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Date: 7/1/2026

Event: Long-Term Services and Supports (LTSS) Subcommittee Meeting 10:00 a.m. - 1:00 p.m. ET

>> MATT SEELEY: Good morning, can anyone hear me?
>> SPEAKER: Yes, can hear you.
>> MATT SEELEY: Sound is wonderful. We are here for the July LTSS meeting. Subcommittee of the MAAC. If you are here for that you are here for the right thing. Pam, do you want to go through the stuff?
>> PAM WALZ: Sure. I am going to start with attendance. All right. Maybe let me know, let us know if you are attending in person, via webinar or by phone. Abigail Foster. Ali Kronley. Andrea Costello.
>> ANDREA COSTELLO: I am here virtually.
>> PAM WALZ: Thank you.
>> ANNA WARHEIT: Good morning, this is Anna.
>> PAM WALZ: Carol Marfisi, I know that you are here. Carol is here. Cornelus "Neil" Brady. George Fernandez Ginny Rogers. Jay Harner.
>> JAY HARNER: Good morning.
>> PAM WALZ: Good morning. Are you via webinar?
>> JAY HARNER: S, Virgil, sorry.
>> PAM WALZ: Great. Kathy Cubit.
>> KATHY CUBIT: Good morning, here virtually.
>> PAM WALZ: Good morning. Laura Lyons. Linda Litton. Lloyd Wertz.
>> LLOYD WERTZ: Present in person.
>> PAM WALZ: Thank you. Lynn Weidner? Michael Galvan. Folks who are on the line, if you can mute yourselves. We are getting background noise. Michelle "Chell" Garrett Padraig Tangney.
>> PADRAIG TANGNEY: Here virtually.
>> PAM WALZ: - - B6.[Poor audio]
>> PAM WALZ: Rebecca MacTaggart?
>> REBECCA MAGTAGGART: Present.
>> PAM WALZ: Ryan Johnson?
>> RYAN JOHNSON: Here virtually.
>> PAM WALZ: Michelle is here. Who just spoke?
>> LAURA LYONS: Laura Lyons.
>> PAM WALZ: Hello. Anyone else?
>> ABIGAIL FOSTER: Abigail Foster here virtually.
>> PAM WALZ: Great. Anyone else? All right.
>> PAULA: This is Paula. I think Neil is here but having trouble taking himself off mute.
>> PAM WALZ: Okay. Housekeeping. Should have said this at the top. This meeting is being recorded and your participation is your consent to being recorded. This meeting is being conducted in person and as I webinar to comply with logistical agreements we will end

promptly at 1:00 PM. To avoid background noise please keep your devices muted and the microphones off unless you are speaking. If you are attending the meeting in person please keep background noise to an absolute minimum. The room is fitted with ceiling microphones and pick up everything. One of the chairs will report in person attendance. Remote captioning is available at every meeting. The CART captioning link is on the agenda in the chat. It is important for only one person to speak at a time. Please state your name before commenting and speak slowly and clearly so the captioner may capture conversations and identify speakers. Please keep questions and comments concise to allow time for everyone to be heard. Webinar attendees may submit questions and comments into the questions box and go to webinar or use the raise and feature to be put in queue to speak life. Those attending in person should use one of the microphones and wait to be called upon to speak. The tabletop microphones are reserved for committee members. Microphones are limited so you may need to wait for OLTL staff to bring unto you. The general public should use the microphone on the stand in the rear of the committee tables area. OLTL staff are available for assistance. Before speaking into a microphone he is the power switch on the top middle of the microphone body to turn the microphone on. The switch should be pushed towards the end of the microphone speak into. When you are finished speaking push the same button towards the bottom of the microphone body to turn the microphone off. Time is allotted on the meeting agenda for two public comment periods. If you have questions or comments that were not heard please send them to the resource account email part of the bottom of the meeting agenda and on the LTSS sub MAAC webpage. In the event of an emergency or evacuation everyone must leave the building and assemble in the first responders Plaza. OLTL staff will be available in the safe area to provide assistance. Please see the back of the agenda for more evacuation information. Thanks. Two back to attendance, because we started right at 10:00 AM. Have any other members joined since I last asked?
>> NEIL BRADY: Good morning, this is Neil Brady.
>> PAM WALZ: Hi. I will turn it over to Matt and Juliet.
>> MATT SEELEY: Thank you Pam. I believe the background noise problem was mean. Is anybody here that still?
>> PAM WALZ: It's better.
>> MATT SEELEY: Thank you. Is Kathy available? I don't know if you want to handle that now before we get started with everything.
>> KATHY CUBIT: I am here. [Poor audio]
>> MATT SEELEY: Pardon? Kathy?
>> KATHY CUBIT: I'm sorry. Can you hear me?
>> MATT SEELEY: Yes.
>> KATHY CUBIT: It might fit with Juliet's updates because she has some slides related to what I sent around.
>> MATT SEELEY: Fair enough. On to you, Juliet.
>> JULIET MARSALA: Good morning everyone. I want to welcome everyone to the LTSS subcommittee meeting. Thanks to our sports coronary supervisor joining us on the agenda today. I look forward to that discussion and presentation to LTSS committee members. Members of the public who have joined us, I will give a quick reminder that the SEC's will be presenting to LTSS subcommittee members. They will not be taking questions from the public or during, giving responses during the public comment period. We will give follow-ups to questions folks may have as we do normally with the LTSS service meeting. A lot on the budget today but I do want to say coming back from a week out of the office and in the country. I have a lot of catching up to do. And part of that unfortunately was coming back to the Department of Justice issuing an opinion that is very alarming. Can be

very, very unsettling and for some folks downright scary. I want to take a few minutes to acknowledge that the Department of Justice opinion. Matt seems to attack some very long-standing policy or counters I should say that have been very clearly laid out through the Americans With Disabilities Act, the own decision in the rehabilitation act of 1973. And so I did want to say that this is just an opinion. All right. And as we have with past opinions we need the opinion and go about our day and our mission has not changed here at the Office of Long-Term Living. In the office of Office of Long-Term Living will continue to do our work and efforts in ensuring everyone we serve is served well with dignity, respect, keeping the goals and what identifies. Everyone at Office of Long-Term Living on understands and is committed to moving in that direction. What I do also need to point out is this is a pivotal moment in time. An opinion like this one in my opinion can set up the White House to double down and target focus on CDS labor program. I bring that up because it's a moment stakeholders and the public need to respond. As a reminder to folks. Folks may or may not know because he would have been around a really long time. Since the 1980s or since we have invented dirt, as he might say. They are optional. Individuals who need long-term services and supports have had to fight hard for the option to have community services and unfortunately they remain optional. They are not a requirement of state plan. This is a momentthat challenges the long and welcomed understanding that we have the Office of Long-Term Living. It needs to be set and needs to be said for everyone on this call who understands the importance of home-based services that now is the time to be engaged. To spend time educating and ensure people understand the importance and the need for the service. So it is an and. It has no immediate consequences to our program here in Pennsylvania. I just want to give folks a moment to breathe on that. I also want to acknowledge its July 1 and I don't have a budget. So I cannot answer any questions on budget but this budget will be critical to future years and we are going to be looking closely when that budget is enacted. And we will then look to administer the program as best as we can as we have had successfully done so many years that these programs have been developed and put in place. So I wanted to start with that before my usual routine. We will go through the agenda and getting reoriented provokes online. We have a different view of the room so that he myself oriented. There we go. The agenda, usual procurement update, looking at federal proposed and final rules provokes. I will have an update on the rural health transformation plan human services annual report, federal protective services annual report, Omnibus budget reconciliation act waiver and community health choices waiver and the intruder RAI handsome staffing updates and other items that I would try to work through quickly. For procurement updates for folks awareness on June 1, 2026 we canceled the RFA for the reprocurement of the community health

choices program. In addition we issued a request for information for the current community health choices agreement and anticipated reprocurement of community health choices program and plan. The request for information, the opportunity is open with approximately two weeks left. The deadline is July 15 at noon. not 12:01 PM. 12:00 PM. We encourage you to submit everything good, back, otherwise via the details that are there. We want to hear from as many people as possible. So I put that out there. This means that the Ginny Rogers program will continue to operate under the current CHC MCO program until further notice. Nothing has changed. Any questions about the past RFA goes to an RFA email box with folks that the Department of General services, that is R-PWRFICOMMENTS@pa.gov. Lots happening at the federal level. We want to make sure folks have every opportunity to be engaged. This is as I said the moment to be engaged. There is lots of opportunity so I hope encourage folks to have your voices be heard. On June 1, 2026 the centers of Medicaid and Medicare services released an interim final. Requiring certain adult Medicaid applicants and most as a condition of eligibility meets an 80 hour per month work requirement their employment work education programs for community service. This will includes state data requirements and establishes requirements for how dates assess and verify compliance and communicate the new requirement to Medicaid applicants and beneficiaries. There is a fact sheet. I don't want to read the many, many pages. On that final rule we have the link that CMS website in our package that is available as a download. And certainly emailed out by the listserv. Public comments for the interim final rules are due by the end of July. And so you can submit those comments via the federal registrar. This is a federal opportunity to submit comments. Folks may think that while I am in L TSS this doesn't apply to me but I can assure you it has because we are one big ecosystem and what happens in one area impacts others. We have a lot of direct care workers who may also need Medicaid expansion options so this may impact them. They impact our hospitals, etc. because we are folks who are not eligible to otherwise would be but it's too stringent and you get more uncompensated care. More uncompensated care in the system backs of a lot of things and has made implications of the populations. We are all interconnected so if you don't think this applies take a moment, think about it, talk about it and here's an opportunity to comment. Another on May 20, 2026, centers for Medicare and Medicaid services released a proposed rule for public comment describing alternatives to modify the limit on the total payment rate and other requirements for state payment and Medicaid managed care. This will addresses requirements pertaining to patient health plans, pre-played ambulatory health. Requiring contacts between states and managed care organizations, impacting everyone in our PhD program to provide payments under contract for services and associated manager to cause there actually sound set the limits for certain target Medicaid payments and programs like our cobra programs. CMS is accepting comments on this proposed rule for 60 days and a comment. For this proposed rule and is July 21, 2026 and interested parties can submit comments by the federal registrar. For folks who may not be aware there are significant impacts potentially to our community health choices managed care organizations MCO payments and program specifically because we use state directed payments. It's a comment and important role that stays used to help ensure that we have funding available for our Medicaid program and there's a lot of funding that gets tied up into the state directed payments. When that assess his restricted it caps ways in which states can adequately fund Medicaid programs. So the implications are huge. Particularly for our nursing facility folks and friends. This is a very big impact on that particular state directed payment. For home care agencies it has potential impacts in the it may create a situation where we would have to consider removing a minimum floor rate for agencies. Just for folks awareness, these are some pretty big policy changes. That are being put forward for your comments and I encourage you to think about them and take the opportunities. Another one. Federal proposed and final rule updates on June 2, office of management and budget proposed to revise guidance for federal financial assistance to improve governmentwide policies and requirements related to management of grants, cooperative agreements and other forms of assistance. The federal office of management and budget is proposing revisions including transparency, accountability and oversight for federal awards across federal government. The office proposes changes to reduce recipient burden, the listed federal grantmaking agencies proposed conforming changes to their regulations or in the case of some agencies and other entities establishing new regulations or policies and proposed changes like administrations commitment to accountability to the oversight process. Put out as part of a federal proposed rule. Comments are due on or before July 13. By the WWW.regulations.gov website. This has minimal impact to the office of long-term living. We don't necessarily issue on federal grants but there are impact to us but not necessarily administering many federal grants. There are agencies tied into our

LTSS ecosystem and Medicaid program. Which is very important to be aware of. Moving on to the rural health transformation plan. Our HTTP obtain these - - we encourage everyone in the rural health transformation plan and the work on improving access and opportunities to enlist in that list serve and/or connect to the RHTP via DHSS abstract. We will not always have updates in the OLTL so please do not depend on this committee for those updates. There have been several projects where participants received updates from the Long-Term the office of
long-term living and have projects that will include the enhancement of the nursing facility from the long-term transformation office and Department of Health. We partner very closely. We are product related to expansion of our living independence for the elderly or life services program specifically by life Northwestern Pennsylvania or - - Northeastern Pennsylvania counties. I'm very particularly excited because it means we will have more LIFE program access and more counties. As you know it's been a goal of ours to have this to be of service accessible in every single County. We were at 13 for a long while so through the RHTP process we are bringing for additional on, we have five which leaves us with eight counties left. We are whittling it down. In addition, the paramedics and expansion program post hospitalization will be getting underway and that will allow elderly and older adult participants in areas to be seen at home by paramedics rather than going back to the hospital for follow-ups. I think that is huge. Meeting people where they are at. The office of long-term living team is very link to this as is Doctor Appel, our medical director who is in the room with us today. In addition we have programs related to expanding certified nursing assistant training opportunities for staff in our rural nursing facilities. If you know, the direct care shortage is real. So we are excited about this opportunity and enhancements of the Pennsylvania link network that helps older adults and people with disabilities be connected to resources to help with home care supports, long-term care planning, transportation, Medicaid applications and other resources. The reason there is older adults here and not older adults with disabilities is because this is under a section really dedicated to aging as part of the rural health transformation plan. Not an oversight. Just would like to put those two together. Again, listserv, website, sub stack. If you want more information on RHTP. Okay. Our folks have been busy. The Bureau of human services licensing, this is the Bureau that licenses all personal care homes and assisted living residences across the common. Over 900 personal care home. Over 60 assisted living residences. This is the team that licensing them. Putting out a report of their findings summarizing licensing activities that they have taken, trainings, supports, data on who is being served and where. So the report describes the facilities inspecting the licenses, annual trends we see, number of license facilities going up, down, changes of ownership. The needs of residents served and personal care homes and assisted residences, nature of complaints, those investigated and enforcement action. Plus additional BHSL activities such as resource coordinator, by our team to help those care homes assisting individuals with receiving FSI to connect with resources because we really want to help strengthen those particularly in homes with the lowest income. There Bureau of human services licensing team also oversees the Adult Protective Services for adults with disabilities ages 18 through 59. Helping with the annual report to our DHS website, under act 70 of 2010 when this was originally enacted DHS is required to prepare this annual report to the Senate Health and Human Services committee and the house health and house human services committee about the program and services performed by Adult Protective Services. I encourage you to take a look at that. I know I'm out of time but I will get this as fast as I can. The centers for Medicaid and Medicare, was really happy that we got those before July 1, we got that on June 18. Our federal partners, that renewal continues to provide services to participants within the ages of 18 to 59 with

disabilities. Severe preview of what we intended and now have confirmation of approval. Behavior therapy and counseling services we revise language on quality monitoring process offering benefit support services for our Pennsylvania enrollment broker which is now more important than ever given the short period. For applications that people are facing. Via HR one. We are hoping supports can help folks kinda work through all of that. Required service coordinators include HCS service requirements and all service activities ensuring that we are complying with the community setting will try to reprogram we have improved over waiver on our website for folks would like to dive into that in more detail. Additionally when we do one we do look at our other waivers to ensure continued alignment where possible to reduce administrative burden and make changes that make sense and be efficient and effective with our work resources. We also had submitted approval for CHC waiver amendment. We received that approval as well. Both of these are effective July 1, 2026. This continues our authority to provide home and community-based services to participants aged 21 and over in our managed LTSS program community health choices. Some of these changes are very similar to what we put in the renewal. We added tele-service for behavior therapy and counseling services. We added language to specifically address tele-service delivery waiver services and home and community-based residual. And we removed and modified outdated language throughout the waiver that is also posted to our website and again we have to go through the applications whenever we need to make changes to the program. And minimum every five years to ensure we can have the option of providing a CDS services which is the critical piece. These are options. And those are the options we have to defend and fight for them. The inter-RAI or the international residence assessment. You heard me talk about this a couple of months ago while going through a software update. We are moving from the version I think 9.2. Don't hold me to that. The updated RAI, aging well coordinators will start utilizing the version 10 assessment. ending July 26, 2026. Our approved contractor, the InterRAI team, is in process of publishing the Pennsylvania specific version and manual so kudos to the quality team and all of our stakeholders. We wanted something Pennsylvania specific because our program is for Pennsylvanians. So very excited about that. And officially that workgroup which includes multiple stakeholders and members of the LTSS subcommittee will close out on July 14 officially. And that project will be done and there will be ongoing monitoring but that workgroup will be closed. The first and critical one is I want to share with folks and very pleased to report out that John Eyer will be beginning as our Director of finance July 4. John Eyer is a veteran of the United States Army, graduated from Shippensburg University with a bachelor of science in business administration. Has been with the Commonwealth 27.5 years including many different areas, in DHS. Office of development of programs, the office of mental health and absence abuse services and he was the financial manager at South Mountain restoration center. He has been with the office of medical assistance programs for five years. And has been working very closely with Dan share, our former director of finance for the past five years so he is been very knowledgeable on all things DHS. And hope many of you will feel the same and welcome him to his new position. He also completed his nursing home administrator program at York College in 2015. So wanted to make sure folks were aware of that change. So we are celebrating that. We have another celebration that's more of a mixed bag for many of us in the OLTL family in a broader stakeholder group. I am here also to announce and share that although Randy has been threatening us since the day I started literally as I walk into the lobby he tells me he's going to retired three years ago. Hi how are you? By the way, I'm Randy and I am retiring. We do have a date three years later. And we want to take a moment to thank Randy for your service. Randy started his career in our field back in 1983 and he started with the Commonwealth in May 1994 and has been an incredible public servant for the last

32.5 plus couple of days, years. His official retirement date is coming up on August 15 2026 so it is coming up fast. It's his second to last LTSS subcommittee meeting so I wanted to make sure you knew at this one and not his last. So you have another opportunity to throw things at him for, and see him. He may not come for that one. But you know it's just been an incredible year. Impact, you been been a great member of the public space for many partners across a 32.5 years and you know Randy does so much more. Even beyond his public service with us. It's just an incredible honor to know him over these many years and I did want to highlight the type of man Randy is. Folks may not know this but back in 2005 Randy at 7:00 AM in the morning was walking by and there was a house on fire and without hesitation he ran in with another man from the community to help save a person from a house fire. So this is a testament to who Randy is, how Randy approaches his day today when there is opportunity there is no hesitation to do the right thing and a wealth of knowledge that he has passed on to so many leaders that he has in the office of long-term living team is immense and immeasurable. We want to recognize that and say thank you, Randy. [Applause]
>> RANDY NOLEN: An old picture. It's been a long journey. My background as a social worker, I started out working in a large County nursing facility. So I have worked on about 12 years on that side. I've also done work in ICF ORC types of facilities before I came to the state in 94. I first came to the state and the Department of Health as a family and children program manager. Six years later I moved over to the Department of welfare and long-term care then moved over to running fee-for-service for a few years and then back to long-term care probably about 2005. So I've been back and long-term care for 21 years. My goal was to cruise out. I was overseeing the field operations team in different types of reviews, audits and nursing facilities and it was well set up and I was cruising out on that. And in this little thing called CHC concept came around and things to the deputies who will not be named at this time, Guy got me so involved in this program I ended up running it at this point in time. It has been a journey to switchover from a fee-for-service system to a managed care system. It has taken a lot of work. I've had the opportunity to work with a lot of people over the years. Not just within OLTL but throughout the state, all managed care programs and more importantly breaking with advocates and participants and their family members to try to improve and provide services so they can stay living in the community. We talk a lot about numbers by 35 years ago when I worked in the nursing facility, 90 percent or more of individuals got their services in nursing facilities. We are now close to 80 percent of those getting nursing care at home or they want to live. Everyone in this room has worked over the years to make that occur. So it's been very grateful work to do that. I had the opportunity yesterday with my staff. I did a staff picnic and had the opportunity to let them know that they've done tremendous work moving forward. A lot of times we hear about the issues or concerns in the program but 95 percent of this program is running fairly well. We have issues, yeah. We have issues in any public service program. We work on those issues. We work with MCO's and work with participants. So this dedication has to be to all the staff that is worked on this. I appreciate the opportunity to work with all of you and hopefully we will cross paths in the future. Thank you. [Applause]
>> JULIET MARSALA: All right. With that.
>> RANDY NOLEN: We can pass it to Lloyd.
>> KATHY CUBIT: This is Kathy. Can I make my motion now?
>> MATT SEELEY: Please do.
>> KATHY CUBIT: I like to offer a motion to give a formal accommodation from the LTSS MAAC and a statement of gratitude for Randy. I will read now. The LTSS MAAC to congratulate Randy Nolan on his retirement and acknowledge his distinguished public service to

Pennsylvania. For over 32 years Andy has been a model public servant demonstrating outstanding leadership in the highest standards of integrity and performing his duties. He leads large shoes to fill out the office of long-term living in his hard work and dedication will be remembered by all of those who have the pleasure of knowing Randy. His sincerity, responsiveness and sense of humor will be greatly missed. Randy has had a significant impact in Pennsylvania including his leadership in helping Pennsylvania transition as long-term services and supports system from a fee-for-service model to community health choices, managed care model. In addition his strong work ethic and tireless efforts were evident in helping meet the challenges presented by the COVID-19 public health emergency and the Pennsylvanians LTSS rebalancing work to serve more participants at home versus institutional settings. With this motion the LTSS MAAC formally expresses sincere gratitude and commands Randy for his outstanding public service. Congratulates him on his well-deserved retirement and wishes him all the very best for good health, happiness and success in the future. So I hope all LTSS members hybrid from some I will join in support of this motion. Thank you.
>> MATT SEELEY: Thank you, Kathy. Is there a second?
>> PAM WALZ: This is Pam Walz, I will second.
>> MATT SEELEY: Okay. Anybody in favor? Anybody oppose? Abstentions? None? Motion carries. Thank you, Kathy. With that I will pass it to Lloyd and Pam.
>> LLOYD WERTZ: Thank you. Just briefly elated to your last section, Randy, I have a few comments for later but Juliet, when you refer to the use of the rural investment phones we are getting on, you talk about support for a lot of things. One of them being the workforce that is very endangered for public servants. My recollection of the use of those funds was that you were not allowed to use it for ongoing operational purposes. Keeping that in mind as we keep in mind the purpose that you mentioned.
>> JULIET MARSALA: For operations not already in place. That's kind of why it can be used to lift up rural hospital operations or anything. So all of these sort of programs are program enhancements. So for example the LIFE is for new centers, expansion into new areas. Not those in place but new things coming. Start clarifying?
>> LLOYD WERTZ: That's great. I'm hoping it's right. But that's great.
>> JULIET MARSALA: I got confirmation from our officer, Doctor Appel that that is correct.
>> LLOYD WERTZ: Pam, I can lead in or you can. Your choice.
>> PAM WALZ: I will say a couple things and then you want to talk about the lawsuit?
>> LLOYD WERTZ: Yes.
>> PAM WALZ: I will lead by saying since our last LTSS sub we have not had another meeting for what I think is now HR one informational committee but we do have another one coming up on July 14. At the next meeting of the LTSS subcommittee we will have a report from that that has everyone heard from Juliet the interim final rule that came out has really thrown a wrench into things and is a cause for a lot of concern. States including Pennsylvania had been doing a lot of work preparing to implement HR one including a lot of work getting ready to use existing data to identify people who will be exempt. From the community engagement requirements based on medical frailty. And they were doing that based on guidance they had been receiving in conversations with CMS. The interim final rule took everyone a little bit by surprise by making significant change to the substance really of that exemption by adding a component that the medical condition must affect the individual's ability to work. And so as a result of that, all the states which have really been having to work on this already despite the lack of guidance or having to some extent go back to the drawing board to get ready to implement this. Also it's a big concern because this would narrow the scope of people who can get an exemption from community engagement. We are talking about the expansion population with this particular community

engagement requirement. There's a lot of concern whereas before the thinking was this was an exemption for people who really need to stay connected to Medicaid in order to treat their conditions. This is more a narrowing to people who can show that they are unable to work. With that I'm going to turn it over to Lloyd to talk about a very recent development.
>> LLOYD WERTZ: Thank you. Lloyd Wertz here. I guess at last week's MAAC, figured why haven't we filed a significant legal action to enjoin these animals at the federal level for processing this issue? Beyond their scope and beyond reasonableness the vulnerable population within not only our Commonwealth but across the nation and not having anything to do with the fact that we brought that up. That suit was filed. 25 states, 28 states who are members it's very easily accessible. It starts, was apparently filed in the District Court of Massachusetts. And lists a number of things you just heard Pam talk about. As we went through the influence of this latest interim final rule. I just cannot believe that we as a nation can stand by and watch people have no interest whatsoever in the welfare of anyone but the people they see in the mirror. And then process data and limit funding to services to those people who they never see and believe me, probably for the better, never will. So this is a big deal in my opinion. They can be referenced and should be referenced to determine what type of action it is and it looks pretty complete to me. Of course just because we file doesn't mean anyone will pay attention. We can certainly see our leadership seems to pay not very much attention except for his own. We need to be aware that, we need to read it, take it to local legislators, take it to the folks within the House of Representatives and particularly Senate. And point out why this was a bad idea. And point out why we will not - -
>> PAM WALZ: Does anyone here Lloyd? I just lost a sound for Lloyd.
>> SPEAKER: Same. Last for everybody.
>> PAM WALZ: I will jump in until Lloyd gets his sound back and say the lawsuit was filed by the Attorney General, I think it's close to 28 states as well as several governors and I am proud to say that our governor has joined suit. So we are part of the lawsuit here in Pennsylvania.
>> SPEAKER: Helpful, Pam. Thank you.
>> PAM WALZ: With that, unless Lloyd is able to come back I think we are ready for public comments. Turn it back over to you, Matt.
>> SPEAKER: I think Lloyd was in the room. So we may have lost the whole room.
>> PAM WALZ: Do you think we can continue with everyone on the webinar? Hopefully we still got that. Okay. Juliet says they are working on sound in the room.
>> KATHY CUBIT: She also sent a message saying please continue with HR one update but it only went directly to me.
>> PAM WALZ: I think I was done with the update. I think the main development right now is the lawsuit and just to restate what Juliet said, we are in the comment period. For comments on CMS's internal interim final rule and CLS. I know a lot of other organization are making comments on the rule.
>> JULIET MARSALA: This is Juliet. Can you hear me?
>> PAM WALZ: We can hear you. Just encourage others to make comments as well. Particularly about howthe IFR will affect Pennsylvania yes, we can hear you. Can you hear us?
>> JULIET MARSALA: The captioner can hear us.
>> PAM WALZ: It sounds like, Juliet, can you hear me? This is Pam. We can hear you.
>> SPEAKER: I don't hear anything anymore.
>> PAM WALZ: Matt, are you there? Is anyone able to hear me?
>> SPEAKER: I hear you but that's it.

>> PAM WALZ: I'm glad. Matt, are you there? Juliet says the room Wi-Fi Internet is fluctuating in the room. Matt was probably attending in person. That was probably the issue. Paula, was Matt attending in person?
>> PAULA: I think he was virtual.
>> PAM WALZ: He was virtual? Okay. All right. Well, are we ? Are we able to move on to public comments? If we do will the department staff be able to hear them?
>> PAULA: This is Paula, let me look into that, Pam.
>> PAM WALZ: Apologies for everyone attending gradually. Juliet says they will be able to see the captioner. Paula, it sounds like they will be able to see the comments as the captioner takes them down. Are we able to take public comments?
>> PAULA: Pam, this is Paula, as long as the captioner is able to hear us I think that's the way to go in.
>> PAM WALZ: All right. Are you able to take some public comments? Do we have anybody waiting to comment?
>> PAULA: I'm looking.
>> JULIET MARSALA: Pam, can you hear me?
>> PAM WALZ: You are back!
>> JULIET MARSALA: Fantastic. Nobody moves. We have a jabber microphone. Going old school.
>> PAM WALZ: Great. I believe we may have lost Matt though.
>> MATT SEELEY: No, that's in the room.
>> PAM WALZ: No wonder, go ahead.
>> SPEAKER: Matt's been last for a long time.
>> MATT SEELEY: Any public comment in the room?
>> SPEAKER: It used to be a grievance to the lawsuit as file to be included with the distribution of minutes from this meeting.
>> MATT SEELEY: Yes.
We do not appear to have public comment in the room, Paula.
>> PAULA: Hi Matt, this is Paula. I heard my name but I was not able to hear what you said.
>> MATT SEELEY: Are there any questions online?
>> PAULA: We do have Rebecca MacTaggart has her hand raised if we want to go to her.
>> REBECCA MACTAGGART: I have been looking at work requirements and unless I missed something there does not seem to be any guidance for those people who are required to work or volunteer. There aren't any requirements about while they are looking for a job or looking for an opportunity to volunteer whether or not that's going to be taken into account. We all know finding a job is not as easy as they are making it sound. Am I correct that that is not something in the guidance? Or being planned for?
>> JULIET MARSALA: What I will say is guidance in some areas is very murky. In terms of planning for Department of human services we have been doing a lot of planning to try and engage community-based organization partners to identify and work together to ensure there's opportunities for volunteering. Looking at ways of getting information out there. Perhaps leveraging things like our PA navigate, certainly working in step with the Department of Labor and other departments to ensure that we can as much as possible highlight and offer opportunities for individuals that will be impacted throughout the system. Since this is more on the Medicaid expansion population I am not the lead or most knowledgeable on these pieces or elements. The DHS strategy, for the most part, the LTSS population would be exempt by age or by meeting a definition for medical frailty. So maybe something better served for the MAAC, perhaps? I'm sorry. I can get back to you with answers. Just not the best.

>> REBECCA MACTAGGART: I appreciate it. There's many failings in the federal government as
it relates to this. It is definitely a failing of the government on the federal level not
to think about this because job market is pretty tough out there and even volunteering is
very strict. Thank you though.
>> MATT SEELEY: Thank you Rebecca. I am noticing the time. Do we want to move into that?
>> JULIET MARSALA: Yeah, there's more time at the end for additional public comments.
>> MATT SEELEY: We will come back so we can keep time with our break and whatnot. We will
move into lessons learned while planning for service provision during large
Kerri Zwolak,
sorry if I miss pronounce your name.
>> KERRI ZWOLAK: No worries. We're going to talk about - - numerous celebrations
commemorating America's 250th birthday and of course the city of Philadelphia is hosting
our FIFA World Cup. So on the next slide I wanted to start with sharing the why of why we
planned. The why really becomes the driving force behind our actions a
at AmeriHealth
Caritas Keystone First. Being proactive versus reactive. As health and safety of
participants is first and foremost our goal and we know our participants rely on the
provision of these waiver services. So I'm going to speak about lessons learned
surrounding the FIFA World Cup. Very timely which commenced in mid June and has impacted
the city of Philadelphia. So on the next slide I discuss lesson learned number one where
we learned how key it was to have a formal plan in place. So for the recent events we
started discussing the FIFA World Cup in March. We saw feedback from multiple key players
including the service coordination team provider network management, transportation and
communications. We took the time to understand the scope of the events. We did our
research, learning just how popular soccer can certainly be and developed a formal
contingency plan. We made sure the contingency plan was cross departmental as I mentioned
those key players and approached by identifying barriers to services and developing
solutions. So each department contributed insight from its areas of expertise to address
participants needs and reduce service disruption. And we did make sure that the
contingency plan was flexible to adjust as new information became available. For lessons
learned number two on the next slide we knew as a team that this plan needed to come to
life. So we knew how crucial it was for both internal and external communication to be in
place in order to successfully implement and carry out our contingency plan. So from an
internal communication perspective this consisted of set weekly meetings where each team
had representatives from each department where we reviewed updates, shared concerns and had
the ability to discuss any needed next steps. External communication with our participants
and providers was equally as important. And included our service coordinators conducting
monthly outreach to all of our participants leading up to the FIFA World Cup. As well as
this gave an opportunity for us to share updates with participants of information we had
learned about the event through our research identifying any concerns and verifying the
backup plan. Text messaging was utilized to alert participants of upcoming events. And
email fax communications was also sent to providers to make sure each provider had a plan
in place. Risks. So bringing us into lesson learned number three, we knew that we needed
ongoing review so of course he thought of our service coordination and potential service
provisions we focused providers on our care services, home delivered meals, transportation
and any other services we felt could be impacted. We did review ongoing external source
information and found enrolling in social media and extroverts from the city of

Philadelphia provide ongoing communication and beneficial information to our plan. During the most recent FIFA event we were able to gain from these text messages and website social media review additional action related to a specific area of Philadelphia that was to be particularly impacted. By closure surrounding the FIFA fan Festival. It reinforced the need because of communication. We be able to bring that back, implement and get the information for potentially impacted participants. In addition to the services we know actual service coordination is important. Any traffic, challenges, barriers related to events impacted by the FIFA World Cup were able to be communicated to coordinators as well. We also did not experience disruption in providing service coordination visits and communication with our participants. As we wrap up the World Cup in the next couple of weeks we will continue to review lessons learned. Of a large-scale event. So thank you very much. Any questions? Thank you everyone.
>> MATT SEELEY: Thank you, Kerri Zwolak. There we go.
>> JULIET MARSALA: Pause. There you go. I had to look for the captioner. She had paused.
>> MATT SEELEY: Are we speaking too fast, captioner?
>> JULIET MARSALA: I think you need to sit here. Oh no. She's got you. Go ahead, Taylor.
>> TAYLOR: Good morning everybody.
>> MATT SEELEY: It seemed like the captioner had trouble keeping up.
>> TAYLOR: Imperfect. For those of you who did not hear, my name is Taylor Galvin, I want to talk about lessons learned grievance across Pennsylvania. For this specific topic, we want to talk about lessons learned while preparing for these events in advance. Not just responding once the disruption has occurred. We know many participants really rely on consistent services to remain safe in their home. We know large events can create challenges in staffing, transportation, provider Access, communication and participation outreach. So our experience really reinforces the need to identify participants who are vulnerable. One of the big things we focus on with pH W is participant background plans. We made sure they were meaningful, current,
>> SPEAKER: - - [Away from mic]
>> JULIET MARSALA: You have to move closer to the jabber. Just use this one. Right over here. It's right over there.
>> TAYLOR GALVIN: Is everybody able to hear online now?
>> JULIET MARSALA: Thumbs up.
>> TAYLOR GALVIN: Perfect. As I was saying what we focus on here at PHW was our backup plan. We do training with service coronation entities to ensure they were reaching out to all participants ensuring their backup plans were current, they were aware of the events that were occurring and we also provided clear communication so our providers, transportation partners, participants, caregivers and all internal teams at PHW. If you are calling and to ask questions or have concerns we can address that at those times. PHW LTSS program description emphasizes coordination, participant centered cross effective managed-care including intention to after hours emergency stopping. Communication, SC caseloads in real time sharing about participants and their - - [Away from mic] the PCS P process supports this approach because service plans included risk factors, measures to minimize risk and customize contingency or backup plans while crucial services are unavailable. Documentations that reflect participants are educated on how to notify the provider or SC on any gaps in care and backup plan can be activated and safe alternatives are established. Our external emergency preparedness guide and support is really the same general principle as the Center for Medicaid and Medicare services describing the emergency preparedness requirements as intended to ensure adequate planning for natural and man-made disasters and coordination with federal state, regional and local emergency systems. Medicaid focused disaster planning guidance also highlights continuity of operational

planning, use of risk assessment data and cross agency alignment to support Medicaid members during disruptive events. What we want to highlight is a really strong approaches what we need to make sure we have a plan and model in place to identify risk quickly, communicate and coordinate services, document any actions and use after action learning to strengthen future planning for upcoming events. Lastly we want to focus on that we understand to have effective LTSS program meeting to ensure that we have a duty of care during large events, depend on planning early coordinate and clearly take accountability, not just respond on the day of the actual event itself. Any questions for PHW?

>> JULIET MARSALA: Please pause as we bring up our next speaker, David - -

>> DAVID GINGERICH: Hello, associate Vice President of managed long-term services and support from community clinical operations. Request to talk about large events and how we handle overall preparedness for our participants in our program. When we become aware of large events, next slide, please. We want to focus on the goals. The main want to ensure we are minimizing any participant or programmatic impact of whatever the event may be. Whether the NFL draft held in Pittsburgh this year, the American 250 FIFA happening now or a snowstorm, or large construction that we become aware of. The overarching goal is when we become aware of that to make plans in advance to ensure we are minimizing any disruption for participants or for the programming in general. We want to make sure we had a plan because nothing is perfect and things will happen. We have to have a process to ensure the communication or points of contact during the event are unable to continue to proceed with the provision of services and providers to ensure things flow. And ultimately just continuity of operations. Participants that we support rely on the services for life-sustaining reasons and we want to make sure we are able to be there whether it's snowing, there's a traffic delay or whatever the case may be to ensure the lights are still on. Services are still being provided and we are able to look out for participants we are entrusted to them. Next slide, please. A lot of that starts prior to the event. Sorry. You can go back one slide. Sorry, I am seeing a different screen. A lot of that starts prior to the event. When we have the opportunity to handle something in advance we want to communicate with participants, staff, written communication, telephonic messages and medication within the portal so patients are aware of something is anticipated this time period. So they understand something is coming and we want to do that as far in advance as we cancel if something needs to be scheduled months in advance we can schedule. If it's a weather event, maybe a shorter event but we still want to get that in advance of the occurrence. We want to make sure one possible from a participant service needs that we are taking account, stock and trying to order medications, meals and other supplies. In advance of folks have stock because if roads close or if there is a disruption we may not be able to get it there that day. So we want to make sure that you are not necessarily running out of anything during that time period. We also want to look to see if we can reschedule appointments. The roads around Fairmount Park are closed because of a fever watch party we want to make sure you are not scheduling anything around that area during that time if at all possible. We also, as mentioned earlier, want to discuss backup emergency plans because things will not go perfectly and we want to make sure there's a plan in place of something. Through you know who to contact. And what can be done to support you during that time period. We want to make sure we identify points of contact for our staff, for our participants, and providers as well because again things will occur their unintended during this time period. But we want to make sure that you have a centralized number or person to be able to contact so that we can support you, answer questions and resolve any issues that may come up. Next slide, please. And during the event. The communication needs to continue. As we are getting updates, particularly whether updates or construction updates. We want to make sure we are communicating that

out because again, things may last longer than anticipated. There is a tonal closing in Pittsburgh. That is supposed to be closed for a couple of weeks. It's not going to last longer than that we want to make sure that we update individuals during that time period. So they can prepare for rerouting more potential delays and certain things. We want to make sure we have a centralized team that can respond to issues. If something happens where provider is unable to do something more there is a system issue we want to make sure that we have a means to communicate that and a team that can discuss and respond in real time as is happening. Because we know things are not going to go perfectly. Throughout that. And again, communication is the key lesson. Beforehand planning during an communicating to everybody impacted really makes a difference as to how successful you can navigate through larger scale events. Next slide, please. If anybody has questions.
>> MATT SEELEY: Thank you. Are there any questions? None in the room.
>> LLOYD WERTZ: Wondering how deeply you can get into that FIFA event, okay, you can credit
see that. You've got heavy duty snowfall like the one we had recently. You may not see that as heavy as it was and totally unexpected tornado touchdowns. In - - [Away from mic] County where I live we have mountains. How can you prepare for those things in which you really cannot see? How does that work?
>> DAVID GINGERICH: Sorry, had to turn it on. Great question. That's why we have a general preparedness plan overall because to your point things happen, power may go out today because of the heat advisory and we have to have a plan for how we are going to communicative service coordinators and providers of that area. And so we have steps outlined in internal workflows that when we become aware of something we spring into action and get that communication out whether that's something that we knew in advance or something that just happened and we have to respond to it. We follow a similar process if there's an emergency closure of a facility where we pull together teams to make sure that we set up, we use internal chats a lot to make sure that we are having instantaneous communication on what we are seeing. What we can get out to different parties. As soon as possible.
>> JULIET MARSALA: I know we are coming up for a break. This is Juliet. Just wanted to respond to your question, Lloyd in terms of preparedness, planning and reaction all what we are doing today and what we are doing now. Every service coordinator is meeting with a participant that's required to look at backup planning and emergency planning. It would be my hope that everyone in this program has looked at, visited all of the information that FEMA puts out. The Federal Emergency Management Agency about how everyone should be prepared every day. To be a doomsday person, but basic standard things as much as possible should be in place, three-day water supply, additional food that doesn't necessarily need to be heated or cooked. Identification of backup power supply if you are someone who relies on power for refrigerator medication. For ventilators. Charging power chairs. There is things that can be planned and in place that service coordinators should be - - primary site, what you work. So you have to have those continuation of care and operational plans in place. We have our Jay Harner plan here in the office of long-term living. Tabletop exercises you can do. Lots of information also put out by FEMA, our Pennsylvania emergency management Association. There is information specific to those with disabilities and checklists on what they think about and their planning, their backup planning, registration, their local fire department and emergency medical services, etc. I know that was a lot, annual meeting into the break but I just wanted to take the opportunity to say that everyone has a part in preparation. Thank you.
>> MATT SEELEY: Thank you, Juliet. With that, we will take our break. we will return at 11:36 AM.

[10-minute break]
>> MATT SEELEY: One minute. top off your beverages and we will start in one minute. If you are an SE come towards the table at the front. Everybody online just bear with us for a minute. Let's go folks coming up here. Everybody j
Trying to sit in the back of the
classroom. Are you taking this? Juliet. This is community health choices service corners role in home and community based services. Representatives from all MCU. How do you want to do this, Juliet?
>> SPEAKER: I will take it.
>> MATT SEELEY: I like that.
>> SPEAKER: Good morning folks. This is Randy Nolen. These are those who work with community base individuals out there. As you know we work with nursing facilities and we will do a similar format. I will read through some stuff initially and then there are some design questions that came from the advisory board. I will take turns with question so everyone has a chance to go first, second and third. Ahmad always picking on someone first. We will get started. And go through the questions itself. A couple of things to understand. Service ordination includes the primary functions of providing information to participants and facilitating access to, locating, coordinating and monitoring needed services and supports for participants. This is done through a comprehensive needs assessment. Service coordinators lead the person centered service planning process to identify, coordinate and assist participants to gain access to needed long-term services and supports another covered services as well as other noncovered medical, social, housing, educational, employment and other services. A complete life package that they work with participants on. Service coordinators must meet with LTSS participants at least once every three months to ensure that LTSS service needs, that LTSS services are meeting their needs. At least two visits need to be in person. They can be more. Participants have a choice and can say I want to meet with my service coroner every month. It's out there requested you that and has to be adhered to. They may say I'm good with phone calls, I don't need to see you this month. But the assessments all have to be done in person. Going to go through, got a number of questions like I said. I will read the question and turn it over to the teams to talk about it. First question is please walk us through a typical initial assessment with the participant and their support team. We will start with AmeriHealth. Remember to please give your arm into you are with.
>> TAYLOR HOOVER: Taylor Hoover with OLTL eight. We like to work with each participant around the home if they have pets, any interest in the home. Giving the best way to contact us with cell phones via text, phones, emails, whatever works best. We like to scan the environment using our eyes and ears, we can look at areas of risk, adaptive equipment, what they may be lacking in those areas and we like to ask open-ended questions like tell me about yourself and clarifying questions from there. Filling in the gaps with conversation and observations that we seen. We like to show the participant and families the AmeriHealth search engine for providers or physicians.
>> RANDY NOLEN:All right, PHW.
>> TAYLOR: Taylor here with - - I initially introduce myself, give them all of my contact information and ask standard questions. That way I can get to know them prior to going out to that initial assessment. Doctor I go to the initial assessment I look around to see what the participant has, what they don't and I offer every single service that we have to offer to them. Typically they are kind of on the fence of not wanting to accept it and typically by the end of the conversation they are willing to give it a try. So typically that's how I do the initial assessment with my participants.
>> RANDY NOLEN: UPMC.

>> SANDY THOMAS: Sandy Thomas with UPMC. Our assessment begins with the initial phone call
to welcome us of the program and introduce ourselves. Remind them what the program is about and tell them about how the process works. We establish an appointment, we talk about their location. Do they have pets in the home? What's the best place to park? Are there safety concerns with entering or exiting the home? What things they can do to prepare for the assessment such as make sure you have your list of medications. Tell me your concerns that you may be affect your health and safety at home or your environment. Do you have any behavioral health concerns? Getting them prepared for the appointment. Letting them know it could be a couple of hours and once we get to the home like the other MCO said you are very observant. You look around the home, you notice when they are being mobile throughout the home, are they holding onto furniture? Does it look like they need medical equipment? Do they pretty much stay to one room because they don't have access to upstairs? Can you look at home modifications? Really you are evaluating functional needs talking about their behavioral health needs. Maybe they need a referral for behavioral health. If you are looking at their cognition. Do they have memory concerns when it comes to taking medications? Overall, there safety and how you can enable them to live at home independently with additional supports in place. We take note during the assessment of any declines or improvements. We look at involvement in the community. How we can get them involved with some social transportation if they are needing to go to church or do some shopping. Help them get out and be more involved in their aging in place with their community. Identifying supports. Do they have family that assists them? Do they have friends, neighbors? What are their informal supports? Do they live alone and need additional care? Talking about their backup plan. Like we talked about with planning with FIFA and the 250, talking about their backup plan if there is an emergency, if the caregiver calls out sick. If their electricity goes out and they rely on electricity talking about what shell they would go to. There's a lot in the initial assessment.
>> RANDY NOLEN: Thank you. The next question, how do you assess participants goals, community engagement and supports needed to achieve them? Start with PHW.
>> RENEE LAWRENCE: We discuss strengths, weaknesses, what they enjoyed six months ago, what
are you doing in the past that you are not doing so much now? Things they miss doing. Help them navigate activities that they enjoy in their community. Going to church, stuff like that. Discussing sometimes one of the biggest things is transportation. They are not sure how to go about that. We discussed transportation options, see if they have informal supports that can help, family, friends, people in their community that can help.
>> RANDY NOLEN:UPMC.
>> JANET: Janet with UPMC. We discussed everything with the participant and their care team. I like to ask the participant how their lives work when they were more active even if they were working. What did you used to do? What did you like to do when you were more mobile in the community? We also talk about culture, family, traditions, health, safety, their day-to-day routine. Those close to them are experts on what they want and how they want to live in the community. It's a collaborative process.
>> RANDY NOLEN: AmeriHealth.
>> ALICIA: Alicia with AmeriHealth, service coordinator. Taking what my peers have shared regarding participant goals is first and foremost I had a lot of folks that need translation services like typically said Darren. I can coordinate a translator in person or telephonically, we can look at American sign language or if they need an adaptive device to talk to me because in order to speak and advocate they are not going to meet their goals. So need to understand that portion of their life. If they are not able to

verbalize or communicate with those resources and I'm leaning a lot on the decision-maker or the legal guardian. I typically ask them to walk me through your day. As such will that we use if the person is doing from when they wake up to laying their head on the pillow. Talking about what makes sense to them, what makes them feel stable and grounded. If they walk me through your day is not something that's helpful for someone we do have a formal assessment that helps open up someone to socialization, who's doing what for them? If someone has a goal to have - - compliant I will talk about how to do that. If they can take ownership in doing that instead of going from pill bottles, let's look at the pillowcase. You can do that for you? If you can be present when it's happening. If my participant has some needs related to financial needs, we definitely look at giving them resources for 211 as well as find help. I just want to send and provide an appropriate foundation for them that way they know they can trust me.
>> RANDY NOLEN: Next question. Once someone is identified the need personal assistance services how do you determine the recommended hours, what tools do you use and how do you explain and consider all other services in the program? We will start with UPMC.
>> ANDREA: Hello Andrea, service career supervisor. When doing initial, even annual trigger assessments, when someone needs assessments, having those conversations. What do they need during the day? Meal prep? What do they need with bathing, personal hygiene, dressing? You have those answers, the information on what you perceive the need. You are also reviewing documentation with them for medical, somebody might've just had surgery. Let's say foot surgery for example, they cannot walk currently so you look at that ability wise when it comes to personal assistance. Walking, transferring. It's the open conversation, getting all the details needed, talking to them. What they think but also we have a tool that sort of gives a general hey let's start here. For meal prep, depending on what you need, say you are getting home delivered meals you may only need 20 minutes a day but the participant says well I would like this made. I like this snack or due to diabetes and eat snacks during certain times of the day so you might add time to that. Again, with locomotion it all depends on if they use a walker, cane, do they need assistance transferring in and out of the wheelchair? That determines how many hours but in the end of the conversation with the participant to sort of guide to see what they need.
>> RANDY NOLEN:AmeriHealth.
>> KELSEY:Kelsey with AmeriHealth Caritas. Piggy back off what was said, using the InterRAI and functionalities they have. Having conversations about what each task looks like, how they are helped by internal supports. And asking those clarifying questions to make sure we have a full picture of how a task is done for participants. We also want to talk about bridging the gap and keeping them at maximum functional capacity. So we don't want to just get services and replace their abilities. We want to build off of their strengths and have that conversation about what other services are available that could complement the personal assistance services as well.
>> RANDY NOLEN:PHW.
>> CAMI HOLLINGER: Kami Hollinger. With these services, generally we use time tasking tools to figure out the time things take. We go through and ask what the needs are for meal prep, bathing, how long everything takes, if they need help, if they can do things independently. Just going through those questions, person centered approach, what makes it personal for them? We also try to incorporate other items that may help like assistive technology and personal emergency response. Any kind of needs they may have thought make things more independent and does really person centered approach. Talking about their needs. Going through the time tasking toolsand InterRAI and that's about it.
>> RANDY NOLEN: Thank you. Next question, when intermittent needs are identified like incontinence and supervision for safety how do you work with the participant to address

those needs? AmeriHealth.
>> KELSEY: Kelsey again. We have to keep in mind every situation is personalized per participant. We want to make sure we are meeting individualized needs. We can look at other services like a personal emergency response system if there is concern about them being alone. We can look at specialized medical equipment looking like incontinence. There is technology previously mentioned like a medication dispenser, different things that can complement and help with those intermittent times. We also want to look at informal supports. If there are any able to help in those intermittent needs. We can also look at the hybrid Tempest model where we use agency directed model and a Tempest model for if there is someone at home that can help with those intermittent hours. Maybe overnight. A caregiver could come in. We been using both models of care to meet their needs. Those are just some of the ways we can identify intermittent needs being met.
>> RANDY NOLEN: PHW.
>> TAYLOR: Taylor with Pennsylvania Health and Wellness. She basically stole what I have. That's how we do it here. Especially with the pros. I know a lot of them are doing DPS watches or, making sure they are the cameras and things they would need in the home so I do utilize that a lot. That way we can hit all bases at once.
>> RANDY NOLEN: UPMC.
>> SANDY THOMAS: Sandy Thomas again with UPMC. Once someone has identified needs like
incontinence or supervision we do work with them or their primary care provider to obtain any kind of incontinence supplies they may need as far as wipes, things like that. We also have conversations about their personal emergency response device. Making sure that they know that they can use that at all times even in the shower because they are water resistant. So that kind of ensures their supervision and safety even during bathing times. We can also offer assistive technology such as cameras, door alarms, that alarms, locks pillboxes in case they have any kind of cognition issues or safety concerns with small children in the home they can obtain assistive technology for that. We also asked them about their informal supports that may be available to them that can assist during the intermittent time and need. And force field care. We also talk about split shifts if they have personal assistance services. Maybe if they have an intermittent need in the morning and at night maybe we can split their time. So yeah that's how we address those.
>> RANDY NOLEN: Great. Next question. Can you tell us what happens after the initial assessment and before plans are finalized? How do you engage with utilization management or handle situations where total hours recommended are questioned? We will start with Pennsylvania Health and Wellness.
>> SPEAKER: Hello, my name is - - green. We typically have conversations with the participant. We communicate with them to make sure they have an open discussion of what other services they can be utilized during this time. I do communicate with the participant about the grievance process so I do instructs them. If they are not satisfied with those hours to have the right to upheld those hours but we also communicate whether or not they have informal supports for backup supports in place in the system during that time. I think during assessment and after assessment there is a big communication on what to do after they are not satisfied with those hours.
>> RANDY NOLEN: UPMC.
>> ANDREA: This is Andrea. The information is taken, things are reviewed, what is functionally needed, medically needed and you know, we proceed as an MCO to put what hours determined by the assessments we use forward if that's not inconsistent with what the participant wants we do have utilization management does review that and I look forward in their respect. Again it's come back to participants, this is what we have decided. We

move forward, getting everything in place. We still do that, we still proceed with planning to make sure that services are getting started even though they may not be consistent with what the participant wants. Again, yes the participant is able to appeal that. He system with that, if they need to call and decide I need to start the process and would like to request. We will help them with the call if they need. And we follow them through the process as well letting them know that you'll be getting a letter in the mail, this is what you can do. But the main thing we also like to reassure them is you may not be happy with the hours received that you have hours in place and we will get this started for you seek get services and proceed accordingly with what you need.
>> RANDY NOLEN: PHW, I mean AmeriHealth, sorry.
>> TAYLOR: Taylor again, we reach out to providers to make sure with the participant they can confirm these hours in healthcare available for this or if we have to reach out to multiple providers trying to find available care for this participant. We also have ongoing munication with utilization management with case rounds and providing medical documentation to further backup the request hours.
>> RANDY NOLEN: Next question. A bit of a long one. If a participant identifies anticipated temporary change in condition such as an upcoming surgery with significant supports while they recover for a primary caregiver informal support not being available due to business trips, vacation, which require significant changes to supervision from the participant, how do you plan for these events and address them in a service plan? UPMC.
>> SPEAKER: - - [Away from mic] For UPMC. We look at the backup plan first but if other informal supports, we can approve temporary or respite. We have a discussion with the participant and the care team to find a strategy that aligns with their needs, goals and preferences.
>> RANDY NOLEN: Okay. AmeriHealth.
>> ALICIA: Alicia again with Amir health. Typically when participants or family contact me regarding a temporary change in condition microsurgery I will talk to them about what's the timeline? One is the surgery going to happen? How long is the recovery. For our participant? And just like my tear spoke on backup plan. Let's say my sister has been - - caregiver burnout. We can offer a trigger assessment and I will talk to the sister, the participant. To figure out what the sister has been covering for the participant to ensure a smooth transition for what the expectation is for the agency or tempest to cover. And also again if there is a situation that arises where participant calls you and says I'm in the hospital and will probably be home tomorrow you can again do a temporary increase of hours but then we will circle back to the participant to check in if necessary we may also have to do another trigger assessment. Because as always what's most important for participants is safety. Advocacy and independence.
>> RANDY NOLEN: PHW.
>> SPEAKER: One any of my participants have a temporary change in condition we discussed with some and try to get information from the primary care doctor to clinically support temporary increase needs. Then we will put it in as a request for increase of hours if we can't find informal support or backup plans to cover it. Like Felicia said we circle back with them to see if they still need the increase and if they do we we do a trigger assessment for a longer time period. Also respite, I have used respite a lot in a facility for my participants that have family members that just need a break they're going on vacation and we have short-term respite in a facility quite a bit. And that's about it.
>> RANDY NOLEN: Thank you. Next question, how do you manage your caseload and time? How
much time does it take to finish tasks from initial assessments such as documentation, referrals or gathering additional information? AmeriHealth.

>> KELSEY: Kelsey from AmeriHealth. Hard to put a time on those things because everything is individualized and how her work with everyone involved is ongoing. So we have to stay a little fluid. We have to not put time limits on anything. We just have to worry about time management. That's part of the service coordinator role and having to manage your time. Accounting for those times, ongoing care management be included with your caseload.
>> RANDY NOLEN:PHW.
>> TAYLOR: The way that I manage my caseload is as soon as I see something come in the window, whether a visit, annual, COC, doesn't really matter I am reaching out to that participant as soon as it comes across that way I stay ahead of the game normally whenever I speak with the participant I am asking them what changes they want to make. If there is any that way I can have it in my assessment pre-drafted and ready to go before I even leave my house. Typically whenever I get to a participants house is for some reason they change their mind by the time I get there what I do is update what I already put in and only I already have my assessments submitted and ready to go before even get back home. That's the way I like to do it just because a lot of my participants call me, email me, I am very close with all of my participants so it's just easier for me to do it that way before I go to the assessment and verify everything at the assessment that way I can stay on top of all of my other participants at the same time.
>> RANDY NOLEN: UPMC them.
>> SANDY THOMAS:Sandy with UPMC. How we manage our caseload and time, we have system
tools in place that prioritize our task and yes there are times where you have critical time. How we manage that if we have a new LTSS to see and critical incidents and we have all kinds of things going on we rely on our supervisors, our team because we prioritize our caseload. Other than system tools that help us and our teams, we have our calendars and I do a lot of color coding so I know green is in-person, blue is travel, hot purple is critical. So I do a lot of color coding that helps me plan my days. As far as how long it takes to finish initial assessments, someone said they vary by participant. Because there is a lot of documentation because one person may have more referrals than others. To educate them on next steps, now that the assessment is over we are working on your care plan, let's have a little bit of education and we have the numbers to call for member services. For their service coordinator. How to contact our 24 seven nurse line so they avoid going to the emergency room all the time. How to identify contacting Adult Protective Services for older Adult Protective Services and just letting them know the process. Now that we are done here you will hear from you every quarter. I will be calling and I will stop in but I will make appointments with you and making sure they understand it's important that they answer their phone. It's important that they find necessary documents that come in the mail and letting them know you will be staying in touch.
>> RANDY NOLEN:Okay. I think that was the last of the questions but I will ask one anyways. What are the biggest barriers or frustrations you have in your day-to-day work? Hoping somebody chimes in or I will call on you.
>> JULIET MARSALA: And you can't say none because I used to be in the business.
>> RANDY NOLEN: Going to call by names.
>> SPEAKER: Trying to locate. You get that new participant. Trying to locate is the barrier. Your calling any numbers you're aware of. You're doing pop and visits. Trying to locate to make sure health and safety and getting services in place.
>> STEVE: Steve from AmeriHealth who you have not heard from but you've heard from my colleagues. As a former service corner myself I would say one of the biggest challenges is often getting a lot of buy-in for participants. There's a lot of services out there that

they have available to them. There's a lot of natural supports both within their families, within the community and having supports available to them but a lot of people get really locked in where I need office hours, home care services, some of that is related to I think family members wanting to become caregivers for their loved ones which is certainly an admirable goal and I applaud people. But I feel like a lot of people get locked into the I need a certain amount of hours, I need this, I need that. But really what they're talking about is the biggest barrier I found is breaking that wall down of these are things that you want. Not necessarily things you need. We need to focus on the things you need. And try to find other ways to support you with those things you do want that may be outside of the scope of the program. We can use tools available to us to fill in those gaps like we've said before, getting that buy-in from those participants, participating in those avenues in the supports is what I find to be most challenging.
>> RANDY NOLEN: Other side of the.
>> RENEE LAWRENCE: Transportation, they don't want to take transportation and so it's a big step to take. They are taking the rapid bus on their own there for four hours and they had a 20 unit appointment. That was 20 minutes away. So it's kind of like a barrier. You're not sure how to convince them. Especially if you're in the city. They only have public or rapid transportation. The country is harder. He grew up north, there is nothing. Rabbit doesn't even do a lot of the areas that I go to see. Trying to convince them, take transportation or informal care. Trying to find caregivers that are willing to do it without getting compensated for it. Sometimes it's a tough bargain.
>> RANDY NOLEN: Matt, I will turn it over to you to see if anyone has questions for these folks.
>> MATT SEELEY: Anybody have questions? Some subcommittee member was blown away by the
presentation. Many subcommittee members have questions?
>> PAM WALZ: This is Pam, I do.
>> MATT SEELEY: Go ahead, Pam.
>> PAM WALZ: I have a few but I will start with this one. This is a question I've wondered about for years. When you are completing the time and task tool how do you come up with the amount of time for each task? Does it get fed over from the response in the InterRAI?
Doug extensive help with bathing. Does that spill over into the task tool and associated help with bathing? It's fed into the time you task tool? Do you ask the person again how often do you bathe, how long does it take you to bathe?
>> SANDY THOMAS: Sandy from UPMC. It does feed from the InterRAI to some extent but we do
have the ability to take into account, for instance, shopping. You know during the assessment, the person may need some assistance with shopping and it may come back and suggest an hour a week for shopping. But we know that person lives in a rural area further away than normal from a grocery store or they require fresh foods for their diabetic condition and have to go three times a week. So we can request to increase that but of course we can always seek guidance from our supervisor. Does that kind of answer your question?
>> PAM WALZ: That's really helpful. But in the first instance like the number comes over and is kind of fed in from the InterRAI. Is that right? I'm sorry what?
>> SANDY THOMAS: It's just a suggested amount according to how we assess their functional need. Whether they were independent, needed a little support or extensive support, depending on how we assess them and it does carry over into that.
>> PAM WALZ: Thanks. I appreciate the addition about making adjustments for things like

shopping. Thanks.
>> SANDY THOMAS: You're welcome.
>> MATT SEELEY: Can I follow-up? How much discretion do you then have? I know that suggests stuff. Not trying to put you on the spot.
>> SANDY THOMAS: I'm not quite sure how to answer that. Ask a lot of questions, for instance, shopping. You are 20 minutes away from a grocery store but it also takes you 10 minutes to get into and out of the vehicle because of your physical elements. I work with them and discuss exactly how long they think it takes to make one shopping trip. And justify that. Let's say the test says they should get an hour a week but we think it should be three. We can advocate for that in the time and task tool and speak with our supervisor about it. But ultimately it's up to utilization management. Is it not agreed-upon?
>> MATT SEELEY: The supervisor has discretion.
>> SANDY THOMAS: Yes, I would.
>> MATT SEELEY: So, Stephen.
>> ANDREA: We can have that conversation. This is Andrea with UPMC. When you're in the home, Sandy discussed shopping but if you're thinking about locomotion, mobility, your observing. So let's say you go to the home, the participant answers the door. Walks to the living room. Fine. You're having a conversation with them after doing the assessment and they said I need extensive assistance with locomotion. Okay let's have that conversation. But you are also observing I saw the participant walk unassisted. There's a lot of things going into play. You might be thinking yes they need 10 minutes a day to help with locomotion may be for transfers or getting uneven surfaces, things like that. They are saying no I need assistance three hours a day. So that's where that conversation comes into play but then you are also reviewing. Does that help?
>> LLOYD WERTZ: My primary role is that of a behavioral health advocate. My dad was mentally ill, worked in the field pretty much all my life. Sometimes of course your consumers, participants will come in knowing what does behavioral health needs are and that's good. Hopefully you'll be able to provide services to them. When behavioral health needs crop up between services or unexpected and they sure as heck can't. How long does it take to get out, get in there, assess and get services needed to the individual involved? Do you have an idea of that?
>> TAYLOR: Taylor with PHW, we identify a need for a temporary increase of that service Grenada can actually permit that temporary increase before they get out of the home to ensure the safety of the member. So we try to get them out as soon as possible. But until that time we can put those services in place to make sure they are safe and then go out and identify you need these hour-long term, what other supports can we offer? What waiver services are there? We are able to do that type increase upfront. As soon as possible to make sure that safety.
>> LLOYD WERTZ: Thank you so much for not pointing the finger. I appreciate that. Other folks?
>> STEVE: Steve AmeriHealth. When we do identify behavioral health needs, one of the things we want to redo his address those as soon as we can. Whether through referrals through the internal health coordination, - - mental health services, but there are certainly times and I can attest as a service coordinator that there are times where behavioral health needs and sometimes physical health needs kind of trump what's going on in the assessment process. I've said this to my team members someone in the middle of the mental health crisis, when you're going out to do an assessment, that takes priority. You should focus to provide that medical support and get them to a position where they want to be from a medical side for example. I worked with one participant who I went out to do her

initial assessment and she lives with diabetes and when I went out to meet with her she was having a really hard time. Really anxious constantly checking her blood sugar, her blood sugar monitor she had a continuous monitor and it was constantly saying she was low despite the fact that she was drinking a lot of orange juice, eating canned fruits and doing everything she knew to do to keep her blood sugar up. In that moment I paused and said want you to have fingerstick and it turned out her blood sugar was actually over 300 something. As just an example in the moment. Right now may be doing the assessment to get services in place isn't the priority. Getting the medical help they need and it's the same for behavioral health. Somebody's at an assessment actively having a behavioral health crisis whether it's feeling suicidal or expressing suicidal thoughts, we want to be addressing that. I fall back on the phrase that it does us no good to get services in place if the person isn't there to receive them. Your-take care of those priorities.
>> LLOYD WERTZ: Thank you so much.
>> ALI KRONLEY: I have two questions.
>> PAM WALZ: I'm sorry, can I interrupt for a moment? On my question that I asked before Lloyd's question we only got an answer from UPMC. Could we go back and get an answer to my
question from the other two MCO's? I just don't want it to get lost.
>> JULIET MARSALA: I think we are going to do follow-up because we only have so much time.
I will have them provide follow-up afterwards because I think we should get more questions as best as we can if that's okay. sorry Pam.
>> PAM WALZ: Juliet, I'm sorry, I have been wanting a question to this answer for years. Could we quickly let them answer the question? I'm hearing from other advocates on important question. We hear really inconsistent, different things at hearings about where the numbers, time and task tool come from.
>> JULIET MARSALA: Certainly.
>> PAM WALZ: Thank you.
>> JULIET MARSALA: Each of the MCO's can use their own time and task tool into their process differently so it's not as standardized process that comes from the office of long-term living. There will be differences. - -
>> PAM WALZ: That's why I would like to hear from the other two MCO's.
>> TAYLOR: Hours, specifically from the service coordinator based off of their conversation and what they see while they are in the home. For each of our tasks the service coordinator is able to give us a justification for how many minutes that task takes and how many times per day they do that task and how many days per week. We also use natural to identify what they can do independently by themselves, what they have informal support for and other services they are currently utilizing from labor. There are service Grenada justifying that for participants. Sending that over to UM. PHW side, all hours regardless of total reviewed by medical director. They are the ones making that decision and that letter is sent out.
>> PAM WALZ: Do the specific - - responses or how long does it take you to be for instance?
>> TAYLOR: Talking to the member to see how long it takes them to do those tasks and walking through if they feel the time seems to be excessive or more than they would think it would take they ask additional questions to get to the number of what's needed.
>> PAM WALZ: Thank you.
>> MATT SEELEY: AmeriHealth.
>> STEVE: We have our own internal tool in concert with the walk me through your dinner conversation incorporated into our assessment process to identify how long it takes for a particular task to be completed both based on self-reported participant and service

coordinators observation. We also tried to balance out with the want versus need, a lot of participants might want a lot of services in a particular, for a particular task but maybe the need is a little bit more or less. So we do have the opportunity to report what the participant is requesting for what they need or want with those particular tasks. We have the opportunity for service corners to provide suggestions based on all that gets looked at along with what's medically necessary and services for our team to make their decision and of course the participant feels that what is approved doesn't meet their needs they have the right to appeal that decision.
>> PAM WALZ: Do they separately ask how long it takes to do the task?
>> STEVE: Initial numbers are reported primarily by participant to the service coordinator and service Grenada uses observational skill to make suggestions from their.
>> PAM WALZ: Last follow-up. They will ask about there being a needs for InterRAI and separately during time and task tool how long it takes to bathe?
>> STEVE: Can't speak for each individual coordinator and how they run assessments but I do know a lot of coordinators are doing multiple assessments throughout the process so while completing InterRAI they do the walk me through your day, time and task tool in the back of their mind, gathering information at once.
>> MATT SEELEY: Thank you. Questions. Go ahead.
>> ALI KRONLEY: I appreciate you guys being here. If you like this is very valuable. The role you play in the system overall is important, a description of balancing your caseload I think probably was very calm and I appreciate the work you do. There's a lot of interest in discussion and I would be happy to do more. The first is about direction and what you guys talk about in terms of assessment and finalizing care plans. I didn't hear much mentioned. Tempest has a hybrid model for caregivers interested in having intermittent needs met. So I'm curious. Obviously direction is required for the first choice. If you guys could talk a little bit about how you present direction and present information. We know service coordinators are the only place participants ever receive information. Curious if you could speak to that.
>> MATT SEELEY: UPMC.
>> SPEAKER: It's a discussion in everything we do. Within our training. I know a lot of from personal experience when I was NFC, they didn't know about it. It was like I'm allowed to do that or I can do that? Education is the key. It's a few more steps to take for participant direct, getting the common law employer, things of that nature. I know sometimes makes hesitant, I can get a caregiver and I'm good to go but again it's that education is key. And it's essentially their choice as well.
>> MIKE: It's one of those conversations we have not only with assessment but with every participant. It's our role to let them know it's an option, an ongoing option and you can choose that option at any time and we provide a one page pamphlet on it. Something may have been the home. As a reminder that if you do have somebody in mind, there's other options if you don't have someone in mind. It's also really valuable in rural areas because there is not a lot of agency so that is something that, having that conversation with them so they understand.
>> MATT SEELEY: AmeriHealth.
>> STEVE: We do a lot of the same things my colleagues have shared. Service coordinators, having those conversations, that reassessment afterword and even between making sure they are aware they have the opportunity. And they can make that change from an agency model to self directed at any point in time.
>> ALI KRONLEY: Can I asked my second question?
>> JULIET MARSALA: Really quick point of clarification. Participant self-direction is the first option presented. When indicated as a service need. Not across the board. So while

the majority of participants do have PAS, not everyone uses it. For folks listening in I don't want you to get the wrong impression that it's offered to everyone. It's not. It's the first model option with personal assistant services. As an identified service to meet the need. And we are halfway through public comment but I will defer to you.
>> ALI KRONLEY: Building off of Steve. I'm curious the degree to which you feel like you're increasingly, decreasingly were the same, seeing people who are entering in to the home and community-based services, having a provider identified were having already, speaking to advertisement, getting paid to carry mom, to what degree are you feeling like what prison people are entering the system through those pipelines as opposed to a referral from a doctor.
>> STEVE: Other than speaking anecdotally I would I be able to give you hard numbers on that.
>> ALI KRONLEY: Not asking anecdotally.
>> STEVE: So again we are trying to have those conversations around PAS services is much as
possible. I don't know that I can speak confidently on how much of an increase or you know a certain percentage of participants enrolling with an agency already identified were plans in place I would probably defer to other colleagues here. We have to speak on that a little bit better.
>> MATT SEELEY: In the interest of time, in public comment, George has a question and then Paula, Pam, any questions online? I will leave it to you to set up a queue for that.
>> GEORGE FERNANDEZ: Thank you so much for being here. As a minority developer I would love to hear plans about, what are the challenges around housing? Is it affordable housing, is it not enough units being available? Are you finding any of your members really close to being homeless? Because of whatever challenges you're experiencing.
>> JANET: Yes, yes and yes. I have folks with limited income and limited income housing is very difficult to get. The waiting list or years long. And other than that which is very common, we also have people reading and for example one third floor and they want to live on the first floor. Same situation. Very difficult to find and get. I don't think that's a landlord problem. I think it's availability is not there. I think that's the issue here is the lack of affordable housing across the board. It's not a specific problem that people not wanting to do it. It's just we don't have them. They don't exist.
>> MIKE: We have folks I want to live in their homes as well but there are no longer available. So I don't know where we should turn for affordable housing. .
>> SPEAKER: Echoing the areas mentioned, have close to homeless issues.
>> MATT SEELEY: Thank you guys for coming in providing information to the committee. I appreciate you, the work you do and your time today. I will let you guys k
Go and we will
move on with public comment.
>> JULIET MARSALA: In the interest of time I will go through questions I see. If there are any specific with coordinators we will follow-up as stated earlier and our usual fashion. Comfortable. Either or. Socomments from Kelly Barrett who wants to share. Person who spent time in a nursing facility had a barrier, not enough caregivers was discharge. I want to reiterate that successful community living cannot happen for those with significant disabilities of caregiving workforce is not appropriate refunded. Right now is grossly underfunded and if the plan is to create equity, choose agency. Thank you for your comments and questions. We don't have a budget for general assembly. Working on the budget and it is for them to answer with regards to funding. With regards to equity, participant self directed and agency model going to make the assumption you're referring to investments that Governor Shapiro made in participant self-direction. Past in this last

budget, that investment was actually to create equity in the agency model where it was identified in particular that direct care workers in participant self-directed did not have consideration for things like health benefits, or things like personal time off a person in an organization, needing full-time benefits, and that were built in two assumptions, wanting to level set that, for those thinking that this was creating an equity, it was creating reverse. It was recognizing that those assumptions that go with the different ratesetting were not necessarily their for our direct care workforce. But I would say we agree a DHS that caregivers should and deserve a living wage. So we do hope that we were able to move in that direction. All right. There's a lot of questions and comments we will take note of and respond to some of them. I will go from the bottom up. In case you don't hear me get to all of your questions. We will certainly do follow-up. Can OLTL provide, state directed payments are available on the CMS website. We will ensure the link goes out. You can sort by state. That would be the easiest way to look up all of Pennsylvania state directed Medicaid payments. Of OLTL and our sister offices. Given the significance of proposed changes to the state directed payments stakeholder alignment is important. While organizations may reach certain - - stakeholders provide more informed McCormick back to CMS. For example one potential recommendation would be to ask CMS to clarify proposed changes apply only to state directed payments requiring prior CMS approval rather than Allstate directed payments. Clarification could help avoid unintended impacts from OLTL or ability of NCOs to continue implementing value-based payment arrangements from

a provider. However, if the Commonwealth intends a different strategy stakeholders would benefit from understanding a benefit would - - summoning comments. Will OLTL share comments or policies for additional stakeholders prior to the CMS comment deadline to promote thoughtful and aligned feedback. In short, no. We are not sharing comments prior to their finalization and position. And I certainly understand and welcome the desire to be aligned with us. It's just not kind of how we operate. We want folks to be able to provide where they stand in what they stand for and what's important to them. What I will say is that putting caps on state directed payments that was discussed that have significant impacts, not having caps would be a good thing. I think it would be allowing states to continue to have this flexibility to design and develop state directed payments that meet the needs of our individual state. When you see one state there is one state and is good reason for that. Populations are different. Resources are different. Our cultures are different and you can go on and on. But I do appreciate that. And, we will get back to you on that. All right. So we had a hand up. We are connected, we sent the link out for the court case. Kimberly Sharp has noted that currently there are no providers available listed on the telehealth cognitive rehab rehabilitation therapy in our directory. She knows providers need to go through validation to get signed up and become available. That both required for the new telehealth services. For validation filled out provider network. So that's for folks awareness today. Providers who are out there a listserv went out today from the office of long-term living, can barges team for provider enrollment talking approval for waivers and programs. How to enroll as a provider in telehealth services for providers who are already enrolled within the Medicaid program and Office of Long-Term Living there is an expedited process called adding services. So if you add a service you don't have to go through all of everything all over again. You do also after you change your service with us they need credentialing requirements as part of the process. We recommend you take a look at that listserv and we do encourage eligible providers to please enroll with us, we are eager to get those networks up and running and deployed. Okay. Jeff Theismann had an MCO question. First was can three MCO's comment on how they address housing needs such as home repairs? Second, what about healthy housing

needs for those with multiple chemical, electrical or environmental sensitivity, mold, allergens, different types of building materials, etc.? We will send that question out to each of the three CHC MCO's for follow-up response. I can say generally speaking that from OLTL's perspective the SC service coordinators are to help them connect with housing supports for housing repair programs. The waiver program does not cover housing repair programs. Except for some very, very limited situations where it might be connected to an environmental modification where there used to be a change, something related to an upgrade but those aren't really considered repairs so much as they are part of a home modification piece but service coordinator should be assisting with finding wherever possible home repair resources but it is not currently a covered waiver service. But they can certainly respond to that. Okay. So a question that the CHC MCO's will also receive is for service coordination when you've had consumer hours reduced by medical director does a medical director have a conversation with the service coordinator, our conversations occurring, are there just emails going back and forth describing the situation? CHC MCO's can provide more information. We will send that out and have that out. Rico Sheppard has submitted comments. One, increasingly see that MCO's have follow-up items after comprehensive needs assessment. For example request for further documentation. From their doctor to justify personal assistance services, specifically there seems to be a higher standard to support supervision. Even after hearing input from the caregiver about the participants cognitive impairments who is responsible for helping get about medical documentation following comprehensive needs assessment? How much time is reasonable for documentation to be returned? If it is not the SC was responsible for documentation what supports are available for participants with a cognitive impairment? We will get that question out to the CHC MCO's. Whether follow-up. Number two from Rico. Can each MCO provide comment on
to how routine services are accounted for and passed calculation? Would be helpful to specifically address tasks such as pain management routines like applying heating pads, lidocaine patches, massages, massaging limbs, taking on and off compression. There's a whole bunch here. So we are just going to send that out. It's a very good question. But we will make sure MCO's have that question and a response back to you, Rico. All right. Joey - - commented having significant interest in hearing MCO answers Allie's second question with an agency provider already identified. Can the MCO's answer this question as a follow-up to this meeting? We can certainly give it to the MCO's. But you know, I will go back and have a discussion with my team to see if we, OLTL, may be able to get a more accurate answer for you given we allow OLTL to engage with the Pennsylvania independent broker. One of our vendors. We may be able to get a better sense of folks coming in for the process already identifying some of those things or we may not. I will follow with my team and we will follow up with MCO's as well. Jeff Theismann asked about older Adult Protective Services legislation that is moving through the General assembly and the question was related to what would OLTL look for and can we offer comments about what we hope for with regards to legislation. What I would say, Jeff, back in September 2024 OLTL had participated in a hearing on the older adults protective services act and so that testimony should be available. It can go further in depth into DHS priorities and wish list for the legislation but I can say right now one of the things that we looked for in one of the things we hope for is alignment. Between Adult Protective Services from 19 to 59 and Adult Protective Services for those over 60 because your protections should not change because you got a year older. So that is one of our hopes with this legislation is that we get alignment. We get certain processes and education. - - Being modernized and act 70 of 2010 may be then following suit. Because there are very big distinctions between act 70 which is Adult Protective Services and the older adult protective services act.

Provided we don't substantiate perpetrators. Our mission is to go make sure the person is safe, see what the person needs to be saved and address those immediate needs. Older Adult Protective Services have a whole in addition of substantiating perpetrators. We believe that the law enforcement in the office of long-term living. Suspected time or anything like that we make the referral to law enforcement to take on that piece. We don't do it. They distinction between the two. So those are all of my comments there. Matt is giving me the stair down so I will hand it over to him.
>> MATT SEELEY: I would note the next meeting is Wednesday, August 5. Same place, same time. With that I would accept a motion to adjourn. Anybody left? George. Thank you. We are adjourned.
(End Of Session)