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Date: 11/2025

Event: Long-Term Services and Supports Subcommittee Meeting

The one good morning everyone this is a Kathy Cubit and I want to welcome you to the November LTSS Mac meeting. I want to start with housekeeping talking points. And then we will move on the introductions or attendance as I can see members are still joining. This meeting is being recordeded and your participation in this meeting is your consent to be recorded. This meeting is being conducted as a webinar with remote streaming to comply with logistical agreements and we will end promptly at 1:00 to avoid background noise please keep your devices muted and the microphone is off unless you are speaking. Remote captioning is available at every meeting. The car captioning link is on the agenda and in the chat. It is very important for only one person to speak at a time. Please state your name before commenting and speak slowly and clearly so the caption or may capture conversations and identify speakers. These keep your questions and comments concise and to allow time for everyone to be heard. Webinar attendees may submit questions and comments into the questions box I go to webinar or use the raise hand feature to be in queue to speak live. Time is allotted on the meeting agenda. 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 the LTSS webpage. With that we will move on to attendance. I'm sorry did I cut somebody off?
>> SPEAKER: I apologize, OLTL put the remote streaming link in the chat please? e?
>> KATHY CUBIT: Now we will start the attendance while thatt is being added to the chat. Ali Kronley? Anna war hike sends regrets. Is Austin Cawley here as her r alternate? ? OkayCindy Celi? Carol Marfisi. I think I see arol the . I mean the ist. Kathy Bullinger.
>> Good morning this is Kathy.
>> Cindy Seeley.
>> Good morning this is Cindy.
>> Neil Brady. Gail Weidman. Jay Harner.
>> Good morning.
>> Juanita Gray. Laura Wilmer also sends regrets today. Leslie Gilman.
>> I am here.
>> Hi Leslie sorry to cut you off. Linda Lytton.
>> Good morning. Linda here.
>> Hi Linda. Lloyd Wertz. Lynn Weidner.
>> Good morning.
>> Good morning. Matt Seeley. Michelle Garrett.
>> Good morning I'm here.
>> Good morning. Michael Galvin sent regrets for most of the meeting. Is Luke Raymond here? His alternate?
>> I am here. Welcome.
>> Minto Livengood? Monica Caro sends egrets. Is Jack poplar here? Okay. Pam walls.
>> Hi Kathy I'm here I wanted to let you know I will have to leave early at 11:45 AM.
>> Thank you and welcome Pamm. I am cutting someone off? Okay Patty canola docket.

>> Good ormorning everyone.
>> Rebecca may call. Is there any member that joint while I was taking attendance and did not have an opportunity to announce themselves?
>> Yes Lord works here.
>> Hi Lloyd.
>> Gail Weidman here.
>> Good morning. Anyone else?
>> Hi Kathy. Jack poplar has as joined nd Ali i Kronley is trying to connect to audio. They are both here.
>> KATHY CUBIT: Okay thank you. I think with that we can move on now to Juliet who will provide the OLTL updates. The floor is yours Juliet.
>> Thank you Kathy and good morning everyone. Thank you for joining us for the LTSS subcommittee meeting. As many of you may know or have seen there are public indicators that we may be close to budget but as far as I know it has not been signed yet either at a federal level or estate level. I know we are all eagerly awaiting for both of those budgets to be resolved. I do want folks to keep in mind that even when the budget is passed at the state level there is still additional steps that need to take and be taken before we at the office of long-term living have a full understanding of any of the impacts of the state budget on the office of long-term living. We will need to look for and wait for the human services code and the physical code as well. But we, like you, are eagerly awaiting a hopeful passing of the state budget and certainly of a federal budget. I have heard from a lot of folks since our meeting I believe in September where we started talking about impacts at the office of long-term living. And current and future budgets and the impact of HR one and OB three. I did want to recognize certainly there is a lot of anxiety and concern amongst all of our stakeholders. And also myself and our team. I just wanted to reiterate that we are looking at the system holistically. We are not just focused on H CBS. The CHC system in particular is all-encompassing of health services in addition to long-term services and supports. We continue to welcome folks thoughts and ideas with regards to ways that the system can be more efficient while maintaining the quality that Pennsylvanians deserve and I have heard from folks. And continue to welcome input, particularly during public comment periods of this LTSS subcommittee as the subcommittee does serve as the advisory body for the office of long-term living. I do hope we continue to engage in that important conversation. And invite all stakeholders to participate in the two public comment periods that we have every month during this meeting. There have been some rumors swirling. That the office of long-term living has made some concrete decisions. I'm here to say that is not true. The office of long-term living has not made any concrete decisions with regard to cuts to services or caps on ours or anything of that nature. At this point in time. The focus has been on maintaining the program. And services. That Pennsylvanians need and deserve. DHS is focused on how we help support the money Pennsylvanians that have been stuck without snap benefits. Given everything that has been happening at the federal level. All this to say that as we look to 2027 and beyond and as we look to learning about this year's budget, there is nothing that is on the table but there's also nothing that is off the table. We continue to work together to evaluate and see how we can maintain the best path forward to uphold our mission at DHS. Two serving Pennsylvanians. That need and rely on our services and support. I did want to clarify hat. OLTL will engage in public comment periods and notifications should there be any concrete changes or directions. We will certainly communicate that. I did want to take a minute to also highlight the LTSS subcommittee members. Whom I've been very very grateful to work with. Since the emerging of the LTSS subcommittee into the LTSS subcommittee time has flown by. And I

wanted to share that as part of that merger we added term limits to the LTSS subcommittee appointed members to ensure that the LTSS subcommittee always had varied voices and opportunities for all stakeholders within our system. I'm very pleased to say that we have had an increase in applications to serve. I will always make a call out for additional participants to submit applications to serve. Maintaining a majority of participants voices is very important to us and to me. I did want to take a moment to say we will be looking in January to transition also to a new chair and vice chair. So members of the committee who would be interested in serving and that leadership role, I encourage you to please reach out to me. So we can explore and discuss that transition. I'm so grateful to Kathy for having agreed to remain as chair through the LTSS merger and transition. But I do recognize that I need to be okay with having Kathy transition out of the leadership role. So new leadership can be identified to move the work forward. And she has served the LTSS subcommittee well. We wanted to share this now looking to January so that we can take advantage of her leadership and experience to help a new chair and vice chair when they transition. I did want to share that. We still have Kathy through December. And perhaps beyond. I wanted to elevate that so folks had awareness. All right. Let's go to our agenda. We have quite a few things to talk about today. I will try not to go too much overtime we are going to talk about the usual procurement updates, enrollment reminders, medical director reminders. Recent communications. An additional topics of interest. Let's go to the next slide. There are no new updates for the procurement could it currently remains in a state of activities pertaining to the RFA have ceased. We have no timeline. Folks are continuing to ask about a timeline but we do not have a timeline you can share at this time. The CHC program will continue to operate under the current CHC managed care organizations and agreements until further notice. The office of long-term living cannot comment further on the RFA at all questions regarding the RFA and its contents should be directed to procurement via the resource account RA- two RFA questions at VA.gov. Next slide. Just as a reminder to all of our writers enrolled in Medicaid. We are asking you please review your enrollment revalidation dates. To ensure that your organizations revalidate timely this is quickly important. If your revalidation is not timely you may find your Medicaid enrollment has gone into a disenrollment status. We do not want that to happen. 2025 is a big year for revalidation so please take the time to check your revalidation dates and promise. And also check to ensure that your contact for your organization is up-to-date because all of the communications will go to that contact. And make sure that PA.gov is added to your safe sender sites so communications are not redirected through your spam filters. Update your enrollment profiles ongoing. In addition it is critically important that if you are licensed by the Department of Health that you also pay close attention to your DOH licensure renewals. They are required for Medicaid enrollment. If your licensure lapses with the Department of Health that it is in immediate termination from Medicaid enrollment because you would no longer qualify to be a Medicaid provider. Because that valid license is a requirement. DOH does not backdate the licensure's so there is no backdating of your enrollment. We do not want to have gaps because gaps equate to gaps in care. And also in potential payment issues for your organization. We have emails here for the provider enrollment team. Letter RA- eight CBS E N prov@pa.gov. Folks that have enrollment questions and we have our resource account for provider support team. RA- provider operation at PA.gov for any ongoing questions. Our team is here to help assist you with any and all questions that you have. In addition there is the provider operation hotline for the office of long-term living at 1-800 □ 932 □ 0939. We go to the next slide and I want to share reminders from our article director that October is Mark the official start of flu season. While it typically takes between December and February respiratory illness is already going around. The CDC and others all

agree that everyone's six months and older with rare exceptions should get a flu vaccine every ason. We encourage you to get that vaccine. We encourage you to encourage your staff to get the vaccines that we encourage you to encourage participants to get the vaccine. The influenza vaccines have cut flu associated outpatient visits and hospitalizations by half during the southern hemisphere's 2025 flu season. This is better than usual. I can't reiterate that enough. Let's be proactive and get our flu shots of those hospitalized in the southern hemisphere only 15.9 percent were vaccinated. Vaccinations are key and clutch. Let's have those happen. Next slide please. The Pennsylvania human relations commission P HRC is collecting public comment on proposed guidance clarifying how the Pennsylvania human relations act applies to the dmission of personal care attendants accompanying individuals with disabilities at public accommodations and commercial properties. The proposed guidance explains when the Pennsylvania human relations commission may consider it to be reasonable accommodations for entities to provide personal care assistance free or discounted admission, ensuring that individuals with disabilities have equal opportunity to participate in public life. This is very important to our stakeholders. Public comments are being requested and you can submit them via online survey. The survey time has been open since October 6 and will continue to be open through November 25. For more information or to submit public comment visit the personal care assistant accommodations guidance. The link on the Pennsylvania human relations commission website which is on PA.gov website. There is a link in the e materials that are being sent with this meeting. We are going to talk about snap work and reporting requirements toolkit. If we go to the next slide DHS has developed a communications toolkit to help Pennsylvanians understand changes to the snap program. Changes may be happening every day. Taking place because of the budget bill passed by the Congressional Republicans and into law by President Trump on July 4th, 2025. With these changes some snap recipients must meet work requirements and report to Pennsylvania DHS that they are meeting this requirement. If snap recipients are not meeting this requirement will be limited to three months of snap benefits for a three-year period. Our goal is to make sure Pennsylvanians stay connected to these life-sustaining nutrition assistance programs to help them feed themselves and their families. There are various resources that we've made available on the DHS website at snap toolkit. Department of human services for the Commonwealth of Pennsylvania websites. That we hope that you will help to share and boost the awareness of these requirements. Everyone that you serve and everyone that you know. We are counting on our providers and community-based organizations and MCO partners to ensure everyone within the LTSS system is aware. And understands what they need to do. Also wanting to ensure folks understood in the next slide that the Medicare annual open enrollment period began on October 15, 2025. They want to make sure that folks are aware and lift up and share that the Pennsylvania Medicare education and decision insight or many counselors are ready to help. The annual and open enrollment period for Medicare re beneficiaries again started October 15. It means that they can choose to change how their Medicare benefits are accessed. The PA many counselors can assist new and current beneficiaries with selecting a new coverage plan making changes to their existing benefits during this open enrollment Medicare beneficiaries can sign up for Medicare prescription drug coverage among different types of health plans to complement their Medicare benefits. They can review and join or switch or drop Medicare advantage or prescription drug coverage so it better meets their needs. PA trafficking counselors provide free and objective help benefits counseling were agencies on ging. PA MEDI counselors are available e for anyone who is Medicare eligible, not just individuals over the age of 60. As we know there are many individuals under the age of 60, 65 I'm sorry, that are Medicare eligible. PA MEDI

counselors are working for all Medicare beneficiaries regardless of age. For more information visit the Department of aging website or call the PA MEDI help line at one □ 800 □ 783 □ 7067. If all of our provider partners can elevate that message I would be very grateful. I wanted to talk about the rule health transformation program on the next slide. I am pleased to announce the Pennsylvania did submit for the rule health transformation notice of funding opportunity that was uthorized by OB hree. That empowers the state to o strengthen rural communities across America by having access by transforming healthcare delivery ecosystem. The trauma and menstruation set five primary goals and nts for our applications and nitiatives which included making rural healthy thy again sustainable access strategies and workforce evelopment investments and innovative care and technological innovation. Pennsylvania has submitted an application and so we are going to eagerly await the response for that. I am very y grateful to everyone within in the LTSS SS system that had answered DHS call for request for information leading up to this application. I'm also very grateful to members of the OLTL team that helps support the writing of the application. It was fast, it was various. But we got it done and it was a heavy lift and I'm so thankful that Pennsylvania has applied more to come on that as we wait to hear back from the federal government about our application. The RHD funding if they go to the next slide so folks are aware was $50 billion to be allocated to pprove states over five fiscal years. With 10 billion of funding available each fiscal year. Beginning in 2026 and ending in 2030. As part of our application Pennsylvania schools are to improve access to care and outcomes and use technology to drive innovation. Expand partnerships for change. Create a robust workforce to address the regional needs. Really focus on data driven solutions. And implementing a financially sustainable strategies. Within those initiatives and goals or to achieve those goals and initiatives will spend technology and infrastructure, workforce, maternal health, behavior health, aging and access and emergency medical services and transportation. As this process moves forward we will share more information about these initiatives. Integrally once we hear back about how our application was received. Transitioning into OLTL communications. Provokes the dark medications that go out via our various serves. If you have not signed up I encourage you to do so. Medical assistance nursing facility that hold reports which is the hospital reserve a bed days we have added the orderly MA, and that hold reports or hospital reserve a bed days for the recorders to the long-term facilities website under additional sources. This information is also located on the last pagee of each Medicaid nursing facilities in case in term report for the application which are date under the section titled payment for hospital reserve bed days. We know that there are groups that rely on this information. To create other connections with our systems so we have also highlighted it separate from the interim report so it is easier to locate. The criteria regarding a nursing facility eligibility for payment for hospital reserve bed days can be found at the link here. It is in statue. Further information please read the resident data reporting manual. Which is also posted on the long-term nursing facilities website. It will give you lots of background information and detailed information about the bed holds. How they are calculated. And if you can have, find your answer or have additional questions and concerns please contact Ruth and Bernard at rbernard@pa.gov with any questions or concerns you might have and she will endeavor to provide the answer. We go to the next page. Pennsylvania DHS so launched the human services helpers resource. It iss a sub stack application will cover updates on DHS programs, news from the agency and how organizations and partners can help their communities. More specifically as DHS implements changes required by the federal government under HR one human services helpers will share resources and tips to help Pennsylvanians affected by these changes understand what is happening and what they must do to keep their benefits. We also include news on the federal

government shut down its impact on programs like snap and low income home energy assistance programs. Subsector is an online platform for greater to publish content like newsletters, podcasts and videos so it allows us to be more dynamic with our communications and also allows writers and other content creators to build a direct relationship with the audience which is what we are hoping to expand upon and provide infrastructure for sending content via email. There is a link on the materials that we send out. Where you can sign up for the updates and be a helper for Pennsylvania to help us make sure that accurate and up-to-date information is being shared with the Pennsylvanians we serve. I will pause for any questions or comments.
>> KATHY CUBIT: This is Kathy while we are waiting for questions or comments first I want to thank you for your kind words Juliet and I also want to acknowledge that one integrate and that Seeley have joined. If there re members I missed that were not ced please announce yourself f now. now.
>> Jack Poplar.
>> Hi Jackk, welcome. .
>> Thankss.
>> KATHY CUBIT: Okay questions for Juliet? Is there anything in the chat?
>> Hi this is pine. No questions in the chat.
>> Thank you.
>> KATHY CUBIT: With that I guess we can move into our first public comment period. Is there any comments or questions from members? Am assuming there is still nothing in the chat?
>> That is correct.
>> Folks are letting me off easy today.
>> KATHY CUBIT: Everyone is quiet today.
>> Let's not go that far. This is Lloyd. I wonder about the timing of this horrific draconian HR one. I think it was HR one. The bill from D.C.. The timing becomes essential, and limitation for 26, 27 and 28 obviously having to do with the election cycle. So we don't completely throw all of this including tromp out. But I wonder if that timing has been determined and sifted ut to figure out when it is most likely to impact enrollees in the CHC or is that still yet to come?
>> The specific timing is yet to come. But we anticipate big impacts definitely and the next fiscal year. In the 26, 27 fiscal year. We anticipate there will be big impacts. We have to see what is in this fiscal years of budget. Before we can dig into what next fiscal years budget they also entail. As you know and you've heard me say that we anticipate over $20 million to be removed from the Pennsylvania system. And even though we have opportunities like the Rh TP that does not do enough to fill the considerable impact that we anticipate to have across DHS. How that will impact the separate offices and it remains to be seen. As while the focus has been specifically on the snap benefits as soon as it is resolved we will be looking to shift wholeheartedly into those impacts to the 2027 year where we are going to start really feeling the pain of HR one and OB three. In addition the office of long-term living is also an interesting position because CMS has yet to approve our 2025 agreement and critical information that we need that was submitted as part of that agreement to help us inform critical things moving forward. I'm just going to sit has been very difficult. But I know we are in this together and we are preparing as best as we can. We will have to work together through
[AUDIO LOST]
>> Are lost audio. Am I alone?
>> Juliet cut off at the very endd. I think Juliet you were finished responding to Lloyd?
>> I think so. I saw my computer had indicated that my audio was cut off. I hope you guys heard

everything. I'm not sure when it cut off. I was sharing that we will have to work together to make very difficult decisions going into the fiscal year 2027.
>> We did hear that.
>> Thank you.
>> Thank you. Other questions or comments from members? Is there anything in the chat?
>> This is Shandra. No questions in the chat.
>> KATHY CUBIT: Thank you. Unless someone wants to jump in we can move forward with our agenda and at some time to the second public comment period. But now we will move forward on the agenda to the better food better health pilot with Dr. Crystal Clark. The chief medical officer at UPMC community health choices. Doctor Clark the floor is yours.
>> Thank you so much Kathy and members of the subcommittee. Can you all hear me okay Kim.
>> KATHY CUBIT: Yes we can hear you.
>> Wonderful. I'd like to spend a few minutes and I'm excited to share some highlights and some outcomes from a pilot that we did in the southeastern part of the state. We started in the end of 2022 and it ran for a year and it was called better food better health. I'd like to share with you who we collaborated with and how our participants fared and what we learned. Can we go to the next slide please? Again we collaborated with organizations and we focused on eliminating barriers for our participants who are challenged with illnesses like diabetes, hypertension and heart failure. We got some insights along the way and we were able to plug them back into the program and make changes. We also want to share the impact this has had on individuals and communities and organizations we collaborated with on this project. Next slide. This is a little bit of background. I put resources in these slides. We don't know to go through every line but I want to have resources in the slides so you can refer back to them. There is clear dence that tells us when you u have chronic conditions like hypertension and diabetes and heart failure and others, in addition to the critical importance of medications and physical activity and following up with your positions it is also very very clear evidence that what you eat and when you eat also makes a big difference in how well you manage these conditions and the goal of course being to stop any progress of these conditions where possible to actually reverse any damage these conditions have done. UPMC and collaboration with Phil abundance talk about the food bank Philadelphia and manna and that an organization who delivers meals and both organizations are well established in the southeastern part of the state. We piloted with them to launch this program better food better health to see if we could remove barriers and help our participants who are struggling with diabetes and hypertension or diabetes and heart failure. Make progress in how they manage at home and decrease admissions to hospital and emergency room visits to feel better. Again to stop progression of any of these diseases and their tracks may be even reverse some of them. Next slide please. . Now I want to talk aboutut who the collaborators were. The next slide please. These are the participants and a little bit about them. They agreed to join this pilot. The pilot began was how do we help you with chronic conditions be the best you can be with these things slow down any progression. That entailed giving meals delivered to your home, fresh produce and deliver to your home, nutritional counseling once a month so you can understand how to braid all these things together to get where you are trying to go. Recipe cards to understand how to use the brush produce that we were also having delivered every participants home every two weeks. The thing about this chart I want to point out is that we had 167 folks complete the program and it was for a year. That is longer than most nutrition pilots. We did that because of changing these behaviors is much more complex than people realize. It takes time for people to learn later in

the new things that we want them to do and I just think they want to get rid of the we had 167 people except and I want you to know we reached out to form 25 people. It took going through a list of 425 e and we got to 167 and the big learning was we talked to the people who turn down the opportunity to participate. Reasons were varied across the board. There was no consistent reason that people didn't want to join. They were very valid. Some people worried about they might get too much food and waste of food. Some people worried about taste. Some people were worried that I don't want to come it is hard for me to manage these conditions can my doctor is happy right now and I don't want to do anything to jeopardize that people had a lot of reasons that they didn't want to participate and that was learning as well. Out of 425 folks we reach out to we got 167. More women than men participated and that was not surprising because we have more women than men in the RC HC population UPC. The average age was 57. Not surprising because heart disease, it spirals later. Everyone had diabetes. Just about everyone had high blood pressure and the third had heart failure. Heart value and hypertension were because when we look at our participants in the southeast was driving them into the hospital either to the ER or have to be admitted was heart lawyer and diabetes was out of control. They were in the top 10. Next slide please. This is a map to show you where we zeroed in and this was a pilot to understand what we can learn and figure out if this was something valuable to eventually go statewide. Next slide. The other collaborator is UPMC community health choices. Next slide please. This gives you an organizational chart of UPMC. We are a big organization and in addition to the health plan you know about we have hospitals under the health services division. Have a innovation arm. UPMC Enterprises we also have partners in other countries delivering care and learning and teaching so we are a pretty big organization. UPMC community health choices and we are lucky to be involved in different entities and we learned quite a bit from all of them. Next slide please. Our other collaborator was manna. Manna is the metropolitan area neighborhood nutritional alliance. You can see why they go by manna. Next slide. Manna provides and these are photos of the headquarters and the deliveryman and there's a young man putting together food manna actually puts together meals. Individual meals that are radically tailored. They talk to you and do a nutrition assessment and they design a meal that will work well for the conditions that you are trying to manage whether that is diabetes, health failure, hypertension, kidney disease. Any of those conditions and others. Manna will sit with you and make it nutritional assessment and then design a meal plan that's good for you and they deliver these meals to your home. Weekly. They can be refrigerated and frozen. Next slide. We were very excited to partner with manna. Some of the they remember but back in the 1990s when HIV and AIDS hit we were not really sure on transmission and how you got it. Are you infectious? There were many people suffering with this diagnosis and people were afraid to visit people were afraid to bring food and manna started with a group of individuals who prepared meals and deliver them out of their Subaru to individuals with these diagnosis to keep them healthy and alive we soon learned how we can help people with no risk to each other. At the time we did not know that it manna was born from a very very concrete and critical need to help people, particularly people suffering with illness get healthy nutrition that they need. Next slide. This is to give you the delivered 23 million meals to 50,000 individuals since 1990 these are some teachers the manna staff and we volunteered there several times and is quite the operation and you get to understand what it takes to prepare meals for folks. Next slide. This is a diagram to help people understand when we talk about different food options to help people manage their health we can focus on things that help with dimension of the disease. Snap it food pantries. Senior home delivered meals. We know sometimes helps after hospital admissions. You can get some home deliveries for two weeks

with insurance as we know that helps decrease readmission. Fruit and vegetable programs we've seen evidence that cannot people with weight loss and energy level. This is a diagram to show you there's interventions that help prevent the onset of illness. School lunches to decrease the number of children in the obesity and other chronic nditions. All the way ay to o meals which is what manna helped us do with this project. Which evolved with the treatment. These are the people that have conditions and what they eat makes a big difference. Next slide. Our other collaborator was full abundance. Another well-established entity in southeastern sylvania. ia. Next slide. Phil abundance has been in existence for 40 years and their commitment is to end hunger for good. Next slide. This is who they are they are a food bank that started in 1984. You can see there and the five counties in southeast Philadelphia but they also are in the neighboring counties in Jersey. They are a food bank so they deliver food to other entities and they partner three and 50 entities. The interesting thing is Phil abundance in na never work together not use there is a like but they do different things. Very important things. One is a food bank with fresh produce and canned goods and manna is radically tailored delivered meals. They do different things. They have not had a chance to work together until this project. Next slide please. Phil abundance has multiple arms. I want to point to the top to so they are a food distribution. They distribute food to partner agencies. They have a community kitchen. This is a program they developed and it actually trains folks from the Philadelphia area to get their catering certificate. They go into a intensive catering program and no college degree is required even high school diploma is required. You go through the catering program and leave with the catering certificate. There are statistics with a number of people who have been able to get wonderful jobs and keep them. Next slide please. How did we help our participants that we have can then have had these conditions and willing to see what we can do when we combine medically tailored meals and nutritional counseling and fresh produce delivered to your door. And recipe cards. What can we do to help get you on the right track? This was a welcome kit that we designed every participant got one before they even started the program. In the photo you can see there's a scale and we made sure the scale up to a pretty large weight for folks that are larger bodies. Blood pressure kits. We had small or extra large for some of our participants who had your arms and we wanted them to get an accurate reading. We provided glucose monitors. We provided stickers and you can see that green, blue and yellow diagram. Those are stickers that the participant can put on the calendar which is in the other picture that we developed ourselves. The pictures in the calendar are people that look like a community of participants we were serving. This was not a commercial calendar. The green box you can put on the calendar remind you when you're produce was going to be delivered. The blue would remind you when you had your nutritional counseling appointment by phone. The yellow was to remind you what day of the week you were going to have your radically tailored meals delivered to your door. We got like this was a very very good way to support our participants remove barriers from getting started on day one. Next slide please. This is a schematic of the collaboration between UPMC, manna and Phil abundance and there's a lot of words here but the bottom line is is we sat down and talked about how we help participants move through these different organizations but in the same program. How do we make it so it is not cumbersome? That participants don't get lost in the cracks. We sat down as three entities and had regular meetings and planned out how do we do these handoffs so no one gets lost in the shuffle. UPMC, we identified the participants first and talked with them and had a manager who was phenomenal. When she reached out to participants she helped them understand what exactly they were signing up for. That there was no obligation to continue the program if they were not happy. The only obligation they had was to participate in a monthly nutrition session. If they did

that the meals continued and the produce continued. We also had ways to help participants if they had to go out of town or God forbid they got admitted to the hospital. This was suspended while they were there. We would start as soon as they came home. We transition all the information to manna and manna reach out to participants by phone and enrolled them and did in-depth nutritional counseling so they could design a meal that really worked for them. Since manna had done such a intensive nutritional counseling effort it didn't make sense for Phil abundance to call. They were delivering fresh produce. Phil abundance called them and asked them again so manna left all the nutritional information and was able to share that with Phil abundance so Phil abundance could design the produce box delivered without a lot of disruption and a lot of additional questions to the participant. model of of how we could streamline things for the participants and not be be redundant was very very important. Next slide please. The first link was meeting people where they were. When our nurse and care manager reached out sometimes participants were telling us that things that had nothing to do with the pilot. I have not been able to get my medicine I don't know how to get in touch with my primary care doctor. We had to help them solve those problems first and that was very clear to us. This is pilot would be great for you but you have a more urgent problem you think you need help with immediately. We help them solve that. That was really important. We learned it was critical in helping our participants eventually enroll in our project. Next slide please. Manna. After we enrolled them they did the call with the participant. An outline all of their different concerns and nutritional needs and what their weight was an blood pressure. What they thought their goal weight was and how to get there and how long it would take. In the picture you see all the different meals and snacks and things that came in the box that was delivered to the participant store every week. The meals could be changed from whether they talked with the dietitian if they were not happy with the menus. Next slide please. Phil abundance. The nutrition box was delivered every two weeks. It had fresh produce. Because Phil abundance is a food bank a lot of food they donate and gave up was from donation sometimes it buried from delivery to delivery what you could get. For the participants. Sometimes oranges, sometimes apples. We also learned some of our participants, some of these things are just not in the produce. We found the recipe cards talking with the nutritionist was very helpful in people understanding how to use these produce boxes well. Next slide. What did we learn from all of this? We had these folks that stick with us for a year and I got nutritional counseling every month. They got fresh produce every two weeks and medically tailored meals every week and recipe cards. What did we learn? We learn many of our participants were not used to checking their weight and blood pressure and blood sugar on a regular basis. Because when they were checking with their nutritionist once a month many of them had not recorded those things so they didn't have them to give to the nutritionist the nutritionist understood they would do the weight on the phone while they would jump on the scale or the blood pressure stuck on the also learned that many of our participants, not that they did not care about those things but that was the type of monitoring they got from the doctor's office and they waited for that. They did not necessarily check at home. It was helpful for us to help them understand this is part of self-management. The nutritional counselors also learned that many of our participants, even though we use digital blood pressure and you can press the button and the numbers pop up, some of our participants did not know what the numbers meant they went to the office and the medical assistant or the nurse would take the blood pressure and tell them it was okay or they need to work on it. There was really no detailed discussion about self-management. How can you manage these things better at home? That was a real opportunity for us. One of the things we did was the nutritional counselors got the box so they can talk to the participant about how to make sure you use the blood pressure cuff correctly.

And how to use the blood sugar screener. The importance of weighing at the same time every day. On that we found the participants were able to give us some of their weight data and blood dead and more accurately as we went further into the project. Next slide please. The manna team learned, manna gives three meals a day with snacks. For many of our participants they did not have room to store all that food. They had concerns about wasting food. One of the things manna learned as part of this project was it would be helpful to come out when you're launching a program that you can either have options where there's a reduced portion size or maybe less than three meals a day. Maybe two meals a day or three meals a day for five days a week. Some of these meals could be frozen. There was a lot of learning on the manna team and they thanked us because of the duration of our program. For a year they learned more than they learned usually because most of their things or six months in the past. And also our participants were willing to share their experiences. Next slide. We also learned delivery was important to get the food to the participant. It was really important. It helped us and the participants line up and be there for their dates and times so they could get their deliveries and there was a special instructions about deliveries and the could be shared with the driver. We learned a lot about what to do going forward with that. Next slide. Phil abundance, one of the biggest things was many of the participants were not used to some of the fresh produce they were being exposed to. We initially did not give out recipe cards because we did not want to overwhelm folks with so much information. Once we get the recipe cards all the participants talked about how helpful it was because many of the produce options they were given did not even know how to use. It worked well. Next slide. Then our final project was something called the community cooked in. This was with Phil abundance. They have a community kitchen in West Philadelphia. It is a professional space where they do cooking demonstrations and also where they have the catering program where they teach neighborhood residents from start to finish. They graduate with a certificate that allows them gainful employment we had 80 participants that attended and it was important because many of our participants were a CPS and had caregivers that prepare their meals. If we could go to the next slide. This is some photos of that cook in. You can see the photo in between the shaft was cooking and nutritionist is beside them. They were talking to the nce. . The center picturere. They are cooking the meal and talking to the audience the whole way through we walked around with microphones of participants or caregivers had questions. They got to eat a meal for lunch that the chefs were cooking. It was a healthy meal and there were fantastic questions asked by the participants. The last photo is a shopping cart which Phil abundance and every participant home. It had all the ingredients you need to make healthy meals. They also gave them a cutting board and knives. In a shopping cart. It was a wonderful experience. Our participants raved about it. We are hoping we can continue that in the future at some point. Next slide. So what happened? We had quite a few meals. Almost 170,000 meals over this particular time of year. Produce boxes almost 6000. 15 percent of our folks achieved a five percent decrease in the body mass index. We wanted folks who had a weight issue to lose weight. That was important but that was not the ultimate goal. The ultimate goal was how we teach people how to layer on these behaviors. How do we teach them how to shop. How to cook healthier. Medically tailored meals were for a year but ultimately we would love for people to be able to cook healthy. Folks get tired of delivered meals. How do we help them move from the healthy option which is very important to focus to learn and be comfortable with the caregivers transitioning to cooking and shopping for themselves. The other thing is when we talk to our participants weight loss is important but we got them to talk about how they felt. Many of them come even if they did not have huge weight loss, felt better. More energy, less fatigue. Less swelling in the lower extremities. Some of them

talked about I feel energized and capable of starting an exercise program. We know from this small pilot that we can help our participants prevent the further decline with some of these conditions which is the goal. We may not be able to reverse heart failure, maybe we can but if we can't let's stop it where it is. So it gets no worse. We believe this is a really viable option to support our participants for application free survival. Next slide. I just want to say a big thank you. Particularly to the office of long-term living for allowing us to launch this pilot. Our collaborators, manna and Phil abundance and participants who agreed we learn as much from them as they learned from us. And how we hope we can do this again in the future on a broader scale. The outcomes showed if you were ogether we can make a real difference through food. Next slide please. Thank you very much. I'm happy to answer any questions.
>> KATHY CUBIT: This is Kathy, thank you Doctor Clark for doing this presentation and this program. We do hope you will be able to expand it to more participants. We can take a couple questions before our scheduled break. Are there any questions from our members?
>> Lloyd here. Just a general question about prevention. Prevention is such a difficult thing to get funded because it is so difficult to prove the financial benefit do you think Doctor Clark you reached a level of being able to do that with this study you shared with us today?
>> I think that's a great question. I think it adds to the evidence base. I can't tell you that I think it's a slamdunk but I think it adds to evidence base and to be honest this project was not about defining the science. This project was about how we take what we know works and implement it successfully and make it work for our participants. That was really the goal. I think this studies strengthens knowledge we know about how you translate what we w in science down to just about level. I'm hoping we can push forward and look for funding and extra grants as well. I like to do something like this more broadly. I think the question is excellent.
>> Thank you.
>> KATHY CUBIT: Thank you. It looks like Michelle Garrett has a question or comment.
>> Hi. I don't have a question but I have a compliment. I think this program is very awesome because eating healthy has become so expensive now. I hope this project can develop to have other type of participation. I just want to say kudos.
>> Thank you very much. When we were at the community cooked in the chefs from Phil abundance emphasized how you cook healthy but not like the bank. Just to give you one more quick example they have a special course on how to use a roasted chicken for multiple meals. So that nothing is wasted. To your point they are committed to healthy eating and they also are understanding of having to do it in a budget friendly way.
>> Thank you. We will take one more question or comment from Luke Raymond. I don't know if you will be able to stay for the second public comment period because it looks like there are other questions or comments but we are getting short on time. Luke, the floor is yours.
>> Thank you Kathy and I thank you Doctor Clark this was really interesting presentation. Earlier this year the Alzheimer's Association released a study called U.S. pointer relating to cognitive health and brain function and we found that healthy eating and exercise significantly has a difference in cognitive ability. I know you mentioned on the previous slide the effects of healthy eating and I was wondering as this program maybe expands whether there would be a cognitive component to the measurement.
>> I think that's a fantastic question. We are always looking for ways to enhance the monitoring documentation of cognition. Those participants who are the services is assessed during their annual assessment. I agree with you. The measure would have to be something that we can talk to the clinicians on but I think it's very important. We note blood pressure and movement and diet and all those things can really decrease risk and dementia. I think it is a fantastic

question and something we should definitely put on the list.
>> KATHY CUBIT: This is Kathy. Thank you and look for that and also thank you Dr. Crystal Clark for this excellent presentation and program. With that we are going to start our little shy of 10 minute break and reconvene at 11:20 AM with the presentation from the Pennsylvania health law project. We are going to stop now for a brief adjournment until 11:20 AM. Thank you.
>> KATHY CUBIT: Hello again this is Kathy. We are going to restart the meeting and I want to introduce Katy Mckee the supervising attorney from the Pennsylvania health law project who will be doing a presentation on maintaining home and community-based services while working earning income. This is a topic I know was raised a previous meeting and I want to welcome Katy Mckee and the floor is yours.
>> Thank you Kathy.
>> KATHY CUBIT: Go ahead Katie. Thank you.
>> Thank you very much. Perfect. There are my slides thank you very much for having me today to talk about maintaining home and community-based services while working. If you could go to the next slide please. Just in case you are not familiar with us I work for the Pennsylvania health law project. We are a statewide legal aid organization and we are essentially entirely focused on Medicaid issues. We have a helpline for clients and other folks who need to call us. We talked to a lot of family members and advocates and social workers and doctors offices. They often call us with questions about eligibility. Or people trying to access Medicaid covered services and we do a lot of community education and training like this one. We also have a monthly email newsletter. If folks are interested you are welcome to sign up and we include updates on Medicaid and other public health insurance programs like Penny, Medicaid and chip program. We also do policy advocacy to work to always improve the Medicaid program in particular. Thank you. Next slide please. We are going to briefly talk about waivers today. And then I'm going to talk about the medical assistance for workers with disabilities program. And workers with job success and some other options for maintaining waiver services. When someone is working and the income grows beyond the normal waiver income limit. Next slide. Really this is just to make sure we are all on the same page. I want to talk briefly about Medicaid home and community service waivers to frame what we are talking about today although I'm sure many of you are very familiar with Medicaid waiver programs. Next slide. What are Medicaid home and community based services waivers? They are Medicaid programs that provide services and support to help people with disabilities live in the community and avoid institutional care. Waivers cover medical and nonmedical services on what is covered by regular Medicaid. For example personal services and home health aide services and skilled nursing for adults and medical equipment and supplies and additional therapies. Depending on what waiver program someone is enrolled in there may be different services available. All the waiver programs include service coordination and person centered service plan. Although some waivers serve younger people waivers are really the primary source of in-home support for people who are 21 and older. Next slide please. These are the waiver programs in Pennsylvania. On the office of developmental program side there's the consolidated waiver, community living waiver, parson family directed supports waiver and adult autism waiver. All of the ODP waivers have waiting lists. And on the office of long-term living side there's the community health choices waiver which is the largest waiver program in Pennsylvania. And the OBRA waiver. I did not include the life programs which are not waivers but similar also under the office of long-term living. Next slide please. With all waivers in order to qualify you must meet the clinical financial and other nonfinancial eligibility requirements in order to qualify. Next slide. Just for example in order to qualify for the community health choices waiver you need to

be 21 and over. Have a physical disability that's expected to last 12 months or more and meet the nursing facility clinically eligible level of care. In addition to meeting the financial eligibility requirements. Similarly in order to qualify for the consolidated community living or the PF DS waiver you can be any age if you have a intellectual disability or autism. Under age nine to qualify with a developmental isability that has a high probability of resulting in a ID or autism diagnosis. Or under age 22 with a developmental disability due to a medically complex condition. For these waivers you also have to meet the clinical criteria to be served in a intermediate care facility. That is some of the clinical and other in the financial eligibility requirements for some of the waiver programs. Next slide please. In terms of financial eligibility you must have income below $2901 a month in 2025 so this changes a little bit every year. It is also three times the SSI rate for that year. Because the Social Security has already released cost-of-living increase and what the SSI amount will be in 2026 we already know that the waiver income limit next year will be $2982 a month. Only the applicant's income is counted. In the eligibility for the waiver program. It is the applicant's gross income that is counted. If someone is on Medicare and part B premium comes out of Social Security check it is the amount before that part B premium comes out. There are very few deductions from the income, what is counted in terms of income for waiver eligibility. One example is the aid and attendance portion of any veterans benefits that someone receives are not counted toward the income limit. Otherwise typically all income is counted toward this income limit. Next slide. And then on the resource side if someone is single the resource limit qualify for waiver is $8000. 0. And that would include things like bank accounts, stocks and bonds and mutual funds. If somebody owns more than one vehicle. If they own property that is not their principal residence. If they have any retirement accounts. If they have like insurance with a cash surrender value, part of that would count. Some of the things that don't count is if you own one vehicle that does it count toward the resource limit. The house you live in. Any of your household goods or personal effects don't count toward that limit. If you have term life insurance that doesn't have a cash value that you can cash out while you're living that doesn't count. One thing that does not count toward this resource limit is your spouse's retirement accounts. Revocable burial reserves special needs trusts able accounts. None of those things account for this resource limit. If someone is under 21 and applying for a waiver program or has children and their house under 21 there is no resource limit. If someone is married there are complicated spousal impoverishment rules that allow the couple to keep a little bit more than $8000 in resource limits. The amount that the spouse will share is a amount that can be adjusted every year the County assistance office is a resource assessment to determine the amount of accountable resources the couple has and then let them know how much the spouse who is not applying for the waiver program can protect. Next slide please. Now that we've run through the waiver programs with income and resource eligibility looks like for those programs and we've talked to all of that we can talk about what is someone to do if they depend on waiver for long-term services and supports in Medicaid eligibility but they are working and they start earning more than the waiver income limit we talked about. We are going to talk about two programs that allow you to maintain waiver while working. The mod program and workers with job success. Then I'm going to briefly walk through a couple other options that can be helpful to know about including qualified pooled income spend down trust and act 150 which is not a waiver program that can be helpful if someone no longer financially qualifies for waiver. And these other programs are not options. Next slide please. Before we dig into maintaining waiver eligibility through the mod program I want to start by going quickly over the mod program and how it works. Next de. de. Not as just another way to qualify for Medicaid. We know there's lots of ways people qualify for Medicaid. MAWD is one

category eligibility for Medicaid. It is for people who are between ages 16 and 64 and have a disability or other chronic health condition. Or doing some kind of paid work and we will talk about what that means. And have countable income less than 250 percent of the federal poverty level. Which this year is $3261 per month for one person. Or $4407 for a married couple. The person also has to have resources of less than $10,000. MAWD offers the same benefits as any other Medicaid category that you have to pay a premium if you are enrolled in this program. Next slide. There are some categorical requirements that I talked about. You have to be a worker with a disability often when I'm talking to clients and proposing this program to them and suggesting this is a way you could qualify for Medicaid people will often cite I can't work. But work is defined very loosely. There is no specific hours required. If you are working an hour or two a month is fine the work can be informal. It's important to keep a record of your work and if you are doing informal work you have to provide proof. Either way you have to provide proof you are working. If you are working a traditional job you would supply Paychex. If you are doing informal work you need to provide proof from the person who is paying you. The work does have to be paid, it cannot be volunteer work and you have to be paid a reasonable rate for the work you are doing. It can't be like two dollars an hour. The person you are working for if you are doing informal work can write a letter saying Mary works for me five hours a month. I pay her $10 an hour. I'm paying her to babysit my kids five hours a month. Or whatever the informal work is you are doing. I've had a client who did dog sitting for a friend. I had another client who provided companionship care to an older family member. There's lots of ways people can do informal work. It requires creativity and thinking about what could I do that someone would pay me for other things I've seen is I've had a woman who took out the trash and picked up the mail for someone else who lived in her apartment building who was older and wasn't able to do those things himself. He paid her to do that. Another client who drove an elderly neighbor to the grocery store each week. Again there's lots of ways someone can work. On disability side you have to be a worker with a disability to qualify for this category. If you are already receiving supplemental SSDI income you already meet that criteria. But if you're not on SSDI benefits you have to provide proof that you have a chronic health condition. Or other disability. And then your case is reviewed by the medical review team. To see if they think you meet the criteria. There is no requirement to apply for SSI or SSDI benefits. I think it is useful to remember that having a disability does not mean you are unable to work. We always encourage people if you have a serious or chronic long-term condition, apply. In terms of providing proof I recommend asking your primary care doctor for a letter saying I'm the primary care physician for this person and this person has the following chronic health conditions that require treatment on an ongoing basis for 12 months or more. Typically we found that the medical review team is very generous in finding people meet disability criteria to qualify for MAWD. Someone with diabetes or another chronic health condition that requires ongoing care should be able to qualify. The other nice thing about MAWD is the County assistance office can presumptively offer Isaac benefits based on limited information about the person's disability or chronic health condition. Like the letter from somebody's physician should be enough. If they received information that the person has a disability and they meet the financial requirements to qualify and are doing work the County assistance office can authorize MAWD and continue to gather whatever additional disability proof is needed. Next slide please. In terms of the financial requirements. Your income has to be under tuna 50 percent of the federal poverty level after income disregards. We will talk about that on the next slide. It is your countable income that must be under the tour 50 percent of the federal poverty level limit. In terms of determining eligibility of spouses income is accounted. For the eligibility e. On the resource side the resource limit for MAWD is a $10,000. Again this

includes the applicant and spouses resources if the applicant is a married but the spouse retirement account is not included in that resource determination. Things like your primary y residence and able account and one vehicle and other things are not counted. . For MAWD this works differently than a waiver. If there are children and household your resources are still counted resource limit is $10,000 regardless of how big the family is. Similarly the income limit is the married limit. The two percent household limit regardless of how big the family is. Let's go to the next slide. The income limits for a household of one is $3261 a month. And for a household of two is $4407 a month. I want to pause on these numbers because these are much bigger numbers then we see for other Medicaid programs. If you have earned income with the income disregards we will talk about a single person whose income is entirely earned income could be making up to $79,000 a year and still qualify for MAWD. If you are a married couple you could be making up to $106,000 a year if your income is earned income and still qualify for MAWD. As I mentioned earlier maximum household size is a household of two. If there are kids in the household and they have income that income is not counted toward this income limit. Next slide please. Your countable income is what is household income after all deductions and disregards are taken? I included a link to the medical assistance eligibility handbook if anyone wants to read more. About how income is accounted. If someone has an earned income like Social Security benefits and pensions and unemployment compensation and workers compensation and veterans benefits all but $20 of that monthly income is counted toward the income limit. If someone has earned income through wages or salaried employee the first $65 of their monthly income is disregarded off the top. After that if the person has any impairment related work expenses those are next deducted. They are things like payments for services by an attendant that are needed maybe when traveling to and from work or while at work. Payment or devices or equipment that are needed for the person to work. Essentially anything this person under 65 is paying for that allows them to work, those costs can be deducted for their income. And finally half of the remaining income is disregarded. That is a huge amount. Next slide please. I wanted to walk through an example so everyone understands how these income disregards work. Michaela is 30 years old and single and receives SSDI income $1820 a month and she's also working and earning $435 a month gross income. What is her total countable income for MAWD? For the portion of her income is unearned income the SSDI benefits $20 is disregarded so 1800 of that 1820 a month in SSDI benefits is counted. On the earned income side $65 is deducted off the top. She didn't mention any impairment related work expenses. The amount that's left is divided by two and only $200 of her and income is counted. That leaves Michaela with th $2000 in countable income per month so she is well below the MAWD limit for a single person and would qualify. Assuming she resource qualifies. Next slide please. I mentioned earlier if you're in the MAWD program you have to pay a monthly premium. The monthly premium is based on five percent of your countable income. Essentially exchange for these higher income and resource limits you have to pay a premium. Importantly if you are married your spouse's income is counted to determine your eligibility for the MAWD program but not to determine your premium. Only the applicants income is counted in determining their premium. Just going back to Michaela from our previous example Michaela's countable income is $2000. After all the disregards were taken. Her MAWD premium is five percent of that or $100 a month. Next slide please. Now that brings us to how is MAWD a door to being all remaining eligible for the waiver programs. There is a long-standing policy at the Department of human services allows people to enroll in MAWD and waiver programs simultaneously. I linked the medical assistance eligibility handbook chapter that talks about the general policy for MAWD and MAWD plus H CBS. This ability to continue to qualify for waiver through the MAWD

program is important for people with disabilities whose work earnings would otherwise put them over the income limit for waiver. Because the key difference between MAWD and waiver is in treatment of income the asset limit is higher for MAWD, $10,000 versus $8000 for waiver. But the higher income limit and the earned income disregards is the key. Remember when we talked earlier waiver doesn't have any income disregard. Getting waiver through MAWD gives people a much higher income limit. I think we see this primarily for younger people with disabilities. And particularly for a single person who is working and has disabilities MAWD plus waiver is a fantastic option. Next slide please. People who are over the income or resource limit for waiver can get waiver if they are eligible for MAWD. They have to meet all the MAWD eligibility requirements so meet the MAWD income limit and resource limit and have to be working and have a disability or chronic health condition. And they have to functionally qualify for the waiver. They have to meet whatever those waiver criteria are. Next slide. Let's walk through an example Rory wants waiver services. He is clinically eligible for Medicaid waiver and he filed an application and he's been found clinically eligible for waiver. But Rory gets 1800 a month in SSDI benefits and he's also working and making 1305 a month before taxes so that's his gross earned income. His countable income for waiver which is going to count all his income is $3105 a month and that is over the income limit for waivers. At first he appears to be ineligible. Moving on to the next slide if you look at him for MAWD now we have the income deductions. Rory can be reviewed for MAWD plus waiver. He has 1780 per month as his countable SSDI unearned income. Only part of his earned income counts after you do the disregards and only six earned 20 per month of his earned income counts toward a model limit. For MAWD his countable income is 2400 he is income eligible for MAWD for now he can qualify for waiver number to and pay a monthly premium. Which is based on five percent of the countable income so he's going to $120 a th but he can be in the MAWD program and also be in the waiver program because he meets the eligibility requirements for each program. Next slide please. Here's another example. This is an example of someone who is on the waiver needs to transition to MAWD plus waiver to continue to qualify for waiver benefits. Sarah is 30 and has muscular dystrophy. She needs help with her activities of daily living and is enrolled in the CHC waiver program. Sarah was already working but she finds a new job where she's going to earn a lot more. She reports her change in income to the county assistance office. She has no resources other than a able account. She's worried because her new job puts her over the waiver income limit. Next slide. Once she reports her change in income the county assistance office reviews zero situation and she's over income for waiver she's working so the county assistance office reviews are eligibility for MAWD. They walk through her countable income taking all the deductions and find that her countable income is $2000 a month so she's under the income limit to qualify for MAWD. The county assistance office is supposed to reach out and counsel the individual so they reach out to ask Sarah if she's interested in MAWD. Councils are about MAWD premiums. And Sarah agrees to pay a monthly premium so she's a group for MAWD plus waiver and will pay a monthly premium of $100 a month which will allow her to take that race or take that new job or raise or whatever it is and continue receiving the waiver services she needs. Next slide please. I just wanted to point out in at least two examples everything ran smoothly but we know that doesn't always happen. I always say people don't call a law firm if things are going well. We get many of calls from people who are challenged to state and MAWD plus waiver or make this transition. I think it is always a good night Dia, like Sarah's example when she was reaching out to the county assistance office to report the change in income to affirmatively ask proactively ask the county assistance office to review her for MAWD plus waiver. MAWD is a small category and people in MAWD plus waiver is even smaller the

county assistance offices workers are doing with lots of programs and lots of Medicaid categories so they don't always think of this. It is always a good idea to proactively ask to be reviewed. Next slide please. In order to stay on MAWD like any other Medicaid program have to report any changes. What is different about MAWD from other Medicaid programs is county assistance office we determines your MAWD eligibility and premium every six months. The person has to verify they are working and what the current earnings are a time of renewal. It somebody has a change in income in between the semi annual reviews the MAWD premium can be adjusted. Certainly it can be adjusted at the review. The person does have to keep paying the monthly premium in order to keep their coverage. They are billed monthly and they can pay the premiums by mail or online. Premiums can be temporarily waived in certain cases for good cause for up to two months. Typically that could be if someone loses their job but they are planning to go back to work and making an effort to find new employment. Or they are experiencing medical problems that are impacting their ability to work and things like that. That is something the county assistance office can review. Next slide please. People can lose MAWD coverage. If they don't complete that semi annual review paperwork. If they turn 65 and they aged out of MAWD. If they are not paying their MAWD premiums or not able to work anymore. The county assistance office has to send a advance written notice prior to terminating MAWD and that is appealable. If someone is losing MAWD because they have not been paying premiums that is a curable issue. If they can pay their premiums they can retain eligibility. Next slide please. Go ahead one more please. Next we are going to talk about MAWD workers with job success. Really this program is a expansion of the MAWD program. It is entirely state-funded Medicaid program could created by act 60 September 20, 2021. Really this program creation was led by people with disabilities. It did not start until April 2023. Because of the covid-19 continuous coverage protections in place. This program is still very new. It allows people with disabilities to increase their income and assets above the normal MAWD limits critically without losing the important health coverage or waiver services that allow them to work. Next slide. Let's talk about who qualifies. In order to qualify for workers with job success you have to have been on MAWD for 12 months without a break. You also have to meet the normal MAWD criteria and be between 16 and 64. Your income has to be above and be working. You have to meet the normal MAWD criteria 16 64 and be doing some work and have a disability or chronic health condition. Beyond that to qualify for workers with job success you have to have been on MAWD for 12 months without a break and your countable income has to go be above the MAWD limit because the income limit is so generous especially with people with earned income have to be making a decent amount of money to qualify for workers with job success. That countable monthly income must be between 250 and 600 percent of the federal poverty level. It is going over the MAWD income limit the triggers you to be reviewed for workers with job success. The county assistance office should review people automatically when they report income has gone over the MAWD income limit but there is so few people in this category it's a good idea to flock to the county assistance office to ask for review for this program. At the time you transition to workers with job success your countable resources must be under $10,000. That is also important to remember. Next slide please. These are the income limits for workers with job success. For a single person you can be making the countable income up to 7825 a month. And the countable income limit for household of two is $10,575 a month. With disregards this means someone could be single and earning up to $188,000 a year if all of their income is earned income or married and making up to $250,000 a year and still qualify. It is the same income disregards we talked about for MAWD. Again you have to be over 250 percent of the federal poverty level that MAWD income limit and have resources of $10,000 or less countable

resources at the time of enrollment. With this category addition it really means disability no longer holds people back from being high earners. You can get the waivers of boards and Medicaid coverage you need to earn a lot more money. Next slide please. As I mentioned I'm mentioning this again and again because people are often confused about this. We get calls from people interested in this program and this always seems to be the point of confusion. A MAWD recipient must have countable resources at or below $10,000 to qualify for workers with job success. But then once you are enrolled in workers with job success the resource limit goes away. Which is huge. Sometimes people will call the office and say I'm over the MAWD resource limit, can I qualify for workers with job success? No you have to and in MAWD for 12 months and meet the MAWD resource limit of $10,000 begin to workers with job success want you are in the resource goes away. Resource limit goes away. Even if someone is on workers with job success they reduce their work hours or lose income and they go back into normal MAWD, the recipient will continue to have no resource limit in that category. I included in the resources at the end of the presentation the workers with job success operations memo from the Department of human services which is useful and has a nice discussion of future planning and why someone might choose MAWD thinking ahead to trying to get into workers with job success. I encourage folks who are interested in this program to look at that operations memo. Next slide please. Things get much more complicated in some ways when you're looking at workers with job success premiums. We are really getting down into the weeds now. If the household countable income is between 250 and four and 50 percent of the federal poverty level, for most people on workers with job success the premium is going to be 7.5 of the individuals countable come. For some people they may have to pay a much higher premium. If there household countable income is above for 50 percent of the federal poverty level and household adjusted gross income is above $144,000 this year they would have to pay the full cost premium which is 948 a month in 2025 these numbers get adjusted every year. Most people are going to be paying 7.5 percent of their countable income as their premium. But there are going to be some people in the full cost category. If they are in that situation they need to submit their tax returns for the county assistance office to review and determine what the premiums should be. Because this is complicated let's switch to another slide and walk through an example. Jordan has a disability and works full time. Jordan gets a promotion and her earnings increase from $60,000 a year to $84,000 a year. She's been on MAWD for two years and pays $123 per month and monthly premium. Her countable resources are under $10,000. She reports her change in income to the county assistance office. The county assistance office is going to review her new income. Now she's making $7000 a month gross. They determine her countable income is 3004 $67 and $0.50 a month. Which is above the MAWD income limit. But because she's been MAWD for two years her resources are below $10,000 nd she could be transitioned to the workers with job success program. Her premium is going to increase instead of paying five percent of her countable income and she's going to 7.5 percent of her countable income with her race. This means she's going to start paying $260 a month which is a significant premium increase. But now she can save more and she doesn't have to worry about any resource limit if she doesn't want to. Next slide. This is someone who's on MAWD plus waiver and they are transitioning workers with job success plus waiver Sam is 40 and has been on MAWD plus waiver for three years and is offered a promotion going to earn individually more at work. He has $8000 in resources in his 401(k) and a able account and he wants to save for his own home because he currently lives with family. He reports the income change. His countable income is now over the MAWD limit but his countable resources are below $10,000. He's able to transition to workers with job success and get a new premium amount and is able

to keep his waiver services. Now that he's been moved to workers with job success he can save more than $10,000 limit. And even if his income decreases and he is moved back to MAWD is resources will still be excluded. I want to move forward to slides because I know we are tight on time. If you could do that please. One more slide thank you. Go back one. Sorry. One thing I wanted to highlight is that resources are excluded for people on workers with job success only when determining eligibility for MAWD. If the person is moving from any MAWD category or workers with job success to a different Medicaid program in which resources are counted they would have to meet the resource limits for that program. Where this will become an issue is when someone ages out of workers with job success at 65 and still needs home and community-based services but maybe they accumulated a bunch of resources while they were in workers with job success. I think this is a new frontier. Something we haven't encountered something that people considering this program should be thinking about. They could deplete their savings they built up by buying a house and think ahead and set up a special needs trust before they turn 65. There are certainly options but it requires thinking ahead. And of course aging out of MAWD and workers with job success means the person will need to make sure there under the waiver income limit in order to keep waiver. Moving ahead. Another slide please. Just briefly another way people can keep waiver if they are over the income limit. The possibility of income spend down trust is a pathway to become income eligible for a Medicaid waiver. You can only do this if you are no more than $500 per month over the waiver limit. Every month someone who is using this income spend down trust in order to qualify for waiver has to deposit their excess income into a pool of income trust that has been vetted and determined to qualify by the Department of human services. And must use the excess income. This is a option of last resort. In order to qualify through using it income spend down trust it must be approved by DHS Council. This is complicated and I have only to the resource in the materials but it is an option. One more option on the next slide is the act 150 program. This is not a Medicaid program. Being an act 150 does not you Medicaid. If you qualify for act 150 you need other insurance. But it allows someone who clinically qualifies for waiver is over the income and resource limits to get service coordination and personal assistant services and personal emergency response systems. This is a very small program and there's only 1100 people the last time I checked the data enrolled in act 150 but it's another option. Next slide please. In order to initially qualify for act 150 have to be between 18 and 59 if you are in act 150 you can stay in it pass age 59 and you are essentially grandfathered in. You have to have physical and permit expected to last 12 months or more. Be capable of managing your own financial and legal affairs and be able to select and supervise your own attendance. And be eligible for Medicaid waiver because your income resources immigration status make you ineligible. Be on that there is no income or asset limit but there are sliding scale fees. That is it. I know there's another slide about how to apply for that program but we are out of time. There are more links to resources in the materials and I'm happy to take questions if there are any. I know it was a quick run through of the rather complicated programs.

>> KATHY CUBIT: This is Kathy, thank you Katy Mckee for an excellent presentation and for explaining complex step in understanding way I think your slides will be an excellent resource for folks. Let's start with questions for Katy Mckee from committee members. Okay is there anything in the chat? Quick afternoon this is Patty I have a question. Looks is there a side-by-side comparison of each of these programs available on the website?

>> Let me see. I know we created one. We did recently create a chart but I don't think it has made it to our website. If you want to email me I can send it to you because I don't think it's on our website but it compares different programs including different options. I can send that to

you.
>> KATHY CUBIT: Katie this is Kathy if possible if you can send that to me or OLTL we can include in the follow-up meeting follow-up documents as I'm sure there will be other people that will find that beneficial.
>> Absolutely, I will do that right after.
>> KATHY CUBIT: Thank you. Other questions or comments for Katy Mckee? Go ahead.
>> There is a question and chat if you are ready for that.
>> Go ahead, thank you.
>> The question comes from Elizabeth Barr. Do you need attorney volunteers and where are you located?
>> I'm so sorry but your sound is articled so I wasn't able to understand you.
>> I'm sorry I will repeat it. Elizabeth says do you need attorney volunteers and where are you located?
>> At the health law project? We have offices in Pittsburgh and Philadelphia. We occasionally take volunteers so certainly you could reach out to us if that is something of interest to you.
>> Thank you the next question is from Jeff Eiseman. Can you offer comments on MAWD and HR impacts here.
>> I cannot comment on that but I don't know if other folks can. As Juliet said earlier it sounds like DHS is working through snap changes and hasn't started chilling with that Medicaid changes coming with HR one quite yet. We don't know how these programs will be impacted.
>> I can hop in on that with regard to impacts of HR one on MAWD. We are not anticipating that there will be significant changes to MAWD eligibility. And we don't anticipate significant changes to that program moving forward. I have not seen any indication to that specificity. I would say OLTL is 100 percent in support of maintaining MAWD as best as we can because it is a critical pathway to supporting employment for people with disabilities. As an employment for state is something we are committed to doing and would like to see more success in I hope that helps Jeff.
>> Are there other questions? Or anything else in the chat? We can move on to that after we clear the chat.
>> Those were all the questions for Katy Mckee I believe.
>> Okay thank you. Thanks again Katie. We appreciate this information. Thanks ain for sending that follow-up chart. With that we will move into our second public comment period. It looks like the hand that was raised is down so let's start with members that might have anything to add for the public comment period. Is there anything in the Czech Republic comment?
>> There is a questiontion. I'm sorry it took me a while to get off of new this is for Doctor Clark I believe that comes from Kyle Fisher on the question of funding. This was little match available for this project or is it considered a value added enefit?
>> This is Doctor Clark. This was a quality improvement project funded by UPMC. We are going to explore other funding opportunities when we are ready to expand. We are finalizing the data analysis now. This was originally funded internally.
>> Thank you. Anything else in the chat?
>> This question comes from Jeff Eiseman. For the rural help transformation program can you, if healthcare is part of the PhD grant focus resented to the CMS earlier this month?
>> Jeff the specifics of the initiatives and personnel additional products there is still a lot of work to come on the certainly the buckets within the themes are there so that may fall under the workforce development or aging and integration services. There wasn't anything specifically that called out home care agencies. It is much more higher level in terms of talking about the full

systems. And how it can impact care at the systems level versus provider levels with the exception of emergency medical services. There is still a lot more work to come on the Rh TP but those themes and buckets are there and we will have to wait and see what response we get from the application to focus on the next steps. They are certainly incorporated with regard to the health professional consideration.
>> KATHY CUBIT: Thank you. Is there anything else in the chat?
>> At this moment Kathy I do not see any other questions in the chat.
>> KATHY CUBIT: Anything else from members? Any comments? I know that you been sending me things in the chat. Did you want to make a public comment?
>> I don't know that my commentsents, I'm getting frustrated with these meetings. I will be honest with you. The presentation last meeting where you were telling us what we should be saying and this meeting where this has gone on for an hour. We've been talking about this. I think these are important topics. But the audience here, did anyone make it through the last presentation without going for a drink or going out for a cigarette or whatever you do. You deserve a prize. I think there's a lot of people that don't want to join these calls because they are struggling with services and this is what we are hearing I'm a panelist and I should have more constructive feedback and be adding things but this is becoming a waste of time. That is my comment.
>> Thank you for sharing that. Again I encourage members come as you say that, think through what you want these meetings and we will convey that at future agendas. The last presentation was a request from a few members who have additional questions and concerns when this was raised at a previous meeting. We do try to drive the agenda based on feedback from what we get from members, in particular and even others who share thoughts with us.
>> I understand that that is not my issue and I think the presentation is very good. Please, don't get me wrong. What was her name? I think it is a good presentation at the law of good information. This is just too much information. This is a fountain of information come on earned income. Who in the audience knows about this? Seriously, I'm sorry Juliet. Go ahead.
>>I I take your points and feedback. I will challenge a little bit to s it is dense information and a lot of information that is critical to know. For the medical assistance workers with disabilities in particular yes it is a complicated program. It is a federal program. Yes it can be simplified. That is outside of our hands. What is critically important is the correct information is out there and people understand it. Even if they don't take it all in. It is reviewed and provided as a resource. It is opening up an opportunity to discuss it. And show a increased awareness. Because I'm going to be quite frank. The numbers in the office of long-term living for employment, while nationally are average, they are still far too low. They need to be increased and part of increasing it is elevating the awareness of the medical assistance for workers with disabilities program. Arming people with the specific information about what is involved with the eligibility for it in the hopes if someone gets misinformation there are more people out there with the correct information. That can spread the correct information to ensure that people are not turned away from eligibility that folks understand there are real pathways to work. This is the appropriate forum to house this. Because we do have hundreds of people on the call. That hopefully will take something from it. I do hope that folks are joining this call with the intent to learn and we've actually seen the numbers of folks joining these LTSS calls increasing so something is also working well.
>> Juliet I agree completely but what you said should have been set an hour ago. That should have led of this presentation so people understand. That is my point. There could have been a lot less. There is a discussion you are talking about? There are number of discussions. Looks the discussion part is not something I can generate but it comes from the committee members

and the public who join us. I I have and continue to encourage the engagement we are here to answer questions and have discussions. Many members can bring up topics of discussions on the agenda in the public comment period and bring up other topics of interest as well.
>> To clarify I've always looked at this as a question and answer thing not as a discussion thing. Like we are asking and talking to different members and things like that. Is that what you are saying this is and can be?
>> Yes 100 percent that could that is what that could be. That is also also something that I hear you have expressed interest in supporting while we look to the new and new ansitions I do hope you would consider being a big part of that transition.
>> I love voicing my opinion and I would love to hear other people's opinions. I will shut up for now.
>> KATHY CUBIT: This is Kathy, thank you for sharing those thoughts because I think that's helpful because I think people want to have these e discussions and nd hopefully that will make more people comfortable raising issues and concerns. rns. I see two hands are raised. I don't know if we unmute meone from the audience?
>> This is George Gilmer.
>> We can hear you George.
>> Go ahead.
>> For many decades it was David Gates that had this information about the MAWD. The information was like a closely guarded secret unfortunately. It would have been nice where this would have been produced. CHC or even before that would have ability to give those consumers so they can review them. Whether they were paper materials, that would be great. And updates. Additionally I'm going to digress for a second. If I could. I was in the hospital recently. It was a horrific experience. I came back with BBT's. This was one of the Penn State facilities. When I left they did not have a wheelchair. They did not have a walker. They had no crutches. They did not have a transfer board. They did not have a transfer belt. There was great confusion even getting me out. I had to call Michael Goodson to react with my CHC to get a ride home otherwise I would have been paying for the ride. All those things were extremely confusing. The most profound part of it was they didn't come they left me in the bed and the bed wasn't working. There were no sequential compression ces. At every turn it seem like I had a couple of tax daily that would put my life in jeopardy. We will to e o the 1557 and the affordable care act. So that those kinds of things and facilities are there. Things that necessitate ambulation. Requirements to have ambulation rather than leaving someone in a bed. If there was an emergency not even a way to get me out and off the floor. Just in a bed. If you want to have people working it is a good idea to support their lives and these crucial situations. So that their lives are not so unhinged because of disability. I will relate a lot to disability. They did not know what to do with me. Of course I was in a an accessible room. I'm sure I'm not the only one who encounters this very draconian depreciated shocking care. Maybe there should be some ideas and supports to make sure facilities that have this amount of employees, that is not only included in the ADA things that need to be done but also these kinds of important things for somebody that's going to the hospital system. I'd be glad to discuss it further. I know this meeting is important in a lot of other ways. To have been exposed to what I was exposed to was shocking. The facility I was in, Penn State Holy Spirit, the gasification of Pennsylvania psychiatric is it to, they are moving to a couple floors. So they did not want beds to work. They were moving the gentrification to Hampton hospital. Where probably with people with disabilities will have a harder time getting to because of bus routes and transportation and etc.. Those are some of the real things that exist in different communities that hopefully OLTL can look at.

Because when you get into those systems they abdicate and they live in the equivocate. And documentation and those kinds of things they did. It puts anyone in the community in a very bad position. Not just disability related so to speak. The people that go in the hospital and cannot ambulate because they don't have a walker. They are not getting out of bed and they are not ambulating. It was so shocking and I will give you one instances. I had a physical therapist that's come in my room. I've been paralyzed for 52 years. The physical therapist came in my room and said George and this is George Gilmer for record, if I get your legs out over the edge of the bed can I stand you and ambulate you cannot can you walk? Obviously it was gross incompetence because they did not even read my chart. Often that was what I encountered firm many people coming in. They did not know what they were oing. Those e things should be extremely glaring and shocking because any of this can find ourselves in the hospital uation. Very quickly and readily due to some incident. Thanks for your time.
>> KATHY CUBIT: This is Kathy, thank you for sharing your story. You raised a multitude of issues Mr. Gilmore. I think hospital stays are critical in how people transition out of hospitals and that is also critical to the persons future health and well-being. I'm sorry to hear what you've gone through. I don't know Juliet if there is anything you want to respond to what he said. Books may be expansion of the 1557 provision. At some fraction and sylvania.
>> KATHY CUBIT: I'm not familiar with thatbut I don't know if Juliet, if OLTL wants to have response to Mr. Gilmore's comments.
>> First thank you again for sharing your experience. And sharing the experience and reaching out to members of OLTL staff to make them aware. It is certainly an area of concern. I am not going to be able to respond to the specifics of your situation on this call today but my team can certainly continue following up with you. I would take a moment to highlight for situations that occur in hospital settings. That the department of health licenses and regulates hospitals and hospitals are required to meet their regulatory requirements. I would encourage anyone who is in that situation or has a loved one in that situation where they have significant concerns about the quality of care and the responsibilities of the hospital not to hesitate to contact the Department of help and reported. That way from the hospital system rspective ve DOH can do the appropriate investigations and ensure their plan of corrections in place to address these things on a systemwide level. I did want to share are that for the betterment of the whole. Thank you for sharing.
>> Then you get blackballed. And they eject you from hospital systems. Not only do you have to do that but you have to do the human relations commission and it becomes a big problem. So you can adequately have a chance to go back and be treated accurately in the facility that should be nondiscriminatory in the way they are treating.
>> I absolutely agree Mr. Gilmore. There should not be any discrimination. Or retribution to those actions.
>> I've experienced the same.
>> I think we have Brenda who has her hand up.
>> Thank you Juliet Marsala can you hear me okay?
>> KATHY CUBIT: Yes the floor is yours.
>> I want to make a comment first for Doctor Clark. I want to say thank you very much for your presentation. I think better food better health is a valuable pilot. I hope as you move forward you will really embrace as a whole health system the importance of fresh preparation for folks who are on H CBS. I know a lot of times people I support have felt pushed into delivered meals because they need so much assistance with cooking and meal prep. They are often told by service coordinators that delivered meals are a better way to achieve that goal and I know it can

be a part of it but folks are feeling a lot of times squeezed out that time for fresh meal prep and fresh grocery acquisition. I hope your pilot and help demonstrate the value for folks that receive caregiver assistance to prepare their meals. Secondly in terms of case presentation I really want to say I believe part of the target audience for these presentation needs to be County assistance office workers. I've supported a lot of people and ecoming waiver consumers over the course of my career. I can tell you that County assistance office staff are not well-versed enough to be able to walk people through making intelligent choices about these programs. They are overwhelmed and understaffed and they are not really portraying these programs as options. I think that contributes to the low employment numbers for these programs. As much as these presentations can be valuable to us to generate discussion and make sure we are putting forward correct information, County assistance office workers desperately need ongoing in-service training on these programs and the numbers associated with them. Thank you.
>> Thank you Brenda.
>> KATHY CUBIT: Thank you Brenda. I do know health law project doesn't do advocacy on a broader level to do just that with the office of income maintenance. I don't know if Katy Mckee wants to add anything to Brenda's comment.
>> I think it is a well taken,. Thank you Brenda.
>> KATHY CUBIT: Thank k you. ou. Anything else in the chatt?
>> This is generally got. his comment comes a hooter. ooter. I support the gentleman that spoke and he's 100 percent about the Black Mountain retribution and I hope OLTL takes the time to get back to him. Thank you for your comment. The next comment comes m Pam am Rotella I seem to recall the Department of Health can keep the patient identity anonymous at least in some cases. Perhaps he can check in with the Department of Health before assuming they will reveal his identity. H CBS programs for example require ability to file anonymous complaint. . That looks like that is all the comments.
>> Thank you. Are there any other comments that members wish to contribute at this time? Since there's a little bit of time left we will get a chance to see if anything else is added to the chat or if anyone else wants to jump in. While we are waiting I wanted to mention that our next meeting will be on Wednesday, December 3. It is a virtual only meeting like today. I encourage members to contribute to the agenda and discussions to that! So we can e these se meetings meaningful to as many people as s possible. Again I will do a last checkeck. To see if there's anything else that was added or anyone else that wants to jump in. Before we adjourn.
>> Hi Kathy this is Juanita Gray. How are you.
>> Go ahead the floor is yours.
>> Thank you so much. Hello subcommittee members and everyone else who is joining. I am not going to be on the direct topic and I thank you for the programs that were spoke about today. My issue and I wanted some clarity and I will send in some correspondence for the next meeting so we can cover the topic of problems with service coordination. Acting inappropriately and unethical. I am going to leave it at that. It is a very dire need to address and it is causing a lot of serious, I believe not just unethical but legal problems. Where they are acting inappropriately and illegally. Doing things through the course of providing services. To us participants. Thank you.
>> KATHY CUBIT: This is Kathy, thank you Juanita. I will be sure to make note of that for the agenda request for next or future meetings.
>> Thank you so much. Have a good day.
>> You too. Any other comments or input from committee members? Has anything been added to the chat?

>> Kathy we do have a comment from Jeff Eiseman. For next month I hope we can have the state budget summary for OLTL that includes any related human services updates that's equitable.
>> This is Juliet and I hope for the same thing. I can't guarantee it but I certainly share the hope.
>> Just a comment that spent ongoing item. Request that we have been helping and I know the department has been hoping for a budget and be able to make that presentation. Thank you Jeff for raising that could anything else in the chat?
>> There is a requestto t next month's meeting date. December 3 and virtual nly. There are no other questions in the chat.
>> Thank you. One last call to members before we adjourn. Okay I want to thank everyone again for your participation today. I want to wish everyone a happy Thanksgiving. I look forward to hopefully being able to joining us again on Wednesday, December 3. With that we will adjourn. Thanks again.
>> Thank you Kathy.