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Date: 10/7/2026

Event: Long-Term Services and Supports Subcommittee Meeting

>> MATT SEELEY: Two minute warning, everybody. Get your drinks, get your snacks, and we will go very shortly.

>> MATT SEELEY: Good morning, everyone. Welcome to the October Long-Term Services and Supports Subcommittee. I'll hand to Pam for the quick business. Pam, if I can ask and pass back to me before going to Juliet.

>> PAM WALZ: Sure. This is Pam Walz. I first need to mention this meeting is being recorded. Your participation in this meeting is your consent to being recorded. So I'll take attendance now. I know that Matt is here. I am here. Abigail Foster. Ali Kronley.

>> ALI KRONLEY: Good morning. I'm here.

>> PAM WALZ: Andrea Costello. Anna Warheit.

>> ANNA WARHEIT: Good morning, this is Anna.

>> PAM WALZ: Carol -- hi, David Gates. Sorry, I have you're her alternate today. Great. Neil Brady. Is there an alternate here for George Fernandez? Per happens in-person in the room? Jay Harner.

>> JAY HARNER: Morning.

>> PAM WALZ: Kathy Cubit.

>> KATHY CUBIT: This is Kathy.

>> PAM WALZ: Laura Lyons. Sorry, she's excused today. Linda Litton. Lloyd Wertz.

>> LLOYD WERTZ: Present.

>> PAM WALZ: Great, Lynn Widener.

>> LYNN WIDNER: Good morning, this is Lynn.

>> PAM WALZ: Chell Garrett.

>> CHELL GARRETT: Hi, this is Chell.

>> PAM WALZ: Padraig Tangney.

>> PADRAIG TENGENY: Here.

>> PAM WALZ: Rebecca MacTaggart :

>> REBECCA MACTAGGART: Here, couldn't kind the mute button.

>> PAM WALZ: Ryan Johnson.

>> RYAN JOHNSON: Here.

>> PAM WALZ: Anybody else join since I started attendance and you missed your opportunity? All right. So I'm gob that -- oh. Hi.

>> PAULA STUM: Pam, this is Paula. Andrea Costello is here.

>> PAM WALZ: Great. I'm going to turn to housekeeping rules. This meeting is being conducted in-person and virtual. To comply with logistical agreements we'll end promptly at 1:00 p.m.. Keep your microphones muted unless you're speaking. If you're attending in-person, keep background noise to absolute minimum. The room is fitted with ceiling microphones that I can attest pick up absolutely everything. One of the chairs will report in person attendance. Thank you. Remote captioning is available at every meeting. The CART captioning link on the agenda -- is on the agenda and in the chat. It's important for only one person to speak at a time. State your name before commenting and speak slowly and clearly so the captionist may capture

conversations and identify speakers. Please keep your questions and comments concise to allow time for everyone to be heard. Webinar attendees may submit questions and comments into the question's box and GoTo Webinar or use the "Raise hand "Feature to be put in cue. Those should be waited to be called on. Tabletop microphones reserved for committee members. Microphones are limited and wait for staff to bring one to you. General public should use the microphone in the stand in the rear of the CPI it tee tables area. OLTL staff are available for assistance. Before speaking into a microphone, use the power switch on the top middle of the microphone body to turn the microphone on. The switch should be pushed toward the end of the microphone you speak into. When you're finished speaking, push the same button towards the bottom of the microphone body to switch the microphone off. Time is allotted for two public comment periods. If you have questions or comments that were not heard, send them to the resource account e-mail found at the bottom of meeting agenda and on the LTSS SubMAAC page. OLTL staff are available in the safe area for an emergency in front of elevators to provide assistance. If you're in person, see the back of agenda for more information about emergency evacuation procedures. Thanks, and I'll hand it back over to you, Matt.

>> MATT SEELEY: Thank you, Pam. I was thinking for awhile, I want to say something at this meeting, and I didn't really know what I want to say. I want to say it for awhile. My name is Matt Seeley, and I'm the Director of Statewide Independent Living Council and chair of this council or committee. In the -- ultimately, I'm a consumer that lived in a nursing home and now on Act 150 and the chair of this program. A lot of you know that I had a service dog named Owen, and Owen, I take Owen everywhere with me. Owen was gone for about a week -- about a month and a half now. He had to get extra training, and I don't really want to get into the whole provider thing about that, but in dealing with that, it became very apparent that me, as a person with a disability didn't matter in that. I got more and more frustrated with the whole process because I didn't seem to matter. I come onto these calls now, and I'm even the chair now, and I'm starting to wonder if these calls matter. I'm going -- I'm going to leave this call at 12:00 today and going to pick up Owen because he's like one of the few things that matter in my life much anymore. I'm going to ask Pam to take the call at that point because I know that she can handle it. I'm going to ask Juliet, she asked me at some point to be the chair of this committee, for some reason. I don't know why, but I'm going to ask her to reevaluate that and I don't know that I've been very productive in making anybody talk here more or having more conversation or anything, any of the things that I've -- that Juliet and I talked about. So I'd like her to reevaluate that on me, and I guess I'd also like to ask every committee member or council member, whatever we are here, to take a minute and think "Do I really want to be on this committee? Am I helping all the people talking out there or asking questions "?" I don't know if I am anymore. People seem to be asking less questions. I hope you all know I don't have any control over who asks questions, what your questions are or whatnot. It's just a number up on the screen, and I ask who the questions are from. But I guess I'm just wrapping all this up to say, I would really like to matter once again and I hope the rest of you would too. So with that, I'll pass it over to you, Juliet. I'll be leaving unfortunately. I apologize, at 12:00.

>> JULIET MARSALA: Thank you, Matt. First, Owen's training, I hope it goes well. What I would say is I know that we at the office of long-term living do take this committee very, very seriously. I certainly can recognize that there is work that we are doing together to have an increase in making changes with regards to the committee to continually embrace its role as a advisory committee, and I think we have seen some really good strides along the way with how we've adjusted some of the Peteing agendas to have more back -- meeting agendas to have more back and forth and understanding the teams and things of that nature. Your point is well taken.

We at OLTL certainly do want every member of LTSS subcommittee to know they have a voice and know they're most definitely wanted and relied upon as we do this work together. Particularly as in today, as in future meetings, we are going to have some difficult conversations, and I will be relying on this LTSS subcommittee meeting to be a representative voice. Many stakeholders that touch the Office of Long-Term Living and the services we provide to folk OSS certainly more to come there. Thanks, Matt, for letting us know you're leaving at 12:00. I too unfortunately will have to step out at 11:00 and then return. There's a great mentoring event for disability youth that is happening today led by the Disability Advisory Commission to the Governor and Dr. Josie Badger. So I've been asked to join them for a little bit today to speak to the youth with regards to career opportunities, what we do at the Office of Long-Term Living and how they can be connected to us. But then I'll be back, particularly for the second public comment period, but my chief of staff is here with me to run and facilitate the meeting in my absence. In addition, I want to take a moment to introduce Erin Slabonik as our Acting Bureau Director of Coordinated and Integrated Services. There's a virus going around and she's not with us in person because we don't want that to be her first gift to us, but she's joined us virtually and transitioned into Randy's role very well over the last couple of months. And will continue to do so for the foreseeable future. So very excited to have her step into that role [Inaudible] she comes to us -- was previously a division Director overseeing our LIFE program known as PACE and over 20 years with the commonwealth and had experience with the office of medical assistance programs and health choices. So brings a lot to that role to support and continue that work. Yes, Erin. Do you want to say anything?

>> ERIN SLABONIK: Sure, can you guys hear me?

>> JULIET MARSALA: Yes, we can.

>> ERIN SLABONIK: Thank you for that introduction. As Juliet said, I am sick and sorry I can't be there in person. I look forward to attending many future meetings in person and meeting you all. Thank you for that introduction.

>> JULIET MARSALA: Thank you. The next in-person meeting you'll see Erin is December because November is virtual. In today's agenda, very kind of short agenda in terms of topics, but very big topics to kind of go over. We're going to do procurement updates, I'll go over the RFI teams that we've received and the OLTL updates and announcements. The first thing as you guys know, on July 15, 2026, we had issued a request for information that's closed and no additional comments are accepted officially for that RFI. My team has spent considerable time, the Bureau Director, Jen Hale, leading the team and had over 200 comments that's wonderful. Thank you all who submitted comments. We take all of those comments very seriously. Summary of the report that I will discuss today will be publicly posted and you can see those directly and you don't have to scribble down notes every day and it will be publicly posted to the website. Until further notice, may already be aware the CHC program will operate under the current CHC grant agreement with the current managed care organization. Pennsylvania health and wellness and Amedisys caritas / keystone first and UPMC CHC. It's going away until such time there's new things to talk about. Don't panic. It'll be back at some point. I don't know when. Won't know. But this particular slide for the purposes of time will now be removed from the deck. Okay, the Community HealthChoices request for information public comment and some of the themes we saw. Lots of great comments, lots of variety of comments from associations and advocacy organizations and providers directly. We even received comments from NCQA so national attention on our RFI so like I said, really great pull for that wide, broad submission of comments. And so what we did was we received -- reviewed each comment. We summarized the comments into themes, major themes and then those major themes we will take into

consideration for the development of future RFI. I will not speak about anything directly related to the RFA and everything that I'm talking about today is about the comments received from the RFI. All right. So we received a lot of themes about the quality improvement for service coordination. Commenters remark on service coordination included recommendations to the overall quality of service coordination through some of the following recommendations. Service coordination ratios, consider basing them on acuity, lower the service coordination to participant ratio, increased requirements around minimum participant contacts and customer service, and require additional training on specific support for individuals with cognitive impairment so again, these are general themes. If you didn't see me or hear me say your comment, understand we're talking in general.

We also received a lot of other comments from the themes with assessment and service planning as a theme. Several commenters that recommend a standardized time and task tool to be used by all CHC managed care organizations and the recommendations highlighted the increased consistency and inter-reader reliability among plans as one of the intended outcomes. Commenters recommended specialized training requirements related to complex populations, including individuals with acquired brain injuries, cognitive impairments and neurological conditions and behavioral health needs. The adoption of a person who entered outcome measure set was recommended to support Pennsylvania person-centered planning requirement. If you're not familiar with the persons centered outcome measure set, there was measure set that NCQA put out and there are others across the way. Okay. Let me do an audio adjustment. Can folks online hear me better now?

>> PAM WALZ: Sounds about the same, Juliet.

>> JULIET MARSALA: Let me do another adjustment. Is this better?

>> PAM WALZ: It's about the same. I don't know what the comment was. I can hear you fine. It's just it sounds like you're in a wind tunnel kind of.

>> JULIET MARSALA: I think this room it's the air conditioning humming in the background. So I know my team worked hard on finding an alternate location, and so December will be the last time we're here then we'll transition to hopefully a new location in the new year. Then information will come out and hopefully there won't be as -- that quirk in the new room. I know they've been working hard on that.

>> MATT SEELEY: If I can ask then, if no one in the room is talking, can you please mute the microphones.

>> JULIET MARSALA: You wouldn't be able to hear me.

>> MATT SEELEY: If no one in the room is talking.

>> JULIET MARSALA: I have Gabe at the controls so that's what he will do. Another theme related to changes or additions regarding covered services and there were changes including covered services and revision to limits within the service definitions. Commenters recommended the inclusion of community health workers to support service coordinators. We also had comments around the theme of self-direction. So most commenters noted strong support for participant-directed services, but we received mix comments on how participant direction should be operationalized and while there continues to be strong support for utilizing one financial management services or FMS vendor to assist in the administrative activities associated with self-direction, some commenters recommend that OLTL allows individual MCOs to choose and offer at least two FMS providers to support the participant in the participant-directed model. Around the theme of transportation, commenters recommended that the department conduct a comprehensive review of transportation rate for reimbursement structures to identify strategies to improve access, facilitate collaboration, and establish stronger performance expectations for

transportation brokers. We had a strong theme on housing. We had commenters recommend a landlord risk mitigation fund to support access to locally-based housing resources that reduced perceived risk for landlords, support landlord engagement, and strengthen pathways for participants transitioning from institutions or unstable housing.

Technology around the theme of technology. Commenters recommend requirements for technology assessments. In addition to education on a available enabling temporal integrationnology, and the integration of technology into person-centered planning discussions. There was a theme of overall quality improvement to the program, and commenters recommended quality improvements in a variety of ways. These included department develop state-wide nursing facility quality dash boards to give AMACOs access to care quote, transitions and performance trends to support target improvement acrossed facilities. Increasing expenditure requirements for value-based purchasing was another recommendation. And increasing standardized and transparent reporting. So we had a theme that we characterized program logistics. Under this theme, most of the commenters indicated that the current structure of CHC is sufficient and limits administrative and provider burden. However, a few stakeholders commented on need to increase the number of plans across the state, to increase participant choice and insert competition to drive logistics and under the question asked how many plans would be good for Pennsylvania. Several commenters recommended considerations for longer contract terms that allow the CHC MCOs, providers, and community partners sufficient time to implement innovation, strengthen care coordination program, invest in workforce development and evaluate long-term participant outcomes. There was a recommendation that in the future RFA consideration we consider longer terms. We asked a question about Medicare and Medicaid integration. At federal level and here in the state, integrating Medicare and Medicaid is a priority for us so we want to learn more about how we may go about doing that, and what we needed to be aware of. So most commenters highly recommended additional steps to further Medicare/medicaid integration efforts. Commenters highlighted several other states as examples of how to implement additional requirements for increased integration. Including integrated service coordination, integrated assessments, and integrated person-centered service plans. Commenters also noted the CMS final rule has established requirements for further integration. So it's along the same themes on that. So those were the major themes. These are themes where we had multiple commenters comment on them. Certainly we have individual commenters that commented on very specific things. If you did not hear your comment, we're not disregarding it. We review and regard each comment that we receive.

All right. The RFI summary of public comments will be posted and certainly that posting will also go out on the LTSS list serve and anyone that's not with us today, and should be, will see it on the List Serve. Okay. I'll pause there. Anything from the committee members? Okay, hearing none. All right. So let's go onto the next topic here, which is about long-term services and supports sustainability. Back about a year ago in September, we had a conversation and a focus on how do we get upstream? How do we contemplate ways in prepare for HR1 implications to the Medicaid system on a whole? We talked a little bit about laying the ground work and really understanding what is the state plan, which cents mandatory covered services, what are optional services, which are HCS services for the most part and I reviewed the list of what's federally-mandated service in the state plan and all the optional services that Pennsylvania added to our state plan. Some of which are very surprising like ambulance transportation. Federally is not a mandatory service. Pennsylvania make it is a mandatory service. Dental benefits. Things of that nature. We shared that at that point in time, that we were not looking at HCBS for services. We were looking at anything and everything where we could.

How could we reorient to get upstream? How could we do proactive measures to support individuals and prepare for HR-1. And in the last couple of years, we did make some significant changes. One of them that we highlighted was changing GLP1s and no longer covering it outside of diabetes so we wouldn't be covering it in the state plan for weight management purposes. That's one of the sort of things we've had to do to be able to sustain our Medicaid program across the board and another one for the office of long-term living was reducing the P for pool of funds that would have been available to the CHC MCOs and reduced down from \$150 million down to 100 million. What I want to talk about today with the LTSS subcommittee team, and, Matt, this goes to your point at the very beginning about does this committee matter? It most absolutely does because we at the Office of Long-Term Living will need this committee members' help with regards to planning for and advising us and providing feedback on continued sustainability of LTSS program. Even if HR-1 was not impacting us and was not, you know, looking to impact us in 2028, we still have a sustainability issue. We have an older population, that is ageing rapidly in double digit in Pennsylvania. We are the fifth largest ageing state across the nation. We have individuals with disabilities that are living longer, which is a good thing because of advanced in medication, because of advancements in home supports, and that's all good. But it also meant over the last four years that the gross of individuals that meet our nursing facility clinically eligibility population has continued to grow beyond expectations. In addition as you all know, the cost of healthcare, and the cost of HCBS has also been growing. And we know that our direct care workforce needs investments. We also know from our budgets over the last three years, that the Community HealthChoices program and the cost to just continue services, continue the current state has gone up hundreds of millions of dollars every year. What has not gone up is revenue generation. And so unless that occurs, we have -- at the department, we don't hold the purse strings. We don't control what is allocated to us. We have the great responsibility of taking what is allocated to us and deploying that in the best way possible to help as many Pennsylvanians who are eligible and need services, life-sustaining services, we can in the best way that we can informed by our stakeholders with an eye to helping the most people we can and trying to do no harm. In the next couple of years and in fiscal year 2028 and fiscal year 2027, as you've seen, we've been doing the best we can with what we have with the cost to carry, but that sort of tension and pressure is continuing to build, the population growth is not slowing. The need for services is not slowing. What I would like to do with the LTSS committee over the next couple of meetings, which is why I'm talking about it now so you can also reach out to your stakeholders, and you can also reach out to participants and family members to talk about these big issues. We have seen over the last couple of years other states have done things to mitigate this cost containment and sustainability. And sometimes in ways that are very blunt. Saying we're reducing everyone's Medicaid rates by 4%. That's very blunt. That's not what we're hoping for in Pennsylvania. We've seen states change level of care determinations to kind of control growth of population. We've seen soft caps, full caps, reduction of services, elimination of certain service definition categories that have been deployed. We've seen waiting lists start and we haven't had a waiting list on OLTL for over a decade. There's only so many tools that we can do and use if sustainability becomes an immediate need. That's what I need us to think about as subcommittee members and that's what I hope we can build to really talking about in our November and December meeting, to gain that feedback we've been trying to get upstream and that's been the focus since I start to get upstream, keep people healthier and delay the need for services, and it has been a difference. We do need to talk about changes in the future. If the next budget is a cost to carry budget, if we get reductions and capitation, there's going to

be real need to make significant adjustments in the program.

And so, some of the RFI themes are very, very helpful. We want to make sure all ideas are on the table, and the subcommittee group is one of the places I look for those ideas and that thinking, you know, because again, some of the blunt tools are adjusting level -- not saying we're doing any of these now. Just saying we need to think about the tools in our toolbox of what may need to be used if we face that benefit -- Matt, not sure. Are you talking to me?

>> Matt Seeley: Yes -- no, it's not me talking. I had my hand raised though. I wanted to comment on something you said earlier and you sort of implied what I said in the beginning was about the committee. I was only talking about my participation on the committee and not speaking about the relevance or importance of the committee. The committee is obviously essential. I just don't know that I myself am bringing what is necessary. That was my point, period. But I believe Jay had his mic un-muted. That was the noise you heard.

>> JAY HARNER: Apologies. Sorry.

>> JULIET MARSALA: Thanks for clarifying that, Matt. For folks awareness. So big system changes, again, I'm not saying we're not doing -- that we're going to be doing this, but I'm saying we need to start really thinking about some of the big, sweeping changes that may need to happen. This is not to cause anxiety. I know it will cause anxiety. I know these are decisions we don't want to have to make, but I would prefer to have these hard conversations now and over the next couple of months so that we can go on this journey together, and sort of being informed and thinking about this together. Okay. So again, just a bit of education in terms of policies and things of that nature when state has to contemplate things that really move the needle on cost because that's the barrier right now. It's not something any of us want to do, my team member or any member joining public service wants to do. We want to help people, but we have to look at being the most responsible stewards of the resources we have. We have that dual point; right. We want to help as many people as we can in the best way possible, ask we need to also be the most responsible we can with the resource limits that are provided to us. And many have done lots of education and advocacy with your representatives, and that needs to continue, and I'm really grateful for that. It's just sort of the anticipated reality. Folk has told me that Pennsylvania in comparison to other states have very, very generous benefits. I've heard feedback from other states that we have a very generous level of care determination in comparison to other states for our Nursing Facility Clinically Eligible (NFCE). I think these are good things. But. I bring that up to say folks will question that, they'll look at that, and so we need to have this kind of open, honest discussion. So some states look at level of care determination and look at whether or not there are adjustments that need to be made. Some will -- and we, may need to look at changes in our service definition, evaluate which ones are really making impacts and having outcomes, focusing on the outcomes to individual's health and lives and access. We'll need to potentially look at service definitions. Do we look at soft caps on personal assistant services? Do we look at splitting personal assistant services into different tiers? Is personal assistant service, should it really be about the activities of daily living? Then IADL or coaching or supervision, should they be split out? Should there be a time and task tool to kind of standardize things. Should we consider budget limits on different acuity categorizations? How do we look at those things? Looking at state medical plan and the optional services that Pennsylvania has put in, are there ones that we should make adjustments to that impact everyone, children, adults, people with disabilities, older adults, you know. I am kind of relying on many, many minds from this advisory committee, particularly in November to KAMONTE back to me with your thoughts, with ideas -- come back to me with your thoughts and with ideas on things that hopefully we don't have to contemplate but the reality is we might

have to contemplate. That's kind of my task and my ask for the LTSS subcommittee to go back to your advocates, to go back to your participants, to dig deep, to make sure like I named a couple of things but to make sure that Pennsylvania is contemplating anything and everything that we can. If there are innovative ideas, if there's data we need to look at, you know, that's what I'm going to need from this committee over November and December. To have dedicated time to really talk about this. I'll pause there. It's lofty and it's a lot, but it's tough talk time.

>> hi, four gubernatorial terms ago, a Governor I refer to as one-term Tom implemented a tax reduction program that removed the great deal of taxes from the gas mining industry. It was never replaced. Same Governor reduced the mental health funding in the communities initially intend to be 20% and reduce to 10%. And that's never been -- it's been partially replaced by the current Governor, never totally replaced and you can't go back and collect on the inflation that would have occurred for those funding measures. What we currently experience in Washington I guess is unprecedented, but needs to be recognized, and all of those things together I believe need to be put forth when we advocate with our local politicians. We do not determine the revenue that comes into the commonwealth to support these programs, they do. They need to finally find the time to put on their big boy pants and affect a tax increase, that's perhaps a personal income tax or property incomes tax and if it's the bottom line and providing services that are intend to save money down the line, by the way, I think the more we allow for folks to not get community services, they go into a nursing home, the more they cost us, the more we underfund community services and mental health and allow those folks to need the higher shoveses of in-patient care and partial hospital. They cost us more. We need to find a way to find legislators who can understand that, not that I have yet, not many. And then we need to go out and do something about it. That will be the day before our meeting in November. That would be election day. We need to find ways to go out and make things happen so that what we've established here in Pennsylvania is not looked back on as oh boy, they were nice back then and they're not now. We need to find that way to make folks understand politicians, especially, that we vote, we have interest in it, and we have families who will vote with us in order to make that happen. I'm done now.

>> JULIET MARSALA: David.

>> DAVID GATES: Let me talk about how do we make that happen because I agree that's exactly what we need to do and by the way, I think that two tools are the election as you pointed out coming up November 3, and by the way, DHS has a substack and they just put out a thing about voting rights so I would recommend people look at that. I know that the disability rights of PA has a website talking about voting rights for people with disabilities so definitely look at that because people with disabilities have every right to go out and vote, and there's a lot of accommodations, which they are entitled to. That's one thing. I also point out there are several flipable districts in Pennsylvania, at least four that I'm familiar with, one of which is right here in District 10 by the way. Go out and vote, please. The other thing is grassroots organizing. I think that's really, really critical so there are organizations out there trying to do that. It's a matter of really explaining to elected officials and candidates what the lives of people with disabilities are like in terms of the supports that enable them to participate in their community and have full meaningful lives. And so, I know that we've been doing some of that as the Beyond Diagnosis Project with doing video tape interviews of individuals and showing them to members of the administration. Also, this has been done through another organization called imagine different coalition. I know that PA Health Access Network has been doing this as well and I encourage people to participate in those. There's also a national grassroots effort being led by an organization called Caring Across Generations and they're a grassroots effort calling a 1 million

care conversation, and they're actually training community organizers to go out and capture these stories and be able to compile them so they are provided to legislators and people running for office so that's the other part, I think, it goes with your point that I know, Juliet, you're stuck on the service side and the cost side. we however, are not just stuck on cost. We can also look to revenue so I think all of us should go out there and make the efforts to connect with other groups and organizations to do that grassroots organizing that's necessary to educate candidates and elected officials as to the critical importance of these supports.

>> JULIET MARSALA: I appreciate those comments Lloyd and David. I think to your point, David, as that's really important, the department is stuck on the services and what's allocated to a side. That's where my realm is; right, and you certainly have the wherewithal to educate and advocate for the things that matter most to our populations and certainly appreciate that call to action. I will say that what would be help., what we'll be looking for in November/December, and I did really speak to the subcommittee members because they are the advisory groups so certainly connect with them. But I am remiss in not also highlighting that every one of our meetings has a public comment period so it is a call out to everyone. participants, providers, vendors, brokers, health plans, those active, those nationally that are visiting. Those public comment periods are very beneficial to us as well. And so November and December would encourage you to utilize that public comment period if you also have ideas and thoughts that you'd like to share with us. Specifically to sustainability innovations in sustainability that we should contemplate, which is a little different than the exercise that we just went through for the RFI. If there's particular states that you believe are policy team should look to as well that are doing interesting things in the LTSS space, we would certainly recommend that. So feel free to come forward with those things. I would say, and I need to reiterate, that every member of my team understands what the possible impacts of any reduction or waiting list in services would be. You don't need to convince us they could be individuals that could be negatively impacted. We feel that deeply. What we really, really are asking for at this point is the innovative ideas, the thoughts that's on your mind, ways if we have to do hard decisions, how to do the least appointment of harm, how to approach things in a way that is equitable, knowing these are hard discussions and decisions that we don't want to make. Okay. All right.

>> MATT SEELEY: I see Padraig had her hand up.

>> JULIET MARSALA: Thanks, Matt.

>> MATT SEELEY: You put your hand down then Rebecca.

>> REBECCA MACTAGGART: Yeah, I'll try to be quick. We did at chooses community sports services pair up with the rev up team to get the vote out to people with disabilities. It was woefully disappointing how many people with disabilities said their vote doesn't matter, and that they do not vote or that they want to vote but they don't have transportation to vote or, you know, they talk about it but somehow along the lines of support systems aren't there to make sure they remember or actually do it. So this is my call to action as all the people on this call who provide services to people with disabilities to find ways to get them actively participating in things like these meetings, actively participating in the voting process, the League of Women Voters who have very nonpartisan and can help with that disability rights obviously that's been mentioned. These folks need a push because they don't believe their vote matters, and it does. But we need to find ways of self-empowerment for these folks. Yeah, I think that's it. I had something else but now I forget.

>> MATT SEELEY: You can come back once you remember. Go ahead, Padraig.

>> PADRAIG TENGNEY: Sorry, hit the wrong button. Juliet, asking for budget challenges for November and December but what's the best way to present those ideas or submit or meant to

be more of a brainstorming session when we meet next?

>> JULIET MARSALA: Great question, Padraig. Anyone in the public or committee members want to put things forward to add to the agenda, build out the agenda topic with some of the ideas to present, I would send them to our LTSS subcommittee RA account listed on the agenda and I would open that up to everyone. If there's information about those topics you'd like to share, send to the RA account. The chairs will receive all of that so that we can really build out adequate time for future conversations around some of the topics and things we might receive. So I think that would be the best depository for the subcommittee because that is the resource account for subcommittee at this point and plan for subcommittee members to be prepared with your thoughts in the discussion because it's perhaps ideas and discussion from the subcommittee members. Folks that are part of the larger stakeholders that wish to take advantage of the public comment period to be prepare to submit those comments. You know, I anticipate that a lot of folks would have a lot to say so it would also be helpful to send those comments to the RA account in the event that we don't necessarily have time to get to everyone during a public comment period. I know that's hundreds of folks that join these meetings virtually or in-person. I am always thrilled by the amount of participation that we have so just for this particular -- oh, and any topic at any point in time, folks know that I with love and receive as many public comments as we can during the meeting but follow up afterwards. Does that answer your question, Padraig?

>> PADRAIG TANGNEY: It did, thank you.

>> MATT SEELEY: I see hands up and I want to try and clarify something you're saying, Juliet. You're talking about this specific topic and looking for specific ideas and strategies of ideas, but in general, you're still -- you want to hear from the general public about their concerns with the overall subject matter; correct?

>> JULIET MARSALA: Yes, always.

>> MATT SEELEY: All right. I just department want to make anyone think we were trying to say those weren't a concern anymore or anything like that.

>> JULIET MARSALA: No, I was just suggesting that given we would probably anticipate receiving a lot of public comment in those meetings and it would be thinking ahead and good for folks to submit comments as well to resource account so in the event they couldn't speak and they wanted to that we would still have that on record as well. Both and to make sure there's room and space for lots of public commentary.

>> MATT SEELEY: Good. Good. We want to hear from everybody out there. I assume Rebecca has her second question. So I'll start with Jay, go ahead.

>> JAY HARNER: Thanks, Matt. Well, first of all, Matt, thank you for your comments earlier. I haven't be asking many questions and speaking on the meeting and I'll make an effort to do better. I didn't catch the woman's name that talked about voting a few minutes ago, but listening to that is infuriating. I broke my neck when I was 18 years old and started receiving services in January of '98, my service coordinator in 1998 helped me register to vote. As far as my job when working for center of independent living, every individual that we do intake for, one of their questions is we ask them if they're registered to vote and if they're not, we help them. The apathy among the disability sector in this state and throughout the country when it comes to our rights and doing our civic duty, it's pathetic sometimes. I mean, we're not voting and we're losing services and we turn around and wonder why. It's always, you know, I didn't know that was going to affect me or I voted for this and I didn't think it was going to affect me. To be -- I know there are -- not saying everyone but for the majority of us, we can vote by mail, absentee ballot. The state is very, very easy to vote in. If you choose to the no vote in Pennsylvania, there's a

reason why you're not voting. Not because there's disruption. What Lloyd said earlier, funding is available. The tax revenue is there. If we serve appropriately in proper ways with the tax cuts not going where they should be going, we can fund these programs and have wind falls of cash but we don't follow through and we don't voice and we don't debate and we don't plead our cases, that's why we get put in these sitwayses. I won't keep going -- situations but thank you for the time.

>> JULIET MARSALA: I appreciate the comments. I want to share that we at Office of Long-Term Living, we have also been looking at a lot of our administrative processes and things of that nature within our internal department as well. So folks may not always hear about some of the internal changes to how an OLTL process is going to try and save resources in order to kind of re-deploy resources to serve people. So I'll just share two examples. Going off script and then I do unfortunately have to leave, but I will be back before the second public comment period. One is that we added two case managers to our adult protective services team. We did an evaluation, and we realized adding two case managers to really located long-term, complex cases that were receiving adult protective services direct services to mitigate their health and safety would actually create savings. So the bureau of human services licensing under Teresa's leadership added those two positions, and we did see savings in excess of their cost of bringing on staff members and building efficiency and effectiveness and monitoring services and connecting services and helping folks regain some more stability faster. So we've been doing things like that. We in partnership with some of the advocates, took a look at our Medical Director Review (MDR) processes. We made improvements to how we did those reviews looking at the NFCE and NFI, you guys remember we had a lot of focus on why are there high amounts of NFCEs going to NFIs and we redid the whole operational procedure of the MDR flow. When we did that, we also identified that there were some activities that were being contracted for that became redundant. We reduced those redundancies and in particular desk reviews because we were doing a lot more of our reviews in-house so instead of having almost 100,000 desk reviews or tens of thousands of desk reviews, we're able to reduce that requirement down to a few thousand for quality management purposes, and that identified savings of, I think, almost \$30 million annually that could then feedback into that allocation line towards services so just so you know, that we internally in the office of long-term living have been like shaking every couch cover, cushion, looking at things, moving forward, we're engaging with CMS to look at potential innovative model, looking at the lead model that will look at integrating Medicare and Medicaid service in coordination for the fee for service population. Again, there's very, very early stages, no work plan, nothing really to talk about with significance, but we are going to engage in CMS and just exploration of this possibility of joining a 10-year pilot so we are looking actively at many different ways to again, try and mitigate the need to make significant programmatic changes, but we should also talk about those worst-case scenarios as well. I did want to let you know that we are looking at all places and all things and encourage you to do so along with us. All right, I have to leave so I'm going to hand over to Jermain and I'll be back shortly. Thank you.

>> MATT SEELEY: Jay, is there a follow-up or is your hand just still raised? Rebecca, going to your second question.

>> REBECCA MACTAGGART: Yeah, real quick. It's football season and getting that word out to the general public how important these services are and what they mean, this is a great opportunity to have whatever organizations can get together as a coalition and build some kind of commercial to put out there.

>> MATT SEELEY: Thank you. Natalia, can you be quick. We are beyond schedule, but it was

a good conversation so please.

>> NATALIA GOMEZ: I just want to clarify something. I know that Jay talked about apathy for some of us disabled individuals. With apathy, a lot of us are just frustrated because we -- those of us who do speak, we feel that our voices and our concerns are falling onto deaf ears. And I believe also that if we kind of evaluate or see how service agencies, how contractors, how even administration is keeping or evaluating how services are being done and how they're being provided to us, and I believe some don't even understand the [Inaudible] because if we already do what it is, we will have a better way to keeping the cost contained. Thank you.

>> MATT SEELEY: Thank you, Natalia. I apologize. Pam [Inaudible]

>> PAM WALZ: Okay, moving to the report back. This is Pam Walz. We're moving onto our report back on the HR-1 work group meeting and I think Lloyd is going to start us off.

>> LLOYD WERTZ: We're good. Just kidding. There was a meeting held on I believe it was October 2 of the work group and the next meeting is the second Friday of November just for those that are on that group and their awareness but at that meeting with that work group, we heard from Secretary Arkoosh noting there was a huge agenda and a bunch of people attending and then they brought out a PowerPoint that was used by Carl Feldman from the office of maintenance and I hope we have that PowerPoint as well. These meetings have begun to get into the weeds of sharing DHS's intentions and moving forward and how to move forward in the context of an unchanged house resolution 1. And first piece was 640,000 Medicare enrollees and the subject of periodic outreach efforts. They're sending out notices with the expectation that many, many of these folks will not even know that their benefits can be impacted by HR-1. So that's -- those are getting out there now and then in the process, there is a larger grand plan for being able to share the -- actually update the PA600 and most people out here know what the PA600-4 was or is. I had an interlude with it about 20 years ago, and it's been changed a lot since then. There are a number of pieces on that form that have not yet been changed to accommodate HR-1 implementation, which kind of officially starts and really gets underway for the enrollees in January of 2027. Those are listed on PowerPoint, which if we cannot find we're going to change and send those out to you we'll page on and get to those. Keep in mind, and we were warned by the secretary at that meeting that these are not the final copy of the HR-of the EA600 and the work requirements compliance. These are just a stab in the right direction is believed but, please, take a look at them and if you have specific suggestions you can make, they would appreciate -- be appreciated by these Department of Human Services and they certainly could only help to advance awareness of the people that are going to be impacted. Again, primarily the Medicaid expansion 700,000 people to prevent the loss of benefits for those people and then of course the reduction in medical assistance copay on the part of the federal government. Even with those changes, it's expected at the DHS level we'll lose close to 200,000 enrollees. It's a big number. Both for the enrollees and for the revenue that the commonwealth can expect. Pam, if you have any input on those two processes, I would appreciate it otherwise I'll move on.

>> PAM WALZ: Just a few things about the PA600. The draft, which has been shared, it adds four pages with questions that are intended to elicit answers to help the department figure out whether people are exempt or meet the work requirements, community engagement requirements so it means the PA600, which was already pretty lengthy, is now 36 pages and very, very dense. It would be good for people to take a look at that, provide feedback and another thing I just want to add is that the 650,000 people that we're talking about here are the expansion population. They're people in categories MG90 and 91. So this outreach that so far we're talking about has been to that population rather than the LTSS population.

>> LLOYD WERTZ: Thank you, Pam. I think we had a question in the room.

>> DAVID GATES: Not everybody uses the paper copy. Will these be added to the compass website for applications?

>> PAM WALZ: I can start that off but someone can jump in and help me. It is being added into the compass. I think we had at one of the earlier meetings a presentation on the pages they're adding in Compass that will also ask these questions. It's a bit more information that was given to us at most recent meeting about this is that the Compass visualization will say if the person is eligible under the rules all though not why. These questions -- this will only show up for people for whom the community engagement rules apply. It's going for which pathway they were found eligible. David, I don't know if that answers your question and there's a lot more questions out there about the Compass changes and don't know if the department wants to add anything or if we have the right people here for that.

>> LLOYD WERTZ: I'm not fully aware of that all though I do believe there was mention enough of the Compass instrument it will be adjust to be able to be used and even more importantly referenced by the enrollee to be able to understand any impact that might occur to him or her. As to look back eligibility period, it's been and now is three-hundredths prior to the application for benefits that will be -- three months prior to the application benefits that will be reduced and one month 1127 under the direction of Harbor Resolution 1. There's also a Snap waiver, and I don't know what that is, but they're not possible under that resolution after that time period as well. There does seem to be expectation of mental health issues and might impact the case for eligibility. We don't know how far that will progress in the particulars of that, which of course are of interest to me as behavioral health advocate have not been shared. There was a question posed by the delay or difficulty in working with local county assistance offices in processing applications, and there was an expressed appearance of being kind of overwhelmed at the county assistance office level. That was news it seemed to be for secretary Arkoosh and asked for specific county Orlikowski CAO activity -- activity or CAO activity that might be looked at that way. If you're aware of county assistance office delays, just in the way it looks to be reduced staffing or new staffing that are really not ready to handle that responsibility, share with Carl at office of income maintenance or directly send to -- we could use it through the resource account or send directly to Secretary Arkoosh.

Questions about delays and how they might relate to incomplete applications that are received by the department or for re-validation or re-determinations. The clear response from the department of leadership level was, yeah, that's where they are. Those are the problems. So when the applications or re-determination requests are sent in, they need to be checked and make sure they are indeed complete and that they don't waste additional time and perhaps loss of benefits on the part of the potential enrollee, not to mention at the County Assistance's Office. A look at data not chasming up with the application process immediately so that might cause further delay and that of course is a possibility. There were two then outreach examples that were shared, one from the Pennsylvania health access network by a gal named Ann Bacharach and staffers we are on the line and could be contact to help folks maintain their benefit status, and they are available and they have a QR code to be followed up. And there's more support and training for community groups like churches, good distribution centers and other places that might expect to encounter individuals that will be impacted from HR-S. and from the Jefferson health plan offered by Rachel Pryor and 400 people in that system with 300,000 on medical assistance and providing awareness-raising information and joined a state-wide effort in that theme of build, transform, and mobilize as part of the dis-enrollment operation part of the plan. She hopes to have community meetings with -- meetings with community partners to take action

steps across the commonwealth and certainly help move the process along for Pennsylvania. That's all I got. Pam, anything to add?

>> PAM WALZ: Sure, a little about Jefferson health plans and it was a great model and they're using predictive technology which of their members are likely to fall out of the program and get dis-enrolled and also what they're looking at what data they have about how those folks like to be contacted, what the best way is to reach out to them and get them re-enrolled and so in order to do this, they're deploying community health workers and they have some funding for community health workers. So it looks like a really innovative and kind of hands-on program to reach out to their members. I think that it would be a great thing for CHC MCOs to also take a look at. I just want to go back for a couple of other topics that were covered. One is about the changes affecting non-citizen participants so notices were sent out to 6800 recipients, Medicaid recipients who were found not to be in categories of integrations, status categories that will continue to be eligible so HR-1 with the changes is that many fewer immigrants will now be eligible for federally-funded Medicaid and only categories of immigrants who will be eligible now for federally-funded Medicaid are permanent residents, COFA migrants and Haitian immigrants and refugees, and others are losing eligibility for federally-funded Medicaid so that went into effect on October 1. Giving out advanced notices to 6800 recipients that were affected by this. People had the -- you know, people had the right to appeal this and if they appealed before October 1, they can keep their benefits pending a hearing and the department shared that all of these recipients will be evaluated for any other category that they may be eligible for, including refugee Medicaid which covers people just for eight months after arrival. Emergency Medicaid if they have an emergency medical condition and state-funded Medicaid for those that qualify for that. It was really importantly note that had people who are receiving SSI are eligible for state-funded Medicaid. So even if they are in -- if they're a refugee or another category not otherwise eligible for federal Medicaid, they are eligible by virtue of being SSI recipients. So just -- there's a lot more going on with LTSS recipients that are non-citizens and affected by HR-1. This was sort of covered separately, but people who are -- there are several hundred, I don't know the number exactly offhand, but there's something about 400 people who have been in Community HealthChoices, LTSS who are under 60 and losing eligibility for federal Medicaid, and the department is together with the MCOs reaching out with those individuals and encouraging them to apply for ACT 150. For about another 300 individuals that are on the CHC waiver, who are over 60, there is not a good program to try and transition them onto unfortunately, so this is a real problem. I just want to also add there was also a presentation on some SNAP, update on, SNAP changes. Appears Pennsylvanians with employment and engagement requirements so in general, HR-1 changes mean that now unless people are exempt from work requirements, they can only get three-months of eligibility in a three-year period. Unless they're compliant with work rules so the three-year period in which people can get the three months is a set clock for all Pennsylvanians and it's going to reset on January 1, 2027. One thing to keep in mind about this is people subject to the work requirements and I understand this to mean they are only eligible for the three months and three years, that's a specified exclusion from the Medicaid work requirements. Those folks can get Medicaid. So I think that's our report. Are there questions?

>> MATT SEELEY: Are we ready for questions? I don't see questions from committee members?

>> PAM WALZ: One thing we forgot is OMAP released a bulletin on the changes of eligibility and that may be of interest particularly to providers.

>> MATT SEELEY: Given that, I still don't see any questions from committee members. Paula, I guess we can open -- are there questions in the room?

>> JERMAYN GLOVER: This is Jermayne, there's no one in the room.

>> MATT SEELEY: No one in the room?

>> JERMAYN GLOVER: No one in the room for questions.

>> MATT SEELEY: paw la: Questions online?

>> PAULA STUM: I have a question online for eligibility changes. Eligibility changes relating to citizenship, how many people are impacted by the change that are LTSS eligible?

>> PAM WALZ: Yes, we do. I don't have the number in front of me, but it's approximately 7 or 800. I can look through my notes in a minute. From a different meeting.

>> PAULA STUM: I have another question, Pam, while you're looking through your notes. This is from Amy Tomkins, will the updated PA600 be provided in paper form to SCE providers?

>> PAM WALZ: What are SCE providers?

>> PAULA STUM: Service coordinator entities.

>> PAM WALZ: Oh, SCE. That's a great question for the department. I imagine it would be available online. And probably -- probably a question for the MCOs about what they'll make available to their service coordinator peeps.

>> PAULA STUM: Matt, this is Paula, that's all the questions I have related to HR-1.

>> MATT SEELEY: There's no committee members that have questions I don't think so are there any public -- go ahead.

>> RYAN JOHNSON: Sorry, Pam, this is Ryan Johnson. I wanted to follow-up on your statement. The 7 or 800 participants, those lists were provided to the MCOs and all of the service coordinators did outreach to all of them and to your point, some of them that our own internal service coordinators did outreach and reported and worked closely with OLTL as well as if any were assigned to service coordination entities and on the list as well, we engaged their support as well. Just want to share that information.

>> PAM WALZ: Thank you, this is Pam again and I found the numbers. Number of HCBS recipients likely to lose with their immigration status is the total for OLTL participants is 672. Of those 403 are 60 or older, 269 are under 60. There are also some that are fewer than 10 in OBRA and in life respectively, and in the ODP waivers also, there are some but fewer than 10. It's going to be really, really important to help those that we can particularly there's a good -- pretty good pathway for people under 60 to try to qualify for the Act 150 program. All though there are issues about whether all of those people can qualify because in order to participate in Act 150, people need to be able to self-direct and so for people who have cognitive impairments that mean they will be deemed unable to self-direct, they may not be eligible, which is a real problem.

>> MATT SEELEY: Are there any questions regarding HR-1 from committee members online or in the room? If the answer to that is no, then we can move to public -- or questions regarding anything OLTL relating to Juliet's presentation. Anything else for the morning part. Is there any questions from committee members in general? All right. Paula. go ahead in the room first, please.

>> ALI KRONLEY: I want to let people know this goes to the discussion we're having about mobilizing to increase resources in the state and to push back against HR-1 cuts. At 1:00 today, our union is hosting a national bus tour at the fountain in the capital. That's going to be lots of people who have been impacted by these cuts sharing their stories, lieutenant Governor is joining us so if you're looking for advocacy opportunities and want to walk down the street with me like a block, to be part of that at 1:00 today, we'd be really welcome and excite to have you there.

>> PAULA STUM: Hi, Matt, this is Paula. Is that Ali asking that question or making the

comment?

>> ALI KRONLEY: This is Ali Kronley.

>> PAULA STUM: If folks could say their name before making a comment or question to help with our captioner and our transcript to reply with accuracy to folks.

>> MATT SEELEY: Paula keeps reminding me to say that and I fail to do it. I'm the biggest culprit of that so I will -- this is Matt speaking again. I forgot right now. But are there any other questions in the room first, Jermayn?

>> LLOYD WERTZ: This is Lloyd Wertz and I'm wondering when that 10-minute break is going to happen.

>> MATT SEELEY: Oh, it is time, isn't it. I guess on Lloyd's cue, we'll take our 10-minute break. We'll be back at 11:38. My apologies to the transcriptionist.

[meeting on break until 11:38 a.m.]

>> MATT SEELEY: Welcome back, everybody. We are scheduled to talk about community integration. I hope Jermayn in the room, I assume we're going to bring some MCOs together to talk about this?

>> JERMAYN GLOVER: We're going to un-mute the room so if we can cut down the conversation, please. This is Jermayn. Back in the room. Ready to go.

>> MATT SEELEY: So I assume we're bringing some people together? Kerri is going to talk.

>> KERRI ZWOLAK: Good morning. I'm Kerri Zwolak and I'm with service coordinator and I'm presenting the community integration efforts. So how are we looking here to accomplish the following? We're going to talk through this today, more choice, easier access, and a better life through service coordination. So we truly believe that connection to the community matters, it supports independent living, preserves dignity, and leads to better health for our participants. We examined four areas to identify a clear path forward and strengthen the role that we play in advancing community integration. Those four areas were how we engage in conversations, the quality of our interventions, the understanding of what is important, and our coordination and follow-up. Thank you for letting us share the work we're doing to help people take part in the activities that they truly care about. On to the next slide. So how are we taking action? First, we built a team from across departments so our community integration work group's focus was to guide staff training, best practices, virtual resources, caregiver engagement, success stories, as well as work to develop and initiate our Social Isolation Campaign. Next slide, please.

Where we identified that we can do better and what we did to address is we added a discussion topic surrounding community integration to every participant contact that our service coordinators make with their participants. We increased service coordination's awareness of online resources to share with participants. We used the participant advisory committee to obtain meaningful participant feedback and the participant advisory committee to house community feedback. Next slide, please.

As we're taking action, we added community integration to person-centered service plan. We truly can note that participant choice drives any community integration goal. Additionally, you've trained staff and clarified roles, which involved reviewing reference material, retraining of the staff, and adding community integration content to all new hire training and setting the foundation for its importance. Next slide, please.

Additionally, we've been sharing community resources, which has involved partnering with the community outreach team and creating centralized community events bulletin board for our service coordinators. Additionally, again, we've obtained feedback from participants during the participant advisory committee meetings that were held during the month of August, and as a result, we've work to implement process improvements so this involves AmeriHealth Keystone

First, implemented process first with participants and implement meaningful engagement and service coordinators are leading these conversations through a strength-based, person-centered lens and this approach is guided by our participant's preferences and available supports.

Now tracking progress and we're building additional issue measures that show implementation progress and participant impact as well as use data to identify participants at risk for social isolation and in the next steps, we're going to work to build ongoing community partnerships and look for ways again to promote community integration for participants who live alone. Next slide.

So that is an overview of our focus on community integration in what we have certainly done within our plan, and I welcome any questions and feedback, thank you for allowing me to share.

>> PAM WALZ: Hi, this is Pam Walz, with Matt having departed, I'm now sharing the meeting. I actually -- I actually do have a question. So in order for people to -- in order for participants to be able to leave their houses and engage in the community, they need to have the supports built into their service plan that will enable them to do that. And some feedback that I have is that in my experience representing clients, in appeals of numbers of personal assistant services hours they have, Keystone uses -- all the plans use a time and task tool, and the one used by your plan doesn't include any time for community integration or for going out into the community. I have a hearing tomorrow for a client whose hours are -- he's 88 and his hours are being reduced, and the decision was based on pretty mechanical application of the time and task tool. You get this much time for toileting, this much time for getting out of bed. And there's 20 minutes a day for locomotion, for walking, which he needs help with. One of the things he likes to do is take a walk around the block and go to a coffee shop that is a couple of blocks away. But he's got 20 minutes a day that's been allowed for all of his walking, that includes help with going up and down the stairs in his home, walking around his home, it really leaves no time for his direct care worker to take him out, to take these walks. Also includes no time for the other things that he loves, that he likes to do like going to visit family and so this is just some feedback that if you want to make this actually happen for people, it needs to get built into the service -- the services that you provide to support people in doing this. And also not just the service coordinators who need training on this, the people that really make the decisions about the amount of services we get and utilization management, corporate people, they need to know this too and there's no sign that in their decision making, that they're incorporating any of this.

>> KERRI ZWOLAK: Pam, thank you and we look at each case and each participant and I'd be happy to revisit the specific case offline with you. Our time that we do incorporate certainly does include the opportunity for the support of past hours to provide our participants to fulfill their care plan goals so certainly again, I'd be happy to speak to you offline about this.

>> PAM WALZ: Thank you. But the reason I'm bringing up that case is not just one case. It's a pattern that we see over and over and over again. Just for that reason, I want to share it with you.

>> KERRI ZWOLAK: Thank you, Pam.

>> PAM WALZ: Other questions from committee members?

>> NATALIA GOMEZ: This is Natalia, Natalia Gomez. All these changes and all of these adjustments that you have created are they live? When were they implemented and if so, as of when?

>> KERRI ZWOLAK: Thank you, Natalia. We did hold the PAC meetings in August and since formed our community integration work group during the month of September as well as provided additional trainings and a focus for service coordinators to ensure that they very much

are involving the discussion surrounding our participants' preferences for things they'd like to do in the community as well as things they may not be able to do currently in the community but would like to. We have reinforced that training during the month of September as well with all of our service coordinators.

>> PAM WALZ: Other questions among the committee? In the room or online?

>> JERMAYN GLOVER: No questions in the room.

>> PAM WALZ: Any questions in the question box?

>> PAULA STUM: Hi, Pam, this is Paula and no questions from committee members in the box.

>> PAM WALZ: Sorry, Matt usually does this. Any questions from anyone else? Okay. All right, thank you. I think we can move onto our next plan.

>> TAYLOR DOWDEN: Good morning. I'm Taylor Dowden and senior manager for LTSS and I'm providing integration initiatives we're doing here at PHW and including key findings from the participant feedback, opportunities for our improvement strategies being implement to strengthen community engagement and how it'll evaluate the impact on these efforts. So when I'm reviewing today's information, you're really going to see a common theme, and that is that meaningful community integration requires intentional planning. So individualized supports focusing on outcomes that matter to the participants. Our goal is to ensure that participants are not only connect to these opportunities, but are empowered to actively engage in our communities and achieve lasting, meaningful results. So with that, I am going to share our lessons learned from the feedback from our CAHPS survey. If you can move to the next slide. You'll see on the left-hand side we presented this back in April for our CAHPS survey for planning, timing, and activities for the ability to do things in the community. These survey results highlight several opportunities for us to strengthen how we support participants in achieving meaningful community integration. So first off, we often identify interest in activities that participants enjoy but may need additional support turning those into interests and specific measurable community-based goals within the service planning process. So we know our service coordinators can really play an important role in helping participants connect their personal interests to actionable steps that promote greater community involvement and independence. Secondly, we've identified transportation continuing to be a significant barrier to participants and participants may not always be aware of available transportation options in their area or they may need assistance if coordinating that service to be able to go out and do community activities, go to appointments, go to volunteer opportunities or social events so really improving that education in planning can really help reduce that obstacle. Finally, participants express a need for community opportunities that are easier to identify and more accessible and better aligned with their preferences and their choices. So this reinforces the importance of person-centered planning for activities and resources are tail Herreraered to the individual's -- tailored to the individual's goals, desires, abilities and outcomes. If you look at our findings, this demonstrates that community integration is not just about identifying opportunities, but it also requires helping our participants translate their interest in the goals. Addressing transportation challenges, ensuring accessible options that reflect participant choice. So our focus moving forward is to convert these survey insights into person-centered actions that improve community engagement in the quality of the life for our participants. Next slide.

So you'll see here this is really going to be what our strategy is going to look like so the first step is really to ask. We want to have a discussion with our participant, we want to explore what their interests are, their preference, routine, strengths, any barriers limiting them from community participation. This goal was really to understand what is important to the participant and what meaningful community involvement was it like for them for the perspective. The second step of

our plan is to actually plan so our interest has identified the service coordinator working with our participant and specific and measurable goal and goal meaningful to the participant and outcome they want to achieve. The third step is to connect. This involves identifying and matching local resources, programs, organizations, and community opportunities that align with the participant's interest and goals. This focus is on expanding awareness of available options and -- awareness of options and reflect the participant's choice. Fourth is the support process and they may require assistance to successfully participate in community activities and coordinating transportation, addressing accessibility needs, connecting natural supports or ranging other services necessary to promote success. And the final step is really that follow-up piece. Community participation is an on-going process. So the service coordinator should review the progress, discuss participant's experience, celebrate successes, address challenges and identify next steps to support continued engagement. Most importantly what we want to focus on on this slide is that throughout every step of the process, we want the participant to remain the author of their goals and our role is to provide individual support and take into account the participant's preferences, readiness, accessibility needs and personal choice. By following this structure, we can create more consistent meaningful and sustainable community integration outcomes. Next slide.

So this slide is the actions we're taking to really make sure that everybody is getting out in the community and doing what they want to do. The first step for us is working with the service coordinators. We hold a biweekly call with all of our service coordinators, and we always bring vendors on and we do updated trainings about the services that are available that can be built into service plans. So we're encouraging the SCs to have more intentional conversation about community interest during those assessments and reassessments. These discussions will help identify activities that align with each person's preferences, goals, strengths, and desired level of participation. Second focus is transportation education and survey results identify that transportation is a common barrier to community participation. So to address this, we're working to increase awareness to available transportation options and resources that help participants access communities and services, social events and other opportunities. The goal is to ensure participants and the caregiver really understands the transportation benefits that are available to them. And we're also planning to do some performance reviews of the transportation vendors to really start digging into those missed trips and covered gaps. A third strategy for us is community resource connection, so we are expanding our awareness of local resources. And we're looking at like senior centers, libraries, volunteer opportunity, faith-based groups and hobby clubs and adult-learning opportunities and these will be valuable for social connections, skill building, recreational needs, and then finally just our community partnership. So through collaboration with our community liaisons and local organizations, we can really build a stronger relationship with community partners that will allow us to create more referrals, improve access to resource and connect participants with opportunities. So all together, these efforts are designed to really strengthen the tools, knowledge, and community connections available to participants. Next slide.

So here we talk about community integration and success isn't measured by the number of referrals that we make, it's really success is measured by whether the participants are actually engaging in their community and we can make as many referrals that we want and not getting out to do what we want, we're not successful. We want to make sure we're actively engaging, we're developing new skills, building meaningful relationships and moving towards outcomes that matter most. So this slide really illustrates how we move from identifying a need in achieving a measurable person-centered goal. So this quickly here, the process starts as we

identify that need such as life change and transition or opportunity for growth, next we assign a specific measurable goal and reflects what the participant wants to achieve and we then authorise and connect the participant to the appropriate provider and support needed to work towards that goal, and then lastly again, we monitor that progress and review participation, skill development and barriers, and finally that piece is reassessment so that quarterly contact, that annual follow-up. We want to determine whether the goals have been achieved, do the supports need adjusted and is the participant ready to continue independently. The key take away is community integration is a process and not just an event here so referral alone doesn't just create change. Real success occurs when a participant gains skill, builds connection and increases independence and achieves goals they identify for themselves. Next slide.

So our improvement strategy is focused on creating meaningful opportunity for community engagement in ensuring that we achieve outcomes. So you'll see here the process measure focuses on action that supports the participation. This includes participants having documented -- participants having documented community-integration circles and resources and organizations that align with their preferences and their needs. The outcome measure focuses on the results of those efforts so this includes participation successfully engaging with the activities, resolving transportation barriers, and reporting improved experiences through your CAHPS survey results. So really in closing here, community integration is most successful when it moves beyond the identifying needs and focuses on achieving the outcomes and identifying goals, connect with community resources, address barriers and build lasting skills and relationships, we can create opportunities for greater independence and engagement. So really the strategies I outlined today are really design to strengthen our person-centered planning, expand community connection, and support measurable progress towards outcomes that matter to participants. Ultimately, our goal is to ensure each participant has the opportunity to actively engage in their community in a way that reflects individual preference, strengths and goals.

>> PAM WALZ: Thank you. This is Pam. Thank you for that presentation. Are there questions from the committee?

>> PADRAIG TANGNEY: How many people are going to be enrolled in this program. It's Padraig Tangney: Apologies.

>> TAYLOR DOWDEN: During that care planning process, the service coordinator should be revealing what they're looking forwards working with or who they're working with and then really providing them that guidance on putting in an authorization for transportation need or if it's meals or volunteer activity or employment so there's a lot of different options but we can get specific numbers to you.

>> PADRAIG TANGNEY: Options don't mean they're using the service and good to know how many are taking advantage of benefits you're providing and whether or not educational opportunities are others to improve feedback that was provided in earlier meetings.

>> TAYLOR DOWDEN: Yeah, absolutely.

>> PAM WALZ: Other questions from committee members?

>> NATALIA GOMEZ: This is Natalia Gomez and I have the same question and will ask to the MCOs and when are the programs and things implemented because I continue to hear a lot education and training and service coordinators and community integration and liaisons and resources in the community. Just as an example, there's a case where this participant continued to explain or state that food worries, just an example, food worries was one of their biggest concern and the service coordinator never addressed that issue and we got involved with this participant, we were able to get them the application and help them fill out the application for the snap benefit. And this participant started receiving those benefits so the reason why I bring this

example up is because I keep hearing a lot about educating and education and community link and some things as serious as that, a service coordinator should have picked up on it and acted on it. With this community integration, all the MCOings are working on and trying to create this integration, but the still big issue that some of us have is in the transportation issue. For instance, the August meeting but that was a work meeting that was discussing transportation issues and transportation obstacles so not to mention those of us who use power wheelchairs and we cannot just get any type of transportation. We need specific transportation. And I keep asking the same question. Has this gone live and if so, is this being really projected to the participants and service coordinators go do their assessment? If so, are they making sure that the participants and another thing I heard here, caregivers also are supposed to be involved and I notice they're not allowed to even ask questions or get involved or service coordinators completely ignore them. So this is something I'd like for the MCOs to keep in mind, and the entire group that's here because as a participant, whether it's on paper, whether it's being presented here nice and pretty on paper, I don't know if it was -- who asked the question or number as to how many participants are participating, it would be nice to see that and if there's a low participation, then what else because we know transportation barrier and no one is mentioning the language barrier and other issues that make it is even harder.

>> TAYLOR DOWDEN: That's great feedback and we've been implementing this process over the last year and taking initiative to ensure one of the points you talked about was specialized transportation so we're aware that not everybody can jump in an Uber or Lyft or regular vehicle and may need a specialized van and touched on it earlier and ambulances or stretcher transportation and we've implemented a process for the team to review those cases and ensure those authorizations get built and we work with our provider to ensure that we can find a ride and we're really making sure that we have those authorizations in place ongoing so that our participants can really get to where they want to go and where they need to be.

>> PAM WALZ: Thanks. This is Pam. To keep on track for time with the agenda, we should move onto UPMC's presentation.

>> SIA GUTEKUNST: Good afternoon, I'm Sia Kpakiwa Gutekunst and I'll do the first part of the presentation and then turn over to Lauren Marshall. Next slide, please. One of our tactics of advancing community integration through meaningful engage is the community connection initiatives, which was developed with -- to expand opportunities for participants to be fully engaged in their communities and this initiatives was informed by participant feedback doing all UMPC and committee meetings and reinforce discussion at prior LTS subcommittee meetings and community connection provides addition until support to help participants connect with meaningful activities and work towards person-centered goals and the community connection initiative aims to augment the support and resources provided by service coordinators by offering participants receiving home and community-based services with a goal of being active in the community and an expressed need towards working towards a goal. The goal is to assist participants in identifying meaningful opportunities to engage in their communities, support participants in accessing recreational, leisure and peer support, spiritual and social and other community-based activities and to empower participants to work towards their person-centered service plan goalings while addressing barriers that may impact community integration. So the successful launch community connections reflect as strong cross functional partnership across service coordination, clinical operations and program management and analytics and LTSS leadership. It's the referral process, operational workflow and reporting structure and ongoing support needed to connect participants with meaningful community-based opportunities for engagement. Just a quick status update on community connections. It launched in June of

2025. So far actually there's some corrections to this number, I'll have Lauren do that, so as of September 1, we had over 306 referrals come through, and another status update here so NHT support and it's a pivotal resource transitions from nursing facilities to the community-based settings and this is a snapshot statewide and launching geographic reach, we're active in 34 of 67 counties so again, community connections is an option for participants who express the need for additional supports to help them reengage in their communities in ways that are meaningful to them. With that, I'm going to turn it over to Lauren Marshall, and she is our -- she manages day-to-day operations for Community Connections and walk through the process, and preliminary outcomes and share the impacts of Community Connection sharing participant stories.

>> LAUREN MARSHALL: Hi. Nice to be here with you all. This is -- I'm Lauren Marshall, as she said. I'm a Team Lead community health promotion specialist with UPMC. We'll get into more of what does this actually look like? Sia already mentioned that when a participant has an identified goal on person-centered service plan and being more active, what happens is the participant identifies the need and specifically for dedicated engagement support and the coordinator updates their care plan and Helios with needs more resource assistance and our team behind the scenes completes an internal assessment and then there's a referral that is submitted literally called community connection. What happens is that goes into a queue where all things coming through the state are in one queue and myself as the project lead or any of our other folks covering it, the co-owners, we see where a participant lives, we assign a region-specific member from the community engagement team. That team member then makes contact and works with the participant. This isn't a one and done phone call. This is a first touch base very much like motivational interviewing and getting to know someone, and then we schedule time to do research on behalf for that participant based on their need, and we schedule a follow-up call within two weeks. And if that participant in that two-week period then says you know what, I'm good and I got what I need. We'd consider that a "Case closed." Within that framework and this is not meant to take away anything like Sia said from service coordination and we're working smarter. With the resources and our engagement team has excellent partnerships with the community and community connections led to more partnerships with the community processes. If you go over to the next slide, I'll show you -- I'm with you all, I can do without numbers sometimes, but this is based off of a CAHPS requirement and need so we do have to talk a bit of numbers. I think my favorite slide is going to be the next one, which is more about the actual experience. Our numbers to date, whenever someone goes through that process of working with us, what happens is we ask closeout questions because we want to know if we're on the right track. This benchmark here that you see of a goal of 8.6 or above and these are 1-10 scale questions, this is the benchmark for each of these and it was not picked out of thin air and based off of the office of long-term living's goal of 86% for planning time and activities across all of the managed care organization. Within these closeout assessments, and I will read these only because I think it reiterates the point of the reason why we're all here today sharing this. Please note that the overall score for this is 9.17. We actually exceeded 8.43 our last one is obviously a opportunity, but the first question of how helpful was the community engagement team staff in helping meet the community needs? That was a -- excuse me, a strong result. Very much speaks to making sure that it is region specific. I think matters. We have to know the communities that folks are living in. How closely did the activity suggested bid our team match interest, 9.4. Last one was how closely did the activities -- I just caught a typo. The last one is supposed to read how much do you feel that you are likely to stay engaged in your community? That actual last question was an 8.43. I can attribute that number because

everybody's situation is so individualized, but one thing we can say that it's a blessing of this approach is that we're able to reach people in really rural locations that we wouldn't have otherwise necessarily been able to reach in these very creative ways.

The slide afterwards here, which, you know, again I think all this just encapsulates the meaningful engagement is driving better outcomes and that's our goal to strengthen the natural supports. A lot of phone calls actually happen with me or a member of our team on speaker phone or caregivers and members of the family understanding that they'll need support taking the first step in the community, and the next slide will showcase more of what we keep in mind when we find resources for these folks. So the first one and I'm not going to go down the rabbit hole one, because my boss is sitting beside me but I could talk about this for so long and the first one is a individual stating you gave me a lot of leads and I'm more motivated and your support made it easy. This one highlights expanding access, confidence, advocacy only because this particular individual had a major life event where they resulted in blindness and able to remain and want to remain active in their community. We identified accessible library programs for them, including tactile art that the individual did during rehabilitation therapy that she really enjoyed. We connected them with the Pennsylvania Council of the Blind, we connected the individual with local NOME chapter and resources to join virtually if she want that had and increased confidence she reported and participant was very very interested in more advocacy. We meet people that want to be better advocates but don't know where to start. We heard that echoed in some of the responses today as a member of the disability community myself, I feel that way sometimes. One thing that came was exposing participants to new opportunities like NOME and PA Council for the Blind and had a individual on this meeting a couple weeks ago and spoiler alert, all three of the individuals are now part of the participant advisory committee as well.

The second individual, I could say so much more. I'm trying to do well here, Sia. The second individual, this is a individual stating I'm more likely than ever and now have even more support and resources. You opened a lot of doors for me to explore. It's about restoring independence and meaningful past time. This participant, and in is a showcase of CHC I think at its best. This participant was a nursing facility participant on the committee when we first met them. Community connections was still being massaged and not ready to go quite yet, this participant wound up transitions back into the community and receiving home community-based services and started attending the committee meetings in person. He was one of the first brave souls to work with us in our cohort of ten folks that came about from our committees telling them along the way, as we were building it what was happening. So this individual as a result, we were able to connect them with genealogy groups and a love of history and digging into that for more themselves. Library programs, accessible community activities, part of those conversations this individual said to me, I think I brought to this committee before because I like the story, he was talking about fishing stuff. He'll have to have his brother get rid of it and I kept that in the back of my head and wound up having a wonderful 45-minute conversation with a fish and boat commission, and we were able to identify seven power chair accessible spots where he literally didn't even need to have transportation and just goes. He said he caught a whole lot of nothing but that's all right. The point is I don't think this participant ever thought they'd cast a rod again. So I saw the impact. This last story and one that highlights reconnecting through shared values and creativity. This individual stated "I appreciated all the information in the way in which it was given. You listened and you found really great stuff that I love." This individual is in their late 80s, formal social worker and mental health advocate extraordinary. I only hope to fill half of her shoes one day. She sates she lived in a rural area and likes to get together with her follow

friends and so what a gift. We were able to identify a local coffee shop to this participant whose focus was mental health awareness. Huge. So guess who's going there with her comrades. This is one step. This individual also had a real desire to give back and volunteer and we connected her with things through that. What's really powerful and it's been echoed in some way shape or form with all three of the individuals is that I have heard specifically coming from people's mouth, I feel like I have a sense of purpose. I feel like you truly are doing something -- finding things that matter to me. I had one participant that had shared no one ever asked me these questions before. SHAH GILANI we know happens. Our team is leaning in, we're seeing great results like Sia said and we're actually at 317 referrals up from 306 just since when these slides were due on the 23rd. I'm really proud of that. With that, I'll turn back over to see Sia to close. thanks for having this space for us.

>> Sia Kpakiwa: Thanks, Lauren. We'll have more than 317 referrals by the end of the day and these showcase the intentionality behind community connection and goals to assist, support and empower the participant. Community connections offering person-centered support and restore identify and create space for meaningful participation by really listening to what matters most to the participants, community connections helps to create connections that support purpose and creativity as Lauren highlighted so these personalized connections can build confidence, longing and ultimately leadership and serving on the participant advisory committee. Thank you for listening and the opportunity for the update.

>> PAM WALZ: This is Pam again. Thank you for that presentation. I'm going to ask if there's any questions from the committee.

>> JERMAYN GLOVER: David in the room has a question, Pam.

>> DAVID GATES: Thank you. Two questions. first one is fairly simple on behalf of my wife in CHC. Any age limit on the community connections, community integration models, for any of the plans? Any age limit?

>> LAUREN MARSHALL: I'm already talking and I'll take this. It's Lauren from UPMC. I am who I am. I see Lloyd laughing at me. So, David, that's a great question. All the managed care organizations when it comes to this community integration, it's for all participants. How we all go about doing that is going to look different. I know for us, we work with people across the span of ages that come into and are eligible for Community HealthChoices. The only thing that's a "Requirement" per se is right now this is focused on home and community-based services folks that are recipients.

>> DAVID GATES: Yeah, that's what I'm talking about.

>> Lauren : There's no time stamp. This is not a one and done conversation. Let's say something changes in that person's life and maybe a trigger assessment. They say, you know, what I used to do here doesn't make sense doing it now. Maybe it's just seasonal things and especially if people were immunocompromised and they'll have the ability, the service coordinator will send another assessment throughout the service queue and match with a region-specific community engagement team member and start the ball over again.

>> David: Okay. I would just mention my wife is in UPMC and she has a great service coordinator but never mentioned this community -- what did you call it again?

>> Lauren Marshall: Community section.

>> David: Community connection and never mention it had and let you know not all the service coordinators know about it. Sounds like a great idea. I'm certainly going to talk to her about it.

>> Lauren Marshall: And I'll take your information before I leave.

>> David: Okay. The second one comes from Carol Marfisi and asked me to ask this again regarding community integration and just to understand, it's not something that's just applicable

to Carol, but to give it some context or talking about individual with cerebral palsy and limited manual dexterity tearty and also has challenges using speech-enabled devices because of effect on her speech of her CP. She engages in the community and one tool that's essential for her engagement in the community is using a computer. She's working on coauthoring a book with a local University. She uses it to review documents in preparation to participate in the meeting and uses it to identify other opportunities in her community when she could participate in. The challenge is direct care workers quite honestly lack the education and knowledge and frankly academy ten seizure disorders to do the kind of -- competency to enable Carol to use her computer in an effective manner to further her community integration. So she asked me toe ask, is this something that could be covered under the community integration service, and how would the plans provide support to someone like Carol who has these physical challenges but uses the computer as her entry point into the community?

>> SPEAKER ??: Hi, David, this is the vice coordinator for UPMC health. Kerri did our presentation and had to step away to give another one at provider conference. Answering your question not in Carol's case but a more broad response and if we have a direct care work tear needs training in assistive technology in order to provide care and support for the participant, we would definitely work with their provider agency to be sure they receive the training that they need. Also we have assistive technology experts within the fields that provide education on assistive technology we could engage in order to get that direct care worker more education to be helpful to a participant.

>> David Gates: I would like also to ask would this be something that the plans would consider under the service definition of community integration, which is a separate service? If the goal was identified in her person-centered service plan. In addition to training the workers, quite honestly what she's told me is, you know, given the amount of money these folks are being paid, and she's in a rural area, so this would be particular applicable for those participants in rural areas. I'm lucky just to get somebody that gets me out of bed and often she can't even get that. So the question is, is it realistic to say, okay, this person whose really viewing their job as doing the direct personal care kind of stuff, for them to spend the time to learn computer technology and then do this kind of assistance that Carol or I'm sure a number of participants need, to utilize computer, the internet, e-mails, to ooze an entry point to their community. Is that something that folks are saying, well, it's your direct care worker, which case Carol would say that's not realistic at least in my case.

>> Yeah, I get your question. So -- let me know if I don't understand the question. Is the question can community integration services pay attendants to be trained in the computer services and skills that nay need to have in order to be an increased support to the person? Is that the question? So the answer to that is unfortunately community integration services is not set up to pay people to acquire new skills. The waiver program at this point in time, the services are to the benefit of the participant, and I understand the logical reasoning of if you pay to up skill the direct care worker, that then in turn benefits the participant by meeting this need. I get the thinking of in the fee for service kind of menu world, would community integration be that pathway? I actually think cash and counseling would be a different more flexible path way. Where you have full budget authority to address very unique needs and creative person-centered planning goals. There's not a lot of people that take out services my way, but when you're talking about things that are that unique and like we need to solve this problem in a way that's putting widgets into very tight services might not work, a more flexible budget authority thinking process may provide some of those avenues. I can't speak directly to that individual person, but I did want to add that to the conversation. We tend to forget about services my way,

and it's a very, very powerful type of model.

>> David Gates: I appreciate that having been involved in a work group on Services is My Way years ago and we kept coming back to -- vulnerabilities back then service coordinators that -- there were very few service coordinators back then and it's a delay in when the wages get sent totem misses and they do the -- to temporal integration misses and they do the payroll and how much it in your budget and timing is challenging and need a service coordinator that understands that, and unfortunately there were not a lot so became a disincentive, but I agree. I think it could be a great program, but really requires well-trained service coordinators to make it work.

>> SPEAKER ??: 100%. It's not something you give a service coordinator on the first day. For sure.

>> Pam Walz: All right. Sounds like Juliet is about to do the same thing that I'm about to do. Which is to thank all three MCOs for these great presentation and the really great work you're doing and interested to see how the CAHPS score reflects that. Juliet, I was going to move on to the public comment section of the meeting.

>> Juliet Marsala: I was going to add walking across the street and walking back from my other commitment, I realized that I did not provide numbers and I don't know if my team did, but currently as of yesterday, with regards to HR-1 and individuals that are losing coverage due to a change in their immigration status being recognized, at the federal level, we had 115 applications to the act 150 program. I did want to share these are not -- I'm not saying their eligible or enrolled but saying of the under 60, around 250 individuals and 116 applications for Act 150 were received as of yesterday, which is a good thing. Certainly we're worried about everyone else, but we do know our MCO partners have been really working hard to connect them to the triple ways and PIAB and Office of Income Maintenance reviewing them for eligibility under general MA and received for emergency Medicaid and unfortunately a transition out of CHC in and of itself would not qualify someone for emergency medical assistance that's really if they have a very acute episode like showing up at the emergency room. Not just a transfer out of waiver. Working really, really hard on those things and we'll continue to kind of monitor the numbers where we can certainly we cannot report out on what the triple-As do and Department of Ageing do. That's outside of our lane. We're certainly very encouraged and still following things along. Public comments.

>> PAM WALZ: What is the order we do this? Start within the room?

>> JULIET MARSALA: We do because they traveled here.

>> PAM WALZ: Any public comments from in the room?

>> JULIET MARSALA: David.

>> DAVID GATES: I do want to point out, I mean I think it's great that DHS is taking Act 150 applications just so people understand. That just puts more financial strain on commonwealth because Act 150 is purely state funded and no federal match. The federal match is available in community health choices and once people move over and it's great and important but nonetheless here again is the federal government pretty much screwing Pennsylvania, in my words. , because we're going to lose the federal match for those folks in order to enable them to keep their medical assistance. That's just one comment. Next one is Carol specifically asked me to tell people about a webinar being presented with the keynote speaker will be a former member of this committee, who was the Executive Director of the central PA and Theo Brady and building leadership and dismantling systemic ablism. I have brochures if anyone is interested and we encourage you to sign up. It's free. The link is [BIT.LY/beyondinclusion](https://bit.ly/beyondinclusion) to sign up online. Again, October 22 at 1:00. And the last question I had, I've had some questions

from participant and agency model who were thinking about moving to participant direction and the question was, in making that decision, where can they find a wage ranges for participant-directed care services?

>> JULIET MARSALA: Is the question is where they can find the waGe rates for individual MCOs or the wage range for fee for service? It's either PPL or tempis and they can wall one of the provider ifs they prefer the telephone and ask. Tempis is the provider. PPL is Act 150 and OBRA too. Those are the two SMS, FEAs for the Office of Long-Term Living.

>> DAVID GATES: I didn't know that. they can call Tempis and call and ask I'm in this county, what's --

>> JULIET MARSALA: If they're in CHC, ask their SC and they should be able to readily get that information to them.

>> DAVID GATES: Oh, okay.

>> JULIET MARSALA: The common law employer will determine the wage. The range, the SCs should be able to tell them what the range is for their plan. And if they need more information they can talk to Tempis.

>> DAVID GATES: Thank you, that's it.

>> PAM WALZ: Great, anymore public comment from within the room?

>> JULIET MARSALA: I'm not seeing anything. Back to you, Pam.

>> PAM WALZ: Great. Any questions online?

>> PAULA STUM: Hi, Pam. This is Paula. I have quite a few. Might take awhile to get through them. This is from Matthew BarbEe related to RFI, I'm curious if you can elaborate further on what most commenters express strong support for participant direction means by the number of commenters. I ask because I know of at least six commenters who expressed a desire to remove language around participant direction as the first option or preferred option and instead focus on the mod model, which is best for the participant.

>> JULIET MARSALA: Certainly. Talking about general support for participants off direction, it's that commenters are generally saying that it's a good model to keep. Certainly there were commenters that wanted the removal of the first option language, you know, so the way the language is sort of written and presented is that Lynn, personal assistant services, is identified in a person-centered service plan, not all the time but when that service is identified, the service coordinator is supposed to educate on participant self-direction as a first model option. That doesn't mean that they don't educate on agency. It means that they are presenting participants-self-direction first and explaining it and giving a good understanding and orientation to what it is so participants can make their choice to decide which model is best for them. With regards to the first option of office of long-term living as a policy, specific direction cost us less than the agency model historically. It also provides individuals who can direct their own care, the most autonomy and independence of hiring firing, training, selecting their own attendant without an agency. This is not a judgment on agencies, just the independence of that model. So that's why it's been a policy stance for office of long-term living for some time. That's a model that's supported and we saw a lot of comments where that model is supported. Hope that's helpful.

>> PAM WALZ: Next question, Paula.

>> PAULA STUM: This is Paula. Next question again from Matthew Barbee, related to sustainability, is this focus on all DHS departments or is OLTL an area of particular focus?

>> Juliet Marsala: That's a great question. I would say across DHS as a whole, every Deputy Secretary has been evaluating their program, effectiveness and efficiencies. Looking at their budgets, that's allocated and engaging their stakeholders in ways that are appropriate for them. So for example, the GLP1 change, that's across OMAP and OLTL and ODP so we're all looking

at this from our various lenses right now at office of medical assistance programs and they're hit harder with HR-1 and all of those changes and dis-enrollments and the many thousands of people that will not be having healthcare in the future to David's point due to changes beyond our control. They certainly have a different focus and different need of their time and resources. Those dis-enrollments impact their budget in lowers their budget issues so each department has -- each office within the department has sort of different issues with us in the Office of Long-Term Living. It is the recognition that we have the largest budget so it behooves us to be prepared to have those conversations, particularly since the Office of Long-Term Living with the largest budget, we do have the largest optional services in the commonwealth under Medicaid and put those pieces together and this is why the Office of Long-Term Living needs to have these option discussions. So across the board, yes. That's the particular reason for here in the LTS committee. You're welcome to sit at the table but if you're more comfortable in your own seats, you can do that too. Sorry, Paula, back to you.

>> PAULA STUM: Next question from Brenda Dare, when CHC began, we were told it would cost contain. When you looked at thing in a wide lens, including things related to legal issues around CHC has that cost containment been successful? Is the CHC model of services effective for Pennsylvania or is it perhaps time to reconsider whether or not returning to fee for service might save money overall?

>> JULIET MARSALA: That's a very good question and that's one we continue to look at and study, and we work with our partners at MRC to study many, many different things. I would say from my perspective CHC has been very successful. I can point to many different reasons why. If you looked at cost of the fee for service, and the rate that was going pre-CHC, it was astronomical. That curve was really high. Under CHC, there's been significant improvements in monitoring of the call of services that was not there before. There's been significant Advancements in looking at data, collecting data, looking at claims, being able to actually provide services in a whole-person centered way with more integration than we had in fee for service. I can say that's someone that worked in the fee for service world many, many years ago from my perspective. In addition as we look further and further to integrating Medicare and Medicaid, we are identifying ways in which we can maximize our state dollar funding so an example of that is if our Medicare partners and Medicare advantage partners implement supplemental benefit, that could shift tens of millions of dollars to Medicare-funded and covered service. What does that mean? That means that there are then tens of millions of dollars under the state Medicaid portion that can be redirected and focused on other life sustaining HCBS services. In fee for service world, this would be unlikely to happen. That's just one example of ways in which CHC as an integrated program has benefited and sort of cost sustainability. Will we know for absolute certainty? No, because we're not in a fee for service world right now. It's indicators like this that tell me it is definitely a benefit to Pennsylvania to have had this CHC program implemented.

>> PAULA STUM: Thanks Juliet. From George Gilmer, has the department look to fast track -- cells and infusion to reduce the impact of diabetes that spend one quarter of healthcare dollars, noted as curing at least type 1 diabetes?

>> JULIET MARSALA: One thing, George, I saw the news article on that but it's way outside of my Wheelhouse, and data committee would be OMAAC because that sort of pharmacy changes and medical coverage falls more under the state plan, which is overseen by the Medicaid Director Sally Cosack but I'll pass that question onto her.

>> PAULA STUM: This is Paula. Next question from Michael Scisarinau, should Pennsylvania reform it is long-term care laws by codifying home and community-based services as primary

mandatory standard of care streeting institutional nursing home placement as a last resort to promote individual independence and lower state expenditures?

>> JULIET MARSALA: Thank you, Matt. I'll answer them all and it's a great question for the subcommittee members. It's certainly the subcommittee members could take up and decide whether or not they want to put that forward as a letter to the General Assembly members. The Office of Long-Term Living don't have the power to codify things into law. Yes, there are some states that have done that, that have codified HCBS services in their state regulations and via legislation to make HCBS a sort of mandatory service option within their state plans. States have the option to add that in their state plans there's certainly some significant considerations with regards to doing that. But the General Assembly member and other policymakers have to take into account in terms of how it's done but certainly there's been states that have done that on average and aggregate at very high level like taking everyone into account, HCBS services are generally costing less than nursing facilities and some states have gone to that direction and a task for the committee and the General Assembly. OLTL doesn't have a role in that piece.

>> PAULA STUM: Next question, this is from Cindi Haggart, who pays for the gas for the direct care worker to take the participant to see family or visit a community festival? If there's no viable transportation in the area, can the gap be addressed without paying the DCW mileage? For most of our participants a direct care worker is necessary in the community with the participant.

>> JULIET MARSALA: Thank you for that I request. There's specific bulletins related to attendance service asks travel. One of the premises to bear in mind is there is the policy position a person is either a driver or a personal assistant services person providing hands-on assistance. They cannot be both at the same time. So if they're a driver, they have to meet all the eligibility criteria of being a driver. If they're an attendant, they need to meet the criteria of being attendant. There's a bulletin that's been long standing that outlines that in accordance with the CMS technical guides and rules around those service definitions so to answer your question quite plainly, the office of long-term living and Medicaid program would not pay for case for attendant to drive someone to a family member's home. At this time.

>> PAULA STUM: Next question from Pamela Silver. This is for PHW. You identified transportation as a barrier to communication integration. I think they meant community integration. How is it planning to track progress on this? Has PHW sent measurable targets for increased utilization for non-medical transportation?

>> JULIET MARSALA: Hi, Paula, I think that was a question to the presenters. The presenters and their presentation time is done. We'll send to MCOs for follow-up. If you see a question we think is for the presenters, that calls out a specific MCO, please know we'll follow-up with them and answers from them will be posted at post-meeting FAQ documents that we send out across the list serve.

>> PAULA STUM: Okay, in saying that, Juliet, I think most of the questions will be sent to the IA box. I see George Gilmore and Colleen Tomco have their hands raise. If you want to go there, Pam.

>> PAM WALZ: That sounds great. Whichever put their hands up first, if you know who that is. We can start with George since you mentioned his name first.

>> PAULA STUM: George, you should be un-muted.

> GEORGE GILMER: Thank you. I'm un-muted. Program integrity, I find a lot of problems. With AmeriHealth Caritas and the amendment in the constitution and translates down to Pennsylvania also. That's one thing. My service coordinator has I think case load of 73, which is way, way, way too much. Then things on the Tempis side which are also very important. We take into account for program authority --

>> if you've not received retro payment, please note Tempis began distributing June 11 --

>> GEORGE GILMER: The recording is still there and payments not distributed and quite a few months since update. We have a lot of problems maybe one of the presentations you can have with OLTL is those of us that sit on the Tempis advisory and all the issues we see and the tasks that want to be put onto the people in the consumer program listing tasks that are done, which is really an aim and we Mo what we've asked attendant to do and what's done. It's not like attendant is reporting to agency to see what the task is. We have a lot of problems on committee believing this is going to make anything better and any program integrity with Tempis.

>> JULIET MARSALA: That you can't, George. I appreciate you bringing up those two important points and CHC MCOs are in the room and ask them to connect with Tempis to make sure the recordings and audio and any remaining issues related to the retroactive payments are addressed. Our team has been working with them to track that so I'll certainly ask for an updated report. We have four minutes left. George, hold on.

>> GEORGE GILMER: No one on Tempis on advisory in the committee and might behoove you to touch base.

>> JULIET MARSALA: Let me finish. What I recommend to chair and Vice Chair for a future meeting is to dedicate time for those changes that you mentioned or upcoming changes that you mentioned that I believe were communicated to the advisory groups. But have not yet been implemented. So I think there was some discussions in the community advisory group. There's some steps that need to be done with regards to involving the office of long-term living and our review of any materials, draining, steps, communication and participation. I believe they were trying to engage you for your feedback versus trying to inform you that this is a done deal and implementation starts tomorrow. That's not the case. OLTL has to be involved in approving and evaluating things. I don't want folks to be panicked. I believe what you experienced, George, was engagement with advisory committee to get advice and feedback at this stage. But certainly in a future meeting, we can have the MCOs present specifically about that direction. Historically and future state so I didn't want you to feel like it wasn't heard. It was definitely heard loud and clear the feedback from the advisory committee, and I'm glad we have the advisory committees for that purpose. Pam, there's two minutes left.

>> PAM WALZ: Let me say quickly, George I'm the Vice Chair. We will follow up on this with everyone. Is there time to take that last question from I think it was Nicole?

>> JULIET MARSALA: Probably not, 60 seconds to announce the next meeting.

>> PAM WALZ: Do you have the date for the next meeting to announce?

>> JULIET MARSALA: Wednesday, November 4 and virtual only. Wednesday, November 4, virtual only. Then I think you have time to move to close.

>> PAM WALZ: All right. Other comments and questions can be sent to the resource account, and there'll be responses to them distributed, and do we have a motion to adjourn our meeting?

>> KATHY CUBIT: This is Kathy, I make a motion to adjourn.

>> PAM WALZ: Thank you, Kathy. I don't know if I need a second. So I think we'll just declare the meeting adjourned. Thank you. Thank you, everyone, for coming and am the great conversation and really good presentations today. Bye bye.

[meeting adjourned at 1:00 p.m.]