Community HealthChoices

Managed Long-Term Services & Supports

TOPIC	COMMENT	RESPONSE
Main Module, 4-C Geographic Limitation	The Aging Waiver expires June 20, 2018 however CHC will not be implemented in the Lehigh/Capital, North East and North West Zones until January 1, 2019. What will be the authority to continue the Aging Waiver in those zones during that interim timeframe?	OLTL will be submitting an amendment to CMS in early 2017 to request a waiver of statewideness in order to continue the Aging, as well as Attendant Care and Independence waivers, in the non-mamaged care counties. OLTL will work with CMS to ensure continuity for all participants during this period.
Main module, 6-I Public Input	The document addresses a Sole Source agreement with P4A to execute a plan to make contact with 95% of future CHC enrollees. Will this plan included contact with residents currently residing in nursing facilities, personal care homes and assisted living residences? It will be important as the program is implemented for these providers- especially nursing facilities- to have the support of entities such as P4A to ensure that all MA residents have a clear understanding of the program, the process and the need to select a CHC-MCO plan that will meet their needs.	OLTL Agrees and will be working with stakeholders to identify a process to ensure nursing facility residents have a clear understanding of the program.
Main Module, Attachment #1, Transition Plan	Request Information; Attachment 1 – Transition Plan – 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?	This statement should reference participant's Priary Care Physician(PCP) rather than HCBS provider, as individuals who are currently receving HCBS are subject to the 180 day continuity of care period.

Main Module, Attachment #1, Transition Plan	The Transition Plan outlined in this section discusses the ability of CHC participants to keep their current individual service plan, services, and providers for the first 180 days of CHC coverage. PHA stresses the importance that this continuity of care period apply to all MA provider types equally, both institutional and home and community-based. CHC-MCOs should not be permitted to unilaterally extend the continuity of care period for certain provider types, such as nursing homes, to the exclusion of others. PHA once again urges DHS to extend the continuity of care period to the first 12 months of CHC implementation to ensure providers and MCOs can negotiate fair contracts and to protect current waiver participants from losing access to the providers with whom they have built meaningful, important relationships. The CHC program description in this section seems to contain an error regarding the covered population and the availability of the LIFE program. It is PHA's understanding that current LIFE program participants would be excluded from CHC and that LIFE would remain an option for dual eligibles to receive care. This is likely an oversight in the application document. PHA would like to reiterate its support of the LIFE program as an option for older adults to receive care in their homes as they age. It should remain carved out of the CHC program.	The proposed 180 day (six month) continuity of care period exceeds the 60-day period required in state statute. The Department Believes the 180-day time period provides a suffient period of time for providers and CHC-MCOs to negotiate contracts and provides protections to current waiver participants.
Main Module, Attachment #1, Transition Plan	The transition plan notes that the IEE will be available to participants for telephonic or face-to-face choice counseling to choose the best plan for their needs. It is assumed that this service will be made available for residents currently residing in nursing facilities- is this a correct assumption? It will be important for the IEE to coordinate this service with the appropriate staff at the nursing facility so all the residents that can benefit from the service have the opportunity to utilize it.	Yes, the IEE will be responsible for enrollment and choice counseling of all CHC participants.
Main Module, Attachment #1, Transition Plan	The transition process does not reflect that the IEE will make outgoing calls to individuals in the Southwest zone after they receive the enrollment information packet if the individual does not contact the IEE to make a choice of MCO. Will this happen? This would be a highly effective means of outreach and is especially important given that the rate of response to the written materials is likely to be low.	Education, outreach and participant communication efforts include help reaching participants by many community partners, the IEE, APPRISE Counselors, AAAs, to ensure plan selections are made by the maximum number of participants.

Main Module, Attachment #1, Transition Plan	Individuals transitioning from the CommCare waiver should be included among those who will have 180 day continuity of care protections.	All participants transitioning to CHC regardless of the waiver from which they are transitioning, are subject to the 180 day care period.
Main Module, Attachment #2, HCBS Settings Transition Plan	Attachment 2 states that individuals living in Domiciliary Care homes will be prohibited from receiving LTSS services by CHC-MCOs. Our understanding is that this would force Dom Care recipients to relocate, most likely to Nursing Homes or similar residential facilities. We would like assurance that older adult Dom Care recipients who are receiving LTSS are taken into consideration in this decision, as we strongly believe that these individuals should be allowed to age in place with the support of LTSS.	DomCare settings that comply with the HCBS Allowable Settings Rule will be allowable settings in which CHC-MCOs can provide LTSS.
Main Module, Attachment #2, HCBS Settings Transition Plan	As the Department moves forward with the transition plan and the assessment of settings in which HCBS services can be provided – it will be imperative that the Department develop a plan to ensure assisted living residences are an acceptable service setting under the CHC waiver. The regulatory provisions ALRs are subject to include requirements that would meet the HCBS setting provisions – the areas of uncertainty are around the physical location of the licensed ALR and the special care units. PHCA is happy to offer our assistance and the assistance of our members to accomplish the inclusion of ALRs in CHC. It is our belief that ALRs will be an important component to the success of meeting the goals of CHCs.	The Deparment has included ALRs as an allowable setting in which CHC-MCOs can provide LTSS. All settings must be in compliance with 42 CFR § 441.301(c)(4) and (5).
Main Module, Attachment #2: HCBS Settings Transition Plan	If the HCBS setting is a licensed setting it is recommended that QMET coordinate this activity with the licensing Bureau. This will improve efficiency of the activity and be less disruptive to the licensed entity.	We agree, have been working with the Department of Aging as well as the Office of Developmental Programs to coordinate these efforts.

Main Module, Attachment #2: HCBS Settings Transition Plan	In the document it states: "NFCE Participants who are residing in Personal Care Homes or Domiciliary Care Homes as of the Start Date will be permitted to remain in those settings while in CHC. Services must be provided in accordance with 42 CFR § 441.301(c)(4) and (5), which outlines allowable settings for home and community-based waiver services." These sentences appear to be in conflict and are somewhat confusing. We are seeking clarification on what exactly this means. For example, if a consumer is in a PCH in SW zone and on January 1, 2017 they are NFCE – can they remain in the PCH and receive LTSS through CHC? Will the CHC-MCO pay for the services provided, including services provided by the PCH? If a consumer is in a PCH in SW zone and does not become NFCE until January 29, 2017,– will the consumer be required to be discharged from the PCH and go to an acceptable HCBS setting to receive services under CHCs?	If a participant who is NFCE is residing in a PCH on the date that CHC begins in their zone, they will be permitted to receive CHC waiver services in the PCH. If a participant who is not NFCE (NFI) is residing in a PCH on the date that CHC beings in their zone and subsequently becomes NFCE, they will not be permitted to receive CHC waiver services in the PCH. Participants who are or will be enrolled to receive residential habilitation services and who reside or will reside in a qualifying PCH under that service definition, will be permitted to receive CHC waiver services in those PCHs regardless of when they began to reside in the PCH. Any PCH in which a participant lives who is receiving CHC LTSS waiver services must meet the requirements of 42 CFR 44.301.
Main Module, Attachment #2, HCBS Settings Transition Plan	It is unclear what the Department's plans are regarding heightened scrutiny for settings that are not current settings for waiver services. PHCA would just like to reiterate the importance of the inclusion of ALRs in CHCs and encourages the Department to include a process for ALR heightened scrutiny in the transition plan.	The Deparment has included ALRs as an allowable setting in which CHC-MCOs can provide LTSS. All settings must be in compliance with 42 CFR § 441.301(c)(4) and (5).
Main Module, Attachment #2, HCBS Settings Transition Plan	We urge the Department ensure that the HCBS Final Rule is embedded in MCOs' contracting, credentialing, and monitoring processes for provider sites. The waiver should describe how the Department will do this and include relevant language from the Department's agreements with MCOs. Further, the Department must detail what types of quality mechanisms it will use to monitor MCO compliance with the HCBS Final Rule. It is imperative that the Department provide strong oversight in order to maintain providers' continuous compliance.	The HCBS Final Rule will be part of the MCO agreements. The CHC-MCOs will be required to follow policies and procedures developed by OLTL related to compliance with the HCBS Final Rule.

Main Module, Attachment #2, HCBS Settings Transition Plan	The Department should refer to Tennessee's Statewide Transition Plan, which recently gained approval from CMS. As a state that has already implemented MLTSS, Tennessee's STP assigns MCOs a role in ensuring providers are compliant with the HCBS Final Rule. However, the STP also describes the state's ongoing monitoring processes and comprehensive validation process to ensure that MCOs' policies and provider responses represent complete and accurate interpretations of the final rule requirements. For example, the STP outlines how Tennessee conducted a readiness review of MCOs for compliance with the HCBS Settings Rule. This review included both: 1) a paper review of policies, training materials, and provider agreements; and 2) an on-site visit to each MCO, during which MCOs were required to demonstrate how the MCO would ensure initial and ongoing compliance from HCBS providers. Tennessee also required MCOs to review and validate 100% of provider self-assessments, supporting documentation, and transition plans, and the state trained MCOs on Tennessee's expectations for the validation process. The state then completed a post-review of provider self-assessments and transition plans to ensure that both MCOs and providers were interpreting requirements accurately. Future validation steps will include the state comparing provider self-assessments with assessments that are completed by individual participants during their annual person-centered plan review. The state will also identify settings that may require heightened scrutiny review and conduct thorough evaluations, including an on-site visit, of each setting.	The Department has referred to Tennessee's HCBS transition plan, as well as other states that run an MLTSS program. Compliance with the HCBS Final Rule will be a part of the overall readiness review process with the CHC-MCOs. These comments will be considered as we move forward with Policy developement and readiness review for CHC.

APPENDIX A SECTION	TOPIC	COMMENT	RESPONSE
	Timeline	We continue to have major concerns with the plan to implement the proposed Community HealthChoices (CHC) program statewide with the proposed timetable. Managed care organizations (MCOs) have little understanding of LTSS, the needs of LTSS consumers, and the LTSS provider network. MCOs are accustomed to contracting with acute health care providers and other medical services.	The Department feels it is well prepared to begin CHC roll out in January of 2016. We have engaged some of the top experts on managed LTSS in the country to assist with our program design; we have solicited significant stakeholder feedback; and, through our administration of HealthChoices and the LIFE program, we have significant experience in starting up, implementing and monitoring programs in a managed care environment. Additionally, there will be an intensive readiness review period in which all required functions of each CHC-MCO will be thoroughly reviewed and assessed prior to going live. Rolling CHC out in zones will also allow us the ability to address any challenges we encounter in one zone before we move to the next.
	Goals, and strategies	DHS should incorporate the recommendations, goals, and strategies of the Pennsylvania State Plan for Alzheimer's Disease and Related Disorders (ADRD) to the greatest extent possible in its CHC program.	Thank you, the Departments of Human Services and Aging worked closely in the development of CHC, and will take this recommendation under consideration.
A-3	Use of Contracted Entities - Home Mods Broker	We recommend that there be a choice of home modifications brokers regionally.	Based upon stakeholder feedback, the Department has decided to not move forward with the Home Modifications Broker.
A-3	Use of Contracted Entities - Home Mods Broker	We recommend that the Home Modification Broker focus on individual consumer needs and not "efficiency and effectiveness of the home adaptation service".	Based upon stakeholder feedback, the Department has decided to not move forward with the Home Modifications Broker.
A-3	Use of Contracted Entities - Home Mods Broker	An additional bullet point should be added to provide for the home modifications broker to arrange for necessary repairs and replacements to home modifications installed by the waiver program.	Based upon stakeholder feedback, the Department has decided to not move forward with the Home Modifications Broker.
A-3	Use of Contracted Entities - Outreach and Education	Outreach and Education is a very important component for the success of the program. There must be adequate time and available education for consumers and providers to support a smooth transition from FFS to CHCs. It is unclear how the Department intends to offer education on CHCs to residents in nursing facilities, personal care homes and assisted living residences. It is recommended that the Department include outreach to residents in these communities in its educational plan and efforts. We are open to supporting the Department in that endeavor.	Thank you, the commonwealth is committed to a robust stakeholder education process, that will include outreach to participants in facilities, to ensure the success of CHC, OLTL will be working with stakeholders to ensure nursing facility residents have a clear understanding of CHC.
A-3	Use of Contracted Entities - Outreach and Education	We recommend that there be an emphasis on persons with disabilities providing the outreach and education described in section 3 – "Use of Contracted Entities" We recommend that all outreach materials, including but not limited to flyers and palm cards, be made available in a variety of formats accessible to persons with disabilities. Outreach materials must also be accessible to persons who use a language other than English or to persons who have limited English proficiency.	The Commonwealth agrees that outreach and education materials are to be available in formats accessible to persons with disabilities. The contractual requirements of the CHC-MCOs and IEE are described in Appendix B-8 of the 1915(c) waiver application and applicable to all vital documents and notices that are critical to obtaining services.

A-3	Use of Contracted Entities - Outreach and Education	Please clarify what is meant in A-1:2.3, Use of Contracted Entities; Outreach and Education, by "procuring entities" and how this relates to discussion of Pennsylvania Association of Area Agencies on Aging (P4A) in the main module of the CHC 1915(c) application in section 6. Public Input.	Thank you, the two references are for the same contracts, and will be with Aging Well PA, LLC. The Language in both sections will be clarified to more accurately indicate the activities are synonymous.
A-3	Use of Contracted Entities - Outreach and Education	Will the coverage be 95% as noted in section 6 or 100% as noted on page A-1:2? 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.	The correct percentage is 95%, the clarification will be made in Appendix A.
A-3	Use of contracted entities - Outreach and Education	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.	The correct percentage is 95%, the clarification will be made in Appendix A.
A-3	Use of Contracted Entities - Outreach and Education	Please notify stakeholders (provider stakeholders being key in their role) when the procurement is posted for the entities that will educate and inform consumers and their families about CHC.	Thank you. The Department will be contracting with Aging Well PA, LLC through a sole-source agreement to perform education and outreach.
A-3	Use of Contracted Entities - Education and Outreach	This section, as well as portions of the 1915(b) waiver application, discuss the procurement of an entity that will provide education and outreach to the public on the CHC program. Can the department please elaborate on this procurement process? The projected effective date is July 1, yet there does not seem to be any procurements currently open. Will this be a sole-source procurement?	Thank you. The Department will be contracting with Aging Well PA, LLC through a sole-source agreement to perform education and outreach.
A-3	Use of Contracted Entities - Level of Care	The entity that will be performing the initial CED and annual Redeterminations must be well trained, experienced and evaluated on their knowledge and ability to conduct the assessments correctly. Ongoing training should be provided on the form and the process that will be used for these determinations.	OLTL will be working with the Independent Assessment Entity to ensure initial and ongoing training is provided to assessors.
A-3	Use of Contracted Entities - IEB	We recommend that the Independent Enrollment Entity (IEE) receive training on disability-specific issues. This should include, but is not limited to, effective communication with individuals who are deaf or hard of hearing, and effective communication with individuals who are deaf-blind. This includes the need to provide qualified ASL and/or tactile interpreters in the enrollment process. We also request that OLTL identify and provide the qualifications of the IEE	The Independent Enrollment Entity will receive training, including disability specific issues. OLTL will include training on effective communication for individuals that are deaf/ blind including ASL and tactile interpreters. Qualifications of the IEE can be found in the on-line contract that appears at www.patreasury.gov.
A-3	Use of Contracted Entities - IEB	It is our understanding that OLTL has a contract with a single Independent Enrollment Broker, not the Independent Enrollment Entity, for which an RFP has not been released.	This is correct. The question seems to address a request from the CMS pre-print, requesting who will perform enrollment services.
A-3	Use of Contracted Entities - IEB	Add "Respond to questions about how CHC enrollment and benefits will affect and inter-relate with Medicare coverage, either directly or through a 'warm hand-shake' transfer to Apprise (State Health Insurance Assistance Program)"	Thank you. OLTL will add the suggested language to the application.
A-3	Use of Contracted Entities - IEB	The Independent Enrollment Entity (IEE) should have sufficient numbers of adequately trained staff to meet the demand of consumers who need to access LTSS. They should have adequate numbers of staff that can provide in-person assistance to consumers to complete the enrollment process. They should be adequately trained on estate recovery and be able to respond to consumers questions about seta recovery.	We agree that adequate staff is crucial. Estate recovery falls within the purview of the Office of Income Maintenance.
A-3	Use of Contracted Entities - Fiscal Employer/Agent	We recommend that there be choice of Fiscal Employer/Agent (F/EA). We understand that in other states lawsuits have been filed when there is no choice of F/EA.	CMS allows for the selection of one Fiscal Employer/Agent through the competitive bid process because the Commonwealth funds the F/EA using the administrative reimbursement method. A single F/EA contract is preferred to lessen confusion for members, ensure continuity of fiscal management activities and quality oversight.

A-3	Use of Contracted Entities - External Quality Review Organization	Please provide information about who the External Quality Review Organization will be and how they will evaluate the care to participants in CHC. In addition, please make the reports they submit to DHS publicly available within 30 days of receipt.	At this point in time, an organization has not yet been procured. The RFP will be posted publicly when available. The requests for reports to be made public will be taken under consideration.
A-6	Assessment methods and Frequency	We support DHS in its active engagement in monitoring of the CHC-MCOs, but in addition to the reports provided by the CHC-MCOs, We recommend availability of a provider hotline (through OLTL) to be available when significant issues are not able to be resolved between the CHC-MCO and the provider. This hotline is an essential early opportunity for DHS to hear about and address issues that might otherwise languish and harm the program. Other state MLTSS implementations use provider hotlines to identify and expedite chronic credentialing delays and claims payment issues, for example.	OLTL agrees and will utilize hotline calls to monitor and mitigate early implementation issues.
A-6	Assessment Methods and Frequency	We request that the various monitoring reports be made available to the general public in a timely fashion and that these reports be made available in an accessible format upon request of a participant or other interested individual.	Thank you, this request will be taken into consideration.

APPENDIX B SECTION	TOPIC	COMMENT	RESPONSE
B-3-a	Unduplicated Number of participants	We request that the limitations on the number of participants be shared with stakeholders before being included in the application to CMS. This is important information indicating the number of people who will be served and can have enormous implications if the numbers represented are too low.	The Department's intent is to maintain and continue services to those individuals who qualify for the CHC waiver program, not to limit them. There are no plans to discontinue services as CHC is implemented. Historically, the Department has consistently submitted amendments to its waivers to change the unduplicated numbers throughout the life of a waiver as increased enrollments occur. The number of unduplicated participants is a projection based on enrollment trending data, which may change during a waiver's life.
B-3-a	Unduplicated Number of Participants	In regard to the limitations on participant numbers, we have a few concerns: First, the process that is being used to determine the limitations is not defined. Second, the numerical fields in the tables within this section are blank. We believe this information should be shared with stakeholders prior to being included in the CMS application. As a related concern, in the event that a cap prevents a Participant from immediately receiving Home and Community Based Services, will this Participant have the opportunity to receive OPTIONS services without 100% cost share?	Please see response above regarding this section. Regarding the OPTIONs program, this program is administered by the Pennsylvania Department of Aging to whom eligibility questions should be referred.
B-3-a	Unduplicated Number of Participants	We request that tables B-3-a and B-3-b describing the unduplicated number of participants and the maximum number of participants served at any point during the year should be populated and shared with stakeholders. In addition, we would request that DHS include breakouts by MCO's as a separate table, similar to that provided for the HealthChoices program.	Please see response above regarding this section. As this is the 1915(c) waiver, numbers are submitted only in the aggregate.
B-3-a	Unduplicated Number of Participants	This section also discusses the priorities that OLTL will use if capacity is reached in the CHC waiver, but fails to state what the capacity will be. If the goal is to move people from nursing facilities into community homes, there should be no capacity limit, at least not for those who are in or at risk of nursing facility placement. We are concerned that this section contains blanks regarding the number of participants and maximum number of participants to be served. We are concerned that the missing information may be filled in before the waiver application is submitted to CMS, but without an opportunity for stakeholder comment. We request that this missing information be shared with stakeholders promptly.	Please see response above regarding this section
B-3-a	Unduplicated Number of Participants	We request that table B-3-c describing the waiver reserve capacity should be populated and shared with stakeholders. In addition, we note that someone who is in the community awaiting services is likely to have a more acute need than someone who is in a nursing facility and so would recommend factors such as a person's situation, safety, and immediate need for services be considered for reserve capacity, in addition to their residence in a nursing facility. In addition, We would request that DHS include breakouts by MCO's as a separate table.	Please see response above regarding this section

B-3-b	Number of Individuals Served	We are concerned about the state's plan to limit the number of participants that it serves at any point in time during a waiver. Since the MCO is responsible for providing waiver services without limitation to all eligible enrollees, what is the purpose of a limit in the number of waiver participants? A limit, if reached, would prevent the MCO from serving all enrollees in need of LTSS. Is the purpose solely to limit new enrollment into CHC through the waiver if the program limit is reached? To the extent that a limit may indicate the intent to limit the number of participants enrolled in CHC who may receive HCBS at a given point in time, this is contrary to the stated design and purposes of the program and would be unacceptable. Moreover, we note that Table B-3-b (maximum number of participants) is not completed.	The Department's intent is to maintain and continue services to those individuals who qualify for the CHC waiver program, not to limit them. There are no plans to discontinue services as CHC is implemented. Historically, the Department has consistently submitted amendments to its waivers to change the unduplicated numbers throughout the life of a wiaver as increased enrollments occur. The number of unduplicted participants, and the number of participants served at any point in time, is a projection based on enrollment trending data, which my change during a waiver's life.
B-3-c	Number of Individuals Served	We do not understand why the state is reserving capacity. If the MCOs are responsible for serving all enrollees in need of HCBS, why is there a need for reserved capacity?	The Department's intent is to maintain and continue services to those individuals who qualify for the CHC waiver program, not to limit them. There are no plans to discontinue services as CHC is implemented. Historically, the Department has consistently submitted amendments to its waivers to change the unduplicated numbers throughout the life of a wiaver as increased enrollments occur. The number of unduplicted participants is a projection based on enrollment trending data, which my change during a waiver's life. However, in the event that a waiting list for LTSS is necessary, a small number of "slots" are reserved to serve these two specific sub-populations.
B-3-f	Selection of Entrants to the Waiver	There appears to be a conflict under (f). Individuals who are eligible for the waiver will be served, but in the next paragraph it indicates that if the number of enrollees exceeds capacity, priority will be given to specified situations. How can the Department say that "individuals who are eligible will be served" and in the next paragraph say but if they can't be served, this is how they will be prioritized.	The number of unduplicated participants is a projection based on enrollment trending data, which may change during a waiver's life. It is the Department's intent to continue to serve those who are enrolled in current OLTL waivers and those who qualify for LTSS services in the future. However, waiver enrollments are governed by the state budget and language is included to indicate how waiting lists would be handled if the need were to arise to put them in place.
B-3-f	Selection of Entrants to the Waiver	We do not understand the reason for a list concerning priority for enrollees to enter the waiver program. If this list is intended to govern the order in which individuals already enrolled in CHC can access HCBS, it is contrary to CHC's design, which requires that MCOs provide LTSS to all eligible members in community-integrated settings. If the list would apply only to limit new enrollment into CHC through the waiver if the program limit is reached, this should be clarified.	The number of unduplicated participants is a projection based on enrollment trending data, which may change during a waiver's life. It is the Department's intent to continue to serve those who are enrolled in current OLTL waivers and those who qualify for LTSS services in the future. However, waiver enrollments are governed by the state budget and language is included to indicate how waiting lists would be handled if the need were to arise to put them in place.
B-4	Medicaid Eligibility Groups Served in the Waiver	Current financial eligibility rules require those who have income just above the income limit to spend their money on medical care down to below the poverty level before they can get HCBS waivers. However, individuals can be placed into nursing homes easily because the nursing home provides room and board. This is contrary to the stated goals of the CHC, which is to prefer home based services over facility based services.	Thank you for your comment. Given current budget constraints, the Department is not in a position at this time to make changes such as the one you are proposing. As we continue to look for ways to eliminate institutional bias, and as finances allow in the future, we will consider the possibility of implementing spend down in the future.

B-4	Medicaid Eligibility Groups Served in the Waiver	Given that the goal of the CHC program is to keep more individuals at home as they age, DHS should take the opportunity in this waiver amendment to expand income eligibility guidelines for home and community-based services. Currently, 56% of all Pennsylvanians receiving Medicaid long-term services and supports live in nursing facilities because of tremendous disparities in financial eligibility rules for individuals who enter nursing homes as compared to those who choose home-based care. Individuals who have just one dollar more than the $2,199 special income limit cannot choose care at home. DHS should apply to CMS to reset the home and community-based service income limit to match that of nursing facilities: $8,916. DHS should also explore a more reasonable spend down method than what is currently available to people living in the community. Current rules only allow people to keep $425 a month to cover community living expenses, an amount that makes spending down and maintaining one's own home impossible. Raising the income limit to $8,916 is a first step toward resolving the broader issue of home and community- based spend down rules and will help the CHC program meet its goal of caring for more individuals at homes rather than in institutions.	Thank you for your comment. Given current budget constraints, the Department is not in a position at this time to make changes such as the one you are proposing. As we continue to look for ways to eliminate institutional bias, and as finances allow in the future, we will consider the possibility of implementing spend down in the future.
B-4	Medicaid Eligibility Groups Served in the Waiver	We continue to urge the Department to allow applicants with incomes above the special income limit to "spend down" their excess income on medical expenses in order to qualify for waiver services. We understand that the Department feels, due to budget concerns, the need to quantify the expected demand prior to implementing a spend down policy. However, we urge the Department to take a first step by allowing nursing home residents who receive Medicaid coverage under a nursing home grant but whose income exceeds the waiver income limit to access HCBS through a spend down. Far from creating budget concerns, permitting this group to spend down will save the state money, since HCBS is less expensive than nursing home care.	Thank you for your comment. Given current budget constraints, the Department is not in a position at this time to make changes such as the one you are proposing. As we continue to look for ways to eliminate institutional bias, and as finances allow in the future, we will consider the possibility of implementing spend down in the future.
B-4	Medicaid Eligibility Groups Served in the Waiver	Pennsylvania should allow spend-down for CHC home and community-based services.	Thank you for your comment. Given current budget constraints, the Department is not in a position at this time to make changes such as the one you are proposing. As we continue to look for ways to eliminate institutional bias, and as finances allow in the future, we will consider the possibility of implementing spend down in the future.
B-4	Medicaid Eligibility Groups Served in the Waiver	Pennsylvania should disregard the amount of income deducted for Medicare premiums from consumers' Social Security checks when calculating eligibility for CHC.	Per the Office of Income Maintenance, Long Term Care (LTC) eligibility starts with an individual's toatl gross monthly income, as specified in 55 Pa. Code §181.71. Determining income and resource eligibility for MA and MA LTC are multi-step processes; a level playing field or "estimate equalization" is achieved by starting a the same point of total verified and monthly earned and unearned income for all home and community-based services applicants, recipients or their representatives. Certain exclusions may reduce this total figure for eligibility purposes but predominantly, deductions are factored into the equation after income eligibility is initially established, and if and when a cost of care contribution determination becomes necessary.

B-5	Post-Eligibility Treatment of Income	The section on spousal impoverishment is very confusing. This section needs clarification and providing illustrative examples would be helpful to participants.	Thank you - we agree that this can be confusing to participants. However, the waiver application is not the place to provide the additional clarifications that are being requested. Medicaid.gov has a section on spousal impoverishment - please refer to https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/spousal-impoverishment-page.html and http://www.dhs.pa.gov/citizens/longtermcareservices/medicalassistanceandpaymentoflongtermcareservices/index.htm
B-6-a	Evaluation/ Reevaluation of Level of Care	The number and frequency of services is left blank. We are concerned that the missing information may be filled in before the waiver application is submitted to CMS, but without an opportunity for stakeholder comment. DRP requests that this missing information be shared with stakeholders promptly.	Thank you - this was an oversight, and has been corrected.
B-6-a	Evaluation/ Reevaluation of Level of Care	The boxes for "minimum number" and "frequency of services" are blank. We would recommend inserting the minimum (at least one waiver service and frequency of at least once per month or monitoring to assure health and welfare at least monthly).	Thank you - this was an oversight, and has been corrected.
B-6-b	Evaluation/ Reevaluation of Level of Care	As noted above the entity that will be conducting the level of care determinations must be well trained on the process and related policies to ensure consistency in the manner in which the determination is performed. Adequate time must be given to test the CED tool to validate and ensure the accuracy of the tool and the skill level of the assessors. It is recommended that the Department evaluate the volume of determinations that required OLTL's Medical Director to intervene – if a high percentage involved a particular physician and assessor – the Department should consider offering additional training to these entities to help reduce the number of instances and ensure their understanding of the NF level of care.	Thank you - your suggestions will be incorporated into the training and oversight of the assessment entity.
B-6-b	Evaluation/ Reevaluation of Level of Care	The third sentence in this section seems to suggest that the CHC-MCO will be conducting the annual clinical eligibility determinations and the conflict free entity that OLTL is contracting with to do so will merely "validate" the results of the information and documentation collected by the CHC-MCO without actually performing the CED Assessment in in order to make the clinical redetermination. Aside from the fact that CHC-MCOs will not have CED qualified and trained assessors on staff to do this, it would create an inherent conflict of interest by allowing the CHC-MCOs to conduct the annual CED resulting in either an NFCE or NFI outcome for individuals (members) enrolled in their own plans. We recommend this sentence be changed to read: "The selected entity will also be responsible for validating the results of the documentation collected by the CHC-MCOs, conducting the in-person CED Assessment and officially making the annual clinical eligibility redetermination." This addition of specifying an assessment visit, like those done for an initial clinical eligibility determination, would eliminate any possibility of actual or perceived conflict of interest on the part of the CHC-MCO in the process.	The Commonwealth agrees that if the CHC-MCOs were responsible for making the eligibility determinations there would be a conflict of interest. The independent Assessment Entity will both validate the documentation compiled by the CHC-MCO and make the annual level of care redetermination. In addition, OLTL will be conducting random validations of level of care redeterminations.

B-6-b	Evaluation/ Reevaluation of Level of Care	We have concerns about the role of CHC-MCOs in annual level of care redeterminations. The purpose of having the conflict-free entity conduct level of care assessments is to ensure that participants' needs are not minimized in order to reduce the MCOs' costs in meeting those needs. The same concerns exist during the redetermination process. Since the level of care determination is based on data collected in the Clinical Eligibility Tool, this data should be gathered by an independent entity with no incentive to minimize or overstate the participants' needs. If the service coordinator collects the data in the the Clinical Eligibility Tool data, how will it be validated? And what role exists for the conflict-free entity in redetermining eligibility if they do not complete the Clinical Eligibility Tool?	The Commonwealth agrees that if the CHC-MCOs were responsible for making the eligibility determinations there would be a conflict of interest. The Conflict-Free Entity will both validate the documentation compiled by the CHC-MCO and make the annual level
B-6-b	Evaluation/ Reevaluation of Level of Care	Clarification isneeded on who will actually conduct the Clinical Eligibility Determination for Aging Waiver Annual Recertifications; the AAA SCE or the sub-contracted selected entity. Currently the sub-contracted selected entity completes this function for all SCE's with the exception of the AAA SCE.	The independent Assessment Entity will both validate the documentation compiled by the CHC-MCO and make the annual level of care redetermination.
B-6-c	Evaluation/ Reevaluation of Level of Care	Please clarify whether each MCO will be able to adopt different qualifications and standards for SC's and SC Supervisors, which could suggest that qualifications and standards may vary from one MCO to another.	The qualifications that are outlined in App B-6-c are the qualifications of individuals performing Level of Care assessments, not SC's or SC Supervisors.
B-6-c	Evaluation/ Reevaluation of Level of Care	The initial evaluation assessor should be at the least a RN, since the initial evaluation should focus on the consumer's medical needs.	Thank you, the qualifications for assessors follow current civil service requirements.
B-6-f	Evaluation/ Reevaluation of Level of Care	The process identified under Initial Level of Care Evaluation/Reevaluation appears to indicate the order in which the steps to apply must occur. We recommend that DHS carefully outline how applicants will access the eligibility process from point(s) of contact through the eligibility determination and specifically needs to assure a common linkage between the principle entities (i.e. data base / application) is in place so that the process can move fluidly from start to finish. The current process is not occurring smoothly, therefore a common system of linkage to communicate between entities (CED entity, IEB, CAO) is strongly recommended.	We agree that a common linkage needs to be in place to ensure a smooth process. The process will be monitored and corrected as part of the ongoing early implementation.
B-6-f	Evaluation/ Reevaluation of Level of Care	The third bullet uses outdated language in the last sentence "…to determine institutional level of care" which is a phrase no longer used.	Institutional level of care is a common phrase used by CMS in regard to HCBS Waiver programs. The term "institution" is used to convey long term services and supports that are not delivered in a home and community-based setting.
B-6-f	Evaluation/ Reevaluation of Level of Care	The fourth bullet appears to conflict with the second bullet where in the fourth bullet it states that the IEB obtain the physician certification form and then a request for a CED will be referred to the conflict free entity. We want to ensure that the process outlined above, where an individual may approach a AAA first, the AAA does the CED and then sends it to the IEB along will still be accepted.	AAA's should not be performing levels of care or requesting physician's scripts. All participants must be referred to the IEB to begin the Medicaid eligibility process.
B-6-f	Evaluation/ Reevaluation of Level of Care	For the second bullet, we reiterate the changes on page B-7:1 relating to a home visit for redeterminations.	Thank you for your comment, this is addresssed above relating to CHC MCOs collecting information and a conflict free entity making the determination.
B-7-a	Freedom of Choice	We recommend there should be an identified limit on how long a new participant can go without a service coordinator.	The CHC-MCO must offer the Participant the choice of at least two Service Coordinators. If a Participant does not select a Service Coordinator within fourteen (14) business days of Enrollment for a comprehensive needs assessment, the CHC-MCO must make an automatic assignment of Service Coordinator. The CHC-MCO must make every effort to determine Service Coordination choice and confirm this with the Participant prior to the commencement of the CHC-MCO coverage.

B-7-a	Freedom of Choice	There is no identified limit on the number of days that a new Participant can go without Service Coordinator auto assignment. We recommend that there be a limit of no longer than 7 business days.	App B-7-a states "If a Participant does not select a Service Coordinator within fourteen (14) business days of Enrollment for a comprehensive needs assessment, the CHC-MCO must make an automatic assignment of Service Coordinator."
B-8	Access to Services by Limited English Proficient Persons	During the enrollment process, the Independent Enrollment Entity (IEE) must identify applicants who are limited English proficient, i.e. applicants whose primary language is not English and who have a limited ability to read, write, speak, or understand English. See Section 1557 Final Rule at 40; 45 C.F.R. §92.4. The waiver application currently states that the IEE will "identify applicants who speak or read a language other than English as their first language." This definition of limited English proficiency should be amended so as to track the definition in new federal regulations.	OLTLhas made revisions to the language in Appendix B-8 to reflect the new LEP provisions in both the Affordable Crae Act and the managed care final rule.
B-8	Access to Services by Limited English Proficient Persons	This section also makes no mention of who will be providing interpretation and translation services. CHC-MCOs must ensure that they use qualified interpreters, translators, and bilingual/multilingual staff. Section 1557 defines who is qualified and emphasizes that individuals providing language assistance must demonstrate proficiency in English and at least one non-English language; possess knowledge of any necessary specialized vocabulary, terminology, and phraseology; and interpret/translate effectively, accurately, and impartially. Additionally, CHC-MCOs must generally be prohibited from using participants' friends, family members, or other informal interpreters to provide language access (see Section 1557 Final Rule at 151; 45 C.F.R. §92.201(d)), and we recommend that the CHC-MCO should never use minor children under the age of 18 as interpreters.	OLTL does not believe this level of detail belongs in the waiver application, but has added language to reflect that LEP services must be provided in accordance with federal regulations.
B-8	Access to Services by Limited English Proficient Persons	The waiver application must include more information about what type of notice CHC-MCOs will give to participants about its language assistance services. Section 1557 outlines the requirements that CHC-MCOs must adhere to regarding notifying participants and the public about non-discrimination policies; the availability of language assistance and other auxiliary aids and services; contact information for responsible employees; grievance procedures; and instructions for filing a discrimination complaint with the Office of Civil Rights of the Department of Health and Human Services. See 45 C.F.R. §92.8.	OLTL does not believe this level of detail belongs in the waiver application, but has added language to reflect that LEP services must be provided in accordance with federal regulations.
B-8	Access to Services by Limited English Proficient Persons	Additionally, while federal regulations now require CHC-MCOs to include taglines about language services on all documents in at least the top 15 languages statewide, we urge the Department to require CHC-MCOs to include taglines in at least the top 15 languages in CHC-MCOs' respective service areas. Taglines should be conspicuous and placed on the first page of any documents and notices.	OLTL does not believe this level of detail belongs in the waiver application, but has added language to reflect that LEP services must be provided in accordance with federal regulations.

APPENDIX C SECTION	TOPIC	COMMENT	RESPONSE
C-1-a	Summary of Services	Inclusion of Assisted Living Services will improve the Commonwealth's ability to provide Medical Assistance Long-Term Services and Supports (LTSS) supervision in a community setting to seniors with cognitive issues, for example.	Residential Habilitation services are able to be provided in Assisted Living settings. In addition, various waiver services ca be provided in assisted living settings as described in Appendix C-2-c.
C-1-c	Delivery of Case Management Services	For service coordination entities who have staff in place now and are providing services to participants, will they be "grandfathered" in? Concerned that Service Coordination Supervisors on staff do not hold an RN degree and are not licensed SW. What are the qualifications and standards proposed by the CHC- MCO referred to in Appendix C?	OLTL is not "grandfathering" existing service coordinators. As each region of Community Health Choices is implemented, participants will have a six-month continuity of care period. This permits service coordinators to remain in place for 180 days following implementation. In addition, the language in the MCO agreement includes a provision that MCOs can propose SC qualifications that will be reviewed and approved by OLTL. This provision gives the MCOs an opportunity to propose the qualifications of current SCs in order to work with individuals that are currently in the SC field. These proposals will be reviewed and approved by OLTL.
C-1-c	Delivery of Case Management Services	Please clarify whether each MCO will be able to adopt different qualifications and standards for SC's and SC Supervisors, which could suggest that qualifications and standards may vary from one MCO to another.	Yes, there may be various qualifications across MCO's.
C-1-c	Delivery of Case Management Services	This section states that Service Coordination will be an administrative function of the CHC. Service Coordination must be independent of the CHC. One function of Service Coordination is: "Performing a comprehensive assessment for the appropriateness of a transition from an institution…" Anyone who desires to transition to the community can and should be transitioned. This language implies otherwise and the bolded language should be added to state, "Performing a comprehensive assessment of the services needed to transition from an institution…" This is particularly concerning if the service Coordinators will not be independent of the MCO, which may have a financial incentive to discourage or deny transition services to people who have expensive nursing needs.	OLTL is required to assure for the health and welfare of participants. This includes that assuring the setting in which a person receives services is appropriate for their assessed needs. The reimbursement methodology is designed to incentivize community-based care. The monthly capitated rate paid to the CHC-MCO will not be greater for an individual receiving care in a nursing facility (NF) than for an individual meeting a NF level of care and receiving care in a community-based setting.
C-1-c	Delivery of Management Services	We are also concerned regarding the proposed service coordinator qualifications. Will existing service coordinators who do not meet the new qualifications be grandfathered in? This issue has been raised before and our concerns remain that if all service coordinators are expected to meet these new qualifications that there will be a shortage of coordinators at a time when there will be more people receiving community based supports.	OLTL is not "grandfathering" existing service coordinators. As each region of Community Health Choices is implemented, participants will have a six-month continuity of care period. This permits service coordinators to remain in place for 180 days following implementation. In addition, the language in the MCO agreement includes a provision that MCOs can propose SC qualifications that will be reviewed and approved by OLTL. This provision gives the MCOs an opportunity to propose the qualifications of current SCs in order to work with individuals that are currently in the SC field. These proposals will be reviewed and approved by OLTL.

C-1-c	Delivery of Case Management Services	In the paragraph which begins “Service Coordinators are also responsible to collect additional necessary information”, the language in lines 5 and 6 should be amended to require service coordinators to assist (rather than simply coordinating and prompting) the Participant, where necessary, with the completion of activities necessary to maintain waiver eligibility. This should include assisting participants with completing forms, returning them to the CAO, and locating and submitting eligibility verification documents. Suggested language: “and coordinate efforts, prompt and assist the Participant to ensure the completion of activities necessary to maintain waiver eligibility, including where necessary assisting participants with completing forms, returning them to the CAO, and assisting enrollees in locating and submitting eligibility verification documents”. This assistance has been provided by service coordinators in the current system, and is crucial to avoiding churning during renewals among participants who are unable to complete the process on their own due to cognitive or physical functional limitations.	Assisting participants successfully complete the financial eligibility redetermination process with their local CAOs is an expectation of the CHC-MCOs. The CHC-MCO's Service Coordinators may be involved, but the MCO is the accountability entity.
C-1-c	Delivery of Case Management Services	Service Coordinator and Service Coordinator supervisor qualifications: We appreciate the Department’s effort to ensure that persons currently employed as service coordinators and service coordinator supervisors have the opportunity to continue to work in these positions even if they lack the academic credentials which will otherwise be required. The language in the draft should be clarified, however. It states that the exception will apply to service coordinators or supervisors hired prior to the CHC zone effective date, but it does not say by whom they must have been hired. In other words, does the exception include only service coordinators hired by an MCO (or by a service coordination agency contracted with an MCO) prior to the CHC zone effective date or does it include service coordinators who had been hired by any service coordination agency prior to that date? If the former is intended, it would exclude long-time service coordinators who happened to be hired by an MCO after the effective date (perhaps because the MCO continued to grow its network in the initial months after the CHC roll-out). It would also allow MCOs to hire staff prior to the roll-out date without the requisite academic credentials even if they had not previously worked in these positions, which we assume is not the Department’s intent. We would encourage the Department to provide this exception to all service coordinators working in their positions prior to the roll-out, regardless of when they are hired by an MCO or a contracted service coordination agency.	OLTL is not "grandfathering" existing service coordinators. As each region of Community Health Choices is implemented, participants will have a six-month continuity of care period. This permits service coordinators to remain in place for 180 days following implementation. In addition, the language in the MCO agreement includes a provision that MCOs can propose SC qualifications that will be reviewed and approved by OLTL. This provision gives the MCOs an opportunity to propose the qualifications of current SCs in order to work with individuals that are currently in the SC field. These proposals will be reviewed and approved by OLTL.
C-1-c	Delivery of Case Management Services	The second to last full paragraph, which begins “Every Participant who has a PCSP or care plan” references “care plans”, but there is no explanation of how a care plan differs from a PCSP or in what circumstances a care plan is created. It appears that this may refer to care coordination provided to non-NFCE participants who have unmet needs or a need for service coordination, but it is not explained and should be clarified.	Thank you for your comment. "care pans" does refer to care coordination provided to non-NFCE participants. This term has been removed from this section of the waiver application.
C-2-a	Criminal History Background Investigations	This Appendix explains the option currently available to participants under the participant-directed model to choose to employ individuals with a criminal history. This option continues to undermine the efforts of the department, the legislature and healthcare providers throughout the continuum of long-term care to protect older adults and individuals with disabilities from the risk of abuse, neglect and exploitation that comes from hiring individuals with past convictions. Our members have always supported the right of consumers to choose the participant-directed employment model, but this disparity puts everyone at risk. In addition, it creates the potential for a great waste of government funds as the F/EA continues to pay the cost of criminal history checks that will only be ignored. We urge the department to remove the option for participant employers to waive this protection and choose to hire an employee with dangerous past convictions.	Thank you for your comment. The commonwealth feels honoring all aspects of participant centered service planning is important in CHC. Completion of the criminal history background clearance allows the participant to make an informed choice on hiring a worker with a criminal record.
C-2-a	Criminal History Background Investigations	We are pleased to see that individuals choosing to self-direct services have the right to employ a worker regardless of the outcome of the background check. Individuals will be able to make informed choices about their care providers.	Thank you for your comment. Participant choice and person centered planning is a key component of CHC.

C-2-b	Abuse Registry Screening	In those situations in which an agency or waiver participant does obtain certification from the child abuse registry that indicates that the direct care worker is listed as a perpetrator on the child abuse registry, the following applies: 23 PA C.S. Chapter 63, the Child Protective Services Law ("the CPSL"), bars employment of such individuals only for five (5) years after a Founded report of child abuse. It does not bar employment of any individuals with Indicated reports of child abuse, nor are there any other statutory or regulatory prohibitions on hiring such individuals. The Department of Health previously had a regulation forbidding home health agencies from hiring any individuals with reports on the child abuse registry. However, the Department has recently determined that that regulation is unenforceable in light of the Commonwealth Court's decision in Peake v. Commonwealth, No. 216 M.D. 2015 (Pa. Cmwlth. Ct.) (Dec. 30, 2015). Agencies should make individualized assessments about an individual's qualifications for employment based on a balancing of factors that include the age of the child abuse record, the circumstances of the record, and the life and employment experiences of the individual since the record. This section should be amended to comport with these legal requirements.	There is no reference to the employability of an individual who has been named as a perpetrator, only that the clearances must be conducted. The employer, administrator, supervisor or other person responsible for employment decisions should make individualized decisions about an individual's qualifications for employment, and must have policies and procedures in place that document how those decisions are made.
C-2-e	Payment for waiver services furnished by relatives/legal guardians	Spouses should be permitted to be paid caregivers in the CHC waiver	Thank you for your comment; while the Department is committed to expanding participant-direction, we will not be making that change at this time.
C-2-e	Payment for waiver services furnished by relatives/legal guardians	Pennsylvania needs a Waiver Amendment that includes a "Risk Mitigation Policy" for Participant Directed Services (PDS). This policy needs to include protections of support workers, the individual, families, natural supports and the Common Law Employers (CLEs) for Correction Action Plans (CAP). Family members and surrogates become Common Law Employers (CLEs) who are entitled to protections under 1915 (c) and (i) waivers. The State of Pennsylvania is allowing PDS service to occur across all waivers even though the state, counties, support coordination units, or provider agencies, do not provide any orientation or training of what they can and cannot do that would be considered criminal and interpreted as Medicaid Fraud.	The F/EA is responsible for providing orientation and training to participants prior to employing their direct care worker. In addition, participants choosing to self-direct their services receive assistance and support from their Service Coordinators and, when requested, a Support Broker. Please see Appendix E-1-j for additional information.
C-2-e	Payment for Waiver Services Furnished by Relatives/Legal Guardians	This section states that payment will not be made to legal guardians, rep payees or POA's. We find clients' parents are frequently pressured into obtaining guardianship of their adult children, sometimes by case- workers and Supports Coordinators. And sometimes there is no one else willing to serve as a rep payee. Relatives should not be penalized for taking on these responsibilities. As long as relatives and legal guardians comply with the requirements and standards there is no reason why they should not be able to provide services.	OLTL sees payment for waiver services provided by a legal entity as a potential conflict of interest.
C-2-f	Open Enrollment of Providers	The standard outlined in this section on the number of providers that an MCO must contract with is too vague. Additional language or guidance must be given other than "MCOs are required to contract with a sufficient number of providers". The term "sufficient number" must be defined to provide examples of how this standard will be determined.	OLTL agrees; network adequacy is very important. A comprehensive readiness review of the managed care organizations will ensure network adequacy.
C-5	Home and Community Based Settings	Appendix C-5 indicates that the required information regarding larger facilities subject to §1616(e) of the Social Security Act is contained in Appendix C-5, which does not appear to be among the 1915(c) waiver application postings on DHS' website. We request that Appendix C-5 be available to stakeholders for public comment.	CMS has directed states to include information from this section into the Settings Transition Plan which can be found in Attachment #2 of the main module.
C-5	Home and Community Based Settings	• What if the provider has contracts with multiple CHC-MCOs? Which CHC-MCO will be chosen? p. 15 Request Information; Attachment 1 – individuals living in Domiciliary Care homes would be prohibited from receiving LTSS services by CHC-MCO. This is concerning as it would require the individual to move their living in such homes. We recommend that individuals living in Dom care homes receive LTSS services through a CHC-MCO.	Participants have freedom of choice over the MCO that they choose. The question regarding Dom Care Homes: revisions have been made to ensure individuals residing in Dom Care Homes may receive LTSS services through CHC.
	Service Coordination	How much will the service coordinators be expected to do in the enhancing employment opportunities process. Many of them have tremendously heavy case loads as it stands and I hope PA is ready to provide the SC's with the necessary support and funding to make the employment enhancement a true possibility.	Thank you, as service coordination is an administrative function under CHC, fulfillment of the stated requirements will be the responsibility of the CHC-MCOs

APPENDIX C SERVICE DEFINITIONS	SERVICE NAME/TOPIC	COMMENT	RESPONSE
Appendix C-3	Service Support Professional for the Deaf/Blind	Include a service definition into the Appendix C participant services document to include services of an SSP for deaf/blind participants.	The CHC-MCOs are required to support individuals who are deaf-blind in their communication needs while accessing physical health services. In addition, CMS will not approve a service in the waiver that is targeted for a specific population or disability. OLTL is working with OVR and the Bureaus of Deaf and Hard of Hearing and Blind and Visual Services to find an alternative way of providing this service to the deaf-blind community.
Appendix C-3	Service Support Professional for the Deaf/Blind	Deaf/Blind Support Service Providers (SSP) must meet the following criteria: • completed a recognized training program that includes diverse communication methods that may be employed to communicate with people who are deaf-blind; • trained in human guide techniques; • met all required clearances; • have completed/possess other training/certification necessary to meet the needs of the deaf/blind person who is being supported.	The CHC-MCOs are required to support individuals who are deaf-blind in their communication needs while accessing physical health services. In addition, CMS will not approve a service in the waiver that is targeted for a specific population or disability. OLTL is working with OVR and the Bureaus of Deaf and Hard of Hearing and Blind and Visual Services to find an alternative way of providing this service to the deaf-blind community.
Appendix C-3	Vehicle Modifications	This service does not include, but requires, an independent evaluation. Depending on the type of modification, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist; a speech, hearing and language therapist; or physical therapist meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Such assessments may be covered through another waiver service or the State Plan, as appropriate. An independent evaluation may also be conducted by a Certified Mobility Consultant. In these instances, the cost of the evaluation must be broken out and documented in the request that is submitted to OLTL.	Thank you. In CHC, requests for Vehicle Modifications will not be forwarded to OLTL for review and approval. The CHC-MCO will be responsible for procuring this evaluation as part of the monthly capitation fee.
Appendix C-3	Self-Direction	In alignment with other waivers, add an option to self-direct the following services: Community Integration, Non-Medical Transportation, and Job Coaching. These (or equivalent) services are currently available in both traditional agency models and self-direction in the Consolidated and Person/Family Driven Services (P/FDS) waivers.	Thank you. The Department will consider this recommendation for future amendments, but will not be making this change at this time.
Appendix C-3	Self-Direction Supports Broker	Include Supports Broker services as an optional service so that people who need additional assistance to self-direct have that support available. Ensure the availability of meaningful "information and assistance" in-line with the CMS guidance on Participant Directed Services (PDS). In a 2014 survey, Attendant Care and Aging Waiver participants were asked, "If you use Consumer-Employer model or you would like to use it, do you feel like you need more help with your responsibilities as a Consumer-Employer (for example, completing payroll paperwork, finding staff or scheduling staff)." 49% of respondents said "Yes." To provide robust PDS options including both employer and budget authority that all Long Term Services and Supports (LTSS) participants could access, Pennsylvania must build capacity to provide the appropriate "counseling" via Supports Brokers or a similar role outside of general case management.	OLTL will not be creating a discrete service definition for Support Broker services in the waiver. These supports are however, being included in the F/EA procurement.

Appendix C-3	Personal Assistance Services	We suggest a change to the current language, “Services to accompany the Participant into the community for purposes related to personal care, such as shopping in a grocery store, picking up medications and providing assistance with any of the activities noted above to enable the completion of those tasks.” We suggest that the following language be added at the end of the previous quoted sentence to read, “…and to enable the Participant to work and to otherwise engage in activities in the community.” The language as currently drafted limits the purposes for which PAS can be used in the community, and is inconsistent with he stated purpose of the service to enable the Participant to "integrate more fully into the community."	Thank you, OLTL will make this revision to the service definition.
Appendix C-3	Personal Assistance Services	To increase consumer control and decrease staff shortage issues we suggest the following language change. Under the section regarding Personal Assistance Services provided by a Home Care Agency licensing requirements, we suggest the following bolded language be added: “Personal Assistance Services are provided by a Home Care Agency which must be licensed by the PA Department of Health, or by a qualified Individual Support Service Worker as defined in the current Attendant Care Waiver.”	The proposed qualifications for an Individual Support Service worker in the CHC waiver mirror the requirements that are in the approved Attendant Care Waiver.
Appendix C-3	Personal Assistance Services	We again urge the Department to include a broader array of home support services incidental to the delivery of Personal Assistance Services, including light cleaning and laundry (beyond towels from bathing), where the participant in unable to perform these tasks and has no one else to do them for him and her.	Thank you. OLTL believes that the current language in the service definition allows for these types of activities and do not anticipate adding this elaboration to the service definition at this time.
Appendix C-3	Speech and Language Therapy Services	The definition references 49PA Code CH 45, this initial part of the code only outlines the broad aspects of Speech Language Therapy and does not specify the duties related to Speech Language Therapy. Code CH 45 links to the PA Speech Practice Act - which specifically and repeatedly states that Speech Language Therapy is to address the COGNITIVE aspects of communication. It is recommended that the Department revise its’ definition of Speech and Language Therapy Services to reflect PA Practice Act.	Thank you. Upon review of the Pennsylvania Speech-Language Practice Act, OLTL does not believe that the service definition precludes addressing cognitive aspects of the service.
Appendix C-3	Physical Therapy, Occupational Therapy, Speech Therapy	In the current waiver definitions, the Provider Qualifications include “Certified by CARF as a Medical Rehabilitation Provider”. It is strongly recommended that CARF accreditation continue to be recognized as an allowed alternative, particularly since the Department has acknowledged that brain injury providers do not meet the requirements to be a Home Health Agency. It is also recommended that the Department consider developing a different “Provider Type” that would recognize the unique needs of the brain injury population which requires a comprehensive treatment model.	OLTL's current Physical Therapy, Occupational Therapy and Speech-Language Therapy service definitions do not currently provide for CARF accreditation as a Medical Rehabilitation Provider. OLTL will review this recommendation and discuss with the Office of Medical Assistance Programs and the Department of Health for the future.
Appendix C-3	Physical Therapy, Occupational Therapy, Speech Therapy	The current definition option is for Providers to be either a Home Health Agency or an Outpatient or Community Based Rehabilitation Agency. The correct reference for an Outpatient or Community Based Rehabilitation Agency is the Federal Designation 42 CFR Chapt IV Subpart H, 485.701– 485.729. This is a Federal Designation certified by DOH, but there is not a PA license that corresponds to this. Should the Part 485 Agency Type be an allowed provider type, then Providers should be allowed adequate time to secure this designation, recommend until January 1, 2019.	Thank you. OLTL has corrected the federal citation for this provider type.
Appendix C-3	Cognitive Rehabilitation Therapy Services	One of the key therapeutic disciplines with the expertise to provide CRT, Speech and Language Therapy, is not included in this definition and should be added.	Speech and Language Therapists have been added to the list of individual providers who can provide this service.
Appendix C-3	Cognitive Rehabilitation Therapy Services	There needs to be a requirement that those providing CRT to individuals with brain injury possess knowledge and expertise in that field. It is recommended that practitioners be Certified Brain Injury Specialists, a national certification requiring clinical experience and demonstration of knowledge through examination. It is recommended that the definition recognize that individuals with a Masters or Bachelors degree in an allied field, but who are not licensed, have the CBIS certification (Certified Brain Injury Specialist). It is recommended that unlicensed Certified Brain Injury Specialists providing CRT work under the supervision of a licensed Psychologist, licensed Social Worker, licensed Professional Counselor, licensed Occupational Therapist or licensed Speech Therapist.	The proposed provider qualifications are the minimum requirementsfor those providing Cognitive Rehabilitation Therapy. Providers may certainly obtain additional certification for their practitioners to meet the needs of the individuals they are serving. CHC will be serving individuals with more than brain injuries.

Appendix C-3	Cognitive Rehabilitation Therapy Services	The definition as it now stands in the CHC document does allow for the provision of service by Bachelors or Maters degreed individuals under the supervision of licensed professionals (OT, Psychology, Social Work or LPC), but limit the types of degrees allowed by specifying the only degrees accepted. Additionally, the requirements proposed for providers would not guarantee any knowledge or expertise in brain injury and does not recognize the benefit of that expertise and experience. First, it is recommended that the definition of CRT recognize that Speech Language Therapists are one of the key practitioner types listed to provide CRT directly, as the Cognitive aspects of communication are an integral part of the PA Practice Act for Speech Therapy. Additionally, it is recommended that the definition recognize that individuals with a Masters or Bachelors degree in an allied field, but who are not licensed, have the CBIS certification (Certified Brain Injury Specialist). Such individuals would provide CRT under the supervision of a licensed Psychologist, licensed Social Worker, licensed Professional Counselor, licensed Occupational Therapist or licensed Speech Therapist.	The proposed provider qualifications are the minimum requirementsfor those providing Cognitive Rehabilitation Therapy. Providers may certainly obtain certification for their practitioners to meet the needs of the individuals they are serving. CHC will be serving individuals with more than brain injuries.
Appendix C-3	Counseling	"Counseling services are provided by a licensed psychologist, licensed social worker, licensed behavior specialist, licensed professional counselor…." Recommend that the following be added to this definition of who can provide Counseling services: Individuals with a Masters degree in a related human services field but without licensure can provide Counseling services under the supervision of a licensed psychologist, licensed social worker, or licensed professional counselor.	Thank you for your comment. The provider qualifications for Counseling Services was reviewed with our colleagues at the Office of Mental Health and Substance Abuse Services (OMHSAS) to ensure there was no duplication in State Plan behavioral health services. These are the qualifications that have been recommended by OMHSAS.
Appendix C-3	Counseling	It is recommended that these individuals providing Counseling Services have the CBIS certification (Certified Brain Injury Specialist).	Thank you for your comment. The department does not see a need for this additional certification as individuals providing Counseling Services in the CHC waiver will be serving not only individuals with brain injuries.
Appendix C-3	Behavior Therapy	"Behavior Therapy services are provided by a licensed psychologist, licensed social worker, licensed behavior specialist, licensed professional counselor…." Recommend that the following be added to this definition of who can provide Behavior Therapy services: Individuals with a Masters degree in a related human services field but without licensure can provide Behavior Therapy services under the supervision of a licensed psychologist, licensed social worker, licensed behavior specialist, or licensed professional counselor.	Based upon consultation with our peers in the Office of Mental Health and Substance Abuse Services, the following language is included in this service definition: "Individuals with a master's degree in social work, psychology, education, counseling, or a related human services field who are not licensed or certified may practice under the supervision of a practitioner who is licensed."
Appendix C-3	Cognitive Rehabilitation Therapy, Counseling Services, Behavior Therapy Services:	Brain Injury providers are not able to obtain the required Home Health Agency licensure proposed, as recognized by the Department. Alternatively, a new provider type recognizing the unique requirements of providers working with individuals with brain injury could be developed. It is recommended that CARF accreditation as a Medical Rehabilitation Provider of Brain Injury Specialty Services, as well as one of the following additional program specialties, Outpatient Medical Rehabilitation, Home & Community Services, or Residential Rehabilitation Program, be recognized as an allowed Provider type for brain injury. Additionally, Home Health Agency licensure does not include CRT, counseling or behavior services in the scope of practice. As such, Home Health Agencies are not an appropriate provider type for these services.	The Department has consulted with the Department of Health regarding this concern. Under the federal regulations, these types of services are not provided in Out-Patient or Community-Based Rehabilitation Agencies. In addition, OLTL does not feel that a brain injury accreditation is appropriate since the CHC waiver will be serving individuals with more than brain injuries.
Appendix C-3	Residential Habilitation/Enhanced Staffing	"Individual considerations may be available for those individuals that require continual assistance ….to ensure their medical or behavioral stability. By the nature of their behaviors" (please add: or medical complexity)… "Residential Enhanced Staffing…is only available when participants require additional behavioral (please add: or medical) supports."	Residential Habilitation, Enhanced Staffing, is intended to provide additional behavioral support to individuals. If an individual requires additional medical support, the support should be provided by a nurse.
Appendix C-3	Residential Habilitation/Enhanced Staffing	Residential Habilitation – Provider Type/Staff Qualifications "Staff employed to provide Enhanced Residential Habilitation must also have initial training in behavioral programming and crisis prevention which must be renewed annually"; please add: "if serving individuals with behavioral needs". Please add: "If serving medically complex individuals, staff must also have initial training in medical impairment issues and the specific care needs of the individual with the medical complexities which must be renewed annually".	Residential Habilitation, Enhanced Staffing, is intended to provide additional behavioral support to individuals. If an individual requires additional medical support, the support should be provided by a nurse.

Appendix C-3	Residential Habilitation	Residential and structured day habilitation providers require “CARF Brain Injury Residential Rehabilitation Accreditation”. The language should be “CARF Community Housing accreditation or CARF Brain Injury Residential Rehabilitation accreditation”, as it is in the current OBRA waiver. Residential habilitation is not just for people with brain injury.	Thank you. We have corrected the CARF accreditation citation.
Appendix C-3	Residential Habilitation	The language as drafted states: “Long-term or continuous nursing cannot be on the same plan as residential Habilitation”. This will result in the most vulnerable consumers having no option but to enter, remain in, or be returned to, nursing facilities. These consumers not only need continuous nursing, but they need to live in a place where someone has responsibility to provide trained backup if a nurse does not show up. For consumers who do not have family to live with who are willing to take on this responsibility, they need access to residential habilitation. While currently there are some such consumers living in houses owned by a provider who owns a home health agency and has been willing to ensure continuous care, this is not a model that can easily be replicated across the state, as needed. Denying this service to individuals simply because their disabilities are more severe than others, violates the Americans with Disabilities Act	OLTL has added an exception process where the CHC-MCOs may consider an exception to the limitation on long-term or continuous nursing and Residential Habilitation Services with documentation from the Service Coordinator that supports the participant’s need to receive both services.
Appendix C-3	Residential Habilitation	The Waiver appears to allow residential habilitation services be provided in a licensed setting such as a PCH or an ALR. This seems to be in conflict with an earlier entry which stated “The CHC-MCO is prohibited from providing LTSS services for Participants who are NFCE in Personal Care Homes or Domiciliary Care Homes.” We are seeking clarification on this provision.	Personal Care Homes (PCH), Assisted Living Residences (ALR), and Dom Care settings that comply with the HCBS Allowable Settings Rule will be allowable setting in which CHC MCOs can provide LTSSS. In addition, Residential Habilitation can be provided in PCHs and ALRs. All settings must be in compliance with 42 CFR § 441.301(c)(4) and (5).
Appendix C-3	Structured Day Habilitation	“OLTL will consider enhanced staffing levels for those individuals that require continual assistance…to ensure their medical or behavioral stability. These individuals, by nature of their behaviors” (please add: or medical complexity), “are not able to participate in activities or access the community without direct staff support.”	Residential Habilitation, Enhanced Staffing, is intended to provide additional behavioral support to individuals. If an individual requires additional medical support, the support should be provided by a nurse.
Appendix C-3	Structured Day Habilitation	Structured Day – Provider Type/Staff Qualifications “Staff employed to provide Enhanced Structured Day Habilitation Services must also have initial training in behavioral programming and crisis prevention which must be renewed annually”; please add: “if serving individuals with behavioral needs”. Please add: “If serving medically complex individuals, staff must also have initial training in medical impairment issues and the specific care needs of the individual with the medical complexities which must be renewed annually”.	Language in the provider qualifications require training to meet the unique needs of participants, "which may include, but is not limited to communication, mobility and behavioral needs." The Department believes this language appropriately addresses the commentator's concerns.
Appendix C-3	Job Coaching	A few concerns I have though regarding the employment opportunities idea and the idea of job coaching and all of those services is this; is it the hope that the participant or consumer can eventually get a career to support themselves without needing services someday or is it simply a hope to get a person a part time job to integrate them into the community further? The reason I ask these questions is because I feel like it should be stated that if it is the hope that a person with a physical disability can have a career, something needs to be remembered, that on average the person with a physical disability better be able to make a minimum of $80,000 to help them cover services at an average care level.	Benefits counseling is available in CHC to allow participants seeking employment to make informed decisions about their options surrounding employment.

Appendix C-3	Job Finding, Job Coaching, Employment Skills Development, Career Assessment	All four Vocational categories require that the provider be a "Job Finding Agency"; a "Job Coaching Agency"; "Employment Skills Development Provider or Vocational Facility licensed under PA code 2390"; and a "Career Assessment Provider". All four definitions require that staff have a Certified Employment Support Professional (CESP) or a Basic Employment Services certificate from an ACRE approved training course. Neither the Agency Type not the Staff requirements is the standard of practice for individuals providing vocational services to individuals who have sustained a brain injury. In brain injury programs, therapists provide vocational services as well as staff trained in brain injury rehabilitation as represented by the CBIS (Certified Brain Injury Specialist). Under CARF's Medical Rehabilitation Program Standards, providers are accredited as a Brain Injury Specialty Program and are also accredited to provide Vocational Services. In brain injury programs, the individual is typically receiving other core services, such as residential habilitation, cognitive rehabilitation therapy or structured day services, and vocational services are part of the individual's comprehensive treatment plan, not the sole focus. The key difference in brain injury treatment programs is that services are provided as part of a holistic, integrated treatment program – clinical research supports the effectiveness of this treatment approach and it is the standard of practice for brain injury programs. It is recommended that CARF accreditation for Vocational Services be recognized as an alternative to both provider type and staff qualifications in lieu of both the CESP or Basic Employment Services certificate through ACRE. CARF accreditation is designated as the only acceptable certification for Structured Day Habilitation Agency Provider, thus establishing CARF accreditation as an acceptable Provider type. It is recommended that all providers of brain injury vocational services be accredited by CARF in Vocational Services by January 1, 2019.	OLTL will not be adding the requested CARF accreditation at this time.
Appendix C-3	Job Finding, Job Coaching, Employment Skills Development, Career Assessment	It is recommended that staff be able to provide services under the supervision of someone with ACRE certification. ACRE certification is a 40 hour course that is conducted over 12 weeks at a cost of $325/person and it appears that the course is only offered 2x/year. This is both cost and operationally prohibitive. It is recommended that providers have until January 1, 2019 to meet the requirement of having a Supervisor with ACRE certification.	OLTL has revised the certification requirements in the employment service definitions tot allow individuals seeking accreditation to achieve that certification within 18 months of employment. Individuals seeking certification must be supervised by a certified professional.
Appendix C-3	Job Finding	This section outlines that services must be provided in a manner that supports the individual communications needs. This language should be changed to reflect the requirements of the Americans with Disabilities Act. It should state "Services must be delivered in a manner that supports the participant's communication needs, including reasonable accommodations as requested and ensuring effective communication with the individual. The individual should be consulted to determine what is effective for him or her. Auxiliary Aids and Services will be provided if necessary to enable effective communication." The definition outlines requirements for quarterly document review by the service coordinator to ensure that the training objectives are being met. We suggest that language be added "or more often if needed" in cases where an individual has been receiving the service for a long time or is not progressing in skill development. Regarding the limitation on when the waiver can fund employment skills development, DRP recommends that if OVR has not made an eligibility decision within 30 days that it is a presumed denial by OVR and that individuals are eligible to start receiving employment services under the waiver. Currently people can wait several months for the OVR assessment process to occur and may lose job opportunities waiting on a decision by OVR. Setting a timeframe for OVR evaluations to occur will ensure that people are not waiting for extended periods of time before they are able to access the services they need to get or keep a job.	The Commonwealth agrees that materials are to be available in formats accessible to persons with disabilities. The contractual requirements of the CHC-MCOs and IEE are described in Appendix B-8 of the 1915(c) waiver application and are applicable to all vital documents and notices that are critical to obtaining services
Appendix C-3	Job Coaching (Intensive and Follow-Along):	The language "Coaching supports within this range should be determined " Should be changed to "within this range will be determined based on the participants needs." This change will ensure that the supports will be based on the participants needs.	The change from "should" to "will" has been made.

Appendix C-3	Job Coaching (Intensive and Follow-Along):	The exclusion that "Job coaching does not include facility-based other similar types of vocational services furnished in specialized facilities that are not a part of the general workforce." If this section intends to exclude job coaching from being provided in a sheltered workshop, it should refer to the regulations governing workshops as occurs in other parts of the waiver.	OLTL does not believe the addition of the 2390 citation is necessary, and may lead individuals to think that sheltered workshops are the only settings to which this language applies.
Appendix C-3	Job Coaching (Intensive and Follow-Along):	We are concerned about the time limitation on this service as well as the total combined hour limitation for job coaching and employment skills development of 50 hours in a week. While we recognize that there is an exception process to allow the service to be provided for more than 18 months, there is no guidance given on how DHS or its designee would grant or approve the exception. Any exception processes should be clearly outlined and available for public comment so that it is applied in the same manner to all who are requesting the exception.	OLTL does not believe the exception process belongs in the service definition. This process will be outlined in upcoming policy guidance on employment.
Appendix C-3	Job Coaching (Intensive and Follow-Along):	This particular service revision states in part, "the service coordinator will monitor on a quarterly basis to see if the employment objectives and outcomes are being met." We recommend that the method of monitoring be defined in more detail, and that the monitoring include, at a minimum, production of a written report, and a meeting with the participant and his/her SC to discuss the results.	OLTL's expectations of Service Coordinators monitoring employment outcomes will be addressed in upcoming policy guidance on employment.
Appendix C-3	Job Coaching (Intensive and Follow-Along):	We are concerned that for supported employment, as well as other employment related services under this proposed waiver revision, there is a requirement that before services can be provided, the participant must have been determined ineligible for services by OVR, or have had his/her case with OVR closed. We are concerned that this requirement will result in an unnecessary delay for participants seeking job coaching because OVR has 60 days from the date of application to make an eligibility determination and often asks for a waiver of the time period, so the process may take even longer. This could result in participants losing employment opportunities. We recommend that if OVR has not made an eligibility decision w/in 30 days that it is a presumed denial by OVR and that individuals are eligible to start receiving employment services under the waiver. Currently people can wait several months for the OVR assessment process to occur and may lose job opportunities waiting on a decision by OVR. Setting a timeframe for OVR evaluations to occur will ensure that people are not waiting for extended periods of time before they are able to access the services they need to get or keep a job.	DHS does not have jurisdiction over OVR. DHS has been working closely with OVR on employment related issues as a result of the Employment First Executive Order.
Appendix C-3	Employment Skills Development	This proposed definition includes volunteer work for individuals to gain employment skills. While we recognize that some volunteer work can lead to development of job skills, volunteering should not be the primary work experience provided to participants. We suggest that there be an hour limitation placed on the number of volunteer hours a participant can use under this service definition to ensure that people are engaging in paid work experiences.	Subject to the person centered planning process, participants preferences and goals will be considered and determine the duration of their volunteer work.
Appendix C-3	Employment Skills Development	We are also concerned that this proposed service will be provided in places that have traditionally been Sheltered workshops. We suggest that OLTL stop allowing providers to bill services in segregated settings on a named date to ensure that the state is in compliance with applicable federal rules related to home and community based services. The goal of this service is to lead to increased employability in a competitive integrated setting, so the service should be provided in integrated settings.	States have until March 17, 2019 to come into compliance with the HCBS Allowable Settings Rule.
Appendix C-3	Employment Skills Development	The definition outlines requirements for quarterly document review by the service coordinator to ensure that the training objectives are being met. We suggest that language be added "or more often if needed" in cases where an individual has been receiving the service for a long time or is not progressing in skill development.	OLTL's expectations of Service Coordinators monitoring employment outcomes will be addressed in upcoming policy guidance on employment.
Appendix C-3	Employment Skills Development	Regarding the limitation on when the waiver can fund employment skills development, we recommend that if OVR has not made an eligibility decision within 30 days that it is a presumed denial by OVR and that individuals are eligible to start receiving employment services under the waiver. Currently people can wait several months for the OVR assessment process to occur and may lose job opportunities waiting on a decision by OVR. Setting a timeframe for OVR evaluations to occur will ensure that people are not waiting for extended periods of time before they are able to access the services they need to get or keep a job.	DHS does not have jurisdiction over OVR. DHS has been working closely with OVR on employment related issues as a result of the Employment First Executive Order.

Appendix C-3	Employment Skills Development	There is a total combined hour limitation for job coaching and employment skills development of 50 hours in a week. There should be an exception process that allows an individual to receive additional hours if needed to become or stay successfully employed. The service has a proposed limitation of 24 continuous months. While we recognize that this service is meant to be temporary and lead to development employment skills, there should be an exception process based on individual need. An individual may only need a few extra months of job skill development to be successful in employment. Allowing an exception process would recognize these few cases where a person may need a limited amount of additional time on skill development.	OLTL does not believe the exception process belongs in the service definition. This process will be outlined in upcoming policy guidance on employment.
Appendix C-3	Employment Supports	DHS should consider requiring employment-related service providers to be registered as Ticket To Work (TTW) ("Employment Network") providers or participate with a TTW experienced provider. There is no harm to the waiver participant and the strategy brings new federal funds into the PA infrastructure. CMS permits a provider to bill for waiver sponsored supported employment while simultaneously enrolling the same person in the TTW.	Thank you for your comment, the department will consider your comment as we move forward with our employment strategy.
Appendix C-3	Career Assessment	We are supportive of this new service definition including transportation as a component of the service. Transportation to various worksites is a critical piece of assessing an individual's skills and abilities. This section outlines that services must be provided in a manner that supports the individual communications needs. This language should be changed to reflect the requirements of the Americans with Disabilities Act. It should state "Services must be delivered in a manner that supports the participant's communication needs, including reasonable accommodations as requested and ensuring effective communication with the individual. The individual should be consulted to determine what is effective for him or her. Auxiliary Aids and Services will be provided if necessary to enable effective communication."	The Commonwealth agrees that materials are to be available in formats accessible to persons with disabilities. The contractual requirements of the CHC-MCOs and IEE are described in Appendix B-8 of the 1915(c) waiver application and are applicable to all vital documents and notices that are critical to obtaining services.
Appendix C-3	Job Finding, Job Coaching, Employment Skills Development, Career Assessment	We are concerned about the requirement that the four Vocational Services can only be provided when the individual is not able to receive them through OVR or through and Individualized Education Program (IEP). This is seen as a significant barrier to providing service to those who clearly are not eligible to receive these services through OVR or an IEP. OVR would be required to do an Evaluation in order to close a case or deem someone ineligible for services. That will create a significant increase in the demand on OVR and will cause delays in the provision of service.	The requirement to refer individuals to OVR for employment services and supports is not a new requirement. OLTL will continue to monitor the process to ensure participants are able to access services in a timely manner.
Appendix C-3	Job Finding, Job Coaching, Employment Skills Development, Career Assessment	It is recommended that Vocational Services be authorized through the person centered planning process and that referrals would be made to OVR if appropriate. Additionally, if efforts to secure a letter of proof from OVR that a consumer is ineligible or has a closed case, is delayed or not obtainable, that this be documented in the participant record and not delay the provision of Vocational Services.	The requirement to refer individuals to OVR for employment services and supports is not a new requirement. OLTL will continue to monitor the process to ensure participants are able to access services in a timely manner.
Appendix C-3	IDD Population	As I read the proposed waiver, it would transition any individual with developmental disability and with intellectual disability to the CHC provided they have a NFCE level of care. The department should ensure through the assessment determination process that each individual is being served in the model/system of care that is best for that person	Thank you, we agree.
Appendix C-3	Home Adaptations	We suggest that an exception process be created to the limited adaptations proposed under this definition. This will ensure that individuals can remain in their homes under the CHC. Suggested language is, "Exceptions to any exclusions or conditions will be made if it is determined by the Department that a failure to approve the exception will likely lead to the initial or continued placement of a Participant in an institutional setting."	Thank you for your comment, the department will consider your comment as we move forward.

Appendix C-3	Community Integration	We suggest that a section for Life Sharing and Partner Families: Life Sharing is a residential service in which Participants live in a host life sharing home and are encouraged to become contributing members of the host life sharing unit. The host life sharing arrangement is chosen by the Participant, his or her family and team and with the life sharing host and Family Living Provider Agency in accordance with the Participant's needs. Partner Families are part- time life sharing arrangements where the Participant lives with his or her own family when not with the life sharing host. For Participants who need continuous care and services, this arrangement provides for family life without overwhelming either family.	Thank you for your comment. OLTL does not anticipate adding this service at this time.
Appendix C-3	Benefits Counseling	We are supportive of benefits counseling as an available service under the waiver. The limitation on the number of hours and frequency of the service should have an exception process that is clearly spelled out and available for public comment.	OLTL believes the amount and scope of Benefits Counseling services are adequate. We will continue to monitor data and stakeholder feedback on this topic and consider amending the limitation in the future if necessary.
Appendix C-3	Nursing Facility Services	There should be a strong number of nursing homes within each MCOs network to ensure that if this level of care is needed, a participant will be able to remain in their community. The location of a facility is often a factor of a whether a resident's family and friends can visit. And, these visits are often a factor in receiving quality care. CHC should allow for hospice and palliative care.	Thank you, network adequacy for all provider types will be monitored closely by OLTL. Hospice services are covered services under the 1915(b) waiver.
Appendix C-3	Community Transition	Community Transition Service should be open to consumer find themselves homeless as of NO result of their own	Thank you. Community Transition services can only be used when transitioning from an institutional setting. However the DHS housing plan may address issues relating to homelessness.
Appendix C-3	Respite	We note that a nursing facility is no longer listed as a location where respite care can be provided. While it is preferable to provide respite care at home when possible, we have had clients who needed and used respite care in a nursing facility where receiving services in their own homes was temporarily not an option due to an infestation or other unsafe condition or the temporary absence of an informal support whose overnight presence was needed, and we accordingly urge the Department to add nursing facilities as a location where respite care can be provided.	Medicaid-certified nursing facilities have been added as a setting where Respite Services can be provided.
Appendix C-3	Home Delivered Meals	Please be sure that individuals will not be forced to utilize home delivered meals rather than fresh fruits and vegetables.	Subject to the comprehensive participant-centered service planning process, no participant will be forced to utilize home-delivered meals.
Appendix C-3	Pest Eradication	We strongly applaud the Department for including Pest Eradication as a service under CHC. We have concerns with two portions of the description. First, where it states that the service coordinator will ensure that local health departments or other available resources can't provide pest eradication services. This provides a great burden on the service coordinator to require this.	Thank you, as service coordination is an administrative function under CHC, fulfillment of the stated requirements will be the responsibility of the CHC-MCOs
Appendix C-3	Pest Eradication	Where it indicates that the service coordinator will "ensure that pest problems do not return to the participant's residence if other adjourning properties are not taken care of…" The service coordinator is not capable of "ensuring" this.	Thank you for your comment. OLTL has revised the language in this section of the service definition.

APPENDIX D SECTION	TOPIC	COMMENT	RESPONSE
Appx D	General Comment	A general comment about this appendix. We recommend that the use of acronyms such as CHC- MCO be limited throughout the appendix. Instead, each appendix should spell out words completely to make the document more user- friendly to all, and accessible to persons with disabilities.	Acronyms are spelled out the first time they are used in each Appendix. Unfortunately, the waiver application includes character limitations that limit the length of the state's response.
Appx D	General Comment	Appendix D: 7 – Please review this section for inconsistent language usage. Our understanding is that the service coordination function can be provided either directly through the CHC-MCO or can be contracted through a service coordination agency. The CHC-MCO service coordinator is not noted here. Further the terminology throughout this section refers to the Individual Service Plan (ISP) where it may now be more appropriate to refer to the Person-Centered Service Plan (PCSP).	Thank you. We will ensure that language is consistent.
D-1-b	Service Plan Development Process	The Department should address in more detail how it will resolve conflicts or disagreements in the person-centered service plan (PCSP) development process. Although service coordinators will not be providing direct waiver services to participants, potential conflicts of interest still exist because service coordinators will be employed or contracted by CHC-MCOs. This potential conflict is a natural result of incentives built into the system and should be addressed explicitly in the waiver application.	The MCO's are required to outline the processes they will have in place to resolve conflicts or disagreements in the person-centered service planning process. During the readiness review phase of the implementation of CHC, OLTL will review and approve policies related to this subject.
D-1-c	Supporting the Participant in Service Plan Development	The information provided to individuals by the Service Coordinator must be provided in an accessible format as needed to accommodate the individual's needs. Written materials and the orientation packet must be available in large print, audio format, or any other alternative format needed by the individual. As a general rule, Participant-Centered Planning should include a requirement that easy to understand language is used in documents. This will encourage an individual participant to direct his or her own plan. We are concerned with the following language, "If the participant uses an alternative means of communication…the process utilizes the participant's primary means of communication, an interpreter or someone identified by the participant that has a close enough relationship with the participant to accurately speak on his/her behalf." Supports Coordinators and MCOs cannot rely on family members, friends, or others to provide interpreter services for individuals who are deaf, hard of hearing, or deafblind, or other individuals who do not communicate using English unless the participant specifically requests it in writing. Individuals are entitled to effective communication under the Americans with Disabilities Act. Arrangements must be made by the Service Coordinators for certified interpreters to ensure that the participant receives effective communication as required under the Americans with Disabilities Act and can participate fully in the enrollment and orientation process. Finally, we also suggest that the LTSS Provider Directories that are given to participants must be available in alternative accessible formats.	The Commonwealth agrees that outreach and education materials are to be available in formats accessible to persons with disabilities. The contractual requirements of the CHC-MCOs and IEE are described in Appendix B-8 of the 1915(c) waiver application and are applicable to all vital documents and notices that are critical to obtaining services. OLTL believes this concern is adequately addressed within the language contained in the appendix.

D-1-c	Supporting the Participant in Service Plan Development	When serving participants with limited English proficiency, CHC service coordinators must not use family members or friends – particularly minor children – to speak on behalf of the participant unless 1) the participant specifically requests an accompanying adult to interpret or facilitate communication; 2) the accompanying adult agrees to provide assistance; and 3) reliance on that adult for assistance is appropriate under the circumstances. See Section 1557 Final Rule, 45 C.F.R. §92.201. We are concerned about language in D-1-c stating that service coordinators may use "someone identified by the participant that has a close enough relationship with the participant to accurately speak on his/her behalf" during the PCSP process. The Section 1557 Final Rule stresses that "family members, friends, and especially children, are not competent to provide quality, accurate, oral interpretation. For communications of particularly sensitive information, oral interpretation by an individual's family or friend often also implicates issues of appropriateness, confidentiality, privacy, and conflict of interest."	OLTL has revised the language in this section of the application to address the commentator's concerns.
D-1-c	Supporting the Participant in Service Plan Development	While participants' orientation packets will provide, as this section says, "a basis for self-advocacy safeguards," participants will need more support to meaningfully direct the PCSP process. For example, participants and their representatives should receive training on self-advocacy, self-determination, and person-centered principles. This and any other training or counseling regarding the PCSP should be documented.	Thank you for your comment.
D-1-d	Service Plan Development Process	The Department must ensure that re-assessments of service plans are not simply opportunities for CHC-MCOs to cut services. We appreciate that the PCSP will be reviewed either annually, when a participant's needs significantly change, or when a participant specifically requests a review. This policy will ensure stability in care as well as responsiveness to the participant's needs.	The CHC-MCOs will be required to provide OLTL with weekly reports identifying changes in participants' PCSPs. These reports will be monitored by OLTL on an on-going basis.
D-1-d	Service Plan Development Process	We respectfully request that in e. How responsibilities are assigned for implementing the plan, cognitive issues should be specifically included under "Known needed physical and behavioral healthcare and services".	Thank you, the recommended language has been added to the application.
D-1-d	Service Plan Development Process	We are pleased to see that the service plan development process is directed by the participant. This will ensure that the planning is person centered. We further suggest that the locations where planning meetings are held are easily accessible and have nearby accessible modes of transportation to ensure ease of participant access.	OLTL believes this recommendation is already addressed through the following language: "The process of coordinating invitations includes the participant's input as to who to invite to the meeting(s) and at times and locations of convenience to the participant."
D-1-d	Service Plan Development Process	Reassessments: This section outlines the reassessment process when certain events occur for a participant. There should be clear guidance given on how this will be enforced to ensure the reassessment occurs. It should also be documented and reflected in the PCSP. If a participant requests a reassessment and the request is denied by a service coordinator or other individual, it must be clear that the participant has rights to appeal the denial.	If a specific service is denied, it is appealable. In the case of a participant requesting a reassessment, the SC is required to perform the reassessment no more than 14 days after it's requested. If the SC does not perform the assessment - and in a timely fashion - the participant may file a complaint either with the MCO or with OLTL . The complaint would be followed up on to ensure the reassessment is done.
D-1-d	Service Plan Development Process	We recommend that the appendix include a direction that the participant can choose his or her own team members, and can direct who receives a copy of his or her PCSP.	OLTL believes this recommendation is already addressed through the following language: "The process of coordinating invitations includes the participant's input as to who to invite to the meeting(s) and at times and locations of convenience to the participant……Every Participant must receive a copy of his/her PCSP. A copy of the signed PCSP is given to the participant as well as all members of the PCPT."

D-1-d		We recommend that when a copy of the signed PCSP is provided, the following must apply: a. The plan is provided in a format that is accessible and understandable for the participant; b. The plan must include written information concerning how to initiate an appeal process if the participant disagrees with any aspect of the plan.	The Commonwealth agrees that outreach and education materials are to be available in formats accessible to persons with disabilities. The contractual requirements of the CHC-MCOs and IEE are described in Appendix B-8 of the 1915(c) waiver application and are applicable to all vital documents and notices that are critical to obtaining services. OLTL believes this concern is adequately addressed within the language contained in the appendix D.
D-1-d	Service Plan Development Process	Participant Centered Plan Process and Plan Implementation: At Appendix D1 at page 6 it states, "The CHC Service Coordinator must obtain the signatures of the participant, participant's representative and any others involved in the planning process, indicating they participated in, approve and understand the services outlined in the PCSP and that services are adequate and appropriate to the participant's needs." It fails to state what happens if the participant does not agree. It should state that the participant need not sign until he or she is actually satisfied that the plan will meet his or her needs and will be notified of appeal rights if the Service Coordinator does not include the services requested by the participant in the service plan, or if the MCO or DHS rejects an item in the service plan. Language must also be added to ensure that it is clear that a verbal denial made by a Service Coordinator at any time, for any reason, is a denial that triggers appeal rights.	OLTL has added language to this section of the application to address this concern.
D-1-d	Service Plan Development Process	Finally, we are concerned that this section requires participants to be responsible to initiate their own back-up plans if providers do not show up. The following language should be added, "If a participant is not capable of initiating a back-up plan, a person or entity (ie: family member or residential rehabilitation provider) will be designated the responsibility to do so". We recommend the CHC-MCOs be required to have a hotline that Participants can call in the event that both the primary and back-up providers do not show up. The toll- free help line must also have accommodations available to ensure that individuals who are deaf or hard of hearing are able to access the help line. A TDD line and use of the Pennsylvania Relay service must be available.	OLTL has added language to the waiver application to address this concern.
D-1-d	Service Plan Development Process	It is important to have a process that is culturally and linguistically competent for participants. Lesbian, gay, bisexual and transgender (LGBT) individuals and people living with HIV/AIDS often feel unwelcome at health or human services organizations and more needs to be done to ensure their inclusion and access to care. Person-centered program design and service plan development should be expanded to include a process that is inclusive and sensitive to the needs of a consumer's sexual orientation (SO) and gender identity (GI). All staff, including DHS and provider staff, should be trained on how to provide culturally competent care to ensure both the consumer and staff person are comfortable talking about gender and sexual orientation.	Thank you for your suggestion. OLTL is developing a number of trainings for MCOs on a number of topics. OLTL will consider this as a topic for inclusion.
D-1-d	Service Plan Development Process	This section must also make clear that unpaid natural supports are voluntary. CHC-MCOs must not reduce paid services by assuming that qualified caregivers are available and willing to provide care. If a participant plans to rely on natural supports, PCSPs must incorporate caregivers' abilities, needs, and preferences. Minnesota, for example, uses a Caregiver Questionnaire to inform the person-centered planning process. (See Caregiver Questionnaire: DHS-6914-ENG, Minnesota Department of Human Services, available at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6914-ENG).	Identifying unpaid, natural supports is part of the Person-Centered Planning Process, as is assessing and incorporating caregivers' needs, abilities and preferences.

D-1-d	Service Plan Development Process	In coordinating waiver services and other supports, the service coordinator must be guided primarily by the participant's needs and preferences. The waiver application currently states that coordination will be "guided by the principles of preventing institutional placement and protecting the person's health, safety, and welfare in the most cost-effective manner." (See D-1-d-f.) Encouraging service coordinators to factor in the cost-effectiveness of services is highly problematic and represents the inherent conflict of interest presented by service coordinators who are employed or contracted by CHC-MCOs. We are deeply concerned that service coordinators will prioritize cost-effectiveness during development of the PCSP. Therefore, the waiver application should clarify that the service coordinator must maximize the participant's self-determination so that the participant, not the service coordinator, leads the PCSP process. This clarification is critical because a planning process that is truly driven by the participant minimizes the potential conflict described above.	OLTL believes that the language in the waiver which outlines the expectations of the CHC-MCO Service Coordinators around a person-centered service planning approach addresses these concerns.
D-1-f	Informed Choice of Providers	The LTSS Provider Directories that are given to participants must be available in accessible formats. The toll-free help line must also have accommodations available to ensure that individuals who are deaf or hard of hearing are able to access the help line. A TDD line and use of the Pennsylvania Relay service must be available. We also suggest that language be added to stress that a participant can suggest his or her own service provider.	The Commonwealth agrees that outreach and education materials are to be available in formats accessible to persons with disabilities. The contractual requirements of the CHC-MCOs and IEE are described in Appendix B-8 of the 1915(c) waiver application and are applicable to all vital documents and notices that are critical to obtaining services.
D-1-g	Process for Service Plan Approval by the Medicaid Agency	Will the Department be conducting audits of PCSPs? The waiver application is unclear regarding how OLTL will provide oversight of PCSPs to ensure that they have been properly developed. Currently, the application explains that CHC-MCOs will report monitoring results to OLTL and that OLTL may review, question, and request the revisions of any PCSP. CHC-MCOs will also provide "weekly aggregate reports on PCSP changes," which OLTL will then review. More detail is needed here about the aggregate trends and changes to person-centered plans that CHC-MCOs will be required to report.	The State will monitor CHC-MCO PCSP development and implementation to ensure that PCSPs are developed in the best interest of the participant and in a conflict free manner. CHC-MCOs are required to develop quality assurance tools and protocols that include internal safeguards for PCSP development in addition to the external monitoring by OLTL.
D-2-a	Service Plan Implementation and Monitoring	The Department must also clarify the process it will use to review PCSPs themselves, not just aggregate reports on PCSP changes. How will OLTL choose which PCSPs undergo review? What will the sample size be? What methods will OLTL employ to evaluate PCSPs? How often will OLTL complete these reviews? It is vital that OLTL conduct in-depth reviews of individual PCSPs and avoid over-reliance on CHC-MCOs' reports on PCSPs. OLTL should also complete reviews on a routine basis, use representative samples, and assess PCSPs not only in terms of how well they guarantee participants' health and safety, but also how well they facilitate participants' independence and integration in the community.	The State will monitor CHC-MCO PCSP development and implementation to ensure that PCSPs are developed in the best interest of the participant and in a conflict free manner. CHC-MCOs are required to develop quality assurance tools and protocols that include internal safeguards for PCSP development in addition to the external monitoring by OLTL.

APPENDIX E SECTION	TOPIC	COMMENT	RESPONSE
Appx E	Participant Direction of Services	We are concerned that Independence Plus designation is not being requested. If the Department is committed to providing participant direction of services, this designation would show a strong commitment to participant direction.	The Department is committed to person centeredness and participant direction, without indicating the "Independence Plus" designation.
E-1-a	Description of Participant Direction	In addition to offering Financial Management Services, DHS should include Information and Assistance in Support of Participant Direction (Supports Brokerage) as an additional benefit under CHC. Supports Brokerage is a specialized area of practice, which would be best delivered by providers that are skilled in employer support activities. Moreover, these activities fall outside of the primary responsibility / role of the service coordinator, which is "assisting Participants in obtaining the services they need" (rather than directly providing such services). Therefore, we would recommend changing Information and Assistance in Support of Participant Direction from an Administrative Activity to Waiver Service Coverage.	OLTL is including Support Brokers in the F/EA Contract. Language reflecting that decision has been included in this Appendix.
E-1-a	Description of Participant Direction	In addition to offering Financial Management Services, we recommend the DHS include Information and Assistance in Support of Participant Direction ("Supports Brokerage") as an additional benefit under CHC HealthChoices. We believe Supports Brokerage is a specialized area of practice, which would be best met by providers skilled in employer support activities. Moreover, we believe these activities fall outside of the primary responsibility of the Service Coordinator, which is "assisting Participants in obtaining the services that they need" (rather than directly providing such services). Therefore, we would recommend changing Information and Assistance in Support of Participant Direction from an Administrative Activity to Waiver Service Coverage.	OLTL is including Support Brokers in the F/EA Contract. Language reflecting that decision has been included in this Appendix.
E-1-a	Description of Participant Direction	The handbook and orientation materials must be made available in accessible formats.	The Commonwealth agrees that outreach and education materials are to be available in formats accessible to persons with disabilities. The contractual requirements of the CHC-MCOs and IEE are described in Appendix B-8 of the 1915(c) waiver application and are applicable to all vital documents and notices that are critical to obtaining services.
E-1-e	Information Furnished to Participant	The orientation materials must be provided in plain language and in alternate accessible formats as needed by the participant.	The Commonwealth agrees that outreach and education materials are to be available in formats accessible to persons with disabilities. The contractual requirements of the CHC-MCOs and IEE are described in Appendix B-8 of the 1915(c) waiver application and are applicable to all vital documents and notices that are critical to obtaining services.

E-1-f	Participant Direction by a Representative	This section notes that in some instances a representative may be appointed for a participant who is unable to direct her own care. Who makes the determination about whether a participant has capacity to direct her own care? The criteria listed to evaluate whether a participant needs a representative are subjective. We suggest that the CHC-MCO must properly evaluate a participant prior to taking away her right to direct her own services. This evaluation should be done by a doctor with experience in the area.	The determination is made by the Person-Centered Planning Team, which includes the SC, the participant, individuals of the participant's choosing, and other professional staff depending on the participant's needs.
E-1-f	Participant Direction by a Representative	The draft waiver states "the individual, a Service Coordinator, the CHC-MCO or the F/EA may request a personal representative be appointed." This language is confusing. Why would anyone other than the individual or a potential representative request the appointment of a representative? Hopefully this language means that at the request of the individual or a potential representative those entities may request a personal representative be appointed. We do not believe those entities should be given the power to unilaterally determine that a participant needs a personal representative and then request one. Lastly, who are these entities requesting to? Who makes the ultimate decision about capability of the participant or the potential representative?	OLTL has revised the language in this section of Appendix E to address this concern.
E-1-f:	Participant Direction by a Representative	The draft waiver states the Service Coordinator must determine whether the representative is acting in the participant's best interest. We urge the department to adopt specific criteria that must be used to make this "best interest" determination. It should be centered on the participant herself, and her desires, if she is able to adequately express them. Absent identifiable criteria, there is a significant risk the participant will lose a representative she has chosen for herself.	Criteria for personal representatives are outlined in the Common Law Employer Designation form. In addition, OLTL believes that if there has been a negative impact on the participant's health and welfare, and/or services have not been provided as outlined in the PCSP, the Personal Represenative is not acting in the best interest of the participant.
E-1-f:	Participant Direction by a Representative	Any decisions regarding the capacity of a participant to direct her own services or the adequacy of a personal representative should be appealable by a participant.	As noted in Appendix F-1, a participant may request a State Fair Hearing when the participant is denied the opportunity to self-direct their services.
E-1-g	Participant-Directed Services	In alignment with other waivers, add an option to self-direct the following services: Community Integration, Non-Medical Transportation, and Job Coaching. These (or equivalent) services are currently available in both traditional agency models and self-direction in the Consolidated and Person/Family Driven Services (P/FDS) waivers.	Thank you, your input will considered for a future waiver amendment.
E-1-i	Provision of Financial Management Services	In this section, we strongly urge the department to create a participant centered complaint process that a participant may utilize to file a complaint against the F/EA Contractor. The FMS are integral to ensuring a participant has necessary care. If the F/EA contractor fails at its job it could be extremely detrimental to the participant. In addition to the listed oversight plan in the waiver, we urge the department to create a complaint hotline and a system where individual complaints may be logged and monitored.	OLTL will continue to operate the participant helpline for all complaints and monitor the types of complaints received.
E-1-m	Involuntary Termination of Participant Direction	A service coordinator should not be responsible for determining whether the participant is capable of directing her own care. That decision is a medical decision and should be made a physician. We support the provision giving the participant the right to appeal involuntary termination.	OLTL believes the reasons for involuntary terminating a participant from self-direction are clearly outlined in this section, and is not a medical decision.
E-2-a-ii	Participant Employer Authority	This section should make clear that a participant has a choice to employ her own personal assistant, regardless of the assistant's criminal background. This must be made clear to the participant, as it is likely that the prospect of a criminal background check may deter a participant from proposing a certain assistant, when in fact that person may be appointed, regardless of her criminal history.	This is described in Appendix C-2-a. OLTL will continue to require criminal background checks and supports for participant' ability to make choices about the employee they choose.

E-2-b-iv	Participant Budget Authority	We oppose requiring participants to notify the F/EA prior to reallocating funds to implement changes that do not require prior approval. If prior approval is not needed, why is it necessary they inform the F/EA before they make the changes? This is cumbersome and unnecessary. The participant should be required to inform the F/EA within three days of making the change.	OLTL has incorporated this recommendation into the application.
E-2-b-iv	Participant Budget Authority	We are concerned with the timeframes in this section. Changes that require amendments to the PCSP will take an inordinate amount of time, as the service coordinator must meet with the participant and then send the change to OLTL for approval. During this time, the participant is forced to go without the needed changes. This process should be streamlined. The participant should not be required to meet with service coordinator. She should be able to express the desired change over the telephone and the service coordinator then can get approval from OLTL. Once that is done, then the PCSP and spending plan can be amended. Why require the PCSP or Spending Plan to be amended before even learning whether the proposed amendment will be approved?	Under budget authority, the participant can make minor changes to the PCSP without approval. This will not change under CHC. For changes that do require approval, the SC may hold the meeting with the participant over the phone, depending on the extent of change requested and the reason for the request. The MCO will approve PCSP changes under CHC, not OLTL.
E-2-b-v	Expenditure Safeguards	If a participant is exceeding hours in the PCSP, then the PCSP should be re-evaluated to ensure it is meeting the participant's needs.	It is OLTL's expectation that if a participant is over or under-utilizing their Spending Plan, that the Service Coordinator will contact the participant to resolve potential service delivery problems. This may include referring the participant to a Support Broker for additional training and/or reviewing the PCSP to ensure it is meeting the participant's needs.
E-2-b-v	Expenditure Safeguards	What protections will there be for participants who purchase necessary goods and services that are not documented in the Spending Plan? If the F/EA will not reimburse for these services, does that mean the participant will be liable for necessary medical needs? In those instances, retroactive changes to the Spending Plan should be allowed, in order to ensure participants are not burdened with unpaid bills.	Goods and services that are not documented in the Spending Plan will not be reimbursed by the F/EA.

APPENDIX F SECTION	TOPIC	COMMENT	RESPONSE
Appx F	General Comment	We offer the following comment for this entire appendix. All notices, materials, and communication regarding appeal and grievance rights must be provided in accessible formats to ensure effective communication under the Americans with Disabilities Act. Language should be added to show that alternative formats are available to individuals to facilitate effective communication.	The service coordinator is responsible to ensure that notices, materials, and communications related to appeals and grievances are provided in an accesible format specific to each individual participant. As such, ADA compliance related to communication is addressed in Appendix C of the waiver under Service Coordination.
F-1	Opportunity to Request a Fair Hearing	The language in appeal circumstance number 3 should be clarified by adding this sentence: "This includes any situation where a participant requests a service formally or informally and the request is not submitted to the CHC-MCO, or is denied."	The language in Appendix F states that a participant has a right to appeal anytime the listed appeal circumstances occur. This includes service requests that are both formal and informal. To ensure participants are aware of these appeal rights, Appendix D-1-c of the waiver requires SCs to provide participant education at regular intervals, including education on due process and appeal rights.
F-1	Opportunity to Request a Fair Hearing	We appreciate and support the waiver's trigger of appeal rights at a point when individuals have been denied a choice of willing and qualified providers. It is important that the department maintain a role in hearing from participants on this issue. With the advent of the CHC program, many "touch points" between the participant and the department will be removed. In the current waiver program, there are some instances where participants are not offered a fair choice of homecare providers, whether by hospital discharge planners or service coordination entities, and they are grateful for the opportunity to turn to the department for recourse.	OLTL will continue to operate a state sponsored help-line and monitor the types of complaints received.
F-1	Opportunity to Request a Fair Hearing	Consumers should have access to an independent ombudsman as well as free legal services to help them through the grievance and appeal process. These procedures are critical particularly when consumers are subject to service denials, reductions, and terminations. Without these resources, the process is stacked against the consumer.	Existing language in Appendix F-1 the waiver indicates the CHC-MCOs responsibility in informing participants about resources available for grievance and appeal assistance.
F-1	Opportunity to Request a Fair Hearing	DHS and the public should receive regular data updates on the number of denials, appeals and grievances filed, and the decisions. Further data should be compiled and shared about the outcomes to those who were denied services.	Thank you. We will consider these measures as we finalize reporting requirements for MCOs.
F-1	Opportunity to Request a Fair Hearing	Although the waiver provides for a hearing when a participant is involuntarily terminated from participant direction, it does not explicitly state that denials of initial requests to self-direct are appealable. This must be added to the list of appealable decisions.	OLTL has added this to the list of appealable decisions.

F-1	Opportunity to Request a Fair Hearing	The language regarding to which agency a participant must be filed is confusing. We are not sure if it means the participant must file an appeal with agency that made the decision, or that the participant may file an appeal with any agency, as 55 Pa. Code §275.1(a)(3) states that all agencies are part of the Department. If this section means the former, we strongly oppose requiring a participant to file an appeal with a specific agency. There are potentially seven different entities in this process, the CAO, OLTL, the CHC-MCO, the F/EA, the Service Coordinator, the IEE, and the service provider. Requiring the participant to discover the exact agency with which to file an appeal will be extremely confusing, and will negatively impact participants' ability to exercise their rights. However, if it means that the participant may file an appeal with any agency listed above, we support this section of the waiver. Any agency that receives an appeal from the participant, regardless of whether it was part of the decision, should be required to forward the appeal to BHA. As §275.1(a)(3) makes clear, all of these agencies are included in the term Department and therefore the receipt of any appeal by an agency functions as an appeal to the Department.	The language means that the participant must file the appeal with the agency that made the decision. This better ensures a timely response and adherence to required appeal timeframes if the agency most familiar with the participant's program and services is processing the appeal request. This is because BHA requires information from the program office over and above what is on the appeal form such as LEP information and program coding. All appeal forms contain instructions for participants on how to appeal and to which agency based on the agency making the decision. In additiona, the SC can direct the participant if he or she has questions about where to appeal a specific issue.
F-2 -b	Additional Dispute Resolution Process	This section requires considerable additional attention. It appears that it may have been drafted prior to the issuance of new federal managed care regulations, and in many places it is inconsistent with them. We urge the department to rework this section so that that it will be clearer and comply with the federal regulations.	The Commentator is correct; this section was drafted prior to the issuance of the new federal managed care regulations, and will be rewritten to comport with both the new federal regulations and the Department's Health Choices Program.
F-3	Grievance and Complaint System	In this section, it appears that the state is citing the federally required MCO grievance system as the State Grievance/Complaint System. However, federal guidance defines this Grievance/Complaint system as one run by directly by the state, not by providers. Yet the draft waiver cites the mandated MCO grievance system as being a state-operated system. We do not believe that the OLTL monitoring of the MCO grievance system qualifies as a separate grievance/complaint system run by the state, especially since the state is already required to monitor this system. We urge the state to create an autonomous Grievance/Complaint system run by the state, and not rely solely on the MCO to resolve grievances, as the MCO will not be as objective about complaints regarding its own services as a grievance/complaint system run by the state would be. If the state chooses not to do this, we suggest it indicate in this section that it is not creating a State Grievance/Complaint system.	The language in this section of the Appendix has been corrected to reflect the State Grievance/Complaint system.

APPENDIX G SECTION	TOPIC	COMMENT	RESPONSE
G-1-b	Incident Reporting Requirements	We recommend streamlining the incident reporting functions described in G1:1 for both HCBS and nursing facilities. There are currently several different lists of incidents to report and an array of entities to which providers are to report. It would be extremely beneficial to all involved for the Department of Health (DOH) and DHS to coordinate reporting functions and definitions. Ideally, one coordinated list of incidents for all providers, including nursing facilities and HCBS providers, would be reported to one central agency which would distribute the appropriate elements of the incident report to the appropriate agencies.	Thank you for your comment, the commonwealth is always interested in streamlining processes. We will consider this in the future.
G-1-b	Incident Reporting Requirements	The waiver application states that CHC-MCOs will be responsible for investigating critical incidents reported through the Enterprise Incident Management (EIM) system. The CHC program presents an opportunity for OLTL to streamline the reporting of critical incidents through the EIM system. Providers currently must report critical incidents involving waiver participants to the Department of Health (DOH) and OLTL. In cases in involving Aging waiver participants, providers must also contact the local Area Agency on Aging (AAA). If CHC-MCOs are to be the entity responsible for investigating these incidents, they should also serve as the central reporting body replacing the current duplicative process. Incident management policies should focus on protecting participants and preventing inappropriate conduct, rather than burdensome and redundant documentation requirements that could defeat the purpose of protecting CHC beneficiaries.	Thank you for your comment, the commonwealth is always interested in streamlining processes. We will consider this in the future.
G-1-d	Responsibility for Review of and Response to Critical Events or Incidents	We strongly oppose the delegation to the CHC-MCO of responsibility for investigating incidents or events reported to the electronic reporting system. We are troubled by the state's abrogating this duty to a private entity which may have a conflict of interest, since some critical events will involve the actions of the CHC-MCO or its staff. Moreover, a participant may be less likely to report an event if she knows it will be investigated and evaluated by the agency that provides the services she is complaining about, rather than an independent oversight entity. This delegation of authority would be similar to allowing nursing homes to investigate allegations against themselves. Further, there is a direct conflict of interest for the CHC-MCO. CHC-MCOs are paid by the state to provide services. Negative findings involving their staff could directly impact their eligibility to be a providing MCO. This is most problematic in that the waiver states that if the MCO makes a finding that a participant was not safeguarded, OLTL will come out and audit the MCO. Surely, this policy creates disincentives for the MCO to properly conduct an investigation. We strongly urge the state to take the role of receiving and investigating critical incidents.	OLTL is responsible for reviewing and investigating all allegations of abuse, neglect, or exploitation that identify the CHC-MCO and/ or their staff as the alleged perpetrator. OLTL retains the right to review any incident reports, conduct its own investigations and require further corrective actions by the CHC-MCO. In addition, OLTL's Participant Helpline will continue to function to provide participants with a direct way to contact OLTL.

G-2	Restraints and Restrictive Interventions	These sections highlight our grave concerns regarding the delegation of receiving and investigating critical incidents to a private entity with a potential conflict of interest. Here OLTL takes a passive role, only reviewing reported incidents of chemical restraints or restrictive interventions. It is not even clear that OLTL would ever conduct its own investigation into these kinds of incidents. The protection of Pennsylvanians from chemical restraints and restrictive interventions cannot be delegated to a private entity with no enforcement power. OLTL must be the entity to receive and investigate these incidents.	OLTL will provide adequate oversight of the MCOs to ensure that the health and welfare of waiver participants is protected. Sufficient checks and balances through the use of EIM exist to ensure that use of restraints is reported, either by service coordinators, numerous direct care provider that interact with participants or the participant-centered service planning team. OLTL staff from the Bureau of Quality Assurance and Program Innovation will review reports generated in EIM weekly to track and trend critical incidents on restraints to identify systemic weaknesses or problems that will result in reports to the CHC-MCOs, corrective action plans and additional training to address the problem if indicated."
G-3-b	Medication Management & Follow-Up	Includes a reference to “C-3” under (b)(i) in the second paragraph. We believe this may be an outdated reference as we could not find a reference to the Service Coordinators have registered nurse consulting services available in Appendix c-3.	Thank you for your comment. OLTL has made this correction.
G-3-b-ii	Medication Management and Follow-up	The draft waiver seems to separate out “medication errors” from “adverse reaction to medication”. It is not clear why the waiver takes this approach. It does not appear that the waiver requires a provider to report via EIM an adverse reaction to medication. We oppose this. If a participant is hospitalized or requires medical intervention after taking a medication, it should always be reported. Currently, the waiver states the provider must consult a physician and then note the problem in the record.	All critical incidents listed in Appendix G must be reported in EIM along with the cause of incident. Adverse medication reactions resulting in hospitalization are included.
G-3-b-ii	Medication Management and Follow-up	We support the requirement that providers obtain training for medication administration. However, we are concerned about the cost of the course and also its availability to providers. It appears the OLTL approved course costs $415. This amount will be prohibitive to many individuals applying to be providers, and will result in a restriction of participant choice. MCOs should be required to pay these fees in all instances. Further, this is an online course. Access to the internet is not possible for many people. MCOs should be required to provide a place where providers may be trained and at no cost to the provider.	CHC-MCOs will be free to manage their provider networks. They may chose to pay this fee themselves or require that it be paid by providers. Providers will be able to choose whether or not to pursue participation in each MCO network. An MCO's decision on this issue would likely include consideration of the impact that such fees may have on the adequacy of their provider networks, which must be sufficient enough to assure for participant access.
G-3-c-ii	Medication Management and Follow-up	If a participant is denied the right to self-administer medication, and expresses a right to, this decision should be appealable. Self-administration of medication is a significant component of self-direction, any decision to take away this right should be appealable.	The waiver states that a person who wishes to self-administer medications needs to be assessed by a medical professional to determine the ability to self-administer. If a participant disagrees with the determination, he or she would follow the MCO grievance process.

APPENDIX H SECTION	TOPIC	COMMENT	RESPONSE
Appx H	Quality Improvement Strategy	In addition to provider training, participant communications, testing and development of setting standards, we recommend that DHS provide opportunities for additional, ongoing stakeholder input into the development of its quality improvement strategy and process. Further, LeadingAge PA would be pleased to work with DHS and other stakeholders to assist OLTL in continuing to develop its approach to quality improvement, including monitoring activities and performance measures.	OLTL is committed to involving stakeholders in the development of the quality improvement strategy and process. This topic has been discussed at a number of MLTSS Subcommittee meetings as well as OLTL's Third Thursday webinars.
Appx H	Quality Improvement Strategy	We recommend that in order to promote continuous quality improvement, provider training must be part of an ongoing, uniform, well-designed educational process, jointly coordinated by CHC-MCOs and monitored and regulated by DHS on a continuing basis. DHS should have a vested stake in the design and curriculum of the educational programs. Providers should have input into the educational program.	As defined under the CHC-Agreement, all CHC-MCOs must submit any and all training curriculum to the Department for review and approval. The CHC-MCO must have a training work plan that is developed in conjunction with the Department, and must include all topic areas identified by the Department.
Appx H	Quality Improvement Strategy	We also recommend that the CHC Waiver application and MCO agreements outline and commit DHS and CHC-MCOs to provide liaisons for providers whose role includes assistance in resolving complex billing and administrative issues. As stated earlier in our comments, a provider hotline administered by OLTL would further serve as a vehicle to receive, track and resolve significant issues between providers and MCOs, and allow DHS another avenue to monitor MCOs.	OLTL agrees, and plans to utilize both the Participant HelpLine and the Provider Inquiry HelpLine as a way to identify and address issues between participants, providers and the CHC-MCOs.
Appx H	Quality Improvement Strategy	It is important that a standardized and validated assessment tool is used that is not proprietary to a MCO provider. One tool should be used by all providers for consistency and the data collected should be shared with the state and public, particularly in regard to quality measurements and outcomes. It is important that this be a transparent process. Any algorithms used to authorize services should be made public so it is clear how any tool is used to determine eligibility and level of services as well as the number of service hours.	OLTL will be requiring the MCO's to utilize the Inter_RAI home care assessment tool. OLTL will take your recommendation for sharing data under consideration.
Appx H	Quality Improvement Strategy	There should be more detail to ensure quality care for consumers. The methods for measuring access to qualified providers should be clearly defined and should go beyond the typical time and distance standards. It is important that small home and community-based providers not be excluded from the MLTSS system. This is particularly important for more unique type service providers such as those that provide services in different languages.	OLTL has been working with both the Department of Health as well as a small stakeholder group to more clearly define network adequacy for providers of LTSS.
Appx H	Quality Improvement Strategy	MCOs should not be granted independent authority to determine credentialing criteria for network providers. DHS should establish uniform credentialing criteria to ensure uniformity throughout the state, increase efficiency, and ensure a solid standard. Having consistent standards will also help with research and evaluation purposes.	OLTL has established uniform credentialing criteria and will be enrolling any qualified and willing provider. MCO's will establish their provider network from these enrolled providers.
Appx H	Quality Improvement Strategy	All work products, documents, and data generated from the requirements in this section should be made public. Transparency is critical to help consumers use performance measures to choose providers and for stakeholders to see successes and problem areas of the services provided	OLTL is working with the HealthChoices program to establish shared data protocols. Additionally, OLTL will continue to provide updates and share CHC data at upcoming MLTSS Subcommittee meetings.

Appx H	Quality Improvement Strategy	Strong state oversight is needed. DHS needs enough qualified, trained staff that can monitor all aspects of CHC as well as have the ability to quickly identify and respond to problems and systemic issues. DHS should have the ability to impose sanctions and corrective actions among other remedies for poor performing MCOs and providers and these actions should be made public.	OLTL agrees that strong state oversight is needed to ensure a successful program, and has been working to identify activities that need to occur during readiness review, implementation, and "steady state" monitoring. In addition, the CHC agreement puts in place penalties and liquidated damages for contractual non-compliance.
Appx H	Quality Improvement Strategy	It is vital that DHS be vigilant in monitoring and taking action against fraud and abuse. Fraud is a serious problem in both Medicaid and Medicare. Medicare fraud is estimated to cost taxpayers anywhere from $60-$80 billion every year. DHS should have a verification system that prohibits any MCO or provider from participating in the CHC program that has or have owned a company that previously defrauded the government. If DHS is planning to reimburse providers based on a risk score (reimbursing health plans based on a calculated fee paying higher rates for sicker consumers) DHS needs to monitor for "upcoding" by plans.	The Commonwealth takes integrity of the program very seriously and is confident in the processes which are in place to address fraud and abuse issues.
Appx H	Quality Improvement Strategy	Performance-based payment incentives should be based on evidence-based best practices to achieve the identified goals and avoid discrimination. And, the focus of any performance-based incentive should be informed by consumers and their caregivers.	Thank you for your comment, the commonwealth agrees and is looking to include performance based incentives in future years, and will consider this in their development.
Appx H	Quality Improvement Strategy	We strongly urge the Department to establish an independent ombudsman and advocacy program and involve the ombudsman in evaluating CHC-MCOs' performance. 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.	Thank you for your comment. The department is working to create a beneficiary support system for all of DHS's managed care products in an effort to streamline processes and experience for participants.
Appx H	Quality Improvement Strategy	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 department is working to create a beneficiary support system for all of DHS's managed care products in an effort to streamline processes and experience for participants.
Appx H	Quality Improvement Strategy	With regard to participant surveys, the Department should consider using Wisconsin's "Personal Experience Outcomes Integrated Interview and Evaluation System" (PEONIES) as a model for the supplemental survey. PEONIES is an interview tool designed to identify participants' individually-desired outcomes and assess whether they are receiving the supports and services needed to achieve their goals.	Multiple monitoring and evaluation tools are being used to ensure participant's needs and goals are being met by their CHC MCOs. The department is considering other states' tools, best practices, and lessons learned in the development of these monitoring tools.
Appx H	Quality Improvement Strategy	The final managed care plan rule requires the state to have a quality improvement plan that reduces health disparities based on age, race, ethnicity, sex, primary language, and disability status. See 42 C.F.R.§ 438.340(b)(6). However, the Department's quality improvement plan makes no mention of addressing disparities. In fact, the 1915(b) waiver application explicitly shows that the state will not be measuring any disparities based on race or ethnicity. The Department must therefore amend its quality monitoring activities to account for strategies to eliminate health disparities and achieve compliance with federal regulations.	Thank You. The Department is in the process of updating the Department-wide quality improvement plan.

E MEASURES APPENDIX/SECTION	TOPIC	COMMENT	RESPONSE
Administrative Authority		We appreciate that OLTL will monitor and work with MCOs that are not meeting minimums. Appendix A indicates that technical assistance will be provided if the issue is not resolved following a corrective action plan. We request information regarding what remedies, including at which point termination will be considered, for an MCO that consistently fails to resolve issues. If an MCO is terminated, we suggest that DHS consider additional "any willing provider" terms to ensure participants can remain in the care of their preferred provider under a new MCO.	OLTL does not believe this language is appropriate for the waiver application and does not intend to add it to the waiver application.
Administrative Authority		This section of the proposed waiver application fails to delineate performance measures with the specificity needed to determine whether adequate service delivery is achieved. We recommend that data measuring contract compliance be collected with specificity to determine the areas of non-compliance, particularly with regard to service category and delivery.	The purpose of the 1915(c) waiver performance measures is to meet the six waiver assurances as outlined by CMS. The activities that you are describing are more related to monitoring activities that would be conducted with MCO's.
Administrative Authority		For performance measures AA2, AA3, AA5, I think the sampling approach in Data source should be 100% and the frequency of data collection should be done quarterly and the data aggregation and analysis should be continuously and ongoing.	Thank you for your comment. The sampling and frequency will be evaluated on an ongoing basis based on program experience.
Administrative Authority	Use of Contracted Entities - IEB	We suggest adding the following to the list of performance measures and data collection: • Number of calls requesting to apply for services • Average wait time to respond to calls to call center (including length of time until the caller receives a call back to discuss her issue, if the initial call results in the caller being told that she will be called back).	Thank you for your recommendations on the type of data elements to be collected from the IEB. OLTL will take these recommendations into consideration as we finalize reporting requirements for the IEB.
Level of Care		It is unclear what Performance Measure LOC1 seeks to measure. It is our understanding that each waiver participant must have a Clinical Eligibility Determination (CED) before enrollment in the waiver. Therefore all new enrollees should have had a CED prior to receipt of waiver services. The more appropriate information to be measured is how many applicants for waiver services receive a timely CED before waiver enrollment divided by all applicants. Similarly, the timeliness of annual CED should be measured against the total number of participants requiring annual CED.	Performance Measure LOC#1 addresses the LOC sub-assurance which requires that an evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future. Performance Measure AA#2 addresses the timeliness of the evaluation.
Qualified Providers		This section refers to "qualified waiver providers" and it refers to license or certification requirements. We are concerned about what will happen to individuals who are providing services and whether they will be considered as providers. We recommend that anyone who is a provider be able to remain a provider of services. This is not addressed under the continuity of care provisions	OLTL has established uniform credentialing criteria and will be enrolling any qualified and willing provider. MCO's will establish their provider network from these enrolled providers. Individual support workers who are hired by the waiver participant or their representative are considered providers and will be able to continue working for their employer.

Qualified Providers		We PA believe Performance Measure, QP1, the number and percent of newly enrolled providers who meet licensure and/or certification standards prior to service provision to waiver participants is not a necessary measure, as it appears to be under DHS' control rather than that of the CHC-MCO, and should be 100% compliant. Similarly, QP3, the number and percent of newly enrolled non-licensed or non-certified waiver providers who meet regulatory and applicable waiver standards should also be fully under DHS' control.	Performance Measures QP#1 addresses the Qualified Provider sub-assurance which states: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services. Similarly, QP#3 is in response to the Qualified Provider sub-assurance "The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements." OLTL will be responsible for verifying all providers meet the approved provider qualifications and enrolling the providers into Medicaid. It is from this pool of providers that the CHC-MCOs will be establishing their provider networks.
Service Plans		Performance Measure SP3 seeks to assure that Individual Support Plans (ISPs) are revised when warranted by a change in participant needs. The measure specifies 100% review of ISPs. However, it is a concern that if the ISP has not been revised to reflect change in need, that even review of 100% of the ISPs will not provide information about which waiver participants had a change in need that should have gone into the ISP. We support the 100% review of service plan complaints.	The State will monitor CHC-MCO PCSP development and implementation to ensure that PCSPs are developed in the best interest of the participant, when the participant's needs change, and in a conflict free manner. CHC-MCOs are required to develop quality assurance tools and protocols that include internal safeguards for PCSP development in addition to the external monitoring by OLTL. In addition, the CHC-MCOs will be required to submit regular reports to OLTL identifying complaints received by the MCOs. OLTL will review and track 100% of all service plan complaints received by the MCOs.
Appendix G		Please define "restrictive interventions." All use of "restrictive interventions" should be investigated.	Restrictive interventions are outlined in Appendix G. The critical incident bulletin requires that all restrictive interventions be reported as a critical incident. In CHC, the CHC-MCOs are responsible for notifying OLTL of the unauthorized use of restrictive interventions, and investigating/addressing their unauthorized use.
Appendix I		Performance Measure FA1. We suggest expanding sub-assurances to include measurement of accuracy and timeliness of payments by the CHC-MCO to providers within Center for Medicare and Medicaid Services (CMS) standards.	Readiness review efforts and on-going monitoring will help identify and address these types of issues, as does the data collected for Performance Measure AA1.
		We ask DHS to 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.	The CHC agreement puts in place penalties and liquidated damages for contractual non-compliance.

		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 LTSS providers. It is critical that claims be paid accurately and on time from Day 1, so that providers do not experience cash flow and payroll issues due to CHC. We would be pleased to assist by recruiting providers for each provider type to test the CHC billing, claims adjudication and 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 receive and process claims and make accurate, timely payments, and refrain from implementing in advance of a successful dry run. 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.	Readiness review efforts will address this issue. This will also be addressed in the final contractual agreement with the MCO. Performance Measure AA1 also addresses this issue. Finally, timeliness of payment is a federal requirement.
		We recommend that the following data is captured either as a requirement in the waiver document or within the MCO contracts: 1. Data from the existing waivers should be used as a base line to assure that the number of individuals and quantity of each category of services are not reduced for the people already served by waiver services; 2. Encounter data organized by month and by each category of service; 3. The number of providers in each network and how many individuals each provider can serve by category of service. Since a provider can be in more than one MCO network, data analysis must include a determination of overall system capacity of unduplicated providers and numbers of individuals that can be served within each category of service. 4. The number of service requests denied by category of service; 5. The number of grievances filed by category of service.	Thank you for your recommendations on the type of data elements that are to be collected from the MCO's. OLTL will take these recommendations into consideration as we finalize reporting requirements for the MCO's.
Self-Direction		Add a performance measure that ensures that participants are fully informed and have access to both the employer authority and budget authority models of participant-direction. Historically, though technically available statewide, consumers have not had access to the Services My Way model. This lack of access appears to be related to lack of training on the model for SCs and lack of outreach and training for consumers. In the Office of Long Term Living's home and community based waivers, 35% of waiver participants self-direct at least one service. This percentage ranges from 16% in Fayette County to 67% in Wyoming County. With the shift in how the waiver program is administered, the Commonwealth needs to ensure that the approach to HCBS promotes a self-determination not a medical model of support.	Thank you for your recommendations on the type of data elements that are to be collected from the MCO's. OLTL will take the recommendation into consideration as we finalize reporting requirements for the MCO's. In addition, OLTL is developing a training for the CHC-MCOs and their Service Coordinators around the models of self-direction and their responsibilities for educating and supporting participants.
		Pennsylvania should update performance measures. There is development of best practices and standardized performance measures regarding MLTSS.	Thank you, the commonwealth has engaged a number of other states and national experts in the development of reporting requirements for MCOs going forward to ensure best practices are understood and implemented.
		We support adding a measure of the number and percent of waiver participants receiving BH care through their BH-MCO. There should be a measure that determines the cooperation and data share between BH-MCOs and CHC-MCOs. Data must be shared between the BH-MCO and CHC- MCO to ensure coordination of care.	Thank you for your recommendations on the type of data elements that are to be collected from the MCO's. OLTL will take the recommendation into consideration as we finalize reporting requirements for the MCO's.
		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.	Thank you, multiple monitoring and evaluation tools are being used to ensure participant's needs and goals are being met by their CHC MCOs. The Department is considering other states' tools, best practices, and lessons learned in the development of these monitoring tools.

		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.	Through the readiness review process, OLTL will conduct desk and on-site reviews of the CHC-MCOs for all aspects of the program including Provider Network Adequacy, Systems capabilities and participant and provider related issues. After CHC goes live, OLTL will continue to perform on-going monitoring of the CHC-MCOs to insure continuing compliance. This will include reviewing the quality of care both from the participant and the provider perspective through surveys, site visits and other means.
		OLTL must evaluate the timeliness and attendance of personal care attendants (see for example the real-time electronic visit verification utilized by Tennessee).	Thank you for your recommendations on the type of data elements that are to be collected from the MCO's. OLTL will take the recommendation into consideration as we finalize reporting requirements for the MCO's.
		The Department must consider the quality of person-centered care planning in its evaluation of CHC-MCO performance.	Thank you for your recommendations on the type of data elements that are to be collected from the MCO's. OLTL will take the recommendation into consideration as we finalize reporting requirements for the MCO's.
		We recommend that the state consider rebalancing measures, to better gauge if, and to what extent, delivering LTSS through managed care improves rebalancing. We suggest the following rebalancing measures for consideration: • Number and proportion of beneficiaries receiving LTSS in the community along with number and proportion of beneficiaries receiving LTSS in an institution; • Total home and community-based services and institutional expenditures as a percentage of total LTSS expenditures; • Number and proportion of beneficiaries who transitioned to the community from an institution and did not return to the institution within a year; • Increase or decrease in the authorization of personal care hours; and • Percentage of new Medicaid LTSS users first receiving services in the community.	Thank you for your recommendations on the type of data elements that are to be collected from the MCO's. OLTL will take the recommendation into consideration as we finalize reporting requirements for the MCO's.
		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.)	Thank you for your recommendations on the type of data elements that are to be collected from the MCO's. OLTL will take the recommendation into consideration as we finalize reporting requirements for the MCO's.

APPENDIX/ SECTION	TOPIC	COMMENT	RESPONSE
Appendix I	Financial Accountability	Appendix I has not been shared with stakeholders. We respectfully request that DHS provide Appendix I to stakeholders for comment.	The information in Appendix I was not available at the time the documents were released for public comment, but will be made available at the time of waiver submission.
Appendix J	Cost Neutrality Demonstration	Appendix J – Cost Neutrality Demonstration is missing from the elements of the 1915(c) waiver application that have been shared with stakeholders.	The information in Appendix J was not available at the time the documents were released for public comment, but will bemade available at the time of waiver submission.
Appendix J	Cost Neutrality Demonstration	DHS must remember to include the cost estimates from the OBRA waiver even though the waiver itself will not be included. Most of the OBRA Waiver participants are NF eligible (in addition to being ICF/ORC eligible) and will be included in the CHC and their institutional costs are much, much higher than standard NF costs. This includes people on ventilators and feeding tubes, with customized wheelchairs.	OLTL's actuaries have included all eligible waiver participants, including OBRA waiver participants, in the cost neutrality projections.

Community HealthChoices
Managed Long-Term Services & Supports

APPENDIX SECTION	TOPIC	COMMENT	RESPONSE
General Comment	Out of state education	Will there be anything done for people who want to pursue degrees such as their masters or their PhD where they may have to go out of state to get the degree and develop the project they want but will not be considered residents in the out of state area they chose to go to school and still be a resident of PA even though they would not be able to live in Pennsylvania for a significant portion of the year. Could there be some kind of program developed to help transfer services and housing back and forth when necessary so more people could be free to pursue out of state education?	OLTL waivers currently and under CHC would allow temporary out of state resident to receive services. Housing is beyond the scope of the waiver.
General Comment	18-20 year olds	A concern I have is regarding the eighteen to twenty year old population. What services will they be entitled to? And how will it be determined who qualifies for what types of services beyond daily living.	Eighteen to twenty year olds are not included in CHC. These individuals may apply for other MA programs.
General Comment	CommCare Waiver	There must be some explanation of the fact that the current Commcare waiver is being modified in order to create this new waiver.	Information about the use of the CommCare waiver becoming the CHC waiver is included in the Main Module of the waiver application. We agree that the format can be confusing, simplified communications are being developed to educate the public about the changes.
General Comment	Program Savings	Finally, we areconcerned that the projected monetary savings are not being directed to fund additional services or to serve more people under the CHC program. The reinvestment is an opportunity to create unique services for individuals who may be difficult to serve.	Thank you, the commonwealth is not projecting financial savings in CHC. National regulation outlines profit limits for MCOs and reinvestment strategies to ensure participants receive needed services
General Comments	Deaf Participants	Communication Assessments should be added as a covered service for instances where a need for assessment is identified. Assessments for Assistive Technology must also be a covered service when a need for assessment is identified. Communication assessments for waiver participants who are deaf must be performed by assessors meeting the following qualifications: a. Are able to sign at SLPI Intermediate Plus level or above; b. Have a background in Speech Language Pathology, sign linguistics, education of deaf, or with verified experience doing communication assessments for people who are Deaf.	The Department agrees that participants have the right to effective communication. The contractual requirements of the CHC-MCOs, IEB and service providers regarding accessible communication are described in Appendix B-8 of the 1915(c) waiver, as well as respective contracts and agreements.
General Comments	24-hr Hotline	It is critical that there be planning to assure that services are actually delivered, particularly in emergency situations. To that end, we recommend the development of a hotline that a waiver participant can call in the event of an emergency where staff have not shown up from either a primary or back-up provider. Data must be collected by number of no-shows by provider and category of service.	The CHC agreement requires all CHC-MCOs to maintain and staff a twenty-four (24) hour, seven (7) day-a-week toll-free dedicated hotline to respond to Participants' inquiries, issues and problems regarding services.

General Comments	Readiness review	As part of its transition to managed care, the state should develop a robust MCO- readiness review process to determine whether managed care plans are prepared to provide all contracted services in a safe, efficient, and effective manner. Plan readiness includes, at a minimum, network adequacy (including the ability to pay contracted providers within a reasonable amount of time); a proven track record of high performance; the ability to offer participant-directed LTSS including, but not limited to, counseling and financial management services; the ability to monitor and improve services; demonstrated financial stability in the plan and adequate protections against insolvency; the ability to generate required data and reports for governmental entities and public reporting; and adequate capacity to respond to enrollee grievances and appeals.	OLTL agrees and is collaborating with OMAP to develop a comprehensive readiness review process.
Appendix C-3	Family Caregivers	We recommend that the CHC Waiver include other ways for MCOs to involve and partner with family caregivers. As the initiative moves forward, we urge the state to include in the Waiver and in its contracts with CHC-MCOs provisions to ensure that: • Family caregivers of all beneficiaries have the opportunity to participate in assessment of need of their family member; • Family caregivers receive an independent assessment to determine how the MCO can work with the caregiver and support their needs; • MCOs train their case managers on how to communicate and work with family caregivers; • MCOs have regular communication with the family caregiver and require paid home care/health providers to communicate/consult with the family caregiver on service delivery; and • MCOs offer caregiver training to family caregivers that covers both effective caregiving techniques and stress reduction practices.	Participants can choose who will be included in their service planning process. The department is looking at best practices and ways to support family caregivers as CHC is implemented.