January 8, 2016

Deputy Secretary Jennifer Burnett
Office of Long Term Living
Bureau of Policy and Regulatory Management
P.O. Box 8025
Harrisburg, PA 17105-8025

RE: Community HealthChoices Draft Agreement Sections – December Release

Submitted electronically via RA-MLTSS@pa.gov

Dear Secretary Burnett:

On behalf of the Center for Advocacy for the Rights and Interests of the Elderly (CARIE), thank you for the opportunity to provide comments regarding the Community HealthChoices (CHC) program draft Agreement Sections.

Founded in 1977, CARIE, is a non-profit advocacy organization working to improve the well-being, rights and autonomy of older adults. CARIE routinely helps older adults and their caregivers understand and resolve problems related to Medicare, Medicaid, and long term services and supports (LTSS). In addition, CARIE currently coordinates the PA-SMP program to help address fraud and serves as the local ombudsman for certain areas of Philadelphia. Through our work, we are acutely aware of the needs, issues and problems that older adults and their families encounter.

CARIE continues to have major concerns with the timeline and the plan to fully implement the proposed Community HealthChoices (CHC) program statewide and recommends delaying the start date as well as limiting CHC to the SW region until problems are resolved. (The rationale for these concerns were highlighted in comments we submitted concerning the CHC Concept paper that we hope will be reviewed and considered.) The draft documents and stakeholder meetings have not relieved our trepidations about the problems that will inevitably occur by moving too quickly through the planning process and implementing a program statewide before it is tested and modified on a smaller scale.

We understand you have received thousands of comments and there are still many details that clearly need to be carefully thought through and resolved before experimenting on vulnerable people. MCOs and other providers should be given ample time to adapt their business models and be fully prepared to transition to this new system. If the Commonwealth continues this course, consumers will no doubt be harmed as a result, despite the well-meaning intentions of the Department of Human Services (DHS). DHS should take the time needed to develop a well-conceived plan with a more realistic timetable for implementation. In recent years, there have been many examples of the state having disastrous outcomes implementing changes to its Medicaid Waiver program and this change is certainly of a much greater magnitude.
The draft agreement sections seem to follow contract information found in HealthChoices agreements and there still needs to be more thought and planning into the LTSS side of the program. Once again, we encourage Pennsylvania to pursue a MLTSS demonstration project as recommended by the Pennsylvania Long Term Care Commission. Ideally, Pennsylvania could test two different MLTSS models to see what works best in Pennsylvania and resolve any problems on a smaller scale before expanding statewide.

We hope DHS will still consider our previous comments when refining its CHC MLTSS program and developing the RFP. CARIE would like to add the following comments to what we submitted last month for the draft Request for Proposal (RFP) and program requirements documents.

Exhibit DDD (2) - Covered Services
Participants should not receive funded services in personal care homes under any circumstances. As per 55 PA. § 2600.1. (b): “Personal care homes are designed to provide safe, humane, comfortable and supportive residential settings for adults who do not require the services in or of a licensed long-term care facility, but who do require assistance or supervision with activities of daily living, instrumental activities of daily living, or both.” Since CHC will be provided for dual eligible beneficiaries who are Nursing Facility Clinically Eligible (NFCE); this would preclude persons from receiving long-term care services. In addition personal care homes do not meet the setting requirements in CMS’ Final Rule for Home and Community-Based Services.

Assisted Living was established on July 25, 2007, Act 56 P. L. 402, No. 56 with regulations contained in 55 PA. Chapter 2800 in large part to allow for older adults to “age in place.” At the time, it was envisioned that there would be a separate waiver for assisted living residences. This never happened. As a result, Pennsylvania has a scant 35 licensed assisted living facilities compared to 1,206 licensed personal care homes, some of which look very much like assisted living facilities. Many are located in continuing care facilities, take care of residents with challenging care issues including dementia and work to help residents age in place. Pennsylvania has no experience in using public funding in assisted living. It is advised that any use of this setting for CHC be closely monitored. It is important, as stated above that consumer preference be honored. Assisted living residences have fewer requirements and less stringent regulations (they are not regulated on a federal level, for instance) while costing less than nursing homes. It will be important to make sure that there is not a cost incentive to move consumers who wish to be in an institutional setting to assisted living if a nursing home is a more appropriate setting.

Palliative care should be a covered service. Palliative care is an approach that is intended to improve the quality of life of patients and their families facing the problems associated with life-threatening illness. This care can be used to alleviate the side effects of curative treatments, such as relieving the nausea associated with chemotherapy. While many patients receiving palliative care have been diagnosed with cancer, patients with other chronic disorders also may benefit from palliative care. This includes patients with progressive pulmonary disorders, renal disease, chronic heart failure or progressive neurological conditions. Palliative care can be integrated with medical care intended to cure disease, and is not intended to be used only when a patient has terminal disease. Palliative care can potentially improve quality of life and make it possible for the individual to continue to be involved in social programming.
Section VIII: Reporting Requirements (pages 5-15)
DHS should require MCOs to report data concerning all terminations or service reductions at the individual level. MCOs must also be required to collect and share data about LTSS in addition to medical information such as quality of life and caregiver-related issues.

DHS should require MCOs to provide needed data to create a monthly enrollment dashboard such as offered by Virginia’s MLTSS program. Stakeholders in Pennsylvania should be engaged to help add additional data points that could be publically shared on a monthly basis. It would also be helpful if DHS posted public quarterly reports on the new MLTSS system to highlight what’s working, problems, and what DHS is doing to address the problems. The reports should include information about how well CHC-MCOs are adhering to their contracts and share quality data once it becomes available. The quality measures should include process measures such as nursing facility diversion rates, transition measures such as nursing home or hospital readmissions within 30 days of discharge, and outcomes measures such as the percentage of participants with a change in ADLs.

DHS should post quality metrics about each CHC-MCO so consumers can make informed choices about the best possible plan for them. DHS or each MCO should be required to post their entire provider network and include quality metrics so consumers can make informed choices about the provider that is most beneficial for them.

On page 11, “Provider Network,” DHS should have standards in place for an adequate network for each provider type and should use these monthly reports to ensure the CHC-MCO is in compliance with having a robust provider network so consumers have choice and can access needed services.

Section X: Termination and Default (pages 17-20)
All agreements should include options for intermediate sanctions so DHS can ensure a poorly performing MCO is brought into full compliance in a timely way.

The provision that requires CHC-MCOs to “coordinate the continuation of care prior to termination or expiration for Participants who are undergoing treatment for an acute condition” should be expanded to include participants receiving LTSS.

A - Managed Care Regulatory Compliance Guidelines (pages 27-47)
DHS should include a process for the exceptional durable medical equipment (DME) grants to ensure that participants are able to obtain needed exceptional DME in nursing facilities.

H - Prior Authorization Guidelines in the CH Program (pages 75-78)
Once approved, the MCO should be required to publicly post its policies and procedures for the prior authorization of services. DHS should collect and post data from each MCO about the number of prior authorization requests, the average time for approval/denial, and the number of approvals versus denials. This will provide an important resource for consumers to compare plans.

M(1) - Quality management and Utilization Management Program Requirements (pages 79-100)
DHS should conduct participant and other stakeholder meetings throughout each region as CHC is rolled out and implemented so staff may interface directly with the public to allow dialogue to learn about problems and what is working well. The MLTSS Advisory Committee should be expanded or
have a subcommittee that focuses on the needs of older adults. No current member has raised issues or concerns specific to older adult consumers who will be impacted by these changes.

It is disconcerting to see a lack of standards to ensure quality care and quality of life in regard to MLTSS. In some ways, this is understandable as there is a lack of standardized measures on a national level. DHS should allow for inclusion of additional standards and measures as they become available such as through the National Quality Forum currently developing performance measures for HCBS to support community living as well as other CMS HCBS quality measurement projects.

It is also disconcerting that each CHC-MCO will be responsible for developing its own quality measures to evaluate providers. There should be standardized measures to ensure more reliable data collection for comparison among providers.

DHS should expand the standard “N’” on page M(1)-4, “The CHC-MCO shall ensure that reimbursement of nursing facility care is provided for Participants who have been determined to be eligible for reimbursement of nursing facility care for the period specified. The CHC-MCO shall monitor the Participant’s condition for ongoing care and potential discharge back to community living.” Standards should be specified for MCOs to ensure that its nursing facility providers are providing participants high quality care and that consumers can access nursing facility care for rehabilitation or for longer stays near where they live. MCOs should be required to participate in the nursing facility quarterly care planning conferences for participants to monitor care and ensure smooth transitions when needed.

On page M(1)-6, the Quality Management Committee should include membership and meaningful participation by plan participants. MCOs must hold meetings with its members to address grievances raised by individuals and make public meeting minutes. They should help with transportation to the meeting if the participant needs assistance. Telephone access or other provisions should be made for participation by people who cannot travel. All meetings should be held in locations that are physically accessible.

The list of QM and UM programs in Standard VI, found on page M(1)-11-12 should be expanded to include:

- The CHC-MCOs and the Fee For Service Medicare program;
- The CHC-MCOs and Medicare hospice providers;
- The CHC-MCOs and nursing facilities;
- The CHC-MCO and hospitals, and
- The last item on the list should be expanded to include “and other HCBS LTSS providers.”

Standard XIV.I, on page M(1)-22 should be expanded to include the requirement of accommodations to address visual, hearing and other impairments.

M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting (pages 105-106)
DHS may want to consider adding “falls that result in injuries” to the list of critical incidents.
The following statement should be more specific, “Providers must report in accordance with applicable requirements.” We recommend changing it to, Providers must report in accordance with all applicable federal and state laws and requirements.

This section should further explain the process as to what happens after an incident or preventable condition is reported, including timeframes for response.

**N - Notice of Denial (pages 111-137)**

It is important that all denial notice samples are printed in a large and accessible font. MCO inserted explanations should be written so those with low literacy levels will understand the message.

Participants must have the right to file grievances about the service and treatment provided by the MCO, its subcontractors and its providers. We are pleased to see that services will be covered during the appeal process until a decision is made. Language should be added to the contracts that require decision-makers in the appeals process to be trained to understand and evaluate the necessity of LTSS, and consider the non-medical goals and benefits of these services.

The public should receive regular data updates on the number of denials (including partial denials), appeals and grievances filed, along with the outcomes including the number of appeals that result in the reversal of a CHC-MCO decision. Further data should be compiled and shared about any negative outcomes to those who were denied services.

DHS should establish an independent ombudsman for CHC to assist participants in exercising their rights through the appeals and grievance process.

**ZZ - Automatic Assignment (pages 138-139)**

CARIE has extensive experience helping consumers choose a managed care plan. More often than not, the primary factor in selecting a plan is whether the consumer’s physicians are in the MCO’s network. Therefore, we strongly recommend auto-assignment process include assigning the consumer to a MCO plan that includes their doctor in the network. If the doctor is part of more than one MCO, the consumer could be randomly assigned after the other identified factors are considered.

**EEE - Participants' Rights and Responsibilities (pages 140-141)**

The list of participants’ rights seems thin. All participant rights should be spelled out in bullet form and be required in all written MCO communications about participant rights and responsibilities. Having rights clearly spelled out for consumers is vital to their understanding of their rights as almost all would have no way to know what is included in the law, regulations or contract. Therefore, the specific rights associated with the following language in the draft document should be spelled out in bullet form:

“Each Participant is free to exercise his or her rights, and the exercise of those rights may not adversely affect the way the CHC-MCO and its providers treat the enrollee.

CHC-MCO must comply with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of
1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).

DHS should post these rights and responsibilities and approve CHC-MCO drafts of consumer materials that include statements about participant rights to ensure the information is complete, clear and understandable.

All rights that relate to a consumer receiving information should include that they receive the information in a timely way.

Some additional rights that should be included:
- Have the right to control the development of your LTSS service plan.
- Have the right to consumer-directed care in LTSS.
- Be aware that consumers who are in a nursing home have additional rights.
- Have the right to choose and change CHC-MCOs, providers etc.
- Have the right to choose the setting where to receive services.
- Have the right to access their health records at no charge upon request.
- Have the right to know about any fees, copayments, or payment obligations, and be protected from balance billing.
- Have the right to have family or caregivers involved and be notified of critical information related to health care or LTSS.
- Have the right to file grievances about the service and treatment provided by the CHC-MCO, its subcontractors and its providers.

This is another area where an ombudsman could serve a vital role in helping consumers understand all their rights and how to exercise them. How will DHS monitor compliance with CHC-MCOs respecting these rights and compliance with all laws, regulations, and contract provisions? Again, the ombudsman could serve a vital role in identifying consumer rights violations and other related issues.

GGG(1)-(9) - Performance Measures (pages 143-185)
Since there are very few validated tools to measure the impact of MLTSS in regard to quality of care and quality of life, DHS should include provisions to allow for the addition of tools or measures as suggested by the National Quality Forum measures once complete as well as other measures that are being developed and tested.

On page 146, the National Core Indicators performance measure should be sure to include the National Core Indicator – Aging and Disabilities assessment.

CARIE commends DHS for including “transgender” as an option in the demographics data elements found on page 149. This is a historic first step for Pennsylvania to begin to collect needed data to help address the health gaps and needs of the transgender community. We would recommend also collecting data on the individual’s sexual orientation (Gay, Lesbian, Bisexual, and Heterosexual) as we know the LGBT population is typically undercounted and underserved. Collecting this information is an important first step to address the needs of the LGBT community.
We are pleased to see a draft uniform comprehensive needs assessment for use in the CHC program. Has this tool been tested and validated for consistency and reliability? It is vital that DHS publically share the algorithms used to authorize services so it is clear how any tool is used to determine eligibility and level of services as well as the number of service hours.

Other
Once AGAIN, knowing that the transition to CHC will cause major disruptions and problems for consumers, it’s disappointing not to see any mention of an ombudsman program or any independent consumer advocate to assist consumers with problems and complaints or in understanding their benefits and rights.

Consumers should have access to an independent ombudsman as well as free legal services to help them through the grievance and appeal process. These procedures are critical particularly when consumers are subject to service denials, reductions, and terminations. Without these resources, the process is stacked against the consumer.

It is important that CHC consumers have access to independent, free ombudsman services to help with issues such as understanding their rights, enrollment, accessing care, and appealing adverse decisions regarding their care. Ombudsman can also help identify systemic issues and should have access to state and MCO officials to resolve these problems in an expeditious manner.

It would be prudent to build upon Pennsylvania’s long term care ombudsman program rather than creating a new entity. Combining ombudsman services into the current program will be more cost effective, seamless for consumers regardless of how they may transition through settings or payers. Illinois is a state that has successfully combined its ombudsman program. It is important that any ombudsman program have adequate funding to be able to respond to the needs and concerns of MLTSS consumers. All consumers should receive information about ombudsman services upon enrollment, in any correspondence from the MCO or DHS about their plan or services and periodically throughout the year.

Conclusion/Final Comments
It is important that DHS ensure meaningful consumer participation and transparency at the state and MCO level, including making public agreements between and among CMS, the state and the MCO. Results of readiness reviews, evaluations and quality measures must also be made public. MCOs must be subject to freedom of information act laws. It is also important that DHS hire and train needed staff to ensure that staff have expertise needed to operationalize, oversee, and monitor MCOs and the CHC program.

CARIE hopes there will be more opportunities for feedback when more details are available and before decisions are finalized. We hope that Pennsylvania will create a thoughtful and deliberative state planning process and take the time needed to create a MLTSS system that promotes person-centered care, independence and dignity. The current timeline should be scrapped since it does not allow enough time to ensure meaningful consumer input, avert risks, optimize opportunities, or ensure a smooth transition for consumers. Stakeholder input should not be constrained by the procurement process. This historic change could be positive if all stakeholders are actively engaged in an ongoing, transparent process that includes significant discussion before formalizing or
implementing any plan. DHS should continue to engage with stakeholders regularly in the monitoring and oversight of its MLTSS program. Should this process be instituted, CARIE is pleased to participate.

Thank you for the opportunity to provide comments. If you have any questions or need additional clarification, please contact Diane Menio at 267-546-3434 or menio@carie.org, or Kathy Cubit at 267-546-3438 or cubit@carie.org.

Respectfully Submitted,

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