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

Date: 3/11/2026

Event: Long-Term Services and Supports Subcommittee Meeting

>> PAM: Hi, good morning. This is Pam Walz. I am the vice chair of the Long-Term Services and Supports (LTSS) Subcommittee. And I will be pinch-hitting this morning for our chair, Matt Seeley who was also in attendance, though. And so, I'm going to give the call to order now. And we will begin the meeting. I am going to start with, this is a reminder that the meeting is being recorded. Your participation in the meeting is your consent to being recorded. And now, we are going to start with, the attendance which I will go through. At the end of the list, if I have missed anybody or if you were not able to unmute, let me know? Otherwise, you can also let us know in the chat that you have joined. Let me just confirm everybody can hear me, can you all hear me?
>> JULIET MARSALA: Yes.
>> PAM WALZ: Okay, good. All right, Matt Seeley. Just calling the attendance, Matt, are you here?
>> JULIET MARSALA: He has present, I seem on the list.
>> PAM WALZ: Okay, great. Abigail Foster. Andrea Costello.
>> ANDREA COSTELLO: Good morning, everybody.
>> PAM WALZ: Hi, good morning. Anna Warheit.
>> ANNA WARHEIT: Good morning, this is Anna.
>> PAM WALZ: Carol Marfisi.
>> JULIET MARSALA: Carol will be unable to attend today.
>> PAM WALZ: Thanks. Cody Jones.
>> CODY JONES: Present.
>> PAM WALZ: Thanks. Neil Brady. George Fernandez. Ginny Rogers.
>> GINNY ROGERS: Good morning, I am here today. Thank you.
>> PAM WALZ: Hi. Jay Horner.
>> JAY HORNER: Good morning.
>> JULIET MARSALA: Good morning.
>> PAM WALZ: Yes?
>> JULIET MARSALA: My apologies, I do see George Fernandez on the participation list. For participants who general participation, my team can help move them over that would be great. But I do believe he is in attendance.
>> PAM WALZ: Okay, great. Kathy Cubit.
>> KATHY CUBIT: Good morning, this is Kathy I am here.
>> PAM WALZ: Good morning. Laura Lyons.
>> LAURA LYONS: Good morning, I am here. Linda Litton. Linda? Lloyd Wertz.
>> LLOYD WERTZ: Happy springtime and I am present.
>> PAM WALZ: Happy springtime. Lynn Weidner.
>> LYNN WEIDNER: Good morning, I am here. Michael Galvan.
>> MICHAEL GALVAN: I am here.

>> PAM WALZ: Chell Garrett.
>> CHELL GARRETT: Hi, good morning I am here.
>> PAM WALZ: Good morning. Monica Vaccaro. Natalia Gomez.
>> NATALIA GOMEZ: Good morning, I am here.
>> PAM WALZ: Good morning. Rebecca MacTaggart.
>> REBECCA MACTAGGART: Good morning, I am here.
>> PAM WALZ: Are there any members who have joined since I have started the roll call Oakley who have since joined or who were not able to unmute themselves. Just let us know.
>> This is Rebecca, I am here.
>> ALI KRONLEY: Good morning, this is Allie from the CRU.
>> PAM WALZ: That is great. Thank you. Any other members that I have mystically I have missed? All right, thank you. Now I will read some housekeeping rules and then, we can start. A few housekeeping talking points, the meeting is being recorded. Again, your participation in the meeting as your consent to being recorded. This meeting is being conducted as a webinar with remote streaming. To comply with logistical agreements, we will end promptly at 1 PM. To avoid background noise please keep were devices muted. And the microphone is off unless you are speaking. Remote captioning is available at every meeting. The CART captioning link is on the agenda and in the chat. It is very important only one person to speak at a time. Please state your name before commenting and speak slowly and clearly so they can capture conversations and identify the speaker. Please keep your questions and comments concise to allow time for everyone to be heard. Webinar attendees may submit questions and comments into the questions box in go to webinar or use the raised hand feature to be put in Q to speak live. Time is allotted on the meeting agenda for two public comment periods. If you have questions or comments that were not heard please send them to the resource email found at the bottom of the meeting agenda and the LTSS subcommittee webpage. Thank you. The first topic on her agenda is the OLTL update. Juliet, the floors is yours.
>> JULIET MARSALA: Thank you and good morning. The first thing I will start off with, I echo Lloyd and my wish for spring. It is almost honest we have another cold week ahead. I also wanted to share my excitement will be virtual this month. We will be in person next month. I know that information is on the agenda. But I did want to call it out for folks. Okay, diving into the OLTL updates. I also wanted to note really quickly, there will be sometime after I finish my updates for questions from subcommittee members. But there is a slight change in our usual agenda because immediately after my OLTL updates is a standing agenda item. We have invited the House Resolution 1 (HR 1) Implementation Committee Updates. I will talk a little bit about that. And then after the HR 1 Implementation Updates is when we will open up to public comment for everyone. It is a slight change to what we usually do. But often times, my updates and I would imagine the HR 1 updates, they fit well together which is why we have format. Next slide. Going to give you a lay of the land for my updates. Procurement updates. Talk a little bit of a participant self-directed fee schedules. The HR 1 committee and then, reviewing some recent OLTL communications. The next slide, folks. A lot of folks are familiar with this slide. Hopefully. It is the procurement update for the CHC RFA. It is still in a state, there is no activities related to the RFA for implementation at this time. I have no timeline. Our CHC program continues to operate under current CHC agreements until further notice. The mailbox related to this RFA for any questions should be directed to the procurement. Folks via the resource account are made, minus TW RFA questions at PA.gov.
, Please. I wanted to talk a little bit about the participant self-directed fee schedule. And the

implementation to the increase in the fee schedule. Spots may be familiar with, the fiscal year 23 five, 26 budget that was signed into law on November 12, 2025, delayed for quite some time. It included a $21 million investment to strengthen the workforce through increased wages for direct care workers. Providing services in the participants self-directed model for the office of long-term living programs. There are multiple programs that this impacts. There is the fee-for-service programs. Which is the OBRA waiver and the act of 150 participants self-directed personal assistant services program. Then of course, the CHC managed care organizations through our managed long-term service living supports programs. Also has a participant self-directed model within their required service. So this additional funding for fee-for-service, provided for a rate increase in the OBRA River and the act 150 program for participants self-directed personal assistance services. Folks that have been around for a while also know this is the consumer directed personal assistance services. Those are procedure codes, W 1792 and W 1792 with a modifier letter to you. --TU We have published the
notice of the official change in the fee schedule rates for the fee-for-service programs. On February 28, 2026. Again, that is for the OBRA waiver and act 150 programs for participants self-directed procedure codes. It is open for a 30 day comment period. And those comments will be considered for subsequent revisions to the fee schedule. But what this means is the fee schedule is active. And the teams that are in the OBRA and act 150 programs are pushing out communications to the common law employers. About the wage increase and the automatic opt in that is available for individuals in the OBRA waiver and the act 150 program. There were a lot of questions, I understand, from the last meeting about participant self-directed and there were presentations from a CHC MCO's and their vendor, Tempest. I did want to touch on, that may have sent out materials, answers to those questions. I would recommend folks reference those materials for the answers with outstanding questions that the team was not able to get to the last meeting. All really good questions and I really love seeing how folks are invested in this. So let's switch to the CHC. The program and their participant self-directed in the fee schedules. The CHC, NCOs as folks are aware, are able to set their own rates. You know, historically, they have mirrored the fever schedule participant self-directed rate that is published by the office of long-term living. And that was also directed by the agreement. Given the way the funding is distributed, for folks who may not be aware, for the majority of our programs there is a federal match to our state dollar funding. In the fee-for-service program, the OBRA waiver can draw down a federal match to the state funding. But the act 150 program, which is a state only funded program cannot. So there is a difference between the total amount of potential funding available for this initiative. Between the fee-for-service program and the Lynn Weidner CHC program. Because of that, the CHC managed care organizations were directed to do their own analysis and publish their own rates separate from the fee-for-service schedule. Because there is confidence in the assumption that based on the funding that was allocated, for this initiative that the CHC managed care organizations should be able to accommodate rates beyond what is published and available in our fee-for-service programs. The act 150 is a stately dollars. The OBRA waiver can draw down. The funding spread is slightly different between the programs. The CHC MCO's have been working on that. My understanding is that you published their rates. We did receive several comments and I will address this one now. About why is that each of the CHC MCO's might have different rates , why are the rates not the same? And that is because there is a lot of different factors that could potentially go into ratesetting. I do not know all of the assumptions the CHC MCO's may have factored in. I am just speaking in general terms. I am not an actuary or a CPN. Generally speaking, each of the CHC MCO's from different population

mixes. They have different populations in different regions. They may have different numbers of participants who utilize OBRA time or have different sets of hours. Or a variety of reasons. They may make business decision investments and indifferent service lines and programs and innovation things they are doing. So there is a wide variety of reasons, potentially by the rates are different. I will leave… And certainly leave the CHC MCO's to answer any additional pertinent questions to how they do those rate developments etc. So we are very, very excited this initiative is taking off. We are very excited it is able to impact all three of our programs that have participant assistant services. In participant self-directed direct care workers. And so with that, folks should be receiving communications the common law employers are the ones that ultimately make the decisions with regards to the payments to direct care workers. And so, please be on the lookout for that communication. So that the appropriate actions can be taken. The increase to the maximum fee rate that will allow changes to hourly rates for direct care workers will be retroactive to January 1. As indicated by the common law employers direction. Next slide. I think I went through all of this but I will review it quickly again. So that I do not miss any salient points my team has put together. In the fee-for-service is OBRA and act 150 program, as many may know the vendor is public partnerships, LLC. They are the office of long-term living fiscal management service vendor. They have launched their communication campaign to address and verify feedback related to the rate increase for the fee for services. I did mention it will be an automatic opt in for the fee-for-service program retroactive to January 1. Unless the common law employer selects another great change provides alternate direction. By April 10 2026. Within the community health choices program, the CHC MCO's administrative participants self-directed program. Their vendor is Tempest, Tempest is launched their communication campaign to address and verify feedback received for the rate increase related to community health choices program for the common law employers will need to complete a rate change form and return to Tempus to have the increase applied for their respective direct care workers. The processes are different so please, make a note of that in regards to what program your folks are in and certainly spread the word. As long as the common law employers complete the form within a CHC MCO designated time frame their increase will be retroactive to January 1 26. Next slide, please. Just as a reminder, common law employers are the employer of record and they always have the ability to set employer wages in the participant self-directed program. Keeping in mind the various maximum fee rates allow to support that. Additional information for common law employers can be accessed via the vendor websites, the fiscal employer agent websites that are listed on the slide. For participants in the fee-for-service, OBRA waiver, and act 150 programs you can navigate to the public partnerships LLC website. And for participants in the community health choices program, please visit the Tempus Unlimited incorporated website, the links are on the program slides that will be distributed shortly after we conclude the meeting. Next slide, please. So now, I want to switch to Department of human services HR one implementation committee. The long-term services and supports subcommittee was asked to put forward two representatives from our committee. To participate in the Department of human services HR one limitation committee. That is led by our secretary, Val or Koosh. There is going to be an update from the committee members. I did want to introduce them. We are very pleased and excited that Pam Walz and Rebecca MacTaggart will be representing the LTSS subcommittee meeting. Both of these individuals have had over 20 years of experience in our industry. With a lot of years of experience in advocacy, understanding and creating policy, discussing legislation, and really having a window and insight into many populations. And service delivery issues and concerns and feedback

across our LTSS delivery system. Encourage folks to reach out to them. And they will talk more about their role a little bit later on. Next slide. Alright so, going to talk about some recent office of long-term living communications. On March 5, 2026, the nonpublic medical assistance day one incentive state plan amendment was submitted to the centers for Medicare and Medicaid, CNS. -- CMS For their review and approval. CMS Has 90, the days to review and approve, reject, or request additional information. The 90 calendar day approval process runs through June 3, 2026. Medical assistance day one incentive payments to nonpublic nursing facilities are used to provide services individuals form on medical assistance, who are medical assistance eligible on the day of admissions. And the payments are intended to encourage nonpublic nursing facilities to increase access to care for the poor and indigent citizens of this Commonwealth. And if we go to the next slide, I think I am on the question slide. Before I take questions again, from subcommittee members, at this time and we will do public comments after the HR one update. I did want to note, on our agenda today, there is a topic of personal assistance service reductions. And wanted to share with folks that this is a topic and a subject area that we have touched on over many years. At the request of the subcommittee. For a topic of discussion and review. And prior LTSS subcommittee meetings and in the current LTSS subcommittee meetings, so this topic is not necessarily a new one. But I did want to clarify for folks who may want to pop up early, the personal assistance services reduction topic that may team in the CHC MCO's will be presenting on later in the agenda after our break, is about the monitoring of personal assistance services reductions. And decisions in the CHC program. It is not about any other policy changes or any service changes or anything of that nature. So I did want to lift that it provokes awareness. I know we all have busy schedules. And alone to do list. I would prefer folks stay until the end of the meeting but I do recognize some folks may have been extra curious about that topic. With that, we have about five minutes on the agenda for questions from subcommittee members.
>> LLYOD WERTZ: I think I'm correct in understanding the HR one committee has had one meeting. That is correct, could we receive a bit of an update on what was discussed and happened at that meeting? Do we know when the date of the first meeting will be equally .
>> JULIET MARSALA: I am glad you brought up the man about four minutes Pam and Rebecca MacTaggart will given HR one limitation committee update. I am not going to steal their thunder and I am going to let them do their update.
>> LLYOD WERTZ: I'm glad I brought that up. Thank you very much.
>> PAULA STUM: This is Paula, we have a question from. [Inaudible] You should be able to unmute.
>> CODY JONES: Put a couple of the questions in the chat. With the participant directed rates being higher than the base rates for OBRA and act 150 are we expecting the spend on participant directed will exceed the 21 million create allocated for the budget.
>> JULIET MARSALA: Not at this time, no.
>> CODY JONES: Thank you for that.
>> JULIET MARSALA: Cody, I think it is important, I will take a moment to add some additional clarification. The $21 million that is allocated is separated and a portion that goes to the fee-for-service program. The fee-for-service program, we do not anticipate it going about what is allocated for the fee-for-service programs. In the community health choices managed care organization, just a reminder to folks, the way that the Commonwealth makes payments and funds the community health choices program is through a capitation payment to the CHC MCO's. And so, the initiative, the participants self directed enforcement indicated by the

governor's budget is foundered into the CHC capitation payment. So we do not anticipate within the CHC capitation, that there is going to be material movement that would require additional funding in CHC, specific to this initiative. There could be other reasons why a CHC appropriation is increased or decreased or things of that nature. Mostly due to enrollment numbers and overall utilization of services. But it is a capitation payment that is sat. And once sat has not been changed. So I hope that is helpful to give you a little bit more context to why we are pretty competent, particularly in the CHC MCO's, that we will not go above the $21 million that is allocated within the enacted budget.
>> CODY JONES: I appreciate the further explanation on them. Just trying to wrap my head around the mouth. If you calculated the reimbursement rate in a certain level, utilizing 21 million the MCO's went about that. Just trying to math the math. I appreciate.
>> JULIET MARSALA: Sure, that is a good thing, Cody. As I pointed out in my presentation, there is a difference in the funding mechanism. Because the CHC managed care organizations, because it is a fully CHC waiver, every dollar of that investment pulls down a federal match. In the fee-for-service program, the act 150 program has no federal match. So the amount of dollars that are allocated in the fee-for-service, those numbers I am quoting is only state dollars. The OBRA waiver can take their state dollar and pull down approximately $0.57 to every dollar based on the F map. There is a larger population served an act 150 program that does not have that same additional F map drawdown. That is the key reason why the CHC MCO's would have more resources to have a higher rate than we did in our fee-for-service program. Because not every dollar in the fee-for-service program is able to pull down more federal funding. Every dollar in the CHC MCO program, that is used for this initiative, does. I hope that helps.
>> CODY JONES It does come I really appreciate it.
>> NATALIA GOMEZ: This is Natalia. Have a question on the rate increase for the personal hours for the self-directed program. As we all know, there is huge issues with mailing, there was an issue with the Department of Social Services, CHS mailing situation, on top of the regular issue with the post office. And my question is, the CHC Tempus is going to be sending these forms and they have to be submitted back within a timeframe. What is in place when this is not participants are not able to, or the CLE's are not able to comply within the timeframe? What remedies or what expectations will be put into place to remedy this situation for those participants?
>> JULIET MARSALA: Natalia, that is a really great question. I am glad you raised it. Certainly would ask the CHC MCO's to incorporate their response to that question. The we can perhaps send out after the meeting. I will share kind of what I know at this point in time and can certainly add more a little later on. The participants in the community health choices program, for my understanding will get several text messages, they will get letters, they will have supports, broker supports, and that was noted to assist them. They also have supports of the service coordinators. Who will be ready to provide assistance and support. Certainly, every common-law employer who is in the participant self-directed program should be aware of how they can also contact Tempus directly. In the ways Tempus supports common-law employers to assist them through this process. I understand the while the form does require some printing and some signatures and things of that nature, that returning it could be done certainly, through email as an attachment, the other ways Tempus ordinarily does not. So I have been assured from the CHC MCO's that they very much invested in supporting each of the CLE's. In making the determination and being successful in doing so, including having an extended, I believe 60 day timeframe for response. And being robust with communications. And public awareness

campaigns for those who are directly utilizing this service. I hope that helps.
>> SPEAKER: Juliet, I did have my hand raised, I'm not sure if it is my turn on. I will throw it out there. Thank you for responding to that. I also had a question about it. In our last meeting, we actually had brought up that we wanted or suggested that similar to what is being done with OBRA index 150, Tempus take up a similar process. It sounds like that did not get relayed where it was turned down. It sounds that they are not going to do an automatic often in like the other programs. I kind of want to know why. After that kind of response, or the discussion we had about it. I do not understand why we would put an additional barrier of doing, having a drink participant help to complete a form and send it back I can tell you it is not that easy. A lot of participants have thumbs their working with. It is not that easy to download and get a signature type return it if you were not formally working around the devices laptops, those kinds of things. I kind of want to know, was that just ignored, was a just a, if there is a particular reason for why it was not taken up. I kind of want to know why. Like, if any of the MCO's are there, they potentially explain why? Because I understand that there may be a couple of months or whatever that people have to respond. But if they do not get it in time, then their direct care worker may not get the advance all the way back to January. I do not think that is not returning the form is a good enough reason for them not to get there advance. I will stop now.
>> JULIET MARSALA: So, I do appreciate that question. And the comments, JD. I can say it certainly was not ignored. Or related. You know, certainly the CHC MCO's work. Present when the discussion and committee recommendation was put forward. I know it was most certainly relayed to me as well that that was the LTSS subcommittee's recommendation. In the meeting follow-up items, it was asked with regards to who makes the decision. And I can certainly clarify that, that is the decision that is up to the CHC MCO's in their role. Appropriate to the CHC agreement and how the program operates. As you know, and CMS they are sort of not allowing under HR one additional or new state directed payment types of initiatives. That kind of makes it very difficult for us at the office of long-term living to turn this into a state directed payment type of process. So working in those parameters and those considerations, as I said, the role of the CHC MCO's, this is an operational decision. Thought is well within their wheelhouse to implement with their vendor, Tempus. Certainly understand that you would like to hear from the CHC MCO's. And give a response to that. So, I also know that wanting to be respectful to the agenda, as well. Perhaps, what we can do is ask the CHC MCO's to be prepared to respond to that in the second public comment period. Or in the first comment, public comment.
>> PAM WALZ: This is Pam Walz, that sounds great. I am sure we would love to hear from MCO's about that. I am going to close for now. The comment period of time. Because we do need to get to the next agenda item. Which is the HR 1 implementation updates. But please note from everyone we have public comment. Coming up in about 10 minutes or a little bit less from more comments and questions. I will go ahead with the report now. About the HR 1 implementation committee update. My fellow person who was attending, Rebecca MacTaggart, was not able to attend the first meeting because of something unexpected. So I am going to give the update on this. We have the first meeting. Last week. I can find the exact date. And it was led by Secretary are crucial as well as a number of her staff. And we went over a number of things paired first of all, the, we have slides which I believed were distributed. If not, can go through this and see what the whole presentation is. And there is a lot of information. We talked about what the goals are for this series of meetings that will be taking place. And first of all, we got a lot of information which I will talk about and you can review in the slides. Bowel the different pieces and acquirements of HR 1. And affect both snapping and Medicaid. And the

implementations are for those. And initial planning by the department for counsel complying with that. The goals for the gripper first of all, to provide information on the HR 1 requirements, timely, and DHS, and partly DHS plans for implementation. And of course, the group, the purpose of the group is to get feedback on DHS plans for implementation. Also, to share information and resources to get out to communities about this entire process. Future meetings, the next meeting is in May, another one in July and then, in the fall it is going to go to a monthly meeting. There is a sub stack the department has created. My understanding is it is to get out information about the HR 1 of the mentation process. In the slides, which you will get, there is a QR code and you can sign up from the sub stack. Just a little overview of what was talked about in the first meeting. The first part of the meeting was pretty detailed review of the various HR 1 requirements. And a timeline for them. First of all, the first set of things going into effect our requirements around SNAP, including the expansion of work requirements. Changes in eligibility for noncitizens. A big reduction in which categories of noncitizens are eligible. In administrative cost sharing shifts that are going to increase costs for the state. And then, starting in October 2027, HR 1 includes a change to the cost structure for SNAP. That could create changes for the state if error rates and envelope a certain level. That if we are not below a certain level it could cost an additional $600 million from a worst-case scenario. Fortunately we heard the current error rate for staff is under that level. The department is doing a lot of work to keep the error rate below that level. But assorted very briefly some of the SNAP changes in these and the first ones going into effect really now. There is also a moratorium on CMS rules that we are intended to streamline enrollment into Medicaid. That is HR one includes moratorium on that. The probation on new provider taxes that Juliet was just talking about. As well as reductions in provider taxes over the next several years. That are going, likely to remove a lot of money from the state budget. There are payment limitations for state directed payments. They are being capped at 100 percent of the Medicare rate. Rather than partial rate is currently. More from Medicaid, reductions in categories of noncitizens are eligible for to go into effect this October. And again, it is going to exclude a lot of categories of noncitizens who are currently eligible, like refugees, societies, victims of trafficking. There is reduction at map for emergency Medicaid will result in $24 million annual loss in federal funding. And then, in January 2027, work requirements also being called community engagement requirements, go into effect for the Medicaid expansion population. At the same time, without population is going to have its renewals increased from annually to semiannually. That is going to be a big increase both in possibilities for people to get churned off the program and in caseworker burden. And then, there is also a reduction in the ability of a retroactive coverage from three months to just one month for the expansion population in 3 to 2 months for everyone else. A couple of bright spots they mentioned, one is that the Pennsylvania received hundred and $93 million through the rural health transformation project that began and January 26. We got some information about that. And there is another bright spot I am not finding right now. So then, the meeting went on to discuss the work they DHS is currently doing to implement this. And that includes a lot of work, a lot of IT work that is detailed in the slides. And I can get information from a more information from people about it they would like more details. There is a lot of work that has currently being done trying to get the word out to affected populations. Particularly so far, SNAP populations. Because the work requirements for SNAP have already gone into effect and figures. Since June 1, 2025 83,334 people have lost SNAP in Pennsylvania. And since September 1, 59,578, the more recent numbers. With these work requirements going into effect a lot of people are losing their SNAP. There is a lot of work going on to try to get the word out to people about the

availability and exemptions. How to apply, how to get an exemption. The department also talked about ongoing work they have in implementing exemptions for SNAP and Medicaid work requirements for people who are considered medically frail. There is a lot of work going on how we will define that, what can be done to proactively identify artistic fence believing medically frail. For instance, by looking at Medicaid claims information. To try and identify people who are using certain services or high-intensity services to try and proactively identify them as potentially qualifying for an exemption from the work requirements. To make sure they do not lose their SNAP or their Medicaid. We heard about IT updates being done. Two try to get the error rate down for SNAP. Also to try to minimize the enormous burden HR one is creating administratively. To try to use ex parte procedures as much as possible. To help with renewals, help identify people who may qualify for exemptions. There are a lot of great material in the slides including the chart that shows who DHS sees as the stakeholders in this process. And timelines. Another bright spot is the department is trying to do some proactive things. There is $2.8 million in state funds, I think in the budget this year. So leverage in verse $7.5 million total funding for several initiatives that DHS is rolling out. Including food is medicine, some housing initiatives, and reentry sports. That is a bunch of information. In advance of the meeting, the department asks participants, people who are on the committee, to share what their concerns are for this process and the top concerns included, of course, concerns about service cuts, eligibility cuts, housing. The need for communication. To the community. And one thing that Secretary mentioned in particular, there they do not call the department does not have a budget for getting out information about work requirements, and all of this only the unwinding in order to help people get their eligibility for Medicaid. There is not a budget for it here so the secretary really implored all of, everybody else who are stakeholders to try to get out information as much as possible to their communities. I think that we are coming up on a public comment section. And people have questions, maybe they can ask during the park. Does that sound okay? Department?
>> JULIET MARSALA: That is Juliet, that sounds great, Pam. I just need to take 30 seconds, maybe a minute. Because I was reminded of a hot off the press update that I did not review. I will do so very quickly because I am very excited about this. OLTL in partnership with the national and LTSS healthcare Association is providing a unique opportunity for providers to pitch their most innovative ideas for value based purchasing models. As folks know, there is a required spend for our CHC MCO's and their LTSS that needs to be in a value-based payment model. And so, this value-based program innovation showcase is an opportunity for providers offering the benefit or service covered in the CHC program, to submit proposals for VPP models. In the medium or high risk categories. So I am certainly excited and we welcome providers that already operate in Pennsylvania, that may or may not be already contracted with one or more of the CHC MCO's. To put those thinking. Get Your Ideas Together and Polished. Because this is going to be happening. Where we are out in the stage of the work plan is that OLTL is currently reviewing what the draft application looks like. And what we will need in the process. And so is the M LTSS Association. Once that is all wrapped up, the application process and supporting materials, we will notify providers via our list serve without the application is available and open for submission. The application is going to include all of the details that you are going to need on what types of providers can participate, what types of VDP models will be considered and more about the application process and the whole kit and caboodle. Note, very important, legal team will get mad if I don't say this, it is important to note participation in this process for VDP's does not in any way guarantee a contract with any of the

CHC MCO's. The individual MCO's make all of the select providers whose pictures are in the interest for further discussion. More on that, I do not have any answers to anything beyond and I want to quickly go to public comments. Thank you.
>> PAM WALZ: Great so, we will now have a 10 minute public, the first of our public comment periods. The first one will be 10 minutes.
>> LYNN WEIDNER: This is Lynn, can I make a comment?
>> PAM WALZ: Yes.
>> LYNN WEIDNER: My name is Lynn, I am a homecare worker. And as a direct caregiver, who is directly impacted by the increases in, I really want to say thank you to Governor Shapiro and Secretary and the General assembly, again , for including increased funding for participant directed caregivers in this budget. The increase is about two dollars an hour. Which is going to really help me offset the cost of my pending plan billing of $300 a month. It will help me keep my healthcare which is really important to obviously my consumer that I am healthy so I can take care of them. I'm also a member of the United homecare workers of Pennsylvania and over the last week I have spoken with hundreds of caregivers across the state. Will obviously have some concerns and questions about how Tempus in the MCO's have chosen to implement this increase. On a positive note, I've spoken to some members who are currently living out of a hotel were going to be able to secure housing because of the increase. People who will be able to pay off their electric bills and keep their lights on. People who were able to pay down debt and take vacations for the first time in years. There is a lot of really good things going on but also, last month this committee made a formal recommendation to increase implemented should be using an opt in method and provide all caregivers with a raise in this consumer specifies otherwise. I would like to think PTL and LTL for using that method. Which I believe is the easiest and most effective. We appreciate the changes MCO's did implement in response to feedback from caregivers and participants. We did get a longer response time for the back pay. And they included a max wage rate box on the form and a prepaid envelope is going to be mailed out. All of these changes will make the process a lot better than initially described. I also wanted to express my disappointment that the MCO's and Tempus, decided to disregard the recommendation that is outlined in the liquidation the other month. This method is putting unnecessary admonition to burden on consumers into displacing a barrier between deserving caregivers, and funding that was allocated specifically for them by the governor. And I will and to request in the spirit of making sure that all this funding can allocated funding makes it directly to caregivers, the MCO's and Tempus publicly report how many participant drugs and workers are actually receiving these increases. And also, additionally, I and many caregivers have spoken to him about this increase and have questions about how the MCO's calculate the new max wage rates. Mostly regarding, obvious discrepancies between how the three MCO's plan to utilize the funding. For instance, in every region of the state PA health and wellness offers a higher max wage rate than the other MCO's. I believe their commitments to ensuring that new money gets to caregivers is evidence there is a lot more that UPMC and Keystone numerical could be offering. And in contrast, I would like to call it Keystone Mayor health specifically, their new rates are significantly lower than the other MCO's. I would ask they would probably share the calculations behind their decision. It is disappointing their new rates are actually leading some caregivers below $15 an hour while PA health and wellness and UPMC have pushed their rates to wear caregivers are all about $16 an hour. This funding was allocated specifically to the participant directed caregivers. It is critical that 100 percent is used to increase wages and strengthen system. We fought too hard and the price is too large to do anything other than

ensure that every single dollar makes it directly to care. Thank you.
>> PAM WALZ: Thank you, Lynn. We have additional questions or comments?
>> ALI KRONLEY: This is Allie.
>> JULIET MARSALA: Hold on a second card not to be disrespectful to our committee, subcommittee members. Certainly can get back to them. I just wanted to interject to see if Paula can go through questions in the chapter as well. I do want to be mindful we want to get people time.
>> PAM: Thank you, yes.
>> PAULA: This is Paula, question from Diane Roth, what changes to the and VO one payment policy are coded in the amendments and CMS?
>> JULIET MARSALA: That is a very good question, Diane from I am glad you brought up the MD01 payment policy and changes were pretty standard with regards to what is submitted to CMS. But I will ensure my finance team gets back to you with an answer and send it out after the meeting.
>> PAM: Thank you.
>> PAULA: This is Paula, there is also a question from Rob. How soon in advance of the deadline can we expect all of the information -- sorry. All the information to help prepare.
>> JULIET: Rob, I assume that is the VDP summit if it is not, certainly let us know in the chat. I will say it is going to be a fairly fast workplan and timeline. I would prepare as much as you can now. Again, I do not have the exact dates but I think from updates from my team that we anticipate more information coming out. You know, with in the next few weeks.
>> PAM WALZ: Paula, I think I see Amy has her hand raised. Can we call on her cleat .
Go ahead, Amy. She is muted, can someone unmute Amy?
>> AMY LOWENSTEIN: Thank you. I wanted to comment on the rate increase as well. Which I am really glad to see. I was excited to see how high some of the rates were going to get. It was noted that OLTL, when he directed the managed-care plans to do their own rate analysis, there was confidence they can accommodate more than what the fee for services rate were due to the ability to draw down federal funding. In contrast, the 150 program is all state-funded. But looking at the rates, with the exception of two rates in region two, all of them are actually, the MCO's are lower than the fee-for-service rates. Do you know why this is and is this permitted by the CHC agreement to go below the floor of fee-for-service?
>> JULIET MARSALA: I do not know if that is correct. My understanding is they are all above the fee-for-service schedule. Amy, if you can send me what you are seeing so that I can follow up with my teams and the MCO skull that would be greatly appreciated.
>> AMY LOWENSTEIN: I will do that, thank you.
>> PAM WALZ: Paula, do we have more questions were hands raised?
>> OBRA unmute, having trouble and muting.
>> PAULA STUM: I have a question from Cindy. She is asking where can they find more information on the VBP suggestions.
>> JULIET MARSALA: The VBP information will be sent out via the provider list serve with all of the details and information. I do not know when it will be released because it is been reviewed and finalized. But if you have not signed up for the CHC provider list serve for the DHS provider list serve, or OLTL's various list serves I highly recommend you do so. I believe we share that information out in the LTSS subcommittee materials. If you need additional help I would reach out through, to the provider resources at OLTL.
>> PAM WALZ: More public comment questions or comments?

>> PAULA STUM: Yes, Pam. I am looking here.
>> PAM WALZ: Thank you, Paula.
>> PAULA STUM: I have a question from -- thank you for this information about the value-based innovation showcase. We are looking forward to this event. Can I ask if an agency will be eligible to apply to the event if there rates with the MCO's are currently on the states fee schedule rate cleat since these are medium and high risk arrangements, if there is a risk shared that is negative to the provider, could this put them below the rate for requirements in the CHC agreement?
>> JULIET MARSALA: Mio, always great questions, as I noted in my announcement do not have the answers for all of the particular details of the application process. I would look to the application process and sleep just fine. Though, generally speaking the CHC MCO's are very mindful of the requirements of the CHC agreement. And will certainly take that into consideration. But the eligibility for any provider will be noted from my understanding in the application materials when they are sent out.
>> PAULA STUM: Do we have time for another question, Pam?
>> PAM WALZ: Maybe one more and then we'll move onto the next agenda item.
>> PAULA STUM: This is from Joshua Cott. Will the MCO's decisions, not to do retroactive payments result in increased profits to the MCO's? If the CLE's do not elect wage increases. Can the MCO still bill at the full rate cleat --?
>> JULIET MARSALA: Very good question, Joshua. I can answer that very quickly. As I noted, it is a capitated payment. Which is based on assumptions. Across the entire program. That is done in concert with our actuary consultants. So they look at a lot of different things. Utilization assumptions and estimates. All of these are estimates, not a strict dollar to dollar type. But yes, it money is not spent -- if money is not spent it is rolled up into a capitation payment. We are not the office of long-term living, we are not taking that money from the capitation payment. There is not a dollar to dollar type. We will however, be able to monitor through reporting. And claims data, how much of a spent change has occurred and participant self-direction from the point in time January 1 through the end of the calendar year. And expectations to see changes within the range of what was allocated to the CHC MCO's through their capitation payment assumptions. And you know, there is a sense month lag until we see the full claim process. But yes, if, within a capitation the MCO is given a certain amount that we estimate will cover all of the services and all of the changes to services. Both in medical spend, pharmacy spend, and LTSS spend. All together, right, so we could not necessarily say, they saved here and did not have access spent there. And then, they manage that program. I want to remind folks CHC MCO tele-profit cap. They cannot profit beyond three percent in the program. I think you profit beyond three percent there is a sort of state share program. Where they could potentially get an additional 1.5 percent if they invest an additional 1.5, this is laid out in the CHC agreement. At maximum they could get another 1.5 percent if they matched additional spending. If they were to go above eight three percent profit. There are some tools in place to manage this and certainly we will be evaluating the spend and looking at this as we go along. And certainly, we could have that as agenda topics throughout this upcoming year. Good question.
>> PAM WALZ: Thanks, that does sound like an interesting topic.
>> ALI KRONLEY: Can I get in euros we need to wait till the next public comment cleat sorry, it is only.
>> PAM WALZ: Ali, you were trying, is it quick?
>> ALI KRONLEY: I think it is quick. I really appreciate the question from Joshua and the

response, Juliet. That was an interesting discussion but I will be quick. I represent United home care workers in Pennsylvania. Just really wanted to appreciate the work of the department and implement this increase. I had been on a lot of union meetings over the past week . I was with someone who I met years ago and reminded me that we met first fight for 15 rally in Pittsburgh. She said you know, I was out there fighting for the fast food workers to get to 15 and I was out there fighting with all the nursing home members and finally, as a home care worker I remember the first time ever seen my we just go above 15. I was really excited. Just a reminder of how long and hard people have fought for this increase. Just wanted to put up in the room. And so, the question , I want to shout out the department on the work around the rate analysis. We really advocated and thought that it was critical that folks, the department director the managed-care organizations to do the analysis and really understand the funds that were actually available. Specifically, the federal match funds are drawn down and used for this increase. Appreciate that. I think the question we are wondering is, if it is possible to ask the managed-care organizations to meet those calculations and that kind of work they did public. Obviously, as folks have mentioned, there is a high degree of variability here. We are seeing AmeriHealth still has folks under 15. And PA health and wellness has everyone up and about 16. 18. Also curious, but Natalia brought this up, folks brought up what happens, like if the rate was based on the assumption that 100 percent of the existing direct care workers moved to the max like, that would be an important thing to understand about the calculation as well. Because then, it goes to this point, Juliet was raising, there is a six month lag. But the MCO's do the copulation on 100 percent pickup, and we know in two months it is really 60 percent, it feels like there's a significant gap in resources. We are interested in having more discussion and public transparency around both the process of the rates and sort of, is, are the assumptions that were used to set those rates coming clear is the implementation process rolls out. So hopefully, that was a clear question. It is the kind of question that we would like some follow up on. Hopefully I said that correctly but happy to talk more. Thank you for letting me jump in and the comet section.
>> JULIET MARSALA: Sure, great question.
>> PAM WALZ: Julia, you want to address that now cleat .
>> JULIET MARSALA: I certainly think a bulk of that question is directed to the CHC MCO's. And I'm going to leave that to them. Paula, I don't know if you know you are not muted. Certainly, very happy to continue to engage in that. But I do not have specific now.
>> PAM WALZ: Okay so, maybe that is part of what you were suggesting the MCO! Try to begin to address even this morning. We are going to move on to the next agenda item. Which is assisted-living in lieu of services option in community health choices. I think I am turning it over to Damaris Alvarado to start with.
>> DAMARIS ALVARADO: ,Hi, thank you, Pam. This is Damaris Alvarado I serve as the director of communications management within the Bureau of long-term living. And today I would like to share some insights into our efforts to educate and support our partners on this exciting initiative. To offer assisted-living in lieu of services within the community health choices program. To provide some background, the office of long-term living issued an operations memo in November 2023. Outlining the instructions for the CHC MCO's --
>> PAM WALZ: Someone who may need to mute themselves, please.
>> JULIET MARSALA: I got it, Pam.
>> DAMARIS ALVARADO: So the office memo published in November 2023, outlined the instructions for the CHC MCO to follow if they wish to participate in the auction. Subsequently,

we added language to the 2024 CHC agreement. And began receiving applications and proposals from the CHC MCO's also in 2024. Currently, all three MCO's are offering in lieu of services option. Next slide please. Here are some examples of the education efforts that we have been engaged in. Our staff development in lieu of enrollment application guideline. This document is available to all providers. Interested in participating in the in lieu of services option. We also met with the office of income maintenance staff. They are the folks who determine the financial eligibility for our programs. We were 2000 two align their assisted-living in lieu of services eligibility policy. With our current procedures. And we were very successful. On January 7 of this year, the office of income even added a new chapter, 492 there long-term care handbook. Which provides instruction to their eligibility workers on the in lieu of services option. This new long-term care handbook chapter does replace the operations memo that was previously issued by the office of income maintenance. If you are still access and not on any of the websites, please make sure to refer back to the new chapter. Of this book, this handbook. Which we will provide the link for later in the presentation. Another step we are taking is revising our current policy. This is the OPS memo 2019 – 05 which outline circumstances when the community health choices, MCO's should be issuing the PA 1768 form to communicate changes to the county system offices. The revisions will include, instructions for when a participant is transitioning to the AL ILOS option. Also, on a monthly basis, we provide an updated report of all of the improved in lieu of services providers to the CHC MCO's. And to the office of income maintenance. This is to ensure that records are up-to-date. We notify the CHC MCO's when our Bureau of human services licensing places and assisted-living provider on a provisional license. And this is to make sure if any of the findings could impact their contracts for the in lieu of services option that they are aware of what is going on and they can take action if necessary. Next slide, please. In addition, the office of long-term living offered technical assistance sessions on August 19 and October 2. With the CHC MCO's and the assisted living community respectively, regarding eligibility, enrollment, and monitoring processes for the in lieu of services option. Here are some of the key points that we talked about during the sessions. We explained the in lieu of services is an option. This is not a standalone program that individuals can apply for. It is an option available only to community health choices participants. And this option is offered with the same appeals, grievances, and other protections which are specified in federal regulations. We emphasize that the in lieu of services option is driven by the CHC MCO's and their agreements with the specific assisted-living provider. Again, the CHC MCO's are the lead in this initiative. We also underlined that in order to ensure successful outcomes, everyone needs to work together. The assisted-living provider, the CHC MCO, and the County assistance office must collaborate in the completion of required forms, and in the timing of related activities. This is really important in presenting unnecessary burdens on our participants. We answered questions about individuals who are not enrolled in the community health choices program. Who are interested in the in lieu of services option. And we made it very clear that these individuals must be referred to the Pennsylvania independent enrollment broker. To complete the community health choices application process. Once enrolled in CHC, the selected CHC MCO will step in and complete the assessment. To determine the individual's needs and service preferences. Again, emphasizing that the CHC MCO is the partner making that determination of appropriateness for the in lieu of services option. And last but not least, we created and provided training on a operations report calling it OPS 41. That will assist the office of long-term living in the monitoring of CHC MCO's activities with the in lieu of services option. The implementation was effective January 1, 2025. Next slide, please. In a few minutes from

the CHC MCO's will present on their in lieu of services plans and related activities. But I would like to report that received the final reports on the in lieu of services activity for the 2025 calendar year. And this is what we received on reports, 15 participants utilizing in lieu of services option. Seven were transitioned from nursing facilities to an assisted living residence for the in lieu of services. Eight participants were at risk of nursing facility placement. Were found to be appropriate for the in lieu of services option. And successfully moved into an assisted living residence. We have more reports coming in 2026. And they are due quarterly on May 15. August 17, November 16 of this year, for the fourth quarter the report will be due in February of 2027. Next slide, please. We would like to share with you some in lieu of services policy resources. So here is the link to chapter 490 of the long-term care handbook. Published by the office of income maintenance in January 2026. We also have the link to our OPS memo released in November 2010 three with instructions for the CHC MCO's interested in the in lieu of services option. And also, we have resources or questions. If the questions are about eight participant who is already involved in community health choices, they should be contacting their selected CHC MCO. Questions about individuals who are not CHC program participants regarding the application process, should be directed to the Pennsylvania independent enrollment broker. By either completing the online contact form, for which we provide the link on the slide. Or they may call their toll-free number which is 877-550-4227. Providers who have questions about how to enroll for the in lieu of services option may contact our provider enrollment unit. By sending an email to the resource account showing on this slide. The address is RA H CBS ENPROV @PA.gov. This concludes my portion of the assisted-living in lieu of services presentation. I will now handed over to Renee Abbs from UPMC. Thank you.
>> RENEE ABBS: Thank you Damaris. Good morning, my name is Renee Abbs. I am the senior manager of our nursing facility service coronation here here at UPMC community health choices. Thank you so much for bringing me the opportunity to speak with you about how we are managing the assisted-living in lieu of services option here at UPMC. Next slide, please. The first thing want to talk about is our population focus. UPMC community health choices utilizes assisted-living in lieu of services for or, AL ILOS to support participants we serve who cannot maintain health or safety independently and require significant supervision. AL ILOS may be appropriate for nursing facility participant or me in option for home and community-based services who are participants in risk of being placed in a long-term care nursing facility setting. AL ILOS can be considered to be helpful when there are the following, barriers securing housing, long meeting, activities of daily living support, a lack of informal supports more of a reliable backup safety plan, or need for assistance with medication administration. One of the biggest ones being .
. In determining the appropriateness for the assisted-living in lieu of services option, as per the Department of human services guidance in the program charter, all AL ILOS referrals and criteria are determined by the managed care organization or MCO. And include but are not limited to, an imminent risk of long-term care in a nursing facility setting. Or participants who are in a long-term nursing facility setting that have barriers returning to the community, such as lack of housing and informal supports. Next slide, please. The sources of assisted-living in lieu of services request it is important to note for community health choices MCO's are the lead in all AL ILOS activities. As such, the CHC MCO initiates the transition of the participant from under the home and community-based services setting or from a nursing facility setting into that ILOS option. The request for consideration of AL ILOS can come from any of the following sources, the participant themselves, their power of attorney or legal guardian, a nursing facility social

worker, or that request and come from the assisted-living residence. If you believe one or one of your patients could be appropriate for the assisted-living residence option, please reach out to your service quarter later or network manager. Next slide, please. Just wanted to talk about our review process here at UPMC. All request to utilize the assisted-living in lieu of services option are reviewed and approved by the UPMC community health choices leadership committee. This committee consists of three members of our senior leadership team all of whom have clinical nursing backgrounds. If additional reviewer consideration is necessary, the CHC clinical operations associate vice presidents, medical directors and medical care managers, are also included in the review process. If the request is not approved an adverse determination is made, and the participant will receive a letter explaining the with instructions on how to file a complaint and grievance if they so desire. Next slide, please. Participant informed choice is very important. Once assisted-living in lieu of services request is approved the service coordinator will do the following activities, they will inform the participant of the option to move to an assisted living residence. They will review the anticipated financial responsibility for room and board with the participant. We are finding this is typically comparable to the nursing facility patient liability. Which does include a personal needs allowance deduction. The AL ILOS approval and participant discussion is always recorded in the participants record. If the participant wishes to pursue the AL ILOS option the service coordinator is going to assist the participant in identifying a contract assisted living residence within the preferred geographic area. And then, will review ALS resources with the participant that includes websites, which typically have a virtual tour, to help them to facilitate informed decision-making. Next slide, please. Once an assisted living residence is identified, the service for Nader is going to do a couple of additional things. They will contact the assisted-living residence intake coordinator so we can verify if there is a unit available and then from initiate their admission process. When requested by the participant, the service department will also arrange an in-person tour and will typically join that participant on site for that tour to support the visit and address any questions they might have. Something that is important to note, the County assistance offered her -- County assessment office will be the one set administer the patient liability, an officer was put in for the CAO must remain involved to support the participant with any necessary paperwork to determine what the patient pay portion will be. Next slide. At UPMC, we do have a moving assistance fund. This is a fund that is available to the participant in the event they require household items to support their independence in the community. Some of the items that we can purchase with this include, they are broken up into areas. The kitchen essentials, microwaves, toaster oven, coffee pot from oven mitts, dishtowels, dishes, some groceries. Thanks for the bathroom, towels, shower curtains, formats, shower counties, hampers, trash cans, toothbrush, toothpaste, shampoo , conditioner, hand soap. In the bedroom we can provide things that might discover some of those, bed in the bag sets, alarm clocks, power strips, and hangers. And some miscellaneous items would be a phone or a phone card, a lockbox, dressing aids, and some clothing. Next slide. This is an exciting slide. This is our very first successful placement we had and her name, her initials are ST. She had resided in a nursing facility for about a year and and a half before she successfully transitioned to an assisted living setting and August 2025. She was very excited for this opportunity to live more independently and as such did give us the consent to share these photos in her story. Next slide. Assisted-living in lieu of services at UPMC community health choices, we are focused on fostering independence with support. In 2025, and the time the slides were done, UPMC has successfully transitioned nine participants into the assisted-living residence. We are currently up

to 14 participants and we have many more that are somewhere in the process with identifying facilities, scheduling territories, getting finances in order. In order to do a transition with them as well. To date, only one of those participants has returned to the nursing facility and that was following an unexpected illness that resulted in the need for a higher level of care. All of our participants currently living in assisted living residents to report they are satisfied with their new home. If they should express dissatisfaction with the ALR, service coordinator will discuss further with the participant to identify and address the issue. If they prefer to leave the residence for a different setting will also assist in facilitating that. Next slide. I think that was the last one. Thank you so much.
>> PAM WALZ: Great, thanks. Our next MCO.
>> LISA MANNI: Good morning everyone, my name is Lisa Manni. I'm a manager with PA health and wellness. To provide an overview of our assisted-living in lieu of services, program within PA health and wellness. Next slide. As mentioned earlier, some of our target populations for the in lieu of services program, really with the goal overall we jingled to provide a setting where the participant can still maintain a level of independence. And really still ensure a safe living environment. So we see those individuals that elected transition from a nursing facility, either before and during the community, use it as a bridge. Or to move permanently into an assisted living as their permanent residence. Participants who are currently receiving home and community-based services and they have a desire to move to an assisted living setting, based on perhaps, increased in care needs, other social considerations, as mentioned prior. Formal support, backup plan, and perhaps, they help lost housing. They want to use this as an alternative placement in a nursing facility. And also can we have individuals who have a diagnosis of dementia who could benefit from special care unit within the assisted living setting. Within the context of those same scenarios above. But these are settings where the participant could provide more socialization and things about the trip. Next slide. Understanding our implementation process, we did a lot of initial education to our service coordinators. For them to be able to have the best understanding and provide the best information to our participants. We did do an overall introduction to the assisted living ILOS, program. Within the CHC waiver. With an understanding that this is really an alternate setting for participants to receive long-term services and supports. Have an understanding of what does in lieu of services mean? All of their needs for personal care and activities of daily living are provided by that assisted-living setting. Understanding the financial aspects. That there is a daily contracted rate the MCO. And what is the financial responsibility of the participant and across sharing model. It is noted earlier that is determined by the County assistance office. In a communication with the participant. We also reviewed clinical criteria nursing facility clinically eligible level of care but they don't need 24 seven physical health services. Some of the things that we have worked with them to understand is, what are those aspects of activities of daily living, what are their needs, what is the ability to participate with care? And any other special care needs, for instance someone has to wear BiPAP or night or maybe they have a colostomy. Things of that nature that they would need to manage that with assistance from the staff at the assisted living. That we are really able to meet their mental health services with access to care specialists. And/or psychiatric care. And the assisted-living is all do provide medical providers particularly, for the physician care, Cisco services, PT, OT. The participant also has access to any of their private providers in the community that they are interested in continuing care with. Also, it is required for the completion of a specific documentation of evaluation that is for the assisted living. Next slide. Overall, in looking at the process we have the individual, the participant who desires a different living

environment. And what kind of setting will best meet their needs. We do pursue and discuss all options for them. If the participant declines to decline assisted-living we do note that in a documentation within our medical records. If the participant chooses to move forward with the assisted-living option, we will review all of the services that will be offered by the assisted living. Happened, have an understanding of the financial responsibility. And the level of care needs that they have. Then we will discuss with the assisted living processes, and terms of the review and application for the assisted living. And also, internally what our process has to review their requests. We will gather signatures at that time on the freedom of choice form. Which is maintained in the participant's medical record. That they are choosing this option to live in an assisted living. We do then review a list of all of the assisted-living participating facilities and locations in their preferred geographic location. We currently do coordinate on-site visits for all of our participants to tour the assisted living. And to meet at that time with the admissions representative. Our staff, service coordinators also will meet. And participate in the tour with the participant. Our service coroners will assist with the application process to the assisted living. If the participant wishes to proceed, to apply for. Once there is a determination, of the participant's admission, we will coordinate a planning meeting for the admission date and determine what other needs are identified. One thing is about, the different assisted-living's are able to provide different aspects of what is needed for their sweet or their individual room at the assisted living. Once they do transfer, we have a nursing facility service coordinator who is assigned to the assisted living. Who will make contact and schedule a visit with the participant. We do have an internal review process. Thought we review the medical record to ensure medical appropriateness with their current medical conditions, what is their current and ongoing needs? And we document this within the Michael record to ensure appropriate plan of care is in place and the assisted living can meet their care needs. Next slide. Related to participant satisfaction, the service coordinator will review and assess for any participant concerns on any contact with the participant. They do provide their contact information so the participant can reach out to them regarding any needs or concerns. We will assess with each initial visit and each encounter thereafter. If there are any issues or concerns that are brought forth by the participant, we, a service coordinator would have follow-up with assisted living director of nursing or director of nursing to attempt to seek resolution those concerns. We would advise the participant of the process to file a formal complaint. If they feel they do not still have resolution. They are concerned in-depth the participant chooses to move to another participating assisted-living setting, other option, we could assist them in relocating or moving to a different setting. moving to a different setting. Currently just to summarize, we had in 2025, we had six participants who moved into the assisted-living setting. Five of those were from the nursing facility. To transition into the assisted living. And we did have one community-based participant who moved into the assisted living. And so far for this first quarter of 2027, we have approximately about five people who have moved into the assisted living within the first two months of the year. And probably about approximately, 10 others who are in the process to be admitted. And consider assisted living. That finishes it for me this morning. Thank you.

>> GREG PAPAZIAN: Hi, good morning. My name is Greg Papazian. I'm the director of strategic development for AmeriHealth and I was the project lead on the assisted living in lieu of services option. Next slide. I just want to review the background on the in lieu of service option. We held a series of assisted living, meetings with assisted living providers back in late 24, early 25. Kind of what our assisted living in lieu of service model design looks like. The role of our service coordinator. The role of our UM department. Documentation, training, and participant

rights. Next slide. As everyone knows, OLTL did in insert language into the community health choices agreement. Allowing for the managed care, CHC managed care organizations to create in lieu of service option. For assisted living, for those nursing facility clinically eligible participants. Our application was approved effective January 1 of this year. And when we designed our in lieu of service model, we were really targeting two populations. Within the CHC program. One where those exceeded she participants that were currently residing in a nursing facility. And had the desire to transition back into the community. And the second group, CHC participants that lived in the community who were at risk for various reasons. For nursing home placement. We believe it is a great transition option as well as a very good diversion option for the CHC participants. Next slide. In late 2024 into 2025, the health plan, the CHC health plan, along with leadership at our corporate office, held a series of listening sessions with both leading age and the Pennsylvania healthcare Association. Which are the two provider trade groups that represent most of the assisted living providers in Pennsylvania. In these meetings were really designed so that we could understand the assisted living model that was currently in operation and under regulation in the PA code chapter. As well as, any insight or any concerns the assisted living providers had with the in lieu of service option. Next slide please. So following those meetings, the health plan had a number of internal design meetings. And develop three levels of care that we are offering to our CHC participants. The essential living level, which is the participant must display limited assistance with up to two activities of daily living. The enhanced living model level, which requires extensive assistance with two or more ADLs. And then the memory care support level, which is targeted for participants who have moderate to severe impairment with cognitive skills and daily decision-making. And they must also require support in at least two of the memory deficits. So, they have problems with short-term memory, procedural memory, and/or situational memory. In addition, they must require or demonstrate two of the three behaviors, and that is easily distracted, episodes of disorganized speech and/or mental function varies over the course of the day. Next slide. So, the assisted living in lieu of service option really starts with our service coordinator. When they are doing their normal contacts with participants and a nursing home or in the community, they are looking to see more trying to identify participants that would benefit from transitioning from a nursing facility back to the community. For those community residents that are at risk for a nursing home placement. Our service creditors will inform an educate our participants on the in lieu of service option that it is voluntary, that they are under no obligation to accept in lieu of service, and that participants will be educated on the need to turn over their income to pay for room and board. As well as any patient pay liability determined by the county assistance office. If the participants elects in lieu of service will then documented that with the freedom of choice form. Which the participant will sign and will be kept in their case management file. And if they decline the in lieu of service, again we will have them sign the freedom of choice form , declining that option. And again, that we documented in their case management file. The participant has the option to continue to receive nursing facility services. Or home in community-based setting services in the community. Next slide. If the participant is interested in pursuing assisted living in lieu of service, our service for Nader will complete a new inter RAI assessment as well as our functional needs assessment to identify which service tier the participants assessed needs will meet. The service coordinator will recommend, based on the outcome of those assessments, that service tier. And will then send the assessments to our UM department who will review the tools. And authorize the medically necessary AL service tier for one year. This will then be countered in the participants person centered service plan. It is been updated. The service coordinator will

collaborate with our transition for later to facilitate a smooth and timely transition to BAL residence. And the service quoted are will ensure that the participants person centered service plan aligns with their assisted living support plan.
. Next slide, please. Prior to January 1 of this year, our community health choices training team has developed two trainings on assisted living and fluid service. Both are computer-based training modules. But one is really an overview and introduction to assisted living. And the in lieu of service option. The second training, which is targeted for our service coronation and utilization management staff, is actually a step-by-step process on how members are authorized and the steps involved in authorizing the service and transitioning the participant to the assisted living residence. All of our service coordinators and UM staff are educated on the CHC grievance and appeal process. Certainly, our participants who are interested in lieu of service, who have perhaps been denied or maybe deny that service from the right to file a grievance and appeal. And in addition, our CHC handbooks have been updated to include information on the assisted living in lieu of service option. Next slide. As I said earlier, participants rights are paramount in this new option. As I have said before, all of our CHC staff have been educated. Received an overview and introduction to assisted living in lieu of service. They have also been educated on participants rights and access to the new community option. In our service coordinators will educate and explain to our participants there authorized rep if they have one, that their income will be used to pay for the room and board as well as any patient pay liability as determined by the county assistance office. They will also receive as part of their income will also go to pay for the personal needs account of the assisted living residence. And then, our service coordinators are also trained and educated on what we address participants dissatisfaction. Through our grievance process and they can file an appeal if and when our health plan denies the in lieu of service. And all of that information again, included in our CHC participant handbook. Next slide. As I said, were approved to offer the assisted living in lieu of service option beginning this year. We are in the process of negotiating contracts with various OLTL approved assisted living providers. And we hope to have several contracted by the end of the month. So that we can formally implement this program. Our outreach and contracting activities will continue throughout 2026. I think that is it. Thank you.
>> PAM WALZ: Great, thank you so much for all of those presentations. I think we need to take our 10 minute break now. We will have another agenda item on personal assistance services reduction when we come back and then a public comment period. Can the presenters stay for the public comment we --?
>> GREG PAPAZIANl Yes, I can.
>> PAM WALZ: That is great, I hope the others will too. Paula, she'd been over to the 10 minute break?
>> PAULA STUM: Pam, this is Paula. Yeah, I think we can go ahead and do the 10 minute break.
>> PAM WALZ: It is 11:54 AM right now. We will reconvene at I guess, 12:04 PM. And take that 10 minute break. Thank you.
>> PAM WALZ: Personal assistant services reduction from the three CG MCO spread we will start with pH W. Thank you.
>> RANDY NOLEN: This is Randy, before we start. I want to give an overview as what the department does to monitor -- as far as any data relatable that the MCO's -- we see a little over 2000 reductions about a 4.8 percent type of reduction that we see in that. Reductions occur for many reasons, there could be increases in other services, new services added, there could be

changes in in-home support and there could be changes in a person's condition. The understanding is any reduction would have to be reflected of the assessment and the person centered assessment process. As far as the monitoring that LTL does, weaves a couple of operations reports that we utilize monitoring from. We gather information on changes to the person centered service plan. And that will list all of the changes that we see with plans from all of them. We also have a report that takes a look at service denials so we, the service denial rates when they come in. We do some specific monitoring of cases. We will do case reviews, take a look at all the notes and assessments and reviews for various cases. And internal reviews on that. And ask questions of the MCO's. Utilizable clinical staff, compliance staff, and support staff doing some of these here. We do monitor number of cases and some of the cases are sent in either through a legal representative or somebody advocating. Some of the cases come in through the affairs office and send them to us. Some random cases that we pull. We take a look at cost reductions, we take a look at the OPS report really centered on what is in the person centered progress plan. This report captures any increases or decreases in service hours. We really take a close look at that. One of our quality reports really measures the number of denials of services, counters the services, denials, based on various services. It could be passed services committed, we manager a lot of things utilizing these reports. We really think of the number of denials, it doesn't really get into the lookout why they have been denied. But that is by Wednesday of the number of denials we follow up with the MCO. We do some case specific monitoring, like I said. When we see cases come in we work back with the MCO's to answer the questions of what is going on. We can take a look at the service quoted her looks, the person centered service plan, we will review them internally. Medical director also reviews them. We take a look at these reports on a month-to-month basis. So I'll LTL does a number of things as we are looking at and tracking. Tracking production and changes in service plan. As Juliet emphasized earlier, I will emphasize it again, I think it is a very important point. The discussion we are having today about PAS reductions has been ongoing discussion for quite a while with the committee and with the MCO's. And this is just a follow-up to the previous discussions we have had and an opportunity for the MCO's to have a little discussion of what they look at when they are doing PAS reduction services. And also, little bit of the overview I gave in regards to how LTL monetary exist. This is not any foreshadowing of any other changes that will occur. In anybody's mind. This is strictly a look at process we have been discussing the last few months. With that being said, I will turn it over to pH W to talk about their services and I think AmeriHealth and UPMC will follow. PH W.
>> TAYLOR DOWDEN: Thanks, Randy, good afternoon everyone. My name is Taylor L. Dowden, Cassandra and I will be presenting the data for PA health and wellness. I am going to get us kicked off. I want to go over that today's presentation is really intended to provide visibility into personal assistance service reductions decisions. Cassandra and I are going to go over what we review, how our decisions are made, and how often reductions actually occur. Next slide. The personal touch on today.
>> MATT SEELEY: Commands the question real quick? This is Matt. I am kind of under the weather so, please pardon my , whatever I have. I feel like you guys are really putting us in a box of what we can ask about. Does anybody else file five --
>> SPEAKER: I agree with you, Matt.
>> MATT SEELEY: Only this, only ask, not --. Juliet? Pam?
>> PAM WALZ: I will jump in, I know that a lot , this is Pam. I know a lot of questions from my own part, I have a lot of questions that may or may not be part of what we are encouraged to

ask. But I agree.
>> MATT SEELEY: Saying exactly what I am saying. Juliet?
>> JULIET: Yes, Matt?
>> MATT SEELEY: Can you address my otherwise, I have no need for the next 30 minutes. I mean, Pam, I am not trying to, that did not come out right. I know there are a lot of important topics in the next 30 minutes. I do not care about it, I have the button to leave and I am going to leave. I think you gave me the option in the beginning, Juliet.
>> JULIET MARSALA: If the question is that you want to change the agenda to dedicate time to other topics, I certainly understand that. As a chair and vice chair you can direct the meeting.
>> MATT SEELEY: Actually, I feel like this presentation is checking the box for you.
>> JULIET MARSALA: To be clear, the agenda topics are set by the LTSS committee.
>> MATT SEELEY: I know that.
>> JULIET MARSALA: I don't to go into a back-and-forth, this is not checking a box for us. We are bringing topics that we feel are pertinent to the LTSS subcommittee. Across the spectrum on topics that were asked and requested.
>> MATT SEELEY: I agree, I believe I was a part of that asking, that whole topic. But I am very interested in seeing what is important. What is it the committee wants to see. So like we have 10 committee members here? Is this what you guys want to talk about or do you want to talk about stuff we talked about earlier? I don't know, I want to hear what you guys want to talk about for a little while. We interfering these presentations forever and we never hear what we talk about. I was listening for a while. It was great but I was hoping things would go a different direction. I will shut up again.
>> PAM WALZ: I will open it up to other members but I am really interested in this topic. I guess I would like to let them present. With the understanding that we will have questions and that what we need to do is take whatever information we do get today and really come back with agenda items that can dig into the details of the issues we see with PAS reductions. To really try to get answers and discussion around the issues we are all concerned about concerning these reductions.
>> MATT SEELEY: Pam , please, I did not mean to say this was not important. I think a lot of us have focused questions we want honest. We keep getting redirected. Please, I am not trying to influence this committee when we or another that this is important or not. Please understand me.
>> PAM WALZ: I know.
>> NATALIA GOMEZ: This is Natalia, do not want to interrupt either. But I argue with Matt in regards to, I do not think it is necessary that an entire presentation should be given in regards Azteca how a service plan is developed, as to how the service coordinate is this and I pray because I believe that everyone in this meeting and the subcommittee, committee, and public should know how the process though. What we are more interested in is finding out blind to the PAS reductions happen. And what remedies are being done or what utilization management, or what monitoring is being done to alleviate and deter all of these PAS hours reduction. And this is from eight participant as well as a subcommittee member. I don't think that Matt and I are saying this is not important or that we want to go tit for tat with the committee. But we really want to go to the substance of the issue. Rather than an entire presentation by this MCO's as to how the process gets done. Because we do have a lot of questions with regards in lieu of service and the medical assumptions we were not able to get in with the medical exemption extensions.

>> PAM WALZ: Thank you, Natalia. Two others member have thoughts about how they would like to proceed here?
>> LYNN WEIDNER: This is Lynn Weidner, I would say that I do agree about the lumber presentations. But as you can download on top the attached files, we already started looking at the numbers. And I would like to hear the MCO's justify their numbers. Because I see one of the MCO's has extremely higher numbers than the others. I am interested in hearing the production, PAS reductions. Maybe not the entire lengthy , this is how we break everything down because that is a little repetitive but that is my opinion.
>> PAM WALZ: Thank you, Lynn. Other thoughts. I think there is a couple of choices here I can think of. You know, we can either have the presentations, I am not sure how easy it is for the MCO's to sort of cut them down on the fly. I think the other option would be, -- instead, move the questions people have. Go ahead.
>> MATT SEELEY: I would suggest, it sounds Natalia and me are in the minority and the fact that the is nothing in lieu of this, I would just proceed as you planned.
>> PAM WALZ: I mean, you have may partially convinced.
>> MATT SEELEY: My point is valid but this minor point, people are interested in this enough.
>> PAM WALZ: Okay, I was going to suggest we could move to questions and people could read this. I know people have a lot of questions.
>> MATT SEELEY: You are in charge today.
>> PAM WALZ: Anybody else want to weigh in on which way we go, questions now and read this or let the presentations go?
>> If we start out with some questions than the presenters will know where they should focus. Rather than receiving a bit of a show as to how each determination is made we are more interested in how they are made. And how those decisions could be reached and have individuals impacted can address them. So perhaps, questions taken now than could be focused upon by each of the MCO's would be a good way to go.
>> PAM WALZ: I am not sure we will have time for the entire thing. How about we take a few questions now to get a sense of peoples particular concerns. And then, time permitting we can do the presentations. I guess, Juliet does that sound?
>> JULIET MARSALA: I deferred to the chair and vice chair. It sounds fine with me.
>> PAM WALZ: Okay, do we have any additional questions? From the members first. For the MCO zone this topic.
>> NATALIA GOMEZ: I know there is seven hands raised, I do not know who they are or what. I noticed throughout this whole presentations, the service 40 meters have been mentioned the majority of the time. If I go back to the in lieu of service, my question, are the MCO's hiring a specific group of service creditors who are going to be doing all of this services? That is one of many. And then, on the PAS, I noticed every MCO mentioned person centered team develop and person centered service plan. I would love to know who is this team? Because as a participant, I have only meet with the service coordinator. And when I advocate or represent other participants, in regards to the PAS or developing a PC SP, on paper everything sounds very beautiful. This is a person centered service plan. And like I have mentioned in other meetings, as a participant I feel like I am in the outfield and not in the center. Since this is a person centered service plan, that is the one that coordinates and helps to coordinate to request this PAS, can we start there? As to who, what composes the person centered team? So that the right recommendations or PAS hours is done. Or for the right strategy to be developed to fight back on the reductions.

>> PAM WALZ: Sure, Natalia. Maybe we can ask the plans to speak a little bit about how it is determined who is on the person centered service planning team. I will just add that it is my impression there is not a lot of discussion with participants about whether they want to include anyone else besides themselves and whomever else happens to be there. So, could we ask the plans to respond to this with their approaches? I guess, we would start with pH W.
>> NATALIE GOMEZ: I am very interested because I still cannot get over the fact that I lost a client that I was representing which I feel this person centered plan failed. Failed her. There was no team. And those that wanted to be in the team that have the right to be there, we were excluded. With no reason given. Besides the fact that it felt like the service coordinator did not want to be there.
>> PAM WALZ: Well, that does sound like that should not happen. Again, what the plans like to respond? Question.
>> SPEAKER??: I can respond for pH W. The person centered team is the choice of the participant into they want to be involved in this process. So they are able to invite those individuals who they want through their competence of needs assessment. To provide any additional information on behalf of the participant. Or submit any documents. And the service coordinator should allow you to be a part of that if the participant chooses for you to be there.
>> PAM WALZ: Okay, the combined motion which was next. Looks.
>> SPEAKER??: I am from AmeriHealth from Keystone first. I agree with Taylor. Participants can invite anybody they would like to their assessment. A person centered planning team can consist of the participant and service coordinator if that is the participant's choice. The participant can also choose to invite others and also, if the participant needs assistance in scheduling the person centered planning team to meet for the assessment, the service coordinator is able to help with the scheduling of the chosen participants for that team.
>> NATALIA GOMEZ: Everybody gives this beautiful explanation and then my next question, my follow-up will be, especially to AmeriHealth, who ensures and who does follow-up to ensure the service coordinators are following this policy or procedure that is in place with the MCO's. To ensure this is being carried out in the field. Because the time and unprofessional attitudes, this doesn't happen in the field. It does not.
>> PAM WALZ: Natalia Kemeny can you describe what happens? Is it just a meet with whoever is there without offering a lot of explanation about what could happen?
>> NATALIA GOMEZ: I will tell you what has been happening at least with me and some of the clients I have been advocating and fighting for. The majority of individuals in this area are with AmeriHealth Carita and to this day we are waiting for response from AmeriHealth Carita from December and November. Because first, it was the excuse that they need authorization from the participant in order for us to be there. We are still waiting for the service coordinator to get back because she was going to talk to the supervisor to see if it was allowed. We would be in this participant centered service assessment plan. And I believe that the person centered service plan, I am assuming, and I do not like to assume, this has to be implemented even from the initial development for the first plan of service. That is not being done out here. That is not to mention when the language is a barrier. On top of participants being seniors and having a huge amount of challenge to get through this process. And then you end up with our service coordinator that will not allow you to put a word in. Even the person, the participant called to be there presently. Was not being allowed to be present or to express the concerns or answer or talk on behalf of this participant. That is why to me as a participant, and a member of these services becomes very frustrating. If you notice, I am sorry I can tell by my own voice and my

spirit and my mood all raised my voice. Please do not take it as unprofessional or as rude or discourteous. But as a participant living in life moments of life, these situations is frustrating. And when you don't have where to turn to because you are not being properly told about these resources, for instance, in lieu of services option, it would have been an amazing option for the client that passed away. An amazing option, but we did , nobody knew about this. And AmeriHealth said they were approved back in January of 2026. And our client passed away in February March 2026. How can the service coordinators that were dealing with this could not mention back in November that we are in the process of developing in the lipservice option. That I think will be very beneficial for this participant. We are not being informed of thought. We are not being told of that. And I will not say it will be the service coordinators fault. I will blame it on the MCO's. Because between time constraint and everybody else internal reviews, and people reviewing that do not have, if the write ups and the words are not right in those reviews, in those records, please I will not even mention the process of filing complaints with the MCO's. And how they are being handled. I mean, who is training who complete --I mean from it frustrates me because this is cross containment and I am one of those participants who makes a conscious effort to do cost-containment that a little bit is over for the next participant that might need the services. But this is frustrating because on paperwork, in presentations, in slides this sounds beautiful. It sounds great. But that is not what we are getting with participant out in the community. That is my biggest input with regards to this. And that PAS hours reductions, let's go straight to the blunt of it. Tell us what is it that is costing a reduction. Tell us that. Because supposedly, we know the process of create the plan and whatever, whatever. But I think, the poor service coordinators, just like the County assistance office workers, are being buried with this work. And not to mention that we just went live with HR one and the work requirements and everything else. We are all very down and work and I think that what I am seeing is a part of this agenda. But you see on the last meeting, we had a lot of participants on here because a lot of them care about the self directing. I think at least in my area, will start promoting that participants be allowed to get more involved in this kind of need. But with my area, and with my clientele this meeting is going to need an additional slide occurring because you will end up with the language barrier. And someone will have to be interpreting for those participants that have opinions but they cannot express it because they do not know the language. So for the sake of time, and the importance of this, let's go to the grit of this discussion. Tell us what is the reason why PAS are being rejected. By are they being reduced. What is costing these huge reductions in hours?
>> PAM WALZ: Okay. I am trying to think what the exact question is for the period I mean, for the MCO's. Natalia, do you want to just like frame that is a question for them?
>> NATALIA GOMEZ: Yes, each MCO's must have data in how they are keeping track of the PAS hours.
>> MATT SEELEY: Can I interject? I hate to pull apart here. I do not think the six people they have out there are prepared to answer any of that. Am I wrong?
>> PAM WALZ: Are you thinking rather than asking responses we share our concerns?
>> MATT SEELEY: May be,
>> NATALIA GOMEZ: I think we mentioned before that we needed a meeting specifically just to discuss this topic. I remember we mentioned.
>> It is just hers.
>> I am sorry?
>> Do not be sorry. I think what you suggested is a good idea could maybe we spent the rest of

the meeting and we give an opportunity to the , those of us listening at home. Share something specific with this one topic that seems to be such a head banger.
>> Excuse me, I will interject if I may.
>> JULIET MARSALA: This is Juliet. A couple of things, we really need to try and make clear only one person is talking in time for the CARTperiod the second thing I wanted to suggest is absolutely, my team is documenting all of the questions that are raised. Those that go unanswered. And like we do traditionally, we will request answers to all of the questions that are asked. Both through the chat and from subcommittee members that are not entered in the moment. And those answers will be provided in the follow-up materials of the LTSS committee. That is a tool that is always in place because we know we have limited time and lots of great questions. That is why we do that for the accountability and for extending the ability to ask questions. The last thing, this topic is certainly very important and very critical, do also want to be mindful of the respect to the public comment period. For any and all topics, the public also wants to be put forth, bring forth to answer. But with all that being said, I turn it over to you, Pam.
>> PAM WALZ: Okay. I guess maybe we could move forward for a few minutes with questions from the members and we can expand the public comment. Public comment is coming up. Paula, do we have more questions? I know we have raised hands.
>> PAULA STUM: I do have questions in the chapter. In the questions balls. If we do have time, if we could possibly ask a couple of these questions.
>> PAM WALZ: If we can try and keep these questions to the ones that are concerning PAS reductions and then move to more general.
>> PAULA STUM: I would have to read through all of the questions to know which are which.
>> PAM WALZ: Right, I got it. I have a question that was shared with me. That I could ask. The question that I have. Amy Lowenstein had this question as well. The community legal services are still seeing in general notices of reductions. They are not complying with the OPS memo from early 2025. Which she said that notices reductions help to explain either what has changed, the necessitates the reduction. Or what the mistake was in the first place. We are really not seeing this at all and we have been reporting these cases. I know Randy was doing some follow-up but this was a big question. We want to make sure all of the MCO's understand and act on this being the standard. So, I guess that would be a question for the MCO's. What they are doing to really integrate this as a standard into their decision-making and what they are doing to fix their notices. Another question that I got, are the reductions being reported, all decisions to reduce regardless of whether they were acting on? Are those only reductions that were implemented? Is it a series of questions about the numbers, I think that are in some of these presentations. Are there other questions about PAS reductions from people on the call? I like Natalia's idea. Of having a meeting. They're here with a lot of time or a separate meeting to address the PAS issues. Because they are really the biggest concern the participants we see. They talk with us about. And it is so multifaceted problem.
>> NATALIA GOMEZ: Pam, the event to add. Not , this is life impacting. Believe it or not this is a life and death, health and safety issues. For a huge number of participants. Spending 20 minutes trying to explain PAS reduction, I think that is a disservice to us, the participants. And to a lot of the family members that depend on this program in order to trying to earn a living will someone else cares for their loved ones. The is not to mention the lack of caregivers and the lack of agencies not complying. So PAS services reduction should be a one topic, one meeting subject. Not thrown together or put together with other issues that are also life impacting. Like

the HR 1 implementations. Like the in lieu of service option. I think we are all very busy individuals and time is precious. And we want to take the gain or obtain the best of this. Because right now we should be in public comment. And not even finished talking. The biggest reason for the reductions.
>> PAM WALZ: Natalia, I think we need to take that back to the agenda planning meetings. And we will do that. With the department, with an eye to really giving this topic the time it needs. I think with that being, it makes sense to move onto public comments. Since we only have 20 minutes remaining. Paula, do you want to start with the questions?
>> PAULA STUM: Yes, thank you, Pam. This is Paula. I have a question from Matthew Barbee. In 2021, a DHS bulletin was issued to raise rates for participant directed services. And the MCO's much estate base rates. Acts 150 was in place at this time. CHC agreements were in place at this time. And I assume federal matching was systemically the same at that time. As it is now, so we are still trying to understand why there was a departure from how MCO's calculated rates in 2021. Can you elaborate more on why there was a departure from how it was done in 2021 outside of the federal matching you are speaking of? Since that was in place the last time rates were calculated.
>> JULIET MARSALA: This is Juliet. I can take that. Matthew, thank you very much for that very thorough and thoughtful question. And I do have an answer for you. 2021, that you referenced or thereabouts, the reason why the increase at eight percent occurred at that exact eight percent, was because that is how the language was put in place in the physical code and the legislation. So because it was so specifically directed, that is what occurred and how it was implemented. So that is to answer your question. It was prospectively described by the legislature to direct us how that funding should occur. I hope that answers your question but it is a very good one. In the case it is now, it was not prescriptive to an eight percent increase for a two percent increase. And that is why the analysis is needed. Because it is not expressly stated that it is an eight percent and it is more of a bucket of money then an actual directed percentage increase. So that is the difference between what occurred then and what is occurring now. But very good question. Thank you very much.
>> PAULA STUM: Pam, do you just want me to continue?
>> PAM WALZ: Sure, please do that.
>> PAULA STUM: Question from Linda Anthony. Are we putting CHC money into it assisted living?
>> JULIET MARSALA: This is Juliet. I can answer that. Community health choices funding covers the entire spectrum. Of health choices, home and community-based services, and long-term care nursing facilities. There is not a state Medicaid plan service that is assisted living. However, the CHC MCO's are about them as a part of in lieu of service, to provide services in assisted living settings. In lieu of more costly facility settings. To answer your question, yes. There is CHC funding that is going to assisted living residential settings. As a part of the in lieu of service program. Great question, thank you. back to you, Paula.
>> PAULA STUM: Next question is from Lisa Hall. Will in lieu of services be included option in the nursing home transition program? It seems like if a nursing facility resident wishes to leave the facility, and their needs can be met at a lower level of care, that may mean a home in the community, in an assisted living residence. Are there two different programs to refer or apply for, or will the participant be assessed for both options?
>> JULIET MARSALA: Another great question. I know Damaris was presenting and is still on the line so I will have Damaris answered.

>> DAMARIS ALVARADO: Yes, each MCO submitted their individual proposals to the office of long-term living. And they will make sure to communicate to participants , we are calling them targets. So which individuals they are looking to serve in the assisted living in lieu of services option. It is absolutely a nursing home transition activity to have somebody who is in a nursing home facility wanting to transition back to the community. And it is something the CHC MCO's should be discussing with everyone interested in coming out of a nursing facility. Paula, back to you. Unless there is anything further on that question.
>> PAULA STUM: This is Paula, this is from Bridget Lowery. Do the MCO's need to meet the final rule limit of eight people living together in the assisted living environment?
>> JULIET MARSALA: This is Juliet. I will take that one quickly. A really good question. I just want to clarify the in lieu of service for assisted living services, the 19 presented about prior in the CHC MCO's presented in, it is not an H CBS service, it is in lieu of service to the state plan particularly, for the nursing facility. As such, that in lieu of service is not necessarily beholden to the final settings rule. Which is specific to home and community-based services as defined and delivered through the 19th, 15 C waiver. Assisted living residences are not defined H CBS service in the 1915 C waiver authority. The final rule only applies to the 1915 C services as noted in the H CBS waiver. And, Damaris please add anything if needed.
>> DAMARIS ALVARADO: You are correct. The only thing I would like to add is that, the assisted living residence regulations do not have a limit. And so, the MCO's will have specific contracts with residences. As to how many individuals they will have in those specific environments when we really do not have any regulations giving a limit or placing a limit to how may participants can be served in the in lieu of services option.
>> PAM WALZ: Paula, next question?
>> PAULA STUM: Hi, this is Paula. A comment into questions from Jeff Eiseman. Some of us involved in long-term services and supports now long ago a part of crafting the original assisted living regulations for several years. After the enabling legislation was passed back and 2007. Much was put in for resident rights. Can you tell us the following, is there a separate PA assisted living rights sheet or booklet shared with the perspective residence upfront? Not just MCO information. And two, how many assisted living consumers went from assisted living to home and community-based services programs, CHC or over waiver act 150.
>> JULIET MARSALA: Great questions. I will take the second one first with regards to how many assisted living consumers went from assisted living to H CBS programs. I can say from the Bureau of human services, licensing that is not data they track so we would not be able to tell you how many assisted living residences amongst the thousands that are served go from assisted living to H CBS programs. Or are receiving H CBS services while they are in assisted living. Because some of you may know, not all assisted living residences are participants of community health choices. So we do not track their sort of health services outside of what is required in the licensing services of the assisted living residence. With regards to number one, many assisted living resident in an assisted living license facility must receive the assisted living facility is information on residence rights as they would normally be required to in their licensing. In addition to that, there is additional information the CHC MCO's would provide as it is related to their CHC enrollment services the CHC is putting forward in their in lieu of service. Hope that is helpful. Always good questions, just. Back to you, Paula.
>> PAM WALZ: Back to you, Paula.
>> PAULA STUM: Pam , this is Paula. We do have quite a few hands raised, do we want to continue with the questions or go to a couple of the raised hands?

>> PAM WALZ: Let's go to a couple of the raised hands.
>> PAULA STUM: If you could unmute yourself. Are you there, Bill?
>> BILL HERTZOG: Can you hear me?
>> PAULA STUM: You are a little low.
>> BILL HERTZOG: I will try to move it closer. I will try to make this brief. I want to say the PAS reductions have always been an issue since the inception of the MCO's. Some of them are worse than others. I experienced a reduction attempt a few years ago. And luckily, I appealed it and it was overruled. So yes, there is a continuing problem with that. And some MCO's, like I said are worse than others. A quick comment and some of my research , a lot of our service plans are basically determined by a computer program. That is based on input from service coordinator questions and inflated basically into a computer. If my memory serves me correctly. Of course, those computer programs are designed towards the benefit of the MCO's in my opinion. I will leave it at that with the fact that I wanted to change a little bit to the PAS rate change, the increases. Just a few comments on that. I think there is a potential of an exodus of participants from the A, AmeriHealth, and the UPMC. Given that Pennsylvania health and wellness is substantially higher rates, at least a dollar an hour in the summer regions take even more of that and others. I guess my question would be, do we have a document or something that will guide participants in switching MCO's? This is typically an issue with switching MCO's. There are potential lapses in service. There are potential service plan reassessments. Even though you just had reassessments etc. What is the process of a participant to change MCO's? To take advantage of the higher rates of that say, PHW offers, thank you very much but I wanted to make a comment, thank you to United care healthcare workers of Pennsylvania. We are very grateful of increases that we do with her. But we do have questions about why are there so big of a discrepancy between Pennsylvania health and wellness and AmeriHealth and UPMC. Thank you very much.
>> PAULA STUM: Hi, Pam. This is Paula. I have a clarification from Juliet on a question that was raised earlier.
>> PAM WALZ: That's fine, go ahead, Julia.
>> JULIET MARSALA: Thank you, Pam and Paula. Earlier it was brought to the committee's attention, concerns about the CHC MCO participant self-direction rates being lower than the posted maximum fee schedule. That was posted in the fee for services. I did take a look, thank you, Amy for sending me the documentation. My team is also able to take a look at the documentation that you were referencing for that information. It is our understanding which I believe has been confirmed by the CHC MCO's, that the documents that were noted, Amy, are net of taxes. What that means is that is not the full max rate. That is the sort of come hourly designation minus the taxes that are required as a part of every worker who is working. There are multiple documents posted on the Tempus, website related to the maximum rate of the full cost of the participants self-directed, related to wages, taxes, unemployment, workers compensation, etc. So there are two great forms and I believe that when you were referencing was specific to like an hourly wage net of taxes. We have provided immediate feedback to the CHC MCO's on that particular form you sent that needs to be made abundantly clear in layperson terms of that is indeed what you are looking at. Because if it is confusing, if it is confusing for you, and myself, and it will be certainly confusing for others. So we will certainly take that back. But I believe if you do reference the full maximum rate posted, that is not net taxes, you will see all of the MCO rates are above the maximum fee schedule rate. With the exception of potentially one. And so, my team is following up on that one region rate that I

believe has a 4 cent difference, and certainly will get back to you. And the group with regards to our findings. I just wanted to give folks assurances because I was a little startled to get that feedback. And I am comforted to know that is not the case. Thank you.
>> PAM WALZ: Thank you, Juliet. We have four minutes left, Paula, time for one more question?
>> PAULA STUM: Yes, I have Susan bought. If you could go ahead, Susan.
>> SUZANNE OTT: Hi, my name is Suzanne. I am also a caregiver and a UHWB union, I'm a caregiver to region two according to MCO's findings as impaired in my region the max rate varies from 1442 to 1806 an hour, can someone explain to me how all three MCO's receive the same funding amount of new funding but are now for the very first time offering free wages? Can we also figure out why they are offering free wages. Another question as well, when people are returning in their max rates so Temps, whether emailing or faxing, they are not responding. Is there a way that people could no tempus received their rates? I submitted mine, personally on the seventh and my participant has not received anything. He never received a phone call. He did receive an email from Tempus, stating the rates were coming out and that is how we printed it and everything. But once we were emailed it in, we just never received anything back to say like, thank you for turning this form in or anything. Are they going to --
>> JULIET MARSALA: I will take all of those questions and comments and feedback because they are really great, thank you, Suzanne. So for Tempus, in the CH C MCO stop listening, I will make sure that feedback regarding to the improvements to the confirmation process for when we deserve wage changes forms are received. That is undertaken by them and they can see about addressing the communication plan to close that loop. Certainly, I think in the communications it does indicate when the pay increase is expected. If I am not incorrect, the next pay. Upon receipt, so you would be able to see that confirmation of that change. I believe, in the paystub information. But certainly, room for improvement. I know we only have two minutes. With regards to the different rate wages available in each CHC MCO, I did talk about that earlier on in this meeting. But just as a quick refresh, the CHC MCO's is a capitated payment. Capitated payments are certainly complex. It does incorporate estimated costs for participants self-direction rate changes. And in the amount proportionate to the utilization or participants served. Each CHC MCO, it is not like we said CHC MCO you have got five dollars. It is sort of an estimate based on what we think the trends in utilization hours will be. The CHC MCO's you checked different populations across the state, as mentioned. Some may have more participant utilization and higher with overtime than others. That impacts on the funds kind of stretch across their programs, which is why they are coming up with their own rates. In addition, some CHC NCOs may decide to make a business decision or investment, or put more of their own capitation funds available towards one way or another. I do not know. Those are business decisions that CHC MCO could have made. Certainly, we will look to have the CHC MCO's provide a written response as follow-up to the extent they can with regards to how they do their own business things. But assuredly, we at the office of long-term living will be watching very, very closely, the change in claims and expenses and costs and wages. That go out across both the fee-for-service participant self-direction and the CHC MCO participant self-direction. We will be looking to monitor and partner with the CHC MCO so they have opportunity to show us this funding is getting rate is supposed to be. Which is supporting our very incredible direct care workforce. And very deserving direct care workforce into the participant self-directed program. I hope that is helpful to know we are overtime so back to from a pan.
>> PAM WALZ: Great, the last Likert comments and questions can be sent to the email address

on the screen. I want to review there is a LTSS subcommittee website there. Our next meeting is Wednesday from April 1. In the forest room, at the Keystone building. In Harrisburg. Let, I believe there is both an in person, it is an in-person meeting but I think there is an opportunity to participate remotely. Is that right, publicly.
>> PAULA STUM: That is correct.
>> PAM WALZ: Great, thank you so much. Do I have a comfort people whose questions were not answered, OLTL will respond to them. Those answers will come up for the next meeting. Do I have a motion to adjourn?
>> KATHY CUBIT: Kathy, I make motion to adjourn.
>> PAM WALZ: Thank you, Kathy. Second?
>> NATALIA GOMEZ: I second.
>> PAM WALZ: Thank you, Natalia. Thank you everybody for all of your participation. Bye-bye.