COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

Mr. Ron Barth
President & CEO
LeadingAge PA
Mechanicsburg, Pennsylvania 17050

Mr. Russ McDaid
President & CEO
Pennsylvania Health Care Association
Harrisburg, Pennsylvania 17101

Dear Mr. Barth and Mr. McDaid:

Thank you for your organization's participation in discussions around the Department's Community HealthChoices (CHC) program. This letter serves to summarize the measures that our respective organizations have agreed to as it relates to CHC.

1. **Any Willing Provider for Nursing Facilities**

CHC Plans will be required to enroll 'any willing provider' or any nursing facility currently enrolled in the Medical Assistance (MA) program licensed to operate within a given CHC 'phase' or zone for a period of *18 months* from the date of full implementation in each CHC 'phase' or zone.

No later than 3 months prior to the expiration of the initial 18-month 'any willing provider' period, the Department of Human Services (DHS) shall convene a group of stakeholders including LeadingAge PA, the Pennsylvania Health Care Association, the Pennsylvania Coalition of Healthcare & Living Communities, and the Hospital, Healthcare Association of Pennsylvania (hereafter referred to as the Associations) and the CHC Managed Care Organizations (MCOs) to review guidelines on network adequacy under the CHC program after the expiration of the 18-month period.

The stakeholder group shall recommend guidelines for DHS' consideration on quality/performance standards for nursing homes and monitoring tools for the CHC MCOs. These guidelines, in addition to minimum access standards established and enforced by DHS, are designed to ensure that access to quality nursing facility care is maintained following the expiration of the 18-month any willing provider period. These quality/performance standards will not rely on any one criterion but should be a combination of applicable standards. DHS will commit to issuing requirements to CHC MCOs with consideration of the input received from stakeholders, and to monitoring and enforcing the MCOs' compliance with the requirements.

2. **Rate Floor for Nursing Facilities**

Payment adequacy is essential to ensuring that continuity and quality of care are maintained as the CHC program is implemented by DHS. As a result, it is necessary and appropriate that DHS continues to create a basis for rates paid for MA funded nursing facility care. These rates shall serve as the rate 'floor' for payments by CHC MCOs for both in-network and out-of-network providers for a period of *the first 36 months* following the initial implementation date of each CHC phase or geographic zone. This rate floor will maintain access to nursing facility care, provide certainty for consumers, and allow for negotiations by CHC MCOs and participating nursing facilities for higher rates as necessary based on resident acuity and the availability of nursing facility care. This rate floor shall apply unless the nursing facility **and the CHC MCO enter into a mutually agreed upon alternative payment structure such as Pay for Performance. Any agreement by the nursing facility and CHC MCO to waive the established rate floor shall be in writing and signed by both parties.**

As part of the rate floor, the existing 'case mix' rate setting system as defined at 55 Pa. Code Ch. 1187 and 55 Pa. Code Ch. 1189 will be used, as it provides a known and reliable rate setting methodology which rewards facilities serving higher acuity residents year after year. The Budget Adjustment Factor (BAF) will continue to be used, as it provides a discount factor to apply to a facility's full case mix rate so that the MA long-term care appropriation isn't overspent. The formula used to establish the BAF for future years shall be developed in consultation with the Associations and will be reviewed and agreed upon annually.

DHS will continue to calculate and publish nursing facility rates using the state mandated case mix reimbursement system through the implementation of the CHC program to ensure the acuity of residents in each nursing facility is considered.

In addition to a nursing facility's specific per diem rate, DHS shall provide targeted funding as part of the CHC rates that represents certain additional payments in place prior to CHC implementation. The targeted funding will represent zone-based allocations of the following current programs: county MDOI payments, NF allowable cost supplemental, and NF direct care supplemental. DHS will require the CHC MCOs to distribute all of the targeted funding provided for in the rates to nursing facilities; however, DHS cannot instruct MCOs on how the funds are distributed. Payments for health care-associated infection (HAI) and any targeted legislatively established payments will continue to be made by DHS directly to nursing facilities. An example of legislatively established payments includes the non-public MDOI. Additionally, as outlined in the draft CHC agreement, the CHC MCO's will establish grants for ventilators/tracheostomy care and exceptional DME. Although DHS will work in good faith to implement the payments as planned in this paragraph, both parties recognize that the plan is subject to change to ensure the payments are compliant with the Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability final rule published by CMS on May 6, 2016.

METHODOLOGY TO ESTABLISH A RATE FLOOR FOR THE FIRST 36 MONTHS OF THE CHC PROGRAM:
For the first 36 months following the implementation date of each CHC phase, DHS shall establish a floor for nursing facility per diem rates and direct CHC MCOs to contract with nursing facilities at rates no lower than the provided rates in this schedule. For each CHC phase, the rate floor shall be established at the facility level as the average of the facility's four quarterly case-mix rates in effect prior to CHC implementation of that phase. The rate floor will not be adjusted over the 36-month duration. However, DHS will instruct their actuaries to account for any fee for service per diem rate increase in the CHC rates, which can then be negotiated between the CHC MCOs and the nursing facilities. DHS will also instruct their actuaries, as part of the annual rate setting process, to account for any assumed increase in nursing facility costs as a result of subsequent mandates on staffing, wages, or related cost drivers enacted following implementation. DHS will require the CHC MCOs to demonstrate that they have addressed the facility-specific impacts of any such mandates in their rate negotiations with impacted facilities.

The rate floor would not limit the CHC MCO or nursing facilities from agreeing to higher rates if necessary based on acuity, provider supply, or alternative payment methodologies. Any alternative payment methodology that would result in an initial rate that is lower than the established rate floor must be agreed to in writing by both the nursing facility and the CHC MCO.

The payments funded through Appendix 4: Nursing Facility Access to Care Payments, shall be in addition to the rate floor established in accordance with the methodology described above.

3. **Readiness Review**

CHC-participating MCOs, as part of their readiness review with DHS, must complete successful testing of their claims processing system before implementation of the phase in which they are participating. Test samples must include all types of payments and adjustments (see attached list for specific claim types) and nursing facilities of varying sizes, types, and corporate structure will be solicited and included in the claims testing. The results of the test samples for each MCO must replicate identical claims billed through the PROMISe system.

Following DHS' formal sample testing for CHC MCO readiness, any facility wishing to engage in claims validation will be given the opportunity to do so before the implementation date of the CHC phase where they are located.

4. **Data Sharing and Availability**

DHS and statewide trade associations, to the extent they are able under law, will continue to work together to identify, gather and share all necessary and available utilization, cost, acuity and reimbursement data so all parties may continuously analyze and assess the relationship between nursing home reimbursement, actual costs and access.

5. **Agreements**

In exchange for the program amendments included in this document, the Associations agree to:

1) Continued authorization of the BAF as established in 67 P.S. § 443.1(7)(iv) through June 30, 2019.
2) Continued authorization of the nursing facility assessment program as established in 67 P.S. § 801-A – 815-A through June 30, 2019.
3) Refrain from initiating legislative proposals on the issues agreed to in this letter through June 30, 2019, the date of enactment of the FY 19-20 general appropriations bill, or the implementation of CHC phase 3, whichever is later.

6. **Federal Impacts**

If regulatory amendments, executive orders, or other policy guidance at the federal level eliminate or amend provisions that effect the content of this letter such as those contained in 42 CFR § 438.6 (relating to special contract provisions related to payment) in a manner that alters the rules governing the CHC program or payments of any type to nursing facilities, the Department will convene a meeting with the Associations for the express purpose of evaluating the impact of the revisions, and discussion of program changes that may be required of the Department, or desired by the Associations.

Sincerely,

Theodore Dallas
Secretary

Russ McDaid, PHCA

Ron Barth, LeadingAge PA