ProVantaCare

Response to Request for Information for Community HealthChoices Re-procurement
April 14, 2023

Thank you for the opportunity to respond to the Request for Information (RFI) issued on March 6, 2023 regarding the upcoming procurement of Community HealthChoices (CHC), with contract awards targeted for January 2025. We appreciate the planning and foresight to commence the process currently. On behalf of the 85 ProVantaCare network of providers, we found that there are many areas where comments are necessary. In this response, we lay out a series of topics and areas where we believe the program can address the needs of Pennsylvanians effectively. Given the time and space constraints, we view this response as the beginning of the open communications with the Department of Human Services and the Office of Long-Term Living, and look forward to more elaborate and detailed exchanges and collaboration.

We divided our response into three categories: Program Design, Specific Service Opportunities, and a discussion about the need to incorporate provider-led entities into the path forward for this program. We regard all three as opportunities for improvement, based on our experience since the rollout of the program in 2018. Also noteworthy is the recognition that consumer choice and control need to continue to be essential building blocks for sustainable community living and rebalancing of services away from institutional settings.

PROGRAM/SYSTEM DESIGN OPPORTUNITIES

Stakeholder Involvement in the Design of the Next Generation of CHC – While we are encouraged by the opportunity to respond to this RFI, we find this process insufficient for the significant opportunities that are available to seek out and embed stakeholder input. Specifically, we recommend:

- Public listening sessions across the Commonwealth, providing consumers, providers, and community stakeholders the opportunity to provide more detailed input.
- Additional public input prior to recommendations for the waiver amendments.
- Sharing the draft MCO contracts with groups like the MLTSS Sub-Maac.

MCO Regional Concentration – The current approach for auto-assignment has resulted in a very high regional concentration of MCOs. We urge the department to consider more consumer-centric approaches to auto-assignment and target to reduce the levels of auto-assignment, which would result in a more informed selection of the MCO. While we do not have a view regarding the number of MCOs awarded, we would like to see a higher level of direct consumer decision making in this area.

MCO Monitoring and Oversight – As the program has stabilized and matured, it has become increasingly evident that the framework requires more systemic monitoring of the MCO. Recent examples of sample reviews of person-centered plans highlight the opportunities to establish ongoing monitoring of a number of areas beyond the operations reports currently employed by the department. We recommend the development of ongoing transparency of such monitoring, with input from stakeholders beyond the occasional reviews shared in the MLTSS meetings.

The department has established a dashboard for enrollment, which can serve as a platform for such reporting.

An additional area of opportunity exists in the manner with which pay rates are established between the MCOs and providers. With the exception of personal assistance services (PAS), rate increases and Federal Medical Assistance Percentage (FMAP) changes during the Public Health Emergency (PHE) have not been passed on to service providers.

In the spirit of stakeholder engagement and transparency, we also urge the department to establish more consistent leverage of the Participant Advisory Councils, by building in oversight of the Grievance and Appeals Process, MCO Scorecards, and Program Improvement Plans.

Whole-Person Care/Coordination of Care – The development of CHC since 2018 has evolved to incorporate many physical health indicators being monitored by MCOs and embedded into Value-Based Payment (VBP) programs. We recognize the value of health plans and acknowledge the relevance of such measures. One of the most valued and anticipated benefits of CHC had been the coordination of care across the service spectrum, including physical and behavioral health. We recognize the value of health plans and acknowledge the relevance of such measures. However, while CHC is moving closer to a medical model, we have yet to see the alignment of behavioral services supporting our consumers. It would be important to build in significant incentives and requirements into future program design to assure such alignment. Specific opportunities include:

- Create continuing funding for access to data to support whole-person care like Health Information Exchange (HIE) data;
- Require more specific performance measures about access and utilization of behavioral health services; and
- Encouraging the MCOs to develop and contract with providers using VBP, with shared savings and rewards ensuing to the provider community.

Introduction of Population Health Groups – As we reach a steady state in CHC, a number of groups are emerging as having complex needs, which could be addressed more effectively if these groups are identified in the waiver. An example of such groups are individuals who have a brain injury diagnosis. We would like to see this population health group:

- Defined in the waiver based on the ICD-10 codes;
- Referred to a specialized service coordinator once they select an MCO;
- Provided services which could be bundled;
- Including credentialing, accreditation, and network adequacy to support these individuals;
- Requiring the MCO to contract with providers using a VBP construct; and
- Monitoring the service delivery and outcome on a whole-person care basis.

The desired flexibility allowable under a VBP model would have the necessary flexibilities to appropriately meet these individuals' needs.

There is a growing number here of consumers in CHC with a primary or secondary IDD diagnosis, based on data from OLTL. This group is not receiving the services they need to maintain their independence in the community. By defining this as a population health group, it would allow the MCOs to leverage the "in lieu of" services to deliver the required support.

We urge the department to seek stakeholder input on this initiative to meet a growing need in the Commonwealth.

Service Coordination – While service coordination (SC) was identified as one of the main reasons why CHC was needed, and the transfer of SC to an administrative activity was one of the main solutions presented, this change resulted in a significant reduction in the number of service coordinating entities (SCEs). The remaining SCEs are generally NCQA accredited and are performing at a very high level.

We would like to see service coordination returned to a service with accreditation requirements and with no budget authority. The ability to deliver community-based service coordination and nursing home transition service coordination as services would bring the support closer to the recipient and establish closer community relations.

Transparency of Rate Escalator for ALL Services – As stated earlier, PAS is the only service where rate escalators have been public and required to be passed through. In the future, all rate changes and FMAP shifts should be public.

SPECIFIC PROGRAM RECOMMENDATIONS

Personal Assistance Services – This service is prevalent in the CHC program. However, we recommend the following:

- Establishing quality standards that can be applied uniformly across MCOs. This may also entail requiring accreditation and measures of quality relating to whole-person care.
- Adding "specialized services" code, providing a structured approach to delivering nurse delegated services by non-medical personnel.
- Addressing the requirements of EVV utilization in a proactive and consumer supportive approach, enhancing control and self-direction.

Brain Injury Services – Approaching these consumers as part of the population health group, as addressed earlier. Specifically, we recommend:

- Implementing a population health group strategy, as outlined earlier;
- Requiring a referral to well-trained specialized service coordinators;
- Embedding flexible and adequately-funded VBP services, incorporating funding coordination of care delivered by brain injury providers; and
- Ensuring network adequacy for services across the Commonwealth.

Employment Services – The promise and potential for these services has not been delivered. We recommend:

- Redefine the services and employment readiness services;
- Train service coordinators to effectively present these services;
- Establish higher targets for MCOs to deliver in enrollment; and
- Revisit the rates built into the current capitation to encourage providers to proactively seek these consumers.

Support for the Coalition for Choice – The principles of consumer choice and control and their impact on consumer-directed services (FMS and AWC) are clearly outlined at www.CoalitionForChoicePA.com.

ADVANCE PROVIDER-LED PARTNERSHIPS IN PENNSYLVANIA

Pennsylvania does not currently encourage payers to contract with groups of providers who are committed to delivering high-quality services, leveraging innovation and technology, able to support VBP, and risk sharing. These models have been promoted and funded by the Agency on Community Living, but only when the states are receptive to them.

Provider-led models have taken different forms across the country, and have been successful when the state provides an engaged partnership and advances a balanced approach to service delivery partnerships between payers and providers. We recommend:

- Review the opportunity these partnerships provide;
- Open the discourse with current and prospective MCOs about the validity of these models; and
- Encourage the conducting of pilots to demonstrate efficacy.

This opportunity to comment on the potential of this opportunity is limited, but we recognize it as an important first step to advancing this model of care.