Kelly Andrisano, J.D., *Executive Director*
PACAH
PO Box 60769
Harrisburg, PA 17106-0769
Kandrisano@pacounties.org
(717) 526-1010 x 3132

Via Email
April Leonhard
Office of Long-Term Living, Bureau of Policy and Regulatory Management
P.O. Box 8025
Harrisburg, PA 17105-8025

Dear Ms. Leonhard:

I am writing on behalf of PACAH, a statewide nursing facility association representing county, veterans' and private and non-profit nursing facilities, regarding the Department's Community HealthChoices (CHC) Program Concept Paper. Below are our comments on this Concept Paper. We remain supportive of Governor Wolf's efforts to implement Community HealthChoices in Pennsylvania, and recognize that there is room for vast improvements in the ways we serve those receiving long term care services. However, a program change of this magnitude raises a lot of questions and issues, and should be done cautiously to insure success. We thank you for the opportunity to offer some suggestions on how the program is implemented.

In addition, we would like to add that PACAH is an affiliate of the County Commissioners Association of Pennsylvania (CCAP). CCAP supports a participatory role for county government in the development of all state human services policy. Pennsylvania's counties have a vested interest in the long-term care system and have oversight and control of several long term care programs as well as other human services programs that impact long-term care. Counties are also on the front lines of insuring that those who are most needy are provided with necessary care and support to live healthy and independent lives. While all counties are organized differently, some counties in Pennsylvania have oversight of Area Agencies on Aging (AAA), county nursing homes, waiver programs, behavioral health choices programs, local mental health and developmental services programs, Medical Assistance Transportation programs and others. We ask that above all, the counties' role in the long term care continuum and their choice to provide services not be limited or impacted negatively as CHC is implemented, and that the state continue to see the counties as partners in providing these services moving forward. Below are our comments on the concept paper.

County Home Considerations:

Adequate Reimbursements for County Homes:

Nowhere in the concept paper did I seen an indication of how reimbursement for Medicaid Providers would change as CHC is implemented. Having a limited knowledge of managed care, I know that the MCOs would be setting rates based on negotiations with various types of providers, which raises some issues and suggestions when it comes to county nursing homes.

Pennsylvania has 22 county nursing facilities from 19 counties. These homes have historically served the safety-net population, a fact which is supported by numbers and not just rhetoric. Not only are county homes required to take Medicaid patients on day one, but according to December 2013 cost reports, the average MA occupancy rate of county nursing facilities was 80 percent while the average MA occupancy rate of all skilled nursing facilities in the state of Pennsylvania (including county homes) was just 65 percent[1]. Because of this, county homes are not just providers of long-term care services, but instead, are partners with the state in insuring that the needs of the community's most vulnerable individuals are met.

In the past, to encourage and support county homes taking on the role of the safety-net, they have been carved out of the traditional skilled nursing facility payment system. Their rates are not based on their CMI as private nursing facility rates are, and instead, only fluctuate if there is an increase in rates as part of the state budget. With rates having been set almost ten years ago, and after several years of flat-funding in the state budget, county homes have continued to serve Medicaid clients through rates that have fallen significantly below the rising cost of providing care over the last ten years. Recently, PACAH was able to show, through an independent study, that if these homes were all to privatize, there would be an increased cost to the state in terms of Medicaid reimbursements of almost $30 million per year. This would indicate at the very least that county homes are providing safety-net care in an extremely efficient manner and county homes have continued to serve as the safety-net with costs that far exceed what they are being reimbursed.

Because of the unique type of individuals served within the county homes, many questions arise as we transition to CHC, particularly around payments and reimbursements. First, as safety-net facilities, how will the new payment system recognize this and support this? Will counties continue to be "carved out" of the payment system? With rates being set by MCO's, how will the high Medicaid population of these homes and unique history of county payments be reflected? Where will the incentive be for county homes to continue to fulfill this role of safety-net facilities? How will unique payments available to public facilities continue to be maximized (the IGT, CPE, etc.)?

We strongly believe that counties should not be expected to negotiate rates in direct competition with for-profit nursing homes, some owned by national companies who already have existing relationships with managed care entities and experience in a managed care environment. Forcing this upon our public, safety-net facilities who have partnered with the state for decades would jeopardize their ability to continue to provide much-needed services. In addition, the costs of providing service within the county nursing homes are unique for the following reasons:

a. Medicaid populations nearing 85%-95%,

b. Significant population without any Part B type coverage,

c. Of those that have Part B type coverage, it is rare that any coinsurance coverage exists,

d. Unionized facilities,

e. High cost of care factors that cause non-county homes to avoid similar admissions

f. Expensive specialty units that service specific populations.

Recommendation: We strongly recommend, due to the unique population served and the nature of services provided by county nursing facilities, that there be incentives included in rates (prior to any

[1] These numbers come from a 2012 study done by Avalere Health LLC

negotiations) for county facilities due to their status as safety-net providers. We would also ask the state to explore the possibility of setting aside funding for the MCOs to allocate specifically to safety-net providers to insure that the population served by the county homes continues to receive care. This safety-net funding could be restricted to county nursing facilities. Without some provisions in place to account for the differences in funding county nursing facilities and the unique population involved, it will be difficult for the counties to continue to serve in this role.

In-Network Provider Status for County Facilities:

Another major concern for the county nursing facilities in this transition is the timeframe for remaining an "in-network" or preferred provider. County homes are not equipped with consultants at the ready to prepare them for managed care and their focus has never been on providing for-profit care but instead has been on serving as the safety-net facilities in the long term care continuum. In addition, county nursing facilities serve a unique population compared to the other skilled nursing facilities. Many of their residents do not have a support system in the community, would be considered homeless with no financial means of support, or have corresponding behavioral health issues. They also often serve a low CMI population who would not be accepted by other nursing facilities due to the differences in reimbursements.

While we believe the county homes provide quality services in the most efficient manner possible, forcing them to operate successfully in a managed care environment in just six months with a unique population is unrealistic and has the potential of forcing the remaining county homes out of business. When they have operated as the state's safety-net for decades, not enabling them the time needed to be successful in this large scale system change does not seem to align with the stated policy goals of CHC.

Recommendation: Ideally, county homes would be considered in-network providers indefinitely, in order to maximize their collaborative potential and to reduce the risk of eliminating core safety-net providers. The concept paper references the need for a "sufficient network." It would be difficult to have sufficient networks without the inclusion of county nursing facilities who have operated for decades as the community safety-net provider.

The county's role in the continuum of care at the county level and beyond is such that they should not be given six months to adapt or else be in jeopardy of not qualifying as an in-network provider. Instead, they should be seen as partners with the state in providing safety-net services, with common goals to provide services for the most-needy residents while meeting community standards. As partners in this transition, the counties should automatically be considered "in-network" providers. This would also allow them to adapt to unforeseen system wide changes that they are not accustomed to or prepared for and to prevent the widespread elimination of county nursing homes that constituents and their families have relied on for decades.

In addition, counties that have chosen to provide long-term care services to their communities in the form of a county nursing facility should be able and encouraged to continue to do so. By enabling CHC-MCOs to determine after just six months whether or not a county should be able to continue to provide these services would force them out of business and create a noticeable void in the continuum of care. We strongly urge the state to consider including county facilities as in-network providers past the original six-month "continuity of care" period.

County Collaborative Potential:

The concept paper references the need to streamline and standardize the way people access LTSS options, as well as the need to develop new models of care that integrate care coordination, service delivery, and financing. The counties are in a unique position to assist in meeting these goals. They are poised and oftentimes already operate as successful collaborative entities. In many counties, not only is there a county nursing facility, but there is also a county run Area Agency on Aging, and a county run behavioral health department. Counties also oversee and fund housing opportunities and Medical Assistance Transportation. There is also a level of accountability in a county based program not seen in the private sector. Constituents expect a level of service from local elected officials and are easily able to communicate with them on issues.

Recommendation: We would recommend that in implementing CHC the state try to maximize the collaborative opportunities available at the county level. For example, are nursing facilities able to provide additional services from a central location especially in rural areas? Having the public facilities available to serve in additional capacities should be explored.

Other issues not exclusive to county homes:

CHC-MCO requirement to contract with any willing provider/ six month Continuity of Care

While the requirement to contract with any willing provider is positive, the limitation of that requirement to **six months is not reasonable**. Neighboring states have implemented a longer period of time up to two years. This would allow the CHC-MCO and the Nursing Facility to develop the relationship and assure that all goals of the individual CHC-MCO area being met. In addition, the any willing provider requirement should include the Nursing Facility pharmacy and ancillary services as well as physicians.

We strongly believe that the type of facility that will best be able to position themselves positively with the MCOs at the end of only six short months is going to be limited, and certainly those larger facilities operating out of state with pre-existing MCO relationships will be in a much better position. While this is not likely the type of provider network DHS would have intended on limiting CHC to, it is likely to be the result. What is the harm in extending this to at least to two years? At the very least it would help insure a more sufficient and diverse network with more choices for our consumers. The argument has been made that in most regions, providers will have more than six months to get ready for this since it is being phased in. However, that is assuming the facility/provider can devote sufficient time to maximizing MCO relationships while still trying to provide services in a fee-for service environment prior to CHC implementation, which is not realistic.

Recommendation: Extend the any willing provider requirement to 2 years and expand to include all ancillary services (Pharmacy, Lab, Diagnostics, Physicians).

Pre-authorizations

While this was not really addressed in the concept paper, we want to continue to stress that a CHC-MCO not be permitted to require a Nursing Facility admission prior authorization that is in addition to the IRED/CAO eligibility and Department of Aging options processes.

Recommendation: If the resident qualifies medically and financially then the CHC-MCO should be required to pay the nursing facility.

Mandatory enrollment in MLTSS as of the implementation date for each region

Unlike neighboring states (NY, NJ) that have implemented MLTSS by mandating all newly approved Medicaid residents select or are assigned an MCO while keeping existing nursing home residents in a fee for service program unless they voluntarily select MCO enrollment, PA is mandating that all approved Medicaid residents in nursing homes be enrolled in a MCO starting on the date of MLTSS implementation for the region. It is also projected that the enrollment process will begin three months prior to the implementation date (enrollment notices in October 2016 for January 2017 implementation).

This mandatory enrollment for nursing home residents requires the Nursing facility to have all the processes in place that will be necessary to deal with multiple MCO Plans (up to five according to the concept paper) and to have billing processes in place to prevent negative cash flow impact. In addition, for facilities with limited Managed Care experience, it requires education and training of staff to assure appropriate implementation of each MCO contract. This affects functions such as billing, Case Management, Nursing, as well as social service/discharge planning. Phased in implementation allows facilities to develop and modify their processes with each MCO before the volume of residents is overwhelming.

Recommendation: Implement mandatory MCO enrollment for all newly approved Medicaid residents as of the implementation date with phase in of any existing approved Medicaid Nursing Home residents over a period of no less than 12 months.

Rate Setting

The concept paper states that the rate setting will be a 100% negotiated rate between the Nursing Home and the MCO. The assumption is that the MCO will want to increase their volume at the Nursing Home and will negotiate a reasonable rate for services provided to both new and existing residents.

Neighboring states have established a “benchmark rate” which is a minimum rate that the MCO must reimburse the Nursing home for care. In both NJ and NY, the MCO can choose to negotiate a higher rate but the benchmark rate becomes the “floor” and is based on the most current Medicaid reimbursement rate for the Facility as well as the contract between the state and the MCO.

The concept paper assumes that the MCO will want to contract with Nursing Homes to increase their enrollment volume however maintaining that reimbursement will be a 100% negotiated rate allows the MCO to contract at a low rate in order for the Nursing Home to maintain their census especially if mandatory enrollment is implemented. In addition there are nursing homes who have limited or no experience with Managed Care contracting who may experience a negative financial impact if unable to negotiate an equitable rate.

Recommendation: Establish a “benchmark” rate for each nursing home as the floor for negotiations between the MCO and the nursing home.

Requirement – MCO must offer a Medicare D-SNP to be eligible for contract with the State

While we applaud the state for not requiring that dual eligible MLTSS beneficiaries be enrolled in a Managed Medicare MCO, the requirement that any approved CHC-MCO must offer a Medicare D-SNP may limit the availability of qualified organizations who may qualify to contract with the state for this program. As seen in the neighboring states who have implemented MLTSS, there are MCO organizations that specialize in providing Medicaid MLTSS coverage but do not offer Medicare Managed Care D-SNP coverage. While it is understood that there is a desire to assure that care is coordinated between both the Medicare and Medicaid programs, requiring that a CHC-MCO be able to provide both may result in cost shifting to Medicaid rather than Medicare since the CHC- MCO will be controlling all authorizations for

Medicare coverage. In addition, this may increase the cost of care for the Nursing Facilities who are required to assure that residents maintain their highest functional level and yet may not be authorized to provide the services to achieve that by the CHC-MCO.

Recommendation: Eliminate requirement that an approved CHC-MCO provide Medicare D-SNP coverage.

Quality Assurance

There are multiple references in the concept paper regarding the assurance of the quality of services delivered, and that MCOs must be include in their management plan an indication of how they will evaluate the quality of services delivered by network providers. We fully support the assurance of quality services, and especially maintaining a system where quality is valued over cost-savings. There are concerns, however, on how quality will be determined and there are no specific indications in the concept paper on how an MCO would determine how a provider meets quality standards.

Recommendation: There are multiple requirements for skilled nursing facility licensure in PA, and facilities continue to strive to insure that they are meeting the ever changing requirements. When developing quality measures for CHC, DHS Should work collaboratively with DOH to assess the priority that should be given to licensure standards and initiatives that facilities have been focusing on previously before implementing new quality standards that have not been a focus in Pennsylvania. Also, as the RFP is established and as MCO's begin to assess the level of care provided to individuals through CHCs, DOH should remain apprised and an integral part of the discussions so that they can insure none of the licensing requirements are in jeopardy and that long-standing safety and quality of care goals are continuing to be included and made a priority.

Rumors continue to circulate that quality measures will include CMS' five-star rating system. If this is the case, then providers need to be notified as soon as possible so that they can put greater focus on this. Whatever the quality measures for providers are, in particular for skilled nursing facilities, there needs to be enough time given to the providers to be able to implement internal policies and procedures to insure they are maximizing what is being measured. With a short implementation timeline, our concern is some providers, especially smaller providers with no national managed care experience, will have difficulty focusing on whatever particular quality standards are chosen in just a few months' time.

Increase Community Housing option. This has been a focus for years with the active transition plans to get low CMI patients into the communities. In many counties there is little to no real estate available for safe placement of these individuals in the communities. Also due to criminal and/or credit histories many of these low CMI patients could not be placed. How will CHC plan obtain such real estate or increase housing options for these individuals?

Further, we know there are residents within skilled nursing facilities that cannot safely be placed back in their home in the community and cannot afford the private pay Personal Care or Assisted Living facilities in their area.

Recommendation: Please consider adding a provision under Managed MA that would allow for residents to transition from a skilled nursing short term stay to a Personal Care or Assisted Living community and allow them to utilize their Managed MA funds to do so. The cost for a resident to reside in a Personal Care or Assisted Living setting is lower than the cost to live within a skilled nursing community. Further, we know there are disabled persons age 21+ and seniors in their home in the community who receive MA in the community under various waiver programs that would benefit physically and socially in a Personal

Care or Assisted Living environment, reducing hospital and skilled nursing stays, but they cannot afford to move.

Other issues:

Below are a few other issues that did not seem to be clearly addressed in the concept paper, but for which we don't necessarily have recommendations, just questions:

Accountability:

The concept paper indicates that the CHC-MCOs will be rewarded with value based incentives for increasing the home and community-based services model, and that there will also be P4P programs for CHC-MCOs. We would like to emphasize the need to insure that these incentives should be tied to quality. For example, a MCO should not see incentives for less costly care without corresponding positive outcomes. Many HMO plans will end coverage and discharge a patient to home with very limited home care or supportive services, only to lead to readmissions in the end and more costly corrective services.

Promote PCP Care. This has been the Health Maintenance goal since it's been in place. Today we see a shortage of primary care MDs that will take FFS MA; and many are also opting out of various commercial HMOs due to low reimbursement. How can more PCPs be enticed to participate in an HMO that is likely to be less in reimbursement? There is already a shortage of availability for well patient appointments now. The above serves another issue – If a CHC-MCO recipient's long-time physician is not going to enroll in the HMO we have a hole in the continuum of care. Here again, LTC MA eligible patients are sometimes refused appointments or they are charged copays for services. We have this happening now.

Level of Care Tools – Is there a plan to create yet another tool either specific to Department of Health Services, or the insurance companies that would be in addition to the MDS?**

Service Coordinators – Is this role considered to be a CHC-MCO employee in addition to the facility care coordinators?**

** Both of these will require more employees and possibly more software costs

Provider Services will have provider representatives Mon-Fri 9-5. How will this help in the 24 hour care setting of SNF? Xrays, Labs, other services are usual needs in the SNF setting.

When a beneficiary has a Medicare HMO and CHC MCO. If there is a conflict on coverage and care planning who will intercede?

Thank you for considering these comments. Please feel free to contact us if you have any questions. We look forward to working with the state on the implementation of CHC>

Sincerely,

Kelly Andrisano