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Date: 07/02/2024

Event: Long-Term Services and Supports Meeting

>> JULIET MARSALA: All right. It's just about 10:00. So we're going to get ready to get started.
>> CARRIE BACH: Good morning, everybody. This is Carrie Bach, your co-chair of the committee. We would like to get started if everybody is ready. If we could take a seat.
We are going to go ahead and start with our roll call of our committee members. And I would like to mention, again, that this meeting is being recorded so your participation in this meeting is your consent to being recorded.
And with that, Kathy, are you on the phone?
>> KATHY CUBIT: Yes, good morning, everyone. Good morning, Carrie. Before you start the roll call, I just would like to announce that Carl Bailey has resigned from the LTSS MAAC. And I want to take this opportunity to acknowledge and thank Carl. He is a veteran and served as a consumer advocate for about 15 years on the LTSS MAAC. And I'm sure all of you who have worked with Carl will want to
So I just wanted to --
[Applause]
>> Thank you for that, Kathy.
Ali Kronley.
Anna Warheit.
>> Good morning, this is Anna.
>> Hi, Anna.
Cindy Celi.
>> Sorry, this is Cindy. I'm here.
>> Hi, Cindy.
Neil Brady.
>> Good morning, everyone.
>> Hi, Neil.
Gail Weidman.
>> Good morning, everybody.
>> Hi, Gail.
Juanita Gray.
>> Good morning, I'm here. This is Juanita Gray.
>> Hi, thanks for joining us.
>> Latoya Maddox.
Laura Willmer-Rodack.
>> Good morning.
>> Hi, Laura.
Leslie Gilman.
>> I'm here.
>> Hi, Leslie.
Linda Litton.

>> Good morning, everybody. Linda Litton here.
Lloyd Wertz.
Matt Seeley.
Michael Grier.
>> I'm here. Thank you.
>> Thank you for joining us, Michael.
Minta Livengood.
Monica Vaccaro.
>> Good morning, this is Monica. I'm here.
>> Hi, Monica.
Pam Walz.
>> Hi. Good morning. I'm here.
>> Good morning, Pam.
Patricia Canela-Duckett.
>> Good morning, everyone.
>> Good morning. And Rebecca May-Cole.
>> This is Kathy. Rebecca will be joining late.
>> All right. Thanks, Kathy.
And with that, I'm going to turn it over to you for housekeeping and committee rules. Thank you.
>> KATHY CUBIT: Thank you.
This meeting is being conducted in person and as a webinar to comply with logistical agreements, we will end promptly at 1:00. 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 clear so the captionist can capture if conversations and identify speakers. Please keep your comments concise. Webinar attendees may submit questions and comments into the questions box located in the Go To Webinar popup window on the right side of your computer screen or use the raise hand feature to put in queue to speak live. Those attending in person should use one of the microphones and wait to be called upon to speak.
Before using a microphone, please press the button on the base to turn it on. You will see a red light indicating that the microphone is on. When you are done speaking, press the button again to turn the red light and microphone off.
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 sub MAAC web page.
In the event of an emergency, everyone must evacuate and go to the assembly area to the left of Zion Church at the corner of Fourth and Market.
If you require assistance, you should go to the safe area located right outside the main doors of the Honor's Suite and OLTL staff will be there to help you.
Further instructions can be found on the back of your agenda.
And with that, I think we can turn things over to Juliet for OLTL updates.
>> JULIET MARSALA: Thank you, Kathy. Good morning, everyone. Before I open up with OLTL updates, I did want to take a moment to recognize disability pride month. Latoya Maddox and I had the honor of being in Philadelphia yesterday for the flag raising celebrating the 11th annual disability pride month. So I just want to reflect on that. It is an important movement to

make disability proud in Pennsylvania and across the nation.
Also I wanted to recognize that today is the 60th anniversary of the Civil Rights Act, which was monumental legislation and land mark civil rights and labor law legislation that outlawed the discrimination based on race, color, religion, sex, national origin, and included disability and sexual identification.
So also wanted to recognize this is a month for 34 years of Americans with Disabilities Act. We have come a long way. But there is a lot of work to do.
With that, I will go into the OLTL update. I will talk about the procurement updates, updates on the adult protective services, comments on behavioral health for the LIFE program and Community HealthChoices program. An update on the transportation summit, talk about data breaches, and share OLTL communications. I'm happy that Robyn and Jen are both here. If there are questions on those, I will defer to the folks who are more expert than I.
For the OLTL procurement update, the CHC procurement is live and we are in a black out period should you have questions relate to do the procurement, please send them to the resource account.
In addition, the agency with Choice procurement is live and there are no updates to share at this time.
With regards to the federal APS standard that's been out for a couple of weeks now. We are working closely with the department of Aging to identify how the recent federal regulations in adult protective standards will impact our programs and its programs. Once the impacts are known, we will release those communications as we fully understand all the implications for us in the Commonwealth.
However, we did want to make folks aware that the Adult Protective Services team under the OLTL will be starting a public service awareness campaign regarding the Adult Protective Services hot line. You should see those coming out across the airways, across the Commonwealth a little later on this month.
With regards to Behavioral Health Services for the LIFE program and Community HealthChoices participants, we're making progress collaborating with the office of mental health and substance abuse services to collect and analyze data. So the state is not ready for prime time yet. Due to the nature of the data, we're not going to want to misrepresent behavioral health service data. So it will take us a little bit more time as we work to evaluate and analyze the data that we have in place.
For the Community HealthChoices transportation summit, I am pleased to share that we finally got approval for the new license to start yesterday. So now we're in the process of obtaining the license and getting it up and running and getting our staff familiarized and trained with the ZOOM capabilities and features. We will be scheduling that summit hopefully very soon and sending out that announcement across all of the ListServing for folks with regards to the date and time that will be released. Be patient with us. We're to the final stage. It will happen.
Okay. The next update, I wanted to revisit the change health care data breach. In February of 2024, Change health Care became aware of the deployment of ransomware in the system. And they began the investigation. March 7, 2024, they did confirm a substantial quantity of data has been ex-fill traited from its environment.
And beginning in June of 2024, Change health Care has begun providing notice to their customers, the providers, that utilize their systems of which one of them was a large MCO in Pennsylvania, that were impacted so that they can in turn share that information with potentially impacted individuals.

They also have a link which is posted here which is changehealth care.com/hipaa-substitute-notice where individuals can get information.
And the investigation is still ongoing. It's not necessarily clear all the personal identifying information that may have been impacted.
However, it serves as a good moment for us to revisit some best practices for individuals who may have been impacted and for all of us generally ongoing.
So with regards to our data, health and financial, individuals should be on the lookout and regularly monitor the explanation of benefit statements that you receive from your health plan and from your health care providers.
In addition to your financial statements, bank statements, credit card activities, credit reports, tax returns to see if there's unfamiliar activity. For example, if you see on your health benefits that someone has ordered on behalf a knee brace for you and you did not receive a knee brace nor need a knee brace, that would be a time to contact your health care provider.
It's also important that if you notice that there are these anomalies that you reach out to your doctor and make them aware.
And any suspicious activity on your bank or credit card statements or on tax returns should be reported to your financial institution, your credit card companies, or any other relevant agency in addition to filing a police report.
So these are steps that folks can do routinely to help protect your own health and financial information.
Data breaches will happen despite everyone's best efforts. But that is the reality of the world.
Moving into recent OLTL communications. In September of 2024, it is our intention to submit the amendment to CMS or the Centers for Medicare and Medicaid Services, for the OBRA waiver 1915c home and community-based services waiver. We have posted a notification that it is out for public comment.
In addition to our intention to submit the renewal for the Community HealthChoices waiver. That also is out for public comment period. The waivers are required to be renewed every five years. So in addition to submitting the required renewal, we are submitting for the OBRA waiver so they align. And they will go through a side by side comparison of the changes.
In addition we have published the revised need for comprehensive needs reassessment following a lapse in medical assistance. Long-term care eligibilities operations memo. That is a mouthful. That has been posted to our public site. It had an issue date of May 13, 2024. That memorandum identifies when a comprehensive needs assessment is required following a lapse. In addition, some of the revisions were made to remove the language referring to the Medicaid unwinding because that process concluded.
We published the revised home accessibility durable medical equipment memo referred to as HADME. That has been posted to our public site with an issue date also of May 13th. And that operation memo was revised to provide additional clarification as to what should be considered HADME under the state plan and what should be considered a home adaptation under the waiver program.
In addition, Jen and Robyn have been very busy, we also published our 2024 pre-administration of the home and community-based services consumer assessment of health care providers and systems CAHPS survey. The OLTL is in the preparation phase and calling on the service coordinators in all of our programs to start having conversations with our human and community-based services participants to provide an introduction and education that the CAHPS survey process will be beginning.

And we encourage every participant in the upcoming administration of this CPHPS survey to participate in that survey opportunity. It really provides us valuable information with regards to our services, our programs, and the participants' experience. Again, CAHPS surveys are about experience, not necessarily satisfaction. But understanding people's experience is really important to help us all continue to improve the program.
So the HCBS CSHPS survey will be administered from August 1, 2024 through October 31, 2024. Someone from Press Ganey may call participants to set up a time to talk. And participants may also call Press Ganey toll free at 1-800-588-1659 or via TTY711 if they would like to take the 30-minute survey. And certainly do encourage folks to do so.
And with that, I think that's all the updates I have today. Looking at my staff. Yes, that's all of the updates.
>> This is Carrie. Thank you. That was quite a bit of information, Juliet, in a short period of time. Just to let you know, there is more information for you and remind you that the questions from last month's meeting, there are a number of responses. And those are getting posted to the ListServ instead of reading them during the meeting for the sake of time. So just a reminder.
And also I wanted to make note for the record that Lloyd Wertz and Ali Kronley have joined us.
And with that, it's Jen and Robyn. Let's go.
>> KATHY CUBIT: Carrie, this is Kathy. I had a quick question for Juliet and a comment.
The comment is I just wanted to let people know that the CHC Ops memo when you go to that web page, it looks like the old -- it looks like it hasn't been updated. But if you click on the Ops memo numbers, you do get the current Ops memos that Juliet was talking about.
And my question is is the CAHPS survey being administered in any language other than English?
>> JULIET MARSALA: Yes, it is. It is done in Spanish and my understanding is the CAHPS survey will have access to the language line to do the survey live with an interpreter. So it will be available in all the languages that our members need.
>> KATHY CUBIT: Thank you.
>> Great. Good morning, everyone. This is Jen hale, the director of policy for OLTL. And I am joined by Robyn, the division director for policy development and analysis within the bureau.
So we are excited to be here today. I feel like it's been a while since Policy has presented at the LTSS or the MLTSS previously to review the proposed waiver changes for the CHC renewal and the OBRA waiver amendment.
Juliet did steal a tiny bit of my thunder. I will reiterate and give a little bit of background that the waiver was last renewed and submitted in 2019 and renewed for a five-year period, which is standard for a 1915c waiver. CMS typically approves for a five-year period. So we are approaching the end of that five-year period November of this year.
So CMS requires states to submit a renewal at least 90 days ahead of the renewal effective date. For OLTL, our goal is to submit the waiver renewal and also the OBRA waiver amendment in September of this year to have effective dates of January 1, 2025.
So many of the changes, major changes in CHC are also applied to the OBRA waiver for consistency.
And I just want to take a minute and outline most of the proposed changes that Robyn is going to go through and review with everyone today are really a result from stakeholder feedback. So we evaluated the information that was received during the OLTL listen and learn sessions that Juliet spearheaded last year.
We also took a look at the feedback we received and heard from previously it was the MLTSS

and also the LTSS. As well as the long-term care council and the master plan on aging, which is officially titled Aging Our Way PA.
And we also incorporated a few changes that were a direct result of CMS's on site visit in February to review the state's compliance with the HCBS settings role. So there will be some changes as a result of that.
As Juliet mentioned, there was a public notice published in the PA Bulletin on June 15th which started the 30-day public comment period. We did send out a ListServ email on June 16th is what I have here, but it might have been the 18th, notifying stakeholders of the availability of the proposed changes on the website.
And so we wanted to also use this meeting to review the changes and obtain public comment verbally or via chat on the changes that we're proposing.
So any comments that are received as part of the LTSS meeting this morning we will take back and review for consideration.
So with that, I will hand it over to Robyn who will walk through the proposed changes.
>> ROBYN KOKUS: Thank you, Jen.
So I'm going to go over some of the changes that we're looking at. Some apply to CHC. Some apply to OBRA. Some apply to both.
On this slide, we will talk about changes to service definitions made in CHC and OBRA.
For the OBRA waiver -- excuse me, for benefits counseling in both of those waivers, we're adding a WIP-C certification for providers of benefits counseling. And this is really to just expand the pool of individuals who may provide this service.
For employment skills development, we're adding language to really emphasize that sheltered workshop employment is not funded through the waiver.
We're adding that it says handicapped employment, that is the actual term in our regulations right now, may not be funded through the waiver. Waiver funding is not available for the provision of employment skills development. Example, sheltered work performed in the facility where participants are supervised in producing goods or performing services under contract to third parties. And we're adding the text that at sub minimum wage and are not community integrated to really emphasize that sheltered workshops are not funded by the waiver.
In CHC and OBRA, we are proposing to make revisions to the home adaptation service definition. And this is to add language to better differentiate between the home adaptations which are funded by the waiver and the home accessibility durable medical equipment covered by the state plan. This comes at a good time since we have released the revised memo for how to differentiate between home adaptations and HADME.
So structured day rehabilitation services, we proposed to change the years of experience for individual support staff from five years to two years just to really increase the pool of eligible workers to address workforce shortages.
For service definitions, in CHC only, we're motive identifying Telecare. So the service definition refers to a Telecare services directive, which is obsolete. So the Telecare services directive is removed from the service definition just to clean it up a bit.
In the OBRA waiver, for home adaptations and personal emergency response systems, the PERS, for home adaptations in PERS, the service definition for those who services are just being revised so that they align with the service definition in CHC. Over the years, they kind of diverged a little bit. So we want to make sure that the waivers are consistent with home adaptations in PERS.
So this is a very exciting change. I'm really excited for this one. Teleservices. We're adding a

teleservices delivery option for Cok rehab they're services and counseling services. So the waiver will contain a description of teleservices and it's going to address that teleservices may only occur when the person-centered planning team determines that using remote technology is the most appropriate service delivery method to meet the participants' needs and goals.
Also, that teleservices are remote, two-way, live communication. It will provide the description about how the participants' privacy will be guaranteed.
The waiver will also say that the person-centered service plan, the PCSP, must describe how teleservices will support community integration and will promote improved health and welfare. It will emphasize that the are to use teleservices was initiated by a request from the participant and/or the family or representatives that this is not going to be something that comes from the providers and the participant will have their choice to use in person or teleservices for cognitive rehab and counseling.
It will talk about how the person's need for in-person support during service provision will be met. For example, perhaps the technology is not working properly or there is some other kind of barrier that would prevent is use of teleservices, so there has to be a contingency on how the person can receive the services.
And the provider will be responsible for ensuring the HIPAA compliance.
I'm very excited to add a remote service delivery to the amazing ways that we have been able to pivot during the COVID pandemic to teleservices and remote. This is be nice to play out in the waivers.
To the CHC waiver, we're adding chore services. So chore services will consist of heavy household chores which are necessary to maintain the functional use of the home for provide a clean, sanitary, and safe environment.
The service may be authorized only when an unclean and cluttered living space impedes service delivery or increases the probability of injury from environmental hazards such as burns or falls.
So covered chore services are limited to the following.
Washing floors, windows, and walls.
Moving or removing large household furnitures and heavy appliances in order to provide safe access and egress, a way out, for the participant, the direct service worker, or emergency personnel. This may include addressing items that are stored outside of the home on porches or in front of doorways.
It also will include securing household fixtures and items, including tacking down loose rugs and flooring, in order to prevent falls or injuries.
And it will also include the seasonal installation and removal of window air conditioners.
Additionally, for individuals with hoarding disorders, this service is intended to be utilized in conjunction with behavioral health services. The participant must be actively engaged in the the behavioral health services or attend a consultation.
The following additional chores may be provided when a hoarding disorder is present.
Cleaning attics, basements, common living spaces to remove fire hazards as determined necessary by the service coordinator.
Dumpster rental and refuse disposal.
Sorting, pack, or removal of the participant's belongenings.
And remediation and dispose of waste.
This will be house cleaning, janitorial, or clean out contractors.
Some other revisions that we're looking at is we're going to remove language about the

organized health care delivery system and the participant review tool from the CHC waiver. Both of these items are outdated. So we're cleaning up the waiver.
For child abuse clearances for both CHC and OBRA, we're tightening up the the requirements to emphasize how we need to protect our children. What we proposed is that clearances are required for all direct care workers and service providers, including service coordinators and contractors, providing services in homes where children are present. Previously, it says only where children reside. But there are several occasions, substantial occasions where perhaps an individual is baby sitting children after school while the parents are at work. So that individual has children present in their homes, therefore the direct care worker and staff would need child clearance.
In appendix G under participant safeguards in both CHC and OBRA, language was revised throughout regarding critical incidents. We wanted to ensure that the time frame stated in the waiver in responsibilities of entities involved in the process are accurate. As the programs mature and evolve, sometimes the waiver can get left behind as the bulletins are updated. We want to make sure we get parity between the published guidance and what's in the waiver.
And we're doing the same thing in appendix H, our quality improvement strategy. That is CHC only at the time. The last time we did an amendment for OBRA, we were able to update the strategy at that time in 2013. Now we're catching up with CHC.
Other revisions. Again, service plans, CHC and OBRA. We're adding these items in response to feedback from CMS during the home and community-based settings final rule heightened scrutiny visits. We will reinforce that a participants right in the setting needs to be modified, it must be documented in the person-centered service plan. If a provider creates a treatment or service plan, that plan must be incorporated into the person-centered service plan. So there won't be two stand alone plans, they will be all one.
For fair hearings in the OBRA waiver only, the change is already in CHC, we're going to change the time frame in which a participant may request a fair hearing and have services continue. We're changing it from 10 days to 15 days to give the extra five days to file a fair hearing request and have your services continued. And that is in response to stakeholder feedback regarding hearings and appeals.
Sorry. I missed one. I apologize.
So also regarding the person-centered service plan in CHC, PCSPs, we're changing the language to be completed. Originally it says completed no later than 30 days from the date of the comprehensive needs assessment or reassessment. We're updating the language to clarify that they must be developed and implemented no later than 15 days from the date of the comprehensive needs assessment or reassessment is completed.
Thank you.
So I think that concludes the review and walk through of the proposed changes. I think hit, if there are questions, we're happy to answer questions. But also if anyone has a public comment that they would like to have on record, please feel free to let us know.
>> JUANITA GRAY: Yes. My name is Juanita Gray and I have a public comment and I would like to go on record.
>> Go ahead, Juanita.
>> JUANITA GRAY: Hi. Who am I speaking with again?
>> Sure. This is Jen hale.
>> JUANITA GRAY: Hi, Jen. How are you? Good morning.
>> JEN HALE: Good morning.

>> JUANITA GRAY: And good morning to everyone here from the panels and boards and the public as well and other participants.
And I'm ready to speak.
I have listened to the changes. Some are good, some aren't. I am thankful for the Televisits portions that was implemented for behavioral health. I like that.
The changes to input around to change the chore services and to issue those duties to other contractors, I believe to me that's wasteful spending where there was direct care workers doing those jobs already. It's moving services around unnecessarily.
The next thing is they said there was an emergency implementation of protective services that was put in. I have an issue with coordination and there being the issue. I wanted to note that I am a participant and have been mistreated and abused by CHC Keystone coordination team, the managers and some of the uppers in the hearing panel. I was never able to be apart of my service plan. My coordinator lied. She never asked me any of those questions. She wrote up a service plan that did not fit my needs. She never asked me what my needs were. As a matter of fact, she never saw me.
And then they took her and the whole team, I asked for my service plan so that I could report them to you guys, I wanted everyone to hear it. And what they did was she forged my signature and they did it through an online portal, which you can't do, because I asked them to send it to me and they never would. I never signed I want. So she forged my signature. That's fraud.
So I wanted to let you guys know. It's not right. It's not working. I am in the process of getting a lawyer. They took my hours as punishment. And I'm tired of sitting here listening to all these changes and nobody is listening to me. And nobody listens to all of these hundreds of thousands of other people that they keep doing this to. We have had calls coming in that my direct care worker, the families, they have been calling and saying the same thing is happening to them. That these people are manifesting these and saying that you guys want them to do this. You can't want that if you care for sick, disabled, and unable people to take care of themselves. Then that means that is abuse of a disabled person. That's systematic.
So I wanted to speak. I was waiting for the president. I called, made a call, and they said he would call me back and he never called me. I wanted to know how much concern they had. Because you're heading this. So if the head is bad, then the team is going to be bad. We need more oversight.
So I have people writing letters on my behalf because I feel like I'm being taken advantage of because I'm sick. That's bully mentality. That shouldn't be in this kind of organization. And I feel as though I wanted to be a part of some of the decision-making process -- I'm sorry, I have to take a breath.
I heard and listened to you said they had a listen and learn. I was never contacted to be a part of that. I should have been. Especially since I voiced a lot of concerns.
So you didn't hear from everyone. You didn't hear from everybody.
So I wanted to let you guys know that I don't know what you're going to have to do to make it right because of what they did. And this is something that I can prove. I have it documented. And I have this girl's signature that's not mine electronically. And you can trace it if I asked for an audit.
So I need somebody to contact me. And the doctor that sat on the panel, I let they know that the girl lied and they still made the decision. They were not very kind to me. It's because I'm reporting the problems that I'm being taken advantage of, it's like a whistle blower situation and all of that is going to count for bringing in the Federal Government and an investigation because

this is unfair to me and everyone else.
And it's unfair to you that's doing a good job for us. It is.
So I have to get the bad apples out, I will. And I want to say, again, all these changes, you don't ask everybody. I asked for me and someone that can speak for the masses of us. We have some, I guess, for people supposed to be speaking on our behalf, advocacy, you need to meet with them. I need us to have a conference call. matters. Because if you don't, I will be calling the news and I will start a Federal investigation. This girl needs to be fired. This is fraud. And if she's not fired, I'm filing a lawsuit. And thank you.
>> Thank you, Juanita, for your comments and your needback. And Robyn and I certainly jotted down some of the comments regarding the waiver. And we'll follow up with Randy Nolen regarding some of the other information you provided. So thank you for your comment and feedback.
>> JUANITA GRAY: You're welcome. Thank you too for listening, everyone.
>> CARRIE BACH: This is Carrie Bach. I wanted to make note for the record that Matt Seeley is present. And with that, do we have any other committee members with questions or comments? And then we'll open it up to the public.
Go ahead, Lloyd.
>> LLOYD WERTZ: Lloyd Wertz here. I'm referring to page 11 of this presentation. And you talked about, Robyn, the quality strategy portion of the update for the waiver.
Is that the same quality spread is the update being composed now and sent in by DHS that will include all of the MA-funded services? Or is this a separate and distinct update?
>> This is specific to CHC. In the waiver, it describes how OLTL does our surveys and quality metrics and the reports we run and the results of those reports that we refer to CMS about how we're going to operationize the quality improvement strategy in the waiver. It is not for all Medicaid programs.
>> LLOYD WERTZ: Will there -- it seems you have two quality updates going at the same time. And one of them specifically refers to service delays, the larger one that DHS is going to be responding to. And I wondered if that would have any impact on the one that's being put into this waiver. As we all know, in order to get a behavioral health appointment in the community, you could be waiting three, four, five months. Not okay. Obviously, if you have a physical health problem, you would not be told to wait three, four, five months. But you are with behavioral. Are there ways that will end up being collaborated with the DHS commission? Or will this remain a separate filing?
>> That's a good question. I don't know that there won't be a point in time where the information we include in the waiver feeds into the strategy plan or vice versa. For the renewal, it's a really great point, Lloyd. It is focused on how the state has oversight and monitoring of the waiver in particular. But you raise a good point. I feel like at some point, we would want to make sure that they are leading into one another.
>> LLOYD WERTZ: Thank you.
>> I think it would be a good point to clarify that the difference between the 1915b portion and the 1915c portion.
>> Sure. So the overall DHS Medicaid quality strategy encompasses the 1915b, which are the physical health services, behavioral health. And parts of the C because that's part of the program and the 1915c waiver focuses on what the state is responsible to monitor in terms of the waiver specifically.
So there are some differences there. Great point, Juliet. So I feel like as we move forward, we

can definitely look at the two. Like I said, sometimes the information in the waiver does roll into the overall DHS quality strategy because the DHS quality strategy contains the CHC program. So I feel like there's definitely a distinction. But as we move forward, there's probably room to make sure that they're consistent with each other.
>> LLOYD WERTZ: Thanks for the clarification.
>> CARRIE BACH: This is Carrie. Kathy, can you see any committee questions in the chat?
>> KATHY CUBIT: There are no committee member questions in the chat.
>> CARRIE BACH: All right. Thanks, Kathy.
All right. We'll open it up for public comment. Go ahead.
>> Hi. This is Rick from Voices for Independence. And I have two questions. One was related to the -- I brought up a couple of months ago that there's still a big disconnect with the two. We look at it from a consumer perspective, if you do a bathroom and a stair glide, they should go hand in hand. It doesn't make sense to do a stair and wait for a bathroom.
Also, I had asked, again, two months ago, about is there -- was there a way to add an additional modifier or language to the modifier to include the design? Like I said, not a port-a-potty or a shower chair. All the providers have to go out. They have to lay it out. They have to design it to present it to utilization management. There's a lot of work wrapped around that. But there's not a modifier to bill it. When I work with MA, I have to eat that time. And that's -- I was asking for some language change in there to see if that could be added for the providers.
Is second one was under the chores, is this going to be a benefit that can be included with -- [indiscernible]
>> Yeah.
>> Okay. I didn't see language in there.
>> So the chore services will be have language because it is a distinct service in CHC. If chore services were needed and pest eradication, it would be done to two separate services which can be performed at the same time.
>> All right. Thank you.
>> I had a clarification, Rick. And I do remember your prior comments and we did note them at the time that you made them at the MLTSS meeting.
With regards to the modifier were going out and doing a design and assessment, just so that I'm clear, is that talking about the time when there might be multiple providers bidding?
>> It could be. It could be both. One provider or multiple that we don't know about.
>> So thanks for that. And certainly, we'll take it under consideration. When I think about home modifications in my house, I'm not paying for three plumbers to come and give me an estimate. It sounds to me what you're asking for is along those lines for billers to be paid for potential estimates coming from providers. And I understand that the assessments might be a little bit more complex under HADME. So that's just, to be transparent, to share one of my concerns with regards to a modifier for billing out and providing a bid.
The other piece I would say is under Community HealthChoices, there are alternative payment opportunities that certain the MCOs could consider to address that. And with regards to HADME, that impacts the state plan, which falls under OMAP and is driven by OMAP. We will certainly take that feedback to them. But OMAP is the driver for the state plan. So it would go through that office. But we will definitely share the feedback with Sally.
>> This is Bill.
>> Can you talk into the mic?
>> This is Bill. I wanted to elaborate a little bit.

[Indiscernible]
I generally can do that in about an hour. Then we're doing home modifications, preparing on average 14, 15-page proposal, drawings, format a certain way, broken out, et cetera. It's taking us five project managers doing this at this time somewhere four and a half hours in the office. And then there's also some considerations regarding the time to have somebody making sure we're doing a good job of explaining from the participants who their needs simply provides estimates for doing construction activity alone.
>> Thank you for that additional information.
>> Juliet, one of the things you brought up is from the provider side, there's a lot of paperwork that has to be submitted. Measurements of every egress. On that site visit, it could take a couple of hours. And on the back side, I get two or three more hours in the office putting a packet together. I don't know if there's multiple bids submitted on something. We're just asked to submit it. That's what I'm talking about. There's nothing that we can be clear to say it's going to cost another $500 for us meeting the criteria of the HADME.
So it's not just submitting a bid. There's a lot of work wrapped around that. That's why I was asking for a modifier or a language change.
>> Thank you for that feedback.
>> Go ahead.
>> This is Jeff from Pennsylvania SILC.
Two questions on what was just presented. One was can we make a request to get Sally from OMAP to come in and talk a little bit about that from their perspective?
>> Absolutely, I can put a request in for someone from OMAP to talk about HADME specifically.
>> And the second comment was also guidance might be helpful to how this works with the DCDE home repairs program.
>> Yeah. I can answer that. So waiver is the payer of last resort. So supports coordinators should be working with individuals, homeowners, landlords to evaluate all other community resources as a first resort, which would include services through DCDE. Medicaid is the payer of last resort.
>> Right. I'm thinking that a lot of people need a home repair before they can get the home mod, though.
>> Correct. That's part of the service coordinator's role with regards to helping to coordinate both community supports as well as waiver supports. So if an individual does require a home repair, home repairs are not included in the waiver services. So service coordinators would often times work with the MCOs, I believe all the MCOs have a housing specialist within their ranks as well. And that will become a required position. So that's a basic tenant of service coordination to help and support to pull those things together. Are there enough housing repair programs? Possibly not. But certainly service coordinators should make the best effort to provide all the resources available to an individual so they can make the best choice for themselves.
>> Hi. This is May from Liberty Resources.
Regarding the services, will -- hoarding was mentioned. Will this require a behavioral health diagnosis and take additional assessments?
>> Yeah, that's the intention is that if someone does have that type of disorder, that the service coordinator would be making that referral and getting them the diagnosis in the behavioral health link that they need.
>> I would like to clarify a little bit that chore services are going to be -- there were two pages.

The one talked about what chore services include. And for individuals that do have a diagnosis or have a hoarding disorder present, there is more services that are available to them because of that diagnosis. So that would be on pages 8 and 9. There we go. These are the services available to anybody who would need chore services. And on the next is those additional services provided when the hoarding disorder is present.
>> So when a diagnosis is needed, would this extend the time frame of completing the job? For example, would you guys need the diagnosis prior to beginning services?
>> I think the way Robyn laid it out is it's available for anyone for the services she outlined. If there is a diagnosis or a hoarding disorder that thoseadditional items or activities can occur. And that would need to be present on the service plan for those additional activities to occur.
>> Good morning, everyone. I have a question on the chore services as well. Is it two distinct services? This one says providers house cleaning and janitorial and clean out contract. The first one is also for those providers or direct care workers providing the services?
>> No, that would be the providers for both slides. It's all one service definition. We couldn't get it on one slide. But it's contained in one. And that provider type would be providing all chore services, including the additional when hoarding is present.
>> Thank you.
>> I'm asking these questions as myself as a participant. I am self-report some comments as a representative of --
My first thing is I was excited to see chore services. My husband was one of the first advocates for chore services under Act 150. He believed in them so strongly. And actually do what you would do if you didn't have a disability. And that's what this allows. Thank you for that.
My other thought on it was that I had it mixed up a little bit. I know for years, we have been asking for homemaker services. They are so important for our community because a lot of us are just one fall or accident away from going to a nursing home. If we don't have attendant care and we're doing our own home making or we have a disability significant enough borderline -- I think if we were able to apply for services to get homemaker and not necessarily attendant care or a maid service is really important and would help a lot of people and save a lot of people who wind up in a nursing home because they have to go through rehab because of a student thing that they didn't have enough support for.
>> Real quick. So for the purposes of the audience who may not be familiar with the term homemaker that you're using, could you expand a little bit on that?
>> Thank you. Just helping people do their cleaning, their cooking, getting things done around the home. Cleaning your bathroom or helping clean your kitchen up. It's just a little piece of what attendant care is. It is an attendant care, the homemaker stuff. But being able to keep up your apartment. A lot of people unfortunately it's another reason they lose their home because they can't keep that up and they get the apartment inspected, they lose the place. I hear it with people with a visual disability and are blind, it happens with that. With the physical disability community, it's more when they're trying to keep it up and their body can't handle it, they're going to fall, they're going to have accidents and something happens and they end up in a facility.
>> So another clarifying question on the home maker services. Included in attendant care services in the waiver program. Are you specifically saying that the request is to have it available for nursing facilities in eligible populations? I'm a little unclear on what's not included where.
>> Well, the idea that you have to have the physical need to get the attendant care, then you

get the homemaker.
And if there was a way to fund it somehow for people who may be on the nursing facility -- they don't qualify. Being able to not have to necessarily have the -- but you need help around your home, but you may not need people are searching for the needs to qualify for attendant care for -- I'm trying. I didn't plan to talk about this today. But getting the homemaker in there for people. And it is an -- but don't necessarily have the physical personal care need. They still need to live in community, the homemaker side of it.
>> Thank you. That's helpful.
>> Thanks.
Another question. I'm glad you're really considering the telehealth for counseling. I use it. One of the things that you said early on in your description of it is finding a way to ensure privacy. That's really going to be important. Because when you have an attendant in the house that has to set up the computer for you, if necessary, or any of that, they're still in the room. So coming up with a policy and procedures for some consumers is going to be really important too.
So just I think it's a good thing. I'm glad you're thinking about the privacy aspect of it.
And here is my last question. Could you please explain the habilitation services and what they mean? Is that trying out the assisted living stuff in the waiver? Or what are the habilitation? And if it's been in there a long time and I'm not paying enough attention to it, what is it and what's changing in it?
>> So you're referencing residential? So residential habilitation has been in the waiver for a long time. It's been in the OBRA waiver for a long time. It was in the Com care waiver. If you recall, that was the waiver for individuals with traumatic brain injury that I believe came out in 2002 was when that started. And residential habilitation was in that. It's group home settings, supported living settings. One is for individuals with one to three persons in the setting. And another one is slightly larger with four to eight persons in a setting.
When the Com care waiver pulled together the aging care, independent waiver, and Com care waiver, it reset the population. It wasn't like you had to have traumatic brain injury for this and physical disability that. Residential habilitation availability has expanded not to just individuals with traumatic brain injury, but people who may benefit from that setting as a means to avoid further institutionalization. So there's a continuum of services that goes from nursing facilities to injury own home, apartment, et cetera. Residential habilitation falls along that line.
The hope is that individuals who are in those settings can get help, support, rehabilitation skills, maybe learn things with additional supports to eventually hopefully go to an independent living setting.
There are different steps along the way. It's a choice for individuals. Residential habilitation providers need to meet the final settings rule that comes out of CMS. So there's very specific things that have to be in place. For example, someone could choose to receive residential habilitation. But may also need physical therapy, occupational therapy, speech therapy, other things. They don't have to have it from that residential habilitation provider. They can still choose another provider.
So it doesn't impede on people's other choices.
Habilitation day services often times go hand in hand. That's a structured day option for adult day services. Again, these may not -- for folks who are not in the room, these are not -- I see facial expressions. They are not choices for everyone. But some people, they are.
And so it's important within our programs that we meet and have services that are available and will meet people where they're at along any continuum. So that's what those are. And there's

additional questions, I would be happy to answer them.
>> Thank you. I appreciate that description. So anywhere in the service definition changes for CHC and OBRA, is there anything opening the door for assisted living and anything added for CHC provider to pay for assisted living?
>> So assisted living services are added through the ability for us to put it in lieu of services. We talked about that for a couple of years now. Assisted living services has not been added as a Medicaid service across the board. It is being an option so that managed care organizations can choose to pursue to in lieu of service to a nursings facility along that continuum of services.
It's not a waiver service that's written that's available to everyone. It is by MCO based on pilots and services that they want to pursue or build a program around. And that has to meet the six criteria of the independent in lieu of services criteria put out by CMS. That was included in both the 2023CHC agreement and the 2024CHC agreement that they have that flexibility to pursue that.
And there are some MCOs pursuing that.
Great questions. Thanks for bringing them up.
>> This is Kathy. Juanita Gray put something in the chat that says it should be two separate services. Juanita, did you want to clarify your points on the record?
>> JUANITA GRAY: Yes. Thank you so much. Thank everybody again. I appreciate the time to talk.
Yeah, the chores, I heard the gentleman, he was a contractor. And I do believe there should be special services instead of regular daily chores. Those services cleanliness every day. And them services are for chores that are extensive. So I think it should be categorized not just under regular chores, but under chores. But not in the same category.
>> Thank you, Juanita. Appreciate those comments.
I think I need to kind of clarify that chore services is not replacing anything that's already in personal assistant services. So all of the housekeeping, the light cleaning that your attendants do, chore service is not going to replace that. They are two distinct different services.
>> JUANITA GRAY: I did second this improvement and I just wanted to thank y'all.
>> Thank you, Juanita. That means a lot.
>> JUANITA GRAY: You're welcome. Absolutely.
>> CARRIE BACH: This is Carrie. Thank you, Juanita. I'm looking at the clock and I want to make sure that we are fair to our upcoming presenters. So we're going to take two more questions that I have seen come up. And then if everybody else would save their questions for the public comment period at the end of the meeting.
Go ahead.
>> LLOYD WERTZ: Lloyd Wertz here. I haven't been involved in clinical services in over a decade, a decade and a half. I don't think I recall having a patient with a hoarding disorder as a diagnosis. So would it be required there's a hoarding disorder diagnosis to receive the chore services? Or is that a red flag to look at to establish the services?
>> Let me clarify that. Chore services, there's a standard package that's available to anyone who might need it who meets the criteria set forth for anyone. If someone is living in a home and they have rugs that are awry, creating a fall hazard, an SC would go in and say hey, we will bring chore services in place and have them tack down the rugs, reduce the fall risk. We see you have some boxes cluttering the hallway of the way to your bedroom, we're going to have someone come in and help you work through that.
That's sort of more of the basic.

For individuals who have been identified as having those additional diagnoses of the hoarding disorder, what they are attempting to do is have the waiver be in a place where it can provide additional services. Because what we have found, and OLTL has worked with the Philadelphia hoarding task force prior to and learned a lot. We want to make sure that task force, because when you're supporting an individual who is living in a hoarding situation, it's not a one-time deal. It really involves a lot of different services coming together.
And so the enhanced package of the chore services that are specific to supporting hoarding disorders and behaviors is allowing us to provide more supports than we would otherwise. One of the barriers we have found sometimes is not having enough additional and ongoing support to stabilize the situation and assistant from elevating back up to a level 7 or 8 or 9 in terms of the clutter scale.
I hope that helps clarify the universal package and the additional supports for that very specific reason.
>> It helps a great deal. Thank you. I will stop giving it too much thought.
>> Thanks. I need some clarification on the section H regarding the role of SMEs in the quality management program. My concern comes from replacing what has been very clear guidelines with a subjective input of SMEs.
So asking for clarity before I overinterpret.
>> So we live in an acronym soup. What is SME?
>> In the side by side comparison, there are a bunch of sections red lined and replaced with subject matter experts who would be part of the oversight of the MCOs. So we would like to understand that role a little better. Because it seems to be a divergens.
>> With OLTL, we have identified individuals who work for OLTL to be subject matter experts on various reporting projects that we have with the MCOs. The MCOs are required to submit operational reports, which are then monitored by a subject matter expert at OLTL. And that's how we on goingly monitor the MCOs. So the subject matter experts are in house experts we cultivated.
>> Those would become reviewers, for lack of a better term, of the quantitative data that is now being used in the Ops reports, but they are going to continue and those standards are not being changed. So even though we are taking that language out, we are not replacing it with just SME opinions?
>> So the process that we maintain right now for the quality improvement strategy is not necessarily changing what we're doing. The Ops reports will still be monitored by OLTL staff who are experts in that particular subject matter. The reports are not changing. We're not shipping it out of house or anything like that. We keep it all in the house to continue to monitor the MCOs. And I guess I don't --
>> Yeah. New language. It's new language in the waiver. And I'm trying to understand the purpose of it being inserted at a time when we have plenty of quantitative data from the overwhelmingly large number of quantitative data.
So I want to make sure that we are not replacing any -- and that the quantitative data will still be shared in the way that it has, maybe with the input of the SMEs. But more reliant on the data itself.
>> I think you have me in a bit of a lopsided because I don't have the appendix H changes memorized. And I think -- yeah.
>> And this is Jen. Robyn is right. Nothing is changing. This is really just aligning the language to make it more up to date, cleaning up the waiver. But the Ops reports, it's the same process

that we use today. The operations reports come in from the MCOs and the subject matter experts review them. It's not changing the data that you're referencing from our quality area that gets reported out here or reported out in various other subcommittees or published. That's not changing.
>> It would be nice for that to be in the waiver.
>> Nothing is changing.
>> But we're adding it for clarity rather than -- because by eliminating the language and replacing it with it, it appears that we're taking a different approach to it.
So if you're just aligning with a current practices, then we can discuss about the practices. But it sounds like we were changing it. And that's a concern.
>> Understood. We will take that comment back and talk through what that would look like in the waiver. CMS reviews the waver.
>> I have another question. But I will save it.
>> Thank you.
>> KATHY CUBIT: Hi. This is Kathy. I want to report that Rebecca May-Cole has joined remotely. And if we could take a question before 11:25 for our next agenda item from the chat from the general chat. I don't know if there's anything there that we can address in a short amount of time.
>> Hi, this chat question is from Glenda. I would like to know why agencies are not required to provide specific trainings for individuals' needs.
>> Okay. So under the Pennsylvania Code in roles providers in programs have trainings that they're required to provide, which includes an understanding of individuals' disabilities, specific medical conditions, and things of that nature. Providers should ensure that attendants are going out into homes and supporting our participants have an awareness and understanding of those participant needs that they are being tasked to help support.
So I'm not sure if that clarifies or answers the question. But there are standards specific requirements and trainings that all of our Medicaid providers are required to do.
>> Thank you, Juliet.
I want to sneak another question in from Mark. In the CHC Telecare, will activity and medication advice and adherence monitoring still be there?
>> Yes. The only change to that service is just the removal of that teleservices directive. All other parts of the service will remain the same.
>> Thanks, Robyn.
>> CARRIE BACH: This is Carrie. Thank you, Jen and Robyn, for your presentation and your time. Are you going to be sticking around? Okay.
If there are additional questions, they will be here for the second public comment period.
And with that, do we have Spencer and Amy on the line from Mercer?
>> AMY KORZENOWSKI: Yes. Good morning. Can you hear me okay?
>> KATHY CUBIT: I'm sorry. This is Kathy. I need to jump in to acknowledge that Latoya Maddox is present. I'm sorry. Thank you. Go ahead.
>> Thank you, Kathy.
>> AMY KORZENOWSKI: Good morning, everybody. Thank you again for allowing us the opportunity to speak with you all today.
Our plan for our time here is to go a bit more about this project's goals. And then we would like to dig in further to the categories within the provider survey. And conclude with the survey distribution plan and project time line and questions.

So OLTL, as shared last time, is partnering with Mercer to conduct this rate study. Some basic additional background about Mercer from what we shared in our previous LTSS subcommittee. Mercer has been working with DHS since 1995. We are the actuary of record for DHS. So we assist with setting actuarial sound rates, capation rates for the Medicaid managed care participant program.
What this means is that Mercer helps DHS determine what the managed care companies who support Medicaid participants are paid.
We do a lot of other things such as financial monitors, policy, and fee development, including conducting similar studies to what we're here to talk about today.
So generally, the goals of this project are to ensure the existing fee schedule rates are adequate by building up market base provider rates as a benchmark.
Where we identify any potential gaps, we will provide a fiscal estimate with associated rate ranges for OLTL for recommendations.
And then the underpinning of this entire project is engaging with stakeholders along the way to assure that the results that we are finding seem reasonable.
So first, again, we want to thank all the folks participating on this LTSS subcommittee for allowing us the time on this agenda to bring visibility to this project.
Also, thank you to the United Home Care Workers of Pennsylvania and the Pennsylvania Home Care Association for reaching out to members for feedback and comprehensive suggestions for this review. We have incorporated the feedback and we will walk through those later today.
On the right hand of the slide, just as a refresher to what we introduced last time, the services that are a part of this specific study are adult day, residential habilitation, structured day habilitation, employment and training services, and personal assistance.
And I want to clarify that personal assistance is for both agent and participant directed. While the participant directed is a service being reviewed, we want to clarify that the FMS in personal assistance is a procured component of the service and a review of the FMS is outside the scope of this review.
If we can go to the next slide.
Thank you.
So again, the survey background, the intent of conducting a provider survey is to collect information regarding items that we do not have access to, data that we do not have access to regarding staffing costs, your operations, and other workforce components that providers would like to share.
Specifically, the survey focuses on the services that you provide, the specific wages for positions, benefit costs, and other related costs regarding your operations. And ultimately, also just other general workforce elements that you would like to share.
One additional call out is regarding the participant directed agencies are receiving this survey. But there are specific questions for them and there are some specific questions for them to review. But there will be noted that they are as a difference between the questions being asked for the agency as well as from the participant directed. And those two main reasons stem from, one, Mercer is leveraging a recent participant directed project work group report that was completed earlier in the spring of 2024 which was comprised of participants, direct care workers, MCOs, OTL, and others. And it had comprehensive suggestions for us to consider in working through the HCBS rate review.
In addition, one other thing to mention is is unlike PAS agency, OLTL has access to the full wage data set for the participant directed, which we are also able to leverage and use within this

rate study.
So again, we have access to different data between PAS participant directed and agency. And there will be slight differences in the type of information we're requesting depending on agency versus participant directed.
And now we'll get into the survey introduction and I will hand it over to Spencer to kick this off.
>> SPENCER SVENSON: Thank you so much, Amy. And that's a great transition actually. Because as we note on the slide here, the survey is just one component of the study, the review that we're do you think. We have other sources of data that we're taking a look at. But ultimately, we did decide to do a survey because there are hole ins the data that we're looking to fill. As we walk through the survey questions today, you guys will get a view of ultimately what questions we're asking and what information Weaver hoping to get from this survey.
The second item that I want to note particularly in response to the letters that we received is that this survey does not represent a cost report. And so we're not asking for full financial reports, we're not asking for every cost from ultimately providers that are going to receive the survey. But we did include some additional sections around specific cost categories where folks could submit additional content if they wish to share that additional detail with Mercer and with OLTL.
So on the next slide here, we'll start getting to the actual survey itself. We overviewed this during the June LTSS call. We will go into a little bit more detail again. At the top of the slide, we're noting this is draft. We're still taking in feedback from the two letters that Amy mentioned from OLTL and of course from the committee today.
And so what we'll walk through here, each of the larger categories, the larger components that we're looking to ask for in the survey, as well as specific data points that we'll will looking to get from the survey.
And the first few are on the slide here. The first section is going to be provider demographics. This is your basic information, your provider ID, your provider name. Ultimately information so that we can accurately categorize the survey that's coming in.
From there, number two is going to be where you select your service category. We have a note here and we did note this on the June call as well, we're looking to get one survey per service type. So if the provider delivers multiple service types, they will submit multiple surveys. And this is ultimately to simplify the reporting and the summarization of the survey. We did a look into the data, and the majority of providering only provide one of the services that we have in our survey. And so we feel comfortable asking for one survey for each service type.
From there, as Amy noted, we have the person assistance services or PAS. Participant directed, we have a specific questions for the agencies aside from all of the other information. So those individuals will only submit a survey under that section and none of the other sections, unless specifically noted.
Next we get into one of the most important pieces that we're looking for in the survey. That's going to be staff wages. Of course, staff wages are the foundation for the rates that we will be taking a look at. And in this section, we're looking for both average base and average overall wages per hour paid to what we're calling direct care workers and what we're calling front line supervisors.
A couple of clarifications to make here. One, base wages, and this is explained further in the survey too for the providers that will be filling this out. But base wages are before things like overtime, bonuses, et cetera. And overall wages are including items like overtime and bonuses. And the reason that we're asking for both of those separately is that it's important to understand what the base wages are, but then also what those increases are for overtime, bonuses, et

cetera. This came up on the last time that we were here on the June LTSS call. But those are critical pieces to ensuring that the workforce can sustain and deliver services that participants need. So ultimately, we want to make sure we're building in an appropriate amount of those additional pieces on top of the base wage.
In looking at the two different categories here, we have our direct care workers. These are going to be the folks directly delivering services. And then we have what we're calling front line supervisors, which is just that next level up. So whoever is directly supervising the direct care worker, those are our front line supervisors.
We do have a section in the survey for additional staff related to the delivery of direct care. But ultimately, any individuals within a provider agency that are not directly tied to the delivery of services will fall into the indirect or administration categories of cost we'll be building into the rates.
From there, in section five, we have request for starting direct care wages per hour during January 1, 2019, and during January 1, 2023.
This is in response to house bill 1300 and ultimately, this data will be used not only to inform the rate study, but to inform OLTL's response to house bill 1300 that is required.
So those are the first five survey components. From there, we'll get into staff benefits. This is related to what I had just discussed, of course, wages are only one part of the equation when calculating a rate. Over time, bonuses, those are sort of the next layer. And then from there, of course, staff benefits on top of that are large costs ultimately that providers incur to deliver the services.
And so we'll be looking at typical staff benefits both from a full-time and part-time perspective. And we have some examples here. Health insurance, which will include both dental and vision. Retirement. Short-term disability, and items such as this.
And what we will be asking for here is ultimately whether the benefits are offered to full-time and part-time employees, or just one. And what the cost per full-time equivalent is. A full-time equivalent is someone who works 2,080 hours a year. Really what we want to know here is when we're building the rates, assuming how many individuals are going to be delivering a service within a provider, what is the total cost of the provider per that full-time equivalent. And that's going to help us ensure we're building an accurate and reasonable amount of cost for staff benefits into the rates.
Beyond the direct benefits, we are also asking for average paid time off for vacation, holiday, and sick time in order to make sure that we offset the total number of units that we expect the provider to deliver in a period ultimately for those times when staff are out on paid time off.
And that's important because ultimately, when we're calculating the rate, we're looking at in the numerator, the top section of the calculation, the total cost to a provider. And then the denominator, the bottom section of our calculation, we're looking at the total units that that provider is expected to deliver.
So in a case of paid time off, the provider is still incurring the cost. That's a paid day off that ultimately that individual is not providing services, they're not billing units. But the provider is still incurring that cost. So we want to make sure that the equation is balanced for the paid time off. That's why we will be asking for that as a part of the survey.
A couple other questions under benefits that we'll be asking are average annual on boarding and ongoing training days per employee, again, that follows that same logic that I mentioned about paid time off regarding balancing that equation.
And lastly, workers compensation is obviously another common benefit. So we want to

understand for each provider what the total number of claims they had in that period was. But then also what the average cost per claim was on top of the regular insurance rate ultimately that providers will pay for to ensure that folks have workers compization.
So when we're talking about wages and benefits, those ultimately bump up against the FTEs for the full time equivalents that we're building into the rates.
So the next step that we're going to look at is the actual staffing. We want to understand that the average number of, again, direct care worker and front line supervisor FTEs are for a provider. What the average proportion of direct agency individuals considered full time are. We do have a suggestion typically what we see is anybody that works over 30 hours a week is considered full time. But really if a provider ultimately defines it a little bit differently, that's totally fine as well. Really what we want to see here is related to staff benefits. Typically, again, a provider is going to offer more benefits to a full-time employee versus a part-time employee. So having that proportion is important because if we build in, let's say, staff benefits for everybody, but half of the workforce is part time and will never get those benefits, we'll be building in too much, and vice versa. So it's an example of why a full-time percentage is important.
From there, we'll be going into the ratio of front line supervisors to direct care workers. We'll build in the appropriate ratio and ultimately, it's important for us to understand what that ratio is on the ground today.
And very similarly, the ratio of direct care worker FTEs to participants to ensure that we're building a necessary and reasonable rate.
The last two sections that I have here are the percentage of staff turn over. That's not only important to understand the health of the workforce and what's going on today out in the field. But also important to understand the cost that we're building in for things like on boarding.
And then finally, in 7F, we have additional direct staff. That's related to the item that I mentioned before, any indirect staff are going to be built into the indirect or administrative cost. But direct staff, let's say a clinical supervisor or director would be built into the actual staffing, medical, or direct part of the rate.
So we can go to the next slide here.
So now that we have talked a little bit about staffing and some of the costs that we're looking to validate as a part of this survey, we can get into some more service delivery specifics.
A number of the services that we're looking at are group-based services. And so understanding the average group size today is very important when we talk about balancing the rate. Again, that idea that we want to ensure that the cost that we build in and the units that we spread those costs over makes sense.
So if something has a range of group sizes today, if we just assume the average within that range, it perhaps lacks some of the clarity in the field today all of the group sizes are smaller or larger. Those are going to result in different rates. We want to make sure we're using the survey as an opportunity to take a temperature check on what those average group sizes look like today.
Next up, similar to what I talk about about the paid days off, we want to understand what percentage of direct care workers' days are spent on billable activities. Again, this relates to the bottom section of the equation that I was mentioning where we talk about the number of units that a provider ultimately can bill within a given year.
And so understanding the productivity or the percentage of a direct care worker's day spent on billable activities is important because, again, if they're spending half of their day on nonbillable activities, we need to make sure we're building in the full cost of the whole day into the half day

of units to make sure that the total program is funded.
A couple additional questions that we have under service delivery, the first is an expansion of the nonbillable activities. So let's say, for example, a direct care worker is spending half of their day on nonbillable activities, what are those activities? We're hoping to see from the survey the highest activities that are taking up the most percentages. So let's say charting. Let's say travel. We want to see those top line items and ultimately the percentages that are corresponding with those.
From there, we're also asking for vacancy and participant no show percentages, again, to understand any offsets to the units that a provider will ultimately deliver in a year.
The next section, additional cost, number nine, is where we get to the indirect and administrative costs. So the first item that we have here is the average cost for direct care worker for all trainings and certifications. We would like to see as a part of the question those trainings and certifications broken out. As we take a look at the variance between the submissions that we get from the survey, it would be great to see the cost drivers for the trainings and certifications and are there things that providers are doing on top of the required trainings and certifications that should be ultimately evaluated for inclusion in the rate.
From there, we go into a few more items. Transportation. We will exclude the wages paid during transportation because we're offsetting the productivity as part of the nonbillable percentage. We want that direct transportation cost.
And then the last two items here are around those indirect and what we're calling direct care supply costs. Ultimately, we have examples here of the items. We'll include those in the survey. But we want to see for those items, what is the percentage of those costs compared to their total expenses? And those percentages will be used to understand if the percentages built in today are reasonable or if they need to be re-evaluated.
And lastly, one of the questions that we have in this section is just around which EVV system that providers are using because ultimately, which system they're using does drive the cost of that system.
So curious to see that the utilization rates are across the different systems and how that impacts provider costs.
And then on the last page here, we have the additional questions. These are more open-ended questions that we would like to take the opportunity to ask stakeholders as a part of the survey. The first one is a broad based question similar to the information that we received in the letters, is there anything else that the providers would like OLTL and Mercer to know as we're conducting the rate study.
A couple of items we have heard as part of the letters and part of the conversation on the committee is what industries or types of companies are providers hearing perspective or former employees choosing to go work for outside of HCBS? This relates to requests that we have heard to take a look at wages and ultimately staffing costs outside of this direct agency environment.
That is a challenge and not everything is going to be equivalent, but we recognize that other industries and other companies have a higher wages for sometimes even easier work does put pressure on providers. So we want to hear what industries and companies are we seeing most often folks going to work for outside of the HCBS arena.
And then lastly, as the workforce of course is top of mind for providers and many folks today on the call, we want to hear aside from increasing pay, are there any other incentives that providers have tried or were encouraged others ultimately to recruit and retain workforce to

ensure, again, that there is a proper level of staff to deliver proper services to participants.
So those are the additional questions that we have. Definitely on the more open end side of things when you think about the other questions that we have in the survey, those are much more data driven. Those are going to inform the rate study directly. These are more open ended questions where we're looking to gather high level information from folks to better understand the broader environment around those assumptions that we'll include in the rates.
On the next slide here, we have the survey finalization and tentative distribution plan. And for this, I will pass to Amy to talk about next steps.
>> AMY KORZENOWSKI: All right. So yes, so we are taking questions and some feedback today, as well as we have been going back and forth with OLTL with the additional feedback we have incorporated into the provider survey. Our intent is to finalize we have a provider meeting on July 18th. We want to finalize the provider survey so we can get it distributed via Question Pro to the distribution list by no later than July 25th.
And we are hoping to have 30 days for providers to review and complete the survey and submit. You're going to notice there's two email addresses up on the screen. The first is email box that we put together Mercer, which is specific to rate study or the provider survey related. So it's just specific to those two topics.
If there's other topics regarding registering for meetings or other meeting logistics, we have included the RAPWCHC email box below as well.
And if we can go to the last slide, I will do a recap of where we're at in regards to the time line. As of today, we are holding review at this LTSS committee.
The next meeting will be with providers on July 18th. We will give a recap of this project. We will dig in further to the rate study components. And then also dig in regarding the provider survey itself.
And then the provider survey will be launched in July and August through Question Pro. We will collect the information and analyze the data and provide an update at the July -- excuse me, at the September LTSS subcommittee meeting.
So with that, we'll pause and see if there's any specific questions or discussion that folks would like to have.
>> Hi, Amy. I wanted to make Kathy aware I will be facilitating the questions. She had to step out for a moment.
Before we go to questions, I wanted to clarify that the provider meeting on July 18th is the provider and common law employers meeting. So common law employers who are part of participant direction are invited to that session as well. Notifications have gone out or will be going out, communications, et cetera, are being added to tempest and PPL. So all common law employers will see those notifications on the sites. And the information is posted on the web serve.
I want to clarify that the register link has not been posted yet because of the afore mentioned Zoom license. We are trying to get that set up as quick as possible. As soon as we do, the registration link and meeting link and information will be sent out.
So I hope that answers some of the potential questions that may have come in. I look to the committee members first for any questions.
>> Hi, this is Monica.
>> JUANITA GRAY: I'm sorry. I wanted to say please forgive me, you did answer my question. I will be in attendance at that meeting. Thank you.
>> Thanks, Juanita.

>> JUANITA GRAY: You're welcome.
>> LESLIE GILMAN: Juliet, this is Leslie. My question is related to some of the wages that were described. I'm concerned that with adult day, we need to be looking at RNs, we need to be looking at Rec therapists because of the fact that that is how most of the centers have to staff.
>> JULIET MARSALA: That's a good question. Those are categorized as part of the definition of direct care workers. So you would be submitting those as part of your survey response.
>> LESLIE GILMAN: Also as a follow-up to that, adult day centers have building costs that you wouldn't find necessarily with home care. So all of the increased food costs and all of the physical facility maintenance costs and things like that, will that be taken into consideration as well?
>> JULIET MARSALA: Yes.
>> LESLIE GILMAN: Thank you.
>> MONICA VACCARO: This is Monica from the brain injury association of Pennsylvania. Thank you for this detailed overview. Just a couple of quick questions.
For the provider meeting on July 18th, if we want to give feedback to this draft, it's not finalized, it's a draft, would we do that in advance of that meeting? Or is that what is going to happen at the meeting?
>> JULIET MARSALA: Monica, we welcome anyone who would like to give comments in advance of the meeting through the Mercer email box that is noted in the presentation. In addition to any feedback you have about the survey or the rate study and process. We welcome comments and feedback at any time, including at the meeting or via email, or via already correspondence directly.
>> MONICA VACCARO: Thank you. From the brain injury community, our concerns are around residential habilitation and structured day. We're a relatively small but critical population that really provides primarily those services. So we'll send some ideas.
>> Thank you. Other committee members?
>> Do we have any ETA on when the Zoom license will be up and running? It's getting procured. I'm going to take this moment to re-introduce everyone to Jermaine, who has been following the process. I will not embarrass him. But please give him a warm welcome as he is now officially in this role.
>> Thanks, Juliet. Thank you, everybody. So as Juliet said, we're working on the process. I know it's been a while we're working on it. But we're close to the end stages. We have licenses. We just need to get them in place. We'll keep you up to date.
>> So hopefully days, not weeks. Is that fair? Okay.
Other questions from committee members?
>> PAM WALZ: Hi. This is Pam from community legal services. This is sort of a foundational question, which reflecting the fact that I don't know much about wage rate studies. But particularly for personal assistance services direct care workers, it seems to me that the wages that people earn are pretty directly related to what the MA rates have been. So when you seek that information, the wages you learn about are going to be tied to the amount of funding that's been available.
But we know that those wages are low enough that they are often not livable wages for the workers and they result in staffing shortages.
How does this rate study take that into account in determining what the rates should be? It feels sort of circular to me, the wages are based on what MA has been and so they are low. And so if you look at those rates, they're going to continue to be low. At what point and how do we

address the problems of the inadequacy of the wages both for staffing and in terms of them being livable information on I think the last page goes to that a little bit. And if that's how it happens, how does that actually get incorporated into the numbers that you generate?
>> SPENCER SVENSON: That's a good question.
>> Go head.
>> SPENCER SVENSON: It's a great question. Thank you for asking. Ultimately, we know that the survey is one of the data points that we're going to take a look at. And so one of the other data points that we're going to take a look at are average wages report from the bureau of labor statistics. And while those don't include the wages that ultimate the providers are paying today, they also include additional wages outside of this arena. If you think about registered nurses, as an example, that will include all registered nurse wages from the survey within the Commonwealth of Pennsylvania. So while Medicaid providers are a piece of that pie, the entire pie is ultimately the average that we'll be taking a look at.
In addition to that data source that we'll be using, we'll be evaluating the results we get from the survey, but we'll also be providing OLTL with a range of wages, a range of rates at the end of the day. And so OLTL along with this group can see the results and comment ultimately on where the existing rates fall in the range and also what the future might look like depending on the range chosen. Does that answer your question?
>> PAM WALZ: I think partially. I would like to, I don't know, encourage everyone in the process to make sure that these concerns are taken into account in choosing the rates. So that we don't just perpetuate what we currently have, which we know is the source of a lot of problems.
>> All good points. Thank you for asking that question. The one point of clarification that I also want to point out is the wage study is just that. It's a study. It's based on the ranges. It's going to provide a lot of valuable information. Ultimately, though, OLTL is going to have to get permission and a lot of support across the street to be able to make any changes to rates long term.
So I want to sort of level set expectations. We want to have the best wage setting we can and trend it out appropriately and absolutely support direct care workers with a livable wage and a career. And once this study is done, I can't overemphasize this enough, there's going to need to be a lot of education and a lot of support and a lot of amplifying of the information. And that would be in the stakeholders hands. We don't necessarily control the ability to change the outcomes fully.
>> PAM WALZ: Totally understand that. And we in the all of that.
>> JULIET MARSALA: Thank you so much.
Any other committee member questions? Any questions or comments in the chat?
>> Rebecca had a question.
>> REBECCA MAY-COLE: Thank you, Kathy.
>> KATHY CUBIT: Go ahead.
>> REBECCA MAY-COLE: This is Rebecca. Do you want me to go or wait?
>> KATHY CUBIT: Rebecca, why don't you go. And Juanita, follow Rebecca.
>> REBECCA MAY-COLE: Thank you. My question was just to make sure that sign on bonuses were included in either exist.
>> AMY KORZENOWSKI: Yes, they are included. All bonuses.
>> REBECCA MAY-COLE: Thank you.
>> Juanita?
>> JUANITA GRAY: Yes. I am here. Thank you so much Rebecca and Kathy. I really appreciate

your input, Rebecca.
The direct care workers are the persons that care for the participants. And I feel as though they're being made to be the lowest person on the totem pole and not being considered for the hard work that they do. And they're being underpaid. Their hours are being taken away. And that is bad for our care.
And I think that should be more important than all of the other administrative stuff. And they need to challenge that -- channel that funding back to our care.
So I don't think it should be an issue because the program is based on taking care of disabled individuals and their families. And it's not for the other purposes. And if that's the meaning of it, then why is it hard to pay the people that's doing the job?
>> JULIET MARSALA: I don't disagree with those comments what so ever. Thank you for bringing them up.
>> JUANITA GRAY: Thank you.
>> JULIET MARSALA: Any other committee members?
>> Good morning. This is Ali Kronley with the united home care workers of Pennsylvania. I have a couple of different questions. Really appreciate this report happening in general. And hopefully stand ready to see what comes out of it.
I was wondering on the question about the rates are low so how do we not just replicate that. We often find that direct care workers go to work, leave home care to go to work at grocery stores, gas stations, and easier work that often pays the same. So it's not just looking at the same job class, but competing industries is one of the recommendations that we included.
And then I'm curious if you guys can say a little bit more about what kind of information you will gather an health insurance. We find that it's not necessarily employer sponsors which is in the survey for agencies, how are you going to capture not just what the costs are, but what the actual use of the direct care workers and whether or not you are able to access and use the health insurance that you want for -- and ask if there are thoughts about it.
>> SPENCER SVENSON: Great point. That's why we're asking for the average cost per FTE and not just an employer contribution for a health insurance plan. We want the providers to take the total cost of all of the employer contributions for the health insurance premium, divide that by the total number of FTEs, and we'll utilize the average cost for the real enrollment in utilization rates. There are a lot of cases where an employee will elect not to enroll in health insurance. Or let's say for example if they're a part-time employee and it's not offered to them, they will not have an opportunity ultimately to get that health insurance.
So yes, fully understand that there is a difference between, let's say, an $800 or $900 employee contribution for the premium and cost for FTE at the end of the day.
>> Thank you. I appreciate that.
>> JUANITA GRAY: I have a question. A comment. I'm sorry. I heard the person speaking before and he answered her question. The way to develop the pay rate, I think that's kind of not a fair way to develop it. If you do a comparison to a grocery store clerk and a gas station worker taking care of a life, that's a little degrading the way of the development of the pay rate. I don't think that should be a way to do it. I think it's an honorable and more important role. And it should be paid and addressed as much.
>> JULIET MARSALA: Also agree with you. I think the point being made is that the wages are so low for this professional and honorable profession that folks are choosing other industries versus this one. And that's part of what the study is evaluating. So you're right on point. Thank you.

>> JUANITA GRAY: Yes. You're welcome. And I have one more last thing. And I just feel as though the way that the office of long-term program is set up, it's to me is debilitating on a participant. And it's taking away our independence and rights and voices and ability to choose. To me, like I said at the last meeting, to me, it's like being dictated. We don't have our own way of doing our services and I thought that's what it was supposed to be for us to have -- to live respectable and for them to come in and assist us, but not take over our lives and to choose. And also, they tell us what we can do, what we can't do, how much we can give our direct care worker and we're there by ourselves in if pain, we can't do things. We need help.
But it's not working. It's not working good for us participants.
And I don't think they're doing a good job for us with our care. Juanita. I think Ali had additional questions. And then I'm going to hand the facilitation back to Carrie. We're still on committee member questions only.
>> Thanks for that clarification also. And Juliet, apologies. Obviously, we believe all work has significant dignity. And yes. I think Juliet clarified my point, which was really about looking at wage markets overall.
And on the health insurance, just repeat the attempt not to evaluate based on the current insurance cost, but looking at what the cost would be to offer coverage that the majority of direct care workers can afford to ensure we're able to keep the workforce healthy.
And then just a couple of small points and suggestions. Also on the agency -- I think it would be useful either in the demographics or the staffing category to do analysis of the percent of direct care workers who are family caregivers or providing care to someone that they know or someone what they brought with them to the agency. That has a significant impact on turnover and overtime costs. I think it's worth taking a look at that as part of the rate analysis.
And then on the participant directive piece, really appreciate just the clarity the last meeting to this meeting that participant directed employers will be included and be in the survey and processed in the stakeholder engagement. Appreciate that clarification and inclusion.
And also, Juliet, you lifting up how people will know about it and find out about it.
I heard you say questions will be different and the rest of the presentation I think was the questions related to the agency side. Can you share a little bit about what questions you plan to ask or what data you're looking to gather in the survey directed to employers?
>> SPENCER SVENSON: Yeah. Thank you. Again, I think Amy mentioned earlier which data sources we already have for participant-directed. So we're able to get wage and compensation data. We have access to the report completed earlier this year. So really, the questions for participant directed services are going to look a lot more like just the additional questions that you saw at the end of presentation where we're getting the higher level, more open ended questions. The exception so that is the starting wage data that we're looking for. Ultimately to, again, answer the house bill 1300.
But in general, they are less data driven and more influence and ultimately those open-ended questions just to understand some of what's going on today with participant-directed services outside of, again, that data we already have on hand and are able to utilize in a setting.
>> Thank you.
>> This is Carrie. Do we have any more committee questions in the room? Kathy, do you see any in chat?
>> KATHY CUBIT: Nothing more in chat. Thank you.
>> CARRIE BACH: Okay. Well then we have a number of individuals from the public who have lined up. And I apologize, I'm not sure what order you came to the table. Carl is first? Okay.

We'll open you with Carl, thank you.
>> Good afternoon. This is Carl Berry with Pennsylvania association of human and community-based services. And again, we do applaud the wage study and the review of the direct care worker wages. As we said several times before, if you don't have direct care workers, you don't have in-home care.
In addition to the direct care workers, I have a question for Mercer consultant about the additional costs studied. In fact on slide 7 under additional costs, it talks about indirect cost. There is a cost to providing quality services. It's more than the wage of the direct care worker and the benefit costs. Those are important. But there's a number of indirect cost that goes into making sure there's reliable, high quality services. Everything from recruiter costs, to scheduler costs, trainers in the field, nurses, human resources staff. For the Mercer consulting guests, will the study capture those additional costs of quality?
>> SPENCER SVENSON: Definitely. So in the survey and what you will see on the screen is we're looking for the percent of cost to total expenses. So included in the percentage would be anything ultimately that is related to delivering those services.
In the survey, we do include a link to the CMS guidance on ultimately what is included as a cost related to patient services and what's not included. So there is that additional clarification for folks who haven't worked through that before.
But these indirect costs, we include some examples here. But certainly indirect costs can take a lot of different shapes and forms. So we're looking for that total percentage. So those would be included in ultimately the submission that folks will send in as a part of the survey.
And there is an opportunity for folks to submit a detailed list of the indirect expenses that make up the total percentage.
So we're hoping that providers will be able to submit that additional list so that we can get an idea of some of the expenses, like you're mentioning today on the call, and what those represent for providers. But at the end of the day, definitely required is that total percent of indirect costs, the total percent of direct care supply costs to total expenses so that we can understand, like you said, ultimately the expenses that relate to delivering quality care, what do those represent for providers? And are we building enough into the rates today to account for that? Or does it need to be evaluated.
>> And I would like to emphasize that the survey and the data we provide is only going to be as good as the data we are provided. We are significantly counting on a provider community to help us have the best survey results and study as possible.
So I encourage folks when this goes live, if there are questions, technical assistance needs, clarifications, do not hesitate to reach out and send an email to the Mercer email for that support. This is faster than usual. Also I have confidence that we can do it well.
And in addition, folks in addition to answering the questions, we do have the option for providers to send us their reports if folks could like to send the reports that account for all of their service ex-pensions, we will welcome and receive them.
So just want to point that out we're trying our best effort to have allowances to get as much information as possible to help us get the survey portion and component as high quality as we can within the time constraints that we have.
>> This is Jeff from Pennsylvania SILC. Where are supports coordinators as far as this? Are we looking at supports coordination providers and individual SCs? And with the turnover and the seem to be shifting, maybe it's getting better in terms of the number of consumers. Wondering if that data is going to be included?

>> JULIET MARSALA: This is Juliet. With regards to the question about service coordinators and service coordinator services, that is an administrative function of the Community HealthChoices program for that part under the OBRA and Act 150, certainly there is a fee for service component. But service coordination, that is not part of the services that we are focusing on for the purposes of these home and community-based services rate study that Mercer is conducting at this time.
>> Okay. And a follow-up question on bilingual staff -- I think Spanish speaking that somebody told me recently -- I'm wondering if they will look at demographics on that too in terms of comparing everything.
>> SPENCER SVENSON: This is Spencer.
>> JULIET MARSALA: Hold on, Spencer. I need to repeat the question.
So let me paraphrase, if I may.
So the question for our Mercer colleagues is regards to service coordination or direct care workers, there's a need for bilingual staff. There's differences in populations, for example, a growing Nepali population in one of our regions. So the question goes to our regional differences or demographic differences, those sort of characteristics going to be factored in?
>> SPENCER SVENSON: So while those won't be directly included as a part of the survey, we would see those average wages included as a part of the survey. So let's say a provider is paying bilingual or multilingual individual to deliver any of the service categories that we're taking a look at. Even something like ASL, for example. That would be included in the average wages.
There is an opportunity ultimately if there are let's say a couple of providers or a large community of providers that would like to submit additional information on that, we welcome any additional information. But the underlying wages of individuals that have additional qualifications, whether it be related to the languages that they are able to deliver services in or additional trainings and certifications they have, we expect those to be included in the average wages reported in the survey.
>> JULIET MARSALA: Just to point out in the survey, there is those open-ended questions. So providers, as you guys heard me say often, I love comments and input. Those are the opportunities for the providers to talk about that, to provide additional context, to provide additional information.
>> Just for clarification, I think Spanish is probably the biggest one. But there are a variety.
And my last question is something brought up in the June meeting is are we going to be looking at other states overall in comparing Pennsylvania in terms of the provider rates as well as the attendant and SC wages? My understanding is we're lower than some other states. A few, New York and New Jersey, you might expect when you're looking at Ohio and West Virginia and others, I would think we would be ahead of them.
>> JULIET MARSALA: Yeah. I can take that. That was great feedback from the June meeting. We did evaluate the resources and we will do a state comparison, high level, but actuarially sound with Mercer. We have engaged them to include that. Happy to say we are going to do that.
I think there are very few states lower than New York. As you notice. But the other thing that I want to point out is Pennsylvania is still one of the states that has not raised its minimum wages. We have a real opportunity this year. The administration is in full support of raising the minimum wage. And so that also has a factor with regards to other states as well.
And so hoping that that moves forward as well.

>> Thank you. This is Amy from the Pennsylvania health project.
I had two questions. I don't know a lot about wage studies. So I'm trying to understand.
I notice that the survey isn't asking what the actual reimbursement rate the providers are getting is. So I think OLTL knows that reimbursement rates it pays for fee for service and direct care work and personal assistant services. But the organizations are negotiating wages individually with the home care agencies. Is that going to be evaluated? I think it's important to understand the reimbursement rates to understand how the provider -- these are the wages we're going to -- this is the wage we're going to pay, these are the additional benefits we might be able to offer.
>> JULIET MARSALA: So no, we are not getting the rates provided that the MCOs negotiated directly with the providers. OLTL is not involved in that process. And the rate evaluation study is really looking at the fee for service.
Quite a bit of that data influenced by value based payments, et cetera, will be captured through the survey process. But no, OLTL is not asking for or receiving any rate information from the MCOs. In the agreement, the MCOs have a minimum floor that they don't go below. This is really focused on our Medicaid fee for service schedule.
>> Okay. So to clarify, if you're looking at the Medicaid fee for service schedule and you really -- are you really asking providers to provide information about their clients fee for service program or through all the programs?
>> JULIET MARSALA: We're asking through all the programs. But we don't need the CHC rates with their providers to conduct the study.
>> Okay. And I don't know a lot about rate studies and whether or not, but it seems like if you don't know what they're being reimbursed, you won't be able to understand how they came to conclusion to offer $13 versus $16 an hour.
And is there work being done to evaluate the scope of the direct care personal assistant shortage? And I'm not talking about missed shifts. I know there was a question about missed shifts. I think in terms of how many people are out there who have hours that have been approved, but are not getting filled on a regular basis because there's no workers available for the agencies to available to go to work.
>> JULIET MARSALA: I think you're talking about underutilization evaluation. That's separate from this. Not engaging in a full underutilization. That's something we can certainly look at. Missed shifts really address services that are authorized and aren't being provided.
>> Well, in the past missed shift and this is the data that OLTL collects on missed shifts has been from the agencies that have already agreed to provide the services. I'm talking about people who are authorized, let's say, for 84 hours a week. But their service coordinator has not been able to find somebody to fill 20 of those hours. So it's not underutilization, it's not that the person doesn't want to utilize the hours. It's due to the aid short only, there's nobody available to fill the shifts.
I guess I'm bringing this up because it seems relevant when you're trying to understand whether wages are adequate to provide adequate wages understanding where there are gaps maybe in different geographic areas would be helpful to know.
>> JULIET MARSALA: We'll certainly take that back.
>> Thank you.
>> JUANITA GRAY: A comment. I just wanted to say thank you for bringing that underutilization issue up. But my issue is when a direct care worker wants to work to make sure you're fine and they don't have to have -- there's no issues, but they're taking hours, forcing the direct care workers to have to go somewhere else, leaving you without your direct care worker. That's

another issue.
>> Thank you, Juanita.
Are you talking about when an attendant at a particular agency may be getting into overtime then the agency is making the attendant go somewhere else? I'm a little unclear.
>> JUANITA GRAY: I'm talking about when like she said you already have your hours and then your coordinator comes in and takes a reassessment to take your hours. But it's not an adequate reassessment. It's not your needs. It's just what they are doing. They don't even ask you. They go back and go to a panel and tell them you don't need these hours. But that's not true. You really need your hours. They're making your decisions for you is what I'm saying.
>> Okay. So service reduction. Thank you. Appreciate that.
>> JUANITA GRAY: Thank you. Okay.
>> Thanks. My name is David. I'm here as a common law employer and also a consultant at the Pennsylvania technology foundation.
I had a comment on the point with the folks from Mercer said one of the additional questions you will be asking is what industries or types of companies are perspective or former employees choosing to work for outside of H -- I would say having run into this issue, I think it is important to look at those perspectives and former employers who have chosen to work for other HCPS programs. There are four other HCBS waivers outside of OLTL. And I can tell you as former supports worker who was charged with recruiting people for those waivers, those waivers offer a significantly higher wage. So there is real competition not just between someone who might go to work at a McDonalds, but someone who may choose who wants to do this work and wants to assist people with disabilities, but could do so at a much higher wage if the individual they are serving happens to have a different diagnosis and therefore is in a different waiver.
So I think it's really important that in doing this survey, not just at where people are going outside of Pennsylvania currently provides, are in fact folks going to different waivers outside of Community HealthChoices and OBRA where the wage levels are significantly higher. Thanks.
>> Thank you for bringing that up, David. Part of the study is looking at other rates within our system such as ODP.
Yeah, so we had in June. So I wanted to make sure you knew that. That sort of what often people refer to as parity, the evaluation is occurring particularly across OLTL and ODP.
The survey is one component. There is many others keeping the Mercer consultants busy.
>> Thank you, David.
Do we have any questions from the chat? We have lots of questions in the chat. Okay. Let's go.
>> This question comes from Brenda. Is training considered a direct cost for an indirect cost?
>> SPENCER SVENSON: It is considered one of the direct costs of delivering services since it's related to the direct staff. But it's handled separately from staff wages. So typically what we see when we look at training costs are things that are required as a part of delivering that service. Things like first aid or CPR training. So those are the costs that we'll be looking at. And those will be direct costs.
>> Thanks, Spencer.
The next question is from indicate Blaker. Why weren't supervisor rates included in the direct care worker rates?
>> SPENCER SVENSON: So I'm not sure which part of the survey they're particularly asking about. But supervisors and direct care workers, along with any other staff that are directly related to the delivery of service, will be built into beverage mark rates that we're doing. There will be separate line ins the built up of the rates. Let's say you have a direct care worker and a

supervisor and that supervisor supervises, for example, six direct care workers. We'll take one sixth of that supervisor's wage and attribute it to the delivery of the service from the direct care worker. They don't go on the same line. But anybody related to the direct delivery of that service will be considered.
>> Thanks, Spencer.
The next question comes from Margaret. Will OLTL consider a rate adjustment or rate analysis for service coordination in the OBRA waiver, which unlike the CHC waiver is a service in the OBRA waiver?
>> That's a great question. With regards to service coordination, the fee for services, that's something we will have to take back. At this point in time, we do not have a study underway.
>> Thank you, Juliet.
The next question comes from Laura. How will you ensure providers complete this only accounting for the settings being surveys and not for inTANS covering the wages under other programs that receive a higher reimbursement, such as private pay?
>> SPENCER SVENSON: So -- yeah. So we're not looking by payer in this survey. We're looking for, let's say you're a personal assistance agency. We want your average wages. Not the proportion that you would say is private pay or the proportion that you would say is MA versus commercial, anything like that. We want the average wages that you are paying your individuals.
So no separation by payer. And really the distinction that I would make is we're asking that any providers that are delivering more than one type of service, let's say you deliver personal assistance and some of the employment services that we're looking at, we would like one survey for each of those. Ultimately, to make sure that we're separating out those wages correctly. Because somebody who is delivering employment services is paid differently than someone delivering personal assistance.
That's the clarification there. But not looking for differentiation by payer.
>> Thanks, Spencer.
This next question, there are several comments from Kelly. I'm going to read them separately. My son is my caregiver. He has never received any training. One agency told him the answers were on the back. I said he won't be using them.
These cases are invested by the department of Health protective services through the office of Aging. They investigate if someone is physically abused or financially exploited. How can they assess clients when only doctors are able to provide diagnoses?
>> JULIET MARSALA: Service coordinators do not diagnose clients. I don't know if we have clarity on that information. That is not the role of service coordinators. They work with the participants to build their service plan, their person-centered service plan. They work with participants to complete a comprehensive needs study utilizing an internationally validated tool that they received training on that is well within the scope of their credentials to complete.
In addition to other elements within either the managed care organization Community HealthChoices program and our fee for service program, that service coordinators are required to do as part of their responsibilities in supporting participants in the programs.
Service coordinators that are not licensed and credentialed clinicians do not do any diagnosing whatsoever.
>> Thank you, Juliet.
Kelly, also I see your hand is raised if you want to unmute to ask follow up questions. I'm going to unmute you now.

Are you there?
>> Hello?
>> Hello.
>> Hello. Thank you. I know those were a lot of questions. Kind of typing them as we were going.
I wanted to let Ms. Juanita know that she's not alone. I had a bad experience with an aide screaming at me on several occasions. I actually recorded it and turned it to the department of Health. And they investigated it. No one reached out to me. I did play it for the intake worker. But no one reached out to me to hear it. And they found it invalid because it was a he said, she said kind of thing. When I actually had proof.
And so it's very difficult. I understand how you felt. I worked for the Office of Aging and started the waiver program. So we essentially did the investigations, and it was very disheartening. And I'm sure that's how you feel. Just hang in there, girl. We really do need better reform on there are so many agencies. When I started, there were ten agencies in York County. And now there are so many. I had one that somehow had a young lady who was employed with them who had a PSA against her. And I think we need to do background checks more than once a year. I think we need to -- they aren't training these individuals. Like I said, my son is my caregiver, and they are not training them. My adopted nephew is my other caregiver, and he hasn't received any training. And actually, he hasn't even had to take a test yet.
So there's things that things we really need to be concerned about. I know that's not the topic of this meeting. But because it was brought up, I wanted to just mention that.
>> JUANITA GRAY: This is Juanita. Thank you. What is your name?
>> My name is Kelly.
>> JUANITA GRAY: Thank you, Kelly. I'm glad you inputted your comments. Like I wanted to panel to know, thank you for being a part of the opening of the waiver program and having knowledge of what it takes to do a better job for the participants. And I know you're a participant yourself.
And we are being mistreated from the coordinators and the management in the CHC. We are deft being exploited, I believe, taken advantage of. And I heard what you said. And they don't -- I wanted the panel to know your process the OLT and CHC is terrible. It doesn't benefit the participant at all. It actually hinders us from getting our work out and our needs met. And it is an abusive process. That's what we want to eliminate. The hearing process, everything is only to protect the coordination team, the management, and it's against the participants. So it should be outlawed and taken out and be redone with participants having their own panel. You guys don't have the right process put up.
So I made a complaint as well. I already made a complaint, Kelly. But it wasn't within the OLTL, because they don't hear it. And I'm going to go further, like I said. But I just wanted y'all to know this is what we have to do. And our direct care workers deserve better. process, through our care, through our hours. Through everything. And it won't stop here.
>> Thank you, Juanita. And thank you, Kelly.
>> JUANITA GRAY: You're welcome.
>> Kelly, in response to some of your comments with regards to your concern about the agencies and the quality of the experience of the agencies in your area that you have. I'm sorry you have had that experience. That is not the type of experience we want anyone to have from any of our agencies within our Medicaid enrollment networks. I imagine the MCOs would not want those agencies within their networks. We are really focused on improving the quality of our

agencies.
In addition to the great notification to the Department of Health of your concerns, I also wanted to take a moment to highlight a couple of things.
One, we also have our participant hot line within the Office of Long Term Living. Feel free to use that as well. We want to know what's happening in agencies in our network.
The second thing I wanted to let you know is also all of your MCOs, I don't know which one you are with, but they also have a complaint hot line and I'm sure they would want to know about that type of operation within their networks. They also strive for quality.
In addition, I would be remiss if I didn't pick up on the fact that you hired two great family members to support you. I want to be sure that you're also aware of the participant self-directed model of services where participants can hire their own attendants and work through that model instead of an agency model. It's a model that should be offered to all participants as a first choice for participant assistance services within participant directive. Similarly to agencies, participant directed workers are offered trainings, including an eight-hour safety and orientation training. That is how if you were in Community HealthChoices via and through the FMS provider, the MCO's contracted trainer. I wanted to make sure you were aware of those things as a response to your comments. I encourage you to please always let us know. There's an organization out there that is not beholden to the requirements and responsibilities that they have to be enrolled within our program. Thank you.
>> Thank you, Juliet.
I see that another hand is raised. Gwenda, you are being unmuted.
Are you there?
>> Yes, I'm here. My name is Gwenda Forker and I keep hearing about how these trainings are offered. I'm here to tell you I just went through an on boarding with an agency. Those trainings that you speak of are so general that none of it is geared toward the individual.
I have circumstances where I have three different people that require direct service provider. And one of them has stage three dementia. And I requested the agency to provide training, and their response to me was they're not required to provide trainings that are geared toward the individual's needs.
Now, I just went through the on boarding with somebody else that has dementia, and the training that they gave me was a piece of paper that stated what my duties were such as lighthouse keeping or what her needs were as far as transporting to the bathroom. There are no specific trainings.
My mother has the stage three dementia. And her care workers were never offered any type of training, except for the one that I requested. And they did it and it pertained nothing toward her specific dementia.
I don't know if that makes any sense or not. There's such a -- dementia is so wide that each person is different. And the service coordinators are made aware of what the differences are. So I feel like when an agency takes on a client, they should be made aware of what her individual needs are. As far as a person. They're not being treated as a person. They're being treated as a general public. And that just can't happen. It cannot happen.
>> JULIET MARSALA: What you're saying makes absolute sense to me. And I thank you for raising those comments. Certainly has wheels turning in my head.
>> Can I make a comment about training? It's directly to this point.
>> Go ahead, David.
>> Thanks. I want to actually enhance on what Juliet was saying about the consumer directed

model. As a CLE, I have seen our employee go through the training. I can tell you that she did have training on dementia care. She did have training on a variety of different support needs. And was paid to do that training.
And in fact, got a bonus for completing additional trainings. Now that's the participant directed through Tempest. So I hear you about the agency trainings. I would just say that really you should consider participant direction. Because from my experience as a common law employer, the training that at least being provided right now is much more expansive than what you folks are saying the training that you're receiving through agencies.
>> Thank you, David, for your comments. And happy to hear that those trainings and the self-directed, participant directed are going well.
>> This question is from Perry. The word present seems very broad under the proposed revisions to the child abuse clearance section. Requiring additional background checks clearances, requirements, any time a child is present would create compliance issues any time a child visits a consumer while services are being provided. It would also be difficult for providers to monitor or anticipate unexpected or irregular visits in advance. Children being present every day such as day care as an example is occasionally. Would OLTL consider making this language more specific to address circumstances when children are present on a regular or consistent basis on opposed to occasionally or a nonregular basis?
>> Thank you for the comments. I see that Robyn is writing it down. And making a note of it for consideration. Thank you.
We just talked with them. But thank you, Pam. I appreciate it.
>> This question comes from Dan Hart. Who will be responsible for determining the hoarding disorder? Will there be an expected turn around time to identify the hoarding disorder and establish behavioral health services? In our experience, even though the CHC participant may have a hoarding disorder, they do not have a preexisting hoarding diagnosis and wouldn't be actively engaged in appropriate health services.
>> A couple of things there. All important comments and questions, Dan. First is hoarding disorders can only be diagnosed by those clinicians of the appropriate licensed level to diagnose a hoarding disorder.
Should individuals need behavioral health services and they are being served in the Community HealthChoices program as a member in our LTSS program, the service coordinator would certainly do all that they can to help connect that individual with behavioral health services, identify their needs, follow that through, and within each of the MCA programs, some of them have their own assessment tools that they work through. So the diagnosis if it's not already present and needs to be pursued, certainly, they will get the support to help them access those resources. But I want to make something very clear. It's support to help them access those services. If someone doesn't want to access behavioral health services, it is not something that we can do for them.
Okay? We can encourage, use motivational interviewing, try all the tools in our toolbox, educate and inform, but unless that person chooses to pursue those behavioral health services, we can't force someone into getting a hoarding disorder diagnosis.
>> Thank you, Juliet.
This next question is from -- what date does the public comment end for the HealthChoices amendment? Can you give the address for submissions again?
>> Jen is coming up.
>> I'm coming up with Robyn. This is Jen. I will ask Robyn to correct. But I believe the public

comment period for the waiver renewal and the OBRA waiver amendment will end close of business July 14th.
>> That is a Sunday. And we will keep them open until that time frame. So even though it's a Sunday, keep the comments coming.
>> And I think the second part -- I'm sorry, Robyn is going to take over. I think the second part of the question was to get the address where to send the comments. I will turn that over the to Robyn.
>> Are you looking for the web address to find the documents for public inspection? Or are you looking for the email address to submit the comments to? Because the email address would be -- let me write it down so I say it correctly.
So the address would be Ra-pwoltlwaiverstandard@Pa.gov. This web address appears on the website and in the public notice that was published in the Pennsylvania Bulletin on June 15, 2024.
And I'm looking at the captioning. And that does look correct.
>> And this is Carrie. With that, I think we are going to have to close our meeting for today. I thank everybody for the vibrant conversation and submitting your comments and questions. And those that are in the chat, please look for the follow-up documents as OLTL will go back and try to answer those for the next meeting.
Thank you so much for everybody attending both virtually and in person. Hopefully, we will see you next month. The dates are -- somebody help me out.
>> Sorry. Wednesday, August 7th, 2024. Same great place, same great topics.
>> Thank you very much.