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Date: 8/5/2026

Event: Long-Term Services and Supports Subcommittee Meeting

>> MATT SEELEY: There it is. Good morning everyone. Welcome to the August meeting of the long-term services and support committee of the chain of whatever is about to happen. You are here for the long-term services and support meeting, you are in the right place. Before the boring stuff, Pam has some very exciting things to talk to you about. Go ahead.
>> PAM WALZ: All right. This is Pam. To begin, this is a reminder that this meeting is being recorded. Your participation in this meeting is consent to being recorded. And with that will take attendance. All right. I know that Matt is here and I am here. Abigail Foster. Abigail Foster? All right. For Ali Kronley we have an alternate. I'm not sure how to pronounce your name. Joie Mentry? Andrea Costello.
>> ANDREA COSTELLO: I am here.
>> PAM WALZ: Great. Austin Cawley attending as alternate for Anna Warheit. Someone has background noise. But everyone who is not speaking please mute? Perfect. Thank you. Carol Marfisi.
>> CAROL MARFISI: I am here. How are you, Pam?
>> PAM WALZ: I'm great. Nice to hear your voice. Cornelus " Neil" Brady. George Fernandez? Ginny Rogers. Jay Harner.
>> JAY HARNER: Morning.
>> PAM WALZ: Hi. That was Jay Harner?
>> JAY HARNER: Yes.
>> PAM WALZ: Kathy Cubit.
>> KATHY CUBIT: Here.
>> PAM WALZ: Laura Lyons.
>> LAURA LYONS: Good morning.
>> PAM WALZ: Linda Litton. Lloyd Wertz.
>> LLOYD WERTZ: Present.
>> PAM WALZ: Hi, Lloyd. Lynn Weidner?
>> Good morning, I am here.
>> PAM WALZ: Good morning. Michelle "Chell" Garrett?
>> MICHELLE GARRETT: Here, good morning.
>> MATT SEELEY: Can I stop you for a minute. Who is Christian Allie? That person seems to have an open microphone.
>> DAMARIS ALVARADO: That is from in the room, his sound needs to be on.
>> PAM WALZ: Okay the sound we are hearing is the sound of the microphone in the room. All right. I apologize for what I'm going to do. Padraig Tangney?
>> PADRAIG TANGNEY: I am here.
>> PAM WALZ: Thank you. Rebecca MacTaggart and Ryan Johnson. Has anyone joined since I started attendance?
>> LINDA LITTON: Yes, Linda Litton.
>> CORNELUS BRADY: This is Neil Brady. Good morning.
>> PAM WALZ: Good morning. Any additional members?

>> PAULA: This is Paula. - -
>> PAM WALZ: Were going to move to housekeeping and committee rules. This meeting is being recorded. Your participation 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 1:00 PM. To avoid background noise please keep your devices muted and microphones off unless you are speaking. If you're 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 captioning link is on the agenda and in the chat. It's important for only one person to speak at a time. Please state your name before commenting and speak slowly and clearly so the captioner made captioning 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 and go to webinar or use the raise hand feature to be put in queue to speak lives. Those attending in person should use one of the microphones and wait to be called upon to speak. Tabletop microphones are reserved for committee members. Microphones are limited so you may need to wait for OLTL staff to bring one. On the rear of the committee tables area are stands. OLTL staff are available for assistance. Before speaking into a microphone use the power switch on the top of the microphone body to turn it on. The switch to be pushed towards the end of the microphone you speak into. When you are finished push the same button toward the bottom of the microphone body to turn it off. Time is allotted on the meeting agenda for two public comment periods. If you have questions or comments not heard please send them to the resource account email found at the bottom of the email agenda and on the LTSS webpage. On 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. For people there in person please see the back of your agenda for more evacuation information. And I will turn it back over to you, Matt.
>> MATT SEELEY: Back to me?
>> PAM WALZ: Yes. And I guess Juliet is next.
>> MATT SEELEY: I guess I am it. So tag, you're it, Juliet.
>> JULIET MARSALA: Thank you. Morning everyone, apologies that I am joining virtually but I was unable to be in Harrisburg this morning. And I do miss seeing folks in person. So let's get started. Pretty excited with this first segment before we get into our usual agenda. In usual routine. We wanted to share in our excitement back in April 2026 Governor Shapiro signed an executive order 2026 ? two establishing commission, an advisory commission on people with disabilities. Since then he has been busy and they have appointed members to the commission. And they have appointed Executive Director. The purpose of the commission is to gather information regarding the experiences and needs of people with disabilities in Pennsylvania. All aspects. Review, evaluate and assess programs affecting them. Provide the governor with information and recommendations regarding how best to meet their needs and provide information about programs and services information about programs and services that may be relevant to the needs of those with disabilities in Pennsylvania. The Governor's advisory commission on people with disabilities can slip up to 30 volunteer members and is it responsible for advising on and advising programs, policies, legislation that fit Pennsylvanians with disabilities. With that I am really excited to welcome to the LTSS subcommittee meeting Doctor Josie Badger who serves as the first

Executive Director of the Governor's commission for people with disabilities and she is going to lead the commission's effort to advise the Governor on all policies and initiatives that improve the lives of Pennsylvanians with disabilities. In partnership with the commissioners, state agencies like ours, community organizations and leaders across the Commonwealth. She works with fans accessibility, increase representation and insured disability perspectives are meaningfully included in state government. And I have had the pleasure of working with Josie on the implement first commission and other topics that we have collaborated on. With that I'm going to hand it over to Doctor Josie Badger. And say welcome. Over to you, Josie.
>> DR. JOSIE BADGER: Thank you so much, Juliet and thank you for letting me be a part of this call. I am really excited to both be able to bring some of my personal experience but a lot of what we are hearing from the state to these conversations. And I know that I am in great company here. With a number of representatives here. And so as Juliet said we are really getting started. We just had our first commission meeting. We have all of our officers appointed and three workgroups. There were groups for this year our health and mental health, community integration and education/youth development. Those groups will be doing a huge amount of the work in those topics. My opportunity is to kind of connect the Governor's office, and all of you great commissions together and ensure we inform the commission on what we are doing. And increase collaboration among all of the sites that exist. One thing that I don't want to do is be working against each other. These are so important. One of the initial, I have heard several that have been really involved in, some of the Olmsted work and how Pennsylvania is responding to it. You will see more in the future regarding the Olmsted spirit. Excited to be doing that. Right now within workgroups here, still identifying exactly their priorities for this year as I mentioned. This was their first meeting on Saturday. And of course they are still pulling those together. But any time that you all have events coming up that you know are happening. Whether they are directly with LTSS or disability related, please let us know. Would b love to be able to support that. If there are issues you feel I and/or the commission should know about, please let me know. I am going to put my email in the chat. So it's my first three initials, jlsbadger@pa.gov. But we also have an email I am using for individuals that may be don't necessarily want to talk to me if that makes sense. More of a public email that is disability@pa.gov. Putting that in the chat. That's for anyone who wants to share what's going on and anything that would be helpful. That is jlsbadger@pa.gov and Cornelus " Neil" Brady. Is there anything else, Juliet, Paula, that you would like to know? I'm also open for questions.
>> JULIET MARSALA: I would open up now to questions from subcommittee members.
>> MATT SEELEY: Any questions?
>> LLOYD WERTZ: Welcome aboard, certainly happy to hear the commission has been established and that you are in charge of it and looking forward to the direction it takes. Going forward. However I will warn you that three years ago the governor initiated the behavioral health commission when there was a $100 million allocation placed in the enacted budget and was to be determined as to its division by the commission. By the end of that commission work, that money went to the Board of Education and we have yet to know exactly how it was spent and whether it did anything to improve their behavioral health services involved in the community or in the educational setting. About a year and and a half ago there was a mental health commission established and a determination there was that it was going to help coordinate and establish the way mental health is delivered

within the Commonwealth and even more disappointing on the first I still haven't seen the report from the commission.
>> DR. JOSIE BADGER: Is actually being finalized right now. I have seen it. I have physically seen it.
>> LLOYD WERTZ: I will also look forward to doing that myself but just giving you a better background we have experienced in the community from the advocacy standpoint and saying commissions are great things but only if they do something. And we look forward to that coming out of this commission. Thank you.
>> DR. JOSIE BADGER: If you want to see things done, they hired the right person. Happy to be the outlier, the commission I gets a ton done. Things that go off on the side, things are still happening and like I said that report, it is in its final draft. And that is on its way but I also want to validate what you are saying that sometimes it's hard to see was actually happening. So I hope that we are able to provide more of a visibility to what's happening. I can promise the governor is committed to disability inclusion. But that I come as ED of this commission will be working incessantly to ensure that.
>> LLOYD WERTZ: Thank you.
>> MATT SEELEY: Any other questions?
>> CAROL MARFISI: I want to extend my congratulations to what has been done. - - I will email it to you, or do I email it to somebody on the board?
>> DR. JOSIE BADGER: You can come straight to me. Number one, I really appreciate that. But use either of those emails that are in the chat right now. Those will go directly to me and if it is a commission thing that's for a work group I will direct it that way. If it is something separate I will handle it personally. And I think one thing that we always want to elevate, you know if there is a personal barrier, let us know. We will be working to make sure we are triaging where we need to but we are really focused on statewide issues. And so if you're seeing a barrier, bring it to me so I can do some research on whether this is something that's happening. For a lot of folks. But if it is a personal issue I am happy to help direct you to somebody that might be able to help you. But that is not necessarily what the full commission is therefore.
>> CAROL MARFISI: Even though I'm not a member of the committee right now I am willing to do whatever helps. I could be.
>> DR. JOSIE BADGER: Thank you. I appreciate that. As we start with priorities of the workgroup I anticipate there being some listening sessions. I anticipate work to gather feedback on specific issues and I definitely have your digits. Also, I appreciate that and it's true for anyone here. Any other questions? Your thoughts? Okay, well if it's okay I wold love to stick around and listen. I might have to drop off at some point but if I am allowed I would love to stick around.
>> PAM WALZ: We would love to have you stick around.
>> DR. JOSIE BADGER: Thank you. Once again, use those emails. Whatever you need. I would love to connect. Thanks, guys.
>> MATT SEELEY: Okay. Back to you, Juliet.
>> JULIET MARSALA: Thank you. All right, moving on to our regular scheduled program. So today for the agenda we are going to go over our usual. Procurement updates, community health choices request for information. Provider of validation, compensation reporting, proposed role and Pennsylvania Tech accelerator announcement. In addition, I believe we were, if there's time allowed also going to talk about the transportation workgroup report that will be posted publicly very shortly. Okay, let's get into it. The CHC

RFA was canceled. June 1 we are taking that off the slide momentarily. We also, in June publish a request for information that was released. Public commentary for the RFI closed on July 15, 2026. CHC program will continue to operate under the current CHC MCO's and agreement until further notice. If you have questions about the RFI you can send them to - - PA-PWRFAQUESTIONS@pa.gov so, you know I know in the room the slides may be difficult to see. So the team will be dimming the lights to enhance the visibility of the portable screen that we need to use in the room. I just got a message. So just want to let folks know about that. All right, so as I mentioned we put out an RFI. Go to the next slide. The next public comment period, noon on July 15, 2026, the office of long-term living received over 200 comments from 61 commoners. And we are currently in the process of reviewing those comments, looking at those comments. In evaluating those comments. After we complete that process we intend to publish as we have routinely in the past a high-level summary of the comments received. And sort of OLTL responses to the comments where we can and where appropriate. And so I just wanted to take a moment to say thank you. We requested comments, we wanted to hear from folks and 200 comments is fantastic. So, thank you all for taking the time. And being thoughtful. Giving us a lot of feedback on the CHC RFI. It's going to take my team, of 200 comments, thinking about it, responding to and summarizing it focusing on this in addition to all of their routine day-to-day work in addition to all of the extra federal level work that they have been doing, it is going to take us time. So I'm going to ask for some patients. As we get through this process. I know you guys are all eager to know but we want to do this well and thoroughly. Please have some patience with our team. We will look to add this onto the agenda for LTSS sometime in September or October. So those will be hot meetings to attend. Next slide. We are going to do a pitch again for provider revalidation. It's very important. In addition on April 23, 2026 the Department of human services received a State Medicaid Directors letter from Doctor Oz requesting that the state acknowledge receipt of said letter and that there would be a swift revalidation of high-risk providers within 10 days. And, sorry, within 10 days Doctor Oz wanted the state to acknowledge the receipt of his letter. And acknowledge that Pennsylvania would undertake a swift revalidation of high-risk providers. In addition Pennsylvania DHS, Doctor Oz requested a comprehensive revalidation strategy to be sent to CMS within 30 days of issuance of the state Medicaid Directors letter. For those who don't know who Pennsylvania state Medicaid director is, that is Sally Kozak, Deputy Secretary of the office of assistant living. DHS satisfy both requirements, we submitted for 30 provider revalidation strategy on June 5. Revalidation strategy is currently with CMS for review. PA DHS is actively working internally on getting ready to implement the strategy and prepare documents provider communications. We plan to issue or information in the coming months. I would also encourage providers to come as always, check and promise for your revalidation date. We have mentioned before you can start your revalidation process early if it's coming up. And certainly make sure that you are registered with our listserv. Our listserv is going to be the place where we push out all of this information to our Emerald providers. So if you have not registered for the listserv and have not tested either of them, make sure it does not go to your spam box. That's what you need to do now to prepare. This is how we will get our information out to you for the most part. Let's get into the state fiscal year budget. This is at a very high level of things in the budget that impact the office of long-term living directly. The first one is the budget adjustment factor. The budget adjustment factor was set to sunset this year. It has been reauthorized to June 30, 2028. Beginning January 1, 2027

Office of Long-Term Living will utilize a BASF not less than .86 to nonpublic nursing facility rates. This means there needs to be funds allocated. In the statute, one of our tests will need to be, we result in a BAF budget adjustment factor not less than.86. In addition we had some changes to the resident care and related cost language. Recounting nonpublic nursing facility shall demonstrate on its submitted MA 11 report or form. 70 percent of its total cost as reported by the facility are resident care costs or other resident related cost under our Pennsylvania code. This was reauthorized to December 31 2031. What's important also to note, particularly for our nursing facility providers is that the language was modified in section 1603 T to the methodology in determining a facility compliance with the requirement to make methodology more clear. This was issued in 2024 and became clear to us in the first year that there was not uniform reporting. What we were receiving from the nursing facilities. So it was not clear to us, there were some facilities that Matt the 70 percent mark and some facilities that did not meet the 70 percent mark based on how they were doing the reporting, they have met the 70 percent mark.

So it became clear that there needed to be some additional guidance and requirements to the methodology to make sure that we were all reporting the same thing in the same way. Providing that additional guidance was added here. We go to the next slide. Another important piece of the budget is that there will be a capitation payment delay. To our Community HealthChoices managed-care organizations in the fiscal year 2026, 2027. Capitation to our Community HealthChoices MCO's is typically paid in the month following the service. For example, the month of March, capitation is paid in April. During a capitation delay services, service months of April and May will be pushed back and paid in July of the next fiscal year along with the June service payment. This year the MCO's will receive payment for only 10 service months but next year they will receive the back to capitation payments. This is something, language that has been in the CHC MCO's agreement that the states can exercise this option and the general assembly has directed us to exercise this option and we have provided almost one year's notice to ensure our CHC MCO's and our system at large can prepare for that. And while we at OLTL file with this advance notice there shouldn't be much disruption to the system because everyone is getting advance notice to prepare with transparency. I am going to take this moment to remind our providers about our CHC MCO's have really been for the most part good at processing claims a lot faster than what they are required to do in the agreement. The agreement has very specific language on how fast the CHC MCO has to process a claim. So 90 percent of clean claims need to be processed I believe within 30 days, they'll have it in front of me. Forgive me for that. Often times our CHC MCO's are paying at a cycle that's much faster. So our providers have been used to a much faster pace cycle for the most part. And what I want to remind providers having been a small business provider myself is that we always need to be prepared, right? For an MCO being able to exercise their full time frame. I'm giving you the heads up now. Just as practical manner to remind you of that. Now we hope the CHC MCO's will be able to continue regular cash flow has you have been used to but I did want to draw your attention to that. Okay.

The life program which is nationally known as pace, living independent for the elderly program, there has been changes to the human services code with regards to additional requirements that the office of long-term living are required to put in place. Thankfully most of them are already in place. And it happened on going. This just codifies the and makes it very clear and there's some additional requirements that our team is preparing to implement

as well. In addition to Matt our life program receives an additional investment of 3.588 million to serve 300 additional participants in the life program. So we were very happy to see that in there. Certainly there were things in the budget that we wish were there. That did not get across the finish line. And there is additional work and advocacy to continue for those pieces that are important. To our participants, to their family members, direct care workers and our providers. And I'm sure you will continue that good work. These are the high level budget points that we wanted to share today. We are digging through the numbers and preparing in past years. There were, we provided you with the numbers chart of what was asked, what was in there. What the change was, we are still preparing those and we will be giving a full report out at our next meeting. Okay. Now we are going in to a review of the CMS Access rule. I'm trying to be mindful of time because I might even be over time. But, I have lost my place. In the access rule there is a direct care worker compensation reporting. And if we go to the next slide, under CMS ensuring access to Medicaid services final rule, the H CBS final reporting which is section 441.3 02K and 401.3 11E. - - 2028, states must report annually on the percentage of payments for certain H CBS services spent on compensation for direct care workers. This applies to homemaker, home health aide, habilitation and personal care services even if the states use different names for these services. Really speaks to the service definition. So this is the 1915 C waiver and other H CBS authorities where services are covered by Medicaid. It applies to both fee-for-service and managed-care delivery models. We go to the next page. We are going to go over the OLTL affected services. For us, affected services are adult daily living, basic and enhanced. Half and full day, implement skills development, personal assistant services, residential habilitation, respite, structured they habilitation, home health aide services in Community HealthChoices only. Because it is not a fee-for-service. And home health nursing. So treatment of certain payment data under self-directed service delivery models. So if the state provides homemaker, home health aid, habilitation, or personal care services under the self-directed services delivery model where the beneficiaries directing the services and the direct care workers, that beneficiary sets the direct care workers payment rate, that direct care workers compensation does not need to be reported and the state does not include that payment data and its calculation of the states compliance with the minimum performance level. And that's because the common law employers are the direct employers. So we are not setting their rates, their wages. Okay. Let's move on. There is a lot of information here.

Direct care worker, here's the definition. That feeds into the required services that we will be reporting on. Direct care worker means any of the following individuals who may be employed by Medicaid provider, state agency or third party from a contract with a Medicaid provider, state agency or third-party or delivering services under self-directed services delivery model. Remembering the caveat that I just talked about. So it lists here a registered nurse, licensed practical nurse, nurse practitioner, license or certified nursing assistant who provides services under supervision of registered nurse, licensed practical nurse, nurse practitioner or clinical nurse specialist. They direct support professional, personal care attendant or other individuals who are paid to provide services to address daily activities of daily living or instrumental activities of daily living, behavioral support, employment support or other services to promote community integration directly to Medicaid beneficiaries receiving H CBS available under that subpart of the rule. Which includes nurses and other staff providing clinical supervision. Then it goes through and there are a lot of slides. It goes through additional things like the definition of compensation, what does that mean on

the next slide which is salary, wages, things of that nature. As a list of excluded costs that we will not use in the calculation of the percentage of the Medicaid payments. So cost of required trainings, travel costs, cost of personal protection equipment. There's a minimum performance level, the state must ensure that each provider spends 80 percent of total payments received for total compensation on direct care workers. And at our discretion we identify providers determined by the state to meet its state defined small provider criteria. We do not have that criteria for you right at this moment but we are certainly working on it. The reporting timeline, just so you know where we are at, July 2027, that's one year where we are. Before reporting requirements begins we must report on readiness to collect direct care worker compensation data. And start Medicaid payments in July 2028. That's when we must annually report the percentage of certain Medicaid payments spent on compensation to direct care workers. In 2029 we are required to establish an interested parties advisory group to advise and consult on provider rates where payments are made to direct care workers. In 2030 states must ensure a minimum of 80 percent of certain Medicaid payments be spent on DTW compensation. Time for our entire Medicaid program, OLTL as part of that and there's a lot of information across different offices. I know many of you will have questions about 2029, that is a little ways off and we will be sharing information when prepared to do so. But we wanted to make sure that you all knew where we are at in our timeline which is August 2027. Gearing up for our first required reports.
>> I have to be able to hear it, so.
>> MATT SEELEY: Can you please mute yourself?
>> Because I have to go to work at 4:00 PM.
>> MATT SEELEY: Linda, can you please mute yourself?
>> JULIET MARSALA: Great. We wanted to talk about on the next slide one of the ways that we are going to be addressing, collecting data as required. The Office of Long-Term Living will be participating in a national core indicator, state of the workforce survey. So you can take a look at that what is on that survey and kind of see the questions that we will be asking. The national core indicators state of the workforce survey, or address or other TW collects data every year offering a detailed snapshot of workforce conditions at state level. Completed by providers and captures key workforce indicators including indication on ratios, vacancy rates, benefits and compensation. Recruitment and retention and demographics and training. This is a national survey. Pennsylvania has not typically or Office of Long-Term Living has not typically participated in and. We are electing to do so now is one of the best ways to collect the data in a standardized format. That could then make, be compared across different states. So if we go to the next slide the current national core indicators state of the workforce, they are doing work to combine aging and physical disabilities as well as intellectual and developmental disability providers. Currently it is separate. This is the last sort of year it's going to be separate. So we are going to do the physical disability one now and then in all future years it will be one combined survey. So the current survey tool is being revised by advancing states and the national Association of State Directors of develop mental disabilities. And in collaboration with the human services research Institute so that the collection of the required direct care worker payment adequacy reporting under the access rule requirements of that.
The office of developmental programs or ODP presently uses the NCI state of the workforce and has been for the developmental disability programs. They too will be using

it for the same requirements for the access rule. Trying to align to make it easier for our providers and our team and to have consistency. So we intend to use the revised date of the workforce for required reporting. In 2028. All providers who provide affected services which is the list I talked about before will have to annually complete the NCI state of the workforce survey to remain in compliance. So the next steps, we will provide an opportunity for advanced recommendations or feedback on outreach, education and training of providers as we begin to think through the steps. We will provide an opportunity for advanced recommendations or feedback on the office of long-term living oversight and monitoring of the submission accuracy and data reporting as we began to work through these processes and activities. We are looking forward to that partnership and engagement. As we roll things out to meet requirements in the final rule. Okay, how am I doing, Matt? I think I am way over time but I have like three slides. Can I keep going through?
>> MATT SEELEY: Can you not read them? Can you just summarize them? We are really over time.
>> JULIET MARSALA: Okay. The next slide, policy is very specific. Lots of information. So CMS has a proposed rule of amending indirect harmless threshold of healthcare related taxes. This is the rule that really impacts for OLTL the nursing facility assessments. So it has specific items in there with additional reporting requirements and changes to how we do testing on those assessments. And healthcare related taxes. So I will go on the next slide. There is a fact sheet for our providers who are interested about amending the indirect harmless threshold of the healthcare related taxes. And public comments are due by September 21, 2026. As you know I always encourage folks to exercise their rights to provide comments. We will be providing comments as well. Lastly, the Pennsylvania Tech accelerator. Very excited about this. This project was made possible through the American rescue plan act. Long story short there is a whole slew of resources and trainings that we have posted to the PA.gov website. These trainings and resources are for service coordinators, all of the HCBS service providers, anyone from community based organizations or participants if he wants another process is on our website. We encourage you to visit it because technology is going to be one of the strategies that need to continually advance as we continue to face a human shortage to our workforce. All right. That's it. Thank you Matt and everyone else.
>> MATT SEELEY: Passing it to you, Pam.
>> PAM WALZ: All right. Great. Lloyd and I are going to report on the HR one stakeholder meeting which was held on July 14. And I will start by sharing secretary are Koosh, her initial opening comments included a few things. Including the state can't get to 1115 waiver is approved for reentry and housing supports. And the other ones were not. They will continue to work on that. She noted we should be and what she described a fairly manageable place for managed-care programs in the budget. This fiscal year. She made a comment Lloyd and I both noticed but we are not sure what it meant where she said she believed DHS will have to begin implementing cost-saving provisions connected to HR one in fiscal year 28 and continuing in 2029. Assuming there are no changes at the federal level and requirements. That is sort of the question, what that comment meant. She noted that the state attorney general and states including Pennsylvania have filed a lawsuit challenging the interim final rule. Concerning implementation of work requirements in HR one. As not being based on the statutory provisions. The plaintiffs including Pennsylvania were hoping for a preliminary injunction that would've pushed back hopefully the timing on implementing work requirements but that was actually denied by the court this

week. So that means work toward implementing work requirements will have to continue going forward at the pace, a very rapid pace that the government has set. If we can go to, I just wanted to mention also, just as background, what this presentation was largely about is implementation by Pennsylvania of work requirements also known as community engagement requirements which go into effect in January. I want to note, these requirements affect Medicaid expansion population. In other words, people who are getting Medicaid through the expansion that was part of the affordable care act or Obama care. It affects that population and not people in LTSS categories. Of Medicaid. So by and large these particular provisions where people have to show they are working or volunteering that I'm going to be talking about right now are not going to directly affect people in LTSS categories of Medicaid. It will affect their caregivers, though. And it's important to remember other pieces of HR one will affect the LTSS population. Immigrant provisions and the overall effect on the budget. Of HR one in future years. So with that if we could go to slide.
>> MATT SEELEY: Pam, real quick, is there an easy way to know if you are in the expansion population?
>> PAM WALZ: So first of all, you are not in the expansion population if you were in the waiver program.
>> MATT SEELEY: Not for me. I assume there are people listening.
>> PAM WALZ: When I say you I don't mean you personally I mean you, the global. People in CHC will not be an expansion population. I think it comes down to what your category is. I don't know if there is anything any department wants to add about a quick and easy way to know that. There's been talk. About trying to make an easier way for people to check that out. That's been under discussion.
>> MATT SEELEY: I will accept it depends.
>> PAM WALZ: Great. We will take that question away and try to get a better answer. If we can go to slide four.
>> JULIET MARSALA: I can just say, Pam, it is certainly being worked on and contemplated but I don't have details to share from YM. So more to come.
>> PAM WALZ: Thank you. So we got information. What we are talking about here is the work the department is doing getting ready for what I will call work requirements. And so information is going out to the affected participants again, expansion population. So these are letters that are going out. Letters are going out August, September. Pretty much right now for current Medicaid recipients who are affected. Informing them of these changes that are coming. People who are newly eligible will start getting letters between October and December as well as everyone will get texts and Robo calls trying to alert everyone that this is coming. Starting January 2027 expansion population will go into effect. It is going to be verified whether people are in compliance at their first renewals after January. After implementation. At that time people are going to have to show that they are meeting the requirement through either work, volunteering or training or attending school. They have to show they met the requirement for at least one month since their last renewal. In a six-month time, once we have six-month renewals for this population they will have to show they met the requirements at least one month. As I was just saying HR one also means that for the expansion population renewal starting in 2027 we will have six months instead of every 12 months. This is not for the LTSS population, that will still happen every 12 months. Next slide. Everybody has hopefully have the opportunity to share them with everyone. There is a lot of detail in them about how this

will actually rule out for people. This is a slide that describes a timeframe on how this will begin to affect for instance a new Medicaid recipient as of January 27. And it shows as people are coming into the program when they will have their renewals. When they will have to show that they are in compliance. One thing to say is when people get their renewals for the first time under the new rules, they will receive a packet with renewals. If it cannot be determined by information that the department electronically has access to or otherwise has access to, whether the person is in compliance with work requirements they will get a notice at the same time as they renewal packet saying it's a notice of noncompliance saying you are not in compliance or we don't know that you are in compliance with these work rules, here is what you need to do in order to verify that you are in compliance. Next slide. Renewing is a current recipient is going to be the timeframe. People who are, it explains when this will begin to actually apply to people. We don't have a lot of time so I'm not going to go into a lot of detail about this. But it explains that people will have their regularly scheduled 12 month renewal and after that renewal in 2027 that is one six-month renewals will begin. Just like in similarly, there renewal packet will contain a notice of noncompliance if the department can't determine that they are in compliance. And it will explain what it is that they have to show. Alright so you can move to slide eight. Deputy Secretary Kristin - - from ODP spoke on how they are preparing for this. Like people in LTSS, most folks enrolled in Medicaid services administered by the office of double mental programs are not going to be subject to work requirements. But she also noted that there direct support professionals and their relative caregivers, may be. ODP is responding to this by, with an informational campaign on redetermination and pushing out information to explain to people how to maintain and verify what needs to be verified in order to keep their Medicaid eligibility. So here is some information about that. And people can watch for that. If you could move to slide, I think I'm actually handing it over to Lloyd.

>> LLOYD WERTZ: Thank you. Thank you very much, Lloyd Wertz here. Thank you very much Pam. The next section was handled by OIM deputy secretary. What Pam went over so well, the details and weeds are not something that I would tend to dive into except for this time. Because this time it can directly impact the individuals and their medical assistance benefits. Again, not folks in LTSS. Not folks in the CHC program but people caring for them and other folks that are part of that MA expansion population brought into being under Tom Wolfe. So while details still need to be attended to. The next section is when the workgroup had a presentation by OIM - - page directive that is set to begin January 2027. Good luck with that. And thenLexi Dyson wrote the division of health services share therefore exception pathways as part of guidance. The first being mandatory exceptions. So based on the federal rules, anyone under the age of 18, those are already on Medicare and certain mandatory Medicare groups, those having recent incarceration or part of the mandatory exception groups. There is also a self attestation for folks that meet certain qualifications that can be accepted during calendar 2027. I'm thinking we can move a slide or two. Those need to show that the individual has performed the work requirements and these will be accepted through self attestation. But these can only be used once and only through one. A renewal. Just as a specific exception. Other exceptions include former foster care, caretaker relatives, family caregivers, veterans with 100 percent his ability, those with medical frailties and drug and alcohol program. Those who are pregnant or an postpartum, it was also noted caregivers do not need to live with an individual with whom they're providing care. Compliance with work requirements

include and can include work hours, community service hours, work program participation, at least a half-time enrollment in educational program and any connotation of those appreciating a monthly income of $580 which I think was calculated to equal 80 times the minimum wage of the Commonwealth. Their short-term hardships that can also override limitation rules and that is someone needing inpatient admission, residents in a disaster area, those living in a high area of unemployment and interestingly, those required to travel longer distances to receive treatment. I don't have the details on those longer distances but I think it's an important category to watch especially for folks in rural areas in the mid-stated our Commonwealth. For those using volunteer hours, you cannot just go and clean people's windshields. You have to have some verifiable resource that can document your volunteer hours. This can be half-time enrollment education program but the hours must be verified by the educational institution. One credit is not enrolled for half-time enrollment. One credit will count as three hours of work per week to meet requirements. There are key decisions by the DHS that were shared and that's that they will share attestation to verify as to January 1 2028. That's kind of the deadline to get those in including what I just reviewed with you. DHS cannot accept use of attestation of income excluded in the HR one mandate. And will have to be verified. DHS hopes to be able to perform many of these reviews on an ex parte basis for expansion recipient in order to establish continued eligibility. If it's determined that the individual is not able to demonstrate eligibility then the issue and notice of noncompliance will be sent and be get to work with the individual in the county offices.
>> MATT SEELEY: This is Matt. We are so far behind. Lloyd, can you try and sum it up quickly? We are going to have to take a break and we have public comment. I'm sorry, is there any way that you can get to the end quicker?
>> LLOYD WERTZ: Absolutely. In general I do believe DHS is on the side of the right and trying to attack the animalistic approach of an overbearing legislation from the federal level. If there's a way we can help do that we should. Including advocating with your federal legislator and letting them know that these are real people being affected. These aren't numbers on papers. I would encourage that and and my presentation at this point. Thanks.
>> MATT SEELEY: Thank you, Lloyd. And your word that they and there are very, I think a lot of us share that. That said, Pam, how do you want to handle this? I would suggest Juliet do transportation report, do a break and then comments after. We can do a public comment for the whole thing. What do you think?
>> JULIET MARSALA: There are six minutes till the break and I can do the break in six minutes.
>> MATT SEELEY: Let's have it.
>> JULIET MARSALA: As you know, there was a transportation workgroup that concluded. And a lot of good work came out of that. A lot of good information came out of that and recommendations. Came out of it. So if we go to the next, let me see here. And so with that, we will be, we are finishing up some accessibility portions of reporting and the information that was compiled prepare it for public posting in our website. We intend to post it shortly as soon as those final editing formatting pieces are complete. And then it will be up for public consumption. But the group did a lot of excellent work. It was led by Randy Nolan and other members of the Office of Long-Term Living team. And, sorry. It is across workgroup of stakeholders with participant representation, managed care organization representation, representation from the MCO's, the other offices, like all

map, - - To look at all different kinds of transportation that is provided to participants, nursing facilities with our program. There was a lot of data review. For example, fun fact, only 1.9 million and change were scheduled by transportation. There were six workgroup sessions that compiled it. And they came up with a methodology from all different stakeholders to put forward their recommendations. Recommendation kind of show a roadmap of what we should try and focus on first because we cannot boil the ocean, identify what's within the DHS control, what's not. And all of that information will be out in that report. So in the top 10 recommendations that were weighted by the voting groups, the first was expand transportation network. The second was to integrate trip reminder calls and text messages. Have some systems enhancements to the scheduler. Approved post medical travel arrangements. Reeducate service coordinators, increase collaboration with M ATP, standardized process across groups, brokers, offices. Implement sensitivity training for transportation drivers. And pursue contracting with shared ride services, predominantly that are available for older adults. So we have made some progress in some of these areas since the workgroup convened. So for example the recommendation on post medical appointment travel arrangements, we have submitted proposed edits in the 2027 CHC agreement. Adding transportation considerations to discharge planning to assess better coordination with M ATP. That is still going to the works. we have been working with OIM to distribute large quantities of the updated Department of human services M ATP brochure. That's available on every County assistance office. And folks are kind of playing from the same playbook with regards to reinforcing county level MATP outreach expectations. And we are working on some additional considerations for next steps with regard to the MATP contracted providers. Looking at ways in which that network can be expanded. Evaluating potential changes of scope. Flagging different recommendations and operational recommendations. You know, so there is a lot of work still continuing on with this but the nuts and bolts of it is the report will be made public hopefully very very soon on our website so everyone can go through it and work through it. And keep an eye on it. Thank you.
>> MATT SEELEY: Thank you, Juliet. I have 11:10 AM. We have 25 minutes for questions. Right? That's quick math. Do we have, I noticed there's no questions in the box, right Paula?
>> PAULA: Correct.
>> MATT SEELEY: Any committee members with questions online? Wow. Anybody in the room?
>> LLOYD WERTZ: Yup. I just want to refer back to the state budget. Which is by Constitution mandated to be a balanced budget and established on July 1. So this year we went over two. Since the budget didn't happen until after July 1 but included, I believe a 17 percent decrease in the payments made to the MCO's across the Commonwealth. That are being pushed forward into the next year. 17 percent is a decent bit of change when talking about $54 billion. In addition they can sit and look at a rainy day fund. The total is now I believe $8.7 billion of unspent funds sitting somewhere in a bunch of bank accounts earning interest but are not being used for the purposes that they were intended in the first place. So if you have a legislator that sits in the Senate, perhaps, you may want to talk to them about the way the presentation values of though we did not increase taxes or spending, I would be thinking twice. I felt the need to put that in there. Sorry, thanks.
>> MATT SEELEY: Well said. I agree completely. Any other questions from committee members or people in the room? Any questions in the box, Paula?

>> PAULA: No, no questions.
>> MATT SEELEY: Wow. So should we give the captioner some time to rest her fingers?
>> JULIET MARSALA: I can share some additional updates and my planned presentation.
>> MATT SEELEY: You can do that. I have one question right off the bat for you. The presentation about the caregivers, what is that percentage at now?
>> JULIET MARSALA: I don't have that information for you.
>> MATT SEELEY: If you had to guess.
>> JULIET MARSALA: I wouldn't even be able to speculate. I would imagine most are very close to if not at the expected spend. That's what I would expect and hope to see when we do collect data.
>> MATT SEELEY: Okay. Go ahead with what you were going to bring up.
>> JULIET MARSALA: My second act?
>> MATT SEELEY: Yup.
>> JULIET MARSALA: Okay. Many of you may have seen yesterday that a group visited Philadelphia and had some announcements to make about the home and community-based services. And fraud, waste, abuse. Andshared some pretty egregious examples of fraud with our system for some really bad actors. And you know, unfortunately there are bad actors that take advantage of our programs and Rob from everyone else. And you know, we all work together to try to highlight, elevate, report, monetary and be diligent about the services that we provide. There's a couple of things that I wanted to just highlight since I have time. One is that it was kind of pointed to.
>> MATT SEELEY: Juliet, can I make a request. If you are going to talk about a bunch of things can you address the Olmsted thing?
>> JULIET MARSALA: Oh, yeah. Do you want me to switch? Or add?
>> MATT SEELEY: Whatever you are about to talk about just include it in there somewhere before okay.
>> JULIET MARSALA: There was a press release on Medicaid fraud with the Department of Justice. And in some of it it sort of indicated that you know, Pennsylvania has the fifth largest spending on HCBS and seemed to elude that that is an example that we have a lot of fraud going on. Pennsylvania is the fifth oldest state in the nation. So, you know, that is a good reason why we have one of the largest programs that serves older adults and people with disabilities. I just wanted to kind of highlight not Pennsylvania is the first in the nation in convictions because we have been diligent in implementing best practices from the beginning at our eligibility process. A conflict free assessment for our level of care determinations with a very rigorous evaluation of any Medicaid applicant and through our office of income maintenance. And all of the pieces we designed into our program for many years. Will fraud happen? Yes because there will always be bad actors and we will continually be pursuing them to end their profiteering and bring them to account. The Department of Justice, I think I talked about this a couple of meetings ago, states did not have to necessarily uphold the Olmsted decision and ensuring that everyone had access to community settings. It was very disappointing and disheartening to see that. In addition they then double down on that opinion with clarification. Which was equally disappointing. But you know, Pennsylvania remains resolute. And you may have seen some short video posts, messaging from the secretary and Executive Director Josie Badger, Christine Erickson and myself, reiterating the Northstar and the focus of DHS which is to serve individuals where they wish to be served. To help them live their lives to the fullest extent. That they wish to pursue their goals to have the right to pursue happiness which happens to

be in very important documents of our nation. So you know, all of this to say those opinions can be put out there. That does not change our mission here at the Department of human services in the office of long-term living. And Governor Shapiro is also absolutely resolute in protecting the rights of people with disabilities and promoting the rights of people with disabilities across our Commonwealth. Is there anything specific you want me to go further into on the Olmsted?
>> MATT SEELEY: Just to touch on it. Thank you.
>> JULIET MARSALA: Okay. So that's where we are with that. It's not going to change our day today here in Pennsylvania in our continued efforts to give people, provide people life-sustaining services at the right time in the right place. Towards their goals. All right. Any other questions? Topic areas?
>> MATT SEELEY: Anything online, Paula?
>> PAULA: No questions in the box.
>> MATT SEELEY: Wow. Then I guess we will take our break.
>> GEORGE FERNANDEZ: Are you there? Are you there?
>> MATT SEELEY: Yes?
>> GEORGE FERNANDEZ: Juliet, thank you for highlighting from the press conference from yesterday, as I'm sitting here and thinking of all of those different individuals that have to file forms, paperwork, become licensed, does the department offers some sort sort of technical assistance and registration, paperwork, billing, and to further help individuals understand how that paperwork should be filed? I'm a big fan of going after bad actors, fraud and so forth but I'm also a big fan of being proactive in the education of filing paperwork and technical assistance for individuals providing services in the space.
>> JULIET MARSALA: Yeah, absolutely. Really glad that you brought that up. We have a website full of provider trainings. That providers can go to for their trainings. You know, we have all of our kind of mandatory trainings up there. I can put the link in the chat for folks who haven't done it. Already to go to some of these basic trainings that are available for anyone at any time. You know, it goes over mandated reporting, Adult Protective Services, the requirement for critical incidences, what participant directed services are, risk mitigation, other HCBS services, the act 150 services. It also has our technology services in there, there's a lot of services and promise training related to promise, the promise portal. There are annual trainings that during provides to providers with enrollment. If you are licensed through the Department of Health, may have a lot of trainings with regards to licensing and regulations. Folks can go through having done this before. That are through the listserv, all of our bulletins, as someone has been a provider the number one thing I can say is this is the most highly regulated, and my opinion one of the most highly regulated industries. So if you are going to be providing services under Medicaid you need to love to read. That's just sort of a bottom-line piece. And that is reading the waiver standards, reading the regulations that you are required to follow, reading the laws that you are required to follow. Reading your contracts with the CHC MCO's. Every single page. Attending all of the webinars. Reading our bulletins, coming here to ask the visually great questions that you're asking, George. To be engaged. Natalia, the provider trainings are not provided in other languages. At this point in time that I am aware of. To answer your question in chat. As Holly asked if these trainings are provided in other languages for LEP individuals. Provider trainings are not at this time. I would say providers should engage with their trade associations. Many trade associations also provide additional supports and trainings. One of the trade

associations has free training for anyone. There are training specific to claims, fraud, abuse. There are other trainings that folks can get from the small business Association or the Department of Labor and industry. To make sure you are on the right side of human resources and labor laws. We see some of that happening. So there is a lot of training and a lot of materials that can be digested by our provider communities out there. And if there are specific trainings, if you see there is a specific gap in training we can certainly address that and come up with more. But we have done fraud, waste, abuse, claimant spelling, EDB trainings, there is a whole bunch out there. Thank you for raising that and giving me a platform to summarize.
>> GEORGE FERNANDEZ: Offered in that space of training, I encourage continuing that training with limited English proficiency. Spanish, Creole, Cambodian, those are the communities ultimately growing. With the age sector of the folks we are providing services with and if you don't know the rules how can you effectively follow them? So I understand there's trainings are not yet offered at this time but I would be thrilled to be your champion in helping move that conversation forward with MCO's as to what are they doing to make sure that we are providing those trainings and registration and paperwork in the appropriate first native language of the person providing the services. I really appreciate your comments. Thank you.
>> JULIET MARSALA: Let me be clear, the information required to be provided to participants receiving services must be in their language of choice. This is talking about provider training.
>> GEORGE FERNANDEZ: I will connect with the off-line.
>> JULIET MARSALA: - - Language of choice.
>> GEORGE FERNANDEZ: Thank you Juliet. I have follow-up questions that I will follow up with you off-line.
>> JULIET MARSALA: Sounds good, thank you.
>> GEORGE FERNANDEZ: Thank you, Juliet.
>> MATT SEELEY: Any other questions?
>> PAULA: This is Paula, I have no questions.
>> MATT SEELEY: Then should we take our break until 1145? I guess we are adjourned until then.
>> JULIET MARSALA: Thank you.
>> MATT SEELEY: Welcome back everybody. This is not again. We are moving into the next section. Which is recognizing and assessing cognitive support needs. I don't know, is this being done in the room?
>> RANDY NOLEN: Matt, can you hear me?
>> MATT SEELEY: I can.
>> RANDY NOLAN: It's Randy, I have three MCO's at the table with me that we will one through and hopefully we are done by 12:30 PM. Because I need to leave here this afternoon. We will go to the first light. The first slide is a combination of feedback and outlook of the three MCO's. We are talking about recognizing and assessing cognitive support needs for our participants. Cognitive challenges can occur with many different conditions and may not always be obvious. Service coordinators do diagnose cognitive conditions. Instead they identify support needs through a combination of a comprehensive assessment, the InterRAI. Observations, interviews from caregivers and providers. The assessment looks at how cognitive challenges affect daily life including daily communication. Understanding and following conversations. Looking at memory issues,

attention, spatial awareness and changes in thinking or mental function. Problem-solving, decision-making, looking how individuals manage daily tasks such as medication, shopping, getting around. Personal strength of the participant and with a veil support needs, safety concerns, risks, goals for the individual to be safe. The assessment findings in the assessment help MCO's work with the participant and their planning team to create a plan that supports health, safety and involvement in the community. Personal goals align with the needs and abilities of participants for maximized independence. As a result the care plan is tailored to individual needs rather than using a one-size-fits-all. Cognitive support needs are reviewed and updated when other there are changes in support or living arrangements or if anything changes with the participant. It's kind of an overview of what the MCO's look at and how they are trained on this. These are a list of questions I will go through, I will read the questions, pick on the MCO's and in varying order to go ahead and give input. Next slide. The first question we will talk about is how does your plan determine whether cognitive impairment is present and whether it creates a need for personal assistance services including supervision and who was included in the determination? We will go with PHW.
>> TAYLOR: Thank you. We look at the participant's response to the questions to the interview looking at the InterRAI. We want feedback from family members, any caregivers, any other individuals the participant wants involved. We look at the service coronation findings, observations of the participant abilities while in the home. To make safe decisions, complete tasks safely, manage medications, finances and respond appropriately to help with safety risk. We also would then look at records from a diagnosis or any clinical documentation as it is available. What we are looking at for supervision, we are looking at functional abilities, safety risk rather than diagnosis alone. We would authorize supervision when cognitive impairments results in impaired judgment, memory, deficits, medication, nonadherence, any wandering behavior, and any inability to really recognize a hazard in the home for the participant. We really are looking at assessment findings, documentation, clinical review, really to make sure service in the home it's participants needs.
>> RANDY NOLAN: Thank you. UPMC.
>> JOHN: Good morning, John - - with UPMC. Ours is the same, cognition is part of the assessment, the InterRAI. It is captured similarly rather than distinctly but within the questions we are asking about memory, short-term procedural situation and that would be called disordered thinking, speech but also in more common areas, independent decision-making regarding daily life task, managing finances, taking medication, shopping, mental functioning, interests, activities, support of cognition, how much are you engaging in puzzles that help activity. Other aspects of cognition. But it's not a distinct aspect. Like all other areas that we are assessing as we are care planning with participants about what services do they want from us and how we can assist. It's all included in the assessment process.
>> RANDY NOLAN: Thank you. AmeriHealth Caritas.
>> - - Noting each assessment is individualized including cognition is, is that better? Is that better? Perfect. I would agree with them as well. Noting that each assessment is designed to be person centered and individualized, noting that cognition is different across all participants. To assess participant cognition the coordinator would combine informal observations, former and standardized tools as well as any type of medical or environmental factors. In addition, service coordinators also provide feedback from family

members, caregivers and clinicians as needed.
>> RANDY NOLEN: Thank you. We are going to move on to the next question, next slide. The question is is a diagnosis of dementia or another condition which affects cognition necessary for cognition based functional needs to be included in personal assistance determination? If yes is a diagnosis of dementia from the primary care physician sufficient or must it be from a neurologist or other specialist? We will go with UPMC.
>> JOHN: We collect diagnosis which includes their history but we do not determine six service hours per diagnosis. Speaking as a professional counselor and someone who's loved one goes through this, cognition can be secondary to a variety of conditions. Yes, dimension and all its varieties but also dramatic brain injury, recent severe medical episodes, stroke, thrombosis, hypoxia, infection, mismanaged chronic condition, diabetes, cardiovascular disease, respiratory issues, - - low oxygen, things like dementia but it's not behavioral health. There is my bias, schizophrenia methods schizoaffective disorder, - -
>> MATT SEELEY: Sarah, do you mind slowing down?
>> JOHN: Sure. As long as - - at the end.
>> MATT SEELEY: The captioner is having a hard time capturing up.
>> JOHN: Apologies. Recreational substance use, medication side effects and later stages of other neurological conditions. Overall we will always recommend that people are assessed by the PCP who is a driving force in the CHC being referred to the program. But also specialized accordingly. But no, not one specific diagnosis.
>> RANDY NOLEN: Thank you. AmeriHealth.
>> GINA: Cognitive base needs can vary with medical diagnoses. Advanced age, acute, chronic illnesses, medication side effects and other factors that involve our day-to-day activities of daily living. All of these factors are taken into consideration when completing a utilization review. A confirmed diagnosis is preferred as it is in the participant's best interest to have a care team approach to make sure all functional and cognitive needs are being addressed and evaluated.
>> RANDY NOLEN: Thank you. PHW.
>> TAYLOR: We want to take individuals with intellectual disabilities, we are evaluating their cognitive function and looking at the need for keeping supervision, assistance with completing activities, maintaining health and welfare, and we pick those considerations into consideration when looking at the past determination regardless if there is a dementia diagnosis or not. So if there is any clinical information it's great for us to have. Just so we can look at that but outside of that it's not something required to receive services with a cognitive issue.
>> RANDY NOLEN: Thank you. We will move on to the next slide. Next question, is a cognitive functional assessment required? What does such a cognitive functional assessment consist of and who completes it? AmeriHealth.
>> Apologies, this is - - with AmeriHealth. We complete cognitive functional assessment evaluating a person's mental capabilities regarding memory, attention and function. We complete a comprehensive needs assessment with the participant and any other additional parties. If the participant may want to help represent them, tools such as the InterRAI, asking questions relating to these points. Additional questions may arise depending on answers such as if someone has a short-term memory issue. That team may ask for participants to memorize three words and ask him again in five minutes and see what their answers were. Were there answers complete? ? Did it take them additional time to answer?

Did they only answer a couple? Did they need additional assistance with that? We also take feedback from family members and caregivers, what they see on a day-to-day basis. Obviously what we are observing during assessment. If they are attentive during assessment, if they are able to answer questions accurately or completely. And additionally we have cores to review any medical documentation.
>> RANDY NOLEN: Thank you. PHW.
>> TAYLOR: Taylor from PHW. We do not have a separate cognitive assessment. We need the assessment planning process for individuals in areas that we are looking at that we include in their review is memory and recall. Decision-making abilities, the ability to recognize and respond to safety risk, medication management, ability to manage finances and daily activities, any need for keeping supervision or assistance with activities of daily living, and the impact of cognitive deficits on health, welfare and community living.
>> RANDY NOLEN: Thank you. UPMC.
>> JOHN: My answer is the same as PA Health & Wellness. We would not be doing an assessment, separate would be performed by a professional psychologist, neurologist, psychiatrist but our skills are all embedded within the InterRAI as described my colleagues.
>> RANDY NOLEN: Thank you. We will move onto the next question. How does your plan determine the personal assistance services needed to support an individual with a cognitive impairment? How does your plan determine the time needed to address the participant's needs? We will start off with PHW.
>> TAYLOR: When looking at personal assistance needs with regard to cognitive impairment we are not focusing solely on the participant diagnosis but how that cognitive impairment really affects the participant's ability to perform daily activities. So we are incorporating again that information from participants, caregivers, family members and providers. And any other individuals familiar with that participant's daily functioning.
We are reviewing memory, judgment, decision-making, cueing vomiting and supervision. We are also looking at the informal support and any other labor services the participant may be using to consider how that may be addressing some of their needs. And then looking at the unmet needs for personal assistance services. We are looking at the activity they need support with. How often they need support, how many minutes it takes for them to do the activity, the frequency throughout the day that that happens for each of our members. Animal number of days or weeks they actually need support.
>> RANDY NOLEN: Thank you. UPMC.
>> JOHN: This is discussing care planning process. Me and coordinators, assessing their environment and home, who is there to help them, we asked him a couple hundred questions on various tasks. Looking at the holistic picture. And as mentioned before participants rarely have one condition we are dealing with but they have different ones that might be impacting their ADLs differently and how they do certain tasks a certain way. When we review that and have a conversation how much time it takes to do this or that for particular skills, for which they do need assistance. As well as if their loved ones are present providing feedback. But it would not be based on one's soul list. We don't have a work list if you have cognitive impairment you only get X amount of minutes to open a can of food or something. Because it does not exist. This is a conversation that we form.
>> RANDY NOLEN: Thank you. AmeriHealth.
>> ASHLEY: We follow a similar process. Walk me through your day, for any observed or reported needs related to cognition. We conduct a one year look back to the last

assessment. Current assessment, we look at personal services support tool, the InterRAI helps us identify any changes, decline, any concerns that are related to the participants cognition. And then we do use a collaborative approach. So if we need additional information on the participant's level of cognitive impairment we will make outreach to the service coronation team to obtain that information which can help support us in making sure we are getting the most accurate picture of the participant's needs to ensure safety in the community.
>> RANDY NOLEN: Thank you. We will move onto the next question. This one, how are the InterRAI assessment tool items concerning cognition subsection C and E3 or wandering taken into consideration with personal assistant service needs? How are these items consider if there is no doctor letter provided with dementia diagnosis? Considering how you are using wandering and safety of individuals. We will start with UPMC.
>> JOHN: We do not have specific guidelines for if wandering. Then it is, now this impacts service answer and needs but the holistic picture, and as noted we do not require the doctor to give us a dementia diagnosis but there are additional conditions, traumatic brain injury for example. What we were wondering. With that, how and where and when does wandering occur? And what are the different needs for that in addition to personal assistant services, people want personal alert systems. If there is wandering during certain episodes or person loses track of where they are. Or if this is a consistent theme, how does mental status fluctuate throughout the day? Again, we look at the entire InterRAI, the holistic picture. But beyond assessment we are having a conversation with the person. We are personalizing the standard level and I cannot state this enough. Looking at the conditions and how does that impact for the service.
>> RANDY NOLEN: Thank you. AmeriHealth.
>> ASHLEY: This is Ashley with AmeriHealth. We follow a similar process reviewing all aspects of InterRAI. Section C on cognition and the section on wandering. We look at progress notes, walk me through your day and identifying supervision needs related to wandering. When wandering is reported. We take the caregiver or family reports of wandering or safety concerns into consideration during our review process.
>> RANDY NOLEN: PHW.
>> TAYLOR: InterRAI plays an important role in looking at the members needs. We are really happy with the updated questions in the V-10 version. They have been able to identify the cognition and wandering and really ask additional questions around what you need is for the participant, how is it currently being monitored, what is that need for PAS. We are reviewing overall status. Reported risk, whether that's from participants, someone in the community, anybody involved. Caregivers. We are looking at the assessment to determine whether cognitive impairment creates any need for PAS services. So really, again, we don't need a letter from a physician because we understand not everybody that has a memory issue is going to have a dementia diagnosis or Alzheimer's diagnosis. We are looking at that picture as a whole. Determining the need for each one of those tasks.
>> RANDY NOLEN: Thank you. I think that was the end of the set of questions that we will go to questions here. I will start off with a question, actually. The question I have for you, if you have a participant that seems to be okay at 10:00 AM when you go to assess them but you get reports that at 5:00 PM they are not. Or in the evening when the sun goes down and the light dim, they have wandering issues and confusion issues. How are you guys assessing for that? How are you working with the family and participant? We will start with AmeriHealth.

>> This is - - [Name?] With AmeriHealth. That's where observation comes in with the caregivers or the family members and they are telling us what exactly is happening. When there is wandering like you said, what time of day is that happening? What exactly are they doing in reference to that? How are they being redirected? Are there any health and safety concerns? I think this is also important to note, sometimes having a discussion is, if there's any technology to help assist with that like doorbells and/or alarms. I think that's pretty much.
>> RANDY NOLEN: PHW.
>> TAYLOR: When we look at that we look at the members daily routine. The reason that we are going to focus on that and structure that out is because we want to ensure when we provide PAS services and members home that we look at the time that they need them. If they sun down in the evening, like you said about 5:00 PM throughout the night and there up all day but at 10:00 AM, that's when they're having breakfast and laying down for their normal nighttime routine even though it's the morning. We are really looking at the daily routine, what the person has in their home currently, was additionally needed and ensuring we schedule that PAS person who's supporting their needs during the time that's needed. Individuals with cognitive functioning, we want to make sure we follow up and enjoy the caregiver is going into the home at the times needed. The person is in getting taken advantage of in the person is coming at the times they are available. The 20 UPMC.
>> JOHN: Similarly we try to capture not just what is going on in an unusual time in different circumstances, a couple hundred very personal questions about your life by a stranger. Or somebody you see once a year but you are describing your daily routine, weekly. How often do these activities happen? What's been going on the last few months? We are assessing once a year and updating with monthly contact and so on. But we do understand complex situations we have feedback from the participant themselves as well as their loved ones. And this happens at this hour of the night. We have people tell us if they tell us at 3 AM they wake up in the engage in different symptoms and behaviors. The other thing is of course if it is dementia or similar you will see a progressive decline over time. That they are not there capturing the time correctly, maybe two months later the wandering starts. That's when we would have the loved ones are professionals report that to us so we can reassess because of a change in need of that presentation.
>> RANDY NOLEN: Thank you folks. As you move forward for questions I want to thank the panel for speaking on this. Opening up questions of the advisory board or counsel only at this point in time. Any questions?
>> MATT SEELEY: Any questions in the room?
>> RANDY NOLEN: Lloyd?
>> LLOYD WERTZ: Yes, I do have one and you may have covered it, John, in the last comment you made but as we all know there's a number of different types of cognitive impairments. And some of them can take place over a really extended time. And so some of them can take place overnight. For over a couple of months. How are you able to, of course they result in very different approaches in dealing with dementia. How are you able to establish that timeframe of development of cognitive impairment within your enrollee?
>> JOHN: Lloyd, you brought up cognitive impairment and dementia, this can come from a lot of different conditions and somebody and others of different medical episodes would be collecting information from different specialists. Anyone that can help illustrate what needs to be reassessed and if something needs to be tailored. Dementia, it does not happen

the same in two different people. At different stages or even a type of dementia you are in. So since we are not having service corners take the role of their neurologist, psychologist, but plan for the model. These are the needs now. If there is a change of status go with that but we will not be able to predict if this person deteriorates rapidly or not. And our own staff, their own loved ones at home, have quite a few are going to the same. If they have first-hand experience working with this not only at work but when they leave work and head home. I myself in the course of this job support my father-in-law and just seeing how he's great for a week. It's kind of slowing down, may be improving. Then the next day we get a call from the brother-in-law that he wants to take a taxi cab to go back to his farmland that he lost 40 years ago. It's euchre season, have to take care of that. I'm like okay, who do we call now? What do we do about the doors he's wandering out of? And then talking like nothing happened the next day. So it is variable. Can we project that: there's different types of cognitive delays, issues so we know it's protein, so-and-so affecting this neural pathway over here. Therefore based on the diet and other genetic factors we know that this will occur the next 45 days, that will be great when we get there. We are not there yet so at this point it's report from professionals, caregivers and loved ones as per the course of that disease and there conditions, ADLs, IADLs and how we can support that.
>> RANDY NOLEN: Does PHW want to add anything?
>> TAYLOR: I would add that there is an authorization in place to give the caregiver - - to monitor was happening in the home to support that participant and receiving additional care whether it be from the neurologist, PCP, any other services. We look at an adult day care center where maybe they are in the community getting socialization, working with PBI providers to see if there is something that may be they can benefit from their. So we would be looking at trying to have somebody in that home monitoring them ensuring the SC does monthly contact, face to face quarterly visits for that person to ensure that if we need to do that trigger assessment, reassess or change services that can happen immediately. Whether it be on a permanent basis or temporary basis.
>> RANDY NOLEN: AmeriHealth anything else?
>> I agree with that as well. We would look at documentation from primary doctors as well as a specialist and look at previous InterRAI, PS SPA, walk me through your day to track that.
>> RANDY NOLEN: Thank you. Any other questions in the room? Open for board members at this point.
>> PAM WALZ: I have a couple, oh, sorry.
>> MATT SEELEY: We were looking for people in the room. Are there none? Go ahead, Pam.
>> PAM WALZ: Okay. One question is specific for AmeriHealth. On the question about whether you require a cognitive functional assessment, the question was really intended to be do you require a cognitive functional assessment by an outside like medical provider? So that's one and then my second question for all MCO's, that don't have space on their time and tasking tool to add time for supervision, related to safety monitoring or wandering. Why does your time and tasks will not include time? For safety monitoring and supervision.
>> RANDY NOLEN: AmeriHealth.
>> GINA: We do not require a functional cognitive assessment by a neurologist or outside provider but we do look as part of the participants assessment at these pieces as stated,

our InterRAI does assess for those cognitive functions and we take recommendations from the caregivers, from family members, from the person themselves as far as how they are functioning day today and what may be impairing their functional needs. We also do as stated suggest and recommend assessment from a provider whether it be your family care provider, because we do want to make sure if there is a cognitive decline the cause of the decline is being assessed and treated appropriately.
>> RANDY NOLEN: Do you want to address the time and task tool?
>> - - Thank you for your question, Pam, our time and task tool does not include time for supervision because we really need to drill down on the hands-on care needed for participant so we focus on just those areas. If supervision is also needed as part of those areas of hands-on care that can be included in the documentation but there's times when supervision is needed and no hands-on care is being provided. Therefore it is not showing up on our time and task tool. However being taken into consideration as a need for safety by the service coordinator and the team that is looking at the person centered plan of care and we do take feedback of the team, as such, formal supports informal caregivers on routines throughout the day. It is hard to just put in supervision maybe 24 hours because that's needed. Then you have additional time and tasks, time they need to do tasks. It's admitted because it's included in the person centered service plan and another way.
>> RANDY NOLEN: PHW.
>> TAYLOR: We also removed that safety area for supervision because we really wanted to work with the SC's to be able to document the need and and maybe a specific area. The one example of trainings I provide for individuals for wandering, we would add to that time and locomotion. Walking, then we would walk the SC, walk through what the participant is doing in that time. If you're just putting it in one specific section it's really not giving the participant, it's giving the SC enough information on the participant in one box. We wanted to open it up to the entire time and task tool so they can provide all additional information and spell out each step. Instead of someone need support with XYZ in one sentence. We look at it as a whole. What's the daily task needed, what's the supervision, queuing, spelling that out in each section.
>> RANDY NOLEN: UPMC.
>> JOHN: It's not excluded. The rest of the questions apply.
>> MATT SEELEY: All right. Kathy?
>> KATHY CUBIT: Thank you, two questions, how do you measure the participants with dementia satisfaction with services and when you do cut PAS or other services do you monitor for any adverse outcome to quickly address them? My second question is I'm just curious if any of the MCO's are participating with the Department of aging cells on my disease and related disorders task force working to update the estate plan. Thank you.
>> What did you say for the first question? Were you specifically identifying?
>> KATHY CUBIT: First question about how you participants living with dementia, how do you assess satisfaction with the services? When do you cut PAS and other services do you monitor for any adverse outcomes to address them?
>> For any services we would cut in the member's home we would really be looking at how they are participating and that additional activity. So we may be having the service grenade or go to the adult day care center, or whatever they are receiving and that service to see how they are participating in services there. Eventually benefiting the person, getting reports or care plans from the providers so that we can see their progress in those

areas. If we were to determine that was not meeting their specific need we would absolutely then send that SC back out to get services back in place back in the home. If what was put in place wasn't really in the best interest of participants. And then we really want to look at making sure we are determining permanent hours long-term and not always putting in temp increases. I think I talked about that earlier but if we identify that means long-term and I think Lloyd's question is sometimes we had to put those services in place. Even if it is something that may not be needed one day a week but needed the additional six. Someone is in the home securing that person, making sure they are safe, that their needs are met. And we are talking to the participants as much as they are able to answer how they are satisfied with their services, working with maybe a POA or their caregivers. To get that feedback if they are not able to express it. And obviously looking at surveys and things of that nature to follow up with participants.
>> RANDY NOLEN: UPMC.
>> JOHN: As far as satisfaction services, we have found that we will hear from them when we do our check ins as per agreed with the person be it monthly, or how it would be. It's something that we see in the process, observation. We would also hear from providers and unless people living with dementia are living completely alone we would hear from family members quite definitely if it is something less than satisfactory with the service. And ways to improve. My colleagues are eluding, there is a process of observation, however person is in their environment with the services and addressing accordingly. As far as the second part regarding the workgroup I would have to take that back and get back to you on that.
>> RANDY NOLEN: AmeriHealth.
>> - - Lakeland was AmeriHealth. I'm going to say ditto to my colleagues. We asked participants and families and we hear from providers on their concerns. There are multiple ways that can get in touch with us including the HHA portal. We are also checking on participants and to answer Kathy's question, if the reduction goes into effect we follow up with the participant to ensure needs are met. If we find they have unmet needs following reduction we can always go back in for a trigger event assessment. To answer your question about the workgroup aging, estate plan, we are currently not engaged with aging or the Alzheimer's Association regarding specific state plan. However we do have a relationship with the Alzheimer's Association and we also are funding training for direct care workers to go through training developed in conjunction with the old-timers Association. We have involvement. I'm not sure if that answers your questions.
>> KATHY CUBIT: Thank you very much.
>> RANDY NOLEN: Real quick, this is Randy. I'm going to wrap this up because like as I have to leave. When you make a gentle comment. Folks, as you know this is the last comment I will be at on the side of the table at least. My last day is next Friday. I am retiring, I am out of here. What I wanted to let you know is that I have worked with this committee for a long time. As we brought up Community HealthChoices. I've been here since the beginning of Community HealthChoices. It has been primarily my life for the last 10 years. I've gone through a lot of iterations of people on this committee. A lot of dedicated individuals who want to improve the services and all of them, the lives of participants and provide them the needed services to keep them in the community living the way they want to live. I wanted to let you know that I appreciate the work that you guys have done. I appreciate the opportunity to work with you. We work together to accomplish a lot in this program. We have but has along the way that we have worked in the process.

And I want to tell you I appreciate the work you've done. I encourage you to push the envelope and let your opinions and your knowledge be used and known to drive this program forward. And to address some of the issues occurring with budget at the federal level. And really push the envelope to continue to provide the best services for individuals that need them in this program. That being said here's a little microphone drop and I'm out of here. [Applause]
>> MATT SEELEY: Thank you, Randy. I was almost afraid that we weren't going to hear his voice today. [Applause] Can I give it back? If the panel is not there anymore - -
>> PAM WALZ: Is the panel still there?
>> MATT SEELEY: I don't know, I am not in the room.
>> JULIET MARSALA: I think Randy close the segment so we are back in public comment but certainly there is questions for MCO's were additional questions for MCO's, you know committee members can certainly send them to OLTL and get them answered. Folks in the audience have feedback they can certainly use the usual resource account for the LTSS subcommittee and we will do follow-ups as we usually do.
>> MATT SEELEY: Okay. That said, Patrick, do you have a comment or question?
>> PATRICK: Yes, a two-part. You MCO's understand what percentage of person served have a cognitive impairment while completing the InterRAI? In the second part of that question was for those who identify with the dramatic brain injury how many are offered cognitive rehabilitation therapy in addition to PAS services?
>> JULIET MARSALA: We will send that out to CHC MCO's. But I will share a couple of things if you want percentage of individuals who have an identified cognitive related diagnoses, our OLTL team can get that to you in aggregate. We can do that as a follow-up. It may not be for some time because it goes through data governance but we are happy to supply that. With regards to cognitive rehabilitation therapy, SC's should be educating and providing services needed to every participant of the program regardless of diagnosis. If they meet they need for that service. I can answer that broadly for the program. Otherwise you will get ditto, ditto, ditto from the CHC MCO's. Good questions.
>> MATT SEELEY: I want to follow up with something Pam said to the MCO's. She was talking about safety and that you MCO's set is considered somewhere else. I would really love to hear what considered means. I mean that sounds like something you say as a CYA. Oh sure, we have considered it.
>> PAM WALZ: Matt, can I piggyback on that? I was going to follow up on that. When they say they consider it, we don't see that happen. And we read a lot, we have clients with denials and reductions. We do a lot of reading of the records including service coordination records and UM records. We ask about safety monitoring and supervision are not included in the PS ST is that we see for the MCO's that don't include it in their time and task tools. What we see is the decisions healing very closely to the outcome of the time and task tool. Being very focused on those responses to ADLs and IADLs. What we don't see in the notes is much consideration of supervision needs. Service coordinators will note the need but it tends to be not taken into consideration. Kind of ignored. When it is reviewed. And taken out with UM reviewers sticking really closely to results in the time and task tool. So I also have a real question about how it is considered and I think we really do need something other than the address very general language.
>> JULIET MARSALA: We will send that out for follow-up so they can supply a specific response. We are aware and have been working particularly with a couple of those CHC MCO's

where you have highlighted and sent us specific examples. And our medical directors had conversations with his peers on that specific topic. To ensure that that area is improved. And our team is gearing up to provide additional monitoring. What I would request as you do is to continue to send us examples. It's my hope you will begin seeing a significant change in documentation. Particularly with areas you have shared with us already. We have certainly made it clear our expectations. And it will be providing more monitoring oversight in that particular space. Having raised it with CHC MCO's in our meetings with them. So definitely they will get the asks. My team is taking notes and they should see that as a response to follow-ups.
>> PAM WALZ: Thank you, Juliet.
>> MATT SEELEY:: Any other questions from committee members? Anyone in the room? If not we will go to you, Paula.
>> PAULA: Brenda Dare is asking when discussing exceptions to Medicaid working requirements, Medicaid is its own category. How is it defined?
>> JULIET MARSALA: That is a very good question, Brenda. It is still in process as many of you may be aware. The CMS had sent out additional technical guidance on medical frailty with a definition we believe goes beyond the scope of what was intended and HR one. Some have been sued over that and unfortunately we did not get the injunction we wanted. But there will be the judge and courts have committed to hearing the merits of the case. Around that very question. So it's a little bit in flux. At the federal level.
>> PAM WALZ: Can I add to that a little bit?
>> JULIET MARSALA: 100 percent.
>> PAM WALZ: This is a part of the update of the stakeholder meeting that we just did not have time for. And so Brenda, I would direct you to the slides from pages 30 on that go into this. I was going to describe it in my update and did not have a chance to. I don't know if there is time now but I would be happy to talk with you about it and it is described in the slides. Basically it's grouping conditions into three categories. Some of which are going to be considered serious enough in and of themselves to be considered to create medical frailty. Some of which are temporary acute conditions that will be considered to exempt people for as long as that condition exists and a middle category where there is going to be a diagnosis plus consideration of other factors to determine whether or not they meet the IFR new requirement that the condition significantly affects somebody's ability to work. So in addition to the diagnoses the department is looking at factors like how high acuity is it? How frequently, the frequency of treatment needed. Whether requires treatment at high risk or needs a lot of monitoring like dialysis and chemo. Whether people are getting services that reflect functional impairment like DME or home health and whether they have additional risk factors that indicate the diagnosis is serious enough and that person to impair her ability to work.
>> JULIET MARSALA: I would add that's the approach we hope to take in Pennsylvania. We believe it's a good approach. We believe it's for our purposes, the right approach. We have not received approval on our approach but certainly we believe it's a positive direction because CMS has referred other states to us to learn more about the approach we are taking. To my earlier point I cannot say definitively that that's the definition. It is the route we are going pending CMS approval and acceptance of that process. We are running short on time. I hope to hear something definitively from CMS at some point.
>> Thanks from both of you.
>> JULIET MARSALA: Pounded a good way of summarizing, that is the way we want to go,

100 percent.
>> We have an audience questionn, waiting for 20 minutes or so. Not sure we can go to that.
>> MATT SEELEY: Who is not talking?
>> JOHN: John from UPMC, one of the MCO's. We, the panel are still hanging around. We had an audience member with a follow-up comment. My apologies if I'm out of turn.
>> JULIET MARSALA: Yeah I'm sorry, I don't know if I was clear, the panel is excused. To steward questions, if that's all right.
>> DAMARIS: We do have a question from Shawna if we are taking public comments now.
>> MATT SEELEY: Yes, go ahead.
>> SHAWNA: I have three subjects I want to discuss. The panel is here-want to talk about cognitive questions first. As a person who works with a lot of folks with disabilities I understand how and I heard a 200 question survey can be very daunting and could in some ways affect the outcome of the answers, especially if that 200 questions was asked all at one time. I'm not sure any of us can do that. That's concerning. The other thing I wanted to say about that is I think now more than ever is the time that Pennsylvania needs to look at supportive decision-making over guardianship because we have a practice in the elder community particularly of guardianship and for people with disabilities as well. Just because someone cannot make financial decisions does not mean they cannot direct their own care and often we see that being abused. I really would like Pennsylvania to look at supportive decision-making as a model. In lieu of guardianship, that's one thing.
>> JULIET MARSALA: Shawna, can I respond quickly? One is absolutely supportive decision-making is something we support in Pennsylvania. We do a lot of work with and have done a lot of work with guardianship and we continue to do a lot of work with guardianship. We absolutely do not want to take away someone's rights. Unnecessarily. Appointing guardianship is a very critical thing and the office of long-term living does have a position where we want to make sure that we support the person's independence and autonomy as much as possible. I will point to an example of that. Over the last three years we have done the significant guardianship work in our Adult Protective Services area and doing a lot of workfare along this philosophy. You will see that guardianship appointments have gone down drastically by the hundreds to the point where the courts provided our team feedback that they were very much impressed with how we have reduced guardianship appointments over the last few years and it was very noticeable in their court hearings. So 100 percent agree, we want to support people, lifts them up, consider alternatives. Prior to any kind of guardianship appointment.
>> SHAWNA EAKIN: Thankfully when I was 17 I had a wise judge otherwise my family might've declared me mentally incompetent and it would be a very different outcome today. That's one comment I wanted to make. The other has to do with first, House Bill 1939. A house built for ODP. There's going to be a hearing on August 18. But it has to do with rate settings. And when I read it I wondered, why OLTL wasn't included. So I would ask that OLTL be as forward as ODP and getting legislation that kind of helps us define when rates are increased in the services. And then my last comment just to go on record and I know I spoke with samaras about this already. The transportation report that is coming out, there was maybe 15 minutes worth of consumer stakeholder sessions regarding transportation. The second one was canceled because there was no interpreter available. And I was wondering and I know Jim Harris is going to get me information but I wanted to go on record because I'm being texted by members of my community who are listening to those. I was

wondering how stakeholder input was really gathered and whether there is still opportunities because there are people that felt like they were not completely heard in the stakeholder meetings we had especially the one that was canceled due to a lack of interpreter.
>> JULIET MARSALA: I will certainly look into that. But I can say, Shawna is OLTL is not a one-time situation. I would share the LTSS subcommittee resource account with those individuals and encourage them to submit their comments and thoughts about any and anything related to the LTSS services and systems. In addition the CHC RFI was an opportunity to provide public comment very specifically to services related to CHC. I hope that I haven't gone deeply into the comments. I hope individuals took advantage of that. Also additional comment Avenue. There is for individual situations, the participant Hotline is available. So Shawna, you know these things. Certainly go back to them. OLTL is always open for feedback and folks can use those resources, those resource accounts in public comment at any point in time to provide feedback to us.
>> MATT SEELEY: Any other questions, Paula?
>> PAULA: Yes I have a question from Rico Sheppard. She is asking what trainings to service coordinators receive on available assistive technology?
>> JULIET MARSALA: Hi Rita, thank you for that question. If you go to my side in my updates, we just pulled a slew of additional resources and SC specific trainings around assistive technology diving deeper into that subject. Then sort of the basic training that SC's might provide. So all of that training and those resource materials are available on our website for anyone to see and engage with. Take as part of our Pennsylvania tech accelerator. Thank you for that question and allowing the additional opportunities to highlight those opportunities for everyone.
>> PAULA: The next question is from Jeff Eiseman. What is OLTL doing to address any HCBS consumer Medicaid services and supports whose immigration status is in question? Also is there anything in this space regarding direct care workers who may have a similar status and any discussions with providers.
>> JULIET MARSALA: Very good questions, Jeff. I can tackle them one by one. Unfortunately we cannot control how the feds determine who would have citizen rights, and who doesn't. There certainly have been changes in temporary protective status that we are aware of and we are very concerned about. With regards to participants our staff have worked very closely with the office of income maintenance. To identify anyone who may have a change of status. Changes of the federal level, and identify them so that we can begin work on evaluating alternative services for them. If they are not eligible for the federal programs, federally funded programs then we cannot continue their enrollment and community health choices. We do have the act 150 program for individuals under the age of 60. And the options program in the Department of aging for individuals over 60 though I can't speak to whether or not with regards to aging services, my team will be looking at that as well. For individuals who would be eligible for the act 150 program which is a state-funded program we will certainly be working through the PA IEP and our community-based partners and advocates to support them. With any eligible transition that can be made to continue to support them. The individuals who have been identified will, may have already been but will be communicated with the current service providers and service coordinators who are supporting them. To try and assist as much as possible. With alternative planning prior to eligibility status. It is unfortunate. I wish that I could change the situation but we have to operate within mandates of the federal government. Stats with participants. We have received outreach with some organizations that would very much like to work closely

with us on this transition and provide feedback. We will be having this as a topic in our participants and advocates call. It's certainly very important to us. There are a little over 600 individuals that we have identified so far. I don't have an exact number to share off the top of my head but that is the universe of schools that we know will be tremendously impacted. Now flipping over to the provider side, it is also similarly concerning. We understand the impact of individuals in our industry and workforce who have worked diligently to serve Pennsylvanians that may now find themselves ineligible to work. It's incumbent upon the provider to have planning for operations. I don't mean to sound on empathetic. I am not. This is not where we want to be. But it is where we are. So there will be potentially transitions for participants in our programs because they will have dedicated direct care workers they may have worked with, nurses or other clinic staff they have worked with within their service plan that will now no longer be eligible to work with them. The Commonwealth of Pennsylvania is not able to circumvent federal rules around citizenship. Unfortunately. So I wish there was more we could do but unfortunately this is where we are today. I hope that answers your question, Jeff. Thank you for raising this important issue. It's so important to be mindful what's happening at the federal level as much is the state level.
>> MATT SEELEY: Carol, can you mute your microphone, please? Thank you, Paula.
>> DAMARIS: We do have a question in the room.
>> MATT SEELEY: Go ahead.
>> Hi this is Misty Dion from roads to independent - - Pennsylvania is not currently a state that recognizes supportive decision-making so it's really important that we have our partners at the state level encouraging that to happen sooner than later. But also to the topic of the IRA and the time and task assessment. It's very important like Shawna brought up. To make sure that the participant's choice and control and direction is continued during the healthcare process. And whether or not they want to live in the community which takes me to the next point of the nursing home transition continuing to be an administrative task and hopeful that throughout many of the public comments that the department receives for community health choices horrifies, that would be a glaring one in this committee. To take a look at special consideration on how consumer decision-making could be influenced by those assessments. Thank you.
>> MATT SEELEY: Any other comments in the room?
>> DAMARIS: Nothing further.
>> MATT SEELEY: Anything online, Paula?
>> PAULA: Hi, Matt, this is Paula.
>> MATT SEELEY: I see that Natalia has a hand up.
>> NATALIA GOMEZ: I want to go on the record saying that anytime something comes up cognitive needs it doesn't become a reality. I have different conditions, now put in there someone who is a multiple lightning strike survivor who has a cognition issue that we already have the barrier of finding a medical professional who don't know how to deal with lightning strike survivors. And I noticed, I just participated in a reassessment and I noticed that you talk a lot about observation and what's happening while they are there. And even though it was mentioned sometimes you can go to a participant home and you may see a lot of movement there with other family members visiting and observing and asking questions is two different things. And I believe that cognitive support, I feel sorry for the service coordinators because everything goes to the service coordinators. And put on top of that, doing an assessment within LEP individuals that don't speak anything at all of

English and go through third parties to get this information and to get these observation, notes and activities. Implemented dental plan of service. And whenever I hear a participant center, I as a participant feel that we are not in the center. We are in the center for certain things but not for what really matters. For our health and safety. And I just wanted to put it out there. I believe that the cognition saying that they don't require or need a medical doctor, that's not true. I was just in an assessment and they are waiting for a decision to be made in order for the decision to be made family members have to get medical documentation of the conditions. So I just wanted to make that public and let it be known.
>> MATT SEELEY: Thank you. Go ahead, Paula with the other questions.
>> PAULA: This last question relates to the CHC MCO's and cognition. So I think Juliet stated we would be sending those questions to the CHC MCO's to be responded to.
>> JULIET MARSALA: Yes.
>> PAULA: So I have no other questions in the chat.
>> MATT SEELEY: Okay.
>> JULIET MARSALA: Matt, looking at time, can I do my announcement as part of public comment?
>> MATT SEELEY: Please.
>> JULIET MARSALA: Okay I know we just have one minute, this is important. So we have again announced additional investments for the rural healthcare transformation plan. There was a press release sent out with regards to additional rounds of funding. The deadline for submitting and eligibility certification is quickly approaching. The funding is open for federally qualified health centers and federally qualified health center look-alikes until August 7. The opportunity is open for hospitals, long-term care nursing facilities, behavioral health providers and others that are listed on the Rh TP website until August 14. The funding opportunities are posted on the Rh TP website. And there is also another funding opportunity that is set to open on August 17. For round two of rapid response stabilization. There is an RA email account specific to the RHTP, rural health transformation plan. I'm going to bring it up there because those due dates are coming up fast and I would like OLTL and LTSS providers to have the opportunity to respond to it. Please remember RHTP has its own listserv and website and while we are part of it we are not the leave so we encourage our rural providers to please ensure they are registered on listserv and routinely checking the website for any and all funding opportunities that may be put out because we may not always highlight them timely in this particular meeting. So I wanted the opportunity to highlight the, we will send more information about this funding round throughout trend because it is time sensitive but if you haven't, please follow along the great work of RHTP.
>> MATT SEELEY: With that, it is 12:58 PM on my clock. Hopefully we see you all September
2. I will take a motion to adjourn.
>> NATALIA GOMEZ: I second.
>> MATT SEELEY: We are adjourned. See you in September.