April 13, 2023
Re: Response to OLTL's Request for Information on the CHC Program

On behalf of RCPA members who utilize and are directly impacted by Community HealthChoices (CHC), RCPA submits our response to the Department's solicitation for comments regarding stakeholder areas of interest about the current CHC program and opportunities to strengthen and improve the quality of health care and long-term services and supports (LTSS).

We strongly support the Department affording the opportunity to provide input about the various elements and features of CHC; however, we were disappointed to see there is no mechanism for responding to stakeholder concerns and suggestions through the Request for Information (RFI) process. The absence of individual or collective responses erodes the perception of a fair and transparent process in this critically important program that supports thousands of individuals daily. We urge the Department to summarize comments received and present them and their dispensation to stakeholder groups as well as posting them on the CHC website.

The meaningful involvement of all stakeholders in the design and operation of CHC is important and should be strengthened by a participant-led advisory body with true, codified oversight authority and input into all aspects of the program, including a formal review process with findings that are made public. We urge proactive involvement in program design by individuals with lived experience and the ongoing discussion of solutions and recommendations before policy is developed. This approach would ensure robust stakeholder input and control over services, which would be more meaningful than the receipt of reports and the opportunity to comment.

We identify areas below that we assert would improve the quality of the program for the benefit of participants:

Appendix A: Program Requirements
Appendix A. 4. Expanded Services and Value-Added Services
The Department notes that a possible in lieu of service is Assisted Living Services. The providers of residential habilitation services who serve individuals with complex needs, such as individuals with a brain injury, have concern over this possibility and should be excluded. There are times when assisted living services are appropriate and times when they are not appropriate; instead, it should go through a team who understands residential habilitation services. Ensuring someone is fully evaluated is key, alongside extensive evaluations. We feel this decision should be based on need, not economics and finances.

The Office of Long-Term Living's (OLTL) Complex Care Unit (CCU) should review these cases, and the complex care unit team should include a community-based individual who has familiarity with the population or disabling condition of the individual being evaluated.

The waiver agreement states that MCOs must promote workforce innovations to improve the recruitment, retention, and skills of direct care workers, which may include, but not be limited to, enhanced payments. The Residential Habilitation/BI providers are CARF Accredited and provide training that is above and beyond what DHS requires. In fact, BI providers are the only CARF accredited group of providers that have standards that exceed what DHS requires. The MCOs should evaluate the CARF standards for direct care workers (e.g. career ladders, specialized trainings) that Residential Habilitation/BI providers provide and reward these efforts as outlined by the Department's requirement of supporting workforce innovation.

Appendix A.16. Participant Self-Directed Services
RCPA supports the requirement that CHC-MCOs must offer participants who are eligible for HCBS the opportunity to self-direct Personal Assistance Services as a first option.

Appendix A. 22. Complex Care Unit
We feel complex care units should be comprised of knowledgeable and trained staff who will conduct on-site reviews and assessments rather than completed telephonically. In-person assessments are key and should include individuals who have knowledge about the individual and could include the medical director, nurse at the nursing home, family members, or anyone who would have knowledge of brain injuries. Neurocognitive issues should be considered, as well, and not just social and medical issues.

B. Prior Authorization of Services
Appendix B.1. General Prior Authorization Requirements
During the prior authorization process, there should be one system that all CHC-MCOs must utilize. On an annual basis, a decision should be made on the process and guidance issued to ensure all are following it. If there are more than three CHC-MCOs, there needs to be continuity in everything, especially the processes. Otherwise, this causes undue burden to every provider, which could ultimately lead to the need to hire additional staff. Additionally, it could create a service gap because of the inability of providers to take on this burden.

E. Comprehensive Needs Assessments and Reassessments
When CHC-MCOs are conducting comprehensive needs assessments, consideration should be given to include providers as part of the assessment team. The more information available for placement and for the providers, the better the placement for the client. Providers have the knowledge and expertise and should be considered a partner in this process.

J. Service Coordination
We feel the caseload ratio for Service Coordinators serving HCBS participants is too high to ensure quality care and accuracy with completion of all position requirements. We recommend a lower caseload number to ensure adequate time is given to participants. Lower caseloads are especially important for residential habilitation clients due to the complexity of their care. Consideration of having dedicated Service Coordinators for this population would be extremely beneficial.

O. Participant Enrollment, Disenrollment, Outreach, and Communications
Appendix A. O. 8. Transitioning Participants Between CHC-MCOs
We strongly recommend that the CHC-MCOs notify all current providers listed on the ISP when participants change CHC-MCOs. Service Coordinators currently do not share this information, and it causes extra work for providers who spend additional time researching if and when changes occur. This results in further time being spent correcting billing that has already taken place.

W. Other Administrative Components
Appendix A. W. 12. A Contract Compliance Officer Who Monitors the CHC-MCOs Compliance With All the Requirements of the Agreement
Providers were not aware of this position and the support that exists. Not only does this hold the CHC-MCOs accountable, but it also provides transparency. It would be beneficial to share additional specifics surrounding this position, such as the names and roles of these individuals and an organizational chart. RCPA's Brain Injury Committee recently established quarterly meetings with the CHC-MCOs and feel it would be beneficial that they include their contract compliance officer in these meetings. Some additional questions surrounding this position:

1. Who currently holds this role within the CHC-MCOs?
2. Does anyone currently check to ensure the CHC-MCOs are being compliant? Who is holding them accountable?
3. How frequently does this individual check to ensure the CHC-MCOs are in compliance?

Z. Selection and Assignment of Service Coordinators
At a minimum, CHC-MCOs must go further to conduct training to ensure a clear understanding of the population served through Community HealthChoices. Documentation must be completed to show accountability. It would be advantageous for a select group of SCs to be trained in not only brain injury, but all neurological disorders (cerebral palsy, multiple sclerosis, stroke, etc.). RCPA's brain injury providers are willing to offer training as needed. We feel strongly that each CHC-MCO should have an expert in the area of brain injury/cognitive issues**.**

Appendix D. Revenue Sharing
While the CHC-MCOs may retain fifty percent of the Realized Revenue in excess of the Maximum Retained Revenue with express written approval from the Department if the MCO agrees to expend the remaining fifty percent (50%) of funds in excess of the Maximum Retained Revenue on initiatives, revenue above thirty percent should be passed on to providers.

We request that financial statements be made publicly available and posted on the OLTL website for transparency purposes.

Exhibit F. Quality Management and Utilization Management Program Requirements
Every Service Coordinator should have written back-up plans, especially if someone doesn't show up to work. This information should also be included in the ISP; however, providers are not granted access to the ISPs.

Exhibit H. Coordination With Behavioral Health Managed Care Organizations
We recommend that each CHC-MCO has a team of experts that includes an expert in the disabling condition, who will then determine when the participant may be better served by the CHC provider rather than shifting it to the BH-MCO.

Exhibit T. Provider Network Composition Services Access
d. LTSS Providers
Long-term services and supports (LTSS) must include telerehab as a value-added service if there are not enough providers. The definition of network adequacy for LTSS providers is written in a way that appears to only apply to Personal Attendant Services (PAS) providers. Network adequacy should be defined and written as appropriate for every service available in the waiver. If no provider exists and it is therapy specific, telerehab should be a viable consideration.

Exhibit Z. Person-Centered Service Planning
We request that there be transparency with person-centered service planning (PCSP), with the plans being made available to all providers serving an individual. Participants should be able to request audits of the plans. RCPA brain injury providers feel it would be beneficial for a form to be developed and used by Service Coordinators to note meetings. The number of meetings would be on an individual basis.

Providers need access to the PCSP or to a copy of it if they are to support this. Currently, participants have to request this and provide it to the providers. The reports should be completed to verify visits and to follow-up with timeliness to visit with QM.

ADDITIONAL FEEDBACK

Increase Stakeholder Input

Standards for Provider Network Adequacy
There should be transparency for the provider network adequacy standards for all services in the Community HealthChoices waiver.

Training
Mandatory training, above and beyond initial training, should be required on an annual and ongoing basis for any staff that would benefit from this. In addition to the Service Coordinators, this could include those individuals that conduct initial assessments, thus training them on how to interpret the results of the assessments.

Staff should identify a primary diagnosis to be used in the development of the person-center service plans (PCSP).

Recommendations surrounding training:

1. Content should include diagnosis-specific content, including the diagnosis being identified. Specifically, identify ICD-10 codes that trigger the Service Coordinator to consider the list of services more specific to the condition of the individual.
2. Services that are offered and who can use those services should be addressed.
3. There should be a focus on how cognitive deficits impact services.
4. Annual training should be competency-based.

Number of CHC-MCOs
RCPA feels that rather than providing a recommended number of CHC-MCOs, the primary focus needs to be avoiding increased administrative burden on providers. This is most important. All of the CHC-MCOs should utilize the same authorization and billing system. OLTL should have more oversight of the CHC-MCOs. Consumer choice needs to be increased, and consistency among all of the CHC-MCOs is key.

Transparency
Transparency is critical to a successful program and relationship between OLTL, the CHC-MCOs, the Service Coordinators, and the providers.

Coalition for Choice
RCPA supports the Coalition for Choice, which is a group of advocacy organizations and providers of various aspects of community-based, long-term care services and supports in Pennsylvania.