pennsylvania
DEPARTMENT OF HUMAN SERVICES

ODP Updates

ISAC

June 11, 2024

Overview

- Performance-Based Contracting (PBC)
- CMS Settings Rule On-Site Report
- Mid-year Capacity Initiative to address the Waiting List
- Supplemental Payments
- New Federal Rules

Performance-Based Contracting

On April 20, 2024, the Office of Developmental Programs (ODP) released the following for 45-day public comment:

- PBC Implementation Plan
- New 1915(b)(4) Waiver Application for Residential Services
- 1915(c) Waiver Amendments for Community Living and Consolidated Waivers
- Proposed Rates

As of June 4th deadline, preliminary analysis of comments from 9 public sessions and written submissions:

- Approximately 100 commentators, 700+ comments

How is ODP Helping Providers to Prepare For PBC

pennsylvania
DEPARTMENT OF HUMAN SERVICES

- ODP published provider preparedness tools
- June Provider Preparedness Summits to review performance standards in more detail
- Provider preparedness tools include:
  - Residential Provider Performance-Based Contracting Preparedness Assessment
  - Residential Provider Performance-Based Contracting Workplan
  - Provider Summits
- Quarterly Provider Forums beginning in September 2024 for on-going provider support

Provider Preparedness Tools
Preparedness Self-Assessment
Preparedness Self-Assessment Workbook

Provider Preparedness Summits	
June 3	1:30pm-3:30pm
June 10	1:00pm-3:00pm
June 12	1:00pm-3:00pm
June 20	1:00pm-3:00pm

Residential Performance-Based Contracting Agreement

All residential providers must sign a new Agreement for Provision of Residential Services.

- The residential services waiver provider must submit one completed and signed agreement per legal entity. Regardless of the number of residential services provided or number of service locations operated by the legal entity, only one agreement must be submitted.
- Completed agreements must be submitted by July 31, 2024 to ODP via email or mail.
- Providers that do not submit a new agreement will not be qualified to render residential services as of 1/1/25. Providers that do not submit a new agreement cannot be in Select or Clinically Enhanced tiers
- June 4 – Residential Provider Agreement sent out via several listservs:
  - BHSL-managed ODP licensed providers listserv, Provider, AE, and QA&I

Performance-Based Contracting Payment Structure

- Providers will continue to bill their daily fee schedule rate for each person receiving residential services.
- Providers who meet the requirements for Select or Clinically Enhanced tiers will receive a rate add-on.
  - Proposed language: Select providers will receive a rate add-on of 5% per individual served and Clinically Enhanced providers will receive a rate add-on of 8% per individual served.
- Providers that meet the requirements for Primary, Select, or Clinically Enhanced can receive pay-for-performance payments for meeting/exceeding targets in the proposed areas of:

Staff credentialing	Employment of individuals served
Transition to Supported Living or Life Sharing	Reporting on use of technology

- Primary providers eligible for all P4P. Select and Clinically Enhanced eligible for some.

Performance-Based Contracting Tiers

- All performance standards will be assessed at the MPI level.

- ODP will assign providers to tiers based on documentation submitted in July 2024 and available data

- Providers that do not meet the performance standards for the Primary tier but don’t have a revoked or provisional license (Conditional tier) will be assigned to Primary and receive a CAP or DCAP to remediate the areas where they don’t meet the tier requirements.

Next Steps for PBC – Public Comment

- ODP will review public comments received and make revisions.

- ODP will finalize performance standards and publish them in a bulletin. Goal for publication is the end of June.

- ODP will finalize waiver language: (1915(b)(4), Consolidated Waiver and Community Living Waivers) and submit to CMS. Goal for submission to CMS is July. Submitted waivers will be publicly available.

CMS HCBS Settings Rule On-site

- CMS conducted an on-site visit the week of February 26, 2024
- Assessed the implementation of the HCBS Rule:
  - Person-centered planning and Supports Coordination Services
  - Met on-site with providers
  - Interviewed individuals, DSPs, Supports Coordinators
- DHS received a written on-site report from CMS on May 13, 2024:
  - DHS response required by June 13, 2024
  - Key remediation areas for ODP: choice of setting including non-disability specific settings, lease agreements

ODP Program Growth Strategy

February 2024 Governor Shapiro directed ODP to release an additional 1,250 Community Living waivers and 400 Consolidated waivers in FY23-24

Progress to date (6/4/2024) - as a result of the mid-year capacity release

- **907** individuals enrolled in Community Living waiver
- **319** individuals enrolled in Consolidated waiver

Supplemental Payments

- **ODP Announcement 24-041 -** amendments to the Consolidated, P/FDS, Community Living, and the Adult Autism Waivers were approved by CMS on April 29, 2024. Effective May 1, 2024.
- One-time supplemental payment to cover recruitment, retention, and any unusual staffing expenses resulting from the COVID-19 pandemic for direct support professionals, frontline supervisors, program specialists or Supports Coordinators. …
- Payments calculated at 6% of fee schedule revenue received for services rendered between July 1, 2023, through December 31, 2023 for listed services.
- Payments calculated at 3% of revenue received for Residential Habilitation Needs Exception rates for providers that render Residential Habilitation to more than one person between July 1, 2023, through December 31, 2023.
- Payment requests must have been received by May 15, 2024.
- As of June 4, 2024, ODP processed payments for all providers who have applied. Payments should be visible on the provider's Remittance Advice on June 17, 2024.

pennsylvania
DEPARTMENT OF HUMAN SERVICES

New Federal Rules

Recently Issued CMS Final Rules

- Ensuring Access to Medicaid Services
- Managed Care Access, Finance, and Quality
- Minimum Staffing Standards for Long-Term Care (LTC) Facilities and Medicaid Institutional Payment Transparency Reporting
- Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes

Overview: Ensuring Access To Medicaid Services
“Access Rule”

New Requirements:

- Payment Adequacy & Transparency
- Critical Incidents
- Timeliness of Access
- Quality Measure Set
- FFS Grievance Process
- MAC & BAC

Payment Adequacy: Minimum Performance Standard

The state must ensure 80% of Medicaid payments go to compensation for direct care workers (DCWs).

Affected services:

- Personal care services
- Home health aide services
- Homemaker services

Compliance timeframe: 6 years

Payment Adequacy: Reporting Requirements

The state must report to CMS annually on the percentage of total payments for furnishing personal care, homemaker services, home health aide services, **and habilitation services** that goes to compensation for DCWs

The report must:

- Separately report by service
- Within each service, separately report self-directed services
- Within each service, separately report services with facility-related costs

Compliance timeframe: 4 years

Rate Analysis and Disclosure

Rate Disclosure:

- State must publish rate disclosure FFS personal care, home health aide, homemaker **and habilitation**
- Disclosure must be updated every 2 years and include:
  - Avg. hourly payment rates, separated by agency and self-directed options, and stratified by population, provider type, and location
- Number of Medicaid-paid claims
- Number of beneficiaries who received a service within a calendar year

Interested Parties Advisory Group

- State must establish an Interested Parties Advisory Group to advise and consult on FFS payment rates for DCWs.
- Membership must include DCWs, beneficiaries and authorized reps, and other interested parties.
- Group must meet every two years, at minimum
- Group to make recommendations on the sufficiency of State plan, 1915(c), and 1115 demonstration FFS payment rates.

Timeliness of Access

Final rule adds habilitation to homemaker, home health aide, and personal care services as a service type for which states must report on two timeliness factors:

- Average amount of time from when homemaker services, home health aide services, personal care services, and habilitation services are initially approved to when services began, for individuals newly receiving services within the past 12 months.
- Percent of authorized hours for homemaker services, home health aide services, personal care services, and habilitation services that are provided within the past 12 months.

Effective Date —3 years (July 9, 2027)

Waiting List Reporting Requirements

States must report:

- Description of how the State maintains the list of individuals who are waiting to enroll in the waiver program. Must include:
  - Whether the State screens individuals on the list for eligibility for the waiver program;
  - re-screens individuals; and
  - the frequency of re-screening, if applicable.
- Number of people on the list of individuals who are waiting to enroll in the waiver program.
- Average amount of time that individuals newly enrolled in the waiver program in the past 12 months were on the waiting list

Effective Date —3 years (July 9, 2027)

Quality Measure Set

- The state must establish performance targets, approved by CMS, for each measure in the HCBS Quality Measure Set identified as mandatory, and describe state's quality improvement (QI) strategies to achieve performance of those measures.
- Replace minimum 86% performance level for states performance measures from 2014 guidance
- States report every other year on all measures in the HCBS Quality Measure Set that are identified by the Secretary (following phased in approach)

Measure set for Medicaid-funded HCBS is intended to:

- Promote more common and consistent use within and across states of nationally standardized quality measures in HCBS programs;
- Create opportunities for states and CMS to have comparative quality data;
- Drive improvement in quality of care and outcomes for people receiving HCBS; and
- Support states' efforts to promote equity in their HCBS programs.

Grievance Process

Grievances are defined as "expressions of dissatisfaction or complaints." This system does not impact existing member fair hearing rights.

- May be filed related to state or provider performance with **person-centered planning** and **HCBS settings** requirements.
- Beneficiaries, authorized representatives, or other disinterested individuals or entities with permission from the beneficiary/authorized representative may file a grievance and/or support a beneficiary through the grievance process –with no punitive or retaliatory action taken because of grievance filings

Compliance Date: Two years following effective date of the rule **(July 9, 2026)**