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Via Email and Regular Mail
April Leonhard, Department of Human Services, OLTL
Bureau of Policy and Regulatory Management
PO Box 8025
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Dear Ms. Leonhard:

I am writing on behalf of PACAH, a statewide nursing facility association representing county, veteran's and private and non-profit nursing facilities, regarding the Department's Managed Long Term Services and supports (MLTSS) Discussion Document. Below are our comments on the Discussion Document. We are supportive of Governor Wolf's efforts to implement a MLTSS system 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 requires feedback from all types of stakeholders. PACAH would be happy to serve as a resource and asks that we continue to be involved in the discussions. We represent over 100 different long term care entities in Pennsylvania and would be able to provide input on a wide variety of issues.

In addition, 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. Counties often 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 needed 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. Due to the county involvement in long term care, in particular the coordination of cross-system care, we ask that you continue to involve them in the conversation moving forward.

While we tried to keep our below comments within the matrix provided by the department, there were some comments that did not easily fit into the pre-determined headlines. Please feel free to contact me to discuss this further or with questions.

PROGRAM DESIGN:

Timeline: We have some concerns with the timeline that has been recommended for implementation of an MLTSS system in Pennsylvania. Such a drastic change to Pennsylvania's Long Term Care System should be done with as much stakeholder feedback as possible. To receive comments on July 15, 2015, and then issue an RFP only three months later seems would seem to leave very little time for actual discussion on the specifics of the proposed MLTSS system. While the discussion paper is helpful, it clearly provides just a general overview, and if true stakeholder input is to be considered there needs to be

more time for discussion. Due to the number of service areas and consumers that will be impacted, we want to make sure that important issues are addressed and adequately reviewed. We would also like to see additional time for research on MLTSS systems, innovative ideas, and evidenced based practices. We would recommend at the very least that stakeholder workgroups continue to advise the administration as you implement this program, and a best case scenario would expand the proposed time-line to not only provide additional time to review comments, but more time to review the program after the first phase is implemented.

County (Public) Nursing Home Role in MLTSS System: PACAH, as an association that represents the 23 remaining county nursing homes, is concerned about the role of the county homes in an MLTSS system and advises the state to take special consideration of these facilities and the potential for carving them out. As you are aware, the county nursing homes serve a unique population. County nursing homes are required to take Medicaid patients on day one, and are the only homes required to do so. In addition, county home rates are flat and not subject to fluctuations in a CMI or cost allocations. Because they have been carved out of this payment system, they often care for the most vulnerable consumers. County facilities are also already in a unique position be poised for care integration across systems due to the fact that counties often also oversee the Area Agency on Aging, local Behavioral Health and Intellectual Disability Services, drug and alcohol services, housing programs, etc.

Another consideration for county nursing facilities and a MLTSS system is the potential for Intergovernmental Transfer (IGT) Funding. The state is looking at unique solutions to fund both county nursing facilities and provide supplemental funding to the state long term care program. One way to do that is through implementation of a limited IGT program, which could provide much needed funding to both county facilities and state long-term care programs. IGT funding, however, is based on the Upper Payment Limit which is calculated using Medicaid Fee-For Service spending. Therefore, under a capitated program, the amount of funding available through an IGT would be negatively impacted. This needs to be explored further, and if the potential funding impact is significant, carving the county nursing facilities out of a capitated program may be necessary. The alternative – a reduction in funding for county nursing facilities, would result in services being diminished for a core population as well as an increase in state Medicaid spending as these facilities continue to privatize.

Emphasis on HCBS/Eliminating Institutional Bias: Our organization is supportive of an emphasis on Home and Community Based Services (HCBS), including community integration and opportunities to participate in a fully integrated workforce. Our concern, however, is whether or not the current HCBS system in Pennsylvania is adequately equipped to handle additional consumers and an increased focus on HCBS services under MLTSS. The paper speaks of an "institutional bias," existing in Pennsylvania. We believe that while there may be a bias, it exists partially because HCBS services are underdeveloped in Pennsylvania, and there will need to be significant growth in some services for the MLTSS program to be effective. Implementing an MLTSS program in and of itself will not lead to increased available services; and if there are not adequate services and settings available for the post-acute care consumer, then they are going to have to receive institutional care. Available alternative programs for seniors have not been created or fostered by state and federal regulations and reimbursement systems.

Often, and in the county facilities in particular, there are extremely vulnerable consumers who may otherwise be considered homeless that the facility would be eager to place, but have no suitable "home" in which to receive services or to transition to. There is often also little to no caregiver/family support services in this low-income, elderly population.

Until this is corrected, there will remain an institutional bias. We believe that in order for a renewed focus on HCBS to be successful, Pennsylvania needs to first do an assessment of the HCBS services available for eligible consumers and realistically determine if they will be adequate to meet the needs of an MLTSS system. This assessment should not just focus on waiver services, but also homeless assistance and housing and supportive services that are available for these individuals. Reducing the institutional bias would welcomed by all long term care providers; however, this cannot be done in a safe and effective manner if we do not have the appropriate HCBS resources, including housing, available for our consumers. If after an assessment of available programs it is determined that HCBS are not adequate, then there needs to be a concrete plan of action in place to ramp up these services in time to meet the needs of the new MLTSS program as designed. Development of such services needs to be a priority if vendors will be permitted to use discharge metrics to grade providers.

In addition, when focusing HCBS under an MLTSS system, it is imperative that there is not a penalty for a provider that moves a participant into an institutional setting. The clinical judgement of the provider caring for the resident must be given priority over that of a service coordinator that sees the participant only occasionally, and penalizing such decisions will inevitably lead to care being sacrificed in order for providers to avoid penalties, and a decrease in the quality of care being provided overall which should not be our goal.

Provider Network/Performance Incentives: One of the challenges that is inherent in a MLTSS system is insuring that there a robust, high quality pool of providers continues to exist. It is important that the program be designed in a way that insures quality providers, regardless of their size, will be able to continue to be reimbursed for services. Often, when a “preferred provider” network is created providers are excluded because there are not preexisting relationships with vendors, they are of a smaller size, or they have not been educated on how to put themselves in a position to for “preferred.” We would recommend that Pennsylvania allow all willing and qualified provider to be included at the outset of the program for a minimum time frame of at least two years. If the intention is to limit providers, selection criteria should be published well in advance of any selection process that does not include every willing provider so that providers can choose to work toward achievement of the criteria to continue participation. The selection of providers and criteria used should be transparent, and the end goal should be a large and robust network of quality providers; not the limitation of providers excluded on a subjective basis.

In addition, performance based incentives must be clearly delineated in advance so that providers have adequate time to adjust their services to align with the designated goals. If the desired outcome is to improve performance, through innovation, health, safety, transparency, etc. then there must be assurances that current quality providers are given the opportunity to meet new performance objectives. Without adequate time to adjust, the provider pool will become limited and will not be able to meet the diverse needs in Pennsylvania.

Coordinated Care: While coordination of care between Medicaid and Medicare services for the target population is critical, coordination of care across the entire healthcare system also needs improved for MLTSS to be successful. Between post-acute care, skilled nursing, ambulatory, behavioral health, physical health, addiction treatment, housing services, rehabilitation, etc. there needs to be better coordination and collaboration. A focus on coordination between all of the long term care, aging, human services, and other relevant service providers is critical to success. In addition, there is limited preventative care coordination in our long term care system. Nursing facilities, in particular county owned facilities providing care at the county expense try and focus on preventative care within the communities, among residents, etc., yet the payment models do now incentivize preventative care which needs to change.

Evaluation of other current long-term care managed-care models in Pennsylvania: There are certain areas in Pennsylvania where Medicare is implemented through a managed care model. We have heard provider complaints regarding levels of therapy being approved, care coordinators' evaluations of patients, etc. Prior to implementing a state-wide MLTSS program it would be prudent for the state to evaluate the issues that have arisen in the Medicare managed-care arena.

PLANNING PHASE:

It is difficult to comment on the planning phase at this time, without knowing more about the type of vendor that will be. As stated above, we ask that stakeholder groups be formed to guide the process and assist in the flow of information as the implementation moves forward.

IMPLEMENTATION:

Once the program is fully designed and ready to be implemented, there are wide array of issues that need to be addressed and anticipated ahead of time. There are more issues to address then can be listed, which is why focused stakeholder groups to guide implementation are critical. Long-term care providers have a vast amount of knowledge on these issues and should be utilized for innovative ideas throughout the process. While this list is not exhaustive, these are some of main issues that will need to be adequately addressed:

Options Approval Process: will the state retain control or will it be the responsibility of the managed care entity?

Billing Requirements: are we going to fully implement electronic billing requirements, what will the time-frame be, and do denials have to be fully processed prior to payment from the vendor? If we are not fully implementing electronic billing, vendors should still be required to accept electronic billing from those providers who have implemented it.

Participant Choice: Participants need to be assured of an opportunity to change vendors if they find the vendor does not offer access to the providers the participant desires or services the participant considers essential are not available.

Additional Administrative Burdens: In a system where reporting requirements and administrative duties can be burdensome, it is important that a transition to a MLTSS system focus on eliminating undue administrative requirements such as paperwork and reporting, streamlining where possible, so that providers can focus on innovation and quality of care as opposed. While we encourage the development of performance based goals and quality measurements, but it is imperative that the state consider all of the reporting that is already in place for providers and insure that there are no duplicative requirements added under a MLTSS system and that integration with current requirements be a priority.

Minimizing payment delays: Implementing a new capitated payment system will inherently come with payment delays during the transition. For example, in the New Jersey MLTSS system which was implemented in July 2014, providers have reported a delay of four to six months in payments. Delays of this significance can have a detrimental impact on providers and their ability to meet service needs. Pennsylvania needs to put a process in place that would result in minimal payment delays.

Hold Harmless Period: Can there be a period of time after implementing MLTSS where providers would continue to receive the current MA per diem rate or an acceptable rate set by the state prior to having to negotiate with the vendors? Or is the intent that vendors be permitted to immediately set new payment per

diems? We recommend that similar to other states there be a hold harmless period to allow providers to time to adjust to the new system prior to a drastic change in per diem rates.

Patient Liability: Will the vendor recognize patient liability and if so who will calculate the patient liability

Transition Period: What will the timeframe be for transitioning residents currently in the fee-for-service program? It will take time for all of these consumers to move from a fee-for-service system to the new system, and that should be built into this plan. In other states you typically see an 18 month to two year transition period, which we would recommend here.

High Level of Care Reimbursement: Will there be a multi-tiered system when it comes to reimbursements and billing? For example – a patient requiring a higher level of care should generate reimbursement a higher level than a lower acuity, lower level of care patient. A tiered reimbursement system would be preferred.

Pre-Authorizations: There should be guidelines developed requiring vendors to permit retroactive authorizations in certain cases, and not deny payment purely because of this. If a resident qualifies for care and the care is medically necessary care at that time, payment should not be withheld from a provider purely due to lack of pre-authorization. We agree that there needs to be communication, coordination, and authorization guidelines, but vendors should be discouraged from using the lack of pre-authorization in order to deny claims – and their claims processing staff needs to be properly and thoroughly trained on how to handle these authorization issues.

The pre-authorization process should also be uniform among all vendors. We have been told that Ohio has not implemented such a provision and the confusion for providers referring to lower levels of care has become confusing and burdensome. A uniform process will promote discharge to lower levels of care rather than impede it, consistent with the goals of the MLTSS program.

Service Plan Development: When developing a service plan for individuals falling within the MLTSS system, it would be helpful to utilize an assessment tool already in place, such as the Minimum Data Set. Adopting a tool already in use lessens the burden on providers and eliminates the need to develop and test a new tool.

Evidence-Based Practices: There seems to be a lack of evidence based practices and innovation in long-term care, due to limited research dollars. Even though it does not appear as though the plan is to evaluate the MLTSS system through a traditional demonstration project, we hope that Pennsylvania plans on allocating some funding to research the effectiveness of MLTSS as well as other evidence-based practices that could help improve the long-term care system in Pennsylvania. Without that type of research, it is difficult to determine the effectiveness of program changes.

Physician Participation: For those currently operating in a managed care arena, there are concerns about adequate physician participation. How will we insure physician participation in Pennsylvania?

OVERSIGHT: While some facets of oversight have been listed above, again it is important to emphasize the need to have vendors and/or the state announcing criteria well in advance so that willing providers are able to adjust, and that we retain a robust system. In addition, convening stakeholder groups throughout the process would allow for feedback on the oversight of the program throughout implementation. Also, our affiliate organization, PACA MH/DS, submitted comments regarding the oversight of individuals who are dually eligible for Medicare and Medicaid who do not reside in nursing homes. HealthChoices, Behavioral Health, has promoted and supported best practices as well as

evidenced based practices, and we support PACAH MH/DS' proposal regarding the oversight of this population.

QUALITY:

High-Cost Consumers:

Often times in an MLTSS system, quality becomes secondary to increasing efficiencies and reducing costs. There are numerous stories from reputable publications explaining that the downside of an MLTSS system is that often consumers can fall through the cracks. These stories often highlighting individuals being provided care in the home because it is less costly, and then are ultimately harmed due to having been provided an inadequate level of care. Providers know all too well that often times the individuals that are being served have no other place to go to receive services, with no home or family members willing to assist. While everyone should be receiving care in the least restrictive setting possible, we have to ensure that we are not forcing individuals into lower levels of care simply to save money or gain efficiencies.

What is Pennsylvania's plan to assure that a denial of service does not occur under any circumstances, specifically when costs begin to get too high? This question needs to be specifically addressed, as there will still be high-utilization consumers with high care costs. We cannot simply stop serving these individuals, so how are we going to ensure they continue to receive necessary services in an MLTSS system? What types of checks and balances will come into play in the person-centered assessment and service planning process or when services are denied?

Quality as a Performance Measure:

While performance based measures are encouraged, quality of care must be part of that "performance" measurement. Even with cost-savings, innovations, safety improvements, etc., quality of care must remain the main goal for our long-term care consumers. As a skilled nursing facility based association we can state that our member facilities in Pennsylvania offer top-notch quality care and are poised to deliver successful outcomes in collaboration with other providers and payer entities. In addition, there are already numerous regulatory measurements of quality already in place for skilled facilities that can be reference throughout the process to eliminate duplications when it comes to quality evaluation. Also, as mentioned below, a credentialed provider's recommendation for a level of care that differs from the vendor/care-coordinator's recommendation must be given priority and there must be systems in place to insure this. We encourage Pennsylvania take the time in this process to insure that adequate measures are in place so that each consumer is receiving quality care at the necessary level, regardless of cost.

Service Coordination:

In a system that will undoubtedly rely heavy on service coordinators, here are some suggestions on how to insure quality of care in a home and community based settings:

- Service coordinators must be expected to make face-to-face contact with participants prior to any placement for services and periodically thereafter. Verbal reports by participants of their needs and current status are often not accurate and should be validated by face-to-face physical and environmental assessments at periodic intervals.
- Service coordinators should be health care professionals with experience in post-acute, long-term services

- Training for service coordinators should be extensive since they are the liaisons between providers and vendors and in many ways, are perceived as “regulators.” Providers should have a roll in the performance evaluations of service coordinators if they so desire.
- How a service coordinator is assigned is critical and factors such as case load, experience level, supervisory chain are all important in insuring quality care is received.

Rehabilitation/Therapy:

Another concern in assuring quality of care is to insure rehabilitation remains part of the interdisciplinary approach for the patient:

- Concerned with the managed care per diem that has been seen in other states where rehabilitation is very limited, resulting in declines for the residents we served skilled facilities
- Residents with many co-morbidities would continue to decline with limited rehabilitation involvement

SUMMARY:

Thank you again for the opportunity to submit comments. The goals and objectives listed in the state’s discussion paper are supported by our association and we would be more than happy to answer questions and collaborate going forward. Please consider us willing and happy to participate in any further stakeholder opportunities as well. With input from all aspects of the provider arena (county, non-profit, for-profit, and veterans homes) we have a lot of expertise to offer.

Sincerely,

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