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December 11, 2015

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 Request for Proposals (RFP). Below are our comments on this RFP. First, we want to thank the Department of Human Services (DHS) for allowing us to submit comments at such an early stage of the process in regards to the RFP. We appreciate the opportunity and believe this will ultimately help to insure the RFP process addresses some critical issues. We also 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.**

Last, we ask that you continue to review the comments we have supplied in the past in response to both the CHC Discussion Paper, and the CHC Concept Paper. We have tried to limit our comments below to new comments, so we hope our previous comments are still being considered and will be responded to. These comments are still relevant and applicable at this point in the process and should be fully addressed.

General Comment – Program Standards: The RFP asks for extensive information from MCOs, but there is very little in here by way of program standards. While that is not necessarily required, a lot of the questions and concerns we have are around those standards that have been yet to be developed such as specific expectations, timeframes and numbers around transition of participants, authorizations, coordination of care, billing requirements, etc. While I am certain these will be dealt with in contracts between DHS and the MCOs, it would be helpful to hear the MCOs intentions to meet these standards when they are identified.

Problem Statement – Implementation: We have stated before and continue to feel that a January 2017 implementation date is too soon. There needs to be more time for DHS to address issues and questions that have been presented by providers and consumers, and to effectively prepare those in the Southwest zone for the changes. We also need more time for providers to be able to potion themselves as innovative, cross-system providers. Which is not going to happen over the next year without significantly more information about CHC. Extending the Continuity of Care period as addressed below would help with this as well.

Adequate in-home services/Smooth Transition: The RFP asks MCOS to describe the process for care coordination to ensure that Participants receive adequate in-home services to divert them from entering or returning to acute or long term care facilities. There should also be a requirement or plan to comply with federal and state regulations that require "safe and orderly" discharges from nursing facilities. How will this be accomplished? What if the discharge results in readmission? Who is responsible for making these determinations?

Licensure Requirements: There should be discussion on how knowledgeable the MCO is on licensure requirements of nursing facilities in Pennsylvania and how they will determine that their policies and procedures comply with these requirements.

Adequate HCBS Settings: One of the bigger issues facing facilities is the lack of availability of safe settings to discharge patients to. How will this be addressed by the MCOs? What are the plans for increasing the availability of these settings?

Overall Care Coordination and Nursing Facility Issues: As this process progresses, we would strongly encourage the state to insure that a workgroup is formed between the MCOs and nursing facility providers to address some of the smaller details and issues that they may not be aware of. Things such as MA pendings, billing issues, discharge issues, etc. I think this would be a prudent practice to insure that these issues are all addressed.

Coordination of Behavioral Health Services: Other than a requirement for the CHC-MCOs to "coordinate" with BH-MCOs, there are few directives or language clearly defining what this will mean. Currently our Behavioral Health HealthChoices program, is a successfully run managed care program, often overseen by the counties. There are concerns that without additional input from the BH-MCOs some important and critical issues will be missed impacting coordination of these services. We would recommend that the state take some time to work with the BH-MCOs on how coordination will be achieved, as well potential issues that may result, and address these more clearly in the RFP process.

Continuity of Care: As we have raised in our previous comments, we are very concerned about the short period provided for the continuity of care. We believe that this time frame be established at a minimum of a two year period, as was done in many of the other states implementing long-term care managed care. Extend the any willing provider requirement to 2 years and expand to include all ancillary services (Pharmacy, Lab, Diagnostics, and Physicians). Requiring participants and providers to adapt to a system

change of this magnitude in just six short months is unrealistic. There will be numerous changes being made from billing to rate setting. Providers and consumers need more than six months to educate themselves and transition. We once again ask that the state take a serious look at this provision, and that it be extended for all providers including ancillary providers like therapists and pharmacists.

Notification to Department – We would recommend that the notification period be at least 90 days. Transitions to new providers can take longer than this, and to insure a "safe and orderly discharge," the provider must have adequate time to insure that the consumer is being transitioned into adequate care.

Respite Care: The definition for Respite Care needs to include care in an institutional setting. Many nursing facilities are currently providing this service and to eliminate them from the definition would limit services that families and consumers are currently utilizing and are happy with.

Any Willing Provider: In order to allow "any willing provider," to continue to serve in this system, we believe that there should a rate floor implemented. Rates for nursing facilities should not fall below the current rates. Rates are already much lower than the cost of providing care, and to cut them further will force many providers to serve fewer Medicaid consumers.

In addition, for our county nursing facilities who by nature of being public homes have historically served the safety-net population, we need to determine how MCOs can build incentives into their rates to continue as safety-net providers. 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.

As safety-net facilities, how will the new payment system recognize and support the county homes? 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 have not heard answers to these questions yet.

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%,

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

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.

As previously stated, we continue to 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 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

Sincerely,

Kelly Andrisano