April 14, 2023

Pennsylvania Department of Human Services
Office of Long Term Living
555 Walnut Street
6th Floor Forum Place
Harrisburg, PA 17101

Re: Community HealthChoices RFI

Dear OLTL,

PHLP and CLS write jointly in response to the Department's Request for Information concerning the Community HealthChoices (CHC) Agreement, in anticipation of the reprocurement of managed care organizations for the program.

The Pennsylvania Health Law Project has been providing legal services to people with Medicaid coverage for thirty years. As a statewide program, we have counseled people in every county of Pennsylvania about getting and keeping Medicaid coverage, including Medicaid long term care as well as helping people challenge service denials or address other barriers to care. Since the rollout of CHC began, we have handled over 4600 cases helping people navigate CHC and get or keep CHC coverage and/or services. Almost half of these cases involved advising or representing clients about service denials, primarily related to Personal assistance Services.

For more than 50 years, CLS has provided free legal assistance to low-income Philadelphia residents in civil matters affecting the most essential human needs, including housing, employment, public benefits, access to health care and long term supports and services. Our Health & Independence Unit focuses on public benefits, including issues affecting dual eligibles and access to Medicaid-funded long-term services and supports, as well as quality of care and residents' rights issues in nursing homes. Systemic policy advocacy, informed by the experiences of our clients, is an important component of CLS' mission.

Our organizations recognize and appreciate the tremendous amount of work accomplished by the Department in creating the CHC program, from its conceptualization and the initial groundwork for the program, to its multi-year launch, through the complications of the COVID-19 pandemic and now to a steady state. We particularly thank OLTL for your consistent openness to feedback and dialogue with us and other stakeholders about the program.

PHLP and CLS have been deeply invested and involved in CHC since its inception, and we have dedicated significant resources to working with OLTL, the MCOs, CHC

providers and CHC participants. We recognize that our comments are voluminous, and please do not take the length of our comments as a sign of disrespect or of us ignoring the request to keep comments as brief as possible. Our organizations are submitting our comments jointly to provide synthesized input and minimize duplication as much as possible. Given the scope and importance of the CHC program, the vulnerability of the people served in CHC, and the size of the CHC agreement, we did not want to miss this opportunity to provide feedback and recommend changes informed by our vast experience helping CHC participants navigate the program since it was rolled out.

Our comments reflect themes which have emerged from our clients' experiences with CHC during the past five years. Due process rights must be honored to guard against arbitrary and capricious decision-making, to ensure that adequate explanation is provided for service determinations and to enable participants to fully exercise their appeal rights. Service authorizations must be based on validated and appropriate processes, consistent with person-centered service planning principles. Increased Department oversight is needed to ensure that MCOs comply with these principles. This moment also presents an important opportunity to add and enhance initiatives to advance health equity and improve quality of care.

Thank you for the opportunity to provide input at this momentous juncture in the CHC program. The following is contact information for our organizations, and we would be happy to answer any questions you may have:

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Respectfully,

/s/
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Community Legal Services & Pennsylvania Health Law Project
CHC RFI Response

Principles to Guide the Planned Request for Application and the CHC Program

In developing the Request for Application (RFA), which determines factors to score applicants and operating the CHC Program in future years, we urge DHS to adhere to the following five principles.

I. Stakeholder Engagement – Putting People with Disabilities and Older Adults in the Center of Both the RFA Process and the CHC Program

The CHC program was designed to "Create a person-driven, long-term support system in which people have choice, control, and access to a full array of quality services that provide independence, health, and quality of life." To fulfill this goal, the opinions, insights, needs and experiences of older adults and people with disabilities served by the CHC program, and their family members and representatives, must be taken into consideration in ***every*** aspect of developing the RFA, evaluating the RFA responses and operating the CHC program. Pennsylvania has a robust stakeholder engagement process through its various Advisory Committees. We believe the following recommendations will further enhance opportunities for engagement.

Recommendations:

- Include people with disabilities and older adults, nursing facility residents, consumer advocates, their families, and other representatives in the confidential review of applications.

- Continue the monthly MLTSS meetings but increase opportunities for non-members attending by phone to ask questions and provide public comment. The current approach of having non-members submit questions in writing does not allow for meaningful engagement and stunts robust conversation.

- MCOs should be required to include an HCBS recipient on grievance committees reviewing denials of HCBS services. OMHSAS has a similar requirement for a consumer representative on 20% of grievance reviews conducted by BH-MCOs. The CHC program should aim for all HCBS-related grievances to include an HCBS recipient but may start with at least 50%.

II. Accountability, compliance and oversight

Given the scope of the program and vulnerability of its participants and now that the program is in steady state, we make the following recommendations in this area.

Recommendations:

- RFA applicants should be required to describe any enforcement actions levied against it or its affiliates for the previous 5 years as a result of health plan performance, including corrective action plans, financial or non-financial (e.g., loss of auto assignment allocation) sanctions and/or liquidated damages. Applicants should be required to disclose this information for Medicaid managed care (including behavioral health MCOs and LIFE (PACE) programs), commercial and Medicare contracts in Pennsylvania and all other states.

  This information will help DHS evaluate past performance of applicant MCOs within and without Pennsylvania which will be useful in gauging applicants' compliance with state and federal rules and plan quality, as well as comparing applicants' performance to each other.

- DHS should increase monitoring of MCO compliance with due process requirements to guard against arbitrary and capricious decision making, to ensure participants are given adequate explanations to fully understand the bases for denials, have full access to information used in denials and are fully able to exercise their appeal rights.

- DHS should increase its monitoring and oversight activities with respect to service denials. To do so, DHS should develop an operations report to collect monthly data on complete and partial service denials. For PAS denials, the most widely used and important HCBS service under the CHC program, MCOs should be required to include what percentage of denials were reductions in previously authorized services and a breakdown of the severity of the reductions (i.e., how many reductions were between 0-24%, 25-49%, 50-74%, 74%-100%).

  DHS should no longer rely on operations reports showing PCSP increases and decreases or grievance data. The operations report showing PCSP changes is not reliable because it masks service reductions by not accounting for situations where a person receives an increase in a service simultaneously with a decrease in another services. Moreover, the report is not timely and accurate as it does not capture service plan reductions if a person appeals a reduction and the service at issue is continuing pending the appeal. Therefore, DHS is not able to assess trends in service reductions in anything close to real time, which interferes with monitoring MCOs for potentially inappropriate denial activity and outliers. Grievance data is also not a substitute for tracking denials as, historically, most people do not appeal denials.

- DHS should publicly report data on MCO corrective actions, sanctions and other enforcement actions in real time.

- DHS should increase its monitoring and oversight activities as they relate to service coordination and person-centered planning. This includes monitoring unfilled shifts and gaps in care. The current reporting does not accurately capture

unfilled shifts. We suggest that MCOs be required to report on all PAS, Home Health Aide, and Nursing hours that are approved, but which have not yet been accepted for coverage by an agency and are therefore unfilled. MCOs should also be required to do more to monitor gaps in care and be held accountable for ongoing care gaps. One way to do this would be to require providers to identify to the MCOs where authorized hours are not provided in full for more than a week and the reasons why. Also require MCO reporting to OLTL at regular intervals on ongoing gaps in care and MCO actions to address them.

- DHS should increase monitoring and oversight activities of network adequacy. This oversight should include random calls to providers listed in MCO directories to see if they are still participating with the MCO, accepting new patients, are accessible to people with physical disabilities, providing the services they are identified as providing in the directory, etc. This oversight should be informed by gaps in care, unfilled shifts, and complaint data in terms of using trends in that data to focus network adequacy activities.

III. High Quality Care and Performance

Now that the program is in steady state, we make the following recommendations to ensure that CHC participants get quality care.

Recommendations:

- DHS should only award contracts out of the RFA to MCOs that exceed quality performance measures and have a history of providing high quality care through their Pennsylvania and out of state Medicaid and DSNP products.

  While it is important that MCOs minimally meet quality benchmarks (demerits should be given for MCOs that have not), Pennsylvanians deserve to be served by MCOs that can demonstrate their ability to improve quality and exceed expectations. In evaluating applicants, DHS should pay particular attention to applicants HCBS CAHPS results and the applicant's affiliated DSNP products star ratings, particularly around care management and care coordination.

- Applicants should be required to discloses the following information for it or its affiliates' Medicaid managed care (including behavioral health MCOs and LIFE (PACE) program), commercial and Medicare contracts in Pennsylvania and all other states:
  - Number of member complaints, including the nature of the complaints (access to care, quality of care, timeliness of care, etc.), outcome, whether the outcome resulted in favor of the member, and timeframe for resolution for the previous three years.
  - Whether the proposer conducted a trend analysis of those complaints and the results of that trend analysis for the previous three (3) years.

- We are pleased that DHS is using incentive payments to plans for meeting quality benchmarks. We urge DHS to develop criteria to claw back payments from MCOs who fall below the benchmarks in multiple categories for more than one year.

- DHS should begin using the HCBS Quality Measure Set developed by CMS to evaluate MCO quality. The HCBS Quality Measure Set, which is encouraged by CMS, will significantly expand DHS' ability to monitor and evaluate the quality of HCBS services provided in Pennsylvania and will allow the state to compare PA MCO performance with MCO performance in other states to help identify areas where PA MCOs are most successful and areas for improvement.

- DHS should publish on its website comparative performance measures (see, e.g., Physical HealthChoices 2021 Consumer Guide Rate Chart) and implement a star rating system for CHC-MCOs similar to what is used in the Medicare system and for the Physical HealthChoices program. Currently, new and existing CHC participants have no readily accessible tools to make an informed choice about plan quality and whether to enroll in a particular MCO. Since the CHC program is now five years old and in steady state, such comparison information should be developed and made public.

IV. Health Equity

Recommendations:

- DHS should identify health disparities across multiple identifying characteristics including, race, ethnicity, gender, language/LEP status, LGBTQ+ status, as well as multiply marginalized Participants, and analyze physical and behavioral health inequities among these groups. DHS should further set targets for reduction of such inequities and focus their efforts to invest in health outcomes for those who face the most barriers to access.

- DHS must collect data from the CHC-MCOs on enrollment, service reductions, service denials, grievances, complaints, and appeal outcomes disaggregated by race, gender, and language at minimum to analyze trends in health outcomes. This data should be made publicly available to ensure transparency in the delivery of services to Participants.

- DHS must also require CHC-MCOs to disclose the use of algorithms used in any part of case management, utilization management and service authorization and provide policies and procedures as to how CHC-MCOs will identify potential bias. DHS must further provide oversight of any use of algorithms and specify what mitigating steps it will take to resolve bias.

V. Transparency

Considering the substantial cost of the CHC program, the significant impact of the program on the lives of older adults and people with disabilities, and the considerable delegation of Pennsylvania's responsibilities under the Medicaid program to private entities, some of which are for profit and publicly traded, DHS should make transparency in the RFA process **and** the CHC program a priority. Transparency includes working under the presumption that all information, data and documentation related to the RFA and the CHC program should be made publicly available unless substantial interests such as participant confidentiality, weigh against disclosure. Transparency is necessary to drive accountability, ensure public monies are being used for their intended purposes and ensure information is publicly available to enhance oversight.

Recommendations:

- The RFA should direct applicants not to mark any portion of the RFA response, any RFA attachment, or other item of required documentation as "Confidential" or "Proprietary" and note that DHS will disregard any language purporting to render all or portions of an application confidential or proprietary.

- Following the announcement of the selected applicants, submitted applications should be accessible to the public through the DHS website.

- MCOs participating in the program should be required to make all information on their prior authorization, utilization review and approval processes available on their websites. Tools that are used as part of utilization review and assessment processes should also be publicly available and MCOs should not be permitted to withhold information used in evaluating services as proprietary.

- The following information should be regularly made available for each MCO on a public website: Information and data on access to and quality of care; profits and reserves; corrective actions and other enforcement actions; and quality improvement and health equity activities.

Program Logistics Recommendations

I. Number of CHC Plans

We feel DHS should keep the number of MCOs at three. Having three MCOs balances the need to provide participants with a choice of plan with the need for OLTL to have capacity to provide robust oversight and monitoring of the plans. Now that the CHC plans are in steady state and the COVID emergency has ended, we expect OLTL to increase its expectations on the MCOs and also its oversight of plan activities and quality. To do this, OLTL will need sufficient staff. If the number of MCOs were to increase above three, there will be a concomitant need to increase staff to oversee the

additional plans. If the budget doesn't allow for sufficient monitoring staffing, the CHC program, and its participants, will suffer.

II. Geographic Breakdown of Plans

Consistent with the recommendation that the number of MCOs not exceed three, we urge OLTL to require all applicants to serve the entire state of Pennsylvania. We feel it is important that members have a choice of three MCOs in each region. Allowing MCOs to provide services less than statewide, while maintaining a minimum choice of three MCOs would necessarily require increasing the total number of MCOs overall in the program. As noted above, this will require an increase in OLTL staff to conduct thorough monitoring and oversight.

We also urge OLTL to require that the MCO networks be statewide rather than regional to avoid problems accessing care for people who live on the border of regions and cannot see a close provider because they are across a county line. This has been a challenge for people in one CHC plan and should not be permitted to continue. Should OLTL choose to allow regional plans, we urge it to require plans to serve at least two contiguous regions and have networks that serve all regions the MCO serves.

III. Evaluating MCO Applicants and Other RFA Requirements

Recommendation: Ask applying MCOs to provide a comprehensive description of how it will identify participants who need behavioral health services and connect them with those services, given the carve out of behavioral health services and the challenges of Medicare paying primary.

Recommendation: Ask applying MCOs to provide a comprehensive description of strategies it will use to address the direct care workforce shortage in Pennsylvania and ensure that participants whose authorized hours of care are not filled are able to remain safe in the community and avoid institutionalization.

RFI Appendix A: Program Requirements Recommendations

I. Covered Services (RFI App. A, Sec. A and RFI Exh. A)

Note, recommendations in this section pertain to both RFI Appendix A, Section A (Covered Services) and RFI Exhibit A (Covered Services).

a. Amount, Duration, and Scope.

Recommendation: Clarify in this section that MCOs may not authorize a limited the number of personal assistance services (PAS) hours on the basis that those hours can be structured to be used "flexibly" when doing so is likely to make staffing those hours unrealistic.

We have repeatedly seen CHC-MCOs presume, for example, that a 50% reduction to a participant's PAS is workable so long as the hours can be restructured for the day and evening, and used "flexibly" to meet the participant's needs. However, in reality, trying to schedule a caretaker in small increments of 1.0-1.5 hours for a morning or evening routine is not realistic and would require those workers to be "on call."

Recommendation: Clarify in this section that PAS hours should not be authorized in daily or weekly amounts so low that they cannot realistically be staffed.

b. Home and Community-Based Services.

Recommendation: Clarify that for all participants, not just those who were living in the community at the time of implementation of CHC in the zone, the CHC-MCO must support their choice to live in the community and provide services to support this, by editing the first full paragraph in App. A, Sec A, pdf p. 2 as follows:

> For Participants ~~who were~~ living in the community ~~at the time of implementation of CHC in the zone and~~ who chose to remain in the community, the CHC-MCO must support that choice and support the Participants in the community.

Recommendation: Revise the **Nursing Services** specification in the CHC Waiver (and include the revised definition in the RFA) to allow the provision of long term or continuous nursing and short term or intermittent nursing simultaneously with PAS and respite.

At the outset, it is rare for someone to need both nursing and PAS or respite simultaneously. Nevertheless, there are participants whose needs are so significant that they require ongoing nursing as well as additional assistance that a nurse could not perform on their own. Examples include a person who needs a two-person assist for transfers and bathing, or a participant who needs continuous monitoring and assessment by a nurse, while a second person performs tasks outside of the home such as shopping. For clients with needs like this, nursing is generally needed side-by-side with PAS or informal supports during some portion of each day. Removing the prohibition on providing nursing simultaneously with PAS will ensure such participants get the care they need. Removing the prohibition on providing nursing simultaneously with in-home respite will allow informal caregivers to take a break from caregiving knowing that their loved ones are receiving a sufficient level of care for both their nursing and non-nursing needs.

Recommendation: Add a Guardianship Support Services for those receiving HCBS. Guardianship fees of up to $300 monthly can be paid for nursing home residents as a deduction from their payment to the nursing facility. However, no such payment source is available for individuals living in the community. This creates a disincentive for guardians to support individuals in the community, especially since this is likely to involve more work than nursing home placement. Adding guardianship support as a

service furthers rebalancing goals and community integration and is cost-effective, since it is generally less expensive to provide services in the community.

Recommendation: Add Chore Services for deeper cleaning that is sometimes needed to make a home safe for habitation.

Recommendation: Require MCOs to contract with providers that offer culturally appropriate home delivered meal alternatives.

Recommendation: Allow representative payees, agents under power of attorney, guardians, and spouses to provide PAS with guardrails and in circumstances where it is necessary to accommodate religious practices and disabilities.

Especially in rural areas, the workforce shortage can make it difficult or impossible to find PAS staff and disqualifying the above candidates exacerbates the problem. In some cases, cultural or religious practices prohibit non-family members from providing intimate care and the spouse may be the only viable worker. Concerns about conflict of interest are minimized where the worker is employed by and under the oversight of an agency, rather than through the consumer directed model. The Office of Developmental Programs Waivers does not prohibit representative payees or agents under power of attorney from being paid caregivers. While these positions come with certain responsibilities, they do not confer the status of a legally responsible person. The ODP Waivers do allow legally responsible people, such as spouses, and legal guardians to be paid caregivers of services that have personal care components when certain conditions are met. The CHC program should do the same.

c. Nursing Facility Services

Recommendation: Add to services which CHC-MCO is responsible for monitoring: care plan development, delivery of services, transfers and discharges, and discharge planning.

Recommendation: Clarify that nursing facility services are available for NFI participants and the scope of these services.

This has not been clear in prior Agreements and has resulted in difficulty for NFI participants in accessing coverage for short term rehabilitation stays. This clarification should be included in RFI Appendix A, Section A.15, pdf p. 10. (It is already noted as a state plan service in RFI Exhibit A.)

d. Service Delivery Innovation

Recommendation: Under Housing Innovation (RFI App. A, Sec. A.19.a, pdf p.13, add assistance resolving utility shut-offs and referrals to resources for home repairs.

e. Settings for HCBS

Recommendation: Requirements should be added for service coordinators to assess for potentially non-compliant settings during assessment and person-centered service planning. The SC should check for housing characteristics that may violate the HCBS settings rule, including but not limited to whether the participant's residence is owned or controlled by the HCBS provider (or spouse or close relative) and whether it is a congregate setting. If any of these characteristics are present, the setting should be reported to the MCO's point person for HCBS settings compliance or their designee. In turn, the MCOs should be required to report these situations to OLTL for further investigation and compliance activities. (RFI App. A. Sec. A.18, pdf p. 12.)

II. Prior Authorization of Services (RFI App. A, Sec. B)

a. Concurrent Review

CHC program requirements must include standards for MCOs conducting concurrent review of services (e.g., personal assistance services, ongoing nursing, and physical therapy) and notification when a determination not to continue the service in the same amount, duration and scope is made. Specifically, the program requirements should incorporate the following recommendations.

Recommendation: For concurrent reviews of services, such as PAS or skilled nursing, the MCO may not deny, reduce, substitute or terminate the service unless the MCO determines that the participant's medical or mental condition has materially improved or their social circumstances have materially changed since the previous authorization such that the amount, duration or scope of the previous authorization is no longer appropriate and medically necessary.

Recommendation: Where the MCO finds a material improvement in the recipient's medical or mental condition or a material change in the recipient's social circumstances, the MCO's written denial notice to the recipient must:

- Specify the participant's condition or circumstance that has changed since the last authorization;
- Identify the specific change that has occurred in that participant's medical or mental condition or social circumstance since the last authorization; and
- Clearly state why the services should be reduced, discontinued, substituted or changed as a result of that change in the member's condition or circumstances.

The two recommendations above are critically important to comport with due process requirements for when a benefit may be reduced or terminated and how participants are informed of that change. Yet, especially in cases involving PAS, CHC-MCOs almost never identify a change to warrant service reductions. Indeed, in the past six months, PHLP has been contacted by more than 90 participants enrolled in one CHC-MCO whose PAS was reduced despite no improvement in their condition or other material

change in their circumstance. We are confident there are numerous others who have similarly been reduced as service coordinators have told participants the MCO is cutting many hours and to expect a cut even before the SC has begun the assessment. Most of the reductions PHLP has seen cut hours by between 25-50% -- 43% were cuts of 50% or more. Many of these individuals had been receiving their PAS at the same rate for years before the cut. None of the notices the participants received identified any improvement in condition to warrant the reductions – some denials even noted a deterioration in the participant's functioning. Except for a small handful, the notices contained no explanation for why the PAS hours were reduced. CHC participants who rely on supports like personal assistance services deserve better. Participants with chronic or worsening conditions should not, as they do now, fear their annual assessment because of the high risk that their hours will be cut without explanation.

The MCOs, and DHS, as the single state agency, are also obligated to do better. Where a participant has been receiving ongoing services, like PAS, that a CHC-MCO decides to reduce or change, the CHC-MCO must be able to identify what about the participant's circumstances has changed to warrant the change or reduction in services. If reductions and terminations occur when there has been no change, or a participant's condition has worsened, the MCO's action to reduce that service violates due process and undermines participants' confidence in the CHC Program.

An MCO cut to services that it had previously approved for a participant whose health conditions and functional needs have not improved or have worsened can only be seen as arbitrary or capricious. See, e.g. Mayer v. Wing, 922 F.Supp. 902, 910-11 (SDNY 1996) (finding homecare recipients likely to succeed on due process claim where their homecare hours were reduced "while in the same or worse physical condition they were in when home care was initially authorized, and were given no explanation for why they were assessed differently the second time around."); Weaver v. Colorado Dep't of Soc. Servs., 791 P.2d 1230, 1235 (Colo. App. 1990) ("due process prevents a termination of … benefits absent a demonstration of a change in circumstances, or other good cause. The presumption that a condition, once shown to exist, continues to exist … require[s] a showing of some change in circumstances if the termination of benefits is not to be deemed arbitrary.") It is not enough to claim "your needs are able to be met with X hours" when the CHC-MCO previously authorized the hours now being reduced on identical facts. Due process requires that decisions on public benefits are made according to standards applied in a rational and consistent manner.

b. Availability of Prior Authorization Policies and Procedures

Recommendation: MCOs should be required to make available their coverage guidelines, and prior authorization requirements, procedures and standards for state plan and HCBS services on their websites and upon the request of a participant.

Recommendation: MCOs should be prohibited from using proprietary or confidential methods, instruments or assessment tools when making prior authorization and UM decisions.

Recommendation: Algorithms and assessment, tasking tools and similar instruments, including information on how their outcomes are used must minimally be made available whenever a participant appeals a service denial and preferably available on MCO websites.

Recommendation: MCOs should be prohibited from using assessment instruments and tools, including tasking tools, unless they are evidence based and have been independently validated for the population with whom they will be used.

Recommendation: Require MCOs to detail in their prior authorization policies how a participant's goals and other information from the PCSP as well as input from the Service Coordinator, are considered when determining amount, duration, and scope of services.

Our experience has been that Service Coordinators try to compensate for areas missing from the plan's time tasking tools (I.e., supervision, unscheduled needs) by adding more time for ADLs/IADLs or by commenting on that need in the tool's comments section and recommending additional hours. Utilization management reviewers then strip those hours out and ignore the Service Coordinator's comments, sticking strictly to the minimum hours dictated by the tool. This eliminates the person-centeredness from the process, as the input from the SC – who has actually seen the individual and assessed their needs – is bypassed in favor of an algorithm-based determination which fails to capture all of the member's needs.

Recommendation: MCO prior authorization policies should also detail how they apply every prong of the definition of medical necessity when deciding whether to approve a service or item, including the fourth prong for LTSS that focuses on how a service or item helps the participant access the benefits of community living, achieve person-centered goals, and live and work in the setting of his or her choice.

Recommendation: For LTSS such as PAS, MCOs should detail how a participant's goals and other information from the PCSP are also considered when determining amount, duration, and scope of services.

c. Temporary Authorizations:

Recommendation: Add to the CHC Program Requirements information about the MCO's responsibilities to provide advance notice and appeal rights prior to the end of a temporary authorization.

Although OLTL has provided operational guidance and a notice template to MCOs regarding how the end of temporary service authorizations should be handled, PHLP clients have had temporary services abruptly cut without the required notice over the past couple of years. We therefore request that OLTL incorporate into the CHC Program Requirements language making clear how MCOs must handle temporary

authorization, and how and when they must provide notice about the end of a temporary authorization and appeal rights.

We note that the current way OLTL's operational guidance allows MCOs to notify participants of the end of a temporary authorization and their appeal rights is overly burdensome on the participant and violates due process. Under the current process, as we understand it, the MCO must send the "PARTICIPANT REQUEST FOR SERVICE REDUCTION OR TERMINATION, OR EXPIRATION OF TEMPORARY SERVICES" letter to the participant at an unspecified amount of time prior to the temporary authorization end date. That notice directs the participant to contact the MCO prior to the temporary authorization end date if they wish to extend the authorization. Only after contacting the MCO is the participant finally sent a notice with appeal rights, that they can formally appeal. This multistep process to accessing the appeal system is complex and confusing. We are concerned that participants who do not timely receive or respond to the first letter will lose their appeal rights entirely and participants who call to continue services but do not use precise terminology, or reach MCO staff who are unfamiliar with the temporary authorization process, will not be sent a notice with appeal rights. In addition to the process being unduly burdensome on participants, it violates federal regulations which require, without exceptions for "temporary authorizations," that participants receive advance notice with appeal rights when a service is terminated or reduced.

To ease the burden on participants and comport with due process, we urge the CHC program requirements be amended as follows:

> When a CHC-MCO authorizes a service on a temporary basis, it must immediately send the participant a notice outlining the specific service to be provided, the end date of the service and the reason the service is being authorized on a temporary, as opposed to ongoing, basis.
>
> If the service is authorized for 15 days or fewer, the notice regarding the temporary authorization must include information about how to request a grievance regarding the duration of the service and the right to continue receiving the service if the grievance is requested prior to the expiration of the authorization.[1]
>
> If the service is temporarily authorized for more than fifteen days, the MCO must send an advance notice (Standard Denial Notice N(1), N(2) or N(3)) prior to terminating, reducing or changing the service. The notice must include information about the right to continue the service if a grievance challenging the denial is timely filed.

[1] See 42 CFR § 438.420(a) ("Timely files means files for continuation of benefits on or before the later of the following: (i) Within 10 calendar days of the MCO, PIHP, or PAHP sending the notice of adverse benefit determination. (ii) The intended effective date of the MCO's, PIHP's, or PAHP's proposed adverse benefit determination.")

d. Prior authorization decision timeframe for LTSS.

Recommendation: The two-business day notification timeframe for LTSS requests resulting from an assessment should be revised to conform with federal and state managed care regulations and therefore be calculated from the date the assessment is completed, not the date that the updated PCSP is finalized as a result of the assessment.[2]

Federal managed care regulations require that a service authorization decision be made "within State-established timeframes that may not exceed 14 calendar days" from the service request. 42 CFR § 438.210(d). There is no exception to this time frame for LTSS services; indeed, authorization of LTSS services is discussed in the same regulation, making the time frame's application to those services indisputable. See 42 CFR § 438.210(b)(2)(iii). The Pennsylvania-established timeframes for making authorization decisions is two business days after receiving "all supporting information reasonably necessary to complete the review"; state regulations also have no exception based on the type of service requested. 28 Pa Code § 9.753. Read together, the federal and state time regulations require a decision on a requested LTSS service within two business days of receiving a service request that includes information reasonably needed to make a decision and up to 14 days to make a decision, regardless of what information is provided.

For most LTSS, the MCO will have "all supporting information reasonably necessary to complete the review" – the event that triggers the timeframe under 28 Pa. Code § 9.753(b) -- when the comprehensive needs assessment is completed. The date the needs assessment is completed therefore must be the date from which the two business-day timeframe is calculated. If the MCO determines it needs additional information from the participant or their providers after reviewing the needs assessment, it can request that information using the procedures and time frames already provided for in the Agreement.

To the extent that OLTL is concerned that authorizations for LTSS need to be incorporated into the PCSP or other service plan before being provided, as discussed below under "Person Centered Planning process," this can be accomplished by shortening from 30 days to two business days the time between an assessment and finalization of an amended PCSP incorporating the requested service for current recipients of HCBS (i.e., those who already have a PCSP) and using a provisional service plan for new HCBS recipients.

Recommendation: Under "Other care or Service Plan Transition, " add "Options" at the end of the last sentence to ensure that participants who are not eligible for Act 150 due to their age receive a referral to this alternative. (Pdf p. 20.)

[2] We agree with the current Program Requirement calculating the two business day notification timeframe for HCBS requests beginnings on the date that the updated PCSP is finalized as a result of the assessment, or on the date the request is made by the Participant or Participant's representative when an assessment is not necessary.

III. Comprehensive Needs Assessments and Reassessments. (RFI App. A, Sec. E)

Recommendation: Shorten the time to conduct comprehensive needs reassessments based on trigger events from 14 days to two business days.

The current requirement, that a reassessment following a trigger event be completed as "expeditiously as possible" but no later than 14 days, gives CHC-MCO's too much discretion to determine whether circumstances warrant a quicker assessment and reassessment. If a participant requests a new or increased service warranting a new needs assessment, the CHC-MCO should conduct the assessment needed to make a decision within two business days. CHC-MCOs should not be able to delay the decision by delaying the assessment process.

IV. Person-Centered Service Planning process. (RFI App. A, Sec. G)

Recommendation: Shorten to two business days the time frame for developing and implementing a PCSP following a comprehensive needs assessment or reassessment. The Department should be prepared to "claw back" CHC-MCOs capitation payments if they fail to provide waiver services within two weeks of a participant enrolling in a plan.

For participants who are newly LTSS eligible, the Agreement recognizes the need for a quick assessment of their needs (within five business days) but allows an additional 30 days for development and implementation of the PCSPs needed to authorize services. Too often, CHC-MCOs take the full 30 days to implement a PCSP. Having already gone through a several months long LTSS eligibility process, this additional wait of a month to receive authorization for services and supports is unacceptable; especially since, during that month, the MCOs collect a substantial capitation payment while providing only service coordination. Participants and the state deserve better.

A 30-day wait time for services is also unreasonably long for current CHC waiver participants reassessed for new or increased services. As noted above, once the comprehensive needs assessment/reassessment is completed, the CHC-MCO generally has the information it needs to decide the scope of services in the PCSP and it should promptly do so instead of taking an additional 30 days. This delay harms participants and is contrary to Pennsylvania regulations, discussed above, which require decisions about service requests to be made within two business days of the CHC-MCO having the information needed to make a determination. It follows that the PCPS, or at least those aspects of it requiring service authorizations, must likewise be completed within two business days of the comprehensive needs assessment.

In the alternative, if finalizing a PCSP in two business days is too difficult with respect to new HCBS recipients, OLTL should give CHC-MCOs the option of authorizing services based on a provisional service plan, which is permitted by CMS under Olmstead Update #3, which states:

> To facilitate expeditious initiation of waiver services, we will accept as meeting the requirements of the law a provisional written plan of care which identifies the essential Medicaid services that will be provided in the person's first 60 days of waiver eligibility, while a fuller plan of care is being developed and implemented.

DHHS Olmstead Update No. 3., Att. 3a at 1, available at https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd072500b.pdf

For new waiver recipients, we urge OLTL to adopt policies and arrangements that incentivize CHC-MCOs to initiate services promptly. CHC-MCOs should not be permitted to collect hefty capitation payments when no services are provided. To that end, we urge OLTL to "claw back" capitation payments received for waiver participants who do not receive waiver services other than PERS within two weeks of their enrollment date.

Recommendation: Align the timeframe for commencing new or increased services included in a PCSP with the 72-hour timeframe for commencing services after an appeal.

Currently the CHC Agreement allows seven days for an MCO to initiate new or increased services, while participants who win an appeal regarding services are required to receive those services within 72 hours. There is no basis for providing a longer time frame for providing services that are not subject to an appeal, especially since the MCO will have been aware of the service request, may have assessed the person regarding the request and took time to include the service in the PCSP. We therefore urge the following amendment to RFI App. A, Sec.G, pdf p. 25:

> When new services are authorized or services are increased via inclusion on a Participant's PCSP, the new service or increased service level must commence within 72 hours ~~seven (7) business days~~ of the approval, unless the Participant requests a longer timeframe for the services to start.

Recommendation: Reinstate prior PCSPs for participants who lost LTSS eligibility for six months or less.

Participants who temporarily lose LTSS eligibility during Medicaid renewals struggle to get their eligibility reinstated only to have to wait extended periods of time to get their waiver services reinstated as well. Yet the participant, having previously received HCBS services through CHC, has a service plan that could be used to immediately reinstate services. We understand that OLTL requires CHC-MCOs to reinstate a service plan if the participant lost LTSS eligibility for 30 days or less. We urge OLTL to extend the requirement from 30 days to six months. A six-month time frame is consistent with the time for automatically reenrolling participants in the same CHC-MCO after a lapse in coverage. 2023 CHC Agreement, Exhibit J (p. 317) (Participant Re-Assignment

Following Resumption of Eligibility). If service coordinators are fulfilling their function to help maintain LTSS eligibility, it should be a rare situation in which a person goes without eligibility for six months. But if they do, the CHC-MCOs should be ensuring that a participant who has gone without care is restored to services as quickly as possible.

We suggest adding the following language after the second paragraph in "Person Centered Service Plans" located in RFI Appendix A, Section G (pdf page 23):

> When a Participant loses LTSS eligibility and becomes eligible again within six (6) months of losing eligibility, the receiving CHC-MCO shall immediately reinstate the PCSP and LTSS services that were in effect at the time the Participant lost LTSS eligibility. If the annual comprehensive needs reassessment is overdue, the CHC-MCO shall conduct the reassessment no later than fifteen (15) days from the date the Participant is reinstated into the CHC-MCO.

Recommendation: Add a requirement that PCSPs be finalized and that the finalized version be agreed to with informed consent by the participant, as required by 42 CFR 441.301(a)(2)(ix).

Currently, participants are asked to sign PCSPs prior to review and approval, which means that they do not have the opportunity to sign and approve (or decline to approve) the final version. In our experience, PCSPs are not updated after utilization management review and their service levels may therefore be inaccurate.

V. Service Coordination (RFI App. A. Sec. J)

a. Service Coordination for HCBS Recipients

Service Coordination is a linchpin of the CHC program, but its promise has largely been unrealized. Our clients often do not know their service coordinator's (SC) names, what their role is or how to reach them. Others report leaving many messages for their SC but not hearing back from them. Service coordinators are limited by time pressures to the most basic aspects of their jobs -- performing assessments and service planning meetings -- often in a rushed, rote manner, that does not center the participant in any meaningful way. Issues that could have been identified through the process are not identified or addressed, as was the case for a recent CLS client with epilepsy who is not taking seizure medication because he cannot get a neurology appointment, but whose need for medication and connection with a provider was not identified during his assessment. Moreover, we have seen no evidence that SCs are able to assist with accessing social, housing, educational or other services.
Recommendation: Service coordinator to participant staffing ratios should be no higher than 50:1.

To create a truly person-centered program where meaningful service coordination takes place, staffing ratios must be lowered. The current ratios are unrealistic, especially now that service coordinators will return to performing in-person visits, and probably

contribute to high turnover rates which further prevent the development of good working relationships between SCs and participants.

Recommendation: We strongly urge DHS to require that participants be provided with direct phone numbers for their service coordinators with an outgoing message explaining how to reach a supervisor or alternate in an emergency.

At least one of the MCOs requires participants to call a general line, and our clients find this cumbersome and a barrier to reaching or getting a call back from their SCs.

Recommendation: Ensure that Participants understand in advance when a waiver service will be denied and are educated on their right to appeal.

OLTL has shared its expectation that, as part of a person-centered approach, service coordinators must discuss service denials with HCBS recipients ahead of time so that they are not taken by surprise by the denial, can discuss alternatives to the service and understand their options to appeal. This expectation should be codified into a requirement and added to the CHC program requirements by adding the following language:

RFI Appendix A, Sec. J (pdf pp. 26-28)

> If a CHC-MCO makes a decision to deny in whole or in part an LTSS item or service requested by a Participant, the Participant's Service Coordinator shall inform the Participant of the planned denial prior to the CHC-MCO issuing a denial letter and discuss with the Participant the meaning of the denial and their right to appeal.

RFI Appendix A, Sec. G (pdf p. 25)

> PCSPs must be developed by the Service Coordinator, the Participant, the Participant's representative, as appropriate, and the Participant's PCPT. Participants may appeal part or all of their Service Plan as provided in Exhibit G, Complaint, Grievance and DHS Fair Hearing Processes. At each PCSP meeting, the Service Coordinator shall inform the Participant verbally and in writing of the availability of this appeal option including how to exercise it.

b. Service Coordination for Nursing Facility Residents

Service coordination for nursing home residents must be strengthened and should be addressed in more detail in the RFA.

Recommendation: It is essential that service coordinators visit participants in person in the nursing facility, just as they do for HCBS participants and OLTL should monitor compliance with this requirement.

While SCs are required to meet with participants in nursing facilities at least twice per year, in our clients' experience, that does not occur.

Without visiting, the service coordinator has no real idea who the participant is or what their goals and needs are. And there can be nothing person-centered about services rendered to an individual who the SC has never laid eyes on. Our clients who reside in nursing facilities invariably have no idea that they have a service coordinator or even which CHC plan they are in.

Recommendation: DHS should remove the current flexibility for SCs to meet with nursing facility staff if a resident does not have direct telephone access and require SCs to meet such individuals in person.

Calls to nursing home staff should not be substituted for direct contact with residents, as the facility's perspective on the member's situation may differ drastically from the member's own concerns. If a resident does not have access to a telephone, then SCs should conduct all meetings with that resident in person. That is the only way to ensure the resident's concerns are heard and wishes understood.

Recommendation: Reduce the 250:1 nursing facility resident to service coordinator ratio.

The 250:1 ratio appears to assume that there is little for service coordinators to do for nursing home residents, but nothing could be further from the truth. Serious quality of care problems and resident's rights violations are prevalent in nursing facilities. Service coordinators must be actively involved in monitoring the development of care plans to make sure that they address all of their participant's needs and goals, and they must also monitor to ensure that participants are receiving the services they are supposed to. To achieve this, it is essential that service coordinators attend care planning conferences, which they should do in person; several can be scheduled for one visit for efficiency purposes.

Recommendation: More detail should be added about what SCs are expected to do for nursing facility residents and what kinds of assessments SCs complete for nursing home residents – do they complete the InterRAI? If not, how do they know what the residents' needs are? If they rely on the MDS completed by the nursing home, do they take any steps to confirm its contents?

Recommendation: MCO contracts with nursing facilities must include a requirement for the nursing facilities to notify SCs when they seek to transfer or discharge residents, so that transitions can be managed smoothly and to protect residents from being discharged to settings where they are at risk.

CLS represents nursing facility residents facing involuntary discharges; often, the facility seeks to send the resident back to their empty home despite the fact that they have no one to provide care, the home has stairs that the resident cannot climb, and even that the house is uninhabitable. All of this goes on without the service coordinator being notified or getting involved.

c. Service Coordination Generally

Recommendation: Strengthen provisions requiring service coordinators to help participants maintain LTSS eligibility.

The CHC Agreement currently requires service coordinators to "coordinate efforts and prompt the Participant to complete activities necessary to maintain LTSS eligibility." CHC RFI Appendix A, Section J (pdf page 27). However, we have had clients whose service coordinators made no effort to inform them of or assist with renewals, which, before the COVID-related continuous coverage requirements, resulted in loss of LTSS eligibility, sometimes for several months. We urge OLTL to strengthen the requirement that service coordinators assist with LTSS renewals by specifying activities that must be completed to support participants through the renewal process. To implement this proposal, we recommend the following additions to RFI Appendix A, Section J (pdf p. 27):

> Service Coordinators must provide assistance with and prompt the Participant to complete activities necessary to maintain LTSS and Medical Assistance eligibility. With respect to Medical Assistance renewals, Service Coordinators must, at a minimum:
>
> - Notify the Participant of the Medical Assistance renewal deadline at least 30 days in advance of that deadline;
> - Offer to assist with all aspects of the renewal;
> - If assistance with the renewal is accepted, identify and assist the Participant in obtaining and submitting all information and documentation required by the renewal process, including assisting with obtaining documentation from third parties;
> - Provide to the Participant the names and contact information for organizations that can assist with Medical Assistance eligibility appeals if the Participant is determined ineligible for ongoing LTSS eligibility; and
> - Document in the Participant's case record all the above activities.

Recommendation: Require CHC-MCO's to provide meaningful choice of service coordinators.

From the beginning of CHC, OLTL has emphasized that LTSS participants should have a choice of service coordinator, but the reality is that most people are given no real choice but are instead assigned a service coordinator, often without any consideration of individual preferences or needs. For example, frequently, our clients with limited English proficiency find themselves with service coordinators who do not speak their language, even a common language like Spanish, resulting in miscommunications, inaccurate assessments and service coordinators speaking with family members instead of the participant.

Because service coordinators play a critical role in assisting LTSS participants in accessing services and navigating systems, it is imperative that the participant feel comfortable with, can communicate with, and have a meaningful say in who fills this role in their lives. To implement the above proposal, we recommend the following additions to RFI Appendix A, Sec. J (pdf pp. 26-27):

> The CHC-MCO must provide each Participant with a choice of at least four (4) available Service Coordinators employed by the CHC-MCO or Service Coordination entity contracted with the CHC-MCO who can communicate in the Participant's preferred language (including ASL). If no available Service Coordinator speaks the Participant's preferred language, the CHC-MCO shall offer other Service Coordinators and ensure that the Participant is notified and afforded the opportunity to switch Service Coordinators should one that speaks their language become available. The CHC-MCO must provide sufficient information about available Service Coordinators to assist the Participant in making a meaningful choice. This information must include (but is not limited to) the Service Coordinator's:
> - Basic biographical information;
> - Language(s) spoken (including ASL);
> - Length of time working for current CHC-MCO or external Service Coordination Entity;
> - Current case load (compared to average SCs);
> - Certifications and relevant experience, including prior experience in service coordination, case management, social work, or healthcare settings;
> - Expertise or experience, if any, with specific disease management, and/or working with people with dementia, intellectual/developmental disabilities, behavioral health needs, brain injury, hearing or visual impairments, and/or HIV/AIDS; and
> - Experience working with people who are LGBTQI.

Recommendation: Require CHC-MCO's to notify participants in writing and by phone within two days of when their service coordinator changes.

We frequently hear from recipients who complain their service coordinator is switched and they are not told of this change. They may not find out about a change for months and possibly not even until they try to contact the person. This is an unacceptable practice for a program where the service coordinator is charged with protecting the health, welfare, and safety of the participant and ensuring access to and coordinating all of a participant's care. We therefore request that MCOs be required to notify participants of a change to their service coordinator in writing and by phone within two business days. This notification should include the name and contact information for the new service coordinator and a reminder of how the person can request a different service coordinator if they wish.

VI. Nursing Home Transition. (RFI App. A, Sec. L)

Recommendation: Add more detail to the Nursing Home Transition section about how MCOs must determine whether participants residing in nursing facilities wish to return the community, including how and by whom this is assessed, and with what frequency.

Recommendation: Require MCOs to refer all people who express interest in transition from the community to an NHT provider that is external to the entity.

While NHT is an administrative function of the MCO, in our experience the process is smoother and more efficient when NHT services are provided by a contracted entity rather than by the MCO itself. When the MCO provides NHT, it is usually through the nursing home resident's service coordinator who is simultaneously responsible for up to 249 other residents, some of whom may also be seeking to transition. Yet nursing home transition is a very involved process requiring the coordination of many different parties and many different services. In our experience, when MCOs use their own service coordination to provide NHT, the process unnecessarily drags on for many months and requires frequent intervention by advocates to the point where the advocate often ends up doing more coordination of the transition than the service coordinator. PHLP has a current case where a resident, who has a home in the community has been seeking to transition home for four months. The MCO has not assigned an NHT provider and hasn't even assessed the resident's needs despite PHLP's involvement and specific request for such an assessment. Simply put, this and other experiences of our clients show that service coordinators are not adept at managing a nursing home transition while performing their other functions.

Recommendation: Require the MCO to issue a denial of HCBS services notice with appeal rights whenever the MCO determines for any reason that the NH resident will not be transitioned. This includes when the MCO determines the resident cannot be transitioned for safety reasons or until certain goals are met (e.g., improve functioning, obtain a backup plan, increase independence).

> If a Participant is found eligible for HCBS services, but the CHC-MCO assesses the Participant and determines it would not be a safe discharge from the nursing facility, determines the resident must meet other prerequisites prior to transitioning, determines it cannot transition the Participant in the time frame desired or denies or ceases assistances with transition for any other reason, the CHC-MCO must issue a notice of denial of HCBS services with appeal rights.

Recommendation: When a participant residing in a nursing facility requests to receive services in the community and later changes their mind, require MCOs to provide a confirmation letter to that recipient explaining that they have voluntarily withdrawn their request to receive services in the community, explaining they can reinstate the request at any time, and informing them of the CHC complaint process.

We have heard anecdotes of participants being persuaded not to pursue nursing home transition when an MCO believes the participant is not ready or it would be unsafe. While the participant might agree with the MCO's assessment, to protect against miscommunications, MCOs should be required to confirm all voluntarily withdrawals from nursing home transition in writing.

Recommendation: Require notices denying HCBS services and withdrawals from NHT services to be hand delivered and explained to the participant by the participant's service coordinator and copied to the NHT provider that was assisting the client.

Nursing facilities are notorious for withholding and delaying providing mail to their residents. Because MCOs should be aware of this issue, they must take additional steps to ensure important communications, like denial notices, are actually received by residents. Hand delivering the notice and providing it to the NHT provider will help ensure the resident receives and understands the notice.

Recommendation: Require MCOs to track and report data on nursing home transition requests and their statuses.

When CHC began, one of the stated goals of the program was to rebalance LTSS towards people receiving services in the community. While that rebalancing has occurred incrementally for two of the MCOs,[3] much of it is due to nursing facility diversion (more people applying for the waiver than NF), rather than nursing facility transition.[4] As part of its monitoring of NHT, OLTL should require MCOs to report on requests to transition to the community and the outcomes of those requests both when the transition is successful and when the transition is denied and withdrawn. Analyzing this data and comparing it across plans, will help OLTL identify MCOs with practices worth emulating and those whose processes need improvement.

VII. Participant Enrollment, Disenrollment, Outreach, and Communications. (RFI App. A, Sec. O)

Recommendation: Clarify that a printed copy of the Participant Handbook must be mailed to Participants who request one. (RFI App. A, Sec. O.16, pdf p. 38)

Recommendation: Require Participant Advisory Committee meetings to be open to the public. (RFI App. A, Section O.18, pdf p. 40)

[3] Between May 2020 and February 2023, one MCO's HCBS population went from being 75% to 82% of its LTSS population; a second MCO's HCBS population went from being 60% to 70% of its LTSS population; a third MCO's HCBS population remained stable at 59% of its LTSS population.

[4] Between May 2020 and February 2023, the CHC nursing facility population decreased by 5,192. During the same period, the CHC HCBS population increased by 23,190. Compare 2020-05 CHC Data Brief (no longer available on line) with 2023-02 CHC Data Brief.

VIII. Complaints, Grievance and Fair Hearing processes. (RFI App. A, Sec. R)

Note, the recommendations below apply both to the Complaints, Grievance and Fair Hearing processes section of RFI Appendix A, Section R and Exhibit G.

Recommendation: Include requirements around how CHC-MCOs must process appeals (complaint, grievance and external review requests) if it determines that a person who requested the appeal did not have authority to do so. Specifically, CHC-MCOs should be required to take the following steps:

a. If the appeal is requested by phone, ask the caller if the participant is present and obtain the participant's consent to the appeal request. Follow up with any required documentation to formalize the caller as the participant's representative.
b. If the participant is not available by phone or if the appeal request is not made by phone, send a letter the next business day to the participant clearly explaining what is needed to process the appeal, including deadlines. The letter must include any necessary documents needed to process the appeal.
    i. For completing documents, if the participant has accessibility needs, the Service Coordinator should directly work with the participant by whatever communication works best for their disabilities to deliver necessary documents. The service coordinator should be aware of any communication limitations the participant has, so this duty should not fall on CHC-MCO intake staff who are unfamiliar with the case.
c. If a recipient sends in the information to designate a representative or signs an appeal form themselves, utilize the date of the original appeal request (e.g., the telephone call) for purposes of establishing the appeal request date.
d. If the MCO, including the SC, knows, or has reason to know, the participant does not have the mental capacity to make the appeal request, the MCO must take steps to identify who is acting as the person's health care representative pursuant to 20 Pa. C.S. §5461 and obtain necessary appeal documents from that person. MCOs must be prohibited from reducing existing services for people with limited capacity until a health care representative is identified and given advance notice of the proposed service reduction.

Recommendation: Clearly state in the acknowledgements of a Grievances or Complaint the following information:

1) The date and subject of the denial notice about which the grievance or complaint was filed. (Some recipients have multiple appeals and this information will help distinguish them;
2) If there are any issues with the appeal request that would otherwise delay the scheduling of the Grievance;
3) Any timelines for returning documentation, such as an authorization for a representative to be involved in a Complaint or Grievance on behalf of the Participant;

4) Whether any adverse actions will be taken against the Participant should such issues not be resolved by the date given; and
5) Whether the CHC-MCO will decline to decide a Complaint or Grievance within the time frames specified for any reason.

Recommendation: Prohibit MCOs from adding an additional step requiring Participants to affirmatively communicate their intent to participate in a Complaint or Grievance in response to a scheduling notice. At least one MCO is doing this and departing from prior practice where it was presumed the Participant would participate unless they stated otherwise.

Recommendation: Require MCOs to develop and publish on their websites and handbooks a plan for accommodating participants with disabilities in the appeal process, including appeal request process.

Recommendation: Make permanent the right to continue to receive a service or item in dispute at the previously authorized level pending resolution of an appeal when a grievance, complaint, external review or fair hearing is requested within 15 days.

Making permanent the expanded appeal window for continuation of services significantly improves the likelihood that participants will be able to exercise their right to keep getting the service or item at issue – which, by definition, the CHC-MCO previously found to be medically necessary – during the appeal. Expanding the appeal window to continue services would also reduce consumer confusion by standardizing appeal policies between OLTL and OIM, which already provides 15 days advance notice before making changes related to MA eligibility. (Supplemental Handbook 870.3).

This change can be accomplished by requiring MCOs to issue notices terminating, reducing or changing previously authorized services fifteen days in advance of the effective date, which is permitted under federal regulations that provide, “The State or local agency must send a notice at least 10 days before the date of action….” 42 CFR § 431.211 (emphasis added). Since a participant has a right to continue benefits during an appeal if they file that appeal prior to the “intended effective date of the MCO's … proposed adverse benefit determination,” requiring fifteen days advance notice will effectively expand the right to continue benefits when an appeal is made within 15 days.

Recommendation: Modify language that incorrectly states an MCO does not have to comply with a CRE decision if the MCO appeals that decision to a court of competent jurisdiction.

State regulations governing external grievances requires MCOs to “authorize a health care service and pay a claim determined to be medically necessary and appropriate by the CRE whether or not the plan has appealed the CRE's decision to a court of competent jurisdiction. 28 Pa Code 9.707(j) (emphasis added). The language in RFI Appendix A impermissibly allows an MCO not to provide services if there is a court appeal in violation of PA regulations. Therefore, the last paragraph on pdf page 44 in

Appendix A should be amended as follows:

> When a Participant files an external appeal of a Grievance decision, the CHC-MCO must authorize a health care service and pay a claim determined to be medically necessary and appropriate by the CRE whether or not the plan has appealed the CRE's decision to a court of competent jurisdiction ~~abide by the decision of the certified review entity (CRE), which was assigned to conduct the independent external review, unless appealed to the court of competent jurisdiction.~~

Recommendation: Clarify that the requirements for provision of and payment for services or Items following appeal decisions applies to external review/external grievance decisions.

Providing and paying for services determined at an external grievance to be medically necessary is required by 28 Pa Code 9.707(j). DHS should amend Exhibit G, Sec. E (Provision of and Payment for Service or Item Following Decision) as follows:

> 1. If the CHC-MCO, CRE, PID, BHA, or the Secretary reverses a decision to deny, limit, or delay a service or item that was not furnished during the Complaint, Grievance, or Fair Hearing process, the CHC-MCO must authorize or provide the disputed service or item as expeditiously as the Participant's health condition requires but no later than seventy-two (72) hours from the date it receives notice that the decision was reversed ….
> 2. If the CHC-MCO, CRE, PID, BHA, or the Secretary reverses a decision to deny authorization of a service or item, and the Participant received the disputed service or item during the Complaint, Grievance, or Fair Hearing process, the CHC-MCO must pay for the service or item that the Participant received between the time of the initial denial and the implementation of the favorable decision.

Recommendation: Set a minimum time frame for the MCO to provide to participants documents relevant to a complaint, grievance or fair hearing request as follows:

For grievances and complaints, amend Exh. G.A.13 to require relevant documents to be provided within two business days of the request for documents or 15 days prior to the date of the grievance or complaint review, whichever is shorter.

For fair hearings, amend Exh. G.D.1.g to require relevant documents to be provided within two business days of the request for documents or 15 days prior to the date of the grievance or complaint review, whichever is shorter.

Recommendation: Prohibit MCOs from withholding documents relevant to the subject of an appeal for any reason, including because the MCO considers the documents to be proprietary, confidential or trade secrets.

MCOs should not be permitted to withhold materials, such as assessment instruments, that are relevant to a service denial as doing so violates state and federal regulations which require the MCO to provide the participant "access to all information relating to the matter being grieved," 28 PA Code § 9.705(c)(1)(iii), which includes the participant's "case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO." 42 CFR § 438.406(b)(5).

Recommendation: Specify that when the matter on appeal involves a termination, reduction or change to a previously approved service, relevant materials required to be provided to participants in the course of the appeal must include documents that were reviewed or generated when the service was previously authorized, including prior assessments, notes and tasking tools.

In order for participants to evaluate the basis for an appeal and prepare to challenge a service reduction, they must be able to compare the documentation and policies that were reviewed or generated as part of the initial authorize of a service with the documentation and policies reviewed or generated when that same service was reduced or terminated.

Recommendation: Require MCOs to document and forward to OLTL any fair hearing requests, along with the envelope in which they were received if received by mail, inadvertently sent by participants to the MCO and to send a notification to the participant explaining that the fair hearing request has been forward to OLTL for processing. OLTL should use the date the participant sent the fair hearing request to the MCO as the fair hearing request date.

Because there are two, non-exclusive options for appealing an unfavorable grievance decision that have different methods for appeal, participants are easily confused and unfortunately there have been instances where participants inadvertently request a fair hearing from the MCO instead of OLTL. Requiring MCOs to forward these requests to OLTL and honoring the original appeal mail date will ameliorate the harm the confusing process causes.

Recommendation: Require that MCOs send someone with full authority to settle a case at a fair hearing, or that the representative be able to procure such authority via telephone.

Some MCOs have contracted with outside attorneys to handle fair hearings. Although the Bureau of Hearings and Appeals provides an opportunity for a pre-hearing conference to allow the parties to try to settle appeals, these contracted attorneys have no or very limited authority to settle, resulting in the need for hearings, which are time-consuming and stressful for participants, even where the merits of the case are clear.

Recommendation: Clarify that when an MCO approves in part and denies in part requested items and services, it may not withhold provision of the authorized services or

items if a participant appeals the denial. Specify that this includes situations where a person has requested more than one home adaptation, one of which has been approved, and one of which was denied.

Despite the CHC Agreement's prohibition on MCO using "the timeframes or procedures of the Complaint or Grievance process to avoid the medical decision process or to discourage or prevent a Participant from receiving Medically Necessary care in a timely manner," we have clients who have been told if they appeal a partial PAS denial that they cannot get any of the approved hours during the appeal process. We also have been told by counsel for one MCO and in a complaint decision that, in the case of home adaptations, the MCO will not proceed with installation of an approved home adaptation until the outcome of an appeal on a denied home adaptation is decided, even where the two home adaptations were entirely unrelated to each other. The CHC agreement must include language to stop this approach which acts as a deterrent to appeals and violates federal regulations requiring MA services to be provided with reasonable promptness (42 U.S.C. § 1396a(8)).

IX. Other Administrative Components. (RFI App. A, Sec. W)

Recommendation: In addition to the duties identified on pdf pages 47-48, the behavioral health coordinator should also be responsible for developing processes to coordinate behavioral healthcare with nursing facilities. (RFI App. Sec. W.2.)

X. Provider Network (RFI App. A, Sec..BB, pdf p. 72)

Recommendation: Require MCOs to contract with any willing provider for services for which there are staffing shortages (e.g., nursing, PAS, cognitive rehabilitation therapy, dentists).

The direct care workforce shortage for nurses, PAS workers, cognitive rehabilitation therapists and others – has been persistent. Since MCOs are required to utilize out-of-network providers if they are unable to locate an in-network provider, requiring the MCO to offer contracts to any willing MA provider in a field in which workforce shortages exist will hasten the process of connecting participants with the care they need. Too often, we have found that service coordinators have to be reminded to contact out of network providers and, even when they do so, they contact them two at a time instead of doing broad outreach, unnecessarily delaying access to care.

RFI App. B: Financial Requirements

XI. Financial Responsibility for Dual Eligible Participants (RFI App. B, Sec. E.9)

Recommendation: Clarify that enrollment in Medicare is not a condition of eligibility for Medicaid and therefore a MCO may not insist that a Dual Eligible participant enroll in Medicare Part A and/or Part B in order for the MCO to authorize and pay for services that would otherwise be covered by Medicare as primary.

Several PHLP clients who have refused Medicare Part B due to the cost of the premium have been denied coverage of medically necessary services by MCOs because they were not fully Medicare enrolled. While OLTL addressed this issue with MCOs in the past, it is a recurring issue that MCOs need to better understand.

I. Value Based Purchasing (RFI App. B, Sec. E.16)

With the movement from volume to value envisioned by Value Based Purchasing, more and more physical health and HCBS providers will be engaged in risk-based payment models. The participants whose health and lives are impacted by this delivery system reform need to be made aware of the impact VBP arrangements may have on them and their care.

Recommendation: DHS should develop consumer-oriented Value Based Purchasing template letters. This work should engage consumer stakeholders.

A standard template for each type of risk-based value-based arrangement – including bundled payments, shared savings, and Accountable Care Organizations – could include information on the model's design, how it affects consumers and providers, and what a consumer's rights and options are. Stakeholders could help translate complex or technical issues into plain language.

A template letter that explains the value-based model would not only increase transparency and help participants trust their providers' motivations and incentives, it would also give participants the information they need to "buy-in" and be more engaged in their healthcare treatment. It would also promote shared decision-making, where a participant is presented the full range of treatment options, including the benefits and risk and medical evidence behind each option. Shared decision-making clearly improves the patient experience of care; a growing body of evidence suggests that it also leads to better health outcomes and possibly lower costs.[5]

Recommendation: MCOs should be required to use the above templates to educate participants when their providers are in shared-savings or risk-based arrangements.

It is critical that participants be informed when their providers potentially have financial incentives to restrict access to more expensive care options. Transparency is key when the role of gatekeeper has shifted from the MCO to the medical provider. No notice and appeal rights attach to a provider's decision to recommend one course of treatment over another, or to discuss some treatment options and not others. When financial considerations could skew provider behavior towards potentially stinting on care and recommending less expensive services, even if only subconsciously, participant disclosure is paramount.

[5] Julia James, "Patient Engagement: People Actively Involved in Their Health and Health Care Tend to Have Better Outcomes-and Some Evidence Suggests, Lower Costs," *Health Affairs Health Policy Brief,* February 14, 2013, https://www.healthaffairs.org/do/10.1377/hpb20130214.898775/full/

Medicare recognizes the importance of transparency, and mandates consumer disclosure of hospital gain-sharing arrangements. These are described in a recent OIG Advisory Opinion, "The Arrangement includes safeguards, including monitoring and documentation requirements, intended to maintain patients' quality of care and protect against inappropriate reductions in services."

Drawing in part from Medicare's requirements, we recommend the following new language in RFI App. B, Section E.16 (pdf p. 25):

> d-1. Transparency & Disclosure
>
> For value based purchasing strategies i. and iv. through vii., the CHC-MCO and participating providers must develop safeguards, including monitoring and documentation requirements, intended to maintain participants' quality of care and protect against inappropriate reductions in services.
> At a minimum, these safeguards must include the following:
>
> i. Either the CHC-MCO or the participating provider shall provide written notice to the participant that discloses the VBP arrangement in plain language;
> ii. The disclosure notice shall also inform participants of their right to seek a second opinion for any recommended treatment or service;
> iii. The disclosure notice will inform participants that they have the opportunity, upon request, to review the details of the VBP arrangement and discuss with their provider how any financial incentives might impact the provider-patient relationship;
> iv. For any elective procedures, participating providers shall provide members with informed consent documents that discuss the benefits and risks of the proposed treatment and alternative treatments. Informed consent documents shall disclose any VBP financial incentives in place and be provided to the participant in writing and in advance.

Recommendation: DHS should require MCO provider directories to include the method used to compensate or reimburse the provider, including details of measures and compensation percentages tied to any value based purchasing arrangement.

This approach, which is used in Massachusetts, will further the transparency goals described in the previous recommendation. See 211 Mass. Reg. 52.15(1)(a)(1).

Recommendation: DHS should include patient experience of care surveys in evaluating the success of the Value Based Purchasing initiative.

DHS currently requires only that the MCOs report their expenditures by VBP model. It is unclear how DHS is measuring the success of individual value-based models or the initiative writ large.

RFI Appendix D: Revenue Sharing

We support the Department's proposal to reinvest MCO profits beyond a modest threshold back into the CHC programs and initiatives that directly serve CHC participants.

Exhibit F: Quality Management and Utilization Management Program Requirements

I. RFI, Exhibit F, Section C. (pdf p. 1)

This provision does not clearly articulate how QM and UM programs will be based on data identifying prevalent medical conditions, barriers to care and services and racial/ethnic disparities to be targeted for quality improvement.

Recommendations:

- We urge you to clarify: 1) How frequently data will be collected, and 2) How the Department will provide oversight.
- We also urge the Department to require the CHC-MCOs to obtain and track data stratified by race, ethnicity and SOGI data with regard to enrollment; service levels, reductions and denials; outcome and survey measure results; and grievance and appeal filings and outcomes.
- The Department should develop and provide any data needed to facilitate the collection of this data, and the data collected by the Department and MCOs should be available to the public.

II. Standard I (E)(5)

Recommendation: Require CHC-MCOs to expand the current barriers to care and services they evaluate. The Department should consider standardizing barriers to care that each CHC-MCO will have to investigate. We know, for example, that illiteracy is not uniformly included as a barrier to care.

III. Standard III

Recommendation: We strongly urge DHS to strengthen requirements concerning the monitoring, measurement and evaluation of the quality of nursing facility services and requiring MCOs to engage in vigorous quality improvement activities. Nursing homes present some of the most serious quality of care issues experienced by the population CHC serves, and CHC presents an important opportunity for quality improvement. Many studies have shown that Medicaid recipients and racial and ethnic minorities receive inferior nursing facility care.[6] While we applaud and support the Nursing Facility Quality

[6] See, e.g., Mor V, Zinn J, Angelelli J, Teno JM, Miller SC, Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care. The Milbank Quarterly, 82(2), 2004,

Incentive Program, it is also important that the MCOs monitor for and address racial and ethnic disparities in their members' nursing home care and create processes to identify, investigate and resolve quality of care issues that arise for individual members or for multiple/all members residing in a troubled facility. Where members are residing in facilities in CMS' Special Focus Facilities programs (facilities with history of the most serious quality of care problems – generally the worst 5 nursing homes in each state) or with one star in the CMS star ratings system, MCOs should supplement the care provided by facility staff with contracted additional staff to ensure that their members receive adequate quality care.

IV. Standard VI

Recommendation: Define the mechanisms to ensure that Participants receive "seamless, continuous, and appropriate care and services" outside initiating an appeal through a Complaint or Grievance.

V. Standard VII:

Recommendation: Any QM and UM functions that are delegated to other entities should be publicly announced. We also urge the Department to report the qualifications of any entity delegated by the CHC-MCO to review records, documents and data of Participants and what vetting the CHC-MCO completed before contracting with the delegee.

VI. Standard VIII

Recommendation: Require consideration of licensing history and enforcement actions, which are key quality indicators for nursing homes, to the list of criteria which must be considered in credentialing decisions.

Exhibit H: Coordination with Behavioral Health Managed Care Organizations

Recommendation: Considering the low level of behavioral health service uptake by CHC participants, this Appendix should be strengthened to identify procedures for the MCO to document participants' identified behavioral health, authorization from the participant to reach out to their BH-MCO, and action and follow up taken by the MCO regarding identified behavioral health needs.

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690171/ ; Yearby, Ruqaiijah, "African Americans Can't Win, Break Even, or Get Out of the System: The Persistence of "Unequal Treatment" in Nursing Home Care", Temple Law Review, 2011, https://www.templelawreview.org/lawreview/assets/uploads/2011/07/Yearby.pdf; Fennell ML, Feng Z, Elderly Hispanics More Likely to Reside in Poor Quality Nursing Homes, Health Affairs, 2010, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3825737/.

Recommendation: Require MCOs to develop and implement a comprehensive plan for identifying participants who need behavioral health services and connecting them with those services, given the carve out of behavioral health services and the challenges of Medicare paying primary.

Recommendation: Require MCOs to track communications with BH-MCOs and Medicare plans regarding participants' needs for access to behavioral health services.

Recommendation: Require all MCO Service Coordinators to be trained in the use of PHQ-9 depression screening tool. Participants with PHQ-9 scores of 10 or higher, with participants' permission, should be referred to their BH-MCO for further assessment.

Recommendation: Require MCOs to coordinate with BH-MCOs to provide biannual trainings to nursing facility staff and residents on availability of Medicaid behavioral health services.

Exhibit N: Provider Directory

Recommendation: Modify the requirement to include in the provider directory information about accessibility as follows:

> Identification of sites which are wheelchair accessible for people with physical disabilities, including separate identification of whether each of the following are accessible: offices, exam room(s) and equipment.

Separately identifying which elements of a provider office are accessible is critical for people with mobility impairments as an office whose entryway may be accessible but none of whose equipment or exam rooms, is of no use.

Recommendation: For services that are available as a limited state plan benefit and a more enhanced waiver service, such as physical therapy, occupational therapy, speech therapy, nursing and cognitive rehabilitation therapy, require provider directories to differentiate between providers who provide such services on a short term or intermittent basis and those who provide them on an ongoing basis. Also require directories to indicate whether the service is provided only on an on-site outpatient basis, in home, or both.

Currently there is no way to identify in the MCOs directory providers who providers such as those noted above, willing to provide long-term services. A PHLP client recently called numerous providers identified as providing in home physical therapy and most noted, "we don't provide physical therapy as a waiver service." Setting aside the concern that there is a deficiency in the number of such providers who will provide ongoing physical therapy, the client should not have had to waste hours trying to identify appropriate providers when the provider directory could have included that information.

Exhibit CC: Financial Management Services (FMS)

Recommendation: Add a requirement that the FMS provide training to participant common law employers and their DCWs on the rules governing who may provide personal assistance services, and where personal care services can be provided and billed.

We have seen well-meaning DCWs and CLEs get into trouble because they did not realize that they could not assist their patient in the hospital and bill for that time, and stronger training appears to be needed to ensure that participant-directed providers understand what they can and cannot do.