July 1, 2026 Long-Term Services and Supports (LTSS) Subcommittee Meeting Follow-Up Items

Assigned to the Department of Human Services (Office of Long-Term Living and Office of Income Maintenance)

1. **Related to Work Requirements,** subcommittee member Rebecca MacTaggart stated that there does not seem to be any guidance for people who are required to work or volunteer. There aren't any requirements about while an individual is looking for a job or opportunity to volunteer or if that is going to be taken into account. Rebecca asked, "Am I correct that this is not something that's in the guidance or being planned for?" Juliet responded that the Department of Human Services (DHS) strategy, for the most part, is that the LTSS population would be exempt by age or by meeting a definition for medical frailty and this inquiry may be better served for the Medical Assistance Advisory Committee, but she can get back with answers.

   Carl Feldman, Director of the Bureau of Policy with the Office of Income Maintenance, responded that nothing has been released on this issue as of yet. That said, the Centers for Medicare & Medicaid Services rules require compliance determination based upon:

   - **Work (including paid work, work in exchange for goods or services, and unpaid work),**
   - **Attend school or an educational program at least half time,**
   - **Participate in a work or job training program, or**
   - **Volunteer or do community service,**

   Hours spent on job search alone cannot be counted unless that time is counted as part of a structured work program under the Work or Job Training Program pathway.

2. **Related to the Direct Care Worker (DCW) shortage,** subcommittee member Natalia Gomez stated in the chat that there is a huge shortage of DCWs. Currently, when a DCW registers with a second agency they have to go through the entire process a second time in order to get hired while Participant care is not provided during that time, including those that have no backup informal care. Natalia asked if DHS can explore how to alleviate this process.

   Robyn Kokus, OLTL Division of Policy Development and Analysis Director, responded that regulations at 55 Pa. Code § 52.19 require all providers/agencies to run a criminal history check for every new hire. When the DCW will have routine contact with children in the Participant's home, a child abuse clearance check must also be run. While criminal history clearances cannot be transferred between employers, child abuse clearance can be transferred, and they are valid for 5 years.

In the case where a criminal history check needs to be completed and is still outstanding, the employer may choose to provisionally hire a DCW pending the result of the criminal history check meaning the DCW can provide services to Participants while waiting for the results of the criminal history check. Provisional hiring and its requirements are found in 55 Pa. Code § 52.20.

That being said, OLTL will continue to look into this issue.

3. **Regarding Participants Entering Home and Community-Based Services (HCBS),** subcommittee member Ali Kronley asked how many consumers are entering the HCBS system with an agency provider already identified as opposed to a referral from a doctor. Juliet responded that this question will be sent to the MCOs to answer, but she would also like to discuss this with her team to see if OLTL may be able to get a more accurate answer for Ali since OLTL is able to engage with the Pennsylvania Independent Enrollment Broker (IEB) and 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.

   OLTL does not have this information readily available, however it is being discussed internally, and a response will be provided as soon as possible.

4. **Related to an Act 150 Participant Utilization Review,** attendee Brenda Dare stated in the chat that she is an Act 150 participant and she was flagged for a utilization review. Brenda's service coordinator (SC) had no information as to what this process was. Brenda asked if this is something new program wide or just to her?

   Brian Lester, OLTL Division of Fee For Service Operations Human Services Program Executive 1, responded that OLTL recently conducted a state-wide analysis of Act 150 and OBRA Waiver DCW service utilization. In some instances, there were individual DCWs noted to be working a significant number of hours per day/week. To ensure the health and safety of Participants as well as quality of services in these instances, OLTL requested the completion of in-home visits for direct observations and ensuring services were being provided as prescribed in the service authorization form by each Participant's SC.

5. **Related to Participant Service Hours,** attendee Kate Blaker asked in the chat if the waiver for Community HealthChoices (CHC) works on the same timeline as the medical waiver if the CHC waiver is used due to the medical waiver not covering them. Kate gave the example of wheelchairs being allowed every five years as a comparison.

Robyn Kokus, OLTL Division of Policy Development and Analysis Director, responded that the CHC waiver does not limit items such as wheelchairs like Medicaid does. As long as the Participant is assessed to need the item and it is medically necessary, the waiver may cover it.

6. **Related to the Nursing Facility Quality Incentive Program (NFQIP),** subcommittee Vice Chair Pam Walz asked at the May LTSS subcommittee meeting if it would be possible to see what performance measures were improved in various facilities and which facilities are achieving those improvements. Jill Vovakes stated that information about the improvements over the last three years can be provided.

   Please see attached Excel spreadsheet with the requested NFQIP information.

7. **Related to Participant Medical Supplies,** attendee Kate Blaker on behalf of Kris Byrd stated in the chat that supplies are ordered every 30 days, but there are months that have 31 days. Kate asked how that works when supplies cannot be ordered but two days before and most suppliers ship through mail- which takes another two to three days.

   OLTL is reaching out to Kris for additional information to ensure an individualized response directly to the Participant.

Assigned to the Community HealthChoices Managed Care Organizations:

8. **Related to turnover of SCs,** subcommittee member Kathy Cubit asked in the chat if the SCs could please describe the process for when there is a change in a SC with an active participant with a service plan. If possible, please include timelines as well as role and responsibilities of the outgoing SC and the new SC.

   AmeriHealth Caritas (ACH)/ Keystone First's (KF) response:

   Planned SC Transfers - When an SC transfer is planned, the outgoing SC contacts the Participant to notify them of the reassignment and to provide the new SC name and direct contact information (including SC's email and direct phone number). During the handoff, the outgoing and incoming SCs review the Participant's current service plan and any pending or unresolved care plan issues. The incoming SC then contacts the Participant within two (2) business days of the re-assignment to introduce themselves, provide the Participant with their direct contact information (including SC's email and direct phone number), and continue the Participant's care and contact schedule based on the established timeframe.

   Unplanned SC Transfers - Unplanned transfers occur when the standard handoff process cannot be completed. In these situations, the incoming SC

contacts the Participant within two (2) business days of assignment to introduce themselves, provide direct contact information and assumes the Participant's care and contact schedule.

PA Heath & Wellness (PHW) response:

When there is a change in SC for a Participant with an active Person-Centered Service Plan (PCSP), PHW's goal is to ensure continuity of services and minimize disruption to the Participant's care.

Participants have the right to request a change in SC at any time. Requests may be made verbally or in writing and are reviewed based on factors such as Participant preference, geographic location, language needs, cultural considerations, and specific service needs. Outreach will be made to the Participant to confirm any preferences that may be relevant to the requested change. When a change is requested, PHW processes the request promptly and offers the Participant choice of a new SC in a timely manner.

During the transition process, the current SC remains responsible for managing the Participants' needs, maintaining required contacts, addressing any urgent concerns, and ensuring all documentation is up to date until a new SC has been chosen. The current SC also participates in a "warm handoff" process to facilitate the transfer of information and ensure the new SC is aware of the Participant's needs, services, preferences, and any pending issues.

Once the new SC is in place, they assume responsibility for ongoing service coordination activities, including Participant outreach, monitoring service delivery, ensuring required contacts are completed, maintaining the PCSP, coordinating with providers, and addressing identified needs or changes in condition. SCs are responsible for assisting Participants with all required encounters, documentation requirements, care planning activities, and coordination of services across providers and supports.

UPMC's response:

When Participants have a change in SCs, the new SC will send an introductory letter and complete an introductory phone call with the Participant. In most cases, a transition meeting is also scheduled between the previous SC and the new SC. If the previous SC is not available because they are on leave or no longer with UPMC the meeting occurs with the supervisor.

9. **Related to Participant Support,** attendee Alexanra Khristitch asked in the chat how SCs support people who have no family or other informal support when it comes to renewing their benefits. How do they ensure these individuals are aware of renewal

requirements, complete the necessary paperwork, and avoid losing essential services? How many of these losses are due to administrative barriers rather than actual ineligibility?

ACH/KF's response:

Service Coordination includes reviewing LTSS eligibility requirements with Participants and assisting them, as needed, with activities necessary to maintain eligibility. When benefits are due for renewal, the SC receives a system reminder and contacts the Participant to review renewal requirements and identify any barriers that may affect timely completion. If the Participant does not have family or informal support to assist with the eligibility process, the SC completes a visit to review the eligibility process and help with related forms. SCs also educate Participants about available resources through the Independent Enrollment Broker (IEB) Beneficiary Support Services, which can assist with completing required forms and documentation.

ACH/KF is notified 60 days in advance when eligibility is scheduled to terminate; however, the County Assistance Office (CAO) does not provide the reason for the loss of eligibility. When ACH/KF receives notice of a future termination date, SCs contact the Participant within two (2) business days to assist with reestablishing eligibility, when appropriate.

PHW's response:

SCs play a key role in supporting Participants through the renewal and recertification process, particularly for individuals who do not have family members, caregivers, or other informal supports available to assist them. As part of their responsibilities, SCs educate Participants regarding upcoming renewal requirements, provide reminders of important deadlines, and assist Participants or their authorized representatives in gathering the financial, medical, and other documentation needed to maintain eligibility. According to PHW's oversight processes, this outreach begins well in advance of the renewal date and includes ongoing support throughout the renewal period. SCs remind Participants to begin preparing required documentation and assist in obtaining necessary materials to help prevent disruptions in services.

For Participants who are at risk of losing eligibility due to missing documentation, SCs conduct proactive outreach and attempt multiple contacts when timelines permit. The process includes identifying potential barriers, providing education, assisting with coordination between the Participant and external entities, and documenting these efforts within the care management record. Reasons for eligibility concerns can include missing physician certifications, overdue assessments, or Participant non-responsiveness, among other factors.

UPMC's response:

UPMC CHC takes a proactive approach to Medicaid renewals by contacting Participants approximately 60 days before their renewal date. Participants receive a renewal letter and outreach from their SC, both of which provide information on how to obtain assistance. When support is needed, the SC refers the Participant to an Eligibility Specialist, who assists with completing and submitting the renewal through COMPASS. Following submission, Participants receive notices from the CAO and the Eligibility Specialist regarding any required documentation, deadlines, and next steps. When we are made aware that a Participant loses coverage due to an incomplete renewal, they are informed of the reconsideration process and may be able to restore coverage by submitting the required documentation within 90 days. The question of how many terminations result from administrative barriers versus actual ineligibility is best addressed by the CAOs. We do not consistently receive reliable information regarding the specific reason for a Participant's termination.

10. **Related to Participant Service Hours,** attendee Kate Blaker stated in the chat that it's unrealistic to only do grocery shopping for one hour as an individual could be stuck waiting in line that long. Kate asked if this is considered timewise since every day could be different. Kate also asked how riding with a consumer on the bus is taken into account when the Participant is stuck on bus but only has one hour of PAS allotted for grocery shopping.

ACH/KF's response:

Services are reviewed individually based on each Participant's needs and circumstances. Potential delays related to travel or shopping are considered when determining the time needed to complete these tasks. During the Comprehensive Needs Assessment (CNA) process, SCs discuss these needs with Participants and encourage them to promptly report any changes or concerns with their current services. Participants are also educated on the importance of notifying their SC when established services no longer meet their needs. If a Participant reports concerns that the authorized time is not sufficient to meet their service needs, a Trigger Assessment is scheduled to reassess those needs.

The determination of Personal Assistance Service (PAS) authorizations is not based on a standardized time frame for each activity, including shopping. PAS authorizations are authorized according to a Participant's documented medical and functional needs as reflected in the CNA. The Utilization Management (UM) Reviewer considers all needs related to accompanying the caregiver on a shopping trip, including ambulation assistance, transfer

assistance, cognitive considerations, supervision needs, and hands on support requirements when authorizing PAS.

PHW's response:

The time authorized for grocery shopping is intended to reflect the Participant's assessed need for assistance with that task, rather than account for variables such as store wait times, traffic, public transportation delays, or other circumstances that may vary from day to day.

When evaluating the need for PAS, we focus on the amount of time the Participant requires hands-on assistance to complete the activity. While we recognize that actual shopping trips may occasionally take longer due to factors outside of the Participant's control, authorization decisions are based on the routine support required for the task itself.

Similarly, time spent riding with a Participant on public transportation is not automatically added to the grocery shopping task. Transportation and travel time are considered separately from the assistance required to complete grocery shopping. If a Participant's functional limitations create a need for additional support related to transportation, those needs should be clearly documented and evaluated as part of the overall assessment and service planning process.

Each case should be assessed individually, with consideration given to the Participant's specific functional needs, available informal supports, and the most appropriate way to safely meet those needs within program guidelines.

UPMC's response:

The allotted time, for Activities for Daily Living (ADLs) and Instrumental Activities for Daily Living (IADLs), varies per Participant based on their unique assessed needs and support system. UPMC CHC allocates hours weekly based on the Participant's individual circumstances. If more time is needed for a specific activity on a given day, the Participant has flexibility to designate how authorized hours are allocated throughout the week to perform these activities.

11. **Related to Reduction of Participant Hours,** attendee Lauren Alden asked in the chat, when SCs have a Participant's hours reduced by a medical director, if the SCs have a conversation with the medical director about why and not just emails back and forth explaining the situation.

ACH/KF's response:

Reductions in service hours are reviewed through a case round discussion involving the SC, the UM department, and/or the Medical Director. Discussions may occur by telephone or virtually; however, the SC has the opportunity to engage in open dialogue with the Medical Director regarding the decision.

PHW's response:

Medical Director determinations are based on a comprehensive review of the Participant's assessment findings, supporting documentation, identified functional needs, available informal and formal supports, and any relevant medical records. If additional information is presented that was not previously considered and it impacts the assessment of need, the Medical Director may review that information as part of the determination. However, the expectation is that authorization decisions remain supported by the documented clinical evidence and assessment results.

If there is disagreement with the determination after review, the Participant retains their appeal rights and may request further review through the established process.

UPMC's response:

Medical Directors engage with the SC team through both ad hoc consultations and regularly scheduled interdisciplinary care team rounds, which includes representation from Service Coordination, Care Management, and the CHC Medical Director team. When a Participant's hours are reduced, SCs have opportunities to discuss the rationale directly with the Medical Director in these forums, rather than relying solely on email communication. These discussions are especially common for clinically complex cases and may address factors such as changes in functional capacity, cognitive status, or new diagnoses that significantly impact life expectancy or care goals. This collaborative approach ensures a comprehensive review of each Participant's needs and supports transparent decision-making regarding increases or decreases in PAS hour recommendations.

12. **Related to Comprehensive Needs Assessments (CNA),** attendee Rieko Shepherd stated in the chat that, increasingly, the MCOs have follow-up items after the comprehensive needs assessment. For example, a request for further documentation from their doctor to justify the PAS. Specifically, there seems to be a higher standard to support supervision even after hearing input from the caregiver about the Participant's cognitive impairments. Rieko asked who is responsible for helping get that medical documentation following the CNA? How much time is reasonable for the documentation to be returned? If it's not the SC who is

responsible for getting the medical documentation, what supports are available for participant with a cognitive impairment?

ACH/KF's response:

In the event additional documentation is needed following a CNA, the SC contacts the Participant's medical and/or specialty providers (the "provider") to request additional documentation. In some cases, Participants may choose to obtain the documentation themselves. When this occurs, the SC offers assistance with obtaining the documentation directly from the provider.

AHC/KF may request documentation when clarification or additional information is needed to support the Participant's request and/or functional or cognitive needs. The request for information is sent to the provider. This is an essential piece of verifying the Participant's assessment. When cognitive impairment is noted in the assessment but there is no supporting medical documentation, the MCO will request the documentation to obtain a complete picture of the Participant's assessed needs. Caregiver responses and the "Walk Me Through Your Day" are an important piece of the CNA along with all confirmed medical diagnosis when authorizing PAS. When AHC/KF requests additional documentation, the provider has 14 days to provide additional documentation. In all cases, AHC/KF will make a decision to approve or deny the requested covered service within 21 days. The Participant, authorized family member, or SC can obtain the requested information.

PHW's response:

The SC plays an important role in gathering and submitting information that supports the Participants' assessed needs. When additional clinical documentation is requested following the CNA, the SC should assist the Participant in obtaining and submitting relevant records from treating providers, particularly when the Participant may have difficulty navigating the healthcare system independently.

There is no universal timeframe that applies to every situation, as the availability of medical records and provider responsiveness can vary. However, documentation should be requested as soon as the need is identified, and all parties should make reasonable efforts to obtain and submit the information in a timely manner to prevent delays in care planning and authorization decisions.

It is important to note that a diagnosis alone does not necessarily demonstrate the need for supervision. When supervision hours are being requested, supporting documentation should clearly describe how the Participant's cognitive impairment impacts their daily functioning, safety, decision-making, ability to complete tasks independently, and the specific risks that would exist without supervision. Information provided by caregivers is valuable and is

considered as part of the overall assessment; however, additional clinical documentation may be requested when further evidence is needed to support the level of service being requested.

If a Participant has a cognitive impairment and supporting medical documentation is not immediately available, SCs should continue to assess and document the Participant's needs, risks, and available supports. This includes identifying informal supports, community resources, environmental modifications, assistive technology, emergency response systems, ADL services, and other waiver or community-based services that may help address the Participant's health and safety needs. The Participant's circumstances should be evaluated holistically to ensure the PCSP reflects the supports necessary to maintain health, welfare, and community living.

UPMC's response:

Following completion of the InterRAI/CNA, the MCO may request additional medical documentation to support the need for PAS, particularly when supervision is needed due to cognitive impairment. While the SC plays an important role in helping the Participant and caregiver identify and obtain needed information, responsibility for providing medical documentation typically rests with the Participant, caregiver, and treating provider. Because PAS services are based on assessed need and must be supported by documentation in the PCSP, timely follow-up is important; however, the timeframe for receiving documentation may vary based on provider responsiveness. Per the CHC agreement, if additional information is needed to make a decision, the CHC Managed Care Organization (MCO) must request such information from the appropriate Provider within two (2) business days of receiving the request and allow fourteen (14) days for the Provider to submit the additional information. While additional documentation is being obtained, the SC will continue to support the Participant through care coordination, monitor health and safety risks, explore available informal and community supports, and identify other authorized services or interventions that may help address supervision and safety needs.

13. **Related to PAS,** attendee Rieko Shepherd asked in the chat if each of the CHC-MCOs could provide a comment as to how routine support services are accounted for in the PAS calculation. It would be helpful to specifically address how tasks such as a pain management routine (e.g. applying heating pads, lidocaine patches, massaging limbs), assisting with taking on and off compression wraps or orthotic devices, cleaning specialized medical equipment, maintaining breathing tube connections, and supervision for someone with cognitive impairments are accounted for when these may not be explicit IADLs and ADLs listed in the respective time and task tool. How would the time for these activities be added to the PAS calculation?

ACH/KF's response:

Time allotment for routine support activities that are not explicitly listed as IADLs or ADLs are incorporated into the Participant-Centered Assessment process.
PAS and the level of service needed (DCW/ Registered Nurse/ Licensed Practical Nurse) are individualized and reflect the Participant's unique medical conditions, functional limitations, and daily care needs. The MCO evaluates the entire assessment, not just the InterRAI and Personal Services and Supports Tool, which includes:

- **The Walk Me Through Your Day – a critical component where Participant's and/or their representatives describe the specific assistance needs required throughout the day, including pain management routines, device management, and other hands-on tasks not explicitly captured in other areas of the assessment.**
- **Progress Note – which documents both observed and stated functional needs, caregiver tasks, and the context of medical conditions throughout the Participant's daily care needs.**
- **Medical Documentation – including physician recommendations based on confirmed medical diagnosis, treatment recommendations to manage conditions, treatment plans/prescriptions that substantiate the necessity for tasks.**
- **Confirmed Medical Diagnosis – by clinicians, such as from the Participant's Personal Care Provider, where the MCO consider both the diagnosis and the Participant's current stage in the disease process for supervision needs.**

PHW's response:

When evaluating these situations, the focus is not solely on the specific activity being performed, but rather on the underlying functional limitation that creates the need for assistance. Activities such as applying heating pads or lidocaine patches, assisting with compression wraps or orthotic devices, cleaning Participant-specific medical equipment, maintaining connections to medically necessary equipment, or providing supervision related to cognitive impairments should be clearly documented within the assessment narrative and discussed as part of the Participant's overall functional needs. PHW's Time & Task tool is only a guide for the SCs to use, and additional time can always be requested by the SC based on individual needs.

UPMC's response:

UPMC's InterRAI V10 and PAS calculation process allows SCs to identify and justify time required for needs that cannot be adequately represented through the ADL/ IADL calculations alone. Examples may include pain management

routines (e.g., applying heating pads, lidocaine patches, massage), assistance with compression garments or orthotic devices, cleaning specialized medical equipment, maintaining breathing-related equipment, and supervision related to cognitive impairment when the Participant cannot be safely left alone. The assessment process first establishes the Participant's total functional support need and then permits the addition of documented hours beyond the calculated ADL/IADL baseline when supported by assessment findings and clinical rationale. Additional time entered must be supported by thorough Participant-specific documentation describing the need, observations, risks, and why the activity could not be fully captured within the standard ADL/IADL framework.

14. **Regarding Participants Entering HCBS,** subcommittee member Ali Kronley asked how many consumers are entering the HCBS system with an agency provider already identified as opposed to a referral from a doctor.

ACH/KF's response:

The PAS service model and provider agency are Participant-driven choices and are not based on a physician referral. Participants have the right and responsibility to choose both the service model and the agency that will provide the service. While some Participants enter services with a preferred agency in mind, SCs review the list of participating providers with the Participant, including options for both the agency model and Participant-directed model.

PHW's response:

At this time, we do not have data available that quantifies how many Participants enter the HCBS system with an agency provider already identified compared to those who enter through a physician or other referral source.

Generally, Participants may be referred to HCBS through a variety of avenues, including healthcare providers, hospitals, family members, community organizations, self-referral, or in some cases after independently identifying a provider agency. Because there are multiple pathways into the system, and referral source information is not always captured in a standardized manner for reporting purposes, we are unable to provide a reliable percentage or comparison.

While some Participants may begin the assessment process with a preferred provider already identified, service eligibility and authorization determinations continue to be based on the Participant's assessed needs and applicable program requirements rather than the referral source or provider selection.

UPMC's response:

Based on information gathered from the Participant, between 62-68% of the Participants have a provider identified.

15. **Regarding Participant Housing Needs such as Home Repairs,** attendee Jeff Iseman asked in the chat if the three MCOs can comment on how they address housing needs such as home repairs.

ACH/KF's response:

Because home repairs are not a covered waiver benefit, SCs assist Participants by connecting them with available community resources.

PHW's response:

Housing needs are addressed through a combination of service coordination, community resource navigation, housing-related supports, and, when appropriate, waiver-funded services. SCs are responsible for identifying housing-related needs during the assessment and person-centered planning process, and assisting Participants in accessing available resources and supports that promote safe and stable community living. This includes helping Participants identify housing resources, connecting them with community programs, and coordinating services that support housing stability and tenancy.

When housing concerns involve accessibility or safety within the home, Home Adaptations may be available for eligible HCBS participants. Home Adaptations are intended to support a Participant's health, welfare, safety, and independence in the home and may include items such as ramps, grab bars, handrails, bathroom modifications, door widening, stair glides, wheelchair lifts, and other approved accessibility modifications. Repairs to existing approved home adaptations may also be covered when necessary to maintain their functionality.

It is important to note that Home Adaptations are not intended to cover general home improvement projects or routine home maintenance. Requests must be supported by the Participants' assessed needs, documented in the PCSP, and meet applicable waiver requirements and approval criteria.

For housing issues that fall outside of waiver-covered services, such as landlord-tenant concerns, major home repairs, housing instability, rental assistance needs, or other housing-related barriers, SCs work to connect Participants with community-based resources, housing programs, legal aid organizations, local agencies, and other available supports that may be able to

assist. PHW's housing-related responsibilities also include overseeing pre-tenancy and transition services that help Participants obtain and maintain housing in integrated community settings and develop the resources necessary to successfully maintain residency.

Ultimately, each housing situation is evaluated individually. SCs assess the Participant's specific needs, identify available waiver and non-waiver resources, coordinate with community partners, and work with the Participant to pursue the most appropriate solution to support their continued health, safety, and community living.

UPMC's response:

The UPMC Housing Team has created county-specific Housing Resource sheets which include the Whole Home Repair and Weatherization programs. SCs utilize the Housing Resource sheets to provide referrals to community agencies that offer home repair and weatherization programs and services when home repair needs are present. The Housing Team may be brought in to do additional research and assist, if needed.

16. **Regarding Participant Housing Needs such as Home Repairs,** attendee Jeff Iseman asked how the healthy housing needs for those with multiple chemical, electrical, or environmental sensitivities such as mold, allergies to certain types of building materials, etc., is handled.

ACH/KF's response:

If a housing need is identified, SCs are tasked with making a referral to our housing department. Our housing department can work with the Participant to see what options may be available for them to assist with issues related to housing that may arise. There may be external options that we could connect them with or if the housing is deemed unsafe a referral to legal support may be appropriate.

PHW's response:

Participants with multiple chemical sensitivities, environmental sensitivities, mold-related concerns, or other housing conditions that may impact their health and well-being are assessed on an individualized basis. SCs work with the Participant to identify how the environmental condition affects the Participant's ability to safely live in the community, as well as any resulting functional limitations, health and safety risks, or barriers to maintaining housing stability.

When housing-related conditions are identified, SCs incorporate those concerns into the assessment and person-centered planning process and coordinate with the Participant's healthcare providers, housing providers, community agencies, and other supports, as appropriate. SCs are responsible for helping Participants access needed services and supports, exploring available community resources, and coordinating efforts to address Participant-identified needs that may impact their ability to remain safely in their home.

If an environmental issue creates a need for housing modifications or accessibility-related changes, available waiver benefits such as Home Adaptations or possibly chore services may be considered when they meet program requirements and are supported by the Participants' assessed needs. Home Adaptations are intended to promote health, welfare, safety, and independence within the home environment.

UPMC's response:

Addressing the housing needs of individuals with multiple chemical, electrical, or environmental sensitivities begins with a thorough initial assessment. Identifying potential contaminants - such as mold, moisture, allergens, poor ventilation, or other environmental triggers - allows the team to develop an individualized plan of care. Based on the findings, UPMC's Healthy Home Environment program partners with remediation specialists such as Steri-Clean and ServiceMaster, who use specialized equipment and techniques to mitigate mold and improve indoor air quality. This assessment-driven approach helps ensure that interventions are tailored to each client's unique environmental health needs.