SECTION A PROGRAM DESC./PAGE	TOPIC	COMMENT	RESPONSE
page 3	Language Clarification	recommend clarifying the language that currently states: "CHC will be the sole Medicaid option for full Dual Eligibles. Other Nursing Facility Clinically Eligible consumers residing in these five zones will have the choice between CHC and the PACE program known as Living Independence for the Elderly (LIFE) in Pennsylvania, which is a separate managed care program option that is available in certain geographic areas of the Commonwealth." Our understanding is that the LIFE program, if available, will be an option for all Community HealthChoices (CHC) dual eligibles who are nursing facility clinically eligible (NFCE). The discussion of the enrollment process on 1915(c) waiver appendix A-1:3, for example, provides a better description of the options available to dual eligibles.	Thank you, we will be clarifying. LIFE is an option for individuals over age 55 who meet clinical eligibility requirements.

Page3,4,7	D-SNP	Please clarify D-SNP options on pages 3, 4, and 7. These pages (3-4) note that participants who have Medicaid and Medicare coverage (dual eligible participants) will have the option to have their Medicaid and Medicare services coordinated by an aligned Special Needs Program for Dual Eligibles (D-SNP) operated by the same company, and (page 7) that a central broker will assist eligible individuals in choosing among Managed Care Organizations (MCOs)/Prepaid Inpatient Health Plans (PIHPs). We request clarification about how the enrollment entity will handle choice counseling for both CHC and the D-SNP. This aspect of the implementation will have an equal impact to our providers and participants in both the Medicare and Medicaid Programs as providers will need to watch for, and expect participants changing plans in both public programs. Our providers may not be accepted or participating (in-network) in one, or both Managed Care Organizations. The manner in which choice counseling of Medicare options is delivered could create confusion and unintended impacts for our participants, as well as unexpected losses or possibly even new residents in a short time period for providers. All of this requires preparation and careful and consistent messaging. We would be interested in participating in the key messaging content and strategy.	The IEB will be educated about the coordination of Medicare and Medicaid options. The IEB will counsel on CHC MCO options, but will refer to APPRISE for Medicare counseling. The Commonwealth will engage statekeholders in the development and messaging to participants and providers.

Page 8	CHC Renewal	The next renewal application for the PA-67 HealthChoices waiver, effective January 1, 2017 will include populations to be served under the Behavioral Health Prepaid Inpatient Health Plan (BH-PIHP) authority as a result of the implementation of CHC." We are hopeful that DHS will incorporate our input on the observed scarcity of behavioral health providers and services for seniors in all settings as part of this program change. Leading Age and our providers are concerned that without specific and deliberate planning to address this, only those individuals with serious mental illness will have services coordinated. Seniors with dementia or other memory diagnoses continue to experience difficulties accessing needed services, both in the nursing facility setting as well as in community settings, and would like DHS to consider alternatives so that there is a vehicle and system in place to meet these needs.	Thank you, network adequacy standards exist and are continually monitored to ensure participant access to needed services. OLTL has been working closely with the Office of Mental Health and Substance Abuse Services as well as service providers to better understand coordination opportunities and best practices, including for older Pennsylvanians. The 1915(c) waiver includes counseling services; the CHC MCO is responsible for coordinating all services a participant needs.
Page 16:	FFS Clarification	Since Medicaid beneficiaries are excluded from CHC for the period of retroactive eligibility, it appears that the state may continue to pay fee-for-service for the period of time while the Medicaid application is in process for people who enter nursing facilities as private pay and later become Medicaid eligible. To address provider concerns, please clarify this process.	There are no proposed changes to the financial eligibility process.
Page 16:	OBRA Waiver	Participants who are enrolled in the OBRA Waiver or an HCBS waiver administered by the Office of Developmental Programs are excluded……Will all current OBRA waiver participants remain in the OBRA waiver and not be transitioned to the CHC waiver?	Current OBRA waiver participants that are eligible for CHC, will be transitioned to CHC.
Page 28	AAA	specifically refers to Area Agencies on Aging (AAAs), however in the recent draft amendment to the Aging waiver and in the CHC 1915(c) waiver application, in Appendix A-1:3 – Initial and Annual Level of Care Determination, it is stated that the determination is conducted by a non-governmental entity. Please clarify who will be conducting the assessments.	Language has been changed to indicate "an independent assessment entity."

p. 29 (d)(1)	treatment plans	add “including their service coordinator” after “any specialists’ care” to ensure that the service coordinator is consulted with when developing the treatment plans of enrollees with special health care needs. The service coordinator will also assist with following up with the enrollee.	Thank you, this is part of the CMS pre-print template.
p. 31	quality strategy	We recommend the “quality strategy” be shared with stakeholders for review prior to submission to CMS.	OLTL is working with the Office of Medical Assistance Programs to update the statewide Quality Improvement Strategy.
p. 40/41	CHC-MCO must make vital documents available to participants in “an alternative language”	The CHC-MCO must make vital documents available to participants in “an alternative language” upon request of the participant. This should also be required of the IEE on page 41. The concern is that the current IEB does not offer documents to participants in languages other than English and Spanish currently, as reported during the MLTSS Sub-MAAC meeting in May.	Thank you, CHC-MCO and IEB requirements on alternative language requests are outlined in their respective agreements.
	Alternate Language	Additionally, when a CHC-MCO or the IEE contractor is aware that an LEP participant speaks a prevalent language, the CHC-MCO/IEE must automatically send translated materials rather than just at the affirmative request of the participant. CHC-MCOs and the IEE should also document requests for materials in non-English languages.	The Department has decided to adopt the requirements of the HealchChoices program and will require CHC-MCO compliance with provisions of the Affordable Care Act relating to LEP.
Page 41	Vetting process	Please clarify the vetting and approval process for communications and materials disseminated by the IEE listed on page 41. It is imperative that DHS prepare, or at a minimum review and approve, the plan comparison chart and other pre-enrollment materials in order to ensure fairness. As previously indicated, please also address whether information regarding Medicare D-SNPs as well as LIFE organizations will be included in the pre-enrollment materials. Also the impact to a CHC member for changing plans, should be included and addressed, but appears to be absent from the list on page 41.	Thank you, the Department will review and approve documents regarding plan additional services.

Page 43	Outreach	On page 43, it states that the Department will procure contracts with local partners to provide general education and information about the CHC program for potential enrollees. In the 1915(c) waiver application in section 6. Additional Requirements I. Public Input, the document states that the Department of Human Services (DHS) will pursue a sole source contract with the AAAs to conduct outreach. Please clarify whether these are two separate outreach efforts. If they are not, we recommend that you consistently address all known efforts in both waivers to eliminate confusion.	Thank you, OLTL will ensure the language is consistent.
p. 43	local partners to conduct outreach and education	At the end of the first paragraph outlining the efforts of local partners to conduct outreach and education on CHC, we recommend that "efforts may include, but not be limited to IN PERSON MEETINGS, cold calls…" to ensure that for those most frail and home bound will be reached through this mechanism if needed.	Thank you, OLTL will ensure the inclusion of many modes of sharing information in the education and outreach effort.
p. 43	statement of work for the outreach and education plan for CHC	Indicates that the statement of work for the outreach and education plan for CHC is to make contact with 100% of future CHC enrollees, however elsewhere in the application it states 95%. We recommend that the application be consistent and cite 95% as the goal. 100% is an unrealistic expectation due to circumstances outside of the contractor('s) control.	Thank you, OLTL will ensure the language is consistent.
p. 44	independent Enrollment Entity RFP	The independent Enrollment Entity RFP has not yet been released, therefore how can the Department specify a broker? Maximus is currently the IEB broker, however IEE is the terminology used throughout the application.	This question is relative to the CMS Pre-Print requesting the name of the broker. Maximus is currently the enrollment broker. The IEB RFP will go out for bid in upcoming months.
P. 45	Auto enrollment process	Auto enrollment process – According to the hierarch for auto enrollment, "if a participant is receiving HCBS and their HCBS provider is contracted with a CHC-MCO, the participant will be enrolled in that CHC-MCO." We raise the following questions: • Which provider is being referenced here? A participant may have multiple HCBS provider so which one will be used to make this determination? • What if the provider has contracts with multiple CHC-MCOs? Which CHC-MCO will be chosen?	Thank you, the Department is clarifying this langauge to be more explicit.

p 44-45	Auto Assinged MCO	The fifth sentence of this subsection appears to say that new enrollees who do not require LTSS will not have the opportunity to choose an MCO, but rather will be immediately auto-assigned. If so, we are not sure why this population would be enrolled differently from HealthChoices, in which all new enrollees are given an opportunity to choose a plan. We recommend that the Department use the same process as HealthChoices, giving enrollees a period of time to choose a plan prior to being auto-assigned. We also note that immediately auto-assigning enrollees appears to contradict the box checked in subsection ii (at the bottom of page 45) which states that "the State must first offer the beneficiary a choice". A.IV.C.2.c.ii. (p. 45) We recommend that an additional level be added to the auto-assignment hierarchy which would consider which MCOs include the participant's primary care provider in their networks prior to the participant being placed in the pool of participants to be equally auto-assigned among the available CHC-MCOs.	For the NFI, Dual population, the CHC MCO selection process will be exactly the same as the HealthChoices enrollment process. Individuals will have the chance to select their MCO immediately after determining to be eligible for CHC. The Department has added an additional level of the auto-assignment hierarchy to consider the enrollees primary care physician.

A.IV.E.3.a, b, c (p. 50)		These subsections are inconsistent with the requirements of the new federal managed care regulations, at 42 C.F.R. §438.400 et seq. The regulations, at 42 C.F.R. §438.402, require MCOs to have an appeal system in place, with no more than one level of appeal, and require enrollees to exhaust that appeal before requesting a state fair hearing. The election in this subsection not to require exhaustion of the MCO grievance and appeal process before a request for a state fair hearing does not comport with these regulations. In subsection b, the definition of "grievance" is contrary to that at 42 C.F.R. §438.400(b), which provides that grievances are limited to "an expression of dissatisfaction about any matter other than an adverse benefit determination." Contrary to the draft waiver's 45 time limit for filing a "grievance" (which it appears should be called an "appeal" since it concerns an adverse benefit determination), the regulations provide that enrollees must be given 60 calendar days from the date of the adverse benefit determination to file an appeal, and that enrollees may file a grievance at any time. This subsection also provides 45 days to file a "complaint", a term which does not appear in the federal regulations. As "complaint" is defined in the draft waiver, it includes appeals of certain adverse benefit determinations, which should be the subject of "appeals" under the federal regulations.	The Department has made changes to the agreement and the 1915(b) waiver to comply with the federal managed care rule.
p. 50	grievance	We recommend that the state's timeframe within which an enrollee must provide a grievance should be the maximum allowed: 90 days. We recommend the same 90 days to file a complaint.	The timeframes outlined in the waiver applications will be consistent with the managed care final rule.

Page 50	Complaint/Grievance	lists a process for participants wishing to file a complaint, grievance or request for a fair hearing. This process allows for assistance from a participant's service coordinator in completing documentation and facilitating resolution. Please explain what actions are in the scope of this facilitation of dispute resolution. We further request to expand the process to allow providers to file complaints, grievances and requests for fair hearings, on behalf of enrollees, upon request, and with their consent. In addition, providers should also have the opportunity to utilize complaint and grievance systems for provider-specific issues. Many providers will be new to managed care and will need assistance from the state in making the transition. We recommend that the DHS Office of Long-Term Living (OLTL) establish a provider hotline, as well as a participant hotline to assist providers in reporting on, and dealing with significant CHC-specific issues that have not been able to be resolved with a CHC-MCO. Other state MLTSS implementations use these state hotlines to identify and expedite chronic credentialing delays and claims payment issues, for example.	OLTL will continue to operate both participant and Provider help lines. Information on allowance of providers filing grievances on behalf of participants is in the CHC MCO contracts. CHC MCO contracts require provider resolution processes.
Program Description: B:	Information to Potential Enrollees & Enrollees	An important role of the IEE Contractors is to help MA beneficiaries determine whether the plan they are selecting contracts with their PCP or other providers. Will current HCBS participants be using this process to be initially enrolled in the CHC waiver? Many participants have expressed fear over losing their PCP.	Yes, an important role of the IEB Contractor is to help MA beneficiaries determine whether the plan they are selecting contracts with their PCP or other providers.

SECTION B PROGRAM MONITORING/ PAGE	TOPIC	COMMENT	RESPONSE
p. 60 – 61	self-report information	We recommend that (c) be checked indicating that consumer self-report data will be used in monitoring activities in this waiver application and to not wait for future renewals. This self-report information is critically important, especially at the beginning stages of implementation of CHC. Behavioral Health HealthChoices has an excellent process of independent organizations conducting consumer satisfaction surveys. They are called "Consumer Satisfaction Teams" and would be a benefit to the CHC program's monitoring tools.	Thank you, OLTL is collecting this type of information, and has contracted with an external entity to evaluate impact on participants and providers. We will use this information to improve CHC through implementation and ongoing.

	ombudsman	We strongly urge the Department to establish an independent ombudsman and advocacy program and involve the ombudsman in evaluating CHC-MCOs' performance. The 1915(b) waiver application (under Section B: Monitoring Plan) and Appendix H indicate that an ombudsman is not currently part of the state's monitoring plan or quality improvement strategy. CMS guidance, however, considers independent ombudsman or advocacy services an essential component of providing support for participants. (See "Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs" at 10.) Medicaid managed care regulations also require states to develop a "beneficiary support system" that will (among other responsibilities) review LTSS program data in order to provide guidance to the state on identification, remediation, and resolution of systemic issues. (See 42 C.F.R. §438.71.) An ombudsman program could fulfill that role.The ombudsman should provide free assistance to participants in navigating the MLTSS landscape and be housed in an independent organization with an established record of consumer advocacy and experience with LTSS. Through its individual case handling, the ombudsman will be able to generate data of its own and identify systemic problems, thus contributing to program oversight and monitoring. The ombudsman should be considered an equal partner with the state and CHC-MCOs in addressing systemic issues, and the ombudsman should have ready access to data and records (such as grievance and appeal records) from the state and CHC-MCOs. The [illegible]	States have until July of 0f 2018 to develop a beneficiary support plan. The Department will be engaging stakeholder to develop this plan.

SECTION C MONITORING RESULTS/PAGE	TOPIC	COMMENT	RESPONSE
		We urge the Department to consider carefully whether the existing standards are adequate to ensure quality care in the context of MLTSS, where the key goals are not just clinical quality of care, but also non-clinical outcomes, such as quality of life.• Because HEDIS and CAHPS are outcome measures developed within the framework of traditional managed care, they are not sufficiently tailored to the needs of participants receiving LTSS. Measures of outcome and quality in MLTSS should promote a holistic view of well-being and reflect the values of the social model of care (for example, participant control and integration within the community). The Department must not over-rely on HEDIS and CAHPS data to evaluate the performance of CHC-MCOs, and it must use additional data as necessary. • OLTL must not only conduct paper reviews of provider policies, but must also conduct site visits to a statistically valid random sample of providers (such as nursing facilities) to review quality of care provided.• OLTL must evaluate the timeliness and attendance of personal care attendants (see for example the real-time electronic visit verification utilized by Tennessee).• The Department must consider the quality of person-centered care planning in its evaluation of CHC-MCO performance.Performance evaluation must also include measures to gauge LTSS rebalancing, yet many of these measures are missing from the Department's current plans. Because serving more participants in the community is cited as a primary objective of CHC, CHC-MCOs should be held accountable for reporting measures intended to capture rebalancing progress. To that end, the Department should adopt these four performance metrics:1. The number and percentage of participants receiving LTSS in the community, along with the number and percentage of participants receiving LTSS in institutions. (These numbers should also be measured just prior to CHC implementation in order to establish a baseline.) 2. Total HCBS vs. institutional expenditures as a percentage of total LTSS expenditures. (A report on overall LTSS spending will track whether CHC results in a shift to increased spending on HCBS services and a decrease in institutional spending.) 3. Number and percentage of participants who transitioned to the community from an institution and did not return to the institution within a year. (Transitions to HCBS are only successful if participants have the supports they need to avoid re-institutionalization.)4. The percentage of participants who experienced a decrease in the authorization of personal care hours, along with the percentage of participants who experienced an increase in the authorization of personal care hours. (This measure is especially important because a key concern regarding CHC-MCOs is their discretion to cut or terminate services.) How often will performance measure reports be issued by Core Teams? Under federal regulations, states must review at least annually the impact and effectiveness of the quality assessment and performance improvement program of each MCO, including each MCO's results on performance measures, outcomes on performance improvement projects, and results of any efforts by MCOs to support community integration for participants needing LTSS. See 42 C.F.R. §438.330. Data from performance measures must be shared publicly with stakeholders. The data must be presented both on a CHC-MCO and statewide basis so that stakeholders can identify whether trends are specific to certain CHC-MCOs or systemic. We recommend that reports of performance measures sufficiently analyze and correlate data so that stakeholders can draw meaningful conclusions about the quality of a CHC-MCO and the CHC program in general. The Department must also incorporate performance measures into overall ratings for CHC-MCOs that will allow participants to make informed enrollment decisions. The waiver application seems to indicate that OLTL's Core Teams will monitor CHC-MCOs' compliance with waiver standards on a biennial basis, but CHC-MCOs should be monitored on at least an annual basis. Moreover, the Department should provide more details on: 1) the appeals process that CHC-MCOs will have access to if they are found to be non-compliant with program requirements; and 2) sanctions that the Department will impose on non-compliant/poorly performing CHC-MCOs. It is critical that the state impose a full array of intermediate sanctions on CHC-MCOs that violate program requirements. These sanctions must include, at a minimum: civil money penalties, appointment of temporary management, granting participants the right to terminate enrollment without cause, and suspension of new enrollments and suspension of payments.	The information provided in the 1915(b) waiver application is intentionally brief to provide CMS with a high level overview of the CHC Quality Strategy. DHS will present a comprehensive Statewide Quality Strategy for public comment in late April or early May 2017. The Statewide Quality Strategy contains some of the elements suggested by the commenter, and OLTL will consider additional elements proposed by the commenter as the Statewide Strategy is finalized.

ATTACH A-1 FRAUD AND ABUSE PLAN/PAGE	TOPIC	COMMENT	RESPONSE
Section B	Fraud Detection	Solutions are available to detect fraud, waste, and abuse through both individual transactions anomalies as well as trends, patterns, and clusters that may indicate suspicious activities. These systems generate fraud risk scores for every program participant (business and individual). In other states, the results of embracing these solutions have proven worthwhile. This waiver should include fraud detection as a solution. Additionally, electronic visit verification solutions should be incorporated into home and community-based waivers such as this. These solutions are automated monitoring systems that provide real-time data that allows for monitoring and verification of the providers delivering services under the waiver. States that have done so, such as South Carolina, easily recouped their investment in this solution as they generated 10% savings initially and are currently generating 6%-7% savings annually. Not only does this type of solution ensure quality of care, it allows for workforce evaluation – both at the provider level and the state level. The state would have the capacity to run a number of reports using the data, including workforce turnover and retention rates and how many people work for multiple agencies. This type of solution is built for states, tuned for managed care organizations and providers, and is focused on the transparent administration and delivery of healthcare services to clients. It is saving money and delivering program integrity in several states where it has already been deployed, such as South Carolina, Oklahoma, Kansas and at the Federal level. This waiver should include electronic visit verification solutions.	Thank you, the Department is considering solutions for fraud, waste, and abuse detection. In addition, each selected CHC MCO will be required to submit a fraud, waste, and abuse plan to the department, many of which are expected to include the use of EVV.

ATTACH B-1 DETAILS OF MONITORING ACTIVITIES/PAGE	TOPIC	COMMENT	RESPONSE
Page 70		We appreciate that DHS has shared a high-level description of the readiness review for CHC-MCOs on page 70. Based on the Managed Long Term Services and Supports (MLTSS) start-up experiences of our colleagues in other states, we strongly urge DHS to require a "dry run" of each CHC-MCO's claims processes and payment systems to determine whether they are ready to process claims and make payments to each LTSS provider type. It is critical that claims be paid accurately and on time, even at the beginning of the CHC-MCO operations, so that providers do not experience cash flow issues due to CHC. We would be pleased to assist by recruiting providers to volunteer for testing CHC MCO claims submission process and claims payment systems. We strongly urge DHS to recognize that CHC is not ready to proceed until all of the CHC-MCOs in the roll-out can demonstrate that they can process claims and make accurate, timely payments, and refrain from implementation in advance of a successful dry run. In that regard, we also ask DHS to include as well as enforce contractual provisions with material penalties that have a meaningful financial and contractual impact for MCO contractors. Contract penalties should be designed to motivate MCO contractors to proactively meet contract provisions and minimize a circumstance whereby the contractor has budgeted for the penalties associated with non-compliance, resulting in unacceptable losses and financial instability for providers. Additionally, we recommend that DHS require CHC-MCOs to adopt a common code set for claims and billing and a consistent methodology or set of requirements for submitting bills. This would reduce the complexity of the program. This would also facilitate program measurement.	When developing the payment dry run, the Department will will engage MCOs and providers in the process. CHC will be consistent with HealthChoices, billing and claims coding is left to MCOs.

SECTION D COST EFFECTIVENESS	TOPIC	COMMENT	RESPONSE
		Not Available for Comment at this time It is imperative that Section D – Cost Effectiveness be available for public comment prior to implementation of CHC. The public should have an opportunity to comment on the rates. We recognize that one of the goals of the CHC Program is enhance quality and accountability. We believe that providers of care are one of the most important (secondary only to the participant) elements in successful quality of care. As such, we believe that DHS has an obligation to institute mechanisms to ensure established LTSS providers and the participants they have established supportive and critical relationships with are not adversely impacted by the shift to CHC. To assure a seamless implementation, we have requested and again requests and recommends that DHS set and maintain threshold minimum rates for CHC-MCOs to pay providers that are at least the current MA fee-for-service rate. This will safeguard that providers are able to continue relationships with their current participants, preserving continuity of care. It will further facilitate negotiations with Managed Care entities, preserving the current network of providers in so far as they meet all requirements for those provider types as required by DHS and MCOs, and MCOs do not limit the amount of providers they are willing to sustain in their network, or require or promote exclusivity agreements.	The cost effectiveness data was not available at the time of public comment; however it would not have provided specific information on the capitation rates that will be paid to the MCOs. Section D contains projections of 1915(b) waiver expenditures in future years and establishes upper limits on the amount the Commonwealth is able to spend during the CHC waiver projection years. The actual capitation rates that DHS will pay to the CHC MCOs will be finalized during rate negotiations with the MCOs. The Department will consider the suggestion to set and maintain threshold minimum rates for CHC-MCOs to pay providers that are at least the current MA fee-for-service rate.