The following printout was generated by Realtime Captioning, an accommodation for the deaf and hard of hearing. This unedited printout is not certified and cannot be used in any legal proceedings as an official transcript.

Date: 06/03/2026

Event: Long-Term Services and Supports Subcommittee Meeting

>> MATT SEELEY: Good morning, good morning. We have about four minutes before we are going to start. Get your beverage ready.
>> MATT SEELEY: Good morning everyone. One minute and we will get started.
>> MATT SEELEY: I have 10:00. Good morning, everyone. It is June 3, 2026. I believe. If you are looking for the long-term services and supports subcommittee, you are in the right place. I am your chair, Matt Seeley I wish I was there in person but there are good days, there are bad days and there are disability days. Today is one of those days, if you know what I am talking about then you know what I am talking about. If you do not know what I am talking about then, I wish you did then services would be a lot better. But that is where we are. Pam, are you with us?
>> CAROL MARFISI: Hi Matt.
>> MATT SEELEY: Good morning, Carol, how are you?
>> CAROL MARFISI: OK. I know what you mean about one of those days. Believe me.
>> MATT SEELEY: You know those days too, I know, Carol.
>> PAM WALZ: Hi Matt, this is Pam. I am here. I was just struggling to get unmuted.
>> MATT SEELEY: You can take it from here, Pam.
>> PAM WALZ: Okay, all right. I think our next is Roll call. Matt I know you are here. Abigail Foster. Abigail Foster. If people could let me know also, if they are in the room or not. Andrea Costello.
>> ANDREA COSTELLO: I am here in the room.
>> PAM WALZ: Great. Anna Warheit.
>> ANNA WARHEIT: Good Morning. This is Anna joining virtually.
>> PAM WALZ: Carol, I know you are there. Are joining virtually or are you there?
>> CAROL MARFISI: Virtually.
>> PAM WALZ: Thank you. Neil Brady. Ginny Rogers. Jay Harner.
>> JAY HARNER: Good morning, virtually.
>> PAM WALZ: Kathy Cubit.
>> KATHY CUBIT: Good morning, this is Kathy I am joining virtually.
>> PAM WALZ: Laura Lyons.
>> LAURA LYONS: Good morning, I am joining virtually.
>> PAM WALZ: Linda Litton. Lloyd Wertz.
>> LLOYD WERTZ: Present, taking up space.
>> PAM WALZ: Taking up space in the room?
>> LLOYD WERTZ: Yes.
>> PAM WALZ: Okay.
>> JULIET MARSALA: Lloyd Wertz is in the room, Pam, I will go through, Andrea Costello and Chell Garrett and Ryan Johnson are also in the room with me.
>> PAM WALZ: Great, all right. Lynn Weidner.
>> LYNN WEIDNER: Good morning, This is Lynn. I'm joining virtually.
>> PAM WALZ: Michael Galvan. Chell Garrett, I know you are there and in person. I am going

to pronounce this badly. Padraig Tangney.
>> PAULA STUM: Hi, Pam, this is Paula and Padraig Tangney is here.
>> PAM WALZ: Great. Natalia Gomez.
>> MATT SEELEY: Is that Nathan Lampenfeld? Do you mind muting your microphone? What is that noise?
>> PAM WALZ: Sounds like wind blowing. Sounds like someone may be outside.
>> MATT SEELEY: I apologize.
>> JULIET MARSALA: Matt and Pam, I believe that maybe the HVAC system in this room because sometimes it does cause that difficulty and unfortunately we have checked with building maintenance and it is not an issue that we can resolve.
>> PAM WALZ: Okay. Natalia Gomez. Oh, I don't know people can hear me, I seem to have lost sound.
>> MATT SEELEY: No, that noise stopped you are fine.
>> PAM WALZ: Okay, Natalia are you here?
>> MATT SEELEY: She is not.
>> PAM WALZ: Rebecca MacTaggart. Ryan Johnson. Has anyone else joined since I have called the role? -- roll All right, I think we are done.
>> MATT SEELEY: When you guys are unmuted in the room that is when we hear it.
>> PAM WALZ: Yeah, it did go away for a moment and it is gone again.
>> MATT SEELEY: It's Shanrica's Mic. That's the one that's causing it.
>> PAM WALZ: I will read the housekeeping talking points. This meeting is being recorded. Your participation in this meeting is your consent to being recorded. This meeting is being conducted in person and as a webinar. To comply with logistical agreements, we will end promptly at 1 p.m. 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 that 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 and 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 captionist may capture conversations and identify speakers.
Please keep your questions and comments concise to allow time for everyone to be heard. Webinar attendees may submit questions and comments into the questions box in GoTo Webinar or use the "raise hand" feature to be put in queue to speak live. 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 one to 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, use 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 you speak in to. 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 found at the bottom of the meeting agenda and on the LTSS SubMAAC 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 in front of the elevators

to provide any assistance. Please see the back of the agenda for more information. if you are there in the room please see the back of the agenda for more emergency evacuation information. I think that is it.
>> MATT SEELEY: Okay. Thank you, Pam. On to you, Juliet.
>> JULIET MARSALA: Thank you. Is the noise back now that my microphone is on clay .
>> PAM WALZ: Not really.
>> JULIET MARSALA: Very good. All right. A little bit of an agenda today for my update. We can get started and do the usual procurement update. I'll talk a little bit about assisted living in lieu of services, some of the supposed rulemaking that we have received. Particular provider revalidations, payments and targeted Medicaid practitioner payments and a quick review of OLTL communications at the end, and certainly, we will have the HR 1 team do their updates. And then go into public comments. The next slide, we have some new news. With the procurement update. So on June 1, 2026, we canceled the RFA for the reprocurement of the CHC program. Also, on June 1, 2026, published a request for information. That is on the PA E marketplace PA – eMarketplace. We are seeking information to assist us with suggested input and information concerning the current CHC agreement which is posted on our website, for an anticipated reprocurement of the CHC managed care organization in the CHC program. So, anyone, anyone, interested in providing feedback and comment can do so by July 15, 2026. And that is by submitting them to the email address as noted on the bottom of the slide (slide 3). If you have questions regarding the RFA that was canceled, that email box is still open for a little while. You can send any questions about the cancel CHC RFA to the RA-PW RFA questions @ PA.gov (RA-pwrfaquestions@pa.gov) – that's for the old one. All questions regarding the request for information (RFI) that was posted, should be directed to a different email address, with procurements team. And that is RA-PW RFIcomments @ PA.gov (Certainly encourage everyone to take a look at that and encourage folks to submit their comments as directed in the RFI. It also means we are in a blackout. Please do not send comments to us. Please send them into the RFI comments account.
>> MATT SEELEY: Juliet.
>> JULIET MARSALA: Yes, Matt.
>> MATT SEELEY: Just a quick question about that and not in particulars but , the average participant, what does this mean for them?
>> JULIET MARSALA: This means the current CHC program will continue to operate as it has been, under the current CHC agreement, until such time as a new procurement occurs. For the average participant who is utilizing services, -----changes, do the day-to-day operations as we routinely have done since the inception of CHC. All right. Good question, Matt. Thanks, I should have added that. Okay, if we go to the next slide.
Moving into assisted living with in lieu of services option, wanted to give folks an update. Effective January 2026, all three of our community health choices managed care organization partners submitted and received approval from us to offer the assisted living in lieu of services option. And I know in past meetings we have had lots of presentations about what that means and how that runs. But we wanted to give you an update on the progress. Currently, there are 18 assisted living residential providers enrolled for the in lieu of services option. In the 2025 calendar year, since CHC runs on calendar year, we had 15 participants choose to utilize the assisted living in lieu of services option. In quarter one of calendar year 2026, so that is this calendar year, the CHC-MCOs collectively reported that 13 additional individuals chose to use and selected to receive assisted living in lieu of services as an option for their services. This is almost doubling the total number of participants utilizing the option in just one quarter as

Commented [PS1]: 15:08

compared to the last year. A lot of that is probably due to the increase in education, availability, understanding, and getting through some of the operational processes a little faster than when it was first implemented. Out of the 28 participants currently participating in assisted living in lieu of services, to kinda bear in mind, each MCO can develop the program differently. This is not a program that OLTL designs and puts out, this is a program that CHC-MCO's can choose to develop and put forward in this category of flexibility as an in lieu of service. Out of the 28 participants currently participating in assisted living in lieu of services option, 12 individuals were transitions from a nursing facility directly to an assisted living residence. And 16 individuals were diverted from an intending nursing facility admission. The office of long-term living, since this is new, has engaged the medical research Center, MRC, out of the University of Pittsburgh, to assist in completing an independent satisfaction and experience survey of the assisted living in lieu of services participants and providers, as a means to success of monitoring the implementation of the program, the services, and the impact, and we, the team here continues to provide education, guidance, and support to all partners there are regular meetings, through outreach efforts, technical assistance, we have certainly encouraged more of the assisted living residence providers who might still be a little anxious about getting their toe into our Medicaid enrollment program to please consider enrolling so we can build out that network for coverage across the Commonwealth. If folks are interested in learning more about assisted living in lieu of services, can we go to the next slide? My team has provided a list of resources commonly available, a lot of information for folks. If you were interested in the policy pieces, we have the long-term care handbook from the office of income maintenance policy - Chapter 490 that was released January 7, 2026. There is the in lieu of services operations memo from the office of long-term living that was released back in October of 2023. And the ops memo number 2026 – 04 related specifically to the PA 1760 change form which was released in March of 2026. If you're interested in sort of some the policy stuff behind it, some of the details and how it operates, etc. , these would be good resources for you. In addition, it’s also included in the CHC agreement. If you have specific questions regarding assisted living in lieu of services option, please direct it, if it is a participant question related to participant services please direct that specific question to the CHC-MCO that is serving that participant. General questions about assisted living can also be sent to our Pennsylvania independent enrollment broker. Their team has been trained on assisted living in lieu of services option. And or questions can be sent to the office of long-term living provider enrollment unit. Particularly, for those assisted living providers who have yet to enroll and might have questions or need support, the OLTL team is ready to assist you there. I would say, as an important caveat, that the assisted living in lieu of services is not available to anyone in assisted living residence. You cannot just say I want assisted living in lieu of services. Assisted living in lieu of services is a service that is available to individuals who are eligible for this community healthchoices program and long-term services and supports. You have to be a CHC enrolled participant with a CHC-MCO before enrolling or selecting an assisted living option. There is always some confusion with that so I hope that helps clear that up. To the next slide.

I am going to switch and talk about a little bit of provider revalidation. So we, as many know, we received on April 23, 2026, a letter regarding the request for states to develop and submit a comprehensive two-year provider revalidation strategy. This came from CMS. This was to include a description of how Pennsylvania ensures the accuracy of our provider enrollment data through revalidation and other approaches. We have been analyzing that letter and that request and are speaking amongst all the different offices because this is --- wide, to finalize the response, the response is being finalized. I do not have specifics to share with folks today. But

Commented [PS2]: 21:06

certainly, DHS and the secretary's office and the exec team will be sharing additional information once that response is finalized. And for that response, I am talking about the 30 day expensive response. There was a 10 day response as well. Which we did respond back to and that is simply an acknowledgment of the letter. We did that. We said, we received the letter and now the 30 day response is being finalized. What I would say there also, since we're talking about provider revalidation is I encourage all providers to take a look at your provider revalidation date in PROMISe and to be very timely on your revalidation. You heard me talk about this before but if you let your revalidation lapse that means you out of the program and you will not get paid. It is not retroactive. For folks who are licensed by the Department of Health, if you let your Department of Health license lapse, then you are out of the program. There is no retroactive payment because there is no retroactive licensing reissuance from the Department of Health. These are very important dates and activities, please stay on top of them so we can maintain a robust provider network. Let's go to the next slide.

Commented [PS3]: 22.58

Now I'm going to be switching to the Medicaid community engagement requirements Interim final rule from CMS. Which is document CMS-2454-IFC. On June 1 of this year, CMS released an interim final rule, or IFR, requiring that certain adult Medicaid applicants and enrollees must, as a condition of Medicaid eligibility, meet an 80 hour per work requirement through employment, education or programs or community service. The rule also includes state data reporting requirements and establishes requirements for how states must assess and verify compliance in communicate the new requirements and Medicaid applicants and beneficiaries. A fact sheet, a condensed version of the Medicaid community engagement requirement interim final rule, we have included a link to that Interim Final Rule (IFR) so that folks can access of that fact sheet will be directed to the fact sheet that was posted by CMS. CMS has requested public comment on this interim rule. Let me say that again. Any member of the public can submit a comment to CMS on this rule about community engagement that they are putting out there. Interested parties can submit their comments through the Federal Register, and we have included a link for that in our program but you can certainly go to the CMS website and find it there. This is very connected to our work around HR 1 and the Medicaid expansion community engagement /work requirement. I will reiterate, any member of the public or any stakeholder can submit comments to CMS directly about the interim final rule. Those comments are due by July 31. 2026. All right, another proposed rule, we go to the next slide.

Commented [PS4]: 23:15

Is on state directed payments and targeted Medicaid practitioner payments. Back in May of 2026, CMS released a proposed rule for public comment describing alternatives to modify the limit on the total payment rate and other requirements for state directed payments and Medicaid managed care. What is a state directed payment? State directed payment is where the state can direct how certain funds are distributed through some of our agreements and CHC. For the office of long-term living specifically, this is really part and parcel with our nursing facility rate process and our nursing facility assessment process. All right so it's a, pretty big deal for CHC. The proposed rule addresses requirements pertaining to prepaid inpatient health plans and prepaid ambulatory health plans, requirements pertaining to the contracts between the states and managed care organizations like our agreements with us and community healthchoices to provide payments on a risk-based contract for services and associate administrative costs that are actuarially sound, changing how we report things. It set the limit for certain targeted Medicaid payments and Medicaid fee-for-service. And CMS is accepting comments on the proposed rule for 60 days with a comment period ending July 21, 2026. Interested parties can submit comments via the Federal Register. It's fairly easy to do. We encourage anyone, because anyone can submit comments directly to CMS, to take a look at that and submit

Commented [PS5]: 25:26

comments it you so choose.
OLTL communications. We had some recent communications go out. Just a reminder, our 2026 nursing facility quality incentive, NFQI program attendance list went out in May. On May 19 via our list serv to nursing facilities, we released who we had on record for a chance at attending the training through the long-term care learning network webinar. We also included the attestation form required for 2026. Take a look at the list, if you are not on the list and you believe you should be on the list, please submit the attestation form and if you have any questions regarding attendance or the attestation form submission, please send them to the following resource account at RA-PWNFLNATTEST@PA.gov. Webinars for the 2026 NFQI are currently occurring on Thursdays at 2 PM. You can find more information and links to those webinars at www.tomorrowshealthcare.org. For our nursing facilities. We do encourage you to participate in those. Now, I am going to hand things over to Pam and Lloyd for the HR 1 update. We are going to hold questions for me or comments for the public comment period that will immediately follow. Pam, back to you.
>> PAM WALZ: Okay, great, thank you. This is Pam Walz, Lloyd would you like me to start since you are a little bit newer?
>> LLOYD WERTZ: Go right ahead.
>> PAM WALZ: Again, I am our LTSS, one of LTSS's liaisons to the HR 1 implementations stakeholder group, a series of meetings the department is holding with stakeholders to get feedback, and tell us about how they are implementing the requirements of HR 1, also known as the big beautiful bill. And Lloyd Wertz is now our second liaison to the group. We had a stakeholder meeting on May 8. The power points from that have been distributed, I think. It focused on, first of all, I just want to say that the secretary, secretary Arkoosh began by telling people that they are very focused right now on implementing community engagement requirements. Which I will talk about little bit more in a second. But there is currently no work going on that would reduce benefits, reduce eligibility, anything like that. We are just not at that point in the process yet. And in fact, she said she is hopeful that anything like that, if it ever does come to pass as a result of HR 1, would not happen until perhaps, as late as maybe 2029. Just as a reassurance for starters, the department is not working on figuring out any kinds of cuts to programs currently and does not seem to foresee doing so anytime in the near future. The rest of the presentation went through the work the department is doing around implementing community engagement requirements which go into effect in October 2026. As a reminder, the community engagement requirements also called work requirements, they only affect the Medicaid expansion group. This is Obama care, Magi, people who became eligible for Medicaid after the affordable care act and when Pennsylvania adopted that option. So it does not apply to anyone in community healthchoices because those populations are, as they are defined, just not included in this. The population we are thinking about are adults between the ages of 19 and 64. And so, we heard about the departments plans for implementing the community engagement requirements including a lot of information on the approach they are taking which involves using electronic data they have to the greatest extent possible. To determine whether people are in compliance because they are working enough hours. And also, to determine whether people meet various exemptions. Which means they do not have to comply with the work requirements. Having said that people in CHC are not going to be affected by this, we are aware that a lot of people in their lives will be, family caregivers, direct care workers, the population also includes a lot of people who have health issues and disabilities but are not getting SSI or Social Security disability. We also had a demonstration of the work the department is doing on compass to start to enable people to input information about their work,

Commented [PS6]: 27:21

Commented [PS7]: 28:59

Commented [PS8]: 32:00

their other community engagement, or whether they meet criteria for exemption. There was a demonstration of that. So after that meeting, and all of the materials that were released, the department asked stakeholders to provide feedback by May 31, 2026. And so, we had an ad hoc meeting as I hope most people know, of the LTSS last week to present this in more detail and to gather feedback. And I think that feedback has been shared and if not, we will. It, just to go through it quickly, a lot of the concerns were around the importance of DHS having enough staff to implement this because it is going to require a lot of verification, a lot of touches on people's cases. We made a number of recommendations including that information be used to cross check whether people are in compliance or exempt with information that verification has been gathered for the snap program. We had a question about whether HR 1 will affect people in the MAWD program. We also provided a lot of feedback on outreach letters that the department had released. The department released draft outreach letters that they are planning to send to people who will be affected by the community engagement requirements. First of all, a general letter telling people that this is coming and later letters telling people they need to comply or they are not in compliance and how they can be in compliance. We had a lot of feedback, as I know a lot of other people who gave feedback did about the readability, making sure these letters are written at a sixth grade reading level, and to avoid terms that are needlessly complex. We had some specific recommendations around clarifying some of the language that was a little bit vague and confusing. And also, one of the forms had a list of different criteria. Which would make someone exempt from the community engagement requirements. Like being a caregiver to a person with a disability or having certain medical conditions. Fairly long list. We recommended the list to be reordered so the more common ones be put at the top of the list. Just in case people do not manage to read all the way through a fairly long list. We also had some recommendations around making sure that there are translations that are done for the language population, the LEP populations and we had some volunteers who asked to review draft letters in Spanish translation. That is most of the recommendations that we submitted formally. And I was just going to also say that the interim final rule was released by CMS, Juliet just covered that. Public comments, she said, are due on July 31. And people are really going through those, that rule and it addresses how the state will implement community engagement requirements. And there are going to be a lot of webinars for people who want more information about it. National health Law program is doing one tomorrow. Watch for those. And finally, the next stakeholder meeting is July 14. And we will report back after it. Lloyd, you want to add --?

>> MATT SEELEY: Was Lloyd adding anything?

>> PAM WALZ: Lloyd, are you there? Sorry, that was a lot. Sorry, now we can hear you.

>> LLOYD WERTZ: Is it working?

>> PAM WALZ: Now it is working.

>> LLOYD WERTZ: I can say that again because the pure intentions for my opinion is the effect of HR 1 is to balance an unstable and unbalanced federal budget on the shoulders of the most disabled in our Commonwealth and across this nation. That is the reality. However, those same folks and their advocates including myself and many people in this room, need to create recommendations and comments that can be filtered through Pam and myself to the work group that can be understood and are well thought out from your perspective. I do not have that, I'm not sure Pam has that. We really need to have those comments and suggestions delivered to us. If you decide not to do that and we reach the end of this and we are all run out and everything is tragic, get a mirror because you will be looking at the person responsible. We need to hear from you as to what type of questions and what needs we have to address at the

Commented [PS9]: 33:32

Commented [PS10]: 37:50

DHS level and eventually hopefully, to address at the federal level. There is one question in my mind and that I believe is, there was a response sent to CMS that has not yet been shared publicly, am I off with that? Am I wrong with that?
>> PAM WALZ: Which response is that, Lloyd?
>> LLOYD WERTZ: There was a letter sent by DHS to CMS in response to their initial issues, I believe, and that has not yet been shared publicly.
>> JULIET MARSALA: So there is two For the revalidation. There was a 10 day response letter which was essentially us saying we got your letter. You have asked us saying we got your letter and we have got your letter. Then there was a 30 day response plan expansive letter, that second response is under final review.
>> LLOYD WERTZ: Okay, so there are apparently two letters that are eventually going to be shared?
>> JULIET MARSALA: I mean the details of the letter will be shared I cannot say what the final ---- will be because I am not the lead on that.
>> LLOYD WERTZ: Since I have not yet attended a workgroup meeting, I do not know if there are any providers on that group. I heard a presentation yesterday from behavioral health providers that there is a limited or very few.
>> JULIET MARSALA: Just to go over who is on the HR 1 informational committee, there are two representatives from every Medicaid advisory committee and subcommittee. Two people from the MAAC which is the steering committee, two people here from LTSS, Lloyd, you and Pam, two individuals from the Medicaid service delivery system, two individuals from the IMACC, two individuals from the consumer sub MAC I apologize I might be missing some folks. There were a limited number of individuals that were also added from non-Medicaid advisory groups for very specialized groups that are not typically connected to the Medicaid advisory group. From like the Child and Yourh or folks and things of that nature. But otherwise, there is expansive representatives and we try to make sure there is expansive representatives within the MAAC for each subcommittee kind of decided their own way. We had volunteer so I do appreciate the volunteers. But there are some provider associations, Richard Edly is there, so that represents our ----- when they had providers.
>> LLOYD WERTZ: That is the Association not the provider. That is the question I'm asking are there actual people that are in the trenches doing the services who are represented on that workgroup or not.
>> JULIET MARSALA: I believe there are. I would have to go back the list and I can certainly ask Catherine Stetler to maybe publish the list. But the charge of the HR 1 committee, is again, like what we do here, those representatives are charged to go back to all of their stakeholders and inform and collect and get that feedback. Like Richard would do, he would go back to his x-hundred number of providers and say hey, what is going on?
>> LLOYD WERTZ: That is good because the same stuff I gave today at the RCPA board meeting yesterday. I don't know if they are ready to hear it or not. But anyways, the more impact we get from folks who are in the services and providing the services, then we can then detail and share at this workgroup, the better our lives and the lives, of course, of our consumers will be. Thank you.
>> MATT SEELEY: Thank you, Lloyd. It warms my heart really to hear that stuff. The reason we have HR 1 is because many people in government do not hear from us anymore. Here is an opportunity. They are asking for comments. Give us your comments. Give us your feedback.
>> PAM WALZ: Thank you, thank you, Lloyd. That's really important context. Get into the weeds and forget where this all came from and what it means.

Commented [PS11]: 41:02

Commented [PS12]: 42:24

Commented [PS13]: Lloyd Wertz - follow up

>> MATT SEELEY: Do you want to start with public comments, Paula?
>> JULIET MARSALA: Do you want us to start in a chat, Matt?
>> MATT SEELEY: Do you want to start with panelists first? I don't know, we called it public comments.
>> JULIET MARSALA: Sounds good.
>> MATT SEELEY: Panelists have questions? Go ahead Lynn.
>> JULIET MARSALA: Lynn Weidner has her hand raised from the committee.
>> MATT SEELEY: You didn't hear me? I said go ahead, Lynn.
>> LYNN WEIDNER: Sorry, no, I did not hear you. Actually, I just want to make a comment and appreciate the ----- that was published in May by the secretary to explain the extensive, the process the Department uses to prevent Medicaid fraud in the Commonwealth. But I was also wondering how the department is approaching the threat of investigation in Pennsylvania's Medicaid system? We are seeing in Minnesota and California, given how those investigations seem to be based, do not seem to be based in good faith attempts to actually prevent fraud in the system. Can you give us insight into ways the department may be prepared to defend the Medicaid program beyond the traditional broad measures we already know about?
>> JULIET MARSALA: Thanks, Lynn. Appreciate the comment and the question. And I do hope a lot of folks take a moment to read Secretary Arkoosh's ---- about program integrity. I mean, every program integrity process, procedure, operation, always has room for continuous improvement. As soon as we figure out a scheme that is going on, schemers be changing, right? So it is an ongoing process. I think Pennsylvania, we are very proud of our program integrity process. We have the highest conviction rate in the nation in terms of pursuing those that would commit fraud within our programs. We have a lot of data analytics that we utilize and leverage, EVV electronic visit verification is a big component of that, for instance, in community healthchoices and our long-term services and supports program. It provides a lot of data to help us monitor and identify and elevate situations. We certainly do a lot of retroactive review of claims encounter and other data. We have a very, I think, robust public awareness campaign. If you see something say something. We take all of those tips very seriously within our program. For the office of long-term living, as with my sister offices, we have very strong systems and coordinations and requirements in our agreements with our health partners. They have very strong integrated, kind of vertical processes within all of their organizations. To take a look at things to flag sending or circumstances or patterns that they see that would raise alarms. We have a very high percentage of referrals to our Medicaid investigative unit, our Bureau of program integrity unit. I think in Pennsylvania we have very sophisticated processes. Certainly, we always have room to continue to innovate, to continue to do better, do more and do it faster. Unfortunately, there will always be individuals in systems as large as ours that will be looking to take advantage of it. Because there are billions of dollars in our system. It will always be a target. We always rely on everybody within our system to be a part of our program integrity process. I don't know if I answered your question, Lynn. But the best I can give for today.
>> LYNN WEIDNER: Thank you.
>> MATT SEELEY: Kathy. It is hard to hear you. Or is not just me?
>> KATHY CUBIT: I am sorry. I will speak a little louder. The information shared today and -- [inaudible] I have a quick question regarding the assisted living in the service.
>> JULIET MARSALA: I am sorry, Kathy, we cannot hear you very clearly. There is either feedback or it sounds like you are far away from the microphone. I am so sorry. I do not know if you might want to try using a different means to perhaps call into the meeting. Because it really is coming across pretty garbled. Matt looks like she might be trying to log in a different way.

Commented [PS14]: 44:32

Commented [PS15]: 46:37

Might I suggest going to public comments in the interim?
>> MATT SEELEY: Sure, is their somebody in the room who has a comment quick? .
>> JULIET MARSALA: Nope, no raised hands from the committee members and less you want me to have folks coming from the audience, there are raised hands in the audience in the public.
>> MATT SEELY: Sure, go ahead.
>> JULIET MARSALA: Alright, Linda.
>> JULIET MARSALA: Well, so the captioning can here come if I can have a staff member. Thank you.
>> SPEAKER (LINDA?): Hi, My name is Linda ----. I'm actually a consumer of services. I wanted to say to you, I hope that either that online and whatever handouts you give, you are giving people some explanation of HMO, DMO, CTO and all these abbreviations that we use in this business. Because I have not been here for a while and there is a new abbreviation. And I was getting kind of lost. If you want to get public comments and you want them to understand what it is you're trying to get from them, you are going to have to make this a little more consumer friendly. And make sure that online there is an ongoing, active, abbreviation list. And any that you would use should be added to that list. So that, that is just one thing that would help consumers, I think to try to understand this process. And I would hope on your consumer subcommittee the stakeholders meeting, I do not know what that consists of now, but I would think that is the place. Anyway. I appreciate the time. Thank you.
>> JULIET MARSALA: Thank you, Linda. I believe, my staff can correct me if I am wrong, whenever we send out the documents and packet , we do have a list of commonly used acronyms in our wonderful alphabet soup. I certainly will always endeavor to try and not revert to the acronyms as much as possible. Thank you for keeping me honest on that. And I do agree that we have some new acronyms on there that perhaps we added so I will have my team take a look at that so we can add some new ones like HR 1 and more on the budget. And work on doing more of that to help prepare and educate our participants. Great comment. Thank you.
>> LINDA?: Thank you.
>> JULIET MARSALA: We have some additional in the room.
>> MATT SEELEY: Go ahead.
>> PATRICK DRISCOLL: First time I have been here. My name is Patrick Driscoll and I belong to community healthchoices. I am here to find out how I can get into long-term living. When I was three years old I failed first grade and went to school through the –
>> MATT SEELEY: No personal information here.
>> PATRICK DRISCOLL: Like I said, had a concussion when I was three years old. And I belong to community healthchoices. And I'm interested in trying to get into long-term living. My seizures were controlled.
>> JULIET MARSALA: Patrick. I am so sorry to interrupt you, Matt, our chair wanted me to remind you that if you are asking for assistance in getting into the services, what I am going to do is have a staff member talk with you because there are hundreds of people on this call. And certainly, I want you to share your story
>> PATRICK DRISCOLL: I can do that after the meeting.
>> JULIET MARSALA: Okay, great. Thank you.
>> MATT SEELEY: I did not want you to share personal information in front of all these people. Is there another question in the room?
>> JULIET MARSALA: I do not see any other indicators of public comment from the room.
>> MATT SEELEY: Paula, there's no other hands on the committee.

Commented [PS16]: 50:07

>> PAULA STUM: Hi Matt, this is Paula. I have a question from Jodi Ricketts. Will consumers who go with assisted living but then decide they want to live in the community, for example, an apartment of their own, would they be able to get an Nursing Home Transition (NHT) to access or what service will be available to assist consumers?

Commented [PS17]: 54:54

>> JULIET MARSALA: Hi Jodie, that is a great question. To answer your question, in the community healthchoices program, where assisted living residences is available as an in lieu of service, one of the home and community-based services is community transitioning support. And I just going to read the definition for you. Community transitioning, which is available to any individual who received home and community-based services, provide services for one-time expenses for individuals transitioning from an institution, and this is a key thing, OR another provider operated living arrangement to a private residence where the person is responsible for his or her own living expenses. Now, these are one time. They have lifetime limits on them. It really depends on the individual. And so, for a member who is in an assisted living residence either by in lieu of service or by other means, who is eligible for HCBS, that benefit is available to them and they should be asking their CHC-MCO plan about that benefit, any limits that they have had previously, or any additional benefits that the community healthchoices managed care health plan might have in that category. Some of the health plans go above and beyond the minimum benefit. I hope that answers your question. Really going to be individualized based on the person and their health plans.

>> PAULA STUM: Hi, Matt, this is Paula. I have Kathy Cubit's question here. Will the Medicaid research centers assisted living in lieu of services participant satisfaction survey breakout data for participants who transition from nursing homes and those who have been diverted from nursing home placement. There may be differences between the two groups.

>> JULIET MARSALA: I do not know the answer to that question but that is certainly feedback that our team will get back to the MRC. It will be important to delineate between the two. But I do not know specifically if it is cut out that way. Given the small number of participants currently, it may be possible to discern that. But it depends on how the survey process is occurring, but our team will give them feedback to MRC.

Commented [PS18]: 57:43

>> PAULA STUM: Thanks, Juliet. This is Paula. I have another question from Joie Mentry. Can you provide any more information on how the department intends to use electronic data sharing to enable the exemption of family caregivers and direct care workers from the community engagement requirements?

>> JULIET MARSALA: So Joie, that is a very good question. Pennsylvania intended to have a very robust data process and direction to try as much as possible, through kind of like an exparte kind of process, to exempt family caregivers and direct care workers that we know of through our managed care organizations or through our own data or if they are a paid caregiver. And Pam and Lloyd have spoken about that. And we had pulled together a great foundation for a plan to try and implement and take advantage of that. Unfortunately, Centers for Medicare & Medicaid Services (CMS) has put out this interim rule which has potentially put a wrench in some of those best laid plans. So, I cannot speak today about how definitively we are going to be able to do that because we are working through the over 300 pages of that additional information, some of which has fundamentally changed some of the prior direction we had thought we would get from CMS. We are back to the drawing table a little bit trying to be able to determine how much of our best laid plans we can continue forward with.

>> PAULA STUM: Hi, Matt, this is Paula. Should I go ahead and continue?

>> MATT SEELEY: Yea, please do.

>> PAULA STUM: I have a question from Mia Haney. We have asked that the HR 1 workgroup

be made open to public listening but never heard a response from DHS on that request. Can DHS please consider opening these discussions to public listening so that all interested parties may hear discussions and not get information through alternative sources?
>> JULIET MARSALA: Thank you for your question, Mia. I am not sure if you've missed responses at any of the MAAC meetings but I think the other deputies and I have kind of been on the same page with sharing that the HR 1 subcommittee is not going to be opened up. It is intentionally designed to be a manageable group. So and I think that has been relayed at all of these subcommittee meetings. So, I do not know. That is the response I can give you today. Certainly, that feedback has been provided to Catherine Stetler who is leading it and has been shared with the secretary but the intention and design of that program, again, is to leverage the Medicaid managed care. The Medicaid advisory committees and how we function as the advisory committees. So that is where it stands today and I am not aware of any changes to that. It is not going to be sort of a public, open process at this time.
>> PAULA STUM: Hi Matt, this is Paula. I have another question from Anthony house.
>> MATT SEELEY: After that, I see Carol has her hand up.
>> PAULA STUM: Concerns, questions from individuals in recovery, will participation and psych rehab count or those who volunteer services on advisory committee, will these activities count towards requirements?
>> JULIET MARSALA: Anthony, really great question. With regards to participation in psychiatric rehabilitation services, that is a little outside of my main with regards to if they are receiving psychiatric rehabilitation services. It is likely they may have a diagnosis that might exempt them. But I am not necessarily certain given the changes in the direction of CMS with regards to work eligible or work able. If you are talking about if someone is acting in psych rehab services, lets say such as they are volunteering or working as a certified peer specialist, I would have reasonable confidence that would count as a volunteer or community engagement hour. Public service on advisory committees, such as this one, I would certainly argue is providing volunteering in a public service and is a community engagement activity. Certainly, when we get to all of those very specific details, we in Pennsylvania would work to be as expansive as possible. You know, this is a service that each of the committee members are providing with volunteering their time and expertise. I would say yes, an advisory committee like this one should count as hours. I would definitely make the argument.
>> MATT SEELEY: It is already 11:00. Carol, your question in regards to HR 1?
>> CAROL MARFISI: It is in regards to assisted living.
>> MATT: Maybe we can wait until the1215.
>> CAROL MARFISI: Yes, That's okay great.
>> MATT SEELEY: Okay, you will be first at 12:15 PM. If we can remember that later so we can have the presentation with Jessie Pierce. Are you prepared, Jessie?
[In
>> JULIET MARSALA: Paula, do you see Jessie Pierce online? Or my team Or can we move them over to be a panelist?
>> MATT SEELEY: I see the microphone and I see them unmuted. Carol, can you mute your microphone? Thank you. I do see Jessie Pierce unmuting muting but do not hear him.
>> JULIET MARSALA: Jesse, if you called in via telephone, you may also need to unmute your telephone in addition to the system but I think it is usually star 6, that may help.
>> JULIET MARSALA: We can hear you now.
>> JESSIE PIERCE: Hooray, wonderful. Thank you for your patience. Sorry about that. Thank you all for inviting us to present. I am excited to talk through some, one of the key

Commented [PS19]: 1:00:52

Commented [PS20]: 1:02:35

innovations that we at the Department of aging are moving forward in support of implementation of aging our way PA, which is our 10 year multi sector plan for aging. I have never been on this call before but it is nice to see some familiar faces. I know we have with a couple of long-term-care counsel folks in the audience or former members as well. Excited to give a little update to you here. I will start by describing my role just really quickly. And then, we will jump in. I am Jessie Pierce, I am the executive director of the PA Council on Aging. I support an independent advisory Council of mostly older adults, although they are not all over the age of 60 but the majority of them are. They act as a voice for older Pennsylvanians across the state. However, I am an employee of the Department of aging so I report to the secretary. One of my main roles here is to support the implementation team for aging our way PA. I am very excited to talk to you today about resilient environments in aging and dementia in your communities, parentheses, ready communities funding collaborative project. We can go to the next slide, please. And the next slide, thanks. Great. Okay, the READY (Resilient Environments for Aging and Dementia in Your Communities) funding collaborative, grew out of one of the tactics from aging our way PA. Which, I think many of you are familiar with the plan. The plan has 163 specific actionable policy tactics. Tactic number 46, for those following along at home, commits the Commonwealth to funding and supporting policy and projects that increase age friendly, dementia friendly and ADA compliant communities. This project also emerged from robust stakeholder feedback that we got following the implementation of the plan. Of course, I think we all know and have been discussing on this call one of the principal, one of the principal gaps in solving problems in state government and across all of our communities, lies in funding. The Department of aging set out to create an innovative model, essentially, to streamline the process of matching public funds with philanthropic (charitable, generous) funds at the community level. It is a new model. It has really never been tried in this way before. Pennsylvania is very excited to be piloting this model. And our goal is to increase funding for community driven projects that support older adults, people with dementia, caregivers, and family members and neighbors of all ages in communities across the Commonwealth. We are working with a contracted vendor called grantmakers in aging (GIA). They have been a tremendous support to us and their role is to act as the fiscal agent for the project and this, we hope, this will eliminate a lot of the challenges that are often faced when we try to match public funds, when we try to invite our philanthropic (charitable) organizations to match public funding. We are going to test our public philanthropic structure and the strength of our model using a through a pilot grant cycle which is already up and running. The Department of aging has contributed $325,000 in seed funding for the project. And the application for the grant is currently open to nonprofits, local governments, and project coalitions to apply at funding levels of 10,000, 25,000, or $50,000. And then, once the applications close, once the application period closes, the Department of aging will select projects we hope to fund. And our vendor, Grantmakers in Aging, will work with, we actually have more than 35 participating funders, this number goes up pretty much every time I give this presentation. But our vendor will work with participating funders across the state to identify matching funding for the projects PDA will fund. In the future, if all goes well, we hope to use this funding collaborative model to support additional grant cycles in future years. We may be able to leverage it for tactic specific requests for proposals to support specific tactics for meeting our way or other plans. And also, present a replicable model for other states and other sectors. We can go to the next slide, please. The pilot grant cycle, the 2026 ready communities pilot grant cycle will focus on projects that align with at least one priority from the multisector plan for aging our way PA. I will briefly review the priorities. And then, highlight some potential examples of projects that might fit within, that

Commented [PS21]: 1:06:55

Commented [PS22]: 1:07:56

Commented [PS23]: 1:12:05

might fit within those respective priorities. I always want to emphasize, with these project examples, these are in no way intended to be prescriptive. They are merely suggestions to help us imagine what could be possible within each of these. Unlocking access is our priority that kind of opens the door to the rest of the priorities. Unlocking access focuses on ensuring that all older adults are able to access services and opportunities regardless of their background. One example of project that could fit would be creating culturally tailored programming for Asian American immigrants with dementia and their caregivers, focusing on a specific population. Aging in the community is creating safe, accessible, affordable housing and neighborhoods that meet people's changing needs over time. A potential project example could be establishing an intergenerational afterschool art, music, or theater mentorship program. With aging and community we really want to focus on both the built environment and the social environment. We know that social isolation is a huge risk for older adults so we want to be, that is why the project example does not focus on housing specifically or infrastructure. But we want to make sure we are countering the community aspects. Gateways to independence: this one is about transportation from all things mobility in any way you get from point A to point B. And making sure that is again, safe, affordable, accessible and independent. In project example could be conducting a volunteer-based walk audit to assess and improve safety and accessibility of active transportation routes. Caregiver supports: we know our caregivers work very hard. We know that they are often the unsung heroes of our support systems. Both paid and unpaid caregivers need our help and we uplift them in the plan. A potential project example could be establishing a memory café people dementia and their caregivers can relax in an accommodating environment. Education and navigation ties the entire thing together. Making sure people can access information from sources that they trust and the information is easily understandable. A potential pilot example could be, or a project example, rather, could be piloting a navigator position that supports individuals with complex needs. Perhaps, this could be done in a project coalition between a number of organizations to support the navigation. And again, these are just some examples. We can go to the next slide.

Commented [PS24]: 1:14:44

Some key dates to be aware of if you are a potential applicant or if there is a project ringing a bell in your mind, oh like this would be perfect. The application will close on June 12, 2026. We are closing in on that date. There is a ton of information on the grantmakers in aging website that I will share in the chat after I conclude my presentation to support applicants in the application process. But that deadline is midnight on June 12, 2026. Following that, we will start our selection process, or project selection process here at the Department of aging. Then grantmakers in aging will conduct their philanthropic matching process. Sometime in December we plan to announce the awards for the 2026 grant pilot. In 2027, the awards will be dispersed. And there will be a one year project period. So we want the projects that we fund to take around one year. Go ahead to the next slide please.

Commented [PS25]: 1:15:27

Okay, I want to talk a little bit about the process here. I won't get to into the weeds but this just provides an example of how this would actually work. Let's say, an applicant submits one proposal. Let's say someone gives us a proposal for, I think I have an example. I will hold off on the example. So the applicant submits one proposal. The Department of aging scores the proposals. Funders are not required to contribute but they considered. And then, there is the potential for coinvestment with the department contributing at least 50 percent of the funding. And then, awardees will work directly with the contractor with the vendor, grantmakers in aging to coordinate the disbursement of the public and philanthropic funds. The goal here is to make it easy for everyone. Applicants, beneficiaries, and philanthropic partners. We can go to the next slide, please.

Commented [PS26]: 1:16:34

Here is an example. Let's say an organization applies for $10,000. They submit their application, Department of aging says we love it. We decide we will commit 50 percent or $5000. Our partner, grantmakers in aging will share the application with mission aligned foundations and they come up with a match of $4000. Collectively the project can be funded at $9000. Grantmakers in Aging (GIA) would then reach out to the organization and say can you submit a revised budget to us? We were able to come up with $9000 for your project, can you submit a budget indicating that will be enough? And if we approve that, then the award will be dispersed. The reason we want to highlight this example is that full funding is not guaranteed. It could be above or below depending on the appetite for match from our philanthropic partners. But we are going to aim to fund -- try as hard as we can to make sure we can meet the full ask for each application that we choose to help. We can go to the next slide. Okay, so that is the presentation. Does anyone have any questions for me?

>> MATT SEELEY: Do any panelist have any questions? Paula, any questions from the audience?

Commented [PS27]: 1:19:16

>> PAULA STUM: Matt, this is Paula. I have no questions from the audience.

>> JULIET MARSALA: Hi. I am sorry, Matt. I am sorry to interrupt, there was a pause when you asked for committee member questions. We do have one in the room, can Chell ask her question?

>> CHELL GARRETT: Yes, this is Chell here. In regards to the log-in access, the programming, does that need to assist patient on their race or cultural background?

>> JESSIE PIERCE: It certainly could. It really can apply to any specific demographic or just improving Access more generally. The goal is to support any population that is historically marginalized or is facing some kind of barrier to accessing an opportunity or accessing care or accessing what they need.

>> CHELL GARRETT: Okay, thank you. I think it is a great idea.

>> JESSIE PIERCE: Thank you.

>> MATT SEELEY: Any other questions?

>> JULIET MARSALA: None from committee members in the room.

>> MATT SEELEY: Paula, any online .

>> PAULA STUM: Hi Matt, this is Paula. No questions for this presentation.

>> MATT SEELEY: Carol, is your consumer question in general or is it about this topic? Her hand is still up from the other question. Thank you. Jessie Pierce. Great presentation.

>> JESSIE PIERCE: No further questions, I will go back on mute. I will post the further information on the grantmakers in aging website in the chat for anyone who is curious. Thank you very much for the opportunity to present.

>> MATT SEELEY: Great, thank you so much. We do have some time can do we want to go back to questions? Go ahead, Carol.

>> CAROL MARFISI: The grant program. Going to provide enough for --

>> JULIET MARSALA: Carol, I just want to confirm you are talking about for assisted living for providers who are interested in enrolling. What the requirements are?

>> CAROl MARFISI: Talking about -- all about the program.

>> MATT SEELEY: I think about the aging you are way program. The presentation could I think --

>> CAROL MARFISI: Yes. Is that only for providers that write a grant?

>> JULIET MARSALA: I see, no, it is not only for providers and CHC. The community grants that they were talking about in aging is open to community-based organizations, it is not just an enrolled provider and CHC. It’s not a Medicaid program at all. It is for all folks in the community.

And so, yeah. So, I would not just think of it as a Medicaid program because it is much , much bigger than that. It is for all aging organizations, community members, etc., townships, bouroughs, things of that nature. It is very expansive could I would encourage you to go to the website to get the specific details. Thank you for bringing it up to give the opportunity to clarify. Not a community healthchoices grant.
>> MATT SEELEY: Carol, did you want to ask the question you had earlier?
>> CAROL MARFISI: Yet. I know you are going to -- but I wonder, if you know, -- in the program. Juliet. Or anybody. Did you get what I said?
>> JULIET MARSALA: I am going to need you to repeat it one more time, Carol.
>> PAM WALZ: I think part of it is how much assistance is provided in assisted living, is that right, Carol?
>> JULIET MARSALA: Okay. So, assisted living residences are regulated by the Chapter 2800 regulation. And so, they are to build out a service plan with the individual. They're able to address the activity of daily living needs, support with ancillary activities, assisted living can help with some skilled needs as well, arrange for therapies to occur. If someone is in assisted living as an in lieu of service, that assisted living residence works in partnership with the participant and the service coordinator to make sure that there is a plan that addresses the needs to meet their goals within that setting. So, unlike personal care homes they can provide more skilled care and services.
>> CAROL MARFISI: Juliet, if somebody knows this. -- If it is in a good match. --
>> JULIET MARSALA: Just like, if a participant chooses to go into assisted living and they determine it is not a good fit for them, they would work with their service coordinator to put forward a goal to transition to a different setting. And/or, if they went to assisted living and they have been there for a while and decide they want to become more independent and seek out their own apartment, they will be assisted in doing that as well. It is not a once and done deal for anyone. It follows the same kind of experience as anyone who is selecting assisted living. It is a choice to be there and it is a choice to leave.
>> CAROL MARFISI: Okay, thank you.
>> MATT SEELEY: Thank you for the questions. Thank you for the responses. With that, we will take a 10 minute break. See you all back here at 11:35 AM.
>> JULIET MARSALA: For folks in the room, just a reminder, when the green light is on they can hear all of your conversations online. I would hold and pause until that light turns. [10 minute break.]
>> MATT SEELEY: We are going to get started in about one minute. I got 11:35 AM. Paula, before we get started from his anybody come in that we have not recognized?
>> PAULA STUM: Hi, Matt, it is Paula. Neil Brady had joined. That is the only addition I have.
>> MATT SEELEY: Okay, thank you. With that, we're going to move into our presentation on the service coordinator's role in nursing facilities from the MCO's. We have three representatives, three volunteers.
>> RANDY NOLEN: Hey Matt, It's Randy Nolen. Hi, how are you?
>> MATT SEELEY: I am well, Randy, how are you?
>> RANDY NOLEN: Good, I'm going to preface this presentation and oversee it, and walk through it so we get what we need out of it. I have a group of service coordinators from each of the MCO's. There is a couple, they all work with nursing facilities, there's a couple of supervisors, couple managers and a couple of front-line SCs that will be able to answer some questions and walk through the presentation. Question wise, when the come in, we will filter the questions and work through them, the goal is to provide some education, background on what

Commented [PS28]: 1:28:16

Commented [PS29]: 1:39:03

they do as nurse facility service coordinators. And they work they do with the facilities and maybe any barriers they are having with the facilities. We will walk through that part of the process with them. When we ask questions I will direct them back to the questions and switch off MCO order every once in a while so one is not first all the time and not on the spot all the time. It also gives the opportunity for the other staff not to just say ditto, ditto. We will make people talk through it. With that being said we will go ahead and move on to the next slide and bring them up to the table to go over some stuff. Basically, just to give you some background. The service coordinator's role in the nursing facilities, basically, they are there to help ensure participants have the opportunity to reside in the least restrictive setting of their choice. They work with facilities to develop service plans based on the person's individual needs and desires. They work on developing partnerships with the nursing facilities multidisciplinary teams to work towards the participants goals. They partner with facility staff to assist participants and advocate to ensure high-quality care. They identify participants with a personal goal that want to transition back to the community. They work with specialists, behavioral health providers, to durable medical equipment providers, to get the equipment and materials and services that a person needs. They will assist with relocation of participants during emergency situations. We had a number of them in the last year, the service coordinators were on the ground and really assisted in helping move people out of those facilities. Worked with the families and kept them coordinated. They did a lot of work around that. Hopefully, in the next year we don't have situations like that, but they are always on the ground and are prepared to do that. What I will do is there is a set of the questions that came up, they were kind of outline so I will bring the service coordinators up to the table and have them sit around and discuss the questions that came up. You have microphones back there?
>> JULIET MARSALA: They should come up. They are honored guests.
>> RANDY NOLEN: Give us a minute as we move them all up to the table. Then we will start going round robin and having discussions with them. Reminder to you folks, when you speak please identify yourself and what MCO you are with. Mics, Are fairly easy to use, push a button. There is seats up hear folks. I bite that I will not today. I will try to be nice.
>> JULIET MARSALA: Anyone brave can take the hot seat right here?
>> RANDY NOLEN: Matt, the logistic setup in the room, they are all around the table and ready for discussion. The first question on the next slide. The service coordinators do assessments and what are the assessments used for? I will go in random order and call on UPMC coordinator.
>> JANEL: My name is Janelle. Can you hear me okay? Can you hear me okay?
>> PAM WALZ: It is a little faint.
>> MATT SEELEY: Yeah, it's a little low.
>>JANEL: Can you hear me now? [laughing]
>> PAM WALZ: Much better.
>> JANEL GOODHART (UPMC): Of humor perfect my name is Janel. We complete a comprehensive assessment that is done initially and annually and also completed after a participant has a hospitalization and there has been a change in need. We also complete an outreach assessment that is done one out of three of the outreaches done quarterly is done in person. These are just like a check-in visit to capture any changes in need. To ensure all care is being met. Any concerns with care and also to check in and make sure there is no desire to transition back to the community. We also complete a PASRR (Preadmission Screening and Resident Review) assessment. This is done whenever someone is a PASRR 2, and has been deemed eligible for services and helps us identify activities that are important to the participant.

And helps us indicate what specialized services they may be interested in and also helps us collaborate with the nursing facilities and their supports as well.
>> JULIET MARSALA: Thank you, I will put Randy on the spot because PASRR is a pretty long acronym. [laughing]
>> RANDY NOLEN: Randy knows a lot about the PASSR process. Preadmission screening resident requirement process, two pieces to it for the first piece is a screening to determine if a participant who is entering a nursing facility has a mental health diagnosis, an IDD (intellectual and developmental disability) diagnosis or another related condition diagnosis. If they do meet the criteria and have one of those diagnosis, they have to go through the level II which is a full evaluation assessment. For nursing homes, usually completed by the AAA. Or field operations which is part of OLTL. That assessment includes review of all medical notes, backgrounds, psychiatric evaluations, school records, and needs that the individual may have. The goal of a level II is to ensure people going to the nursing facilities are being appropriately placed in a nursing facility. And would not benefit from other services. The other goal is to determine whether the need, let's call specialized services, those are services that anybody in the community can get that have to also be offered to people in the nursing facilities that can include day programs, counseling, different types of services. And there is a long list of them on the PASRR form. It is a process every nursing facility has to go through. It has been part of the program since 1989. And yes, I was working in nursing facility in 1989, I am old. So I have worked with the PASRR process over the years with the department, I've actually redesigned, rewritten the forms at least five or six times. So it is a big component to ensure people are being appropriately placed when they have a certain diagnosis or need. We will move over to CHW. -- They are all sitting around the table going to talk. They are all sitting around the table going to talk.
>> When you talk, turn the microphone on and when you are done talking, switch it off so the folks online can hear you more clearly.
>> KIMBERLY SCHIN My name is Kimberly Schin, with PA health and wellness. Want to speak a little bit about the Corporation before we do a assessment. Most of us have access to EMR, electronic medical records from the nursing facility. We are able to get the face sheet, care plan, the MDS, done quarterly by the nursing facility, we look at medications. We can look at progress notes. And when I do an assessment, especially in annual assessment I go back to the year before coming to the documents. To see does the person need more or less help with their ADLs? Any more behaviors, have the medications changed? We are constantly tracking how they are doing on their goals. We do goals every year. That's about it. For the addition -- I just want to say, there is a lot of preparation before we go in and say, hi, how are you? In addition with preparation we also partnered with real-time medical ticket that real-time data as well.
>> NICOLE SNYDER: My name is Nicole Snyder from AmeriHealth. Basically, similar to what they are saying, we also do but additionally, we also meet with a social work and try and engage family. Attend care conferences as needed as well just to get the multidisciplinary approach to getting that, like you said, though comprehensive assessment and getting a better picture of what the participant needs are that they may not be able to recognize. Cognitive deficits or additional services we can assist with.
>> JAMIE JOHNSON: Hello, my name is Jamie Jackson, supervisor at AmeriHealth. I wanted to hide with with the assessment were using all of the elements we discussed him using them to support the participant and also identifying goals important to them. Not just transitioning into the community, but seeing what they need to feel safe and comfortable within the nursing facility. Those assessments are bringing those things out. And giving them knowledge during

those assessments just to know what services they have access to. Whether they qualify for specialized services or they need understanding of what nursing home transitions are. Or just developing plans that are centered around them. We use all of the knowledge that comes from our discussions to help build that person centered approach for them. So they know where they stand and the place they are and if they want to transition or how they can do that.
>> RANDY NOLEN: Thank you, move onto the next slide. Next question. Do service creditors participate in the care planning conferences and what is their role in the conference or meeting? Start with peach W. PHW.
>> THERESA CRAWFORD: My name is Teresa from pH W. And we do participate care planning conferences when invited and we do that is a part of the integrated team and want to make sure that we are advocating for the participant and their wants and needs. Making sure they are getting the quality of care they need. If there are any gaps in their care. Basically trying to make sure the participant is getting what they want and need. At their level. Whether it is in the nursing home or if they want to transition to working as a group.
>> RANDY NOLEN: AmeriHealth.
>> NICOLE SNYDER: Nicole from AmeriHealth. Yes, we do participate in the care planning conferences. Basically, to advocate for the participant and to support their voice in the nursing facility one they have concerns or hope something to address. Same thing with the nursing home transition example. I'm had one recently were the participant did not feel they are being heard in the family was overriding their decisions, concerns with cognition. We were able to advocate for her to have a competency evaluation which the family would have been able with decision and assist them with goals. Services like therapy, nutrition, a a lot of complaints about food at the facilities. [laughing] There to provide that voice as well. Just to be there to support them.
>> RANDY NOLEN: UPMC.
>> SHARI VIANO: Hi, this is Sherry. I am Sherry with the UPMC community health choices. We also participate in the care planning meetings when asked. We participate when we are invited and asked to attend. We also make sure the participants themselves are invited, the families are invited that is what they prefer. We do our regular visits and we just ensure their needs are being met and their voices are being heard. But always will be there if they request us to be there. And we also hold our own meetings if needed, and we find there is a need, the care plan meetings are held quarterly in the facilities. There may be a need in between that time so we always encourage the participants, do not wait until the care plan meeting. If there is a need or something we need to address then we would request a meeting be held as well.
>> RANDY NOLEN: Thank you. Moving onto the next slide. Next question, how do service coordinators determine whether residents care needs are being met? And what do service coordinators do if a participant has complains about the nursing facility or tells you they are receiving poor quality of care? Start with AmeriHealth.
>> ANDREA FLEXER: Hi, I am Andrea from AmeriHealth. When meeting with the participant, if they do express a complaint or concern with care they are receiving we tried to rectify immediately if possible by meeting with nursing facility staff and social worker, nursing staff, director of nursing. Whether it also be the administrator. Following up and making sure those care needs are being met. If it is more of us of your complaint or depending on the severity, it may also require adult protective service , older adult protective service referral to be made on their behalf. We do follow up with our internal critical incident process as well.
>> RANDY NOLEN: UPMC.
>> ERIKA HALVORSEN: Can you hear me? Hi, this is Erica Halverson from UPMC. We follow

the same rule, we really want to make sure the participants complaint, so to speak, is validated. So they do not feel that what they are reporting is just swept under the rug. So we meet with the social worker, director of nursing, and if it is very severe or anything that we need additional support with, we can outreach our critical incident team and APS as well.
>> RANDY NOLEN: PHW.
>> Hi, this is Teresa from PHW. We do a lot of similar thing, if a participant has a complaint we want to make sure we are validating their feelings and how they are feeling. Whether or not they want us to take a little further because sometimes they just want to be heard. And a big complaint is about the quality of the food, they do not like the food a lot but not necessarily something I need to take to the social worker. We try to validate their feelings. If it is something very concerning for my talk to the social worker, director of nursing or nursing staff. Again, if it is severe then we would follow our processes, critical incidents, making sure they know who their investment is and how to get a hold of them and making sure their needs are being taken care of.
>> RANDY NOLEN: Thank you. Move on to the slide. How do USC's determine which residents should be referred to nursing home transition? UPMC.
>> RANDY NOLEN: Hello, Erica Halverson again from UPMC. We work with the participant first, of course, if they have the desire to transition into the community. That is where we start and then we work with person centered planning team which would include the facility staff, the doctors chemotherapy, activities, anybody that works with them regularly and can help support their transition into the community. Even if it is not able to be done, maybe it is not a healthy or say transition of the moment, we work as a team to put in place a goals that will get them closer to transition.
>> RANDY NOLEN: PHW.
>> SHAMIRAH FLAGG: My names Shamir a flag, one of the senior transition specialist at Pennsylvania health and wellness. With Pennsylvania health and wellness, we have a specialized nursing home transition team. What we do at Pennsylvania health and wellness, first we use real-time medical. To see if a participant does want to transition from we do meet with our participants quarterly and if they do desire that, we also meet with our social workers. Also, with our transition team as well. They come in. We do assessments with them to determine if they are a good candidate for transition. And then, we also work with our team , their care team and attend those care conferences to eliminate any barriers to get them to be able to safely transition to the community.
>> MATT SEELEY: I heard this person and someone else also asked, talking about real-time medical. I assume that a some kind of software. How does that indicate somebody want to transition quite. Can you also tell us what it is?
>> RANDY NOLEN: Good question from what I asked him to explain that at the end but I will now come if you want to talk about what you real-time medical system is.
>> SPEAKER: Hello, this is PHW, one of the managers that overseas nursing homes. Real-time medical is a cloud-based platform that allows and gives us the data entered into the electronic medical record. In real time. As the nurses and therapists are entering in the data we are able to see that data in real-time. And so within that platform, there are levels that allow us to determine how a resident is able to transition, if they are able to transition. They are color-coded, green, yellow, red. Obviously, for those easy alerts to let you know this person is ready to transition and able to see all of their clinical information, PT, OT, anything entered in the EMR record we are able to see. If a person has a fall, if a person goes out to the hospital, we are able to see that and it has become very helpful when we are trying to locate residents. If they have been

discharged to other facilities variable to go in and see them and find them.
>> JULIET MARSALA: This is Juliet, I will hop in because I have Anna's voice in the back of my head for those of you who remember. We have to share her now with multiple states, not just Pennsylvania. This is one of her babies of innovation. I just want to highlight in terms of innovation and CHC, the comment you made this point but I want to highlight it for folks. They use real-time medical to proactively engage residents that they feel would be good candidates for NHC. They are not just waiting for someone to raise their hand, they are having those proactive conversations based on the green indicator of the real-time medical. I think that is a really important thing to highlight. That is a different change that came about through CHC's implementation, actively going out and identifying folks to encourage transition conversations. Randy, back to you.
>> RANDY NOLEN: AmeriHealth.
>> DESIREE VEGA: Hi, I am Desiree with AmeriHealth. At AmeriHealth whenever a participant expresses their need or want to transition to the community, we make the referral through our internal nursing home transition department. We collaborate with the social workers. The therapist, facility staff, to talk a little bit more about what their needs are and what barriers there are. It is not only the participant to my social workers who reach out and say this participant is interested in going home. They have finished their physical therapy and they are ready to move on. We kind of start helping them with their thorough process is they have not had waiver services reaching with independent broker. Getting that referral made for them and starting that process for them.
>> NICOLE SNYDER (AHC/KF): Hi, this is Nicole. I would like to add to that, when reviewing the medical records the MDM indicates plans for discharge but facility care plan also does. The social worker might notify family. Basically anyone that is able to speak on their behalf as well and we confirm with the participant that is there desire and then we move forward from there.
>> RANDY NOLEN: Thank you, that is a key point on the MDS, the minimum data set , the assessment every nursing facility has to do when every resident on admission, trigger events, quarterly basis. There is a question that asks them if they want to return to community living and that is where some of the information comes from. As far as the MCO's finding out people's desire to return to the community. Part of the assessment process the nursing facility does. On to the next slide. What is the service quarter Nader's role in the discharge process from nursing homes? Start with PHW.
>> SPEAKER: From PHW, with our discharge planning process for nursing homes, it starts when we first get the referral for nursing home transition. With our team commencing as a participant expresses a wish to leave the nursing facility we are meeting with the participant to see what their barriers are, coordinating with the participants and their support, their social workers, their therapists, the physicians, the services they would need a place to get home. With our team we are applicable to the community to see what that looks like to eliminate any barriers. Whether that barrier is, they need any type of home adaptation, any type of deep cleaning processes, we also establish any services they need in the community before they get home. Doing great things with our assisted technology program right now, community integration is also a big thing we are doing and establishing any services they need for transportation, but also the assisted living right now. That is really big. Within our part of the state right now. Anything we can do to safely set them up for success once they get discharged.
>> RANDY NOLEN: AmeriHealth.
>> ANDREA FLEXER: Hi, this is Andrea from AmeriHealth. Just to go along with what you said, we do participate in home and community-based services incomplete the comprehensive needs

assessment in the facility. Then we collaborate with our utilization management team. To determine medically necessary services. We do participate in the discharge planning meeting with the nursing facility. That might include the participant from anybody they would like to be a part of that meeting, a nursing home transition provider, coordinator, involved. Also engaging with our community service coordinator that will be taking over the case in the community. During that meeting any durable medical equipment needs, any home health referrals that may be required, just ensuring they have primary care physician set up in the community for discharge. Having that visit within a few weeks of discharge is important to ensure they get their medications and having a pharmacy set up. On day of discharge we meet with the participant at the facility to ensure they are getting their discharge orders. They are being educated on their medications for home. And making sure any durable medical appointment is in place for their discharge and also, home health referrals.
>> Is your question for now or can it wait?
>> I am sorry, it can wait till the end. Sorry.
>> JULIET MARSALA: I will help it because I'm surprised Lloyd has not, just to confirm if they have behavioral health needs is a part of the transition. Appointment is also being set up and plan for.
>> I will add we make sure that they are leaving services after the dinner companies need assessments, those providers are all set to go the day of discharge. They are not left with a gap of service. We do the full circle to make sure the transition is smooth and everything is in place. Along with the medical appointments and referrals to appropriate services that might not necessarily be in the home. But like you said, community-based behavioral health services as well.
>> PAM WALZ: Matt, this is Pam. Can I ask a question? It has to do with what they are talking about right now.
>> MATT SEELEY: Go ahead.
>> PAM WALZ: The responses that we are getting are about how the role in cases where nursing home transition is involved. But what is the role of the service coordinator and discharges where it is not a nursing transition case? Just people who were being discharged for one reason or another from the facility. What is the role of the service provider in those non-nursing home transition discharges process?
>> JAMIE JOHNSON: This is Jamie Johnson with AmeriHealth. Every participant that is enrolled in our, MCO, and discharging into the community, we are aware of it we are considering it a nursing home transition. Whether they are going with home and community-based services, whether they are determined to be eligible, we still work to provide a safe transition. Unfortunately, if they are knowledgeable from community-based services that means we are not able to put those authorizations in. But we have other resources, such as, we will set up the Muslims are in agreement with that, a six week home deliver nutrition plan labor get food delivered to them and help access to nutritional counseling. We ensure we give them resources for the community they can access and is not necessarily tied to benefits. Every individual that is transitioning from a nursing facility and our plans, we are still identifying them as NAC is in working with them.
>> JULIET MARSALA: To kind of clarify, operationally, does not look different, just doesn't eventually wind up as a data point in our report. Traditional transition but operationally they get the same service assessment, support, and identification process.
>> PAM WALZ: Quick follow-up, this is Pam again. How do you find out those people are being discharged? How does that happen?

>> JAMIE JOHNSON: Jamie from AmeriHealth. The nursing facility team will inform us and sometimes the participant will. There is an opportunity before the service ordination team to be informed. We will do the necessary steps to determine eligibility, and support with transition. So, referrals with a hand raised or a nursing facility, social worker, director of nursing, service coordinators attention that someone wants to transition into the community.
>> RANDY NOLEN: Thank you, I will turn it over to UPMC to into question and the follow-up questions that came through.
>> SPEAKER: High dimensional UPMC. The service parameters role in the discharge process to address and identify barriers to the participant discharging back to the community. Barriers can range from a barrier can be the participant getting in and out of their home, perhaps from another barrier and talk with in the past couple of years has been diagnoses. Such as, diabetes. Making sure that participant is educated on their diabetes, making sure there is documentation, EMR, nursing doing diabetic training. Also, blood thinner medications depending upon what occasion they are on, they could be doing testing weekly making sure there is transportation to and from to ensure they are getting the testing done. Making sure their PCP appointment is set up. We also have two discharge meetings. To ensure everybody is cooperating. Participants, support from a nursing facility, staff. To ensure that everybody knows their and the discharge process to ensure the participants health and safety is insured after discharge.
>> RENEE ABBS: Hi, Renée with UPMC also. I just wanted to add, to answer one of the most questions from a community member, we do strive very hard to work with the nursing facility to make sure they tells about discharges ahead of time. We all know we have these services we can put in place but we need to know where they are going so we can take those steps. We worked with our network department to strive to make sure they understand how important it is they tells about discharges but unfortunately, I think everybody here can testify to the fact they still discharge people without telling us. One of the things we have done, we have a team of nurses at UPMC that helpless with discharge planning. We created a postdischarge assessment. As soon as we find a person is discharge my facility the assessment is completed and set up to identify any concerns that could result in a safety issue for participant for things like do they have their medications, food? As they are doing the assessment is not when we're just doing the assessment and identifying the issues, we are resolving them real-time and that exact moment. So we can make sure we ensure our participants health and safety in the community.
>> PAM WALZ: Thank you for, what is your name?
>> RENEE ABBS (UPMC): Renée.
>> PAM: Renée, thanks.
>> RENEE ABBS: You are welcome.
>> RANDY NOLEN: Pam, I will get PHW to add any additional information based on your questions.
>> SPEAKER: -- I can agree, we do struggle and PHW with our facilities as well with participants discharging and facilities not telling us. When we are notified either by the participant, or the facility, we do also work in real time to find where our participants are going and discharging. Like I said, PHW we do have a specialized team that will in real time go to either that community addressed to resolve any barriers. We do work in real time to make sure they do have a follow-up appointment with their PCP. They have any medications and work with providers to make sure they have food on the table. We have folks we work within the community that we pull together to work with getting any resources. Sometimes when they do leave the facility they leave the facility with the clothes on their back. So we work with them.

Because we establish those relationships with most of our participants in those facilities. Because we are in their daily. We want to make sure that for one, they are safe and that we are able to find them. Then again like I said, we do have real-time medical so we can rely on that to see if they been hospitalized within the last 24 hours or discharge.
>> RANDY NOLEN: Thank you. The last question before we open it up to questions. What obstacles do service creditors face while performing their duties? AmeriHealth.
>> ANDREA FLEXER: This is Andrea from AmeriHealth. One obstacle I run into a few times in the discharge planning process, you are collaborating with, discharge date and you are collaborating with a bunch of providers with the goal of that discharge date in mind. However, sometimes personal care agency provider -- have not been able to staff the case or you wait on the waiver code to be in place for discharge. Those providers have authorization to start those authorizations overcome instances where the code is not in place for that date of discharge. We may have to have some flexibility with that date and changing that date a little bit but I'm pretty much upfront illness from the start of the process with participants, it could happen. And I appreciate that possibility with that as well.
>> RANDY NOLEN: UPMC.
>> SUSAN STEMMERICH: This is Susan with UPMC. One of the biggest challenges we have, getting access to the facility electronic medical record. The facilities give us permission and access to these systems. And sometimes they can be a challenge for the facility to give us access to the systems. Where we are able to see physician orders, and all of the treatments they have, with the medication record. That is a big obstacle that sometimes we have working with facilities.
>> RANDY NOLEN: PHW.
>> KIMBERLY SCHIN: I think one of the barriers, sorry, my name is Kim PA health and wellness. One of the barriers is one of the best things about being a service coordinator. That is make connections with people in the facility. With the social workers and with the director of nursing, therapist. But sometimes the barrier is a high turnover of social workers in the nursing facility. The barrier can be a high turnover with leaders as well. Once we have somebody new you have to get access to electronic medical records. The easiest ones that we use is point click care. Very easy. User-friendly. We hope that we have real-time, all six of myself facilities are point click care in 5/6 are real-time. I do not have to bother the social worker that much. So that other facilities do not give us access. Or it is very difficult to get access. They want you to use their own computers. Just a lot of conflict there sometimes. The big thing is to get a good relationship, build relationships with everyone in the facility and it makes our life much easier.
>> RANDY NOLEN: All right, thank you. That is the questions, think is the little question guide. We need to figure out how to change it. Matt: is the next thing is to look at any questions from the committee.
>> MATT SEELEY: Right. Any questions?
>> PAM WALZ: I do. There is a scenario that we see kind of on a regular basis. I have been wondering how it should be handled. Person will have an accident or something like that. They are in the hospital and go into nursing facility for rehab. They are not ready to leave after rehab and they stay for months or a year or maybe a couple of years. And then eventually, they are recovered enough they no longer need nursing home level of care. The scenario we see is that what happens then is that the nursing home choice to discharge them. In the meantime the person does not have housing to start with or has lost their housing and now they want to discharge them to a for instance, homeless shelter. What should happen in the scenario? I guess, what should happen in order to prevent this from happening and what is the role of the

MCO and the service coordinator if we are facing something like this with a person who is being discharged now, maybe even probably NFI at this point but has nowhere to go.
>> RANDY NOLEN: Thanks, Pam. AmeriHealth.
>> NICOLE SNYDER: This is Nicole from AmeriHealth. Actually, recently had a similar scenario. With the facility looking to issue a 30 day discharge notice and send them to a homeless shelter. That is where care conferencing has come in where we are advocating good lighting them know what we are doing. This particular individual's already active with a nursing home transition and looking for housing, been on waiting lists. We keep an active open communication with the facility about where we are at. And they have been patient in just knowing that is a better option for them if they allow us to put the services in place.
>> RANDY NOLEN: PHW.
>> SPEAKER: At times I feel good comes down to education with our facilities. And with the social workers. I tried to educate all of my facilities and our team does to put our nursing home does transition programs with these participants and help those in need of housing to find affordable housing in the communities. Because a lot of times with participants like that that come into the nursing facility lose everything, including identification. They have trouble with their finances to even establish housing in the community. And our team actively helps with that. We have community partners that will help establish, getting their identification back and help with enrollment with applications to affordable housing. And sometimes we just have to kind of educate our social workers and facilities that we are working with our nursing home transition team. Actively on waitlist and that is better for them to work with us to get housing in place for them to safely discharge into the community. Instead of the shelter.
>> RANDY NOLEN: UPMC.
>> RENEE ABBS: This is Renée. I agree. Education of the nursing facility staff is very important but I think even more important is education of the participants themselves pray they need to understand their rights to be in that facility on the facility cannot just discharge them to a homeless shelter. Without an education, whenever we find out about an eviction notice we immediately go into acting and make sure the participant understands they have the right to appeal that. If they appeal that they may lose but it gives us more time to be able to get them housing or whatever they might need so they can be safe in the community. We do continue to educate the nursing facility staff. And I have mentioned in several meetings myself to the nursing facility staff, do you realize if you discharge this person it is an unsafe discharge and APS referral and they're going to come back and investigate. Pretty frequently that gets them to change their mind.
>> Adult Protective Services could go out and investigate and figure out who made that decision and follow-up accordingly.
>> RANDY NOLEN: Let me ask a follow-up. What involvement or work with the ombudsman's in your area? UPMC.
>> We also involve ombudsman's immediately and make sure participants know and we provide, they can reach out to them as well. They are often very instrumental in helping us to delay these discharges or stop these eviction so we can make sure we get services in place so they can be safe in the community.
>> PAM WALZ: Can I ask a question? This is Pam. If for instance, we have a case like this, who do we reach out to at the MCO? If the service carbonate or is not clear what they need to do. To try to get someone to meet.
>> SPEAKER: If you are a service -- if a service coordinator is not doing what they're supposed to do?

>> PAM WALZ: I mean, we can try reaching out to them but I am taking advantage of the fact that I have you alter because sometimes the service coordinators do not know what to do.
>> Absolutely, we have a hug number that you can call into. And you need to let the person know that you have some concerns about a particular service creditor, the message will be sent immediately to their supervisor or manager and we will do an outbound call if we are not available to take the call the moment and get back to you within two days. And get some specifics on what the issue is and work internally to make sure we resolve it.
>> PAM WALZ: Thank you.
>> RANDY NOLEN: I want to let the other two MCO open the answer the questions about investments. AmeriHealth.
>> NICOLE SNYDER: Nicole from AmeriHealth. Similarly, we do contact the whenever there is any circumstances they might be needing discharge currently have assisted in contactinor providing information depending on what the participant wants. We also assisted in the appeal process and being available on the calls as needed to provide any additional insight and information regarding what our role as in-service as we are providing to aid in vaccine for discharge.
>> RANDY NOLEN: PHW.
>> SPEAKER: PA health and wellness. Ditto for what everyone has said. We have also decided to pull in the ombudsman. Just because some Sc were not familiar with the Rosalie brought ombudsman and to provide additional training. Then in turn have our participants be aware of the role of the ombudsman as well.
>> RANDY NOLEN: Any other questions from the committee? Lloyd.
>> LLOYD WERTZ: I figured I would ask for you. For the service corridors, my will is primarily behavioral health advocate. Family members with behavioral health issues important in the field for a number of years but I wonder about your impressions and feelings about the training you have received in behavioral health and assessing them. But also, in finding ways in places you can make referrals for prompt and effective action we do find behavioral health issue in one of your residence.
>> RANDY NOLEN: PHW.
>> Manager of PA health and wellness. Within the assessment, the service coordinators have determined in behavioral health need, a couple of things. Referral to our behavioral health department. They will pull in our complex care team if needed. To have an ICP meeting. Two discuss what behavioral decisions need to be made with regard to that participant. And then, as far as training, we from training be complete yearly. To be able to review and determine the different behavioral health aspects of a participant.
>> RANDY NOLEN: UPMC.
>> SPEAKER: We also have questions in our assessments that can give us some insight into behavioral issues or concerns that there might be for a participant. We have a very robust educational system that UPMC them all staff are trained on fire with regard to behavioral health. They also have annual training on how to identify behavioral health issues and on those services available to our participants in the nursing facility, so we can make sure those are met. We also have an additional step we take, monthly meeting called a consult with a psychiatrist. Where we have some really complex behavioral issues. And we do not know where to go with it and the facility is does not know where to go with it. We can present those cases to psychologists and their able to give us some additional insight and resources.
>> RANDY NOLEN: AmeriHealth.
>> SPEAKER: -- As the other MCO's with mandatory behavioral health training. We provide to

every source code in order so they have awareness of how to assessment our assessments, there are questions to determine behavioral health needs. And if there is one identifiably work with the participant to connect them to behavioral health services. We understand a lot of the nursing facilities to offer behavioral health services internally. But we do try to clarify with the participant if they feel those needs are being met. If it is not we will work with our behavioral health department to connect them to additional services. Or explore other options they can access. Also with behavioral health needs, sometimes it is tied to the PASRR so we ensure we review the PASRR level twos to see what they are triggering for trade and work with the participants to let them know what their options are as far as what they can access. Mental health service. And utilize thought. The -- help them see in a sense of what each service is in the definition of them and how they feel if it is something they would like to utilize. If it is we do try to make a goal with the participant and their person centered plan. To support them in connecting to those services and make the necessary behavioral health referral to access the service and connection and monitor as needed.
>> JULIET MARSALA: Matt, I just wanted to do a quick time CheckIt I know we started a few minutes late, we are 15 minutes into the public comment. I know this is a great presentation and discussion, I do want to reserve a couple of minutes to say a few words at the end. I do not know if you wanted to direct folks that if they are waiting to do public comment they can do so in the chat, email, etc. good and/or to see how much you want to extend this topic.
>> MATT SEELEY: We can do all of those things Juliet just said. But may become any more questions for this presentation quite .
>> SPEAKER: I think Lloyd has a follow-up in one more.
>> LLOYD: One brief follow-up when you find presence of behavioral health issue and you make referral for services mother and the community where the SNF, do they get it? Are you able to get the services delivered?
>> SPEAKER: Waiting for you, Randy.
>> RANDY NOLEN: PHW. [laughing]
>> SPEAKER: So, yes, dependent on if it is in a specialized services or services for behavioral health within the nursing facility, we want to make sure we are contacting and regional social worker. The psychiatrist or psychologist of the nursing facility. Sometimes they are already receiving those services but may not be at the level of care that is required. We want to make sure we are completing assessments and making sure the services are appropriate. With regards to specialized services, we make sure that once we outsource the referral, and we get confirmation that services are in place or have begun we follow-up to ensure the services are in place with in the nursing facility and also follow-up within the community.
>> RANDY NOLEN: AmeriHealth.
>> Just to speak on the services were discussing. My nursing facilities are in a more rural area. So fortunately, a lot of the providers may have been exhausted already by the time someone does mean something. Recently, same things somebody is going different dividers in the area. He has not done well with those so they are not accepting PennDOT. So the facility is trying their best advantage is care about very difficult to continuously outreach the different providers. But the actual proximity of the facility is very rural. It is difficult. Unfortunately, just continuously exploring and trying to find something. But it does occur that is possibly not happening because of the rural nature of the facility.
>> I want to add to that sometimes getting transportation to the outpatient services as a barrier. Just making sure they have those resources. That is set up for them to go out to those services.
>> MATT SEELEY: Juliet was trying to say it very elegantly, I will say it abruptly, --

>> JULIET MARSALA: I did not quite catch them, Matt.
>> MATT SEELEY: We need to keep our responses in order so we can long.
>> JULIET MARSALA: I mean, I will walk in because I will say thank you for highlighting the rural needs. Very real and very much something we need to look at. Thank you.
>> RANDY NOLEN: I will often and think everybody from the three MCO's and all of the folks who come in and done this, UPMC do you want to answer? You interrupted in the middle of it.
>> We do agree, rural areas can be difficult. We do work to identify providers and get them in place. Maybe sure once they are in place they are meeting our participant needs.
>> RANDY NOLEN: Thank you all for coming in. Matt, I think we are ready to go to public comment.
>> MATT: One question in the room and then we can go to online.
>> JULIET MARSALA: I want to say thank you, the public comments are separate from the SC presentation so let's get back in your other seeds. Thank you so much for coming and sharing your thoughts. We will go to the public comment period.
>> SHONA EAKIN: My comments were related to the presentation. In preparation for today's meeting and knowing that presentation is going to be on the agenda. I've a couple of things I would like to mention. I am sorry, my name is Sean Aiken and I am the CEO of voices for independence. We are seeing a trend. Where MCO's are not sending referrals for transitions. Where people use power chairs. People who use wireless. People who the service coordinator may be siding there is a need for too much care. Not allowing certain participants to break down barriers to give them a chance to transition. And we are getting this from participants themselves. People are calling our office, people are stopping our and HT coordinators and hallways and facilities. Because they have expressed interest to transition and they are not getting an opportunity to do so. And we are also seeing folks who have diabetes be refused the opportunity to transition, citing diabetes management as the reason. I just wanted to, we are beginning to see the type of transition, people who are ambulatory and only people who can transfer themselves out of their wheelchair. And so, it is concerning to us. And I do not know who this goes to. But something we noticed and it is gradually increasing. I thought I would bring it here today.
>> JULIET MARSALA: Thank you so much for your comments. Public comments for any reason at any time. Not just on a particular topic. You heard me say this multiple times but I will say it again today. It anyone anywhere comes across a participant who wants to transition from a nursing home and is not getting what they need. I would hope as a center for independent living you would notify Randy and his team immediately so he can jump on it. Because we are H CBS oriented as a priority and you have heard me say it time and time again. If these are trends you are seeing these are also trends I would hope my staff would be seeing because of those direct and immediate communications from you and your team. Certainly also, the participants in the ombudsman office would want to keep track of that because to me that is a serious complaint. That should be pursued. That we would want to support. I will hand it over to Randy but I take those very seriously. we are not looking at low hanging fruit, I am excited about real-time medical because it has a proactive measure so folks can engage in conversations proactively. We are looking to try and support anyone who does not want to be institutionalized. To find a safe plan home. Randy.
>> RANDY NOLEN: Yeah I agree. The goal is to safely discharge people back to the community. Anytime you run into a situation like that, let us know and my team will look at it. Our participant support team will look at a and work with the MCO's to figure out what is going on with the case.

>> SHONA EAKIN: I will get you name and participant numbers.
>> RANDY NOLEN: Sounds good.
>> SHONA EAKIN: Get them right over.
>> RANDY NOLEN: When the cases come up.
>> SHONA EAKIN: In my defense, I honestly, the day before I come there to Harrisburg I say is anything I need to bring up? And this came to me as I was traveling yesterday as an issue so, I will get you those participants names and any identifying information.
>> SPEAKER: Fantastic, thank you.
>> RANDY NOLEN: Sounds good.
>> MATT SEELEY: That is very concerning. There is nothing the department, I mean, do not and how you would look at data that would show that. If that is really happening, isn't that a red flag?
>> JULIET MARSALA: It is a red flag, Matt. Which is what you folks, time and time again, please empower participants to use the participant hotline to make a complaint. No complaint is a bad complaint for every complaint is a good complaint. This is why you hear us time and time again when we providers tell us they have trends, if they have a trend and we do not someone is not giving us data. About a complaint or an issue in the system, it OLTL does not have the data and we do not have the trend. And there is nothing we can do to act on it. If we have general anecdotal information, this is a trend I am seeing, needs to be fixed! We do not for people bringing forward the name, the date of birth, the time of incident, did it happen yesterday, six months ago, last year? My team cannot fix it we do not know how to find the root of the issue.
>> SPEAKER: This is a public comment period.
>> JULIET MARSALA: An issue they have told five people, very important things, he implored everyone if there are complaints, send them here without fear of retaliation. Randy will not yell at a participant. MCO's, maybe, thank you.
>> SPEAKER: And Juliet, the participants are not -- that is my only point. George Gilmer here.
>> JULIET MARSALA: I hear you, Matt. If there is a provider who has heard those voices and are not advocating on behalf of the participants in real-time, I will just say I get frustrated. They do know the participant and they can ask. They can ask the participant if they can help advocate with them and jump on it. It really frustrates me when I hear this and we see a case that comes in and it is weeks ago this conversation happened. I am not going to live. We want to be here to help. But we need everyone to help us do that. I will stop there. Sorry.
>> SPEAKER: Matt, another person in the room.
>> MATT SEELEY: I believe George is on muted.
>> GEORGE GILMER: Michigan off mute? Hello?
>> MATT SEELEY: Go ahead.
>> GEORGE GILMER: George: oh, same problem, injury, six weeks ago, no attending care. Problems with lifting devices. By the way, my food is being delivered down in my yard the last time, safe food on the table, all of those things are questionable. I am running the same thing that with our, seems like the low hanging fruit is what wants to be delivered for attending care services. So yes, pretty concerning, I'm experiencing it myself.
>> Thanks, George. I appreciate you bringing that up.
>> JULIET MARSALA: Matt, somebody in the room. We'll go ahead.
>> SHEA ROBINSON: Shea Robinson, -- IMT PAS agency and I will just steal this time to ask the question. My question is that we know it is the summer time. And our SC, our our SC, allowed to add additional addresses to participants care plans, getting pushback and sometimes

saying the restrictions make them feel they are in jail. It is home and community-based services and am not saying we need to add Walmart, I am saying I have a participant for example, today, received 70 hours a week. A Wonder Bread. So her great-niece takes care of her and there are times where the niece will take her to her home and she does not feel comfortable if no one is at home to take care of her. She will take her to her home so in the morning time she will clock in and the niece is home. We ask the service coordinators if she can add in the care plan as an additional address. Because these addresses where caregivers are going in and out or not in the care plan. And then, getting pushback because the SC's I don't know if they are being educated in what they can put in the care plan. But it is getting frustrated because it is the summer time and participants should be allowed in the community, called home and community-based services. I would like to get more insight into whether or not SC is allowed to put an additional address in the care plan.
>> JULIET MARSALA: Thank you for bringing that up. Send the name. I appreciate you bringing that up because this has come up quite a bit with EDD. There is no restriction on the service location from a policy perspective. For electronic visit verification. Or limit in terms of location that the participant should be able to receive those services in their home and community along the guidelines that are required in the program. Okay, no restrictions, right? For eligible locations, for example, if they are admitted to hospital -- these locations should be as a part of the person centered service plan, should be able to be entered. I know all three MCO's do things a little differently and that is allowed. To address the issue, not restricted. Very different thing. If there is pushback in restrictions about things not being in a service plan, and hypothetical, details always matter and I do not know them.
>> SHAE ROBINSON: I just want a blanket policy.
>> JULIET MARSALA: OLTL's policy, there are no restrictions to the number of service locations. They should be documented and reasonable as to why those services are happening in that place. If someone is supposed to be bathed we do not see that happening in a supermarket. There has got to be some logic to that. But in the hypothetical you put forward, I do not see any reason for it I would imagine it would be incorporated and then emergency backup and safety plan without appears to be the safety plan family is putting in place hypothetically. Randy.
>> RANDY NOLEN: Will follow, Mike and his team will follow up on the MCO with their policies to adding addresses.
>> SHAE ROBINSON: That would be great. Because then we will have a printout that we can send to the SC's because there is a lot -- that would be great if we can get that as reference.
>> RANDY NOLEN: So you know, all three MCO sitting here on the line so they certainly heard the message.
>> SPEAKER: Again, they heard the message again. We talked about this multiple times.
>> SPEAKER: I have no other questions in the room. I don't know, Paula, anything?
>> PAULA STUM: This as Paula. I have several questions, you will have to stop me when it is time for the first question is from Kathy Cubit. What challenges do you as a service coordinators faced when a nursing home changes ownership? What are some of the issues participants raise after a new owner takes over and how do you address these issues, especially when the problems appear to be impacting multiple participants?
>> JULIET MARSALA: Paula, the SC panel is concluded for that question, Kathy. But we will send it out to the CHC MCO's and ask them to provide the perspective on that. Very good question, sorry we did not get to it when the panel was here.
>> PAULA STUM: This is Paula. The next question I have from -- I am sorry if I mispronounced

your name. What provisions of HR1 will actually affect people with disabilities in Pennsylvania and how we --how?
>> JULIET MARSALA: A very good question. A learning in process with regards to HR1 and what specific things will impact people with disabilities. Across the board. You know, I will have a very long and complicated answer for you today and a lot of moving parts still rolling out. What I would say right now, there is additional clarification coming out from CMS we are working through. When we see people with a disability, that can run the gamut. You know, I think the important thing is it will impact all of us. People with disabilities and without. One of the biggest impact areas will be uncompensated care. Our hospital systems, health systems, when individuals who would otherwise be eligible are then not receiving services from administrative burden. Be it from limiting services across the whole system, what will impact everyone is uncompensated care in our healthcare system. Potentially, experiencing longer wait times in emergency rooms, experiencing more strain on hospitals in rural areas. Those are real concerns that we certainly have. With regards to specifics, the office of long-term living, we are not making any specific changes to our CHC program today. We are certainly working as much as we can as an entire department. To be as effective and efficient with every dollar we found and be smart about getting upstream and doing a lot of preventative care stuff. We have made some changes in our Medicaid program that you have heard about last year. Which is we had to make a change in our GLP-1 medications and authorizations. A big example. We are hoping the bold of the impact will not be necessarily seen until 28, 29 even, we have additional time to plan, fully comprehend what is coming out from the federal level and see how that will impact things we do possibly we need to know more vocally what will happen with the budgeting process and things of that nature. We do not have all the pieces to answer the question specifically but keep raising identity will keep doing our best to answer it. Thank you.
>> PAULA STUM: This is Paula. Next question is from Samantha. Could you explain the 80 hour work requirement for Medicaid services again? And if there are any individuals who are exempt from this, such as individuals who are living with disabilities.
>> JULIET MARSALA: Yeah so, the community engagement or the work requirements that have come out is really focusing on the Medicaid expansion population. And Pennsylvania's estate that has a Medicaid expansion population, expanded eligibility allowances at the state. Individuals could be exempt from those work and community engagement requirements if they fall under the definition of medically frail, is one example. Or an individual who is providing care for someone who has a disability. Work meets the definition of a significant disability. The definition of medically frail has kind of been a moving target. That is part of what we are evaluating with the new interim rule that has come up for public comment. And that is something I think it's really important for this particular group to take a look at that. To take a look at that and provide your comments on what you think that should be. How should they define it, what should those exceptions be? That impacts people with disabilities. You know, and their caregivers and their families. So it is kind of defined more globally in the house resolution but how it is enacted in the finer details is in that CMS interim will notification for public comment. The other part of the explanation is within a given month, briefly, an individual would have to show or prove they have engaged at least 80 hours in either work or volunteer them, formal education. That is the other piece of it.
>> PAULA STUM: Hi, this is Paula. The next question I have is from Poland. On the meeting notes or the transcripts from the HR1 meeting available to the public?
>> JULIET MARSALA: Yes, Paula, the meeting materials , the PowerPoint publications were sent out on our list serv so we encourage folks to sign up for the Department of human services

list serve. To get those publications. In addition, you can find more information by going to the DHS website. DHS .PA.gov. There is a website kind of dedicated to the house resolution one and information and details. In addition, for folks who sell stock, not a sub stacker about trying to be a sub stacker today, there is a sub stack with a DHS channel. That often times includes updates and information on HR1. Multiple ways to engage. And get materials. We have three minutes. Back to you.
>> MATT SEELEY: What?
>> JULIET MARSALA: We have three minutes left, and handing it back to you.
>> MATT SEELEY: Thank you, thank you. I do not see any more questions. Any questions online Paula?
>> PAULA STUM: No questions. But several comments. I will follow your lead.
>> MATT SEELEY: Um, Can you read a couple of them and then point we can save some.
>> PAULA STUM: Sure. This is Paula. This comment is from Rebecca Meikle. I understand the desire to keep the HR1 committee manageable in size when it comes to who can contribute during the meeting. I respectfully do not understand why allowing interested parties to join in, listen only mode, is not being considered. In terms of transparency, allowing the public to listen to the discussion would ensure all have access to the information shared. I believe keeping the size manageable for direct discussion. I do not believe the desire to just listen to the discussions. Understanding the public tax dollars are being used to fund services, I lost my place, I am sorry. Understanding the public tax dollars are being used to fund services impacted by HR1, I asked a listen only option be considered again.
>> JULIET MARSALA: I appreciate those comments, Rebecca. We will certainly share them with the folks organizing the HR1 meeting and the secretary directly. Thank you.
>> MATT SEELEY: Because Rebecca's question so lengthy and enjoyable, I would like to ask for a motion to adjourn.
>> SPEAKER: Seems like everyone wants to stay, Matt.
>> MATT SEELEY: We can hang out a little bit.
>> PAM WALZ: This is Pam Walz, I make a motion to adjourn for.
>> MATT SEELEY: Thank you, Pam , we are adjourned. We will see you on July 1.