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Date: 07/02/2025
Event: Long-Term Services and Supports Subcommittee Meeting

>> KATHY CUBIT: Good morning, everyone. This is Kathy. And this is the LTSS MAAC meeting will be starting in one minute.
Good morning again. This is Kathy Cubit. I want to welcome everyone to the July LTSS MAAC meeting.
We're going to start with the introductions or roll call. And we will start with the room.
Is someone from OLTL able to identify members who are present?
>> JULIET MARSALA: Good morning. This is Juliet. Thank you, Kathy.
For committee members in the room, it is Lloyd Wertz and myself. And Mike Grier is here.
>> KATHY CUBIT: Thank you. In terms of the members I can see on the remote side, I see Anna Warheit, Laura Willmer-Rodack, Leslie Gilman, Lynn Weidner, Chell Garrett, Patricia Canela-Duckett, and Rebecca May-Cole.
I suspect since we're still so close to 10:00, others will be joining.
I will move on to housekeeping and we will circle back to announce others that have joined.
I want to begin by saying this meeting is being recorded. Your participation in this meeting is your consent to being recorded.
This meeting is being conducted in person and as a webinar. To comply with logistic agreements, we will end at 1:00. Please keep your devices muted and the microphones off unless 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. Please mute yourself. Thank you.
Remote captioning is available at every meeting. The CART captioning link is on the agenda and 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 captionist may capture conversations and identify speakers. Please keep your questions and comments concise for time for everyone TOR heard. Attendees may submit the comments and questions in the question box in Go To Webinar or use the raise hand feature to speak live. Attending in person should use one of the microphones and be called on to speak. The table top microphones are reserved for committee members. You may need to wait for staff to bring you a microphone. The general public should use the microphone on the floor stand at the rear of the tables. 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 are finished speaking, please press the same button to turn it off.
Time is allotted on the meeting agenda for two public comment periods. 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 web page.
In the event of an emergency or evacuation, everyone must leave the building and assemble in the First Responder's Plaza. The staff will be available in the safe area in front of the elevators to provide assistance. Please see the back of the agenda for more

information.
With that, we will circle back. Have other members joined in the room?
>> JUANITA GRAY: Yes, Juanita Gray.
>> KATHY CUBIT: Thanks, Juanita.
>> JULIET MARSALA: There are no additional committee members in the room.
>> KATHY CUBIT: Okay. Looks like Carol Marfisi has also joined. Matt Seeley. Monica Vaccaro.
>> MONICA VACCARO: Here. This is Monica.
>> KATHY CUBIT: Thanks, Monica.
And if I missed anyone, a member, please feel free to introduce yourself.
Okay. With that, Juliet, we will turn things to you for OLTL updates. Thank you.
>> JULIET MARSALA: Great. Thank you, Kathy.
Good morning, everyone. Thank you for joining us on this holiday week. We have quite a bit of updates for folks.
The first thing I did want to say is as many of you know and people have seen in the news, at the Federal level, the bill passed the Senate and goes to the House. That occurred yesterday. So needless to say, we are working through it. So I don't have answers to questions folks might have today.
So for the other updates, go to the next slide. That's our agenda. We have procurement updates. We can talk about the house resolution 165. A little bit about the InterRAI and the nursing license compact, the PA link evaluation, and some of the recent OLTL communications.
For the procurement update, we have no news. There are no new updates on the procurement. It remains in a stay.
We wanted to share that the HR resolution 165HCBS study that the legislative budget and finance committee was tasked with back in 2023 has been released. So they conducted a study on the effects of the HCBS workforce shortages. Commonwealth supported Medicaid waiver programs and the Pennsylvania lottery-funded area agency on aging program and the Act 150 programs. We're making folks aware the final report was published in June 2025 and we have added a link to where it can be found.
And also I wanted to highlight as part of that study, of course, they reached out to the Department for comments on the study back in May on a draft, and we had no comments on the study that they had.
So for folks, the study is out there. It's in the public. They did use a lot of our OLTL HCBS rate study. If you have questions, we have received questions related to the study, I would ask that you redirect those questions to the legislative budget and finance committee because they are the authors of that study and should be the folks tasked with answering any questions you have about their study and results and recommendations.
If we go to the next slide.
We wanted to make folks aware that we are evaluating the inter-RAI. It's an international validated assessment tool that is used for the comprehensive assessments that inform person-centered planning. So these are the -- one part, the assessment tool that's one part of questions that the SC goes into when they go out to the home to the person-centered planning meeting with participants within CHC. And we have used it since 2018 since the inception of Community HealthChoices and used the inter-RAI version 9.1.2.
So the InterRAI, the body that oversees that assessment tool, they released version 10, so

they do upgrades periodically to the assessment tool. And they released version 10 of the InterRAI back in 2021.
So we have begun evaluating and preparing to upgrade from the 9.1.2 version to the 10 version. It requires a lot of work with regards to crosswalking and looking at how any of the clinical questions have changed, what's been included, what's been removed.
So it's our intention to have participants and advocates included in the process. So the work planning process is underway kind of looking at how do we break down all the different steps of the work plan, the training plans, things like that, evaluating questions and things like that.
One of the things that is important to us is that any kind of those changes or updates would not have a material impact on the functional eligibility determination for folks who recall when CHC was rolled out, the functional eligibility determination tool kind of brings in a portion of the InterRAI so there's a lot of focus on making sure that there are no material changes.
We anticipate that this time frame is probably going to take up to about 12 months of work collectively. So we wanted to be sure that we announced it here, let everyone know that this work is going to be underway or is underway. And Kathy wanted to come and ask if there was perhaps a participant or advocate of the LTSS Subcommittee, if there is a participant or advocate of member of the LTSS Subcommittee that would be interested in working alongside us as we embark on this work. We wanted to open that up so those committee members could come -- send me an email if they are interested in working alongside us as we move forward with that work.
All right. On the next one, we also -- sorry? Randy is asking to add some additional comments. Go ahead, Randy.
>> Yeah, this is a major change for us to change versions. The concern is that we had an opportunity a couple of years ago to look at that and didn't make the change then because of the amount of work it would do. It's a lot of work with systems that all the MCOs will have to do and the Department. The reason we decided to go with the change now is University of Michigan who oversees the InterRAI tool may not support version 9.1.2 in the future. So we wanted to make the change now. So there's a lot of work with that.
And the other piece we're doing is working on trainings with our training contractor Deering and InterRAI fellow staff to do trainings for the SC and the SC supervisors and Aging Well staff. We're in the planning process of planning out trainings on 9.1.1 and on 10.0. So there's a lot of work going forward with this. I wanted to let everybody know we will be doing the training piece of it. There's always concern out there of the reliability between SCs and MCOs. So we will -- MCOs. So we will train across the board so everybody hears the same message. It's a major under taking to do the training. We will pull the SCs in to do this. It will probably be virtual. I don't want the MCOs to start having heart attacks that we will cause them all kinds of travel headaches. We will move forward with this and try to improve the process with this tool. That's what I wanted to add.
>> KATHY CUBIT: Thanks, Randy. This is Kathy. Two questions. One, will you be engaging with the University of Pittsburgh like was utilized when the Fed was developed? And when you say there's no material changes to the Fed, does that -- do you anticipate tweaking the Fed to align with 10.0?
>> RANDY: We are looking at the questions. There's a number of changes on version 10 of the InterRAI that may affect the questions on the FED. The questions on the FED are a

subset of the InterRAI questions and there may have to be changes based on that. There's things we wanted to look at with the FED anyway. So we will evaluate that. We don't anticipate significant changes to the FED. It's not like we're tearing it down and rewriting it like we did a few years back. But there may be a question or two that changed to meet some of the needs identified, especially the needs of the behavioral health side. So we may be doing some of that.
I don't know that we will entertain or work with the University of Pittsburgh on this. Right now, we're working as far as training with our Deering group. We're also working with Deloitte because they work with our community system as far as changing the system to accommodate version 10. So that's where we're at at this point with the outside entities we're working with.
>> KATHY CUBIT: Thanks again.
>> JULIET MARSALA: So Kathy, the work plan is still under construction. We will certainly bring that back to Jill.
Okay. So moving on to the nurse licensure compact. We wanted to make sure folks were aware that Pennsylvania has joined the nurse license sure compact, or NLC. This is exciting news for us, particularly with the workforce need for nurses. So effective June 27, 2025, nurses with a valid multistate license from an NLC participating state may enroll with Pennsylvania medical assistance without obtaining a separate license from the Pennsylvania Department of State.
So we wanted to make sure that folks took note of this update for your credentialing purposes. And we ask that you consider publicizing this to your credential providers or anyone who employs nurses that you can expand your pool of qualified candidates for nursing.
If we go to the next slide, we wanted to highlight on behalf of our sister agency the Pennsylvania Department of Aging, as part of their Aging Our Way, the ten-year strategic master plan that they are conducting an evaluation of the Pennsylvania Links to inform the design of a strategic plan to improve and redesign the program to better serve older adults, people with disabilities, and caregivers.
So the entire project has been informed by extensive stakeholder engagement, including consultation of advisory committee that they have. So there's this open comment period. We have the link in the slides that are available with the meeting documents today to review the draft evaluation report and the draft recommendation report before providing public comment.
And the public comment period will close Monday, July 28, 2025, so a little under a month. And all comments received will be considered in the creation of the final strategic plan to refresh the Pennsylvania Link.
So the Pennsylvania Link is Pennsylvania's version of the aging and disability resource centers. And so I do encourage all of you to provide commentary on that.
All right. Moving into recent OLTL communications.
Notice of public comment for bed exception request. So our participant review unit is responsible for reviewing bed requests from providers who desire to enroll a new nursing facility in the medical assistance program or increase the number of medical assistance certified beds at a participating nursing facility. So we publish notices when those requests occur. And so this notice serves to inform all interested parties of the bed requests submitted by Schuylkill County. So in interested persons are invited to submit written

comments regarding the notice. We have the address for the Office of Long-Term Living there. Or you can submit comments electronically at RA-partreview@pa.gov. There's a 15 calendar day comment period that will be reviewed by DHS for any potential revisions to the notice.
The next slide.
We also put out information on the Office of Long-Term Living critical incident management change in the OBRA waiver health and welfare measures. On June 20, 2025, we released via our ListServ communicating an update to the health and welfare performance measure number 8 in the appendix G of the OBRA Waiver. And so in accordance with this requirement, any participant with more than three critical incidents in a 12-month period, the service coordinator must perform an analysis, this is a trend analysis, and take action as necessary to prevent or mitigate further incident.
So the SC is commencing analysis and implementing the actions to address the potential issues relay lated to the health and welfare of the participant within the 30-day investigation period. This trend analysis document must be provided to the critical incident management university team member for review upon request. And subsequently uploaded to the respective enterprise incident management upon completion and submission of the final section.
If there questions regarding this change, please contact the critical incident management unit via the resource account RA-OLTL, underscore, EIMimplement @pa.gov.
All right. More communications. Excited about this one.
So from our sister agency, the Office of Income Maintenance, we wanted to share that effective June 16, 2025, there is a new phone application option for long-term care and HCBS participants that has come online. So the Pennsylvania Consumer Service Center, often referred to as Inspiritec, began accepting long-term care and HCBS applications over the phone. The applications tend to be part of the most complex applications in the process, so we're really excited that it is now available to be done via phone and individuals have another method to apply for Medicaid.
So individuals can call the 1-866-550-4355 to apply for Medicaid. That's always been in place. But now we have included the long-term care and HCBS applications as well. And this information can be found online at the apply for benefits Department of Human Services Commonwealth of Pennsylvania page.
And if folks have questions about this initiative in general, please call the DHS help line at 1-800-692-7462.
Going to the next slide.
We also put out communications about scams. Certainly come up with lots of new ones all the time. So with regards to reducing scams, fraud, and exploitation against veterans. On June 23, 2025, we shared a ListServ from the Department of Military and Veterans Affairs addressing financial scams and unscrupulous people seeking to profit from the benefits veterans earned through their military service. To safeguard this population and reduce the likelihood of scams, fraud, and exploitation, the Department of military and veterans affairs released a pension poaching tool kit filled with educational materials for you and your community to print and post and continue sharing electronically. If any of you are serving veterans or members of the military within your program, we certainly would hope that you would share that resource as well.
The centers for Medicare and Medicaid issue fraud alerts and they have a new one with

regards to a phishing scam related to fax requests for medical records. On June 23rd, we issued a ListServ about the alert for the fraud scheme that using the phishing fax requests that falsely claim to be from a CMS staff to obtain the medical records for auditing purposes. We do not conduct audits by requesting items if I fax. If you have additional questions about that alert, we have included the CMS contact that is in the PowerPoint.
I also wanted to touch base. We understand that there were questions related to House Bill 640. As you are aware, there are proposed changes at the Federal level related to limiting provider assessments. One area that has been and remains unclear is how the Federal Government will interpret statutory reauthorization of an existing assessment. So that was a serious concern was the significant risk. Our provider assessments total billions of dollars, so there was a concern that a statutory reauthorization could be determined as a new unauthorized assessment. Because of that risk, House Bill 640 was signed into law by the governor June 30, 2025, known as Act 14 of 2025. The changes include removing the statutory sunset, expiration date for all existing provider assessments and aligning the MCO's assessments per member per month amount with that issued via a PA Bulletin effective January 1, 2025.
So the removal of the assessment sunset dates is a preventive measure to protect the Commonwealth's ability to continue collecting provider assessments in the face of the looming Federal cuts or changes to provider assessments.
There are no other changes to the existing statewide quality care Philadelphia Hospital, nursing facility. So the HB 640 really just removed the sunsetting piece of it.
So that was the last update that I had for OLTL. I know there was lots. And in closing, I wanted to make sure I took a moment to wish everyone a happy Independence Day and open it up for questions.
>> KATHY CUBIT: Thanks, Juliet. This is Kathy. Before we move on to questions, I want to announce additional members have joined.
Looks like we have Ali conly, Carol Marfisi, Cindy Celi, Gail Weidman, and Jay Harner.
Is there any member who hasn't been announced at the meeting that's present? Okay. With that, we'll turn things open to questions. We can start with the room and move from there.
>> JULIET MARSALA: Lloyd?
>> LLOYD WERTZ: Lloyd Wertz. Behavioral health advocate. I know there's no projection we can make about what's going to happen at the Federal level, nobody is driving that bus that has the idea of where it's going to go. But can we figure out how it might effect and impact the Commonwealth at this point given that's the worst scenario, you drive into a new fiscal year, how is that going to impact the way we're able to provide funding and support for consumers going forward?
>> JULIET MARSALA: Yeah. So at this time, the bill goes from the Senate to the House. If you have seen, there's been big shifts and changes along the way. So you're right, Lloyd, I don't have that crystal ball, so I couldn't be prepared to say worst or best case scenarios in terms of the impact to OLTL. I can say the Department and the administration and have been looking at it very closely, particular, as you have seen, Governor Shapiro put out the potential impact with regards to Medicaid and SNAP. We serve over 3 million individuals in our Medicaid programs. It is anticipated with regards to some of the significant requirements that in Pennsylvania, up to as high as 300,000 individuals may lose health care coverage. 9 out of every 10 meals is supported by SNAP. That is not -- we certainly recognize states cannot cover the entire cost of that. So with regards to best and worst

case scenarios, we're not at a place. We're still analyzing. The bill passed last night through the Senate is over 900 pages. We're working through all of that and it takes time to really evaluate all of those things.
>> LLOYD WERTZ: Thanks.
>> JULIET MARSALA: Yep.
Kathy, doesn't look like we have any other questions in the room.
>> KATHY CUBIT: Thanks, Juliet and Lloyd.
Moving on, are there any members joining remotely that have questions for Juliet or anything for public comment?
And how about is there anything from the general audience in chat? It doesn't look like there's any hand raised. Is there anything in the general chat?
>> Hi, Kathy. This is Paula. There's a question from Janelle. Is there a possibility that the three-day lookback used for the FED can be changed to capture more?
>> JULIET MARSALA: I assume that you're talking about the three-day lookback for long-term care nursing facilities? Or the -- oh, for the InterRAI assessment. Okay.
So for the three-day lookback on the InterRAI assessment for the 9.1.2, no, we would not make those changes because it's part of the internationally normed and validated tool.
I don't know the particulars in the InterRAI 10 crosswalk. So I will hand it over to Randy.
>> At this point in time in talking with InterRAI, that's a standard that they came up with with all the studies they have done across the world of utilizing this tool. So I don't anticipate we will change that lookback period.
>> KATHY CUBIT: This is Kathy. Are there any other questions in the chat or hands raised?
>> Kathy, there are no other questions in the chat. There's a comment asking if we can maybe -- there's a lot of background noise coming through. So it's making it hard for folks to hear.
>> KATHY CUBIT: Okay. If everyone could please mute and minimize the background noise in the room as best as possible. And I believe I heard Juanita's voice. Did you have a question or comment?
>> JUANITA GRAY: Yes, I do. Thank you. I wanted to go back. You said something about you and Randy were speaking on the version 10 of the InterRAI that would be coming out. And you said that would participants be able to give an opportunity for us to be a part of it?
>> JULIET MARSALA: Yes. So yes, we will have some work groups working on the InterRAI. So certainly if you are interested in participating, if you can just let me know or send me an email, then we can get in touch and follow up for the LTSS Subcommittee members, particularly participants and advocates.
>> JUANITA GRAY: Thank you so much.
>> JULIET MARSALA: Of course.
>> MONICA VACCARO: This is Monica from the brain injury association of Pennsylvania. I think we would like to have someone from our community be part of the group looking at it. Should I send an email to you about that?
>> JULIET MARSALA: Yes. Please do, Monica. Thank you.
>> KATHY CUBIT: This is Kathy again. I think looks like Pam Walz also just joined. Are there any other questions for Juliet or questions, comments for the public comment period?
>> Hi, this is Leslie from PATSA.
I have a question about providers have gotten in touch with us about some Keystone

contract terminations. And other providers have gotten in touch with us regarding consumers that are contacting them because of the Keystone contract terminations of other centers and home cares.
So I was wondering if there's anything that could be shared about that and any cause for concern?
>> JULIET MARSALA: Thank you for bringing that up. The first thing I understand whenever there's changes for a participant and their provider is that can potentially cause some disruption as they're choosing other providers.
The Managed Care Organizations under our Community HealthChoices agreement are required and responsible to oversee their network providers. And they have the responsibility to cultivate a provider network that meeting the needs of their members and their participants. The Office of Long-Term Living typically does not get involved in those individual contract relationships between the Community HealthChoices MCOs and their providers. So I wouldn't be able to speak to those contract terminations or why or what have you. The Community HealthChoices MCOs are required to provide us with a notice of their intention and also a 45-day notice to the participants. So it's my understanding that did occur. So if folks believe that did not occur, certainly, I know Randy and his team would like to hear about that. But my understanding is that did occur according to the CHC agreement. Randy, anything you want to add there?
>> Randy: Yeah, we're working with Keystone First on this. They are providing us information that is required by the contract. And we are working through the process with them.
>> Thank you.
>> KATHY CUBIT: This is Kathy. I have a quick follow-up to that. How does OLTL define an adequate provider network for adult day?
>> JULIET MARSALA: Sure. We do network monitoring, so we have reports that relate to network monitoring and access in choices. I will hand it over to Randy who oversees those operations and is doing work on network adequacy.
>> Randy: We look at the network adequacy across the whole program of physical health and LTSS services. So we have a number reports that come in and a number of reporting we do out to CMS. So we have a lot of work that goes into reviewing network adequacy. We do secret shopper campaigns. We have hired staff that are working directly on network adequacy. There's a lot of things coming out with CMS on network adequacy in the future as far as how it needs to be monitored. We do monitor every provider type and take a look at if complaints come in from participants that they can't find a provider. We will look at various reports that come in. So there's a lot of oversight of the network. It's one of the most critical parts of the program to ensure that we are covering everybody that needs coverage. So we will continue to do that work with the MCOs.
>> Thank you.
>> Kathy, this is Paula. There's a question in the chat from Amy Lowstein asking if OLTL could speak to how many Keystone home care agencies and adult day providers are set to be terminated.
>> JULIET MARSALA: Amy --
>> I'm sorry. And does Keystone provide details on how it will continue to meet network adequacy when it reports on such contract terminations.
>> JULIET MARSALA: Sure. So I can address the first one with regards to home care

agencies. I don't think I will need specific numbers for that. I can say pretty confidently that I believe that Keystone First would still have significant numbers of home care agencies within their network. I believe at one point, they had as high as 1400 home care agencies. So I personally would not have concerns with recent terminations of home care agencies and network adequacy.
With regards to adult day providers that are set to be terminated, I don't have those numbers in front of me. We can certainly do a follow-up or ask Keystone to do a follow-up. Randy?
>> Randy: Again, we know who the providers are they are working with. But I won't release that information in a public meeting. We will continue to work with these providers on that. We continue to monitor the situation. We get weekly reports from Keystone and any MCO that terms a provider that serves more than 10 individual participants in the program. So we will continue to monitor that on a weekly basis throughout the next couple of months to make sure that people have adequate choice of the services they want, whether that's switching to another adult day center, whether that's switching to home care and a direct care worker, or switching MCOs. All of those are options for the participants. All participants are given those options. We will continue to monitor through that way.
>> JULIET MARSALA: Thank you for the question, Amy.
Kathy, Lloyd has a question in the room.
>> LLOYD WERTZ: Lloyd Wertz, behavioral health advocate.
A question along the lines but related to behavioral health. In that the determination for the need for behavioral health often will generate from the service coordinator in the reassessment process done by the MCO. But the service itself is not provided by the MCO. Can you tell me more about how the adequacy of that network or those networks is determined by your office level? Or is it?
>> JULIET MARSALA: So in speaking about the behavioral health managed care organization network adequacy for services related to the long-term services and supports, for those individuals, the YAEFRL health services are coordinated with the behavioral health managered care organization.
So those individuals would likely be receiving their behavioral health through the BH-MCO. So the BH-MCO does their network adequacy providers that aren't overseen by the Office of Long-Term Living, but are overseen by the office of mental health, OMHSAS. We are in connection with them. So in terms of we don't oversee the BH-MCO network adequacy.
>> LLOYD WERTZ: Do you chat about it? Are there points -- maybe there's a place in Franklin County where it ain't there.
>> JULIET MARSALA: All of the organizations have required in their agreement behavioral health person that has to integrate all of that and talk with them. Certainly at DHS, we do connect with our sister agencies and kind of work collectively. The bottom line is, Lloyd, there is a workforce shortage. I wish I could wave a magic wand and have -- yeah.
But certainly we do as much as we can to support those needs.
>> LLOYD WERTZ: Part of my job is bringing it up.
>> JULIET MARSALA: I know. I love it. I love it.
>> Kathy, this is Paula. I have a hand raised by Carol Marfisi, Carol, if you could unmute.
>> KATHY CUBIT: And I want to quickly jump in to mention that Neil Brady has joined us. Go ahead, Carol. The floor is yours.
>> CAROL MARFISI: Maybe I didn't this. But what is the -- what is that committee that you

mentioned, UA? Juliet? That committee, that work group -- the UA?
>> JULIET MARSALA: Asking about one of the committees so that -- the UAC committee? In my presentation, I talked about the purchase review unit for the bed exceptions request that the unit was in OLTL. I talked about the critical incident management unit. That's another team within the Office of Long-Term Living. So those are an advisory group.
The Pennsylvania Department of Aging, they had an advisory committee that they had worked through through PDA. So that doesn't fall under us.
And --
>> CAROL MARFISI: It was a group where you said one of the committee members --
>> JULIET MARSALA: Oh, right. Okay. Okay. So that is for the work that we are doing within the Office of Long-Term Living to evaluate updating the InterRAI from the 9.1.2 to version 10. So as we're doing that work and that work plan, we wanted to know if folks from the LTSS Subcommittee, participants and advocates in particular because this impacts participants and advocates more so, would want to be included in those work plans.
So that committee doesn't have a cool name yet. But I'm sure we can think of one.
>> CAROL MARFISI: InterRAI --
>> JULIET MARSALA: Can you repeat that, Carol? Oh, what is the InterRAI?
>> CAROL MARFISI: Yeah.
>> JULIET MARSALA: Okay. So the InterRAI is an international validated assessment tool that helps to kind of raise up and evaluate individual medical history and needs, maybe functional areas of need and things like that. So it's one part of an assessment tool that service coordinators use when they are working with individuals toward their person-centering planning team and needs.
So they use the InterRAI as part of that comprehensive assessment of needs.
>> CAROL MARFISI: The committee member --
>> JULIET MARSALA: If you're interested, Carol, we can certainly put your name down as someone who is interested in being engaged.
>> CAROL MARFISI: Would I be working with --
>> JULIET MARSALA: If that's something you're interested in, the work plan is still underway. So we don't know the kind of full scope of sort of the involvement requirements. But I can make sure that you're connected and informed so you can let us know once you get that information about your interest and whether or not you want want to work with the work group when it comes together.
>> CAROL MARFISI: Okay. Thank you.
>> JULIET MARSALA: Of course. Thank you, Carol.
>> Any other questions from members or in the chat before we move on to our presentation from the MCOs around behavioral health strategies?
>> JULIET MARSALA: So we do have a question in the room. Seana?
>> Yeah. Is it possible for anyone other than committee members to participate in this process? Because I can think of some folks that are not on the committee that might want to be part of the process. That's part one of my question.
And part two is does this review of this affect the time and task tool that is part of the assessment process for assessing the amount of minutes or hours that people get of attendant care? The reason I ask that is for years, we have been asking about the time and task portion of the assessment because it often takes longer than a tool can prescribe to complete certain tasks.

So I'm just -- I wondered if others can participate and if the time and task tool is also going to be part of this review.
>> JULIET MARSALA: Sure. So the -- in terms of opening us up participate outside of the committee, I will bring that back to Jill in terms of the work planning process and give you an update on that. We do want the initial work group because they are kind of really deep into the weeds to be pretty small so that we will be coming to the LTSS Subcommittee providing updates along the way for public comment as well. So that would also be available to larger stakeholder groups. So as I said, it's just underway. So I will certainly take that back.
For the second issue and question about the time and task tools, OLTL does not put out a time and task tool. We understand that MCOs do use other assessment tools for the building of service plans. OLTL does not have a time and task tool that we put out. So this work group would not be evaluating any kind of time and task tool. That's not part of the InterRAI.
>> Okay. Years ago, there was an issue with the rounding of the time or the rounding down or rounding up. And it was around the InterRAI. That's why I asked the question. You weren't around then. But it was a lot of conversation among participants in this meeting about the InterRAI -- the process. So I'm just asking if that's going to be reviewed as part of it. Because it may come back around again. That's all I'm bringing up.
>> JULIET MARSALA: Yeah. You're right, I don't recall being here for those conversations.
>> It was before you.
>> JULIET MARSALA: Okay. Taking a break. So I will certainly go back and look into it and try to go through it. But in terms of that, certainly we'll bring that up and make sure that folks are aware of that. And I will get up to speed on that, Shauna, and maybe follow up with you afterwards for additional context. As I said before in terms of time and task tool, OLTL has not issued one and don't plan on issuing a time and task tool at this time.
Randy?
>> Randy: Yeah, I was here. I have been here. We had those conversations. There was concern of how things interacted with each other and how things were calculated from the time and tasking tools into the InterRAI. We have had a lot of discussion and meetings with the MCOs over the years about this and looking at their tools. I think it's something that they continue to evaluate.
The InterRAI, so you know, that's the assessment tool that the Department, OLTL dictates that the MCO has to use as the base for their assessments. We do allow them to use various other assessments, the time and tasking tool, dementia tools, wandering tools, informal supports tools. There's a number of tools that they can utilize as they're doing their assessments. We know that a lot of concern comes from the time and tasking tool and we will continue to work to improve the process as needed. Those are ongoing discussions as we look at the program with the MCOs. But Juliet is right, we don't approve those tools. We don't say that they have to use those tools. It's the MCO's responsibility to make sure the assessments are done appropriately.
>> JULIET MARSALA: So there's two pieces here. One is the person-centered planning process. Right? Everyone's lives are very individualized and their needs are individualized. Right?
The other part is the HCBS service needs have to meet the medical necessity threshold. So you have both of those coming together. So just to kind of keep that in mind, that's one of

the reasons why there isn't a perfect time and task tool that OLTL is interested in putting forward.
There are no additional questions in the room, Kathy.
>> KATHY CUBIT: Thank you, Juliet.
With that, we're going to move on now to our presentations from the CHC-MCOs. Starting with Amerihealth Keystone First. And I just want to thank the committee has had numerous requests and questions around behavioral health, and I want to thank the MCOs for tailoring their presentations today from the questions and concerns that have been raised thus far by members.
So with that, we'll turn it over to Jennifer. The floor is yours. Yours.
>> JENNIFER FORD-BEY: Good morning. Can you hear me? Thank you.
Good morning. I am Jennifer Ford-Bey. I am the manager of behavioral health and collaborative services at Amerihealth Caritas Keystone First. I'm here to discuss the support strategies for behavioral health. I plan to review the team's tracking process for behavioral health referrals and the data we gather from those referrals. And from there, I will talk about our interventions, such as how we support our service coordinators through trainings, suicide prevention methods, our nursing facility population support, and our approach to multiple antipsychotic drug reductions.
Before I go into that, I want to stress the importance of this conversation with just a few quick facts. Based on data made available in March 2025 from the National Alliance and Mental Illness in Pennsylvania, one in every five adult experiences mental illness every year.
I know we spout a lot of facts and it's easy to hear the one in five. But I want people to think about five people you know and how prevalent this is.
Another statistic from the National Alliance of Mental Illness is that in Pennsylvania alone, 1 in 20 adults have serious thoughts about suicide each year. That's a lot of people having this health problem. And I do say health problem because mental health is health. In fact, according to the Center of Disease Control, mental health conditions are among the most common health conditions in the United States. So at Amerihealth Caritas Keystone First, we are working hard to increase the connection of services and promote the interdisciplinary collaboration to support the CHC population as much as possible here.
Next slide.
Thank you.
For every behavioral health referral our team gets, we input the information from the referral in our electronic medical record system so we can track a variety of items. We get a weekly pull of information from these referrals for myself and my team to track and monitor. On a quarterly basis, we pull a report on the number of behavioral health referrals we have gotten, how many of those participants are in nursing facility, how many of these participants are participating in nursing home transitions. We track the outcomes of those referrals, what kinds of services were requested. And we also track the number of collaboration coordination calls that we have with BH-MCOs or the D-SNP.
At the bottom of the slide, I made a note in our reports, we focus on the past quarter of information. But we collect this information cumulatively and track it by regions as well so we can see how things ebb and flow from quarter to quarter or by region to region. Next slide, please.
So quick note. For the last 12 months, this is what the data is capturing. So the status

source is specifically from June 2024 to May 2025.
And the last 12 months, we received 2,206 YAEFRL health referrals. 12% of those were from nursing facilities and 200 participants that we got referrals from were specifically nursing home transitions. Out of those, we provided 40% of these participants with information, resources, and they chose to self-connect to a provider. So to break that down, that means when our behavioral health coordinators outreach to the participant, the participant is in control of how much support they want from us. So we may have participants who simply want a list of providers that accept their Medicare and Medicaid plan coverage. Or they might want to know how to connect with their D-SNP to start the services or call the provider directly to coordinate that intake appointment.
It's always about participant choice with us and that 40% represents those participants who got the information they wanted and just did not want our YEFRL health coordinators to be involved with the direct scheduling of that appointment.
20% of our referrals were fully connected, meaning not only did our coordinators assist in the navigation, but helped schedule the intake appointment for the participant and we followed up with them to make sure transportation is arranged. We even follow up after their first intake appointment to make sure there is no concerns and everything went well. So that 20%, that's what we consider fully connected here.
We have a 21% that falls into an other category. So I want to quickly address that. I will say probably a majority of the participants are people that we have referrals for that are still open, meaning I don't have an outcome from them yet because we're still working with them. The category also describes people who might have lost eligibility while we were working on a referral with them. Or participants who asked us to follow up at a later time because they're interested in BH services, but had a recent change in physical health. Those kinds of items.
We did have 8 % which we're unable to reach for referrals made post-hospitalization. 4% of the overall referrals did decline services.
And the services requested in the last 12 months, outpatient therapy is the most popular at 71.%. And they make a smaller population, but we have seen an increase of utilization of the services in the last few years.
We also have had over 340 joint calls documented collaborating participant specific cases with the behavioral health MCOs. We have seen year over year the number of referrals increase, both for our participants in the community and in a nursing facility setting.
As stated earlier in this meeting, service coordinators are a primary referral source. So it's integral to promote education and resources to them. So on the next slide, I show the trainings for our service coordination team that they must complete to support them and our participants.
So for on boarding, all of our service coordinators get trained on mental health first aid, Mandt crisis prevention and intervention training. They get person-centered thinking, field safety. A review on substance use disorder overview, BAIFRL health overview, motivational interviewing and trauma-informed care.
And then annually thereafter, they attend zero suicide trainings, Mandt crisis prevention and intervention, motivational interviewing, and trauma informed care.
We do track the attendance of these trainings, and most of them have knowledge checks build into them.
In addition, our behavioral health team frequently highlights the 988 line and the utilization

of that. And we like to highlight the lines where participants can call into a hot line to talk to a certified peer specialist.
Next slide, please.
So in 2024, we created an interdisciplinary work group including a variety of staff from departments such as the service coordination team, quality team which manages our critical incidences, case management, YAEFRL health team, medical director, training team. And provider networks in there. We have a lot of teams all working together.
And the purpose of this is to create and implement interventions to promote the mental health wellness of our participants. So as a result of the work group, we created the PHQ9 intervention. It's a valuable tool for screening for depression and can identify individuals at an increased risk of suicide but having follow-up from a trained clinician for those who score at a high risk can be key for having the appropriate interventions in place. They create one of these with each participant during their annual assessment for changing condition. The team has been given direction on actions based on the participant's score. I do go into that more on the next slides. So I will touch base on that.
But the behavioral health team -- no, it's okay. Stay where you are.
Thank you.
So our behavioral health team pulls the PHQ-9 scores every single month from the most recent assessment. From there, we look at anyone with a PHQ-9 score of 10 or higher. We then check and see if any of those participants did not have a behavioral health refer. If they had a score of 10 or higher and a YAEFRL health referral and we know the outcome, wonderful. If not, the team starts doing a chart review. We start seeing if services were documented as being involved in their attending. Did they decline services outright? Was there a recent change in this purpose to cause this? Kind of what's going on here.
So unless there is a clear decline noted by the participant that they do not want the behavioral health services, the BH team would make outreach to the participants with a score of 10 or higher and not previously connected to BH it wases to talk to the participant about the services available to them.
We put this in place in August 2024. Since then to June, we have seen that 51% of those participants we outreached to agreed to services and we were able to connect them to those services.
We still have about 26% that declined, but they were outreached and educated. The other 23% that I didn't note here broke up in several categories. Unable to reach, lost eligibility, interested but not right now, those kinds of items.
We also developed an intervention where our team identified at the end of the calendar year 2023 that we had 300 behavioral health referrals made to us throughout the year. But the outcome was that we weren't able to reach them based on our data tracking. So my team put in place this intervention where at the end of every quarter, we review the participants we weren't able to reach after three outreach attempts. The BH team outreaches to the service coordinator. One, to ensure that they don't want us to call. Or to make the service coordinator aware that we will be reaching out again. We certainly appreciate that many participants might screen numbers they don't recognize. We find that when we make the service coordinator aware, we have better success.
We re-reviewed the numbers at the end of the calendar year 2024 and we noted that we had only 157 referrals that were unable to reach. So almost 50% reduction. And the goal is to promote the connection of services as much as possible. We did consider this a success.

And I want to quickly note just our teamwork with our provider networks management team. They have been wonderful to work with from BH perspective. We previously hosted mental health first aid for the providers, employment providers were offered that opportunity at the mobile wellness center in Chester last year. And we continue to discuss more opportunities to provide information and education to our network, including nursing facilities. Which I touch base more on another slide.
This group talks a lot about interventions that we might want to do in the future, support that we can provide our teams to our participants. Women health initiatives surrounding cardiovascular disease and breast cancer. So the work group covers a lot. Next slide, please.
Thank you.
So I referenced on the last slide that we created an intervention chart to support our service coordinators. And you will see it here. I will put the caveat that this goes through two sides. I wanted to make sure it was big enough for everyone to see. So you will notice that there is an overall score. The severity and then the action to be taken. And you will also notice that if they score higher than a repeat PHQ-9 should be completed to monitor.
If you go to the next slide.
You will see how the severity will call for different actions, different reassessment intervals so they can range from simply outreaching to the PCP primary care physician to make them aware of the risk for depression to following up daily with that participant and making sure that they are working to get connected in services and making sure that we're getting those referrals and reassessing on a monthly basis.
Next slide, please.
Okay. So our behavioral health team does try to provide as much support to our nursing facilities as possible. And we do this in a few ways.
We meet with our provider network management team that specifically works with our nursing facility groups to provide them information on the behavioral health supports available. We include them in our quarterly CHC and BH-MCO calls where we provide education and information. We talk to them about the PASRR specialized services and more.
We give all of this same information to service coordinators to relay this information back to the nursing facilities. We found a group of individuals and those are provider network -- are different. And the more awareness we spread, the better for everyone, the more understanding there is. And even our provider network management team knowing how to utilize our team, how to make sure that they get the information needed to those nursing facilities has been important.
We also have behavioral health office hours available for our service coordination team to, quote, drop in, ask questions, problem solve scenarios. We also provide education on upcoming trainings held by the partners at the the BH-MCOs or in general. We spotlight session about the population and the YAEFRL health impact for that culture.
We have seen an increase of referrals. You heard me say earlier --
>> Jennifer? I'm so sorry. We have some technical difficulties in the room. This is Juliet. Wondering if you can restart this slide because you had cut in and out of your presentation.
>> JENNIFER FORD-BEY: Absolutely. Thank you for letting me know.
The team works to provide as much nursing facility support as possible. And we do that in a few different ways. The first way is that we'll talk about right now is our provider network

management team that specifically leads our nursing facility groups. We provide them information on BH supports available, what our referral process looks like, we include them our quarterly calls and provide education and information. We talk to them about services for PASRR individuals and so on.
Some we provide all of the same information to our service coordinators to relay that to the nurse facility. But the group of individuals they might interact with and the nursing facility level are different. So the more awareness spread, the better for everyone. We also have our behavioral health office hours available to our service coordination team to drop in, ask questions, problem solve scenarios, provide education on upcoming trainings that might be held by our partners and the BH-MCOs or in general.
And last year, we did spotlight a topic, one of the topics was about our Nepali speaking population and the behavioral health impacts that are unique to that culture.
We also have noticed an increase of referrals in our nursing facility population. So in 2020, our behavioral health referrals only consisted of 1 % being in the nursing facility. In 2024, overall, we had 11%. It is going up, as you guys saw in an earlier slide I preferenced from June to May. And now that's 12%. So certainly seeing that increase coming and we have our multiple antipsychotic medication review in the year 2024, we had identified 55 participants in nursing facilities that were prescribed multiple antipsychotics that was reviewed by our CAC pharmacy director and our coordinating behavioral health MCOs. I have more information on this on our next slide, which we'll go to.
So our multiple antipsychotic medication review process consists of a monthly data poll of Medicaid only participants. It's reviewed by the pharmacy director, her team, our behavioral health team representatives. We track this information by setting, who the prescriber was. It's important to see what the psychiatry and PCP, or were there other specialists? Sometimes they aren't aware that they are both prescribing antipsychotics. So putting interventions in there as applicable.
We also reviewed for all of those participants that were prescribed multiple antipsychotics just a review on are they getting behavioral health services. Certainly getting behavioral health services is very integral along the medication adherence. So we would like to see those things in conjunction. And if they don't have the services but are prescribed multiple antipsychotics, why not? And can we connect them and the interventions put in there.
So as a result, we were able to note a 38% reduction in participants who had multiple antipsychotic drugs prescribed from the beginning of the year as compared to the end of the year.
Next slide, please.
And data sharing. We do have a file data share with HBMCO exchanging information on participants claims information and a monthly data file share. And that information is sent via secure file transfers.
All other information that is shared with the BH-MCOs or D-SNPs are done when we have a signed release of information form from the participant to have those in depth conversations.
And if you go to the next slide.
I sincerely appreciate everyone's time and attention. Does anyone have questions for me that I can answer right now?
>> KATHY CUBIT: Jennifer, thank you. This is Kathy. I appreciate your presentation. We're going to hold questions until each of the MCOs have given their presentations to ensure

each has an opportunity to get through their presentation.
So hopefully, you can stay on for the Q and A.
>> JENNIFER FORD-BEY: Perfect. Thank you, Kathy.
>> KATHY CUBIT: Thank you. And with that, we will move on to Pennsylvania Health and Wellness. And I will turn the floor over to Heather and Olivia. The floor is yours.
>> OLIVIA MARTIN: Thanks. I lead the service coordinate teams here. I will pass the baton to Heather Clarke, our liaison and director of case management about halfway through the presentation. Thank you for having us. This topic is extremely important and we're excited to be able to present a little bit about our approach here.
Next slide, please.
So what is our approach? PHW always aims to promote collaboration across the entire team. The purpose of this is because overall health is very interconnected and shouldn't be separated or disconnected.
Our goal is long-term wellness and better outcomes through whole person care by treating the whole person, not just the individual conditions they may be experiencing.
We have five pillars to our approach. I will briefly touch on them in the upcoming slides.
Next slide, please.
Okay. So what does an integrated care model mean? Integrated care to PHW means bridging the gap that sometimes exists between physical health providers, BH providers, families, SCs, PCPs, case managers, and other care team members to ensure all conditions are addressed together because they're often intertwined. Early intervention is important. Proactive mental health screening is key to identify possible BH issues early to allow for prevention, awareness with the hope of stopping further development into more serious conditions.
Social determinants of health can also contribute to BH conditions. We perform SDOH assessments that look for needs such as food insecurities, housing, and employment to connect those in need with resources that may be available to them and also community supports that may be available to them.
Next slide, please.
Okay. So care management is available to work in complement to the SC work. They do work side by side and closely together. With CM, participants can receive support with issues such as complex health conditions, medication compliance and adherence, and discharge planning, to name a few.
I'm sure you have noticed from the last few slides that I spoke here that coordination is key. Our BH coordinators will work alongside the BH-MCOs and the Medicare MCOs to personalize their care. The point of the personalization is to tailor it to how it best meets the needs of the individual, which looks different from one person to the next.
Next slide, please.
Okay. So we're going to go into a couple of questions that were posed. So I will be touching on those questions and then I will turn it to Heather shortly.
So has progress been made in accessing BH in counterutilization data for those enrolled in original Medicare? Not currently. We are continuing to investigate options. Unfortunately, the data is limited.
Do Community HealthChoices MCOs or BH-MCOs cover Medicare funded care and treatment when there's no access to a Medicare BH provider? So the coordinators work with the BH-MCOs and the Medicare providers to ensure a BH provider is secured. PHW

will work to coordinate primary care physician treatments and medication. And then also opioid addiction treatments. PHW has assessments aimed to support dementia and Alzheimer's related conditions through the mind at home program that works in collaboration with Johns Hopkins to support those participants experiencing dementia and Alzheimer's conditions and their families and support systems.
Supporting the families and also the care providers is key here. We all know how frustrating it can be caring for someone and how exhausting it can be caring for someone. So our approach is also to wrap that around those supports as well as the participant.
Next slide, please.
Provide an update on how the mental and behavioral health needs of CHC and life participanting living in nursing homes are addressed. As you may know, PHW's nursing facility specialized in only nursing facility participants. During those initial encounters with the participant and the initial assessment being completed, the coordinator will view the health records and as Jennifer spoke about, the nursing facility pre-admission screening, the PASRR. If there's determined by the screenings that BH specialized services are needed, the SCs work with the OLTL field offices to coordinate the services as recommended and also work with the BH-MCOs.
What is being done to address access issues to skilled nursing care for CHC participants with serious mental illnesses? The BH coordinators can help find mobile behavioral health providers to go into the nursing facilities and Telehealth appointments are an option is access is an issue.
Next slide, please.
Okay. Do CHCMC ordinary cares monitor to ensure residents do not receive unnecessary and potentially dangerous medications such as antipsychotic, antianxiety and hypnotic drugs.
So outreach does occur when interactions are a concern, such as drugs that interact with certain conditions and also drugs that interact with other drugs.
Provider outreach occurs for excessive therapies such as Benzodiazepine overuse. Inappropriate medication use. And lack of needed therapies.
Next slide, please.
And I am going to turn it over to Heather.
>> HEATHER CLARKE: Thanks, Olivia.
PHW does have several data exchanges with our other partner. There is a bidirectional daily inpatient notification file that exists between PHWs and the BH-MCOs. There's also a bidirectional daily admissions discharge transfer file that exists between the CHC-MCOs and the Medicare plans. All data exchanges are submitted through a secure file transfer protocol and suppressed data related to substance abuse and HIV.
Next slide, please.
PHW participant facing staff receive a variety of trainings on interacting with participants who have behavioral health needs. Some of these trainings include behavioral health 101, which includes an overview of common behavioral health diagnosis, behavioral health stigma and the overview of priority behavioral health service types. Suicide awareness and training how to screen for it. Depression awareness and how to screen for it. And overview of behavioral health managed care organizations, how they operate and some resource information regarding that.
Escalation techniques on how to respond to participant who may be in behavioral health

crisis. And then motivational interviewing techniques.
Next slide, please.
All PHW staff interact directly with participants are trained to recognize early warning signs of suicide and follow appropriate protocols when concerns are identified. We also deploy predetective modeling to proactively identify individuals at risk for suicide. Some of the logic that is built into that predictive modeling include claims, some health risk screenings, depression screening. Particularly questions surrounding pain. All of that data is ingested into our predictive modeling system that helps us proactively identify when a participant may be at risk for suicide.
When a participant is flagged, a licensed clinical social worker will reach out and assess for suicide and offer support through our Choose Tomorrow care management program. Suicide rates and attempts are continuously monitored and this data informs ongoing updates to the predictive modeling I just spoke about used in our Choose Tomorrow program.
Next slide, please.
So some questions -- other additional questions here. How do the CHC-MCOs provide incentives to our contracted providers to encourage the joint offering of behavioral health and physical health services? And what are the parameters that have been established to determine compliance with the Department's expectations for this type of collaboration? PHW does not have any informal incentives for contracted providers given that behavioral health is carved out for the CHC program and service coordination is required to coordinate these behavioral health services, as well as monitor and coordinate physical health services. We follow OLTL guidance for the coordination of both needs when presented.
What type of restraints are used and what type of reporting is required by skilled nursing facilities when used on residents with psychiatric diagnosis? PHW does not require reporting on restraints, but the nursing facilities monitor the application and removal of mechanical restraints. Details about how the individual is being monitored, the presence of a physician's order and criteria for release for discontinuation of restraints.
Next slide, please.
PHW monitors medications in relation to their diagnosis by symptom tracking to diagnosis with participant. When symptoms tracking, we assess if symptoms are improving or are there new symptoms arising. Registered nurses are utilized for completing standard reading assessments. We also monitor side effects and safety by looking at metabolic testing, lab tests, and routine blood work are encouraged to ensure all medications are being used safely.
And then we provide education on the importance of medication compliance. We have conversations about missed doses, challenges with the regimen, or lack of perceived benefits to promote compliance.
We also review pharmacy claims for any lapses or irregularities in medication refills. Or newly prescribed medications that those irregularities are also brought into the discussion if indicated.
And then pharmacy also monitors medications and misuse. They outreach to participants and providers to discuss any concerns that they may have uncovered during their review.
Next slide, please.
Lastly, I wanted to take a moment to provide an overview of a newer pilot program PHW started about three months ago that focuses on female participants who have a mental

health diagnosis and a history of stroke. We identified this population by utilizing our plan developed dashboard which incorporates data from claims and the comprehensive needs assessment. Our care managers take a four-prong approach in the care management of this unique population.
Next slide, please.
The first prong is care team coordination. The care manager will communicate with providers to coordinate services and avoid duplication of services and having those case conferences when needed. We encourage attending in-person visits with behavioral health providers and primary care physicians. And we help coordinate that transportation as needed.
The second prong is life style management. This includes the promotion of healthy eating habits and providing resources for referrals for dietary support. We emphasize weight management by encouraging regular activity and the benefit it has for overall health and disease prevention. A smoking tobacco use screening is completed. And a referral is made to our smoking cessation program if indicated. And lastly, education on stress management techniques is provided.
Next slide, please.
The third prong is health management, which includes both physical health and behavioral health needs. It also includes coordination and education on the completion of labs with an emphasis on the LDLC testing of bad cholesterol that can contribute to a buildup in the arteries and provide assistance with scheduling.
We have a home LDLC kit that can be delivered to the participant's home and returned to a medical office for testing.
The PHQ-2 depression screening is completed on every outreach to monitor depression levels. Assistance is provided in locating and scheduling with behavioral health providers and other specialties.
And lastly, we provide education on self-management strategies. One could be teaching -- one example could be teaching participants how to properly measure and track blood pressure at home.
Lastly, the last prong is medication monitoring. A medication review is completed on every outreach to ensure medication compliance, safety, and effectiveness. We do monitor pharmacy claims for any discrepancies in regimen and provide guidance on proper use. And then for participants who may be taking an antipsychotic medication, we provide education on the risk associated with antipsychotic medications and their potential effects on cardiovascular health and the importance of monitoring cardiovascular health while on antipsychotic treatments.
I believe that would conclude our presentation. Thank you.
>> KATHY CUBIT: Thank you, Heather and Olivia. This is Kathy. And again, we appreciate the presentation and your work. And we're going the move on to UPMC and John McFarland. And we will open it up for questions.
John, the floor is yours.
>> JOHN McFARLAND: So hello to the people who are seeing me. This is kind of awkward to have my back turned to some of you. And hello to everybody online. I'm John McFarland. I am a licensed professional counselor by trade. And I like to thank Jennifer and Heather and my colleagues for presenting first, as you're going to make it easier for me to repeat the same thing all over again. And this time, perhaps build more on it.

So explanation for anyone listening in is perhaps going to pick up as the presentations are rather similar. We were given specific questions and topics in advance. So none of our presentations are the whole scope of our behavioral health interventions, efforts, and services. We could be here all day. But it's just addressing these specific items.
And given that all three CHCs are respected behavioral health units, we have been working together and learning from each other on the last eight years on how to do this. And when one of us does something that the other does similar, you will see overlap then in these presentations and our efforts and strategies.
So next slide, please.
So for consideration, first is how many of our participants have a known behavioral health diagnosis? Understanding that yes, there can be some people underdiagnosed and there are also some people overdiagnosed and have a historical diagnosis carried over by a provider once you submit a claim. But we distinguish here mental health diagnosis is something defined as such by diagnostic statistical manual revised. Any conditions that you have component of behavioral health, excluding neurologically based conditions, such as dementias, that fall outside of the traditional psychiatric diagnosis due to the deteriorating conditions other than ones that respond to the traditional treatment.
We include that group and separately people who have a known diagnosis of reported substance use disorder. And those who have both.
So most of our participants do not have a diagnosed behavioral health condition. About a third have a mental health one. And we see a smaller number with known substance use issues. And again the population from UPMC.
Next slide.
So 27% of all of our UPMC Community HealthChoices home and community based services participants reported being connected to a PL provider in to 24. It could be a psychiatrist or a therapist. There has been an increase over the last two years.
As far as our internal referral process where participants identify having behavioral health issues either in our formal or informal reaching out to us. And requests, we have had over 2,800 instances last year of service coordinators and behavioral health coordination team collaborating on requests for getting new, different, or additional behavioral health services. Now we'll say 90% of requests are with the general population for outpatient psychiatry and therapy.
Now, some of the questions we received in advance regarding do we know anything regarding medicare engagement? It is a primary for most participants. Understandably with the latest wave of enrollments, we have seen the shift in the southeast, perhaps that's the decrease maybe to being 70 %. But overall for Pennsylvania, still primary. Unfortunately, we do not have those stats yet. We can speak generally regarding the specialized -- special needs plans for our own UPMC. Across all three CHC combined, they saw 12,765 participants attend a behavioral health service last year. Give that some idea. For us as far as these are concerned, it's our largest one. Most of our participants have a variety of different conches.
Next slide, please.
Now, the Medicaid BH managed care organizations, are typically the secondary for both inpatient and outpatient claims as set up by the Federal system.
They collectively reported for UPMC participants in 2024 that we have had just over 1,600 in inpatient behavioral health that they're aware of that they had received a claim for. And

over 20,000 had a claim for some form of outpatient mental health treatment.
Now given that each claims team set up their names for each codes rather differently when they report back to us details on some of the specifics were all over the place. Psychiatry, individual therapy, group therapy, family therapy, federally qualified health centers, and various forms of specialized therapy, trauma, sex offender, hoarding programs even.
So we are seeing a variety of treatment and pretty good engagement, 20,000 people.
And again, this is a secondary provider having these claims. A lot of primary Medicare providers are not Medicaid enrolled or will not ever bill Medicaid for that co-pay.
Next slide, please.
Now, the specialized services. These are the ones that only the Medicaid BH-MCOs will cover that's not inpatient or outpatient. They report to us the following.
Peer supports, certified mental health peer support among our participants, 1,363.
Targeted case managements, so behavioral health case management separate from the CHC service coordination, 5,339.
Psychiatric rehabilitation, mobile psych rehab or the clubhouse programs or people building more of their social skills, career skills, educational preparation skills, 1,134.
Crisis, be it in person, tell phone, or mobile, 2,758.
Now, seeing this many people using crisis sounds bad, but actually, we have been encouraging more crisis use properly as they do intervene rather than people being quiet. We have had every agency I know, every county I know of encouraging people to use 988 and the crisis services.
That shows a good engagement. These are distinct participants, not instances.
Partial mental health, 257. Now, we would expect low for Medicaid funded partial mental health that they usually take nonacute partial programs. So partial is for those who are not aware, are the programs that are intended to be -- give hospital-like services, but you just go in for the day. You get a psychiatrist, groups, nurses checking on you. And you go back home. For people who need more than outpatient and less than inpatient. They last a couple of weeks and funded by Medicare. The nonacute ones are the ones funded by Medicaid. So 257. These numbers are similar to the last two years. We have seen the Medicaid enrollment go up and down again due to things beyond our control. And we are seeing good engagement in population.
Next slide.
Now substance use. Self-reported substance use. So 2% of our home and community based service participants report drinking alcohol heavily more than once a year and are using unprescribed substances more than once annually.
Of those unprescribed substances by -- marijuana is what they would report or cannabis. Only about 40 of the same group of participants will agree to and referred to substance use treatment.
Now, there is a catch here, of course, that some people will prefer some other harm reduction strategies or attending support groups. Talk to their PCP about alternative options. It depends where they may be in the stage of change and awareness. As well as how they view, say, their alcohol use. That's usually the bigger issue. Many may not engage in much enough alcohol use to qualify for a alcohol use disorder diagnosis, but there is enough use that we are concerned and we share that concern with them. So the strategy they take, will they address it with the PCP, for example?
These 40 are stillen increase as to what used to be 7 when we launched.

A new diagnosis substance use have varied with Medicaid enrollment and we suspect that the opioid use disorders we start funding the fiscal health based opioid use disorders centers of excellence back a couple of years ago. So initially, we more diagnosis came in via billing. Now that that's levelled out, we see about 900 a year new diagnosis substance use disorder.
Next slide, please.
There is other evidence that our participants are engaged in substance use disorder across all eligibility cohorts. And are engaged in treatment. We know from the claims from the opioid centers of excellence that we fund, we have an average of 170 monthly users. And again, from the BH-MCOs, we have Medicaid just shy of 2500 people outpatient substance use --
Intensive outpatient going to a combination of counseling. The partial, 69. And then the residential treatment, those who considered the 28 day program rehab, that's for more complicated than that, all the level 3 and level 4 programs, the detox, the halfway house, just shy of 1500.
Medications treatments, methadone and we saw 1,864, which is pretty good.
And substance use disorder case management, 152. Some more might have been engaged via other services that were billed as other, which includes certified recovery specialists and similar.
Next slide, please.
Now, no progress has been made in accessing the claims data from Medicare fee for service or the special needs plans. There are ongoing meetings regarding data exchanges of special needs plans. We had a productive meeting with them last week. So we're exploring the the best way. There's ongoing discussions about which method they used to share the data. And whether there's existing fees or not.
For Federal regulations, we had questions about what happens if Medicare doesn't fund the service, does Medicaid kick in? Federal regulations Medicare funded services can only be covered by Medicaid when there's a denial. Or if Medicare is exhausted, which you see more common in long-term inpatient stays.
In practice, what we have seen is this few instances where a participate encounters no outpatient behavioral health providers funded by the D-SNP in the area. In the instances, it's usually a specialized form of treatment. When you have an outpatient therapist provider in the rural area that speaks such language or that does certain type of treatment. And that's enrolled in Medicare. The D-SNPs have been willing to do an out of network agreement with the Medicare enrolled providers if we find one. Some of these are involved and they have been willing to add them to a network. I was in a exchange with them this morning about a scenario.
Telehealth services have been a popular alternative option when you have the few instances that there's no available providers physically available nearby and people have been open and accepting of telehealth.
And one other newer thing that's started rather recently before Medicare was only open for psychologists and licensed clinical social workers to provide outpatient therapy. Licensed professional counselors were given the green light to join Medicare enrollment. They have to apply, of course. This is significant as in Pennsylvania, we have five times more licensed professional counselors than we have psychologists. So it opens the pool quite a bit. And what we have seen is yes, the numbers -- I can't cite exactly how many, but we have seen

for more availability via Medicare.
Next slide, please.
Nursing homes. On an individual level, how do we know if our participants have behavioral health needs? Similar to the others, we ask questions in all of our assessments that include behavioral health items. Our service coordinators are trained on behavioral health. We maintain a dashboard of participants who are identified as mental health target in the pre-admission screens and resident review, the PASRR-II evaluations. And then monitoring more closely what is done for the treatment.
On our larger scale, how do we identify which facilities have behavioral health access issues? So we do it both at the ground level and the higher up levels. Service coordinators do inquire with facilities about the services arranged for participants. If they are struggling with that, they come back to the behavioral health team and we work it out. We identify one off or the facility lost the usual provider or in there's another situation that needs to be addressed.
On our larger scale, our behavioral health coordination team has been serving the publicly available information about behavioral health services in each facility. So the 700 nursing facilities in Pennsylvania, about two-thirds of them do advertise on the websites or in public listings whether they have a psychiatrist or a psychologist on staff or use off site services. We do track referrals of requests for specialized behavioral health services in nursing facilities. If a facility trends, it's an opportunity to work with a behavioral health MCOings and see if they need assistance.
And how this is happening in different facilities that attend, what are the needs, is what they have enough? We have seen the BH-MCOs take initiative to reach out to facilities that have a high amount of participants with diagnosis and/or have had more referrals or more PASRR-II identified and mental health target participants. And then trying to see if they need something else and connect with mobile mental health treatment team, for example, or peer support or need some sort of psychiatric peer feedback.
Next slide, please.
We received questions about medication monitoring in nursing facilities. For all participants, the pharmacy monitors the medication use and misuse. That includes some initiatives to reach out to physicians for antipsychotic overprescription and opioid overprescription. These initiatives do include our nursing facility participants.
Our service coordinators have been trained on antipsychotic overprescription awareness in the spirit of trying to detect evidence of chemical restraints.
And we have also identified our overall antipsychotic use and UPMC CHC participants is about the same as the average U.S. population. Studies from Federal Government determined about 1.6% of the population was described a psychotic. For mood regulation, for example, given Xyprexa for anger. And it was also 1.6 in 2023.
Next slide, please.
As far as what we do to train nursing facilities, a nursing facilities received several rounds of basic training on accessing the behavioral health services in the CHC. Back five years ago, all of us were on the road meeting with various facilities at their closest communities and different presentations and explaining how this worked. And we did the same virtually. So around collaborating with the BH-MCOs that would travel with us in person and virtually. And we have done them again.
But we have also given our nursing home transition providers training on behavioral health,

how does it apply to their circumstance when somebody is transitioning from being in a facility to the community. At what point should they alert us and the right methods of communication, what they should be looking out for.
Nursing if facilities are invited to the quarterly meetings. We had one last week. And we have presentations with behavioral health. I hosted the one in December and led a panel discussion with representatives from four of the nursing facilities and had a discussion about the YAIRL health concerns that they have regarding treatment -- behavioral health concerns they have regarding treatment and management and what we can offer to support that.
CHCs and BH-MCOs train on behavioral health topics. CCBH just wrapped up one they were doing every Wednesday throughout last month.
And for learning network collaborative for nursing facilities included an emphasis on behavioral health. The most recent was a multifaceted approach to behavioral management and nursing homes in April. And another one in the works.
And they also facilitate a free online community via the tomorrow's health care platform, which includes materials and recordings from trainings and a behavioral health resource folder.
Next slide.
So just one last note on nursing facilities. We are aware that when we train sometimes it's the administrators rather than staff who are available to be present at a training. The staff are too busy. So we encourage that the administrators share the information with the staff. And we're aware of the turnover and the facilities have to be trained and retrained.
As far as our data exchange. Per the CHC agreement, we have data exchange agreements set up with ever BH-MCO. Each one of the health choices contracts through which we exchange daily reportsover inpatient admissions through a secure file transfer protocol process. The individual clinical cases with collaboration are discussed in the conferences with limited follow-up via secure email encrypted. We try to avoid those endless email chains. If somebody has a concern that requires discussion, I always ask my team to stop is email and schedule a conference to talk it through.
Regular conferences are routinely scheduled. And we have quarterly meetings. It's an opportunity to add anybody else that you might have missed.
Excluded from the exchanges are substance use information and HIV information. Unless there's additional information to satisfy the requirements of legal teams of the respective MCO and this is in compliance to the Federal regulations in 42CFR, understanding while Pennsylvania law did loosen the regulations more from the local level, it deferred it to to Federal level and we're waiting for that to be weighed in as far as if this can be interpreted differently for MCO to MCO or not. As it is right now, somebody has to sign additional releases of information to address this. If not, we will not exchange that information whatsoever.
Next slide.
So BH training of service coordinators. The new hired service coordinators are trained including suicide awareness and prevention. We have been doing this training for the last two years and several hundred staff. Additionally, we hold trainings on various topics, including suicide prevention and crisis, motivational interviewing, mental health first aid, trauma informed care, among the other topics. And overall refreshers on behavioral health coordination.

We also hold sessions twice a month in which anonymous case, no names, are discussed with a psychiatrist for educational group discussions on UPMC CHC staff regarding how to best work with something's needs and understanding their diagnosis better.
These sessions are recorded for viewing by staff who are unable to attend.
Next slide.
Suicide rate in UPMC CHC. There's an annual average of only two instances of completed suicide in UPMC CHC participants. One is too many. Screening, like with the other two MCOs, our participants receive PHQ-9 screenings in the InterRAI. We have it embedded. Nursing facility ineligible participants receive the screenings as follow-up to health risk assessments when related questions to mood are answered.
And for nursing facility participants, we rely on the screening for mood and behavioral health concerns for information applied to the nursing facility.
For any of these, if there's concern, we will address it. We place special emphasis on scores of 15 and up, but even if somebody scores a one, we will encourage connection to behavioral health resources.
And in addition to trainings I have mentioned of suicide prevention, I want to clarify it's a main topic and it's become a sub topic of various other trainings. And the community engagement team has been given a 0 suicide effort and giving information to the community at various events. It's been a focus of training for providers.
Next slide.
So the last few questions we received were regarding the integration of physical health and behavioral health services in the CHC context to provide the joint offering of behavioral health and physical health services. As UPMC CHC is not the funder of behavioral health services and only a limited capacity of physical health, we cannot offer this. Our primary of management is long-term service and support service providers which have little ability to add this to the services.
What are the parameters established to determine compliance with DHS and expectations in these types of collaboration? The collaborations that we mentioned, the BH-MCOs have an annual agreement, exhibit H and R and mentioned in other sections. But those are the main ones. These are the basis of the individual cooperation agreements with each.
And UPMC CHC tracks all of the behavioral health coordination and SNP coordination regarding behavioral health.
And a question about whether we offer pay for performance rewards regarding inpatient, psychiatric, similar to how traditional MCOs were asked. Since we do not fund the inpatient providers or the type of behavioral health, we cannot offer this. BH-MCOs tend to have their own pay for performance initiatives. Not specific to CHC population. But most of the high volume providers have various form of this.
How are prescribed psychoactive medications monitored relative to their identified diagnosis? As previously mentioned, our pharmacy department manages it and includes initiatives to reach out to physicians for antipsychotic overprescription and opioid overprescription.
And what type of restraints are used and what type of reporting is required by skilled nursing facilities when used on residents of psychiatric diagnosis? It is our understanding that chemical restraints are the most common. That said, any type of restraint have reportable incident to the appropriate state agencies rather than CHC. There's a separate couple of guidelines on that on long-term care facilities and restraints. And the other one I

believe is code 55 that oversees this. So there's various state agencies or initiatives, state oversights so which nursing facilities have to report the instances. It's not tracked by the CHC. And that's by design. But again, we have encouraged -- we trained the service coordinators in detecting antipsychotic overprescription to detect if there's a chemical restraint.
And I believe that concludes our presentation. Next slide.
>> KATHY CUBIT: This is Kathy. Thank you, John, for your presentation and for your work in this area. Before we move to questions from members in the room, I just want to remind people that are at our June meeting, we did hear from life providers about behavioral health. And in the June meeting follow-up, there is additional information in response to that conversation that I wanted to make sure people were aware of that that was just sent.
So with that, I don't know if Lloyd or if there's other members in the room that have questions for our speakers?
>> JULIET MARSALA: Kathy, we have some questions in the room. I did want to take a moment to remind folks that this room is hot mic from front to back. So if folks are having side conversations, there's a very good chance that everyone joining us virtually is hearing that conversation. While people in the room may not hear it, people with us virtually will likely hear that conversation. I wanted to make sure folk ins the room were aware of that before I hand it to Lloyd.
>> LLOYD WERTZ: Thank you, Lloyd Wertz, behavioral health advocate. All three of these presentations were impressive in the sense that you're looking at it. You have really kind of gathered the intentions of viewing behavioral health issues as a serious component to the health and welfare and well-being of individuals enrolled in the system. And that's such a good thing.
For the first presenter, the fact that you were able to track your number of -- your percentages of referrals from nursing facility residents to the total behavioral health service referrals you made and it started at 1% in 2020 and is now at 11% in 2024 is very, very impressive. I did not hear that number from the others. My guess is you know it. If you could share that at a future meeting, I would appreciate that. That's progress. You get more people participating from a skilled nursing facility. The folks with numbers on the doors weren't served before that, and they are now. That's a good thing to hear.
The training that's delivered for the service coordinators, is all of that online? Or is that delivered in person as well?
>> Good afternoon. This is Jennifer from Amerihealth Caritas. Can you hear me? Perfect. First of all, thank you for your feedback. I appreciate it greatly.
The trainings are done in a few different ways. So our mental health, our crisis prevention and intervention are live trainings, meaning our service coordinators see a calendar of events that offer all sorts of trainings. So anyone who has done the training can certain re-register. But most of those are live trainings. There's a few that are recorded and are done on the any time learning behavioral health overview, those items. But I would say the main four, the mental health, first aid, Mandt crisis prevention intervention, trauma informed care, those are live trainings. I hope that answers your question.
>> JULIET MARSALA: This is Juliet for the purposes of questions. If they are asked to all the CHC-MCOs, I would follow in the direction that the presentations were made. The next up would be PA Health and Wellness to answer your question.
>> Yep. Most of our trainings for service coordination are done virtually since the service

coordination entity and service coordinators are throughout the Commonwealth. And we do record some of them. They also have access to many of our trainings online as well.
>> All of our trainings are virtual and we have close to 1,000 staff spread over 67 counties. So found that cramming them all into one room not only disrupts, of course, the work day and a lot of travel fees, but it's not necessarily more productive to have them in person for the mental health trainings. They have the same presentation flash in front of them. They are virtual on the retention rate and popularity of them to be quite good.
>> LLOYD WERTZ: Did you take mental health first aid?
>> Yes, I did.
>> LLOYD WERTZ: In person or virtual?
>> Virtual. And I have taken more than once. I was trained as a license professional counselor and licensed. A lot is repetition. And the slides and information given and the quality of the presenter speaking in the room was equal, in my experience. Different people encountered online and in person with the same quality.
>> LLOYD WERTZ: I'm glad you found that to be the case.
My question specifically focuses on the UPMC portion. And the other MCOs may do this and didn't mention it. Your need to continue to follow the super protected information of substance abuse treatment as part of your information gathering is of concern for me as that was obliterated from state law. If you don't listen to lawyers, you don't do anything and they will be happy. But my overall concern is if there were HIPPA applications used for that purpose, would be there greater coordination between the mental health, physical health, and substance use provision for your consumers?
>> As I stated initially, in the background, I'm a licensed professional counselor and a substance use counselor and others and part of crisis work groups at the peak of the opioid crisis. So as far as I'm concerned, in practice, the more people involved and the more MCO to MCO coordination regarding substance use, the lot better it is. And yes, it is a burdensome process to get somebody going in and out of rehabs or in the midst of a withdrawal to sign not one, but two different seven-page forms for release of information. So I have been pushing for this. Unfortunately with the state law, it eliminates the state provision and refers back to federal. And 42CFR has not changed. And that's where I'm equally concerned as I wanted to change to enable more of this. And I think most MCOs are more comfortable with exchanging, but more clarity is needed by the legal teams regarding this. And we have to be creative about does a person have needs, we can't tell you, reach out to them to clarify and let's talk about all of the other components except that one. Agreed. But there is a big gap with Federal laws being terribly specific.
There was one measure introduced in late 2023 that seemed to improve MCO to MCO coordination, but in very limited circumstances. So it is not clear how it applies to the whole HCBS model. Being that I'm not a legal representative, yes, lawyers will argue about this to death. And understandably. There's also of course a lot of stigma regarding substance use. That's the flip side of it.
But yes, I agree with your sentiment. But there is additional tweaking needed to the Federal guidelines 42CFR.
>> LLOYD WERTZ: Thank you. One more.
Quick question. We all know that the only usable predictor of future behavior is past behavior. So you have individuals living in skilled nursing facilities who may have acted out in the past or who may have attempted to hurt themselves or a roommate in the past. Is

there a specific way that you recommend to having worked in it and managed skilled settings, is there a way or a method or a recommendation for how those rooms can be set up to be safer for individuals who have history of having acted out?
>> JULIET MARSALA: Is this for all the MCOs?
>> LLOYD WERTZ: I'm sorry. That would be for all the MCOs. Thank you.
>> JULIET MARSALA: Keystone First?
>> Yes. You're asking in skilled nursing facilities when there's been history of participants either trying to hurt themselves or hurt others, has there been recommendations made to make the rooms safer? Is that what we're asking?
>> LLOYD WERTZ: Yeah. Sorry. You couldn't hear my head going up and down. Yes.
>> I would probably have to go back to our teams to see if there's anything in the past about that. I personally am not aware of any recommendations that have been given.
>> JULIET MARSALA: PA Health and Wellness?
>> Hello there. I am also unaware of any recommendations or accommodations that have been set forth. But happy to consult with our provider --
[Indiscernible]
If they have anything on their radar.
>> And UPMC, I am unaware of any specific requirement for providers to have the room set up with a certain way and whether that falls under our purview for regulations to how the room is set up, which I believe falls outside of us. But I think so recommendations are made when it is appropriate. And depending as to what the nursing facility has set up. That said, 700 nursing facilities, I found each one of them to be set up very differently. One from the other. And manage each differently. We have been encounters more often when we learn of a participant with aggression and it's brought to our level, then it's examined and run through the list what would be the underlying causes. Is it roommate issue? Is this a staff interaction issue? Do they have a diagnosed neurological condition that had no follow-up with a neurological condition in a year and a half in which one of the symptoms is aggression? My personal experience anecdotally, I found three out of five times. That said, we don't have that many. Just running through the list, environmental, physical health, psychiatric, is it something else? Substance use ruled out? What are the different things? But to this point, again, we do not know any specific recommendations regarding room design and set up and environmental recommendations. But we can follow up with our network.
>> LLOYD WERTZ: Thanks. Just having a little bit of that experience, it's a common sense stuff. How easy is it to get to the IV pole and whack somebody with it? Are the windows accessible? Do they open? Can you climb out of them? Are there wires in the room that might be used for nefarious purposes? Just laying out common sense stuff. Having worked in a number of settings, including hospital ICUs, by the way, the worst possible place for an acting out to occur. There might be a prescription that you could come up with to organize the thinking on the part of the very, very busy nursing home administrators and staff.
>> JULIET MARSALA: Lloyd, I will take that back to our network with the nursing facility quality initiative. So the Office of Long-Term Living does quarterly trainings with all of our nursing facility operators as part of the quality initiative. So we work with the health care foundation to put those trainings out there. This will be one of the topics that perhaps can be discussed in that forum. In addition, I would say the Department of Health to John's point regulates and licenses the nursing facilities. So I don't know where they are with regards to

updates regulations. But for certainly when they do, that would be a beneficial time to -- those comments regarding recommendations for physical updates or regulatory updates related to what you're speaking to as well. And I can certainly share that with my counterparts at the Department of Health.
Kathy, there are no more committee member questions at this time if you wanted to open it up to our virtual members. However, I did want to note that we do have little bit of a line for public comments as well.
So I leave it to you to direct us.
>> KATHY CUBIT: Okay. Thank you.
I see Carol has her hand raised. Carol, do you want to ask your question or make a comment?
>> CAROL MARFISI: I don't know what would be the best answer, but I was wondering if you work with people with mental health -- and -- their family --
>> JULIET MARSALA: Carol, I wanted to confirm. So when working with people with mental health in the community, are you also working with their families and their friends? Was that the question?
>> CAROL MARFISI: Yes.
>> JULIET MARSALA: Okay. So Amerihealth Caritas, you go first?
>> Yes. Hi, Carol, thank you for your question.
We do work with any family and friends that the participant designates is okay for us to work with. So every participant identifies their own person-centered -- their own team. Right? So anyone that they state is okay for us to collaborate with and work with, we would do that.
But if we don't get that permission, we usually wait, talk to the participant to confirm they want us to work with those people too.
>> JULIET MARSALA: Hold on, Carol. You want to go through all three MCOs first? Or do you want to ask your follow-up question?
>> KATHY CUBIT: This is Kathy. Unless there's a different answer from the other MCOs in terms of their approach, for the sake of time, I think we can move on to her next question. Unless there's something another MCO wants to add.
>> UPMC has the same answer. And it's noted in the care plan.
>> JULIET MARSALA: Sorry, Carol. Go ahead.
>> CAROL MARFISI: Talking about -- I wonder if you ever provide training to people who may be patient in a facility? I can see why a person may have a mood disorder -- did you get that?
>> JULIET MARSALA: Carol, I want to confirm. So you're asking whether the MCOs provide training to additional people or support persons in a participant's life to help them understand why a person might be acting out. Is that correct?
>> CAROL MARFISI: Like a roommate, other people in nursing homes.
>> JULIET MARSALA: Yep. So other people might be folks in their lives, be it a roommate or nursing home staff, et cetera, to help them gain a better understanding of why a person might be acting out.
Is that correct, Carol?
>> CAROL MARFISI: Yes.
>> JULIET MARSALA: Okay. Thank you.
Amerihealth Caritas?

>> Yes. So we do provide trainings to our provider network teams. We certainly want to offer more behavioral health supports to them as time goes on. But as far as roommates or other friends, they would have to be identified. We don't necessarily go to nursing facilities right now and train the whole nursing facility on behavioral health items. But if there is some type of conflict that we're identifying or if we're noticing that there is a need, we would always talk to the participant about the plan, confirm that they feel comfortable with anything like that, and then give that education.
>> CAROL MARFISI: I'm talking about more of a general overview.
>> JULIET MARSALA: Carol, just for clarification for my understanding, when you're saying a general overview of training, are you talking more about connecting roommates or other person-centered support plan members with sort of general community resources and awareness and additional groups that can help support them?
>> CAROL MARFISI: Yes.
>> JULIET MARSALA: So I can speak to that generally speaking. Certainly we would hope the MCOs and SCs would provide community resources to the individual that they most certainly could share and provide community resources to all the individuals within the person-centered service plan. That could be helpful to the individual.
There is certainly a benefit of providing information more broadly. I do want to kind of caveat, though, that the service coordinator's primary responsibility and focus is the individual. And certainly they would share information that the information can choose to share with others or their legal representative, et cetera. But I did want to make that distinction.
But certainly it's a great point to bring up.
>> CAROL MARFISI: There may be a person that needs to know but who could --
>> JULIET MARSALA: I would say it certainly could be.
One of the things that I would mention, Carol, it's really person-centered planning specific. There are other services within Community HealthChoices that might be identified as beneficial that could involve other members of their support team. Which is sort of very different for the specific individual's goals and plans and something that is more general community wide. Yeah.
So --
>> KATHY CUBIT: Thank you, Carol and Juliet. We will move on to other members. I know this is an important topic and also the open forum.
Other member questions for the remotely that have questions or comments for the public comment period?
>> MONICA VACCARO: Yes, this is Monica Vaccaro. For a point of clarification, I'm not sure if I heard it correctly, but I heard that UPMC folks talk about using telehealth in case there are access issues for behavioral health treatment. I wanted to clarify if that is -- if I heard that accurately and that mental health treatment can be provided generally speaking through telehealth.
>> Hi. Yes. This is John McFarland. Just clarifying. Is your question related to people with traumatic brain injury diagnosis and their ability to receive treatment when they have that diagnosis?
>> MONICA VACCARO: No. About generally speaking, can behavioral health treatment be provided through telehealth? Can it be remote? It's about at the he health as a mechanism.
>> Sure. The research from the American psychological satisfaction surveys and ongoing

changes of regulation, both at the state and federal level, yes, telehealth has been found to be popular and effective. That said, at the end of the day, understand perhaps there's techniques that their version of telehealth may not be as appropriate or some people that given the personal circumstances might require to be in person more. But what we have found, which perhaps not surprising given that always the best indicator of good outcomes of therapy are good therapists to patient connection. That's all been by far the best predictor of a good outcome. If you're comfortable in doing that connection in your home or elsewhere and have a good rapport with the person telehealth, yes, that's effective. And thus far as the research indicating this. So telehealth has been around for 20 years and most popular post-pandemic.
>> JULIET MARSALA: Monica, in regards to your question, we would be happy to follow up with OMHSAS to determine if there's been changes to the criteria or regulations and put that out as a follow-up. You're welcome.
All right. Kathy, back to you.
>> KATHY CUBIT: Okay. Are there other members joining remotely that have questions before we open it up for the general audience? Okay.
Are there any questions in the room?
>> JULIET MARSALA: Yes. We have questions in the room.
Shauna?
>> Is this a public comment period?
>> JULIET MARSALA: I think it's both. Public comment or questions?
>> KATHY CUBIT: We're in the public comment period. But if people certainly have questions, I know this is a big topic. So certainly I think it's public comment, but feel free to ask additional questions to our panel.
>> Okay. Since we're in the public comment period, I would like to just remind this body that on June 10th, the Centers for Independent Living came together and we were doing advocacy around an increase in the rate of reimbursement for home and community-based services. We successfully did a number of legislative visits, as well as we formed the human chain that stretched from the Senate side of the Capitol all the way to the outside of the Capitol with over 100 people in person, but also we had about 38 stories from people that couldn't travel that were connecting the chain members on -- and stretched all the way across the rotunda.
We were able to get media presence. However, when we attempted to deliver the message to the Governor, we were stopped. Those of us in wheelchairs were not allowed to go to the Governor's floor with the folder of stories. And we were denied access to him.
But my request is to you, Juliet, to ask that you would send a letter to Secretary Arkoosh and the Governor on behalf of us expressing the need for an increase. And even maybe how our voices were not effectively heard that day. Because there is a need for an increase across the board, not just in consumer directed. But there's 140,000 workers that won't see the benefit of the increase that the Governor proposed to give to just consumer directed.
So we were trying to send the message that day that every worker matters. And that the system needs to be looked at in a way that truly fixes the problem.
So I'm asking if you could do that for us in sending a letter to the secretary, a letter to the Governor asking that the rate of reimbursement be reviewed systemically and that there be a provision that allows for every other year or every three years it looked at again so we're not in a situation where we get an increase every 12 years.

And so it's unfortunate that our message got clouded by people being arrested because we didn't get access to the Governor's floor. I personally have been there 100 times. And they chose that day to limit my access and other wheelchair users' access while not blocking the stairs to people who could walk up the steps.
But the message still needs to get there, regardless of how it was interrupted and overshadowed by our lack of access to our Capitol. The message still needs to get there that everybody needs a pay increase. That the rate of reimbursement needs to go up in order to make that happen.
>> JULIET MARSALA: So Shauna, I am deeply troubled with your experience at the Capitol. To clarify, are you asking for the LTSS Subcommittee to put forward a letter versus me? Me putting a letter might be --
>> Sorry. If that was unclear, I would like the subcommittee to put a letter forward to Secretary Arkoosh and the Governor reminding them that the system needs an across the board increase, not just one to the consumer directed side. Because what that does is fragment our workforce even more. So yes, sorry I was unclear.
>> KATHY CUBIT: This is Kathy. If you would like to draft a letter, I can share that with the members and then we can vote on that at the next meeting or try to take a vote since the timing may be too late. I can certainly try to get support from a letter from members between -- you know, if you want to get something to me in writing.
>> JULIET MARSALA: And I'm going to add, this is Juliet, certainly if you want to share any of those letters, messages, or stories with me, I will certainly be willing to put them forward.
>> We have a follow-up meeting with -- yesterday and I finally hand delivered those stories to her. The issue of blocking our access to the Governor's office is one of ongoing concern. So it's not over yet. But to Kathy's point, this issue is very timely and I don't think we have time to wait for the next LTSS meeting. So if there's anything we can do in short order to get this letter from committee to the secretary and the governor, I would appreciate it. And yes, I will work with you to draft something. But I don't think we can wait until the next meeting.
>> KATHY CUBIT: That's fine. Excuse me, Juanita. That's fine. If you can get me something in writing, as soon as I receive that draft from you, I will circulate it to all the members and request any feedback or support in following through and sending it out on behalf of the committee.
I'm sorry, Juanita, I want to make sure Shauna has anything else before we move on.
>> JUANITA GRAY: That's fine. I wanted to assist her with the letter. I was on the same line of writings and information. And in regards to that. So if you don't mind, if if you can pass her my email and I would love to help her out with that.
>> JULIET MARSALA: We can certainly do that, Juanita. Thank you. We will make sure that you are connected.
We have Tom Earl in the room with public comment or question.
>> Thank you, Tom Earl from liberty resources in Philadelphia.
Two questions. One piggybacking on Shauna's comments, we now have three substantive studies, the blueprint that was put out by the long term advisory council, the rate study report by OLTL, and Mercer, and now the HR 165 Office of Budget and Finance rate study reports. They're all consistent in acknowledging the need for a rate increase. And I would strongly suggest that those reports be referenced and included in the letter. And that the June 10th event was pretty momentous in that we also were joined by SCIU and the United Homecare Workers and actual caregivers and consumers, not just providers. And it was

very impactful. And most unfortunate that some participants, including those who use wheelchairs, were not allowed to use the elevator to get up to the Governor's office.
So very noteworthy.
My second question is back to the behavioral health report. And kudos and many thanks to the three MCOs for tracking this information and seeking to optimize the integration of behavioral health with the physical health side. Something that is long overdue and something that we really need to optimize in the future. So many participants have diagnosis of mental health that need to be addressed and improved in the way we access that mental health care.
I was wondering do the three MCOs provide behavioral health data to OLTL on a monthly or quarterly basis? I guess that could go to OLTL.
>> JULIET MARSALA: So we have lots of reports. And Randy has left the room, for folks who are virtual. He would know that answer best. We certainly do coordinate with the MCOs. With regards to specific claims and counters and things of that nature for that reporting, I would have to get back to you on what those specifics might be.
>> Yep. And just a last comment. It would be -- this is more of a suggestion to OLTL that the dashboard begin to include behavioral health data, perhaps basic level of care and how many participants received residential treatment, intensive outpatient treatment, partial treatment, et cetera. That would be a great metric to begin looking at or including in the dashboard.
>> JULIET MARSALA: Yes. Appreciate those comments. We can certainly take that back and evaluate that.
Hold on, Shauna. You had one go and we have people who are still -- yeah.
So all right. So Kathy, we have some questions that came virtually. Do you want to move to that before we cycle around to another round of questions for folks in the room?
>> KATHY CUBIT: Yeah, I would prefer that people that haven't had a chance to have that opportunity. So proceed to the submitted questions.
>> JULIET MARSALA: Sure.
So I can kind of see them here. So from Dyann Ross to the MCOs, the question for behavioral health referrals, I believe the question is are referrals coming from SCs only with regard to those behavioral health services or other sources?
And then the second question also from Dyann, maybe you can do a two-part response, is do your SCs get training on certified peer specialists and mobile mental health services? And a comment that those services were least utilized in those presentations.
Amerihealth Caritas Keystone First?
>> Yes. Thank you for the question.
So a majority of our referrals do come from our service coordination team. However, we have open lines of communication with our UM department, our utilization management department, our case management department. We certainly try to work on an interdisciplinary team as much as possible. So if they notice things that are concerning to them, we have a general mailbox that anyone of our team members in Amerihealth can reach out to the BH team and say hey, I noticed this in the chart or I had a conversation with this person, whatever.
But I will say probably about 95%, 98% of our referrals do come from our service coordinators. As far as the services they are trained on, we do train all the service coordinators on all the services available. However, like I kind of shared in my presentation,

we have these spotlight series. So one of the spotlight series we're planning on hosting in the near future probably more in the fall time frame is about peer support and what that looks like for our participants. How it's leveraged, what the services do, just kind of all of those information that they might not be knowledgeable about at the ready. So I hope that answers your question.
>> JULIET MARSALA: Thank you. PA Health and Wellness?
>> Hi there. This is Heather. Our process looks very similar to Amerihealth. Most of our behavioral health referrals do indeed come from service coordination. However, we receive referrals from many different health plan representatives, ranging from critical incidents all the way down to utilization management.
And our service coordinators are trained on all of the available behavioral health -- however, we want them to be knowledgeable on all the service types.
>> JULIET MARSALA: John from UPMC.
>> Yes. Similarly, our referrals -- backtrack. Behavioral health services are voluntary, both by design by each individual provider, as well as for best outcome.
Now, our service coordinators will primarily hear from the participants that they want behavioral health services, but may get reports of concern and suggestions that behavioral health engagement from other people involved in their care. Ideally the ones that we have permission to talk to so we can clarify that further, but sometimes we will get additional calls from loved ones, family members, landlords, and so on indicating behavioral health concerns.
And as we mentioned the exchange side of it, we get the behavioral health information from the BH-MCOs and SNPs. If they want an aftercare planning session, we address it from there. There's different sources the referrals come in.
As far as the services that are trained, peer support, mobile mental health, yes, we do include that both in the general training for new hires and we have had some one off presentations by certified peer support specialists explaining what the services is about. And we send refreshers.
More importantly, when it comes up, referrals, most people like the general population just want an outpatient therapist, a psychiatrist, and are not interested in more. But the behavioral health coordinators discuss and bring up the suggestion of those services whenever it's applicable or raising the possibility that maybe it could be relatable to the case and might have of interest to the person.
For example, peer support teams take a limited case load. Even if we wanted to assign everyone to a peer support team, there's not enough staff available to handle that. The teams don't have the capacity nor do they want to take that. They have to be more efficient. So the poor support providers, unlike outpatient therapists that might have 500 clients, whether they actually see everybody or not, the peer support is limited to a much smaller case load. So having various levels of engagement.
And I would want to point out when I did do a study two or three years ago, the peer support engagement was above the overall Medicaid usual engagement of peer support. We had more per population better than the general population of Medicaid in general in Pennsylvania.
>> JULIET MARSALA: I will add, Dyann, to your question as well, thank you, John and others for the additional information. So for certified peer specialists and mobile mental health services, those have been behavioral health services added on the behavioral health

MCO side. And certainly it's good to hear at that the SCs are getting trained on it. Former certified peer specialist supervisor, know the value of and benefit of peer supports across our spectrum in all areas.
So thank you, Dyann, for bringing that up.
A couple of questions directed at our BH-MCO folks.
How do CHC-MCOs inform consumers of the the availability to receiver behavioral health supports and track the referrals?
And are behavioral health supports available to the nursing facility and eligible consumers, talking about the dual eligible folks non-LTSS. How are those consumers assessed and referred to behavioral health services?
Another two-part question. Amerihealth Caritas?
>> Yes. So the behavioral health referrals tracking, I kind of shared that in my presentation that the outcomes on the services requested. As far as nursing facility participants who are not eligible, they still have access to behavioral health supports. What they would not have access to is an assigned service coordinator to support them with our behavioral health teams to navigate that through. But they can always get support that service -- the social worker in the nursing facilities should be assisting those participants obtaining information on behavioral health supports in the facility.
There has been times the behavioral health team will assist with participants who are considered NFI, but getting that information a lot of times is sometimes the barrier, but if we are aware that there is a need and we need to support that person, then we can.
>> JULIET MARSALA: Thank you. PA Health and Wellness?
>> Hi there. We do have our behavioral health coordinator assist with finding providers and behavioral health services for participants that are NFI. These participants sometimes are hard to identify. We don't get as many referrals for NFI participants.
However, we do have some predictive modeling that proactively identifies participants that may have behavioral health needs based on how they have answered some of their health risk assessment questions, particularly the PHQ-II depression screening. So we will proactively outreach to participants to ensure they have the needed services.
>> JULIET MARSALA: Thank you. John, UPMC?
>> Hi. I think the first question all three of us covered in detail in our presentations. So perhaps I will flesh this out more. We have a service coordinator meet in the hope of a participant and doing the InterRAI. We have several dozen questions, I think it's over 40 on mental health matters or symptoms or trained to detect that. So ideally, we wrap up all the different questions on the needs. And when we're in the care planning process, the same that we are discussing the various ADL needs and what sort of services we might need for that, these questions will also trigger in the carry plan having items related to behavioral health and having that conversation with the participant. You have these mood concerns, you have the psychiatry concerns. Are you connected to a behavioral health provider currently? And I think that's something that's missed in all of this. There's the assumption the participants aren't connected and we're doing the referral for the first time. If there's a 5% referral, the other 95% don't have services. It's -- the referrals can often be misleading as far as how many people have all of the services they want and need.
So for those who don't have it or want additional and different services, that's where you have the conversation as well. That's where you have more of the prompts of the service that starts it. For the people who more desperately need it or even if they're not in

agreement with us, how to motivate them to get the services that the rest of us see they need. That's the trickier part of that. That's part of the care planning process. We ask if you have the service, the symptoms, do you need anything else or want something for it? Just regular care planning process. Which is different from the other more traditional MCOs of tracking claims, did you attend the sessionover a provider or not and that's the end of mental health. It's different with CHR. A therapist something showed up one time for a session doesn't mean that the mental health improved. We're capturing everything in a holistic picture and the needs changing over time.
The second part, we did cover in the presentation for the nursing facility ineligible population given that we don't have the same contact, it is harder. We send out the assessments and managers will reach out and ask if they need assistance and will screen them additionally for more questions.
And if we hear from the behavioral health MCOs that a person with in patient mental health admission, care managers similarly reach out and ask if they need behavioral health supports. Often, the special needs plans are way ahead of us and reached out to the same participants with their own teams and tag teaming the two setsover professionals asking the same participant if they need more behavioral health supports in addition to whatever the hospital set up.
>> JULIET MARSALA: Thank you.
Another comment that came in virtually is to all plans by Janet. The question is how are behavioral health needs factored into the level of personal assistance services a participant requests? We see clients with depression and anxiety that impact their ability to address their ADLs and IADLs.
We'll start with Amerihealth.
>> KATHY CUBIT: This is Kathy. I want to jump in to mention we have a hard cutoff at 1:00. I don't know if you could briefly respond and then add any additional information in writing for a follow-up document.
But we do have a hard cutoff at 1:00.
>> JULIET MARSALA: Kathy, if you would like, we could do the whole question as a follow-up. I don't think we will have time to give equal opportunity to all three.
>> KATHY CUBIT: That's my concern as well hearing that important question.
I don't know if there's anything left that can be answered quickly, Juliet?
>> JULIET MARSALA: I don't have any additional questions in chat or in the room. But Randy has come back into the room. So maybe Randy can spend two minutes sharing how behavioral health data and reports are collected by his monitoring team. That question came up earlier. Maybe we close on that.
>> KATHY CUBIT: Okay. Thank you.
>> JULIET MARSALA: So is question from Lloyd how we track the claims and services -- it was from Tom, my apologies. And what do the CHC-MCOs report to us in the monitoring team?
>> Randy: I will have to follow up on that and pull which reports we have as far as getting data back and forth. I will pull that and include that in the follow-up to the meeting.
>> JULIET MARSALA: That's what I said too. We have a lot of reports and we would have to take a look at it. It's good thing I verified that. Thank you.
All right, Kathy, back to you.
>> KATHY CUBIT: Great. Thank you.

I want to thank everyone again for attending today and ask members to please stay tuned for an important follow-up message once I hear from Shauna and get the letter. So hopefully, you will reply to that so we can keep that moving.
The next meeting is Wednesday, August 6th. Again, it will be both virtual and in person.
And with that, I want to wish everyone a safe and happy Fourth of July. And thanks again today for this very important discussion.
And with that, the meeting is adjourned.