The following printout was generated by Realtime Captioning, an accommodation for the deaf and hard of hearing. This unedited printout is not certified and cannot be used in any legal proceedings as an official transcript.

Event: Long-Term Services and Supports Subcommittee Meeting
Date: 09/03/2025

>> SPEAKER: Good morning. This is Kathy Cubit. I want to welcome everyone to the September LTSS sub MAC meeting and I can tell that there's people still joining so I'm going to start with the housekeeping, committee rules and then we'll circle back to the rollcall and introductions.

To begin, 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 logistical agreements. We will end promptly at one. To avoid background noise please keep your devices muted and microphones off unless you are speaking.

If you are attending the meeting in person please keep background noise to an absolute minimum. The room is fitted with ceiling microphones that pick up everything. The OLTL staff will report in person attendants. Remote captioning is available at every meeting. The CART captioning link is on the agenda and in the chat and it's important for only one person to speak at a time especially today.

Please state your name before commenting and speak slowly and clearly so the captionist may capture conversations and identify speakers. Please keep your questions and comments concise to allow time for everyone to be heard. Webinar attendees may submit questions and comments into the question box in GoToWebinar or use the raise hand feature to be put in Q2 speak life.

Those attending in person should use one of the microphones and wait to be called upon to speak. The tabletop microphones are reserved for committee members. Microphones are limited so you may need to wait for OLTL staff to bring one to you. The general public should use the microphone sitting on the table at the rear of the committee tables.

OLTL staff are available for assistance. Before speaking into a microphone use the power switch on the top middle of the microphone body to turn the microphone on. The switch should be pushed towards the end of the microphone you speak into. When you are finished speaking, push the same button toward the bottom of the microphone body to turn the microphone 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 sub MAC webpage. In the event of emergency or evacuation, everyone must leave the building and assemble in the first responders Plaza.

OLTL staff will be available in the safe area in front of the elevators to provide any assistance. Please see the back of the agenda for more information. And with that, we will move on -- we will start in the room. Hopefully Juliet is there and I don't know if you or someone wants to announce the members and others in the room.

>> JULIET MARSALA: Good morning Kathy.. I am here. Joining me at the table are committee members Cindy Celi, Michael. Randy is in the meeting who has to step out at 10:25 but he will be returning and those of the committee members in the room.

>> KATHY CUBIT: I will read off who I see here that have joined remotely. It looks like we have transcendent, Cara Mafsis, Matt Seeley, Shel Garrett, Patricia Canela-Duckett, Rebecca May-Cole. Are there any members that are not announced. I'm trying to see. I'm sorry. It looks like we have Olivia Benson who is in for Laura Willmer-Rodack. Is there anyone that hasn't -- any members that haven't been introduced or announced?

Before we move on to Juliet's OLTL updates, I did want to take the time to mention that we've had two resignations from the committee. Our vice chair Carrie Bach and Michael Grier and I just want to put it on record the appreciation for their service and leadership on this committee. I know for myself I will miss both of their voices in this group.

With that, I will turn things over to Juliet for the OLTL updates.

>> JULIET MARSALA: Thank you Kathy. This is Deputy secretory for the Office of Long Term Living. We have a different agenda today than what we are normally used too. I will start us off with our general Office of Long Term Living update and then go into the first round of public comments. The purpose is to have folks be able to ask questions or submit comments. Then with the LTSS subcommittee, we're going to focus on more of a working session, listening session.

As we collectively discuss the impact of HR1 or OB3 or the Republican reconciliation bill, potential impacts on the Office of Long Term Living in the coming years. Ali Kronley has joined us at the table so I wanted to know that for the record. Jay Harner is present virtually with us. Just a few of the --

>> KATHY CUBIT: Also (name?) Shepherd has joined as alternate for Pam Walz. I'm sorry for the interruption.

>> JULIET MARSALA: Alright. Thank you. Our updates for today, our usual procurement updates, recent communications and then we will move into spending considerable time having the difficult conversations that we need to have today. With the procurement update, there are no updates to provide. Community HealthChoices, the RFA remains in this day and all activities related to the RFA remained ceased and we do not have a timeline to share.

But we do still have the open mailbox should anyone have additional questions related to the RFA. They can send them to that resource account that we have been using since the publication of the RFA. We go to the next slide. My team has asked that I put out the alert for our Pennsylvania long-term care learning network in partnership with the Jewish Healthcare Foundation. On August 21, 2025, we released a listserv communication to alert folks to the upcoming webinar on to recovery for older adults in nursing homes. That is scheduled for tomorrow from 2 to 3 PM for our nursing facility participants.

There is a registration for the webinar. We encourage you to register because we do check attendance and that feeds into the nursing facility quality centric programs for our facilities. The focus of this training will be to review the nursing home regulations and additional information that examines the health risks related to tobacco use in older adults. Discuss the evidence-based tobacco recovery strategies, provide resources and clinical tools that support the tobacco recovery.

And we will as part of this request have a five question survey that can be taken before the training. Pre-webinar survey so we ask if you do intend to participate in that training you also take that pre-webinar survey. The quarter three learning collaborative is set scheduled for September 5, 2025 at two to 3:30 PM so look forward to that information on the listserv. Another communication that went out from our medical director Doctor Larry Appel wanted to make sure we have were all aware that in this late summer months we have seen an uptick in COVID 19 in Pennsylvania.

On August 26 we did release a listserv sharing that health advisory. There has been a sharp increase of testing for positivity in COVID 19. The current COVID 19 vaccine offers protection against circulating variance including the ones, Nimbus and Stratus. The Department of Health encourages people eligible to get the COVID vaccine now and especially those at higher risk rather than waiting for the updated fall formula. Also through the Department of Health packs livid remains effective in preventing severe oral illness and patients with additional risk factors...

Is there any questions from any providers or any participants or anyone in the general public about this advisory? Feel free to contact the Department of Health at 1877 PA health or 1-877-724-3258. Or you can also visit your local health department. We also shared an opportunity regarding foundational leadership in HCBS of a brand-new certificate program, and on August 25 we released a listserv sharing that announcement coming from advancing states. Many of you know the leading national Association that focuses on advancing HCBS. They have partnered with the Department of policy and management of the University of North Carolina Gillings school of global public health to create a first of its kind online training program to support our nation's HCBS program workforce.

The initial foundational leadership in HVC yes building expertise to better support people ...certificate program launches September 2025. It's going to deliver core training sessions and curriculum covering HCBS systems policies and operations. It is

exclusively online and is self-paced. It's anticipated takes about two hours per week and 10 weeks to complete and participants will learn more about the populations utilizing LTSS, the organizations providing LTSS, the various sources of funding. It's going to focus on key HCBS policy areas including the elders and Americans act, Americans With Disabilities Act, Medicare, Medicaid and the processes by which individuals access services.

We put this out. There were limited spots available. I don't know if there are still spots available. There will be another session January 2026. So we've listed the cost and fees for those trainings. The registration for the September training (Microphone Interference) advancing states should anyone in Pennsylvania have any questions specific to the HCBS certificate program. If they do they can contact Annie Kimbrell at AKIMBRIL@advancing states.org. We also on the next slide wanted to share the communications about important federal benefit transitions to electronic payments.

This impacts a lot of individuals so we wanted to get this information out there. On August 27, OLTL adult residential licensing team released a listserv communicating upcoming changes for the federal government benefit payment method for personal care home and assisted living residence providers. Noted and we think this is beneficial for more folks as well that all federal disbursements have been mandated to transition to electronic payment I the end of this month.

Starting October 1, recipients of Federal benefits such as retirement, survivors and disability insurance, supplemental security income which impacts a lot of our participants, and railroad or veterans benefits will no longer be eligible to receive paper checks. This is a federal change. The federal benefit transition to electronic payments will have very few exceptions. So please get this information out. The exceptions are individuals 94 years of age who were born before May 1, 1921 will continue to automatically receive paper checks unless they have signed up electronically of their own accord.

The Social Security Administration indicated other exceptions will only be granted in quote extremely rare circumstances. I do not know what the circumstances are. There were two options for the electronic benefits disbursements. They will be through the direct express debit MasterCard for individuals who do not have bank accounts or it will be available via direct deposit into the individuals or their legal guardian’s direct deposit however they have that set up. Our Bureau of services licensing team has resource coordinators in the various regions to help support our personal care homes and assisting living residence to help residents make this transition and change provide additional information.

We are also providing a webinar for personal care homes and assisted living providers on September 10 at 1 PM to provide an overview of this change. And we have registration for that webinar link. For beneficiaries who are receiving paper checks, what you need to know. Is that the shift to electronic payments from the federal government are intended to increase the speed and efficiency with which payments are distributed.

It is intended to be a cost saving measure and intended to advance security against fraud, waste and abuse.

Again as I stated, the payment options are the direct deposit, the direct express card. For Social Security recipients, you can update your payment information anytime through the my Social Security account online, which is www.ssa.gov/myaccount/. Any recipients of the other federal benefits can update their payment method by visiting go direct.gov/ GPW we will also take this moment to whenever there's a change to the federal government there's always the opportunity for scammers to pick this up and dupe their best to relieve you of your money.

Make sure you are going to the official website. Understand the Social Security office will not contact you to update your direct payment. They will not text you. They will not email you. They will not call you directly. Please go to them and understand all of the other contacts are more than likely to be fraudulent. We go to the next slide. This is critically important for our participants and our providers. This is an EVV update for the electronic visit verification released on August 29 through a medical decisions bulleting so it's impacting across HCS.

We have released the manual edits noncompliance and the need for service and managed care delivery system EVV update. I ask all of you to review those updates so you can be aware of the changes moving forward. So the purpose of this bulletin is to inform providers how the department will enforce compliance with EVV requirements and remind providers of our existing EVV resources and supports for you.

This bulletin applies to all providers enrolled in the Medical Assistance Program who render personal care services and home healthcare services. It impacts the office of developmental programs, adult autism waiver, community living waiver, consolidated waiver, person family directed support waiver copies funded program, OBRA waiver, Act 150 program and Community HealthChoices as well as the office of Medical Assistance Program, Medicaid fee for service and physical health choices program.

As we discussed beginning in January 2025, we went up to 85% minimum requirements for compliance. With a maximum of 15% manual edits allowed. We rolled that out and sent out that information. We provided folks time to raise the level of their compliance and beginning (Microphone Interference) (Audio Gap).

>> KATHY CUBIT: This is Kathy. I'm not sure if anyone can hear me. I'm not getting sound anymore and I just got a message from another remote member that also isn't getting sound.

>> SPEAKER: I can hear you. We cannot hear Juliet so there must be something going on in the room.

>> KATHY CUBIT: Yeah. Is this Monica?

>> SPEAKER: This is Patti.

>> KATHY CUBIT: Patti. I'm sorry. I didn't recognize your voice. Yes. I did -- okay.

>> MINTA LIVENGOOD: I can hear you. I'm on the computer.

>> KATHY CUBIT: A message came from Juliet. We are working on technical difficulties. Please bear with us. Like Patti said, it must be something in the room. Hi remote folks. I just got -- hi remote folks. I just got a message from Juliet that they are rebooting the system. Please bear with us a few moments.

>> SPEAKER: Hello?

>> KATHY CUBIT: Hello. Remote folks were having technical difficulties. They are rebooting the system. It should only be a few more moments.

>> SPEAKER: Can you hear me Kathy?

>> KATHY CUBIT: Hi Juliet. Yes.

>> JULIET MARSALA: Thank you greatly. We have sound but it's going to take us a few more minutes to get the captioner back online. She's good? Alright. Alright. We are going to rewind. I was talking about electronic debit -- visit verification and manual edit noncompliance in the fee for service and managed care delivery system. That was posted --

>> MINTA LIVENGOOD: Can you hear me?

>> JULIET MARSALA: We can hear you. Thank you. A bulletin has gone out about the electronic visit verification manual edits noncompliance. As you know, we have a 15% manual edits compliance measure. For providers who have more or go over that 15% compliance measure, noncompliant providers in two consecutive quarters will have requests for corrective action plans to correct their noncompliance. If there continues to be subpar performance, sanctions could be applied by the Department of Human Services.

This is in addition to what your MCOs may already require of you in your separate contract with them. I want to also kind of point that out and make that clear. We are setting the minimum compliance. You may have other agreements with other funders that are higher than our compliance. You should comply with the highest level you're required to comply with. We have included in the PowerPoint that will go out the links directly to the bulletin so that you can read through the whole process and procedures.

You can also look up the bulletin search DHS's bulletin search website and be able to find it there. If you have comments or questions regarding the bulletin, they should be directed to via phone the fee for service provider service center 800-537-8862 and that

is the number for providers. Physical and CHC providers should address any questions regarding EVV to the applicable MCO and I point that out because your contract with them may be up to a higher degree than what our minimum standard is at DHS.

I don't want you to think this is your standard if you have other contractual obligations through managed-care organizations. And/or you can visit our Office of Medical Assistance Program website and the website link will be included in the meeting materials. Going out on the listserv. OLTL is human and not perfect. We made an error so we have put out a bulletin to inform folks that an error has occurred with the rate file that was loaded that impacts our nursing facilities and the nursing facility rate. Our team has taken corrective action to correct that error.

On September 2, 2025, we issued an important notice via our nursing facilities listserv that the rate file errors were discovered. The rate loaded into our promise system known as the claim system with the effective dates of 7/1 through September 30, 2024 and October 1, 2024 through September 1, 2024. The payment period January 1, 2025 through March 31, 2025 and ...That resulted in incorrect payments to our facilities. To remediate the error, we have uploaded the corrective rate files into promise.

Beginning this week, the week of September 2, 2025, the rate files will be loaded into promise. Sorry, the rate files moving forward from sevens one 2025 through December 31, 2299 until it changes again will be loaded beginning of next week so payment correction should go out. If there's any questions regarding this notice please contact the OLTL provider operation section at RA-provider operation at PA.gov or 1-800-932-0939.

We know this hasn't had an impact to our nursing home facilities. We apologize for that error and have been working very quickly to correct it as soon as we have been able to. That concludes I believe all of the OLTL updates and recent communications for today. Kathy, we are ready to go into our first round of public comments. Happy to say only three minutes late.

>> KATHY CUBIT: Juliet, before we do that, I want to acknowledge members that have joined since roll call. Leslie Gilman, Minta Livengood, Monica Vaccaro and I understand Lloyd Wertz has joined in person. Are there any members not identified that are present? With that, we can open up the public comment period. We will start with anyone in the room with questions/comments.

>> JULIET MARSALA: Is there an OLTL staff member running the mic? On the table over there? Any public comments in the room? I am seeing none Kathy.

>> KATHY CUBIT: Any remote members that have a question comment at this point? Otherwise I do see a hand raised. I assume that's from the general audience. We can move to that person.

>> SPEAKER: Hi. This is Brenda Dare. Can everyone hear me?

>> KATHY CUBIT: Yes Brenda. Go ahead.

>> SPEAKER: Juliet I was wondering if you could give us an example of what sanctions look like to the individual service recipient for violations of the 85% EVV compliance.

>> JULIET MARSALA: I think the sanctions would be highly dependent on how -- the extent that the provider is noncompliant, the duration of the noncompliance and any earnest attempt or barriers to correct their corrective action plan. So it's sort of determine at that time. There should be an outline within the bulletin that provides additional information on those specific details in terms of different scenarios, various levels, repeat offenses and things of that nature. I would recommend going to that bulletin and reviewing that fully because there are certain different nuances that are case specific.

>> SPEAKER: I will do that. The situation I'm most worried about is for participant directed individuals. Does the bulletin address that in detail?

>> JULIET MARSALA: I don't know if it does for participant directed individuals. Sanctions I do not believe apply because it is for providers. For common-law employers and individuals and participants in self-direction, they are not under the provider category. However, individuals and participants self-direction who are noncompliant with the 15% manual edit requirement can be at risk of being transitioned from the community self-direction into potentially an agency model should attempts to educate, provide training and support be insufficient to bringing that common-law employer, group of employees up to EVV compliance.

We have to meet the cures act requirements. This is not a state requirement. It is a federal requirement. For participants self-direction, they do have a responsibility to meet those compliance requirements. I hope that's helpful. We are not going to be sanctioning the LE. However the risk being evaluated is not able to continue.

>> SPEAKER: It's the same standard of 85% that it is for providers, correct?

>> JULIET MARSALA: That is correct.

>> SPEAKER: Thank you for that clarification.

>> JULIET MARSALA: Of course. It's a great question. Thank you for asking it.

>> KATHY CUBIT: Are there any other questions? I don't see any hands raised. Are there any other questions in the chat?

>> JULIET MARSALA: I am not seeing any questions in the chat post our technical difficulties. Hold on. There is one. I apologize. Jeff Iseman submitted a question. The question raised can OLTL and the CHC-MCOs comment on their use of artificial

intelligence including any decisions requiring benefit reductions in Pennsylvania. At least one other state has approved legislation of artificial intelligence and is using it for managed-care both private and public healthcare benefits. Would like to hear about this for both fee-for-service and managed-care programs under the Office of Long Term Living.

Great question Jeff. Can always count on you for really great questions. The Department of Human Services has looked at artificial intelligence, but not in the aspect of utilizing it to make any clinical determinations regarding any of our services or benefits within our fee-for-service programs that we administer. Our managed-care organizations are not allowed to use artificial intelligence to supplant or take the place of any of their clinical determinations with regards to decisions on service plans, LTSS services etc. That being said, the Commonwealth embraces artificial intelligence.

We see it as a powerful tool and potential resource and support, especially in light of our very limited workforce that's going to be shrinking over the next couple years. So we do look for appropriate applications of artificial intelligence within our work. However, it's not DHS intention to have that replace any sort of people interactions. For example, if we're updating a computer system, we may look at artificial intelligence to do some kind of coding, transfers and checking and things of that nature, sufficient and effective.

In DHS, particular in meetings with the Office of Long Term Living, we do not have artificial intelligence programs within our laptops or computers and do not use them for notetaking. We are at the beginnings of really evaluating the promise and potential of artificial intelligence. But there's certainly nothing in place that I'm aware of or should there be that would directly impact decision-making situations that clinicians should be doing. I hope that's helpful, Jeff. Does that answer your question?

It's a great conversation for the LTSS subcommittee to have in future meetings to see what could be beneficial, what we may be able to look at further within our systems and services. You did want the managed-care organizations to comment. Let's start with the UPMC. Do we have a representative for UPMC who would like to comment?

>> SPEAKER: This is David Geer. Hopefully you can hear me.

>> JULIET MARSALA: We can David.

>> SPEAKER: Similar to what you had mentioned UPMC does not use artificial intelligence in any circumstance that would require a human decision. That is for service coordinators as well as physicians. We do not use artificial intelligence in any of that capacity. As an organization, we do have strict guidelines about circumstances similar to the Office of Long Term Living where it's looking at potentially processes or systems in nonparticipant facing enterprises. But it is not used in any way relating to services or supports for participants.

>> JULIET MARSALA: Thank you David. Pennsylvania health and wellness?

>> SPEAKER: Good afternoon. It's Angela.

>> JULIET MARSALA: We are running a microphone to Angela.

>> SPEAKER: We do not use AI for any decision-making around PCSP's or service decisions as well.

>> JULIET MARSALA: AmeriHealth Caritas Keystone First?

>> SPEAKER: We do not use any AI artificial intelligence to use for any service coronation.

>> JULIET MARSALA: Thank you. I know ChatGPT could probably improve my communications and correspondence, but I'm not allowed to use ChatGPT either. Alright. Let's see if there's any additional questions. There is another one. Met (name?) apologize if I missed the announcement by can I touch on the addition of...Are there any updates or is this still in this day? Matt, we are still in a stay. There have been no additional updates to this CHC RFA. Thank you for your question. How can participants be assured AI is not being used? For your decision-making? I can say from the Office of Long Term Living we don't allow it.

If we discover it is being used in those clinical decision-making in lieu of a clinician we certainly would address it within our programs and with our CHC-MCO's. That's the assurance I can provide for you, Natalia. Mia has provided a comment that they are hearing from a few members that they are on the OLTL listserv but (Microphone Interference) (Audio Gap) am I aware of any issue with the listserv?

Thank you for bringing that comment or read Mia. I'm not aware of any issues from our end with the listserv. There are Common things that are arise on the listserv that arise that I'm aware of. Sometimes the listserv gets caught up in people's spam filters because it is an email. It needs to be added to your safe senders list or perhaps if you have more sophisticated IT teams, you would need to have your IT team and the various listservs into acceptable websites and uses that will come through your firewall.

I will say honestly when I was on the private side, I had experienced this myself. What I did was I set up a personal email that all my listservs feed into. I know it's an extra step. But sometimes you can have that automatically forwarded to your inbox. No scammers are listening. And get it delivered that way. But from our end going out, I'm not aware of any technical issues. We can certainly take a look at that. That's my work around hack for today.

I would say also that we have multiple listservs. Not all of the bulletins I reviewed today will be going out on all of our listservs. The Department of human services has a DHS wide listservs so Medicaid bulletins will go out to the DHS wide listserv. We pick up some of those bulletins and feed them out to providers if they are provider specific. We

have nursing facility listservs that nursing facility providers. I would recommend sign up for that's where all nursing facility bulletins go out.

We wouldn't send out a nursing facility payment bulletin to every provider because we are trying to be intentional with not overloading everyone's inboxes. That's why there's different categories of listservs. You have to sign up for the ones most applicable for you. We have a CHC provider listserv, service coordinator listserv. These are public service so if you want to receive all the information from everywhere but buyer beware you will sometimes get the same bulletin multiple times. I will have my team check just in case. Comments from Tom Earl in the room?

>> SPEAKER: Yes. Tom Earl from liberty resources in Philadelphia. Just a follow-up from a couple meetings ago. A letter was prepared and sent to the governor for requesting consideration of a rate increase for PAS and CHC, PAS and OLTL services. And referenced the two studies that have been released. Has there been any response from the governor's office to that letter of two LTSS?

>> JULIET MARSALA: There has not been. I don't have any updates on the state budget and there has not been direct response from the government's office to the LTSS subcommittee. I can follow up if you'd like >> SPEAKER: That would be wonderful. Thank you.

>> SPEAKER: This is Shawna again. I do have one comment. I don't know if this is the appropriate forum, but within the last month, we have seen a lot of County Assistance Office mistakes as it relates to them indiscriminately switching consumers who are midnursing home transition.

From one end CO to another. And the consumer doesn't know they have been switched. When we do the research, it's not on the MCOs side. It's coming directly from the CAOs part of the process. I don't know if it's a statewide problem or just a northwest problem, but it's happened more than a few times.

>> JULIET MARSALA: If you can give may the specific cases so we can track them down to the root cause on our end, that would be really helpful. Have you sent them through?

>> SPEAKER: I haven't sent them through because I learned about it yesterday before coming here but I will.

>> JULIET MARSALA: Thank you. That's the best way for my team to figure out what happened and how to address it and to see if it's more systemic or a one-off or with a specific caseworker or what occurred. To make sure that doesn't happen in the future.

>> SPEAKER: I will get you the list.

>> JULIET MARSALA: I appreciate that. Thank you Shawna for bringing that up. Hannah Krantz is asking me if we can clarify how many nursing facilities were impacted by the rate file error, and also can you confirm that the retrograde adjustments only would impact fee-for-service claims. Hannah to the second part of your question and promise it should only impacted fee-for-service claims because fee-for-service is going through promise and MCO billing is handled a different way. With regards to how many nursing facilities were impacted, I would imagine it would be all the individuals who submitted fee-for-service claims within those time frames.

I can certainly as a follow-up ask our finance team if they are able to give us a number to facilities that would've been impacted during that time. Thank you for that question. Alright, going through. I am taking a moment to scan through all the questions and comments. I want to make sure I did not miss anyone in the public comments. There is a comment that has come in from the Hager. In terms of the County Assistance Office making mistakes, the Westmoreland County Assistance Office was making this mistake a year ago. They attributed to new staff. Thank you Cindy for submitting that comment.

I can't speak for the office of income maintenace but I know the Office of Income Maintenance is hiring a lot of new staff and LTSS services and eligibility are part of the most complex eligibility processes in our Medicaid system. For a wide variety of reasons from federal regulations etc. I would say inexperienced new staff coming in, learning a complex situation could be attributed to human error.

But we want to make sure it's not something systemic. But just do want to recognize the complexity of learning our LTSS systems and will certainly endeavor to liaise with deputy secretory (name?) and provide that feedback and review the cases. I believe that’s all the public comments for now. I know we're now running four minutes behind. Kathy, I want to check in with you to make sure you're okay with us moving on into the agenda.

>> KATHY CUBIT: Thanks Juliet. Please move forward with the next item on the agenda. Thank you.

>> JULIET MARSALA: Okay. Thank you. At the request of the LTSS subcommittee and because it's been really important to have these conversations and spend time having these conversations, we have dedicated the remainder of today's meeting to, as I mentioned before, potential impacts of the House of Representatives H.R. 1 bill and the One Big Beautiful Bill, sometimes referred to as the Republican's reconciliation bill. As you know from my last LTSS meeting, there are some very specific direct impacts to Pennsylvania that we feel pretty immediately.

That will have monetary impacts. I did share the last meeting but just to kick us off, I'm going to give a little bit of that summary and then we'll move towards a facilitated discussion. This is just to anchor us into the discussion we will go into. Some of the immediate impacts, which is based on those bills, will have an extraordinary impact on

our Medicaid expansion population. It's estimated over 300,000 Pennsylvanians will lose health insurance. That's huge.

That's going to have ripple effects on rural hospitals and other hospitals experiencing upticks potentially in uncompensated care. That's going to put a huge strain on our health system. That's when impact populations beyond Medicaid and Medicare, as we all seek out healthcare. This isn't just a Medicaid problem. This is an everybody issue. I just want to make that clear. Unfortunately as we move through our conversations, the people who will bear the brunt of that impact will be the Medicaid population.

But it is an everyone issue. We serve in Pennsylvania and Pennsylvanians on Medicaid, which includes 1.3 million children. It includes over 420,000 individuals with disabilities. It includes older adults, people with disabilities, behavioral health, SUD needs, LTSS needs. It includes nearly 10,000 veterans. So these cuts will impact a lot of people. We estimate, just on the redetermination requirements alone -- so the federal folks have told us that we need to do so more administrative stuff, red taping, beneficiaries particularly in the Medicaid expansion population where we have redeterminations every six months instead of every year.

That's an administrative burden that did not come with any additional support to implement. We know that that is going to require us to hire significant amounts of staff. That is only also going to cost our programs significant dollars to do that. We also know there's been adjustments to the assessment, provider assessment allowances, hospital assessment allowances that we believe will impact additional monies. We're talking hundreds of millions of dollars currently of additional administrative burden cost in addition to not being able to generate revenue to match a federal match for our Medicaid programs because of changes to provider assessment programs.

It's a squeeze on both ends there. In the big picture of our programs, we also know care costs are going up. Not only do we have cuts. We know the cost of healthcare is going up. The cost of HCBS is going up. The reality is Pennsylvania, for many of our HCBS providers, have not seen a rate increase in over 10 years, right? So we are unlike our sister state North Carolina where they rebased a couple years ago we haven't rebased rates in over a decade. That's sort of the big picture issue and lay of the land of what we're looking at in terms of the headwinds we're facing.

As the deputy secretary for the Office of Long Term Living, as my colleagues in DHS, as we've seen in other conversations, we have been very helpful on advocacy efforts, education efforts. There is still no state budget. There is no update to the state budget. But in a potential reality where we as a department are not appropriated funds enough to make up for the additional administrative burdens and account for potential cost increases in healthcare, that would then require us as an office to look at some really difficult decisions.

Right? That's our intention today over the next couple hours with our members of the LTSS subcommittee, with members in our audience in the public, many of whom I have

known for decades as well over the years who have fought very, very hard for the rebalancing of LTSS, we are going to have those discussions that are going to be difficult, that may make us feel angry, that we are very passionate about the work that we do. It is my intention today and the team's intention that they will be taking notes about the conversation we're having.

I have not, as I said in the last meeting, had deep internal discussions about what decisions have to be made because there's a lot of things we don't know still. You've heard me talk about this. We can't make decisions until we know what we're deciding about. But we can solicit your feedback, and I can bring those views and values with me into discussions that we will likely need to have. Right? In addition, knowing that impact of what's happening federally and once we get information about what's happening at the state budget, when we get to start looking at numbers and looking at what decisions can be made, we also simultaneously have to prepare now for those potential decisions in the future.

As I said, we have made no decisions about any impacts on. The Office of Long Term Living and HCBS services. But we need to talk about it. That's the reality so that's what we're going to talk about it. Folks may have seen recent communications from Idaho. They just cut 4% of Medicaid provider fees and nursing facility fees and some fees were cut as much as 10% in recent days. Folks may have seen a letter from North Carolina indicating a 3% Medicaid reduction cut across the board indiscriminately because they rebased a couple years ago and clawed that back including a 10% reduction in nursing facility rates.

Those states have made difficult decisions. We are going to face similar things and we hope our discussion today that we could be strategic and bring that information and those learnings from you. We are going to dig in. I do hope that folks can come along with me in this journey and this discussion. As I said, it will be difficult but needed as we talk about this and my main goal and intention is to hear from folks, share different things I can.

But really to have the LTSS subcommittee and through public comments, our public, take the opportunity to give me what you value most. What I can't change is what the representatives decide to do. I can't wave a magic wand and magically make $300 million appear. But those conversations aside, we need to hear what those impacts could be. As the department looks at services, it's not just LTSS. We're part of a larger Medicaid system. It's made up of the state plan benefit and then the different waiver programs and then another additional support services, initiatives and programs that all of them are important and critical and impactful.

When we look at our biggest program, Community HealthChoices, one could say limit the decapitations on the managed care organizations. That could be a blunt sweeping thing but that has impact because they in turn have to look at services and supports and cuts and rates and things like that. So we want to talk about all of those things. We want

to talk about does it make sense to try and look at reducing, slimming down, putting in prior authorization for medical services, pharmaceutical drugs?

Does it make sense to look at potentially a waiting list so that folks who receive services maintain services? As you know ODP has had a waiting list for many years. Folks remember going back to 2010 or before we had waiting lists for waiver services. Doesn't look like that? Soft cap for services? What does the LTSS subcommittee members think about these big, hard questions? With that, I am going to open it up for the LTSS subcommittee to share thoughts and/or ask questions that I may or may not be able to answer.

>> KATHY CUBIT: There is one in the room. Do you want to start with the room Juliet?

>> JULIET MARSALA: I certainly can. Lloyd is warming up his microphone.

>> LLOYD WERTZ: I wonder if there are or have been or thought being given to the creation of potential situations. If we were to cap at last year's funding or if we can expect last year's funding even, who would not get serviced or how would services be impacted by our consumer base? Has that been done or can that be done at this point?

>> JULIET MARSALA: It can be done. That's part of our listening session today is to help us focus our limited resources on what should be looked at, targeted and evaluated. If we're looking at what does soft cap or what do cap on ties look like we can run the numbers if that's where the committee is that. And come back with those scenarios. What's difficult to be frank with you, I don't know any numbers. I don't have a target. I just know the numbers could be big and big numbers have impact. We also know everyone in this room knows that HCBS services cost less than nursing facility care.

We know this. We also know and it makes sense potentially want to keep HCBS giving services as much as possible so we aren't increasing costs in another area. It's a delicate balance. But we have not run scenarios. There is a lot of data and information that we have. It would be helpful for us to have direction and know in terms of prioritization what direction we as the office should look at.

>> SPEAKER: (Indiscernible) Can I speak?

>> JULIET MARSALA: Kathy, not seeing additional comments in the room. Shawna does have a comment and would like to speak but I did want to hand it over to you and the other committee members online first.

>> KATHY CUBIT: Thanks Juliet. It looks like Carol has her hand raised. Carol can you unmute and speak?

>> CAROL MARFISI: Hello. Juliet, I was on the phone with the (word?). Could you repeat the ask? Quickly? What would be impacted by the decrease?

>> JULIET MARSALA: Carol I'm happy to repeat some of the direct impacts that will show now but that doesn't directly impact the Office of Long Term Living. What I was talking about is that there's several hundred million dollars that are born in additional administrative costs that are tied to the requirements of the Republican reconciliation bill. That is going to essentially mandate our sister offices to hire hundreds of new staff just to handle the requirements and redeterminations. That's a cost we haven't had to bear prior.

>> CAROL MARFISI: (Indiscernible).

>> JULIET MARSALA: It certainly is an administrative issue but it impacts direct services because every dollar we have to spend on potentially unnecessarily administrative issues is a dollar taken away from direct services. It all ties together.

>> CAROL MARFISI: Okay. Thank you Juliet.

>> JULIET MARSALA: Thank you. You're welcome Carol.

>> KATHY CUBIT: Why don't we move on -- Anna has her hand up and then we will go to (name?) and have other members remotely raise your hand if you want to speak.

>> ANNA WARHEIT: Thank you. I was just thinking about the timeframe and the best way to compile the data that's going to be needed to make these decisions. I don't know if the department has had any timeline for when these decisions will need to be finalized. But it might be helpful if we could forecast out when the bulk of the impact will be felt. For example, the provider changes, the hospital cap ...Currently just over five or four I forget but either way we know we are not at six. That gradual reduction is not going to hit us in the next year or two.

It might be helpful if the department could at least forecast out that timeline of when the biggest chunks of funding are going to be missing from the state budget and when that impact will hit. That way we know how much time do we have? My other thought was with limited resources for the department to try to forecast out these different scenarios and anything could some sort of a formal comment opportunity be organized to where the different people who might be impacted and stakeholders could contribute to that effort by running data with the resources that they have and then compile it to give the department something to react to versus having to actually run it all themselves.

>> JULIET MARSALA: Very, very good comments and questions. Thank you. For the first piece in terms of timeline, again, that's a little murky. The redetermination impact is immediate, so that's the now. That's the additional administrative cost is what we're dealing with now. That's the expansion. It is the expansion. But folks think it's the expansion and it doesn't impact LTSS. It does because we have individuals with disabilities that are in the expansion program and also in our programs.

We did some data on that and I believe there are tens of thousands of individuals that will be caught up in that loupe. Certainly our CHC-MCO partners have learned a lot with us of the PHE unwinding and are certainly preparing for those redeterminations. They don't impact LTSS but I can't ignore the NFIP population as well. They are critically important too. For the purposes of folks online, Randy has joined me at the table.

It is murky. You are absolutely correct. That administrative impact burden that's happening now. There is the state budget that we don't know anything about. If it's flat funded, that's an immediate impact. Because we know costs have gone up. If our representatives choose flat funding, we have to make choices. I hope that's not the case. But that's a potential timeline. Impacts to HCBS more broadly. I would hope we would have time in the next budget year. That's why we're having these conversations now. As soon as possible 2027 budget year potentially, so that's kind of the importance for we might have a really short runway depending on what happens in the budgeting process today or we could have a slightly longer runway to 2027.

With regards to HCBS services specifically, because of the ARPA funding that we received and partook in, we wouldn't be making drastic changes prior to June 2026. Because we have those obligations, right? But we do have to make preparations should we have to make significant changes later through waiver amendments or things of that nature. Like I said, these are not conversations any of us want to have. They are not conversations that my team ever wanted to have. That was not our hope for where we are at, but it is where we are at. Anna, that's the timeline. The last thing I would say in response to your comment with regards to help from partners, private industry, nonprofits, think tanks etc.

We welcome your feedback at any time. You don't need to wait for a public comment period although we also recommend you resubmit at a public comment period. But if there is data that you have been working on that you would like to share as part of education, positions, things like that, Anna. You have my email box. Everyone has Randy's email. Don't ever hesitate to send anything. Hold on one second. I don't see any other hands from our committee members. Shauna I know was waiting. Can we move to Shawna and then Tom Earl also has comments as well.

>> KATHY CUBIT: Sounds good. Thank you.

>> SPEAKER: Thanks. A couple things. Looking around to make sure no one throws anything at me. Three things I want to say and then I have an idea. I hope that we can prioritize in any funding conversations home modification programs and nursing home transition programs. Because we've already had proven data how much that saves us and many people end up in nursing facilities because they can't age in place. And stay in nursing facilities when they don't need to when we know that nursing facilities by and large are higher cost.

The other thing that I would say is four years -- this is the part that worries me about getting stuff thrown at me -- back when Estelle Richmond was in our government

because she had a vision, and at first when I heard that vision I was a little bit like are you nuts? It's never gonna work. But the more I'm in this system and the more I see it play out, the more I agree with her. She it one point said, we need one waiver with one administrative system.

The problem that I see us having is we're competing amongst ourselves. We have 32 services in CHC and there is a list of services in behavioral health and a list of services in mental health and there is a list of services in head injury and there's a list -- it goes on and on and on. There's so many people who cross lines. If you could pick from a list of services that would meet the needs of Joe Smith, Shawna Aiken, just one administrative system so the administrative burden is less.

I think that would save Pennsylvania money. But I also think too that having this conversation in this -- and I know the agenda is public. But I think too that having this conversation in this room, we need a public hearing. We need to have a public conversation where we bring groups together so that everyone can talk about it. I as a recipient -- the other thing I want to say is that I use these services. I have the unique position or curse -- however you want to look at it -- of seeing both the administrative side and the end-user side in real time.

For me, and I know others that I've spoken with that our users, sometimes I think if we restructure how the hours are used, we could save money and time. For example, I for one would love to have the option of a daytime cluster situation. So that I didn't have to have an attendant scheduled for my eight hour workday. But if I needed to use the restroom or have help with lunch or have help in the middle of the day, I can call somebody on a cell phone and they would come and help.

But we don't have a system in place to make that stuff happen. You know? We don't really because cluster is something that no one really talks about anymore. Not to mention using it during the day. But I think that we really need to think about ways that we can use our services differently and ways that that's promoted through the Office of Long Term Living. I also think that there could be, with that, say Shauna gets -- I don't know -- I get 95 hours a week. Whatever that ends up being.

But some of those hours are dedicated to me. Just for me to use when I need help one-on-one. But some of those hours could be used in a larger, circular sort of operation so that -- we don't have enough attendants. And we need more bodies to do this work but it's not structured in a way to make that happen. So we need to use the people we have. I think there's ways that we can sit down and look at it from an end-user perspective and operations perspective and administrative perspective and tweak things we currently have that would save us time and money. That's all.

>> JULIET MARSALA: Thank you, Shawna, for those comments and giving us lots to think about. I know you and I have talked about cluster a lot back in the day. We used to have cluster. Cluster is still a possibility today. It still has the service code (Away from Mic) For our MCO partners, that's a potential thing to look at today. With regards to

reviving cluster services, there's lots of different ways to go about that. Certainly, it's very flexible in the Services My Way cash and counseling program opportunities.

That's another option to think about if we have to move forward with different decisions. Do we think about how they have some of the ODP program budget limits versus service limits. Budget limits based on some factor. That's another thing that states have used. When I throw these things out there, I just want to give folks a caveat. I'm not saying one thing is better than another. I am just throwing out things that states have considered. No, I'm not trying to endorse one thing over another. Tom?

>> SPEAKER: The severity of the problem is really compounded because you mentioned that if there's capitation at some point we could see more people forced to live in nursing homes, which is obviously more expensive institutional setting than a community-based setting. But at the same time, we already have a crisis with the shortage of home care workers and inadequate pay structure and reimbursement rate for that system. And it's really going to be a double whammy unless something happens, and nothing has happened.

LTSS wrote a letter to the governor after months at every LTSS meeting this issue coming up and this was before the Big Beautiful Bill. So we really need to be attuned to part of the problems we've created by not addressing the issues that we're facing currently. The other issue I wanted to bring up was in the redetermination, if there's gonna have to be our second redetermination done annually, if those redeterminations could be done as simply as possible with elements of presumption of eligibility to make them as easy as possible and not burdensome on participants and not burdensome on the staff that OLTL doesn't have.

>> JULIET MARSALA: Additional redetermination is not for my understanding for LTSS. It's for Medicaid expansion populations that have forced work requirements....The Feds have made it clear that presumptive eligibility is off the table. Unfortunately. Again they are not making it easy on us. So we need to bear that in mind in terms of what's happening today and who is responsible.

>> SPEAKER: Right. Presumptive eligibility is off the table. But elements of it could still be used. Same thing with streamlining the services that Shawna mentioned. There's so many -- Pennsylvania is so fragmented and so siloed between ODP, OLTL and the other major systems that if we could really move towards streamlining it and making it as efficient as possible and consolidating the waivers, that would be awesome.

>> JULIET MARSALA: Ali?

>> ALI KRONLEY: I can never work the microphone in this room. Hi. I appreciate you opening the door to this conversation.

>> SPEAKER: excuse me. Could you identify yourself before you comment?

>> ALI KRONLEY: This is Ali Kronley from SEL you healthcare PA. I appreciate opening the discussion here and I appreciate the idea of bringing multiple stakeholders together to face a really challenging situation together. I think what I would like to put in the room for all of us is resistance to the idea that this bill is a mandate for cuts, and I think maybe that just has to do with where we're sitting, but I think our union is strongly advocating there just is no strategic way to deny services to seniors or to deny hours to caregivers.

We have to stand together and protect our care and find ways to do that. We are going to come up with the best plan like what's the least good way to harm our seniors or put more people in nursing homes. Some of the conversations we're having here and across the country and again like some of this requires brave politicians willing to act. Some of it requires strong administrative focus. But we can raise revenue in this state. There are plenty of ultra-wealthy people that can be taxed. There are tax breaks we are giving away. We can fund a healthcare system that works. What Shawna and Tom are saying is our healthcare system isn't working right now and there are tons of efficiencies and ways we can look at...

Decreasing enrollment time and participant direction is another to allow people to enter the system and looking at ways to implement a lot of the new requirements that cause the least amount of harm. We are having conversations with state departments across the country particular on the West Coast about data sharing agreements with Department of revenue as a way to address the work requirements. People are paying payroll taxes, we know they are working so the requirement for that person to go in every single month improves they are working is unnecessary if the state can provide that info.

Those are just some of the ideas but I think it starts from a different place where we're starting this conversation and I'm not saying let's all get together and decide (Indiscernible) but I do think it's really important for us to be confidently saying what we can't actually do is decrease services or harm people and instead we need to figure out how we support the healthcare system and don't give into (Microphone Interference).

>> JULIET MARSALA: I don't disagree with you by any means. This conversation today is just not to detract from the incredible advocacy, education and opportunity that should continue. This is the opportunity that as the person who has to leave the office long-term living who gets handed a number that is not sustainable that then has to mobilize to make sure that that's the number that we have to work with it. Unlike our federal partners our budgets have to be balanced. I get marching orders and we get marching orders on how the data is structured.

Wanting to have that conversation with all of you again like I said is not the conversation we want to have. It's a conversation we need tab so I can be informed and bring in the voices of my stakeholders. When I am asked to inform. On decisions that will be highly difficult and not ones we want to make or put forward at all. That's the discussion today in that context. I would hope everyone every day -- Shawna to your point you can ask

your representatives to have public hearings. The committee of human services, older adults, families and youth, appropriations.

That is the role of Pennsylvania. The conversation for today is not meant to discount that. That work and effort is necessary because you're absolutely right. There could be decisions to raise revenue. The governor put forward two of them. That's outside of my hands and my role today. So coming back to a little bit of the discussion -- Kathy, can I go to folks online who had their hands up for quite some time? I know we've had some public comments with regards to in the room, but I want to give time for folks online. I know we have Brenda Dare with her hand up. Can we go to Brenda Dare?

>> KATHY CUBIT: That sounds good. Thank you.

>> SPEAKER: Hi. I want to thank Shawna and Tom for their comments thus far but I have a question. In regards to fee-for-service programs and then I have a comment. As an Act 150 user for the better part of 30 years -- I spent a couple years out-of-state. for the better part of 30 years I depended on Act 150 to keep me at home in my community and working productively.

Can you comment on whether or not -- if cuts to services need to be made eventually because I think we're headed in that direction. As much as we would like to stop it. Our programs that are fee-for-service and particularly programs like Act 150 that rely exclusively on state dollars, are we at greater risk than programs like CHC?

>> JULIET MARSALA: I would say not necessarily. Brenda. That program is somewhat limited and small. One of the potential things we could see are wait lists. Looking at all the different options. In lieu of getting rid of a program, the Act 150 program has incredible value. They all have incredible value. Do we look at wait lists? Do we look at caps on hours? Do we look at budget limits? What I will say, perhaps what I'm also hearing is the incredible importance of Act 150 and its impact on folks who are also working. To be highlighted.

>> SPEAKER: Right. One of the things that I think could save some money, at least from my perspective as a thirty-year user and most of the people that I've spoken to, is to really look at whether service coordination meets the need that the department has in mind. Because my service coordination entity has collected money on my behalf every quarter for 30 years and I can tell you there have probably been less than 12 quarters in those 30 years where I have actively needed something from them.

Obviously, they do my budget once a year. But four quarters a year, they are collecting money for nothing more than a maintenance call saying are you alright? When I do need them, I can't get a hold of them. I really just think that that's a place where some slimming down or some reallocation of resources could be -- I've said it jokingly among my friends. I could coordinate my own services and I think many of us who have been long-term users would gladly give up half or three quarters of our service coordination

units in the year to reallocate them towards services to serve ourselves or our brothers and sisters.

>> JULIET MARSALA: I certainly appreciate those comments Brenda on the fee-for-service world. Certainly making a note to take a look at service coordination and usage because it's fee-for-service. In Act 150, they should only be billing for services they actually provide. In that 15 minute increment. That's certainly something to take a look at and I will take that back.

>> SPEAKER: The last comment and I'm really glad I'm not in the room because I'm going to get things thrown at me if I was. I want the state to take a look at whether or not managed-care is where Pennsylvania needs to be in light of the times we're living in. Obviously, we have to live out current contracts. But are we really in a situation where managed-care is the cost savings we had hoped it would be? The cost containment we had hoped it would be? I don't want someone's refusal to admit that our needs as a state have changed to lock us into a system that maybe doesn't serve us. That's the last thing I have to say for now but I do reserve the right to bend your ear a little later in this process.

>> JULIET MARSALA: Of course. Thank you, Brenda. I am just going to go down the list of the folks online and also take a moment to look at questions and comments in the chat. Natalia Gomez.

>> JULIET MARSALA: Natalia Gomez, are you able to unmute? She can't seem to open her mic. Can my team confirm whether we are able to unmute on her behalf?

>> SPEAKER: Thank you.

>> JULIET MARSALA: There you are.

>> SPEAKER: This has been very informative. Thank you so much. Like Shawna, I don't know if it's a blessing or a curse, but being in a nursing home, being a participant in HCBS, being an advocate for many years and working as a paralegal for legal services, I always say this. I believe there was a problem always. Once COVID hit, I think it brought out all those problems out to the open. And to the forefront, and they cannot be eliminated. On top of those, we're adding the new things that are coming.

I am a firm believer, as a recipient of the services, I love being home. My experiences in the nursing homes have been horrendous and horrible. To the point where I have told my children unless I am unconscious do not put me in the nursing home. That being said, since we're looking for opinion and suggestions and cost savings for the future, I will mention I know that there's a lot of policies in place. The program changes, the money, the finances change. But the policies and procedures, no one revisits them.

I believe a lot of the MCOs need to evaluate and really, really comprehend what cost-containment is. Especially for a HCBS recipient that's a homeowner. One of the

changes that was made to the program is it supposed to be participant centered. As a participant, I don't know if the rest of the participants that are here feel the same way, we are far, far, far from the center. Because I feel at times in our opinion and our suggestions are not heard or not counted.

To make positive cost effective changes to the program. HCBS, I believe it's a very, very valuable program and service to have. I agree with the suggestions of combining all of these waivers and doing one administrative. That would be really nice cost-containment. However I think the programs need to revisit how some of the eligibility and determination for some of these services are made. For example, the modification part of those programs needs to be monitored. It needs to be watched.

I don't know if it's always been like this or is it like this because of MCOs management. But we cannot have cost-containment if a homeowner opinion and suggestion is not taken into account for home modifications. We have to pay all this back. The cost-containment can also be evaluating how decisions and eligibility are determined. For example, for field modifications. Everyone follows the same rules. Nothing has been evaluated or visited with regard to how cost-of-living have changed.

Now we want to add on these cuts, and I know it's going to be affecting our services. That's a given. As much as we try to kind of not really see it. But as participants, we would love to see that but cuts of services should be all the way at the bottom of the list. And evaluation of cost-containment with regard to modifications being done properly once and for all. Not being revisited over and over again and a whole bunch of errors being made, which makes it expensive.

The vehicle modifications. That has to be also reevaluated. All the agencies followed the same guideline. OVR, Pennsylvania technology, the waiver program. Everyone follows the same process. Yet if a participant thinks of cost-containment and we try to find things that are reliable, still under warranty, less expensive, but a $7000 modified vehicle even though it's used is a lot of cost-containment from a $49,000 modified vehicle. These are things I think needs to be taken into account.

The services are provided differently when you are a renter and you are a homeowner. I believe that if we start evaluating in that area, we can find a big chunk of cost-containment and savings there. Also when you look at the different models with a self-directed -- I've done self-directed. I've done agency models. It's a problem. We don't have enough caregivers but we don't have enough, caregivers because there's no pay. There is no incentives. There is no benefits. When you talk to the caregiving agencies, they tell you the same thing. The state only gives us so much so we can only pay a person so much.

A lot of the money goes into the administrative part and I understand. Obviously, all the new changes that are coming are going to require a lot of staff. I sympathize with those folks that are having to make these decisions. Those folks that are working in the County assistance offices, folks working in the OLTL's. But if we all work together and

listen to the participants' needs and suggestions, as participants and recipients of these services, we don't want to lose our services.

>> JULIET MARSALA: Natalia? I apologize a little bit. I'm going to summarize what I'm hearing and provide time and opportunity for additional input. If that's alright with you. I want to make sure that I have things clearly understood. One of the main points that I heard is that it would be beneficial for the Office of Long Term Living to pay more attention to the home modifications, how they are being implemented to ensure they are implemented with quality and efficiency so we don't do repeat work or repairs that might be unnecessary to the processor having to repeat procedures to get home modifications in place in the first place. There are efficiencies to be gained there.

We should be looking at the eligibility of the evaluations first and foremost. It seems participant choice, being participants at the center is not truly being heard. There are opportunities if participants were to be at the center of the services that there would be cost-effective solutions to those services in place. Noting the direct care workers shortage. Noting the many homecare agencies that are out there, and you had mentioned the administrative cost. Going to all of those agencies. That does get my mind thinking to administrative cost burden savings. Is it time for us at the Office of Long Term Living to go to a certificate of need process with providers versus us enrolling and licensing any willing and able provider who may or me not get a contract with an MCO because MCO networks are closed.

Yet you still have hundreds of new homecare agencies opening that we as the Office of Long Term Living have responsibilities to go out and visit every two years. Is it time for us at the Office of Long Term Living to reconsider that? And close that enrollment? That's another question. Brenda, thank you for bringing that up. It gets my wheels turning. Would welcome folks if you don't comment today on stuff like that, feel free also to send us stuff afterwards to the LTSS resource account for this conversation. If you mull on things and have a moment. I should've said, would've said this, that and the other.

Thank you so much Natalia for sharing all of that. I have notes. My team is taking notes. I wanted to have that moment to respond. I also -- because this is a difficult conversation an emotional one, it's also a difficult conversation an emotional one for me. That's not why I came into this position. I did not come here to cut people services.

That is not what I intended to do personally. I also need to take a break. We have a break in our agenda at 11:540 for 10 minutes. So we are going to take that break for our folks online and then we are going to reconvene in 10 minutes at 12 PM for additional open public comment. Then continuing to resume this discussion. Really have been grateful for all the input so far and look forward to continuing it after our break. Thank you.

(Break)

>> JULIET MARSALA: This is Juliet checking in with Kathy. We in the room are back from break. Are you online?

>> KATHY CUBIT: Yes, I am. Thank you.

>> JULIET MARSALA: Fantastic. We are going to resume. We are just giving a minute. The captioner is back online in the room as well.

>> KATHY CUBIT: Before we get started, I just want to acknowledge that Juanita Gray has joined since rollcall.

>> JULIET MARSALA: Welcome Juanita. After the break, we are coming into another public comment period which again public comment period could be anything related to LTSS. Conversation that we've been having prior or anything other that folks would like to comment, raise or contribute on. I will also take this time to go into the chat and share some comments that have come through as well that we haven't yet heard from the public. But first, Brenda Dare, you have your hand raised.

>> SPEAKER: I'm sorry about that. I must've hit the wrong button. I did have a comment you don't need to respond to. There's a secondary comment after it saying it's just a comment, not a question.

>> JULIET MARSALA: Great. Did you want me to read the comment you shared in chat or did you want to share yourself?

>> SPEAKER: You can go ahead and read it.

>> JULIET MARSALA: Okay. The comment in chat from Brenda is yes, there are too many provider agencies. Often they are not really serving a participants needs. They are a little more than paycheck printers to be honest given the workforce shortage. They only accept participants who bring caregivers with them. None of the people that I interact with on irregular basis who use services get useful backup from the agencies they are aligned with. It's just not happening right now and if an agency can't meet that need, why do they exist? Thank you for that comment, Brenda.

Let's see here. Yes. A comment from Mia. Given the coming months -- the finalized budget may shape how we think about these recommendations and recognizing the need for a longer-term reproach that can be continuous refined while carrying implications across many sectors, I would recommend considering an establishment of a subcommittee or Council. This group could share data sources to better inform recommendations that would ultimately be presented with broader stakeholder agreement.

Appreciate the comment, Mia. Does -- David Burnett had a question. Does the department intend to pursue a good-faith waiver of the work requirements under the new Medicaid restrictions? We can do a follow-up response from the Office of Income

Maintenance. I know as DHS, we have considered any and all opportunities to address and preserve the needed services where we can. But I do not have a specific answer for you David on that. Very good question. That's all we have for questions and the chat. I'm not seeing any additional online. Not seeing any in the room.

>> SPEAKER: I have a question.

>> JUANITA GRAY: Who am I speaking with? I came on late. I wasn't well earlier and I had to come on later.

>> JULIET MARSALA: You are speaking with Juliet Marsala deputy secretary of the Office of Long Term Living.

>> JUANITA GRAY: It's a pleasure to speak with you and the rest of the subcommittee. And all the members. I was listening to Natalia. She had some great, great ideas and concerns. I had spoken some time ago about the administrative -- I wanted to know the cost incurred with administration. I think it was into the millions. When we talk about cuts, we would probably want to look at that because of the fact the participant needs are number one.

So I don't think that any of the services for the participants should be at hand. I think the program, as I noted -- I wanted to be a part of coming up with a new plan for the participants and some of the decision-making process because I looked at participant model, which I have which is great to me. I think we can do without having a bunch of over administrative. I think that's where I see an issue with is too much coordination and a lot of times they're not needed.

They're overlapping with what the direct care workers already do. So we can reconstruct that. It's what I'm saying. I also heard what the young lady said that there needs to be another oversight board. But I think we could handle it. It's just that there needs to be an agreement where cuts need to be made and shouldn't be made on disabled and needy participants. It needs to be made starting at the administrative levels. That's where the cuts should be at because there's millions of dollars that could be saved. The program is for participants. It's not for other individuals per se. I think they can handle running the program without impacting the participants as much.

>> JULIET MARSALA: Thank you Juanita. Appreciate those comments. I'm going to switch a little bit. We understandably have a huge focus on LTSS and HCBS. That's where the LTSS subcommittee, that's where our hearts are, but our Medicaid program is not just LTSS. It is the whole person, whole health, birth to death system of support. Pennsylvania has been a strong supporter of health and welfare that impacts children, youth, families, people with disabilities for decades. One of the questions that I bring up in terms of health and healthcare is that we have critical, life-sustaining services.

We have must have, like hospital and safety nets, emergency rooms and trauma care. We have upstream services that prevent cost for future generations that are sometimes

very hard to tangibly estimate. We have requirements. We have things that we do that are not required that we do because they have benefit and value. They are nice to haves and other wish lists. The wish list stuff, we're probably just going to have to say that's not going to happen.

But just for folk's awareness about our program in Pennsylvania, it's very robust and that's why we are faced with some significant decisions. In our Medical Assistance Program, when you hear about conversations of the state plan, there is this potential need for us to look at the state plan. These are the services that Pennsylvania must provide. HCBS is not part of the state plan. It is an optional waiver program. What's in the state plan today are the mandatory services.

Part of the question and the discussion that you may have or may need to think about over the next couple months or probably want to think about and provide feedback to us are on elements of potentially the state plan that if DHS had to cut something of services that are not on the mandatory list that we have added because we know it's good for Pennsylvanians. Everything Pennsylvania has added to our state plan, we wholeheartedly believe is good for Pennsylvania. But if we have to take some of those nonmandatory programs or scale them back, it would be a good opportunity for folks to take a look at those.

Think about those. And perhaps provide feedback on those elements. I will give an example of that. In the last couple years, the GLC -- GLP-1 drugs. We know life critical for diabetes. Diabetes, insulin management, life critical. There is much debate around GLP-1 for off label prescribing, for obesity management, for levels of obesity management. These are very expensive drugs. Do we look at the authorizations, prior authorizations or approvals of these very expensive pharmaceutical drugs? Within our state health plan?

It gets complicated just to give you a sense of things. There is a whole pharmacy rebate program that also hopes with different funding of programs. When folks like my colleague, deputy secretory Kovach who oversees OMAP, as we all tackle all these big pieces that are huge to Medicaid it might not necessarily always be clear why this and not that because lots of things are interrelated but I just want to raise that up because Pennsylvania does have a lot of benefits and services in our state plan that also impact the LTSS population that may need to be looked at.

As my stakeholder community, we look at those. We would certainly welcome your feedback on those. Not conversations we want to have. Practical realities of what we might need to look at. We are seeing some of this on the Medicare side where they are looking at -- again not my value statements -- low value clinical procedures or diagnostic screenings. They are looking at those cuts in things like how often should someone for example get an x-ray for plantar fasciitis? I'm not a clinician. It's way outside my realm.

Do we have to look at some of those things within our program? Should that be directions that we give to our CHC-MCO's in terms of when they look at their data for

recommendations of things? I -- Again, not conversations we want Taft but lifting it up to dispute because LTSS, DHC is not just HCBS. It's the whole kit and caboodle. I don't know if folks are aware of some of the mandatory versus nonmandatory services or the optional services. And some of these are going to be how is this an optional service covered by the state plan? I'm going to tell you what they are.

Ambulance is optional. These are the optional services not the mandatory services. Ambulatory surgical centers, anesthesia, audiology, the hearing folks -- bear with me -- targeted case management, chiropractic services, dental services, dentures, eyeglasses for adults, hearing aids for adults -- it boggles my mind. Hospice is an optional service. Certain intermediate care facilities. Intensive behavioral health services.

Nutritional supplements, optometrist services, certain other practitioner services, certain medical and surgical center outpatient services, certain drug and alcohol services, certain psychiatric outpatient clinical services, certain outpatient psychiatric partial hospitalization services, personal care services, pharmacy services, podiatrist services, private duty nurses services, psychology services, renal dialysis services, residential treatment services, residential services, social work services, certain tobacco cessation services. That's a list of things that are offered that we embrace because we know they are critical and beneficial. But I just wanted folks to be aware that, out of federal level, the Feds don't see those as critical. They see those as optional for states.

>> SPEAKER: Can you please send us that list or email that list? I think Pennsylvania and all of everyone here that fight for us to have these services. And hopefully a lot of them won't be cut. I would think dental because you can die from a dental infection. Some of these things I think we need to try to rescue that with the governor, back to the Senate and the governor and the state and the federal government level and let them know. Maybe to the physician. Because there's no way. I can understand that they would have specifics taken off as far as dental and other. They are actually critical. You can literally die from a dental problem.

>> JULIET MARSALA: I agree with you Juanita. That's why in Pennsylvania we find these things to be important and of value. The reality is if the state budget isn't where it needs to be to cover all of this, and with the looming impact of the federal government, these are the reality of choices the department will have to evaluate. I'm sorry. Michael go ahead.

>> MICHAEL GALVAN: Hey. Alzheimer's Association. I really appreciate this conversation. It's really critical. I wanted to jump in on this part specifically because I wonder if it's worth doing some downstream impact analysis of those cuts. If we cut things like dental coverage or dental and -- insurance, psychiatry service, home healthcare services, what happens to the fiscal in that bill? Does it blow up in the long run or is it something we have managed care on downstream or other opportunities? I'm thinking broad strokes too. In the space of this isn't necessarily a space I feel comfortable with us talking about cuts.

I know we are living with the reality of the One Big Beautiful Bill. But where are the cost-saving efficiencies? When you get laid off with a job, you don't stop eating food. You buy different kinds of food and maybe reduce your budget or reduce the types of food you're taking in. You look for cost-saving efficiencies overall. I'm curious to see what HCBS programming, if we were to get reimbursement rates up at high enough to where we have a stabilized workforce where we were missing shifts. I bet Mia and Cody have data on how much we could save in that process.

From the Alzheimer's Association standpoint medication coverage. We know that the Pennsylvania just past biomarker legislation last year. That's one prevention treatment screening tool in a broader array of diseases however there are treatments in the Alzheimer's space if they were covered by Medicaid Medicare we could reduce long-term costs overall to the department. Further what about coordinated Care? I think this was brought up several times throughout this conversation. If we have the opportunity to have a dementia care specialist program for individuals living with Alzheimer's or other dementia.

Does that reduce cost and impact to the system overall? Which others seems to have done and found it's a really big cost-saving measure as a whole. I just think that it's within the reality of the situation. I would love for us to plus one me as -- Mia's comment about working as a group on this and also continue to have this conversation as the state budget develops because I think there's a lot of opportunities for us to continue to really think strategically about what are better ways we can inform our decision-making process to efficiently serve those Pennsylvanians in need without going straight into slash everything mode.

>> JULIET MARSALA: Definitely appreciate that, Michael. And a couple of responses. One is I appreciate the call for a workgroup on the specific subject. But I do also point out that the consumer sub MAC, the LTSS subcommittee, these are our committees and workgroups and the predominant ones. Certainly at the direction of the committee, we can do things. Along the lines of having in-depth conversations as we have today, continuing this on our agenda next month and those type of things as we continue to get additional information.

With regards to how another committee meets, again, doing real-time feedback. Real feedback. What would that accomplish? It's not a public forum, right? But it doesn't engage all our stakeholders. That's my only concern. I think this is a conversation for our stakeholder group in the public realm. That's just my thoughts and reactions. That's not to say that the workgroup wouldn't have value. I would just have to take that back and understand it a little bit further. It makes sense for very specific things where we are trying to get to a very specific endpoint. But this is not where we're at in this moment right now. Not to say it's not appropriate for the future.

With regards to the preventative efforts. Everything you said related to individuals impacted by dementia, Alzheimer's dementia situations. Certainly would love that

research and that feedback from other states. I do think, and I have said this before, we're going to work on pathways for this. I think CHC has been relatively new and then was hit with COVID and is coming out of it and now we're seeing the reality of H.R. 1 and OB3. I feel like, to respond to you, Michael, I feel like there's so much potential in CHC that has yet to be realized that could capture exactly what you're thinking about.

As MCOs think about how to recapitalize on in lieu of services development? How do we use all of their flexibility so they can have value-based payment arrangements? Is it a matter of there are new drugs out there that could have upstream? Do folks know how to submit it to our pharmacy team for review to be added to the benefits plan? And that rationale? I don't know if everyone knows how to do that. Some of these things could be just listing those up, sending those in.

It's why the intention of this open forum is to do exactly that. My CHC-MCO partners online and in the room, Michael has some stuff he wants to talk to you about. (Chuckles) It's hard -- if the studies are there and the savings are there and it's demonstrated, we can talk about those things. It's incredibly difficult to convince representatives to give us additional funding in years that we're not getting funding to start new things. But there's so much flexibility available in the current CHC program. I just think (Away from Mic) Lloyd?

>> LLOYD WERTZ: Psychiatric leadership Council and family training and advocacy. 13 years ago we had a governor who I'm referring to as one term Tom who reduced the tax revenues by the Commonwealth reducing the taxes charged to Shell which did really well fund his election process. That was never reinstated. We never collected those taxes. Two years later we found ourselves having a 3.5 to $4 billion deficit. Could we figure out why since you reduced to the taxes by that amount at that time?

Let's bring us up to the present and the first budget year of our current governor, there is in fact a basically 50% reduction. We call it 5% because it sounds like less but there's a 50% reduction in corporate taxes that were enacted over a five-year period. Basically scheduled to end at the end of our governor's first term in office. More revenues we have turned back and turned away. It's not just a bottom-line issue. It's a top line issue. The revenues from the federal government when they are reduced maybe some of them could be replaced by revenues from the state government if we could just reenact or pull back those reduced taxes.

I just think we have to look at both sides of that equation if we can and try and work with our state senators in this case to get them to grasp the fact that you need to get more revenue in order to provide the services that are so very important for your constituents. In some cases, their very own family members. I just wanted to say it.

>> JULIET MARSALA: Thank you Lloyd. I appreciate those comments. I don't disagree. It's a bottom-line raising revenue, cost efficiencies question. Unfortunately, I can't wave the wand on the revenue building side. That's everyone's role on that piece. Thank you. It certainly is true. There is work that everyone in our stakeholder community can still do

to address those comments. Jeff Iseman, one second. Jeff Iseman has posted to the list and we will certainly do as a follow-up the list from Medicaid about optional versus required, state plan services.

The list I reviewed that was Pennsylvania specific but you can see all of them certainly online. Go ahead.

>> SPEAKER: Hi. Paula Robinson daily gov care. I know we talked about the budget and from my understanding correct me if I'm wrong the governor came out with his budget in February and it's now August and then we have all these potential cuts. I think just the uncertainty and the fear of the unknown is what we have to brace ourselves. It's August already. Do we have any idea? Because now I would assume that budget of February was for 2026, correct?

Is that going to be revised or is he going to stick to his budget for 2026, and we just kind of have to get that approved?

>> JULIET MARSALA: The administration and the representatives are currently in that negotiations process of the budget. He proposes. The general assembly reviews, revises, moves to enact their versions of the budget. I have no updates on the state budget. I have no idea when we might have one. I have no idea what will be in it. There is no budget approved, do we continue to send allocated dollars as is? On the state budget, there are certain allocated lines that are mandatory and others that are not.

For example, folks who were part of allocated items that were not mandatory. They received letters telling them that their grants are held or what have you. Because no funding can go out because it isn't approved. There are significant areas across the Commonwealth that are impacted because their funding is paused.

>> SPEAKER: Do we know what those services are?

>> JULIET MARSALA: I don't know what the other office services are. I can tell you the long-term care allocation and the CHC allocation, the Medicaid program, state allocation, that's mandatory. For OLTL, the budget stay impact is minimal to our system. Save potentially some smaller grants and programs. It will continue to remain because we are mandated. It's mandatory. So it will stay at the current level until something is approved, the budget gets approved. For the next couple of months, for us, certainly, we can keep the holding pattern. But here's the reality of it. If the state budget gets enacted at flat funding --

>> SPEAKER: And there's no match.

>> JULIET MARSALA: We get the federal match.

>> SPEAKER: I thought there were grants.

>> JULIET MARSALA: No. The federal match for the Medicaid program that we pulled from the Fed's, there's still a federal match. There's different percentage for administrative matches and different percentages for general operating matches. There's different percentages. Blended in Pennsylvania for the Office of Long Term Living it's currently 55.09% generally speaking. What you're hearing about with regards to H.R. 1 and OB3 that have impacts to our Medicaid program you hear a lot of talk about how will FMAP change if states don't follow things that FMAP at risk if they don't do redeterminations. (Away from Mic)

The other piece you generally here that's been enacted is that there are very specific changes to provider assessment assessments but it's kind of attacks Provider assessments. We in Pennsylvania have a nursing facility assessment fee program. That's not impacted. We have a hospital one and managed care organization one where hospitals and managed care organizations pay as an assessment fee. That assessment fee helps us generate the state required portion that we pay into the Medicaid program to be able to draw down the federal dollars.

When the federal government lowered our ability to raise that revenue, it means states have to find other revenue streams. We can't have our providers help us bring down federal dollars so we have to find other revenue sources to do that. That's part of that risk. We relied on 5% of that. If it titrate's down to 3% -- I don't know the percentages. Long morning. The state would have to say we are going to have to fill that with state dollars.

>> SPEAKER: If they choose to do that.

>> JULIET MARSALA: If they cheat -- choose to do that. Or representatives could say we don't have to have that and we get a funding hit. That's why we don't have the information but we need to have the conversations. You will need to continue your work with the representatives to make sure they understand we need what we need. But if we need to make very difficult decisions that we don't want to make, that's the conversation.

>> SPEAKER: The frustration is the hopes of we did that long survey I think. The study. It's like well, we should be thankful if nothing is eliminated at this point. We did this amazing study that was really intensive. Two now it's like well, let's be thankful for where we are right now.

>> JULIET MARSALA: That's not the message I intend. Two Ali's earlier point, you don't have to accept that. You guys can decide to do a whole bunch of stuff in response to what you're seeing from your representatives or not seeing from your representatives. That's in the control of the public. You don't have to go -- the message I'm trying to get out --

>> SPEAKER: I think we are just fearful, but I think on a lighter note if the budget isn't approved, you explaining really well what's mandated on there gives us hope.

Everything's so dark because of the unknown but I think the light you're giving us is letting us know there are things that are mandated that have to be paid out that there are a few things that may be cut or they received letters. But as far as certain things are mandated.

>> JULIET MARSALA: To your point, what I'm saying is that we have the ability to keep the lights on while they are still figuring out the money. But if they make changes to the money, if the budget is enacted and they cut hundreds of millions of dollars from my program, it means that I only have from October to June to figure out how to make those cuts real. That would be an immediate impact.

>> SPEAKER: You also said the staffing for the redetermination of eligibility and then you said something along the lines of agencies being approved or --where the MCOs have closed the door. You see that with New York. They have cut licensing or stopped accepting licensing applications and I think our neighboring states do a good thing as well. That would be a burden if you have to come out every two years. That cost with the administrative cost you need. I think last month it was 257. It's going to cost 30 something million dollars. The people, there's a lot. Thank you for -- I think we should just take a light -- it's June and there's things but stay hopeful.

>> JULIET MARSALA: Hope can be better achieved with action as well. Certainly, the budget process is still the budget process. There's opportunity and time to connect with your representatives to make sure your thoughts are known as well.

>> SPEAKER: It's February. That will be for 2027? I thought in February, the governor has to come out with his bill?

>> JULIET MARSALA: They are working on this bill. Then the budget as soon as this is done and/or now they are probably thinking about the out years as well. The question was in February when the governor comes up with the new budget is that for 27? Yes. That would be for 2027. Most certainly. Hopefully we have this budget done before that budget. Paul Weaver submitted a comment.

>> KATHY CUBIT: This is Kathy. I wanted to jump in. If we could focus on people that haven't had a chance to comment yet, prioritize that way. If there's time, I have a list of things I would like to share as well that I prepared for the meeting. Go ahead.

>> JULIET MARSALA: Absolutely, Kathy. Can I save the last 10 minutes of our meeting for you to close us out for that or do you need additional time is our chair?

>> KATHY CUBIT: No. I only need a few minutes to share what I jotted down. I know there's a lot of people that want to say things and I just want to make sure the people that haven't had a chance get that chance. Thank you.

>> JULIET MARSALA: Absolutely. I wanted to share Paul remark from the chat submitted a comment speaking from the service coordination end service coordination

is in ...Person-centered. Removing them from the process leaves participants to navigate complex systems alone, often leading to worse outcomes. At the same time, quality concerns among some personal assistants service providers suggests review is needed. A temporary moratorium a new personal assistant provider enrollment paired with review of existing provider performance and network advocacy could prevent misuse...

And can be critical to improving access to services, better health outcomes with some of the downsides being inefficient use of resources, loss of advocacy and potential decline in well-being. Thank you Paul for those comments. Let me just see here. Elizabeth R. has added wooden analysis of the cost of the MCOs managing the CHC program versus the state managing it be any benefit? Perhaps more care could be administered if the state went back to managing the program. Just a thought. Thank you.

>> JULIET MARSALA: I'm going talk about this for a second and I know there's talking about going to one administrative waiver and administrative cuts would be found. Part of the CHC implementation process is an independent assessment entity we've been working with. MRC medical research center that's been following along the health outcomes, Community HealthChoices and satisfaction in addition to I believe a couple years back earlier on there was a review by Mercer of the cost showing and indicating that the CHC implementation has reduced cost or projected cost of maintaining it in a fee for service world.

Certainly we can look to refresh that information and we do want to continue analyzing that benefit year-over-year. But again, to point out in the fee-for-service world for HCBS, HCBS was disconnected from health services. They were siloed. HCBS over here. MCOs over there. Service coordinators did not talk to your doctor. The data was definitely not shared. It's even more fragmented than it is today. I want to have folks remember that. I lived that too. Today the entities are connected with the health services. It's more integrated.

That was the goal today than it was in the past. Sorry. I am trying to multitask. Taskswitch is not always the easiest thing for me to do. Alright. I think I have everything in the chat. I saw your hand raised. I'm going to yield the floor to you. Carol? On mute end? Unmute and speak?

>> CAROL MARFISI: I know we don't know about (Indiscernible) thinking about (Indiscernible) I think it was (Indiscernible) who said there could be different models of PAA and money would be distributed (Indiscernible) there is a possibility of (Indiscernible) make them more amenable to people who are not sick but who only need personal care (Indiscernible) they only need personal care. (Indiscernible) It can be taken away and their identity (Indiscernible).

>> JULIET MARSALA: Thanks a lot, Carol. I'm not sure that I got all of it. I'm going to have to follow up with you on questions that I have after the meeting.

>> CAROL MARFISI: (Indiscernible) My personal care. Why can't we use (Indiscernible).

>> JULIET MARSALA: I don't disagree. I think there certainly an opportunity to look at different agency models and options, the impacts on the attendant workers and the network overall, if I'm understanding correctly.

>> CAROL MARFISI: Yeah.

>> JULIET MARSALA: We've heard that from other comments. So I do think there's opportunity there. Certainly, what I have learned when something seems easy to do, it's not always the case. There's a lot that we do have to evaluate and look at in terms of regulations and laws about providers, about whether or not and how easy and quickly they can go to something like a certificate of need or something to that effect. From the state perspective. Certainly the MCOs have control over their networks and been evaluating their networks by quality on other needs to streamline administrative costs and lift up the quality of agencies for providers.

But maybe this would be a good idea to do. That doesn't mean it's going to be easy and doesn't mean we won't find some obscure law that says we can't do it. We are going to take that back and research it. At the beginning what's important for us is we have limited resources. We are going to be having difficult conversations. We are going to be looking at bringing your input, what you value, your feedback.

I know I am and I know my team will be taking those notes and taking that input with our conversations. Kathy, it's 12:50 and I know we end exactly at one. I want to say thank you to everyone. It's not our last conversation. I do hope we continue to include this as part of our agenda moving forward. I welcome folks to send to the resource account, reactions, additional thoughts or materials, things for us to consider, things you like us to know. I know it's not a formal public comment but it's our committee to work with. With that, Kathy, gratitude. I yield the floor to you.

>> KATHY CUBIT: Thanks Juliet. Clear everyone who wanted to say something in the room?

>> JULIET MARSALA: Yes.

>> JULIET MARSALA: Okay. I'm going to go through quickly the thoughts I wanted to share and I don't know if there would be time for you to go through any additional comments that were received in the chat. But again, very quickly a few potential thoughts. One is knowing that unpaid and low-paid caregivers are really the backbone of the LTSS system. Really help eligible, unpaid and paid caregivers enroll and maintain Medicaid coverage when the work hours documentation is going to be needed. By creating a seamless or exparte system.

I think it will be particular burdensome for unpaid caregivers to have to do this every six months. It would be great if the system could support that proactively. Next, look for funding, Department of Labor, private public, for workforce training program for direct care workers for targeting people who will need these work hours. They should be screened and then again potential pipeline for new workers. Next, identify CHC participants and applicants or their spouses who are veterans and proactively integrate or connect with veterans benefits and vision or veterans integrated service networks services.

Next modify DSNP or MIPS.....Next explore funding opportunities through the new 50 billion rural health fund to look at potentially accessing that for past or LTSS workers enroll communities. Next, his practices and intensify efforts to divert hospital discharges to SNFs for skilled nursing facilities whenever possible such as early discharge planning and service approval and if the federal government approves the continuation of hospital at home. I know Penn has a program.

That should also be utilized. Next, adopt and adapt dementia care programs like Michael mentioned the dementia care specialist or guide into CHC to prevent or delay nursing home placement. Next, explore the no wrong door Medicaid administrative claiming option to help people obtain and maintain gay coverage. Last, work with pace, the Pennsylvania pharmaceutical program strategize on cost-saving ideas and perhaps ways to work together to minimize costs across the programs. Those were my comments. I don't know if anything else has come into the chat that you want to share in the last few minutes.

>> JULIET MARSALA: Certainly. Kathy thank you so much for that list & very tangible action items that certainly can be pursued. I don't see any additional information in the chat. If you would indulge me for a couple minutes I did want to respond to say I can check off one of the things on the list that the Department of Human Services is absolutely looking at the rural healthcare transformation fund. Specifically looking at how can Pennsylvania submit a plan to capture up to $200 million to help support our rural healthcare transformation.

Many of you have seen recently DHS put out a request for information for ready-made impact project proposals and ideas specifically targeting the rural healthcare funds that are coming out of the federal government. What's fun there because stuff is fun, the Feds have not given us any specifics on what we need to do to apply for those funds, how those funds come out or that technical guidance for the grants we will expect to come out in a couple weeks in September.

Dates will then have to rapidly apply for that grant once we get the actual direction. I believe by the end of October. That's why we've been trying to proactively bring out and collect what some could say shovel ready ideas or shovel ready projects that will help us, inform us and help us be successful in pulling down that grant availability from the Fed's. I'm going to check that off. Working on that one, Kathy.

>> KATHY CUBIT: That's great. Thank you Juliet.

>> JULIET MARSALA: Certainly good stuff I will bring back. Last call in the room. Just for today. Nothing in the room. I am not seeing anything in chat. Again I am so incredibly thankful for the conversation and it's very valuable to me. I hope you found it valuable as well. It's not the end to the conversation. You know our resource account and materials and we will continue the next time we meet. Thank you Kathy and LTSS subcommittee members and certainly thanks to my team.

>> KATHY CUBIT: I do want to thank everyone and remind folks our next meeting is Wednesday, October 1 and it will be available both remotely and in person in the room you're in now. I hope everyone has a great rest of your day and with that the meeting is adjourned. Thank you.