Dear Secretary Snead:

I am writing this email to appeal to the decision makers to use the enhanced FMAP to fund an increase for home and community-based provider payments.

Caring Hearts Health Care Services provides personal assistance services (home care services) and skilled Services to members of the community who are aging, physically disabled, or intellectually disabled.

Our industry is one that helps keep medically compromised individuals in their home instead of nursing homes and hospitals, preventing the high cost of hospitalizations and Nursing home admissions. The reimbursement rate of $17.72 - $19.52 creates a challenge for organizations like ours in hiring and retaining qualified employees to provide services to many medically compromised people who are in dire need of these services. We are competing with hospitals and other medical organizations who are in the position to pay their staff more than double the amounts that we can afford to pay our employees based on the current reimbursement rate that the state pays for these very essential and crucial services.

Our employees have continued to receive 2-3% raises every year yet our reimbursement rate has not been increased to support these raises and we are now in a situation where we are competing with industries we never have before due to the pandemic. Additionally, we are now competing with an unemployment benefit that encourages people to stay home. As a result, our patients are going without care. We are struggling to get people to work. Without an adjustment to the reimbursement rate, not sure we can survive.

Our patients deserve quality care in the comfort of their home and our employees deserve better pay but we cannot accomplish these goals with a reimbursement rate less than $20/hour. Please help us by increasing the reimbursement rate so that we can provide the necessary care that our patients need as well as pay our hard-working Caregivers for the much-needed services that they provide. This will also allow us to recruit qualified Caregivers for those patients who are on a waiting list for Caregivers.
Thank you for your consideration,

Edith Walters-Wilson
President – Caring Hearts Health Care Services

Good afternoon,

PA Families Need Nurses Now (PAFNNN) is a grassroots collaborative of families with medically complex loved ones committed to ensuring access to in-home nursing and improving quality and delivery of those services across Pennsylvania. We provide ongoing peer to peer support, education, connection, and advocacy - empowering families like ours to be active participants in all processes and planning that impacts our access to skilled nursing and other supports at home and in the community. We strive to continually partner with providers, policy-makers, and other stakeholders to create lasting systems-level changes that guarantee everyday lives to individuals with medical complexities across the state. The families of PAFNNN are glad to see the department highlighting the nursing workforce crisis in their ARP spending plan, and we truly appreciate the opportunity to share our comments.

As several of the families in our network took part in the OMAP Pediatric Shift Care Initiative, we are pleased to see recommendations such as the Medical Home model being supported here, though as you may imagine the most urgent and ongoing need we hope to see addressed is that of the significant home health nursing workforce shortage. The candid truth is that many of these wonderful ideas cannot truly help anyone until a highly valued, appropriately compensated home health nursing workforce is in place to support medically complex individuals with consistency. Sign-on and retention bonuses may indeed be acutely helpful, but to truly attract and maintain a dedicated workforce, home health benefits and compensation must parallel that of their peers in other areas of the healthcare industry.

We ask that the department strongly consider narrowing some of this focus to areas of compensation, benefits, and financial assistance for home health nursing professionals. To start, we suggest a tiered reimbursement approach, increasing compensation rates for nurses providing care to higher acuity/tech dependent patients. This one step could be the beginning to transforming of how we, as a community and as an industry, view and value our home health workforce.

Thank you for engaging the public in this process. As always, we are available to the department to discuss our experiences and ideas further.

Regards,

Meghann Luczkowski
Program Manager, PA Families Need Nurses Now
PA Families Need Nurses Now
A Program of Vision for Equality
The Cast Iron Building | 718 Arch St., 6N
Philadelphia, PA 19106
T. (215) 923 – 3349 [redacted]
www.pafamiliesneednursesnow.org
www.facebook.com/PAFNNN

To Whom It May Concern:

I am writing this email to request that the enhanced FMAP be used to fund an increase for home and community based provider payments. My organization provides personal assistance services (home care services) to members of the community who are aging, physically disabled, or intellectually disabled. Since 2008, our reimbursement rate has increased a total of 4%. That means that in 15 years, the state has given only a 4% increase to fund these essential services. This is a program that has kept MANY medically compromised people safe at home during this pandemic.

Our employees have continued to receive 2-3% raise increases each year since 2008, but we are now in a situation where we are competing with industries we never have before. We also now compete with an unemployment benefit that encourages people to stay home. As a result, our patients are going without care. We simply can't get people to work. **Our model of giving raises to staff so as to retain them, but not receiving standard reimbursement adjustments from the state of PA, is NOT SUSTAINABLE.**

Our patients deserve better, our communities deserve better, and our employees deserve better. We want to pay our employees fair wages, but with a reimbursement rate that is less than $20/hour, we simply can't. The VA pays more. Our private pay clients are paying upwards of $25+/hour. And **the Office of Long Term Living is at $17.72 - $19.52. This is a disgrace**.

Please consider an increase so that we can provide care to patients who are WAITING for caregivers, so that we can train caregivers more thoroughly, and more importantly, so we can pay caregivers a fair and competitive wage.

Thank you for your consideration,

Diane Turner, PAHM
Senior Account Manager - CMO (CSW) | BAYADA Home Health Care
99 Cherry Hill Road, Parsippany, NJ 07054
[redacted] Fax 973-909-5112 | bayada.com
[redacted]

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Thank you for your consideration,

Brian Eber
BAYADA Home Health Care

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Thank you for your consideration,

Julie Trenery
Account Manager - CMO (CCN) | BAYADA Home Health Care
99 Cherry Hill Road, Parsippany, NJ 07054
[redacted] [redacted] | Fax 973-909-5112 | bayada.com

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Our patients deserve better, our communities deserve better, and our employees deserve better. We want to pay our employees fair wages, but with a reimbursement rate that is less than $20/hour, we simply can't. Dog walkers are paid better **than the state of Pennsylvania pays our agency to take care of medically fragile patients.** This isn't right.
The VA is reimbursing at $24 per hour. Our private pay clients are paying upwards of $25+/hour. And **the Office of Long Term Living is at $17.72 - $19.52. This is a disgrace**.

Please consider an increase so that we can provide care to patients who are WAITING for caregivers, so that we can train caregivers more thoroughly, and more importantly, so we can pay caregivers a fair and competitive wage.

Thank you for your consideration,

Debbie Barry
BAYADA Home Health Care

To Whom It May Concern:

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Our patients deserve better, our communities deserve better, and our employees deserve better. In order to recruit, train and staff our staff we must consider our reimbursement rates to provide quality care to your patients – a service they **deserve.** Our private pay clients are paying upwards of $25+/hour. And **the Office of Long Term Living is at $17.72 - $19.52.**

Please consider an increase so that we can provide care to patients who are WAITING for caregivers, so that we can train caregivers more thoroughly, and more importantly, so we can pay caregivers a fair and competitive wage.

Thank you for your consideration,
Alyssa Aiello

Alyssa Aiello
Account Manager - CMO (CSW) | BAYADA Home Health Care
99 Cherry Hill Road, Parsippany, NJ 07054

Dear Secretary Snead:

I am writing to you on behalf of Samaritans At Last, LLC that provides personal care and private duty services to more than 100 Pennsylvanians. Our agency also employs more than 100 caregivers. Thank you for the opportunity to provide comments on the American Rescue Plan (ARP) funding specifically for home and community-based services (HCBS). Though our company may be small, we are preparing for our CHAP accreditation and expansion into Home Health. Our constant challenge is retaining good employees due to the poor reimbursement rates which do not allow us to afford a "living/competitive" wage to our caregivers. This funding comes at a critical time, when demand for home care is at an all-time high, costs are increasing sharply, and rates have remained almost stagnant for over a decade. Recruiting and retaining caregivers has reached a crisis point, and I write today to ask that you direct a significant portion of the new funding toward increased reimbursement rates and financial support for bonus and other provider payments to preserve access to quality care.

The following priorities outlined in the Department of Human Services' *Spending Plan for the American Rescue Plan Act of 2021, Section* 9817 are critically important and must be funded:
HCBS Provider Payment Rate and Benefit Enhancement

- Providers need additional funding for increased reimbursement rates, sign-on and retention bonuses for direct care workers, nurses, and other home caregivers and believe that this is where the bulk of the funding should be allocated.
- Although we support funding that is intended for caregiver wages or bonuses, it is important that flexibility be given to providers, as individual agencies will have the best sense of where funds would do the most good to address recruitment and retention challenges in their communities.
    - Reimbursements do not reflect the cost of providing services, which have skyrocketed in recent years. With the lowest reimbursement rates across comparable state programs, PAS providers simply cannot compete with private employers (or even other programs)

        - PA State OPTIONs: $20/hour
        - VA: $24/hour
        - Private Pay: $30/hour
        - ODP: $24-32/hour
        - OLTL: $17.72-$19.52/hour

    - Demand significantly outstrips supply, with more and more hours going unfilled, or requiring an agency to pay overtime to meet the need and provide care. We urge funding to reimburse for this overtime; as you know, caregivers in the consumer-directed model already receive overtime funding.
    - Rate increases must be provided, and they must be permanent. This is a long-term problem that requires a long-term solution.
    - Again, it is critically important that funds provided for these purposes also include funding to support additional employer payroll tax, overtime, and other financial responsibilities.
- For agency-model funds, we believe that these funds should be paid directly to the agencies in order to streamline and facilitate quick, efficient distribution.
- We also support payments to providers to provide tuition incentives, student loan repayment, and similar educational/training supports.

<u>Supplies & Equipment</u>

- We support funding and reimbursement for the purchase of personal protective equipment and testing supplies for HCBS providers. Throughout the PHE, home-based care providers have not been prioritized for PPE, and a recent PHA survey showed that PPE Expenses have risen almost 500% for home-based care providers. PPE expenses will continue for the foreseeable future (although price gouging has eased), with DOH/CDC/CMS and OSHA rules requiring its use.
- We ask that this support come in the form of direct funding/grants, as agencies can be required by PPE vendors to have a certain “buying power” in order to be prioritized for access.

<u>Work Force Support & Training</u>

- We support additional funding for caregiver training.
- As you know, PHA has developed My Learning Center, a free online training platform for direct care workers and family caregivers. To date, 181,309 users have completed more than *four million courses*. The cost associated with developing new videos and administering the platform is approximately $120,000-$150,000 per year, which includes new videos and language translations each year. We urge the Department to provide funding for new videos and translations for FY21/22, 22/23, and 23/24.
- We support non-internet-based learning materials for individuals without easy access to the internet or those who are more comfortable with hardcopy materials.
- We also recommend and support reimbursement for caregiver pay during training.

Caregiver Support

- We oppose the development of a registry of direct care workers for the same reasons set forth in Markham v. Wolf, NO. 176 MD2015, Pa. Commonwealth Court, which is ongoing litigation. We have continued concerns about DCW privacy rights and the Department's prior/current efforts to create such a registry, and FMAP funding should not be used in this way.
- In addition, PPL/PCG already has a caregiver database, as does www.care.com. A mandatory registry is inappropriate and unnecessary, when multiple alternatives to find care already exist, at no cost to consumers. Funding through the enhanced FMAP should be directed to programs that will advance the level and quality of services, not to recreate a resource that already exists.

Thank you for your consideration of our comments and for your leadership on these important issues. Please let us know if you have any questions or if we can provide any additional information. We urge you to move forward with increased reimbursement rates and any bonus payments as expeditiously as possible. The need is immediate, and access to quality care is at risk. I can be reached at [redacted]

Sincerely,

Debra Broccardi BSN, RN
Director of Nursing
Samaritans At Last, LLC

Forgive the length and repetitiveness of some of my comments; I was not able to carve out time to complete my edits.

I do appreciate the opportunity to share my concerns.

1. While I support access to HCBS, to continue to do so inequitably is unacceptable. There are counties with conflicts of interest who are also providers and hand select individuals to receive services while others who have demonstrated needs are made to wait; this needs to be discontinued and no county should also be a provider. PUNS needs some statewide standardization that is objective and funding to individuals should follow needs, not county lines.
2. While payment rates may (or may not) attract more workers, the care and keeping of DSPs is much more than the paycheck. A careful look at the financing of all agencies should occur. The pay rate of administrators and management and DSPs as well as benefits and costs to those individuals for those benefits needs to

be scrutinized. I have reason to believe that, were funds to DSPs increased, providers would find ways to keep more of that themselves.

3. In my mind, the larger issue is the skill set of the entire facility staff, including management, and the caliber of individual these jobs attract. Let's face it, these are not easy and to be a caregiver takes a special type of person; many would not find the work honorable . Throw in challenging behaviors and the job can become hazardous. Many places pay more for easier work. Levels of certification linked to training, experience, years on the job without incident and with acknowledgement of skills should be linked to compensation. Recognition of exceptional staff should be noted, rewarded, and those staff could serve in the role of a mentor to newer staff. Lack of high quality training with mentoring, fidelity checks and corrective feedback leads to accident, injury, shaping up unwanted (and sometimes dangerous) behaviors, hospitalizations, police intervention, and the like. Many in positions of management are themselves an oxymoron, with skills and characters more likened to a barmaid than a manager.
4. There needs to be equity for those who are self-directing to get high quality (not just reading a paper) training, services, supplies and support. Funding to pay for this staff training should be provided in all models.
5. A significant chunk of monies should be used to gather information from families and individuals served with regard to operation during the pandemic. Never again should the doors be closed on family. The lack of oversight by SCs and management, open doors to any and all who come knocking to become DSPs (whose adherence and the adherence of those they intersected with to Covid protocols is indeterminable), failure to support individual's remote visits with their family, and failure to keep family informed should never happen again. Focus groups, individual calls to family/individuals in a private and safe setting hosted by neutral parties (and individual visits when necessary) should be conducted to gather honest feedback about experiences during Covid and those should be acted upon. When DSPs did not follow masking protocol during Covid, why was that not an incident? (Family may have been just as safe or safer than staff, but weren't permitted in.) Review should include unbiased information pertaining to abuse and neglect and evaluation of the work of APS. This should include the families of those in state centers and include information concerning to barriers (real or perceived) to transitioning to community and how their loved one can be supported in the community. Many of these family's loved ones previously had negative experiences in community homes; how can a positive experience be guaranteed?
6. Increased oversight needs to be instituted: a) Placing cameras in all residential public areas needs to be considered with this funding. b) Unannounced inspections by state staff and neutral individuals should occur with great

frequency. We all know of institutions, industries and hospitals who “clean up” because they have been told the inspector is coming. We are dealing with people’s lives: this cannot happen in these environments. c) When an individual being served no longer has involved family, a regional independent support person should be assigned to every individual in a community residential and state facility - perhaps positions could be filled by individuals who have family members with a disability. Allocate a number of hours to acquaint one another and with any family, join the individual during ISP and other meetings, and be available for a weekly visit. This independent individual then could serve in the role of a family surrogate in providing some watch-care and assisting the person in whatever ways were necessary. (Similar to but broader and deeper than an Ombudsman). d) DPW’s historical construction regarding Section 4417(c) of the Pennsylvania Mental Health and Intellectual Disability Act which permits providers to make health care decisions beyond "elective surgery" for individuals in their care who have no living relatives nor legal guardians. These decisions could be made in cooperation of the family surrogate and director with a third-party independent arbitrator in case of disagreement.

7. Better yet, hire parents who are familiar with the system, train them to do the job and eliminate SCs, many of whom are poor. There are too many people in the system who don’t do very much. Hire, train and certify parents, give them more control, give them more authority about providers/staff, make them accountable like the SCs who seem to little but completing paperwork and moving to another job. There are knowledgeable, informed parents who know the system, are good problem solvers, and could train/mentor others. Eliminate some of the superficial and employ those who genuinely understand the needs of individuals. Empower parents to create the programs their children need.
8. The Incident Mgmt policy (to begin on July 1) exemplifies a lack of care and concern of the state for “its most vulnerable citizens.” When abuse and neglect abound across the country, to leave the investigation of incidents in the hands of providers is nothing short of allowing the fox to run loose in the henhouse. Shame on PA. Shame on PA for allowing providers and staff to leave involved staff unnamed. If you want families to trust the system, spend some monies here.
9. Similarly, contracting out APS workers so they don’t have to be paid state wages and benefits left those positions difficult to fill. APS workers similarly have conflicts, come to know staff and begin to distrust families. They should be rotated so as not to develop friendships and should exclude themselves when this happens.
10. An independent entity should craft a family-friendly booklet about Waiver services, ODP, the philosophy, family and individual rights, interpretation of regs, a clear understanding of a ‘Designated Person,’ regional contact

information, the complaint process, FAQs, etc. For example, as the home the individual lives in is their home, how can fsmily visits be restricted (at the unreimbursed cost to families due to their time and travel expenses). Why does no one answer the phone at the home? What does one do about that? As models for our individuals, what are staff permitted to do (unlimited phone use, smoking, drinking, watching/listening to violent/sexist/sexual content, use of language that if repeated by the 'resident' could put them at risk, etc. that may not mesh with the family/individual's values)? Why are families left out of decision making? How is a POA or Designated Person honored, etc? Additionally, we are still waiting for the Gold Book.

11. A statewide family group should be funded out of these monies without linkage to ODP. (PA Family Network does little as an organization and answers to ODP.). Providers have organized groups but have funding that enables them to do so and have conflicts of interest in driving regulatory decisions.
12. Counties are laced with failed county-based programs; most families of children with ASD have used these: BHRS/IBHS, family-based, and, as adults DDTT. The CRSU exists in only one county and is not centrally located; they take only a few individuals and hand pick those. Even there, residents were incarcerated - how does that inspire a family to place a love one (one of our most vulnerable citizens) in any facility? Psychiatric hospitals, established to stabilize, do not have the wherewithal to address severe behaviors, simply medicate, and send patients back home without support. Some of these, as teaching hospitals seem to prioritize serving their students, not treating the patient. Waiver service providers for the most part are following suit, using a bandaid approach to reactively, versus proactively, address situations. The system NEEDS a major revamp. Use some of this funding to look for better ways; are other states and countries doing a better job genuinely meeting the needs of those the serve?
13. PRIORITY: The inclusion of those with ASD into an existing system that served those with ID lacked forethought. While it may have saved a great deal of money, those with ASD (with or without ID) do not present like the population with ID. Providers working with the ID population for decades - with little investment in remodeling their services to the 21st century - were already lagging behind and while they gave lip-service to serving those with autism, appear for the most part to be trying to do things the same old ways. The model for ID services is antiquaited. To provide to the ASD population in the same way they have served those with ID (albeit perhaps with some jump through the hoops online training that deceives them into thinking that they understand autism) simply does not cut it. This is unacceptable. Services unique and appropriate to those with ASD must be provided in any and all waivers. We have created some untenable situations where failure to address the needs of the autistic individual

appropriately have created behaviors, worsened situations, and been devastating to individuals - all in an attempt to fit the square ASD peg into the round ID hole. Again, this is unacceptable.

14. Many of the individuals served in the ID/A population have lived lives impacted by daily traumas with misunderstanding, bullying, pain and lack of communicative skills. While many high schools students graduate with a limited worldview, the worldview of this population is severely impacted due to having been educated in special education classes, being removed from neurotypical peers (or taken advantage of by them), having had fewer community opportunities, and by their disabilities itself. This leaves our kids with a lack of understanding of their choices, the consequences and impact of those and the continued experience of being manipulated, traumatized, abused, and neglected. While COVID isolated world many, our kids have lived with this forever. It is essential that staff understand these individuals, their differences and learn to genuinely care for them and work with the hit kindness and respect.
15. While "protecting the health and well-being" of staff is noted in the priorities, protection of all (individuals, their family and staff) is important. All should have access - no matter how they are served (AWC, Vendor-Fiscal, Lifesharing)- to needed equipment and supplies.
16. Assistive Technology is a great idea, but without those competent to train, support, problem solve, and implement with fidelity, it is flawed. This should include AT for more independent living as well as increased ability to communicate, choose, and . And Much work is required for these tools to be successfully used. The current training for staff and management in all areas is sadly lacking. Supports Brokers and communication specialists are not widely available; where will there be enough AT staff?
17. While there may be a glut of services in urban settings, basing services on Phila and Harrisburg models and failing to consider the structure and differences of rural community where people know one another, relationships exist and there are watchful and caring neighbors, is a disservice to those in rural settings.
18. When the individual is visiting others (parents, family) transport the person there and back.
19. PRIORITY: Serious and significant work has to be done around county, SCO, provider and staff attitudes toward parents. Parents who advocate, speak out, and hold providers accountable are disregarded, disrespected and at times, worse. They are seen as troublesome, the "problem parent," and are at best kept at bay while at other times villianized. These parents have, for the most part, spent their lives learning systems, advocating for what their child needed, sacrificed and done the hard work, hijacked their careers and then made the difficult choice to move their child to a provider setting. They have not divorced

their child, they are simply trying to prepare for the ultimate move when they are still around to see that it works successfully. To treat them like a pariah and not an honored guest in their child's home, like they did not want their child or vice versa, and to not honor their role as the one constant in the life of the child is nefarious,

20. What is being done to engage families.(one engaged family is not adequate for a community of practice). I have never heard about these and when I asked the SC about it she too had no idea. Where are these Communities of Practice? While the reason was given that they could not get families, what was done to advertise/outreach? Was their purpose explained and were they accessible to families? What were their purpose or expected outcomes?
21. With all of the sermonizing on rights, rights, rights, the fact is that the individual's rights are often a sham. Providers, DSPs and SCOs use this in their own interest and are for the most part making the choices about what is done or not done and when. Ex., the choice of a housemate" is rarely ever a real choice - how does that mesh with one's rights? Promoting things that are known to be inconsistent with the individual's family values, culture, etc. in a time when we are claiming to honor diversity (a given in ASD with big differences across the spectrum), is not honoring their family nor them, but is done in the name of rights. Rights must be balanced with responsibility, yet those with ID/A are often ill-equipped to understand consequences. They have not been taught to understand implications, consequences, options, risks and benefits. Where is the balance of rights and safety; the pendulum has swung too far. Additionally, those with ID are often easily misguided by those they intersect with; staff need to be exemplary citizens with good character. Training on rights need to be provided to all.
22. While life in the community is preferred, what is being done to educate and prepare the community for inclusion of our individuals. This needs to be addressed though various campaigns.
23. Additionally, life in the "community" should not mean living clear across the state or even an hour away. One's community is where one lived before entering the facility/home. One's family, connections, and roots are in that community. More needs to be done to bring exceptional and willing providers to community, not attempt to move individuals away. When you list supporting caregivers, support them by keeping their loved one in easy reach; no one is compensating the aging parent with a fixed income for the time and travel to visit their child.
24. Additional training about the weaving of Lifecourse into the ISP needs to be done. Lifecourse,,when done at all, is often just being done as a tack-on and isn't really being used.
25. Internal Behaviorists conducting FBAs and completing BSPs lack the skills, intensive training and awareness and ability to train staff in implementation. This

is particularly a concern in the population of ASD with severe behavioral conditions. Even experience contracted BCBAs, who don't show objectivity, promote inadequate internal plans and fail to point out and improve data collection, ABC charts, and appropriate interventions undermine the success of those with ASD. Behaviorists need to be moved back out of the providers hands and be independent and unaffiliated.

26. Comprehensive medical reviews and testing for those with mental health issues should be conducted. Keeping abreast of research around the holistic treatment of disease is imperative and should not be excused nor overlooked because of diagnostic overshadowing.
27. What would you propose to do for the parents who are the caregivers? Many parent caregivers haven't lived an Everyday life in years. We have given up/not taken work in order to care for our children, paid for services and supports that should have been covered by waiver funding that no one told us was possible, have had difficultly finding a provider willing (sometimes an impossibility) to take our difficult child and/or are unwilling to let them leave our home knowing no one will take care of them appropriately or they will (given their data) face abuse. This is not the story of one, but many. Meg Snead's introductory comments, "All PA deserve the opportunity to live fulfilling, vibrant lives among their family, friends, and peers. The Wolf Adminsitration and the Dept of Himan Services are committed to doing all we can to help the people we serve achieve this while still accessing services and supports that meet their individual needs." It is unfathomable to believe that you are not aware of these situations. What are you doing to help? If families are not screaming for help (and some even then), then seem to be forgotten. What do you propose to support caregivers/ families who are at home taking care of their adult child, some of whom are dangerous, potentially dangerous, and traumatized. Do you have any idea how difficult it was to choose to transition children into a group home with what we see and know? Assumptions are made that we cannot care for or do not want our children; we are often dishonored by those serving our children for this very reason. We are expected to abandon them to the system while we are trying to get ready for the world without us. All too often, even when in residential care, so very much is left to the parent to handle. Who is monitoring outcomes and the decline in physical, mental, oral, and vision health in individuals in residential settings? Teeth should not be falling out of young adults. Obesity should not be occurring. Being given foods that are contraindicated due to health issues is medically neglectful. Even orders from physicians are ignored. Parents say it regularly, "No one will care for them like we do," yet these very parents are struggling to care for their child at home as they age and that becomes more an more difficult. Other children have grown and gone yet these children can, by

nature of their disability, demand full time attention and care; being in the family home has saved the state untold funds, yet parents are not compensated.

With regard to the Spending Plan Narrative:
A. Increased Access to HCBS
#• Fund a medical home program to focus on the comprehensive coordination of care for children with complex medical conditions.
I ask, “What will this look like. “ MH program or Coordinator across providers (why isn’t SNU doing this ... is this not already in their contract!)?

• Strengthen county infrastructure by providing funding to expand county staffing to accommodate growth in home and community-based waiver programs.
(These people do what? Paper pushers... get some data before we throw more money at the county.)

B. HCBS Provider Payment Rate and Benefit Enhancements
• Enhance quality of care by funding a nurse’s ability to shadow the current nurse for private duty nursing cases. (Reasonable, but how many hours and how often? For subs? Which cases get this and which do not; what is the criteria?)

• Support provider workforce expansion with funding to issue sign-on and retention bonuses for nurses, direct care workers, and other home and community-based service providers.
(Sign on bonus? People start, go through training and then quit. Lots of money and time is wasted only for people to leave. Offer it but only pay it if they stay a given amount of time. Get data on nurse pay and benefits in other settings, are we competitive... with sign on bonuses?)

• Incentivize the use of value-based purchasing initiatives that reduce missed shifts to strengthen nursing services.
(This May be reasonable, why are they missing shifts? Where is the data? ... people get sick, have kids who were in school and who get sick)

• Increase rates for 0-3 early intervention providers.
(Maybe... everyone would like more money. Is their pay, in comparison to other provided across all of the systems you serve and the education they need, reasonable? Set some priorities in wage adjustments across the entire system; make incremental changes everywhere and larger changes where there are more significant inadequacies.)

• Increase payment rates for direct care workers in the Community HealthChoices and Omnibus Budget Reconciliation Act (OBRA) waivers.
(Why just these waivers? As in my previous comment(s) equalize rate increases across waivers and models - AWC, self-directed, lifesharing - and link to experience, training, and certifications.

• Increase rates for the Living Independence for the Elderly (LIFE) program.
• Refresh data for Office of Developmental Programs services and adjust rates if necessary.
• Purchase consultation for the development and implementation of selective contracting and alternative contract methods.
• Increase provider rates to support state standards for the facilitation of staff training, education and recruitment based on American Society of Addiction Medicine (ASAM) criteria.

C. Supplies and Equipment
• Reimburse early intervention providers for expenses and supplies necessary to safely re-engage in-person visits.
(Providers of all types)

• Fund the purchase of personal protective equipment and testing supplies for HCBS providers.
(across providers/programs)

• Strengthen emergency preparedness of non-residential HCBS residents through provision of emergency preparedness kits.
(Perhaps but what does the individual need? How will these be distributed/refreshed?)

D. Work Force Support
• Create an online education and training portal for shift care nursing to strengthen supports to nursing professionals.
(Is this really an effective means? Why not one portal with training resources for them, DSPs, families, everyone)

• Enhance shift nursing services through co-training hubs for families and nurses to train together on complex cases.
(Can this be done online as described above?)

• Develop a medical home learning network to expand communications and supports to providers serving children with medical complexities.

(Seems like a job for SNU)

• Enhance quality of service provision for individuals with intellectual disabilities/autism, provider training and credentialing.
(You can enhance this all you want but until you separate ASD from the old ID system and remodel that, all the training in the world won't enable these people to understand and, with fidelity, implement effective programs.)

• Expand current training initiatives to include trauma-informed care, wellness, and other self-directed trainings that enhance service delivery.
(Include nutrition, behavior mod, first aid, etc.)

• Expand the workforce with student loan forgiveness programs to recruit a diversified workforce into employment in mental/behavioral health and substance use disorder fields of work.
(To do what? For the most part these are not college grads. Does forgiving loans of a few workers help with recruitment? College educated aren't vying for these jobs. This doesn't make much sense for some positions, do that for home health nurses for chronically ill children if they commit to working in the field for so long and d/c it if and when they leave.)

E. Caregiver Support
• Develop a registry of direct care workers that allows participants to locate, review and contact direct care workers who will best meet their care needs.
(Remember and prioritize parents as caregivers.)

• Provide respite and family support services to those on waiting lists for Intellectual Disabilities/Autism Services.
EVEN THOSE WITH WAIVERS CANT GET THESE! Without quality highly trained providers of respite for some of our severe individuals with ASD, forget respite,

F. Support to Improve Functional Capabilities of Persons with Disabilities
• Purchase remote support technology for HCBS providers to enhance transparency and quality assurance in service delivery.
(Great idea but how about we assure that all have basic care. Any tech is worthless without trained people to support, turn around train and trouble shoot. There are already too few of various sorts of specialists, where do you expect to get these?)

• Provide funding for assistive and remote support technology to enhance service delivery.

(SAME)

• Enhance training on infection control practices.
(Train, train, train but how many implement? There were DSPs who were t even wearing masks.)

• Purchase electronic incident detection reporting systems and dashboards to enhance HCBS monitoring.
(Sounds like an expensive venture ... when incidents are underreported, APS is pathetic - why waste money on this?)

• Enhance HCBS by improving technology for support coordination organizations.
(To do what? These revolving SCs do little but push paper. Do we really need them?)

• Accelerate the adoption of technology by purchasing a consultant to advise agencies seeking to adopt remote supports and other technology solutions for individuals receiving HCBS.
(This seems reasonable but they also need to do extensive training, fidelity checks and problem solving)

G. Transition Support
• Enhance transitions into the community by incentivizing managed care organizations to meet nursing home transition goals.
(Isn't this their job; why are we incentivizing it?)

• Purchase housing adaptations for those transitioning from institutional or congregate settings.
(Are these portable in case of a move? Are these recyclable to others?)

• Expand consolidated waiver capacity to transfer additional individuals from facility care.
(Is this really the barrier?
So what is the situation regarding the comments pertaining to all of these residents in Personal Care Homes who seem to have NOTHING; is that true? Were these eligible individuals and were providers really only getting $36/day for their care - that in not tenable?)

H. Mental Health and Substance Use Disorder Services
• Establish residential pediatric recovery centers that treat infants born substance-exposed and provide supports to their caregiver.

(Is this not something provided via EPSDT? What kind of support for caregivers? Are there really effective recovery programs that can support these individuals in a timely way so the child in not more at risk? If not, what are other options?)

• Support telehealth services with funding for providers to purchase equipment and training supports to enhance its usage.
(You could perhaps throw a little money at this but most providers already have some capacity to do Telehealth. What about individuals in their family home with aging parents though supporting internet, technology, and training for these individuals may be valuable. Paying for these on a fixed income is difficult if not impossible. On the other hand, having a provider physically see and examine people more frequently is wise)

• Provide for technical assistance to implement assisted outpatient therapy for enhanced outpatient treatment for individuals in the civil court system who experience serious mental illness.
(What kind of TA, is this for Telehealth and is that really valuable therapy?)

• Support the reopening and administration of virtual drop-in centers used to provide a non-clinical support setting for persons in mental health and substance use disorder recovery.

• Fund the administration and delivery of mental health counseling and support groups for frontline pandemic workers.
Is this not covered by insurance for the most part?

• Employ additional student assistance program liaisons to assist in identifying key behavioral health issues in school-aged children.
The SAP programs in existence don't do much of a job, parents don't know anything about them nor do some teachers. How about supporting trauma informed care in SAP programs and developing and funding programs that work.
IBHS has been a disaster with wait lists, lack of staff, trying to deliver the service remotely, etc.; implementation should have been delayed.
Developing effective DDTT programs - the one in my area has been a waste. They have no idea how to work with those with severe ASD, were fearful and did absolutely nothing.
Expanding the step downs for adults with MH/ID/ASD would be a great investment. One CRSU in one area of the state, psychiatric hospitals that do little for those with ASD apart from adding a (warranted/unwarranted) diagnosis so they can add a medication and are teaching hospitals and really exist to serve the student, not the patients,

• Fund scholarships to expand the number of certified peer specialists in Pennsylvania to ensure a strong workforce in mental health service settings.
Why, you do not give peers full time jobs and don't seem to value them - no money where the mouth is.

I. Support State HCBS Capacity Building and LTSS Rebalancing Reform
• Incentivize completion of care plans to improve care coordination and care management activities.
Incentivize... why can't they get this job done? A care plan - or any other plan for that matter - is only valuable in its accuracy and implementation. ISPs are often provider driven and not implemented with fidelity. Why should we expect anything different?

• Provide for enhanced training for private duty nurses to staff cases for children who have complex medical conditions as well as significant behavioral health needs.

• Invest in technology to enhance care coordination for individuals receiving private duty nursing services by connecting home health agencies with Pennsylvania's Patient Provider Network.
Again, isn't this the contracted job of the SNU?

• Introduce the use of electronic health records by state hospitals and HCBS facilities and ensure they are interoperable with the Health Information Exchange.
This is reasonable since EHRs were required long ago, the problem is, sharing diagnoses slapped on in order to get a treatment of add a medication begins a system of misinformation that through Exchange is perpetuated. This has happened to my son and the children of others that I know well.

• Enhance the comprehensive training program for direct care workers to bolster the quality of services for participants.
This really needs to be parsed out. Levels of training (with associated compensation) with testing, mentors (experienced, higher level, higher pay) on the job who provide modeling, teach back, and feedback is warranted. Fidelity checks and monitoring with disciplinary consequences (not dictated by unions) when warranted and systems to flag new hires who are moving for disciplinary reasons or who are suspect of issues elsewhere is warranted.

• Issue one-time grants to HCBS providers that have innovative ideas that will address social determinants of health.

I am not seeing the “Rainy Day Fund” that Nancy Murray alluded to during the June 30 public comments, but it would be helpful to know what the purpose and intent for holding this is.

The provider/speaker who was given the floor during the June 30 session without knowing that his mic was open exemplified the attitude of providers. Not recognizing that the prior provider was, in fact, a provider, he was critical and stated his opinion that only providers (and not stakeholders) should be participating. I have no doubt that that left other parents, lie myself, feeling devalued and disrespected. He mentioned billable hours; while funding is critical to operate anything, it dehumanized our loved ones to hours and money and not people.

Thank you once again.

Kelly King
[redacted]

Dear DHS-

We have Self- Directed our daughter's Consolidated Waiver services for years. Here are some opportunities to help my daughter to live out her Vision for A Good Life, since we helped her create her life vision using the LifeCourse Framework. Many individuals' lives could benefit from;

1. **2:1 DSP service that is NOT restricted by a Fade Plan**. My daughter's disability is NOT going away. She was born with [redacted]. It is not an injury it is a genetic disease. In order for her to live and participate in her community she sometimes needs 2:1 assistance. She enjoys participating and experience LIFE, but it is not safe, nor physically possible for her to do some things without the assistance of 2 SSP's. Using a public restroom is mostly impossible due to her being non-ambulatory and having intellectual disabilities. I know there are countless individuals in the same situation.

2. **Exceptions one week a year for an DSP to be able to work over 40 hours so that we can take a caregiver on a vacation with us for our daughter's care and well being.** It is physically exhausting for my husband and myself to care for my daughter on a vacation and of course not really a vacation for us. Our younger children don't get to have a real vacation experience either as you can imagine. Overnight nurse and SSP's are not allowed to work over 40 hours so that is less than 3 days into a weeks vacation. We don't want to leave her at home - that is not the answer- with her difficult life she needs a vacation too.

3. **Instead of allocating money to supplies for providers, put it toward supplies for the families that Self Direct, who have to pay out of pocket for all the DSP, and family PPE**.

4. **Extra Pay for DSP's who work on a Holiday. Holidays are difficult for special needs families since very few DSP's will work on Holidays but those who do should receive 1.5 pay.**

5. **Benefit allowance has not been increased in years for DSP's. AND the Benefit allowance is attached to wage so it is taxed- that's not right**

6. **Remove 40-60 Rule**

Thank you for your consideration

[redacted]

Thank you for the opportunity to comment on this plan. As you know, the Institute on Disabilities at Temple University is Pennsylvania's University Center for Excellence in Developmental Disabilities.

The first issue we would like to highlight is the funding for immediate relief for family caregivers. We support waiting list relief for both families and individuals, as they have faced unprecedented challenges this past year. Those who had informal support networks were unable to use those networks during the increased risks that the COVID pandemic posed to those with intellectual disabilities. Providing immediate relief to family caregivers who continue to wait for services will require the use of funding pay for respite services and other temporary supports while waiting for their loved one to be enrolled in waiver services. We also believe that there should be a temporary lifting of the cap for individuals in the person family directed supports waiver. American Rescue Plan (ARP) funding could be used to pay for additional services for one year. Moreover, peer to peer supports should be strengthened as they will be critical upon re-entering activities in the community after the pandemic.

The second issue that must be addressed is that there is funding needed to strengthen systems oversight and supports. Risk management funding should be included to improve training for supports coordinators and coordination organizations. The training opportunity in last year's budget was not implemented, so it should be in this year's. There should also be an increased availability in mental health supports, including the continuation of trauma training and trauma informed care for services. More people will need mental health services than before and investing in ensuring that an adequate number of professionals are available will be necessary. Racial equity and cultural competency training for direct support professionals should also be included. Finally, direct care staff study and systems analysis should be funded by conducting a study and analysis of how the workforce shortage for DSP impact individuals with disabilities, their quality of life, and how it impacts their needs. These results should be

used to develop systemic reform ideas and implement new service models to modernize our home and community-based services system.

The third issue is that funding should be used to promote inclusive community lives. This means that there should be a provider transformation where the funding is used to update services and transition away from segregated and congregate settings, providing community participation and support. Furthermore, there should be an increase in supported living opportunities, transitioning people from family home to provider-owned residential setting to supported living. Costs would include "start up costs" and home modifications to allow individuals to remain in their homes. Person centered planning training is also essential, and we must support institutional transitions.

Finally, funding should address the DSP and SSP crisis. Recruitment and retention is a key issue that policymakers must consider. A sign on bonus for new DSPs and SSPs and milestone payments for DSPS who complete 6-12 months of employment would be best. Professional development to increase quality is also essential. Funding would be needed to create an infrastructure to professionalizing the DSP profession, developing new certifications and degrees to establish a professional development credentialing, thereby enhancing quality.

Should you have any questions regarding these comments, please feel free to contact us.

Ms. Jamie Ray-Leonetti
Associate Director of Policy
Institute on Disabilities
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[redacted]

I am a parent of a young adult son who is diagnosed with [redacted] and [redacted] who exhibits severe behaviors of concern. He has the Consolidated Waiver but much good it does

him. A group home was being sought over two years ago. None have come to the surface unless I want to send him an hour or two away - that won't happen; this is his community. When the state centers were going to close, providers were all seemingly interested, but when that fell through, they all stepped back and - as of yet - there is no one to serve him.

Having worked in a group home myself many years ago and witnessed other staff treating residents unequally with favorites given preferential treatment, this was not the first choice for my son, but keeping him at home seemed impossible. Talking to other parents, hearing their horror stories and learning about the current system has made me even less inclined. Yet, across those two years we have only had 40 hours of support in any given month. We all remain captives in our home and to my son's rituals. I keep asking myself how much longer I can do this and if this is even how we should live.

I am asking that you reconsider the priorities with this funding. First, I don't know when [redacted] was lumped into ID services and waivers, that system wasn't really functioning well when I worked in in. I am convinced that this attempt to serve everyone with [redacted] with those who have an ID diagnosis is detrimental to the majority of them. My son, and others I know [redacted], [redacted]. Lumping them together as well as not providing independent behavior specialists with expertise in [redacted] - as I understand was done in the past - is a disservice. My son used [redacted] All of these human services need to be carefully evaluated for genuine impact, not just check boxes of so-called progress. When it comes [redacted], people just don't know what they are doing and are often doing more harm than good.

While I admit that everyone needs a living wage, I can not help thinking that I should not have had to forfeit working/income to care for my adult son when, under this waiver, this was your responsibility. Don't I deserve a living wage; 40 hours a month doesn't pay the bills? [redacted]. Now not only is he not able to contribute to the economy by holding a job, but I cannot either. Where is compensation to parents? So. as far as increased pay, I really doubt that those doing the real work will actually pocket much more after everyone takes their cut. Anyone working with someone like my son deserves good compensation - it is hard - but paying poorly trained staff more because they are the only ones who will do the job isn't going to solve anything. Those clamoring for more pay are the employees and providers who can't hire anyone, part of that is because no one wants to work just now.

If a fair minimum wage was established, that would be a start. However, don't just pay these people more but hire quality workers and provide robust ongoing training. Those willing to do this work are those who can't get other jobs.

Moving my son into a group home was never my preference. The reputation of these and state hospitals terrifies parents. I don't know of one parent who is delighted to send their child to one and I have heard of some who intend not to. The state needs to change their protocols, be transparent regarding abuse and neglect reports and findings. Name the violators. Keep (remove) investigations out of the hands of providers. Openly share data about unsafe situations so parents can make informed decisions. When something is wrong commit to fix it. The quality of care in these places should be the best there is.

Get parents to serve on oversight committees and give them open access. Honor their participation in their child's life and care for these residents as you would your own child.

Everyday Lives looks good on paper but have you ever assessed - from all perspectives - how many are really living this out, certainly not [redacted] children of other parents I know.

Supports Coordinators need training as well. [redacted] Most of these people don't even stay long. What is is they are supposed to do? I think they are a waste of money. Parents do a better job talking to other parents and finding supports themselves.

The handling of COVID needs to be looked at carefully. [redacted] That makes me even less enthusiastic about a group home. Staff were pretty much left to do things as they pleased and they seem even more resentful of parents now that things have opened up and the impact of that is seen. These are the homes of the individuals, staff are the appliances to enable them to live there but it seems the other way around. The entire system, the inclusion of those with autism, equitable pay rates across all workers/administrators, the work of the SCs, treatment, comprehensive training, internal investigations, the APS system, the service to individuals who are still in their homes, treatment and inclusion of parents/family, and the COVID closure need careful reflection and warrant change.

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[redacted]

Thank you for the opportunity to comment on the PA State Spending Plan for Home and Community-Based Services. **We appreciated DHS assurances outlined in the narrative and are supportive of the overarching priorities therein**.

Outlined below is feedback garnered from clinical leaders throughout UPMC Western Behavioral Health, Senior Services, Disability Resource Center, and Pediatric Home Connection. Earlier this year, UPMC strongly advocated to members of the PA Congressional Delegation for the 10 percentage point increase in federal matching funds for Medicaid Home and Community-based Services (HCBS) as part of the American Rescue Plan Act (Section 9817) that became law on March 11, 2021.

We know COVID-19 is having immediate and long-term impacts on behavioral health systems in all states. Pennsylvania is no different as illustrated last month in *The Wall Street Journal*, "Americans Seek Urgent Mental-Health Support as Covid-19 Crisis Ebbs."

If enacted, we know the American Jobs Plan could build on the American Rescue Plan Act by adding further federal support for HCBS, including state efforts to increase access through Medicaid. It also could be an incremental step toward a larger goal of eliminating Medicaid's historical institutional bias and making HCBS mandatory. This would be the mechanism to achieve President Biden's goal of eliminating HCBS waiting lists, which was included in his campaign proposals.

1. **Increasing access to HCBS**;
    a. For ALL ages, HCBS funding will advance prevention, access to early identification, and treatment of physical and behavioral health conditions provided by, or supervised by licensed professionals. Community-based organizations can deliver integrated evidence-based behavioral health preventive programs and treatments while also offering access to social resources such as affordable/temporary housing, and reliable transportation. As outlined, additional resources directed toward counties for HCBS helps to advance these modalities which often lack infrastructure for technology, personnel, and innovation of services, and face financial stress. This can substantially reduce hospital use and improve quality of life. Home visits can effectively treat maternal depression and improve behavior among children by identifying unmet behavioral health needs among families and increasing engagement in services. Moreover, research indicates home visiting programs have been successful in engaging and enrolling families who are at high risk for stress, depression, and substance abuse.

2. **Enhancing HCBS provider payment rates and benefits**;
    a. Fully supportive of all provisions, specifically loan forgiveness – and to the extent possible – allocations to enhance workforce development and support for recruitment and retention among key positions, support and technical assistance for outcomes measurement, improved access to long term care or alternative settings for individuals with frequent hospitalizations, crisis funding to implement rapid response, texting, and other timely interventions.

3. **Recruitment and retention efforts to support the workforce**;
    a. While the demand for care is rapidly growing, the number of mental health professionals is barely holding even. As reported by PA Legislative Budget and Finance Committee in February, 66% of Pennsylvania's mental health

administrators indicated that the lack of psychiatrists was contributing to delays in obtaining evaluations. Nationally, a 2016 report by the Health Resources and Services Administration projects a shortfall of 250,000 mental health professionals by 2025. We simply MUST increase the workforce to meet the demand. Ramping up value-based models such as embedding mental health workforce into primary care practices and HCBS settings will fall flat without increased capacity of mental health workforce as part of larger comprehensive public health pandemic strategy to address increased mental health demands. **Expanding scholarships and loan repayment programs to stimulate workforce growth is imperative.** Expanding the recruitment pipeline for mental health specialty workers will help meet the needs of underserved areas. Policies for doing this include expanding scholarship, fellowship, and loan forgiveness programs that attract more individuals, support more-diverse students, and require a commitment to practicing in high-need settings. Recruitment and retention of underrepresented students and reductions in financial barriers to advanced degrees in mental health educational programs is one way to diversify the pipeline of mental health professionals, improving cultural competence and health outcomes. Moreover, these efforts could improve the availability and quality of peer-support services. These specialists have been proven highly effective in improving patient outcomes. Expanding access to training, credentialing, and reimbursement for peer support has the potential to improve access to high-quality peer-support care.

4. **Assistive technology and other supports to improve functional capabilities of persons with disabilities**;
    a. Expanding Medicaid HCBS also can help people with disabilities participate in the workforce, by offering services such as attendant care or supported employment, and help family members remain in the workforce instead of leaving paid employment to care for a child with disabilities or an aging relative.

5. **Investing in activities to address Mental Health and Substance Use Disorder treatment and recovery needs of Medicaid beneficiaries**;
    a. Improve the availability and quality of peer-support services. Peer-support specialists are people who have experienced mental health or substance use problems and have been trained to join teams caring for those struggling with mental health conditions, psychological trauma, or SUD. These specialists have been proven highly effective in improving patient outcomes. Expanding access to training, credentialing, and reimbursement for peer support has the potential to improve access to high-quality peer-support care.
    b. Support of telehealth services to purchase equipment/training to enhance its usage is strongly supported. Telehealth allows providers to reach underserved populations and provide care in rural areas. Stimulated by the COVID-19 pandemic, state and federal policymakers should codify expansion of these services by ensuring that insurers cover them and that clinicians are adequately reimbursed.
    c. Other provisions with strong endorsement include:
        i. Establish residential pediatric recovery centers that treat infants born substance-exposed and provide supports to their caregiver.
        ii. Provide for technical assistance to implement assisted outpatient therapy for enhanced outpatient treatment for individuals in the civil court system who experience serious mental illness.

iii. Fund the administration and delivery of mental health counseling and support groups for frontline pandemic workers.
iv. Employ additional school-based/student-related liaisons to assist in identifying key behavioral health issues in school-aged children.

We look forward to partnering on opportunities to strengthen, enhance and expand HCBS. Please contact me if you have questions, or would like to discuss further.

Sincerely,

Nicole M. Fedeli

Nicole M. Fedeli
Director, Public Policy & Engagement
UPMC Government Relations
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[redacted]

Acting Secretary Snead and Director Kozak,
Thank you for the opportunity to provide stakeholder feedback on the state spending plan and your willingness to receive innovative ideas.

#1. I would like to propose an alternative, additional idea to provide a non-clinical support setting for persons in mental health and substance use disorder recovery.
NAMI Keystone PA's mission is to provide recovery focused support, education and advocacy to children, adolescents and adults and their families who are affected by mental illness. NAMI Keystone PA and our statewide network of 31 affiliates provide primarily two types of support groups; family peer support groups for family members of a child, sibling, spouse, best friend for whom they are providing support and care; and, a second peer support group for consumers or peers called Connection. In addition, during the pandemic many variations of these two primary types of support groups were started. For example, there are : LGBTQ groups, Black Minds matter groups, Parents of Children with Autism, Teens, etc.
NAMI support groups are facilitated by trained and certified leaders. NAMI national's curriculums are proprietary and everyone leading a group is trained and certified to hold fidelity to NAMI standards. The need for support during the pandemic was/is extreme as people experienced stress, worry and isolation in unprecedented ways. The need for support increased dramatically and the need for support groups increased exponentially. Thirteen NAMI affiliates were able to convert their support groups to a virtual format. Several switched from monthly meetings to twice a month while others began holding weekly meetings. Soon , support groups were being offered 7 days a week, all hours of the morning, day, evening and night. Many of the participants were peers who were struggling with the "lock down" the isolation, the shortage of certified peer specialist, the closure of drop in centers and clubhouses. Some of our support group participants attended groups twice a day, multiple days per week.

The NAMI Keystone PA affiliates conducted 1,634 Connection and 476 family support groups for a total of : 2,110 group sessions

5020 Family Members and 17, 823 Peers: 22,843 Persons Served

Please note: NAMI Keystone PA Coordinated Training for: 44 Family Support Group Facilitators
48 Connection Group Facilitators

#2. I also would like to propose that NAMI Keystone PA and it's affiliates could be effective providing support groups for frontline pandemic workers. With all due respect I want to suggest that rather than mental health counselling the workers would receive more benefit from debriefing sessions, Critical Incident Stress Management(CISM) Sessions. There is a critical shortage of mental health counsellors as well.
We have received calls and contacts from various business partners that we have done presentations for through the years looking for help. One is a large retirement/ nursing home community with 500 employees who says his workers are simply stressed out, can we come help them. We mentioned mental health counseling, and the employer said "No that's not it, they're stressed out." This is disaster psychology, as if a hurricane it. The pandemic is having the same kind of affect on people. Yes, some people will absolutely need mental health counseling but in terms of group trauma, we are looking at trying to do something different. We are looking at bringing in CISM teams to do debriefings and then train facilitators to run support groups on site with their peers. CISM is a nonclinical debriefing protocol used by police, first responders, etc. We can assist and coach after we train and then withdraw and provide technical assistance as needed. We also can provide some basic Mental Health 101 presentations as well as Stress Managements presentations. Other frontline worker companies that have contacted us are a utility company and a city public safety department.

I thank you for any consideration given to my feedback and ideas. I would also like to share that other states fund NAMI programs directly and have done so with some of the MH dollars that are coming into the states. Presently all of the programs that are offered are provided at no cost to the participant.

Thank you very much,

Chris Michaels

1. Provider rate increases for one year. This will help all providers in bouncing back from Covid. EI, ID, MH and D/A. I believe a one-year rate increase, if explained clearly to the providers, would be very helpful to them.

2. Funds directly to providers and counties for recruitment and retention efforts. This would include advertising, sign-on bonuses, bonuses for current staff that stayed through the pandemic etc. also chool loan forgiveness too as a possibility?

3. Funds for specialized trainings as to improve the provider networks in dealing with specialized populations, such as elderly/veterans, LGBTQ, etc….

4. Funds for Telehealth equipment, IT enhancements, etc. directly to the providers and or as a pass-through through the counties to the providers.

5. Funds for supplies to consumers/individuals served who would need this equipment to continue services.

Thank you! Let me know if you have any questions!

Mary Piatt-Bruner, Administrator
Bedford Somerset DBHS

I am writing to you on behalf of AMERICARE Home Solutions that provides personal assistance services to more than 80 Pennsylvanians. Our agency also employs 150 caregivers. Thank you for the opportunity to provide comments on the American Rescue Plan (ARP) funding specifically for home and community-based services (HCBS). This funding comes at a critical time, when demand for home care is at an all-time high, costs are increasing sharply, and rates have remained almost stagnant for over a decade. Recruiting and retaining caregivers has reached a crisis point, and I write today to ask that you direct a significant portion of the new funding toward increased reimbursement rates and financial support for bonus and other provider payments to preserve access to quality care.

The following priorities outlined in the Department of Human Services' *Spending Plan for the American Rescue Plan Act of 2021, Section* 9817 are critically important and must be funded:

<u>HCBS Provider Payment Rate and Benefit Enhancement</u>

- Providers need additional funding for increased reimbursement rates, sign-on and retention bonuses for direct care workers, nurses, and other home caregivers and believe that this is where the bulk of the funding should be allocated.
- Although we support funding that is intended for caregiver wages or bonuses, it is important that flexibility be given to providers, as individual agencies will have the best sense of where funds would do the best to address recruitment and retention challenges in their communities.
- We support both sign-on bonuses, and retention bonuses for employees who remain at the same agency for a specified period of time. To prevent "agency hopping" directly related to any sign-on-type payments, we ask that the Department make payments directly through the agencies and limit sign-on payments to one per individual. Funds provided for these purposes must include funding to support additional employer payroll tax and other financial responsibilities.
- We also support – and need – reimbursement rate increases for caregivers.
    - Reimbursements do not reflect the cost of providing services, which have skyrocketed in recent years. With the lowest reimbursement rates across comparable state programs, PAS providers simply cannot compete with private employers (or even other programs) for quality workers.

    - Sample rates in PA include:

        - PA State OPTIONs: $20/hour
        - VA: $24/hour
        - Private Pay: $30/hour
        - ODP: $24-32/hour
        - OLTL: $17.72-$19.52/hour
    - Demand significantly outstrips supply, with more and more hours going unfilled, or requiring an agency to pay overtime to meet the need and provide care. We urge funding to reimburse for this overtime; as you know, caregivers in the consumer-directed model are already receive overtime funding.
    - Rate increases must be provided, and they must be permanent. This is a long-term problem that requires a long-term solution.
    - Again, it is critically important that funds provided for these purposes also include funding to support additional employer payroll tax, overtime, and other financial responsibilities.
- For agency-model funds, we believe that these funds should be paid directly to the agencies in order to streamline and facilitate quick, efficient distribution.
- We also support payments to providers to provide tuition incentives, student loan repayment, and similar educational/training supports.

Supplies & Equipment

- We support funding and reimbursement for the purchase of personal protective equipment and testing supplies for HCBS providers. Throughout the PHE, home-based care providers have not been prioritized for PPE, and a recent PHA survey showed that PPE Expenses have risen almost 500% for home-based care providers. PPE expenses will continue for the foreseeable future (although price gouging has eased), with DOH/CDC/CMS and OSHA rules requiring its use.
- We ask that this support come in the form of direct funding/grants, as agencies can be required by PPE vendors to have a certain "buying power" in order to be prioritized for access.

Work Force Support & Training

- We support additional funding for caregiver training.
- As you know, PHA has developed My Learning Center, a free online training platform for direct care workers and family caregivers. To date, 181,309 users have completed more than *four million courses*. The cost associated with developing new videos and administering the platform is approximately $120,000-$150,000 per year, which includes new videos and language translations each year. We urge the Department to provide funding for new videos and translations for FY21/22, 22/23, and 23/24.
- We support non-internet-based learning materials for individuals without easy access to the internet or those who are more comfortable with hardcopy materials.
- We also recommend and support reimbursement for caregiver pay during training.

Caregiver Support

- We oppose the development of a registry of direct care workers for the same reasons set forth in Markham v. Wolf, NO. 176 MD2015, Pa. Commonwealth Court, which is ongoing litigation. We have continued concerns about DCW privacy rights and the Department's prior/current efforts to create such a registry, and FMAP funding should not be used in this way.
- In addition, PPL/PCG already has a caregiver database, as does www.care.com. A mandatory registry is inappropriate and unnecessary, when multiple alternatives to find care already exist,

at no cost to consumers. Funding through the enhanced FMAP should be directed to programs that will advance the level and quality of services, not to recreate a resource that already exists.

Support to Improve Functional Capabilities of Persons with Disabilities

- We support the purchase of remote support technology for HCBS providers to enhance transparency and quality assurance in service delivery; these resources should be provided to seniors as well as individuals with disabilities.

Thank you for your consideration of our comments and for your leadership on these important issues. Please let us know if you have any questions or if we can provide any additional information. We urge you to move forward with increased reimbursement rates and any bonus payments as expeditiously as possible. The need is immediate, and access to quality care is at risk. I can be reached at [redacted].

Sincerely,

Mary Claire Pellegrini, RN, CEO

Mary Claire Pellegrini, RN, CEO
AMERICARE Home Solutions, LLC
709 Main St.
Avoca, PA 18641
570-457-CARE [redacted]
[redacted]
570-457-2327 (Fax)
[redacted]

Dear Ms. Snead,

Thank you for the opportunity to comment on the Pennsylvania Department of Human Services Spending Plan for the American Rescue Plan Act of 2021, Section 9817.

SPIN has been a provider of services to children and adults with intellectual disability and autism in Pennsylvania since our founding in 1970, 51 years ago. We have a strong foundation in People and Family-First values, a mission based on a life of possibilities and a culture of quality, inclusion and optimism for our employees and community. We survived through 2020 and the first half of 2021 based on the CARES Act and the Federal Provider Relief Fund. We passed millions of the dollars on to our DSPs and other frontline employees in the form of premium pay for direct work, recruitment and retention bonuses, and increased medical, leave and other benefits related to COVID.

Nonetheless, many DSPs could not hold on. We lost hundreds of DSPs who are no longer able or willing to work in these challenging jobs with low wages, bad schedules and terrible work-life balance. We are now using up our reserves to pay recruitment and retention bonuses and still we struggle with losing more DSPs than we can hire. The relief dollars from 2020 and early 2021 are spent and as premium pay ends, we are losing even more DSPs.

We need help and we need it now.

3,500 children and adults and their families are counting on us to keep doors open for those who continued in services and to re-open doors to those who we have been unable to serve for the past 16 months.

We are greatly concerned about DHS' spending plan. While we understand the plan is a high level overview and intended to engage stakeholder comments along the way, we are alarmed that there is no acknowledgement of the extreme, immediate and growing crisis of our system. With no mention of a workforce crisis, the plan proposes increased access to HCBS and increased quality, during a time when SPIN and other providers are forced to diminish capacity and experience declining quality due to excessive DSP turnover which has turned the crisis into a catastrophe.

The elements that propose to address workforce in the plan are overly prescribed, inadequate and too late. SPIN along with most providers has substantial PPE inventory, access to more technology and telehealth and what we need is immediate and significant relief funds for increased DSP compensation. In particular, we take exception to the "HCBS Provider Rate and Benefit Enhancements" that speak to adjusting ODP service rates "if necessary". SPIN's rates are lower in many areas than they were in 2010 and many others are based on 2015 costs that were already subpar. DSPs who are the backbone of services are earning less when inflation is considered than they were five years ago. Clearly, it is necessary to increase provider rates. Without immediate relief together with increased ongoing rates, the system will not recover.

Providers need an infusion of relief dollars in our attempt to retain the DSPs we have and recruit new DSPs.

As we prepare these comments, SPIN and other residential providers across Pennsylvania are going into a 3-day Holiday weekend. From the time most office employees leave work at 4pm on Friday, July 2nd through 8am Tuesday, July 6th, when they return to work, SPIN needs 15,288 hours of qualified, trained, DSPs to operate all of our Community Living Arrangements. Hundreds of DSPs are scheduled to work this Holiday weekend at SPIN. Experience tells us that up to 50 scheduled DSPs will call out this weekend at SPIN. When DSPs call-out, the staff they are relieving may be forced into a double shift or a Supervisor must work the shift. With Supervisors and management staff as the only back up to DSPs, we are not only overworking DSPs, we are also over-burdening frontline managers. With no work/life balance frontline managers are turning over in record numbers. Losing frontline supervisors or using them increasingly for direct support diminishes support for DSPs and oversight of quality.

Now that the Holiday weekend is over, we are faced with the fact that we have no DSPs to work in Community Participation Support (CPS) Services. We are providing direct CPS at only 15% of our previous capacity. Hundreds of people are not receiving services.

We need help to re-open now.

People who have been home with no services are languishing and need services now. Families, who are caring for their loved ones with a disability with little or no services are on the brink. We have heard from families where the only support they have is going to the ER with their adult child. Families and their loved ones are upset and angry that once again they are being left out. After sixteen months of isolation and boredom, they need services to re-open and that takes DSPs.

We need help now to increase DSP compensation to a level commensurate with their job descriptions and their value to people.

We ask DHS/ODP for immediate $540 M in one-time emergency relief funds and an open, transparent process to establish viable rates that will adequately address the need to pay DSPs a family-sustaining wage and stabilize providers and the system so people we support and their families can count on it for their lives and future.

Thank you.

Sincerely,

Kathy McHale
President & CEO
[redacted]

SPIN
A Life of Possibilities

10501 Drummond Rd.
Philadelphia, PA 19154
1-844-SPIN-CAN
spininc.org

Good afternoon,
Thank you for the opportunity to comment on the plan that DHS has developed regarding American Rescue Funds.

The plan is very well thought out and has some great and potentially beneficial aspects. A great deal of thought and work has clearly gone into the development. Thank you to all involved for the dedication to the individuals and families we serve and those who work so hard at the community level to implement services and supports.

I have a few thoughts and comments regarding the **Work Force and Support section** of the plan. I have outlined my thoughts below.

Student Loan Forgiveness

1) **Consider using this as a method for RETENTION as well as a tool for recruitment. County and provider staff who have worked in the field for a certain number of years could have a percentage of their loans paid off for each year they have worked in the field.**
2) **Make this available for provider staff and for county staff.**

While attracting new staff is important, it is crucial to maintain staff that providers and counties have. Experience and knowledgeable staff are a treasure. It is difficult enough to train new staff on procedures and regulations, but it is even more difficult to teach them about the community resources, culture of the community, unofficial ways to access resources, and the history and culture of the agencies.

Work Force Support-General:
I encourage consideration to make funds available to counties for providers and county programs for retention and recruitment efforts.

1) **One time bonuses for staff who stayed throughout the pandemic.**
2) **Sign on bonuses for staff who take new positions and stay for a designated amount of time. Perhaps it could be tiered. A partial bonus after 3 months, then 6 months…).**

Again, thank you for the opportunity to comment and for the work you do.

Sincerely,

Tina

Tina L. Clymer, MS, LPC
Administrator
CMP MHDS
724 Phillips Street, Suite 2
Stroudsburg, PA 18360
570-420-1900 [redacted]

Dear Jason,

Many community based programs struggled maintain and hire staffing through the pandemic. The services of Keystone Service Systems were no exception. At Keystone, we offer a variety of community based services that include Supportive Living, Intensive Case Management, Peer Support, Psychiatric Rehabilitation, and Domiciliary Care.

Rate increases in fee for service programs and staff pay increases in general would be an essential part of keeping home and community based programs financially viable and enable them to remain strong or even grow so they can support the increased need for services. Increases in salaries would enable us to hire the staff needed to expand our site based psych rehab program into mobile services, and increase program growth in our existing Supportive Living, MPR, ICM and Peer support programs. There have been tremendous staffing needs given the pandemic due to COVID risk given that we cannot require individuals supported to have the vaccine and that staff are leaving direct care human services due to health risks.

Additional program funds would allow for employee education and wellness opportunities, provide access to equipment for individuals without technology, offer adaptive equipment for individuals with disabilities, and allow billing for necessary transportation to in person services. Additional dollars for transportation would also be helpful because individuals may not feel safe taking public transportation due to their COVID risk factors verses taking a 1:1 Uber for example.

We appreciate the opportunity to share our thoughts on this matter and hope you will consider these ideas as useful ways to improve service provision for community mobile services.
Sincerely and with thanks,
Jo Anne Meyer

Jo Anne Meyer, MS
Director of Community Based Services
Keystone Service System, Inc.
8182 Adams Drive
Hummelstown, PA 17036
[redacted]

Good afternoon,

My comments for the American Rescue Plan use of the he 10% increase is related to the rates and payments to providers of Medical Assistance Services. As mentioned in the preliminary priorities the increase will go a long way in helping ensure providers stay in business. The increase in wages, PPE, and overall operational costs due to inflation have put many providers on the brink. Coming out of the closures and shutdowns which resulted in severe loss of business, many providers are struggling to make ends meet. Any financial assistance or guarantees of work with payment will help accomplish several goals of the ARP funds. Without providers, it will be very hard to increase access to services for consumers, increase access and very hard for families to get their loved ones the care they need. All of the service goals center around the providers ability to retain a satisfied workforce and the financial means to purchase equipment and supplies to carry out the service consumers need.

Thank you for your time and the opportunity to provide comment.

Sincerely,

Mark Prasko
Director
Health Ride Plus
406 Magnolia Street
Northern Cambria, PA 15714
Office: 814-948-6510 [redacted]
Fax: 814-948-4821

Dear Secretary Snead,

Thank you for the opportunity to offer input regarding the use of funds per the ARP Act of 2021, Section 9817. Please enter our letter into testimony.

InVision Human Services concurs with the PA DHS plan for expending the HCBS FMAP allotment. We also believe that PA cannot reach its spending objectives with just the resources allocated by the 10% FMAP increase. Measurable success in these areas will require additional expenditures from other ARP allotments, including resources from the $7.3 billion assistance provided to the Commonwealth but not utilized in the FY 21/22 budget as signed by the Governor.

Here are our points of discussion and requests for serious consideration:

- Regarding the “rate refresh” in the current fiscal year:
    - DHS/ODP will set rates that, over a three-year period, ***provide a living wage*** for Direct Service Professionals (DSPs) in accordance with MIT’s Living Wage Calculator (https://livingwage.mit.edu/).

- Prior to setting and publishing rates, DHS/ODP will publicly release in a report to the General Assembly***, an analysis of the cost providing a living wage***.
- DHS/ODP will ***conduct an open hearing*** to receive stakeholder input and to answer questions, during the process of collecting data to assist in the rate data refresh process.

- The DHS/ODP will direct its contractor Mercer, Inc. to present data information related to rate-setting, including not only the current cost for ODP waiver services, but also to specify the amount of rate increase and fiscal appropriation inclusive of state general funds and FFP as well as those ***required to provider services with DSPs paid at a living wage.***

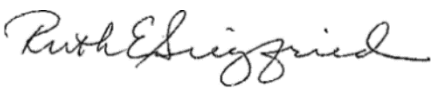
    - Past accumulation of rate data information was based on assessing the average market cost of current pay for DSPs. That process reinforces current poverty-level wages. The desired outcome would instead result in improved wages that would bring DSPs up to a living wage, or at least a level that might allow some of them to discontinue working a second or even third job to support themselves and their families.

A rate achieving a living wage over three years will be consistent with the public commitment of the commonwealth's governor, Tom Wolf, who publicly endorsed a living wage for DSPs in an October 2018 address to the Pennsylvania Advocacy and Resources for Autism and Intellectual Disabilities Annual Conference. Additionally, a rate refresh that reports to the General Assembly and is based on the cost of providing a living wage promotes transparency in government while retaining the final decision on setting rates to the Administration and the General Assembly.

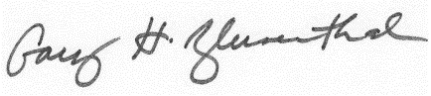
It is unconscionable for the Commonwealth to knowingly fund providers in a way that PA knows will result in poverty-level wages for Pennsylvanians – one that qualifies DSPs for Section 8 housing, SNAP benefits, and/or income eligibility for Medicaid health benefits.

Thank you for the opportunity to comment. The signers bring over 80 years of experience and expertise to the table in this discussion and would be honored to provide additional thoughts if they might be helpful as you consider this critical issue.

Sincerely,



Ruth E. Siegfried, Founder and President/CEO, InVision Human Services



Gary H. Blumenthal, Vice President, Government Relations and Advocacy, InVision Human Services

InVision Human Services
Innovative Approach. Shared Vision.
724-933-5100 [redacted]
www.invisionhs.org

On Behalf of Success Rehabilitation and all Brain Injury HCBS Community Providers,

Home and community based service providers to those with acquired brain injuries are in a desperate situation in attracting and retaining direct care workers. That rates to compensate individuals who perform this vital role have not be changed in over a decade. The associated increased cost of living, cost of doing business, and raising wages in non-healthcare settings has rapidly depleted the pool of potential candidates. Before the pandemic this was a dire situation. Now these challenges have become almost insurmountable and have driven wages to unsustainable levels. My organization, Success Rehabilitation, has always and continues to devote as many resources as possible to fill this need. Now however, our resources both financial and human capital, are stretched to a breaking point. I fear that our organization will not be able to provide the direct support working staffing levels that are needed to keep the individuals we serve in the community. We are faced with the looming decision to discharge many individuals to institutional settings (e.g. nursing homes) where we know their care and opportunities for rehabilitation and community integration will diminish if not disappear.

Success Rehabilitation fully supports the ARP Act funds to address the workforce crisis through increased direct care worker payments. These payments must not be temporary measures. Plans must be put into place to adjust the rates so they promote a sustainable workforce. A short lived solution is not sufficient and could result in an untenable expectation that enticements in the form of one off bonuses would create.

I welcome any and all opportunities to speak further on this issue.

Thank you,

Padraig Tangney, MPH, CBIS
Chief Operating Officer
Success Rehabilitation, Inc.
[redacted]
www.successrehab.com
5666 Clymer Road, Quakertown, PA 18951
Success Rehabilitation, Inc.

Dear Governor Wolf and Secretary Snead,

I am submitting comments on behalf of Pennsylvania Assistive Technology Foundation (PATF) with regards to the spending plan for the American Rescue Plan of 2021.

First, information about and support in accessing assistive technology (AT) should be a priority for the Administration. The federal definition of AT includes any device that helps a person with a disability do the things they need to do. Devices can include ceiling lifts, eye gaze systems, hearing aids, smart home devices (i.e., doorbells, cameras, smart speakers, door locks), adaptations to vehicles, stair glides and more. Home modifications (barrier-free showers, widened doorways, etc.) fall within the federal definition of assistive technology, as well.

Assistive technology devices (along with the necessary supports) can help a person be as independent and safe as possible. AT also helps someone maintain their autonomy. During the pandemic, AT made it possible for people to remain in their homes (via stair glides, lifts, for example) and not be forced into an institution. AT also connected people to family, friends and health care professionals via tablets, computers, smart phones and smart speakers.

It is imperative that supports brokers, supports coordinators and service coordinators learn about assistive technology so that they can help waiver participants discover what devices might help them address a functional need. All too often, we (at PATF) hear that the county, Managed Care Organizations and their staff, & supports/service coordinators have *never* talked about AT, never suggested that a particular device can help them, or that misinformation is, in fact, provided. It's imperative that the professionals who help support people with disabilities in the community, and in nursing homes, understand the range and scope of assistive technology AND they help the participant access those devices.

Second, we urge the Administration to support an increase in pay for Direct Support Professionals (DSPs). The shortage of attendants is real. Direct care workers are critical to helping people with disabilities live in the community; and, yet, the current pay scale for DSPs within Community HealthChoices (CHC) ranges from $9 to $13/ hour *without* benefits. It's not possible for participants to compete with Target, McDonalds and other box store pay scales at this rate. And, we also recommend that the pay scales among the waivers for the same service be similar. People who have an intellectual disability and can hire an attendant at $17 / hour or $25 / hour can raid attendants from participants enrolled in CHC. [This makes it impossible for people who want to live together, but receive services administered by different offices, to do so. Providing personal care is hard work -- DSPs should be provided the respect they deserve with a livable wage (and benefits).

Thank you for providing us an opportunity to submit comments.

Sincerely yours,

Susan

Susan Tachau
Chief Executive Officer

Pennsylvania Assistive Technology Foundation
1004 W. 9th Ave. | King of Prussia | PA | 19406
P: [redacted] | F: (484) 674-0510
[redacted]

THIS ISN'T A RESCUE REQUEST DUE TO COVID19 – THIS IS A RESCUET REQUEST ASKING FOR FUNDING FOR A PROGRAM THAT HAS NOT BEEN AT THE FOREFRONT OF ANYONE'S MIND AS YET.

The American Rescue Plan is a wonderful concept, but the idea needs to be permanent. We are not in a rescue situation due to COVID19. We are in a rescue situation due to the lack of funding/support and decisions made on the behalf of Congress/House/Representatives for YEARS.

I understand that 99% of those receiving this letter will never need to have the government fund your home health care services; but we have millions of seniors in our country who are below the poverty level and receive subpar services due to lack of funding.

Place your parent or yourself in this scenario: "you are ill, recovering from a stroke, illness or just have comorbidities, are in pain, unable to communicate, need help bathing, eating, going to the bathroom and all the activities of daily living that any healthy person takes for granted; and the person hired to help you is not qualified, or possibly unsuited to the situation. You need help and you don't have control or the option to say no to the direct care worker because you are desperate for help. Low wages equal low quality direct care workers. This is the situation most of our senior population is facing because of the funding provided for their care.

Home Health Providers are currently paid $17.88 per hour regardless of the number of hours provided a client. That means any overtime, which is Federally required to be paid at 1.5 times an hourly salary is more than the provider is paid per hour. Most direct care workers make between $9.50 and $11.00 hour.

Governor Wolfe is trying to mandate a $15/hour minimum wage, yet providers are being paid $17.88/hour straight time with no overtime allotment.

Please step out of the privileged life you are living and pretend you are like most of the senior population in America. think of who you want changing your diaper, bathing you, feeding you, helping you with your most intimate and personal needs and then think how much they should be paid to help with those activities. I bet you figure more than $17.88/hour!

Please set aside time to review, research and really think about our seniors. Without those who have gone before us, we would not be who we are today. Your health can change in a moment, and you need

to think of who you would want to care for you in your most desperate moment and how much you would pay for quality care.

Thank you!

Karin Acquaviva
Office Manager
Caden Care Homecare LLC
11900 Frankstown Road
Suite 200
Pittsburgh, PA 15235
[redacted]
F:412-798-2419

Jayson Cohen

Morgan Cohen

[redacted]

[redacted]

[redacted]

July 6, 2021

Consolidated Waiver

Chester County

Via Email To:

Public Comment: American Rescue Plan of 2021 (ARP) provides a temporary 10% increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS).

The following is needed:

1. People opting for Participant Directed Services are requesting access to Quality management, training, and corrective actions for common law employers, surrogates, guardians, employed family members (all of which can be family members), and the participant, just like providers. Participant Directed Services require Civil Rights including all rules and processes as Providers receive because it is the law. All matters, including fraud, are to be remediated civilly as required by federal and state laws, which are to be reiterated in ODP documents. All Participants and their family members are to be protected and afforded 55 Pa Code Chapter 275 Hearing and Appeals as outlined and required under the waiver and DHS BHA Administrative Law Judge for determination because it is the law.

2. All mandatory training listed in the 1915 C waiver and written in the ISP (e.g. prescribed restrictive practices) must be paid via the fiscal agent to comply with federal law. Thus, a service code for training must be established and training budgets identified in ISPs because it is the law.

3. Speech and Language Services including Communication Training: There are no providers who have authorization to work and paid under the 1915C Consolidated Waiver. The services must meet the definition of Home and Community. The public is requesting that a clear service definition is included in the waiver and a Provider List must be generated for families so they can interview and locate a needed service provider for all therapies listed in the waiver because it is a requirement and law.

4. Third Party billing is a requirement under the law. Many families have primary insurance for their family members. It is required that the state authorize and process Third Party billing because it is a requirement. §1902(a)(25) Requires that a State plan for medical assistance must provide that: States or local agencies take all reasonable measures to identify legally liable third parties including: - Collection of health insurance information; - Submission of a plan for pursuing claims against third parties; States pursue reimbursement from third parties; Mandatory pay and chase methods to be utilized in certain situations.

5. In Pennsylvania there are no therapy providers available for Home and Community Based Services (e.g. Speech and Language Services, Occupational Therapy and Music Therapy). Beneficiaries who have disabled insurance through their family must be paid via the waiver (or reasonably limited) to ensure medically prescribed services are obtained without a financial burden on the participant or medical insurance card holder. Providers under Medicaid are charging families co-pays even though the law states that a person receiving Medicaid are not required to pay the co-pay.

6. CLEs should be able to easily establish new service codes if needed services do not have established codes (e.g. 3:1 support, 4:1 support, mandatory training, etc.) to provide medically necessary services to the participant without delay or harm.

7. DHS, ODP and the Counties have not issued the mandatory requirements of Policies as mandated by the Administrative Entity Agreement. Participants and their family members demand an issued bulletin on “What is Billable vs Non Billable”. Families have been indicted under Grand Jury Testimony by PA OAG of the Medicaid Fraud Unit. Families have been

accused of misuse of services in Common Pleas Court without the proper process including notice, remediation and/or Fair Hearing because it is the law.

8. Families have been denied 55 PA Code Chapter 275 for having family members being in their homes instead of placement in an institution. Participants were arrested without notice from ODP or DHS as per the Memorandum of Understanding of Denials of requested Services for the participant. DHS does not allow families to file for Fair Hearing instead relies on the AE or SCO to send the Fair Hearing Request to Bureau of Hearing and Appeals (BHA). Families are being denied Due Process because SCO and DHS refuse the Fair Hearing Request from family members. Families and Participants must be able to submit Fair Hearing requests directly. An independent review panel should be put in place to oversee and protect families from unlawful policies and complaints.

9. Family members who had become Common Law Employers (CLEs) who have been terminated from the 1915 C Consolidated Waiver program without notice, remediation or the required fair hearing process are being misclassified by the OIG, OAG MCFU, as Personal Care Assistants in the National Program Identifier (NPI) for over 236 years expulsion even though there is law that documents a 5 year maximum exclusion. CLEs do not get paid therefore they cannot be classified as a worker. The Public requested the policies and procedures for the Medicaid Fraud Unit to investigate any identified error, including timesheets and Job Descriptions. The public needs to be notified of the difference between families providing services and being criminalized while the enrolled providers receive audits, remediation, and sanctions. Participant Directed Service model require the same process as Providers. DHS must and is required to notify participants of their civil rights.

10. This MONEY must be allocated to the Hearing and Appeal Process to educate family members and the beneficiary of their right to ALJ Administrative Process instead of being sent over to the Office of Attorney General's office without notification, remediation, or corrective action.

11. Communication Services and Speech and Language that satisfy the requirements of Home and Community Based Services (HCBS) Providers are nonexistent in Chester County.

12. Families, Surrogates, and Eligible Participants are requesting that Policies and Procedures be published including all protections afforded to them while working or receiving services under the waiver. We have asked why Participant Directed Services are defined as "Risky" in Chester County and we have never received information, training or policy on what is Billable vs. Non-billable for Job Descriptions of the Direct Care workers which continues to put families at risk of being denied due process as DHS, BPI have circumvented 55 PA Code Chapter 275 and allowed the Office of the Attorney General to terminate preliminary investigation and deny Legislative assurances including; remediation, corrective action, and Fair Hearing at an Administrative Fair Hearing with the Agency, County or whatever jurisdiction .

13. Families have been denied the civil process that includes: Support Coordination and the Administration Entity Failed to follow the QMET assurances. Families are being denied the process to proceed to Fair Hearing because ODP, OLTL and DHS have failed to provide Notice, Fair Hearing and remediation through the Bureau of Hearings and Appeals. This includes errors

on time sheets and cleaning duties in the job descriptions that the family created. If the county, state or anyone disagrees with the job description families should be notified of what is Billable vs. Non-Billable for the family members and provided guidance on how to be in compliance with the waiver policies. Families were criminalized and denied the Administrative Process policy and regulations outlined in 55 PA Code Chapter 275 and therefore, must be made whole and remediate (exoneration) the actions of DHS and the Commonwealth.

14. Families need ODP/DHS to create an expungement process for anyone that was criminalized by the PA OAG. 55 PA Code Chapter 275 must be followed because it is the law.

15. The State Medicaid Plan should be accessible without charge. The State Plan should be published electronically so families and beneficiaries can access the rules, law and processes of the Medicaid Plan.

16. Surveys of satisfaction of services. The public would like to have surveys for all participants under the waiver and every county must have an Ombudsman that can resolve consumer complaints. At this time, ODP, OLTL and DHS have been hostile to families and often terminating phone inquiries and refusing to provide needed information including fair hearing requests.

17. Families require accountability from their county and state officials including all the assurances of the waiver and the services listed. Families require honesty and respect. Families should not be considered liable for services outside of what commercial providers are afforded. The state is getting billions of dollars and there is no oversight of the quality of services for all participants. Families are not provided any information on how to receive and maintain services. Families are not provided any training or information regarding civil rights including fair hearing for all events.

Thank you for your time
Jayson Cohen

June 29, 2021

Resources for Human Development (RHD) appreciates the opportunity to provide feedback on the draft Pennsylvania Department of Human Services spending plan for the America Rescue Act (ARA) funding.

RHD provides an array of Human Services across the Commonwealth ranging from Children's Services, Intellectual Disabilities, Mental Health and Outpatient SUD treatment programs to Homeless shelters.

RHD is extremely concerned about the sustainability of the Human Services systems. After many years of flat funding or cuts, providers are stretched to their financial limit. As a result, we are experiencing a workforce crisis across all these community services. Combined with the aftermath of COVID, we are experiencing the worst work force crisis in our 50-year history. The long-term erosion of funding for the past decade has diminished the ability for providers like us to recruit and retain staff. Current rates do not give providers the ability to fill vacancies for these life-sustaining services. This workforce crisis existed prior to COVID and has deepened during the pandemic making hiring and retaining staff next to impossible.

The ARA funding is the lifeline providers need to get through this post-pandemic year. It is not the solution to the longer-term workforce crisis but will give providers some financial resources to sustain their infrastructure for the coming year to maintain community services.

Recognizing our comments are based on one-time funding, RHD offers the following recommendations:

- The way the spending plan is currently written, it gives very narrow focus to a serious and complex crisis. We ask the state to expand the flexibility so providers can identify, on an individual basis, how to use the funds within their organization to sustain and enhance services as CMS guidance indicates. RHD urges the Department to disseminate to each HCBS provider a fairly determined lump sum to be spent in the coming year. This will allow providers to identify their own individual solution which is critical to achieve optimal impact.

- Expand the eligibility of items which are workforce specific such as bullet points (BP) #4 (Training for ID and autism staff) and #6 (student loan forgiveness for BH staff) under section **Workforce Support** to workforces in all services so they all have equal access to these valuable resources.

- Though RHD supports initiatives expanding access to community services, we feel that it is critical to address the workforce crisis before any attempts are made to increase access to programs. **Without a sufficient well trained workforce providers cannot provide quality services.**

- RHD supports any item that helps behavioral health providers transition to a value-based system of care. Add to the section **Transition Support "***Assist mental health and substance use disorder providers to transition into a value-based system of care. Including but not limited to, items such as* ***establishing new training and technology systems".***

- Delete any item that will lead to mandatory training and credentialing such as BP #4 under **Workforce Support** *"Enhance …provider training and credentialing"*. While RHD is philosophically supportive of enhancing both staff credentialing and training, both have an ongoing cost beyond the scope of this one-time funding. Additionally, enhanced credentialing should lead to increased compensation for that additional knowledge and skill level. This one-time funding will not support that ongoing compensation cost. Rather move the system towards Value Based services where outcomes and compensation will drive quality.

- Delete in BP # 2 under the **HCBS Provider Payment Rate and Benefit Enhancements** section sign on bonuses. Sign on bonuses will lead to staff moving from employer to

employer to receive as many bonuses as possible further destabilizing the workforce. RHD would much rather spend the funds on increasing salaries for a work force that so desperately needs it.

- Add under the **Workforce Support** section the ability for remote supports. Remote supports, in addition to other technology will help address some of the current workforce. In addition, it often help foster independence.

- PPE is no longer a dire need for providers. Most providers have, like RHD, already purchased sufficient supply and stockpiling PPE is no longer a necessity.

Again, thank you for the opportunity to comment and offer recommendations. The ARA funding is a lifeline for providers to financially navigate through this next year. RHD encourages the Department to give flexibility to the providers to innovatively use this one-time funding to strengthen our individual infrastructure and sustain community services. Additionally, RHD urges the Department and the State to address the longer-term solution for the increasingly concerning workforce crisis in ID and BH community services.

Sincerely,

Karin Annerhed-Harris
VP Business Development
Resources for Human Development

Karin Annerhed-Harris
VP Business Development
Pronouns: She/Her/Hers

[redacted]

Resources For Human Development
4700 Wissahickon Avenue, Suite 126
Philadelphia, PA 19144
RHD.org

Good Evening,

Bon Homie Ltd. is an Adult Day Center located in Limerick PA, providing Home and Community Based Services for the past 29 years. I am writing to highlight the need for the American Rescue Plan Act to address the reimbursement rates for those individuals who are currently on or who apply for the CHC Waivers. The Individuals that we serve average 6 hours each day they attend and the reimbursement rate for this waiver is $59.80 a day. Many of these individuals require two staff to transfer them in and out of their wheelchair, using a lift. They also require a dedicated staff member to feed them and support them when getting involved in the activities offered. We have to limit the number of individuals we accept on this waiver because the reimbursement rate of $59.80 does not cover the cost of our staff wages, which are between $13.00 - $15.00/hour, plus the additional costs of food and other supplies that is spent on each individual in our program every day. .

There are only two providers that I am aware of that accept this waiver in our area because of the reimbursement rate. I receive multiple referrals a month and end up placing individuals on a waiting list because of the rate. The rate hasn't been adjusted in years, and because so many young, disabled adults are being placed on this waiver, I feel it would really be beneficial to raise the reimbursement rates. Raising these rates will allow these individuals to pursue services that are "person centered" and not force them to secure lesser services which do not address their needs or do without.

Thank you for allowing me to share my perspective.

Respectfully, Ann Short

Ann Short, Director
Bon Homie, Ltd.
Adult Day Center
470 North Lewis Road
Limerick, PA 19468
[redacted]

As [redacted] who is a consumer of DHS service (specifically, a recipient of [redacted] I implore you to NOT utilize the lion's share of the ARP monies to shore up the HCBS workforce and the agency providers who "serve" it. Throwing more money at a broken system is NOT going to solve the very grave issues that families and consumers face, which, include but are not limited to:

- Unsafe living conditions in group homes due to A)limited oversight of programs B)parents of individuals with severe communication and/or cognitive deficits, and extreme mental/behavioral health conditions being blocked from making decisions (despite having POAs in place) regarding their sons'/daughters' care and C) poorly-trained, uncommitted, and unethical staff, of which you will only get more of the same if you increase wages.
- Applying the Everyday Lives model and a community-or-bust mentality to DHS programs, when the reality is that a vast majority of individuals on the autism spectrum --

and even more individuals dually diagnosed with IDD and mental illness – struggle to even get out of bed or step foot in an automobile due to their anxiety, let alone live and work and enjoy social outings in their community. If COVID taught us anything, it's that isolation wreaks havoc on the mental health of WELL people. Imagine a lifetime of this kind of isolation?! Imagine living with trauma memories, a skewed worldview, and few if any quality mental health resources to address even the simplest of your issues. It should be obvious by now that the Everyday Lives model is not a possibility for a vast majority of DHS' clients, especially now that COVID has put an even bigger burden on these anxious individuals and their burned out caregivers.

- Supports Coordination Organizations that exist only to push paper --- oh, the ridiculous amount of paper! – and who know only a small percentage (my guestimate: 25% or less) of what services and supports are covered under each waiver program and what the processes are to obtain those services and supports. The SCOs have become nothing more than another government bureaucracy that does the bare minimum and collects a paycheck. [redacted] have consistently educated their sons'/daughters' SCs on programs, services, and funding, not the other way around.
- "Middle men" at every level of the system who add little value and suck up dollars that could be utilized BY FAMILIES to provide real-time, critical services that are a better fit, more effective, and that don't require reams of papers and months or years on waiting lists to access.

A better use of your ARP dollars: put it in the pockets of the subset of savvy (and burned out, I may add) caregivers who move heaven and earth to find the right programs and people and resources for their kids. Or who create them when they can't find them. Give them discretion on what and whom to hire and how to manage and oversee at least some of the supports and services their sons/daughters need.

CUT OUT THE MIDDLE MAN AND INEFFECCTIVE SCOs and THE USELESS THING CALLED SUPPORTS BROKERS!

Afraid that this will create inequity among those families for whom this level of caregiver competency does not exist? Then create a model of true parent to parent mentorship so that the savvy caregivers/parents can train up those willing but not yet able to provide a higher level of advocacy for their loved ones. Do away with organizations like the PA Family Network, which is a joke when it comes to training and mentoring families. Instead, create a network of competent parent advocates, certify THEM (not all these other ridiculous state-funded positions) and hold them accountable to support other families within their region.

Please stop kidding yourself that increasing the wage of paid staff will solve the worker shortage. Realistically, NO ONE WANTS THESE JOBS, cause they're difficult. Parents don't want these jobs either, but the vast majority of us will step up. Give us a way to scaffold EACH OTHER to success, do away with the middle man, and create a way that we can train up people WE SELECT to carry the torch once we are arms are too old and too weary to hold it any longer.

Thank you
[redacted]

Good afternoon,

The time to address the reimbursement rates for PAS services is NOW!!!!

- DCWs are healthcare personnel. THeir wages should reflect it.
- Our agency's ability to provide wage increases is directly tied to the reimbursement rate.
- Median hourly wages for DCWs in PA is $12.40. We are unable to recruit and retain quality DCWs under the current reimbursement rate.
- Hundreds of thousands of PAs rely on DCWs to maintain their independence in their home in their communities.
- We MUST address the critical shortage of DCWs to preserve the access to quality care in the homes rather than costly and less-desired institutions.

Sincerely,

Scott Jenco

--
Scott Jenco
Operations Manager
Legacy Home Care, Inc.
111 Walker Drive, Suite C
Edinboro, Pennsylvania 16412
(814) 732-0799 [redacted]
(814) 286-6168 - Fax
www.legacyhomecareinc.com

Dear Secretary Snead,

On behalf of Mainstay Life Services, I'd like to thank you for the opportunity to offer input regarding the Department of Human Services' use of increased federal reimbursement to the state through the enactment of the American Rescue Plan Act of 2021, Section 9817. The ARP increases funding for Home and Community-Based Services by an additional 10%, to be used to "enhance, expand, or strengthen HCBS under the Medicaid program."

For over 50 years, Mainstay has provided residential and related supports to children and adults, and their families, with developmental disabilities in Southwestern Pennsylvania. We support more than 330 people in Allegheny County and the surrounding areas, including Beaver, Washington, and Westmoreland Counties through 24-hour licensed homes, unlicensed homes, supported living, home and community supports, life sharing, behavioral supports, and employment services. Mainstay also operates eight community homes supporting adults with Prader-Willi Syndrome, a rare genetic disorder.

In 1999, the U.S. Supreme Court delivered a landmark decision in Olmstead v L.C. which found that unjustified institutionalization of people with disabilities is a form of discrimination under the Americans

with Disabilities Act. Pennsylvania has been slow to come into compliance with Olmstead but over the last two decades, the Office of Developmental Programs has focused on growing home & community-based services. Unfortunately, some of the most valuable community services that promote both community integration and independence like in-home community supports, companion and respite services have been systemically underfunded. Rates have not been sensitive to the cost of inflation. For example, over the last decade, the reimbursement rate for in-home and community supports has only risen by $0.38 per 15-minute unit. Adjusted for inflation, this means rates have fallen by $0.92 per 15-minute unit. At these rates, the service is not sustainable. Organizations delivering these services consistently experience an operating deficit of about 10% or more. At Mainstay, our in-home and community supports will end the year with $260K deficit delivering these important services. To provide desperately needed relief to the Home and Community-Based Service (HCBS) system of care, we request that the Commonwealth prioritize a rate refresh, specifically targeting in-home and community-based services. Beyond stagnant reimbursement rates, overregulation has made it difficult for organizations to comply with increasingly complex rules that create a significant administrative burden. More worrisome, these regulations have further compounded the costs associated with the services, making insurmountable barriers to recruit and train new workers to serve families and individuals in need in the community. The effects have been devastating. We are forced to decrease services or worse, suspending services altogether. As one of Pennsylvania's first SHIFT Accredited organizations, we believe that considering technology first in supporting greater independence and wellness for the people we serve can both enhance individual's everyday lives and optimize the departments spend on in-home and community supports. As such, we are also requesting investment in both infrastructure and ongoing reimbursement for assistive and remote supports for the people we serve.

We also believe it is essential that the Administration to acknowledge the intent and direction to be given to DHS/ODP and its contractor, Mercer, Inc., in setting rates. Past accumulation of rate data information was based upon assessing the average market cost of current pay for direct care (DSP) workers using the Bureau of Labor and Statistics. That specific process was flawed in that there is no Standard Occupation Code (SOC) for DSPs in our industry and reinforced current poverty-wage payments to workforce members. This is certainly not a desired outcome that would result in improved rates or wages that would bring DSP workers to a living wage. A rate achieving a living wage over three years will be consistent with the public commitment of Governor Wolf, who publicly endorsed a living wage for DSP workers in October 2017 in an address to the Pennsylvania Advocacy and Resources for Autism and Intellectual Disabilities Annual Conference.

We believe it is unconscionable for the departments to knowingly maintain rates and pay providers for HCBS supports that will not sustain the service and result in both poverty-level wages that further exacerbate the system's capacity to serve people in the ID/A system in-home and a community-based setting.

Thank you for the opportunity to comment.

Sincerely,

Kim Sonafelt
Chief Executive Officer
Mainstay Life Services
200 Roessler Road
Pittsburgh, PA 15220

As a DSP Caregiver supporting a [redacted], I highly recommend that the total number of in home enhanced service hours be raised from 60 to 80 hours maximum due to the specifically difficult level<of care and continuous 1on1 support and intervention SIS Needs level 4 patients require AND their lack of suitability for placement or access to other programs, outside activities, services, community events or other options that lower needs level patients regularly participate in and have access to.

In many cases the enhanced in home support is the only safe engagement these autistic adults have available so increasing their access to a full 80 hours (which previously was the limit) essentially makes things fair in terms of the amount of services these more challenged individuals could get compared to more highly functioning autistic adults. And these SNL4 adults require a greater level of direct support so hence the need for a greater number of service hours in the home.

We need to give those with the greatest level of need the largest access to the services they desperately need and not limit service levels as if one size fits all levels of need.

Lea Eller - DSP and Managing Employer providing enhanced in home support thru the ARC of York County

As DSP Caregivers supporting a [redacted], we highly recommend that the total number of in home enhanced service hours be raised from 60 to 80 hours maximum due to the specifically difficult level<of care and continuous 1on1 support and intervention SIS Needs level 4 patients require AND their lack of suitability for placement or access to other programs, outside activities, services, community events or other options that lower needs level patients regularly participate in and have access to. In many cases the enhanced in home support is the only safe engagement these autistic adults have available so increasing their access to a full 80 hours (which previously was the limit) essentially makes things fair in terms of the amount of services these more challenged individuals could get compared to more highly functioning autistic adults. And these SNL4 adults require a greater level of direct support so hence the need for a greater number of service hours in the home.

Let's give those with the greatest level of need the largest access to the services they so desperately need and not cap it as if one size fits all.

Howard Owrutsky - DSP providing enhanced in home support thru the ARC of York County

As DSP Caregivers supporting a [redacted], we highly recommend that the total number of in home enhanced service hours be raised from 60 to 80 hours maximum due to the specifically difficult level<of care and continuous 1on1 support and intervention SIS Needs level 4 patients require AND their lack of suitability for placement or access to other programs,

outside activities, services, community events or other options that lower needs level patients regularly participate in and have access to. In many cases the enhanced in home support is the only safe engagement these autistic adults have available so increasing their access to a full 80 hours (which previously was the limit) essentially makes things fair in terms of the amount of services these more challenged individuals could get compared to more highly functioning autistic adults. And these SNL4 adults require a greater level of direct support so hence the need for a greater number of service hours in the home.

We should give those with the greatest level of need the largest access to the services they so desperately need and not limit it as if one size fits all.

Deborah Owrutsky - DSP providing enhanced in home support thru the ARC of York County

Good day,

The PA REscue Plan Fact sheet lists

$15 per hour minimum wage for Direct Support Professionals serving individuals with intellectual disabilities and autism: $130 million

We think this is a great idea an would love to see this become a reality but we have a few questions about how it would be implemented:

1) When will reimbursement rates be increased for provider's to adjust salaries?
2) Is this something that will be phased in over a period of annual rate increases or will the reimbursement rates be adjusted immediately to allow providers with the budget to make immediate salary increases?
3) How would the sign-on bonuses for Direct Care Workers be funded?

Other question:

4) Is there a plan to make all training platforms mobile friendly? Many of oru Direct Support Professionals do everything on their phones and may not have immediate access to a computer. It is difficult to come into the office to complete an online training when they have a full time job and many have part-time jobs as well. The College of Direct Support program is not mobile friendly And the programs that are mobile friendly can be very costly.

Thank you.

-- Rich

ADVANCED BEHAVIOR TREATMENT

Rich Neal, MS, LBS, BCBA
CEO / Behavior Analyst
Advanced Behavior Treatment
Two Bala Plaza
Suite 300
Bala Cynwyd, PA 19004
www.abtreatment.com

[redacted]

Hello, we are a provider under ODP services. We were hit very hard during FY 20/21 and we have had to layoff numerous managers so we can barely be competitive with our DSP wages as compared to the likes of Target, Amazon and many others.

In the plan submitted by the State to CMS it states:

- Refresh data for Office of Developmental Programs services and adjust rates if necessary.

_____This wording is not good enough and rates should be adjusted regardless. If all other departments are receiving increases why would providers who support the most vulnerable Pennsylvania people be left out? **We request that a guaranteed increase for ODP providers is put in place.**

Kenneth L Gibat
Person Directed Supports, Inc.
CO-CEO/ ACTING CFO
[redacted]
Fax: 610-391-9405

Dear Secretary Snead:

I am writing to you on behalf Christ the King at Home that provides personal assistance services to more than 150 Pennsylvanians. Our agency also employs 85 caregivers. Thank you for the opportunity to provide comments on the American Rescue Plan (ARP) funding specifically for home and community-based services (HCBS). This funding comes at a critical time, when demand for home care is at an all-time high, costs are increasing sharply, and rates have remained almost stagnant for over a decade. Recruiting and retaining caregivers has reached a crisis point, and I write today to ask that you direct a significant portion of the new funding toward increased reimbursement rates and financial support for bonus and other provider payments to preserve access to quality care.

The following priorities outlined in the Department of Human Services' *Spending Plan for the American Rescue Plan Act of 2021, Section* 9817 are critically important and must be funded:

HCBS Provider Payment Rate and Benefit Enhancement

- Providers need additional funding for increased reimbursement rates, sign-on and retention bonuses for direct care workers, nurses, and other home caregivers and believe that this is where the bulk of the funding should be allocated.

- Although we support funding that is intended for caregiver wages or bonuses, it is important that flexibility be given to providers, as individual agencies will have the best sense of where funds would have the most benefit to address recruitment and retention challenges in their communities.
- We support both sign-on bonuses, and retention bonuses for employees who remain at the same agency for a specified period of time. To prevent "agency hopping" directly related to any sign-on-type payments, we ask that the Department make payments directly through the agencies and limit sign-on payments to one per individual. Funds provided for these purposes must include funding to support additional employer payroll tax and other financial responsibilities.
- We also support – and need – reimbursement rate increases for caregivers.
    - Reimbursements do not reflect the cost of providing services, which have skyrocketed in recent years. With the lowest reimbursement rates across comparable state programs, PAS providers simply cannot compete with private employers (or even other programs) for quality workers.
    - Sample rates in PA include:
        - PA State OPTIONs: $20/hour
        - VA: $24/hour
        - Private Pay: $30/hour
        - ODP: $24-32/hour
        - OLTL: $17.72-$19.52/hour
    - Demand significantly outstrips supply, with more and more hours going unfilled, or requiring an agency to pay overtime to meet the need and provide care. We urge funding to reimburse for this overtime; as you know, caregivers in the consumer-directed model are already receive overtime funding.
    - Rate increases must be provided, and they must be permanent. This is a long-term problem that requires a long-term solution.
    - Again, it is critically important that funds provided for these purposes also include funding to support additional employer payroll tax, overtime, and other financial responsibilities.
- For agency-model funds, we believe that these funds should be paid directly to the agencies in order to streamline and facilitate quick, efficient distribution.
- We also support payments to providers to provide tuition incentives, student loan repayment, and similar educational/training supports.

<u>Supplies & Equipment</u>

- We support funding and reimbursement for the purchase of personal protective equipment and testing supplies for HCBS providers. Throughout the PHE, home-based care providers have not been prioritized for PPE, and a recent PHA survey showed that PPE Expenses have risen almost 500% for home-based care providers. PPE expenses will continue for the foreseeable future (although price gouging has eased), with DOH/CDC/CMS and OSHA rules requiring its use.
- We ask that this support come in the form of direct funding/grants, as agencies can be required by PPE vendors to have a certain "buying power" in order to be prioritized for access.

<u>Work Force Support & Training</u>

- We support additional funding for caregiver training.

- As you know, PHA has developed My Learning Center, a free online training platform for direct care workers and family caregivers. To date, 181,309 users have completed more than *four million courses*. The cost associated with developing new videos and administering the platform is approximately $120,000-$150,000 per year, which includes new videos and language translations each year. We urge the Department to provide funding for new videos and translations for FY21/22, 22/23, and 23/24.
- We support non-internet-based learning materials for individuals without easy access to the internet or those who are more comfortable with hardcopy materials.
- We also recommend and support reimbursement for caregiver pay during training.

Caregiver Support

- We oppose the development of a registry of direct care workers for the same reasons set forth in Markham v. Wolf, NO. 176 MD2015, Pa. Commonwealth Court, which is ongoing litigation. We have continued concerns about DCW privacy rights and the Department's prior/current efforts to create such a registry, and FMAP funding should not be used in this way.
- In addition, PPL/PCG already has a caregiver database, as does www.care.com. A mandatory registry is inappropriate and unnecessary, when multiple alternatives to find care already exist, at no cost to consumers. Funding through the enhanced FMAP should be directed to programs that will advance the level and quality of services, not to recreate a resource that already exists.

Support to Improve Functional Capabilities of Persons with Disabilities

- We support the purchase of remote support technology for HCBS providers to enhance transparency and quality assurance in service delivery; these resources should be provided to seniors as well as individuals with disabilities.

Thank you for your consideration of our comments and for your leadership on these important issues. Please let us know if you have any questions or if we can provide any additional information. We urge you to move forward with increased reimbursement rates and any bonus payments as expeditiously as possible. The need is immediate, and access to quality care is at risk. I can be reached at 814-503-1200 Extension [redacted] My email address is [redacted]

Sincerely,

Heather Dodd
Home Support Coordinator
2 Cottage Lane
DuBois, PA 15801
[redacted]

Dear Secretary Snead:

I am writing to you on behalf of BAYADA Home Health Care that provides personal assistance and private duty nursing services to more than 11,664 Pennsylvanians. Our agency also employs 8,686

caregivers. Thank you for the opportunity to provide comments on the American Rescue Plan (ARP) funding specifically for home and community-based services (HCBS). This funding comes at a critical time, when demand for home care is at an all-time high, costs are increasing sharply, and rates have remained almost stagnant for over a decade. Recruiting and retaining caregivers has reached a crisis point, and I write today to ask that you direct a significant portion of the new funding toward increased reimbursement rates and financial support for bonus and other provider payments to preserve access to quality care.

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    - Demand significantly outstrips supply, with more and more hours going unfilled, or requiring an agency to pay overtime to meet the need and provide care. We urge funding to reimburse for this overtime; as you know, caregivers in the consumer-directed model are already receive overtime funding.
    - Rate increases must be provided, and they must be permanent. This is a long-term problem that requires a long-term solution.
    - Again, it is critically important that funds provided for these purposes also include funding to support additional employer payroll tax, overtime, and other financial responsibilities.
- For agency-model funds, we believe that these funds should be paid directly to the agencies in order to streamline and facilitate quick, efficient distribution.

- We also support payments to providers to provide tuition incentives, student loan repayment, and similar educational/training supports.

Supplies & Equipment

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Thank you for your consideration of our comments and for your leadership on these important issues. Please let us know if you have any questions or if we can provide any additional information. We urge you to move forward with increased reimbursement rates and any bonus payments as expeditiously as possible. The need is immediate, and access to quality care is at risk. I can be reached at 570-498-8830.

Sincerely,

Mike Sokoloski

Michael Sokoloski
Associate Director, Government Affairs Office (GAO) | BAYADA Home Health Care
1800 John F. Kennedy Boulevard, Suite 1111, Philadelphia, PA 19103
[redacted] | Fax 267-515-6587| bayada.com | heartsforhomecare.com

As a home health care provider there are many things we do to help keep our clients in their home. We provide Activities of Daily Living Assistance. We help Navigate resources they might need. We help them maintain their dignity and encourage them to be independent as much as possible. Many people don't realize we as home health aides are the clients and their families last line of defense.

[redacted]

I am a caregiver that have been taken care people in homes,facilities and it should be higher pay because it cost for transportation and we got to be healthy our self's and the safety of people we take care of,and there is still viruses out here,[redacted],thanks push for equal pay!!!!

Kamili Berry

Hello,

As a Director of a Mental Health provider, I would like to comment that money could definitely be used for provider payment rates and recruitment and retention. It has been incredibly difficult to keep and find staff in recent times, particularly during the pandemic. We have lost a lot of staff or have potential employees tell us that the work in Mental Health is too taxing for the amount of pay that can be offered currently with reimbursement rates.

Thanks for your time,

--
Jodie Crust
Blair Family Solutions, Director of Operations
1310 Valley View Blvd.
814-944-9970[redacted]

To Whom it May Concern:

Thank you for the opportunity to provide comments regarding Pennsylvania's implementation of the Home and Community Based Services (HCBS) Federal Medical Assistance Percentage (FMAP) increase following the release of guidance from the Centers for Medicare and Medicaid Services (CMS). StationMD

is an organization with a specialized telemedicine program currently serving over 30,000 people with intellectual and developmental disabilities (IDD) across 10 states including Pennsylvania. By having specially trained IDD-informed physicians and other medical professionals ready on demand through a reliable telehealth consultation, we are reducing unnecessary emergency department and urgent care visits. We are also able to remotely address many of the psychiatric issues for individuals. These smart and timely interventions also keep the members integrated in their home and community for longer periods of time and reduce the opportunities for the members to go without seeing their loved ones for days at a time, especially important during these most recent 18 months.

With the HCBS FMAP expansion opportunity, we believe a great opportunity for Pennsylvania to utilize federal funds is to launch a similar program like those begun in Missouri and Tennessee among others, to ultimately lead to a sustainable cost-savings and quality-improving solution like we are realizing in these states where we are currently delivering services. In Missouri, for example, we are partnered with their Division of Developmental Disabilities to directly provide access for the IDD population to our physicians and other health care providers via telemedicine. We are also working with a few managed care organizations to find ways to include our services as part of their benefits package. Here in Pennsylvania, we are already partnering with provider organizations to bring our telemedicine services to the individuals they serve. We are also members of RCPA and PAR and have seen tremendous interest in expanding our solution in the state.

Given what we know about the federal guidance, it is our understanding all our services align well with the intended use cases of this HCBS enhanced FMAP opportunity, specifically expanding the use of technology and telehealth, as outlined in Appendix D of the State Medicaid Director Letter.

In addition to the overall goal of improving the quality of life for those IDD members being served by HCBS, this enhanced funding should:

- allow for the implementation of innovative pilots.
- support solutions included enabling/assistive technology-based solutions.
- foster independence of IDD members.
- address the continuing public health emergency-related concerns for this population (e.g., intervening smartly to keep members of this population out of higher-risk areas for COVID exposure, like hospitals); and
- promote programs serving the IDD population at the state level that are or can become over time sustainable.

We feel strongly that we can bring a unique set of health care services to a population that has never had access to them in the way that other segments of the population have, and that, in turn, we have the potential to show quickly that these services can provide a return on investment for the state—in fact, earlier this year, a study of a small cohort we have been serving in New York showed a savings of over $2000 per person per year. Extrapolating this to Pennsylvania's waiver population could potentially show millions of dollars annually in savings for the state, while providing care that is appropriate, timely, and takes into account the unique needs of these individuals.

We welcome the chance to work with you and your staff to bring our services to Pennsylvania, and believe this opportunity presented by the FMAP increase is one that should be used wisely to benefit those individuals intended to receive these services and believe that StationMD should be included as part of the state's plan. Thank you again for the opportunity to provide input and we look forward to working with you.

urac ACCREDITED Telemedicine Accreditation - C2P Expires 01/31/2024

Maulik M. Trivedi MD FACEP – Chief Strategy Officer

StationMD

515 Valley Street, #203, Maplewood, NJ 07040

[redacted]

[redacted]

Good morning,

I am offering these comments in response to DHS's request for stakeholder input about Pennsylvania's efforts as to strengthen, enhance and expand HCBS.

First, I would like to encourage support for all of the priorities outlined by DHS, listed below. I have also added some additional comments under a few of these priorities to highlight some specific suggestions.

1. Increasing access to HCBS;

2. Enhancing HCBS provider payment rates and benefits

a. this should include payments for collaborative or treatment team meetings or coordination of care which are now required for an increasing number of child/adolescent or family cases given their clinical complexity and involvement in multiple service sectors/providers

3. Protecting the health and well-being of direct care workers and direct support professionals through the provision of supplies and equipment;

4. Recruitment and retention efforts to support the workforce;

a. One of the best ways to enhance retention is to augment clinical competency and access to supervision/consultation. Most providers get little supervision and have limited exposure to content or treatment expertise. I suggest that additional funding be used to disseminate more evidence based treatments (EBT) and the resources that support their training and use, including routine consultation with an EBT expert.

b. Few providers are trained to deliver integrated or collaborative care in healthcare settings where health for all (whole person health) is a viable aspiration. We need to cross-train MH providers to work deliver integrated care, to incentivize primary care settings to hire them, and to provide more reimbursement for integrated care to ensure that it is viable and sustainable. Our work shows that extended care is effective, but requires some ongoing technical supports and financial resources.

5. Supporting caregivers;

a. Outpatient services for children/teens often requires caregiver involvement and in some cases, extended adult participation to address parent-child and family interaction problems. I recommend that greater attention to caregiver involvement and funding provided to enhance caregiver participation in child treatment services and that limitations on what can be done within the constraints of child treatment be modified to support a more family centered treatment process.

6. Assistive technology and other supports to improve functional capabilities of persons with disabilities;

a. More funding is needed to support the incorporation of using apps or digital methods for any mental health condition – especially with children and teens who are native users of digital devices.

7. Supporting the transition of individuals to community-based living arrangements;

8. Investing in activities to address Mental Health and Substance Use Disorder treatment and recovery needs of Medicaid beneficiaries; and,

9. Building HCBS capacity and rebalancing Long-term Services and Supports.

a. EBT use may be one of the few ways to enhance system capacity and client outcome, as noted above.

Thank you for soliciting input from stakeholders,

Have a happy holiday,

David

David J. Kolko, Ph.D., ABPP

Professor of Psychiatry, Psychology, Pediatrics, and Clinical and Translational Science, University of Pittsburgh School of Medicine
Director, Special Services Unit, UPMC Western Psychiatric Hospital
Office address: Room 541, Bellefield Towers
Mailing address: UPMC WPH, 3811 O'Hara St., Pittsburgh, PA 15213
Office phone: [redacted] FAX: 412-246-5341

To whom it may concern, reimbursement rates for HCBS home care providers are critically below the market rate at less than $20 per hour in Pennsylvania. Our next door neighbor Delaware, who has raised minimum wage and Medicaid reimbursement to $26 per hour. This allows us to hire caregivers between $13 and $15 per hour. The agency then bares the burden of Fica tax, unemployment and workers compensation insurance. Market rate for private duty home care is $27 per hour.

I see the PA Home Care association is asking for a 10% increase. Frankly another $2 per hour will get us nowhere. Until we are able to increase wages for caregivers in PA to between $13 and $15 per hour, we will have to continue to turn down cases because we cannot staff the cases.

HCBS continues to be the most cost effective and least expensive use of the taxpayers money to care for the ever increasing population of seniors needing basic personal care like toileting, bathing, transferring, housekeeping and meal preparation. Especially after the Pandemic, home continues to be where most seniors want to age in place, not the nursing home. When home care agencies cannot staff the case, and families are strained by working full time jobs, the seniors ultimately end up in the nursing home, the most expensive and least popular option.

Thank you for your consideration. - Jim

--

Jim Smith

President

Visiting Angels of Chester County

Living Assistance Services

557 Exton Commons

Exton, PA 19341

[redacted]

610-280-3542 fax

Do to the shortage of caregiver staff - why doesnt PA pay for assisted living for individuals who require more then 10 hours a day of service to remain safe at home – Gina Luffy

Since these funds have an expiration date, in order to expand statewide access to LIFE and thus increase HCBS options further, I would ask the state to consider start-up grants for LIFE organizations to stand the program up in the remaining unserved counties which are a very high risk due to small populations over large areas.

Richard A. DiTommaso
President
[redacted] **www.commlife.org**

Dear Sir/ Madam,

We appreciate that DOH is taking notice of this dire situation the providers are dealing with. To solve this problem which is caused by COVID 19 our agency believes by doing the following, we would collectively achieve the goal in providing the best care to our participants and employees:

1. Increasing the rate – will allow agencies to better compete with other businesses such as retail and food industries. (we have already increased the rate to hire employees, unfortunately our profit margin is less, which makes it hard to operate the business). Employees are requesting between $13-$15 per hour. With the current compensation rate it is impossible to accept this request. With the increase of compensation rate we will be able to pay the requesting rate and allow for benefits.

2. DOH communicates to Department of Labor for Stricter requirements for unemployment – we have found an increase of candidates applying just for the sake of applying to show the Department of Labor that they applied and were not hired. We find when we reach out to the candidates they show no interest and most do not bother to reply to our initiation.

Thanks,

Have a successful and Creative day
Best Regards

Satpal Singh, BS, MBA
President/CEO
Sweet Golden Years
Home Health Care 4 U
[redacted]

Fax 412.376.2847

To Whom It May Concern:

My name is Cassandra R. Copper and I enter the developmental disability services conversation through a number of vantage points: [redacted] second, as the friend [redacted] of people with intellectual or developmental disabilities who require LTSS funded via Medicaid HCBS waivers; third, as a pre-professional student of social welfare policy; and fourth, as a Direct Support Professional (DSP) employed by an agency providing HCBS in a licensed group home setting.

Long story short, the lack of sufficient funding—which, in turn, has an affect on the wages afforded to DSPs—has had a significant impact on the quality of professional supports afforded [redacted] to those whom I support. In one of the agencies [redacted], despite it still being licensed, is presently embroiled in a class-action lawsuit by multiple DSPs for the agency's refusal to give them PTO and sick leave for them having tested positive for COVID-19. [redacted] This caused a significant disruption in quality of service provision, and made their already poor integration into the surrounding community, worse. The fact that this particular agency got away with this type of unethical behavior is incomprehensible, and leaves one to question how and why this agency is still licensed.

Yet another individual, [redacted], has not been able to be connected to case management services to be placed on a waitlist for HCBS, largely as a result of poor—almost nonexistent—staffing in our county assistance office. And still, in the agency for which I work—which criminally underpays us a meager $11.25 per hour—the turnover rate is perhaps one of the highest of all HCBS agencies in the Northeast region, as people are overworked, overtired, and burnt out, with rent, groceries, tuition, childcare, and other expenses piling up as I write this comment.

However, funding alone is not the issue. Us DSPs working for for-profit or non-profit healthcare entities are not able to unionize and advocate for better wages and overall employee input into organizational functioning. In my agency in especial, there is no room for advancement from a DSP to higher roles. There is no tuition reimbursement for working, which is why I, myself, will sadly need to leave my clients to focus on an internship full-time, succeeding in a progression to graduate study.

The Centers for Medicaid Services (CMS) is not aggressive enough in defining what constitutes as "community-based care," meaning that agencies operating large facilities—such as the aforementioned one currently involved in yet another class-action against its charge—siphon funding and staff away from what could be genuinely community-based care, even for those with significant behavioral and/or medical challenges. [redacted] do not have meaningful agency in their lives, because staff are tasked with too much work for which they haven't been trained, and because one or two staff cannot fulfill the interests and needs of three or more people at once. Though I understand the present staffing ratios for economic purposes, the reality is that they are insufficient for genuine community inclusion. I don't know about most of you, but I want to be able to do something without dragging my roommates along with me. People with intellectual and developmental disabilities have that same desire and more-importantly, that same RIGHT.

So, in the brief, yes, absolutely increase funding for HCBS. We absolutely need that in order to increase the quality of service provision, increase satisfaction for people with intellectual and developmental disabilities and their staff alike, and ensure that the waitlist for services continues to dwindle. However, the major caveats are that without allowing staff to unionize, we do not have full rights within our agencies of employment; without being more aggressive in the scrutiny of what constitutes as "community-based," we will continue to falter in taking precious funding and staff away from the community, and into private facilities that, in actuality, are little different than the state centers that the state has closed and continues to close in 2021.

We can do better, we can be more powerful, if we actually tap in to common sense.

Thank you.

Cassandra R. Cooper

Hello,

Health Partners Plans (HPP) appreciates the opportunity to comment on Pennsylvania's preliminary Home and Community Based Services (HCBS) spending plan.

As a Managed Care Plan, we understand the positive impact that HCBS can have on individuals' lives and well-being. We applaud the efforts made by the Pennsylvania Department of Human Services (DHS) to expand, enhance, and strengthen HCBS for Pennsylvanians.

Please see our initial comments on the plan. Once again, we appreciate the opportunity to provide feedback.

1. Given the significant disruption caused by the pandemic, HPP believes that funding to improve education equity could be beneficial for individuals who receive HCBS.
    a. Examples could include –
        i. free tutoring
        ii. better equipment in schools
        iii. free internet access
        iv. weekend and evening make-up classes
2. HPP applauds the department's efforts to improve HCBS for individuals. We feel that placing an even greater emphasis on the activities, services, and goods for recipients would ensure the plan is efficacious.
3. HPP would appreciate the opportunity to partner with DHS to ensure that HCBS is provided efficiently and effectively. We look forward to future partnerships or collaborations with DHS that will be beneficial to individuals who receive HCBS.
    a. Furthermore, we hope that DHS will engage HPP when making specific decisions related to this spending plan so that we can assist in improving HCBS programs across Pennsylvania.

Thank you for taking the time to review our comments.

Shane Kovach
Senior Policy Analyst, Government Affairs
Health Partners Plans
901 Market Street, Suite 500 Philadelphia, PA 19107
[redacted]

Some of this funding needs to go into the School Based Access Program! Medicaid funding for related services pales in comparison to the cost to local school districts. For many, many children school is the only place that they receive much needed therapies and reimbursement opportunities for LEAs has decreased severely over the past 6-7 years. Many things that were reimbursable in the past are no longer. Special Education is expensive and with Medicaid reimbursements going down every year, LEAs are scraping to try to make ends meet while still providing quality services to children.

Please consider devoting some of these resources to this program.

Thank you,

Tammy Soltis, Supervisor
Special Education Support Services
Northwest Tri-County IU # 5
252 Waterford Street
Edinboro, PA 16412
[redacted]
F 814.734.2302
[redacted]

Dear Sir or Madam:

I am writing in response to your inquiry for public comment from EI providers regarding the new FMAP plan in regards to HCBS.

I am currently an occupational therapist providing evaluations through the early intervention infant toddler program. I have been working full-time as an independent contractor/LLC for an EI Provider agency for the past 6 years. Since the start of the pandemic, I have been providing evaluations solely via telehealth methods. Generally, evaluations have been going very well. My team members and I feel that we are able to conduct a valid and thorough assessment via Zoom video conferencing for over 99% of our families. Conducting telehealth evaluations has also caused new challenges that we haven't encountered with in-person evaluations. Firstly, many families aren't used to the software and hardware required. It often takes several minutes for families to log on and set up the camera so the team can see the child appropriately. Additionally, the nature of Zoom calls is that only one team member of the multi-disciplinary evaluation team can talk at a time versus in-person evaluations in which one team member can engage with the child while the another interviews the parent simultaneously. Therefore, overall, during Zoom calls there is less cumulative time to gather information from the parent and engage with the child to the degree needed to complete a valid assessment. As evaluators we try to observe the child play in the background as much as we can while the parent talks with our team members. However, it is very challenging to observe, type, and keep an ear out while the parent is answering questions. One side effect that was not anticipated with all of this is the toll that telehealth takes on the mind and body. I'm sure you've heard of the term "Zoom Fatigue" that has been coined in the media including the New York Times. It is exhausting keeping our mind alert and multitasking in this fashion for 6-7 hours per day. Scientists are trying to figure out why. I can only describe that there simply isn't always enough mental space and energy to type meaningful reports while simultaneously observing, listening, and talking with parents with camera directed at our face hour after hour. The structure of our work day remains the same as it was pre-pandemic. This is 3 2-hour evaluations per day. By our third 2-hour evaluation of the day, we are exhausted and we can't figure out why because we've been sitting in a chair all day. It's a strange phenomenon, but it's real. I had to ask my agency to take me off the schedule for one day per week simply because I couldn't do 15 telehealth evals in a week anymore. And I was handling 15 in-person evaluations prior to the pandemic. Early Intervention billing laws indicate that we are only allowed to bill for time we are directly working with families. However, we are spending an increased amount of time completing/writing reports outside of the Zoom calls because there simply isn't enough mental energy to listen, observe, and talk with parents while simultaneously writing a valid and thoughtful evaluation report and IFSP via

telehealth. The way the reimbursement scale has been designed we are not getting compensated for this write-up time outside of these calls, which typically totals at least one hour per evaluation for a total of 3 or more hours per day. Other programs such as school-based and early intervention 3-5 programs are able to bill for evaluation writing outside of direct service. When I saw that the new plan includes a 10% increase in reimbursement rate for providers I was relieved because that will help off-set some of those costs and help make up for the one workday per week I had to eliminate due to Zoom fatigue. Additionally, I was relieved to see that it included reimbursement for PPE costs, as we are embarking on returning to in-person services within the next few weeks and have no answer from our provider agency on how to manage the cost of PPE.

In general, there are have been many advantages to using Zoom as a method to provide telehealth evaluations for families. We have been able to service more families more quickly to due to elimination of travel time, etc. There are also advantages to decreased exposure to all sorts of illnesses which have led to decreased sick time and missed evaluations. However, the reimbursement for writing up reports outside of direct service time has not been addressed although it has had major mental health and financial impacts on EI providers. I hope to continue providing telehealth evaluations long into the future, even after the pandemic ends. However, I would like the billing system to include ways to compensate providers for the time it takes to complete our evaluation reports and IFSPs beyond the Zoom calls with families.

Thank you for your consideration and taking the time to hear my feedback.

Sincerely,

Susan Pernice, MS OTR/L
Occupational Therapist
[redacted]

I believe that some of this money should be devoted to the SBAP program as for many children in school is the only place that they receive much needed health related services. At the very least, SBAP should also be a part of the 10% FMAP increase.

Thank you,
Kim Winkelbauer

Thank you for the opportunity to provide input regarding the American Rescue Plan Act's (ARPA) temporary 10% increase in federal Medicaid funding for home and community-based services (HCBS).

For at least the last decade and throughout the pandemic, the state has failed to increase rates or otherwise provide any meaningful financial relief to brain injury providers. During that time, the increased costs of providing care, rising wages, and the unanticipated expenditures created by the pandemic (e.g., overtime, personal protective equipment, hazard pay, etc.), combined with zero rate increases (not even a cost of living adjustment), have led to a significant degradation of the financing structure for the state's brain injury providers. The fact is that the current costs of providing care are higher than reimbursement.

While we applaud the state's ongoing commitment to HCBS providers, however, our brain injury programs are continuously overlooked and underfunded despite the fact that we deliver interventions and services at the same acuity levels and by the same educational level of staff as Intensive Rehabilitation Facilities. In fact, a prerequisite to securing benefits for brain injury services is the "Nursing Home Level of Care" standard. Our staff includes direct care workers, nurses, physicians, licensed therapists, social workers, billers, case managers and many more support staff that are overlooked in the current reimbursement rates. In order to provide funding that accurately reflects the unique needs of each individual served, real costs of operations and increasing costs of providing care we recommend immediately increasing reimbursement for Residential Habilitation, Day Habilitation and Therapy Services. We further recommend that "tiers of service" be established to better reflect the varying need and cost levels of serving individuals with far ranging support needs as one size does not fit all. Lower reimbursement for lower need (lower cost of care) individuals and higher reimbursement for higher need (higher cost of care) individuals. Theses higher costs are not only reflected in direct care wages but also program supports that include expenditures that are needed to support individuals but not usually traceable or assignable to a single individual. As noted above, these include nurses, physicians, licensed therapists and social workers as well as staff supervisors, trainers, training supplies, amortization of program related equipment, and consultant costs. Additionally, reimbursement should be adjusted annually to accurately reflect the rising costs of all the aforementioned expenses and general inflation.

Every day, our team shows up, pandemic or not, to deliver a full continuum of innovative, high-quality community based programs designed to increase independence and participation in community life. Without our devoted workforce, the individuals we serve would face readmission to hospitals or nursing homes where their outcomes would be worse and the cost of care far more expensive. The pandemic has only worsened our staffing shortages and created additional fragmentation, complexity, and instability for the people we serve.

Accordingly, we appreciate your attention to these important issues impacting individuals living with brain injuries. Now, more than ever, we need to ensure and stabilize their access to the home and

community-based services on which they rely. We look forward to further discussions with you. In the meantime, please do not hesitate to contact us if you have any questions.

I hope this proposal is helpful and leads to much needed relief for HCBS Brain Injury Providers.

Respectfully,

Adam Steinberg
President/CEO

Universal Institute
REHABILITATION & LIVING CENTERS

19 Microlab Road
Suite A • Livingston, New Jersey 07039
P: 1-973-992-8181 [redacted] • F: 1-973-992-7178 • [redacted]
www.uirehab.com

To Whom It May Concern:

I am writing this email to request that the enhanced FMAP be used to fund an increase for home and community based provider payments.

My organization provides personal assistance services (home care services) to members of the community who are aging, physically disabled, or intellectually disabled.

I started in the business in 2008. Since then, our reimbursement rate has increased a total of 4%. That means that in 15 years, the state has given only a 4% increase to fund this essential program. A program that kept MANY medically compromised people home and safe during this pandemic.

Our employees have continued to receive 2-3% raises every year since 2008, and we are now in a situation where we are competing with industries we never have before. We also now compete with an unemployment benefit that encourages people to stay home. As a result, our patients are going without care. We simply can't get people to work. **This model of giving raises to staff, but not receiving standard reimbursement adjustments from the state of PA is NOT SUSTAINABLE.**

Our patients deserve better, our communities deserve better, and our employees deserve better. We want to pay them fair wages, but with a reimbursement rate that is less than $20/hour, we simply can't. **I pay my babysitter more per hour to watch my healthy son <u>while he's sleeping</u> than the state of Pennsylvania pays our agency to take care of medically fragile patients.** This isn't right.

The VA is reimbursing $24/hour.
The state options programs are reimbursing $20+/hour.
Private Pay clients are at $25+/hour.

But the Office of Long Term Living is at $17.72 - $19.52. This is a disgrace.

Please consider an increase so that we can serve the patients who are WAITING for caregivers, so that we can train caregivers more thoroughly, and more importantly, so we can pay caregivers a fair and competitive wage.

Thank you for your consideration,

Mia Haney
President
CareGivers America
A Simplura Health Group company
[redacted] F: 570-586-5225

We would like to see the reimbursement rate increased so we can raise our caregivers pay rates.

Sincerely,
Breann Hartman
Agency Director
157 State Street
Suite B
Hamburg, PA 19526
Phone: 1-888-990-4555
Fax: 1-888-910-7772
[redacted]

Good Morning,

Thank you for taking comments on the below spending plan.

I was shocked to hear today that 2390 CPS programs will not be benefiting in the below plan.

Deborah Roth
COO/CFO
Associated Production Services, Inc.
325 Andrews Road
Trevose, PA 19053
(215) 364-0211 [redacted]

Hello,

Health Partners Plans (HPP) appreciates the opportunity to comment on Pennsylvania's preliminary Home and Community Based Services (HCBS) spending plan.

As a Managed Care Plan, we understand the positive impact that HCBS services can have on individuals lives and well-being. We applaud the efforts made by the Pennsylvania's Department of Human Services (DHS) to expand, enhance, and strengthen HCBS for Pennsylvanians.

Please see our initial comments on the plan. Once again, we appreciate the opportunity to provide feedback.

1. Given the significant disruption caused by the pandemic, HPP believes that funding to improve education equity could be beneficial for individuals who receive HCBS.
    a. Examples could include –
        i. free tutoring
        ii. better equipment in schools
        iii. free internet access
        iv. weekend and evening make up classes
2. HPP feels that placing an even greater emphasis on the activities, services, and goods for recipients would ensure the plan is effective
3. HPP would appreciate the opportunity to partner with DHS to ensure that HCBS is provided efficiently and effectively.

We look forward to future partnerships or collaborations with DHS that will be beneficial to individuals who receive HCBS. We also hope that DHS will engage the MCOs when making specific decisions related to this spending plan so that we can assist in improving HCBS programs across Pennsylvania.

Thank you for taking the time to review our comments.

Kearline

Kearline Jones, LL.D., CHC

Head of Government Affairs & State Government Funded Business

Health Partners Plans

901 Market Street, Suite 500

Philadelphia, PA 19107

Good Morning,

I have worked for the Dept of Human Services for over eight years and seen programs expanded for the elderly by the wonderful state of Pennsylvania. I am proud to be part of the workforce.

[redacted]

[redacted]

I would like to request that rural workers [redacted] County) be considered for increased payment rates, benefits, and bonuses. [redacted] This is a wonderful program and [redacted] deserves a lot more than $11.20 per hour with no vacation pay, no holiday pay nor bonuses.

Please consider future monies for the Direct Care Workers program.

Thank you,

Meg Robeson

Good morning
I am taking this opportunity to offer the feedback I have observed of the many needed changes I have observed in the field of Community Mental Health during the COVID 19 pandemic and some of those changes that I see yet to come. With over 11 years as a Licensed Social Worker and 31 years as a Nurse I could not have imagined we would have been here, but we in many ways we made it. Telehealth has been a god send for many of our clients. It has enabled us to not only stay in contact with, but to reestablish a sense of normalcy for some of the community's most vulnerable population. I was pleasantly surprised to see many of my clients thrive during this time; being able to take the time to focus on their treatment goals without distractions, obtain employment for the first time in many years, reestablish relationships with family and several moved into new to them homes. It enabled to my clinic to retain 100% of our small, but very important, workforce. Now, as we move into a recovery stage of the pandemic, we are facing challenges related to brining on additional staff, new college graduates just aren't there like they had been in the past. Maybe high college debt and the low wages of publicly funded community mental health jobs just don't make sense to new graduates anymore? Tuition reimbursement would strengthen the profession for decades to come. We continue to struggle to finance the most secure technology, despite our most diligent efforts even our agency has experienced numerous hacking attempts. It is encouraging to know we may have additional help as we attempt to grow out of this.
Thank you for your time!

Michele Downing LSW RN
Clinical Program Manager
Pinebrook Family Answers
16 South Broad
Wind Gap, PA. 18091

Please address the lack of qualified Supports Coordinators. SC should be the liaison between the client/consumer of HCBS and the funder (i.e., Keystone First CHC) yet they are not equipped to advocate for us because they either have have a lack of medical knowledge or are told to ignore any and all

consumer requests. [redacted]. SCs need more training to truly assist the consumer in being able to live in their own home and avoid Nursing home placement.

I would be happy to provide further information if you have questions.

Lisa Meade

Hello:

I am writing to provide comments on Pennsylvania's Department of Human Services preliminary plan to use the 10% increased FMAP for Home and Community-Based services as part of the American Rescue Plan. I want to reinforce that the nine priorities identified by DHS are the most important considerations to strengthen, enhance, and expand HCBS services.

1. Increasing access to HCBS;
2. Enhancing HCBS provider payment rates and benefits;
3. Protecting the health and well-being of direct care workers and direct support professionals through the provision of supplies and equipment;
4. Recruitment and retention efforts to support the workforce;
5. Supporting caregivers;
6. Assistive technology and other supports to improve functional capabilities of persons with disabilities;
7. Supporting the transition of individuals to community-based living arrangements;
8. Investing in activities to address Mental Health and Substance Use Disorder treatment and recovery needs of Medicaid beneficiaries; and,
9. Building HCBS capacity and rebalancing Long-term Services and Supports

Of these priorities, I encourage DHS to utilize the maximum amount of dollars to increase reimbursement rates to HCBS providers, who are keeping Community Health Choices clients out of more costly hospitals and nursing facilities (#'s 2, 4, 5). The caregiver workforce is the backbone of Pennsylvania's long term service and support system, especially Personal Assistance Service Providers (PAS). These providers have saved Pennsylvania taxpayers' dollars, particularly during the pandemic in keeping individuals out of nursing homes, which had disproportionately high death rates. For many years, PAS providers have sought increased reimbursement, with only a modest 2% being implemented in 2020, the first in many, many years. Providing personal care is a hard job, with low pay and very little recognition. While bonuses for recruitment and retention, or improved training are nice one-time uses of funds, they will not solve the underlying problem that providers need to pay better, and the only way that can be achieved sustainably is through providers being reimbursed better from DHS through the Legislature and CHC Managed Care Organizations.

I support the priority of paying the workforce better, and again want to reinforce that the associated provider rates need to be increased to accomplish. I also need to point out that in increasing rates to allow agencies to pass funds on to direct care workers, the rate needs to include associated payroll costs such as FICA, Worker's Comp, Unemployment Insurance, benefits, etc. that are costs *in addition* to wage

increases. As Pennsylvania contemplates increasing its mandatory minimum wage, DHS must implement rate increases that address wage and these additional payroll expenses.

I am also in favor of providing more support to caregivers (#5). However, I want to voice concerns about developing a registry of direct care workers. I work as a part of a family of companies where a public registry idea has been implemented in other states. On the surface it sounds like a good idea. The flip side is this registry is then used to unionize employees, which drives up employee costs. Two examples where this has negatively impacted the home care industry:

- In one state, the home care union has taken some very aggressive tactics in approaching agency staff at their home address (information available thanks to the registry) and being very intimidating to get people to join the union.
- In a different state the union represents the consumer directed employees. The metropolis city in this state implemented a mandatory minimum wage increase, separate and higher from the rest of the state. We've approached that state's DHS about implementing a regional rate differential to pay for the higher wages. They are not able to address it because the union's contract is a statewide contract and does not recognize a local municipality differently. The next minimum wage increase will mean wages alone will comprise 80% of the reimbursement rate. Once employee benefits, payroll and employment taxes, overtime, and all administrative costs and margin are added in addition to wages, it is unsustainable. Put bluntly, agencies operating within this city limit will lose money on every single hour of service delivered. Agencies are minimizing and reducing their operations there as a result, which means access to services and agency choice for clients is negatively impacted.

As you can see from both examples, the registry had unintended consequences for both clients and non-unionized home care agencies. I would encourage Pennsylvania to either reconsider this endeavor, or at the very least ensure that the personal information of direct care workers on a registry is maintained private and confidential and not available publicly.

I appreciate the opportunity to provide feedback regarding Pennsylvania's approach and planning for the HCBS increased FMAP.

Thank you for your consideration.

Ford Allison

Ford Allison
MCO/MLTSS Policy Leader
TEAM Services Group
[redacted]

I would like to know if there has been any "real" consideration/discussion to add to the rate of reimbursement for the HCBS waiver program and the home care industry more broadly? If so, can the conversations and it's considerations be made public? If not, where does DHS and DPW stand on the matter? The 2% increase last year was great but really has not moved the needle. With respect to social and economic justice, the pandemic has further shine a light on this historically low wage yet "essential" industry. There should be strides made to achieve a true living wage for this workforce. Short

of that, this workforce's numbers will continue to decline. Leaving some of our most vulnerable more vulnerable.

Thank you,
Charlie
[redacted]

Hello: Please find my comments below. Thank you!

- Although CMS said in their guidance that retainer payments were an allowable use of this funding, ODP did not indicate that payments would be forthcoming. Providers need help NOW - it will be a long time before medically fragile adults with disabilities can return to day programming, and until that happens, providers will remain in critical financial situations.

- Given that the enhanced reimbursement rates are being discontinued, and given that even before the pandemic rates were insufficient for providers to remain sustainable, a rate refresh is absolutely necessary and rate increases are crucial for provider sustainability. I'm interested to know what "data" will be reviewed to inform ODPs decision.

- I'm interested to know what data ODP examined to support their decision to provide sign-on and retention bonuses. In all the data I've reviewed, and given my conversations with other providers, they do not work.

Laura Princiotta
CEO
SpArc Philadelphia
2350 W. Westmoreland Street
Philadelphia, Pa 19140
215.229.4550[redacted]
[redacted]

Hello,
Please allow non physician providers- NPs or PAs - to sign off on the request for home-based care services, the home care plans, and any other required documentation. As a physician medical director supervising multiple providers, the paperwork is burdensome if I must complete it myself.
Thank you
Trisha Acri MD

As a member of the Advisory Board of CHIMES/PA and on behalf of Holcomb Behavioral Health Systems, Inc. (also known as Chimes), I wish to submit this comment about the FMAP spending plan.
In the area of behavioral health, we endorse the Commonwealth's following approaches as most helpful to providers to enable us to furnish needed services:
1.) Support telehealth services with funding for providers to purchase equipment and training supports to enhance its usage;
2.) Support the reopening and administration of virtual drop-in centers used to provide a non -clinical support setting for persons in mental health and substance use disorder recovery; and
3.) Fund the administration and delivery of mental health counseling and support groups for front pandemic workers.
We also would like for the Commonwealth to consider offering loan forgiveness to clinicians who are working with these populations as an incentive which would then increase the available workforce pool.

Thank you,
Paula Budnick, Advisory Board Member with CHIMES-PA
1219 W. Wynnewood Rd
Wynnewood, PA 19096
--
Paula Budnick
[redacted]

Enhancing HCBS provider payment rates is THE critical item for Home-Based and Community Services. Providers must have increased rates to enhance their compensation packages for direct service providers.

Regards,
Shawn Wall RN, MSN
Director of Nursing
Warwick House/Associates Home Care
[redacted]

As a member of Chester County Advisory Council for the Dept of Aging, member of SE PCOA and Chestet County Elder Abuse Task Force, please accept my comments:

Our seniors need increased internet capabilities and equipment to stay in touch with their family and community.
Seniors need food accessibility and assistance that assures they are feeding themselves sufficiently.
Seniors need reliable transportation for medical appointments and other necessary trips.
Seniors need to have support to remain in their homes as many cannot afford to leave their homes for expensive assisted living entities.
Also low cost senior housing in need in my region as rent is exorbitant as well as a cost of a small condo or townhouse. They need to remain in their communities which is their family as so many are neglected by their children or abused by them physically and financially.
Mary Sue Boyle
CCAC dept of aging.

Hello,
I've provided psychological evaluations for families for the past 20+ years. The pandemic caused an abrupt cease in my meeting and working with children and parents. During the past 20 years, I met not only with family members but also worked in the schools and occasionally in family homes. The bulk of my time, however, was spent preparing my report that usually was 7 pages long. I was required to explore many domains relating to children and family members. (I worked with children 3 to 18 years old.) Report preparation often took 90+ minutes; and I was then permitted to bill for my time in two ways; $375 for a new client; or $225 for a return client.
Beacon has now informed psychologists they will no longer be reimbursed for report preparation time; but will continue to reimburse face to face interviewing with just about anyone involved with the client, ie, parents, teachers, school bus driver, coach, etc,. Consequently, that will force providers, who are required to submit a very lengthy report to spend most of their time not being paid. Beacon also stated they will reduce payment if the submitted reports do not contain information on each and every domain required which in and of itself is three pages long of required questions that must be answered. This situation has resulted in many providers such as myself to stop practicing at this time.
Sincerely,
Colleen BreeneMA
Licensed Psychologist

The amount of annual training for staff makes it prohibitive to retain them.
It is time consuming and redundant. If a staff has been
with an agency for a certain number of years
they should not have to do as much annual training.

The burden on the provider to constantly have
changes in policy and requirements to
continue to be a provider makes it
prohibitive for providers to want to continue.

Asking us to less and not more will help with retention,
compliance, and overall morale.

Kim Emmet, ACRE certified
Community Vocational Services
[redacted]

To whom this may concern:

I have a comment and suggestion. As a small business trying to keep several employee's positions in a medical office, I would highly recommend some fiscal responsibility. Stop using money that's not yours. Money is not water but it will go through an unaccountable sieve. How about returning funds and pay off the rising AR's from Medicare and Medicaid? How about posting government spending on healthcare line by line so we can help decide if it's being spent wisely? Let us determine waste, because it appears your wish list looks like someone has a bunch of tax payers cash and doesn't know what to do with it! I'd like to know, who are the recipients of all these free funds? Are they citizens? How about encouraging a return to the workforce but not by employing more government workers!!!

A friendly reminder, we here must be ethical, accommodating, fiscally responsible, make due if the funds don't exist, jump through administrative and insurance hoops and yet serve all populations (with rules that apply to all, but) with compassion especially to those who truly struggle. COVID is not the only bandit in town!!! How about you?

If you ask for public comment, be prepared to receive some.

Maria G. Ciccarelli
Business Manager
Green Hill Family Health Center
503 Bridge St.
New Cumberland, Pa. 17070
[redacted]
Fax: 717-774-8607
[redacted]
ghfp@aol.com

Hello,

I've been in the home care field for about 10 years. This is one of the most important yet low paying and under appreciated industries in the country. We need a rate increase for the HCBS direct care worker. These people are barely making ends meet. If we as the home care agencies pay them more we might as well be running this business for free. We either need a rate increase or Medicaid needs to figure out a way to make this industry volunteer work.

Let's do away with the employer taxes on employee wages. Why are we paying a tax on Medicaid funds we receive that are already not sufficient? Our caregivers need medical assistance for FREE no matter how much they work. We have people who need help yet helping others! Day in and day out for pennies. We have people working for $10-11 an hour and if we offer them insurance they have outrageous deductibles that they can't afford and they're not entitled to free health insurance. We need to be able to pay our employees $13-15 an hour, pay our workers compensation, our insurance (that is all required), our employer tax, and still make a $3 profit per hour billed.

We are set up for failure. We are heavily monitored which is fine but I can't imagine what the budget is for that yet we still have no increase in rates. We're making what a temporary worker makes doing authorizations at Upmc and we have to budget that $17.88.

It's absurd. We're heavily monitored yet this program doesn't want to support us so that we can hire quality people or at least people who don't care to lose their job.

I'm also confused by the section that says "caregiver support" it's very obviously clear that that is not in support of the caregiver but very much supporting the clients. There has been no tax break, incentives, nothing to support these people who are doing one of the most important jobs in society and accepting pennies for a paycheck.

We also need a caregiver monitoring site. A lot of the caregivers bounce around from home care agency to home care agency. We need a reference check portal for these people. Most of them do not give the correct employment information especially if they have abandoned their previous home care agency. They will be less inclined to do things like that if they know it can be noted somewhere that is accessible to HCBS providers.

A lot of us love what we do and that is important but we are burnt out. There are very few private pay clients who can carry this industry therefore our Medicaid clients are more than half of our client base. Something needs done and quick. In all of my years I have never seen caregivers rebel the way they are and I get it.

Thank you,

Morgan DePaolo
--
Morgan DePaolo
Owner at You Belong at Home llc
[redacted]
Fax: 412-774-1527

Thank you for the opportunity to comment on this.

Since the beginning of the pandemic to date, 83% of our overtime paid out to our caregivers has been for Medicaid cases, totaling $13,174.37. This figure does not even include the wages paid for holidays during this time, when families were not able to care for their loved ones and we had to pay our caregivers holiday time, which we are also not compensated for. We have not been compensated for

any of the added expense and have continued service to our clients every shift throughout. Clients have not wanted additional people in their house and requested the same caregivers for their safety. We applied for hazard pay when the state offered it to give to our caregivers, but was denied with no explanation. Our caregiver turnover has been impacted during this time due to burnout, schools and daycare closings, and fear of being on the front line. This has been a huge hit to our business, which is a small family owned and run agency for over 50 years. We have struggled greatly, but managed to keep our doors open, with management staff, who have worked excessive extra hours to keep shifts covered, taking big cuts in pay to compensate for the loss from overtime wages that have been uncompensated. We would have appreciated consideration of this during the pandemic, offering overtime billing and hazard pay to show the caregivers appreciation for their daily sacrifice to themselves and their families while they worked as many hours as required to maintain the safety of our clients. When the payroll protection loans came out, there was no consideration of the additional overtime wages as part of the qualifications to determine eligibility in the second round. It had a huge impact on revenue! Yet, only the Gross Income was considered for eligibility. We appreciate a second look at this, and consideration by the government to rectify the hardship incurred by our agency.

Best Regards,

Debbie

GUARDIANANGELSOF HOMEHEALTHINC.
When you want help, our angels will be there by your side
Visit Us Online | Review us Online
Deborah Popp | Marketing and IT Director
311 West Trenton Avenue, Morrisville, PA 19067
[redacted]
(800)446-6514
Follow us: Blog | Facebook | Twitter

I am the Clinical Director of a SUD treatment non-profit agency. Staff who provide treatment and recovery support services in client home and community locations must be compensated for this extremely difficult work. They have to work in environments that are often very different than what they'd experience if they provided office-based services. Some examples: the burden of travel, wear and tear on personal vehicles, having to plan their day around where there are safe, clean places to stop for restroom and food breaks, working in homes with no furniture to sit on or unsanitary conditions, infestations such as bedbugs and lice that workers worry they will bring home to their own homes/families, very hot or cold conditions in the client homes. These concerns do not even address the population of clients they work with, clients have significant needs that sometimes result in behavior that is difficult to manage and may become unsafe for staff. We need to be compensating these staff at a rate that is significantly higher than what they can make in a similar office-based position, otherwise it

becomes impossible to keep these much-needed programs staffed appropriately. Thanks for your consideration of my comments.

Kara Hall, LPC, CAADC
(she, her, hers)
Clinical Director
Office: 412-243-7535 [redacted]
[redacted]
Fax: 412-643-2972
907 West Street, 2nd Floor
Pittsburgh, PA 15221

http://www.power-recovery.com

I read over the expenditures for the American Rescue Plan Funding. I believe the money is being well spent particularly with the online training component and increased money to providers. I believe one way to use reinvent money, which would be extremely helpful overall to 13 million citizens of PA would be to establish 3 regional television stations and streaming stations, which take evidence-based self-help and move it to a streaming video format.

According to NAMI, 43.8 million Americans have a mental illness. Less than half the people with mental illness receive treatment (Substance Abuse and Mental Health Administration, 2015). therapeutic services for either access issues, because television, is everywhere with over 97% of homes having one t.v. or those not seeking a relationship with a therapist's needs. I believe the video format can address many of the non-seekers of These stations can provide "do-it-yourself training" for people seeking some form of behavioral health treatment but might not want to engage a therapist. Indeed, self-help particularly from a skills training and cognitive behavior therapy perspective has been phenomenally successful with an overall large effect for behavioral health conditions on treatment and moderate effect size on follow-up (see Guild and Clum, 1993). With respect to specific disorders, a moderate effect size was found for self-help treatment of OCD (Pearcy, Anderson, Egan, & Rees, 2016),a large effect size for insomnia (Yan-YeeHoa, Chunga, Yeung, et al. 2015), large effect size for binge eating (Hibert et al., 2019), a moderate effect size for depression (Cuijpers Donker, van Straten, Li, & Andersson, 2010), and even a small to moderate the effect size for treating delusions and psychosis ((Scott, Webb, & Rowse, 2015). Additionally, many behavioral interventions like parent training for parents of oppositional defiant disorder or ADHD or milieu teaching for improving language and communication skills for parents of children with developmental disabilities can be scripted out and trained using videos (some of these videos like Lynn Clarke's S.O.S. for parents already exist). Television stations can be offered both over cable and by streaming services. The state can use several cognitive and behavior psychologists and psychiatrists to serve as a science board for the program. They can ensure matters are not a violation of community standards by having a community board.

Please consider.

Joseph Cautilli

I know that grafts cost more than that. just maybe they need to adapt to the coverage because I'm sure there are other providers that don't utilize grafts due to cost. Just saying

I'll try

Michael J. Cole
VP Insurance Plan Management
6240 Lake Osprey Drive
Sarasota FL 34204
[redacted]

Good Morning,
Thank you for the opportunity to provide feedback about the state of Home and Community Based Services in PA. As a very small non-profit provider of HCBS, we are struggling not only because of the pandemic, but because we have not received a rate increase on any of the services we provide (In Home and Community Supports, Companion, and Family Aid/Respite) in at least 5 years. In turn, we are unable to offer raises to our staff and many months unable to keep up with our bills. The insurances we pay on our staff are extremely high ($10,000 per year, give or take), increase in gas prices but no increase in mileage reimbursement, and the higher demands on staff to find time to participate in multiple annual trainings mandated by ODP has caused a strain on our small agency. We are the only one of its kind in our rural community and families, individuals, and other providers have come to rely on us for providing exemplary services to individuals in need. But we can not continue without a rate increase.

Additionally, if the state raises it's minimum wage, we must insist that higher service rates be implemented! It is time that we be able to afford the best quality staff to work with the most deserving individuals in our community; but we can not continue to do that without an increase in HCBS rates.

Thank you for your time.

Jackie Simmons
Associate Director
Wyoming County Special Needs Association
636 SR 29N
Tunkhannock, PA 18657
[redacted]
Fax: (570) 996-6223
www.wcsna.org

To whom it may concern,

Oral health impacts our whole body health. Oral health impacts just about all systemic conditions. Dental disease if left untreated can be life threatening. People have died due untreated dental infections. It is also one of the highest number of ED visits and cost the state millions of dollars because of the lack of access to dental care for the Medicaid/Medicare population. We need more dental offices to participate with Medicaid and Medicare dental plans. We have very few offices to support this population. Including dental specialist! Such as Oral Surgeons and Endodontists. Loss of a tooth can impact speech, digestion, posture and self esteem. The articulation of your teeth can change your jaw position therefore changing your head position leading to neck and back pain. If your can't chew your food properly it causes digestive issues. We need our teeth to help us pronounce words properly. This population, children and adults, need and deserve access to complete dental care not just extract the teeth. That leads to more cost for the state than to have the access to prevent costly ED visits. Preventive care is more cost effective and beneficial than restorative care. We need to get more dental offices to care for this population. Increase their reimbursement rates. Dental office overhead cost is very high and worse since covid.

Thank you,
Chasity, RDH, PHDHP

Hello,

We are hoping to get the 8% increase for PAS fog the Office of Long Term Living Programs. We need to be able to hire qualified caregivers to provide the services that our participants need on a daily basis. To be able to retain the caregivers that are qualified to do the job. We are looking forward to the increase to provide the quality of care to our participants that they need. And to retain the qualified caregivers that are needed to provide the services to our participants.

Sincerely
--
Warmly,

Ms. Sheila Joyner/CEO
[redacted]
Your Care at Home, LLC
6635 N. 11TH Street
Philadelphia, PA 19126

[redacted]
Fax 1 (267) 297-8006
www.yourcareathomellc.com

Dear Representative,

I wish to take the opportunity to express that the rate for HCBS non-medical home care paid to agency providers fell well below a level where providers can serve those cases and actually make any profit at all – well before the COVID crisis arrived. When all profit was gone a couple years ago (Even EBITDA was significantly negative for us), we reached a point where we could no longer bear the cost to serve Medicaid waiver assistance recipients except for a very few where consumers had a friend or permitted family member willing to serve them for pay that's well below the normal current caregiver rates of the time. And since COVID struck, costs are far greater yet to serve, and the number of caregivers available is far less than the number needed.

We aren't able to pay caregivers nearly what they are worth even at a typical $26/hour private pay case (our low-end base rate to clients), let alone when we receive less than $19/hour as with PDA Aging Waiver, ACT150 and other similar waiver types. And because there aren't nearly enough caregivers available, we must turn-away nearly all prospective cases – even those that reimburse us far greater than that $26/hour baseline for us. (Note that our 1 hour visit standard rate is $48/hour, and 2 hour visits are $60/2-hours and we can't even find many caregivers willing to serve those cases where they are paid special amounts above their normal pay rates)

To have qualified agency providers serve Medicaid waiver recipients, they have to be able to be profitable and also be able to pay qualified caregivers reasonable going rates. That means that Medicaid waiver has to be competitive with private pay or even a bit higher since agencies have to take the cases that they can survive on (And because it costs more to serve waiver cases because of the wait to be paid, costs to deal with special audits, no security deposits received, and more). I strongly suggest that the minimum reimbursement rate increase needed to succeed is currently about 50% or ballpark $10/hour above current reimbursement rates for the waiver types mentioned above. Agencies like ours are pushed into having to choose who will be served and who will not because of insufficient numbers of caregivers. And all of those consumers need help. So it then comes down to choosing between taking cases that can be profitable, or those waiver cases where we pay-out more in total than we're reimbursed. We have no choice but to serve where we can survive and make a living, and those aren't often HCBS Medicaid waiver cases.

I believe that all home care agencies in the country are being confronted with those same choices. If Home Care is to be a part of HCBS, the rate paid to Agency providers must increase substantially or there won't be any providers that can survive to serve, nor any caregivers willing to work at the extremely low pay rates they need to.

From my perspective, this reimbursement rate issue is far greater than all other problem areas or possible improvements combined and needs to be addressed immediately and in a significant way. When Governor Wolf suggests paying people more if enough help can't be hired, he's right. And our caregivers really do deserve better pay. But I'd love to hear him explain how that can be done when EBITDA is already a negative number, costs and inflation are escalating, and waiver rates paid to us to serve are only a tiny bit higher than they were 8 years ago.

Regards,

Keith Zimmerman
Owner
2550 Kingston Rd. | York, PA 17402
[redacted] | F 717.757.7246
https://www.rightathome.net/york-hanover

dear sir
my name is dr eugene young a dentist practicing in center city philadelphia. Due to pandemic we have to spend so much money to upgrade our dental facility- face masks including n95, face shield, negative air flow, hand sanitizers, etc. that its not fasir we have to beara all the financial burden. On top of that flow of patients decreased dramatically and we have to cut back on staff and hours.
we have not had any adjustment of fees for many years. all the dental supplies have skyrocketed after the pandemic.
i hope you listen to our pain.

eugene young dmd

I am a Medicaid Provider for the State of PA. Unfortunately, due to COVID-19, lack of staff or people who are motivated to work, poor reimbursements by Medicaid and it's subsidiaries, lack of financial assistance from the State and multiple other reasons, I will be closing my office. There will be no OMS provider in a 30 mile radius of my town. It is unfortunate that the State and Federal government have not been able to provide enough assistance for those of us who are private practitioners and practice in low income areas. I applied for every program for financial assistance that I could, but it was still not enough. Also, the paperwork involved to receive grants was absurd and a deterrent. The reporting of the "grants" is also so difficult I am sorry I applied for them. My retirement/ closing of my practice will be an extreme hardship for Medicaid patients. I just thought someone there might like to know what is going on in the real world.
Frank Falcone, Jr., DMD
Oral and Maxillofacial Surgery
Hazleton, PA

We are a provider under the Community Health Choices aging waiver. I was glad to see some of the program oriented to assisting with hiring, retention, and other challenges. The difficulty in finding staffing is severe and hopefully these enhancements can help with the shortage.

The budget explanation also refers to enhancing direct care worker rates. It is not clear if this applies only to DCWs who work independently, or if MCOs will be required or encouraged to enhance reimbursement rates. We desire to increase caregiver wages, but cannot do so with the current payment rates for services. The hourly cost, including workers comp, taxes, and liability insurance of field staff paid a $15 hourly wage (which UPMC – one of the MCO companies – recently announced as a minimum wage for their workers) is just pennies under the current $18.72 reimbursement rate, leaving no room for any overhead, let alone profit. Our agency is seriously considering discontinuing care under the CHC program due to the losses we incur. I was hopeful something could be done about this impossible situation.

Thank you for your consideration.

Donald F Davis, President
Specialty Home Care LLC
Hershey PA
[redacted]

Very well written plan. Can individual organizations get access to the additional funding?
Thanks
Bob Gongaware

Robert Gongaware, MBA, FHFMA
Chief Financial Officer
Indiana Regional Medical Center
835 Hospital Road
Indiana, PA 15701
[redacted]

We are an adult day service program who has many clients participating through the Community Health Choices Program. Will this Plan change the rate of pay we will receive from the insurance companies?

Most of the adult day cares are non-profit and struggle with payments being low from the insurance companies and struggle to make ends meet month to month.

Thank you for your time,
Wendi Westervelt
Office Manager/Nurse Manager
Golden Visions Adult Day Services
250 Fame Ave, Suite 125
Hanover, PA 17331
[redacted]
Fax: 717-633-5064

Good afternoon,

I reviewed the spending plan submitted. Working in supports coordination, we serve multifaceted individuals. One area that is LARGELY underserved is treatment for dual diagnosis, and not the SAMHSA definition of dual diagnosis, but treatment for individuals with co-occurring mental health and intellectual disabilities and/or autism. These folks literally got lost in the system. Mental health doesn't want them because they don't know what to do with them, and intellectual disabilities is getting attacked because the behavioral needs are going unmet. Merakey has a dual diagnosis treatment team that is an AMAZING model to support this, but Autism is an exclusionary diagnosis. I would love to see increased funding for DDTT to support more individuals. Currently there is a waitlist that can be up to a year long. It would also be beneficial to allocate funding for a similar model that helps people with Autism and mental health diagnoses. If staff are effectively supported and given the right tools to help these individuals, it will likely lead to a decrease in staff turnover. I can speak from experience; I was severely attacked by a 6' 5" tall non-verbal man with Autism. I was savagely shaken and left with injuries that included being scalped and sustained whiplash and a vestibular concussion; all because he was having a bad day. Something needs to be done to bridge the gap between mental health and intellectual disabilities. DDTT is a great answer.

There needs to be more step-down crisis residential options to support these folks in recovery coming out of psychiatric in-patient. Countless man hours are spent trying to locate some place for our folks to go following a psychiatric stay, but most step-down facilities will deny folks with ID or Autism because they aren't equipped to handle them.

And lastly, there needs to be more options for families who have medically complex children find day care. There are not enough day care options for special needs children. Some families have needs that are so complex it prevents them from working, but then insurance denies them access to a home health aide because there is a parent who is home and not working. These parents need a break. They aren't getting any rest at all and burn out leads to incidents. There needs to be insurance reform to support families maintain their own health and sanity while caring for these complex cases.

I do very much appreciate seeing an emphasis on increasing capacity for consolidated waiver slots. There is a huge need for this.

Thank you for your consideration of my comments at this time. I think that the state did a great job coming up with a plan to meet many needs, but still saw the gap regarding the aforementioned items.

Have a great day,

Jennifer Yocom, MHS
Achieving More
SC Supervisor
400 Franklin Ave
Suite 202
Phoenixville, PA 19460
[redacted]

To Whom It May Concern:
Thank you for allowing stakeholders an opportunity to respond to the American Rescue Plan to provide a 10% increase to the federal assistance percentage for certain Medicaid expenditures for home and community-based services. We are a medium size Home Care Provider with thirty-nine years of home care experience. In the past few years, but especially now, our Agency is struggling to compete with other Non-Home Care Providers able to provide higher wages, sign-on bonuses, and health care benefits. When you compare a Caregiver's essential work duties to that of a fast-food or assembly line worker, it is an injustice that there is no incentive to caregiving in this country anymore. How can low wages and no benefits attract and retain quality employees when we see higher salaries, sign-on bonuses, and college tuition in every other business sector, or still, higher wages on unemployment. Our Agency and many other Home Care Providers seek an increase in a 10% reimbursement, even if temporarily (*although temporarily will still not fix the overall long-term care crisis)*. The Department of Human Services can pass the extra 10% compensation to the front-line Caregivers through the Home Care Providers. Direct Care Workers are servicing the most vulnerable population. In a growing market with a strong need to maintain costs and keep people home and out of hospitals and nursing homes, how can this industry be one of the few remaining where not even a cost-of-living increase has applied? Additionally, with increased regulatory requirements, high operational and employee costs, mandated insurances, and increased business liability, many hypothesize this is the plan for only the large Home Care monopolies to remain.
In over twenty years, we have not seen any significant fiscal increase that could assist the Home Care Providers in maintaining employee satisfaction and ultimately keep employee attrition rates low. How can any business survive in this country when programs and bureaucracy keep expanding, yet, the overall mission of streamlining and cost retainment doesn't get accomplished? All this is doing is furthering and magnifying the crisis of **No Workers.**
If the industry's mission is to provide quality, safe and resourceful Home Care/Long-Term Care, please utilize the 10% increase for the Home Care Providers to pass along to its employees working and caring compassionately. Ethical Home Care Providers like our Agency would have no problem being transparent on where that 10% increase is going. Keeping employees satisfied with secure wages and benefits would minimize the overall fiscal burdens and costs of unemployment within this state and country.

We have graciously worked in this industry for a substantial period and have never complained. We have welcomed all different contractual programs and have been highly compliant. We have also hired, trained, and terminated over 5,000 Caregivers of every age, sex, and ethnicity. In all those years, the common denominator with why Home Care/Long-Term Care continues to have a shortage of workers and an uprise in critical incidents is that the industry cannot compete with attracting and retaining a higher quality workforce. In concluding, if the main objective is to honestly caregive properly, one must first start with the employees who perform the essential duties. If that is not the goal, then all the home care programs initiated within the past decade are honestly in-vane and not cost-effective. For everything to work adequately, one must tackle the root cause of the crisis/problem, and that is, start with supplying the workforce with higher wages through better reimbursement rates to the Home Care Providers.
Thank you for your time and consideration in this matter, and I would be very thankful for a positive outcome; many vulnerable Clients would be appreciative.

Sincerely,

Hope Claypoole, Operations Director
Maximum Care Inc.
I am writing in response to your inquiry for public comment from EI providers regarding the new FMAP plan in regards to HCBS.

I am currently an occupational therapist providing evaluations through the early intervention infant toddler program. I have been working full-time as an independent contractor/LLC for an EI Provider agency for the past 6 years. Since the start of the pandemic, I have been providing evaluations solely via telehealth methods. Generally, evaluations have been going very well. My team members and I feel that we are able to conduct a valid and thorough assessment via Zoom video conferencing for over 99% of our families. Conducting telehealth evaluations has also caused new challenges that we haven't encountered with in-person evaluations. Firstly, many families aren't used to the software and hardware required. It often takes several minutes for families to log on and set up the camera so the team can see the child appropriately. Additionally, the nature of Zoom calls is that only one team member of the multi-disciplinary evaluation team can talk at a time versus in-person evaluations in which one team member can engage with the child while the another interviews the parent simultaneously. Therefore, overall, during Zoom calls there is less cumulative time to gather information from the parent and engage with the child to the degree needed to complete a valid assessment. As evaluators we try to observe the child play in the background as much as we can while the parent talks with our team members. However, it is very challenging to observe, type, and keep an ear out while the parent is answering questions. One side effect that was not anticipated with all of this is the toll that telehealth takes on the mind and body. I'm sure you've heard of the term "Zoom Fatigue" that has been coined in the media including the New York Times. It is exhausting keeping our mind alert and multitasking in this fashion for 6-7 hours per day. Scientists are trying to figure out why. I can only describe that there simply isn't always enough mental space and energy to type meaningful reports while simultaneously observing, listening, and talking with parents with camera directed at our face hour after hour. The structure of our work day remains the same as it was pre-pandemic. This is 3 2-hour evaluations per day. By our third 2-hour evaluation of the day, we are exhausted and we can't figure out why because we've been sitting in a chair all day. It's a strange phenomenon, but it's real. I had to ask my agency to take me off the schedule for one day per week simply because I couldn't do 15 telehealth evals in a week anymore. And I was handling 15 in-person evaluations prior to the pandemic. Early Intervention billing laws indicate that we are only allowed to

bill for time we are directly working with families. However, we are spending an increased amount of time completing/writing reports outside of the Zoom calls because there simply isn't enough mental energy to listen, observe, and talk with parents while simultaneously writing a valid and thoughtful evaluation report and IFSP via telehealth. The way the reimbursement scale has been designed we are not getting compensated for this write-up time outside of these calls, which typically totals at least one hour per evaluation for a total of 3 or more hours per day. Other programs such as school-based and early intervention 3-5 programs are able to bill for evaluation writing outside of direct service. When I saw that the new plan includes a 10% increase in reimbursement rate for providers I was relieved because that will help off-set some of those costs and help make up for the one workday per week I had to eliminate due to Zoom fatigue. Additionally, I was relieved to see that it included reimbursement for PPE costs, as we are embarking on returning to in-person services within the next few weeks and have no answer from our provider agency on how to manage the cost of PPE.

In general, there are have been many advantages to using Zoom as a method to provide telehealth evaluations for families. We have been able to service more families more quickly to due to elimination of travel time, etc. There are also advantages to decreased exposure to all sorts of illnesses which have led to decreased sick time and missed evaluations. However, the reimbursement for writing up reports outside of direct service time has not been addressed although it has had major mental health and financial impacts on EI providers. I hope to continue providing telehealth evaluations long into the future, even after the pandemic ends. However, I would like the billing system to include ways to compensate providers for the time it takes to complete our evaluation reports and IFSPs beyond the Zoom calls with families.

Thank you for your consideration and taking the time to hear my feedback.

Sincerely,

Susan Pernice, MS OTR/L
Occupational Therapist
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