming and people are getting paid 20-25 dollars an hour. $18 to start. Who is going to compete with $10 how am I going to find care givers when somebody is paying them $18. If I have a family to support I want those extra $8 and put that on top when I had to chose to get out of PPO and use the agency models in order for me to retain my good care givers number one I had to find them. Number two I had to help them fill out the paperwork and all of the things. A lot of the agencies don't even have paperwork in other languages than -- only English. Number two, you know, number three, I had to do that in order to get an additional five dollars an hour for my care givers so they wouldn't go to the production lines or logistic centers and now competing with the data centers.
So I don't understand if it is legal, then why don't all of the agencies do it? And if it is iffy why no one is looking into it.
>>JULIET MARSALA: I'm some what on the iffy side and certainly if there are agencies that you are wear of that are doing that, please pass that information on to us. The department of labor is certainly looking at these types of behaviors as I mentioned earlier in my updates.
On these beheirs to address them. Certainly if there is a question about it. About labor practices in the industry, direct care workers can most certainly also call the department of labor help line to get clarification on these practices that they feel they are iffy would encourage you to share the names of the agencies that you believe are doing this.
We certainly want to know.
Matt do you want to --
>>MATT SEELEY: Move to public comments.
>>JULIET MARSALA: Yes.
>>MATT SEELEY: I would love to do that.
>>JULIET MARSALA: Can we go through some of the comments that have been in the thread or would you like to go to --
>>MATT SEELEY: Looks -- I only see one hand up.
>>JULIET MARSALA: Okay. Let's go to Brittney.
>>SPEAKER: Hello everyone. Can you hear me okay?
>>JULIET MARSALA: Yes.
>>SPEAKER: Perfect. So, I have a couple of comments. But first I wanted to ask the question to make sure I clarify my own understanding. I know that Pennsylvania has moved into a direction where the MCOs are saying we want participants to use participant directed care. Is that reason before cost saving?
>>JULIET MARSALA: So there is many reasons why participants self-direction is the preferred

option. One is that it grants more aTony and independence and control. That is generally accepted nation wise. That participant self-direction provides more self-direction for participants. It is also a cost saver in that it does cost less than the agency model still today.
So, yes.
>>SPEAKER: So I say that to say.
>>JULIET MARSALA: Go ahead.
>>SPEAKER: I say that to say, you know, I'm a previous care giver and I'm a previous administrator of a home care agency and a lot of people might not like this comment but the reality is this. There are too many agencies in Pennsylvania. Not enough of them have been pushed out of the CHC network and if Pennsylvania is going in a direction where PDO or participant directed services is the option and cost saving is part of that reason consumer choice is huge and most people should be in participant directed. These small agencies that are usually not reporting how they should that are only serving a little handful of people are usually serving people who are essentially agency with choice or whatever you want to call it because they are covering their own shifts and finding their own back and the agency is sitting there making sure payroll gets processed.
So how can we be more efficient in saying if your agency is only made of 5, 10 or 20 people and they are their own schedulers there is no need for you to be an agency?
>>JULIET MARSALA: That's a great comment and point to raise and certainly appreciate identifying it may not be a popular comment. The CHC MCOs have the ability to evaluate and address their provider networks in the way they feel necessary. Their responsibility is [indiscernible] adequacy. Certainly in the beginning of CHC it was transitioned with any willing and able provider for contributed care the intention is MCOs could cultivate their network and recognizing that there are over, as Matt said 1400 agencies you know, following the implementation, we had the public health emergency with COVID. I think the CHC MCOs and the Office of Long-Term Living at that time rightly did not want to create any additional upheaval within the network but sometime ago they certain are evaluating their network. Many of them have been making reductions based on quality, based on service capacity. Many other reasons why they might decide to do that.
And I do know they are continuing to evaluate their network and I wouldn't be surprise today see more reductions in home care aSKWREUs to come to your exact point having so many does increase their administrative burdens and costs.
>>SPEAKER: Yeah, I left home care for a reason and one of the reasons at some point you stop believing in what you do. When CHC was first presented it was presented in a way that I felt good about wanting to be one of the "good" agencies I wanted to be compliant. But when you are losing care givers and consumers to agencies that are not being held to a standard, it wears you down and you become the one running around doing the care and for what? If anyone can still be part of it and people can do like someone said, that average care giver pay for people working a ton of over time that is very real and I would love to poll agencies and see how many people are a victim of that. Care givers will do whatever they can to get at that pay check. I was desperate to do anything to get some hours. But, I digress because I can go on a rant on that one.
>>JULIET MARSALA: Yeah.
>>SPEAKER: Really quickly is far as the missed shift. As a former provider. I was talking to Matt about this the other day. It is way to easy for an agency to claim a missed shift and marked it as consumer choice or icon assumer had their informal back up cover it so there is no disciplinary action or whatever you want to call it that happens with the ageneral I because if

someone misses a shift and don't have an informal back up which is majority of people I previously have served. It is my understanding an incident report needs to be done however if you mark as consumer cancelled shift, you can just go on about your merry way and it looks like the consumer had everything under control.
How do we know --
>>SPEAKER: What's --
>>SPEAKER: I'm sorry.
>>SPEAKER: I said what?
>>BRITTANY BOYD ?: Again, I -- ran an agency for 8 years and I know for sure the missed shifts are documented and the schedulers you get to decide how you mark that shift. So for instance, if Matt makes me mad and I try to offer him someone I know he can't stand and he says no Brittney absolutely not you know we don't get along. I can say all right well we will see if we can get you care tomorrow and say consumer refused. Not my fault.
>>SPEAKER: Yeah, I hear you Brittney on that and this is one of the reasons why we reduced FC case load so hopefully they also have additional time to follow up with participants on what is happening. That's why we encourage and recommend participants use their MCO complaint hot line and call in and, you know, if that's the case and they are missing care to report that to CHCMCO's as well because I know the CHCMCOs are monitoring for those things to the best extent they can. Certainly, there is area for improvement. That is a quality factor as well in terms of quality of care provided. And, you know, certainly data says one thing and verifying the participants with their experience is another and there is multiprongs to approach that. It is also, I think, going to be very interesting to see when we start doing the state of the workforce survey what that also shows us from all of the providers. I am so grateful for all the comments I don't you are raising up today in that area of vulnerability.
>>BRITTANY BOYD ?: One more and I swear I will be quite.
I wish I had more faith in the instant reporting process, but the number of adult protective services reports I have filed in my career regarding these issues I can't tell you not one that ended in something that was beneficial for the consumer. The best I have seen done when I say best I'm being sarcastic is a consumer who was not receiving the care they were supposed to receive through multiple agencies. None of them were held accountable they all made him the problem and he ended up being put in a facility and it is like everyone just kind of washed their hands of the issue instead of saying maybe these agencies are the ones having the issue and they are part of the problem.
So, I would be curious to know what outcomes look like when incident reporting is done by agencies specifically because if it doesn't make out of the complaint hot line or doesn't make it out of an incident report and no action happens and FCs are just closing them out. What are we wasting our time reporting for.
>>JULIET MARSALA: To your point, we have rolled out some enhanced reporting and trends and additional requirements and service coordinators to evaluate, report, take action on incident reporting trends.
To your point, the individual that had multiple incidents reported, there are additional requirements for FC's to evaluate and take action that just rolled out. I think on the list Serv bulletin yesterday. Definite an a focus of the Office of Long-Term Living to your point.
>>BRITTANY BOYD ?: Thank you for your time I appreciate it.
>>MATT SEELEY: EMI reports. You know, I think this is something the MCO's should be thinking about. They have all of these provider that is are doing these types of things that are reflecting on the MCO's. I am aware of at least one MCO that does self--- I don't know what to

call it self-analysis of abuse and they look internally and their providers to see who was, you know, risky or whatnot. I think we are reached to the point where all MCO's should be doing that very strenuously internally.
Do we have any public comments Paula? There is a question here.
Is Paula still on.
>>PAULA STUM: Hi Matt this is Paula I'm going to defer to Juliet because I think she had mentioned going to the questions in the box.
>>MATT SEELEY: [Indiscernible] public comment now.
>>JULIET MARSALA: My point was there is a lot in chat feel free at Matt's direction to pull things out of chat.
>>MATT SEELEY: Oh you mean that box. I only wanted to handle Brittney because I only see one hand. I don't know whose hand it is now.
>>PAULA STUM: We will go to the box because the hands just kind of came up.
So, comment from Alexranda Cristisch please regard immigration status changes effecting certain participants effective October 1st individuals under temporary protected status reportedly lost their employment authorization for HCBS coverage however reports advised individuals not to take any idea regarding work authorizations until an official announcement is made. Meanwhile the situation remains unclear for participants with TPS. Some have received authorization end dates while others have received renewals all without clear official guidance. [Indiscernible] provides only general information. Could you please clarify how these changes should be interpreted and what steps participants and providers should take while waiting further guidance?
>>JULIET MARSALA: Hi that's a really great question.
So I think there is a couple of things in this question. Some that are related to the group of individuals that were impacted by HCBS and some of it may be directed more at the Medicaid work force expansion population.
So I'm going to say two things one we will post in our FAQs the clarifications for all of those populations and what you should do.
Following this meeting we will connect with OIM so we get their specific language out to you. That is the language and the direction I would say is the best.
Two, individuals and participants in all Medicaid programs should always look for communications from their county assistance office notifications and open those envelopes they have a [word?] On it and they are from the department of human services county assistance office. Those notifications need to be evaluated and responded to in the notification. Not what is on the news or anything like that. If your notification says it needs you to do something that is notification is what you should follow. The official notification from your county assistance office.
For providers I recommend you join the DHS helpers sub stack. You will get updated information from DHS about things and some of them are fast moving and fast changing in terms of government time.
That's one thing.
And the second thing would be certainly to check the DHS web page on the impact of HR1 and the information that is impacting both the Medicaid expansion and other populations to get your information directly from the primary source which would be the department of human services and we will share out all of that in the FAQ's after the committee goes out. And the committees have all of those direct resources. Back to you Paula.
>> PAULA STUM: This is Paula this is just a comment from Kirk Luke in the Washington office speaking on behalf of one of his consumers that he spoke with this morning she has a

wheelchair that has been broken several times in the past year. She has called the company and they don't want to fix it anymore. She called her service coordinator and asked what she was supposed to do and no one is helping her. She can't transfer out of bed to a broken wheelchair her service coordinator stated she didn't know what to do. If you are a summer individual coordinator, please help in assisting and coordinating. This is a comment from Domick Howe we need OLTL and ODP to work more collectively to advocate for Pennsylvanians instead of continuing advocating in silos. This way the administration will have a better understanding of what the need truly is.
This is a comment from Kathy Hertzog. County systems offices are already over swammed. This year it took four months for my annual renewal. My approval to be completed.
This is from Matthew Barbie. As I am reflecting on Juliet's presentation earlier it is clear a driver of over all spending increases is there are more people on the program which is a good thing that more folks are getting help. I'm curious if there were any changes to the criteria for eligibility and/or the functional eligibility determination over the past five to seven years that would be a contributing factor to the increase in folks in this program.
Matt did you want to go to Shona?
>>MATT SEELEY: Yes I can't see who the questions are.
>>PAULA STUM: Shona you should be unmuted.
>>SPEAKER?: Hello we have Kelly Barret and then Shona Akin is going to ask a second question.
>>KELLY BARRETT: So, my question is, is the governor Shapero recently introduced his advisory committee on for people with disabilities so there is a group of people with disabilities that directly advise the governor on issues that are effecting the disability community. I think that it would behoove the LTSS subcommittee to invite the governor's advisory committee to these meetings so they can access the public commentary of other people with disabilities and bring those concerns directly to the administration.
Has LTSS reached out to the advisory committee.
>>JULIET MARSALA: Hi, yes. We have the executive director come to the LTSS subcommittee meeting certainly be introduced.
You know, Dr. Badger. Certainly she is very aware of the LTSS subcommittee I know they have just started getting up and running with the committee and commissioners and their agenda and goals. It could be a two way street so to speak. Certainly, you know if and when they hold public meetings a member of the LTSS subcommittee could potentially attend those and vice versa. If the LTSS subcommittee wanted to engage the commission, you know, certainly the subcommittee could look to do that. Look to see about whether or not to [word?] Would like to change their bylaw to have a dedicated seat for someone from the commission. All of those things are certainly possible and we would absolutely have an open invitation and I can certainly follow up the with executive director to make that recommendation.
>>KELLY BARRETT: If you could, please. Sorry. If you could please because I feel like if we have a direct line to the administration, but they are not actively -- not actively but if they aren't apprised of the information and the issues they are going on then the administration can't make informed decisions.
>>JULIET MARSALA: Quite well taken thank you.
>>SHONA EAKIN: Hi this is Shona is it true center for independent living he didn't understand that when increases were given to ODP they didn't dispense in the OLTL program. In fact one of our consumers introduced themselves to him and the governor said to that individual that he was happy he could give his attendant a raise and we had to explain the governor the raise

given to ODP did not affect OLTL participants and that brings me to the comments that others have made in that I really think we need to look across the systems. Yes there are two service systems under the purview of DHS. There is OLTL and ODP. But in many ways they are so similar and we really need to look across the system, break down the silos as others have said and really look at how this can be reallocated differently. Because I'm not negating the fact that people with intellectual disabilities have needs but when you put the services of PAS next to for example the services of companion, that reimbursement is $13 more per hour than the rate of reimbursement in the northwest which is $21.48. And they are not even providing equivalent services. And then you go up the scale and look at the home and community-based service system in ODP, that rate is $45 now or versus $21.48 and they are very, very similar. I understand there is training and documentation that happens on the ODP side that doesn't happen on the OLTL side but I also know that on the OLTL side we are obligated compliance wise to respond to the department of health and obligated to respond to three different MCOs plus HuMac. We need to look at this entire system and make sure we are doing the right thing for all participants in Pennsylvania.
Hello?
>>JULIET MARSALA: Thank you for your comment. I was waiting for Matt. I didn't want to talk over him.
>>MATT SEELEY: No, thank you Shana. I didn't mean to put anybody on the spot about somebody visiting your center.
>>SPEAKER: That's okay. Thank you.
>>MATT SEELEY: Well, I didn't mean to bait the hook but thank you for that. Um we have about six minutes here people. Any other comments? Thoughts?
>>PAULA STUM: Hi Matt. This is Paula.
>>MATT SEELEY: Go ahead
>> PAULA STUM: A comment from Amy Lowenstien. PHLP also struggles to get clients who want to transition out of a nursing facility connected with NHT. It usually takes repeated requests to high level personnel and then we have to push back on the SC's doing the NHT. Discouraging people from leaving by downplaying the supports they could get and misrepresenting the scope of available services.
Um -- I have one more from Paul Rimar. I wanted to raise an important concern regarding accountability, collaboration and responsibilities of everyone involved in the discharge planning process. Service coordinators work diligently to support participants in returning to and remaining safely in the community. However, I'm concerned that discussions surrounding delayed discharges or prolonged nursing facility stays too often place responsibility on service coordinators without fully examining where barriers or breakdowns occurring. Nursing facility social worker and [indiscernible] beginning at admission including assessing discharge kneads coordinating appropriate skilled services and ensures that community base providers and supports receive the information necessary for safe and successful transition.
How can we establish greater accountability and collaboration across nursing facilities, discharge planning teams, MCOs and service coordinators that responsibilities are clearly defined, barriers are identified early, and no single entity is unfairly responsible for delays that may be outside control. We must recognize successful transitions require everyone involved to fulfill their respective responsibilities and communicate effectively. Rather than continuously focusing on assigning blame I believe we should be identifying where the actual gaps exist and developing proactive solutions that would allow service coordinators and other professionals to work together effectively. Ultimately, our shared priority should remain the participant's health,

safety, choice and successful transition into the community.
This is Paula I have another comment if we have time.
>>MATT SEELEY: Three minutes if you can squeeze it.
>>PAULA STUM: It seems the past service is considered to be the one to be limited and not looked at other options that might be useful. As PT, OT or AT as mentioned in the previous discussion, and this comment is from Justin Wood we have spoken much about SC's but I was wondering if we agree the most important level in services is the SC?
If the service coordinator is failing, we can see the consumer failing as well in most cases. What kind of accountability is instilled in the MCOs about service coordinator training and development? Are SC's being recognized when services are appropriate and needed? SC's need to be proactive opposed to reactive. Many of my consumers are jaded in regard to their SC's and performance. They will ask me to deal with the SC rather than dealing with them personally. I have spoken to SC's who have 60, 70, 80 consumers. There needs to be accountable with the MCO and SC training and development adds well as their caseloads. And I am done Matt.
>>MATT SEELEY: Thank you with that it is 12:58 I will accept a motion to adjourn if anyone has one.
>>SPEAKER: I second it.
>>MATT SEELEY: Well you can make it and I will second it how about that. We are adjourned. See you all next month. Have a lovely Thanksgiving.
>>SPEAKER: Thank you.