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Date: 06/04/2025
Event: Long-Term Services and Supports Subcommittee Meeting

>>KATHY CUBIT: Good morning everyone. This is Kathy. We will get started at 10 o'clock, thank you!
Good morning everyone! This is Kathy Cubit, I want to welcome you to the June LTSS SubMAAC meeting I want to start off by saying this meeting is being recorded. Your participation in this meeting is your consent to being recorded. And with that we will start with our roll call. Is there somebody from OLTL that can announce the attendance in the room?
>>JULIET MARSALA: Hello, good morning, this is Juliet Marsala, can you hear me?
>>KATHY CUBIT: Yes.
>>JULIET MARSALA: In the room currently seated at the table we have Michael Grier in addition to Randy Nolan who is sitting next to him as well.
>>KATHY CUBIT: Thank you, Juliet and Randy! I will do some of the local for folks that are attending virtually, we have Carol Marfisi, Cathy Bollinger - let's see - Laura Willmer-Rodack, Linda Litton - Michelle Garrett and Patricia Canela-Duckett.
>>SPEAKER: I'm here.
>>KATHY CUBIT: Thank you. I do want to mention that Cindy Celi is sending an alternate Brian P who looks like he is also in attendance and Minta Livenwood sensor Gretz and Pam Walz will be joining a little bit late. Is there anybody remotely that joined or that I missed - and I see Anna Wright is now on.
>>SPEAKER: Good morning, thank you.
>>KATHY CUBIT: Anna Wright has joined. Any other members that I miss? It looks like -
>>SPEAKER: Good morning. This is Neil Brady.
>>KATHY CUBIT: Thank you, Neil. And it looks like Jay Harner has just joined.
>>SPEAKER: Yes, thank you.
>>KATHY CUBIT: Good morning. And thank you, Michael, welcome. We are just at the top of the hour.
>>SPEAKER: Good morning, this is Lynn Weidner.
>>KATHY CUBIT: Hello, thank you for joining. Okay, anybody else remotely or members that have not been announced? Okay, we will announce folks as they join and enter the room. I do want us to begin with some of the housekeeping, this meeting is being conducted in person and as a webinar to comply with logistical agreements will end promptly at 1 o'clock. To avoid background noise, please keep your devices muted and your microphones off unless you are speaking, if you are attending the meeting in person, please keep background noise to an absolute minimum. The room is fitted with ceiling microphones to pick up everything. Remote captioning is available at every meaning meeting and the captioning link is in the chat. It is important for only one person to speak at a time, please state your name before commenting and speak slowly and clearly so the captioner can identify conversations and speakers. Please keep your questions and comments concise to allow time for everybody to be heard. Webinar attendees may limit questions and comments into the questions box in the go to webinar or use the raise hand feature to be put in the queue to speak life. Those attending in person should

use one of the microphones and wait till they are called upon. Microphones are limited and so you may need to wait for OLTL staff. The general public should use the microphone in the floor stand at the rear of the committee tables. OLTL staff are available for assistance. Before using a microphone, please press the button located about the middle of the microphone to turn it on. When you're finished speaking, press the same button to turn the microphone off. Time is allotted on the meeting agenda for two public comment times. If you have questions or comments that were not heard, please send them to the resource account email found at the bottom of the meeting agenda and on the LTSS SubMAAC webpage. In the event of an emergency or evacuation, everybody must leave the building and assembled in the first responders Plaza. OLTL staff will be available in the safe area in front of the elevators to provide any assistance, please see the back of the agenda for more information.
And before we move on to Juliet I just want to check to see if any other members have joined that have not been announced yet? Anybody in the room?
>>SPEAKER: Juanita Gray.
>>KATHY CUBIT: Thank you, Juanita Gray, you joined remotely.
>>SPEAKER: (INDISCERNIBLE).
>>KATHY CUBIT: Thank you, Rebecca.
>>SPEAKER: In the room we have Matt Seeley and Ali Kornley.
>>KATHY CUBIT: Thank you, Juliet. With that, the floor is yours Juliet for the OLTL updates.
>>JULIET MARSALA: Great, good morning everyone, thank you for joining us today for the LTSS subcommittee to have a few update to go over. So, we can go to the next slide. You can see a little bit about our agenda, updates and recent OLTL communications, revalidation reminder, what we a reporting and the statewide preferred drug list.
So, if we go to the next slide, folks are familiar with this slide, there are no new updates to the CHC procurement, it continues to remain. If we go to the next slide we will highlights recent communications that have gone out and been posted. The first one is the operations memorandum, 2025 - 07 which is related to denial notices and complaint and grievance reviews, this is an operations memo for unity health choices and it was posted to our public site in addition to the extranet with the issue date of May 22, 2025. So, this memo provides additional clarification related to denial notices, the in person review requirements and requirements for complaint and grievance committee. The memo clarifies that when CHC MCL managed care organization issues a denial notice or complaint for grievance decision notice, the CHC MCL is not required to put the name of the individual who made the decision to deny the services or participated in the review committee on that notice. Instead they should include a description of the individual's pertinent professional background, experience and qualifications. However, CHC-MCO should also maintain a written record that identifies the individual making the determination and that information must be made available upon request by the participant or the department. If we go to the next slide we also wanted to highlight for our sister agency the Pennsylvania Department of aging that they offer a caregiver support program and they have for some time which provides tools, information and support to caregivers. This is a program that aims to alleviate the stress does associated with caregiving by focusing on the well-being of the caregiver. Providing access to respite care and formal and informal supports as well as long term reimbursement for out-of-pocket costs associated with caregiving related services and supplies for individuals eligible for their program which is not a Medicaid program and so we certainly encourage you to take a look at those community resources put out through the Pennsylvania Department of aging.
In addition the Pennsylvania Department of aging on Wednesday, May 28 of this year lodged

APA care camp. And a link to that care camp will be sent out along with our presentation. And DPA care camp is a collection of tools and information to address the challenges in the caregiver journey. And it is a part of the aging our way PA and they were cast with writing a dynamic, interactive and comprehensive caregiver toolkit to address challenges faced by informal unpaid caregivers and to provide practical solutions and resources to support their entire caregiving journey. So, we put this out on our OLTL listserv which was released on June second 2025 and that listserv announcement provides additional information on the care kit which includes a shareable one page flyer which includes a QR code so folks can easily access the information and the resources.

Pennsylvania Department of aging has been invited to the LTSS subcommittee at a future date and I think it is July, we are working to confirm that. That will be to share those valuable resources with everyone on the committee.

If we go to the next page, just a reminder about provider enrollment - the first one is revalidation, it is 2025 and so we anticipate this year is going to be a year of large volume of provider revalidation given this came out 10 years ago at this point and so it is a cycle where there is going to be a large number of providers that need to revalidate for their Medicaid enrollment. This is critically important. The office of long-term living will send out an electronic notification to your primary email, your primary contract contact and so it is important to go into your provider profile and make sure that is both updated and that you add to your email list. So that the email notification does not get caught up in the filters that you have. We send out a notification 90 days in advance and a reminder 30 days in advance and we do highly encourage folk to get started as soon as they get that 90 day notification to be able to get started earlier. So, again critically important to go into your inviterprovider enrollment profile and update those. In addition, as a reminder, if you are a provider type that also requires a Department of Health provider licensure, those renewals are also required for your ongoing Medicaid enrollment. It is critically important that you keep those licenses current. If those licenses with the Department of health lapse, your Medicaid enrollment will lapse. Concurrently at the same time regardless of your validation or not because that licensure is a requirement for your enrollment and so we do not want folks to be terminated from Medicaid enrollment unintentionally and so please keep those, and those renewals up-to-date. On our slide here we have contact for our provider enrollment team and you can go to them for your revalidation questions and needs and concerns related to your provider enrollment profiles and we also have our provider support team, resource account email and so folks can go to the provider support team for questions with ongoing operations and we have our toll-free OLTL provider operations number which is one 800 - 932 - 0939.

If we go to the next slide and I shared this at the last subcommittee meeting and also on April 16 we communicated by the listserv a reminder of the requirement to report the use of the ARPA funds that providers had received and that report to us was due on May 30 and so we are almost a week after that date and there are some providers that still have not put in their report as far as I know that portal is still open and has not been closed yet, but it may any day now and we will have to take a look at those reports and identify who has not submitted the report and potentially pursue fund recruitment. I would not like to do that. So, if providers, please check on your status, please make sure that is done and in particular if you receive the HCBS funding or ARPA funds from act 2022 - 54 COVID-19 relief funding from the office of long-term living. We are required to share those reports to our partners in federal agencies and to account for that funding or potentially have to return it and I also do not want to return it. And so I just want to give you that final notification.

If we go to the next slide, we have a couple questions come in to clearly with the GLP-1 and so we wanted to talk a little bit about the statewide preferred drug list and so the Department of human services maintains a statewide preferred drug list to ensure the Medicaid pogrom beneficiaries in our fee for services and our health choices delivery systems which is the community health choices and physical health choices have access to effective pharmaceutical care with an emphasis on quality, safety and optimal results from the drugs that are prescribed to them. And so the statewide preferred drug list or PDL is updated annually, but it does not preclude beneficiaries from getting new drugs that come to the market as long as they need the Center for Medicare and Medicaid services meeting CMS criteria or Medicaid covered drug. Drugs that fall under a class on the statewide preferred drug list are generally designated as nonpreferred until they are reviewed by the pharmacy and therapeutic committee. And these drugs remain available to Medicaid beneficiaries through the prior authorization process while they are in that evaluation status.

And if we go to the

next line, we have a list of the current treatment agencies that are on the preferred list for the preferred agents on the left side and I am going to get all of these names potentially wrong and so bear with me, Saxenda, Wegovy, Zepbound, P capsule and P tablet (SP?) those are the ones on our current rug list and we know that there are a number of sort of drugs containing a GLP receptor that is also on our nonpreferred list and we will include that list as part of the presentation materials afterward and I will spare you my attempts of reading them out loud.

So, if we go to the next slide we also took a look at based on inquiries and concerns coming in on the community health choices specific utilization of these GLP-1 and what we are sharing today is the utilization based on the data that we have about prescribing and so these are the numbers of prescriptions that have been written and approved and processed community health choices. And so as you can see from this tabulation in total for 2024, the state is clear with 2024, there were a total of 47,000 prescription drugs written for GLP drugs. So, there is a lot of used in the community health choices program and things to keep in mind about this data, this is not account of people, this is a count of prescriptions and if somebody changes a drug, they may get prescribed a different drug and if somebody changes a dosage within the same drug, they may get a second script within the same timeframe for that new dosage. Okay? And we did want to share, this is the best data that we can get on the short notice that we have about the use of GLP-1 to show folks certainly they are in use and certainly they are accessible when medically necessary.

Recently if we go to the next flight the Department of human services connected to our state plan released a Medicaid bulletin related to prior authorization for obesity treatment agents and pharmacy services and that was issued August 7, 2024 with an effective date of September 2, 2024. This Medicaid bulletin outlines the requirements for the prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for obesity agents submitted for prior authorization. This does not go along with the GLP-1 prescription or other already approved needs such as diabetes, this is specific to obesity treatment. And just as a reminder, this is a part of our state plan, the CHC-MCO are required to follow this bulletin in addition to the CHC agreement for how they handle prior authorization and that process has not changed. The bulletin just gives out the criteria of what needs to be evaluated in the already established prior authorization standard process and the CHC-MCO will integrate this bulletin into that process as directed. And so if a participant is prescribed a GLP-1, the request for prior authorization would go to the CHC-MCO to be evaluated through their standard process already. And I did want to highlight that. I also wanted to take a moment to provide an update to

a question that recently came in through the office of long-term living as a follow-up to the last meeting and some additional guidance that went out from our Bureau of human services like think about personal care home and serving individuals who may rise to a nursing facility medical eligibility level of care and we know that our waiver services programs, individuals who are in residential rehabilitation settings, that serves 4 to 8 persons and has been approved and is enrolled in Medicaid waivers and also in the eligibility level of care and also required to be both accredited and licensed in the personal care home and the Bureau of human services team will be reaching out to every enrolled rehabilitation provider to provide technical assistance through the required waiver process that you will need to have on hand and in place by July 1 and so please look to their outreach and information specific to those provider types.
And with that I believe we are ready for the first public comment time, Kathy.
>>KATHY CUBIT: Thank you, Juliet. Before we moved to that I want to mention that Leslie Gilman has rejoined remotely and I don't know if there any other members that have joint if you can announce yourself now.
>>SPEAKER: Hello, Kathy this is Melissa D attending on behalf of Monica V.
>>SPEAKER: Hello, this is Brian Petkoff covering for Cindy. I had to switch my phone, but I'm here.
>>KATHY CUBIT: Thank you. And also before we start for questions with Juliet and the open public comment I do want to follow up to say that the letter that we worked on at the last LTSS MAAC to Secretary Kennedy about the administration for immunity living restructuring was sent and I want to say thank you to everyone again, particularly Mike for the work on that and in this month and the meeting following up to May 's meeting does include some resources for advocacy, because continued advocacy is needed not only for the programs from ACL, but also the Medicaid cuts which we were discussing last month. But, thank you to everyone and I don't know if Mike wanted to say anything before we proceeded with public comments?
>>MICHAEL GRIER: I think you covered it. Thank you everyone for your support and I thought it was really important that we as a subcommittee had some response and so thank you.
>>KATHY CUBIT: Thank you again, Mike. And with that I will put it up in the room for questions to Juliet and public comments.
>>JUANITA GRAY: Thank you to everyone that is present. I have a problem with I want to go back to the removal of the person's name when there is a denial and just listing their credentials. That should not be allowed because that name, that person is the reason for the denial and so therefore it is harder for the participants to make a comprehensive complaint and assessment of what occurred. So, that is something that is not good and I'm going to be against it and I will be writing to have that changed, that is not fair.
>>KATHY CUBIT: Thank you, we appreciate your comments and feedback, just to clarify the linkage in the CHC agreement did not change. It is certainly an interpretation and absolutely will make note of your comment, thank you for sharing.
>>JUANITA GRAY: I'm sorry - please forgive me, one more thing - the process is already difficult and I see that - they lessened the days for the process, but it is still not helpful to us because it does not work for us, everything is getting denied and I wanted to say that I watched and went over things with other persons and that is what is happening with United healthcare and they are doing the same thing, putting people in jeopardy and denying services and is not fair and it is not right and it is unhealthy and unsafe.
>>SPEAKER: Thank you, we definitely appreciate that feedback. I did want to note that we have not changed or lessened the days for the hearing and appeals process. That did not occur for community health choices and I just wanted to kind of give you that assurance that we have

not shortened any time frames.
>>JUANITA GRAY: I have received notification from somebody with five days and 70 with 15 days for them to be able to respond, but it is the process that is just a very unfair process to us as disabled persons, it is like we are fighting all the time and that is not healthy and for our care. It has to be changed. It is very bad the way they have it set up. It is just negative and we are the participants and it does not seem like it is working on our behalf. It is working against us and the program is supposed to be for us, it is not right.
>>SPEAKER: I hear you, thank you so much for those comments. Kathy, Lloyd is in the room with a question or comment?
>>LLOYD WERTZ: I actually have two questions the first one Juanita is for you because I don't understand the process, can you tell me why you feel that removing the name in-service denials is unfair? I saw it as a confidentiality thing and so I don't know if that means anything or not -
>>JUANITA GRAY: I cannot hear because somebody keeps coughing.
>>LLOYD WERTZ: Sorry. Can you tell me why you feel the removal of the applicant's name in the case of a service denial is unfair?
>>JUANITA GRAY: Yes. Because, I just feel that the person is making the - and you said it is confidentiality, will I just feel like - it is like your doctor in other words if a doctor says anything, that is not confidentiality, it is because you have a relationship with that person and they have a relationship with us, but not in that kind of way, but they are making a very important decision on our care and so nothing should be hidden from the participant. That is for a third party, but it is not for us. It does not make sense to me. You have to know what is doing and who is making decisions and so that is not right.
>>JULIET MARSALA: Juanita, this is Juliet Marsala, I want to ensure you that the name is available to the participant upon request and so it is not a secret to the participants, that person is made known through the hearing and appeals process and typically occurs when the individual goes through a hearing or appeal when they request additional information, that information is oftentimes a part of that request and so I just wanted to make the clarification that this change is not to keep the name from participants by any means, the participants do have a right in the process to ask questions to a person who is part of that determining factor.
>>JUANITA GRAY: My last part to this is just the process of requesting information, every time we try to request it, they withholdings and they don't give it to us anytime I've asked for graduation, I never received it and so it is like to me it is like another just - sorry I'm having a hard time today - it is just a bad process for us participants it is like we are always trying to fight for something and it is not healthy for us, that is all I can say right now I am having a problem and I'm not doing well right now. By speaking at stuff today, but please forgive me I'm not well. And I just had to say - I am having a problem with how these services are being you know delivered to us, they are not - it is not adequate and it is not good.
>>SPEAKER: I hear you, Juanita I will have a member follow-up with you today about information you have requested it may not have received from your managed care organization. Kathy, I am handing this over to Lloyd for the second part.
>>LLOYD WERTZ: Thank you very much, thank you Juanita. The next question relates back to the revalidation redetermination processes for providers. And having recalled this from a number of years back and in a few years back, do you know that the current delay time between the time the provider can apply and actually approving that provider and one I have heard it go from 90 days to 24 days - do you know the number right now?
>>SPEAKER: For a new provider enrolling or for the validations?
>>LLOYD WERTZ: Initially for a new provider but the revalidation is the greater concern.

>>SPEAKER: I don't know off the top of my head what the timeline is for new providers in terms of the provider enrollment process processing time upon receipt of vacant needed application and we can certainly acquire with OMAP and for the same with revalidation's we can try to take a look at what information we have and report back out, but it would be for the time of the completed application, there are times where we get incomplete applications and we have to go back and forth if there may be policies or requirements that come in that do not meet the standards that we need that the team provides technical assistance on and so the sum of that can take some time, but we can certainly look at processing time from the time of the complete application, because we certainly do not have control over how folks act or react to those.
>>LLOYD WERTZ: I don't think you want control over that! And can you tell me the day or is there a date by which providers must have been either enrolled or reenrolled or revalidated in the process?
>>SPEAKER: Certainly. And there are bulletins out there that walk folks through the revalidation process - just of note, we recognize in - it was paused during the PAG and came back online in 2021. And it has been enacted again since 2021 and for providers, revalidation is once every five years. And I've had to do in the past as well and it does require a significant list from the provider perspective and so we do encourage folks to get started as soon as they receive that 90 day and we hope providers are reviewing their policies at least on an annual basis and it certainly is important to get started right away with collecting those documents and submitting in the required policies and elements of the revalidation package. And I don't see any additional questions and wait, Michael Grier -
>>MICHAEL GRIER: I was wondering if you could talk about House Bill 13 seven with the nursing home -
>>SPEAKER: The adjustment factor? Okay, this is Juliet.
>>JULIET MARSALA: Thank you for that question. House Bill 1310 and actually it is timely I just presented some testimony on it this week as it was there was a committee hearing with the house committee of older adults and aging house Bill 1310 was introduced by Representative Lazzaro and it is essentially asking or putting forward or proposing is to have a floor for the budget adjustment factor for a nursing facility. Currently and I mean it gets compline needed and I will try to do in brief and currently for nursing facility rates there is a rate methodology that is based on sort of costs, allowable costs of nursing facilities. And there is a rate methodology that looks at all of those factors and looks at the differences in the acuity, like the needs of the population within a nursing facility and each facilities populations needs changes over time as they admit folks and discharge folks and so that acuity can go up and down as well and so there is a methodology that can create a proposed rate for nursing facilities based on costs. And as a part of that methodology, the last piece of that methodology that gets applied is what we called a budget adjustment factor. What the budget adjustment factor does is that it takes that whole process and makes sure that the rates are always within what the general assembly allocates. Okay, so that is what the budget adjustment factor does. If the general assembly allocates $100 million, but the cost as reported in show that may be nursing facility needs $120 million, but the general assembly decided the Commonwealth has other priorities that are taking precedence that they can only do $100 million. The budget adjustment factor makes sure that all of that money, $100 million goes out the door, but it goes out in a way that is equitable to all of the nursing facilities,? Like everybody needs to take a cut and the budget adjustment factor you know distributes the entire amount out to each of the facilities based on the other outcomes of the methodology. House Bill 1310 is proposing that the general assembly is required to limit that to 0.90 and so what it does is that it says to the general assembly that you must allocate at least

0.90 or 90% of the funding that is a result of the cost methodology announcement. And so what that means is that regardless of what the general assembly would want to allocate, they have to allocate at least that much. So, now they can do that at any point and they can allocate up to .95 4.98 or they can allocate lower than 90 and they have the control today and this bill kind of takes away that flexibility and says you must at least do this.
>>MICHAEL GRIER: Do you know what it is right now, is it .90 right now?
>>JULIET MARSALA: It fluctuates every quarter on what it can be and so I think I have it in my testimonial, I think it is in the high 80s right now and the last couple of years it has gone as high as .93 and it has gone lower as well, but I can sure that certainly in the follow-up.
>>MICHAEL GRIER: This seems like a threat to HCBS, that is the way that I am interpreting this, it is guaranteed amount of dollars going to the nursing facilities.
>>JULIET MARSALA: It is a guarantee of a certain allocation - yes, I would concur with that.
>>MICHAEL GRIER: All right, thank you and I am sorry we were not able to be there to help support on that, it just seems - I am not really that familiar with it until your explanation of it and I understand it, I don't necessarily agree, but I understand that they are looking from a dollar standpoint that this is - and now they are saying that it is going to be up to 90%.
>>JULIET MARSALA: Yes, but that is the main part of that bill, there is another part in their where it is proposed like every year nursing facility rates get rebates it is a requirement, the rebates it every year, that is in statute. The proposal is also that rebasing is sort of cause for two years and so if they do the minimum floor, they can also pause the rebasing for two years, right? To offset the cost of what it would be in the office of long-term living has assessed if we were just to raise that it would be approximately $325 million in state funds and in others testimony yesterday they said because the rebasing of two years will be paused, they estimate the cost is only $140 million and that is their estimate, not ours. But, what that means when you pause rate for two years it does not make potential rate increase needs go away, it just means two years from now potentially you will have a much bigger funding need.
>>MICHAEL GRIER: What is that like?
>>JULIET MARSALA: What do you mean what is that like?
>>MICHAEL GRIER: Home care has not seen that.
>>JULIET MARSALA: You know Matt Seeley - does he have a microphone?
>>SPEAKER: Repeat my question.
>>JULIET MARSALA: Okay, Matt Seeley has asked what is that like? And explained that this is what the home care agencies currently undergo, paraphrasing somewhat and so yes - what you may have seen in the rate wages study is that rates don't increase year-over-year and then you get a gap and that is potentially the outcome of freezing the rebates for two years. Does that answer your questions? Okay, Kathy, back to you.
>>KATHY CUBIT: Thank you and I want to mention that Gail Weidman had joined remotely and it looks like Carol Marfisi has her hand raised, are you able to take yourself off of mute?
>>CAROL MARSFISI: I have two. One is about the letter and the administration of my advocate and the decline of OLTL and the other is about the provider ability - administration. My question is why - and in the letter we put that we anticipate a response - now, what is a reasonable time in government language to expect a response?
>>JULIET MARSALA: Carol, this is Juliet, is it okay if I paraphrase?
>>CAROL MARSFISI: Yes.
>>JULIET MARSALA: And you can confirm my understanding. So, what I heard is now that we sent a letter to the Department of Health and human services and it addresses the concerns of you know the dismantling of the ACL or moving of ACL to another agency, we did ask for a

response and what do we believe is a reasonable response time for the federal government to respond if they respond at all.
>>CAROL MARSFISI: Yes.
>>JULIET MARSALA: Okay. I cannot hazard a guess as to what is a reasonable response time for our federal partners, I would hope that they would respond to us within you know 30 to 90 days generally speaking depending on the issue, but there is no set timeframe that I am aware with regards to receiving a response from them. Certainly if one is received we certainly would share it.
>>CAROL MARSFISI: And a follow-up as advocacy effort, what comes next on our part?
>>JULIET MARSALA: So, this is Juliet, what I would say at the federal level in the federal process as you know they are still going through their budgeting process and I understand that Department of Health and human services, they have released customarily their budget letter and proposal and I would say perhaps the committee may want to take a look at that and see what is proposed and certainly what is proposed is often very different than what is enacted. We know this from our own budgeting process and certainly we are following along with that and would recommend that perhaps as a interim step that may be of interest to the subcommittee.
>>CAROL MARSFISI: What I'm hearing you saying is that there is no point for any further advocacy strategy .
>>KATHY CUBIT: This is Kathy, I just want to jump into add to what Juliet had said in terms of further advocacy. I think in terms of the group as a whole, we are not - we don't have any plans at this point, but we are encouraging advocacy from groups and individuals and in the follow-up document sent from May 's meeting, the very and has resources to help with advocacy efforts, because there is a lot of group coordinating advocacy at this time. I know Carol you mentioned you had another question we are going to say that for the second public comment period because we need to move on with the agenda with the presentations for life and so again, we will circle back to your second question at the top of the second public comment period. With that we will move to Aaron Slabonik to introduce our life providers and their presentation. Go ahead, thank you.
>>ERIN SLABONIK: Good morning, everyone, can you hear me okay?
>>KATHY CUBIT: Yes, we can hear you, thank you.
>>ERIN SLABONIK: Okay, you are welcome. I think there is a introduction slide - there we go. If you can go back one - thank you. So, good morning everyone. My name is Erin Slabonik, director for integrative care programs at the office of long-term services and I look at long-term life program and operations for our 11 dual special needs Medicare advantage plans in Pennsylvania. If you can go to the next slide. We do have two of our life provider organizations with us here this morning to talk about how they provide behavioral health purposes in their unique programs and I just wanted to give a little high level overview of the life program who may not be as familiar and so LIFE is the all-inclusive care for the elderly or PACE, we differentiated from the pharmaceutical program in agent, that was the thing at the time of the limitation of LIFE in Pennsylvania. LIFE is a jointly administered by CMS and the state and it is a all-inclusive Medicare and Medicaid program that provides comprehensive medical and social services. So, with that that means all of a person's Medicare and Medicaid services and then some are provided by one insurer and one provider being the life provider organization. As part of that comprehensive model, behavioral health services are a part of that program model and delivered through that same program organization. All LIFE provider organizations are required to provide behavioral health services to all participants who are determined to need them, but there are not requirements on necessarily how they deliver these services and it can be in-

house services, it can be contracted, but we have two providers here today to talk about how they do that within their programs. So, we can go to the next flight. So, today we have with us Leslie and Terri.
>>TERRI AVERI: Thank you so much for having us, we are excited to be able to share this information. Leslie and I have put together just a small PowerPoint and we are open for any conversation or questions and if we are ready, we can go ahead and move forward to the first slide. We are from two Tiffin agencies both within Pennsylvania and we wanted to take a few moments to just go over what we feel are some important definitions. And we talk about behavioral health and mental health and psychiatry and they are often interchangeable. But, we just wanted to put out there when we start looking at these definitions, these are the definitions that we go by with our organizations. Mental health is a individual psychological state purely psychological. Behavioral health however are the habits and behaviors of impacting social health, emotional health, physical health and we look at integrating and we are going to talk a little and explain to you how our goals are to integrate within our LIFE organizations.
The motto that most people are familiar with is the liaison where it describes behavioral health and medical professionals of varied disciplines working together to provide care for the medical comorbidities and psychiatric comorbidities and we know that our behavior and our psychological state impact both of those. And our ultimate goal is to have behavioral health integration and that is to assist where we coordinate between our healthcare providers, the behavioral health component and the support and we want to reduce stigma and so that is receiving and accepting treatment that becomes the norm and we want to improve continuity of care because we know in behavioral health and mental health in general that that can be a problem and that is an area that is addressed often, okay? I am going to turn it over to Leslie for our next slide and we are going to talk a little bit about why we do integrate behavioral health.
>>LESLIE MINNA: Before you go to the next slide I'll add a couple of things that that is okay, Terri if you go back on slide. I have found that folks resume a little bit with understanding mental health is your psychological state. Happy, sad, angry, excited. Those pieces of information. I like to take a step back and then say behavioral health is about how your behaviors, sleeping, eating, smoking, drinking, exercising or lack thereof impact you. So, think about it. How do you do work or how do you do the next day when you were up all night because a fire truck kept you up? Those are very simple ways to understand the nuance difference between the psychological state of mental health and the behavioral health impact from something from a behavior that occurred. Behavioral health integration is about putting it all together in real time. So, when a patient comes into the clinic and we call them participants - I think Terri you call them members -
>>TERRI AVERI: We call them participants, as well!
>>LESLIE MINNA: Wonderful! So, when the participants are in the center, let's say somebody is in an exam room and they are feeling sad because their dog passed away and they are grieving in real time at that moment, that is an opportunity to do what we call in real time sort of a intervention. So, that is the behavioral health integration, the systematic ordination of the healthcare with how they are feeling in the moment. That might be getting in the way of their appointment with her medical provider. I hope that was okay, Terri, I jumped in a little bit there, but we can go to the next slide and I just went to give a little bit more to folks.
So, the why behind behavioral healthcare in LIFE is simply put you are improving the patient's experience, improving clinical outcomes and overall value-based care. So, what does that mean? It means catching people in real time to reduce the possibility of emergency room visits, reducing the possibility of unnecessary psychiatric hospitalization, delayed transitions so that

folks don't end up having to go to multiple levels of care, reduce stigma, reducing stigma is best seen in the concept that behavioral health providers integrated within a center or a clinic become the norm. People understand that Doctor Minna, nurse Terri, are right in the room with people vs. being told or asked by their doctor to go see somebody at a outpatient mental health facility. Also, bridging interdisciplinary teams and engagement through integration meaning sometimes in our model we have folks that let us know things that we would not have otherwise known, that PCP may be would not have known, may be the transfer driver, maybe the CNA, may be the MA. Targeted interventions, how does this come together with value-based care? When you start to see themes and trends with populations, maybe you noticed that you know five or six people have presented with a reaction to a building that collapsed in the area or a fire that happened in a immunity or a social event that have impacted folks. You can potentially put together a group to help support and so maybe pulling folks together in real time. Then it can get even further along the spectrum where you are starting to analyze trends to predict folks needs and lastly and obviously we are all in this together from our internal LIFE programs but also from the larger communities, reducing the utilization management within our community as a whole because we have limited shared resources, limited number of hospital beds, limited number of appointments within AER in real time.

I will give the next slide to Terri to dive in further to what LIFE looks like in the integrated model.

>>TERRI AVERI: Thank you, Leslie. And you will hear us probably interchangeably used the terms PACE and LIFE particularly when we have been in the field for a while because we have gone back and forth and as was said in the beginning, PACE is the nuance in Pennsylvania but not necessarily other areas and so if you can advance to the next slide I would appreciate that. I will talk a little bit about what the model looks like in a LIFE program and Leslie is going to take the next slide and talk a little bit about how behavioral health and mental health fit into that. You know at the core we have the patient, the client, the member, the participant. We called the participant that because the expectation in SubMAAC for programs is that they participate in their care. We want this to be a comprehensive holistic program and they really have to be a part of that process. And we value and respect where they are and so they truly are at the core. Every participant in a LIFE program comes in and is assigned and it is done similarly with somewhat different programs, everybody has a care provider and I can be a nurse practitioner and that can be a physician and they are also provided with a RN, registered nurse case manager to coordinate and implement the interventions and the care. We also realized as Leslie had said on the prior slide when we were talking about behavior health the social impact and so we look at recreational therapy, social implications and there is a recreational therapist at the table that is also a member of this team. Occupational therapy, if people are struggling with their activities of daily living or the modification in their homes that are giving that physical struggle, it is also probably impacting them psychologically and we look at that, as well. Dietitians. We know that we are serving a 55 and elder population and so dietary habits may be a struggle and we have a huge epidemic right now with obesity and we work on that and we work with the folks who have medications or who have heart failure or diabetes and that dietitian becomes a integral part and we also know there is a lot of emotion surrounding food and cultural practices related to eating and so it is important to have that person there, as well. We have a life center manager and they oversee -

>>LESLIE MINNA: I want to jump in really quick, can everybody here Terri?

>>KATHY CUBIT: This is Kathy, no.

>>TERRI AVERI: Transportation has been huge barrier providing care for -

>>LESLIE MINNA: We can hear her now. Terri I want to positive for justice, Terri 's building has

some construction and I think her sound has been intermittent a little bit, Terri I will jump in to help out, maybe your connection will get little bit better. She was talking about our core IDT and she was getting to review the transportation driver and I really think that is an important member of the team and so I will jump in and give you a little bit of the why behind that. And so our transportation driver is often the first person that connects with the person because in the LIFE model of care we provide transportation and so they go to the participant home or facility and they pick them. And so they can often be the person if a participant is having a bad day or does not want to come into the center that plays a critical role in using motivational interviewing and engagement in order to ensure that they want to get on the bus and come into the center for that day. A way that I like to think about is behavior health integration starts wherever the participant is at regardless of disability, that is where you start. If it is in their home, that is where you start. I think she got through the other pieces of the team, but I'll just recap really quickly in case the sound was cutting out during any of them. So, every LIFE participant has a primary care provider and it can be a RN, APA, a medical doctor as well and additionally they are assigned a registered nurse, a recreation therapist, occupational therapist, dietitian, personal care attendant, physical therapist, there is Masters level social workers which play a big role in our behavioral health program, home care coordinator and then the driver as mentioned and also in this model there is a manager of everything a LIFE program that brings an altogether and they often have day-to-day contact with the participants in the center either those that are in the center, walking around, saying hello, ensuring the needs are being met and helping it all be brought together. And then the patient is in the middle. And we call them participants and we provide a model in LIFE that is basically a community in and of itself. We want them to come to our center and feel that they are a part of a family in their community at which they are in. So, all of these people on any given day can be interacting with a participant to help support needs in real time.

I will have you skip to the next slide and I'm hoping Terri will get back on, but I'll keep going and moving along.

>>TERRI AVERI: I am on, I turned my camera off because that seemed to help and I moved into a different office a little further down the hall and I'm hoping that will help. One thing I wanted to piggyback on that you did mention was the LIFE center and that is a integral part of our team, the actual physical brick-and-mortar building where many of our participants come to receive their therapy, have meals, socialized, engage in clinic appointments and participate in groups etc.

>>LESLIE MINNA: That is a good thing to let folks know, all LIFE centers look a little bit different, but when you are walking through them, they all have various types of rooms and the clinics are embedded within the center and in hours they look a little bit different, but sometimes circular design and a day center room where activities happen and dining areas and PT, OT rooms and a lot of action can happen in each of those rooms throughout the day.

The slide that we have up now is about behavior health integration in LIFE. And so in both community LIFE and Innovage we have a behavioral health provider model of care and that person can have different titles and names, behavior healthcare manager, behavior health provider, behavior medicine specialist, that is the person that you see in the picture on the far left corner. That person can be LCS W, RN, psychologist, LMFT, professional social worker or counselor, those persons work in real time with her primary care providers to help support patients. And using an example let's say somebody lost their pet the night before or they lost a loved one and they're supposed to meet with their PCP during the day to address diabetes management, but they are not really engaged and focused in that discussion because they are

grieving the loss and so in that moment in our model, a PCP might poke their head out and go walk down the hall or message a behavioral health provider and say hey, do you have a minute to talk with Jane Smith? I am hoping that we can support her in real time. And so those interactions can happen in vivo, they can happen a few minutes later, maybe somebody, maybe that behavior health provider is with another patient and they come in towards the end of the visit, we call those curbside consults or warm handoffs. The person that represent the psychiatric consultant in the picture is the psychotropic mid management provider, it can be a psychiatrist and those are the fold that help with the phonological interventions that may be needed for the patient. Perhaps they need antidepressants or medication management course psychosis or mood stabilization, those folks play a critical role in working with our primary care provider and our behavior health provider to support the patient. That can look like a couple of different things. It can look like meeting with the patient directly one on one. It can also mean consulting with a primary care provider, perhaps the person is not able to present for an appointment. Due to cognitive decline, psychosis or mania. They work with the primary care provider to help do specialized consultation. Often the behavior health provider and the psychiatric consultant work together to consult on the case to discuss what is being seen to help support the patient. The goal of what you see in the slide is that we want to have the bulk of the interaction between the behavioral health provider in the primary care provider and the patient and less need for ongoing psychiatric consultation and medication management. Some places do it a little bit differently and I think Terri and I, we do a similarly in our programs, but this can also include grounding on patients and so the primary care provider, the BHP and the psychiatric consultant can get together and review Iversen cases and say that Mary was doing really well in the data center today and get real-time feedback that may be the meds are working or the meds are not working. Thinking about how this communication happens we can provide some psychiatric consultants access to medical records to have real-time ability to do chart reviews and that can be a very helpful feature that organizations are starting to do more of now so that all of the nuance information is in one electronic medical record. Terri, did you want to jump and I cannot see raising her hand -

>>TERRI AVERI: I agree with everything you are saying in one concept that kind of struck me which I kind of think really speaks to you know reducing stigma is that you know Leslie gave the example that say somebody had a pet that died in the come in for an appointment, having integrated behavioral health, the providers automatically just include that role into the holistic care of the participant and if you don't have the embedded it is outside, out of mind and we really miss those opportunities. And so that is incredibly exciting as a concept for us in this field to know that our 24 programs are able to do that in real time.

>>LESLIE MINNA: Also want to say one other thing and sometimes people want to know what does it look like when you're doing this with full? It can be as simple as let's say the person says I used to walk in the park with my girlfriends every day and I cannot do that anymore since I had a hip replacement and I had some issues with it. I need assistance, I need a mobility device and we want to get them back to doing what they were excited to do or closer to what they were excited to do in the past. Maybe that looks like talking to the individual and saying what would it look like for tomorrow if we just worked on having you walk down the block with your walker. And maybe they bring a friend and they say their friend moved out of state and what if we call your friend and we walked on the block and we have your friend on the phone. It is about thinking in real time of easy to implement solutions to help support people. Often people think that in behavioral health that they have to be very complex solutions. Often the most simple solution is the solution focused on interventions which are the ones that we utilize the most and

simple actions. We sometimes also do this in a group format because sometimes we start to see that a lot of folks are grieving and we have grief and loss group to help teach people in a socialized setting coping skills and tools that they are able to implement.
Moving onto the next slide I will talk to you about how the pieces of integration look and Terri if your connection is stable -
>>TERRI AVERI: I think our connection is better so we can move onto the next slide. Thank you. We all want to achieve level VI. That is the gold standard and that is true integration and collaboration. Many of our organizations and organizations in general start with level I, minimal collaboration and that is the old model outpatient psychiatry only and presents a lot of barriers. I think that for most LIFE programs we have moved past that and there have been several behavioral health integration grant studies that have been developed through the national PACE organization and Leslie and myself both have participated in that in an effort to continue to integrate and to bring the services to the participants as needed. And so a level I or level II is the very beginning stages where you are just beginning to talk about you know we are not singling out psychiatry and mental health in one arena and medical, there is a total separation. We are hoping that none of our agencies are at that point. I know when I started with the behavioral integration grant I went back and forth between what level I was in and most realistically I think that is a Leggin between levels and the beginning stages that we are having right now will just further get us to level VI which is our goals bantered. Level 3 and level IV are you know more physical proximity and that is what we talk about. We have some collaboration on site and people are available and we have the curbside consults as Leslie had talked about and we also have some integration with other systems and other healthcare providers, because it really does take a village and a team to provide the best level of care. Then we really - the ultimate is moving into primary care behavioral health management and working holistically and that is our goal for the circular slide that we presented to you a few moments ago, we have all of the pieces, but we also need to integrate the behavioral health peace to make it truly holistic. Leslie I will also reach out to see if you have any thoughts and concerns and comments because you also have a great way of presenting it.
>>LESLIE MINNA: Yes - thinking about the differences between each of the three main you know I will bring it to life. And so when you are at coordinated level I minimal collaboration or basic collaboration, think about an outpatient center where somebody goes in and sees their PCP and they may be sent to their external mental health center to see someone you know sometimes they are still collaborating and it is coordinated or maybe it is the building next door or on a different floor. Poe located and I see this a lot in PA where they have outpatient mental health care in a different wing or different floor and sometimes they start to integrate their medical records or in a community mental health center you may see this. When you start to get to four and five and six, what you start to see is physical proximity of folks and being embedded in the clinic and we have our behavioral health providers physically seeing patients in the exam rooms alongside the PCPs. And the participant experience of not being different than working with your doctor or CNA and we look at the curbside consult in real time and also the key piece of stigma reduction in somebody down the hallway going to an office that says mental health provider or counselor can have a stigmatizing effect and we want to reduce that as much as possible. The other piece that I want to speak to is sometimes we get really really creative. There is an individual who is maybe really struggling with doing their physical therapy, but the mentioning of a behavioral health person is not something they are interested in. My behavioral health person may just be walking down the hall while the participant walks out of PT and the PT may say hey, I just want to introduce to you to Betsy and she is just another member of the

team just to start to get people feeling more comfortable. We want to ensure that individuals have agency and autonomy and decision-making in the process that they are not being told that they have to do something. And our model is designed to build up that agency and empowerment and reduce the stigma. I think in our PA center and funny enough I asked one of my PHP this morning and she said we are level VI - and another person said you know level for and people often you know want to think that they are at the gold standard but I would say in the past three or four years since I have been here I have not steady progression closer to getting to the level VI, but we do fall back and regress at times when there are changes in staff, etc. Terri, would you like to jump in and say something else?
>>TERRI AVERI: I think also having the gold standard which we all strive for is an opportunity in real time constantly to provide training and education to all of our staff members, because we all need to look at the participant as a whole. And I am not a physical therapist, but I will work on the things that I have learned from a physical therapy department to encourage and to increase autonomy and independence, because our goal is independence, living independently and safely and by being on-site and being fully integrated, we are able to share that by mentoring and being a role model for that behavior and that also goes in part with the practice change.
>>LESLIE MINNA: Very important, the culture shift that has to occur for behavioral health integration is not just about the participant, it is largely about the staff and getting them used to that as well. And we often do trainings on things like grief, stress management, how do you set boundaries with folks? How do you support folks when they are not interested in engaging? Talking about motivational interviewing and making that accessible for a non-clinician, even to the point as I mentioned before of our drivers, they play a crucial role, they are not trained clinicians, but they get to play an active role and they can help support, as well.
>>SPEAKER: Correct.
>>LESLIE MINNA: I am not sure, I saw Pam jumped on and I'm not sure if somebody was going to pipe in with something or have a question and I wanted to make sure that we offered an opportunity for questions. I think there was a final question slide, as well.
>>KATHY CUBIT: This is Kathy, I want to say thank you to Erin, Terri and Leslie. We can probably take one question now I don't know if you can stay until the end of the meeting when we have another open comment time, but we probably have time for about one question. Anybody in the room?
>>SPEAKER: Hello, I have a comment in this topic I'm sure it will surprise you, two things actually, I am really ecstatic to hear about what you are offering and so sad to know that there are very few of our participants who actually are in the LIFE program comparatively, but if you are listing a person as a patient and you want the person to have engagement in their care, may be participant or some other way to describe them, patients to many of us seem to be people who are acted upon and people who act for themselves and so changing the reference may be a good idea.
The other question I have really is at level VI, how many are there for the individual as far as the program is concerned?
>>LESLIE MINNA: Can repeat the question again and to answer that we do call them participants or members. I apologize in my vernacular if I switched to patients, I have a doing lots of different presentations and I use the word patient to help holistically make sure other health organizations understand what we are talking about, but you are absolutely right. I 100% agree with you and it is a great call out and I appreciate you making it. In the second part of your question I think we missed a little bit of it, you are saying something at level VI and then you said something and I could not catch it.

>>SPEAKER: Thank you for understanding the first part. My question is how many treatment plants are in place when you are at level VI for an individual purpose?
>>LESLIE MINNA: So there are holistic care plans (POOR AUDIO) in the LIFE program that meet social needs and we don't have independent care plans we don't have a psychiatric and a PCP, we create one holistic care plan that we operate from and I believe that Terri does the same at LIFE and so care planning is a very big part of our day and so just to give you a quick overview, everybody and every LIFE program they on the size of the center and last a certain amount of time, but roughly an hour. There is intermittent care meeting that include various members of the interdisciplinary team and there can be ad hoc what we call many team meetings and let's say we have the care plan meeting is not scheduled for two days, but there is a need today, we would pull it off line and say hey, after IDT can we talk about Joan Smith because she had an issue last night in the facility and we need to adjust her meds, that would all get added to the care plan. Did I answer your question?
>>SPEAKER: Yes, you got to the point that I was hoping to hear there was one - as soon as you have other care programs you have problems, but there is one, thank you very much.
>>LESLIE MINNA: And I'm happy for anybody to email questions and I'm sure Terri will do the same and I'm happy to have my work email shared in the chat.
>>SPEAKER: And it looks like the additional comment time is at 1215 p.m., but I would be happy to hop back on for additional questions.
>>KATHY CUBIT: That would be great. Thank you again everyone for your presentation and for joining us today. And with that we will move on to Amy High. Amy, the floor is yours.
>>AMY HIGH: Thank you, good morning, can you hear me okay?
>>SPEAKER: Yes, we can hear you, thank you. And so.
>>AMY HIGH: Good morning, I am the section chief within the office of long-term living and I am going to present today on how we collaborate with other areas within the department to ensure individuals that are receiving services through EPSDT which is the early and periodic screening, diagnosis and treatment services through medical assistance are transitioned to our programs when they turn 21 years of age and maintain continuity of care. And so if you would least move to the next slide -
Just for a little bit of background, the EPSDT program is a federally funded complete care program that is provided through medical assistance to children under the age of 21 that qualify of course for medical assistance. It is coordinated through the office of medical assistance programs through the enhanced services unit. And within that unit they coordinate a monthly facilitation team that includes members of the office of long-term living, the office of developmental programs to track and identify individuals as they transition to adult program. For individuals that are identified and qualify for community health choices, they are not a member with the community health managed care program until they turn 21 years of age as the eligibility for community health choices is 21. And so our CHC-MCO will not engage directly with the participant prior to their 21st birthday, however their services or I am sorry as part of the resource rehabilitation team the office of long-term living coordinates with our CHC-MCO to ensure the information is communicated timely to the CHC-MCO for services to continue without disruption as they are enrolled in CHC and the MCO can assess for services going forward. And so I will go into a little bit more detail in the following slide with the process that OLTL follows and how we coordinate to work to ensure there is no laugh of services and that continuity of care. And so next slide please. So, when a individual is approaching their 21st birthday and has been identified as potentially meeting the eligibility requirements of CHC or that there needs may be met through the CHC program, they will apply through our independent employment

broker and they go through the eligibility and enrollment process which includes the functional eligibility determination, the IEB attains certification and then also gathers and submits a application to the County assistant office to confirm financial eligibility. So, through our coordination with the enhanced member services unit in OMAP that works with the case managers and individuals that are reaching their 21st birthday, they will refer the individual to the IEB or provide that information to the individual and or their representative for example a parent to apply to the IEB prior to the 21st birthday and encourage them to approach the IEB within 180 days of their 21st birthday. Once the functional eligibility is determined of course the County assistance office will confirm their financial eligibility and will notify the independent enrollment individual if they are eligible.

And as noted earlier due to eligibility requirements the enrollment into CHC cannot be processed by the County assistance office until the actual date of their birthday. And so through coordination, a member of the office of long-term living assists or working with the IEB and the RFT team as their 21st birthday approaches and will contact the County assistance office to ensure that code is added and so that way the enrollment can occur and is timely upon turning age 21. However prior to their 21st birthday the EPSDT services that the individual is receiving, the information is provided in advance to the CHC managed care organization and again at the time of enrollment so they have the information and they know and can prepare and can have the information when they start reviewing their plan and for those authorizations to be and to continue without disruption upon their 21st birthday. So, again as part of the coordination, the MCO will start authorizations upon their 21st birthday and so their services can continue with out disruption. Next slide, please. So, again, as required by medical assistance bulletin 99 0313 the MCO must provide continuity of care to participants transitioning into CHC for their agreement and so once the MCO received the EPSDT service information they must continue to provide those services for 60 days or until they complete their comprehensive needs assessment and their person centered service plan or their ongoing CHC waiver services and that is again in reference to the medical assistance bulletin and for continuity of care for individuals transferring between and among fee-for-service and managed care organizations. Next slide, please. So, again this just goes into a little bit more detail about how the OLTL enrollment unit coordinates with our partners in OMAP and so there is a shared list or spreadsheet of individuals that are currently receiving EPSDT services organized by their birthday and are tracked as they approach their 21st birthday. And as you know the over waiver eligibility is a little bit different than our CHC waiver as the age requirement is 18 years of age and so we are also tracking individuals that are receiving EPSDT and are currently enrolled in our over waiver as they approach their 21st birthday and so again those services can be coordinated as needed as their EPSDT benefit ends. So, if the individual is enrolled in the over waiver and they are approaching her 21st birthday, that EPSDT service information will be shared with their service coordinator and that is shared with them at least 90 days in advance of their 21st birthday so that their service coordinator and review the services they are receiving in through the EPSDT program and adjust and complete the service plan in the over waiver to appropriately meet their needs once they reach 21 years of age.

As one thing to note there though as the over waiver eligibility is different and individuals are eligible for EPSDT until the age of 21, we do have participants that are enrolled and are still eligible for EPSDT and so one thing to know through the PBRA waiver, other resources must be explored to address participants need including services provided under the state plan, Medicare or private insurance or other community resources. This includes services covered by EPSDT or assistance for someone under 21. And so somebody receiving through the OBRA

prior to due 21 will not be as comprehensive and limited until they reach .1 years of age and no longer have that other benefit.
Next slide, please. And so again to ensure all of this happens we work collaboratively with our partners at OMAP and through the resource facilitation team to track and coordinate individuals as they turn 21 and are applying to the OLTL program, again we provide the EPSDT information to the service coordinator. Next slide, please.
So, I think that wraps it up. Any questions that you may have?
>>KATHY CUBIT: Thank you for your presentation, Amy. Let's start with the room, we have a few minutes for questions for Amy about her presentation, anybody in the room?
>>SPEAKER: There are no questions in the room, Kathy.
>>KATHY CUBIT: Thank you, Juliet. Any members remotely that have questions for Amy? You know please take yourself off of mute and proceed. Okay, it looks like there is no questions at this time, but again thank you for this informative presentation, Amy. And with that we will move on to Randy Nolan and Damaris Alvarado -
>>RANDY NOLEN: In their previous life, she was section chief that oversaw incident management and she worked very closely with staff over the last few years to build management up and all of the processes that we are going through and she is here to keep me straight because she is the expert on it. I have also just you know there is a new section chief that we are seeing and her name is Beth M, she is a RN that worked in the incident management unit over the last five years with Damaris and they are very knowledgeable of the processes that we have started. And so we will go to the next Slide. So, the purpose behind the presentation is to provide you an overview of critical incident management requirements for the office of long-term living. And our other home and community-based providers. This also affects fee-for-service waiver programs. We will talk about what is a critical incident, went to report it, who is responsible to report, who is responsible to investigate and where to document and report an investigation. Next slide. Content of the presentation is based on requirements outlined in critical incident management issued on fibber 23rd, 2023. The approved 1915 CH DBS waiver document and the 24 community health choices agreement. Legal requirements are found in title 55 PA code chapter 52 and 55 code 52.29 outlines the confidentiality requirements of the program. Next slide.
And in accordance with 55 PA code chapter 52 OLTL critical incident management bulletin and the 24 CHC agreement administrators and employees of long-term services and supports providers CHC managed-care organizations, service correlator and individual providers of home and community-based services are responsible for reporting critical incidents through the enterprise incident management system and that is an electronic data system that collects information regarding incidents regarding waiver and program participants and in addition direct service providers are required to notified participants SC when a critical incident has been discovered. So, basically everybody is required to report. Next slide. And the CHC-MCO service coordinators entities and direct service providers are all mandated reporters under both the Adult Protective Services and the older adult services program and therefore in addition to reporting in the incident management system the IEB service correlator entities and direct services are required to report any suspected abuse, neglect and exploitation or abandonment to the appropriate protective service agency based on the age of the participant. And so Adult Protective Services of the individual 18 to 59 and older adult protective services if they are over the age of 60. Next slide, please.
We have some additional training requirements her 55 code 52.20 1D, a provider shall implement standard annual training for staff members providing services which contains at least

the following. The training should train on prevention of abuse and explication of participants, reporting critical incidents , participant complaint resolution, department issued policies and procedures, providers quality management plan and fraud and financial abuse prevention. This is all a part of the training that should be done on an annual basis.
Next slide. Talks a little bit about the requirements for enrolled providers. To manage critical incidents, you seek critical incident management and we are looking at the prevention and trend tracking, risk management, doing investigations, reporting, notifications and staff training upon hiring and on an annual basis. So, that is the requirement or enrolled providers. The next slide we will talk about individual rights. Participants have the right to make choices. Subject to the laws and regulations of the Commonwealth regarding their life, spouse, relationships, bodies in health, even those choices represent risk to themselves or their property. Participants have the right to refuse to cooperate with reporting critical incident. The CHC-MCO , service coordinators and direct service providers must report critical incident even when the participant wish that they do not. So, as a provider, you must report these the individual may not cooperate with the report, they may not participate in the investigation, but as a mandated reporter, you must report them.
The MCO and service corridors are required to investigate incidences unless protective services are investigating regardless of whether the participant wants to participate or refuses for the incident to be done. You still need to follow up on it. For some of the next slides I will turn it over to Damaris to talk about what this criteria are and let her walk through that process.
>>DAMARIS ALVARADO: Thank you, Randy. So, we have really nine primary categories of critical incidents. But, anything that would jeopardize a participant and their welfare is actually reportable as a critical incident. The main categories are abuse and that includes physical abuse, next slide - psychological abuse, sexual abuse and verbal abuse. Some of these are self-explanatory , but there is a difference between verbal and psychological abuse and we just want you to understand that we have secondary categories within the enterprise to capture all of these differences and make sure that they are investigated appropriately. Next slide.
We also look at allegations of neglect and exploitation as reportable critical incidents. These are abuse, neglect and exploitation are reported to a protected services agent and they take the lead on the investigation, however the managed care organization and service correlator are responsible for cooperating in those investigations and documenting the outcomes in the systems. So, I will paraphrase some of the definitions here, but for neglect it is any failure to provide a participant the care that they need and this can be food, clothing, shelter, medical care and if there is any allegations of seclusion which may be a person who is placed in a room or with a locked door with the inability to leave or contact others is also a form of neglect and this is also captured in our critical incident management system. Exploitation is when the participant is defrauded of any of their property or funds are taken from them without their consent, that is also reportable as a critical incident. Any death other than by natural causes is reportable and we also asked both service coordinators and MCO to report any death to the protective services agency and the protective services agencies do not investigate them, but they make sure that all of the referrals and to all of the other agencies are made. We also have a serious injury or something that significantly impair somebody's physical or mental function and any unplanned hospitalization and so anything that is not scheduled. If they have any surgeries or any preventative care scheduled those are not reportable, but anything that is not scheduled is a critical incident. And requires a critical incident report.
We have a special category to capture any provider or staff misconduct. And so anything that is not abuse, neglect, exploitation, but anything that is unlawful or dishonest and so we have had

reports of individuals who may be borrowing money and then not returning the money or going shopping and then taking things that they are not supposed to. And all of those things are reportable, as well. Next slide.
Restraints. This is any use of restraint or restrictive intervention and this is not including anything used in hospitals for appointments, it does not include any seatbelts or anything that is used for the protection of the participant. Outside of that, anything that is used to control behavior or restrict movement or function of the individual is reportable as a chemical incident. Recapture this category under abuse in the enterprises and management system and we have a special indicator where the reporting person needs to tell us whether the restraints were used and when that critical incident occurred. Next slide, please.
Also service interruption, anything and any interruption of service that places the individual 's health and/or safety at risk. This includes when the backup plan cannot be activated however if there is a informal support that helps the participant while they -- while the paid caregiver is not showing up for shift is not reportable. If any staff person needs to be suspended for any inappropriate behavior and there is a service interruption then the agency must have a plan for temporary stabilization and so they do need to come up with a plan to make sure that the participant is taking care of their
And then the last category listed here is anything that results in a hospitalization or any other medical intervention. If it does not result in a medical intervention, it is not reportable as a critical incident. Next slide.
Randy, would you like me to continue here? So, are equal incident management bulletin emphasizes two providers and all the mandated reporters that the critical incident they are responsible to report is those that are at any time. There is a misconception that there may be a misconception that if the staff is not on shift, they are not scheduled to show up for the participant and something happens that they don't need to report it, but that is incorrect. So, anything that happens while the person is getting paid to provide a service or if it happens when they were supposed to be providing a service and they did not or if they were contracted to provide a service and they were not providing the service and so anytime they become aware of the critical incident, they are mandated to report it. And then the CHC-MCO and service coordinator are responsible for investigating the incident. Next slide.
We do have very strict time frames for reporting and for investigating critical incident. Once the service coordinator or the MCO becomes aware of the incident they have 24 hours to begin the investigation and they need to ensure that the participant is safe that is step number one and they complete on-site fact finding visits so they can observe the participant and we want to put emphasis here and add that the on-site fact finding visit is mandatory unless protective services is investigating. A MCO and service coordinator are also responsible to implement risk mitigation measures and for notifying the participant or the representative within 48 hours of the resolution of the critical incident. And if the responsible person or representative is involved, obviously they do not get to be notified.
All of these are documented in the enterprise incident management and the office of long-term living make sure that the system has analogies in place so that we can capture when it critical incident is untimely and when the investigation is also untimely. Because, they have 30 days from discovery of the incident to complete the investigation and submit that critical incident report in the enterprise incident management system.
Next slide. This is just a flowchart showing within 24 hours of disc every, the service coordinator needs to be notified by a director service provider and so the person who became aware of the event may have seen somebody in the home taking care of the participant or helping them and

if they become aware of the critical incident they have 24 hours to let the service coordinator know and in the service coordinator as 24 hours to begin the investigation. Within 48 hours they have to report it in the incident management system, 24 hours excluding weekends and state holidays. If there are protective services involved then the service coordinator makes sure that there is contact with protective service investigators to make sure that they provide any information or cooperate in ensuring services are not delayed to mitigate risk. And then again 30 days to complete the investigation and said that final section of the critical incident report or the EIN. Next slide. We also make sure that the service court Nader's and MCO let the participant know what is going on with the critical incident and so they have 24 hours from the time they filed or submitted the critical incident to let the participant know that happened and that is an opportunity for the service coordinator to let the participant know that they may or may not want to participate however they are mandated to report it and investigate it. And then within 48 hours of an then resolution there needs to be a notification of all of the findings of the resolution. Next slide, please.

>>RANDY NOLEN: We wanted to show some data that comes out from the critical management system and this is 2024 data. This is for the first slide is the MCO and act 150 program total reported incidents were 652 and broken down by percentage wise 61% of those reported were hospitalizations, 25% were abuse/neglect /exploitation and out of those 32% of those reported were substantiated by protective services. 12% of the report were for emergency room visits and .0046 were first service interruption and .92% were for death and .3 percent were from serious injuries. And that is in the OBRA and act 150 program. Next slide is data for CHC HCBS and just to clarify this is reported by home and community-based services and nursing homes have to relay it and we do not follow up on those. And so for reports on the community health-based services there were 101,677 and 74.4% were hospitalizations, 14.6% were emergency room visits, .03% for reportable disease, 9.7% abuse, neglect, exploitation and out of those 39% of those were substantiated by protective services. And there was 1/2% for service interruption, .34% of death and .12 four serious injuries reported.

Next slide. And critical incident management training and education will provide detailed training on entering and emitting a critical incident report in the EIM and that is available on the learning management system and information and training regarding incident report content and details are responsibility of the director service provider agencies. And for CHC waiver participants the MCO are responsible to provide training. Incident management and protective services training is available for providers and SC is on OLTL 's contractor daring consulting website and I will list the website here so you can make sure you get that training.

And the next slide will show some office of long-term resources for additional information. Participants can always contact the OLTL with any concerns by calling the participant hotline at one 800 757 5042 or they can call the protective services hotline at one 800 490 8505 and for HCSIS and EIM stimulated technical assistance providers may contact the helpdesk at 1866 444 1264 or by email which is listed there. Questions for additional information regarding critical incident management can be sent to the following email address and the email address is listed there. RA-OLTL_EIMimplement@pa.gov. We continue to upgrade the system and the reporting that we get out there is a lot of follow-up that staff at OLTL do to make sure the incidents are reported on time and the follow-up is done in a timely manner and we do allow the request to make sure the follow-up is done, but we monitor this very closely and we work very closely with adult protective services which is a part of the office of long-term living and we also work very closely with older adult protective services in the Department of aging to ensure the agencies are properly reviewed and followed up on an obsolete the goal is always to decrease incident as

you can see from the data, a lot of the incidents probably 70 to 80% are related to hospitalization, ER visit and so the goal is to try to make sure we are providing appropriate services to our participants out in the community to avoid those types of situations. So, if anybody has any questions, Damaris will certainly answer them.
>>SPEAKER: Randy, this is Leslie and I have a passion that is similar to your statistics with the largest amount being hospitalizations, it is what we see in adult day centers as well, but centers are being cited and being responsible for reporting incidents that happened not at the center. So, for example if a consumer does not show up in the day program and the center calls the family to find out what happened at the hospital over the weekend, it is now the center's responsibility to put that into a critical incident when they really don't know anything about the situation. Is that something that can be changed or revised at all back or does not have to be the case? Because we are submitting an awful lot that people are going to the hospital overnight nothing to do with the center or over the weekend and we really don't know other than they did not come to the center what exactly happened.
>>DAMARIS ALVARADO: The current policy if you are an enrolled provider for the office of long-term living you are mandated to report anything that you become aware of and because a hospitalization is one of the primary categories and one of the critical incident criteria then yes, you would need to still report it.
>>SPEAKER: I would add Leslie, this is Juliet, I would say exactly right what Damaris is saying, you are a mandated reporter and not being said , if the person is receiving care over the weekend from another provider, it would be beneficial to note that you are also aware that that participant receives services over the weekend from another provider at the time of or before the hospitalization occurred if you are aware of the information, please make sure that is also documented. It could be that the person received no services from any other provider over the weekend or if they had and you are aware of that, please make a note of that. Our team will review the investigation and make the determination that that particular provider may have been a mandatory provider and the founder of the incident perhaps failed to act and we would certainly follow-up in that situation, as well.
>>SPEAKER: I understand, but to be honest we are not aware of other providers and it would be helpful in terms of continuity of care if the day centers knew that there was healthcare being provided and that sort of thing, but the service court Nader's do not share that with the adult provider and so we are really - there is no way to communicate with one another or to know what the extent of the services are that they are getting outside of the center.
>>SPEAKER: I guess I would human maybe it is the wrong thing to do that if somebody is getting services in a adult day center that you would also as part of your instinct would know that if they are receiving other services in a community and I would think that would be one of the questions that you would ask you and a direct care worker to come into the adult daycare center as somebody who stays with you at night, how do you get your evening meal back I would think those would be questions that you would be following up on as part of your intake. I do realize that some of what you voiced concern wise is that you are reporting an incident that you may not have firsthand knowledge of, but as Damaris said, everybody that has knowledge of the incident no matter how you get that knowledge you are required to report that. I would error on the side of caution and I would rather have three entities report an incident then no into the report an incident and so I would rather see a report coming from the day center, from the direct care worker and from the SC. I would rather see that happen then nobody make the report and something serious happens in the we have no follow-up because nobody is reporting.

>>DAMARIS ALVARADO: I would like to add that if you don't have a lot of details about the critical incident or the hospitalization or whatever the event may have been it is okay to add that to the critical incident report and just state that you were informed by whichever method and that you are submitting the critical incident to comply with policy and that you do not have knowledge of the event and it will be up to the service coordinator or the MCO to investigate it, reach out to you for questions and gather whatever information needs to be gathered to close that incident report. So, you will not be responsible for knowing details or investigating or going anywhere to visit or do an on-site, that would be on the MCO or service coordinator.
>>LESLIE GILMAN: Randy, to respond to your comment we do get some intakes and sometimes they don't know the names of their agencies and they don't know any real details usually and even if we get it in the beginning assessment, things can change during the course of the time that they are attending, it can be six months in, they may no longer have homecare or they added a home care that they did not have at the beginning and that is just not something that we would find out and so I just wanted to clarify that.
>>JULIET MARSALA: Thank you, Leslie this is Juliet and a follow-up to that certainly can be the reality, it is a participant's choice whether or not they share additional information with you. I would recommend as best practice and I think we have been asked this before in other forums here that for any provider I think it is best practice to continually educate the participants on the rights, participants can add anybody, anybody they want as part of their personal support team. That person then should be listed with the CHC-MCO and be invited at the participants direction and so please ensure that you continually educate participants and that is important for their participant to have an adult day provider be a part of that team and they certainly can do so in addition, participants, it is always great to educate them that they can direct their SC or the CHC-MCO to share their care plan and any updated care plan with anyone that they want to have it shared with. So, so I just want to highlight those two very important pieces and continual opportunities to make participants aware of what they can choose to do and that it is available to them.
>>SPEAKER: I'm really glad to share that because I was not aware and that would be very good and we will talk to - I will let other centers know and talk to the families about doing that if they would so choose.
>>SPEAKER: Thank you for bringing that up.
>>SPEAKER: (NAME) Here, Damaris that was a great description of what constitutes an incident and one of them involves your description of basically restraint and by way you stated it, seclusion. These are issues that I've had to do with with inpatient centers for years and another one that we include in restraint and I wonder if you want to have it included as a critical incident is the prescription of a administration of psychoactive medication to help a patient back away from negative behaviors and sometimes it can be self harming or others, without also count as an incident or no?
>>DAMARIS ALVARADO: It does not, it is not a part of the criteria for critical incident, a medication error that has a medical intervention is a critical incident, but not if it is administered as prescribed.
>>SPEAKER: Hello, I am (NAME) and I actually emailed you March 2024 we actually discussed this about agencies reporting and let's just say for the sick of -- let's just say for the sake of argument there may be some form of neglect whether we smell urine in the home and we don't believe the participant is being taken care of, right? And so that would be a form of neglect. And so we automatically a part of our protocol along with the MCO is that we remove the caregiver until the outcome of the investigation - and so when we make the report and we call for the

allegation of the act so when we remove the caregiver this is where it becomes shaky, because we will let the caregiver know that we are not the investigator. We will you know this is our discovery and we have the allegation, but then where the agency gets stuck is that we don't ever get the outcome and it is like cat and mouse trying to get the outcome from the service coordinator and I am looking at the resolution of this 24 hours and 48 hours and I do not believe that is occurring. A lot of the times, APS is calling us because we submitted the allegation and they cannot say who the SC is and they cannot get a hold of them and now what happens is now that client and it could be there stunned that we remove and use the agency and they go to homecare and hires their son when there is a active investigation going on. So, how do we prevent that? How does an agency get to the outcome of these investigations and the SC is aware because there is a EIM and then they switch them to another agency and then hire that same caregiver. I know that is a lot.
>>DAMARIS ALVARADO: That is a lot of part your question but I will answer as best as I can. First I would like to explain that we do have a very good process in place within the office of long-term living for communicating with protective services. So, especially with APS and individuals under 60 we have a straight line of munication and we do receive the outcome of the investigation and we communicate them to the MCO and I will get to that second part in a minute and the MCO then document that in our incident management custom and they are supposed to be talking with the service court Nader and all of the people involved to ensure that the risk is being mitigated. If that means that that caregiver is no longer assigned to the participant, that is one thing, if that means well, it was not substantiated and so it is okay. So, that is one part. If the person is in act 150 or over, it gets a little bit more tricky because we don't have a contract and so we are not receiving all of the investigation outcome all of her time consistently and so that can be a part of the challenge that you are describing.
>>SPEAKER: We have to communicate with the SC and I can give you a great conversation that we had via email and it was because they had to communicate with the SC and then they have to communicate with the agency, that is the dilemma. I don't have any issues with OLTL, it is just getting the outcome or even if we don't get the outcome, how can a SC transfer the client I mean yes, it is the choice, but then it is the same caregiver that we put allegations on, that is where I get confused.
>>DAMARIS ALVARADO: It is hard to answer the question without having specifics. There is so much involved and there is also a element of protective services with APS where they don't actually find the alleged perpetrator and they are not necessarily percolated as working as a caregiver, right? All of that is different. And so there is a lot of things that may be involved in the scenario that I am happy to get more information about and answer the question later, maybe Beth and Randy, we can all work together and get to the bottom of whatever it is. But, for us as communication, you are right, the service coordinator should be communicating with the provider agency about the findings and whatever needs to happen because the mitigation is really the priority and so if that is not happening, please let us know, Beth and Randy to make sure that there is a meeting conversation, whatever needs to happen with communication so that it improves.
>>SPEAKER: So, if I cannot get a hold of the SC, and APS is doing their job, they cannot communicate with us, can we report and can we email you and say like this SC is not -
>>DAMARIS ALVARADO: Yes, you can email the email address that we showed and one of the staff will get back to you. Absolutely.
>>SPEAKER: I would not email Damaris because she no longer works on Randy's team. She will probably forward and be responsive, she will not be - it is not Damaris -

>>DAMARIS ALVARADO: You can email that email address for that.
>>SPEAKER: I have it, thank you.
>>SPEAKER: I just really appreciate that comment and appreciate you listing it out and I feel like it is one of the reasons that our union has advocated for a unique ID number and it is not really possible for us to rehire somebody and I know there is legislation last year introduced as more of a national provider ID and that is a way to address that, as well, but you are right at this point in time somebody can commit fraud and abuse and just move from one agency to another and the real way to stop that is to have these unique identifier numbers like we have with CNA's and other healthcare professions to prevent that from happening. I think the legislation has been introduced and we are getting there.
>>SPEAKER: Kathy, there are no more questions in the room.
>>KATHY CUBIT: Okay, we have one more question from Pam and then we are going to move more directly into our public comment time and we will start with Carol after Pam asks her question. Go ahead.
>>PAM WALTZ: Thank you for this presentation, really interesting and I think the question I have is about the hospitalization investigation. There are obviously many of them and many observations which is not surprising given this is a population given that this is a population with a lot of older people with health problems and I am wondering when a hospitalization is reported, what is the process for then what is actually investigated about that hospitalization, because many of then may just be for you know something happening in their medical condition that does not necessarily mean that anything has gone wrong with regard to the care, but others may in fact mean that there is something of concern about the care like a fall has occurred or somebody's condition has deteriorated or they have wounds or something like that that really does implicate concerns about the care they are receiving or the need for additional services. What is the process, especially given that there is so many hospitalizations that must be reported, what is the process for looking at those and determining what has gone on and whether there is a concern and then addressing it and who does that two I have to say I represent a lot of client who get CHC services and who have lots of hospitalizations and I have never - there does not seem to be a lot of information being gathered by the service coordinator about what happened in a hospitalization or sort of like changing anything too much as a result of it except maybe doing a reassessment if there is a new diagnosis.
>>DAMARIS ALVARADO: This is Damaris, thank you for your question, the hospitalization, the investigation will be for the service coordinator or the MCO staff person where like you mentioned determines the nature of the hospitalization and so they will contact the hospital or anyone who was involved in the incident to find out exactly why the person was hospitalized. But, because we do not know why the person went to the hospital, that is why we won all of those to be reported. After they are investigated and they can find out what happened and why the person went into the hospital, then within that investigation documentation the service coordinator or MCO will describe the finding and so it is very possible that it was not preventable, it is possible that it is related to a chronic condition and all of that is taken into account, but it is very important to report the hospitalization again because we don't know the nature until they reported and investigated. And then the second thing I want to mention about this is that the service coordinator and MCO is also required to do a analysis and so once a participant has more than three critical incidents within a year they need to look into the root cause of those hospitalizations and that is their opportunity to document and report to the office of long-term living hey, we are on top of this, we are looking into why this person keeps going into the hospital and we are going to put these risk mitigation measures in place to prevent them

or hey, there is nothing we can do about these hospitalizations because this participant has a chronic condition unfortunately this will continue to occur and we will keep an eye on it and it would also we can do especially with referrals, but again it comes to the purpose and the service plan and we want to keep an eye on the participant and we have health and welfare assurances that we promise we will and so this is why we have the criteria as part of the critical incident.
>>JULIET MARSALA: And I just want to add another clarification to that when we are talking about hospitalizations and critical incident reports and Damaris will give me honest on this, we are talking about unplanned hospitalizations. If a participant knows that they routinely have to go to the hospital and be admitted for something as part of their sort of ongoing health maintenance and that is listed and known and shared in their person centered service plan, those are planned hospitalizations. If we know a participant is going in for an outpatient procedure and it is planned in advance and they went to the hospital and there was nothing out of the ordinary, they had the procedure, they came home, the SC had an appointment, they did their follow-up after discharge and all of that was known in advance, that is a plan hospitalization and not a critical incident. Looking at Damaris shaking her head, I got this right, yes. And so that may help a little bit and SC should be having those conversations with folks and also you know should be noted with home providers when appropriate and at the direction of the participant if there is ever a plan hospitalization.
>>SPEAKER: Thank you, Juliet, Monai -- may I ask one question in follow-up? So, does the service coordinator, it sounds like they ask be it anybody you involved you said or they contact the hospital, I mean do they contact the hospital or do they ask the family what happened that if the family says you know X happened, they fell, they had a heart attack or whatever, does the service coordinator then accessed some medical records to look at that or do they just accept the family's description of what they understand about it?
>>SPEAKER: I appreciate the question and the details of that scenario. It will vary. Each investigation takes its own path based on who was involved, what the direction is, whether or not it is within a CHC-MCO - sorry and or the fee-for-service system, what information is available and whether or not the person is Medicaid only, duly eligible, has Medicaid advantage plan, so there is no very concrete pathway to answer your specific question to that specific scenario, it is not always going to be done in the same prescriptive way each time. And I think it was Pam, sorry - sorry, Pam! I am happy to have further conversations about this with you.
>>PAM WALTZ: Okay, thank you.
>>SPEAKER: Okay Randy and Damaris, thank you and we will move on now and I don't know if Carol can take themselves off of mute and I think Juliet wanted to make a comment before you ask your question.
>>CAROL MARSFISI: Thank you, Kathy. I wanted to follow-up when you're talking earlier today I made a note of that you are asking about additional responses and sortable was occurring and building on questions that I believe Betsy had asked that prior LTSS subcommittee meetings in terms of what is the office of long-term living doing in response to what is happening at the federal level. And I think at that five I sort of explained the many different layers between what is happening at the federal level until it goes through all of these different layers and decision-making potential points to the office of long-term living which is why the office of long-term living was not doing modeling. I think I have explained that before. I did want to share Carol and maybe some of you have seen this in prior news or what have you that the administration has done a high level analysis of what is occurring with HR one and you may have seen Governor Shapiro and the secretary speak on this in many different foreign and so as proposed, looking

at Pennsylvania specifically as proposed federal legislation would potentially take over 300,000 Pennsylvanians off of Medicaid. It as proposed may shift $1 billion in food assisting cost from the federal government into our state budget. It would strain our house rules. It could potentially lead to closures of rural hospitals that are struggling in Pennsylvania. The requirements and the legislation include new IT and administrative burden for Commonwealth agencies that you no one would consider a funded mandate. And so there are impact of that high level analysis that we know will be very burdensome and detrimental to Pennsylvanians. It will have a impact on their healthcare. The Department of human services or analysis for continuing to update our data page and so you can see this initial information as we are doing this, you have heard me talk about the path that 3 million Pennsylvanians do receive Medicaid, that is 23% of our population and in fiscal year 24/25 between the provider assessment and the general fund you know the Commonwealth already contributes more than $14 billion to Medicaid programs and with that we get approximately $30 million of federal matching funds and those matching funds are certainly the thing that we have the most concerned about. And so just so folks are aware you know that is certainly what we are looking at as part of that analysis and the concern should it pass as proposed is that there is a loss of vital healthcare services that may result in increased utilization of emergency room departments and inpatient services and we may see across our population exacerbation of chronic health conditions such as diabetes, hypertension, because people may be delaying seeking care and you know that is why Medicaid is important. And in addition to the $1 billion food services, that is the snap program, that is a essential and critical food and sustenance that many many people rely on and that will impact about 140,000 Pennsylvanians losing potential food systems from that loss of federal funding - and so the addition is a significant burden that HR one foot on mandates to stay in regards to redetermination, right? And currently as proposed it calls for redetermination every six months of doubling what we do today, right? And I think Pennsylvania is a really good job with redetermination's, but that is an additional burden and that in particular would impact everybody across the board, okay? And they are also looking at implementing reporting requirements for the expansion population which is not our OLTL population generally speaking, right? Because the majority of our population is over the age of 65 which is generally considered nonworking individuals who have a disability and so really when they talk about that it is very unlikely impacting our populations served. But, it is important and so if you want to look at the potential Medicaid loss coverage by County I do believe that that is up on our DHS website and as I said before the office of long-term living is not doing analysis and that is not to say the administration and Department of human services is not doing sort of higher level analysis because that is kind of the stage we are at today. We need to know what is happening at a higher level to then be able to see what the impact is in Pennsylvania. Governor Shapiro certainly has the message out there that if this passes at a federal level the feds may be assuming that the states can carry the burden of additional cost and we may not be able to cover $30 million of federally matching funds. 30 billion, not 30 million. And I just wanted to give that as a follow-up Carol to the importance of the advocacy of each individual that Kathy had talked about before and to answer the follow-up question that you and Matt had had before in the past with what is the office of long-term living doing and why are we doing or not doing certain things related to what is happening at the federal level. And so Carol I hope that is helpful and I know we have had a lot of stuff that we have talked about before your question was posed earlier.
>>SPEAKER: Thank you, Juliet, Carol, are you able to take yourself off of mute and I would ask given the amount of time if people can ask as concisely as possible so as many can speak. Carol, go ahead.

>>CAROL MARSFISI: Thank you Juliet, that is a lot to process. I think that reading different documents that you suggested will give me a more informed answer and a better idea. Additionally I don't want to push to go beyond the capability of being - but, I do understand what you are saying that the federal government would put it all on the state. I have another question, if we don't have time I will address my question somewhere else, maybe it is not a question that needs to be addressed in this form, but I will say I am an older, but very capable person and I have the ability and the right to do things with my life. Fortunately - medical condition and so I - and the agency will who services me for various reasons dropping the ball and I mean dropping the ball on me and as far as I'm concerned and one talk about any other people, but as far as I'm concerned the agency I am with - has been leaving me alone and now may be during the day, but I cannot be alone - and as a result my family meeting my sister and my daughter are beginning to do more than raise their eyebrows. I do not tell them the struggle I go through because I am very able and careful of their response and I will never ever live in a confined living space. My problem with independent living has nothing to do with my disability - growing old - not showing up and not being trained and the agency continues to come back to me and say and one I have - and I have heard about this mantra - my daughter the other day said mom, do you know what is the meaning of (NAME) is an they are trying to do the same thing over and over and getting the same result. And that is pretty hard.
>>SPEAKER: Carol? I appreciate those comments, I absolutely concur with a lot of the potential impact and struggle and what is happening today and the absolute need for ensuring the quality of services and the quality of delivery is a frustration that comes with feeling like you are having the same conversation and basically the same issues over and over again and certainly you know CHS will continue the focus on the mission and I will also follow up on some of the things that you noted in your comment that I would like to get a deeper understanding of and I will certainly follow up with you on those that pertain to you as an individual that you shared today, but I do also want to be kind of mindful of the opportunity for others to also share if I may, there were certainly quite a number of options and comments the have also come in, would you be okay with me following up with you individually about some of the points that you made about your situation?
>>CAROL MARSFISI: I would like to say as quickly as I can say that I am not the only one being affected - I live in a world with the family and friends and they are beginning be more of my worry and I worry about them and what they recommend and I know that I am - and I don't have to live anywhere I don't want to live, but again I don't want a lot of risk in my family. And my - okay, thank you.
>>SPEAKER: Thank you, Carol, I appreciate the comments. Kathy, if I may, I know we may have other committee members comments, but it is the public comment time, can I go through some of the questions we have had on chat for a while we certainly will follow up with additional questions, but I do want to give folks who joined us today opportunity to have their voice heard during public comments, as well.
>>KATHY CUBIT: Absolutely and it looks like there is somebody who has had their hand up for a while. Hopefully we will be able to struggle to them as well, but yes, thank you.
>>SPEAKER: We can start there.
>>SPEAKER: Go ahead, Tiffany, please be as brief as possible, we only have a few minutes left and we want to try to get through as much comments as possible.
>>SPEAKER: I am looking to my staff, do we have Tiffany off of mute? Tiffany you are not on mute on our end.
>>KATHY CUBIT: Okay, Juliet I will go ahead - thank you.

>>JULIET MARSALA: Okay, Amy Tompkins has noted that service coordinators make outreach to many parties including hospitals, doctors, social workers during the event of an investigation, but they do not always get return call as part of their investigation. Erica Perry has noted an on-site visit is required for the office of long-term living confirming that once the on-site visit is complete, even if the participant was not seen for whatever reason the MCO can still document the visit as a on-site visit completed. They can document as a on-site visit attempted, but certainly depending on the reason for an on-site visit for example if the visit requires the comprehensive service planning that the activities may not be complete, by a on-site visit can certainly be documented, it looks like Randy also wants to respond.
>>RANDY NOLEN: Yes, and they should also document if they go to the house or go see the participant and the participant refuses to discuss that, they should document that as their own and make sure that your documentation is clear when you were there, will conversation you had the person refused to open the door, they screamed at you to go away and document that.
>>JULIET MARSALA: All right, Juliet, Cindy put a scenario in the chat related to critical incidents noting that we show up at a participant shift for a routine every Friday shift and a neighbor tells us that we saw an ambulance last Saturday at the home and so we start calling hospitals, sometimes we are successful if the participant allows the hospital to share this information and this happens a lot and that is a great question for the critical incident portion of the meeting.
A question also from Erica Perry, what is the status of the HW%TA report becoming accessible to the MCO for the EIM? I will have my MCO follow-up for that, that seems like a operational question that we can gently put out. In a FAQ, as well. In the event that a participant loses eligibility, what is the expectation of the office of long-term living for the managed care organization of how to proceed with the investigation of the critical incident? Randy? Would you like to follow up with them? It may seem like we need a T letter a session for those folks.
>>RANDY NOLEN: We can surly follow-up, but the expectation is if they follow-up we complete the incident. If the incident happened while the participant was a active participant in the plan, they need to follow up and complete the incident.
>>JULIET MARSALA: All right, if a person receives HCBS -- on their 21st birthday when they transition into theirs of choice and so Brenda I think you're asking whether or not a provider would change as a result of a person transitioning to community health choices. And the answer to that question is that it depends. There is a continuity time between community health choices and MCO are required to follow, but during that time it is also important for that person centered planning process to occur and if the provider is enrolled in immunity health choices, the participant maintains that choice and MCO do have other means by which to potentially contract the provider out-of-network verses in their network and so it depends.
There are some life provider questions that we will give out to our lovely speakers like Leslie, thank you for being with us and we will get those questions out to you and we will allow you to have a response that we will send out to all of our folks by our listserv after LTSS. Amy L submitted a question on the ops memo that not requiring the name of the physician to make a decision, she wanted to know that the inclusion of the name of the decision-making is critical in the early years of CHC to identify a CHC-MCO that was impermissibly using the same doctor to make the initial grievances decision. Regardless, it is true that most MCO have not been included in this information so the ops memo is not change for most practice apparent however I do to clarify that with participants requesting documents, one MCO never gives the name of the physician decision-makers and for the other two you have to piece together who the physician decision-maker is and Randy's team will certainly take that back to the MCO so that

process can be improved for the memo, the MCO must provide the decision-making information upon request just to be clear and we will work to make sure that occurs. Sean asked the name of the bill again, it is house bill 1310. Cindy Hager for the revalidation, there is only one person listed as agencies contact, is it possible to have two? Currently at this time it is not possible to have two contacts within the provider enrollment system and you can have one identified contact, however I certainly am aware that some entities put in a group email that they then disperse on their side out to multiple people and that certainly is your decision to do so, just make sure everyone on the email list pays attention so that someone response to the revalidation email, but at this time we do not have the capabilities within our system, because we want to know who that one person is that is the responsible party.
All right, Kathy, I left you 60 seconds.
>>KATHY CUBIT: Thank you. I want to say thank you to everyone for joining us today, we will be meeting hybrid again on July 2 from 10 AM until 1 PM. I do want to remind members that we have a noon deadline tomorrow, the presentation themes for July's meeting is on behavioral health and please submit your request for the CHC-MCO presentations by noon tomorrow. And again, thank you everyone and hopefully you will be will to join us again next month.
>>SPEAKER: Kathy if it would be okay, Juliet, can I ask you to add one thing - for the folks that did the LIFE presentation and ask the questions, they said something about - motivational interviewing. I don't think everyone knows what that is and if they could explain it and write back I would appreciate it. I was going to ask them that.
>>KATHY CUBIT: Thank you, Mike. Any unanswered questions, members can send to me again for follow-up and others in the audience to the RA account or if you have unanswered questions in the chat that will be followed up, but unfortunately we have to end at 1 o'clock because of the captioning, but thank you again to everyone for joining today. The meeting is adjourned.