| Comment is related to: *enter RFP, or Requirements Document, Requirements Document Exhibit or Other. Please use drop-down to indicate.* | Section Header | Subsection & Page Number | Current Language in Draft Documents Distributed by DHS | Your suggested change/comment/question | Commenting Organization/Individual |
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| Requirements Document Exhibit | B(1) - CHC_MCO Pay for Performance Program | | | If a lower rate of pay is offered to an SNF, the facility needs at least a year to readjust its short and long term budgets, financial obligations, capital investment plans, employee benefits and union contracts, staffing patterns and many other areas. If caught by a short notice rate changes, many SNFs my found themselves unable to meet the payroll and pay basic bills. This may create situations when care will be disrupted suddenly and create uncertainty and safety concerns for residents. We suggest allow at least one year after rates are established before starting CHC program. | Benjamin Katevich, Administrator/Townview Health and Rehabilitation Center |
| Requirements Document Exhibit | B(1) - CHC_MCO Pay for Performance Program | | | Network participation requirements. By the time the MCO will announce their in-network participation criteria, there may be no time left for SNFs to reorganize their operations and focus on meeting the criteria. Operational and care related changes take significant time in a Long Term Care environment. SNFs that provide genuinely good care, may be caught in some paper compliance gaps that will jeopardize their ability to participate in networks and subsequently their ability to survive as organizations. We suggest to allow at least one year after criteria is announced before starting the CHC program | Benjamin Katevich, Administrator/Townview Health and Rehabilitation Center |
| Requirements Document Exhibit | B(1) - CHC_MCO Pay for Performance Program | | | Billing and reimbursement process. Currently nursing facilities are billing and being paid by only one entity for all MA residents. With only a few months available, they will have to learn new billing process with up to five new MCOs while those MCOs themselves will have only a few month to establish their operations and reimbursement procedures in the state of PA. As a result of this short preparation time, there will be a strong possibility for interruptions in reimbursement, which will lead to cash flow difficulties, which in turn may result in inability of many nursing facilities to meet the payroll and other vital financial obligations. Such situations were observed in number of states that made changes towards CHC type arrangements too fast. Allow at least 6 months after all billing training is completed by all participating MCOs before start of the CHC program. | Benjamin Katevich, Administrator/Townview Health and Rehabilitation Center |
| Requirements Document Exhibit | B(1) - CHC_MCO Pay for Performance Program | | | Abolishing current payment rates established procedures. Current MA pay rates to the facilities are based on at least three preceding years of certain operational cost patterns. There are formulas that establish pay rates for every new quarter. The formulas include prior years costs and spendings. This process allowed nursing facilities to plan their current costs with certain budgeting for future pay rates. In this cense, the facilities in western PA will be at great disadvantage in comparison to facilities in other parts of PA. They may never see the pay rates the way they planned through the prior years spending, while the facilities in other zones will have the opportunity to change their rate setting process. This may be a source of potential legal actions against the State. | Benjamin Katevich, Administrator/Townview Health and Rehabilitation Center |

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| Requirements Document | Section XVI: General | | | Solution: allow at least until January 1st 2018 to operate under rates generated by current formulas | Benjamin Katevich, Administrator/Townview Health and Rehabilitation Center |
| Requirements Document Exhibit | B(1) - CHC_MCO Pay for Performance Program | | | No mechanism to assure payment to SNF for entire duration of services provided. If an MCO or another entity establishes that a resident is not qualifying for stay in the SNF, the MCO should be responsible for making a safe transfer arrangements and if such arrangements are delayed the SNF should be paid for the entire duration of resident's stay. | Benjamin Katevich, Administrator/Townview Health and Rehabilitation Center |
| Requirements Document | Section XVI: General | | | In summary, it is apparent that the January 2017 start day for CHC program creates a great uncertainty and disadvantage for SNFs in the "zone one", compare to those in other zones. The uncertainty and disadvantage will be even more hard felt by SNFs that are not part of large corporate chains. Many of such SNFs are non profit and religious based organization that have been providing quality care to MA recipients for many decades. It appears to be very unreasonable to hurry up and put many SNFs at such risk just because of their geographic locations and the urge to start the process as soon as possible. It appears to be necessary, reasonable and fair to give the SNFs in "zone one" sufficient preparation time. | Benjamin Katevich, Administrator/Townview Health and Rehabilitation Center |
| Requirements Document | Section XVI: General | | | The time count should start after all the participating MCOs have been selected, the rates of pay are announced, billing and reimbursement process are established, matters of current formula reimbursement are resolved and in-network participation criteria is defined by MCOs. | Benjamin Katevich, Administrator/Townview Health and Rehabilitation Center |
| Requirements Document | Section XVI: General | | | After all the above matters are settled, a period of at least one year should be awarded to SNF in any "zone" or area of the State. | Benjamin Katevich, Administrator/Townview Health and Rehabilitation Center |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | | | Today, I sat in on the updates from the MLTSS listening session. The presenter had briefly talked about the credentials for service coordinators and service coordinator supervisors. I thought I heard that the credentials for the service coordinator would be RN or 3yrs experience and bachelor's in social worker or related field. For supervisors the credentials were RN and or MSW with at least 3 years experience.<br>My question: Will other areas of education and experience that are related to social work be considered? For example, I have a B.S. in Rehabilitative Services and a Master in Health Administration with a specialty in gerontology. I have over 5 years experience as a supervisor in waiver services. There are others in the same situation as myself. | Jamilah Smalls |

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| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | | | In reading the current documents posted Monday 12/14/15, is it accurate to interpret that the document is relaying that DHS and the MCO's will collaborate to develop additional credentialing for HCBS providers above and beyond the listed requirements for providers in the document? Is NCQA credentialing mentioned in the document apply to MCO's only? In reading the current documents posted Monday 12/14/15, is it accurate to interpret that the document is relaying that DHS and the MCO's will collaborate to develop additional credentialing for HCBS providers above and beyond the listed requirements for providers in the document? Is NCQA credentialing mentioned in the document apply to MCO's only? | Tina Seidel Compliance and Policy Director United Disabilities Services Foundation |
| Requirements Document Exhibit | B(1) - CHC_MCO Pay for Performance Program | | | Where is the funding coming from to pay the capitation rates to the HMOs? | Catherine McCarthy, MS, MBA Supervisor Home & Community Services/MA Compliance Officer |
| Requirements Document | Section XVI: General | | | Since there is a large disparity between the ID waivers and the waivers under the OLTL and the rate of payment to providers for services rendered, how does the department of the OLTL reconcile this fact? How will adding another oversight party (MCO's) help the lack of available services and providers? | Catherine McCarthy, MS, MBA Supervisor Home & Community Services/MA Compliance Officer |
| Requirements Document | Section XVI: General | | | Younger individuals" in the OBRA waiver who for all intents and purposes are ID, but are not recognized as such by the State of PA. In effect they are placed in a waiver that has no means of recognizing their poor adaptive and executive functioning, etc. They are not physically disabled, but need 24/7 supervision and programing. How will CHC allow these individuals who are developmentally disabled to have access to services they need to stay in their home and community? Will a model of services be built under the CHC to ensure MA dollars are used effectively? This model of services needs to be the same as and funded (same rates of reimbursement) similarly to the ID waivers. | Catherine McCarthy, MS, MBA Supervisor Home & Community Services/MA Compliance Officer |
| Requirements Document | Section XVI: General | | | My name is David Kitonga.I am the CEO for Hosana Home health care services ,a provider in aging and several other waivers in pa.I am submitting my comments regarding implementation of MLTSS in pa.I join other stake holders in pa who have expressed | David Kitonga Hosana Home Healthcare Services |
| RFP | Work Statement Questionnaire | Participant Service and Care Coordination, question 9 | Describe your plans for delivering comprehensive services that: increase access to affordable, accessible housing. | While a substantial body of evidence exists documenting the positive impact of housing on health and well-being, including increased health outcomes and lower health care costs, the language in question 9 is not as prescriptive as the wording of other questions within the Work Statement Questionnaire. In order to effectively pursue the Commonwealth's goals to "promote achievement of Triple Aim (better health, better care, lower costs)", the housing needs – in addition to the medical needs - of the most vulnerable participants must be addressed. | Diana T. Myers & Associates, Inc. (DMA) |

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| RFP | Work Statement Questionnaire | Participant Service and Care Coordination, question 9 | Describe your plans for delivering comprehensive services that: increase access to affordable, accessible housing. | ● Housing innovation will need to include additional supports/resources to ensure participants are able to age in place. Many individuals living in their own housing have home repair needs that jeopardize their health and safety. A recent Kaiser Family Foundation report found that 26% of all community-based seniors and 37% of dual-eligible community-based seniors had home repair needs which can "have a deleterious effect on overall health and functioning". The Kaiser report goes on to say, "housing conditions may represent a challenge for programs and individuals trying to serve the population with LTSS needs, particularly since repairs are not covered by Medicaid despite their impact on health". If housing innovation is to occur in a substantial way, the Commonwealth will need to ensure adequate resources exist and state-level coordination/ collaboration/ partnerships are developed to further assist in this effort. | Diana T. Myers & Associates, Inc. (DMA) |
| RFP | Work Statement Questionnaire | Participant Service and Care Coordination, question 9 | Describe your plans for delivering comprehensive services that: increase access to affordable, accessible housing. | ● To ensure that the CHC-MCO is able to able to address community integration and ongoing tenancy supports, the Commonwealth will need to ensure the CHC-MCO has sufficient knowledge and capacity. Per the CMS document, *Summary - Essential Elements of Managed Long Term Services and Supports Programs* , "While current credentialing and network adequacy systems have been developed based on an acute and primary care service delivery model, CMS expects states to assure that managed care networks also meet the needs of MLTSS beneficiaries, including adequate capacity and expertise to provide access to services that support community integration, such as employment supports, and the provision of training and technical assistance to providers". Capacity and expertise specifically around housing should be considered in the evaluation of CHC-MCO RFP responses and/or training and technical assistance should be provided to ensure successful housing innovation occurs. | Diana T. Myers & Associates, Inc. (DMA) |

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| Requirements Document | Section V.A. - Covered Services | 21. Service Delivery Innovation | The CHC-MCO must promote innovation in the service delivery system... The CHC-MCO must participate in any initiatives in these target innovation areas when requested by the Department to participate. In addition, the CHC-MCO must submit a report to the Department annually that outlines the CHC-MCO's efforts in each of the four areas, lessons learned, and plans for the following year. | The current language is not written as a requirement, but more as a suggested best practice. Pre-tenancy and tenancy support services should be required for all participants at risk of homelessness or institutionalization. Furthermore, the report to be submitted annually is not described. It is not indicated if there will be a requirement to report any outputs or specific outcome measures achieved as a result of housing innovation. Additional guidance from DHS indicating specific metrics to be evaluated would further guide the CHC-MCO to better understand the expectations and focus their housing related efforts. | Diana T. Myers & Associates, Inc. (DMA) |
| Requirements Document | Section IV: Applicable Laws and Regulations | **C. Specific to Medicare** | The CHC-MCO must be a Related Party to a CMS approved Full Benefit Dual Eligible Special Needs Plan (D-SNP) for the duration of this Agreement. | This draft requirement, as written, puts non-incumbents at a severe disadvantage and in most instances, disqualifies them for bidding for the Southwest region. Unlike incumbents, non-incumbents will not have an existing Provider network, and experience in other markets has shown that it is difficult to build a provider network without an existing Contract. Additionally, non-incumbents will not have sufficient time to file the appropriate notices with CMS given the timing of the award of the bid and the CMS requirements. As a result, this draft requirement could significantly restrict competition in the Southwest region as well as Participant choice in CHC-MCOs with LTSS experience. We strongly recommend that DHS delay the Southwest D-SNP requirement until 1/1/18 to allow for meaningful CHC-MCO competition within the Southwest zone. We believe this delay can be implemented in a manner that minimizes any Participant impact while assuring continued DHS investment in Participant choice. DHS can build on lessons learned in other states by requiring CHC-MCOs to effectively coordinate care for dual beneficiaries, a process which will be required for the majority of dual Participants who typically do not choose one health plan to manage their Medicare and Medicaid benefits. | Centene Corporation/ Pennsylvania Health & Wellness |

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| Requirements Document | Section IV: Applicable Laws and Regulations | MIPPA Agreement Requirements (no page number, but 142 of 185 PDF) | aligned D-SNP concurrently with its CHC-MCO. This D-SNP will be required to enter into a MIPPA Agreement with the Department. The MIPPA Agreement will address the eight elements required of all MIPAA agreements, and will also include additional requirements to ensure the greatest possible coordination between the CHC-MCO and the D-SNP including, but not limited, to the following. General Provisions a. CHC-MCOs will be required to have a companion D-SNP in place and ready to enroll as of the same dates and service areas as the CHC-MCOs. b. The goal of the CHC-MCO and its companion D-SNP is to provide a coordinated experience from the perspective of Full Dual Eligible Participants who enroll in both. This includes, but is not limited to, an integrated | This draft requirement, as written, puts non-incumbents at a severe disadvantage and in most instances, disqualifies them for bidding for the Southwest region. Unlike incumbents, non-incumbents will not have an existing Provider network, and experience in other markets has shown that it is difficult to build a provider network without an existing Contract. Additionally, non-incumbents will not have sufficient time to file the appropriate notices with CMS given the timing of the award of the bid and the CMS requirements. As a result, this draft requirement could significantly restrict competition in the Southwest region as well as Participant choice in CHC-MCOs with LTSS experience. We strongly recommend that DHS delay the Southwest D-SNP requirement until 1/1/18 to allow for meaningful CHC-MCO competition within the Southwest zone. We believe this delay can be implemented in a manner that minimizes any Participant impact while assuring continued DHS investment in Participant choice. DHS can build on lessons learned in other states by requiring CHC-MCOs to effectively coordinate care for dual beneficiaries, a process which will be required for the majority of dual Participants who typically do not choose one health plan to manage their Medicare and Medicaid benefits. | Centene Corporation/ Pennsylvania Health & Wellness |
| Requirements Document | Section IV: Applicable Laws and Regulations | A. Certification and Licensing p 2 | The CHC-MCO must screen all Providers at the time of hire or contracting; and thereafter, on an ongoing monthly basis to determine if they have been excluded from participation in federal health care programs. CHC-MCOs must use the streamlined credentialing process that the Department develops, in conjunction with the CHC-MCOs. | We strongly recommend that in addition to CHC-MCO involvement, DHS engage LTSS Providers (representing the diverse LTSS Provider groups that exist, including diversity in type of support provided and size of Provider) in all aspects of developing a streamlined credentialing process (e.g. design, piloting, improvement strategies). | Centene Corporation/ Pennsylvania Health & Wellness |

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| Requirements Document Exhibit | ZZ - Automatic Assignment | Exhibit ZZ Automatic Assignment (no page number, but 138 of 185 PDF) | select a CHC-MCO will be subject to the auto assignment process as described below. The auto-assignment process does not negate the Participant's option to change his/her CHC-MCO. Individuals will be assigned to plans that align with the way in which they are currently receiving their services. ? First, if a Participant is residing in a nursing facility at the time of enrollment, they will be assigned to a plan in which their nursing facility is a Network Provider. ? Second, a Participant enrolled in a D-SNP will be assigned to a CHC-MCO aligned with their D-SNP. ? Third, if the Participant is transferring from Health Choices, and the HC-MCO is also contracted as CHC-MCO, and the Participant has not made a CHC-MCO | Please confirm the prioritization process when a provider is part of more than one CHC-MCO provider network. We recommend alternating among CHC-MCOs. For instance, if there are three CHC-MCOs, we recommend the first assignment go to CHC-MCO "A," the second assignment to CHC-MCO "B," the third assignment to CHC-MCO "C," then the fourth assignment back to CHC-MCO "A." | Centene Corporation/ Pennsylvania Health & Wellness |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG(1) Performance Measures (no page number, but 144 of 185 PDF) | Entire Section (Table format not appropriate for cut and paste) | We encourage DHS to engage CHC-MCOs and other stakeholders (e.g., academic partners, providers, and advocates) in prioritizing measures and defining appropriate data collection strategies. In addition, we recommend that DHS provide CHC-MCOs with access to all MDS data to ensure ability to establish appropriate baselines and conduct comprehensive measurement and reporting. | Centene Corporation/ Pennsylvania Health & Wellness |
| Requirements Document | | page 103 | Individual Behavior Specialist | The qualifications for the individual behavior specialist in this document should require all BSCs to be licensed. Indeed, the state of PA licenses these individuals for a reason, it cuts down on waste fraud and abose | Halina Dziewolska, M.S.ED. LBS, BCBA |
| Application for a §1915(c) Home and Community-Based Services Waiver | | page 103 | Behavior specialist qualifications | AS the state has determined that it is in the publics interest for this profession to be regulated and monitored with a license, to use unlicensed professionals for the position is not in the interest of the genatric population. | Joseph Cautilli, Ph.D. |

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| Requirements Document | Section VIII: Reporting Requirement | C. Operations reporting | | This is a very small list. May I suggest another. I recommend the MCO be required to provide a quarterly report that both summarizes their use of informal supports (unpaid caregivers) and formal support (paid caregivers) to meet the participants' needs and data that demonstrates how well this ratio is working out in actually meeting the needs of the participants. Perhaps also consider making this a performance incentive at some point. We should consider encouraging all partiies to use informal supports when ever possible in lieu of government provides supports; but at the same time we need to laso make sure those informal supports, especially when they are relied on a great deal, are effective. | OLTL Doug Tinkey |
| RFP | Eligiblity | | | **Comment:** The Department needs to decide how it will make HCBS waiver services available to all children of all ages with developmental disabilities so that they can live in families rather than institutions. Currently, children under 18 who have developmental disabilities other than ID (such as cerebral palsy, spina bifida, complex medical conditions requiring trachs or ventilators, etc...), as well as infants and toddlers with ID, do not have any access to waiver funded respite, home and vehicle modifications or residential habilitation (such as life-sharing or partner families). As a result, many of these children are forced to grow up in institutions. Currently, Pennsylvania's HealthChoices program pays for long term 24 hour care for children with complex medical needs in congregate care facilities such as Pediatric Specialty Care, Pedia Manor and Firely Pediatrics. With access to HCBS waiver services, these children could be living in families. **We would strongly recommend that DHS create a waiver for all children with developmental disabilities, which includes alternative family living options such as Life-Sharing and Partner Families, run by the Department (through ODP), rather than by managed care.** Alternatively, it might be possible to lower the age of the ID waivers to birth, and include in those waivers children with other developmental disabilities who meet the ICF-ORC level of care. However, if DHS is opposed to creating a new waiver, including children of all ages who meet the ICF-ORC level of care in the CHC - **if and only if it includes and funds alternative family-living options and specialized, independent Nursing Home transition coordinator**s - would be another potential solution . | Disability Rights Network of PA |
| Requirements Document | Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements | page 44 | | **Comment:** Please revisit these qualifications to ensure that current, competent service coordinators who have experience with HCBS waivers are not inappropriately excluded from providing service coordination under the CHC. Ensure that training of service coordinators includes providing services to individuals with the most significant disabilities in community settings, as well as Medicare requirements for dual eligibles. | Disability Rights Network of PA |

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| Requirements Document | Section VIII: Reporting Requirements | H. Sanctions 2.e., page 15 | | **Add**: In the case where a recipient was not provided a service for any period of time due to a CHC-MCO's failure to comply with the access standards of this Agreement, the MCO shall pay an amount equal to that which it would have paid had the service been provided as required. This payment is separate and apart from the corrective action plan and such plan will not obviate the need for this payment.<br><br>**Comment**: In no case should the CHC-MCO be permitted to profit from a failure to meet access standards. Otherwise, the incentive is to ignore the standards until caught, and until the corrective action process is complete. | Disability Rights Network of PA |
| Requirements Document | Section XVI: General | G., page 26 | This Agreement does not, nor is it intended to, create any rights, benefits, or interest to any third party, person, or organization. | **Change**: This Agreement does not, nor is it intended to, create any rights, benefits, or interest to any third party, person, or organization, except to the extent that a CHC-MCO's violation of the Agreement results in harm to a recipient. While the contact between DHS and the MCO does not confer contractual rights as third-party beneficiaries, it does not strip beneficiaries of any other rights they have against the MCOs. | Disability Rights Network of PA |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | A. | Ensure that Covered Services are Medically Necessary and provided in an appropriate, effective, timely, and cost efficient manner; | **Change**: Ensure that Covered Medical Services are Medically Necessary and provided in an appropriate, effective, timely, and cost efficient manner; Ensure that covered LTSS services are provided consistent with the 1915(c) waiver requirements and DHS regulations.<br><br>**Comment**: While LTSS services should be based on need, they are not necessarily "medical". | Disability Rights Network of PA |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | B. | | **Add**: A CHC-MCO must not use guidelines that are any more restrictive than the guidelines promulgated by the Department, if any, for the same service. | Disability Rights Network of PA |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | B. 2 | For children under the age of twenty-one (21), requests for service will not be denied for lack of Medical Necessity unless a physician or other health care professional with appropriate clinical expertise in treating the Participant's condition or disease determines | **Delete:** "For children under the age of twenty-one (21),"<br><br>**Comment:** Appropriate clinical expertise should be required for all medical necessity determinations, not just for children. | Disability Rights Network of PA |

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| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | B. 3. a. Timeframes | 21 days: All other services. | **Change**: Two business days: All other services.<br><br>**Comment**: State law requires MCOs to make decisions within 2 business days of receipt of necessary documentation. Act 68 of 1998, section 2152(4)(i); 28 PA Code section 9.753. 21 days has been the timeframe for automatic approval of a requested item or service under the HealthChoices contracts, which is fine. But compliance with state MCO laws should be an expectation of the contract. | Disability Rights Network of PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | G 1), page M(1)-1 | "problematic patterns of care" | **Question:** How is "problematic patterns of care" defined? | Disability Rights Network of PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | G 1), page M(1)-1 | General comment - accessibility of program | **Question:** How will accessibility of “written program description, work plan, evaluation, and policies/procedures” in M(1)(A) be ensured? | Disability Rights Network of PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard I: B), page M(1)-2 | Be developed and implemented by professionals with adequate and appropriate experience in QM/UM and techniques of peer review | **Add:** including UM/QM for those who have disabilities or are elderly and living in the community. | Disability Rights Network of PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard I: D), page M(1)-2 | contain policies and procedures which provide for the ongoing review of entire scope of care provided by CHCMCO assuring that all demographic groups, races, ethnicities, care settings and types of services are addressed | **Add:** and disabilities | Disability Rights Network of PA |
| | M(1) - Quality management and Utilization Management Program Requirements | Standard I: E5), page M(1)-2 | Allow for systematic analysis and remeasurement of barriers to care, the quality of care provided to participants and utilization of services over time | **Change:** Allow for systematic analysis and remeasurement of barriers to care (including in the community), Nursing Home Transition participation and outcomes, the quality of care provided to participants and utilization of services over time | Disability Rights Network of PA |

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| | M(1) - Quality management and Utilization Management Program Requirements | Standard I: F), page M(1)-3 | Provide a comprehensive written evaluation completed on at least an annual basis, that details all QM and UM program activities including, but not limited to: | **Add:** d) data regarding transitions from nursing facilities to community and regarding new admissions to nursing facilities. | Disability Rights Network of PA |
| | M(1) - Quality management and Utilization Management Program Requirements | Standard I: H), page M(1)-3 | provide for aggregate and individual anaylsis of provider performance and CHMCO performance in improving access to care, quality of care provided to participants and utilization of services | **Change:** provide for aggregate and individual anaylsis of provider performance and CHMCO performance in improving access to care, in transitioning participants from facilities to the community, quality of care provided to participants and utilization of services | Disability Rights Network of PA |
| | M(1) - Quality management and Utilization Management Program Requirements | Standard I: L), page M(1)-4 | include mechanisms and processes which allow for development and implementation of CHCMCO wide and provider specific improvement actions in response to identified barriers to care, quality of care concerns and overutilization, underutilization and/or misutilization of services | **Change:** include mechanisms and processes which allow for development and implementation of CHCMCO wide and provider specific improvement actions in response to identified barriers to care, barriers to transition from facilities to the community, quality of care concerns and overutilization, underutilization and/or misutilization of services | Disability Rights Network of PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard I: N), page M(1)-4 | "The CHC-MCO shall monitor the participants condition for ongoing care and potential for discharge back to community living" | **Change:** The CHC-MCO shall monitor the participants condition for ongoing care and potential for discharge back to community living, and shall ensure the participant is informed about availability of Nursing Home Transition services. | Disability Rights Network of PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard II: A), page M(1)-5 | reports in A2 must be provided in an accessible format. | **Comment:** Ensure accessibility of QM and UM reports | Disability Rights Network of PA |
| | M(1) - Quality management and Utilization Management Program Requirements | Standard II: B B(1)(b) | ensure membership on the QMC and active participation by individuals representative of the composition of the CHCMCOs providers | **Change:** ensure membership on the QMC and active participation by individuals representative of the composition of the CHCMCOs providers, and by individuals representative of participants eligible for LTSS. | Disability Rights Network of PA |

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| | M(1) - Quality management and Utilization Management Program Requirements | Standard 2 F (3) | is familiar with local standards of medical practice and nationally accepted standards of practice | **Change:** is familiar with local standards of medical practice and nationally accepted standards of practice, including those for LTSS and with "most integrated setting" requirements under the ADA. | Disability Rights Network of PA |
| | M(1) - Quality management and Utilization Management Program Requirements | Standard 2 F (4) | has knowledge of due process procedures for resolving issues between network providers and the CHOMCO administration, including those related to medical decision making and utilization review | **Change:** has knowledge of due process procedures for resolving issues between network providers and the CHC-MCO administration, and between participants and the CHC-MCO, including those related to medical decision making and utilization review | Disability Rights Network of PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VI: A), page M(1)-11 | "PCPs and specialty care practicioners and other providers" | **Add:** Expressly add "service coordinators" | Disability Rights Network of PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX: B), page M(1)-15 | "CHC-MCO shall audit a sample…." | **Question:** How large is the sample? How determined? | Disability Rights Network of PA |
| | M(1) - Quality management and Utilization Management Program Requirements | Standard 9 C | medical necessity determinations must be made by qualified and trained healthcare providers | **Change:** medical necessity determinations must be made by qualified and trained healthcare providers with expertise comparable to the prescribing practitioner. | Disability Rights Network of PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX: D3), page M(1)-16 | "contatin language…notifying participants and how to file a complaint/grievance…. | **Add:** In language that is easily understood and can be made known to the individual in an accessible format, or where appropriate, made available to the individual's representative. | Disability Rights Network of PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX: E1), page M(1)-17 | "not contain any definition of medical necessity that differs from the CHC definition" 2) Allow for determinations of medical necessity that are consistent with the CHC definition. | **Change:** not contain any definition of medical necessity that differs from the CHC definition" 2) Require determinations of medical necessity that are consistent with the CHC definition. | Disability Rights Network of PA |

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| | M(1) - Quality management and Utilization Management Program Requirements | Standard 14 C | participants shall provide consent to managed care plans, healthcare providers and their respective designees, for the purpose of providing patient care management, outcomes improvement and research. | **Change:** participants shall be requested to provide consent to managed care plans, healthcare providers and their respective designees, for the purpose of providing patient care management, outcomes improvement and research. | Disability Rights Network of PA |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | | | **Comment:** How would the CHC-MCO become aware of a participant's death? Define "serious injury" as used in this section. Define: "participant's back-up plan" as used in this section. | Disability Rights Network of PA |
| Requirements Document Exhibit | N - Notice of Denial | ALL | | **Question:** Since these notices are only sent when the CHC-MCO has reviewed the request, how does the participant get notice of a denial if the service coordinator does not include a participant requested service in the submitted service plan? | Disability Rights Network of PA |
| Requirements Document Exhibit | ZZ - Automatic Assignment | ALL | | **Comment:** Define D-SNP as used in this section. | Disability Rights Network of PA |
| Requirements Document Exhibit | ZZ - Automatic Assignment | ALL | | **Comment:** Notices regarding how to select a CHC-MCO must be made available in alternative, accessible formats for persons with disabilities as one way to decrease the occurance of automatic assignment. | Disability Rights Network of PA |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Notice | | **Comment:** Notice of Rights and Responsibilities should include a requirement that the CHC-MCO provide written notice of the same both at enrollment and every year thereafter, as well as upon request of the participant. | Disability Rights Network of PA |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | | | **Add:** Right to have notices directed to a representative chosen by the participant | Disability Rights Network of PA |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | | | **Add:** provided in a form that is accessible to persons who are deaf or hard of hearing | Disability Rights Network of PA |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Rights | | **Add:** (as a bullet point) **-** Participants with disabilities are entitled to have the MCO make reasonable modifications in its policies, practices, and procedures in addition to its services. | Disability Rights Network of PA |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Rights | | **Add:** (as a bullet point) - Participants shall have the right to receive services and benefits in a manner that ensures effective communication | Disability Rights Network of PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (2) Data Elements Demographics | Type of residence | **Add**: Provider owned home under four beds; personal care home 4-8 beds, personal care home, over 8 beds.<br><br>**Comment**: It would help to understand whether the type of residence is or could (or could not) be part of Residential Habilitation. | Disability Rights Network of PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (2) Data Elements Demographics | Living Arrangement | **Add**: Residential Habilitation housemates | Disability Rights Network of PA |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (4) Data Elements – Comprehensive Needs Assessment | | **Question:** How is GGG (4) intended to be used? What is its purpose? Is it intended to replace the CMI currently used? Is it part of a level of care assessment? Will it be used in development of a person centered plan? | Disability Rights Network of PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (4) Data Elements – Comprehensive Needs Assessment | yes/no | **Comment**: For many of the questions, such as, "does the diagnosis effect the individual's ability to function", a yes or no answer is not very informative. A scaled rating would help. | Disability Rights Network of PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (4) Data Elements – Comprehensive Needs Assessment | level of care determination (LCD) assessment | **Question/Comment**: Where is ICF-ORC eligible/ineligible? What does LTSS ineligible mean? Anyone eligible for NF or ICF/ORC should be eligible for LTSS. | Disability Rights Network of PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (4) Data Elements – Comprehensive Needs Assessment | individual's preferred residential setting | **Add**: Residential habilitation 1-3 person home; Residential habilitation 4-8 person home | Disability Rights Network of PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (4) Data Elements – Comprehensive Needs Assessment | if NFI, preferred community service program | **Change**: if NFI and ORCI, preferred community service program | Disability Rights Network of PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (6) Data Elements - Care Plan | does the consumer have a residence in the community | **Add**: If the consumer does not have a residence in the community, discuss housing options, including residential habilitation, shared living, and rent subsidies | Disability Rights Network of PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (6) Data Elements - Care Plan | services | **Add**: Residential Habilitation and Support Service Provider (SSP)<br><br>**Comment**: Make sure all covered services are on the list. | disability Rights Network of PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (6) Data Elements - Care Plan | Assistive Devices | **Add**: Hearing aids; Augmentative Communication Devices | Disability Rights Network of PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (7) Data Elements - Nursing Home | Transition: want to return home | **Change:** want to return home, or to another home in the community | Disability Rights Network of PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (7) Data Elements - Nursing Home | Transition: if no, barriers | **Comment:** We are confused by the intent of this section. Most of these listed barriers (with the exception of consumer request, relocation, and death) should be listed under barriers to overcome. They do not represent reasons to not transition a person who wishes to live in the community. In fact some, such as cognitive impairment and mental health issues, represent exactly the population that the Nursing Home Reform Act targets for transition with specialized services in the community. Funding, lack of housing and lack of support are barriers that must be addressed and overcome. And the CHC-MCO should never be allowed to determine that a person's "service needs are greater than can be adequately provided in the community." Nursing facility residents must be informed of their right to Nursing Home Transition Services to help overcome barriers to community living, and this information regarding barriers to the community must be provided to Nursing Home Transition Coordinators. | Disability Rights Network of PA |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (7) Data Elements - Nursing Home | Type of housing | **Add**: Provider owned home under four beds; personal care home 4-8 beds, personal care home, over 8 beds.<br><br>**Comment**: It would help to understand whether the type of residence is or could (or could not) be part of Residential Habilitation. | Disability Rights Network of PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (7) Data Elements - Nursing Home | Living Arrangement | **Add**: Residential Habilitation housemates | Disability Rights Network of PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | (7) Data Elements - Nursing Home | | **Question/Comment**: How does this relate to the PSARR assessment? | Disability Rights Network of PA |
| Requirements Document Exhibit | E - Specific Federal Regulatory Cites for Managed Care Agreements | 1903(i)(17) | The CHC-MCO shall not make payment with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan. | **Question/Comment**: Is EPSDT in the state plan in such a way that all federally coverable services, regardless of whether they are individually itemized in the plan are nonetheless "covered under the Medicaid State Plan"? If not, it must be clarified that EPSDT services must be provided regardless of whether they are in the state plan. Are HCBS Waiver services covered "under the Medicaid State Plan"? If not, this also must be clarified. | Disability Rights Network of PA |
| Requirements Document Exhibit | AAA - Provider Network Composition/Service Access | 4.c. Page 14 | | **Add**: In the case where a recipient was not provided a service for any period of time due to a CHC-MCO's failure to comply with the access standards of this Agreement, the MCO shall pay an amount equal to that which it would have paid had the service been provided as required. This payment is separate and apart from the corrective action plan and such plan will not obviate the need for this payment.<br><br>**Comment**: In no case should the CHC-MCO be permitted to profit from a failure to meet access standards. Otherwise, the incentive is to ignore the standards until caught, and until the corrective action process is complete. | Disability Rights Network of PA |
| Requirements Document Exhibit | DDD(2) - Covered LTSS Service Definitions | Job coaching | | **General Comment concerning the covered service definitions in Exhibit DDD (released previously): Add:** Job coaching should include pre-vocational training in an integrated community -based setting when needed. | Disability Rights Network of PA |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | B. Guidelines for Review; 2. Medically Necessary Requirements; Page 76 | "Medically Necessary Requirements: The CHC-MCO must describe the process to validate medical necessity for: covered care and services; ….." | It is recommended that this section include the definition of Medically Necessary detailed later in the document: "The Service or benefit will assist the Participant to achieve or maintain maximum functioning capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age." This is necessary as most CHC-MCOs will not be familiar with LTSS and will likely have a purely medically-focused definition of Medically Necessary. The measure of successful outcomes should be the progress toward and accomplishment of goals as stated in the member's Person-Centered Service Plan. | ReMed/Vicki Eicher |

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| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | B. Guidelines for Review; 2. Medically Necessary Requirements; For CHC MCOs; c.,e.,h.; Pages 76 & 77 | c., e., h., "The CHC-MCO must identify the qualification of staff that will determine if the service is Medically Necessary." (h) For LTSS, Covered Services will be authorized in accordance with the requirements of the CHC 1915(c) Waiver. | The Document recognizes that the definition of Medically Necessary is different for LTSS vs typical health care services. Therefore, it is critical that the qualifications of the person determining "Medically Necessary" for LTSS, have experience and expertise in long term supports and services. Additionally, should the service in question pertain to an individual receiving disability specific services, then the person determining "Medically Necessary" should have expertise and experience in the disability specific field in question. The measure of successful outcomes should be the progress toward and accomplishment of goals as stated in the member's Person-Centered Service Plan. | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Exhibit M(1)-1; Page 79 | Quality Management and Utilization Management Program Requirements | We strongly oppose the use of standard Utilization Management (UM) processes for those receiving LTSS. We recognize that an MCO must review the efficacy of services for which they are paying. However, using a medical model and typical utilization guidelines to assess goals for individuals that have life-long support needs, the MCO will not be able to support the participant in the way that is needed to provide the long-term services that are required. UM or 'goal reviews' should be conducted by those who have education and experience concerning a specific disability and a clear understanding of the needs of individuals receiving LTSS. | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard I., M(1)- 2; B.; Page 80 | "The scope of the QM and UM programs must be comprehensive in nature... At a minimum, the CHC-MCO's | Policies and procedures regarding LTSS should identify any additional licensure or accreditation necessary for the provision of disability- specific or specialty services. It is recommended that Professionals charged with developing and implementing QM/UM programs have experience and understanding of the unique elements of LTSS that differ | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard II., M (1)-5-6; Pages 83- 84 | C. "The Director of LTSS ensures the provision of LTSS in accordance with the requirements…." | We strongly support the Department for requiring the MCO to have a dedicated, full time Director of LTSS given that these supports and services are very different from the medical services in scope, outcome goals, and quality measurements. | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-7; Page 85 | A. 3) "The QM and UM programs must include professionally developed practice guidelines… Applicable to Providers for the delivery of certain types or aspects of health care." | Recommend that this wording include: Applicable to Providers for the delivery of certain types or aspects of health care or LTSS. Should Providers of certain types or aspects of health care require additional licensure or accreditation, these practice guidelines/standards of care should be incorporated into the QM and UM programs' standards of care. | ReMed/Vicki Eicher |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-7; Page 85 | B. and C. B. "The QM and UM programs must include clinical/quality indicators in the form of written, professionally developed, objective and measurable variables of a specified clinical or health services delivery area…." C. "Practice guidelines and clinical indicators must address the full range of health care and LTSS needs of the populations served by the CHC-MCO..." | For those Providers whose speciality area of care provision require additional licensure or accreditation, it is recommended that language be included that recognizes the clinical/quality indicators already in place for those providers, i.e., in CARF accredited providers. Specifically, CARF accreditation requires adherence to international standards for quality measurement, management and performance. Any requirements of an MCO should not be in conflict with CARF required QM/PI and should accept those standards as the minimum requirements where the CARF standards are more stringent than those required by an MCO. | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-8; Page 86 | E.The CHC-MCO must develop methodologies for asssessing performance of LTSS Providers….These methodologies must: 2) "Demonstrate the degree to which LTSS Providers are complying with requirements of the Department and the CHC-MCO." | It is strongly recommended that the CHC-MCO develop the methodologies for assessing performance of the LTSS Providers in conjunction with the Provider group and other stakeholder groups. For the most part, the prospective CHC-MCOs do not have the experience or expertise to develop methodologies for programs and services with which they are not familiar. Individuals being served with LTSS are a very heterogenous population; therefore, the measure of successful outcomes should be the progress toward and accomplishment of goals as stated in the member's Person-Centered Service Plan. | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-9; Page 87 | H. The QM and UM programs must contain procedures for Participant Satisfaction Surveys…." "The Department will continue to monitor the development of evidence-based LTSS satisfaction surveys.." | It is strongly recommended that the MCOs work with the Provider group and other stakeholders in the development of any satisfaction survey measures for LTSS services, as these questions will be decidedly different from questions concerning medical services. | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-9; Page 87 | K. "The QM and UM programs must contain procedures for measuring Participant and Provider satisfaction with LTSS service delivery." | It is recommended that wording be added to require these Participant and Provider satisfaction surveys "be conducted on at least an annual basis." | ReMed/Vicki Eicher |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IV., M(1)-9-10; Pages 87-88 | A. "The QM/UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided…to include: Utilization, claims, inpatient stays, "community - based LTSS use"…" | It is strongly recommended that the MCOs work with the Provider group and other stakeholders in the development of any measure regarding the appropriateness, cost effectiveness and use of Long Term Supports and Services, as these standards will be decidedly different from those appropriate for medical services. | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VI., M(1)-11; Pages 89- 90 | " THE QM and UM programs must have mechanisms to ensure that Participants receive seamless, continuous and appropriate care….between:" | Recommend that the following be added: "J. CHC-MCOs and LTSS providers" | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII., M(1)-12-14; Pages 90-91 | A. "The QM/UM program must have standards for credentialing/recredentialing Providers to determine whether all Providers, who provide health…." A. "The CHC-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types that satisfies the Department's requirements..." G. "The CHC-MCO shall evaluate a Provider's professional qualifications through objective measures of competence and quality. Providers should be given the opportunity to have input on the CHC-MCO's credentialing practices." | It is recommended that this wording be revised to state: "The CHC-MCOs will work with the Providers to establish appropriate credentialing criteria, particularly for LTSS specialty services." For LTSS services, the CHC-MCO may not have the appropriate experience or expertise to establish or evaluate objective measures of competence and quality. For LTSS brain injury services, it is recommended that the provider qualifications mirror the 1915 (c) approved waiver, which requires CARF accreditation as a Brain Injury provider for specific services, as these are highly specialized services that requires significant expertise and experience. | ReMed/Vicki Eicher |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII., M(1)14,15; I. Pages 92-93 | I. "In the event that a CHC-MO renders an adverse credentialing decision…..All credentialing decisions made by the CHC-MCO are final and may not be appealed to the Department." | It is recommended that a provision be added to allow for an appeal of a credentialing decision. Many of the prospective MCOs have no experience with LTSS, and there is a concern that the MCO may not have the experience or expertise to credential an LTSS provider. | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15; Page 93 | "The CHC-MCO's written UM program must contain policies and procedures that describe the scope of the program…" | Description and explanation for LTSS needs to be provided/included. This section needs to strongly support the person centered plan as part of the medically necessary covered services. The Department must have the oversight of the MCO to monitor and enforce this. | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15,16; C. Pages 93- 94 | C. "...The CHC Program definition of Medically Necessary: ....Medical Necessity determinations must be made by qualified and trained Health Care Providers." | It is recommended that this wording be revised to state: "Medical Necessity determinations must be made by qualified and trained Health Care Providers; Should the determination focus on specialty services, the CHC-MCO will ensure that the Health Care Provider involved in the Medical Necessity determination will have the appropriate expertise and experience." | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15,16; C.(3) Pages 93- 94 | C. (3) "...The CHC Program definition of Medically Necessary: ....The Service or benefit will assist the Participant to achieve or maintain maximum functioning capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age." | The Department is recognized for expanding the definition of Medically Necessary to include achieving and/or maintaining maximum functional capacity in performing daily activities, which is the goal of LTSS. It is recommended that this definition be referenced whenever Medically Necessary items are included, as most CHC-MCOs will not be familiar with this expanded definition of Medically Necessary. | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-18; K. Page 96 | K. "The UM program must contain procedures for providing written notification to Participants of denials of medical necessity and terminations…." | It is strongly recommend the current practice of having an in- person meeting between the Service Coordinator, the Provider and the Participant occur whenever a change in programming is recommended. This is particularly critical given that LTSS services are often provided to individuals with cognitive and language impairments. This in- person meeting should occur prior to any denial of services or written notification of said denial. | ReMed/Vicki Eicher |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIII., M(1)-19; Page 97 | "The CHC-MCO must have written standards for medical record and service planning record keeping…" C. Additional Standards include the following:" | It is recommended that Medical Record standards and standards for participant data reflect the differences in the type and frequency of documentation appropriate in LTSS settings. | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | Healthcare Effectiveness Data and Information Set "HEDIS" M(4)-1; Page 107 | "HEDIS is a set of standardized performance measures designed to reliably compare helth care plan performance. HEDIS performance measures are divided into five domains of care:" | Description and explanation for LTSS needs to be provided/included**.** It is not clear how the HEDIS performance measures will be appropriate to LTSS. MCOs should work with the provider groups and stakeholders in the development of any performance measures. MCOs and the Department should also recognize the Quality Management programs already in place in Commission on Accreditation of Rehabilitation Facilities (CARF) accredited providers. Specifically, CARF accreditation requires adherence to international standards for quality measurement, management and performance. Any requirements of an MCO should not be in conflict with CARF required QM/PI and should accept those standards as the minimum requirements where the CARF standards are more stringent than those required by an MCO. | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | Consumer Assessment of Healthcare Providers and Systems (CAHPS), Page 109 | "The HEDIS protocol for administering CAHPS surveys consists of a mail protocol followed by telephone administration to those not responding by mail." | MCOs should work with provider groups & stakeholders in the development of any satisfaction survey regarding LTSS. CARF accredited providers of LTSS services are required to have a satisfaction tool and system in place to routinely elicit input from participants and all stakeholder groups. This data could be made available to the MCOs as needed. Among the brain injury CARF accredited providers, this satisfaction tool contains consistent questions for all providers to use to allow for benchmarking purposes. Questions regarding LTSS services will be decidedly different from a medical service model. Additionally, it is recommended that a provision be made to assist people with cognitive or language impairments to complete any of these required surveys. | ReMed/Vicki Eicher |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Performance Measures and Data Elements; Pages 143-148 | | MCOs and the Department should recognize the Quality Management programs already in place in Commission on Accreditation of Rehabilitation Facilities (CARF) accredited providers. Specifically, CARF accreditation requires adherence to international standards for quality measurement, management and performance improvement. Any requirements of an MCO should not be in conflict with CARF required QM/PI and should accept those standards as the minimum requirements where the CARF standards are more stringent than those required by an MCO. | ReMed/Vicki Eicher |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG(2), Data Elements-Demographics; Pages 149-151 | | There is an overall concern that the document does not recognize the functional impact of cognitive impairment and the extent to which it is a barrier to accessibility of services nor does it address the accommodations that are required to allow the participant to be an active partner in the process. It is recommended that under "Communication, the general term "Language" be revised to specify: "Difficulty Understanding Language;" "Difficulty Expressing Thoughts." | ReMed/Vicki Eicher |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (3) Data Elements-Needs Screening and Comprehensive Needs Assessment; Pages 152-169 | | Acquired Brain Injury and Cognitive Impairment are not included. A separate needs assessment for ABI and Cognitive Impairment should be added to Exhibit. ABI is currently listed under Neurological. It is recommended that the Department adopt Utah's Intake, Screening and Assessment Form/Tool, Version 2.0 (which can be used for all disability groups). http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury%20Assessment%20(CBIA)%20Version%202.0.pdf | ReMed/Vicki Eicher |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (3) Data Elements-Needs Screening and Comprehensive Needs Assessment; Pages 152-169 | Participant self-identifies social or LTSS needs that are not being met; Medical; Medical-Individual's Cognitive State; Behaviors; Psychiatric; ADL's and IADLs | All elements indicate that the issue is "self identified." It is recommended that this language be revised to allow for and encourage a caregiver or support system to also identify issues. Cognitive Impairment is not included. "Executive Functioning Impaired"- Does everyone know what this means? The following items should be listed under this: *Problem Solving * Reasoning * Planning & Organizing * Insight. For Behaviors, it is recommended that the following be added: suicidal ideations, suicidal actions, impulsivity, and fire setting. For ADLs and IADLs, each item should include if the type of assistance needed is either physical or cognitive. It is recommended that the Department adopt Utah's Intake, Screening and Assessment Form/Tool, Version 2.0 (which can be used for all disability groups). http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury%20Assessment%20(CBIA)%20Version%202.0.pdf | ReMed/Vicki Eicher |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (6) Data Elements- Care Plan | Services | Under Behavior Consultation, add behavior therapy; need to add Structured Day; Residential Supports (specify Residential Habilitation). All items from 1915 c waiver covered services are not included and should be, as both Providers and Stakeholders were assured that services would not change with this transition. | ReMed/Vicki Eicher |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and | M (2)-4 | CHC-MCOs must and must require their network providers and subcontractors to report critical events or incidents via a standard file transaction incorporated in the Enterprise Incident Management System | Currently only those reports for participants under 60 go through EIM. Will Incident Reports for Aging participants go through EIM or SAMS? | Liberty Community Connections |

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| Requirements Document Exhibit | | GGG (2) | Gender: Male, Female, Transgender | We applaud the Commonwealth for identifying and acknowleding "Transgender" as a choice for gender identification in the new Data Elements: Demographic page | Liberty Community Connections |
| Requirements Document Exhibit | M(1) - Quality management and Utili | M (1)- 15 | The UM program must allow for determinations of medical necessity that are consisten with the CHC Program definition of Medically Necessary: Determinations of medical necessity for covered care and services whether made on a Prior Authorization, Concurrent Review or Retrpsective Review basis, shall be documented in writing. The CHC-MCO shall base its determination on medical information prvided by the Participant the Participant's family/caretakers and the PCP, as well as any other Providers, programs and agencies that have evaluated the participant. | We recommend that the RFP more thoroughly define "medical necessity" as it pertains to all service definitions and services offered. We recommend that the Commonwealth look at the definition of Medical Necessity as it pertains to services offererred that aren't medical or LTSS in nature (i.e. signature stamp, Non Medical Transportation). We also recommend a standard definition of Medical Necessity be carried throughout the RFP. | Liberty Community Connections |
| Requirements Document Exhibit | M(1) - Quality management and Utili | M (1), 8 (E3) | The CHC-MCO must develop methodologies for assessing performance of PCPs/PCP sites, high risk/high volume specialists, dental Providers, LTSS Providers, and Providers of Ancillary services not less than every 2 years (i.e. medical record audits) | We recommend that the RFP standardize the requirements for assessing performances for all MCOs. This will allow for clear and uniform standard procedures for all Providers under each MCO. This will also allow for the preservation of the provider network. | Liberty Community Connections |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG (4) | | After review of what appears to be the new person centered assessment, no information was given about the tool itself in the Appendices. Please confirm how the tool will be used? Will it be used to preclude enrollment for those who are not Waiver appropriate | Liberty Community Connections |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG (7) | Page 2 of Data Elements - Nursing Home | After review of the questions, it appears as though under the "Transition" section, the Participant is given a choice of whether they want to return home. If the Participant denies wanting to come home and identifies perceived barriers to transition, does this halt the process and transition? Are step identified to assist the Participant to overcome boundaries to allow for transition to home? | Liberty Community Connections |
| Requirements Document | | | DEFINITATION OF MEDICALLY NECESSARY A service, item, procedure or level of care that is: (i) Compensable under the Medical Assistance Program. (ii) Necessary to the proper treatment or management of an illness, injury or disability. (iii) Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice. | (ii) Necessary to the proper treatment, or management of an illness, injury or improvement of the functioning with a disability . | Casey Ball Supports Coordination / Lester Bennett |

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| Requirements Document | Section X: Termination and Default | 21.NonDiscrimination/Sexual Harassment Clause c. | c. The CHC-MCO, any subgrantee, contractor or any subcontractor shall establish and maintain a written nondiscrimination and sexual harassment policy and shall inform their employees of the policy. The policy must contain a provision that sexual harassment will not be tolerated and employees who practice it will be disciplined. Posting this Nondiscrimination/Sexual Harassment Clause conspicuously in easily accessible and well-lighted places customarily frequented by employees and at or near where the grant services are performed shall satisfy this requirement. | Should include that policy must be given to those who need the policy in alternative forms ..ex braille or larger print | Casey Ball Supports Coordination / Lester Bennett |
| Requirements Document | Section I: Incorporation of Documents | Operational Updates, Page 1 | The Department will issue Ops memos via the intranet | DHS is creating an intranet and posting regulatory updates to that intranet, however all language points to only the State and MCO's having access to it and not the providers. We suggest all contracted providers have access to the intranet for the regulatory updates. | United Disabilities Services |
| Requirements Document | Section IV: Applicable Laws and Regulations | Certification and Licensing, Page 2 | CHC-MCO's must use the streamlined credentialing process that the Department develops in conjunction with the CHC-MCO's. | We encourage adding contract language to clarify that one standardized credentialing of providers for all MCO's who win the CHC RFP will be created. | United Disabilities Services |
| Requirements Document | Section IV: Applicable Laws and Regulations | Certification and Licensing, Page 3 | CHC-MCO's must use the streamlined credentialing process that the Department develops in conjunction with the CHC-MCO's. | We encourage adding the following language: Providers shall obtain the credentials that the department develops in conjunction with the CHC-MCO's no later than the end of the second full year of operation and shall maintain those credentials for the duration of active MCO contracts in relationship to performing PA CHC provider services. This language is consistent with the MCO accreditation on page 3. | United Disabilities Services |

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| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | Page A-27 | Managed care organizations must comply with and require their Long term living home and community based network service providers to comply with the provisions of 55 Pa. Code Chapter 52, Long-Term Living Home and Community-Based Services, with the following exceptions: 52.21 Staff training. Outlines the minimum training requirements for providers and provider staff | We encourage direct training from MCOs & continued education to ensure staff meet training requirements for Service Coordination. Since this is a critical part of compliance, detailed information is needed on the specific requirements suggested by DHS in order to adequately respond. | United Disabilities Services |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | Page A-27 | Managed care organizations must comply with and require their Long term living home and community based network service providers to comply with the provisions of 55 Pa. Code Chapter 52, Long-Term Living Home and Community-Based Services, with the following exceptions: 52.27 Service Coordinator Qualifications & Training | The CHC paper mentioned a SC supervisor must be licensed social worker or nurse. This does not appear to be the most cost effective option. Our SC Supervisors have the experience and knowledge and cost less than bringing in a licensed social worker or RN. 2011 Act 22 discusses this concern directly. If the area of concern is training, we encourage more education in this area. SCE's must utilize their RNs more often to reduce APS reports. Effective teams have a blend of vast experiences including a broad use of educational requirements. A suggestion would be to include in the QA section of this RFP the need to have specific qualifications present during QA meetings and during review of patient specific information. We also recommend that there be a certification program for staff that allows them to be certified in the specific areas required, allowing them to utilize their past experience and degrees that may fall in other areas of study. | United Disabilities Services |

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| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | Page A-28 | Managed care organizations must comply with and require their Long term living home and community based network service providers to comply with the provisions of 55 Pa. Code Chapter 52, Long-Term Living Home and Community-Based Services, with the following exceptions: 52.28 (a)(1) and (b): (a)(1) The SCE is providing the service as an OHCDS under 52.53 (b) If an SCE operates as an OHCDS, then the SCE may not require a participant to use that OHCDS as a condition to receive the service coordination services of the SCE. | We feel this would allow for SCE's to better monitor the contractor who is not waiver approved to determine if they are reliable as a OHCDS vendor. We recommend language be added to include "any willing provider" be added for other services like DME, home health etc. | United Disabilities Services |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | Page A-28 | Managed care organizations must comply with and require their Long term living home and community based network service providers to comply with the provisions of 55 Pa. Code Chapter 52, Long-Term Living Home and Community-Based Services, with the following exceptions: 52.41 Provider billing | Will the MCOs utilize the PROMISe billing database or would this convert to a new system? | United Disabilities Services |

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| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | Page A-28 | Managed care organizations must comply with and require their Long term living home and community based network service providers to comply with the provisions of 55 Pa. Code Chapter 52, Long-Term Living Home and Community-Based Services, with the following exceptions: 52.53 Organized Health Care Delivery System | Are the MCOs planning on keeping OHCDS with Service Coordination Entities for home adaptations & vehicle adaptations? Specific information on the intent of the change is not present in this document which makes it difficult to adequately comment. Our preference would be for it to remain with SCE's. | United Disabilities Services |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | Page A-28 | Managed care organizations are not required to adhere to the provisions of Medical Assistance Bulletins 05-86-02, Durable Medical Equipment Warranties | Would this mean warranties are not recognized by CHC? If so, how would repair costs be covered for the participant's equipment? | United Disabilities Services |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | Section G, Pages 6-7 | The CHC-MCO's and each subgrantee's, contractors and subcontractor's obligations pursuant to these provisions are ongoing from and after the effective date of the agreement through the termination date thereof. Accordingly, the CHC-MCO and each subgrantee, contractor and subcontractor shall have an obligation to inform the Commonwealth if, at any time during the term of the agreement, it becomes aware of any actions or occurrences that would result in violation of these provisions. | We encourage adding specific processes for addressing contractor non compliance or breach of ethical standards. | United Disabilities Services |

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| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | Pages A-U | Terms and conditions as related to the CHC-MCO | Are these terms designated for guidance and regulations for MCO's? | United Disabilities Services |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | Pages H-4 | Prior Authorization | We encourage listing directly the services that are being requested to have a pre-authorization. | United Disabilities Services |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | Pages H-4 | Prior Authorization | We encourage listing examples of the IDT approach | United Disabilities Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Exhibit M(1) Standard I, F, page M(1)-3 | Provide a comprehensive written evaluation, completed on at least an annual basis that details all QM and UM program activities. | We suggest adding contract language to clarify that one standardized method of evaluation will be utilized. | United Disabilities Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Exhibit M(1) Standard II, A.2), page M(1)-5 | The governing body regularly receives written reports on the QM and UM program activities that describe actions taken, progress in meeting objectives and improvements made. | We suggest adding contract language to clarify that one standardized set of goals to be achieved and methods of evaluation will be used. | United Disabilities Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Exhibit M(1) Standard III, page M(1)-7 | The QM and UM programs must include methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services. | We suggest contract language to clarify that one standardized set of goals to be achieved and methods of evaluation will be used. | United Disabilities Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Exhibit M(1) Standard IV, page M(1)-9 | The QM and UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided to participants. | We suggest adding contract language to clarify that one standardized set of goals to be achieved and methods of evaluation will be used. | United Disabilities Services |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Exhibit M(1) Standard XI, page M(1)-19 | The CHC-MCO must ensure that findings, conclusions, recommendations and actions taken as a result of QM and UM program activities are documented and reported to appropriate individuals. | We encourage adding time frames for reporting information. We also suggest having various skill sets including BSN, LSW and other varied professionals be a part of these QA processes to ensure adequate breadth of knowledge during the review process. | United Disabilities Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Exhibit M(1) Standard XIV, page M(1)-20+ | The QM and UM program must demonstrate a commitment to ensuring the Participants are treated in a manner that acknowledges their defined rights and responsibilities. | We encourage adding a step for signed and dated receipt of information with a place for a witness signature and date. | United Disabilities Services |
| Requirements Document Exhibit | M(2) - External Quality Review | Exhibit M (2) B Page M (2)-1 | Accurately, completely and within timeframe identify eligible participants to the EQRO. | Please identify what the timeframe noted is. | United Disabilities Services |
| Requirements Document Exhibit | M(2) - External Quality Review | Exhibit M (2) I. Page M (2)-2 | The CHC-MCO will comply with the PIP timelines as prescribed by the EQRO. | Please identify what the timeframe noted is. | United Disabilities Services |
| Requirements Document Exhibit | M(2) - External Quality Review | Exhibit M (2) I. Page M (2)-2 | After 3 years, the CHC-MCO shall, using evaluation criteria established by the department, determine if one or all of the PIPS should be continued | How will this evaluation criteria be determined and will the information be made openly available? | United Disabilities Services |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | Exhibit M (3) Page M (2)-4 | CHC-MCO's must require their network providers and subcontractors to report critical events or incidents in a standard file transaction incorporated in the Enterprise Incident Management System. | Will the current EIM process remain as stated? Please detail who will be responsible for reporting and when, for example timeframes, etc. Who Investigates? | United Disabilities Services |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | Exhibit M (3) Page M (2)-4 | If these events occur, the provider agency must have a plan for temporary stabilization. | Currently, providers are responsible to have this in place, however it often does not happen and there is service interruption if a participants back up plan fails. What measures are being taken to see that this happens consistently? Who will report when t does not? Will providers be sanctioned should it happen? | United Disabilities Services |

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| Requirements Document | | | The Department of Public Welfare appears multiple places throughout the document. | Change "Department of Public Welfare" to "Department of Human Services". | John Mehler, Administrator/Northampton County AAA |
| Requirements Document | Section VIII: Reporting Requirements | B.1 page 6 | We understand the use of encounter data reporting, however in situations where a provider may utilize volunteers to perform a service, (such as home delivered meals), daily encounter forms requiring signatures can become unworkable. | We would recommend that forms to be used for volunteer-provided services be developed in consultattion with providers | John Mehler, Administrator/Northampton County AAA |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | page 105 | | We recommend the definition of neglect be consistent with the definition contained in the Adult Protective Services Act and the Older Adult Protective Services Act. | John Mehler, Administrator/Northampton County AAA |
| Requirements Document | | Accreditations | | Accreditation for agencies in particular local accessible Independent Living Centers already delivering excellent services is just another financial burden as well as a diversion in terms of time and effort from maintaining their excellent service. If it ain't broke why spend time and money fixing it?<br>Better would be for the CHC along with consumers and MCOs to ask the not for profit IL's to describe how they provide such a good service. To identify wasteful time consuming activities forced upon them and use their long expertise in developing standards for accreditation that are inexpensive manageable effective, efficient and incorporate the IL philosophy. By doing so you would be sharing good practice, developing Accreditation standards that actually reflect the reality of service delivery, innovation and supporting people in the community.<br>Ultimately the final say on this process and the development of new and innovative method of accreditation must rest with CHC and comply with legislation and rules and hopefully in consultation with consumers. | Alan Holdsworth a.k.a. Johnny Crescendo |
| Requirements Document | | Qualifications | | One of the top 10 things that disabled people is professional dominance and with managed care is likely to increase rather than decrease. Job descriptions and standards should be task and experience based with qualifications desirable and not a job killer for the many excellent unqualified Service Coordinators and others currently working in the field. | Alan Holdsworth a.k.a. Johnny Crescendo |

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| Requirements Document | | Qualifications | | There is no evidence that a Social Work of Nursing qualification enhances the delivery of Home and Community Based Services especially in the work of Supports Coordination. Indeed the head sets of Social workers and Medical personnel often goes against the concept of the Social Model and IL philosophy which if injected into the culture through managed care will inevitable dominate the ideas and ideals of the Disabled People's movement developed over the last 40 years. If nurses and social workers are coming out of college with a masters degree and have not heard of Ed Roberts or the IL Philosophy as I have evidenced it is quite clear that their headset needs to be rearranged before their degree qualifies them to be part of the independent living movement and supports and services that we are trying to create.<br>IL's have already developed training for Service Coordinators across the State and these should be looked at critically with a view to using them as a start for developing accredited and appropriate training which incorporates the IL Philosophy. | Alan Holdsworth a.k.a. Johnny Crescendo |
| Requirements Document | | Accreditations and Qualifications | | I think that a good idea would be to create a forum of Service Coordinators and consumers to discuss issues with accreditations and qualifications.<br><br>Finally imposing accreditation and qualifications without careful thought will only drive up the cost of service delivery in terms of overheads and increase pay for Service Coordinators. Rushing into this could also endanger disabled people's lives as there could be a shortfall of Service coordinators in the short term resulting in over load for the few qualified that are left. | Alan Holdsworth a.k.a. Johnny Crescendo |
| Requirements Document | | Approaches to service delivery | | One way of looking at what we are doing is to analyze our approaches to service delivery, something I did working with Professor Mike Oliver in Birmingham in 2002. We came up with 3 fundamental approaches that the Local Authority was taking which could also be said of most service delivery systems including those in PA. | Alan Holdsworth a.k.a. Johnny Crescendo |
| Requirements Document | | Humanitarian Approach to service delivery | | This approach is sees disabled people as helpless cripples who need rescuing and then should be grateful for the poor service they get. It is full of medical and charity model of disability. Disabled people have no rights or entitlements and have to behave in order to get the service. An example of this in Birmingham was the horrible para transit service and some nursing homes. Many advertisements currently on TV in particular Wounded Warrior Project use this approach exploiting our image and identity to raise money. | Alan Holdsworth a.k.a. Johnny Crescendo |

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| Requirements Document | | Compliance Approach to service delivery | | Slightly better that the Humanitarian Approach. This is basically the tick box approach which I find totally dominant in this state. Here we comply with laws and regulations mostly written to protect the administrators. We over complicate and ensure that we deliver inflexible one coat fits all services and disabled people are left unsatisfied. Under this approach people get the very minimum. I am thinking here of the assessment process which highlights medical necessity rather than living independently. | Alan Holdsworth a.k.a. Johnny Crescendo |
| Requirements Document | | Citizen Approach to service delivery | | We should move to this approach which recognizes first and foremost that disabled people are equal citizens with the same basic human and civil rights as any other citizen and takes responsibility for the barriers that society creates. Examples of this would be the development of Coalitions of Disabled People and independent Living Centers. | Alan Holdsworth a.k.a. Johnny Crescendo |
| Requirements Document | | Citizen Approach to service delivery | | At this current time I am pleased that the Governor and his staff are reconsidering the Community First Option as this begins the process of receiving services in the community and delivering on equality as a right not a privilege. The CFCO is well matched to managed care and could provide extra money to drive up standards and achieve the underlying goal of giving people the right to live in the community with the appropriate supports and service. Furthermore the introduction of the Community Integration Act S. 2515 shows the direction that the country is going and the CFCO is a useful step along the way to tie into this legislation. This leads to security for disabled people but also an opportunity for administrator to develop fine tune and perfect the systems and services. | Alan Holdsworth a.k.a. Johnny Crescendo |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | B. Guidelines for Review; 2. Medically Necessary Requirements; Page 76 | "Medically Necessary Requirements: The CHC-MCO must describe the process to validate medical necessity for: covered care and services; ….." | It is recommended that this section include the definition of Medically Necessary detailed later in the document: "The Service or benefit will assist the Participant to achieve or maintain maximum functioning capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age." This is necessary as most CHC-MCOs will not be familiar with LTSS and will likely have a purely medically-focused definition of Medically Necessary. The measure of successful outcomes should be the progress toward and accomplishment of goals as stated in the member's Person-Centered Service Plan. | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | B. Guidelines for Review; 2. Medically Necessary Requirements; For CHC MCOs; c.,e.,h.; Pages 76 & 77 | c., e., h., "The CHC-MCO must identify the qualification of staff that will determine if the service is Medically Necessary." (h) For LTSS, Covered Services will be authorized in accordance with the requirements of the CHC 1915(c) Waiver. | The Document recognizes that the definition of Medically Necessary is different for LTSS vs typical health care services. Therefore, it is critical that the qualifications of the person determining "Medically Necessary" for LTSS, have experience and expertise in long term supports and services. Additionally, should the service in question pertain to an individual receiving disability specific services, then the person determining "Medically Necessary" should have expertise and experience in the disability specific field in question. The measure of successful outcomes should be the progress toward and accomplishment of goals as stated in the member's Person-Centered Service Plan. | Success Rehabilitation/Joanne Tangney |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Exhibit M(1)-1; Page 79 | Quality Management and Utilization Management Program Requirements | We strongly oppose the use of standard Utilization Management (UM) processes for those receiving LTSS. We recognize that an MCO must review the efficacy of services for which they are paying. However, using a medical model and typical utilization guidelines to assess goals for individuals that have life-long support needs, the MCO will not be able to support the participant in the way that is needed to provide the long-term services that are required. UM or 'goal reviews' should be conducted by those who have education and experience concerning a specific disability and a clear understanding of the needs of individuals receiving LTSS. | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard I., M(1)- 2; B.; Page 80 | "The scope of the QM and UM programs must be comprehensive in nature... At a minimum, the CHC-MCO's | Policies and procedures regarding LTSS should identify any additional licensure or accreditation necessary for the provision of disability- specific or specialty services. It is recommended that Professionals charged with developing and implementing QM/UM programs have experience and understanding of the unique elements of LTSS that differ | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard II., M (1)-5; Pages 83- 84 | C. "The Director of LTSS ensures the provision of LTSS in accordance with the requirements…." | We strongly support the Department for requiring the MCO to have a dedicated, full time Director of LTSS given that these supports and services are very different from the medical services in scope, outcome goals, and quality measurements. | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-7; Page 85 | A. 3) "The QM and UM programs must include professionally developed practice guidelines… Applicable to Providers for the delivery of certain types or aspects of health care." | Recommend that this wording include: Applicable to Providers for the delivery of certain types or aspects of health care or LTSS. Should Providers of certain types or aspects of health care require additional licensure or accreditation, these practice guidelines/standards of care should be incorporated into the QM and UM programs' standards of care. | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-7; Page 85 | B. and C. B. "The QM and UM programs must include clinical/quality indicators in the form of written, professionally developed, objective and measurable variables of a specified clinical or health services delivery area…." C. "Practice guidelines and clinical indicators must address the full range of health care and LTSS needs of the populations served by the CHC-MCO..." | For those Providers whose speciality area of care provision require additional licensure or accreditation, it is recommended that language be included that recognizes the clinical/quality indicators already in place in CARF accredited providers. Specifically, CARF accreditation requires adherence to international standards for quality measurement, management and performance. Any requirements of an MCO should not be in conflict with CARF required QM/PI and should accept those standards as the minimum requirements where the CARF standards are more stringent than those required by an MCO. | Success Rehabilitation/Joanne Tangney |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-8; Page 86 | E.The CHC-MCO must develop methodologies for asssessing performance of LTSS Providers….These methodologies must: 2) "Demonstrate the degree to which LTSS Providers are complying with requirements of the Department and the CHC-MCO." | It is strongly recommended that the CHC-MCO develop the methodologies for assessing performance of the LTSS Providers in conjunction with the Provider group and other stakeholder groups. For the most part, the prospective CHC-MCOs do not have the experience or expertise to develop methodologies for programs and services with which they are not familiar. Individuals being served with LTSS are a very heterogenous population; therefore, the measure of successful outcomes should be the progress toward and accomplishment of goals as stated in the member's Person-Centered Service Plan. | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-9; Page 87 | H. The QM and UM programs must contain procedures for Participant Satisfaction Surveys…." "The Department will continue to monitor the development of evidence-based LTSS satisfaction surveys.." | It is strongly recommended that the MCOs work with the Provider group and other stakeholders in the development of any satisfaction survey measures for LTSS services, as these questions will be decidedly different from questions concerning medical services. | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-9; Page 87 | K. "The QM and UM programs must contain procedures for measuring Participant and Provider satisfaction with LTSS service delivery." | It is recommended that wording be added to require these Participant and Provider satisfaction surveys "be conducted on at least an annual basis." | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IV., M(1)-9; Pages 87-88 | A. "The QM/UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided…to include: Utilization, claims, inpatient stays, "community - based LTSS use"…" | It is strongly recommended that the MCOs work with the Provider group and other stakeholders in the development of any measure regarding the appropriateness, cost effectiveness and use of Long Term Supports and Services, as these standards will be decidedly different from those appropriate for medical services. | Success Rehabilitation/Joanne Tangney |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VI., M(1)-11; Pages 89- 90 | " THE QM and UM programs must have mechanisms to ensure that Participants receive seamless, continuous and appropriate care....between:" | Recommend that the following be added: "J. CHC-MCOs and LTSS providers" | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII., M(1)-12, 13; Pages 90- 91 | A. "The QM/UM program must have standards for credentialing/recredentialing Providers to determine whether all Providers, who provide health...." A. "The CHC-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types that satisfies the Department's requirements..." G. "The CHC-MCO shall evaluate a Provider's professional qualifications through objective measures of competence and quality. Providers should be given the opportunity to have input on the CHC-MCO's credentialing practices." | It is recommended that this wording be revised to state: "The CHC-MCOs will work with the Providers to establish appropriate credentialing criteria, particularly for LTSS specialty services." For LTSS services, the CHC-MCO may not have the appropriate experience or expertise to establish or evaluate objective measures of competence and quality. For LTSS brain injury services, it is recommended that the provider qualifications mirror the 1915 (c) approved waiver, which requires CARF accreditation as a Brain Injury provider for specific services, as these are highly specialized services that requires significant expertise and experience. | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII., M(1)14,15; I. Pages 92-93 | I. "In the event that a CHC-MO renders an adverse credentialing decision.....All credentialing decisions made by the CHC-MCO are final and may not be appealed to the Department." | It is recommended that a provision be added to allow for an appeal of a credentialing decision. Many of the prospective MCOs have no experience with LTSS, and there is a concern that the MCO may not have the experience or expertise to credential an LTSS provider. | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15; Page 93 | "The CHC-MCO's written UM program must contain policies and procedures that describe the scope of the program..." | Description and explanation for LTSS needs to be provided/included. This section needs to strongly support the person centered plan as part of the medically necessary covered services. The Department must have the oversight of the MCO to monitor and enforce this. | Success Rehabilitation/Joanne Tangney |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15,16; C. Pages 93- 94 | C. "...The CHC Program definition of Medically Necessary: ....Medical Necessity determinations must be made by qualified and trained Health Care Providers." | It is recommended that this wording be revised to state: "Medical Necessity determinations must be made by qualified and trained Health Care Providers; Should the determination focus on specialty services, the CHC-MCO will ensure that the Health Care Provider involved in the Medical Necessity determination will have the appropriate expertise and experience." | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15,16; C.(3) Pages 93- 94 | C. (3) "...The CHC Program definition of Medically Necessary: ....The Service or benefit will assist the Participant to achieve or maintain maximum functioning capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age." | The Department is recognized for expanding the definition of Medically Necessary to include achieving and/or maintaining maximum functional capacity in performing daily activities, which is the goal of LTSS. "The Service or benefit will assist the Participant to achieve or maintain maximum functioning capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age. It is recommended that this definition be referenced whenever Medically Necessary items are included, as most CHC-MCOs will not be familiar with this expanded definition of Medically Necessary. | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-18; K. Page 96 | K. "The UM program must contain procedures for providing written notification to Participants of denials of medical necessity and terminations…." | LTSS services are often provided to individuals with cognitive and language impairments who may not be able to read or understand a standardized Denial of Services form. It is recommended that notification be provided by whatever method necessary for the participant to understand the denial and the reason for the denial, including an in-person meeting. | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIII., M(1)-19; Page 97 | "The CHC-MCO must have written standards for medical record and service planning record keeping…" C. Additional Standards include the following:" | It is recommended that Medical Record standards and standards for participant data reflect the differences in the type and frequency of documentation appropriate to LTSS settings. | Success Rehabilitation/Joanne Tangney |

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| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | Healthcare Effectiveness Data and Information Set "HEDIS" M(4)-1; Page 107 | "HEDIS is a set of standardized performance measures designed to reliably compare helth care plan performance. HEDIS performance measures are divided into five domains of care:" | Description and explanation for LTSS needs to be provided/included. It is not clear how the HEDIS performance measures will be appropriate to LTSS. MCOs should work with the provider groups and stakeholders in the development of any performance measures. MCOs and the Department should also recognize the Quality Management programs already in place in Commission on Accreditation of Rehabilitation Facilities (CARF) accredited providers. Specifically, CARF accreditation requires adherence to international standards for quality measurement, management and performance. Any requirements of an MCO should not be in conflict with CARF required QM/PI and should accept those standards as the minimum requirements where the CARF standards are more stringent than those required by an MCO. | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | Consumer Assessment of Healthcare Providers and Systems (CAHPS), Page 109 | "The HEDIS protocol for administering CAHPS surveys consists of a mail protocol followed by telephone administration to those not responding by mail." | MCOs should work with provider groups & stakeholders in the development of any satisfaction survey regarding LTSS. CARF accredited providers of LTSS services are required to have a satisfaction tool and system in place to routinely elicit input from participants and all stakeholder groups. This data could be made available to the MCOs as needed. This satisfaction tool contains consistent questions for all providers to use to allow for benchmarking purposes. Questions regarding LTSS services will be decidedly different from a medical service model. Additionally, it is recommended that a provision be made to assist people with cognitive or language impairments to complete any of these required surveys. | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Performance Measures and Data Elements; Page 143 | | MCOs and the Department should recognize the Quality Management programs already in place in Commission on Accreditation of Rehabilitation Facilities (CARF) accredited providers. Specifically, CARF accreditation requires adherence to international standards for quality measurement, management and performance improvement. Any requirements of an MCO should not be in conflict with CARF required QM/PI and should accept those standards as the minimum requirements where the CARF standards are more stringent than those required by an MCO. | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG(2), Data Elements-Demographics; Pages 149-151 | | There is an overall concern that the processes outlined in this document do not recognize the functional impact of cognitive impairment and the extent to which it is a barrier to accessibility of services nor does it address the accommodations that are required to allow the participant to be an active partner in this process. It is recommended that under "Communication, the general term "Language" be revised to specify: "Difficulty Understanding Language;" "Difficulty Expressing Thoughts." | Success Rehabilitation/Joanne Tangney |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (3) Data Elements- Needs Screening and Comprehensive Needs Assessment; Pages 152-153 | | Acquired Brain Injury and Cognitive Impairment are not included. A separate needs assessment for ABI and Cognitive Impairment should be added to Exhibit. ABI is currently listed under Neurological. It is recommended that the Department adopt Utah's Intake, Screening and Assessment Form/Tool, Version 2.0 (which can be used for all disability groups). http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury%20Assessment%20(CBIA)%20Version%202.0.pdf | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (3) Data Elements- Needs Screening and Comprehensive Needs Assessment; Pages 152-153 | Participant self-identifies social or LTSS needs that are not being met; Medical; Medical-Individual's Cognitive State; Behaviors; Psychiatric; ADL's and IADLs | All elements indicate that the issue is "self identified." It is recommended that this language be revised to allow for and encourage a caregiver or support system to also identify issues. Cognitive Impairment is not included. "Executive Functioning Impaired"- Does everyone know what this means? The following items should be listed under this: *Problem Solving * Reasoning * Planning & Organizing * Insight. For Behaviors, it is recommended that the following be added: suicidal ideations, suicidal actions, impulsivity, and fire setting. For ADLs and IADLs, each item should include if the type of assistance needed is either physical or cognitive. It is recommended that the Department adopt Utah's Intake, Screening and Assessment Form/Tool, Version 2.0 (which can be used for all disability groups). http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury%20Assessment%20(CBIA)%20Version%202.0.pdf | Success Rehabilitation/Joanne Tangney |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (6) Data Elements- Care Plan | Services | Under Behavior Consultation, add Behavior Therapy; need to add Structured Day; Residential Supports (specify Residential Habilitation). All items from 1915 c waiver covered services are not included and should be, as both Providers and Stakeholders were assured that services would not be change with this transition. | Success Rehabilitation/Joanne Tangney |
| Requirements Document | | | Stakeholder Feedback | PACA MH/DS thanks the department for recognizing the value of Behavioral HealthChoices carve out and the strong foundation of success that has been demonstrated. We appreciate the Department's continued outreach and effort to engage a variety of stakeholders in the development of the CHC Program. Stakeholder involvement at multiple levels is essential to the successful implementation. The fact that the current Behavioral Health Choices program has purposefully and consistently incorporated stakeholder feedback as a core value is evident in the program's high contract standards and excellent satisfaction levels. PACA MH/DS believes that the ultimate success of Community HealthChoices will also be attributed to stakeholder involvement and adherence to the established standards of excellence at the operational, community and state levels. PACA MH/DS is a willing to provide any assistance possible. | Deb Neifert/ PACA MH/DS |
| | | | | PHA thanks the department for developing a uniform credentialing process as suggested in our previous comments. This will eliminate duplicative efforts from providers, MCOs | |

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| Requirements Document | Section IV: Applicable Laws and Regulations | Page 2 | The CHC-MCO must require its Network Providers to comply with all certification and licensing laws and regulations applicable to the profession or entity…CHC-MCOs must use the streamlined credentialing process that the Department develops. | and the department when providers are applying to be credentialed by more than one MCO in their region. To better streamline the application process, DHS should share provider information with all MCOs that was obtained through the revalidation process. This would prevent duplication by providers and OLTL staff, who worked so hard to collect and correct all provider information in the last year.<br>As discussed in our previous comments, PHA reiterates the need for the credentialing criteria to be flexible to allow providers to meet the requirements while maintaining the independence they need to make decisions that fit their unique business model. For instance, MCOs should not be permitted to require all network providers to contract with the same electronic visit verification (EVV) or electronic medical record (EMR) software vendor. The MCO should instead set broad parameters that providers' EVV or EMR | Pennsylvania Homecare Association |
| Requirements Document | Section VIII: Reporting Requirements | Subsection B(1)(f) Release of Encounter Data; Page 10 | All Encounter Data for Participants is the property of the Department. | Given that all encounter data will be considered property of DHS once submitted by the CHC-MCOs, we strongly urge DHS to implement protocol for publicly reporting this data annually. In the past, the Department of Health (DOH) had published an annual report for home health agencies showing trends in issues such as staffing, patient demographics, primary diagnoses and source of reimbursement. The information for the report is still collected by DOH via the Annual Data Collection Report Form submitted by all home health agencies each year, but due to funding constraints, the report has not been published since 2010. PHA members used this report to evaluate their patient census, expand into underserved regions and develop innovative models to address frequent diagnoses. PHA is currently working with DOH to revive the home health report, but there has never been an equivalent report for homecare agencies. With the implementation of CHC, DHS will have the opportunity to use the encounter data it collects to create a tool to spur industry innovation and foster better outcomes for homecare participants. PHA and other trade associations can be resources to assist DHS in analyzing and publishing LTSS encounter data so providers and participants can stay informed and keep striving to improve the CHC program. | Pennsylvania Homecare Association |

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| Requirements Document | Section VIII: Reporting Requirements | Subsection F Claims Processing Reports; Page 13 | N/A; The draft does not provide claims processing timelines. | The draft documents reference Section VII as the provision of the agreement that addresses claims processing timeliness sanctions, but that section was never provided for public comment. Assuming that the standards would mirror PH-HealthChoices timelines of 30-45 days for the payment of clean claims, PHA urges the commonwealth to consider requiring a shorter timeframe of 15 days for clean LTSS claims. Claims for personal assistance services will be submitted at regular intervals and will not require the same scrutiny as one-time services or acute care interventions, since they are authorized in the person-centered service plan. A short, 15-day timeframe for payment serves both providers and managed care plans and helps guarantee consumers will not see an interruption in care. Other states with MLTSS, like California and New Mexico, have used a 15-day timeline for these types of provider claims. Some small, private homecare agencies do not have the ability to secure lines of credit or other financing mechanisms to account for operating expenses while awaiting payment. This became very clear this past summer when providers were not paid for more than 60 days as a result of complications with the OLTL revalidation process and had to request emergency payment or be forced to stop services to consumers immediately. If payment cannot be made on time, MCOs should be held responsible, not consumers. Some managed care programs, such as Centennial Care in New Mexico, require MCOs to pay providers 1.5% interest on claims that are past the established deadlines. | Pennsylvania Homecare Association |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | Page A-27 | Holding MCOs accountable for following regulatory requirements for service coordinators at PA Code 52.27 | PHA reiterates our previous comments from December, calling for service coordinator hiring standards in the draft agreement to allow for an RN license, a bachelor's degree, or comparable work experience. This would allow MCOs to continue the work of current service coordinators that do not have the required academic background, perhaps because their own disability prevented them from pursuing higher education. To ensure ongoing quality care, service coordinators should be monitored by the MCOs for responsiveness, documentation standards, and quick communication and resolution of participants' needs. | Pennsylvania Homecare Association |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | Page A-29 | Holding MCOs accountable for following regulatory requirements for freedom of choice of providers at PA Code 1101.51 | While we understand the need to waive this requirement given the nature of the managed care model and the need to provide care using only in-network providers, we hope MCOs will still be held to standards that provide for freedom of choice within the established network of providers. With a few narrow exceptions, the Social Security Act requires states to allow Medicaid beneficiaries to obtain services from any qualified Medicaid provider. | Pennsylvania Homecare Association |

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| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | Page 1 of Exhibit H | Specify that Person-Centered Service Plans serve as prior authorization for the services outlined therein | Homecare providers are accustomed to receiving annual service authorizations under HCBS waiver programs to plan for the individual's care. PHA urges DHS to add language to clarify that "Person-Centered Service Plans serve as prior authorization for the services outlined therein *which shall remain authorized for the duration of the PCSP subject to annual reassessment or reassessment as required by a change in the beneficiary's condition* ." Predictable and reasonable service authorizations have a direct impact not only on the consumer but the direct care workforce. Employees often value continuous and predictable work schedules over higher wages and are likely to turn down homecare employment because they cannot be guaranteed a full workweek. MCOs should consider the direct care worker's needs and preferences when developing a person-centered plan and authorizing service hours. | Pennsylvania Homecare Association |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Page M(1)-9 | The Department will continue to monitor the development of evidence-based LTSS satisfaction surveys and reserves the right to implement a CAHPS or CAHPS-like survey at a later date | In the HCBS arena, there is a stark lack of quality data to show the great value that homecare providers add to the lives of the individuals they serve and to the Medicaid program as a whole. PHA recognizes this gap and has formed our own internal workgroup to develop quality measures that fit this unique care and population. We suggest adding language to this provision of the contract to require appropriate stakeholder engagement in the development of future CAHPS-like survey tools. | Pennsylvania Homecare Association |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program | Page M(1)-13 | Recredentialing activities must be conducted by the CHC-MCO | PHA requests a five-year recredentialing standard, rather than the proposed three years, to better align with current federal requirements for provider revalidation. The Centers | Pennsylvania Homecare Association |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Page M(1)-15 | All credentialing decisions made by the CHC-MCO are final and may not be appealed to the Department. | As discussed repeatedly in our previous comments on CHC and PH-HealthChoices, it is very important for DHS to maintain oversight over the CHC-MCOs. DHS must create mechanisms that allow providers to turn to the department if MCOs engage in discriminatory credentialing practices that threaten access to care. Network applicants that have been denied by the CHC-MCO should have an opportunity to submit feedback or complaints to DHS on the particular MCO's credentialing process to alert the department to a potential quality assurance issue. The CHC program needs certain checks and balances such as this one in place to be sure the commonwealth does not relinquish all control over Medicaid funds and give up its role in protecting Medicaid beneficiaries' access to care. | Pennsylvania Homecare Association |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Page M(1)-18 | The CHC-MCO must have a mechanism in place for Provider Appeals/Provider Disputes related to the following:… | As discussed repeatedly in our previous comments, PHA strongly believes it is important for the department to play some role in resolving provider disputes with MCOs. We suggest adding a second layer of provider dispute resolution through the creation of a third party neutral committee made up of commonwealth agency staff. The committee would be responsible for processing second-level dispute/appeal resolutions for any of the CHC-MCOs, so there would not be a need to create more than one statewide committee. Representation on the committee could include staff from OLTL, the Office of Developmental Programs, and the Department of Aging who could serve as a neutral arbitration panel in times when providers are seeing dramatic rate changes or being unreasonably denied entrance to an MCO's network. | Pennsylvania Homecare Association |
| Requirements Document Exhibit | M(2) - External Quality Review | Page M(2)-1 | The Medical Assistance Advisory Committee will be given an opportunity to provide input into the measures to be utilized. | We appreciate the opportunity for stakeholder input on the external quality review of CHC-MCOs through the Medical Assistance Advisory Committee (MAAC). The MAAC's involvement will bring both the provider and consumer perspective to the external review to be sure MCOs' are meeting the needs of the community they serve. | Pennsylvania Homecare Association |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | Page M(2)-4 | CHC-MCO must develop and implement a critical incident reporting system for Providers to report critical incidents. | Providers currently must report critical incidents involving waiver participants to the Department of Health (DOH) and OLTL. In addition, for events involving Aging waiver participants, providers must also contact the local Area Agency on Aging (AAA) to make a report. We ask that the incident reporting mechanism created by the CHC-MCOs be made to replace the reporting to the AAA and OLTL. 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. | Pennsylvania Homecare Association |
| Requirements Document Exhibit | ZZ - Automatic Assignment | Page 1 of Exhibit ZZ | Last, if a Participant is receiving HCBS and their HCBS provider is contracted with a CHC plan, the Participant will be enrolled in that plan. | PHA appreciates the opportunity for participants to remain with their current HCBS providers as part of the intelligent assignment protocol. These providers have built meaningful and trusted relationships with participants over time and disrupting this connection could be detrimental to current waiver participants. | Pennsylvania Homecare Association |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Measures 1-3 | CMS Star Rating (1-3) for Nursing Facilities included as a data element. | Home health agencies recently became the newest provider type to receive five star rating scores from CMS on Home Health Compare. They are measured on items such as preventative care, pain management, treatment of high risk conditions such as pressure ulcers and heart failure, hospital admission, and ER utilization. PHA recommends adding data elements that relate to the star ratings of the home health agencies that are part of the CHC-MCO's provider network. | Pennsylvania Homecare Association |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | N/A | The draft Exhibit GGG(1) is lacking quality measures specific to home and community-based services (HCBS) providers | The draft Exhibit GGG(1) is lacking quality measures specific to home and community-based services (HCBS) providers and their ability to help CHC-MCOs keep participants safe and healthy in the community. DHS should add a requirement that CHC-MCOs be measured according to applicable HCBS quality measures to be developed and finalized by the National Quality Forum (NQF) in September 2016. The NQF is currently midway through a project that involves an environmental scan of current HCBS quality indicator literature, state legislation and pilot programs in the U.S. and in other countries. The project's working group has identified ten quality measure domains along with outcome and process measures applicable to providers across the HCBS care continuum. The identified domains include workforce/providers, consumer voice, choice and control, human and legal rights, system performance, full community inclusion, caregiver support, effectiveness/quality of services, equity and health and well-being. Many of the proposed measures could be applied to show CHC-MCOs' performance in caring for participants in the community, such as "Percent of signed PCSPs that indicate client choice of provider and services" and "Percent of enrollees diagnosed with dementia who are receiving geriatric support services." | Pennsylvania Homecare Association |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG(4) Comprehensive Needs Assessment | N/A | PHA appreciates the commonwealth's effort to standardize the comprehensive needs assessment that will be used by CHC-MCOs. Standardization will help MCOs and providers better serve consumers, but only if the information collected in the assessment | Pennsylvania Homecare Association |
| Requirements Document | | | "Department of Public Welfare" is referenced throughout the December Release. | We recommend this be changed to the new name of the Department Human Services. | P4A |
| Requirements Document | Section VIII: Reporting Requirement | 1. Encounter Data Reporting | The CHC-MCO must maintain appropriate systems to obtain all necessary data from its Providers to ensure its ability to comply with the Encounter Data reporting requirements. | We support the concept of encounter data reporting, however in some instances where volunteers are used to provide a "service" (such as home delivered meals) requiring daily encounter forms to be signed can be burdensome. We recommend that forms used by MCOs for volunteer provided services be developed in coordination with the provider, and that if possible a state-wide standardized form be used for better comparison of data across providers, counties, regions, etc. and this consistency will be beneficial for providers who may be contracting with multiple MCOs. | P4A |

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| Requirements Document | Section XI: Records | p. 20 A. Financial Records Retention | The CHC-MCO must maintain and must cause its subcontractors to maintain all books, records, and other evidence pertaining to revenues, expenditures, and other financial activity pursuant to this Agreement in accordance with the standards and procedures specified in Section V.O.5 of this Agreement, Records Retention. | "V.O.5" Does not appear in either the November or December releases. In the November Release there appears to be a "V.O.5" on p. 50 but that section is called "Alternate Format Requirements." | P4A |
| Requirements Document Exhibit | M(1) - Quality management and Utili | p. M(1)-11 F. | The CHC-MCO agrees to comply with Department requirements and procedures related to the Enhanced Medical Home (EMH) model. EMH model is a system of care that provides access to a primary care provider, as well as targeted care management support for members at high risk of using acute medical services. There are four Pillars of the EMH model with which the CHC-MCO would be expected to participate: ***Embedded Service Coordinators in high volume practices (HVPs)*** | In the Enhanced Medical Home model, the ***CARE*** coordinator would be embedded, not a ***SERVICE*** coordinator. Service coordination is a different function. | P4A |
| Requirements Document Exhibit | M(1) - Quality management and Utili | P. M(1)-21 E (2)(a) | Any special benefit provisions (for example, co-payment, higher deductibles, rejection of Claim) that may apply to services obtained ***outside the system*** ; | We recommend replacing "outside the system" with "out-of-network." This section states that upon enrollment participnts must receive a written statement that includes benefits and how to obtain them. (b) discusses procedures for out-of-area services, and we feel "out-of-network" is a more accurate statement to reflect all services that are not part of the CHC-MCO's offerings. "Out-of-network" is different than "out-of-area services" and we see "out-of-network" as being a broader category. | P4A |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard I., M(1)- 2; B.; Page 80 | "The scope of the QM and UM programs must be comprehensive in nature.... | In setting QM and UM requirements, DHS should take into consideration working with populations that have special or different needs, for example those with brain injury or dementia, and that their needs may be more substanital, comprehensive, or different. | P4A |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard I., M(1)- 2; B.; Page 80 | "The scope of the QM and UM programs must be comprehensive in nature... At a minimum, the CHC-MCO's QM and UM programs must: B. Be developed and implemented by professionals with adequate and appropriate experience in QM/UM and techniques of peer review. E 2) Contain distinct policies and procedures regarding LTSS and shall specify the responsibilities and scope of the authority of Service Coordinators in authorizing LTSS and in submitting authorizations to Providers." | Policies and procedures regarding LTSS should identify any additional licensure or accreditation necessary for the provision of disability- specific or specialty services. It is recommended that Professionals charged with developing and implementing QM/UM programs have experience and understanding of the unique elements of LTSS that differ from the more short term and episodic nature of health care services. | P4A |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-8; Page 86 | E.The CHC-MCO must develop methodologies for asssessing performance of LTSS Providers….These methodologies must: 2) "Demonstrate the degree to which LTSS Providers are complying with requirements of the Department and the CHC-MCO." | It is recommended that the Provider and Participant groups within LTSS be utilized to develop the "formalized standards" needed to assess and analyze the quality of LTSS services. The measure of successful outcomes should be the progress toward and accomplishment of goals as stated in the member's Person-Centered Service Plan. | P4A |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-9; Page 87 | H. The QM and UM programs must contain procedures for Participant Satisfaction Surveys…." "The Department will continue to monitor the development of evidence-based LTSS satisfaction surveys.." | It is strongly recommended that the MCOs work with providers and stakeholders in the development of any satisfaction survey measures for LTSS services, as these questions will be decidedly different from questions concerning medical services. Some satisfaction measures should reflect perceived progress toward and accomplishment of goals as stated in the member's Person-Centered Service Plan. | P4A |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IV., M(1)-9; Pages 87-88 | A. "The QM/UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided…to include: Utilization, claims, inpatient stays, "community - based LTSS use"…" | It is strongly recommended that the MCOs work with the Provider group and other stakeholders in the development of any measure regarding the appropriateness, cost effectiveness and use of LTSS services, as these standards will be decidedly different from typical medical services. | P4A |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VI., M(1)-11; Pages 89- 90 | "The QM and UM programs must have mechanisms to ensure that Participants receive seamless, continuous and appropriate care….between:" | Recommend that the following be added: "J. CHC-MCOs and LTSS providers" | P4A |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII., M(1)-14; G. Page 92 | G. "The CHC-MCO shall evaluate a Provider's professional qualifications thrugh objective measures of competence and quality. Providers should be given lthe opportunity to have input on the CHC-MCO's credentialing practices." | It is recommended that this wording be revised to state:"The CHC-MCOs will work with the Providers to establish appropriate credentialing criteria, particularly for LTSS specialty services." For LTSS services, the CHC-MCO may not have the appropriate experience or expertise to establish or evaluate objective measures of competence and quality. For LTSS brain injury services, it is recommended that the provider qualifications mirror the 1915 (c) approved waiver, which requires CARF accreditation as a Brain Injury provider for specific services, as these are highly specialized services that requires significant expertise and experience. | P4A |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15; Page 93 | "The CHC-MCO's written UM program must contain policies and procedures that describe the scope of the program…" | Description and explanation for LTSS needs to be provided/included. Person centered plans should be included as part of the medically necessary covered services. | P4A |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIII., M(1)-19; Page 97 | "The CHC-MCO must have written standards for medical record and service planning record keeping..." C. Additional Standards include the following:" | It is recommended that Medical Record standards and standards for participant data reflect the differences in the type and frequency of documentation in LTSS settings. | P4A |
| Requirements Document Exhibit | M(2) - External Quality Review | p. M(2)-4 Citical Incident Reporting t | Neglect, which includes the failure to provide a participant the reasonable care that he or she requires, including, but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm. Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect; | We recommend that the definition of neglect follow the lead of the Older Adults Protective Services Act and the Adult Protective Services Act, which includes "self neglect." In OAPSA, the definition for neglect starts with "The failure to provide for oneself or the failure of a caretaker to provide goods or services essential..." | P4A |
| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | Healthcare Effectiveness Data and Information Set "HEDIS" M(4)-1; Page 107 | "HEDIS is a set of standardized performance measures designed to reliablly compare helth care plan performance. HEDIS performance measures are divided into five domains of care:" | Separate LTSS measures need to be included, as HEDIS performance measures do not encompass LTSS and its impact on overall health. | P4A |
| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | Consumer Assessment of Healthcare Providers and Systems (CAHPS), Page 109 | "The HEDIS protocol for administering CAHPS surveys consists of a mail protocol followed by telephone administration to those not responding by mail." | It is recommended that accomodations be made to assist people with cognitive or language impairments to complete the required surveys, including those without a phone who may need in-person survey administration. | P4A |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (6) Data Elements- Care Plan | Services | Under Behavior Consultation, add behavior therapy and mental health care. | P4A |

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| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | B. Guidelines for Review; 2. Medically Necessary Requirements; Page 76 | "Medically Necessary Requirements: The CHC-MCO must describe the process to validate medical necessity for: covered care and services; ….." | It is recommended that this section include the definition of Medically Necessary detailed later in the document: "The Service or benefit will assist the Participant to achieve or maintain maximum functioning capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age." This is necessary as most CHC-MCOs will not be familiar with LTSS and will likely have a purely medically-focused definition of Medically Necessary. The measure of successful outcomes should be the progress toward and accomplishment of goals as stated in the member's Person-Centered Service Plan. | RCPA/Melissa Dehoff |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | B. Guidelines for Review; 2. Medically Necessary Requirements; For CHC MCOs; c.,e.,h.; Pages 76 & 77 | c., e., h., "The CHC-MCO must identify the qualification of staff that will determine if the service is Medically Necessary." (h) For LTSS, Covered Services will be authorized in accordance with the requirements of the CHC 1915(c) Waiver. | The Document recognizes that the definition of Medically Necessary is different for LTSS vs typical health care services. Therefore, it is critical that the qualifications of the person determining "Medically Necessary" for LTSS, have experience and expertise in long term supports and services. Additionally, should the service in question pertain to an individual receiving disability specific services, then the person determining "Medically Necessary" should have expertise and experience in the disability specific field in question. The measure of successful outcomes should be the progress toward and accomplishment of goals as stated in the member's Person-Centered Service Plan. | RCPA/Melissa Dehoff |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Exhibit M(1)-1; Page 79 | Quality Management and Utilization Management Program Requirements | We strongly oppose the use of standard Utilization Management (UM) processes for those receiving LTSS. We recognize that an MCO must review the efficacy of services for which they are paying. However, using a medical model and typical utilization guidelines to assess goals for individuals that have life-long support needs, the MCO will not be able to support the participant in the way that is needed to provide the long-term services that are required. UM or 'goal reviews' should be conducted by those who have education and experience concerning a specific disability and a clear understanding of the needs of individuals receiving LTSS. | RCPA/Melissa Dehoff |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program | Standard I., M(1)- 2; B.; Page 80 | "The scope of the QM and UM programs must be | Policies and procedures regarding LTSS should identify any additional licensure or accreditation necessary for the provision of disability- specific or specialty services. It is | RCPA/Melissa Dehoff |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard II., M (1)-5-6; Pages 83- 84 | C. "The Director of LTSS ensures the provision of LTSS in accordance with the requirements…." | We strongly support the Department for requiring the MCO to have a dedicated, full time Director of LTSS given that these supports and services are very different from the medical services in scope, outcome goals, and quality measurements. | RCPA/ Melissa Dehoff |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-7; Page 85 | A. 3) "The QM and UM programs must include professionally developed practice guidelines… Applicable to Providers for the delivery of certain types or aspects of health care." | Recommend that this wording include: Applicable to Providers for the delivery of certain types or aspects of health care or LTSS. Should Providers of certain types or aspects of health care require additional licensure or accreditation, these practice guidelines/standards of care should be incorporated into the QM and UM programs' standards of care. | RCPA/ Melissa Dehoff |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-7; Page 85 | B. and C. B. "The QM and UM programs must include clinical/quality indicators in the form of written, professionally developed, objective and measurable variables of a specified clinical or health services delivery area…." C. "Practice guidelines and clinical indicators must address the full range of health care and LTSS needs of the populations served by the CHC-MCO..." | For those Providers whose speciality area of care provision require additional licensure or accreditation, it is recommended that language be included that recognizes the clinical/quality indicators already in place for those providers, i.e., in CARF accredited providers. Specifically, CARF accreditation requires adherence to international standards for quality measurement, management and performance. Any requirements of an MCO should not be in conflict with CARF required QM/PI and should accept those standards as the minimum requirements where the CARF standards are more stringent than those required by an MCO. | RCPA/ Melissa Dehoff |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-8; Page 86 | E.The CHC-MCO must develop methodologies for asssessing performance of LTSS Providers….These methodologies must: 2) "Demonstrate the degree to which LTSS Providers are complying with requirements of the Department and the CHC-MCO." | It is strongly recommended that the CHC-MCO develop the methodologies for assessing performance of the LTSS Providers in conjunction with the Provider group and other stakeholder groups. For the most part, the prospective CHC-MCOs do not have the experience or expertise to develop methodologies for programs and services with which they are not familiar. Individuals being served with LTSS are a very heterogenous population; therefore, the measure of successful outcomes should be the progress toward and accomplishment of goals as stated in the member's Person-Centered Service Plan. | RCPA/ Melissa Dehoff |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-9; Page 87 | H. The QM and UM programs must contain procedures for Participant Satisfaction Surveys…." "The Department will continue to monitor the development of evidence-based LTSS satisfaction surveys.." | It is strongly recommended that the MCOs work with the Provider group and other stakeholders in the development of any satisfaction survey measures for LTSS services, as these questions will be decidedly different from questions concerning medical services. | RCPA/ Melissa Dehoff |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-9; Page 87 | K. "The QM and UM programs must contain procedures for measuring Participant and Provider satisfaction with LTSS service delivery." | It is recommended that wording be added to require these Participant and Provider satisfaction surveys "be conducted on at least an annual basis." | RCPA/Melissa Dehoff |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IV., M(1)-9-10; Pages 87-88 | A. "The QM/UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided…to include: Utilization, claims, inpatient stays, "community - based LTSS use"…" | It is strongly recommended that the MCOs work with the Provider group and other stakeholders in the development of any measure regarding the appropriateness, cost effectiveness and use of Long Term Supports and Services, as these standards will be decidedly different from those appropriate for medical services. | RCPA/ Melissa Dehoff |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VI., M(1)-11; Pages 89- 90 | " THE QM and UM programs must have mechanisms to ensure that Participants receive seamless, continuous and appropriate care….between:" | Recommend that the following be added: "J. CHC-MCOs and LTSS providers" | RCPA/Melissa Dehoff |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII., M(1)-12-14; Pages 90-91 | A. "The QM/UM program must have standards for credentialing/recredentialing Providers to determine whether all Providers, who provide health…." A. "The CHC-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types that satisfies the Department's requirements..." G. "The CHC-MCO shall evaluate a Provider's professional qualifications through objective measures of competence and quality. Providers should be given the opportunity to have input on the CHC-MCO's credentialing practices." | It is recommended that this wording be revised to state: "The CHC-MCOs will work with the Providers to establish appropriate credentialing criteria, particularly for LTSS specialty services." For LTSS services, the CHC-MCO may not have the appropriate experience or expertise to establish or evaluate objective measures of competence and quality. For LTSS brain injury services, it is recommended that the provider qualifications mirror the 1915 (c) approved waiver, which requires CARF accreditation as a Brain Injury provider for specific services, as these are highly specialized services that requires significant expertise and experience. | RCPA/ Melissa Dehoff |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII., M(1)14,15; I. Pages 92-93 | I. "In the event that a CHC-MO renders an adverse credentialing decision…..All credentialing decisions made by the CHC-MCO are final and may not be appealed to the Department." | It is recommended that a provision be added to allow for an appeal of a credentialing decision. Many of the prospective MCOs have no experience with LTSS, and there is a concern that the MCO may not have the experience or expertise to credential an LTSS provider. | RCPA/Melissa Dehoff |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15; Page 93 | "The CHC-MCO's written UM program must contain policies and procedures that describe the scope of the program…" | Description and explanation for LTSS needs to be provided/included. This section needs to strongly support the person centered plan as part of the medically necessary covered services. The Department must have the oversight of the MCO to monitor and enforce this. | RCPA/ Melissa Dehoff |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15,16; C. Pages 93- 94 | C. "...The CHC Program definition of Medically Necessary: ....Medical Necessity determinations must be made by qualified and trained Health Care Providers." | It is recommended that this wording be revised to state: "Medical Necessity determinations must be made by qualified and trained Health Care Providers; Should the determination focus on specialty services, the CHC-MCO will ensure that the Health Care Provider involved in the Medical Necessity determination will have the appropriate expertise and experience." | RCPA/Melissa Dehoff |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15,16; C.(3) Pages 93- 94 | C. (3) "...The CHC Program definition of Medically Necessary: ....The Service or benefit will assist the Participant to achieve or maintain maximum functioning capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age." | The Department is recognized for expanding the definition of Medically Necessary to include achieving and/or maintaining maximum functional capacity in performing daily activities, which is the goal of LTSS. It is recommended that this definition be referenced whenever Medically Necessary items are included, as most CHC-MCOs will not be familiar with this expanded definition of Medically Necessary. | RCPA/Melissa Dehoff |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-18; K. Page 96 | K. "The UM program must contain procedures for providing written notification to Participants of denials of medical necessity and terminations…." | It is strongly recommend the current practice of having an in- person meeting between the Service Coordinator, the Provider and the Participant occur whenever a change in programming is recommended. This is particularly critical given that LTSS services are often provided to individuals with cognitive and language impairments. This in- person meeting should occur prior to any denial of services or written notification of said denial. | RCPA/Melissa Dehoff |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIII., M(1)-19; Page 97 | "The CHC-MCO must have written standards for medical record and service planning record keeping…" C. Additional Standards include the following:" | It is recommended that Medical Record standards and standards for participant data reflect the differences in the type and frequency of documentation appropriate in LTSS settings. | RCPA/ Melissa Dehoff |
| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | Healthcare Effectiveness Data and Information Set "HEDIS" M(4)-1; Page 107 | "HEDIS is a set of standardized performance measures designed to reliably compare helth care plan performance. HEDIS performance measures are divided into five domains of care:" | Description and explanation for LTSS needs to be provided/included. It is not clear how the HEDIS performance measures will be appropriate to LTSS. MCOs should work with the provider groups and stakeholders in the development of any performance measures. MCOs and the Department should also recognize the Quality Management programs already in place in Commission on Accreditation of Rehabilitation Facilities (CARF) accredited providers. Specifically, CARF accreditation requires adherence to international standards for quality measurement, management and performance. Any requirements of an MCO should not be in conflict with CARF required QM/PI and should accept those standards as the minimum requirements where the CARF standards are more stringent than those required by an MCO. | RCPA/ Melissa Dehoff |
| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | Consumer Assessment of Healthcare Providers and Systems (CAHPS), Page 109 | "The HEDIS protocol for administering CAHPS surveys consists of a mail protocol followed by telephone administration to those not responding by mail." | MCOs should work with provider groups & stakeholders in the development of any satisfaction survey regarding LTSS. CARF accredited providers of LTSS services are required to have a satisfaction tool and system in place to routinely elicit input from participants and all stakeholder groups. This data could be made available to the MCOs as needed. Among the brain injury CARF accredited providers, this satisfaction tool contains consistent questions for all providers to use to allow for benchmarking purposes. Questions regarding LTSS services will be decidedly different from a medical service model. Additionally, it is recommended that a provision be made to assist people with cognitive or language impairments to complete any of these required surveys. | RCPA/Melissa Dehoff |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Performance Measures and Data Elements; Pages 143-148 | | MCOs and the Department should recognize the Quality Management programs already in place in Commission on Accreditation of Rehabilitation Facilities (CARF) accredited providers. Specifically, CARF accreditation requires adherence to international standards for quality measurement, management and performance improvement. Any requirements of an MCO should not be in conflict with CARF required QM/PI and should accept those standards as the minimum requirements where the CARF standards are more stringent than those required by an MCO. | RCPA/ Melissa Dehoff |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG(2), Data Elements- Demographics; Pages 149-151 | | There is an overall concern that the document does not recognize the functional impact of cognitive impairment and the extent to which it is a barrier to accessibility of services nor does it address the accommodations that are required to allow the participant to be an active partner in the process. It is recommended that under "Communication, the general term "Language" be revised to specify: "Difficulty Understanding Language;" "Difficulty Expressing Thoughts." | RCPA/ Melissa Dehoff |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (3) Data Elements- Needs Screening and Comprehensive Needs Assessment; Pages 152-169 | | Acquired Brain Injury and Cognitive Impairment are not included. A separate needs assessment for ABI and Cognitive Impairment should be added to Exhibit. ABI is currently listed under Neurological. It is recommended that the Department adopt Utah's Intake, Screening and Assessment Form/Tool, Version 2.0 (which can be used for all disability groups). http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury%20Assessment%20(CBIA)%20Version%202.0.pdf | RCPA/ Melissa Dehoff |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (3) Data Elements- Needs Screening and Comprehensive Needs Assessment; Pages 152-169 | Participant self-identifies social or LTSS needs that are not being met; Medical; Medical-Individual's Cognitive State; Behaviors; Psychiatric; ADL's and IADLs | All elements indicate that the issue is "self identified." It is recommended that this language be revised to allow for and encourage a caregiver or support system to also identify issues. Cognitive Impairment is not included. "Executive Functioning Impaired"- Does everyone know what this means? The following items should be listed under this: *Problem Solving * Reasoning * Planning & Organizing * Insight. For Behaviors, it is recommended that the following be added: suicidal ideations, suicidal actions, impulsivity, and fire setting. For ADLs and IADLs, each item should include if the type of assistance needed is either physical or cognitive. It is recommended that the Department adopt Utah's Intake, Screening and Assessment Form/Tool, Version 2.0 (which can be used for all disability groups). http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury%20Assessment%20(CBIA)%20Version%202.0.pdf | RCPA/Melissa Dehoff |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (6) Data Elements- Care Plan | Services | Under Behavior Consultation, add behavior therapy; need to add Structured Day; Residential Supports (specify Residential Habilitation). All items from 1915 c waiver covered services are not included and should be, as both Providers and Stakeholders were assured that services would not change with this transition. | RCPA/ Melissa Dehoff |

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| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-27: 52.27 | Staff Training: "Outlines the minimum training requirements for providers and provider staff." | Service Coordinators must be trained in the disability for the population they are managing. The training that will allow them to do this is:<br>• People with Physical Disability - Certification for Disability Management - www.cdms.org<br>• People with Dementia - National Council of Certified Dementia Providers - www.nccdp.org<br>• People with Brain Injury - Academy for Certification of Brain Injury Specialists - www.biausa.org/acbis/cbis<br>Each of these organizations provide standards and a national certification exam that guarantees a minimum level of training and experience for people serving these populations that are the primary target populations. The state should utilize these organizations' standards and certifications process rather than asking each MCO how they would idiosyncratically guarantee an unspecified type and level of training. | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program | Standard I., M(1)- 2; Page 80 | "The scope of the QM and UM programs must be | Again, it should be specified which QM/QI/UM requirements are for Health Choices and what separate and distinct QM/QI requirements apply to Community Health Choices. | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard II., M (1)-5; Page 83 | C. "The Director of LTSS ensures the provision of LTSS in accordance with the requirements…." | We strongly support having a position specifically dealing with LTSS, and that LTSS requirements as outlined in the Waiver are being followed according to the unique needs of the LTSS populations. The LTSS Director should be trained in the population they are managing. The training that will allow them to do this is:<br>• People with Physical Disability - Certification for Disability Management - www.cdms.org<br>• People with Dementia - National Council of Certified Dementia Providers - www.nccdp.org<br>• People with Brain Injury - Academy for Certification of Brain Injury Specialists - www.biausa.org/acbis/cbis<br>Each of these organizations provide standards and a national certification exam that guarantees a minimum level of training and experience for people serving these populations that are the primary target populations. The state should utilize these organizations' standards and certifications process rather than asking each MCO how they would idiosyncratically guarantee an unspecified type and level of training. | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-7; Page 85 | A. "The QM and UM programs must include professionally developed practice guidelines.." | for Brain Injury, the Commission on Accreditation of Rehabilitation Facilities CARF has a well established and evidence based professionally developed practice guidelines. The state should utilize CARF's brain injury practices guidelines rather than requiring each MCO to idiosyncratically develop their own standards for a practice area in which they have no experience. | Beechwood NeuroRehab/Deb Cerra-Tyl |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-7; Page 85 | B. "The QM and UM programs must include clinical/quality indicators in the form of written, professionally developed, objective and measurable variables of a specified clinical or health services delivery area…." | for Brain Injury, the Commission on Accreditation of Rehabilitation Facilities CARF has a well established and evidence based professionally developed practice guidelines. The state should utilize CARF's brain injury practices guidelines rather than requiring each MCO to idiosyncratically develop their own standards for a practice area in which they have no experience. | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-7; Page 85 | C. "Practice guidelines and clinical indicators must address the full range of health care and LTSS needs…." | Again, for LTSS for people with brain injury, the state should require CARF's brain injury practices guidelines rather than requiring each MCO to idiosyncratically develop their own standards for a practice area in which they have no experience. | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-8; Page 86 | E.2) "Demonstrate the degree to which LTSS Providers are complying with requirements of the Department and the CHC-MCO." | Again, for LTSS for people with brain injury, the CARF accreditation requires a significant and sophisticated Quality Management system, requiring Annual Program Evaluation and Program Development goals. It would be an unwieldy administrative burden to require MCOs to make up their own quality requirements rather than adopting the CARF brain injury - specific program quality requirements - these may be reported to the MCO on an annual basis. | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-9; Page 87 | H. The QM and UM programs must contain procedures…." "The Department will continue to monitor the development of evidence- based LTSS satisfaction surveys.." | Again, for LTSS for people with brain injury, the CARF accreditation requires a significant and sophisticated Quality Management system, requiring Annual Program Evaluation and Program Development goals. This system requires each CARF Provider to annually review quality of care, Participant complaints, access/availability issues, and referral patterns; It would be an unwieldy administrative burden to require MCOs to make up their own quality requirements rather than adopting the CARF brain injury - specific program quality requirements - these may be reported to the MCO on an annual basis. | Beechwood NeuroRehab/Deb Cerra-Tyl |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IV., A6; Page 87 | The QM and UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided to Participants through utilization review activities with a focus on identifying and correcting instances and patterns of over-utilization, under-utilization and mis-utilization. | Utilization Management and Utilization Review for appropriateness and cost effectiveness are common procedures for acute health care, but are inappropriate for LTSS. There needs to be far different approaches for management of LTSS which is why you need to have Service Coordinators who must be trained in the population they are managing to know whether services are being effectively utilized. The training that will allow them to do this is: • ***People with Physical Disability - Certification for Disability Management - www.cdms.org*** • ***People with Dementia - National Council of Certified Dementia Providers - www.nccdp.org*** • ***People with Brain Injury - Academy for Certification of Brain Injury Specialists - www.biausa.org/acbis/cbis*** Each of these organizations provide standards and a national certification exam that guarantees a minimum level of training and experience for people serving these populations that are the primary target populations. A Service Coordinator properly trained in the disability population they are managing can properly monitor and evaluated the appropriateness and cost effectiveness of LTSS services. | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard V., M(1)-11; Page 89 | "The CHC-MCO must develop mechanisms for integration of case/disease and health management programs that rely on wellness promotion, prevention of complications and treatment of chronic conditions for Participants identified. The CHC-MCO must have a Complex Case Management Program and a Disease Management Program that must:...." | Again, for LTSS for brain injury, this complex case management and disease management already exists in the form of CARF accreditation, which requires a significant and sophisticated Brain Injury Practice Standards. To create a separate system of disease management by the MCOs for the brain injury population, when it is already required by the Waiver/CARF would be a duplication of service and would create an onerous administrative burden. | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VII., M(1)-12; Page 90 | The CHC-MCO must demonstrate that it retains accountability for all QM and UM program functions, including those that are delegated to other entities . . . | This could be accomplished simply by adopting the CARF requirements for providers serving people with Acquired Brain Injury. | Beechwood NeuroRehab/Deb Cerra-Tyl |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-18; K. Page 96 | K. "The UM program must contain procedures for providing written notification to Participants of denials of medical necessity and terminations…." | It is strongly recommend the current practice of having an in-person meeting between the Service Coordinator, the Provider and the Participant occur whenever a change in programming is recommended. This is particularly critical given that LTSS services are often provided to individuals with cognitive and language impairments. This in- person meeting should occur prior to any denial of services or written notification of said denial. | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII., M(1)-12; Page 90 | "The QM/UM program must have standards for credentialing/recredentialing Providers to determine whether all Providers, who provide health…." | For brain injury licensed providers, all of these standards for credentialling could be easily established, and not require duplicative work, by utilizing the Council for Affordable Quality Healthcare (CAQH) a non-profit organization whose mission is to accelerate the transformation of business processes in healthcare through collaboration, innovation and a commitment to ensuring value across stakeholders including healthcare providers, trade associations, and health plans. CAQH maintains these provider accreditations on-line, and should be utilized rather than having MCOs set up their own duplicative system of accreditation. For providers of Cognitive Rehabilitation services, where a state license is not available, the standards already established under the 1915c Waivers utilizing the Certification for Brain Injury Specialists (CBIS) should be followed. | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15; Page 93 | "The CHC-MCO's written UM program must contain policies and procedures that describe the scope of the program…" | Medical Necessity as a concept is already pre-determined by the criteria for the 1915c Waiver, and is certified by the physician on the MA-51. It is expected that Long Term Services and Supports are, by definition, Long Term, and that recipients are not likely to move in and out of Medical Necessity. This concept applies to the Acute Health Care side of CHC, and not the LTSS side. For LTSS, the person centered plan services are the medically necessary covered services. The Department must monitor and enforce this, and not allow MCOs to "gut the waiver" by applying an inappropriate principle to LTSS. | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-18; K. Page 96 | K. "The UM program must contain procedures for providing written notification to Participants of denials of medical necessity and terminations…." | It is strongly recommend the current practice of having an in- person meeting between the Service Coordinator, the Provider and the Participant occur whenever a change in programming is recommended. This is particularly critical given that LTSS services are often provided to individuals with cognitive and language impairments. This in- person meeting should occur prior to any denial of services or written notification of said denial. | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | Healthcare Effectiveness Data and Information Set "HEDIS" M(4)-1; Page 107 | "HEDIS is a set of standardized performance measures designed to reliably compare helth care plan performance. HEDIS performance measures are divided into five domains of care:" | HEDIS is designed for Acute Health Care, and therefore should not be required to apply to LTSS. For Brain Injury, a set of standardized performance measures are already required by the 1915c Waiver which requires the providers to be CARF certified. The CARF standards are the standards that should be reported for effectiveness and efficiency for LTSS for brain injury. | Beechwood NeuroRehab/Deb Cerra-Tyl |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Performance Measures and Data Elements; Page 143 | Effectiveness of care . . . | None of the measures listed relate to ABI; MCOs and the Department should recognize the Quality Management programs already in place in Commission on Accreditation of Rehabilitation Facilities (CARF) accredited providers. Specifically, CARF accreditation requires adherence to international standards for quality measurement, management and performance improvement. Any requirements of an MCO should not be in conflict with CARF required QM/PI and should accept those standards as the minimum requirements where the CARF standards are more stringent than those required by an MCO. | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (4) Data Elements-Comprehensive Needs Assessment; Page 153 | Will the needs assessment be standardized? - group says yes | Not sure what this comment means, but again, these data elements belong in HC, and CHC needs it's own Needs Screening that is related to the Needs of the Unique populations being served, so one instrument cannot possibly cover everything for Health Choices and Community Health Choices. It is strongly recommended again that Screening must be done using a tool that the Department specifies, and that is capable of screening for cognitive and behavioral issues, in addition to functional needs. It is strongly recommended that the Department adopt Utah's Intake, Screening and Assessment tool, (Utah Division of Services for People with Disabilities - Screening and Assessment Form/Tool, Version 2.0 (which can be used for all disability groups). http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury%20Assessment%20(CBIA)%20Version%202.0.pdf. Furthermore, for individuals with cognitive impairment, this screening must be conducted face to face, and with additional/corroborating information gathered by family/support system for those with cognitive needs. | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (3) Data Elements-Needs Screening and Comprehensive Needs Assessment; Pages 152-169 | Participant self-identifies social or LTSS needs that are not being met; Medical; Medical-Individual's Cognitive State; Behaviors; Psychiatric; ADL's and IADLs | It is not realistic to expect that people with cognitive impairments will be able to "self identify." It is recommended that this language be revised to allow for and encourage a caregiver or support system to also identify issues. Cognitive Impairment is not included. "Executive Functioning Impaired"- Does everyone know what this means? The following items should be listed under this: Problem Solving, Reasoning, Planning & Organizing Memory for Novel Information, Insight. For ADLs and IADLs, each item should include if the type of assistance needed is either physical or cognitive. It is recommended that the Department adopt Utah's Intake, Screening and Assessment Form/Tool, Version 2.0 (which can be used for all disability groups). http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury%20Assessment%20(CBIA)%20Version%202.0.pdf | Beechwood NeuroRehab/Deb Cerra-Tyl |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (4) Data Elements-Care Plan Page 174-175 | Services | All services that are currently available in the 1915c OBRA and CommCare Waiver must be listed here as data elements. Structured Day is missing as is Behavior Therapy | Beechwood NeuroRehab/Deb Cerra-Tyl |

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| Requirements Document | Section I: Incorporation of Documents | B.1 - Operational Updates Page 1 | Language regarding CHC OPS Memos | The CHC Operations Memorandums and any other substantive policy documents affecting providers or Participants should be made publicly available with notice to all participants and stakeholders whenever DHS issues an Operations Memo. This would be the equivalent to the MA Bulletin under the FFS system. | PHCA |
| Requirements Document | Section IV: Applicable Laws and Regulations | A. Certification and Licensing Page 2 | Language regarding streamlined credentialing process | The credentialing criteria and process developed by DHS in conjunction with CHC-MCOs should be made available for review and comment by stakeholders/providers prior to implementation. This will help to ensure a successful streamlined process. | PHCA |
| Requirements Document | Section IV: Applicable Laws and Regulations | A. Certification and Licensing Page 2 | | We recommend that DHS be involved in disputes regarding any appeal rights that providers may have if they are not approved by the CHC-MCO to participate in their provider network. | PHCA |
| Requirements Document | Section IV: Applicable Laws and Regulations | A.1- National Accreditation Page 3 | Language related to failure to obtain and maintain accreditation | Failure to obtain accreditation and failure to maintain accreditation should be considered a "material" breach. Additionally, it "should" result in termination not "may" result in termination. | PHCA |
| Requirements Document | Section VIII: Reporting Requirements | B. 1. Encounter Data Reporting Page 6 | | The Encounter Data should be made available to interested parties upon request. | PHCA |
| Requirements Document | Section VIII: Reporting Requirements | B. 1.b.iii. Provider Claims Page 7 | | Under FFS nursing facilities bill monthly for the services provided to MA residents - will that process continue under CHC? | PHCA |
| Requirements Document | Section VIII: Reporting Requirements | B. 1.b.iii. Provider Claims Page 7 | The CHC-MCO may require more prompt submissions of Claims or Encounter records in Provider Agreements and Subcontracts. | There must be some protections for providers to ensure that the CHC-MCO does not set submission requirement timeframes that are unreasonable and difficult for the providers to comply with. It is recommended that providers are not required to submit claims or Encounter data more frequently than monthly. | PHCA |
| Requirements Document | Section VIII: Reporting Requirements | c. iii. Page 10 | Demonstrates that the CHC-MCO has processes in place to act on information from the "monitoring program"… | What is the "monitoring program" referenced in this section? Clarification is requested. | PHCA |
| Requirements Document | Section VIII: Reporting Requirements | C.1. Fraud and Abuse Page 12 | | What is meant by "information for all situations where a provider action caused an overpayment to occur"? Additionally, how is an overpayment calculated? | PHCA |
| Requirements Document | Section VIII: Reporting Requirements | C.1. Fraud and Abuse Page 12 | | What is the involvement of the Department's Bureau of Program Integrity? | PHCA |

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| Requirements Document | Section VIII: Reporting Requirements | G. Presentation of Findings Page 13 | The CHC-MCO must obtain advance written approval fro the Department before publishing or making formal public presentations of statistical or analytical material based on its CHC Participant. | It is unclear what is meant by - presentations based on "its CHC Participant" - it is requested that clarification be provided. | PHCA |
| Requirements Document | Section VIII: Reporting Requirements | H. 1. Sanctions Page 13 | | Language should be included that makes it clear that sanctions imposed on a CHC-MCO will not have an adverse impact on the providers in the CHC-MCO's network and providers will be held harmless from any adverse impact. | PHCA |
| Requirements Document | Section VIII: Reporting Requirements | H. 1. f.Termination of the Agreement Page 14 | The Department has the authority to terminate a CHC-MCO Agreement and enroll that entity's Participants in another CHC-MCO…. | It is recommended that clarification be included in this section regarding the timing of the termination response to complaints, and other directive actions. | PHCA |
| Requirements Document | Section VIII: Reporting Requirements | H. 1. f.Termination of the Agreement Page 14 | The Department has the authority to terminate a CHC-MCO Agreement and enroll that entity's Participants in another CHC-MCO…. | There must be some consideration given to the payment rate paid to the provider in instances when an CHC-MCO is terminated and the Participants are enrolled into a different CHC-MCO. The provider may not have an Agreement with the new CHC-MCO therefore there is no payment agreement in place - in those instances the provider should be accepted into the network and until an Agreement is finalized be paid at the higher of the terminated CHC-MCO's rate or the new CHC-MCO's rate. This will ensure continuity of services for the Participant. This will be particularly important for those Participants residing in a NF. | PHCA |
| Requirements Document | Section VIII: Reporting Requirements | H. 2. a. Claims Processing Page 14 | Sanctions related to Claims processing | It is recommended that a provision be added requiring sanctions for delayed payments to providers as well. | PHCA |
| Requirements Document | Section VIII: Reporting Requirements | I. Non-Duplication of Financial Penalties | If the Department assesses a financial penalty pursuant to one of the provisions of……it will not impose a financial sanction pursuant to …..with respect to the same infraction. | We question why the Department is agreeing only to impose one penalty if there are multiple violations. | PHCA |
| Requirements Document | Section IX: Representations and Warranties of the CHC-MCO | B. Disclosure of Interests Page 16 | The CHC-MCO must disclose to the Department information on ownership… | Insert the word "complete" between Department and information. | PHCA |

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| Requirements Document | Section IX: Representations and Warranties of the CHC-MCO | B. Disclosure of Interests Page 16 | The CHC-MCO will not knowingly employ any person having such interest. | The CHC-MCO should be held to the same standards as providers. It is recommended that the Department consider broadening the standard beyond not hiring if the CHC-MCO knows that there is a certain conflict of interest. As written the language would let the CHC-MCO off the hook if the CHC-MCO doesn't know about a conflict because they didn't ask or otherwise do their due diligence. The standard should be that the CHC-MCO must make every reasonable effort to verify that there are no conflicts. | PHCA |
| Requirements Document | Section IX: Representations and Warranties of the CHC-MCO | C. Disclosure of Change in Circumstance Page 16 | The CHC-MCO must notify the Department in writing no later than 45 days prior to any significant change to the manner in which services are rendered to Participants…. | It is recommended that the timeframe be amended to 60-days prior to notice regarding any significant change. | PHCA |
| Requirements Document | Section IX: Representations and Warranties of the CHC-MCO | C.1. Suspension or debarment Page 16 | | It is recommended that this standard be broadened and that the CHC-MCO should not be permitted to employ any person or subcontract with any entity who has been suspended, debarred or excluded from federally funded healthcare programs. | PHCA |
| Requirements Document | Section X: Termination and Default | A.2. Termination for Cause Page 17 | The Department may terminate this Agreement for cause upon 45 days written notice, which notice shall set forth the grounds for termination and with the exception of termination. | It is unclear as to the intent of the last part of the sentence - "notice shall set forth the grounds for termination and, with the exception of termination". Clarification is requested. | PHCA |
| Requirements Document | Section X: Termination and Default | C. 1. c. Continuing Obligations Page 19 | The CHC-MCO is being held financially responsible for hospitalized patients through the date of discharge or 31 days after termination or expiration of this Agreement whichever is earlier.. | The language fails to address the CHC-MCO's financial responsibility for Participants residing in nursing facilities. Language should be added to provide for this responsibility-similar to the obligation for hospitalized patients. | PHCA |
| Requirements Document | Section X: Termination and Default | C.1.f. Page 19 | Arrange for the orderly transfer of patient care and patient records…. | It is recommended that language be added to clarify that a Participant residing in a nursing facility prior to a hospitalization be discharged back to the nursing facility they resided in prior to the hospitalization. | PHCA |
| Requirements Document | Section X: Termination and Default | C.2. Notice to Participants | The CHC-MCO is required to notify Participants of such termination or expiration at least 45-days in advance… | A new Section should be added to require notice to Network Providers of termination or expiration at least 45 days in advance of the effective date of termination or expiration. | PHCA |

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| Requirements Document | Section XI: Records | C. Medical Records Retention Page 20 | The CHC-MCO must provide Participants' medical records to the Department or contractor within 20 business days of the request. | Although we are not concerned with the 20 day turnaround for the CHC-MCO our concern relates to the provision being interpreted by the CHC-MCO to mandate a short turnaround time for providers to produce the medical records. It is recommended that the 20 day clock for the CHC-MCO does not start until after receipt of the medical record from the provider and that the CHC-MCO allow a reasonable timeframe for the provider to produce the medical record. | PHCA |
| Requirements Document | Section XIII: Confidentiality | D. Page 23 | The CHC-MCO is entitled to receive all information relating to the health status of its Participants in accordance with applicable confidentiality Laws. | As written this confidentiality agreement language is too broad to ensure transfer of information regarding patients who have dual diagnosis, HIV or MH/drug and alcohol. The language must be more strident to meet all applicable laws. | PHCA |
| Requirements Document | Section XVI: General | A. Suspension From Other Programs Page 25 | The CHC-MCO may not make any …to a Provider for services rendered during the period in which the Provider was suspended ….excluded | There are words missing in this sentence. "payment" should be inserted after "any" and "or" should be inserted after "suspended". | PHCA |
| Requirements Document | Section XVI: General | C. Invalid Provisions Page 25 | Any provision of this Agreement which is in violation of any state or federal law or regulation shall be deemed amended to conform with such law or regulation, pursuant to the terms of this Agreement, except that if such change would materially and substantially alter the obligations of the parties under this Agreement, any such provision shall be renegotiated by the parties. | It is unclear how the invalid provisions will be deemed amended to conform with changes in state or federal law or regulation. This is especially confusing since the Agreement, via a third party contract, purports to give DHS authority, to repeal current regulatory requirements without going through the regulatory review process. We question how an Agreement can be automatically amended. Further clarification is requested. Furthermore, there must be a provision that requires any change(s) to be communicated to Providers in a timely manner. Additionally, the terms materially and substantial are subjective- clarification must be provided as to what is deemed a material and substantial change. | PHCA |
| Requirements Document | Section XVI: General | G. No Third Party Beneficiaries | This Agreement does not, nor is it intended to, create any rights, benefits, or interest to any third party, person, or organization. | Providers should have third party rights and benefits under this Agreement, the following should be added to the end of the sentence: "other than participating providers". | PHCA |

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| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | | | General comments: We question the authority for the Department to remove/eliminate regulatory requirements through an Agreement and request that the Department confirm this authority. | |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | | | The intent of this Exhibit and its contents are somewhat confusing - in order for it to be fully understood we request that the Department provide a narrative explaining the intent of this Exhibit. For example it is not clear whether the provisions being excluded are not applicable to the CHC-MCO but continue to be applicable to providers. How will this be implemented during the phase-in of CHCs? etc. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-27 | The second bullet states that MCO must provide at a minimum those services on the fee schedule in the same amount, duration and scope as the FFS Program. | Is it the intent of the Department to eventually eliminate the FFS Program under Medicaid? If so, what guidelines will the Department use in place of the FFS guidelines outlined in this Exhibit? It is recommended that the second bullet refer to a date certain by adding "as in existence as of the date of this Agreement" to the end of the sentence. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-27 | Where the managed care agreement conflicts with 55 Pa. Code, the agreement is the controlling document. | Given this provision the Agreement must be a publicly available document. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-27 | 52.21 Staff Training | With the exclusion of this provision it is unclear what will replace these minimum training requirements and the authority of the CHC-MCO to impose different requirements. Clarification is requested. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-28 | 52.64 Payment Sanctions | Clarification is requested as to why these provisions are being excluded. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-29 | 1101.21 Definition of Shared Health Facility | By removing the definitions for shared health facility relating to amount of payment and receiving payment on a FFS basis, the Department has broadened the definition. Is that the Department's intent with this exclusion? | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-29 | 1101.21 Definition of Medically Necessary | By excluding the definition of Medically Necessary does the definition contained in Exhibit H take precedence? Please confirm. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-29 | 1101.31(f) If the managed care organizations impose limits, their exception process cannot be more restrictive than the process established in 1101.31(f). | We question why this provision is listed as an exclusion if there are circumstances when this provision may apply. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-29 | 1101.51(a) | By removing recipient freedom of choice of providers, the Department is allowing narrow provider networks which may be in conflict with provisions of federal law that require freedom of choice, particularly in the NF setting regarding pharmacies, for example. The Department should reconsider the appropriateness of excluding this provision under Chapter 1101. | PHCA |

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| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-29 | 1101.63(b)(1) through (10) | Subsection (b) is referenced in 1101.63(a)- we are seeking clarification on the intent of this exclusion and question how the reference in subsection (a) will be addressed. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-29 | 1101.64(b) | We are seeking clarification on the intent regarding the exclusion of this subsection as it relates to Medicare coinsurance and deductibles. Who is responsible for covering these charges? What the Department is trying to accomplish is not clear. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-29 | 1101.68 | We are seeking clarification on what entity establishes Invoicing for services standards - it will be important for the Department to establish minimum standards that must be met across all CHC-MCOs. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-30 | 1121.53(f) | This exclusion removes the limitation on prescriptions being limited to one dispensing fee for each drug dispensed within a 30-day period. It is not clear of the Department's intent by this exclusion and the implications of the exclusion. We are seeking clarification regarding this exclusion. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-30 | 1123.13(a) and (b) | This excludes the payment for medical supplies provided to a nursing facility resident. We ask that the Department clarify the intent of this exclusion. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-31 | 1123.56(a)(1) through (3); 1123.56(b)(1) through (3); 1123.56(c) | By excluding the provisions contained in these subsections is the Department removing all payment limitations for vision aids? Does this then provide full discretion regarding payment and what is covered to the CHC-MCO? | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-31 | 1123.61(1) through (8) and (10) | By excluding the provisions contained in this subsection is it the Department's intent to remove all limits on payments for these services? Clarification is requested. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-32 | The header related to Birth Center Services states.."with the following" | We assume that the word exceptions was inadvertently left off. The Department should confirm and correct. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-32 | The header related to Renal Dialysis Facilities states...."with the" | We assume that "following exceptions" was inadvertently left off. The Department should confirm and correct. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-34 | 1130.63(b) Hospice Services | Is the intent of this exclusion to expand/or eliminate the limitations on payment of Respite beyond 5 days in a 60 day certification period? If so, is there a new standard established by the CHC-MCO and what is that standard? | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-34 | 1130.63 (d) exclusion of "participating in the Medical Assistance Program." | It is unclear what this means - does it mean that a non-participating provider can be paid for the provision of hospice services? Please clarify. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-34 | 1130.71(c) through (h) | Does the exclusion of subsection (f) result in the nursing facility being eligible to directly receive payment for residents receiving hospice services in their facilities? | PHCA |

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| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-34 | 1130.73 relating to additional payments for NF residents | This exclusion removes the room and board payment provisions for nursing facilities that provide services to hospice residents in their facilities. Does this exclusion totally eliminate any payment of room and board to the nursing facility -or will the CHC-MCO continue to have the ability to make those payments? It is unclear how a nursing facility will be paid for these residents- clarification on how payment will be provided is requested. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-34 | 1141.53(f) and (g) | Does this exclusion mean that direct supervision will no longer be required of physician assistants or midwives or registered nurses? | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-38;A-39; A-40 | Headers for Chiropractor Services; Optometrists Services; Medical Assistance Program Payment Policies; Inpatient Psychiatric Services and Outpatient. | The headers for these provisions seem to be incomplete - are the Regulatory Sections listed all exceptions? Clarification should be provided. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | | | General comment: How will the exclusion be addressed during the phase-in of CHC? Won't the Department need to continue to require all NFs to adhere to the provisions contained in Chapter 1187 so rates can be set for the NFs in areas not yet affected by CHC? Additionally, the manner in which the exclusions are identified makes it very confusing and lacks clarification. It is our recommendation that further explanation is provided as to the intent of excluding the listed provisions. Moreover, we are seeking an explanation regarding the Department's authority to repeal current regulatory requirements without going through the regulatory review process. | |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | | | General comment: Maintaining provisions contained in Chapter 1187 related to costs incurred by nursing facilities, the acuity of residents - i.e. Case Mix index etc., will allow the Department to track from both a cost perspective and resident acuity perspective the impact of CHC as it compares to the FFS program - i.e. are the residents in NFs sicker, are the costs incurred by NFs increasing or decreasing...etc. Before the Department blankly eliminates these provisions it may want to consider the benefits of maintaining them at least through the phase-in of CHC from an evaluation perspective. Additionally, the maintenance of the Chapter 1187 provisions may be of importance as we work through the model for the nursing facility provider assessment under CHC - both the phase-in and long term. | |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-42 | 1187.2 Definitions | Why are the following definitions still relevant under CHCs: Allowable bed; Intergovernmental Transfer Agreement; and Supply? | PHCA |

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| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-42 | 1187.2 Definitions | We are seeking an explanation as to why the following definitions are no longer relevant under CHCs: Case-Mix Index; CMI Report; MA Day of Care; Per diem rate; Picture date; and Resident day? These definitions may continue to be relevant for other purposes such as the Provider Assessment; MDOI payments etc., how does excluding them in this Agreement impact their use for other purposes? Additionally, the acuity of the residents being cared for by a nursing facility may also be relevant to the CHC-MCO when developing the Participants care plan etc.. It is important that the Department take the time to fully consider whether the exclusion of certain definitions is appropriate. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-42 | 1187.2 Definitions | With the exclusion of the definitions of CMI and Classifiable data element it is unclear why the definition of Federally Approved PA Specific MDS continues to be applicable - we are seeking an explanation of the Departments intent. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-42 | 1187.2 Definitions | We are seeking an explanation as to the relevance of the full definition of Resident Data Reporting Manual if the definition of CMI Report is being excluded. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-42 | 1187.2 Definitions | The definition of Specially adapted DME is not on the list of excluded definitions - does this mean that the Department will continue to provide payment for these specialized services? | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-42 | 1187.21(4) | Is the only exclusion under this Subsection the language contained in (4)(i) as noted "Payment will be based on criteria found in §1187.101(b)(relating to general payment policy)" or is it the entire Subsection? Clarification is requested. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-42 | 1187.22(6) | Please confirm that the exclusion is due to the removal of the term "picture date" and "CMI Report" not an exclusion related to the accuracy of the CMI Report. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-42 | Subchapter E related to Allowable Program Costs and Policies | Although after full implementation of CHC across the State it is understood that these provisions are no longer relevant - however what happens during the phase-in of CHCs? How will the Department establish rates for NFs that are not under a CHC zone if they do not require all NFs to continue to comply with these provisions as well as the other relevant provisions contained in Chapter 1187. Again we seek to understand the Department's authority to repeal current regulatory requirements without going through the regulatory review process. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-42 | Subchapter E related to Allowable Program Costs and Policies | Section 1187.51 within this Subchapter provides the provisions related to services included in a NF's per diem rate - who determines what services are included in the rate paid to the NF by the CHC-MCO? This should be established by the Department and standardized across all CHC-MCOs. | PHCA |

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| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-43 | Subchapter G related to Rate Setting | Although after full implementation of CHC across the State it is understood that these provisions are no longer relevant - however what happens during the phase-in of CHCs? How will the Department establish rates for NFs that are not under a CHC zone if they do not require all NFs to continue to comply with these provisions as well as the other relevant provisions contained in Chapter 1187. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-43 | 1187.104 Limitations on payment for reserved beds | As presented on the list this is rather confusing. We are seeking clarification that the CHC-MCO is required to continue to pay NFs for up to 15 hospital reserve bed day per hospitalization and up to 30 therapeutic leave days per calendar year. The payment amount appears to be at the discretion of the CHC-MCO- is that correct? It is our recommendation that the Department set a minimum standard similar to the payment provisions provided under FFS for these days. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-43 | 1187.113a Replacement Bed SoP | We are seeking clarification that the exclusion of this SoP allows NFs to implement replacement bed projects without the approval of the Department. Please confirm. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-43 | 1187.117 Supplemental ventilator care and tracheostomy care payments | Does the exclusion of this Section eliminate the ability of the CHC-MCO to make additional payments to NFs for ventilator care and/or tracheostomy care residents? | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-43 | 1187.141 Nursing facility's right to appeal and to a hearing | CHC-MCOs must be required to provide at a minimum the same due process available to nursing facilities under this Section (1187.141). | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-43 | Subchapter K Exceptional Payments for NF Services | What happens to existing Grants with the exclusion of this Subchapter. Allowances must be made to continue to provide the payments resulting from these Grants until such time that the resident no longer needs the equipment/service. | PHCA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-43 | | There is no mention in this Exhibit of Subchapter L relating to the NF Participation Review process. We are seeking an explanation as to why the provisions of this Subchapter continue to be relevant under CHCs. As noted in prior comments it is our recommendation that the Department eliminate the bed need process as there is little exposure or negative impact on the Department once the CHC program is fully implemented. This will allow NFs that determine a need in their market to add beds without seeking Department approval as well as allow NFs that are not currently MA to be part of the CHC-MCO network without going through a needs assessment. | PHCA |
| Requirements Document Exhibit | B(1) - CHC_MCO Pay for Performance Program | C- | CHC-MCO Pay for Performance Program | Providers and stakeholders should be provided the opportunity to participate in the development of a P4P related to financial eligibility redetermination process. They have first hand experience and can offer recommendations on what will be best for both the consumers and the providers. | PHCA |

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| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 13. Assignment of Antitrust Claims | | The potential impact of this provision is unclear. Consider for example Highmark and UPMC dispute, will the Commonwealth have both sides anti-trust claims assigned to itself? Further clarification is requested. | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 15 Audit provisions | | A five year record retention from date of final payment may differ from other record keeping requirements. How will this requirement be down streamed to providers? What if the record retention requirements the provider must comply with under federal and/or state law are different - which takes precedence and how is that addressed by the CHC-MCO? | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 16 (a)(8) Default - failure to make payment | Failure or refusal within 10 days after written notice, to make payment for materials furnished, labor supplied or performed, for equipment rentals or for utility services rendered.. | We are seeking clarification on failure to make payment to whom? | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 16. (13) | Failure to obtain national accreditation certification or… | It is recommended that the requirement be amended to read: Failure to obtain "and subsequently maintain" national accreditation certification. | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 16 Default | | It is recommended that the Department add a number (15) - which would address the issue of hiring as employees those excluded or debarred individuals or subcontractors. | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 18 2) Termination Provisions | | It is recommended that this provision also address the payment to providers of capitated funds. | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 20. d. Assignability and Subgranting | | The CHC-MCO should not be allowed to assign its rights to payment without the consent of the Department. Under this scenario money could potentially go to individuals or entities who are not approved by the Department. | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 20. g. Assignability and Subgranting | | As written this would allow a CHC-MCO to undergo numerous CHOWS as long as it keeps its name and EIN- we do not believe that is the Department's intent. The language should be amended to ensure this does not occur. | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 20. h. Assignability and Subgranting | | We are seeking clarification as to what the "Contractor Responsibility File" is that is referred to in this provision. | PHCA |

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| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 22. 1d. Contractor Related Parties | | We are seeking clarification as to why contractor related parties are limited to Pennsylvania officers and directors. | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 22. 1e. Financial Interest | | This appears to be the only instance where the term employee really seems to be mentioned. It is our belief/recommendation that it be made clear that the CHC-MCO is to be held responsible for employees not being on the excluded list. | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 22. 2c. | | What is meant by "anyone in privity with Contractor" in the first sentence? Who does this cover? Please clarify. | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 22.2d | | This provision should be expanded so that contractors do not have or acquire a financial interest. Furthermore, it is recommended that there is an ongoing requirement for notification and approval even after execution of the Agreement. | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 22.2e. | | The certifications required under this section should be expanded. The current provisions are not as broad as federal requirements and certainly not as broad as requirements placed on providers. It is recommended that certification be broad and cover not just contractor and contractor related parties but employees and agents. Additionally, the certification and representations should be ongoing even after execution of the Agreement. | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 22.2.f | | The word "or" in the last line of this provision should be changed to "and"..it would read …Contractor shall immediately notify the project officer "and" the Office of the State Inspector General in writing. | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 22.2.h | | We have concern regarding the sentence."Contractor agrees to make identified Contractor employees available for interviews at reasonable times and places." There appears to be no consideration of the employees rights- the Department/CHC-MCO needs to be sensitive to an employees right to refuse to cooperate and to protect their Fifth Amendment rights. | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 23. Responsibility Provisions e. | | This provision does not address other fines and penalties- it is recommended that it be made clear in the Agreement that the CHC-MCO is responsible to pay any fines and penalties assessed by the Department. | PHCA |
| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 28. Integration | | As written the language would preclude the amendments to conform to change in law or other policy changes mentioned earlier in the Agreement. The language should be amended to provide for any necessary amendments. | PHCA |
| Requirements Document Exhibit | E - Specific Federal Regulatory Cites for Managed Care Agreements | Citation 42 CFR 438.6(f)(2)(i) | | This provision relates to provider preventable conditions. Is this intended to include nursing facility PSAEs, and if so, will the Department continue its own independent review or will this be subject to CHC-MCO review? Clarification is requested on the process and the responsible entities. | PHCA |

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| Requirements Document Exhibit | E - Specific Federal Regulatory Cites for Managed Care Agreements | 1903(i) | | There appears to be a potential typo under this Requirement. "The CHC-MCO is prohibited from paying an item or service….furnished by an individual or entity to whom the State has "failed to suspend" payments…We assume the intent is that the CHC-MCO is prohibited from making payment if the State "has suspended" payment. We are seeking clarification of this provision. | PHCA |
| Requirements Document Exhibit | E - Specific Federal Regulatory Cites for Managed Care Agreements | 1903(i); 1903(i)(16) | | There seems to be language missing under the last entry on this page of this Exhibit. Please correct. | PHCA |
| Requirements Document Exhibit | E - Specific Federal Regulatory Cites for Managed Care Agreements | | | There seems to be language missing under the last entry of this Exhibit. Please correct. | PHCA |
| Requirements Document Exhibit | | DHS Addendum to Standard Contract Terms and Conditions | | Paragraph B. This section should be amended to be consistent with Act 169 recognizing surrogate decision makers and powers of attorney and other entities that are entitled to make and be involved in the health care of patients. | PHCA |
| Requirements Document Exhibit | | DHS Addendum to Standard Contract Terms and Conditions | | Paragraph D. It is recommended that the provision be amended as follows: CHC-MCO agrees to obtain "and maintain" all licenses, certifications….. | PHCA |
| Requirements Document Exhibit | | DHS Addendum to Standard Contract Terms and Conditions | | Paragraph F. It is recommended that this provision be amended to reference "and all amendments thereto." | PHCA |
| Requirements Document Exhibit | | DHS Addendum to Standard Contract Terms and Conditions | | Paragraph M. Clarification should be provided as to whether this provision is referring to state suspension and debarment only - if it is referring to federal suspension and debarment reference should be made to applicable federal law. | PHCA |
| Requirements Document Exhibit | | DHS Addendum to Standard Contract Terms and Conditions | | Paragraph O. As noted in previous comments there should be ongoing representation required by the CHC-MCO not just during the initial execution of the Agreement. | PHCA |
| Requirements Document Exhibit | | DHS Addendum to Standard Contract Terms and Conditions | | Paragraph S. Act 13 Application- We are seeking clarification as to the definition of "facility" referenced in the leading paragraph of this provision. "….or may have direct contract with residents form the "facility" or unsupervised access to their personal living quarters in accordance with the following:" | PHCA |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | A. General Requirements. It is recommended that the CHC-MCO be required to provide notice of the policies and procedures related to Prior Authorization to the providers and the public as well. Additionally, any changes made to the policies and procedures must be shared timely with providers and the public. | PHCA |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | B. Guidelines for Review. 2.d. This provisions requires the CHC-MCO to post for public view guidelines used to determine medical necessity of all drugs that require prior authorization. It is recommended that all guidelines used in the prior authorization process be posted for public view not just those related to the medical necessity of all drugs. | PHCA |

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| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | B. 2. Medical Necessary Requirements. The Agreement language adds the proviso "if it is compensable under the Medical Assistance Program" and meets the current regulatory definition of "medically necessary." There should be a review process for a special exceptions/waiver process for hardship where a resident may need a service that is medically necessary, but not on the list of MA reimbursable services. The Guideline for "Medically Necessary" Requirements in this Exhibit are confusing and seem to be pulled from various programs-special requirements for children, the yet to be formalized LTSS Covered Services under the 1915(c) Waiver, national programs...Participants, Providers and any implementing MCOs could benefit from clearer guidance which is consistent across the program at various MCOs. | PHCA |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | B. 2. h. For LTSS, Covered Services will be authorized in accordance with the requirements of the CHC 1915(c) Waiver. What does this statement mean as it relates to nursing facilities and assisted living residences? | PHCA |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | B. 4. Notification, Grievance,...It is recommended that the provisions included in this section be expanded beyond the current requirements which only states that the CHC-MCO must demonstrate how written policies and procedures for requests for prior authorization comply and are integrated with participant and provider notification requirements. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | | | General Comment: We are concerned that there is no language that protects the use and release of QM/UM data, reports etc. It is our recommendation that the following language be added to the Agreement: This is language adapted from 28 Pa. Code 51.3 (i): Information contained in QM/UM reports, records or other documents submitted or received by the MCO by a provider pursuant to the CHC program may not, unless otherwise ordered by a court for good cause shown, be produced for inspection or copying by, nor may the contents thereof be disclosed to, a person other than the Secretary, the Secretary's representative or another government agency, without the consent of the provider. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Section N. Page M(1)-4 | | Clarification is requested on what is meant by the statement: "reimbursement of nursing facility care for the period specified". What if the Participant doesn't want to leave or there is no alternative placement willing to accept the Participant? Consideration must be given to the Participant's choice as well as assuring the safe and orderly discharge of the Participant. If there is no appropriate alternative placement what does ongoing reimbursement look like for the nursing facility that continues to provide care and services? There must be assurances that the nursing facility is reimbursed for services provided. | PHCA |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Section P. Page M(1)-5 | | This provision could be interpreted to mean that the CHC-MCO must comply with the 3-day hospital stay as a pre-condition for nursing facility care payments. It is our recommendation that this not be a requirement - and are seeking clarification of the intent of this provision. The 3-day rule is relaxed under the Medicare MCO programs to afford them with the flexibility necessary to efficiently manage the care of their participants, and we recommend that the CHC program do the same. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard II F. 10. Page M(1)-7 | | The provisions make the CHC-MCO Medical Director accountable for referrals for cases involving quality of care that have adverse effects or outcomes. This appears to be a duplicative requirement which should already be covered by the Department of Health and may result in the CHC-MCO's prosecuting quality of care cases. Consideration should be given to this requirement for Participants residing in nursing facilities as this is a role that the medical director for the nursing facility would normally fill. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III. D. Page M(1)-8 | | It is recommended that CHC-MCOs be required to require providers to comply with all applicable medical recordkeeping standards but should NOT be able to impose new/additional standards. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III.F. Page M(1)-9 | | Item 5. subparagraph g. The provisions contained in this section are troubling and overreaching. The subparagraph permits recovery of inappropriate expenditures related to Health Care Associated Infections, medical errors and unnecessary and/or ineffective care. How is the standard "ineffective care" defined and determined? This standard does not exist under current law. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III. G. Page M(1)-9 | | We question the appropriateness of the CHC-MCO being permitted to investigate quality of care referrals rather then sending them on directly to other more appropriate agencies. Please clarify the intent of this provision and how it will be implemented. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III. I. Page M(1)-9 | | This provision requires procedures for Provider satisfaction surveys to be conducted which are to include PCPs, etc. Nursing facilities and assisted living residences are not listed. It is recommended that both nursing facilities and assisted living residences be required to be part of the Provider satisfaction survey process. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII. A. Page M(1)-13 | | Providers should be provided the opportunity to have meaningful input on CHC-MCO's credentialing practices. This will help to ensure that the process is effective and successful. Language should be added to the Agreement to ensure that occurs. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII. I. Page M(1)-15 | | Adverse credentialing decisions- As written credentialing decisions appear to be final with no opportunity to appeal. The provider should have appellate rights. If the Department is not getting involved in this process where do appeals go related to adverse credentialing decisions? | PHCA |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX. B. Page M(1)-15 | | This requires that a Person Centered Service Plan be developed and implemented for all NFCE participants - Does this requirement apply to current MA nursing facility residents-even those residing in the facility for more than 180 days? | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX. C. Page M(1)-15 | | It is recommended that the provisions under this paragraph be expanded to be consistent with Act 13. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX. D. 8. Page M(1)-16 | | We are seeking clarification as to what is meant by the statement: "Be received under signature of individuals authorized by the plan."? | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard X. Page M(1)-18 | | According to this Standard - provider disputes are not required to go beyond the CHC-MCO - it is recommended that this requirement be expanded to encompass existing appeal rights afforded providers for any adverse action taken by the Department. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XII. B. Page M(1)-19 | | CHC-MCOs should not be permitted to impose additional medical recordkeeping requirements on providers. The existing requirements are more than adequate. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XII. D. Page M(1)-20 | | "All other aspects of patient care." This is an extremely vague standard and should either be further defined or deleted. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XII. F. Page M(1)-20 | | Although Participants have the right to review their medical records there should be recognition in the Agreement that providers can charge for copying and access with HIPAA and other state and federal laws. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XII. G. Page M(1)-20 | | The time period for providing medical records is too short a period of time. We recommend instead of 15 days the timeframe be 30 days for a single record request and 45 days if multiple requests are received within the same timeframe. In addition, there should be some consideration for cost and expense incurred by providers to produce the records and compensation should be provided. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XII. H. Page M(1)-20 | | It is unclear how a provider will know when a CHC-MCO contract has expired to know what the five year period is for retention of medical records. Clarification is requested. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XII. H. Page M(1)-20 | | When a Participant changes CHC-MCOs this requires the transfer of medical records within seven business days - if there is a massive transition, it may take providers more than seven business days to make those transfers. It is recommended that provisions for extensions of time be added to this section. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIV. C. 3) Page M(1)-21 | | It is recommended that consent for research be consistent with other requirements of state and federal laws. | PHCA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIV. D. Page M(1)-21 | | The CHC-MCO's policies on Participant rights and responsibilities should also be made available to the public. | PHCA |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIV. I. Page M(1)-22 | | It is recommended that all vital documents be required to be made available in alternate languages consistent with ADA. Participants should not be required to request such documents. | PHCA |
| Requirements Document Exhibit | M(2) - External Quality Review | D. Page M(2)-1 | | The timeframes established by the EQR must be reasonable so they can be met by the providers. It is recommended that this is noted in the Agreement. | PHCA |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | | | General Comment: It is recommended that language be added that states "CHC-MCOs will satisfy this requirement as long as they insure that providers are using existing reporting systems." This will help to eliminate duplicate reporting requirements and allow providers to focus on care and services instead of reporting to multiple entities. | PHCA |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | Page M(2)-4 | | Clarification is requested as to what the reportable conditions are for "Provider or staff misconduct, including deliberate, willful, unlawful, or dishonest activities;". | PHCA |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | Page M(2)-4 | | Under Provider Preventable Conditions it is recommended that "or was otherwise not preventable" to the end of the first sentence. | PHCA |
| Requirements Document Exhibit | N - Notice of Denial | | | General Comment: The timeframes related to notices seem extremely long and could negatively impact the individuals health and safety. The Department should consider shortening the timeframes. | PHCA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | General Comment: Several of the measures contained in Exhibit GGG(1) appear to be duplicative. It is recommended that the Department review the document and remove any duplications. | PHCA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | General Comment: What is the basis used by the Department to determine this is a predecisional record given that the document has been released publicly? | PHCA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | Exhibit GGG(7) "high risk resident" We are seeking clarification on the definition of this term and the criteria used to determine a high risk resident as it is used in this Exhibit. | PHCA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | GGG (1) Provider Satisfaction Survey- there does not seem to be a provider satisfaction survey for nursing facilities or assisted living residences. It is recommended that one is added for these providers as well as any other provider not currently listed. | PHCA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | GGG (4) Under where was the consumer interviewed there is no entry for assisted living residences - it is recommended that ALRs be added to the list. | PHCA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | GGG (6) Under others at Care Plan review - there is no entry for a nursing facility representative or assisted living representative. There should be an opportunity for representatives from the facility/residence in which the individual is residing to be part of the Care Plan review. It is recommended that nursing facility representative and assisted living residence representative be added to the list. | PHCA |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | GGG (6) Under Transition - if no barriers - it lists "guardian refused participation" - there may not always be a guardian who refuses participation - what if they want to participate- it is not clear what the intent is here. Please clarify. | PHCA |
| Requirements Document | | | Timeframe | One item that has been consistently discussed and is a concern of not only my company but many others across the Commonwealth is the short timeframe that is proposed for this transition. There hasn't been a concrete reason of why the program is being implemented so haphazardly, having region one receive enrollment notices and then implementation all within three months, and then providing only six months for transitioning participants from their current provide to the MCO. This is setting the system up for failure. In addition, after speaking with many of the MCO's, several very impressive companies stated they couldn't meet the timeframes to apply for the Southwest Region. This is a dis-service to the region and to the participants of this region. Not having all of the viable candidates to choose from will not permit the state to select the best candidate.<br>When reviewing other states that have implemented MLTSS, they provided a full year for transition. Why is Pennsylvania being so aggressive in its timeframe? We continue to advocate for the transition period to be extended. | Jennifer Poole, MedStaffers |
| Requirements Document | | | MCO Reports to DHS | The intranet for the MCO to utilize for reporting to DHS still needs developed. I would ask that a feature be included that permits the public to see how well the MCO is doing in its quality plan and according to the requirements set by DHS. This would allow participants to compare the performance of MCO's before deciding who to select to manage their care. I think it is also imperative that a list of provider contracts with the MCO be public knowledge. | Jennifer Poole, MedStaffers |
| Requirements Document | | | Prior Authorizations | For person centered planning the current approved HCBS service plan is the authorization to begin services and continues for one year unless the participants condition changes. We would like this process to remain intact. | Jennifer Poole, MedStaffers |
| Requirements Document | | | Clean Claims Process | A timeframe for payment to the provider isn't mentioned. We are advocating that the payment within 30 days for skilled care and 15 days for non-medical homecare be written as the MCO's timeframe. This is current practice with no reason for change. It is also noted that a reference is made to Section 7, which is missing. We would like an opportunity to review the content and comment on this section. | Jennifer Poole, MedStaffers |
| Requirements Document | | | Credentialing | It has been noted that the credentialing process be completed by the MCO's every three years. We would urge this timeframe to revert back to the current five year period. | Jennifer Poole, MedStaffers |

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| Requirements Document | | | Disputes | We strongly recommend a neutral party be involved in disputes between the CHC-MCO and the providers. Removing the Department is not the answer; if anything, the Department should have a mediation board to make a final decision on the dispute as a fair and neutral party. If anything DHS should be responsible for looking for patterns of denials by the MCO's; especially in regarding the credentialing process. We urge the DHS to rewrite this process and to reconsider remaining a part of the solution. | Jennifer Poole, MedStaffers |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | | | It is not clear in the exhibit as to who will report critical incidents in the EIM system. It appears that both the MCO and the provider are required, which is duplicated reporting. And then the exhibit further states that the CHC-MCO much develop and implement a critical incident reporting system for providers to report critical incidents. We recommend that this exhibit be clean up with definitive direction and concise language. This could be a risk if direction is not clear and a critical incident is not reported and investigated properly. | Jennifer Poole, MedStaffers |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | A scoring mechanism is missing for the non-medical care listed. Also, it would be important for the provider that is selected to have additional information on the home status. For example, how many pets, kinds of pets, any hazards, any children under age 18 etc. We would also like to advocate that it is mandatory that the comprehensive needs assessment be provided to the selected provider. Many times providers get an address with no information that would be useful. Having prior knowledge of the participant helps the provider be prepared and also potentially gather additional resources that would be useful to the participant. | Jennifer Poole, MedStaffers |
| Requirements Document | | | Conflict Free | Over the last 5 years, the HCBS providers have made tremendous strides to become conflict free according to the Office of Long Term Livings definition and with their guidance. After reviewing the companies that are likely to submit as contenders for the MLTSS contract, it is evident that many have their own network of providers and services. In the draft RFP, there is no clarification or mention of a requirement that the MCO must remain conflict free or how the company is to manage freedom of choice for participants. It is clear that the participant may change the MCO, however again, how will the participant's preservation of freedom of choice be protected for home care and home health services? We would like to see this language clearly written out so that the MCO companies are well aware the Commonwealth believes in preserving conflict free services and preserving freedom of choice for participants. | Jennifer Poole, MedStaffers |

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| Requirements Document | | | Freedom of Choice | The other part of choice is providing participants the option to participate in the CHC or to choose not to participant in the CHC. By forcing an estimated 450,000 individuals to enroll with a managed care organization is wrong. Our citizens should have a choice on how their healthcare is being provided, just as they have a choice on many other decisions they need to make in life. As this program is implemented and momentum builds, if the product is good, the enrollment will increase. That would be a great way to determine if the program is designed correctly. Participants should be enrolling willingly, not forced. We advocate strongly that this mandate is lifted and for Pennsylvania to design the CHC-MCO program as a VOLUNTARY program that participants trust and benefit from. Forcing people to participate is not a way to promote buy-in or trust. This is their health care, there should be a choice. Not providing choice is taking away the rights of Pennsylvanians. | Jennifer Poole, MedStaffers |
| Requirements Document | | | Adequacy of Home Care Provid | The draft RFP requires at least two of each type of provider in each region. We feel that it is very unlikely that this requirement will serve our participants appropriately. We recommend increasing this number for each region and for each service type and also providing clarification on the travel limits. Is the 30 and 60 minute requirement from the participant's home? Of the provider? Or from the CHC-MCO? Please provide clarification. This request is to ensure the health and safety of the participants and to increase the choice of providers the participants have. | Jennifer Poole, MedStaffers |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII, p. 12 | Verification that Providers and/or subcontractors have a current Provider Agreement and an active PROMISe™ Provider ID issued by the Department. | Please confirm all providers, including LTSS providers, will have a PROMISe ID. We recommend participants electing to self-direct not need a PROMISe ID, and instead should be required to meet other certification requirements. | UPMC Health Plan |
| Requirements Document | Section VIII: Reporting Requirements | Provider Network, p.11 | The CHC-MCO must provide a file through the Department, to the Department's PROMISe™ contractor, of its entire Provider Network, including the network of its subcontractors. | Please clarify which network will need to be submitted. If submission is for approval, we recommend only requiring non-Medicare providers and LTSS networks to be submitted, as CMS approves the medical network. | UPMC Health Plan |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-22 | The CHC-MCO must have policies and procedures for resolving Participant Complaints and Grievances that meet all requirements outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Processes. | We recommend aligning the CHC Complaints and Grievances process as closely with the Medicare C&G guidelines in order to decrease participant confusion from having to learn two appeals systems. For example, Medicare allows 60 days from the event to file a grievance. We recommend the Commonwealth allow 60 days as well. This is not only more beneficial for the participant, but will bring consitency to the process from a member perspective.<br><br>Other recommendations include a required action time of 30 days from receipt of grievance, 60 days for a participant to file a reconsideration request (up from 45 for 1st level decisions), and 3 days for response time to appeal (down from 5). Overall, we recommend one consistent C&G process as far is at can be attained. | UPMC Health Plan |
| Requirements Document | Section XV: Disputes | A 25 | The CHC-MCO may not make any to a Provider | The word payments was ommitted. | Delaware County AAA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-34 | 1130.71 c through h - Payment for Hospice Care | Please clarify and distinguish if a person is MA only and getting MLTSS in a facility or at home and they require Hospice services, which would/could be covered under Medicare, which entity would be financially repsonsible and if both can be provided simultaneously, as long as the services are not being provided at the same time? For instance, many Medicaid nursing facility residetns also utilize their medicare hospice benefit simultaneously. They may also elect to receive pallative care via a hospice if they don't qualify for Medicare, under Medicaid alone. Requiring CHC-MCO's to have established contractual relationships with hospice providers, especially if the MCO's are d-snip programs will enhance coordination. However, consumers must be able to select a hospice of thier own choosing if they use the Medicare fee-for service option, but it would be important for coordination of care that the MCO at least work along side them. | Delaware County AAA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-39 | 1150.51 (a) and "payment will not be made for services that are not medically necessary." | While the priority should clearly be on the medical aspects of health, Home and Community Based Services have always addressed the the additional 'social' determinants of health that often may go overlooked. For instance assistance with budgets, spending, socialization, community connectedness, and housing services. | Delaware County AAA |
| Requirements Document Exhibit | B(1) - CHC_MCO Pay for Performance Program | | The Department will implement a Pay for Performance Incentive to CHC-MCOs that help Particiapnts successfully complete the financial eligibility redetermination process. | The CHC-MCO will already have an incentive to assist with this process, as failure to do so will mean one less eligible member. How about Pay for Performance regarding the timely implementation of the initial service plan within a specific timeframe? | Delaware County AAA |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | VIII -A | Recredentailing activities must be conducted by the CHC-MCO at least every three (3) years. | Ongoing quality and compliance monitoring is essential in helping to strenghten any MLTSS CHC system. The Department might consider as it's doing with a centralized/coordinated initial credentailing process of providers to establish one entity to perform this function. This will not only help with consistency, but control the number of necessary QA visits and potential duplication of effort if one provider is registered with several CHC-MCOs. | Delaware County AAA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-4 | A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the CHC-MCO shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a member can be transferred to a contract facility in the network, if presently in a non-contract facility; | AmeriHealth Caritas agrees that strong policies should be in place for members admitted to emergency settings who may be transferred from a non-contracted facility to a contracted facility where appropriate. We request that the commonwealth allow for CHC-MCOs to have the flexibility to create their own internal policy that accounts for variances in member needs, with final approval from the commonwealth. | AmeriHealth Caritas |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-4 | Prospective review of same day surgery procedures. | Currently, AmeriHealth Caritas requires prospective authorization for select same day procedures such as those with the potential of abuse or potentially non-covered services. We believe that requiring CHC-MCOs to prospectively review all same day surgery procedures may pose an administrative burden and potentially create a barrier to timely treatment for providers and members. We recommend the commonwealth allow CHC-MCOs to have the discretion as to which same day procedures will require prospective review. This supports program integrity while also allowing for efficient and timely care delivery. | AmeriHealth Caritas |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-10-Standard IV | The CHC-MCO must have mechanisms and processes for aggregate trending of changes to person centered service plans, and reporting aggregate data to the Department | We request clarification on the metrics envisioned by the commonwealth regarding changes to person centered service plans. We recommend that if there is an existing, similar standard reporting metric used in other programs, that the commonwealth consider sharing it with CHC-MCOs to help inform our processes. | AmeriHealth Caritas |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-19-Standard XI-A | The QM and UM program must have procedures which describe how findings, conclusions, recommendations, actions taken and results of actions taken are documented and reported to individuals within the CHC-MCO for use in conjunction with other related activities such as:<br>1) CHC-MCO Provider Network changes;<br>2) Benefit changes;<br>3) Medical management systems (e.g., pre-certification);<br>4) Practices feedback to Providers; and<br>5) Service Coordination or Service Planning changes | We request clarification on how the commonwealth is defining Service Coordination or Service Planning changes and if there are standard metrics the commonwealth is envisioning that measure service coordination or service planning changes. | AmeriHealth Caritas |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-19-Standard XIII | The CHC-MCO must have written standards for medical record and service planning record keeping. The CHC-MCO must ensure that the medical and service planning records contain written documentation of the medical necessity of a rendered, ordered or prescribed service. | AmeriHealth Caritas requests clarification on CHC-MCO and/or physician record keeping responsibilities for medical records and service planning record keeping. In our experience, the CHC-MCO would take the lead role in generating service plan documentation. If the commonwealth's intent is to require physicians to generate a copy of the service planning record, we recommend that the CHC-MCO take the lead in generating the service plan documentation and allow CHC-MCOs to provide a copy of the service plan record to physicians to be added to the member's overall medical record. | AmeriHealth Caritas |
| | | | The CHC-MCO must operate an | AmeriHealth Caritas supports increased integration of Medicare and Medicaid services to | |

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| Requirements Document Exhibit | FFF - MIPPA Agreement Requirements | Exhibit FFF | aligned D-SNP concurrently with its CHC-MCO. This D-SNP | better coordinate care between the two programs and we support requiring CHC-MCOs to offer companion D-SNPs as an initial coordination pathway. However, given the | AmeriHealth Caritas |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG(1) Performance Measures | This section details the performance measures that demonstrate the level to which the CHC MCO succeeds in achieving quality and operational objectives. Exhibit GGG (1) lists the key performance measures. These performance measures will be used to measure outcomes and results and will generate reliable data on the quality, effectiveness, and efficiency of the CHC MCO. Data elements listed in GGG(2) will be used for inputs and resources in that performance measurement and will be part of the evaluation process for quality, effectiveness, and efficiency. | AmeriHealth Caritas believes that strong quality and performance measurements will be critical to the success of the Community HealthChoices program. We applaud the commonwealth for their emphasis on quality; however, we recommend the commonwealth consider streamlining some the quality measurements to support better program efficiency.<br><br>Additionally, while process measurements are important, AmeriHealth Caritas recommends that the commonwealth, in collaboration with CHC-MCOs, consider the development and inclusion of a limited set of meaningful outcomes-based measurements. Performance measurements that focus on outcomes will support the commonwealth in driving higher quality of care provided to Participants. | AmeriHealth Caritas |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG(4) Data Elements Comprehensive Needs Assesment | N/A | AmeriHealth Caritas believes that comprehensive needs assessments are a critical component to determining the needs of our members and developing individualized care plans. Due to the importance of the needs assessment tool, we recommend that the commonwealth give CHC-MCOs the flexibility to use either the state provided tool or our own comprehensive tool, subject to commonwealth approval. This allows CHC-MCOs the option to customize a needs assessment tool that may be better tailored to members, which may be more comprehensive or specific than the template provided by the commonwealth. | AmeriHealth Caritas |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG(6) Data Elements -Care Plan | N/A | AmeriHealth Caritas believes that the care plan is at the center of the Community HealthChoices program as it drives critical service and care decisions for Participants. As such, we recommend that the commonwealth give CHC-MCOs the flexibility and authority to add or amend this care plan template to best suit the needs of our members, subject to commonwealth approval. This will ensure that CHC-MCOs gather the right information to make these critical care plan decisions with our members. | AmeriHealth Caritas |
| Requirements Document | | Other | N/A | Currently, there are provisions within the Medical Assistance eligibility criteria that may impact the ability of Participants to receive care in a home or community-based setting. | AmeriHealth Caritas |
| Requirements Document | Section X: Termination and Default | A. Termination by the Department - | 3. Termination Due to Unavailability of Funds/Approvals | Can the Department provide clarification around Termination Due to Unavailability of Funds/Approvals? | Cigna-HealthSpring/Patrick Gillespie |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in | B. Guidelines for Review, e. - pg. 77 | For children under the age of twenty-one (21), requests for service will not be denied for lack of Medical Necessity unless a physician or other health care professional with appropriate clinical expertise in treating the Participant's condition or disease determines:<br>- That the prescriber did not make a good faith effort to submit a complete request, or<br>- That the service or item is not Medically Necessary, after making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing. | Can the Department provide clarification around whether or not children are included in the CHC population? | Cigna-HealthSpring |

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| Requirements Document Exhibit | A - Managed Care Regulatory Compl | Page 27 | Where the managed care agreement conflicts with 55 Pa.Code, the agreement is the controlling document. | Is this language intended only for instances in which the agreement is interpreted as stricter than 55 Pa. Code? If not, please verify the agreement assumes precedence over codified regulation. | Cigna-HealthSpring |
| Requirements Document Exhibit | A - Managed Care Regulatory Compl | Page 42 | Managed care organizations must comply with and must require their network private nursing facility providers to comply with require their network providers to comply with the requirements of 55 Pa.Code Chapter 1187, with the following exceptions… | Could the Department please clarify this language? | Cigna-HealthSpring |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | M(2)-4, 5 | The CHC-MCO must develop and implement a critical incident reporting system for Providers to report critical incidents.<br>The following are critical incidents: ...Medication errors that that [*sic* ] result in hospitalization, an emergency room visit or other medical intervention. | Does the Commonwealth consider pharmacists/pharmacies providing services to Participants in the outpatient setting responsible for reporting these medication errors? | Cigna-HealthSpring |
| Requirements Document | Section VIII: Reporting Requirement | 1. Encounter Data Reporting - pg. 8 | Pharmacy transactions must be submitted and approved in PROMISe within 30 days following the adjudication date. | CHC-MCOs are responsible for submission of encounters data, but our understanding is that the State is responsible for approving such data. Please consider removing "and approved" from the language in Section VIII B(1)(b)(iv) due to the approval process residing with the State and it is unknown by the CHC-MCO's how long the approval process takes. | Cigna-HealthSpring |

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| Requirements Document | Section VI: Program Outcomes and Deliverables | Subsection: N/A<br>Page: 5 | "If the Department determines the CHC-MCO has not demonstrated readiness to provide services as required by this agreement, the department will not permit the enrollment of Potential Participants with the CHC-MCO and may extend the time period for the readiness review or not operationalize this agreement." | The participants Acme serves in the OBRA Waiver residential habilitation service is not mentioned for residential services. All are dually diagnosed with intellectual disability/developmental disability (DD) and do not match the targeted population. We operate a residential group home for individuals with DD, not a nursing home and not in-home caregiving. The Dually Diagnosed individuals in the OBRA Residential Habilitation service should not served under this CHC system because there is no guidance for residential dually diagnosed DD participants for the MCOs and likely will not pass readiness review and be able to operationalize this agreement with success. | Acme Providers Inc.<br>Kathie Hoffer, Administrator |
| Requirements Document | Section IV: Applicable Laws and Regulations | Subsection: D. 3.<br>Page: 4 | "If the MCO elects not to provide, reimburse for, or porovide coverage of, a counseling referral service because of an objection on moral or religious grounds, the CHC-MCO must furnish information about the serices not covered in accordance with the provisinos of 42CFR 438.102b...." | How can a participant have the civil right of not being discriminated against based on religion and at the same time have the MCO deny their right to chose all provider options based on Consumer Choice Person Centered Planning. | Acme Providers Inc.<br>Kathie Hoffer, Administrator |
| Requirements Document | Section XVI: General | Subsection: Exhibit A<br>Page 31 | "Managed care organizations are to adhere to the provisions of Medical Assistance Bulletin 1123-91-01, EPSDT – OBRA '89 with the following exceptions:..." | This discussion regarding OBRA funded individuals only addresses the health needs of these participants. There are an important group of OBRA waiver funded participants who are Dually Diagnosed with Developmental Disabilities. All those with OBRA Residential Habilitation services we serve also have a DD diagnosis. This Other Related Conditions (ORC) designation is different from the other typical medical model target population of what is being described in this document and CHC-MCO Plan. Our OBRA funded individuals with DD fit better with the Autism, PFDS and Consolidated waivers that were withdrawn from this CHC program for similar reasons and they should continue to be served under these waivers. | Acme Providers Inc.<br>Kathie Hoffer, Administrator |

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| Requirements Document Exhibit | FFF - MIPPA Agreement Requirements | Subsection: Exhibit FFF Pg: 142 | "The CHC-MCO must operate an aligned D-SNP concurrently with its CHC-MCO. This D-SNP will be required to enter into a MIPPA Agreement with the Department. The MIPPA Agreement will address the eight elements required of all MIPAA agreements,1 and will also include additional requirements to ensure the greatest possible coordination between the CHC-MCO and the D-SNP including, but not limited, to the following..." | There is not follow through with the federal government talking about person centered planning and then having a standardized tool for determining need. The participants receiving OBRA Residential Habilitation Services. with MA 51 diagnosis do not fall into the category which this MCO plan covers. I do not believe that the MCOs will take the time necessary to personalize services for a population that they are not familiar with and does not fit neatly into the same model as their concurrent program. . I fear that an MCO agreeing to provide a concurrent program will not even achieve a quality of services that is on par with the states who were attempting to create a similar MCO system specifically for the special needs population and could lead to individuals being warehoused in nursing homes. This is not the way they want to live nor should the state want them to live. | Acme Providers Inc. Kathie Hoffer, Administrator |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Pg. 153 | Comprehensive Needs Assessment | An assessment called the SIS, Supplemental Intensity Scale, has currently been used to assess individuals with DD and is used in PA. The particular OBRA waiver individuals with DD we serve have completed a SIS assessment. I have assisted with completing multiple SIS assessments of individuals with DD. The SIS is a much better assessment than the "Comprehensive Needs Assessment" provided in this draft to assess needs of a SNP population. The assessment presented captures the medical needs but not the needs of the DD individuals we serve. | Acme Providers Inc. Kathie Hoffer, Administrator |
| Requirements Document | Section IV: Applicable Laws and Regulations | Subsection: E Pg: 4 | "The obligations of the Department under this Agreement are limited and subject to the availability of funds." | Only IF "The obligations of the Department under this Agreement are limited <u>to,</u> and subject to<u>,</u> the availability of funds." | Acme Providers Inc. Kathie Hoffer, Administrator |
| Requirements Document | Section VIII: Reporting Requirements | B.1., p.6 | Encounter Data Reporting | To ensure that sufficient information is available to inform assessments of whether MCOs are meeting rebalancing goals and providing quality services, DHS must require the MCOs to report encounter data at the individual level and by type and amount of service (for example, number of personal care hours authorized) and level of care. Individual level data concerning any service reductions should also be reported. The contract must also require MCOs to have data collection systems capable of capturing and reporting information relevant to HCBS and rebalancing, such as beneficiary functioning, quality of life and caregiver-related issues, in addition to medical information. | Community Legal Services Jenny Frye |

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| Requirements Document | Section X: Termination and Default | A, p.17 | Termination and Default | We have not seen, in the draft contract sections that have been released for comment, the provisions on intermediate remedies. It is crucial that the contract include a full array of intermediate sanctions to enable DHS to bring any non-compliant or poorly performing MCO into full compliance in a timely way. These sanctions must include at a minimum civil money penalties, appointment of temporary management, granting enrollees the right to terminate enrollment without cause, suspension of new enrollments and suspension of payments. | Community Legal Services |
| Requirements Document | Section X: Termination and Default | C.2 | The CHC-MCO must coordinate the continuation of care prior to termination or expiration for Participants who are undergoing treatment for an acute condition. | Similar protections should be included for participants receiving ongoing HCBS and service coordination services. | Community Legal Services |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | p. A-43 | Exclusion of "Subchapter K in its entirety" | How will DHS ensure that participants are able to access exceptional DME in nursing facilities? The reason for the exceptional DME grants was the recognition that a nursing facility's per diem rate would not cover the expense of these costly but medically necessary items, and that residents were experiencing access problems as a result. How will DHS ensure that rates paid to nursing facilities by CHC-MCOs do not prevent participants from receiving exceptional DME? | Community Legal Services |
| Requirements Document Exhibit | B(1) - CHC_MCO Pay for Performance Program | | Pay for Performance Program | Assisting participants with successfully completing the financial redetermination process is a worthwhile goal. This should be part of the service coordinator's job and therefore successful performance of this function should continue to be a requirement after the end of the pay for performance project. We would encourage the Department to consider rebalancing-related projects, as well, to ensure that the MCOs start out with a clear disincentive to reduce or deny needed HCBS. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program | p. M(1)-2 | Quality Management and Utilization Management | We have a general concern that this section appears to have been revised only to add LTSS providers into the existing standards. We urge the Department to consider carefully | Community Legal Services |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard I.N., p. M(1)-4 | The CHC-MCO shall monitor the Participant's condition for ongoing care and potential discharge back to community living. | More detail is needed here, including standards for MCOs to ensure that the nursing facilities with which they contract are providing high quality care and that members who are in nursing homes receive the services they need. Nursing facilities are required to hold care planning conferences at least quarterly, where residents' plans of care are developed based on assessed needs and issues of concern are addressed. MCOs should participate in this care planning process and remain involved in monitoring and advocating for high quality care for their members who are in nursing facilities. If contracted nursing facilities fail to provide high quality care, MCOs must be responsible for being aware of this and taking action to ensure the well-being of their members. Mechanisms should be required for the planned assessment and analysis of quality of care provided and utilization of services in nursing facilities (this should be added in Standard I.E.3 – LTSS has been added to this section, but nursing facilities should be specifically included). Finally, more detail is needed on the CHC-MCO's responsibility to monitor participants' "potential discharge back to community living." The requirements concerning Nursing Home Transition and rebalancing should be addressed and cross-referenced here, as these obligations go well beyond mere monitoring for a possible discharge. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard II.B, p. M(1)-6 | | The Quality Management Committee should include membership and participation by plan participants. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III.C, p. M(1)-7 | | Practice guidelines and clinical indicators should be developed to address service coordination services. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III.E, p. M(1)-8 | | The physical accessibility of plan providers should also be assessed, and accessibility problems should be addressed when they are identified. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III.I, p. M(1)-9 | | LTSS providers should be included here (procedures for provider satisfaction surveys). | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IV.C, p. M(1)-10 | | More detail may be needed here about the aggregate trends and changes to person-centered plans which MCOs will be required to report, to ensure that the Department receives all of the information needed to carefully monitor whether participants are receiving the services they need and what service provision changes may be affecting rebalancing efforts. Also, as discussed above, individual level encounter data must also be collected. | Community Legal Services |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VI, p.M(1)-11 | | There are additional parties which should be included in this list [of those between whom there must be mechanisms to ensure coordination of care, etc]., including:<br>• The CHC-MCOs and the fee for service Medicare program;<br>• The CHC-MCOs and nursing facilities;<br>• The CHC-MCOs (service coordinators?) and community-based LTSS providers; and<br>• The CHC-MCO and hospitals. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII, p.M(1)-13 | | Standards for credentialing nursing facilities should be specifically addressed, and CHC-MCOs should be required to include quality of care information as criteria, including the results of Department of Health and CMS licensing surveys and Medicare star ratings. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX.C, p. M(1)-15 | | This standard should make clear that the Medically Necessary definition and the Prior Authorization process do not apply to eligibility for LTSS, and it would be helpful to include some description of the sources of eligibility criteria for LTSS. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX.E, p. M(1)-16 | | This subsection should make clear that Licensed Proprietary Products may not be used to determine eligibility for LTSS. To the contrary, the level of care determination process will determine eligibility for LTSS services generally, and eligibility for specific services will determined through the person-centered planning process. To the extent that these products are used for non-LTSS services, this subsection should be clarified to state to whom the MCO is required to provide it. Participants who are denied services due to the application of such products should be entitled to a copy, and this should be made clear here. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX.G, p. M(1)-17 | | LTSS should be added to the list of services for whom there should be 24 hour staff availability for authorization. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIII, p. M(1)-19 | The CHC-MCO must ensure that the medical and service planning records contain written documentation of the medical necessity of a rendered, ordered or prescribed services | Medical necessity is not the correct standard for service planning for LTSS (or for LTSS services), and this language should be amended to reflect that. | Community Legal Services |

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| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | M(2)-4, 5 | | CHC-MCOs should be required to notify both long-term care facilities and home health care agencies of their duty to report events that fall under the Older Adult Protective Services Act (32 P.S. § 10225.101) (OAPSA) and 28 Pa. Code § 51.3(g). All long-term care facilities and home health care agencies are subject to the OAPSA and the 28 Pa. Code § 51.3. If a CHC-MCO learns that an event covered under OAPSA or 28 Pa. Code § 51.3 has occurred, it should be required to report to the relevant agency or department itself as required by law and ensure it is done by their provider. | Community Legal Services |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | M(2)-4, 5 | | Additionally, home health care agencies and nursing homes should be required to report all of the events contained in 28 Pa. Code § 51.3(g). The current list of critical incidents in this exhibit does not contain critical incidents such as elopements. As health care facilities under Pennsylvania law, home health care agencies and nursing homes must report the events listed at 28 Pa. Code 51.3(g) to the Department of Health. DHS should require CHC-MCOs to require all of its providers or subcontractors to report these events to DHS as well. | Community Legal Services |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | M(2)-4, 5 | | The sections on abuse, neglect, exploitation, and restraint need to be clarified as to what setting reporting requirements apply. We agree that in the HCBS and nursing home settings these must be reported to relevant departments and agencies, by law, and the CHC-MCOs should be notified, as well. It is not clear if these reporting requirements are limited to those settings. | Community Legal Services |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | M(2)-4, 5 | | As written now, these provisions could be interpreted to mean that a provider must report to a CHC-MCO these events in every situation, including situations where the perpetrator of the abuse is not employed by the CHC-MCO or one of its providers or subcontractors. We oppose reporting of those events to the CHC-MCO unless required by law or with the participant's informed consent. The relationship between a participant and her medical provider is private and based on trust. By requiring a provider to violate that trust undermines the patient doctor relationship. It could likely deter participants from reporting one of those events to their doctors. To what benefit will it be to the participant to have her provider notify the CHC-MCO of abuse? What will the CHC-MCO and the department do when this information is received? Unless required by law, a provider must not be required to report abuse, neglect, or exploitation without the permission of the participant. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6 | | Overall, the notice puts too much burden on the participant. It requires drafting of appeals, mailing appeals within short time frames, and making a decision about which appeal process is better. It does not take into account that participants are severely disabled and potentially in a nursing home or homebound. DHS must require the appeal process to be simple for the participant. The current appeal and notice system is simple and effective for participants. We strongly urge that process to be carried over to MLTSS. | Community Legal Services |

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| Requirements Document Exhibit | N - Notice of Denial | O-6 | | We are concerned that there is not enough room for CHC-MCOs to "explain in detail every reason for denial." CHC-MCOs should be required to provide additional documentation on another form, when the required information does not fit into this small area. The language contained in the explanation should be simple and easy for the participant to read and understand. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6 | | Requiring a complaint, grievance, or a request for a Fair Hearing to be "postmarked or hand-delivered within 10 days of the date of the notice" in order for a participant to continue to receive the services that are proposed to be terminated or reduced violates 55 Pa. Code § 275.4(a)(2), which provides for the filing of an appeal orally. Participants in MLTSS are severely disabled. They either reside in a nursing home or require nursing services in their home. For them, filing appeals is particularly hard. In accordance with the Code, oral appeals must be allowed. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6 | | If a participant elects to file a grievance and a request for a fair hearing, will aid paid pending be provided until both processes are completed? We believe in situations where both appeals are filed, aid paid pending must be provided until both processes are completed. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6 | | Request Criteria: This should not be the first option for a participant when she has received a notice denying, reducing or terminating the services, especially in light of the fact DHS requires the CHC-MCO to provide this information in the explanation above. If the CHC-MCO complies with the requirement to fully explain the reason for the denial and cite the criteria, requesting the criteria should not be necessary. The right to request the criteria should be incorporated into the sections about filing for a fair hearing or a grievance. Otherwise, this will lead to delays for participants. Further, it should not require them sending a written request to the CHC-MCO. An oral request should be sufficient. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6-7 | | File a Complaint of Grievance: This should not come before a request for a fair hearing. What is the difference between a complaint and a grievance? If there is no difference, CHC-MCOs should be required to use one term, preferably "appeal." The creation of a separate grievance process from the traditional fair hearing confuses the process and complicates the issues for participants. We often represent individuals in Medicare appeals, where the tiered appeal system is like one proposed for MLTSS. It is confusing to participants and often causes them to forgo appeals. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6-7 | | The multitude of terms, appeal, grievance, complaint, fair hearing will confuse the participant. We strongly suggest using the term "appeal". A participant should be able to file an "appeal" with DHS or CHC-MCO. The use of one term will simplify the process and lead to less confusion about a participant's options. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6-7 | | The notice should contain language that filing a grievance will put the decision in the hands of the CHC-MCO that has proposed the negative action. | Community Legal Services |

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| Requirements Document Exhibit | N - Notice of Denial | O-6-7 | | If a CHC-MCO does not resolve the grievance within 30 days, it should be required to provide interim assistance until it does. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-7 | | Request for a Fair Hearing: This should be the first option for participants, as it is in their best interest to have a disinterested party review the proposed negative action of the CHC-MCO. The language should be clearer here to reflect that a fair hearing will allow a participant to have her issue heard before a person who does not work for the CHC-MCO and was not involved in the original proposed negative action. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-7 | | This section seems to indicate that the participant must draft her own appeal. We strongly oppose this requirement. Currently, a denial notice comes with a section that allows a participant to elect to file an appeal. This is a simplified and easy process for participants. Requiring a participant to draft her own appeal and provide copies of the notice and to mail the appeal is not good policy and will decrease the likelihood of participants filing appeals. DHS should require the provision of notices to participants that contain a section where they may elect to file an appeal. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-7 | | As mentioned above, appeals are allowed to be filed orally. Further, this oral request should be able to be made to DHS or the CHC-MCO. The participant will have a service coordinator who can assist the participant in filing the appeal, as well. Requiring the participant to mail the appeal is contrary to Pennsylvania regulations. Once an oral appeal is made, the participant should be assisted in filing a paper appeal by DHS or the CHC-MCO, as required by 55 Pa. Code § 275.4(a)(2)(iv). | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-7 | | The language stating "the department will issue a decision between 60 and 90 days from when it receives your request" is confusing. This language does not mention a hearing at all. This language should be changed to reflect that DHS has to provide a fair hearing during that time, as well. 55 Pa.Code § 275.4(b) requires final administrative action to be taken within 60 days of the date of the appeal for Food Stamps appeal and 90 days from the date of the appeal for Medical Assistance. This should be stated explicitly. Further, the notice should contain information on interim assistance. We suggest the following language in accordance with the code: "We must provide a hearing and make a decision about your appeal within 90 days of the date you filed your appeal. If we fail to do so, we will authorize interim assistance until we make our decision, in accordance with 55 Pa. Code § 275.4(d)." | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-8 | | Participants should not be required to send a written request to the CHC-MCO in order to obtain documents relevant to the decision. A participant must be allowed to make this request orally to either the CHC-MCO or DHS. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | Exhibits N(2)-N(6) | | Our concerns with the rest of the notices are the same as N(1), and our comments on N(1) are applicable to these notices as well. | Community Legal Services |

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| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Rights | | We are concerned that this list of rights is not complete. We are also concerned that this list of rights is not particular to individuals receiving MLTSS. There is no provision for the right to person-centered service planning and service provision, or to elect to self-direct their care. Additionally, in Exhibit DD of the Draft Program Requirements, there are many rights listed that do not appear here. For instance, rights regarding patient payment amounts and prohibitions on balance billing are not included in this list of rights. | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Rights | | For nursing home residents, the rights contained in 42 C.F.R § 483.10 and 483.12 should be incorporated into this document. The document states that it applies to providers, and therefore the rights afforded nursing home residents in those sections should be incorporated into this document. The rights should be written out and not just referenced by regulation citation. | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | | | In sections where references are made to the Code of Federal Regulations, CHC-MCOs should be required to provide the language of those sections and not just the citations. | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Responsibilities | | We are confused by this section. It appears that a participant has more responsibilities than she does rights? What does it mean for a participant to have a responsibility? To whom is that responsibility owed? If they fail to do one of the listed responsibilities, what will happen to them? The use of the word responsibilities implies that the participant must do these things herself, and that the CHC-MCO will not assist in the matters. We strongly encourage that this section be removed or titled differently. | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Responsibilities | | We strongly oppose the inclusion of this in the document if it in any way may be used by a CHC-MCO to try to disenroll participants. It is foreseeable that a CHC-MCO will interpret this list as duties and use a participant's alleged failure to follow one of these requirements as a means to disenroll her. | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Responsibilities | | We urge the removal of the requirement to review covered items. It is unclear what this means. Does this mean they are responsible for knowing the rules? Should not the service coordinator assist with these rules? | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Responsibilities | | We urge the removal of "To communicate problems immediately to the CHC-MCO." What kind of problems must they communicate immediately? This is very vague. Does it mean problems with services or service providers? This language should be removed. | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Responsibilities | | We urge the removal of "to ask questions and further information regarding anything not understood." We are not suggesting that participants should not ask questions, but to impose upon them the responsibility to do so implies that if they fail to understand something in is their fault. This should be a participant right, not a responsibility. | Community Legal Services |

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| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Responsibilities | | We do not understand why it is necessary to put language in this section about calling 911 or their doctors if they are sick or in an emergency. It goes without saying that these are things a participant should do, but making them a responsibility implies that they and they alone are the ones that must take that action. | Community Legal Services |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | As noted in our December comments, we strongly oppose CHC-MCOs requiring prior authorization of services because this often results in the delay or denial of critically needed care for participants. At a minimum, CHC-MCOs must not require prior authorization for emergency services, post-stabilization services, or urgent care services (treatment for medical conditions that are serious or acute and require medical attention within 24 hours). This rule should apply to both in-network and out-of-network providers. The Department must also not allow CHC-MCOs to require prior authorization for services that do not require prior authorization under the fee-for-service program. If CHC-MCOs were allowed to impose prior authorization standards more stringent than those used in FFS, this would create more administrative hurdles for both participants and providers, along with new avenues for CHC-MCOs to deny participants care. | Community Legal Services |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | If the Department chooses to allow prior authorization, the Department must set out clear standards for a CHC-MCO's expedited review process. Exhibit H states only that CHC-MCOs must have procedures for such a process when services are urgently needed. Prior authorization processes should be as uniform as possible across CHC-MCOs. We recommend that the Department require an expedited review process similar to that outlined in the Hawaii and California MLTSS contracts (see Hawaii Contract, p. 219 and CA Contract, Exhibit A, Attachment 5, Section 2). Expedited review should be applied when the standard time frame for prior authorization could seriously jeopardize the participant's health, independence, or ability to attain, maintain, or regain maximum function. The CHC-MCO must make expedited review determinations as soon as possible but no later than three days after the request for service. This time frame may be extended up to 14 days, either (1) upon the participant's request; or (2) upon the CHC-MCO proving to the Department that the CHC-MCO needs additional information and the extension is in the participant's best interest. If the CHC-MCO extends the time frame, it should issue a written notice of this decision and the participant's right to appeal if he or she disagrees with the decision. | Community Legal Services |

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| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | CHC-MCOs' criteria for prior authorization review must incorporate a broader definition of "medically necessary" than that originally proposed in the draft program requirements. As we emphasized in our December comments, "medically necessary" services must include services that offer the opportunity for a participant receiving LTSS to have access to the benefits of community living. CHC-MCOs' written policies and procedures must describe how they will utilize a social (rather than exclusively medical) model of LTSS in making authorization decisions. | Community Legal Services |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | The Department should ensure that CHC-MCOs educate providers on the types of services requiring prior authorization, as well as the procedures and time frames for obtaining authorization of these services. Additionally, CHC-MCOs must have mechanisms for consulting with requesting providers when conducting prior authorization reviews. | Community Legal Services |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | CHC-MCOs must be prohibited from arbitrarily denying or reducing the scope of services based on a participant's diagnosis or type of illness/condition. | Community Legal Services |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | Administrative requirements should also mandate that CHC-MCOs explain in their written policies and procedures how they will ensure consistent application of prior authorization review criteria. CHC-MCOs must clearly document their reasoning behind each authorization decision. | Community Legal Services |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | For additional recommendations regarding prior authorization, please see Community Legal Services' December comments. | Community Legal Services |
| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | M(4)-1-4 | | 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. | Community Legal Services |
| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | M(4)-3-4 | | The Department must require CHC-MCOs to conduct a more socially-oriented survey to supplement the clinically-oriented CAHPS survey. The supplemental survey should assess a participant's quality of life. 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. | Community Legal Services |

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| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | M(4)-3-4 | | While the draft agreement anticipates that survey administration will consist "of a mail protocol followed by telephone administration to those not responding by mail," surveys must be done in-person. Again, it should be noted that HEDIS protocol was not designed with the MLTSS population in mind. Many seniors and people with disabilities will likely have difficulty completing surveys conducted over the phone or through mailings. CMS guidance on quality of life measures also emphasizes that "data must be collected using best practices for reaching special populations (e.g., phone or in-person as opposed to mail)." (CMS Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs). Further, in conducting surveys, CHC-MCOs should accommodate participants with limited English proficiency and/or disabilities. | Community Legal Services |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | Data from performance measures must be shared publicly with stakeholders. The data must be presented both on a CHC-MCO and statewide basis so that stakeholders can identify whether trends are specific to certain CHC-MCOs or systemic. We recommend that reports of performance measures sufficiently analyze and correlate data so that stakeholders can draw meaningful conclusions about the quality of a CHC-MCO and the CHC program in general. The Department must also incorporate performance measures into overall ratings for CHC-MCOs that will allow participants to make informed enrollment decisions. | Community Legal Services |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | The Department must establish an independent ombudsman and advocacy program and involve the ombudsman in evaluating CHC-MCOs' performance. As mentioned in our comments on the CHC Concept Paper, the ombudsman should provide free assistance to participants on a variety of issues 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. | Community Legal Services |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | Performance evaluation must include measures to gauge LTSS rebalancing. Because serving more participants in the community is cited as a primary objective of CHC, CHC- | Community Legal Services |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | Although OLTL has proposed measures that capture the number of complaints and grievances, these measures alone are insufficient. The Department must also track the nature and outcome of these complaints and grievances. Exhibit GGG(9) seems to propose collecting data about the nature of complaints and grievances, but not the outcomes. | Community Legal Services |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | The Department should find a way to generate data about continuity of care when participants first enroll in CHC and when they switch from one CHC-MCO to another. This information will allow stakeholders to examine whether CHC-MCOs are preventing gaps in care/service disruptions for participants. | Community Legal Services |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | The Department must monitor CHC-MCOs' due process compliance, which is not adequately tracked by the listed performance measures but will likely be a major problem among CHC-MCOs. Due process violations may prevent participants from filing complaints or grievances (for example, participants may not receive adequate notice of decisions or receive misinformation from a CHC-MCO about appeal rights). CHC-MCOs may also refuse to provide aid paid pending, which could have especially dire consequences for the MLTSS population. The Department must thus find a way to evaluate due process compliance (measures 64 and 68 are good starting points) and should consider conducting "mystery shopper" tests of member services to test whether CHC-MCOs respond appropriately to participants who try to file appeals. | Community Legal Services |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | We also recommend the addition of the following specific performance measures:<br>• Actual timely receipt of all services in a care plan<br>• Provider participation accuracy<br>• Provider information accuracy<br>• Time and travel distance from provider to participant | Community Legal Services |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | An evaluation of CHC-MCO performance should also include assessments on whether CHC-MCOs are ADA-compliant. In New York, a study completed by the Center for Independence of the Disabled NY (CIDNY) found that managed long-term care plans routinely violate the ADA. The Department should ensure that it monitors how CHC-MCOs accommodate participants' disabilities. | Community Legal Services |

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| Requirements Document | Section II (Definitions) | | | As noted in our December comments, the Definitions section should define language access. It should also define who is limited English proficient. We recommend the following definitions, which are based on federal agency guidance:<br><br>• **Limited English Proficient Individuals:** Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English are limited English proficient.<br><br>• **Language Access:** Provision of oral and written language services needed to assist LEP individuals to communicate effectively with staff, and to provide LEP individuals with meaningful access and an equal opportunity to participate fully in services, activities, or other programs. For LEP individuals, meaningful access denotes access that is not significantly restricted, delayed, or inferior as compared to programs or activities provided to English proficient individuals. | Community Legal Services |
| | Section III | Term of Agreement | Procurement for the entire state rather than for each region | We strongly urge the state to use this procurement for the SW region only and thereafter procure each region separately so lessons learned and best practices can be included, for quality improvement purposes given the vulnerability of this population | PA Health Funders Collaborative<br>Ann Torregrossa |
| | Section IV A 1 | National Accreditation | If the CHC-MCO is not accredited as of the start date of this Agreement, the CHC-MCO shall obtain accreditation no later than the end of the second full calendar year of operation…. | End of the **first** full calendar year of operation. Comment: Given the vulnerability of the enrollees, it is desirable to shorten the time that they are receiving services from an unaccredited entity. | PA Health Funders Collaborative |
| | iii. Provider claims | p. 7 | The CHC-MCO must require Providers to submit claims CHC-MCO within one hundred eighty (180) days after the date of service. | within **90** days after the date of service Comment: Data is now automated and there is no need to continue standards from before it was. For QI, UR and DHS monitoring, data should be available on a more real time basis. | PA Health Funders Collaborative |

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| | iv. Encounter Submissions | pp 7-8 | All Encounter records except pharmacy transactions must be submitted and determined acceptable by the Department on or before the last calendar day of the third month after the payment/adjudication calendar month in which the within 30 days following the adjudication date. | **120 days** of the date of service. Comment: Data is now automated and there is no need to continue standards from before it was. For QI, UR and DHS monitoring, data should be available on a more real time basis. | PA Health Funders Collaborative |
| | Disclosure of Changes in Circumstances | pp 16-17 | The CHC-MCO will report to the Department, as well as the Departments of Health and Insurance, within ten (10) Business Days of the CHC-MCO's notice of same, circumstances that may have a material adverse effect upon financial or operational conditions of the CHC-MCO or CHC-MCO's parent(s) | with forty-eight hours. Comment: Any of these events could signal a serious problem in the operation of the MCO and given the vulnerability of the enrollees should not wait 2 weeks before DHS looks into it. | PA Health Funders Collaborative |

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| | Termination for cause | p. 17 | The Department may terminate this Agreement for cause upon forty- five (45) days written notice, which notice shall set forth the grounds for termination and, with the exception of termination. The Department will provide the CHC-MCO with forty-five (45) days in which to implement corrective action and cure the deficiency. If corrective action is not implemented to the satisfaction of the Department within the forty- five (45) day cure period, the termination shall be effective at the expiration of the forty-five (45) day cure period. | Add language: Should the grounds for termination be that the MCO or its network providers have failed to take appropriate action or have taken action that has put enrollees in imminent danger to to their health or lives, the Department may terminate the contract immediately and transfer the enrollees of other MCOs in the region. Comment: DHS must have a remedy if the health and lives of enrollees are at risk that is more timely than waiting 45 days. | PA Health Funders Collaborative |
| | Medical Record Retention | p. 20 | The CHC-MCO must provide Participants' medical records, subject to this Agreement, to the Department or its contractor(s) within twenty (20) Business Days of the Department's request. | within 10 days of the Department's request or within 24 hours if there is an urgent need for this information. Comment: Medical records are increasingly in electronic format and the reason for a delay of a month is no longer necessary. DHS must have the ability to gain timely access of records when there are concerns about an enrollees care. Since the medical records will be with the Medicare plan, provision needs to be made to obtain the LTSS and care plan records, not just the medical records. | PA Health Funders Collaborative |
| | Compliance with Program Standards | p. 21 | In addition, the CHC-MCO must include in its contracts or Subcontracts that cover the provision of medical services to the CHC-MCO's Participants the following provisions: | In addition, the CHC-MCO must include in its contracts or Subcontracts that cover the provision of medical services and long-term services and supports to the CHC-MCO's Participants the following provisions: | PA Health Funders Collaborative |

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| | | p. 22 | 3. Language which prohibits gag clauses which would limit the subcontractor from disclosure of Medically Necessary or appropriate health care information or alternative therapies to Participants, other Health Care Providers, or to the Department. | 3. Language which prohibits gag clauses which would limit the subcontractor from disclosure of Medically Necessary or appropriate health care information, long-term care services or supports or alternative therapies to Participants, other Health Care Providers, or to the Department. | PA Health Funders Collaborative |
| | | p.22 | 5.. The definition of Medically Necessary as outlined in Section II of this Agreement, Definitions | 2. The definition of Medically Necessary and long-term services and supports as outlined in Section II of this Agreement, Definitions | PA Health Funders Collaborative |
| | Consistency with Regulations | pp. 22-23 | | Comment: What about the consumer protection provisions of the DOH regulations and the network adequacy requirements? | PA Health Funders Collaborative |
| | Section XIV Indemnification and Insurance | A 1. pp 23-24 | 1. In addition to Section 14 of Exhibit D, Standard Grant Terms and Conditions for Services, the CHC-MCO must indemnify and hold the Department and the Commonwealth of Pennsylvania, their respective employees, agents, and representatives harmless | 1. In addition to Section 14 of Exhibit D, Standard Grant Terms and Conditions for Services, the CHC-MCO must indemnify and hold the Department and the Commonwealth of Pennsylvania, their respective employees, agents, and representatives harmless and CHC-MCO enrollees... Comment: Providers should not be able to seek payment from enrollees should they have a payment disagreement with the MCO. Providers often have consumers sign language saying they agree to pay if the insurance does not. | PA Health Funders Collaborative |

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| | Insurance | B. 24 | The CHC-MCO must maintain for itself, each of its employees, agents, and representatives, general liability and all other types of insurance in such amounts as reasonably required by the Department and all applicable laws. In addition, the CHC-MCO must require that each of the Network Providers with which the CHC-MCO contracts maintains professional malpractice and all other types of insurance in such amounts as required by all applicable laws. The CHC-MCO must provide to the Department, upon the Department's request, certificates evidencing such insurance coverage. | Comment: This may be fine for HealthChoices where most providers have med mal insurance requirement. This is entirely different for HCBS benefits. The Department should make public for comment the insurance requirements for each type of provider. | PA Health Funders Collaborative |
| | Third Party Beneficiaries | p. 26 | This Agreement does not, nor is it intended to, create any rights, benefits, or interest to any third party, person, or organization. | Comment: The enrollees are clearly the intended beneficiaries of this contract. This clause could mean instead of bringing a claim against the MCO if there is a significant problem, they will instead have to sue the Department to mandate enforcement of the contract. | PA Health Funders Collaborative |
| | 110.21 Definition of "Medical Necessary" | Exhibit A page 29 | A service, item, procedure or level of care that is: (i) Compensable under the Medical Assistance Program. (ii) Necessary to the proper treatment or management of an illness, injury or disability. (iii) Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice. | This should be eliminated. It is not consistent with the definition of Medical Necessity in the definition section for HealthChoices, is very medically oriented and not appropriate for long-term services and supports. It requires a lesser level of coverage, which clearly is not appropriate for this vulnerable population. | PA Health Funders Collaborative |

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| | Exhibit B (1) | CHC-MCO Pay for Performance Program | | Comment: The Wolf Administration has acknowledged that is important to change how the state pays for health care from volume to purchasing for value or desired outcome. Exhibit GGG has a lot of potential measures that could be used for that purposed. We urge the Department to rapidly increase the P4P portion of the reimbursement as you roll this out across the state. | PA Health Funders Collaborative |
| | Exhibit H | Prior Authorization | | Comment: Is this needed? Most if not all medical procedures are going to be paid for and delivered by the Medicare MCO or FFS. You've already stated that prior authorization does not apply to person-centered service plans. For other MLTSS, the person will have been determined to need a nursing-facility level of care. Then there is a comprehensive care plan determination. On top of that, does there need to be prior authorization? How many assessment and approvals for level of service should be authorized under this Agreement? | PA Health Funders Collaborative |
| | Exhibit H | Prior Authorization | The DHS Prior Authorization Review Panel has the sole responsibility to review and approve all prior authorization proposals from the CHC-MCOs. | Given the commitment to transparency and the vulnerability of people served under this contract, we recommend that there be an opportunity for public comment before the DHS Prior Authorization Review Panel considers the MCOs request. An opportunity for public comment may also have a chilling effect on the MCOs in requesting these. | PA Health Funders Collaborative |
| | | | h. For LTSS, Covered Services will be authorized in accordance with the requirements of the CHC 1915(c) Waiver. | Comment: The specific requirement of the CHC 1915 c waiver should be inserted here when known to assure that they can be enforced and that the MCO is aware of them. | PA Health Funders Collaborative |
| | | | | Take out all references to children under the age of 21 | PA Health Funders Collaborative |
| | | Administrative Requirements | 21 days: All other services | All other services: 48 hours. Comment: Someone found to have a nursing facility-level of care needs cannot wait 21 days for services to assist with activities of daily living. | PA Health Funders Collaborative |
| | Exhibit M1 | Quality Management and Utilization Management Requirements | The Department will monitor the Quality Management (QM) and Utilization Management (UM) programs of all CHC-MCOs and retains the right of advance written approval of all QM and UM activities. | Given the vulnerable populations the Department should approve in advance in writing all QM and UM activities to assure they are appropriate. | PA Health Funders Collaborative |

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| | | | E 2) Distinct policies and procedures regarding LTSS and shall specify the responsibilities and scope of the authority of Service Coordinators in authorizing LTSS and in submitting authorizations to Providers. | All Service Coordinators should have the authority to authorize LTSS and be able to submit authorizations to Providers. Otherwise they are not coordinating services. | PA Health Funders Collaborative |
| | | | E 3) Include mechanisms for planned assessment and analysis of the quality of care provided and the utilization of services against formalized standards, including but not limited to: | The list is not appropriate for MLTSS because most of the listed care is paid for and managed by the Medicare MCO or FFS. This needs to be customized and particularized to LTSS, e.g., hospice, palliative care; attendant care, etc. | PA Health Funders Collaborative |
| | | | | Add: Periodicity for the assessment and quality of care analysis must be done annually. Comment: Otherwise they could do it every 10 years. Also you need to define or require uniform formalized standard across MCOs. The standard could be: Is the person still alive? | PA Health Funders Collaborative |
| | | | F. Provide a comprehensive written evaluation, completed on at least an annual basis, that details all QM and UM program activities... | Given the need for transparency, shouldn't this report be available to the public? With Hospital Compare, Nursing Facility Compare, something comparable is needed to help enrollees select MCOs based on the quality of services provided and their outcomes. | PA Health Funders Collaborative |
| | | | M. The CHC-MCO shall provide for methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity in accordance with UM policies and procedures.... | The list is not appropriate for MLTSS because most of the listed care is paid for and managed by the Medicare MCO or FFS. CH-MCOs may not even have the data to do most of this. This needs to be customized and particularized to LTSS | PA Health Funders Collaborative |

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| | | | N. The CHC-MCO shall ensure that reimbursement of nursing facility care is provided for Participants who have been determined to be eligible for reimbursement of nursing facility care for the period specified. The CHC-MCO shall monitor the Participant's condition for ongoing care and potential discharge back to community living. | Comment: The MCO must be precluded from facilitating the discharge of a person needing a nursing facility level of care to the community if they are eligible due to spend down for nursing facility care or espousal impoverishment, but would not be eligible for MA-funded services in the community because their income and or resources were too high. Alternatively, the Department should grandfather their MA eligibility. This would assure MA savings and would not raise "wood work" concerns. | PA Health Funders Collaborative |
| | | | C. The Director of LTSS ensures the provision of LTSS in accordance with the requirements outlined in this Agreement and the CHC 1915(c) Waiver. | Comment: The specific requirement of the CHC 1915 (c) waiver should be inserted here when known to assure that they can be enforced and that the MCO is aware of them. | PA Health Funders Collaborative |
| | | Standard III | B. The QM and UM programs must include clinical/quality Indicators in the form of written, professionally developed, objective and measurable variables of a specified clinical or health services delivery area, which are reviewed over a period of time to screen delivered health care and/or monitor the process or outcome of care delivered in that clinical area. | Comment: Over the next several years, the Department should develop, with public input, some uniform QI and UM standards to be used by all CH MCOs. | PA Health Funders Collaborative |
| | | | B. Practice guidelines and clinical indicators must address the full range of health care and LTSS needs of the populations served by the CHC-MCO. The areas addressed must include, but are not limited to: | B. Practice guidelines and clinical indicators must address the full range of LTSS needs of the populations served by the CHC-MCO. | PA Health Funders Collaborative |

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| | | | 3) Pediatric and adolescent preventive care with a focus on EPSDT services; | Comment: The list is not appropriate for MLTSS because most of the listed care is paid for and managed by the Medicare MCO or FFS. This needs to be customized and particularized to LTSS, e.g., hospice, palliative care; attendant care, etc. | PA Health Funders Collaborative |
| | | | 4) Obstetrical care including a requirement that Participants be referred to obstetricians or certified nurse midwives at the first visit during which pregnancy is determined: | Omit | PA Health Funders Collaborative |
| | | | 7) Preventive dental care. | Omit | PA Health Funders Collaborative |
| | | | E. The CHC-MCO must develop methodologies for assessing performance of PCPs/PCP sites, high risk/high volume specialists, dental Providers, LTSS Providers, and Providers of ancillary services not less than every two years (i.e. medical record audits). These methodologies must, at a minimum: | E. The CHC-MCO must develop methodologies for assessing performance of all LTSS Providers, and Providers of ancillary services not less than every one year (i.e. medical/service record audits). These methodologies must, at a minimum: ….Comment: This needs to be more particularized to LTSS | PA Health Funders Collaborative |
| | | | K. The QM and UM programs must contain procedures for measuring Participant and Provider satisfaction with LTSS Service delivery. | Comment: There needs to be a uniform tool to measure participant and provider satisfaction, the results of which should be made public. This provision should reference the uniform tool. | PA Health Funders Collaborative |

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| | | | Standard IV: The QM and UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided to Participants through utilization review activities with a focus on identifying and correcting instances and patterns of over-utilization, under-utilization and mis-utilization. | Comment: Is this appropriate for consumer centered and directed care? The criteria could be very subjective. This involves services to serve people in the community in a consumer centered way. Services will be needed to avoid isolation, depression and to get them out of the house. These are not amenable to the same kind of UR metrics for strictly medical care. This either needs to be eliminated or revamped to reflect the goals of CHCs. In a nursing facility there are programs with singing, art, bingo, etc. There is no UR review to see if they can be eliminated and in fact those kinds of programs are encouraged. | PA Health Funders Collaborative |
| | | | A. Semi-annually, or more frequently as appropriate, the QM and UM programs must provide for production and distribution to Providers, (in either hard copy or web- based electronic formats) profiles comparing the average medical care utilization rates of the Participants of each PCP to the average utilization rates of all CHC- MCO Participants. The CHC-MCO must develop statistically valid methodologies for data collection regarding Provider profiling. Profiles shall include, but not be limited to: | Comment: It should be noted that whenever UR is required, it is every 6 months but if it is quality monitoring it is every 1-2 years. This should not be the case. The LTSS providers who have the best record of keeping people in the community are "high touch". It is penny wise and pound foolish to do this kind of UR comparison with LTSS providers. These are not knee replacements, these are people needing LTSS with varying degrees of family support, living conditions and needs with activities of daily living. This kind of UR requirement is entirely inappropriate and will not have the effect desired of keeping people in the community. | PA Health Funders Collaborative |
| | | | 1. 1) Utilization information on Participant Encounters with PCPs; | Omit except for PCPs for LTSS. These are covered by Medicare MCOs or FFS. Need to particularize this to LTSS. | PA Health Funders Collaborative |
| | | | 2) Specialty Claims; | Omit | PA Health Funders Collaborative |

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| | | | 3) Prescriptions; | Omit | PA Health Funders Collaborative |
| | | | 4) Inpatient stays | Omit | PA Health Funders Collaborative |
| | | | E. The CHC-MCO must develop methodologies for assessing performance of PCPs/PCP sites, high risk/high volume specialists, dental Providers, LTSS Providers, and Providers of ancillary services not less than every two years (i.e. medical record audits). These methodologies must, at a minimum: | E. The CHC-MCO must develop methodologies for assessing performance of PCPs/PCP sites, LTSS Providers (should be itemized and particularized for the range of LTSS providers), and Providers of ancillary services not less than every year (i.e. medical record/care plan audits). These methodologies must, at a minimum: Comment: given the vulnerability of this population and the inexperience of the MCOs in providing these services or in Pennsylvania, this needs to be done more often than under HealthChoices | PA Health Funders Collaborative |
| | | | | Add 6. Include mechanisms to determine and correct adverse patient outcomes | PA Health Funders Collaborative |

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| | | | | Add: 7. Include mechanisms to review ways to improve socialization and avoid depression, isolation and loneliness of those NF level of care who are being served in their homes. | PA Health Funders Collaborative |
| | | Standard IV | A. Semi-annually, or more frequently as appropriate, the QM and UM programs must provide for production and distribution to Providers, (in either hard copy or web- based electronic formats) profiles comparing the average medical care utilization rates of the Participants of each PCP to the average utilization rates of all CHC-MCO Participants. The CHC-MCO must develop statistically valid methodologies for data collection regarding Provider profiling. Profiles shall include, but not be limited to: | Comment: Quality measures requirements are every year or 2 years and UR measures to restrain costs are every 6 months. In comparing costs, it should not be looking only at average utilization rates of all CHC-MCO participants, but compared to how well they are avoiding the need for nursing facility placement. Some of the best "high-touch"providers may have higher costs in the community, but they keep down overall costs by avoiding the need for NF placement. | PA Health Funders Collaborative |
| | | A 1-4; 7; 8 | | Comment: The Medicare MCO or FFS will have information for A 1-4; 7; 8. Number 9 should be eliminated. Is it worth the time to do all this since the CHC-MCO has no ability to do QI or UM for these? | PA Health Funders Collaborative |
| | | | F. The CHC-MCO agrees to comply with Department requirements and procedures related to the Enhanced Medical Home (EMH) model. EMH model is a system of care that provides access to a primary care provider, as well as targeted care management support for members at high risk of using acute medical services. | Comment: Is this really relevant since Medicare services will cover most of this? | PA Health Funders Collaborative |

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| | | | Standard VI: The QM and UM programs must have mechanisms to ensure that Participants receive seamless, continuous, and appropriate care throughout the continuum of care, by means of coordination of care, benefits, and quality improvement activities between | Comment: This is a critical component. On the other standards you specify requirements based on best practice that will help ensure this will happen, e.g. by having mechanisms that… Isn't this the place to put in the behavioral health integration requirements that you have recently added for HealthChoices. | PA Health Funders Collaborative |
| | | Standard VIII | C 1) Seventy-fiveto100%oftheNetworkconsistsofPCPswhohavecompletedan approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics; | Add: geriatrics, CRNPs, P.As | PA Health Funders Collaborative |
| | | C | Determinations of medical necessity for covered care and services whether made on a Prior Authorization, Concurrent Review or Retrospective Review basis, shall be documented in writing. The CHC-MCO shall base its determination on medical information provided by the Participant the Participant's family/care taker and the PCP, as well as any other Providers, programs and agencies that have evaluated the Participant. Medical necessity determinations must be made by qualified and trained Health Care Providers. | Determinations of medical necessity for covered care and services whether made on a Prior Authorization, Concurrent Review or Retrospective Review basis, shall be documented in writing. The CHC-MCO shall base its determination on medical and service need information provided by the Participant the Participant's family/care taker and the PCP, as well as any other Providers, programs and agencies that have evaluated the Participant. Medical necessity and service need determinations must be made by qualified and trained Health Care Providers Service Coordinators . | PA Health Funders Collaborative |

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| | | | Satisfaction of any one of the following standards will result | Satisfaction of any one of the following standards will result in authorization of the service: 1) The service or benefit will, or is reasonably expected to, prevent the onset of | PA Health Funders Collaborative |
| | | | G. The CHC-MCO agrees to provide twenty-four (24) hour staff availability to authorize weekend services, including but not limited to: home health care, pharmacy, DME, and medical supplies. The CHC-MCO must have written policies and procedures that address how Participants and Providers can make contact with the CHC-MCO to receive instruction or Prior Authorization, as necessary | G. The CHC-MCO agrees to provide twenty-four (24) hour staff availability to authorize weekend and after-hour services , including but not limited to: home health care, pharmacy (?), DME (?), LTSS and medical supplies(?). The MCO and/or its network providers providing assistance with activities of daily living in the home must have a system for staff to call in when arriving at the home and the availability of substitute personnel if the service provider does not call in by 30 minutes of the scheduled arrival time. The CHC-MCO must have written policies and procedures that address how Participants and Providers can make contact with the CHC-MCO to receive instruction or Prior Authorization, as necessary | PA Health Funders Collaborative |
| | | | Standard XIII | Comment: Not sure how the CHC-MCO will be able to get this from Medicare FFS or non-affiliated Medicare MCOs. | PA Health Funders Collaborative |
| | | | Standard XIV A is blank | | PA Health Funders Collaborative |
| | Exhibit M(2) | | The CHC-MCO shall perform at least two (2) clinical and three (3) non-clinical PIPs. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and other complaints. | Comment: These should be exclusively focused on LTSS. | PA Health Funders Collaborative |

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| | Exhibit M(3) | Critical Incident Reporting | Service interruption, which includes any event that results in the participant's inability to receive services that places his or her health and or safety at risk. This includes involuntary termination by the provider agency, and failure of the participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization; and | Comment: There needs to be clear requirements for back-up plans for agencies providing assistance with activities of daily living, home health and other services provided in the home. Otherwise a backup plan could be to do nothing if someone does not show up and therefore I would not have a duty to report. | PA Health Funders Collaborative |
| | CAHPs | | | Omit the extensive dental access questions. These CAHPs questions demonstrate that this is not really on point for LTSS. NY uses preventative care, patient safety, advance directives, quality of life, rating of regular visiting nurses, rating of care manager, timeliness of aide, involved in decisions for an overall rating.<br>Mathematica with AMA, Brandeis, NCQA & Truven Health Analytics is building on work of the National Quality Forum is suggesting care coordination, beneficiary experience of care, effective transitions across care settings, quality of life and community integration, use of preventative service, management of behavioral health and avoidance of ER, hospital and NF admissions. The Department has many of these measures in Exhibit GGG and they should be incorporated in the performance measures with the relevant CAHPS measures ASAP. The results of the CAHPS and Exhibit GGG data should be available to the public. | PA Health Funders Collaborative |
| | Exhibit N | Notice of Denial | | Comment: PA residents in nursing facilities must be provided 30 day advance written notice of transfer or discharge and PA law makes the facility responsible for assuring that appropriate arrangements are made for a safe and orderly transfer…capable of meeting the residents needs. The Ombuds program is available to help patients with these problems. There needs to be similar safeguards if the MCO is terminating or reducing a NF eligibles services and there needs to be the assurance that the consumer has the protection of the Ombuds program or legal services at once. Although a consumer can have their benefits continue if the file an appeal within 10 days of the notice, NF eligibles may not be physically able to take advantage of this. | PA Health Funders Collaborative |
| | Exhibit EEE | Participant's Responsibilities | | Comment: This section does not recognize that the consumer may not be able to take the actions specified. | PA Health Funders Collaborative |

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| Requirements Document | Section IV: Applicable Laws and Regulations | | CHC-MCO's must use streamlined credentialing process that the Department develops in conjuction with the CHC-MCO's | Add Contract language to clarify that there is one standardized creditialing of providers for all MCO's | Pennsylvania Providers Coalition Association |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | Page A-27 | Managed care organizations must comply with and require their Long Term Living home and community based waiver providers to comply with the provisions of 55Pa. Code Chapter 52, long term living home and community based services, with following execptions:52.21 Staff Training Outlines for minimum training requirements for providers and provider staff. | In the CHC paper it mentioned a SC supervisor must be a licensed social worker or nurse. Providers of SC have years of experience and it would be an increase cost to hire that level of staff. | Pennsylvania Providers Coalition Association |
| Requirements Document | A - Managed Care Regulatory Compliance Guidelines | | None | Add section with key on acronyms and abbreviations | PA SILC Jeff Iseman |
| Requirements Document | Section X: Termination and Default | 19 | The CHC-MCO must make notices available in an accessible format for participants with visual impairments and in the relevant language for Participants with limited English proficiency. | Add 'and cognitive' after 'visual' before 'impairments. Notices should also be plain language to the greatest degree possible. | PA SILC Jeff Iseman |
| | Section XVI | 31 | Language here and elsewhere has age 21for age of CHC eligibility | CHC should be an option at age 18 | PA SILC Jeff Iseman |
| | Section XVI | 33,35 | Rural Health Clinics | More clarification on which clinics are eligible, roles of FQHCs, state health centers, private clinics and urgent care centers which go beyond rural areas. These are part of access community based care as an alternative to emergency room (hospital) visits when a primary care physician isn't available. | PA SILC Jeff Iseman |

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| | Section XVI | 67,68 | Child Protective Services | Language included updates from 2014 revisions to Child Protective Services | PA SILC Jeff Iseman |
| | Various | 3, 59, 140 | Americans with Disabilities Act | Does this include ADA Amendments Act of 2008 revisions, particularly on employment, where relevant? | PA SILC Jeff Iseman |
| | Various | 71, 113, 117, 121, 125, 126, 130, 134 | Department of Public Welfare | Change to 'Department of Human Services' | PA SILC Jeff Iseman |
| | Exhibit D | 72 | MH/ MR | Change to 'MH/ID' | PA SILC Jeff Iseman |
| | Exhibit M | 110 | handicap accessibility for D4 | Change to 'physically accessible equipment and facility'(2 separate issues) | PA SILC Jeff Iseman |
| | Exhibit M | 110 | D5, None | Add language to D5 -same as D4 recommendation | PA SILC Jeff Iseman |
| | Exhibit GGG (1) | 144 | Adult Protective Services, Older Adult Protective Services | We ask for categories to split up-one for Adult Protective Services and one for Older Adult Protective Services to better understand specific population concerns here. | PA SILC Jeff Iseman |
| | Exhibit GGG (4) | 153 | where interviews | What about State Hospitals, ICF/ ID or ICF/ ORC? | PA SILC Jeff Iseman |
| | Exhibit GGG (4) | 154 | degree | Add 'Masters' after 'Bachelors' before 'Doctoral' for types of degrees. | PA SILC Jeff Iseman |
| | Exhibit GGG (4) | 163 | weight loss | In addition to weight loss, what about 'excessive weight gain'? The section refers to having proper nutrition. | PA SILC Jeff Iseman |
| | Exhibit GGG (7) | 178 | if no barriers-category next to it | What about 'affordable, accessible and healthy housing' ? It should be broken out as 3 separate barriers. 'Healthy' refers to needs for Individuals with Multiple, Chemical and Electrical Sensitivities (MCES) | PA SILC Jeff Iseman |
| | Exhibit GGG (8) | 180 | resources | What about adding in 'trusts' and 'ABLE Accounts'? I would still keep the 'other' category too. | PA SILC Jeff Iseman |

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| Requirements Document Exhibit | M(1) - Quality management and Utili | M (1)- 15 | The UM program must allow for determinations of medical necessity that are consisten with the CHC Program definition of Medically Necessary: Determinations of medical necessity for covered care and services whether made on a Prior Authorization, Concurrent Review or Retrpsective Review basis, shall be documented in writing. The CHC-MCO shall base its determination on medical information prvided by the Participant the Participant's family/caretakers and the PCP, as well as any other Providers, programs and agencies that have evaluated the participant. | The definition of medical necessity should be the same throughout the RFP. | Richard Duckson |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG (4) | "how long can the indivual routinely be left alone? | The how long can one be left alone questions: should be a open-ended question, that is a write in the answer, that would allow for the time to be put in and weather or night the time of day impacts if can be left alone. | Richard Duckson |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG (4) | | Kidney and bladder issues are a main issue for a lot of consumers I know. It should not be left out of the assessment instrument.<br><br>The assessment should include a section for ADL/IADL tasks that are not specially listed. This would improve the assessment tool's ability to be person centered. Care plans should allow for flexibly in ones needs throughout each day. | Richard Duckson |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG (4) | "Specify all types of aggressive physical behavior towards others: biting, hair pulling, hitting, kicking, picking, scratching, sexual acting out/behavior, spitting, other"<br><br>"Specify all types of aggressive physical behavior towards self: biting, hair pulling, hitting, kicking, picking, scratching, spitting, other" | Consumer can be having a bad day and I'm concerned that consumers will be judged based upon the one indentation on the bad day. I don't think a consumer will admit if they do any of these behaviors. I don't think a consumer will admit and tell you if they spit on an attendant. I think that a consumer's actions can easily be misinterpreted by an attendant as aggressive when they are not. Such as if a consumer pulls there arm or leg way from an attendant after it is griped in such a way that cause pain to the consumer. If you grab me in away that cause me pain or hurts me, I'm going to pull back. That's the only alternative I have. I think that these questions are not beneficial to the consumer and could jeopardize there ability to get care. I think that if a consumer does there types of behaviors it can be documented with the PAS and SC agency and does not need to be part of this assessment tool. | Richard Duckson |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG (4) | "Specify all types of behaviors: fecal smearing, hoarding, pacing, public disrobing, rummaging, sundowner's syndrome, other" | I would feel disrespected. I let the case manager in my home and I would feel like I could be labeled as crazy when being asked these questions. These are very personal questions. While some may admit to these behaviors most probably won't. I think that these questions are not beneficial to the consumer and could jeopardize there ability to get care. I think that if a consumer does there types of behaviors it can be documented with the PAS and SC agency and does not need to be part of this assessment tool. | Richard Duckson |
| Requirements Document Exhibit | M(1) - Quality Management and Utilization Management Program Requirements | Standard XIII M(1)-20 | When a Participant changes CHC-MCOs, the CHC-MCO must facilitate the transfer of his/her medical and service planning records or copies of medical and service planning records to the new CHC-MCO within seven (7) business days from the effective date of enrollment in the gaining CHC-MCO. In emergency situations, the CHC-MCO must facilitate the transfer of medical and service planning records as soon as possible from receipt of the request. | In the *November Draft Agreement* Section V: Program Requirements Subsection C: Continuity of Care (p.40): The CHC-MCO must transfer existing PCSPs to another CHC-MCO if the Participant chooses to transfer to another CHC-MCO. This must be done expeditiously, electronically if possible, in no more than five (5) business days after notification of the transfer. **Question:** Respectfully requesting clarification on the time frame requirement for transferring a transitioning participant's service plan to the new CHC-MCO. November Draft document indicates five (5) business days and the December Draft document indicates seven (7) business days. | Health Partners Plans/Patricia Wright |

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| Requirements Document Exhibit | M(1) - Quality Management and Utilization Management Program Requirements | Standard V M(1)-11 | F. The CHC-MCO agrees to comply with Department requirements and procedures related to the Enhanced Medical Home (EMH) model. EMH model is a system of care that provides access to a primary care provider, as well as targeted care management support for members at high risk of using acute medical services. There are four Pillars of the EMH model with which the CHC-MCO would be expected to participate. | **Question**: Is the Enhanced Medical Home (EMH) model being utilized for the LTSS population? EMH is a pediatric medical home. | Health Partners Plans/Patricia Wright |
| Requirements Document Exhibit | M(2) - External Quality Review | External Quality Review M(2)-1 | The CHC-MCO shall perform at least two (2) clinical and three (3) non-clinical PIPs. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and other complaints. | **Suggested change**: We would like to reiterate our comment from the Concept Paper and request a reconsideration of reducing the number of PIPs for a new program implementation year from a total of five (5) to two (2) PIPS; One (1) clinical and one (1) non-clinical. A two (2) PIP requirement would also correspond to the CMS Medicare requirement of two (2) PIPS; one (1) clinical and one (1) non-clinical. | Health Partners Plans/Patricia Wright |

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| Requirements Document | Section IV: Applicable Laws and Regulations | C. Specific to Medicare<br><br>Page 3 | C. Specific to Medicare<br>The CHC-MCO must be a Related Party to a CMS approved Full Benefit Dual Eligible Special Needs Plan (D-SNP) for the duration of this Agreement. | Is it a requirement that the CHC-MCO be a Related Party to a D-SNP; or, would a CHC-MCO that is itself a D-SNP satisfy this requirement, even if it is not a Related Party to another D-SNP, as the term "Related Party" is defined on page 18 of the Community HealthChoices Agreement? | Aetna Better Health® of Pennsylvania |
| Requirements Document | Section IV: Applicable Laws and Regulations | C. Specific to Medicare<br><br>Page 3 | The CHC-MCO must be a Related Party to a CMS approved Full Benefit Dual Eligible Special Needs Plan (D-SNP) for the duration of this Agreement. | To confirm, when read together with other provisions of the RFP and Agreement (including Exhibit FFF), could a CHC-MCO be eligible for award of a contract pursuant to this RFP if the CHC-MCO is not a D-SNP, but a Related Party to the CHC-MCO is a D-SNP?<br><br>If yes:<br>(i) Would the D-SNP, or the CHC-MCO, or both the D-SNP and CHC-MCO sign the MIPPA Agreement?<br>(ii) May the CHC-MCO delegate all services relating to the D-SNP to a Related Party that is a D-SNP? And if so, must the CHC-MCO enter into a formal agreement with the D-SNP to memorialize the Related Party D-SNP's obligations under this RFP? | Aetna Better Health® of Pennsylvania |

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| Requirements Document | Section VIII: Reporting Requirements | B. Systems Reporting<br><br>Page 6 | "B. System Reporting 1. Encounter Data Reporting<br><br>The CHC-MCO must record Encounter Data and submit it to the Department. The CHC-MCO shall only submit Encounter Data for its Participants.<br><br>The CHC-MCO must maintain appropriate systems to obtain all necessary data from its provider to ensure its ability to comply with the encounter data reporting requirements. The fialure of a Provider or Subcontractor to provider the CHC-MCO with necessary Encounter Data shall not excuse the MCH-MCO's noncompliance with this requirement | Can the CH-MCO encounter MLTSS services provided prior to the MLTSS eligibility period or any additional MLTSS services that are not included in the benefit package?<br><br>Will the additional services be included for consideration in future capitation rates? | Aetna Better Health® of Pennsylvania |

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| Requirements Document | Section IX: Representations and Warranties of the CHC-MCO | C. Disclosure of Change in Circumstances<br><br>Page 16 | The CHC-MCO will report to the Department, as well as the Departments of Health and Insurance, within ten (10) Business Days of the CHC-MCO's notice of same, circumstances that may have a material adverse effect upon financial or operational conditions of the CHC-MCO or CHC-MCO's parent(s), including but not limited to the following:...<br><br>4. Any lawsuits or investigations by any federal or state agency involving CHC-MCO, CHC-MCO's parent(s), or any Affiliate or Related Party. | Please define "material adverse effect".<br><br>Would the Commonwealth be amenable to adding clarifying language that this requirement would not include matters such as EEOC and employment cases, interpleader or third-party liability actions to resolve liens against third-party insurance proceeds, subrogation matters, non-judicial state fair hearing cases, OFCCP audits, or wage-hour complaints, etc.? | Aetna Better Health® of Pennsylvania |

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| Requirements Document | Section IX: Representations and Warranties of the CHC-MCO | C. Disclosure of Change in Circumstances<br><br>Pages 16-17 | The CHC-MCO will report to the Department, as well as the Departments of Health and Insurance, within ten (10) Business Days of the CHC-MCO's notice of same, circumstances that may have a material adverse effect upon financial or operational conditions of the CHC-MCO or CHC-MCO's parent(s), including but not limited to the following:<br><br>4. Any lawsuits or investigations by any federal or state agency involving CHC-MCO, CHC-MCO's parent(s), or any Affiliate or Related Party. | To avoid being inundated with reports of "any lawsuits or investigations" involving the CHC-MCO, its parent(s), or any Affiliate or Related Party, would the state be amendable to adding clarifying language to subsection (4) indicating that the lawsuits or investigations CHC-MCO's are required to report under this section are limited to those "that may have a material adverse effect upon financial or operational conditions of the CHC-MCO or the CHC-MCO's parent(s)." | Aetna Better Health® of Pennsylvania |
| Requirements Document | Section X: Termination and Default | A. Termination by the Department<br><br>Page 17 | 3. Termination Due to Unavailability of Funds/Approvals | There is no text under the header. Is there additional language to be added here? | Aetna Better Health® of Pennsylvania |
| Requirements Document | Section X: Termination and Default | C. Responsibilities of the CHC-MCO Upon Termination<br><br>Page 18 | 1. Continuing Obligations Upon any termination or expiration of this Agreement, in accordance with the provisions in this section, the CHC-MCO must...<br><br>B. Be financially responsible for MA Claims with dates of service through the expiration or termination, except as provided in c. below, including those submitted within time limits. | Would the Department consider clarifying this provision by revising it as follows?<br><br>"... Be financially responsible for MA Claims that would otherwise have been approved by the CHC-MCO under the terms of this Agreement, with dates of service through the expiration or termination, except as provided in c. below, including those submitted within time limits." | Aetna Better Health® of Pennsylvania |

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| Requirements Document | Section XII: Subcontractual Relationships | A. Compliance with Program Standards<br><br>Page 21 | In addition, the CHC-MCO must include in its contracts or Subcontracts that cover the provision of medical services to the CHC-MCO's Participants the following provisions... | Since the definition of Subcontractor expressly excludes Provider Agreements, and this provision addresses submission of encounter data and other provider-related functions, should this quoted portion state instead "… include in its contracts or Provider Agreements…", rather than Subcontracts? (At least as it relates to encounter data?) | Aetna Better Health® of Pennsylvania |
| Requirements Document | Section XIII: Confidentiality | C.<br><br>Page 23 | C. The CHC-MCO agrees to return all data and material obtained in connection with this Agreement and the implementation thereof, including confidential data and material, at the Department's request. No material can be used by the CHC-MCO for any purpose after the expiration or termination of this Agreement. The CHC-MCO also agrees to transfer all such information to a subsequent CHC-MCO at the direction of the Department. | This provision appears to be inadvertently overbroad, and is potentially contrary to law as written. For example, the Plan is bound by federal law to keep records on file after termination of the Agreement, and therefore the second sentence is not feasible (e.g., if the Plan were to receive a subpoena for records or be audited by CMS). To clarify, would the Department be amenable to revising slightly and deleting the second sentence as follows?<br><br>"The CHC-MCO agrees to return all data and material obtained from the Department in connection with this Agreement and the implementation thereof, including confidential data and material, at the Department's request. The CHC-MCO also agrees to transfer all such information to a subsequent CHC-MCO at the direction of the Department." | Aetna Better Health® of Pennsylvania |
| Requirements Document | Section XVI: General | A. Suspension From Other Programs<br><br>Page 25 | The CHC-MCO may not make any to a Provider for services rendered during the period in which the Provider was suspended excluded from participation in any federally funded healthcare program. | There appears to be a word missing between "any" and "to." For clarity, please consider correcting this in the final draft. | Aetna Better Health® of Pennsylvania |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | Entire document<br>All Pages | The issue appears throughout the entire document, but | Much of the introductory language in bold print above each section indicates that managed care organizations must comply with the specified requirements in that section | Aetna Better Health® of Pennsylvania |
| Requirements Document Exhibit | E - Specific Federal Regulatory Cites for Managed Care Agreements | 1124(a)(2)(A)<br>1903(m)(2)(A)(viii)<br>1903(t)(6)(A)(ii) | In accordance with Section 1903(t)(6)(A)(ii) of the Act and the regulations implementing | The last bullet point appears to be cut-off such that there may be information missing from this requirement. Please consider providing the complete text in the final draft. | Aetna Better Health® of Pennsylvania |

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| Requirements Document Exhibit | E - Specific Federal Regulatory Cites for Managed Care Agreements | 1903(i) final sentence<br>1903(i)(16)<br><br>Page E(1)-3 | The CHC-MCO shall not make payment with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of | There seems to be verbiage missing from the end of this requirement. Please consider correcting this in the final draft. | Aetna Better Health® of Pennsylvania |
| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | Consumer Assessment of Healthcare Providers and Systems (CAHPS®)<br><br>Page M(4)-3 | The CHC-MCO's vendor must perform the CAHPS adult and HCBS survey using the most current CAHPS version specified by NCQA. | Please provide additional information on the HCBS CAHPS survey tool and process. | Aetna Better Health® of Pennsylvania |
| Requirements Document Exhibit | ZZ - Automatic Assignment | Page 1 | Individuals will be assigned to plans that align with the way in which they are currently receiving their services.<br><br>Second, Participants enrolled in a D-SNP will be assigned to a CHC-MCO aligned with their D-SNP. | In the case of large organizations that may have multiple legal entities under a single parent company, would the Commonwealth allow the D-SNP to be under a different legal entity than the MLTSS contract holder, so long as they share the same parent? If so, if at a future time the D-SNP is transferred to a different legal entity within the same parent can the membership also be transferred?" | Aetna Better Health® of Pennsylvania |
| Requirements Document Exhibit | FFF - MIPPA Agreement Requirements | Page 1 | The CHC-MCO must operate an aligned D-SNP concurrently with its CHC-MCO.....<br><br>CHC-MCOs will be required to have a companion D-SNP in place and ready to enroll as of the same dates and service areas as the CHC-MCOs. | Can a CHC-MCO win a statewide award if it initially has a D-SNP only in the SW zone, which is Phase I of the implementation, but expands the D-SNP to the remaining zones annually so that the D-SNP is in place and ready to enroll in each zone concurrently with the operational commencement dates for each zone? | Aetna Better Health® of Pennsylvania |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG(1) Performance Measures<br><br>Page 4 | 77. Member services reduced by MCO<br>97. Members choosing consumer directed services<br>98. Unpaid caregiver info<br>99. Transportation services<br>100. affordable and accessible housing info<br>101. Respite info<br> | Please provide the additional specificity and measurements for these requirements.<br><br>Origin of Measure<br>Type of Measure<br>Target Population | Aetna Better Health® of Pennsylvania |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG(2) Data Elements - Demographics<br><br>Entire document | Data Elements - Demographics | Are these data elements to be stored at the CH-MCO level or must they be reported to the Commonwealth? | Aetna Better Health® of Pennsylvania |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG(4) Data Elements – Comprehensive Needs Assessment<br><br>Entire document | Data Elements – Comprehensive Needs Assessment | Is this the minimum data set? Is this to be stored at the CH-MCO or must it be reported to the Commonwealth?<br><br>For questions where details or type are requested (for example amputation, arthritis, fractures, assistive devices, skin diagnosis ) is the response free form text or are there specific categories? | Aetna Better Health® of Pennsylvania |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG(4) Data Elements – Comprehensive Needs Assessment<br><br>Entire document | Data Elements – Comprehensiv | Can we seek Commonwealth approval to use a valid reliable, comparable comprehensive assessment tool in lieu of the assessment tool in GGG(4)? | Aetna Better Health® of Pennsylvania |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG(5)Data Elements - Enrollment | Exhibit GGG(6)<br>Data Elements – Care Plan | Given the coordination required between the Commonwealth, the CH-MCO, the AAAs, how will communication flow (i.e. exchange of data, assessment data, existing care plans) prior to a Participant's effective date? | Aetna Better Health® of Pennsylvania |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG(6) Data Elements – Care Plan, Services<br><br>Page 3 | Services adult daily living<br>These services would be incorporated into the goals as appropriate<br>assisted living | Please provide the affiliated HCPC codes and any modifiers be listed along with the name of the service.<br><br>Can we submit alternative care plan templates for Commonwealth approval? | Aetna Better Health® of Pennsylvania |

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| Requirements Document | Section VI: Program Outcomes and Deliverables | Subsection: N/A<br>Page: 5 | "If the Department determines the CHC-MCO has not demonstrated readiness to provide services as required by this agreement, the department will not permit the enrollment of Potential Participants with the CHC-MCO and may extend the time period for the readiness review or not operationalize this agreement." | The OBRA Waiver Residential Habilitation service W0100 is not even mentioned or referred to in this entire document. Review of this document shows the CHC program leans toward a medical model for targeted participants who are elderly or phsyically demanding. The participants we serve in the OBRA Waiver residential habilitation service are dually diagnosed with intellectual disability/developmental disability (DD) and do not match the targeted population. We operate a residential group home for individuals with DD, not a nursing home and not in-home caregiving. The Dually Diagnosed individuals in the OBRA Residential Habilitation service should not served under this CHC system because there is no guidance for residential dually diagnosed DD participants for the MCOs and likely will not pass readiness review and be able to operationalize this agreement with success. | Norma Farruggia, BSC Paula Teacher & Associates, INC. |
| Requirements Document | Section IV: Applicable Laws and Regulations | Subsection: D. 3.<br>Page: 4 | "If the MCO elects not to provide, reimburse for, or porovide coverage of, a counseling referral service because of an objection on moral or religious grounds, the CHC-MCO must furnish information about the serices not covered in accordance with the provisinos of 42CFR 438.102b...." | How can a participant have the civil right of not being discriminated against based on religion and at the same time have the MCO deny their right to chose all provider options based on religious grounds. I would suggest this could even be illegal and unconstitutional and does not adhere to allowing for the rights of individuals to choose. | Norma Farruggia, BSC Paula Teacher & Associates, INC. |
| Requirements Document | Section XVI: General | Subsection: Exhibit A<br>Page 31 | "Managed care organizations are to adhere to the provisions of Medical Assistance Bulletin 1123-91-01, EPSDT – OBRA '89 with the following exceptions:..." | This discussion regarding OBRA funded individuals only addresses the health needs of these participants. There are an important group of OBRA waiver funded participants who are Dually Diagnosed with Developmental Disabilities. All those with OBRA Residential Habilitation services we serve also have a DD diagnosis. This Other Related Conditions (ORC) designation is different from the other typical medical model target population of what is being described in this document and CHC-MCO Plan. Our OBRA funded individuals with DD fit better with the Autism, PFDS and Consolidated waivers that were withdrawn from this CHC program for similar reasons and they should continue to be served under these waivers. | Norma Farruggia, BSC Paula Teacher & Associates, INC. |

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| Requirements Document Exhibit | FFF - MIPPA Agreement Requirements | Subsection: Exhibit FFF Pg: 142 | "The CHC-MCO must operate an aligned D-SNP concurrently with its CHC-MCO. This D-SNP will be required to enter into a MIPPA Agreement with the Department. The MIPPA Agreement will address the eight elements required of all MIPAA agreements,1 and will also include additional requirements to ensure the greatest possible coordination between the CHC-MCO and the D-SNP including, but not limited, to the following..." | I believe there is a disconnect between the federal government talking about person centered planning and then having a standardized tool for determining need. The participants receiving OBRA Residential Habilitation Services W0100 with MA 51 diagnosis ICF/ORC do not fall neatly into the category which this MCO plan covers. The extremely difficult aspect of this plan is that each MCO will run a concurrent D-SNP program while juggling everything else on the medical model side. I do not believe that the MCOs will take the time necessary to personalize services for a population that they are not familiar with and does not fit neatly into the same model as their concurrent program. MCOs have managed SNP plans in Rhode Island, Connecticut, New Mexico and Colorado with devastating results (retrieved from, http://www.ancor.org, n.d.). We can not assume that a CHC-MCO that has a main focus and primary target population of "high risk using acute medical services" and "and enhanced medical home model" will do better and create a new and specialized assessment for their side project. I fear that an MCO agreeing to provide a concurrent program will not even achieve a quality of services that is on par with the states who were attempting to create a similar MCO system specifically for the special needs population and could lead to individuals being warehoused in nursing homes. This is not the way they want to live nor should the state want them to live. | Norma Farruggia, BSC Paula Teacher & Associates, INC. |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Pg. 153 | Comprehensive Needs Assessment | An assessment called the SIS, Supplemental Intensity Scale, has currently been used to assess individuals with DD and is used in PA. The particular OBRA waiver individuals with DD we serve have completed a SIS assessment. I have assisted with completing many SIS assessments of individuals with DD. The SIS is a much better assessment than the "Comprehensive Needs Assessment" provided in this draft to assess needs of a SNP population. The assessment presented captures the medical needs but not the needs of the DD individuals we serve. Even though the SIS is a useful instrument it still has its pitfalls and has failed to create an accurate picture of needs assessment | Norma Farruggia, BSC Paula Teacher & Associates, INC. |
| Requirements Document | Section IV: Applicable Laws and Regulations | Subsection: E Pg: 4 | "The obligations of the Department under this Agreement are limited and subject to the availability of funds." | This sentence must be written in a way to be clear that the limit on the Department's obligations shall be related to the availability of funds and nothing else. I suggest it be written to read: "The obligations of the Department under this Agreement are limited to, and subject to, the availability of funds." | Norma Farruggia, BSC Paula Teacher & Associates, INC. |

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| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | B. Guidelines for Review; 2. Medically Necessary Requirements; Page 76 | "Medically Necessary Requirements: The CHC-MCO must describe the process to validate medical necessity for: covered care and services; ….." | This section does not contain a definition of medical necessity. Since most MCOs are not familiar with LTSS and typically use a medically focused model and definition of what is medically necessary, it is important that the definition of Medically Necessary detailed later in the document be included here in this section as well: "The Service or benefit will assist the Participant to achieve or maintain maximum functioning capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age." The measure of successful outcomes should be the progress toward and accomplishment of goals as stated in the member's Person-Centered Service Plan. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | B. Guidelines for Review; 2. Medically Necessary Requirements; For CHC MCOs; c.,e.,h.; Pages 76 & 77 | c., e., h., "The CHC-MCO must identify the qualification of staff that will determine if the service is Medically Necessary." (h) For LTSS, Covered Services will be authorized in accordance with the requirements of the CHC 1915(c) Waiver. | Medically Necessary is different for LTSS vs typical health care services. Therefore, it is critical that the qualifications of the person determining "Medically Necessary" for LTSS, have experience and expertise in long term supports and services. Additionally, should the service in question pertain to an individual receiving disability specific services, then the person determining "Medically Necessary" should have expertise and experience in the disability specific field in question. The measure of successful outcomes should be the progress toward and accomplishment of goals as stated in the member's Person-Centered Service Plan. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Exhibit M(1)-1; Page 79 | Quality Management and Utilization Management Program Requirements | We strongly oppose the use of standard Utilization Management (UM) processes for those receiving LTSS. Although we do recognize that an MCO must review the efficacy of services for which they are paying, using a typical medical-model utilization guideline that is not sensitive to the needs of the LTSS community to assess goals for individuals that have life-long support needs, will not allow the MCO to evaluate and support the participant in the way that is needed. UM or 'goal reviews' should be conducted by those who have education and experience concerning a specific disability and a clear understanding of the needs of individuals receiving LTSS so that uninformed decisions are not made based on the collection of the wrong data. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program | Standard I., M(1)- 2; B.; Page 80 | "The scope of the QM and UM programs must be | Policies and procedures regarding LTSS should identify any additional licensure or accreditation necessary for the provision of disability- specific or specialty services. It is | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard II., M (1)-5-6; Pages 83- 84 | C. "The Director of LTSS ensures the provision of LTSS in accordance with the requirements…." | We strongly support the Department for requiring the MCO to have a dedicated, full time Director of LTSS given that these supports and services are very different from the medical services in scope, outcome goals, and quality measurements. | MLRA/ Bridget Lowery |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-7; Page 85 | A. 3) "The QM and UM programs must include professionally developed practice guidelines… Applicable to Providers for the delivery of certain types or aspects of health care." | We recommend that this wording include: Applicable to Providers for the delivery of certain types or aspects of health care or LTSS. Should Providers of certain types or aspects of health care require additional licensure or accreditation, these practice guidelines/standards of care should be incorporated into the QM and UM programs' standards of care. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-7; Page 85 | B. and C. B. "The QM and UM programs must include clinical/quality indicators in the form of written, professionally developed, objective and measurable variables of a specified clinical or health services delivery area…." C. "Practice guidelines and clinical indicators must address the full range of health care and LTSS needs of the populations served by the CHC-MCO..." | For those Providers whose speciality area of care provision require additional licensure or accreditation, it is recommended that language be included that recognizes the clinical/quality indicators already in place for those providers, i.e., in CARF accredited providers. Specifically, CARF accreditation requires adherence to international standards for quality measurement, management and performance. Any requirements of an MCO should not be in conflict with CARF required QM/PI and should accept those standards as the minimum requirements where the CARF standards are more stringent than those required by an MCO. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-8; Page 86 | E.The CHC-MCO must develop methodologies for asssessing performance of LTSS Providers….These methodologies must: 2) "Demonstrate the degree to which LTSS Providers are complying with requirements of the Department and the CHC-MCO." | It is strongly recommended that the CHC-MCO develop the methodologies for assessing performance of the LTSS Providers in conjunction with the Provider group and other stakeholder groups. For the most part, the prospective CHC-MCOs do not have the experience or expertise to develop methodologies for programs and services with which they are not familiar. Individuals being served with LTSS are a very heterogenous population; therefore, the measure of successful outcomes should be the progress toward and accomplishment of goals as stated in the member's individually crafted Person-Centered Service Plan (which has been crafted by someone who has an understanding of the disability-specific needs of the individual being served) . | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-9; Page 87 | H. The QM and UM programs must contain procedures for Participant Satisfaction Surveys…." "The Department will continue to monitor the development of evidence-based LTSS satisfaction surveys.." | It is strongly recommended that the MCOs work with the Provider group and other stakeholders in the development of any satisfaction survey measures for LTSS services, as these questions will be decidedly different from questions concerning medical services. | MLRA/ Bridget Lowery |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III., M (1)-9; Page 87 | K. "The QM and UM programs must contain procedures for measuring Participant and Provider satisfaction with LTSS service delivery." | It is recommended that wording be added to require these Participant and Provider satisfaction surveys "be conducted on at least an annual basis." | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IV., M(1)-9-10; Pages 87-88 | A. "The QM/UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided…to include: Utilization, claims, inpatient stays, "community - based LTSS use"…" | Again, it is strongly recommended that the MCOs work with the Provider group and other stakeholders in the development of any measure regarding the appropriateness, cost effectiveness and use of Long Term Supports and Services, as these standards will be decidedly different from those appropriate for medical services. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VI., M(1)-11; Pages 89- 90 | " THE QM and UM programs must have mechanisms to ensure that Participants receive seamless, continuous and appropriate care….between:" | Recommend that the following be added: "J. CHC-MCOs and LTSS providers" | MLRA/ Bridget Lowery |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII., M(1)-12-14; Pages 90-91 | A. "The QM/UM program must have standards for credentialing/recredentialing Providers to determine whether all Providers, who provide health…." A. "The CHC-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types that satisfies the Department's requirements..." G. "The CHC-MCO shall evaluate a Provider's professional qualifications through objective measures of competence and quality. Providers should be given the opportunity to have input on the CHC-MCO's credentialing practices." | It is recommended that this wording be revised to state: "The CHC-MCOs will work with the Providers to establish appropriate credentialing criteria, particularly for LTSS specialty services." For LTSS services, the CHC-MCO may not have the appropriate experience or expertise to establish or evaluate objective measures of competence and quality. For LTSS brain injury services, it is recommended that the provider qualifications mirror the 1915 (c) approved waiver, which requires CARF accreditation as a Brain Injury provider for specific services, as these are highly specialized services that requires significant expertise and experience. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII., M(1)14,15; I. Pages 92-93 | I. "In the event that a CHC-MO renders an adverse credentialing decision…..All credentialing decisions made by the CHC-MCO are final and may not be appealed to the Department." | It is recommended that a provision be added to allow for an appeal of a credentialing decision. Many of the prospective MCOs have no experience with LTSS, and there is a concern that the MCO may not have the experience or expertise to credential an LTSS provider. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15; Page 93 | "The CHC-MCO's written UM program must contain policies and procedures that describe the scope of the program…" | Description and explanation for LTSS needs to be provided/included. This section needs to strongly support the person centered plan as part of the medically necessary covered services. The Department must have the oversight of the MCO to monitor and enforce this. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15,16; C. Pages 93- 94 | C. "...The CHC Program definition of Medically Necessary: ....Medical Necessity determinations must be made by qualified and trained Health Care Providers." | It is recommended that this wording be revised to state: "Medical Necessity determinations must be made by qualified and trained Health Care Providers; Should the determination focus on specialty services, the CHC-MCO will ensure that the Health Care Provider involved in the Medical Necessity determination will have the appropriate expertise and experience." | MLRA/ Bridget Lowery |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15,16; C.(3) Pages 93- 94 | C. (3) "...The CHC Program definition of Medically Necessary: ....The Service or benefit will assist the Participant to achieve or maintain maximum functioning capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age." | The Department is recognized for expanding the definition of Medically Necessary to include achieving and/or maintaining maximum functional capacity in performing daily activities, which is the goal of LTSS. It is recommended that this definition be referenced whenever Medically Necessary items are included, as most CHC-MCOs will not be familiar with this expanded definition of Medically Necessary. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-18; K. Page 96 | K. "The UM program must contain procedures for providing written notification to Participants of denials of medical necessity and terminations...." | It is strongly recommend the current practice of having an in-person meeting between the Service Coordinator, the Provider and the Participant occur whenever a change in programming is recommended. This is particularly critical given that LTSS services are often provided to individuals with cognitive and language impairments. This in-person meeting should occur prior to any denial of services or written notification of said denial. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIII., M(1)-19; Page 97 | "The CHC-MCO must have written standards for medical record and service planning record keeping..." C. Additional Standards include the following:" | It is recommended that Medical Record standards and standards for participant data reflect the differences in the type and frequency of documentation appropriate in LTSS settings. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | Healthcare Effectiveness Data and Information Set "HEDIS" M(4)-1; Page 107 | "HEDIS is a set of standardized performance measures designed to reliably compare helth care plan performance. HEDIS performance measures are divided into five domains of care:" | Description and explanation for LTSS needs to be provided/included. It is not clear how the HEDIS performance measures will be appropriate to LTSS. MCOs should work with the provider groups and stakeholders in the development of any performance measures. MCOs and the Department should also recognize the Quality Management programs already in place in Commission on Accreditation of Rehabilitation Facilities (CARF) accredited providers. Specifically, CARF accreditation requires adherence to international standards for quality measurement, management and performance. Any requirements of an MCO should not be in conflict with CARF required QM/PI and should accept those standards as the minimum requirements where the CARF standards are more stringent than those required by an MCO. | MLRA/ Bridget Lowery |

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| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | Consumer Assessment of Healthcare Providers and Systems (CAHPS), Page 109 | "The HEDIS protocol for administering CAHPS surveys consists of a mail protocol followed by telephone administration to those not responding by mail." | MCOs should work with provider groups & stakeholders in the development of any satisfaction survey regarding LTSS. CARF accredited providers of LTSS services are required to have a satisfaction tool and system in place to routinely elicit input from participants and all stakeholder groups. This data could be made available to the MCOs as needed. Because of the differences between LTSS model and traditionally medical services model, questions regarding LTSS services will need to be be designed to look different. Given the long-term cognitive challenges for many LTSS consumers, it is recommended that a provision be made to assist people with cognitive or language impairments to complete any of these required surveys. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Performance Measures and Data Elements; Pages 143-148 | | MCOs and the Department should recognize the Quality Management programs already in place in Commission on Accreditation of Rehabilitation Facilities (CARF) accredited providers. Specifically, CARF accreditation requires adherence to international standards for quality measurement, management and performance improvement. Any requirements of an MCO should not be in conflict with CARF required QM/PI and should accept those standards as the minimum requirements where the CARF standards are more stringent than those required by an MCO. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG(2), Data Elements-Demographics; Pages 149-151 | | There is an overall concern that the document does not recognize the functional impact of cognitive impairment and the extent to which it is a barrier to accessibility of services nor does it address the accommodations that are required, long-term, to allow the participant to be an active partner in the process. It is recommended that under "Communication, the general term "Language" be revised to specify: "Difficulty Understanding Language;" "Difficulty Expressing Thoughts." | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (3) Data Elements-Needs Screening and Comprehensive Needs Assessment; Pages 152-169 | | Acquired Brain Injury and Cognitive Impairment are not included. A separate needs assessment for ABI and Cognitive Impairment should be added to the Exhibit. ABI is currently listed under Neurological. It is recommended that the Department adopt Utah's Intake, Screening and Assessment Form/Tool, Version 2.0 (which can be used for all disability groups). http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury%20Assessment%20(CBIA)%20Version%202.0.pdf | MLRA/ Bridget Lowery |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (3) Data Elements- Needs Screening and Comprehensive Needs Assessment; Pages 152-169 | Participant self-identifies social or LTSS needs that are not being met; Medical; Medical-Individual's Cognitive State; Behaviors; Psychiatric; ADL's and IADLs | All elements indicate that the issue is "self identified." Given the insight and memory issues for those with Cognitive impairments, it is recommended that this language be revised to allow for and actually encourage a caregiver or support system to also identify issues. Cognitive Impairment is not included. "Executive Functioning Impaired"- SInce few people will know what this means, the following items should be listed under this: *Problem Solving * Reasoning * Planning & Organizing * Insight. For Behaviors, most behaviors seem to focus on aggressive behaviors, but there are other behaviors that can impact function. It is recommended that the following be added: suicidal ideations, suicidal actions, impulsivity, avoidance, frustration tolerance, inflexibility, perseveration and anxiety. For ADLs and IADLs, each item should include if the type of assistance needed is either physical or cognitive. It is recommended that the Department adopt Utah's Intake, Screening and Assessment Form/Tool, Version 2.0 (which can be used for all disability groups). http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury%20Assessment%20(CBIA)%20Version%202.0.pdf | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (6) Data Elements- Care Plan | Services | Under Behavior Consultation, add behavior therapy; also need to add Structured Day. All items from 1915 c waiver covered services are not included and should be, as both Providers and Stakeholders were assured that services would not change with this transition. | MLRA/ Bridget Lowery |
| Requirements Document Exhibit | ZZ - Automatic Assignment | First paragraph and associated bullets | "Any Participant who does not select a CHC-MCO will be | We believe this auto-assignment logic puts CHC-MCOs that are new to a zone at a disadvantage. Since it is likely that all the plans in the zone will have all, or a vast | UnitedHealthcare Community & State |
| Requirements Document | Section III: Relationship of Parties | Section B. "Specific to Medical Assistance Program" p. 3 | "The CHC-MCO must participate in the Medical Assistance Program, and arrange for the provision of those Covered Services essential to the health and support of its Participants, and comply with all federal and Pennsylvania laws generally and specifically governing participation in the Medical Assistance Program." | We are unclear as to what is meant by"participate" in the statement "The CHC-MCO must participate in the Medical Assistance Program". Does it mean the CHC-MCO must obtain a Medicaid number like a service provider or must the CHC-MCO also be a Health Connections MCO or does it mean something else? Please clarify. | UnitedHealthcare Community & State |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | B. Guidelines for Review; 2. Medically Necessary Requirements; Page 76 | "Medically Necessary Requirements: The CHC-MCO must describe the process to validate medical necessity for: covered care and services; ….." | It is recommended that this section include the definition of Medically Necessary, and that the judgement of medical necessity be based on progress toward functional goals identified and written into the individual's service plan. The concern is that MCOs might interpret 'medically necessary' in the traditional sense of the word 'medical,' rather than evaluating the necessity of services to improve and maximize function, which is more relevant to those with long term service and supports needs. | BIAPA/Monica Vaccaro |

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| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | B. Guidelines for Review; 2. Medically Necessary Requirements; For CHC MCOs; c.,e.,h.; Pages 76 & 77 | c., e., h., "The CHC-MCO must identify the qualification of staff that will determine if the service is Medically Necessary." (h) For LTSS, Covered Services will be authorized in accordance with the requirements of the CHC 1915(c) Waiver. | It is critical that the qualifications of the person determining "Medically Necessary" for individuals with brain injury receivig LTSS, have experience and expertise in working with individuals with brain injury. | BIAPA/Monica Vaccaro |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Exhibit M(1)-1; Page 79 | Quality Management and Utilization Management Program Requirements | We are concerned about the use of a traditional medical model to assess goals for individuals that have life-long support needs. Review of the goals of individuals with brain injury should be done by professionals with training and experience in brain injury and who have a clear understanding of their needs. | BIAPA/Monica Vaccaro |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IV., M(1)-9-10; Pages 87-88 | A. "The QM/UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided…to include: Utilization, claims, inpatient stays, "community - based LTSS use"…" | It is recommended that the MCOs work with stakeholders in the brain injury community when in the developing measures regarding the appropriateness, cost effectiveness and use of Long Term Supports and Services for this population. | BIAPA/Monica Vaccaro |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII., M(1)-12-14; Pages 90-91 | A. "The QM/UM program must have standards for credentialing/recredentialing Providers to determine whether all Providers, who provide health…." A. "The CHC-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types that satisfies the Department's requirements..." G. "The CHC-MCO shall evaluate a Provider's professional qualifications through objective measures of competence and quality. Providers should be given the opportunity to have input on the CHC-MCO's credentialing practices." | Providers of services for individuals with brain injury should be appropriately accredited as having expertise in providing services to that population. This would mean requiring that providers have CARF medical rehabilitation accreditation in brain injury, or finding an equivalent solution in locations where these are not available. | BIAPA/Monica Vaccaro |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-15,16; C. Pages 93- 94 | C. "...The CHC Program definition of Medically Necessary: ....Medical Necessity determinations must be made by qualified and trained Health Care Providers." | We are concerned about the phrase "qualified and trained Health Care Providers." which is non-specific. We feel strongly that those making determinations of medical necessity for individuals with brain injury have expertise and experience in working with that population." | BIAPA/Monica Vaccaro |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX., M(1)-18; K. Page 96 | K. "The UM program must contain procedures for providing written notification to Participants of denials of medical necessity and terminations…." | Accessibility needs to be assured for individuals with cognitive impairments due to brain injury as well as the other populations listed. These individuals may be able to read the notice from a techical perspective, but may have difficulty comprehending the content and/or responding to it. One's brain injury may preclude them from being able to act upon information that they can read, but not comprehend. People with brain injuries often have difficulty initiating and following through on seemingly routine activities, despite giving the appearnce of knowing waht to do. They might require the assistance of a facilitator trained in working with individuals with cognitive impariment to explain and structure the content to be sure that the individual not only understands, but can respond as needed. This is a specialized skill. | BIAPA/Monica Vaccaro |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIII., M(1)-19; Page 97 | "The CHC-MCO must have written standards for medical record and service planning record keeping…" C. Additional Standards include the following:" | It is recommended that Medical Record standards and standards for participant data reflect the differences in the type and frequency of documentation appropriate in LTSS settings. | BIAPA/Monica Vaccaro |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (3) Data Elements-Needs Screening and Comprehensive Needs Assessment; Pages 152-169 | | Acquired Brain Injury and Cognitive Impairment are not included. A separate needs assessment for ABI and Cognitive Impairment should be added to Exhibit. ABI is currently listed under Neurological. It is recommended that the Department adopt Utah's Intake, Screening and Assessment Form/Tool, Version 2.0 (which can be used for all disability groups). http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury%20Assessment%20(CBIA)%20Version%202.0.pdf | BIAPA/Monica Vaccaro |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Exhibit GGG (3) Data Elements-Needs Screening and Comprehensive Needs Assessment; Pages 152-169 | Participant self-identifies social or LTSS needs that are not being met; Medical; Medical-Individual's Cognitive State; Behaviors; Psychiatric; ADL's and IADLs | We are concerned about the phrase "self identified." We feel strongly a caregiver or someone from the individual's support system be included in identifying needs.. Individuals with brain injury, due to the specific nature of their cognitive impairment, may lack awareness of their needs, and may represent to the assessor that their abilities are greater than they are in reality. Functional limitations may not be obvious upon a cursory interview style assessment. The assessment tool needs to include probes to elicit information to effectively assess function. It is recommended that the Department adopt Utah's Intake, Screening and Assessment Form/Tool, Version 2.0 (which can be used for all disability groups). http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury%20Assessment%20(CBIA)%20Version%202.0.pdf | BIAPA/Monica Vaccaro |

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| Requirements Document Exhibit | D - Standard Terms and Conditions and DHS Addendum to Standard Terms and Conditions | 22. Integrity Provisions Page 55 | Contractor shall not have a financial interest in any other contractor, subcontractor, or supplier providing services, labor, or material under this Agreement, unless the financial interest is disclosed to the Commonwealth in writing and the Commonwealth consents to Contractor's financial interest prior to Commonwealth execution of the Agreement. Contractor shall disclose the financial interest to the Commonwealth at the time of proposal submission, or if no bids or proposals are solicited, no later than Contractor's submission of the Agreement signed by Contractor. | PALPA supports DHS's inclusion of the integrity provisions described in this section, and hopes that these provisions can be used as a model for the state's other CHC-related contracts. Specifically, PALPA asks that the prohibition of a financial interest between the Contractor and providers of services be included in the states contract with the single statewide level-of-care contractor. | PALPA |
| Requirements Document Exhibit | ZZ - Automatic Assignment | Page 139 | The Department reserves the right to reassess the distribution process and to modify it in accordance with sound programmatic management principles. The Department shall institute such modifications at any time following appropriate notification to the CHC-MCOs via executive correspondence. | PALPA believes that future changes to the algorithm that would automatically assign participants to a CHC-MCO should be public and not exclusively communicated through executive correspondence. DHS has historically shared occasional changes to the physical HealthChoices auto-enrollment algorithm publicly and we ask that the CHC-MCO contract reflect this longstanding practice.<br><br>While not within the scope of the RFP, PALPA would like to remind the department of its commitment to ensuring that participants are informed of their options and enabled to choose the program through which they will receive their care prior to this auto-assignment process. | PALPA |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | 143-end | N/A | PALPA has convened a member workgroup to develop standards for collecting and sharing data for the LIFE program with the state. The workgroup will consider including the data elements identified in Exhibit GGG, but is adamant that the data not be ultimately compared to an essentially incomparable dataset generated from the CHC-MCOs.<br><br>The population served by CHC-MCOs is broader than the population served by the LIFE program. Many of the measures identified in Exhibit GGG would be either irrelevant or misleading for the cohort served by the LIFE program. PALPA requests that DHS ensure that the data submitted by the CHC-MCOs will have sufficient detail to stratify the data by age and nursing facility eligibility status in order to generate a dataset for a more comparable cohort to the LIFE program. At a minimum, DHS should be able to stratify the data by nursing facility eligibility status.<br><br>PALPA also asks that the department retain the right to add and remove items from this list of metrics as it determines is appropriate. | PALPA |
| Requirements Document | Section IV: Applicable Laws and Reg | Subsection A, Pg.2 | Please See Comment in this cell | Please See Comment in this cell | United Way of the Greater Lehigh Valley / Christy Ayala, Alliance on Aging Facilitator |
| Requirements Document | Section IV: Applicable Laws and Reg | Subsection A 1, Pg.2 | Please See Comment in this cell | Please See Comment in this cell | United Way of the Greater Lehigh Valley / Christy Ayala, Alliance on Aging Facilitator |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in | Standard I.G page 81 | Please See Comment in this cell | Please See Comment in this cell | United Way of the Greater Lehigh Valley / Christy Ayala, Alliance on Aging Facilitator |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in | Standard II Page 84 | Page 84 | Please See Comment in this cell | United Way of the Greater Lehigh Valley / Christy Ayala, Alliance on Aging Facilitator |
| Requirements Document | Section IV: Applicable Laws and Regulations | A.1 | The CHC-MCO must be NCQA accredited or accredited by a national accreditation body and obtain such accreditation within the accreditation body's specified timelines. | Does the LTSS part of the program have to be NCQA accredited? | Gateway Health Plan |

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| Requirements Document | Section X: Termination and Default | A.2 | The Department may terminate this Agreement for cause upon forty-five (45) days written notice, which notice shall set forth the grounds for termination and, with the exception of termination. The Department will provide the CHC-MCO with forty-five (45) days in which to implement corrective action and cure the deficiency. If corrective action is not implemented to the satisfaction of the Department within the forty- five (45) day cure period, the termination shall be effective at the expiration of the forty-five (45) day cure period. | The language, " with the exception of termination" appears to be a typo. We would ask that this is removed. The term "default". It appears as though DHS is attempting to define the word "cause" rather than default. Default is not found in the preceding paragraph that concerns termination for cause. | Gateway Health Plan |
| Requirements Document | Section XIII: Confidentiality | | | Gateway Health believes it is essential that the following language (from the HealthChoices agreement) be included to protect Gateway Health's financial reports and information, as well as trade secrets, documentation, databases, etc. "The CHC-MCO considers its financial reports and information, marketing plans, Provider rates, trade secrets, information or materials relating to the CHC-MCO's software, databases or technology, and information or materials licensed from, or otherwise subject to contractual nondisclosure rights of third parties, which would be harmful to the CHC-MCO's competitive position to be confidential information. This information shall not be disclosed by the Department to other parties except as required by law or except as may be determined by the Department to be related to the administration and operation of the HealthChoices Program. The Department will notify the CHC-MCO when it determines that disclosure of information is necessary for the administration of the CHC Program. The CHC-MCO will be given the opportunity to respond to such a determination prior to the disclosure of the information." | Gateway Health Plan |

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| Requirements Document Exhibit | FFF - MIPPA Agreement Requirements | | The CHC-MCO must operate an aligned D-SNP concurrently with its CHC-MCO. This D-SNP will be required to enter into a MIPPA Agreement with the Department. The MIPPA Agreement will address the eight elements required of all MIPAA agreements,1 and will also include additional requirements to ensure the greatest possible coordination between the CHC-MCO and the D-SNP including, but not limited, to the following. | The MIPPA Agreement is historically due by July 1st each year as part of the DSNP application review and approval process. Will this 7/1 due date remain? If so will the MIPPA Agreement with the added provisions noted in the Exhibit be complete and executed by June 30th or sooner in order for Gateway Health Plan to submit the Agreement to CMS by the deadline for the CY2017 application? | Gateway Health Plan |
| Requirements Document Exhibit | FFF - MIPPA Agreement Requirements | | The CHC-MCO must operate an aligned D-SNP concurrently with its CHC-MCO. This D-SNP will be required to enter into a MIPPA Agreement with the Department. The MIPPA Agreement will address the eight elements required of all MIPAA agreements,1 and will also include additional requirements to ensure the greatest possible coordination between the CHC-MCO and the D-SNP including, but not limited, to the following. | Language in this Exhibit only refers to full dual participants. Yet full dual benefit eligibles are not defined in the agreement. Does it include the QMB, QMB Plus and SLMB Plus categories for the purposes of the requirements in the CHC Agreement and MIPPA Agreement? If these categories are not included in this program, will a separate MIPPA Agreement be needed for this DSNP type and a separate DSNP-subset application submitted to CMS for these QMB, QMB Plus, SLMB Plus categories? Will DHS be providing MCOs a separate MIPPA Agreement who also offer Partial dual plans. | Gateway Health Plan |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX.G | The CHC-MCO agrees to provide twenty-four (24) hour staff availability to authorize weekend services, including but not limited to: home health care, pharmacy, DME, and medical supplies. The CHC-MCO must have written policies and procedures that address how Participants and Providers can make contact with the CHC-MCO to receive instruction or Prior Authorization, as necessary | Can this requirement be met by offering a portal to providers and participants to make such a weekend request and receive authorization if deemed necessary? | Gateway Health Plan |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | 2.f-g | The CHC-MCO must outline how the Service Planning process with IDT approach will ensure that Medically Necessary services specified in the Person-Centered Service Plan are authorized by virtue of inclusion in the Person-Centered Service Plan and processed into all appropriate systems. | Is IDT synonymous with PCPT (person-centered planning team)? | Gateway Health Plan |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX-B | A Person Centered Service Plan shall be developed and implemented for all NFCE Participants and others who request or require Service Coordination. The CHC-MCO shall audit a sample of the PCSPs to demonstrate compliance with the requirements of the QM/UM program. The CHC-MCO must use a protocol to select the PCSP that has been submitted to and reviewed by the Department. Audit results must be submitted to the Department as part of the Annual QAPI Program Evaluation. | If NFIs request service coordination, does this mean they have to be assigned a Service Coordinator and have their assessment competed face-to-face? (like the NFCEs)? | Gateway Health Plan |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | M(2)-4 | CHC-MCOs must and must require their network providers and subcontractors to report critical events or incidents via a standard file transaction incorporated in the Enterprise Incident Management System. | Are the Critical Incidents listed only during the provision of HCBS or are these regardless of setting? | Gateway Health Plan |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | P. 148 | Reports 102-108 | Can you please specify the due date and frequency of these reports? For Reports 105 and 106, would a ratio suffice? For Report 108, is it requesting a policy as “process” to be specified as the “Type of Measure”? Can “OLTL” be defined as the “Origin of Measure”? | Gateway Health Plan |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | PPs. 184-185 | Exhibit GGG (9) | Is “Denials” defined as number of authorization denials? For “Level 1 Complaints”, “Level 1 Grievances”, “Level 2 Complaints” and “Level 2 Grievances”, it is to be assumed that the “Date” is the date that the complaint or grievance is closed? | Gateway Health Plan |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | PM #83 | Average Length of Stays (mean and median) for Short (<=180 days)and Long Term Admissions(181+ days) (Goal is to Decrease) | Will there be a short-term stay benefit? Example- if a member is living in the community and needs temporary placement in a facility (non-respite) and the plan is for them to return to the community within 90-180 days. | Gateway Health Plan |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | PMs # 63 &96 | | These two PMs appear to be duplicative | Gateway Health Plan |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | PMs 67 & 97 | | These two PMs appear to be duplicative | Gateway Health Plan |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | CM Database Elements | | Many of the Case Management Database elements need further discussion to define what the requirements are that MCOs will need to report on. (Example- 68- Timeliness of Notice Prior to Care Plan revision—the contract doesn't currently specify a timeframe requirement.) | Gateway Health Plan |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG(2) | Data Elements Demographics | It is unclear if the MCO will be collecting this data or receiving this information from somewhere else. How often and when is this information collected? | Gateway Health Plan |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG(2) | Data Elements Demographics | It would be helpful to have definitions or instructions for each item or questions to understand the intent of each question or what information is being sought. | Gateway Health Plan |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG(3) | Data Elements-Needs Screening | Does the MCO develop the screening internally but just need to include these elements into our screening? What determines if the member needs to move on to a comprehensive needs assessment? Is this left up to the individual MCO? | Gateway Health Plan |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG(4) | Data Elements-Comprehensive Needs Assessment | SLUMS- is this acronym referring to the St. Louis University Mental Status Exam? If so, will MCOs have to incorporate the 11 questions and scoring methodology into the comprehensive needs assessment? | Gateway Health Plan |
| Requirements Document | Section IV: Applicable Laws and Regulations | A. Certification and Licensing, Page 2 | Certification and Licensing requires that CHC-MCOs must use the streamlined credentialing process that the Department develops, in conjunction with the CHC-MCOs. | LeadingAge PA commends the Department on requiring a streamlined credentialing process, and urges that it also be consistent across all of the CHC-MCOs, that a stakeholder process be employed for designing the credentialing process, and that it not be overly burdensome. | LeadingAge PA |

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| Requirements Document | Section VI: Program Outcomes and Deliverables | page 5 | Prior to enrollment of participants, the Department will conduct Readiness Reviews ….. The Department will not permit the enrollment of Potential Participants with the CHC-MCO and may extend the time period for the Readiness Review or not operationalize this agreement. | LeadingAge PA appreciates the Department's commitment to readiness review and willingness to extend the review period or not operationalize if the CHC-MCO has not demonstrated readiness. | LeadingAge PA |
| Requirements Document | Section VII | All | The Financial Responsibility section has not been shared with stakeholders. | It is necessary for stakeholders to have the opportunity to provide comments on CHC-MCO solvency, rates, rate-setting methodologies, claims processing standards such as timeliness standards, retroactive eligibility, payments for out-of-network providers, liability during an active grievance or appeal, value-based payments, third party liability, and estate recovery, for example, which we believe would be covered in this important, yet omitted section. | LeadingAge PA |
| Requirements Document | Section VII | All | The Financial Responsibility section has not been shared with stakeholders. | To assure continuity of care, the Department's MA rates should be set as a minimum rate for the CHC-MCOs. For nursing facilities, the rate floor must include all supplemental payments currently received by nursing facilities most especially those provided by the nursing facility provider assessment | LeadingAge PA |
| Requirements Document | | Eligibility and Enrollment | There must be a thorough discussion of how eligibility and enrollment will work, including discussion of various scenarios, such as spend down, retroactive eligibility, how a healthy dual-eligible, newly needing LTSS is enrolled, how will a provider be paid while the Participant is awaiting eligibility determination, etc. | We are missing the details of eligibility and enrollment in this draft release and strongly urge the department to share these details prior to issuing the RFP. | LeadingAge PA |

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| Requirements Document | | Eligibility and Enrollment | The intake process for Participants who newly qualify for Medical Assistance (MA) or newly qualify for LTSS must be efficient and effective. There should be a detailed descriptions or a flow chart provided. For example, how will the 5-year look-back requirements be handled in the new system? If the enrollment and eligibility process don't work, the CHC program will not work. | We are missing the details of eligibility and enrollment in this draft release and strongly urge the department to share these details prior to issuing the RFP. | LeadingAge PA |
| Requirements Document | | Eligibility and Enrollment | Continuity of care provided to HCBS Participants is described as just 180 days during the transition and only 60 days for newly eligible Participants once the CHC is operational in their zone. | LeadingAge strongly recommends providing at a minimum, a 3-year continuity of care provision for HCBS participants so that they have ample time to identify and change to a participating provider. | LeadingAge PA |
| Requirements Document | | Eligibility and Enrollment | Participants must pick new providers shortly after transitioning to CHC. | LeadingAge strongly recommends requiring CHC-MCOs to include in the provider network all willing and qualified providers for a minimum of 3 years to assure access to an adequate provider network and allow continuity of care for Participants. | LeadingAge PA |
| Requirements Document | | in general | The RFP and Agreement do not provide sufficient detail on how Medicare will be coordinated when a Participant choses either Medicare Fee for Service or a Medicare Advantage plan that is not aligned with the CHC-MCO | Please provide additional guidance and discussion regarding how the Commonwealth anticipates MCOs will coordinate Medicare, especially when the Participant chooses a plan other than the CHC-MCO's corresponding D-SNP. How will the plan know who the Participant's primary care provider is and how will it coordinate care? | LeadingAge PA |
| Requirements Document Exhibit | B(1) - CHC_MCO Pay for Performance Program | P4P | We appreciate the support for speeding the eligibility process. | We recommend that reform of the eligibility process be an ongoing and that stakeholders, including LeadingAge PA have a role. | LeadingAge PA |

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| Requirements Document Exhibit | B(1) - CHC_MCO Pay for Performance Program | P4P | year 1 P4P covers assistance with financial eligibility process | We recommend adding in year 1 or subsequent years, a P4P for assisting Participants with obtaining or maintaining housing. Potentially, CMS would offer FFP for selected services described in it's policy guidance memo, https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf some of which have not yet been implemented by OLTL. Housing providers would be able to assist with some of the services participants need to sustain housing. | LeadingAge PA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | | Exemptions for managed care entities from compliance with many current Medical Assistance regulations | Unanticipated consequences such as the potential inability of providers to comply with provider settlements or agreements reached with DHS that specify a certain MA percentage be attained overall or a percentage of day one MA recipients. Providers should not be held to agreements when circumstances such as CHC have made significant changes that are beyond their control. | LeadingAge PA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | page 7 and exhibit A, A-29 | Exemptions for managed care entities from compliance with many current Medical Assistance regulations | Language on page 7 appears to allow CHC-MCOs to require a shorter period of time to submit claims or encounter records. This creates problems for nursing facility providers who have residents with retroactive eligibility up to 180 days or more. Further, Exhibit A provides exemption from 1101.68(b)(1), which also raises concerns as noted above. The Department should require MCOs to meet the current requirement as described in 1101.68(b)(1) or clarify how the process will differ under CHC | LeadingAge PA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-42, A-43 | This exhibit appears to exempt MCOs from the regulations that govern nursing facilities in Chapter 1187 of the PA Code. | We request that providers be exempt from the 1187 cost reporting and Case Mix requirements if the Department choses to no longer set rates. | LeadingAge PA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | all | | We have a procedural concern regarding the wholesale exemptions to the regulations for MCOs. The regulations have been developed over many years, using processes that offered input from stakeholders including provider, consumers and the General Assembly to achieve consensus, and offered stability and predictability of processes to affected parties. | LeadingAge PA |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | A-29, A42-43 | Absence of rate information | The Department's MA rates should be set as a minimum provider payment rate for the CHC-MCOs. For nursing facilities, the rate floor must include all supplemental payments currently received by nursing facilities. | LeadingAge PA |

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| Requirements Document Exhibit | ZZ - Automatic Assignment | Page 1 of Exhibit (unnumbered) | Last, if a Participant is receiving HCBS and their HCBS provider is contracted with a CHC plan, the Participant will be enrolled in that plan. Plan assignment will follow automatic assignment logic after these conditions are exhausted. | The fourth bullet (HCBS provider) should be moved to the second bullet, so that the participant is auto-assigned based on their HCBS provider. (This should be the provider of the most prevalent services used by the Participant. Please see our cover letter for a more thorough discussion of this issue | LeadingAge PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Whole section | | More transparency is needed regarding the quality management and utilization management program requirements. Stakeholders should be involved in clarifying these standards, including the Medical Assistance Advisory Committee and its Long-Term Care, Managed Care Delivery System, and MLTSS subcommittees. | LeadingAge PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-8 | Standard III-E: The CHC-MCO must develop methodologies for assessing performance of PCPs/PCP sites, high risk/high volume specialists, dental Providers, LTSS Providers, and Providers of ancillary services not less than every two years (i.e. medical record audits). | LTSS providers and their representatives should be involved in developing the methodologies for assessing performance, rather than just the MCOs and OLTL. The Medical Assistance Advisory Committee and its subcommittees should be consulted at the very least. | LeadingAge PA |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-9 | Standard III-G: The QM and UM programs must include methodologies that allow for the identification, verification, and timely resolution of inpatient and outpatient quality of care concerns, Participant quality of care complaints, over-utilization, under- utilization, and/or mis-utilization, access/availability issues, and quality of care referrals from other sources; | Please define "timely" (underlined in previous column) | LeadingAge PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-9 | The QM and UM programs must contain procedures for Provider satisfaction surveys to be conducted on at least an annual basis. Surveys are to include PCPs, and specialists, dental Providers, hospitals, and Providers of ancillary services. | On standard III-I, Provider satisfaction survey includes PCPs, specialists, dental providers, hospitals and providers of ancillary services. LTSS providers and their representatives should be included. | LeadingAge PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-11 | Standard V: The CHC-MCO must develop mechanisms for integration of case/disease and health management programs that rely on wellness promotion, prevention of complications and treatment of chronic conditions for Participants identified. | The LTSS providers and their representatives are experts in management of chronic conditions and diseases and should be consulted in a collaborative process in the development of such programs. | LeadingAge PA |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-11 | Standard VI: The QM and UM programs must have mechanisms to ensure that Participants receive seamless, continuous, and appropriate care throughout the continuum of care, by means of coordination of care, benefits, and quality improvement activities between: The CHC-MCO and Medicare D-SNPs whether aligned or not aligned; | Medicare Fee-For Service (traditional Medicare) programs are not included in the listing. | LeadingAge PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-12-M(1)-15 | Standard VIII | The provider network should include any willing provider in perpetuity for nursing facilities in order to accommodate the grandfathered Participants. | LeadingAge PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-13 | Standard VIII-A-5: The CHC-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types that satisfies the Department's requirements outlined in this Agreement and through guidance to plans. Recredentialing activities must be conducted by the CHC-MCO at least every three (3) years. Criteria must include, but not be limited to, the following: 5) A valid Drug Enforcement Agency (DEA) certification; | This component of Standard VIII(A)(5) suggests that all providers will be required to Drug Enforcement Agency (DEA) certification. Please modify the requirement to indicate it is required only if appropriate. For example, HCBS providers would not likely be required to have a DEA certification. | LeadingAge PA |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-14 | Standard VIII(G): The CHC-MCO shall evaluate a Provider's professional qualifications through objective measures of competence and quality. Providers should be given the opportunity to have input on the CHC-MCO's credentialing practices. | Language in the agreement such as that on page 2 should clarify the role of providers and their representatives for providing input on a streamlined, consistent, and reasonable credentialing process. | LeadingAge PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-12-15; M(1)-19-20 | Standards VIII and XIII are very physician focused. | The standards generally, and VIII and XIII in particular, appear to anticipate physicians, dentists and hospitals, but not LTSS providers. | LeadingAge PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-15-16 | Definition of Medically Necessary | The current language defining services that are medically necessary does not acknowledge directly the issues around end-of-life care and palliation. There must also be recognition of end of life situations, palliative care, and respect for decisions of those at the end of their life to discontinue curative treatment. | LeadingAge PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | page M(1)-18-19 Standard X | Standard X: Provider Appeals/Provider Disputes | We support the requirement that the MCO have a mechanism in place for Provider Appeals and Provider Disputes, however, Providers should also continue to have access to the DHS Bureau of Hearings and Appeals for these matters. | LeadingAge PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-19 | Standard XI: Documentation of QM activities | Language should be added to protect the Quality Improvement program data of providers and the Managed Care entities similar to that included in the Department of Health regulations for health care facilities. Similar language which we request be included follows: Information contained in QM/UM reports, records or other documents submitted or received by the MCO by a provider pursuant to the CHC program may not, unless otherwise ordered by a court for good cause shown, be produced for inspection or copying by, nor may the contents thereof be disclosed to, a person other than the Secretary, the Secretary's representative or another government agency, without the consent of the provider. | LeadingAge PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-19 | Standard XIII for medical record and service planning record keeping. | Patient visit data should also include the medication record. | LeadingAge PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | M(1)-22 | Standard XIV-G (1): Points of access to Primary care, specialty care and hospital services. | We recommend a fourth bullet be added to reflect points of access to LTSS. | LeadingAge PA |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | overall | In general, Exhibit M(1) appears to be written primarily for physicians and hospitals. | The standards should be reviewed again with a focus on LTSS and especially as the system impacts seniors. We continue to have significant concerns that the unique needs of seniors have been overlooked. | LeadingAge PA |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | overall | Impact of CHC QM/UM rules vs. Medicare requirements | Please clarify how it will work when the CHC quality management or utilization management requirements conflict with Medicare or state and federal certification requirements. If the CHC-MCO refuses to authorize payment for a service that is required to be provided by the licensing entity or by federal requirements, will the provider be able to seek payment directly from DHS? | LeadingAge PA |
| Requirements Document Exhibit | M(2) - External Quality Review | overall | Requirements for MCOs to assist with external quality review | Please require that the information submitted be shared in the aggregate with providers. Duplicative reporting should be reduced as much as possible. In item A, the role of the Medical Assistance Advisory Committee should be expanded to provide input generally on the external quality review program, rather than limiting it to assistance with the measures to be utilized. | LeadingAge PA |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | all | EIMS is different from DOH ERS | Nursing facilities should continue to use the Event Reporting System (ERS) developed by the Department of Health and should NOT also be required to use the Enterprise Incidence Management System (EIMS), which is duplicative in some areas and conflicting in others. EIMS for HCBS is different from this system and does not utilize the understanding of nursing homes and their residents provided by the ERS. A significant amount of thought, preparation and education has been put into this system and this work should not be abandoned for a system that is untested in the nursing facility environment. | LeadingAge PA |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | M(2)-4 | Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect; | The definition of Seclusion is incomplete: In the Health Care Facilities Regulations, Title 28 chapter 201.3 (v), Involuntary seclusion is defined as "Separation of a resident from other residents or from his room or confinement to his room (with or without roommates) against the resident's will, or with will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs. We request that this definition be changed to include the entire text above. | LeadingAge PA |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | all | definition of "hospitalized" for incident reporting is too broad | For nursing facility residents, please use the current definition of a reportable hospitalization from Title 28, Chapter 41.3 notification requirements, (g) "...events which seriously compromise quality assurance or patient safety include, but are not limited to, the following:" "... (5) Transfers to a hospital as a result of injuries or accidents." In addition, various state agencies should work together in the defining of terms to eliminate inconsistencies. | LeadingAge PA |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | all | Preventable Serious Adverse Event (PSAE) reporting is not addressed. | This Exhibit should reference the September 13, 2014 Notice with requirements for PSAE reporting to clarify that the Notice is still in effect. | LeadingAge PA |

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| Requirements Document Exhibit | N - Notice of Denial | all | Notices of denial are issued to the Participant | The provider of the requested service that was denied should also be notified of the denial, so that the provider is not unreasonably providing uncompensated services. | LeadingAge PA |
| Requirements Document Exhibit | | Missing Exhibit R | Only a brief discussion is offered of CHC-MCO coordination with BH-HC plans. More detail is needed. | The coordination between CHC-MCOs and Behavioral Health MCOs is critically important to provide high quality services for many CHC Participants. More detail should be shared with stakeholders to assure that sufficient coordination will take place and that services will be accessible to participants in a timely and comprehensive manner. | LeadingAge PA |
| Requirements Document Exhibit | | Missing Exhibit S | Written Coordination Agreements between PH-MCO and Service Providers: Only a brief discussion is offered of CHC-MCO coordination with BH-HC plans. More detail is needed. | The coordination between CHC-MCOs and Behavioral Health MCOs is critically important to provide high quality services for many CHC Participants. More detail should be shared with stakeholders to assure that sufficient coordination will take place and that services will be accessible to participants in a timely and comprehensive manner. | LeadingAge PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG(1)-1 | Five Star Rating | Measures 1-3 - As we stated in our letter of January 8, 2016, caution must be used with the five-star ratings because they are a significantly flawed measure of quality. | LeadingAge PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG(1) item 53 | Provider Satisfaction Survey: Uniform Questions to be developed with MCO Input/OLTL Approval within One Year | We support the concept of a provider satisfaction survey and urge the Department to require provider involvement in the design of the survey. The Department should consider utilizing the expertise of the Medical Assistance Advisory Committees, especially, the LTC-Sub-MAAC. | LeadingAge PA |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG(4) | Data Elements - Comprehensive Needs Assessment | LeadingAge PA is most appreciative that the departments have shared the draft needs assessment in Exhibit GGG (4) of the December release of the draft agreement, and the indication that the departments prefer that the needs assessment be standardized, however, we are concerned that the Needs Assessment has been issued without inviting meaningful input into its development by provider stakeholders. Further, the instructions and definitions for conducting the assessment, which are essential to understanding how the assessment will be conducted and also for defining the information to be collected, are missing from the draft. Finally, also missing is any description of the process that was used to develop the needs assessment and what testing has been conducted to assure that it is a valid and reliable instrument. As an example, how did the group that designed the needs assessment decide which of the typical frailty score or geriatric depression scale measures to use in the assessment and why do the selections not coincide with the OASIS or MDS brief items? | LeadingAge PA |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | GGG(7) | Exhibit GGG(7) lists data elements for a nursing home survey. | Exhibit GGG(7) omits crucial information, such as an explanation of the purpose of the data collection, who will collect the information and what credentials will be required, how the exhibit was developed and whether stakeholders were involved in the development of this instrument. As with all of the other instruments listed, instructions for conducting the assessment and definitions of the data elements are omitted from the presentation. | LeadingAge PA |
| Requirements Document Exhibit | | in general | MCO staff expertise in LTSS and Senior Services: As we stated on December 11, there are few requirements for the MCO staff to be experienced in issues impacting seniors or LTSS and these requirements should be increased. | Given that we do not know that the LTSS expertise at the MCOs will be sufficient, it is necessary that OLTL and the CHC-MCOs consult with LTSS providers and their representatives regarding the standards, quality improvement programs, and delivery of services, because LTSS providers do have this expertise. | LeadingAge PA |
| Requirements Document | Section VI: Program Outcomes and Deliverables | Subsection: N/A<br>Page: 5 | "If the Department determines the CHC-MCO has not demonstrated readiness to provide services as required by this agreement, the department will not permit the enrollment of Potential Participants with the CHC-MCO and may extend the time period for the readiness review or not operationalize this agreement." | The OBRA Waiver Residential Habilitation service W0100 is not even mentioned or referred to in this entire document. Review of this document shows the CHC program leans toward a medical model for targeted participants who are elderly or phsyically demanding. The participants we serve in the OBRA Waiver residential habilitation service are dually diagnosed with intellectual disability/developmental disability (DD) and do not match the targeted population. We operate a residential group home for individuals with DD, not a nursing home and not in-home caregiving. The Dually Diagnosed individuals in the OBRA Residential Habilitation service should not served under this CHC system because there is no guidance for residential dually diagnosed DD participants for the MCOs and likely will not pass readiness review and be able to operationalize this agreement with success. | Acme Providers Inc.<br>Justina Cunningham, CEO |
| Requirements Document | Section IV: Applicable Laws and Regulations | Subsection: D. 3.<br>Page: 4 | "If the MCO elects not to provide, reimburse for, or porovide coverage of, a counseling referral service because of an objection on moral or religious grounds, the CHC-MCO must furnish information about the serices not covered in accordance with the provisinos of 42CFR 438.102b...." | How can a participant have the civil right of not being discriminated against based on religion and at the same time have the MCO deny their right to chose all provider options based on religious grounds. I would suggest this could even be illegal and unconstitutional. | Acme Providers Inc.<br>Justina Cunningham, CEO |

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| Requirements Document | Section XVI: General | Subsection: Exhibit A<br>Page 31 | "Managed care organizations are to adhere to the provisions of Medical Assistance Bulletin 1123-91-01, EPSDT – OBRA '89 with the following exceptions:…" | This discussion regarding OBRA funded individuals only addresses the health needs of these participants. There are an important group of OBRA waiver funded participants who are Dually Diagnosed with Developmental Disabilities. All those with OBRA Residential Habilitation services we serve also have a DD diagnosis. This Other Related Conditions (ORC) designation is different from the other typical medical model target population of what is being described in this document and CHC-MCO Plan. Our OBRA funded individuals with DD fit better with the Autism, PFDS and Consolidated waivers that were withdrawn from this CHC program for similar reasons and they should continue to be served under these waivers. | Acme Providers Inc.<br>Justina Cunningham, CEO |
| Requirements Document Exhibit | FFF - MIPPA Agreement Requirements | Subsection: Exhibit FFF<br>Pg: 142 | "The CHC-MCO must operate an aligned D-SNP concurrently with its CHC-MCO. This D-SNP will be required to enter into a MIPPA Agreement with the Department. The MIPPA Agreement will address the eight elements required of all MIPAA agreements,1 and will also include additional requirements to ensure the greatest possible coordination between the CHC-MCO and the D-SNP including, but not limited, to the following..." | I believe there is a disconnect between the federal government talking about person centered planning and then having a standardized tool for determining need. The participants receiving OBRA Residential Habilitation Services W0100 with MA 51 diagnosis ICF/ORC do not fall neatly into the category which this MCO plan covers. The extremely difficult aspect of this plan is that each MCO will run a concurrent D-SNP program while juggling everything else on the medical model side. I do not believe that the MCOs will take the time necessary to personalize services for a population that they are not familiar with and does not fit neatly into the same model as their concurrent program. MCOs have managed SNP plans in Rhode Island, Connecticut, New Mexico and Colorado with devastating results (retrieved from, http://www.ancor.org, n.d.). We can not assume that a CHC-MCO that has a main focus and primary target population of "high risk using acute medical services" and "and enhanced medical home model" will do better and create a new and specialized assessment for their side project. I fear that an MCO agreeing to provide a concurrent program will not even achieve a quality of services that is on par with the states who were attempting to create a similar MCO system specifically for the special needs population and could lead to individuals being warehoused in nursing homes. This is not the way they want to live nor should the state want them to live. | Acme Providers Inc.<br>Justina Cunningham, CEO |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | Pg. 153 | Comprehensive Needs Assessment | An assessment called the SIS, Supplemental Intensity Scale, has currently been used to assess individuals with DD and is used in PA. The particular OBRA waiver individuals with DD we serve have completed a SIS assessment. I have assisted with completing multiple SIS assessments of individuals with DD. The SIS is a much better assessment than the "Comprehensive Needs Assessment" provided in this draft to assess needs of a SNP population. The assessment presented captures the medical needs but not the needs of the DD individuals we serve. Even though the SIS is a useful instrument it still has its pitfalls and has failed to create an accurate picture of needs assessment in Rhode Island, Connecticut, New Mexico and Colorado (retrieved from, http://www.ancor.org, n.d.) when using it to set rates as I suppose the MCOs would try. There has even been a law suit proving the ineptitudes of the SIS for use in this manner in New Mexico "Waldrop vs. New Mexico Human Services Department" Filed January 15, 2014 | Acme Providers Inc. Justina Cunningham, CEO |
| Requirements Document | Section IV: Applicable Laws and Regulations | Subsection: E Pg: 4 | "The obligations of the Department under this Agreement are limited and subject to the availability of funds." | I would suggest that it is imperative that this sentence is written in a way to be clear that the limit on the Department's obligations shall be related to the availability of funds and nothing else. I suggest it be written to read: "The obligations of the Department under this Agreement are limited to, and subject to, the availability of funds." | Acme Providers Inc. Justina Cunningham, CEO |
| | | Overall | | To accompany these comments, I have included as part of our public comments a letter indicating my continuing and strong concern about OBRA waiver residential habiliative consumers who are DD being included in this model of care. It is not in their best interest nor is it the the right model for them. I have also attached statements written directly by these consumers. | Acme Providers Inc. Justina Cunningham, CEO |
| Requirements Document | Section VIII: Reporting Requirements | B.1., p.6 | Encounter Data Reporting | To ensure that sufficient information is available to inform assessments of whether MCOs are meeting rebalancing goals and providing quality services, DHS must require the MCOs to report encounter data at the individual level and by type and amount of service (for example, number of personal care hours authorized) and level of care. Individual level data concerning any service reductions should also be reported. The contract must also require MCOs to have data collection systems capable of capturing and reporting information relevant to HCBS and rebalancing, such as beneficiary functioning, quality of life and caregiver-related issues, in addition to medical information. | Community Legal Services Jenny Kye |
| Requirements Document | Section X: Termination and Default | A, p.17 | Termination and Default | We have not seen, in the draft contract sections that have been released for comment, the provisions on intermediate remedies. It is crucial that the contract include a full array of intermediate sanctions to enable DHS to bring any non-compliant or poorly performing MCO into full compliance in a timely way. These sanctions must include at a minimum civil money penalties, appointment of temporary management, granting enrollees the right to terminate enrollment without cause, suspension of new enrollments and suspension of payments. | Community Legal Services |

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| Requirements Document | Section X: Termination and Default | C.2 | The CHC-MCO must coordinate the continuation of care prior to termination or expiration for Participants who are undergoing treatment for an acute condition. | Similar protections should be included for participants receiving ongoing HCBS and service coordination services. | Community Legal Services |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | p. A-43 | Exclusion of "Subchapter K in its | How will DHS ensure that participants are able to access exceptional DME in nursing facilities? The reason for the exceptional DME grants was the recognition that a nursing facility's per diem rate would not cover the expense of these costly but medically necessary items, and that residents were experiencing access problems as a result. How will DHS ensure that rates paid to nursing facilities by CHC-MCOs do not prevent participants from receiving exceptional DME? | Community Legal Services |
| Requirements Document Exhibit | B(1) - CHC_MCO Pay for Performance Program | | Pay for Performance Program | Assisting participants with successfully completing the financial redetermination process is a worthwhile goal. This should be part of the service coordinator's job and therefore successful performance of this function should continue to be a requirement after the end of the pay for performance project. We would encourage the Department to consider rebalancing-related projects, as well, to ensure that the MCOs start out with a clear disincentive to reduce or deny needed HCBS. | Community Legal Services |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | p. M(1)-2 | Quality Management and Utilization Management Program Requirements | We have a general concern that this section appears to have been revised only to add LTSS providers into the existing standards. We urge the Department to consider carefully whether the existing standards are adequate to ensure quality care in the context of MLTSS, where the key goals are not just clinical quality of care, but also non-clinical outcomes such as quality of life and rebalancing. The only mention of LTSS in Standard I, which sets out requirements for the scope of QM and UM programs, is a vague requirement of "[d]istinct policies and procedures regarding LTSS" specifying the responsibilities and scope of authority of service coordinators. Quality assurance is a critical area, as this very vulnerable population is moved into managed care – operated by plans which mainly have no experience in long term care - for the services they rely upon for their most basic needs. We urge the Department to devote substantial attention to creating quality assurance requirements which incorporate the best practices in this area. Ideas to consider include but are not limited to:<br>• OLTL and/or MCO reviews, on an annual basis, of a sample of person centered service plans for fidelity to the person centered planning process;<br>• requiring MCO site visits to a statistically valid random sample of providers (such as nursing facilities) to review quality of care provided; and<br>• methods for evaluating the timeliness and attendance of personal care attendants (such as the real-time electronic visit verification utilized by Tennessee). | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard I.N., p. M(1)-4 | The CHC-MCO shall monitor the Participant's condition for ongoing care and potential discharge back to community living. | More detail is needed here, including standards for MCOs to ensure that the nursing facilities with which they contract are providing high quality care and that members who are in nursing homes receive the services they need. Nursing facilities are required to hold care planning conferences at least quarterly, where residents' plans of care are developed based on assessed needs and issues of concern are addressed. MCOs should participate in this care planning process and remain involved in monitoring and advocating for high quality care for their members who are in nursing facilities. If contracted nursing facilities fail to provide high quality care, MCOs must be responsible for being aware of this and taking action to ensure the well-being of their members. Mechanisms should be required for the planned assessment and analysis of quality of care provided and utilization of services in nursing facilities (this should be added in Standard I.E.3 – LTSS has been added to this section, but nursing facilities should be specifically included). Finally, more detail is needed on the CHC-MCO's responsibility to monitor participants' "potential discharge back to community living." The requirements concerning Nursing Home Transition and rebalancing should be addressed and cross-referenced here, as these obligations go well beyond mere monitoring for a possible discharge. | Community Legal Services |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard II.B, p. M(1)-6 | | The Quality Management Committee should include membership and participation by plan participants. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III.C, p. M(1)-7 | | Practice guidelines and clinical indicators should be developed to address service coordination services. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III.E, p. M(1)-8 | | The physical accessibility of plan providers should also be assessed, and accessibility problems should be addressed when they are identified. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard III.I, p. M(1)-9 | | LTSS providers should be included here (procedures for provider satisfaction surveys). | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IV.C, p. M(1)-10 | | More detail may be needed here about the aggregate trends and changes to person-centered plans which MCOs will be required to report, to ensure that the Department receives all of the information needed to carefully monitor whether participants are receiving the services they need and what service provision changes may be affecting rebalancing efforts. Also, as discussed above, individual level encounter data must also be collected. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VI, p.M(1)-11 | | There are additional parties which should be included in this list [of those between whom there must be mechanisms to ensure coordination of care, etc]., including:<br>• The CHC-MCOs and the fee for service Medicare program;<br>• The CHC-MCOs and nursing facilities;<br>• The CHC-MCOs (service coordinators?) and community-based LTSS providers; and<br>• The CHC-MCO and hospitals. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard VIII, p.M(1)-13 | | Standards for credentialing nursing facilities should be specifically addressed, and CHC-MCOs should be required to include quality of care information as criteria, including the results of Department of Health and CMS licensing surveys and Medicare star ratings. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX.C, p. M(1)-15 | | This standard should make clear that the Medically Necessary definition and the Prior Authorization process do not apply to eligibility for LTSS, and it would be helpful to include some description of the sources of eligibility criteria for LTSS. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX.E, p. M(1)-16 | | This subsection should make clear that Licensed Proprietary Products may not be used to determine eligibility for LTSS. To the contrary, the level of care determination process will determine eligibility for LTSS services generally, and eligibility for specific services will determined through the person-centered planning process. To the extent that these products are used for non-LTSS services, this subsection should be clarified to state to whom the MCO is required to provide it. Participants who are denied services due to the application of such products should be entitled to a copy, and this should be made clear here. | Community Legal Services |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard IX.G, p. M(1)-17 | | LTSS should be added to the list of services for whom there should be 24 hour staff availability for authorization. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIII, p. M(1)-19 | The CHC-MCO must ensure that the medical and service planning records contain written documentation of the medical necessity of a rendered, ordered or prescribed services | Medical necessity is not the correct standard for service planning for LTSS (or for LTSS services), and this language should be amended to reflect that. | Community Legal Services |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | M(2)-4, 5 | | CHC-MCOs should be required to notify both long-term care facilities and home health care agencies of their duty to report events that fall under the Older Adult Protective Services Act (32 P.S. § 10225.101) (OAPSA) and 28 Pa. Code § 51.3(g). All long-term care facilities and home health care agencies are subject to the OAPSA and the 28 Pa. Code § 51.3. If a CHC-MCO learns that an event covered under OAPSA or 28 Pa. Code § 51.3 has occurred, it should be required to report to the relevant agency or department itself as required by law and ensure it is done by their provider. | Community Legal Services |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | M(2)-4, 5 | | Additionally, home health care agencies and nursing homes should be required to report all of the events contained in 28 Pa. Code § 51.3(g). The current list of critical incidents in this exhibit does not contain critical incidents such as elopements. As health care facilities under Pennsylvania law, home health care agencies and nursing homes must report the events listed at 28 Pa. Code 51.3(g) to the Department of Health. DHS should require CHC-MCOs to require all of its providers or subcontractors to report these events to DHS as well. | Community Legal Services |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | M(2)-4, 5 | | The sections on abuse, neglect, exploitation, and restraint need to be clarified as to what setting reporting requirements apply. We agree that in the HCBS and nursing home settings these must be reported to relevant departments and agencies, by law, and the CHC-MCOs should be notified, as well. It is not clear if these reporting requirements are limited to those settings. | Community Legal Services |

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| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | M(2)-4, 5 | | As written now, these provisions could be interpreted to mean that a provider must report to a CHC-MCO these events in every situation, including situations where the perpetrator of the abuse is not employed by the CHC-MCO or one of its providers or subcontractors. We oppose reporting of those events to the CHC-MCO unless required by law or with the participant's informed consent. The relationship between a participant and her medical provider is private and based on trust. By requiring a provider to violate that trust undermines the patient doctor relationship. It could likely deter participants from reporting one of those events to their doctors. To what benefit will it be to the participant to have her provider notify the CHC-MCO of abuse? What will the CHC-MCO and the department do when this information is received? Unless required by law, a provider must not be required to report abuse, neglect, or exploitation without the permission of the participant. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6 | | Overall, the notice puts too much burden on the participant. It requires drafting of appeals, mailing appeals within short time frames, and making a decision about which appeal process is better. It does not take into account that participants are severely disabled and potentially in a nursing home or homebound. DHS must require the appeal process to be simple for the participant. The current appeal and notice system is simple and effective for participants. We strongly urge that process to be carried over to MLTSS. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6 | | We are concerned that there is not enough room for CHC-MCOs to "explain in detail every reason for denial." CHC-MCOs should be required to provide additional documentation on another form, when the required information does not fit into this small area. The language contained in the explanation should be simple and easy for the participant to read and understand. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6 | | Requiring a complaint, grievance, or a request for a Fair Hearing to be "postmarked or hand-delivered within 10 days of the date of the notice" in order for a participant to continue to receive the services that are proposed to be terminated or reduced violates 55 Pa. Code § 275.4(a)(2), which provides for the filing of an appeal orally. Participants in MLTSS are severely disabled. They either reside in a nursing home or require nursing services in their home. For them, filing appeals is particularly hard. In accordance with the Code, oral appeals must be allowed. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6 | | If a participant elects to file a grievance and a request for a fair hearing, will aid paid pending be provided until both processes are completed? We believe in situations where both appeals are filed, aid paid pending must be provided until both processes are completed. | Community Legal Services |

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| Requirements Document Exhibit | N - Notice of Denial | O-6 | | Request Criteria: This should not be the first option for a participant when she has received a notice denying, reducing or terminating the services, especially in light of the fact DHS requires the CHC-MCO to provide this information in the explanation above. If the CHC-MCO complies with the requirement to fully explain the reason for the denial and cite the criteria, requesting the criteria should not be necessary. The right to request the criteria should be incorporated into the sections about filing for a fair hearing or a grievance. Otherwise, this will lead to delays for participants. Further, it should not require them sending a written request to the CHC-MCO. An oral request should be sufficient. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6-7 | | File a Complaint of Grievance: This should not come before a request for a fair hearing. What is the difference between a complaint and a grievance? If there is no difference, CHC-MCOs should be required to use one term, preferably "appeal." The creation of a separate grievance process from the traditional fair hearing confuses the process and complicates the issues for participants. We often represent individuals in Medicare appeals, where the tiered appeal system is like one proposed for MLTSS. It is confusing to participants and often causes them to forgo appeals. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6-7 | | The multitude of terms, appeal, grievance, complaint, fair hearing will confuse the participant. We strongly suggest using the term "appeal". A participant should be able to file an "appeal" with DHS or CHC-MCO. The use of one term will simplify the process and lead to less confusion about a participant's options. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6-7 | | The notice should contain language that filing a grievance will put the decision in the hands of the CHC-MCO that has proposed the negative action. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-6-7 | | If a CHC-MCO does not resolve the grievance within 30 days, it should be required to provide interim assistance until it does. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-7 | | Request for a Fair Hearing: This should be the first option for participants, as it is in their best interest to have a disinterested party review the proposed negative action of the CHC-MCO. The language should be clearer here to reflect that a fair hearing will allow a participant to have her issue heard before a person who does not work for the CHC-MCO and was not involved in the original proposed negative action. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-7 | | This section seems to indicate that the participant must draft her own appeal. We strongly oppose this requirement. Currently, a denial notice comes with a section that allows a participant to elect to file an appeal. This is a simplified and easy process for participants. Requiring a participant to draft her own appeal and provide copies of the notice and to mail the appeal is not good policy and will decrease the likelihood of participants filing appeals. DHS should require the provision of notices to participants that contain a section where they may elect to file an appeal. | Community Legal Services |

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| Requirements Document Exhibit | N - Notice of Denial | O-7 | | As mentioned above, appeals are allowed to be filed orally. Further, this oral request should be able to be made to DHS or the CHC-MCO. The participant will have a service coordinator who can assist the participant in filing the appeal, as well. Requiring the participant to mail the appeal is contrary to Pennsylvania regulations. Once an oral appeal is made, the participant should be assisted in filing a paper appeal by DHS or the CHC-MCO, as required by 55 Pa. Code § 275.4(a)(2)(iv). | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-7 | | The language stating "the department will issue a decision between 60 and 90 days from when it receives your request" is confusing. This language does not mention a hearing at all. This language should be changed to reflect that DHS has to provide a fair hearing during that time, as well. 55 Pa.Code § 275.4(b) requires final administrative action to be taken within 60 days of the date of the appeal for Food Stamps appeal and 90 days from the date of the appeal for Medical Assistance. This should be stated explicitly. Further, the notice should contain information on interim assistance. We suggest the following language in accordance with the code: "We must provide a hearing and make a decision about your appeal within 90 days of the date you filed your appeal. If we fail to do so, we will authorize interim assistance until we make our decision, in accordance with 55 Pa. Code § 275.4(d)." | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | O-8 | | Participants should not be required to send a written request to the CHC-MCO in order to obtain documents relevant to the decision. A participant must be allowed to make this request orally to either the CHC-MCO or DHS. | Community Legal Services |
| Requirements Document Exhibit | N - Notice of Denial | Exhibits N(2)-N(6) | | Our concerns with the rest of the notices are the same as N(1), and our comments on N(1) are applicable to these notices as well. | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Rights | | We are concerned that this list of rights is not complete. We are also concerned that this list of rights is not particular to individuals receiving MLTSS. There is no provision for the right to person-centered service planning and service provision, or to elect to self-direct their care. Additionally, in Exhibit DD of the Draft Program Requirements, there are many rights listed that do not appear here. For instance, rights regarding patient payment amounts and prohibitions on balance billing are not included in this list of rights. | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Rights | | For nursing home residents, the rights contained in 42 C.F.R § 483.10 and 483.12 should be incorporated into this document. The document states that it applies to providers, and therefore the rights afforded nursing home residents in those sections should be incorporated into this document. The rights should be written out and not just referenced by regulation citation. | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | | | In sections where references are made to the Code of Federal Regulations, CHC-MCOs should be required to provide the language of those sections and not just the citations. | Community Legal Services |

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| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Responsibilities | | We are confused by this section. It appears that a participant has more responsibilities than she does rights? What does it mean for a participant to have a responsibility? To whom is that responsibility owed? If they fail to do one of the listed responsibilities, what will happen to them? The use of the word responsibilities implies that the participant must do these things herself, and that the CHC-MCO will not assist in the matters. We strongly encourage that this section be removed or titled differently. | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Responsibilities | | We strongly oppose the inclusion of this in the document if it in any way may be used by a CHC-MCO to try to disenroll participants. It is foreseeable that a CHC-MCO will interpret this list as duties and use a participant's alleged failure to follow one of these requirements as a means to disenroll her. | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Responsibilities | | We urge the removal of the requirement to review covered items. It is unclear what this means. Does this mean they are responsible for knowing the rules? Should not the service coordinator assist with these rules? | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Responsibilities | | We urge the removal of "To communicate problems immediately to the CHC-MCO." What kind of problems must they communicate immediately? This is very vague. Does it mean problems with services or service providers? This language should be removed. | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Responsibilities | | We urge the removal of "to ask questions and further information regarding anything not understood." We are not suggesting that participants should not ask questions, but to impose upon them the responsibility to do so implies that if they fail to understand something in is their fault. This should be a participant right, not a responsibility. | Community Legal Services |
| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | Participants' Responsibilities | | We do not understand why it is necessary to put language in this section about calling 911 or their doctors if they are sick or in an emergency. It goes without saying that these are things a participant should do, but making them a responsibility implies that they and they alone are the ones that must take that action. | Community Legal Services |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | As noted in our December comments, we strongly oppose CHC-MCOs requiring prior authorization of services because this often results in the delay or denial of critically needed care for participants. At a minimum, CHC-MCOs must not require prior authorization for emergency services, post-stabilization services, or urgent care services (treatment for medical conditions that are serious or acute and require medical attention within 24 hours). This rule should apply to both in-network and out-of-network providers. The Department must also not allow CHC-MCOs to require prior authorization for services that do not require prior authorization under the fee-for-service program. If CHC-MCOs were allowed to impose prior authorization standards more stringent than those used in FFS, this would create more administrative hurdles for both participants and providers, along with new avenues for CHC-MCOs to deny participants care. | Community Legal Services |

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| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | If the Department chooses to allow prior authorization, the Department must set out clear standards for a CHC-MCO's expedited review process. Exhibit H states only that CHC-MCOs must have procedures for such a process when services are urgently needed. Prior authorization processes should be as uniform as possible across CHC-MCOs. We recommend that the Department require an expedited review process similar to that outlined in the Hawaii and California MLTSS contracts (see Hawaii Contract, p. 219 and CA Contract, Exhibit A, Attachment 5, Section 2). Expedited review should be applied when the standard time frame for prior authorization could seriously jeopardize the participant's health, independence, or ability to attain, maintain, or regain maximum function. The CHC-MCO must make expedited review determinations as soon as possible but no later than three days after the request for service. This time frame may be extended up to 14 days, either (1) upon the participant's request; or (2) upon the CHC-MCO proving to the Department that the CHC-MCO needs additional information and the extension is in the participant's best interest. If the CHC-MCO extends the time frame, it should issue a written notice of this decision and the participant's right to appeal if he or she disagrees with the decision. | Community Legal Services |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | CHC-MCOs' criteria for prior authorization review must incorporate a broader definition of "medically necessary" than that originally proposed in the draft program requirements. As we emphasized in our December comments, "medically necessary" services must include services that offer the opportunity for a participant receiving LTSS to have access to the benefits of community living. CHC-MCOs' written policies and procedures must describe how they will utilize a social (rather than exclusively medical) model of LTSS in making authorization decisions. | Community Legal Services |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | The Department should ensure that CHC-MCOs educate providers on the types of services requiring prior authorization, as well as the procedures and time frames for obtaining authorization of these services. Additionally, CHC-MCOs must have mechanisms for consulting with requesting providers when conducting prior authorization reviews. | Community Legal Services |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | CHC-MCOs must be prohibited from arbitrarily denying or reducing the scope of services based on a participant's diagnosis or type of illness/condition. | Community Legal Services |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | Administrative requirements should also mandate that CHC-MCOs explain in their written policies and procedures how they will ensure consistent application of prior authorization review criteria. CHC-MCOs must clearly document their reasoning behind each authorization decision. | Community Legal Services |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | For additional recommendations regarding prior authorization, please see Community Legal Services' December comments. | Community Legal Services |

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| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | M(4)-1-4 | | 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. | Community Legal Services |
| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | M(4)-3-4 | | The Department must require CHC-MCOs to conduct a more socially-oriented survey to supplement the clinically-oriented CAHPS survey. The supplemental survey should assess a participant's quality of life. 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. | Community Legal Services |
| Requirements Document Exhibit | M(4) - HEDIS and CAHPS | M(4)-3-4 | | While the draft agreement anticipates that survey administration will consist "of a mail protocol followed by telephone administration to those not responding by mail," surveys must be done in-person. Again, it should be noted that HEDIS protocol was not designed with the MLTSS population in mind. Many seniors and people with disabilities will likely have difficulty completing surveys conducted over the phone or through mailings. CMS guidance on quality of life measures also emphasizes that "data must be collected using best practices for reaching special populations (e.g., phone or in-person as opposed to mail)." (CMS Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs). Further, in conducting surveys, CHC-MCOs should accommodate participants with limited English proficiency and/or disabilities. | Community Legal Services |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | Data from performance measures must be shared publicly with stakeholders. The data must be presented both on a CHC-MCO and statewide basis so that stakeholders can identify whether trends are specific to certain CHC-MCOs or systemic. We recommend that reports of performance measures sufficiently analyze and correlate data so that stakeholders can draw meaningful conclusions about the quality of a CHC-MCO and the CHC program in general. The Department must also incorporate performance measures into overall ratings for CHC-MCOs that will allow participants to make informed enrollment decisions. | Community Legal Services |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | The Department must establish an independent ombudsman and advocacy program and involve the ombudsman in evaluating CHC-MCOs' performance. As mentioned in our comments on the CHC Concept Paper, the ombudsman should provide free assistance to participants on a variety of issues 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. | Community Legal Services |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | Performance evaluation must include measures to gauge LTSS rebalancing. Because serving more participants in the community is cited as a primary objective of CHC, CHC- | Community Legal Services |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | Although OLTL has proposed measures that capture the number of complaints and grievances, these measures alone are insufficient. The Department must also track the nature and outcome of these complaints and grievances. Exhibit GGG(9) seems to propose collecting data about the nature of complaints and grievances, but not the outcomes. | Community Legal Services |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | The Department should find a way to generate data about continuity of care when participants first enroll in CHC and when they switch from one CHC-MCO to another. This information will allow stakeholders to examine whether CHC-MCOs are preventing gaps in care/service disruptions for participants. | Community Legal Services |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | The Department must monitor CHC-MCOs' due process compliance, which is not adequately tracked by the listed performance measures but will likely be a major problem among CHC-MCOs. Due process violations may prevent participants from filing complaints or grievances (for example, participants may not receive adequate notice of decisions or receive misinformation from a CHC-MCO about appeal rights). CHC-MCOs may also refuse to provide aid paid pending, which could have especially dire consequences for the MLTSS population. The Department must thus find a way to evaluate due process compliance (measures 64 and 68 are good starting points) and should consider conducting "mystery shopper" tests of member services to test whether CHC-MCOs respond appropriately to participants who try to file appeals. | Community Legal Services |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | We also recommend the addition of the following specific performance measures:<br>• Actual timely receipt of all services in a care plan<br>• Provider participation accuracy<br>• Provider information accuracy<br>• Time and travel distance from provider to participant | Community Legal Services |

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| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | An evaluation of CHC-MCO performance should also include assessments on whether CHC-MCOs are ADA-compliant. In New York, a study completed by the Center for Independence of the Disabled NY (CIDNY) found that managed long-term care plans routinely violate the ADA. The Department should ensure that it monitors how CHC-MCOs accommodate participants' disabilities. | Community Legal Services |
| Requirements Document | Section II (Definitions) | | | As noted in our December comments, the Definitions section should define language access. It should also define who is limited English proficient. We recommend the following definitions, which are based on federal agency guidance:<br><br>• **Limited English Proficient Individuals:** Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English are limited English proficient.<br><br>• **Language Access:** Provision of oral and written language services needed to assist LEP individuals to communicate effectively with staff, and to provide LEP individuals with meaningful access and an equal opportunity to participate fully in services, activities, or other programs. For LEP individuals, meaningful access denotes access that is not significantly restricted, delayed, or inferior as compared to programs or activities provided to English proficient individuals. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIII, p. M(1)-19 | | Standards for record keeping for service coordinators and LTSS providers should be added. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIII.J, p. M(1)-20 | facilitating transfer of records | Seven business days may not be soon enough to ensure a smooth transition for LTSS. Service planning and LTSS information should be transferred as soon as possible from receipt of the request, and the losing CHC-MCO must ensure continuity of service until the new CHC-MCO is in a position to take over. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIV.E.2, p. M(1)-21 | | This list of benefits and services should include:<br>• Information about copayments and the prohibition of balance billing, with an explanation of the respective payment obligations of Medicare and Medicaid for dual eligibles. For participants who are enrolled in a plan's CHC-MCO and aligned D-SNP, this information should be integrated (explaining the roles of both plans in the same notice).<br>• Information on prescription drug copayments;<br>• LTSS services and procedures to access to them;<br>• Person Centered Service Planning and service provision;<br>• Right to consumer direction in LTSS; and<br>• Service coordination services and how to access them. | Community Legal Services |

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| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIV.H, p. M(1)-22 | Participant Information | For participants who are enrolled in both a plan's CHC-MCO and aligned D-SNP, participant information should be provided in an integrated form. This will further the goals of integrating care by providing one set of consistent materials which make it clear how the two plans work together. | Community Legal Services |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | Standard XIV.I, p. M(1)-22 | | This subsection should also include the requirement of accommodations to address visual, hearing and other impairments. | Community Legal Services |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | Performance Measures and Data Elements<br>addresses NHT measures in MDS 7 - 14. These measures are not specific enough to assure that the appropriate rebalancing takes place. 7, 8 and 9 {residents admitted,length of stay) no specific goal is stated. a 10°/o decrease as a goal which would be related specifically to the<br>CHC-MCO Pay for Performance Program referenced in Exhibit B {1) to be developed. The methodology utilized<br>in this process should be transparent and integrated LRI recommends the addition of a measure to transition 2 - 5°/o of current nursing facility residents per year to be directly associated with the Pay for Performance Program. The methodology utilized in this process should be transparent and integrated into the RFP. | Fady Jahhar |
| Requirements Document Exhibit | M(1) - Quality management and Utilization Management Program Requirements | | | Program Requirements correctly defines medical necessity in StandardIX - C, to incorporate maintenance of maximum functional capacity in the least restrictive environment. LRI recommends that this definition of Medical Necessity must be integrated into all the other sections of this RFP which may have been extracted from HealthChoices contracts {Exhibits A, H,M (1), M (2),M{3), N (1),N {1-7)), especially in matters related to consumer satisfaction,complaints, grievances and appeals. | Fady Jahhar |
| Requirements Document | | | | Since issuing the Concept Paper regarding MLTSS in June 2015, OLTL has stated that it intends to provide a single standard of provider accreditation to be used by all MCO's in their contracts with providers. | Fady Jahhar |
| Requirements Document Exhibit | E - Specific Federal Regulatory Cites for Managed Care Agreements | | | E3 appears to leave the option for the individual MCO to identify the manner with which they will measure the performance of LTSS and Service Coordination providers. This document also references Exhibit AAA (published earlier) w here no clear accreditation standards were outlined. | Fady Jahhar |
| Requirements Document | | | | The draft documents continue to be vague about the level of consumer engagement in the development, communications, oversight and appeals processes for LTSS. LRI recommends that consumers should be involved in the committees and processes outlined in Exhibit M (1), Standard I- E3 and E4, Standard I- F, Iand K and Standard XIV. | Fady Jahhar |
| Requirements Document Exhibit | Requirements Document Exhibit | | | Participants should not receive funded services in personal care homes under any circumstances. As per 55 PA. § 2600.1. (b): "Personal care homes are designed to provide | CARIE Kathy Cubit |

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| Requirements Document | Section VIII: Reporting Requirements | | | DHS should require MCOs to report data concerning all terminations or service reductions at the individual level. MCOs must also be required to collect and share data about LTSS in addition to medical information such as quality of life and caregiver-related issues.<br><br>DHS should require MCOs to provide needed data to create a monthly enrollment dashboard such as offered by Virginia's MLTSS program. Stakeholders in Pennsylvania should be engaged to help add additional data points that could be publically shared on a monthly basis. It would also be helpful if DHS posted public quarterly reports on the new MLTSS system to highlight what's working, problems, and what DHS is doing to address the problems. The reports should include information about how well CHC-MCOs are adhering to their contracts and share quality data once it becomes available. The quality measures should include process measures such as nursing facility diversion rates, transition measures such as nursing home or hospital readmissions within 30 days of discharge, and outcomes measures such as the percentage of participants with a change in ADLs.<br><br>DHS should post quality metrics about each CHC-MCO so consumers can make informed choices about the best possible plan for them. DHS or each MCO should be required to post their entire provider network and include quality metrics so consumers can make informed choices about the provider that is most beneficial for them.<br><br>On page 11, "Provider Network," DHS should have standards in place for an adequate network for each provider type and should use these monthly reports to ensure the CHC-MCO is in compliance with having a robust provider network so consumers have choice and can access needed services. | CARIE Kathy Cubit |
| Requirements Document | Section X: Termination and Default | | | All agreements should include options for intermediate sanctions so DHS can ensure a poorly performing MCO is brought into full compliance in a timely way.<br><br>The provision that requires CHC-MCOs to "coordinate the continuation of care prior to termination or expiration for Participants who are undergoing treatment for an acute condition" should be expanded to include participants receiving LTSS. | CARIE Kathy Cubit |
| Requirements Document Exhibit | A - Managed Care Regulatory Compliance Guidelines | | | DHS should include a process for the exceptional durable medical equipment (DME) grants to ensure that participants are able to obtain needed exceptional DME in nursing facilities. | CARIE Kathy Cubit |
| Requirements Document Exhibit | H - Prior Authorization Guidelines in the CH Program | | | Once approved, the MCO should be required to publically post its policies and procedures for the prior authorization of services. DHS should collect and post data from each MCO about the number of prior authorization requests, the average time for approval/denial, and the number of approvals versus denials. This will provide an important resource for consumers to compare plans. | CARIE Kathy Cubit |
| | M(1) - Quality management and Utilization Management Program | | | DHS should conduct participant and other stakeholder meetings throughout each region as CHC is rolled out and implemented so staff may interface directly with the public to | |

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| Requirements Document Exhibit | Requirements | | | allow dialogue to learn about problems and what is working well. The MLTSS Advisory | CARIE Kathy Cubit |
| Requirements Document Exhibit | M(3) - Critical Incident Reporting and Management and Provider Preventable Conditions Reporting | | | DHS may want to consider adding “falls that result in injuries” to the list of critical incidents.<br>The following statement should be more specific, “Providers must report in accordance with applicable requirements.” We recommend changing it to, Providers must report in accordance with all applicable federal and state laws and requirements.<br><br>This section should further explain the process as to what happens after an incident or preventable condition is reported, including timeframes for response. | CARIE Kathy Cubit |
| Requirements Document Exhibit | N - Notice of Denial | | | It is important that all denial notice samples are printed in a large and accessible font. MCO inserted explanations should be written so those with low literacy levels will understand the message.<br><br>Participants must have the right to file grievances about the service and treatment provided by the MCO, its subcontractors and its providers. We are pleased to see that services will be covered during the appeal process until a decision is made. Language should be added to the contracts to ensure that require decision-makers in the appeals process to be trained to understand and evaluate the necessity of LTSS, and consider the non-medical goals and benefits of these services.<br><br>The public should receive regular data updates on the number of denials (including partial denials), appeals and grievances filed, along with the outcomes including the number of appeals that result in the reversal of a CHC-MCO decision. Further data should be compiled and shared about any negative outcomes to those who were denied services.<br><br>DHS should establish an independent ombudsman for CHC to assist participants in exercising their rights through the appeals and grievance process. | CARIE Kathy Cubit |
| Requirements Document Exhibit | ZZ - Automatic Assignment | | | CARIE has extensive experience helping consumers choose a managed care plan. More often than not, the primary factor in selecting a plan is whether the consumer’s physicians are in the MCO’s network. Therefore, we strongly recommend auto-assignment process include assigning the consumer to a MCO plan that includes their doctor in the network. If the doctor is part of more than one MCO, the consumer could be randomly assigned after the other identified factors are considered. | CARIE Kathy Cubit |

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| Requirements Document Exhibit | EEE - Participants' Rights and Responsibilities | | | The list of participants' rights seems thin. All participant rights should be spelled out in bullet form and be required in all written MCO communications about participant rights and responsibilities Having rights clearly spelled out for consumers is vital to their | CARIE Kathy Cubit |
| Requirements Document Exhibit | GGG(1)-(9) - Performance Measures | | | Since there are very few validated tools to measure the impact of MLTSS in regard to quality of care and quality of life, DHS should include provisions to allow for the addition | CARIE Kathy Cubit |
| Requirements Document | Section XVI: General | | | Once AGAIN, knowing that the transition to CHC will cause major disruptions and problems for consumers, it's disappointing not to see any mention of an ombudsman | CARIE Kathy Cubit |
| Requirements Document | Section XVI: General | | | It is important that DHS ensure meaningful consumer participation and transparency at the state and MCO level, including making public agreements between and among CMS, | CARIE Kathy Cubit |
| Requirements Document | Section XVI: General | | | The statewide Imagine Different Coalition is concerned about the nearly 3,000 PA children with developmental disabilities under age 21 living in congregate settings. Family life is essential for all children to promote physical, cognitive, social and emotional growth and development. The well-researched developmental imperative for children to grow up in families with constant enduring relationships with caring adults is as important or even more important for children with disabilities as it is for other children. Right now, children with disabilities living in congregate care facilities, especially those without the resources available to children with Intellectual Disabilities (ID), have few pathways to family life.<br>This is contrary to DHS's intentions as we understand them. Changes to the Home and Community Based Services (HCBS) waiver being considered by the OLTL (1) will eliminate services currently available through waivers to youth ages 18-21 and (2) do not take into consideration the need for waivers for all children under age 21 with all types of developmental disabilities who are living in or at risk of admission to a long term care facility without long term services and supports. | Dianna Ploof, Kenneth Oakes, Co-Chairs. Imagine Different Coalition |
| Requirements Document | Section XVI: General | | | Waiver services have an important role to play in addressing this concern. Waiver services are needed because Early and Periodic Screening, Diagnosis and Treatment (EPSDT) does not cover all the services that children and adolescents with developmental disabilities need to avoid institutionalization: services such as respite, home modifications and residential habilitation (e.g., life-sharing or partner families). Currently, children under 18 who have developmental disabilities other than ID (such as cerebral palsy, spina bifida, complex medical conditions requiring trachs or ventilators, etc.), as well as infants and toddlers with ID, have no access to waiver-funded respite, home and vehicle modifications or residential habilitation. Parents can find themselves unable to care for their children at home and currently have no option but to accept the placement of their child in a nursing or other institutional facility. With access to HCBS waiver services, these children could be living in families | Dianna Ploof, Kenneth Oakes, Co-Chairs. Imagine Different Coalition |
| Requirements Document | Section XVI: General | | | We strongly recommend that DHS create a waiver for all children with developmental disabilities: a waiver that includes a variety of alternative family living options, such as | Chairs. Imagine Different Coalition |