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Date: 12/3/2025

Event: Long-Term Services and Supports Subcommittee Meeting

>> KATHY CUBIT: Good morning! This is Kathy Cubit, and I want to welcome you to December's LTSS MAAC meeting. It looks like some of our members are still joining, so I'm going to begin with the housekeeping and committee rules. First, I want to say this meeting is being recorded. Your participation in this meeting is your consent to being recorded.

This meeting is being conducted as a webinar with remote streaming to comply with logistical agreements. We will end promptly at 1:00. To avoid background noise, please keep your devices muted and the microphones off unless you are speaking. Remote captioning is available at every meeting. The CART captioning link is on the agenda and in the chat. It is very important for only one person to speak at a time. Please state your name before commenting and speak slowly and clearly so the captionist may capture conversations and identify speakers. Please keep your questions and comments concise to allow time for everyone to be heard. Webinar attendees may submit questions and comments into the questions box in GoToWebinar or use the raise hand feature to be put in queue to speak live. Time is allotted on the meeting agenda for two public comment periods. If you have questions or comments that weren't heard. Please send them to the resource account email found at the bottom of the meeting agenda and the LTSS Subcommittee webpage. . . And, with that, we will move on to the roll call of members. And we'll start, Ali Kronley?

>> ALI KRONLEY: Hi, this is Ali. I'm here. Good morning.

>> KATHY CUBIT: Hi, Ali. Anna Warheit?

>> ANNA WARHEIT: Good morning. This is Anna.

>> KATHY CUBIT: Hi, Anna. Carol Marfisi? Okay. Cathy Bollinger sent regrets. Cindy Celi.

>> CINDY CELI: Good morning. This is Cindy.

>> KATHY CUBIT: Hi, Cindy. Neil Brady? Gail Weidman.

>> GAIL WEIDMAN: Good morning. This is Gail.

>> KATHY CUBIT: Hi, Gail. Jay Harner.

>> JAY HARNER: Good morning.

>> KATHY CUBIT: Good morning. Juanita Gray? Laura Willmer-Rodack? Leslie Gilman? Linda Litton? Lloyd Wertz? Lynn Weidner?

>> KATHY CUBIT: Good morning. This is Lynn.

>> KATHY CUBIT: Hi, Lynn. Matt Seeley? Michelle Garrett?

>> MICHELLE GARRETT: Hi. Good morning. I'm here.

>> KATHY CUBIT: Hi, Michelle. Michael Galvan? Minta Livengood? Monica Vaccaro? Pam Walz? Oh, I'm sorry, Pam has also sent regrets. Is her alternate, Bridget Kerrigan here? Okay. Patricia Canela-Duckett?

>> PATRICIA CANELA-DUCKETT: Good morning, everyone. Happy to be here.

>> KATHY CUBIT: Good morning.

>> JULIET MARSALA: I'm so sorry to interrupt Bridget Kerrigan is listed in the participants panel, so we will move her. She's in the audience, and we will have to work on moving her as a panelist, so she is here. I see her.

>> KATHY CUBIT: Okay.

>> MONICA VACCARO: This is Monica Vaccaro. I'm also here. I was having trouble unmuting.

>> KATHY CUBIT: Okay. Thanks, Monica, and thanks, Juliet. I'm sorry - the last person, could you repeat again?

>> JUANITA GRAY: Yes, hi. This is Juanita Gray, Kathy. How are you?

>> KATHY CUBIT: Oh, hi, Juanita. Thank you.

>> JUANITA GRAY: You're welcome.

>> KATHY CUBIT: Okay. Rebecca May-Cole?

>> REBECCA MAY-COLE: I'm here. Good morning.

>> KATHY CUBIT: Good morning. Okay. Is there anyone who, any member that hasn't been able to, wasn't able to introduce themselves during roll call?

>> LESLIE GILMAN: Yes, Kathy. It's Leslie Gillman. I'm on.

>> KATHY CUBIT: Hi. Thanks, Leslie. Anyone else? It looks like I see Bridget has moved over and has her hand raised. You can speak, Bridget, if you wish.

>> BRIDGET KERRIGAN: Thank you.

>> KATHY CUBIT: Okay. And, any member that has not been announced, please do so now.

Okay. With that, we will move over to the OLTL updates, and, Juliet, the floor is yours.

>> JULIET MARSALA: Good morning, everyone. Hope everyone had a good holiday week and a Happy Thanksgiving. Before we get started, I wanted to take a few minutes to go over, and then, first off, Damaris, I don't think you're sharing the screen that you intend to share. We are seeing your whole desktop, not just the presentation, so I don't know if that's intentional.

>> DAMARIS ALVARADO: Hi, Juliet, this is Damaris. I think there are technical difficulties because I wasn't trying to share anything, but I will check it. Thank you for letting me know.

>> JULIET MARSALA: Okay.

>> SPEAKER: As a participant, I was seeing just the presentation, so I don't know. Yeah, now I see the presentation. I'm not sure if it is different for others.

>> JULIET MARSALA: It is. I can see when notes pop up in Teams on the user screen, and I don't think that's what they intend to have being visible to us. So I can, Damaris, I can share my updates that's needed. I think you are sharing a screen not the

application, so I will go ahead and share mine so we can move forward. All right. There we go. Okay.

>> MATT SEELEY: Juliet, this is Matt I'm here.

>> JULIET MARSALA: Thank you, Matt.

>> MATT SEELEY: By the way, the screens look the same. Thanks.

>> JULIET MARSALA: Okay. So, I did want to take a moment at the beginning of the call to provide an update that we are coming to the end of the year for the Office of Long-Term Living. This LTSS meeting, this is the December meeting. So, what this means, since, you know, we have merged quite some time ago now, the MLTSS and the former LTSS subcommittees into the LTSS subcommittee meeting, we are at the point where there are going to be members whose terms are up that will be cycling off the subcommittee. New members, you know, representing different groups of stakeholders will be cycling on to the committee starting in January, and so I did want to thank the committee for their hard work over the last couple of years, and, you know, note my appreciation for folks for all of their efforts and their contributions in working with and advising us and all the time commitment for the committee. I did want to especially thank Kathy Cubit for her leadership role for many, many years. As many of you heard in the last meeting, this is Kathy's last meeting as chair of the LTSS Committee. Very grateful for her partnership and very happy also to announce that Matt Seeley has accepted and agreed to move into the chair leadership position of the subcommittee starting in January. So, we certainly look forward to, I look forward to working with Matt and additional subcommittee members as we work to continue to create a subcommittee in that advisory capacity for the Office of Long-term Living. I also wanted to note that, as you know, we had to move virtual due to the travel ban during the budget impasse. We have made plans to come back in person, however, due to location, physical location, constraints the in person meeting, I believe, won't be able to resume until April, but, you know, I do prefer the hybrid format and getting the opportunity to be with people in person as well as virtually, so you will see that information, and so, just for your planning purposes, we are planning to resume the hybrid meetings effective in April.

Okay. So, going on with updates. Just a very short agenda of updates from my end. There is no new news on the procurement front. The CHC, I am hearing background noise. I think we need to mute some folks in the audience, so if my team can take a look at that, that would be great. So, there are no updates on the CHC RFA. It still remains in a stay, and the program will continue to operate under the current CHC managed care organizations under their agreements. We have agreements for 2026, as well, and, it will continue that way until further notice, and again, the mailbox for any questions you may have regarding the RFA remains open with the procurement team, and that e-mail remains ra-pwrfaquestions@pa.gov. So, we have had some recent state plan approvals. So, on November 13, 2025, the Office of Long-Term Living received from the Centers of Medicare & Medicaid Services, or CMS, approval for the following state plan

amendments. So, we have approval for the SPA 25-0019, which amends the data element in the department's case-mix payment system for nursing facilities and county nursing facilities to utilize the Patient Driven Payment Model (PDPM) in place of the Resource Utilization Groups, Version III (RUG-III). CMS is no longer supporting the RUG III dataset, and the team has been working really, really hard to make the changes and required amendments to be able to move the data element from the RUGs to the PDPM dataset, which is supported by CMS ongoing, and is a really solid reflection of case-mix considerations in nursing homes, and then the SPA 25-0020 also approved is part of those efforts and that work.

We also had some additional approvals from CMS that we were waiting for. We finally did receive the CMS approval of the 2025 submissions for the CHC agreements and finalization of rates from CMS and the state directed payments which were part of that package in late November. So, you know, the agreement and documents as we ordinarily would do would be posted publicly now that we have received that CMS approval.

All right. So, as you all know, we do have a state budget. So, very, very excited about that state budget being enacted. It is better to have a budget than no budget. So, certainly relieved to see both the federal budget, the federal shutdown ending for the most part for now and having the state budget in place so we know where our starting point is. It, you know, certainly was a difficult budget, but it's, you know, it is a compromised budget. Certainly, the Governor's office did get less than what they had originally proposed, but we still do have significant wins in the Governor's budget across the commonwealth and, more specifically, the Office of Long-Term Living did have approximately \$21 million investment in our participant self-direction direct care workforce be approved and accepted by the general assembly.

So, I'm going to go into the numbers a little bit for the state fiscal year 25-26 budget as it relates to the Office of Long-Term Living. I do have Dan Sharar on the line with me. He is our Bureau of Finance Director, so I may phone a friend if there are certain specific questions that folks may have that get a little more detailed. As you know, we are still kind of working through it. When a budget is enacted, there is a rebudgeting process that we all go through based on the final numbers that we have, but I'm going to go through this presentation at sort of that high level for you all.

So, as many of you may know, the Office of Long-Term Living kind of budgets and appropriations generally has three buckets, or three main appropriation lines, so I'm going to go through those lines for folks today. So, the first bucket, or the first appropriation line that you'll see, which you're seeing now, is the long-term living appropriation. Within that appropriation, we have our Office of Long-Term Living Medicaid fee for service programs, our OBRA waiver and our Act 150 program, and so, predominately, those are the main elements that fall into the long-term living bucket of appropriations, and so what you will see here in this table is that you will see these are dollars in millions. You will see what we received for the state general fund, what the

actuals were for the last fiscal year, what was presented in the budget book, and, you know, what we have received as part of the Act 2025-1A, which is what was enacted, and then the percentage change over the prior year. You will see that in this appropriation we also show where we generally get funding from with regards to the Office of Long-Term Living. So, generally, the Office of Long-Term Living either gets funding from, appropriated from the general fund, the lottery fund and the tobacco settlement fund, and then in addition we draw down our federal match, so you will see those pieces of where those resources are coming from.

So, for the Long-Term Living, as you can see here, in 2024-25 there was \$197,496 million appropriated, and in Act-150 we wound up at \$206,870, so there is a 4.7 percent increase in the funding allocated through the general fund when we were not receiving any lottery funds for that or the tobacco settlement fund, and then we go to the federal match share, and you will see that it shows a 10.41 percent increase. So, overall for Long-Term Living, we are seeing a 7.55 percent increase. Now, I caution folks, because folks will be like, oh, it is a 7.55 percent increase so the program got more money. Now, and I just would caution you not to think about it that way because when we project, we project to where we think the program is growing and what the additional needs are. So, I also wanted to point out that in the total appropriations, there are some notes here that, you know, the funds did include for 24-25 \$332,000 in COVID State Recovery funds and another note that the total appropriated dollars were also supplemented by attendant care patient fees and attendant care parking fees.

All right. So, if we look at another bucket, the second bucket of appropriations is the long-term care managed care, and what generally falls into the long-term care managed care appropriation is our LIFE program. The LIFE program is what we call the national PACE program that operates in Pennsylvania. It is a managed care program. It is an integrated dual eligible program. It is a model that serves individuals over the age of 55, and what you will see here, overall, when we take a look at the state funds and the federal match, we do see a slight increase in the appropriations that comes out to an 8.39 percent increase. Much of that is attributed to our estimates of increased enrollments in the LIFE program, particularly as we are looking to expand the LIFE program into new counties this year, which I'm very excited about, and then in the line item that most folks like to pay a lot of attention to is the Community HealthChoices appropriation. So, just for folks awareness, in Community HealthChoices, that is where we have our Medicaid managed care, long-term services and supports, capitation, so that, those are the rates that really run the Community HealthChoices program. That is the bulk of this appropriation. However, this also includes our Office of Long-Term Living grants programs and many of our operating contracts all fall in this bucket, so when you see these numbers, these are not just the numbers that get then given to the MCO. This is the number that supports a lot of the Office of Long-Term Living administrative and operations requirements as well for the program.

So, what you will see here is in the state general funds you will see an increase of 10.69

percent change from the prior year, and a good portion of that, for folks' awareness, is that approximate \$21 million for the personal assistant services increase that the general assembly has supported. We also see here in this appropriations we are getting some lottery funds that help support the Community HealthChoices in addition to tobacco settlement funds, and that is offsetting some of the potential shortfall that we anticipated because we anticipate the growth of this program to continue in its same trajectory.

I did have some additional notes that the total appropriations here also include some additional supplemental funds that you don't see noted on here, and that is our nursing facility assessments in addition to our county intergovernmental transfers, or IGT. It also includes funding from our MCO assessments and hospital assessments, so those are also part of that appropriation line in those funding streams. I did want to note here also that the fiscal code, you know, there is a piece in here that will be important to you folks on this call, the fiscal code did extend the penalty provision for nursing facility resident care spending and those direct service spending requirements through to December 31, 2026. I see Matt has his hand up, but let me just get through these notes, and I will get to you, Matt.

So, as you heard me state before, the long-term living appropriation includes approximately 21 million in state dollars for the nonpublic Medical Assistance Day One Incentive and an additional \$9.25 million in state funds for other legislative special payments that are outlined in the fiscal code. Our long-term living appropriation also includes \$987,000 in state funds for the participant directed personal assistance services increase, so that is the portion in the fee for service that will turn into wage increases for the participant self-directed folks, and in Community HealthChoices it includes \$20 million of the state funds for participant directed Personal Assistant Services increase, and so those are the high level general notes for the budget, and so I can go to questions, and, Matt, I see you have your hand raised.

>> MATT SEELY: Am I on mute? Okay good. Yeah, this is Matt. In the beginning of that presentation, you were talking about \$51. I would really like to hear more about that for the parking enforcement fee. Can you tell me anything about that?

>> JULIET MARSALA: I'm going to have Dan Sharar expand on the \$51 parking fee.

>> MATT SEELEY: I would like to know what one fee is. Like, if I park illegally, what is the fee? How is it possible you only collected \$51?

>> DAN SHARAR: Hi, Matt. This is Dan Sharar.

>> MATT SEELEY: Hi, Dan.

>> DAN SHARAR: Hi. So, I can understand why you might be confused by that number, but just to clarify. So, on the slide for the long-term living appropriation where we note that state appropriation is supplemented by attendant care patient fees and parking fines that \$51 it is actually \$51,000 that gets -

>> MATT SEELEY: That makes sense. I understand.

>> DAN SHARAR: - to support the appropriation, and of course those, I don't know off

the top of my head, I would have to look to see what the specific fine is -

>> MATT SEELEY: No, no, you are absolutely right. I didn't, it was absolutely, it was a moment of ignorance, so I will let it go.

>> DAN SHARAR: Okay. Yep. No worries. Thanks.

>> JULIET MARSALA: Okay. Great. So, I stopped sharing my screen because we are going to questions. I did see some additional questions, and I'm happy to talk a little bit about the participant self-directed care worker additional funding that was earmarked. So, we are very excited about that additional funding. We know we certainly would welcome a lot more investment in HCBS, but I'm going to celebrate any win we get. With the participant self-directed increase to the Medicaid fee schedule, we anticipate and are striving to have that in place for January 1. It is intended to begin January 1 for time worked after January 1 of 2026. So, our fiscal team, our policy team, our operations team are working very hard to get that through and get the pieces in place to be able to do that. We have also talked with our managed care partners about the impact to the Community HealthChoices program, and they are, most certainly, also readying their teams to help us get those pieces in place. Again, it is intended for work that begins January 1, 2026. There are pieces of this that, you know, certainly where timing may be an issue, so I can not guarantee direct care workers will see increases in their first 2026 paycheck that covers that working period because there are pieces that are outside of our control such as CMS approvals to changes to our Medicaid fee schedule, et cetera. You know, there will be system updates that need to occur, but the teams are working hard to get that, those pieces in place as quickly as possible. There is analysis being done on that amount to determine what percentage that equates to in the fee schedule. All of that work is currently happening at this time. I have received several inquiries about what percent will my direct care worker be able to get, et cetera, et cetera. I do not have that information yet as that analysis is still occurring now that the budget has been enacted. We will certainly share that out as soon as we have that available.

I see additional raised hands. I guess I will go to Ahmad.

>> AHMAD ALHADDAD: Yes, I'm here. Good morning, guys.

>> JULIET MARSALA: Good morning.

>> AHMAD ALHADDAD: I have a question about the opening of the MCOs. I know there is, there are two new ones, Aetna and HealthPartners. Just kind of, I don't know if you guys have any updates about that in terms of the newer home care agencies that are trying to get into the CHC programs. You know, just, basically, are they going to be open in the next year?

>> JULIET MARSALA: So, yeah. So, I will tie that back in for you. So, those two MCOs that you put forward as the "new" MCOs, that is all tied in with the Community HealthChoices RFA. Back in August of 2024, they were selected as part of the RFA. However, if that RFA went forward to implementation, then those MCOs would be coming on board. However, there is a stay, which means currently the Community

HealthChoices RFA is working through some legal proceedings in the courts, and so there is no work happening on the implementation or changes of the Community HealthChoices program, so it is continuing today to operate under the three managed care organizations, Pennsylvania Health and Wellness, AmeriHealth Caritas/Keystone First and UPMC. That will continue on until such time as we get resolution on the procurement for the CHC program. I do not have a timeline for when that would be. I wish I did, but I don't. So, that is part of that CHC RFA process. Thank you for that question. I see - yep. Based on my hands, I see Lloyd Wertz is next on my list. So, if you have asked your question, if you could lower your hand that would be great, or maybe I can do it. Oh, I can do it. Okay, Lloyd.

>> LLOYD WERTZ: Got it. Just want you to let you know I'm here, but in addition, other portions of the state budget were not treated nearly as kindly as this one, if this could be considered kind, and if there are points along the way where services cannot be provided due to lack of funding, is there any plan within OLTL to be able to make that up in the behavioral health side or will that continue to just not be offered as part of the reality of the animals in Washington. Just wondering.

>> JULIET MARSALA: Yeah, it was tough all the way around, for sure. So, to your question, Lloyd, if I understand it correctly, are you asking that if there were, say, cuts to specific optional services on the behavioral health side, would there be opportunity for OLTL to pick up some of those services on the, either the physical health 1915B or 1915C side of Community HealthChoices? Was that what I was hearing?

>> LLOYD WERTZ: Yeah, or is there a creative way to turn those needs for behavioral health services into services that could be provided that really result in being behavioral health services on the part of OLTL. I'm just, I'm reaching for straws here. It is pretty ugly on the behavioral health side.

>> JULIET MARSALA: Yeah, no, I understand what you are getting at. So, what I would say is, there are required services in the state plan, there are certainly optional services that all states choose in their state plan, and that is true across the board where there is a core benefit that is required and then states oftentimes add and tailor additional services based on their particular state needs and resources available. If there were cuts to other programs for services, it would not necessarily be cut there, so it can be lifted up here in the LTSS system, but I would say that I think that there are some opportunities within the LTSS services and supports that perhaps could be utilized in a way to help continue to support needs and perhaps behavioral health needs. You know, counseling services being one of them that is in the waiver services, you know, as appropriate. We do have the cognitive therapy, we have behavioral therapy, things of that nature, that certainly could be looked at. Our CHC MCO service coordinators will certainly be working very hard with any LTSS participants to make sure all of their needs are met, be that within the waiver services or outside of the waiver services, and continuing to coordinate with our partners in the behavioral health system. So, are there opportunities to try to mitigate in the event that there may be service loss in other parts

of the system? We will certainly be striving to take a look at that as part of the person centered service planning process.

>> LLOYD WERTZ: Thank you very much. Appreciate it.

>> JULIET MARSALA: Yeah, yeah. Cody?

>> CODY JONES: Yes, ma'am. Going back to the participant directed stuff really briefly. I understand you haven't figured out how much the rates could potentially go up, but have you all figured out what portion of the \$21 million is going to go toward wages and what is going to go toward benefits like affordable health care and paid time off?

>> JULIET MARSALA: So, I need to be very clear here. The participant self-directed program is not standing up the benefits package. That is not, so, I can tell you right now, the \$21 million of state funding, that is going directly into the wages, the typical unemployment costs and the workforce, the workman's compensation insurance. There is not going to be defined benefit in the participant self-directed program because the program is not set up to do that. So, the majority of that funding will be directed to the wages. Very specifically, directed to the W1792 and the W1792-TU fee codes. So, when the HCBS rate and wage study came out there was a recognition that participants self-directed in their assumptions for their rate build out did not have or include assumptions for potential costs of healthcare or personal time off. So, what this \$21 million does is afford individuals that sort of additional purchasing power through a wage increase with the hopes and the intention that it provides greater affordability for them to be able to purchase off of the e-marketplace or other avenues of health insurance that is outside of any kind of defined benefit. It also has the assumption, this is part of the wage build out, you know, recognized that direct care workers in the participant self-direction did not have access to any kind of defined benefit like paid time off, so it sort of pays in advance or pays globally or recognizes that absence and puts that additional into their hourly wages, so I hope that's a helpful explanation.

>> CODY JONES: That is helpful. It just wasn't the way I kind of understood it when the governor proposed it originally, but the clarification is very helpful, so thank you for that. One last question on that. Is overtime being accounted for in how you are calculating the rates?

>> JULIET MARSALA: Yes.

>> CODY JONES: Okay.

>> JULIET MARSALA: Well, you know, in participant self-directed there is a separate billing code for overtime. When, in that rate study, if you look at the HCBS rate study, you should see notes on, you know, overtime. There is a similar assumption, and I don't know what it is off the top of my head, it is in the study, that, based on utilization, there is some overtime that is built into both the agency rate and the participant self-directed rate.

>> CODY JONES: Okay. Thank you very much.

>> JULIET MARSALA: You're welcome. Great questions. All right. Sorry, Kathy, I'm going to go to the chat to see if there is any questions there. I think Anthony House was

having some difficulty with hearing. I hope my team has been able to assist with that. I believe I addressed Brenda Dare, who had a question about the notification and participant self-direction wages. I believe I answered that, but I will clarify that, you know, this is, this work is all together so we are hoping to roll all of this out at the same time through Community HealthChoices, Act 150, and OBRA. For participant self-direction, they will get notifications through their CLE and their FMS provider. I just want to make clear that regardless of what the office of long-term living kind of rolls out with regards to changes in the fees schedule, what have you, it is important for folks to understand it is the common law employer who is the direct employer of the direct care worker that ultimately decides the direct care worker's wages or increase in wages, bearing in mind that they have to do so within the resources or funding allowable to them. So, OLTL is not going to say this person is making this much, and this person is making this much. OLTL is going to put out the new wage rate. We're going to communicate that. We are looking at ways to replicate what was done with the ARPA funding push out, but ultimately it is the common law employer's decision about wages for direct care workers within the maximum allowable rate.

All right. Paul Rimar submitted a question. Is OLTL considering a possible implementation of stronger up-front eligibility or readiness criteria for participant directed services so that potential risks can be identified before a participant is already in a compromised situation? So, very good question, Paul. The answer to that is that participant directed services, you know, are well defined within the waivers, the OBRA and CHC waivers, in particular, about the criteria of participants self-direction, and a large part of determining whether or not that model is most appropriate is between that work between a service coordinator and the participant, and so with regards to implementation of a strong up front eligibility or readiness criteria, the answer to that is, no. OLTL is not looking at strengthening that at this time because the criteria is pretty clear. I would recommend that, as with all services, I think where we can have an area of opportunity is really as much as possible trying to strengthen emergency backup plans and certainly if there are situations where a participant is in a position of self-neglect or abuse or exploitation, you certainly know the pathways of how to report that, but if a participant wants participant self-direction and has the capacity to direct their own care or have a third party CLE support them to those effects, they have a right to attempt that service, they have a right to attempt that service and potentially fail, and it would be our duty to try to ensure that they have backup plans and alternative pathways in that event.

Leslie Gilman asked, any chance of rate increase for adult day per the rate study? There was not any additional allocations for any increase on the fee for service Medicaid schedule for adult day, so with regards to the Medicaid fee for service rates, there is not a planned rate increase for adult day.

Jeff Iseman asked, many individuals with physical disabilities and seniors in OLTL HCBS programs switch back and forth between consumer and agency models of care.

Will this increase help that population during this current year? So, the increase is coming into effect January 1, 2026, so for the remainder of 2025, I would say no, but in 2026, certainly I would imagine that wage increase would be welcomed by the individuals and their direct care workers. I'm not sure if I answered the question as intended, Jeff, but certainly throw another one in the chat if I have not.

From Diane Roth, assuming OLTL and DHS more broadly is working on fiscal year '27 budgets, are you anticipating reduced funding for LTSS due to the pressure on the state from the federal Medicaid cuts and changes? We, you know, at the beginning, at the passing of HR1 and OB3 by the Trump administration, we anticipate that there will be \$20 billion in cuts over the next 10 years, so we do anticipate, you know, that there will be Medicaid cuts and changes coming down the pipe. We are still waiting to learn more from CMS on sort of the impacts of some of their changes as a result of HR1 and OB3. I just want to highlight out there that oftentimes when something comes out like a final rule or a change from the federal government, CMS usually puts out additional guidance to the states to help us further understand the implications to our Medicaid programs. We have not received that additional guidance yet from CMS. We don't anticipate receiving that guidance until the summer, though CMS has indicated that they are going to be putting out rolling guidance. Rolling guidance is a little unclear to us as a state. That is sort of a new term. We are not quite sure what that rolling guidance will look like or what it will entail, so we are kind of still in a little bit of a holding pattern with regards to truly understanding the full implications to the Medicaid and Medicare programs for our purposes from the federal level, but certainly we will share that on, but thank you for bringing that up.

Going to the next question. Will Stennett. When the department submits its new waiver amendment this summer, will remote support for benefits counselling be included? Use of remote support for benefits counseling will make the service more accessible to a wide range of individuals, including those who might have been hesitant to seek help due to social stigma or other barriers. Remote support for benefit counseling offers several advantages, including increased accessibility, convenience and privacy and allows individuals to receive support and guidance through a benefits counselor without leaving their homes, which can be particularly beneficial for those living in rural or remote areas. The flexibility of virtual sessions also makes it easier for individuals to fit sessions into their busy lives, reducing waiting times and the need for transportation, and the Social Security Administration has adapted its approach to benefits counseling by utilizing remote support, and I believe OLTL should, as well, and, Will, thank you for that comment. We are certainly supportive of both benefits counseling and remote support, as many of you may be aware. If you are keeping track of the timeline, the OBRA waiver renewal is due. The OBRA waiver, the current OBRA waiver sort of ends June 30th and then needs to be renewed for July 1, 2026. We are currently working on that, and certainly remote supports for benefits counseling is an area that we are looking at, so we are most certainly welcome taking this feedback back. Thank you for

raising it, Will.

Lynn. Sorry, Lynn is a committee member, so I'm going to go back to Lynn. I'm sorry to keep you waiting, Lynn. You have your hand up?

>> LYNN WEIDNER: Yeah, no worries. I just wanted to say, like, as a participant directed worker, I really appreciate the investment. It honestly is going to offset the increase for the Affordable Care Act health insurance rates and make it so I can continue to purchase my insurance through Pennie. That being said, I also want to acknowledge that the agency side, obviously, all direct care workers in the state deserve to have increased rates, as well, so we are going to continue to keep fighting for increased funding across the board across for the entire, you know, universe of home care, but just wanted to acknowledge we really appreciate, like, the hard work that was done in getting this increase this year.

>> JULIET MARSALA: Thank you, Lynn, and thank you for your continued education and advocacy for our direct care work force and HCBS.

All right. Kathy, I'm going back to you. I think I addressed everything.

>> KATHY CUBIT: Thanks, Juliet. You really got through a lot in that amount of time, and thank you for all of that information and for everyone's input.

So, we are going to move on now to our first guest speakers who will talk about the direct care worker and home health aide training program. We have Mia Haney and Rebecca Jacobs from the Pennsylvania Homecare Association, and welcome, and the floor is yours.

>> MIA HANEY: Thank you so much. Can everyone hear me okay?

>> KATHY CUBIT: Yes.

>> SPEAKER: Yes, I can hear you.

>> MIA HANEY: All right. Wonderful. Thank you so much to everyone for allowing us to present today and give you an update on the direct care worker and home health aide training programs. We are really thrilled to be here, and we are also, you know, very thankful to the Department of Labor and Industry. So, just as a reminder to everyone, back in, I believe it was 2024, the Department of Labor and Industry announced a grant opportunity for direct care worker quality grant, and we were fortunate to be able to receive those grant dollars to provide funding for direct care workers through this training program. So, that is really what we are giving you an update on today is the progress that we have made, and we are really looking forward to getting your feedback and also having your participation in the grant. We would love for you to support getting the word out there that this is available and that it will continue to be available into 2026. So, that being said, if you don't know who I am, my name is Mia Haney, and I'm the Chief Executive Officer here at the Pennsylvania Homecare Association, and the woman behind all of our grant efforts is Senior Director of Workforce Development, Rebecca Jacobs, Becky, as she likes to be called, and she is going to present our presentation today, so I will pass it to you, Becky.

>> KATHY CUBIT: Becky, you need to, oh, I see it looks like you are having trouble

unmuting.

>> JULIET MARSALA: It looks like there is an issue with your audio, so I don't know if your setting is correct. If you look at the cogwheel on the top right, you'll see under audio you have the option of computer or phone or no audio. It looks like your no audio might be selected.

>> MIA HANEY: Becky, while you work on that, I can get us started, and if we can get you unmuted then I'll pass it back to you. Does that work?

>> JULIET MARSALA: I do not know if she can hear us because it looks like the audio is completely turned off.

>> MIA HANEY: I lost the presentation, too. Are you still seeing the presentation, Juliet?

>> KATHY CUBIT: No. This is Kathy. We did lose the slides.

>> REBECCA JACOBS: It would not let me unmute myself. I apologize. Can you hear me now?

>> KATHY CUBIT: We can hear you now, and we have the slides back.

>> REBECCA JACOBS: Wonderful. So, we both have technical difficulties. Thank you.

>> MIA HANEY: I do not see the presentation. I apologize. I see the Office of Long-Term Living updates. I do not see the Department of Labor. There we go.

>> REBECCA JACOBS: Hi, everyone. I apologize for that. I was not able to come off mute, so I apologize. Again, my name is Becky Jacobs. I'm the Senior Director of Workforce Development, and I am so excited to talk to you about the grant today. If you want to go to the second slide.

So, in 2024, when we were awarded the Department of Labor grant for the direct care worker job quality initiative, we launched a direct care worker training program to feature direct care workers as well as home health aides and to provide a track for direct care workers to get trained and to further their training and further their experience with in home care.

So, on the next slide, our program goals were to focus on improving and fostering competency development, safety and compliance, empowerment, person-centered care, and continuous learning. Through that, we were hoping to see improved recruitment, retention, job satisfaction, and quality care. So, our two tracks are the direct care worker track as well as our HHA track. We are going to go through everything that was going through our grants starting with our My Learning Center.

My Learning Center is, oh, the next slide. So sorry. My Learning Center is at the heart of this grant. My Learning Center has been around since 2010. Since 2010, over 17.5 million learning certificates were issued, but we wanted to update this into the 21st century. So, we wanted to have a new improved look and functionality, and part of our grant was to get this up and running and make it smoother for our learners. My Learning Center is free for every learner across the state of Pennsylvania and beyond. Through our grant, we were able to add five new learning center videos. Career pathways for direct care workers, home based cares influence on social determinants of health, improving health outcomes through home-based care, the importance of being a

caregiver, and you have got the job, now what? Part of our upgrade was to also add subtitles for every video in Spanish so that individuals can learn in their native language. My Learning Center meets the Department of Health competencies and the Office of Long-Term Living annual competency requirements minus the competencies that are agency specific that need to be reviewed for Office of Long-Term Living. We have 89 learning center videos, we have 17.5 hours of content and this number is a little outdated. We just passed the half million mark on how many videos were watched, so that is really exciting. Right now, we have 59,000 active users in the system and that grows every day.

So, that is just a sneak peek of what it looks like. We welcome anybody to use the platform. It is free to sign up. It is super easy to engage with, and you get certificates as you complete the training. You can not fast forward the training. You have to watch the training and take a quiz at the end for your certificate.

So, the next slide.

>> MIA HANEY: Becky, I just wanted to celebrate that we have had 59,000 people use this platform in 2025 alone. That is since we relaunched in February with our new look and feel. It is a far more seamless experience, it is very professional, it is mobile friendly, and 59,000 users are in there using it every day, so I am really proud of that number, and I think that Pennsylvania should be proud we have a system that is being utilized to that extent.

>> REBECCA JACOBS: I could not agree more, and I believe when I calculated the numbers recently there has been over 250,000 individuals over the course since we went live in 2010 that have used My Learning Center. So, the fact that we still have about 60,000 still active in the system is just a testament to the platform. I am so excited.

So, our first track is the direct care worker track. This is for individuals that are seeking employment, new to home care, home health or hospice. We are looking really for them to be in the industry less than 6 months. The grant is very, the track is very easy for them to participate. They complete an online grant application. They can do it on their phone. They complete the learning center videos, which is all of the learning center videos, they accept a job or continue with their job in home care and work at least 40 hours and then complete a satisfaction survey at the end and tell us how they did. How was it? What did they learn? Right now to date, we have had over 99 individuals complete the track. There are 350 plus individuals in process right now and over 1700 hours of learning center videos just completed by this grant. If they complete this grant successfully, they receive \$300 direct deposited to their account, which is amazing. So, that is our first track, and we wanted to kind of share what the feedback has been on that track. So, on the next slide, we have summarized a little bit about what their experience is. So, right now, the lowest score out of everything that we have been doing is rating their mentorship experience with the average score of 3.83. We can only go up from there and build programs to make it better, but, really, what we are seeing is that

they do feel prepared for a career in home care. They feel that their hours worked with the agency were great. The My Learning Center videos, they thought were wonderful at a 4.7 out of five stars. They are looking for future training at 4.8, and then the big one is that our net promoter score is 8.85, so we have direct care workers right now that are referring other direct care workers to the program. So, when I see the applications on, hey, how did you hear about us, I often see somebody's name that is another direct care worker, which I find really fascinating and exciting that once somebody goes through it they are referring somebody else. The overall track rating is a 4.79 out of five stars which is really exciting to see just with this first initial group that has gone through the platform.

On our next slide, we will go through the home health aide track. The home health aide track is going to look - go ahead.

>> MIA HANEY: Yeah, I just wanted to clarify that every single direct care worker who goes through the track has to do the satisfaction survey, so they cannot receive their payment until that is done, so those results are aggregate of every single person who has completed the track, so that is 99 folks and all of those ratings were out of five stars with the exception of the one where we specified it's out of 10, so really happy with the results, you know, with the direct care worker experience is the most important and critical feedback that we get, and we are using, you know, those results to enhance and inform what we do as a group. We do have some of our providers as part of our work group to look at these results and tweak how we move this forward into the future, so really appreciate all of the feedback they have been giving us.

>> REBECCA JACOBS: Absolutely. Thank you so much, Mia. So, for our home health aide track, it is very similar to the track we just went through for the direct care workers, but we are looking for a desire to increase skills. These are typically individuals who are currently employed by a home care, home health, or hospice agency or pending employment in one of these. The only difference in this track is that they have to complete 16 hours of face-to-face training overseen by a registered nurse that is part of the federal guidelines for home health aide training. That 16 hours is hands on in the classroom, understanding how to use a Hoyer lift, understanding how to use an oxygen tank, proper body mechanics. It goes through everything, and it is an intense two day training for these individuals.

I was so excited that we have had more people interested and completing the home health aide track than we did for the direct care worker track and it requires more training. Right now, we have had 144 individuals successfully complete the track with 160 plus in process. The number of learning center videos, or hours of videos they have watched, is 2520, and then the hours of face-to-face training that they have completed is 2304. That is a significant amount of training for these 144 home health aides. What they are reporting back to us on the next slide is staggering. They loved the program, and I am excited to share these numbers with you. As you can see, we were a little bit low on the direct care worker track with the mentorship experience. We jumped to a 4.9

out of 5, which is huge. What that shows us is that they value the in-person training, they value their mentorship experience, they include that in that experience of having mentorship, as well. Their overall satisfaction in preparing for the field is a 4.88. Overall satisfaction with their agency is a 4.92. Overall satisfaction with My Learning Center is about the same, 4.84. Their classroom training is a 4.9, so we are really in the high numbers, and then their likelihood to recommend the program is again a 9.24 out of 10. Our net promoter score for the home health aide track is exceeding our direct care worker track, and again, I see it all the time. Aides are referring aides to the program to, you know, get more training and to get into the industry. I have seen TikTok videos made. I have seen all different exciting things to get individuals excited about caring for others in the field.

So, the last part of our training platform is our employer. So, on the next slide, we have our home health aide training sites. So, we identified and had agencies apply to be a home health aide training site. Based off the federal guidelines on a 4.8 condition of participation, and these, we went an extra step. We wanted to make sure these classrooms were a good size, that they had all the durable medical equipment that they needed to provide a great hands on in-person training. So, all of these training sites that were approved, we have right now, I think we are just nearing the over 30 mark of training sites that were approved in the state of Pennsylvania for us. We wanted to make sure that they were able to provide a great training site and great training experience. So, these sites are integral for our HHAs to get trained. We also wanted to get their feedback. So, the last slide is our employer survey feedback. So, we have two different employer surveys that go out, a direct care worker track and then an HHA track, and basically what we are seeing is really great reports of numbers from our employers. So, overall, we are at 100 percent of course working the first shift and working 40 hours. The direct care worker track, we are at a 91.3 percent rate of individuals still employed, which is huge when you are considering the turnover numbers in the state of Pennsylvania and nationally at like a 79 percent if not higher, and then on the HHA track with are at 97.8 percent, so we are seeing that increased training actually keeps them retained longer, so we are excited to see how that plays out as the grant continues and how we get more individuals involved. So far, we have had about 8.7 percent receive a pay raise in the direct care worker track and a 17.2 percent pay raise in the HHA track. This is the one that threw me off a little bit. There are more call offs in the home health aide track versus the call offs in the direct care worker track, but only by about an average of one day. Overall, they are rating the effectiveness of the training, you know, 4.5, 4.8 out of five stars, and the overall satisfaction that they are having, our employers with the program, is a 4.59 and a 4.90 for the HHA track. So, these were really great feedback numbers for us, and we are excited that we did receive an extension to make sure that we can get more individuals engaged with the program and that this is going through the end of September. So, it has been really exciting to see our direct care workers and home health aides engage. I

have received numerous calls and e-mails saying how the funding has helped them pay their bills, it has helped them stay engaged longer, it has helped them, you know, really fill that void of, you know, their low pay rates due the reimbursement rates in the system.

So, are there any questions, or, Mia, do you have anything else to add?

>> MIA HANEY: Becky, I would just add that we did do interviews with some of the employers regarding the pay raises received and the feedback we largely received was that folks were within 30 days of employment, and so they were still kind of within that 90-day probationary and our surveys were early on, so that indication of pay raise will likely go up as we survey later on into their employment.

>> REBECCA JACOBS: Absolutely. That is all I have today. On the next slide, I do have our contact information. If you guys have any questions about the grants, I am happy to answer them, but I really appreciate the opportunity to come here today and present with you guys an update on how the grant is doing.

>> MIA HANEY: Becky, we have stipend availability into 2026 now, so we're really hopeful that folks will help share the news that this is out there, it's available and that we are paying these \$300 and \$500 stipends. Our grant is statewide, so there is no county restriction, and it is for new direct care workers and new home health aides to the industry, and we really wanted to focus on folks that are new because we know that we need to bring more people into the industry and strengthen that pipeline.

>> KATHY CUBIT: This is Kathy. I want to thank both of you for this great presentation and program, and I hope you can get funding beyond September even because certainly this is the type of program that will be needed in the future. I will open it up to any questions or comments from members first.

>> REBECCA JACOBS: Kathy, thank you. You read our mind. We absolutely would love to get this continued.

>> KATHY CUBIT: I do not see any hands raised, but is there anything in the chat?

>> JULIET MARSALA: There is a question from Elizabeth R who asks, can any caregiver do this and be compensated? Thank you.

>> REBECCA JACOBS: Great question, Elizabeth. So, technically, yes, as long as they are newer to the industry, that they can participate and that they can show proof they worked 40 hours with an agency. We look for a paystub or a written letter from the organization that has hired them to confirm they have worked the 40 hours. So, short answer is yes, but if you have specific questions about yourself or an aide, I would be happy to speak offline with you.

>> KATHY CUBIT: Lloyd, it looks like you have your hand up. Go ahead. The floor is yours.

>> LLOYD WERTZ: Thank you for your presentation. Great presentation. I think I heard a little bit from you folks before and asked about any training that might fix the behavioral health issue that might be experienced by the people receiving the service, and I don't remember what that response was. I think it was positive, but can you tell me

if there is and, you know, kind of focus on what that is? Thank you.

>> REBECCA JACOBS: Absolutely. So, we have several videos within the My Learning Center platform that focus on behavioral health, mental health, dealing with different behaviors, aggression, Alzheimer, so we do have several videos that do touch on that, and with the aides taking every video they are going to receive training specifically on behavioral health.

>> MIA HANEY: Lloyd, I will do a shameless plug that we would love to partner with managed care organizations or other entities who would like to create new videos for specific specialized areas. We tend to add 5-10 new videos per year, and we are always looking for partners to work with us and support us in doing that. We have become very efficient at creating new videos and cost effective, so anyone who is listening and is like, oh, we would love to see this particular disease process or behavioral health, please reach out to Becky or I. We would love to talk with you.

>> LLOYD WERTZ: Thank you.

>> REBECCA JACOBS: Thanks, Lloyd. Thanks, Mia.

>> KATHY CUBIT: Any other questions from members or anything else in the chat?

>> PAULA STUM: This is Paula. There is a question in chat from Nicholas. What is the total training hours completed through the HHA track?

>> REBECCA JACOBS: Absolutely. So, the total hours completed, so, 2520 hours of virtual training, so that is the My Learning Center training, and 2304 hours of face-to-face training. So, combined, you are at a little over 4800 hours of training just in that home health aide track for those 44 individuals.

>> MIA HANEY: That is roughly 75 hours per individual, Becky?

>> REBECCA JACOBS: So, the 75 hours, we say 40 hours of actual practical training work, as well, is not included in that figure, so it is not totally, like, reflective of that 40 hours of, like, hands on supervised training in a participant's home, so that is not included, that is just the face-to-face 16 hours and the roughly, like, 19 hours of My Learning Center with all of the quizzes they have to do.

>> MIA HANEY: Thank you.

>> KATHY CUBIT: Paula, is there anything else in the chat?

>> PAULA STUM: Hi, Kathy. Nothing pertaining to the presentation, however, when we get to the public comment section, I do have some questions.

>> KATHY CUBIT: Thank you. I just had a quick question since there is a little bit of time in regard to My Learning Center. I am curious if, I know at one point it was always open to unpaid caregivers, as well, and I know it was always a tremendous resource. I am wondering if that is still utilized and if the CHC MCO service coordinators are aware of and connect unpaid caregivers to this important valuable resource?

>> REBECCA JACOBS: Thank you for that. Great call out.

>> MIA HANEY: Great question.

>> REBECCA JACOBS: The answer is yes. 100 percent yes. It is open to every learner who would love to learn. Paid caregivers, unpaid caregivers, family caregivers. We have

individuals that are in nursing homes that take our videos. We have individuals from hospital systems. Based off of what I am seeing, the primary is home care aids that do take our videos. We were recently featured in the care kit from the Aging Office, and it was featured as professional caregiving as well as family caregiving for several videos. We are definitely trying to get the word out that we want as many individuals who would like to learn, use the platform, to be engaged with the platform and if they need any assistance they can absolutely reach out to me.

>> KATHY CUBIT: Thank you for that, because I know that the challenges and often unpaid caregivers are not aware of getting this kind of training and support, which can make a big difference for them and the person they are caring for, so thank you for that.

>> MIA HANEY: We are very excited to partner Nathan and Gabby with the Department of Aging to get those videos into the care kit to bring awareness that this is for any caregiver, whether they are a family member, whether they are participant directed, agency directed, this is for all direct care workers.

>> KATHY CUBIT: Thank you both. Any other questions that either came in the chat or from members before we stop for a 10-minute break?

>> PAULA STUM: Hi, Kathy. One more question here from Nicholas. To be more specific, does the HHA track fulfill the requirement of 75 hours of training needed for an HHA per 42 CFR 484.40?

>> REBECCA JACOBS: Great question. I am happy to say, yes, 100 percent. So, that is how we designed the track is based off of the 484.80 condition of participation for the home health aide federal regulations, so it has, the track is specifically built around those regulations, and the home health aide training sites have to agree to follow all of those regulations, as well. Really great questions and feedback. I appreciate it.

>> KATHY CUBIT: This is Kathy again. I want to thank you both again for the presentation and this great work, and thanks again for joining us today. With that, we will take our 10-minute break, and we will come back together again at 11:35 for our next presentation on oral health care. Thank you.

>> KATHY CUBIT: Hi, this is Kathy. I want to welcome everyone back from our break, and we will proceed now to our next presenters on the topic of oral health care for CHC participants. We have Dr. Preddis Sullivan from AmeriHealth Caritas/Keystone First, and then we will have Dr. Jeffrey Fike from Pennsylvania Health and Wellness and then finally Kristin Fisher and Richard Celko from UPMC HealthChoices. So, with that, we will move on to Dr. Sullivan, and the floor is yours.

>> DR. SULLIVAN: Good morning, everyone. Can you hear me?

>> KATHY CUBIT: Yes, we can hear you.

>> DR. SULLIVAN: Okay. Very good. I got a little nervous there when I did not hear anybody answer. I was like, oh no, am I having technical difficulties, too, so thank you. Thank you for that.

Well, as mentioned, my name is Dr. Preddis Sullivan. I am the Dental Director for

AmeriHealth Caritas/Keystone First. I oversee the Community HealthChoices program. Next slide, please.

In the presentation today, we are going to cover three quick basic questions. What dental or oral health care benefits are CHC participants entitled to receive? How do we, meaning AmeriHealth Caritas/Keystone First, ensure participants are receiving oral health checkups and care and are there any access related issues to provider shortages. Next slide, please.

With respect to benefits, there are quite a few. With respect to diagnostic services, some of those diagnostic services are oral exams and x-rays. Preventive services, cleanings, application of caries arresting medicament, which basically you may have heard of in a silver diamine fluoride. This medicament allows the provider to see an active cavity, place this medicament on that cavity to stop the progression of that cavity, and in the CHC population this is very effective as it can treat caries that are at the roots of the teeth as well as cavities within the teeth themselves. Also, benefits are oral hygiene instructions and nutritional counseling. With respect to restorative services, both silver and tooth-colored fillings are covered, crowns as well as dentures, both full dentures as well as partial dentures. Root canals and deep cleanings are also a benefit. Next slide, please.

Also, oral surgery services, both simple and surgical extractions, wisdom teeth extractions, as well as, God forbid, someone has an abscess, the drainage of that abscess is also a covered benefit. For CHC participants, orthodontic services are covered through age 23 only. There are no adult orthodontic benefits. With respect to anesthesia, general anesthesia is covered with approved oral surgery procedures, conscious sedation is approved with certain oral surgery procedures, and a relatively new benefit is sleep apnea appliances. So, basically, if you suffer from sleep apnea, you have been tested, the dentist or the provider, and you cannot tolerate the CPAP machine, the dentist can help you by fabricating sleep apnea appliances, oral appliances, that will help treat your sleep apnea. With those comprehensive benefits there really are no gaps in coverage for our CHC participants. That is a truly comprehensive oral health and benefit plan. Next slide, please.

So, the question is how do we, AmeriHealth Caritas/Keystone First, ensure participants are receiving their checkups and care? We do secret shopper calls to verify adequate appointment access, and we monitor complaints, grievances and appeals to identify and address access barriers. So, for those participants, you know, I can not get in, we monitor this and then we will act accordingly either by calling the office and seeing what the issue is. We act as the advocate for the member when we get these complaints and grievances, and we look to make sure that they can always get the proper access to our general offices. Next slide.

One of the questions is, are there any access issues related to provider shortages? We use a program called GeoAccess, and what GeoAccess basically is, it is a report or analysis that demonstrate the accessibility of providers within the network. It is based on

certain criteria. In this instance, it is based on specified travel times. For example, 30 minutes for urban areas, 60 minutes for rural. With respect to AmeriHealth Caritas, the urban area 99.9 percent of participants have access to two general dentists within 30 minutes. In rural, 100 percent of participants have access to two general dentists within 60 minutes. On the Keystone First side, since it is all urban, there are no rural areas in the Keystone First geography, it is 99.9 percent of participants have access to two general dentists within 30 minutes. So, while GeoAccess is consistent with the contractual requirements of our CHC agreement, many providers are experiencing staffing shortages, with staffing shortages with dental assistants and dental hygienists. So, that may increase the wait time some of our CHC participants are able to get, but, you know, it is not something where it is a year out. It may be, you know, instead of a month, it could be three months. but it is all due to staffing shortages, which are hitting everyone not just AmeriHealth Caritas, not just Keystone First. It is all dental offices that are experiencing these staffing shortages that occurred since the COVID epidemic back in 2020. Next slide.

So, that is the presentation for AmeriHealth Caritas/Keystone First. I thank you for your attention. Are there any questions?

>> KATHY CUBIT: Thank you, Dr. Sullivan. This is Kathy. We are going to hold questions until after the other two MCOs give their presentation to be sure of our time. Hopefully you can stay on and answer any questions at that point. So, we will move on now to Dr. Jeffrey Fike from Pennsylvania Health and Wellness. The floor is yours.

>> DR. FIKE: Good morning, everybody. I hope you can hear me. I also hope you had a nice holiday.

>> KATHY CUBIT: We can hear you.

>> DR. FIKE: Thank you. First slide, please. Oh, I'm sorry. My name is Jeff Fike. I am the Dental Director for Pennsylvania Health and Wellness. Today, I am going to talk about PA Health and Wellness dental benefits and some programs. Next slide, please. This slide lists our review of the available services. They include oral evaluations, which are examinations, dental x-rays, teeth cleanings and other preventive dental services, fillings, including tooth-colored restorations, crowns, root canals, gum care, which is periodontal services, including deep cleaning, dentures, full/partial dentures, repairs, realigns, adjustments, extractions, including impactions, sedation and anesthesia when medically necessary, and emergency dental care. I would just like to say that all services listed in the Medicaid fee schedule are covered by PHW. Next slide, please. This slide shows our value add, PHW value add dental benefits, kind of above and beyond. This includes free oral hygiene kits, and this has recently been upgraded to include a full-sized tube of toothpaste. We also, for nursing facility, clinically eligible participants have an additional thousand dollars per lifetime denture benefits above the regular denture benefits. At the very bottom, I included a statement just talking about Medicare may cover additional dental services. This is for those participants with a D-SNP as primary coverage. The D-SNP dental benefits usually include additional

services that Medicaid may typically not cover. So, it is very important in this population, those with a D-SNP, to make sure they access their primary benefits through their D-SNP dental benefits. Next slide, please.

I just added some what I consider important notes on this. For services that are not listed on the Medicaid fee schedule or that exceed limits that are not in the Benefit Limit Exception (BLE) process, the dentist can always submit an 1150 waiver or a program exception request to the plan for review. This is done by MA97 attached to the authorization request. Some of the services I talked about previously have limits, may need a prior authorization or may require a dental benefit limit exception. Just to verify, nursing facility residents do not require BLEs for dental services. Next slide.

I would also just like to take the opportunity to talk about some pretty significant changes recently to the benefit limit exception process, and, as a quick review, I am sure everybody on here is familiar with the BLE. So, if you are not in a nursing facility, you need a benefit limit exception approval for a crown, a root canal, different periodontal services, and additional dentures above the one per lifetime benefit. The BLE criteria are always an exception if the service would jeopardize the life of a participant, result in the rapid serious deterioration of the health of the participant, service is cost effective for the Medicaid program or conflicts with federal law. However, recent changes are DHS has determined that having any one of the qualifying conditions listed on this slide, diabetes, cardiovascular disease or risk of it, cancer of the face, neck, or throat, intellectual disability, pregnancy, including postpartum, these fulfill the BLE criteria and the authorization should then be reviewed for clinical medical necessity. For Pennsylvania Health and Wellness specifically, if your dentist lets us know on the BLE request form you have any one of the qualifying conditions, the request is immediately moved to clinical review for medical necessity. This also includes a new benefit limit exception form that is out, and it actually has check boxes indicating any of the five qualifying conditions. Next slide, please.

A little bit about some PHW dental programs. We have a personal assistance services dental incentive program. The PAS agencies get a financial reward for helping participants get dental care. So, what this comes down to is when the PAS worker helps a participant make an appointment, get to an appointment, anything related helping our participant get to or receive dental treatment, and this is noted, I do believe it is HHA, and we verify with the claim, the PAS agency receives a provider incentive, a financial incentive, for this. Also, in training, service coordinators and care managers get yearly training or dental services and benefits. For participant education, we include a dental health article in all of our newsletters and at community events for the participants. The most recent talks about diabetes is nothing to smile about, and it discusses the effects poor oral health have on diabetes and the effect diabetes has on oral health. We also like to get involved with the medical-dental connection with the PCPs. We have sent out notice to the PCPs regarding how important it is and how good dental care impacts physical and mental health overall. We are also improving our find a provider tool in our

dental search for a dental specialist. I just noted here, too, there is a fee increase noted in the Community HealthChoices agreement for January 2026. This is not specific to PHW, obviously. This is in the agreement, and I am sure it will be fulfilled by all plans. Next slide, please.

On my last slide today, I am going to talk a little bit about network. The first bullet here I have a quote. "Pennsylvania (PA) continues to struggle with a return to pre-pandemic dental workforce levels. PA dentists are working less hours per week than the previous decade and maldistributed to urban areas." This is a quote from the PCOH Access to Oral Health Workforce report. I would just like to say this is not specific to MA (Medicaid), but it does exacerbate the condition of Medicaid trying to build dental networks. We also talk about workforce on here. It is not only dentists. There is a workforce issue with dental hygienists, with assistants, I think Dr. Sullivan indicated this in his previous presentation. This is across the table. Any oral health, you know, worker, there are shortages, and it definitely is an issue. The Pennsylvania Coalition of Oral Health hosted an oral health summit earlier in November in Harrisburg, and the discussion was dominated around dental shortages, workforce, access issues and everything related.

So, in PHW, we are continuously looking at more dentists in underserved areas with focused outreach to meet regional needs. We monitor any gaps in coverage on a weekly basis, utilizing Quest Analytics for time and distance parameters. We routinely check PROMISe for any new dental providers. We look at other MCO provider directories. We review any of our out-of-network requests. We geographically target internet searches for new dentists or just dental offices in general. Once we have compiled a list, we contact the dentists we have identified to discuss about participating with the plan. For specialists, especially in rural areas, we do offer high reimbursement rates and reduction in prior authorization requirements to entice them to join the network. Dental network build is always in process. That is my presentation for now.

Thank you.

>> KATHY CUBIT: Thank you, Dr. Fike, and with that we will move on to UPMC, Kristen Fisher and Dr. Richard Celko. The floor is yours.

>> DR. CELCO: Good morning, everyone. Can you hear me?

>> KATHY CUBIT: Yes, we can hear you.

>> DR. CELCO: Okay. Great. Next slide, please. Okay I think we saw these same questions in one of the other presentations, so what benefits are available? This comes right out of our UPMC benefit grid, and basically it is straight from Pennsylvania DHS website and what is covered and what is not covered. Braces, like Dr. Sullivan mentioned, are not covered, but there are dollar amounts available for anything that is not covered, and I will cover that in an upcoming slide here in a minute. The same services Dr. Fike and Dr. Sullivan presented are covered just like they mentioned. Next slide, please.

Including what is covered, the dental cleanings, dental emergencies, restorations,

impacted teeth, like wisdom teeth, impacted tooth removal there, and simple and surgical removal of teeth. Next slide, please.

As the other presenters mentioned about the benefit limit exception, that is a special request if the limit has been met or if it exceeds one of the other frequency limitations. Certainly, each one of those is looked at on a necessity basis, including those parameters Dr. Fike went over, cardiovascular disease, pregnancy, intellectual disability, cancer. Those are all taken into consideration, and our process is very similar where it goes for once any of those conditions are identified it goes on for the necessary clinical, medical, dental. Next slide, please.

Some services that are not covered include the root canals, crowns and related services. They can be considered with the appropriate benefit limit exception form submitted and they have one of the conditions that would meet that. Go ahead, next slide, please.

Are there any questions so far? Kristen can you take it from there? Okay. No problem. Again, CHC will approve the benefit limit exception, just like Dr. Fike mentioned there. The serious chronic illness that would worsen, if it is a more expensive treatment and certainly if it is against federal law for UPMC Community HealthChoices to deny the exception. These are very common in the contract language in the CHC contract there. All right. Next slide, please.

As, you know, maybe this is already getting repetitive there with the BLEs, the diabetes. Certainly, we have a high volume of membership that have diabetes and coronary artery disease. The cancers of the face are very limit and it has the to be a Stage 0 or 1, noninvasive basal or sarcoma cell cancer of the skin. The intellectual disabilities. There is a whole ICD 10 classification that is used to identify members who fall into that category. For any of the services requiring a BLE that are not covered or that is denied, our participants have a \$500 allowance to use for those services. Go ahead. Next slide, please.

Kristen are you on? Are you able to address these? I just got a text that she is having a challenge getting some technical issue there. So, how do the CHC-MCOs and service coordinators ensure participants are receiving oral health care? Next slide, please.

Here is how they do that. We have service coordinators that work with our participants. They ask certain questions, like when the last dental exam was and assist them in getting into our providers, having, if there are other maybe social determinates of health issues such as transportation, they work with them to get that arranged, so we work with our providers in scheduling. Some patients need, you know, require earlier appointments. We work at their convenience and try to work with the providers to make sure that everybody's schedule is, you know, meets their needs. So, next slide, please.

Again, for our members who are living in nursing facilities, as Dr. Fike mentioned, the BLE is not applicable for that. There is some access. We have some residents from the University of Pittsburgh that address some of our nursing home facilities and our service coordinators who also work with our nursing facilities and obtain dental service for those

members in there. We do have some dental providers in certain areas throughout the commonwealth that provide onsite dental services in nursing facilities. That is a great benefit, and like I mentioned, the University of Pittsburgh School of Dental Medicine has a program who handle for the residents to address some of the complex needs when our members are having difficulty accessing care. These are already licensed dentists who are in their specialties or studying in their specialties. Next slide, please.

Some of the data, the questions from the nursing home. The minimum data set. This is what they ask about. Broken or loose teeth, no natural or abnormal mouth tissues, obvious or likely cavities, broken or natural teeth, mouth or facial pain, discomfort or difficulty chewing, or unable to examine, so just some basic, you know, just a basic survey of what the oral status is. Go ahead. Next slide, please.

For our participants who are in nursing facilities ineligible, we have telephonic care managers who ask questions on oral health during the risk assessment evaluation, and assistance is offered to help secure a dental evaluation for any participant who rates their dental health as fair or poor. We stratify those who have perhaps the most urgency or most complex cases and work to get them in or get them access so their dental needs are met appropriately. So, next slide, please.

Just a simple, this is an example of our questions for the health risk assessment. Just wanted to make sure everybody, you know, has an idea of what we do ask and how many questions there are. Go ahead. Next slide, please.

Are there any issues related to provider shortages? Yes. Next slide, please.

One of our shortages is, and I think this has been covered by other presenters, oral surgery and other dental specialties have always been, not just for medical assistance or Community HealthChoices or the HealthChoices products but for commercial and dentistry in general, like mentioned previously, workforce shortages, having lack of assistants, lack of hygienists and the corporate entities that come in that basically try to pick out providers as well as auxiliary staff from Medicaid practices or primarily Medicaid practices, so they entice them away with higher salaries. I think that is one of the common themes through our presentations is that coverages, you know, the reimbursement rates dictate a lot of where the auxiliaries are going, and they are going for sometimes fee for service or straight, you know, cash or commercial practices rather than staying in FQHCs or Medicaid dominated or government program dominated practices, which is very unfortunate, but it is not just with Pennsylvania. It is throughout the commonwealth of Pennsylvania and all other states. This is a nationwide issue, not just localized to our state. So, this is how they handle it. Our benefit manager proactively addresses the concern, monitors network adequacy with the GeoAccess previously mentioned and use data driven results including directories promise files and we contact some of the dental schools to see if any dental graduates or upcoming graduates plan on staying in Pennsylvania. Many of the dental schools unfortunately take out of state students and then these students go back to their home states or other locations for whatever reason and that limits the supply of dentists in Pennsylvania. The

dental schools do that for the enhanced tuition or the out-of-state residency and the tuition that brings into those schools. However, it really challenges the dental access throughout the state. So, if we do have an issue that we can address, if we have no in network providers, we will work with an out-of-network provider for case arrangement or single case agreement and with the hopes of enticing them to become part of our network, either through an incentive or some type of arrangement that they would, you know, maybe a reduction in prior authorization for certain procedures if that is their specialty so they can address our patients because many of them are having difficulty. Many patients are having difficulty being seen within timely standards. However, I know offices that are already scheduling into April of 2026, so it is very, it is very challenging. Certainly around the holidays, many of the college students are coming in and that is taking time for other patients like many of our CHC membership, but we do work with our dental benefit manager to obtain the necessary dental care in the areas even with provider shortages. Next slide, please.

If there are any questions I will be happy to field them. Otherwise, I will turn the presentation back over to you.

>> KATHY CUBIT: Thank you, Dr. Fike and all panelists for sharing information about the oral health care benefits and including responses to the questions that members submitted in advance. With that, we will start with questions from members. Any questions for our panel? Is there anything in the chat, Paula, before we go to the hand raised since we are not sure it is related to oral health care.

>> PAULA STUM: Hi, Kathy. It is Paula.

>> LINDA LITTON: Kathy? It is Linda Litton, and I have a question.

>> KATHY CUBIT: Go ahead, Linda.

>> LINDA LITTON: AmeriHealth Caritas does cover crowns? Is that correct?

>> DR. SULLIVAN: Yes, ma'am. This is Dr. Sullivan. We cover crowns, and the one thing about AmeriHealth Caritas/Keystone First that is a little bit different than other MCOs, you heard mention of talk about BLEs, benefit limit exceptions. AmeriHealth does not have BLEs. We actually will go through the authorization process. So, for example, under AmeriHealth Caritas/Keystone First with dentures you are allowed today get one every five years and after the five years you can go and have another one done as long as it is prior authorized. The same with the crown, one every five years. If you need one after five years, you would go through the authorization process, and of course you would have prior authorization the first time, too. To answer your question, we do cover crowns but you have to prior authorize.

>> LINDA LITTON: Okay. Thank you.

>> JUANITA GRAY: I have a question.

>> KATHY CUBIT: Go ahead, Juanita.

>> JUANITA GRAY: Hi. Is this Kathy?

>> KATHY CUBIT: Yes, go ahead. We can hear you.

>> JUANITA GRAY: Okay. Thank you for everyone. I listened and he said they do not

do BLEs and you go through the prior authorization, but when you go through the prior authorization, they are always denying it, although, what about, they have, if you need sedation to get surgeries done for your infected wisdom tooth where the regular anesthesia with the needle is not applicable because of your prior considerations of illnesses that you had and also severe anxiety because I am a sepsis survivor and the denials are apparent because I have not been able to get my infected tooth taken care of because I keep getting denied.

>> DR. SULLIVAN: Was that a question for AmeriHealth?

>> JUANITA GRAY: Yes.

>> DR. SULLIVAN: Well, in order to really look at your case, Kathy, is there a way she could connect with you guys or at least, you know, send over her contact information so that we can take a look at her case because, you know, there are so many variables. We have requirements for anesthesia, you know. I could not tell you what has transpired, and of course you know members also have appeal rights, also. So, I would be happy to take a look at the case and see where things are and see what happened, and, you know, we can go from there. I would just need some way for the member to send that information to us or contact us. Kathy, could you or somebody on LTSS help her to get that to us?

>> JULIET MARSALA: This is Juliet. We will make sure the issue is followed up for Ms. Grey. Thank you.

>> JUANITA GRAY: Excuse me. I really would love his information. Can you please send that to my e-mail because I feel as though I get a lot of backlash and I am not supported, and I feel that I have been targeted since I have been part of the subcommittee by CHC and Keystone supervisors and all of those that is involved that they do not, I just have been becoming a target and every time I speak, after the meeting is over, I get a call from one of them, and I just feel like that is bullying and that is retaliation.

>> KATHY CUBIT: Okay. Well, I am sorry about those experiences, Juanita. This is Kathy. As Juliet said, they will make sure the connection is made after the meeting, and, you know, we can not address personal situations, but hopefully they can get to the bottom of, Dr. Sullivan can get to the bottom of your situation for you. Any other member questions or comments?

>> JUANITA GRAY: Thank you, Kathy. Thank you, Juliet. Thank you, Dr. Sullivan.

>> KATHY CUBIT: You are welcome. Any other member questions or comments?

>> LYNN WEIDNER: Hi. This is Lynn Weidner.

>> KATHY CUBIT: Go ahead, Lynn.

>> LYNN WEIDNER: So, surrounding dental care, my participant uses UPMC and we have not had a great experience, honestly. He is in a power wheelchair, and when we asked his caseworker to help him find dental providers that would see somebody in a wheelchair, we were given a list where most of the phone numbers were disconnected or the offices were no longer, like, open. When we finally found a provider who said they

would see him in a wheelchair, when we actually got there, they still made me lift him out of his wheelchair, which is very difficult in the dental setting, and then said that he needed a deep cleaning, which was denied by UPMC, and then they refused to see him at all. Not to do a cleaning, not to do anything. They would not touch him without a deep cleaning and told him, suggested he take out a loan. Since we got to Pennsylvania in 2018, he has not been able to find a single dental provider that would see somebody in a wheelchair without insisting that he either be completely anesthetized, which he does not want and does not require, or they want me to transfer a 150-pound man over to a dental chair. That is ridiculous. I know at his dental provider in his previous state, he was able to stay in his wheelchair, which does recline, and they made accommodations for him. We have not found that to be the case in Pennsylvania at all. At UPMC, the caseworkers basically change off so frequently that by the time we get somebody else, we get the same standard, well, here is a list of providers and once again we have to go through the work of going through a list of disconnected phone numbers. We have just found it to be a completely unsatisfactory situation. Is there any chance that you will be updating your lists, or what can you do for somebody who is in a wheelchair and can not find a dental provider?

>> DR. CELCO: Can you hear me? I am sorry. I was having trouble.

>> LYNN WEIDNER: Yes.

>> DR. CELCO: We work with our benefit managers to update, you know, our directories. Unfortunately, many of the providers do not let us know or they do not send in updated information when they either close or change locations. We are dealing with whatever current information we have. So, I apologize for your experience with that, but, some of that may be out of our control. I will certainly take this back and I am sure Kristen will, as well, to make this a point of concern or raise it to our dental benefit manager as well some of our upper management about the lack of providers. I think you are going to find that everywhere there are going to be challenges with dental access for, say, wheelchairs. That is just not alone in this state at all. It is everywhere. There are very few places other than hospitals and dental schools. That is always a resource. The dental schools are always an available resource because they are usually tied to an academic medical center and they have training programs. I know at Temple Dental School, the Kornberg School of Dentistry, they have a clinic that has the capacity to handle wheelchairs and other types of transportation. I think they even have Hoyer lifts and things like that. We can work with our providers if you say you had one and see if there is a challenge with why they will not accept the patient. I am not sure of all the clinical issues that are going on and why the patient would need sedated like you mentioned. If you wanted to contact me, I would be happy to, or contact me through the organizer here, I am happy to look into it and get you probably a direct case manager or person to really assist you going forward.

>> LYNN WEIDNER: I appreciate the individual problem solving. I am just hoping that at some point that information would be spread widely because I do know other people

who are in wheelchairs and have had similar experiences and not having the caseworkers be informed about, you know, how to help is really detrimental. I think that we should really work on, you know, making sure that there are resources about like your suggestion for dental schools and things like that, like, you know, solving our problem this one time is very appreciated, but like I said, I think it is more of a systemic issue, and I believe that kind of information should be spread widely amongst caseworkers so that information can be share window other people with disabilities having similar issues. Thank you.

>> DR. CELCO: Thank you.

>> KATHY CUBIT: Thank you for raising that and for making that recommendation. Hopefully that is something all the MCOs can try to better address. Any other - go ahead, Linda.

>> LINDA LITTON: It is Linda. I have a response for the previous situation. I am also in a wheelchair, as you know, and going to the dentist, I would pull up next to their chair and my chair reclines and that worked out well, and if somebody goes and has an assistant, they can maneuver the chair to get close to the dental chair so that could help the situation, as well. That was just something I wanted to bring along.

>> KATHY CUBIT: Thank you for sharing your experience, Lynn. I know there are definitely issues. We have a big state and not everyone has access to dental schools and -

>> LINDA LITTON: Well, it is a small area, the dental office. I had a provider that I had moved out of state, and when I came back, I was able to get in to see him, and of course at that time, I was in the chair where previously I had not been. So, you know, he saw that I could maneuver the chair well, but if somebody can and has an assistant with them to do that for them, that would help, as well.

>> KATHY CUBIT: Thanks again for sharing that information. Any other questions, comments from members? Okay. I think we can move on to either the chat or people that have their hands raised.

>> PAULA STUM: Hi, Kathy. This is Paula. I have a couple of questions in chat, and I have a comment here from Diane Roth that Penn Dental has a specialty office that has movable chairs to accommodate wheelchairs, so just an FYI.

The first question I have is from Brenda Dare. This is for all presenters regarding oral health. Her question is, how can people advocate for changes to the BLE qualifying conditions? Folks with physical disabilities have a difficult time flossing and are at increased risk of dental complications, but that is not a qualifying condition on the new list.

>> DR. CELCO: This is Dr. Celco from UPMC. One of the biggest ways to advocate for changes is to contact Dr. Sham Lou and Dr. Kelly. Dr. Sham Lou is the Chief Dental Officer of DHS, and Dr. Kelly is the Chief Medical Officer for DHS, and Dr. Larry Appel, as well. He is involved with the Community HealthChoices program. They are the biggest advocates from the state side and they either add the provisions or have the

ability to strike them from the contracts that we are bound to abide by. So, that would be one way, and certainly legislatively you can contact state legislators and indicate to them they have the ear, since they are the funding component to many of the programs, they have the ear of the, you know, the senior management in DHS, so that really can invoke changes there. So, that would be my recommendation is to write to local legislators or even to the governor. We have had, you know, when people have issues they raise them and that is the only way that they become aware of them. So, those would be my recommendations. I do not know if anybody else has any comments, but that is one way I would suggest addressing it.

>> DR FIKE: This is Dr. Fike. Could I also add to please look at the Pennsylvania Coalition of Oral Health. They have a very good website. They are very involved, and specifically the BLE process, you know, they are trying to actually remove the process not only increase qualifying conditions or something like that. Dr. Celco is right. Contact DHS, contact legislators, and I would also look at PCOH, Pennsylvania Coalition of Oral Health, and they may be able to help that way.

>> KATHY CUBIT: Thank you. Paula, any other, anything else in the chat for the panel?

>> PAULA STUM: Hi, Kathy. Yes, there is a question from Shauna Tenne. Her question is why aren't all people with disabilities included in the BLE? It should not just be those with intellectual disabilities. How do we get this changed?

>> DR. FIKE: This is Dr. Fike. I think we are going back to the same issue that was previously discussed and expanding this, expanding the BLE process, is contacting DHS or OLTL with any legislative type issue and also previously PCOH to get involved in areas that may have some benefit to changing this. You will probably find no arguments from any of the dental providers online here about expanding or removing the benefit limit exception.

>> DR. CELCO: That is our biggest challenge or the one item that draws the biggest amount of complaints is the benefit limits exception. I for one am in favor of its removal. I think you just stated yourself, Dr. Fike, you are, as well. I can not speak for Dr. Sullivan, but it is certainly a challenge for all of us to deal with. I certainly understand the plight of the members.

>> DR. SULLIVAN: Richard, you can always speak for me, but I would agree that if we can, you know, I would be in agreement to removing the BLE because I just think that is another barrier for us for the member, and it does, sometimes it just throws up one more road block to these members who do not need any more road blocks thrown up in front of them. So, as Dr. Fike said, it is unanimous here. We would all be amenable to seeing the BLE being retired.

>> JULIET MARSALA: This is Juliet with the Office of Long-Term Living to answer Shauna and Brenda's question from the Office of Long-term Living's prospective. I would add that you do not need to convince us of the benefits of dental services and we certainly recognize the need and hope our MCO partners will join us in elevating across the dental network more disability competency in their scope of practice and best

practices. Dental services at the federal level is an optional state plan benefit. It is not at a federal level a required or recognized state plan benefit. So, with regards to advocacy, not only would I look at the state level, I would also look to the federal level with regards to educating your representatives about the importance of dental health as part of overall health and the need for additional funding nationwide on dental benefits in addition to much of our restraints here at the commonwealth with regards to optional state plan benefits that we would love to broaden and expand. It really comes down to a question of resources. We certainly are not opposed. We just would need the appropriate resources to move forward. Thank you.

>> KATHY CUBIT: Thank you, Juliet. Any other questions for the panel in the chat before we move into our second public comment period?

>> PAULA STUM: Hi, Kathy. It is Paula. I have no other questions in the chat.

>> KATHY CUBIT: Okay. Thank you, Paula. I know a couple of people have had their hands raised for a while. Let us move, if we can, and unmute and let them speak, and thank you to our panel, again, for this information and your recommendations for advocacy. If you can stay on in case there are additional questions that would be appreciated, but thank you all.

>> JULIET MARSALA: I guess the first person that has their hand up is Brenda Dare.

>> KATHY CUBIT: Brenda, we can not hear you if you are speaking.

>> PAULA STUM: Kathy, this is Paula. She lowered her hand. I think I asked her question that was in chat.

>> KATHY CUBIT: Okay. Thank you. Can I get everyone to self mute. There is a horrible echo. [Indiscernible] the second to last hand that is up.

>> GEORGE GILMER: This is George Gilmer. My hand is up.

>> KATHY CUBIT: Go ahead, George. The floor is yours.

>> GEORGE GILMER: Thank you very much. Thank you to the dentists, and to the dentists, I would challenge you to take a page out of Dr. Larry Coffee's book where there are over 170 thousand patients served through donated dental services. Certainly, a person over 50 years doing that. Pennsylvania is land of dentists. I'm near Camp Hill. There are plenty of dentists and qualified dentists that I can get into, but then paying them is another story. The low-level dentists and even other medical things because I have medical assistance. I am not eligible for PACE. I am not eligible for a lot of doctors' offices. I can not even find a physiatrist to see because they do not want the Obama Care and the Medical Assistance. So, it is a great hamstring and dental things. We have got things like TMJ. We have got other periodontal type cares or they can be diseases of the mouth and need to be covered. There are a whole host of issue that needs to be addressed whether it is maxillofacial reconstruction or any of those things that should be addressed. People with AIDS or a disease or something where most dentistry will not do it because of the contagion. Those things need to be, and of course, dental issues and problems can cause morbidity. If we are only waiting three months to get a root canal done or we need the tooth removed, hopefully the person does not commit

suicide in the meantime because of immense dental pain. It sounds like the Mariel boatlift, and maybe many of you do not know who they were. They are a Cuban boat lift back in 1987 that came to Indian Town gap. They got better dental care than what I am hearing about through the CHCs. So, I challenge Juliet and the other people that control the purse strings on this to at least allow moneys, that benefit amount, to be given to the participant so they can use that for a qualified dental person and maybe Go Fund Me and raise the rest. You are in a system that is in a, it is hamstrung, it is in a quagmire and I do not see movement, and, in central Pennsylvania, no we do not have a dental school, although we should at Penn State Hershey, and Hershey, with the amount of the sweetest place on earth caries, they are not interested in doing any dental work. They are interested in causing you the need for dental work. In Pennsylvania we have all of these strangeness and queerness of issues, and they are not being addressed. My comment for many of the other things, yeah, it is very hard to get dental. If you can, encourage people if they have a dental office and they can not transfer the person into the chair and there is a chair that can be had go and get in the system and allow you to go in by gurney and have the people who are transporting you, two people doing the gurney, transfer the person into the dental chair. Those are the only other things that I can say that would help ameliorate at all the kind of issues that are being expressed by these dentists, I do not, I would be very frustrated to be hamstrung and working the system that would not allow me to have any forward progress and just blow away dental care and not see it happen. That is really concerning.

>> KATHY CUBIT: Thank you for your comment. Paula, anything else in the chat?

>> GEORGE GILMER: Can Juliet respond to this about trying to get these funds to people that need them?

>> KATHY CUBIT: Juliet?

>> JULIET MARSALA: Hi, George. I am going to mute you because there is a lot of echo. So, I do not know, George, if you can self mute. Thank you. That is much better. So, with regard to getting funding directly into the hands of individual participants, there are restrictions related to giving direct funds directly to participants, so that is one thing to kind of note. With regards to dental services and needs, and I am not going to go into a back-and-forth, George. I appreciate your comments. I have stated that we absolutely are in support of trying to figure out ways to remove BLEs to gain more access to dental services. We do recognize that, you know, we have resource restrictions, as mentioned before. So, in terms of continuing to work towards improving dental care access, you know, even, you know, looking at the data with regards to individuals who are utilizing dental benefits, we certainly have work to do in this area and look forward to partnering with our stakeholders in doing so. Thank you.

>> KATHY CUBIT: Thank you, Juliet. Paula, anything in the chat?

>> PAULA STUM: Hi, Kathy. It is Paula. I do have a question in the chat that goes back to the very beginning back to the OLTL updates presentation. Are we okay to go there?

>> KATHY CUBIT: Sure. Everything is open forum now. We can cover anything that is

in the chat.

>> PAULA STUM: Okay. So, this is a comment/question from Shauna Tenne. This is for Juliet. The reason Jeff Iseman's question during the first public comment period is relevant is that many consumers or participant direction use agency model for their backup system. Juliet, I believe I heard you say that one of the hopes tied to the increase given to participant direction was to support a backup system. Can you give more details on this?

>> JULIET MARSALA: You know what, I'm just going to do a little correction. That's not, the increase is not directly related to support a backup system. What I was saying in response to Jeff's comment about individuals switching back and forth from participant self-direction was, actually, let me pause, my commentary about the emergency backup system I believe was actually in response to Paul Rimar's question about strengthening restrictions to individuals selecting participant self-direction that may wind up in kind of, I think his words were, compromised situations and trying to prevent those compromised situations. So, my comment about emergency backup systems is a recognition that I think that there needs to be more work done to ensure stronger backup systems for participants in general across the system. The 21, approximately \$21 million investment in participant directed self-care workers is to strengthen that workforce and that in and of itself investing in that direct care workforce will hopefully perhaps reduce the need because perhaps there will be some additional strength in retaining direct care workers for the individuals in participant self-direction who wish to remain in that model. So, just to kind of clarify, it is not directly tied to setting up emergency back up plans. The \$21 million is a direct investment in the direct care workforce of participant self-direction. Hopefully that helps.

>> PAULA STUM: Thank you, Juliet. This is Paula. Kathy, I have another question here from Jeff Iseman. Jeff has a question on OLTL's role in PA DHS Olmsted plan. He can find information from ODP and OMHSAS but nothing on OLTL. Can you offer some comments about OLTL's role review of Olmsted as it relates to people with physical disabilities of all ages?

>> JULIET MARSALA: Absolutely. Happy to. I think, Jeff, to your question about why isn't OLTL noted in PA's DHS Olmsted plan, I think the first thing I would point to is OLTL does not run any facilities. So, because OLTL does not directly run any institutional facilities, we certainly are a funder in the long-term care system. We do not staff or run a state institutional facility. That is why you do not necessarily see us noted in the PA DHS Olmsted plan because we do not have any facilities within the Commonwealth of Pennsylvania that OLTL directly runs.

With regards to the Olmsted decision, OLTL absolutely is beholden to the Olmsted decision and continually strives to uphold the spirit and the direction of the Olmsted decision, and I think that, you know, we are pretty proud of our ability to have done so over the last few decades since the Olmsted decision occurred in Georgia, and that is evidenced by our rebalancing efforts, our nursing home transition efforts and seeing us

reach the highest peak of community services in our LTSS system at 78 percent, and I think that does show OLTL's commitment to upholding the Olmsted decision. I hope that answers your question and certainly would welcome any other members of OLTL that may wish to weigh in, but that is why I think that is our role and why you do not see OLTL specifically named.

>> KATHY CUBIT: Thank you, Juliet. Is there anything else in the chat?

>> PAULA STUM: Hi, Kathy. This is Paula. Nothing else in the chat.

>> KATHY CUBIT: I see someone has their hand raised. Can we move to that person, please?

>> JULIET MARSALA: Absolutely. It is George.

>> KATHY CUBIT: Go ahead, Mr. Gilmer. If you are speaking, we can not hear you.

>> GEORGE GILMER: There you go. You unmuted me. The follow up with the doctor of UPMC that seemed to be able to cut a deal with the dentist that was out of network. I kind of wanted to know how that happened, and additionally if there is a care worker, let us say like a nurse, do they need to go through the additional trainings to be a consumer employed person when they have had already the training. Isn't that a redundancy? Is the regulation that they have to do all of those trainings even though they may have all of these things and accreditations under their belt?

>> Dr. FIKE or DR. CELCO: Yeah, I can address the question on how we work with a provider for an out-of-network arrangement. We basically contacted them. They came to terms on whatever the services were. They agreed to see the patient, and we agreed to compensate them for the negotiated rate that was, that they wanted. So, that is how it was worked out. You know, it was close to the member. It was the member's, that was who the member wanted to go to. So, they were out of the network unfortunately, so we contacted them, made the arrangement, got the services completed and then kind of connected them with our benefit manager our dental benefit manager so they could try to work in a contract so we could get that doctor into our network in that remote area. So, that is how normally those types of arrangements are made. So, I would be happy to get you more information. I am not part of the contracting piece or the negotiations, but I know the providers and how they came to that arrangement.

>> KATHY CUBIT: Thank you for that, and to the second part of Mr. Gilmer's question, Becky Jacobs, I do not know if you are able to unmute and respond to that question.

>> REBECCA JACOBS: I apologize. It cut out on my end. Can you repeat the question, and I can absolutely help.

>> KATHY CUBIT: I don't know --

>> GEORGE GILMER: The question is, if the person already has the skills and the training and the qualifications and have passed their boards in nursing and are currently licensed, do they have to go through all of this training?

>> REBECCA JACOBS: So, the training is not for licensed professionals. These individuals would be unlicensed, nonmedical direct care workers and then home health aides who would receive their certificates of completion from their home health aide

training class, so they are unlicensed professionals. Does that help?

>> GEORGE GILMER: It did not answer the question. The question is if somebody is working in that capacity. I know people that, one in particular that I spoke to lately is taking care of her mother and she is a nurse, so she had to abandon her job at Penn State to do that.

>> REBECCA JACOBS: This is really for unlicensed professionals getting into home care, so if she has or he has a nursing degree and a nursing license that would not qualify in this case.

>> JULIET MARSALA: So, this is Juliet. I want to make sure I add a little bit to the question and the response here because I think there are two things that we are talking about. One is the training program that PHA is putting out under the Department of Labor grant. That is a private trade association entity grant that is separate from the Pennsylvania code and requirements and regulations surrounding direct care worker training, so I just want to separate those two.

So, George, to the point of the duplication of training, if someone is licensed, it would not be a duplication for the purposes of the training program because they would not qualify for that training program. I want to point out that the PHA training program is not a requirement from the Office of Long-Term Living. It is an opportunity and a resource for direct care workers and for home care agencies to upscale and provide additional training and resources for their professionals. In addition, they have designed it in a way that it would also meet certain regulatory requirements like the home health aide that direct care workers may also be working towards or requiring. So, they have intentionally designed that opportunity to not be duplicative. Now, separating out to the regulations and the requirements for the direct care worker staff training, you know, that is in our Chapter 55 of the PA code, Title 55 of the PA code in Chapter 52. Those things are not changing. They are certainly in there, and they remain a requirement of the provider to verify for their workers that they have met the training requirements either to meet their licensing and certificate requirements, but also in addition to ensuring that they know specific things about the Office of Long-Term Living program and processes that you may not know under your licensure. Someone who is an RN and has a registered nurse's license has a lot of really great training, clinical skills, credentials, et cetera, but nowhere in their track would they necessarily come across the specific reporting requirements for say critical incident reporting for the Office of Long-Term Living, right, so they would still need to get training on the specific protocols and procedures for reporting critical incidences if they are working with any Office of Long-Term Living programs, so just to kind of fine tune that response there for you, George.

>> GEORGE GILMER: Thank you, Juliet, for confirming those things. There are different modules, so would all the modules need to be done?

>> JULIET MARSALA: I am going to put you on mute. When we are both talking there is an echo, so let me just make sure I heard your follow-up question correctly, and then I will mute and then you can unmute and kind of confirm. So, what I think I heard you say

at the end there, George, was that the question was, there are modules in PHA's training that might be duplicative of training someone has had before. If that is the case, are they still required to take that module to qualify for parts of their program. I am going to mute myself so you can respond.

>> GEOGE GILMER: Yes, that module would potentially be a duplication. It might be CPR or something. Those modules would not need to be done. The reporting requirements you talked about, yes, that are specific to CHC and reporting requirements clocking in, clocking out doing all those kinds of things with the consumer model, yes, but other modules maybe not so. Thanks.

>> KATHY CUBIT: Thank you again for those additional details and recommendations. I will shift now to give, since we are getting close to adjournment, any comments or questions from members for the public comment period? Paula, did we clear everything out of the chat, or how many questions remain in the chat?

>> PAULA STUM: Hi, Kathy. This is Paula. No questions in the chat.

>> KATHY CUBIT: Thank you. Well, we will give folks just a couple more minutes if there is anything you want to add, and while we are waiting, I do want to take this opportunity to thank everyone. It has been an honor serving as chair and working with all of the members and getting your ideas and recommendations and working with OLTTL to develop agendas and meetings that meet your needs. I look forward to working with Matt and continuing to serve on the committee, and I look forward to that and also, I know there is, I have heard from a few of you that are rolling off, and I do not have a full list, but I do want to thank the members that are rolling off for your service, and with that, and also, I need to thank the Office of Long-Term Living staff. You work incredibly hard just with getting this program operating and running and also with having these meetings be meaningful.

The next meeting will be virtual only on Wednesday, January 7th, and unless there are any last minute things in the chat or from members, I will just pause for a moment.

>> PAULA STUM: Chat is clear, Kathy.

>> KATHY CUBIT: Thank you.

>> PATRICIA CANELA-DUCKET: I have a -

>> KATHY CUBIT: Oh, I'm sorry go ahead.

>> PATRICIA CANELA-DUCKET: This is Patty Canela-Ducket. I want to say thank you so much for the subcommittee and all that have been involved over the last couple of years and ensuring we continuously bring new information about in this meeting and connect and make sure Pennsylvanians have quality. This, too, is my last meeting as a subcommittee member, and so I am just so thankful for everything I have learned and everything we have shared and connected through over the past couple of years.

>> KATHY CUBIT: Thank you, Patty, for your service and for that comment. Is there anyone else that wants to speak? Okay. With that I think we can adjourn. I want to wish everyone a peaceful holiday season and a Happy New Year. Again, we will meet again on January 7th, and thanks again for your participation today. We are adjourned.