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
RFP				The definition of LTSS does not include any of the current waiver rehabilitation services required by those with brain injury. person centered planning, supports brokers must be provided for those who request them as a cognitive accommodation	Barb Dively Acquired Brain Injury Network of PA
Requirements Document	Section V.A. - Covered Services			Requiring the evaluator to have the same medical credentials as the prescriber does not help the patient, because the prescriber can only be the PCP! The PCP has no expertise in any specialty which the patient may need – but merely refers for special care. This led a gynecologist to evaluate the need for brain injury rehabilitation which was denied in a tragic case....personal assistance needed because of cognitive impairment cannot be denied to a person under 21 – why limit this to under 21? Why not correct the current inappropriate practice of the AAAs restricting the NFCE finding to those with mobility handicaps, rejecting those who are cognitively helpless due to a physical condition like brain injury.	Barb Dively Acquired Brain Injury Network of PA
Requirements Document	Section V.A. - Covered Services	26		why will an exception process be needed for services included in the waiver but not in the Medicaid state plan? This will affect everyone with brain injury because the state limits brain injury rehabilitation to those found NFCE and approved for a waiver – we are denied parity because our medically necessary treatments are not listed in the Medicaid State Plan.	Barb Dively Acquired Brain Injury Network of PA
Requirements Document	Section V.A. - Covered Services	27		why isn't the state going to pay the MCO for services to prevent entering a nursing home?	Barb Dively Acquired Brain Injury Network of PA
Requirements Document	Section V.A. - Covered Services	32		why does the state pay for organ transplants but not cognitive recovery after brain injury like commercial plans?	Barb Dively Acquired Brain Injury Network of PA
Requirements Document	Section V.A. - Covered Services	35		will these housing services provide 24/7 supervision as required by some waiver participants with brain injury	Barb Dively Acquired Brain Injury Network of PA
Requirements Document	Section V.E. - Needs Screening	40		it is essential that a brain injury screening be included to prevent inappropriate referrals for behavioral health care.	Barb Dively Acquired Brain Injury Network of PA
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	54		New Participant Orientation – this far exceeds the cognitive capacities of individuals with brain injury who are found NFCE – a supports broker is essential for ADA accommodations	Barb Dively Acquired Brain Injury Network of PA
Requirements Document	Section V.P. - Participant Services	55		expecting the NFCE waiver participant with a brain injury to comprehend and remember this amount of material is unjust.	Barb Dively Acquired Brain Injury Network of PA
Requirements Document	Section V.P. - Participant Services	58		an ombudsman system is needed to represent those without the cognitive capacity to assert their rights and concerns. The supports broker representing the waiver participant would be another way to protect those with cognitive challenges.	Barb Dively Acquired Brain Injury Network of PA
Requirements Document	Section V.P. - Participant Services	66		the Behavioral Health Coordinator must assure that persons with brain injury are not referred into the behavioral health system because evidence-based care is not available to them there.	Barb Dively Acquired Brain Injury Network of PA
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	84		Service Coordinators for persons with brain injury should be ACBIS certified to guarantee efficient, intelligent, performance.	Barb Dively Acquired Brain Injury Network of PA
Requirements Document	Section V.DD. - Provider Network	89		persons with brain injury must be served, as they are now, by providers who are CARF accredited in brain injury	Barb Dively Acquired Brain Injury Network of PA
Requirements Document	Section V.DD. - Provider Network	90		Disability competency is mentioned in the title but not in the text of this section. By eliminating disability competence from the text, the department can require MCO's to replace providers who are CARF accredited in brain injury with providers who have no such credential	Barb Dively Acquired Brain Injury Network of PA

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Requirements Document	Section V.DD. - Provider Network	92		Integration – this could be used to force those with brain injury into cross disability settings that lack expertise in brain injury. At present, brain injury rehabilitation is only provided by those who are CARF accredited in brain injury, and the settings are limited to those with brain injury. The MCO could use this section to end brain injury rehabilitation, destroying the benefit of the current waiver services which are the only source of this service. Those with brain injury cannot get rehabilitation unless they are NFCE, now this option would be removed for lack of integration.	Barb Dively Acquired Brain Injury Network of PA
Requirements Document Exhibit	J - EPSDT Guidelines			EPSDT Screening – this screening must include a screening for brain injury to avoid inappropriate care and the failure to provide appropriate care. Medical Assistance pays for evidence-based Cognitive Rehabilitation Therapy (CPT97532) for cognitive recovery after brain injury for children under 21– but children are routinely sent into behavioral health instead – as that is the easiest system to enter – there is no familiar path to brain injury rehabilitation, even for children who are covered for whatever they need. This also leads to an administrative classification of intellectual disability based solely on IQ regardless of the cause, as if reversible brain injury were a permanent, genetic, neurodevelopmental disorder.	Barb Dively Acquired Brain Injury Network of PA
Requirements Document Exhibit	DD - Participant Handbook			Participant and Provider Handbooks must include information on preventing, diagnosing, evaluating and rehabilitating brain injury as this information is not in the hands of PCPs	Barb Dively Acquired Brain Injury Network of PA
Requirements Document Exhibit	FF - Provider Directories			LTSS Providers – this must include any accreditations and the web location for checking on complaints and violations	Barb Dively Acquired Brain Injury Network of PA
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes			this Grievance Process is beyond the capacity of those without a law degree. Who will pay for MCO clients to be represented?	Barb Dively Acquired Brain Injury Network of PA
Requirements Document Exhibit	BBB - Pharmacy Services	7		perhaps the pharmacists lobbyist was more powerful that provider lobbyists – because the MCO must accept all pharmacies who are willing and qualified, but the MCO can pick and choose providers for its network, eliminating consumer choice.	Barb Dively Acquired Brain Injury Network of PA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	2		Assisted Living – will the MCO be funding residents who need to live in an assisted living facility? Under a previous administration, Assisted Living Regulations were adopted but the state never completed a filing with CMS for an assisted living waiver. This would be a great blessing.	Barb Dively Acquired Brain Injury Network of PA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	2		Specialized Medical Equipment and Supplies – when extensive medical equipment is needed, the cost of the electric needed to run that equipment must be provided.	Barb Dively Acquired Brain Injury Network of PA
RFP	Work Statement	II-5, pg. 42	Describe how you would approach nursing home transition service delivery	Describe how you would approach nursing home transition service delivery, including populations that may be more difficult to house due to barriers related to rental, credit, and criminal history	Jeffrey Fields, Self-Determination Housing Project of PA
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	44		I have a concern regarding the highlighted section below. I have been an Aging Waiver Supervisor for 15 years and I am not an RN or a licensed Social Worker. I have been a part of the Aging Waiver Program since its very beginning. Based on this regulation, I do not meet the proposed requirements to continue as a SC Supervisor employed by a CHC-MCO or a Service Coordination entity where I am currently employed. I would hope that one's years of experience would be taken into consideration for the position of Service Coordination Supervisor	Mary Gaffney, CILCARES director of Aging Waiver Services.

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Requirements Document Exhibit	DDD(1) - Covered Services List	238	"Behavior therapy services include the completion of a functional behavioral assessment; the development of an individualized, comprehensive behavioral support plan; and the provision of training to individuals, family members and direct service providers. Services include consultation, monitoring the implementation of the behavioral support plan and revising the plan as necessary. Behavior therapy services are provided by a licensed psychologist, licensed social worker, behavior specialist, or licensed professional counselor. A masters level clinician without licensure, certification or registration, must be supervised by a licensed psychologist, licensed social worker, licensed professional counselor or licensed behavior analyst"	In the last sentence, the PA license is behavior specialist not behavior analyst- it could confuse managed care companies. In addition in the sixth line license should appear just after behavior specialist (e.g., behavior specialist licensed), so that it is completely clear only licensed professionals for independent practice in the programs.	Joseph Cautilli, Ph.D.Licensed Psychologist Licensed Professional Counselor Licensed Behavior Specialist Board Certified Behavior Analyst at Doctoral Level Certified Brain Injury Specialist
Requirements Document Exhibit	DDD(1) - Covered Services List	238	In addition, issues of behavioral medicine type are rampant in the elderly population and some ground rules for diagnostics could avoid criticism and turf war problems between groups. For example including:	I think the above might provide physicians with reassurance that psychologists (the only member of the mental health group presented in that paragraph on page 238, who can prescribe) will not be muscling in on their turf. I believe it to be inline with the PA State Board of Psychology's position but you might want to write them to make sure I am correct.	Joseph Cautilli, Ph.D.Licensed Psychologist Licensed Professional Counselor Licensed Behavior Specialist Board Certified Behavior Analyst at Doctoral Level Certified Brain Injury Specialist
Requirements Document Exhibit	DDD(1) - Covered Services List	238	"A licensed psychologist may diagnose, perform or directly supervise interventions including biofeedback and behavior modification services in clinical setting as a component of psychological service for behavioral health disorders. Prior to medical evaluation and supervision are not required. On the other hand, a licensed psychologist shall not diagnosis or design treatment for a medical condition including Alzheimer's Disease that has not been medically evaluated prior. This includes issues of pain and anorexia. Following evaluation, a licensed psychologist may prescribe or perform behavior analytic interventions or behavior modification treatment in consultation of a non-medical nature with a physician, as a component of an integrated approach for a problem such as spinal injury, brain injury or pain which may be reasonably amendable to such treatment as evidence based literature suggests."	In addition, I think it might be helpful to restate, as people may be lining up to treat the elderly for the first time that records must be kept for seven years post treatment even if the client pass away.	Joseph Cautilli, Ph.D.Licensed Psychologist Licensed Professional Counselor Licensed Behavior Specialist Board Certified Behavior Analyst at Doctoral Level Certified Brain Injury Specialist

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RFP	General Information			The last few years of my life have been terrible in my life because of the OLT decision to single source financial management services, but it hasn't all been bad. I would like to see it be possible to have new employees fill out all of their employment package online. This would need to be a part of the system that the consumer would have a password to. This should speed up the hiring process a great deal because the financial management agency wouldn't have to wait for the hiring package to come through the mail and the application would already be typed in the computer and it only takes one day for a background check. If this was possible, it would be reasonable to require that the new employee would be able to start within a week of the submission. Of course consumers would still need to be able to submit applications by mail, because not all consumers have computer and internet access or the knowledge of how to do this. This would also free up the agency's time that they could use to more rapidly process the application sent by mail and they should be able to allow those consumers to hire a new employee within a week of receiving those applications in the mail. Another serious problem with PPL was that they were stealing money from the state. With the help of my congressman, I was able to prove this and OLTL started making them produce more reports to me and I assume other consumers so that we could keep a closer eye on what was being charged to the state. This stopped some of the irregularities that were coming from PPL. After that was done I only saw one or two places where PPL may have been stealing money. With Medicare I get a statement every couple of months that tells me what has been turned in for reimbursement making it possible for me to question any charge that I think is fraudulent. Maybe it would be a good idea for all of PA medicaid to send out this type of report it may help stop some of the medicaid fraud. Thanks for listening. I am hopeful that 2016 will be a much better year since we will have a choice of financial management providers. Competition drive quality much better than single source contracts	Linda Coastal, consumer
Requirements Document	Section V.J. - Service Coordination			First, it is my belief that the consumer should be given a choice whether their service coordination is done through a MCO or is done contracted out through a service coordination entity. One way the state can assure this choice is given is to have each of the MCOs set up in different models. What I mean by that is, because I don't know if model is the correct term, one could have a MCO that does the service coordinating themselves but then have another one to still subcontract it out so people wont have to be so afraid of the change over. It is my belief that some familiarity should be kept under this new system so it will alleviate some fears consumers have moving forward. The other reason why I believe it is vital that service coordinating entities be kept in the state of Pennsylvania is because a lot of physically disabled people are employed by these agencies and if the state is concerned about improving the disability employment rate, shutting down service coordinating entities would only hinder that employment rate further. Another question along those same lines is will the MCOs have to employ a certain percentage of physically disabled workers. I believe this should be mandatory because who would be a better advocate for the disabled than someone who truly knows and understands what it is like to have a disability.	Tanya Teglo, consumer
				Redacted	Redacted
				Redacted	Redacted

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Other				I have not commented on publicly too much yet because I am trying to be fair and not overly critical when I say this, but I believe that something should be done to make consumers have to be accountable for the resources and services that they use to ensure they are using them responsibly. Let me be clear on one thing: I am not talking about the type of time cards that were used under Christian Financial Management where they wanted to track how many times a day you went to the bathroom and other demeaning measures. The type of accountability I am speaking of would be the type where under the new program, consumers actually have to accomplish some sort of goal whether it be big or small with the services and resources they are provided. I believe that this would help people feel better physically, emotionally, and psychologically. I am going to be honest about something: for the life of me, I cannot understand why some consumers, who shall remain nameless at this point, receive 90 plus hours of care a week when they make no effort to even get up and get dressed on a daily basis, but they receive all kinds of time for personal hygiene and dressing usage. How is that time being used wisely and why would those individuals be given all of those resources when they choose to do nothing but sit in a recliner all day and feel sorry for themselves. Should we really go that soft on them just because they are disabled, or should we do something to ensure that that person is being at least a little bit active. As long as it is medically deemed necessary and necessary for their growth as a human being within the community in which they live, I do not have a problem with someone having a high amount of hours. I believe we as individuals and we as a people have a duty to try to reach our full potential and to give back in our own unique ways, and I truly believe from the bottom of my heart if the surrounding communities of people who are not disabled, saw disabled people trying to be a part of the community more all the stereotypes would then change.	Tanya Teglo, consumer
Requirements Document	Section V.J. - Service Coordination	29		Describe how your CHC-MCO will work with each of the different CHC populations and their different needs with particular emphasis on the different strategies for the nursing facility clinically eligible population and nursing facility ineligible population It is recommended that DeafBlind Services be specifically addressed here similar to words used in the Draft RFP, for example.....Describe how you will meet accessibility standards within your provider network for Participants who require reasonable accommodations. Specifically address physical accessibility and cognitive accessibility	Theo Braddy, CEO, Center for Independent Living of Central PA
Requirements Document	Section V.M.- Coordination of Services			Persons wanting to become SSPs must be trained in skills of Orientation & Mobility (O&M) methods, communication facilitation, providing environmental and visual information, and on skills specific to persons who are DeafBlind. This will create a pool of qualified SSPs to work with persons who are DeafBlind (similar to having trained attendants to work with person with physical disabilities). Persons who are DeafBlind must be trained on the use of SSPs, how to manage SSPs such as arranging for SSP services, submitting invoices, use of weekly-allocated hours, (again very similar to the agency or consumer model of attendant care services). There needs to be a coordinating entity who is responsible for oversight that includes ongoing training of SSPs in order to ensure enough SSPs are available for use, that persons who are DeafBlind are trained, handle ongoing issues that may develop, provide continued education of community and state agencies on reasonable accommodations, provide continuing education to trained SSPs, and processing invoices and payments to SSPs.	Theo Braddy, CEO, Center for Independent Living of Central PA
Requirements Document	Section V.M.- Coordination of Services			If this is the option selected, then certain things must be better addressed and described in details such as: How will the MCOs be trained on needs of this specialized group of persons who are DeafBlind? How will Service Coordinators be trained? How will there be continued recruitment of qualified persons to become SSP? How to assess and re-assess SSP's skills and knowledge of persons who are DeafBlind? How to train qualified SSP's to work with persons who are DeafBlind with additional disabilities such as Intellectual Disabilities or physical needs? How will the Independent Enrollment Entity be trained to determine eligibility? How will people who are DeafBlind be educated on the rollout of managed care?	Theo Braddy, CEO, Center for Independent Living of Central PA

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Requirements Document	Section V.A. - Covered Services			SSPs are typically trained paid independent contractors that provide a number of vital services to persons who DeafBlind. These services include, but are not limited to: Human Guide to Assist with Errands: For example: going to get a haircut, picking up dry cleaning, buying stamps at the Post Office, buying clothes or shoes, or going to a Job Bank to pick up job application forms. Reading Mail: The SSP can read mail or written materials to the person who is deaf-blind in ASL, PSE, or English. The SSP is not responsible for interpreting or explaining this information. The SSP will sort the mail and read the bills first. Assistance with Food Shopping: Guiding in the food store and providing visual information – What is there? What's on sale? How much does it cost? What does it look like? Reading labels, etc. The person who is deaf-blind must be able to decide what foods to buy and how to pay for it. Assist with Basic Banking: The SSP can assist with things like writing deposits or withdrawal slips and reading bank statements.	Theo Braddy, CEO, Center for Independent Living of Central PA
Requirements Document	Section V.A. - Covered Services	A.17		NFCE eligible individuals should have choice in locus of care (i.e. HCBS or nursing facility).	Steve Touzell, Philadelphia Corporation for Aging
Requirements Document	Section V.A. - Covered Services	A.20		The LOC instrument should have domains to determine both level and locus of care.	Steve Touzell, Philadelphia Corporation for Aging
Requirements Document	Section V.C. - Continuity of Care			The continuity of care for transitioning waiver participants should be for one (1) year (not 180 days).	Steve Touzell, Philadelphia Corporation for Aging
Requirements Document	Section V.J. - Service Coordination			DHS should prescribe service coordination staffing and caseload ratios and participant contact frequency requirements.	Steve Touzell, Philadelphia Corporation for Aging
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements			SC and SCS requirements should mirror those established under Act 22.	Steve Touzell, Philadelphia Corporation for Aging
Requirements Document Exhibit	DDD(1) - Covered Services List			Interpreter services should be added to the list of CHC LTSS benefits, including services to support limited english proficiency and visually and hearing impaired participants.	Steve Touzell, Philadelphia Corporation for Aging
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Service Coordination	The annual recertification / Level of Care Determination should be conducted by the LOC entity (not by the service coordinator).		Steve Touzell, Philadelphia Corporation for Aging
Other		General Comment		Clarify/specify roles between BH MCOs and CHC MCOs. Idnentify circumstances under which each MCO would be the primary payer.	Blair Senior Services, Inc.
Requirements Document	Section V.C. - Continuity of Care	39		Extend continuity of care period to 2 years insterad of 180 days	Blair Senior Services, Inc.
Requirements Document	Section V.D. - Choice of Provider	44-46	SC and supervisory requirements	Adopt those as provided for in Chapter 52.	Blair Senior Services, Inc.
Requirements Document Exhibit	DD - Participant Handbook	84	CHC MCO must offer choice of at least 2 SCs.	Clarify whether that means 2 SCEs or 2 SC within the same SCE. The latter provides significantly more choice and is what we'd advocate for.	Blair Senior Services, Inc.
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	Providing assistance to participants with disabilities.	Provide that same assistance to older adults with imparments that impact their ability to effectively represent themselves.	Blair Senior Services, Inc.

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		SC conduct re-evaluation of level of acre annually.	To avoid potential conflict of interest, clarifiy that annual level of care redetermiantions are conducted by LCD entity vs. SCE	Blair Senior Services, Inc.
Requirements Document	Section V.A. - Covered Services	7. Behavioral Health Services p 29	All Participants who need behavioral health services will obtain these services from the Behavioral Health Managed Care Organizations (BH-MCOs). The CHC-MCO must coordinate with the BH-MCO as necessary to ensure that Participants receive all Medically Necessary Behavioral Health Services	Dual eligible participants will have either Medicare FFS as primary insurance, or be enrolled in a D-SNP. Please clarify how CHC recipients will obtain their behavioral health services from the Medicaid BH-MCO. How will the Medicaid BH-MCO be expected to care manage and/or prior authorize Medicare funded primary services such as inpatient, partial hospitalization, or outpatient level of care?	Daniel Eisenhauer, Dauphin County MH/ID Administrator
Requirements Document	Section V.A. - Covered Services	15. Transportation page 32	The CHC-MCO must provide all Medically Necessary emergency ambulance transportation, all Medically Necessary non- emergency ambulance transportation, and non-medical transportation. Non-Medical Transportation includes transportation to community activities, grocery shopping, religious services, and other activities as specified in the Participant's Person-Centered Service Plan.	Will the Department require or encourage CHC's to contract with exiting Shared Ride Transportation providers? Will CHC MCO's be the responsible payment entity for persons eligible for AAA/ lottery funded shared ride services?	Daniel Eisenhauer, Dauphin County MH/ID Administrator
Requirements Document	Section V.B. - Prior Authorization of Services	H. Person-Centered Service Plans p 41	PCSPs must be developed for all Participants who have had comprehensive needs assessments. Each PCSP must address how the Participant's physical and behavioral health needs and conditions will be managed by the CHC-MCO and how services will be coordinated by the Service Coordinators.	Can you clarify whether Dual Eligible participants who are NOT assessed as NFCE must also have a person centered plan and team.	Daniel Eisenhauer, Dauphin County MH/ID Administrator
Requirements Document	Section V.B. - Prior Authorization of Services	I Department review of Changes in Service plans page 43	The Department may review and revise any Person-Centered Service Plan. The CHC-MCO must provide the Department with weekly aggregate reports on PCSP changes.	This statement is not consistent with the concept of person centered planning. It is unclear why there is a requirement for a person centered planning team and person centered plan if the Department can negate or override the team's plan without being part of the team, nor having service authorization responsibility at the CHC MCO plan level. Some individuals with chronic conditions needs may change and temporarily require intensive services such as inpatient care which are addressed through UM/UR processes in real time. Why must the department be apprised weekly of person centered plan changes? What will the Department do with the aggregate information collected regarding changes to the plans?	Daniel Eisenhauer, Dauphin County MH/ID Administrator

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Requirements Document	Section V.B. - Prior Authorization of Services	J. Service Coordination page 43	Service Coordinators are responsible for assisting Participants in obtaining the services that they need. Service Coordinators lead the Person-Centered Service Planning process and oversee the implementation of PCSPs. CHC-MCOs must annually submit and obtain Department approval of their Service Coordination staffing, Participant contact plan, caseloads, the required frequency of in-person contact with Participants, and how Service Coordinators share and receive real-time information about Participants and Participant encounters.	How does the Department want CHC MCOs and Service Coordinators to collaborate with mental health targeted case managers who are Medicaid funded as an in plan service in Medicaid HealthChoices. Some Dual Eligible consumers with a mental health diagnosis have a targeted case manager who is also responsible for service planning and service coordination and have consumer contact standards defined by PA Code Title 55 Chapter 5221 regulations.	Daniel Eisenhauer, Dauphin County MH/ID Administrator
Other	Proposal Requirements	Service Coordination Page 7	Delineates Service Coordinator, Supervisor Qualifications and training requirements	PA LSW Education requirement is a Master's or Doctoral degree in Social Work or Social Welfare from a CSE-accredited program and LSW Exam Association of Social Work Boards Master's Level Examination Field requirement of 3 years or 3,000 hours of supervised clincial experience. Most Service Coordinator Supervisors are not licensed social workers but have the necessary experience and social work/social welfare education to serve in the capacity of Service Coordinator Supervisor. This requirement will make many current Service Coordinator Supervisors ineligible . REcommendation is to continue with existing Service Coordination Supervisor criteria outlined in 55 PA Code Chapter 52 Long Term Living Home and Community Based Services S52.27 2b	Area Agency on Aging for the Counties of Bradford, Sullivan, Susquehanna and Tioga 220 Main Street, Unit 2 Towanda, PA 18848 Marlea K Hoyt, AAA Executive Director 570-265-6121
			CHC Request for Proposal and Draft Agreement: All Service Coordinator Supervisors must be employed by the CHC-MCO or a service coordination entity under contract with the CHC-MCO and must be: a licensed social worker with at least 5 years kof relevant experience or a registered nurse with at least 5 years kof relevant experience.		Area Agency on Aging for the Counties of Bradford, Sullivan, Susquehanna and Tioga 220 Main Street, Unit 2 Towanda, PA 18848 Marlea K Hoyt, AAA Executive Director 570-265-6121
Other			Community Care would like to acknowledge all the prior work that the Department has carried out as the Community HealthChoices program has moved from the public hearing phase through concept and on to the program requirements and RFP development. We appreciate the recognition and corresponding responsibility of the Behavioral Health Managed Care Organizations (BH-MCOs) role within Community HealthChoices, and look forward to working with the chosen CHC-MCO partners within the respective zones for a truly integrated and collaborative health service system.		James Gavin President and CEO of Community Care Behavorial Health

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Other			We recognize and support the Program Requirements for CHC-MCOs to coordinate behavioral health service needs for CHC members through the BH-MCOs, and we will work with respective CHC-MCO Service Coordinators. The inclusion of a Behavioral Health Coordinator within the CHC-MCO Administrative Component is welcomed, as well as requirements for primary care physicians within the CHC networks to collaborate actively with behavioral health providers and data sharing between CHC-MCOs and BH-MCOs. Additionally, we appreciate the inclusion of behavioral health representation on the required Education and Outreach Committee, Pharmaceutical utilization coordination between CHC-MCOs and BH-MCOs, and the need for a CHC-MCO Training Plan which includes the identification and appropriate referral processes for behavioral health needs of members		James Gavin President and CEO of Community Care Behavorial Health
Other		General Comment		**Intent/Definition of Service Coordination**-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program.	M. Veil Griffith, Ed.D, Administrator Cambria County Area Agency on Aging
Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	M. Veil Griffith, Ed.D, Administrator Cambria County Area Agency on Aging
Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems-** The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	M. Veil Griffith, Ed.D, Administrator Cambria County Area Agency on Aging
Requirements Document	Section V.C. - Continuity of Care	p. 39	...the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	**Continuity of Care for LTSS Participants**-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	M. Veil Griffith, Ed.D, Administrator Cambria County Area Agency on Aging

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Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	**Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors**-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	M. Veil Griffith, Ed.D, Administrator Cambria County Area Agency on Aging
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	**Limited English Proficiency Requirements**- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	M. Veil Griffith, Ed.D, Administrator Cambria County Area Agency on Aging
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	**Management Information Systems**-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	M. Veil Griffith, Ed.D, Administrator Cambria County Area Agency on Aging
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	M. Veil Griffith, Ed.D, Administrator Cambria County Area Agency on Aging
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	**Willing Provider Definition –** In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	M. Veil Griffith, Ed.D, Administrator Cambria County Area Agency on Aging
Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department** – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	M. Veil Griffith, Ed.D, Administrator Cambria County Area Agency on Aging

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Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	M. Veil Griffith, Ed.D, Administrator Cambria County Area Agency on Aging
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	M. Veil Griffith, Ed.D, Administrator Cambria County Area Agency on Aging
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	M. Veil Griffith, Ed.D, Administrator Cambria County Area Agency on Aging
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	M. Veil Griffith, Ed.D, Administrator Cambria County Area Agency on Aging
RFP	Work Statement Questionnaire	PARTICIPANT SERVICE AND CARE COORDINATION, # 11, page 30	Describe your organization's experience and your plan for using technology such as assistive technology, telehealth, telecare, social media, electronic visit verification, and other methods to deliver services to the CHC Participants.	First Data suggests adding Electronic Visit Verification (EVV) as a requirement in your final Community HealthChoices RFP and not an optional offering. For more information please see the attached Word document "Draft RFP Comments."	First Data / Dan McCurdy

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Other				First Data Government Solutions, LP appreciates the opportunity to comment on the Draft RFP for Community HealthChoices (CHC) First Data suggests adding Electronic Visit Verification (EVV) as a requirement in your final Community HealthChoices RFP and not an optional offering. First Data understands Pennsylvania's desire to improve efficiency and accountability within Medicaid and believes that we can bring significant value to this program through our Electronic Visit Verification solution, AuthentiCare® . This has been made evident in other States, where AuthentiCare® has provided a significant ROI: • Included with this response is a budgetary impact study by the State of Oklahoma. This study compared the programs expenditures prior to the implementation of EVV vs. three years of AuthentiCare activity. You'll see the Department of Human services in that State realized a 500 % + return on investment by implementing AuthentiCare. • Included with this response is a case study completed by a Veterans Administration Medical Center after the implementation of AuthentiCare. You'll see that one of the improvements they recognized was reducing the wait list. More veterans were able to be served within the same program budget. We have the capability of integrating our AuthentiCare® EVV solution with any managed care organization (MCO), FMS vendor or state MMIS system to assist in delivering the goals of: • Reduced cost of delivered services • Being able to deliver services to more consumers within existing budgets • Reduced fraud, waste and abuse • Supporting patient-centered care • Improved efficiency of the Medicaid waivers • Improved provider experience First Data's EVV product also supports automated claims creation, review, confirmation, and submission. Furthermore, AuthentiCare features a portal for the upload of EDI 835 remittance data, which allows visibility to a full cycle of claims payment through AuthentiCare's reporting for the provider and other key stakeholders. To simplify understanding for Providers, AuthentiCare has been designed to be simple and intuitive to use. Even though there may be a set of Providers with back office systems which have some EVV capability, a single EVV system like AuthentiCare® is optimal for the state, especially now with the new DOL overtime rulings. For purposes of oversight, reduction of fraud, waste and abuse, for audit and for reviews of compliance with DOL homecare worker guidelines - all are much easier if done within one common system across the state. In those states where EVV has been mandated or 'recommended' and assigned to each Provider for their own solution, many of the common state functions become quite challenging and some are now evaluating the option of using a single solution. Using a single, hosted EVV solution like AuthentiCare® provides for comprehensive and consistent oversight, common training and reporting for state agencies, and data scoping to each user's role. Training can be provided to different stakeholders,	First Data / Dan McCurdy

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				such as Audit and AG office staff to ensure they can easily get the reporting they need to complete their reviews in a common system. First Data's AuthentiCare® EVV product increases visibility into Medicaid programs, which in turn, promotes accountability of agency providers, FMS providers, and other invested stakeholders. Oversight, which creates additional accountability includes: • Electronic Visit Verification of accurate check-in and check-out times, along with confirmation of the worker delivering the services in an approved location, such as the client's home. • Identify overlapping services to avoid duplicate payments. • Ensure that service is provided in approved locations based on caller ID/GPS location matching and flagging any conflicts. • Real-time interactive dashboards provide claim status and scheduled visit status. AuthentiCare's reporting capabilities also give real-time access to critical data elements. • Review of healthcare workers across the state, to ensure, through a single worker ID, that those workers who may be working for more than one employer is getting tracked for total hours and services. • Through cadenced, escalating alerts, visits can be confirmed as being delivered at the appropriate/scheduled times, or backup workers can be assigned as necessary to ensure adequate levels of service are delivered. • Through comparison of late/missed visit reporting, reviews can be completed to ensure that consumers are receiving services approved and authorized in their Plan of Care. • Through the use of voice biometric identification, stakeholders can be assured that the licensed/approved worker is the one reporting the service visit. First Data is recommending AuthentiCare to improve the quality, efficiency and number of recipients served through our EVV technology solution. One single EVV solution provides an overall program view. Authenticare is a scalable single system providing many benefits, such as: - Real time email notifications of late and missed visits of services to clients, - Real-time provider, worker and claims exception dashboards for faster tracking and issue resolution, - Mobile application support options for Limited Service Zone coverage, and others. First Data would be glad to demonstrate our end-to-end EVV integrated solution for Pennsylvania.	
Requirements Document	Section V.M.- Coordination of Services			I think we need to give the MCO guidance as to how to coordinate benefits. The way Medicaid work is entirely different than the way medicare works.	Drew Nagele
Other		EPSTD		I was very disappointed to see age was raised to 21. Here is why: EPSTD only covers individuals in school and when if you graduate school, EPSTD stops and also for individuals who are in school and stay in school until they are 21, it only covers partial hours, so for me, myself, I had no learning disability so I wanted to and had to graduate at age 18 the Governor has a huge push on for the employment of people with disabilities, and I think several things in the proposal, this being one of the main ones, you are basically saying you want to employ people with disabilities, but then you are telling 18-year-olds, I'm sorry, you have to wait until you are 21 to start college. Basically, I used attendant care right after I graduated to go to college and be successful. I can't imagine waiting three years, that would put off my employment journey and I mean, that just puts everything off until age 21 to even start. People would get very they could get very discouraged in the waiting. I would ask for, if that can't be changed, at least an exception be made for those who are looking for employment and need to start college or for those who EPSTD doesn't cover home modifications. So for those in danger of going into nursing facility because home modifications are not covered, please consider at least an exception to that rule.	Jennifer Howell/Consumer MLTSS member

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RFP	Proposal Requirements	v.k	Educational requirements for sc & supervisors	Prior & established sc & supervisors should be exempt from new educational requirements, based on years of job performance & prior accepted educational accomplishments of a bachelor degree in any related human services field. SC & Supervisors especially have years of experience in successfully assisting in consumer day to day individual situations, concerns, community resources and training that a proposed required level of education does not always ensure. This proposed change globally would impact consumers, and providers by ignoring the thousands of relationships that sc's and supervisors have in their communities that they serve. Also, I AM TIRED OF WATCHING HARD WORKING EMPLOYEED CITIZENS OF PENNSYLANIA LOSE THEIR JOBS THRU BUREAUCRATIC POLICIES, WHEN WE DO OUR JOBS!	Service Coordination Unlimited
Other		General Comment		**Intent/Definition of Service Coordination**-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program.	Potter County Human Services Area Agency on Aging; P.O. Box 241, 62 North St, Roulette, PA 16746
Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	Potter County Human Services Area Agency on Aging
Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems-** The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	Potter County Human Services Area Agency on Aging
Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	**Continuity of Care for LTSS Participants**-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	Potter County Human Services Area Agency on Aging
Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	**Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors**-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	Potter County Human Services Area Agency on Aging
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	**Limited English Proficiency Requirements**- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	Potter County Human Services Area Agency on Aging
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	**Management Information Systems**-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	Potter County Human Services Area Agency on Aging

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Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	Potter County Human Services Area Agency on Aging
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	**Willing Provider Definition –** In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	Potter County Human Services Area Agency on Aging
Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department** – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	Potter County Human Services Area Agency on Aging
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	Potter County Human Services Area Agency on Aging
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	Potter County Human Services Area Agency on Aging
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	Potter County Human Services Area Agency on Aging

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RFP	Work Statement Questionnaire			My comments are directed to the Work Statement Section of the RFP. Iwould ask that RFP requires all respondents to provide information regarding their experiences with identifying and serving the unique needs of people with serious Neuro Muscular/neurological disorders. The respondents should include their approach to coordinating care for individuals with severe physical disabilities and mobility impairments. Co-mobidities of cognitive and behavioral difficulties must be addressed. My comments are prompted by many years of experience in serving individuals with diagnoses such as Cerebral Palsy, Spina Bifida and Multiple Sclerosis.	Dawne Kramer, RN,NHA
RFP	Work Statement Questionnaire			In responding to the Commonwealth's plan to coordinate health and long term services and support systems (LTSS) for older Pennsylvanians and adults with disabilities through their proposed Community HealthChoices Program, Margaret E. Moul Home (MEMH), a Special Rehabilitation Facility (SRF) of Peer Group 13 would like to offer the following. Because of the complicated and complex medical and behavioral issues of this population, the focus for the SRF resident needs is very individualized. SRFs must maintain residents' functional mobility, basic ADLs, and maximize their quality of life, including helping them develop psycho-social skills. Considering the younger age of the SRF resident, the length of stay and the age-appropriate interests shared, quality of life is integral to their well-being.Along with the primary neuromuscular/neurological disorders, secondary diagnoses of spasticity, seizure disorders, intellectual disabilities and mental health issues are much more commonly seen in the SRF than in a traditional SNF. Managing these conditions requires a highly trained and specialized, skilled interdisciplinary team of professionals.	Dawne Kramer, RN,NHA

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Requirements Document	Section V.P. - Participant Services			The neurological/neuromuscul ar disorders combined with the complex co-morbidities of SRF residents are not captured in the current CMI calculation methods or the proposed Community HealthChoices managed care rate model. The rate setting must, in some way, be all inclusive of the extensive needs of this population. Needs such as: • Specialized, customized motorized wheelchairs with complex seating and individualized molding that requires frequent modifications, expensive repairs to and replacement of the electronics involved in the drive controls and proximity switches. • Transferring residents from bed to chair and then to toilet requires mechanical lifts, additional staff, specialized positioning devices and extensive and ongoing safety training for care-givers. • Variety of AAC (assistive augmentative communication devices) and ECU (environmental control units) components, technology and therapeutic support of highly skilled therapists familiar with the needs of the physically disabled adult. These staff members help the residents to learn to use these devices and adaptations, so that they may maximize their independence. • Multiple adaptive equipment needs for eating and drinking, assistance with elimination needs and daily hygiene. • Swallowing and chewing difficulties often result in one on one feeding situations, prolonged feeding times, provision of textured diets acceptable to the resident, aspiration risks. Many residents of the SRFs eventually require enteral feedings as the risk of aspiration and pneumonia becomes more severe. • Maintaining skin integrity despite tone,contractures, spasticity and difficulty positioning requires additional preventative measures, frequent repositioning, costly pressure relieving devices in wheelchairs and bed, tilt mechanism on wheelchairs. The Special Rehabilitation Facilities of Peer Group 13 request that the Department of Human Services continues to maintain its current recognition of the extraordinary needs of SRF residents through a special reimbursement arrangement with SRF providers, untila team of SRF representatives and OHS staff can develop a modified method of reimbursement calculation. We propose working together to develop a payment system that recognizes the costs associated with caring for the needs of SRF residents, preserves the identity of the Peer Group, is accurate and equitable, promotes cost effective care delivery and use of resources, maximizes Medicaid expenditures and is supportive of care in different Commonwealth markets. The four Special Rehabilitation Facilities of Peer Group 13 look forward to proactively partnering with OHS to create a system that will allow a predictable, reasonable and sustainable budgeting and operating process for both OHS and the providers.	Dawne Kramer, RN,NHA
Other		General Comment		**Intent/Definition of Service Coordination**-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program.	Aging Services, Inc.
Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	Aging Services, Inc.
Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems-** The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	Aging Services, Inc.

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Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	**Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors**-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	Aging Services, Inc.
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	**Limited English Proficiency Requirements**- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	Aging Services, Inc.
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	**Management Information Systems**-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	Aging Services, Inc.
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	Aging Services, Inc.
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	**Willing Provider Definition –** In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	Aging Services, Inc.
Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department** – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	Aging Services, Inc.

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Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	Aging Services, Inc.
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	Aging Services, Inc.
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	Aging Services, Inc.
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	Aging Services, Inc.
RFP	Work Statement	II-5, Participant Service & Care Coordination, page 30	No current language is present	Add a separate, additional number to the Work Statement section that requests the Offeror to provide a response to the following: "Describe your experience with and approach for screening to identify people with neurological/neuromuscular disorders that include mobility impairments and are often complicated by physical, cognitive and/or behavioral co-morbidities, whether acquired or developed. Describe your approach to meeting the medical and behavioral health needs, including rehabilitation and communication, of this population.	Good Shepherd Rehabilitation Network/John Kristel
RFP	Section II - Definitions	II-5, Quality Improvement & Performance Measures, page 34	No current language is present	Add a separate, additional number to the Work Statement section that requests the Offeror to provide a response to the following: "Describe your strategies for addressing the needs of participants with neurological/neuromuscular disorders, whether acquired or developed, that include mobility impairments and are often complicated by cognitive, physical and/or behavioral co-morbidities."	Good Shepherd Rehabilitation Network/John Kristel

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Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	K , Page 44	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology or other related field and at least three years of experience in the coordination of services. All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience. Service Coordinators and Service Coordinator Supervisors must also complete Department-approved training in required training topics.	The recommendation is for removal of the proposed language about additional education requirements for Support Coordinators and Supervisors. The Act 22 requirements should be maintained for educational requirements. In addition OLTL should require successful completion of an OLTL approved Case Management Certification Program such as the Commission for Case Manager Certification. Require all SC Supervisors to gain certification within their 6 months of hire and all SC's to gain certification within 1 years. Maintain the current Act 22 requirements but with the addition of requiring that SC Supervisors have five years of experience within the field of human services. Finally, a documented training menu should be developed for all staff to complete within their first 30 days of hire. Support Coordination Entities should also be required to maintain an active relationship with a Licensed Social Worker similar to the relationship currently required with a Registered Nurse.	Service Access and Management, Inc
RFP	Proposal Requirements	II-4, Page 26	Full time positions for executive management mean full time positions dedicated to the CHC Program in Pennsylvania. For the Administrator, Chief Financial Officer, Medical Director, Pharmacy Director, CHC Program Manager, Director of LTSS, Director of Quality Management and Utilization Management, and the Information Systems Coordinator, please provide the following information for each position	For bidders without current operations in the state, it can be difficult to commit to specific leadership this far out from launch. Will the state allow proposers to respond to section A questions 1-3 using details for individuals serving in leadership positions in similar operational circumastances or use temporary or interim executive management staff until permanent executive management staff are appointed?	WellCare Health Plans, Inc.
RFP	Proposal Requirements	II-4, Page 27	The Offeror must describe the role of board members in governance and policy making and specify the manner in which Participants will be represented in an advisory and decision making capacity for the CHC zones. In accordance with Pennsylvania DOH regulations, one-third of the board's membership must be "subscribers" of the CHC-MCO.	Please consider including a clear definition of the word "subscribers" from this section.	WellCare Health Plans, Inc.

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RFP	Proposal Requirements	11-10, Page 46	As part of the Technical Submittal, the Offeror should provide the following information: a. County where the Offeror's headquarters is located if in Pennsylvania. b. The name, title, telephone number, mailing, and email address of the contact person for the CPP. c. Mailing address for all satellite offices located in Pennsylvania, including the county. d. Type of business entity. (i.e. not for profit, government entity, public corporation, university). e. If a subcontractor will provide the primary services, list the company name and mailing address for offices located in Pennsylvania, including the county. f. Type of positions needed for this project. Please specify management or nonmanagement positions.	Please consider including additional clarification and instructions for respondents who do not have a current operational presence in the Commonwealth to respond to this section.	WellCare Health Plans, Inc.
RFP	Proposal Requirements	Cover Page, Page 15	**Cover Page:** One (1) CD-ROM/flash drive containing a copy of the Technical Submittal, withredacted Financial Capability information and Offeror identified confidential proprietary or trade secret information; in Microsoft Office or Microsoft Office compatible format. **Page 15:** To the extent that an Offeror designates information as confidential or proprietary or trade secret protected in accordance with RFP Part I, Section I-19, the Offeror must also include one (1) redacted version of the Technical Submittal, also excluding Financial Capability on CD-ROM or flash drive in Microsoft Office or Microsoft Office-compatible format.	The language on the cover page seems to indicate we must submit a redacted version of the response accounting for confidential or pripietary information. The language on Page 15 seems to indicate it is optional only if we have confidential or prorietary information that we want redacted. Could the state assist by clarifying in one section or the other whether this extra version is indeed required if there is not any redacted information in the response?	WellCare Health Plans, Inc.
RFP	Work Statement Questionnaire	Participant Service and Care Coordination, page 30	11. Describe your organization's experience and your plan for using technology such as assistive technology, telehealth, telecare, social media, electronic visit verification, and other methods to deliver services to the CHC Participants.	In order to ensure CHC includes EVV technology as a base component to support a person-based approach, identify gaps in care, improve care coordination, and support performance incentives and quality improvement, we recommend that the commonwealth remove the words "such as" from this item or include a separate item to specifically ask submitting organizations about their experience and plan to utilize EVV technology. Please see Sandata's Draft CHC RFP Detail document for more explanation.	Sandata Technologies, LLC

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RFP	Work Statement Questionnaire	Quality Improvement and Performance Measures, page 34	The draft RFP does not address the responding vendor's ability to collect EVV data and/or report on missed/late visits and percent of visit auto-verified.	We recommend that the commonwealth include requirements for submitting organizations to be able to: • Report percentage of missed/late visits (supports participants actually receiving the care they need); and • Report percentage of visits auto-verified using EVV (helps ensure only authorized visits are reimbursed). Please see Sandata's Draft CHC RFP Detail document for more explanation.	Sandata Technologies, LLC
RFP	Work Statement Questionnaire	Provider Network Composition and Network Management, page 39 - 42	The draft RFP does not address the responding vendor's ability to collect and store HCBS caregiver credentialing information and prevent caregivers from delivering services unless service credentials are met.	Sandata recommends DHS and PDA include requirements for CHC MCOs to: • Capture and report caregiver credential information such as CPR cards, licensure, and completed training to ensure individual network caregivers meet key compliance criteria; • Prevent caregivers from delivering services until/unless service credentials are met; and • Confirm provider agency and individual caregivers are not currently excluded from participation in Medicaid programs by matching EVV provider data against exclusion and sanction lists. Please see Sandata's Draft CHC RFP Detail document for more explanation.	Sandata Technologies, LLC
Other		General Comment		**Intent/Definition of Service Coordination**-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program.	AAA of Somerset County is in support of the DHS' goal to implement CHC. We believe in proiding freeedom of choice for services, and sustaining quality services.
Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	AAA of Somerset County is in support of the DHS' goal to implement CHC. We believe in proiding freeedom of choice for services, and sustaining quality services.
Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems-** The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	AAA of Somerset County is in support of the DHS' goal to implement CHC. We believe in proiding freeedom of choice for services, and sustaining quality services.
Requirements Document	Section V.C. - Continuity of Care	p. 39	...the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	**Continuity of Care for LTSS Participants**-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	AAA of Somerset County is in support of the DHS' goal to implement CHC. We believe in proiding freeedom of choice for services, and sustaining quality services.
Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- ...All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	**Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors**-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	AAA of Somerset County is in support of the DHS' goal to implement CHC. We believe in proiding freeedom of choice for services, and sustaining quality services.
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	**Limited English Proficiency Requirements**- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	AAA of Somerset County is in support of the DHS' goal to implement CHC. We believe in proiding freeedom of choice for services, and sustaining quality services.

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Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	**Management Information Systems**-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	AAA of Somerset County is in support of the DHS' goal to implement CHC. We believe in proiding freeedom of choice for services, and sustaining quality services.
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	AAA of Somerset County is in support of the DHS' goal to implement CHC. We believe in proiding freeedom of choice for services, and sustaining quality services.
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	**Willing Provider Definition –** In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	AAA of Somerset County is in support of the DHS' goal to implement CHC. We believe in proiding freeedom of choice for services, and sustaining quality services.
Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department** – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	AAA of Somerset County is in support of the DHS' goal to implement CHC. We believe in proiding freeedom of choice for services, and sustaining quality services.
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	AAA of Somerset County is in support of the DHS' goal to implement CHC. We believe in proiding freeedom of choice for services, and sustaining quality services.
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	e	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	AAA of Somerset County is in support of the DHS' goal to implement CHC. We believe in proiding freeedom of choice for services, and sustaining quality services.

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	AAA of Somerset County is in support of the DHS' goal to implement CHC. We believe in proiding freeedom of choice for services, and sustaining quality services.
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	AAA of Somerset County is in support of the DHS' goal to implement CHC. We believe in proiding freeedom of choice for services, and sustaining quality services.
Requirements Document	Section II - Definitions	Other Related Condition, page 14	A physical disability such as cerebral palsy, epilepsy….	Change: A developmental [strike-out "physical"] disability, other than Intellectual Disability, such as cerebral palsy, epilepsy... Comment: The federal definition, as well as the current OBRA waiver definition, does not limit other related conditions to physical disabilities. It can cover sensory and neurological disabilities, such as autism and anoxic brain injury. It is critical that no person be institutionalized because there is no waiver program that covers them. Also, DHS's proposed definition would cause hundreds of OBRA Waiver participants to lose their services unless it is DHS's intent to shift them to another waiver program.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.A. - Covered Services	A. Covered Services, page 26	The CHC-MCO must ensure that…all LTSS provided are approved in accordance with the requirements of the CHC 1915(c) Waiver.	Comment: Stakeholders must have an opportunity to review, comment on, and discuss the draft CHC waiver well in advance of submission to CMS.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.A. - Covered Services	A. 7. Behavioral Health Services, pages 28-29	All participants who need behavioral health services will obtain these services from the Behavioral Health Managed Care Organizations (BH-MCOs).	Change: All participants who need behavioral health services will obtain these services from the Behavioral Health Managed Care Organizations (BH-MCOs), except to the extent that the services are not available from the BH-MCOs and are included in covered LTSS services. Comment: Counseling and therapy are covered LTSS services, per Exh. DDD.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.A. - Covered Services	A. 17 Nursing Facility Services, page 34	The CHC-MCO must, in coordination with the Department, ensure that all Nursing Facility related processes are completed and monitored. This includes but is not limited to: Preadmission Screening Resident Review (PASRR) process, specialized service delivery, Participant's rights, patient pay liability, personal care accounts or other identified processes.	Comment: This language is vague. There are no standards for each of these processes and no reference to the applicable laws and regulations that contain the standards. There are no standards for the monitoring that needs to occur, for example, what the monitoring entails, the frequency of monitoring, or how violations are corrected. Particularly with respect to specialized service delivery, it is unclear what role the CHC-MCO is expected to play. It is the Department's obligation, not the Nursing Facility's obligation, to ensure that specialized services are provided to all eligible individuals residing in, or discharged from, Nursing Facilities.	Disability Rights Network of Pennsylvania (DRN)

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Requirements Document	Section V.A. - Covered Services	A. 20 Settings for LTSS, page 35	The CHC-MCO must provide services in the least restrictive, most integrated setting. The CHC-MCO shall only provide LTSS in settings that comply with the HCBS Settings final rule at 79 F.R. 2948 (January 16, 2014).	Add: If the CHC-MCO serves children under the age of 18, LTSS for children shall be provided in family settings - the child's own family, or if requested by the family or legal guardian, a life-sharing family, or through a voluntary partnership between the two. In no case will LTSS be provided to children in congregate care settings except on a brief transitional basis. Comment: Full adherence to the HCBS Settings final rule is imperative. In addition, the current CHC proposal does not include children under the age of 18, but, while not necessarily supporting their inclusion in CHC, we include this comment in case Departmental plans change.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.A. - Covered Services	A. 21. Service Delivery Innovation, page 35	a. Housing innovation that includes but is not limited to:	Add: iii. Rent subsidies, supplemental payments to residential habilitation providers. Comment: Housing has been the biggest obstacle to community living for persons with disabilities currently in nursing facilities. The state would save money, and comply with the Americans with Disabilities Act (ADA)/Olmstead, by providing funding to Particpants for accessible housing in the community rather than providing for housing only in institutional settings. With respect to Residential Habilitation, the Department has recognized the need for supplemental payment to providers for costs that are not eligible for federal financial participation. The same need exists with respect to the CHC population.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.B. - Prior Authorization of Services	B.2. Time Frames for Notice of Decisions, page 38	d. In all cases, the CHC-MCO must make the decision to approve or deny a covered service or item and the Participant must receive written notification of the decision no later than twenty-one (21) days from the date the CHC-MCO received the request, or the service or item is automatically approved.	Question: For LTSS, how will the date of receipt by the CHC-MCO be calculated? By the date of the ISP meeting when the service was requested by the Participant from the Service Coordinator who works for the MCO? By the date the Service Coordinator submits the plan for approval? If the latter, what happens if the Service Coordinator does not include the Participant's request in the submitted plan? Can a Participant contact the Service Coordinator or the MCO to request a service if there is no ISP meeting scheduled? Add: For purposes of this 21-day rule, the CHC-MCO is deemed to have received a request for LTSS on the day that the Service Coordinator is told by the Participant, or another person acting on his or her behalf, that the Participant is requesting or needs the service or item. Question: Will the CHC-MCOs be required to set their computer systems to automatically generate approval notices, as OMAP has done in the past? If not, how will this "automatic approval" requirement be enforced?	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.C. - Continuity of Care	C. Continuity of Care, page 39	For a Participant who is receiving LTSS but whose LTSS Provider leaves the CHC-MCO Provider Network, the CHC-MCO must continue to allow the Participant to receive services for a 60-day period and must pay that Provider until such time as an alternative Network Provider can be identified and begins to deliver the same LTSS services as the former Provider.	Change: For a Participant who is receiving LTSS but whose LTSS Provider leaves the CHC-MCO Provider Network, the CHC-MCO must continue to allow the Participant to receive services from that Provider (and must pay that Provider) for a 60-day period or until such time as an alternative Network Provider can be identified and begins to deliver the same LTSS services as the former Provider, whichever date is later. Comment: The current language is ambiguous and confusing.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.E. - Needs Screening	E. Needs Screening, page 40	…Any participant whose needs screening reflects unmet needs, service gaps, or a need for Service Coordination will be referred for a comprehensive needs assessment.	Change: …Any participant whose needs screening reflects unmet needs, service gaps, or a need for Service Coordination, or who requests a comprehensive needs assessment, will be referred for a comprehensive needs assessment.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	F. Comprehensive Needs Assessments and Reassessments, page 40	The comprehensive needs assessment will be conducted by a Service Coordinator….	Change: The comprehensive needs assessment will be conducted by a Service Coordinator (or other individual with equal or higher qualifications) who is independent of the CHC-MCO,… Comment: This is critical to avoid a conflict of interest - to counter the financial disincentives for the CHC-MCO to identify expensive needs that can and should be provided in the community.	Disability Rights Network of Pennsylvania (DRN)

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Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	F. Comprehensive Needs Assessments and Reassessments, page 40-41	Participants without existing Person-Centered Service Plans who are identified through a needs screening as requiring a comprehensive needs assessment shall have a comprehensive needs assessment conducted within 15 days of the completion of the needs screening.	Change: Participants without existing Person-Centered Service Plans who are identified through a needs screening as requiring a comprehensive needs assessment, or who request a comprehensive needs assessment, shall have a comprehensive needs assessment conducted within 15 days of the completion of the needs screening or of the request.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.H. - Person Centered Service Plans	H. Person Centered Service Plans, page 43	* Communications plan.	Change: * Communications plan, including but not limited to, when needed, specialized communication assessments, staff who are proficient in the Participant's language, including American Sign Language (ASL), assistive technology such as assistive listening devices and video phones, the use of interpreters at meetings and appointments, and other means to assure communication .	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.I. - Department Review of Changes in Service Plans	I. Department Review of Changes in Service Plans, page 43	The Department may review and revise any Person-Centered Service Plan.	Add: Whenever the Department revises a Person-Centered Service Plan, the CHC-MCO shall provide advance written notification to the Participant explaining the change and providing appeal rights in the same manner as if the CHC-MCO had made the revision.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	K. Service Coordinator and Service Coordinator Supervisor Requirements, page 44	The CHC-MCO must require that all employed or contracted Service Coordinators...	Comment: Service Coordinators and Service Coordinator supervisors should be independent of and not employed directly by the CHC-MCOs to avoid a conflict of interest.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.L. - Nursing Home Transition	L. Nursing Home Transition Services, page 44	CHC-MCOs must offer Nursing Home Transition (NHT) Services…to Participants residing in Nursing Facilities who express a desire to move back to their homes or other community-based settings.	Add: The CHC-MCO must ensure that all nursing facility residents are informed at admission and at least annually thereafter, of the availability and meaning of NHT services, and how to request them. Comment: Many persons will not express a desire to move to the community if they do not know that leaving is an option, that home and community-based services are available, or that someone is available to help them with housing and other issues.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.L. - Nursing Home Transition	L. Nursing Home Transition Services, page 44	Service Coordinators may coordinate NHT services.	Change: NHT services should be provided by a Service Coordinator (or other individual with equal or higher qualifications) who is independent of the CHC-MCO. Each NHT provider agency should be a community-based organization with experience serving people with disabilities. Comment: This is to ensure that there is no conflict of interest in serving an individual who would require complex or more expensive services to live in the community.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	O. Participant Enrollment and Disenrollment, page 46		Add: The CHC-MCO must coordinate with the IEE and county child welfare agencies to ensure that each CHC-eligible young adult has the opportunity and information to choose a CHC-MCO and is provided a smooth transition from the child welfare system to community based LTSS.	Disability Rights Network of Pennsylvania (DRN)

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
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	O.4 Limited English Proficiency (LEP) Requirements, page 50	During the Enrollment Process, the CHC-MCO must seek to identify Participants who speak or read a language other than English as their first language. The CHC-MCO must identify spoken and written language preferences identified by the IEE and CHC-MCO during its first contact(s) with the Participant. The CHC-MCO must provide, at no cost to Participants, oral interpretation services in the requested language or sign language interpreter services to meet the needs of Participants. The CHC-MCO must also provide specialized interpretive services to ensure access to services for Participants who are deaf and blind. These services must also include all services dictated by federal requirements for translation services designated to the CHC-MCO Providers if the Provider is unable or unwilling to provide these services.	Change: During the Enrollment Process, the CHC-MCO must seek to identify Participants who speak, read or otherwise communicate in a language other than English as their first language. The CHC-MCO must identify language(s) needed for effective communication in both oral and written communication [strike-out identified by the IEE and CHC-MCO] during its first contact(s) with the Participant. The CHC-MCO must provide (or ensure the provision of), at no cost to Participants, oral interpretation services in the requested language or sign language interpreter services to meet the needs of Participants in accessing services of both the CHC-MCO and Providers. The CHC-MCO must also provide (or ensure the provision of) specialized interpretive services to ensure access to CHC-MCO and Provider services for Participants who are deafblind. [Strike-out These services must also include all services dictated by federal requirements for translation services designated to the CHC-MCO Providers if the Provider is unable or unwilling to provide these services.] Comment: The DHS language regarding the responsibilities of the Providers is confusing. The CHC-MCO may require the Providers to pay for interpreters, but the CHC-MCO (and DHS) is ultimately responsible to ensure that the interpreters are provided.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	O.5 Alternate Format Requirements, page 50	The CHC-MCO must provide alternative methods of communication for Participants who are visually or hearing impaired or both, including Braille, audio tapes, large print, compact disc, DVD, computer diskette, special support services, and/or electronic communication. The CHC-MCO must provide TTY and/or Pennsylvania Telecommunication Relay Service for communicating with Participants who are deaf or hearing impaired, upon request.	Change: The CHC-MCO must provide alternative methods of communication for Participants who are visually or hearing impaired or both, including Braille, audio tapes, large print (18 or larger point font), compact disc, DVD, computer diskette, special support services, and/or electronic communication. Electronic communications includes, but is not limited to, documents posted on websites and disseminated through email and must be in an accessible file type such as accessible portable document format (accessible pdf), Microsoft Word Document (Doc) or ridge text (txt). Websites must be accessible in accordance with federal standards (Section 508 of the Rehabilitation Act of 1973). Any videos need to be captioned and have audio description. The CHC-MCO must provide TTY and/or Pennsylvania Telecommunication Relay Service for communicating with Participants who are deaf or hearing impaired, upon request and ensure that Video Relay calls are accepted and returned for people who communicate in Sign Language.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	O.18 Participant Advisory Committee, page 57	The meeting schedule must be no less than quarterly with in-person meetings, and travel expenses for Participants or their family members need to be reimbursed. Any reasonable accommodations necessary must be made available to ensure in-person access to the PAC.	Add: Documents and meeting notices must be provided in alternate formats upon request and must be provided at the same time that others receive documents and meeting notices.	Disability Rights Network of Pennsylvania (DRN)

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
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	O. 20 Involuntary Disenrollment, page 58		Question: Are there any circumstances in which a person can be involuntarily disenrolled? If so, what are they? All federal and state due process requirements must be followed.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.P. - Participant Services	P. Participant Services, page 60	Provide for TTY and/or Pennsylvania Telecommunication Relay Service availability for Participants who are deaf or hard of hearing.	Add: and ensure that Video Relay calls are accepted and returned for people who communicate in Sign Language. Comment: Video Relay Service (VRS) is a free, confidential service by which a sign language interpreter, using a remote video screen, interprets a caller's sign language into spoken English, and vice versa, over the phone. This does not require anything of the CHC-MCO, or provider, other than to accept and, if necessary, return the calls. VRS has become the usual mode of telephone communication for Deaf individuals who have access to the internet. VRS is especially important for some Deaf participants who may have difficulty communicating in written English, which is necessary for TTY and traditional PA Telecommunication Relay Service. VRS must be accepted for all communications with the CHC-MCO, not just the participant hot-line, as well as with Providers. Because not all Deaf or hard-of-hearing people know sign language or have access to the internet, traditional TTY or PA Telecommunication Relay Services must also be available.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section V.R. - Participant Complaint, Grievance & DHS Fair Hearing Process	R.1 Participant Complaint, Grievance and Fair Hearing Process, page 62	The CHC-MCO must abide by the final decision of BHA for those cases when a Participant has requested a DHS Fair Hearing and a stay of the BHA decision pending reconsideration and the stay is granted only the Participant may appeal to Commonwealth Court.	Comment: This sentence is confusing. All federal and state due process rights must be protected.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	Exh. AAA 1.p. ADA Accessibility Guidelines, page 10	The CHC-MCO must inspect the office of any PCP or dentist who seeks to participate in the Provider Network (excluding offices located in hospitals) to determine whether the office is architecturally accessible to persons with mobility impairments. Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the Provider, if different from the building entrance.	Change: The CHC-MCO must inspect the office/site of any Provider who provides services on site (such as a PCP or dentist) and who seeks to participate in the Provider Network [strikeout "(excluding offices located in hospitals)"] to determine whether the office is architecturally accessible to persons with mobility impairments and provides accessible medical equipment. Architectural accessibility means compliance with ADA accessibility requirements, including but not limited to, those regarding parking (if any), path of travel to an entrance, the entrance to both the building and the office of the Provider, if different from the building entrance, waiting rooms, exam rooms, and bathrooms. “Accessible medical equipment” includes, but is not limited to, height-adjustable examination tables or chairs with the ability to lower to 17-19 inches from the floor; weight scales with a ramp, handrails, and a wide platform that can accommodate someone seated in a wheelchair; accessible radiology, imaging, and diagnostic equipment; and patient transfer and lift devices such as ceiling track lifts or portable mechanical lifts. A Provider must provide accessible medical equipment in sufficient amounts in each facility so that a person with a disability has access to each examination, treatment, procedure, testing, radiology/diagnostic/imaging service, education, and other benefits and services provided or performed at the facility within the same time period as that of other patients (i.e., without having to wait or return for another visit or go to another location). Providers should ask patients, at the time appointments/procedures are scheduled, what accessible medical equipment is needed.	Disability Rights Network of Pennsylvania (DRN)

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Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	Exh. AAA 1.p. ADA Accessibility Guidelines, page 10	If the office or facility is not accessible under the terms of this paragraph, the PCP or dentist may participate in the Provider Network provided that the PCP or dentist: 1) requests and is determined by the CHC-MCO to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, or 2) agrees in writing to remove the barrier to make the office or facility accessible to persons with mobility impairments within one hundred-eighty (180) days after the CHC-MCO identified the barrier. The CHC-MCO must document its efforts to determine architectural accessibility. The CHC-MCO must submit this documentation to the Department upon request.	Change: If the office or facility is not accessible under the terms of this paragraph, the Provider may participate in the Provider Network provided that the Provider: 1) requests and is determined by the CHC-MCO to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, and it is determined by the Department that there is an adequate number of accessible providers within the Network to meet the needs of Particpiants with mobility impairments and that such an exemption is necessary to ensure an adequate network of providers to meet the needs of other Participants, or 2) agrees in writing to remove the barrier to make the office or facility accessible to persons with mobility impairments within one hundred-eighty (180) days after the CHC-MCO identified the barrier, and the CHC-MCO, at the end of that period, reinspects and confirms to the Department that the agreement was honored. The CHC-MCO must document its efforts to determine architectural accessibility and the availability of accessible medical equipment. The CHC-MCO must submit this documentation to the Department upon request.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document Exhibit	DDD(1) - Covered Services List	Exh. DDD(1) - Covered Services		Add: Life-Sharing and Partner Families. Comment: While this will be critically important if the CHC ever includes children, these can be good residential choices for some adults as well. Add: Support Service Provider. Comment: This is a critical service for those who are deaf-blind.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Exh. DDD(2) - Financial Management Services		Comment: FMS needs to be independent of the CHC-MCO. Each Participant must have a choice of at least three FMS providers. Each FMS provider should be a community-based organization with experience serving people with disabilities.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Exh. DDD(2) - Home Adaptations	Home Adaptations must be an item of modification that the family would not be expected to provide to a family member without a disability or specialized needs....Building a new room is excluded. .. Also excluded are those adaptations or improvements to the home that are of general maintenance and upkeep and are not of direct medical or remedial benefit to the Participant this includes items that are not up to code. Adaptations that add to the total square footage of the home are excluded from this benefit, except when necessary for the addition of an accessible bathroom when the cost of adding the bathroom is less than retrofitting an existing bathroom. *** Rented property adaptations must meet the following: • The landlord will not increase the rent because of the adaptation. • There is no expectation that waiver funds will be used to return the home to its original state.	Add: Exceptions to any exclusions or conditions will be made if it is determined by the Department that a failure to approve the exception will likely lead to the initial or continued placement of a Participant in an institutional setting.	Disability Rights Network of Pennsylvania (DRN)

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
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Exh. DDD(2) - Nursing Home Transition	The following pre-transition activities are essential functions of the Nursing Home Transition Coordinator; Identifying, educating, and assisting Participants enrolled with Money Follows the Person (MFP), acting as a liaison between the facility where the Participant will be transitioning from and the Independent Enrollment Broker for waiver services, performing a comprehensive assessment for the appropriateness of a transition from an institution to the community which gathers information about the need for health services, social supports, housing, transportation, financial resources and other needs.	Change: The following pre-transition activities are essential functions of the Nursing Home Transition Coordinator: Identifying, educating, and assisting Participants who wish to transition to the community, including but not limited to, those enrolled with Money Follows the Person (MFP), acting as a liaison between the facility where the Participant will be transitioning from and the Independent Enrollment Broker for waiver services, performing a comprehensive needs assessment for the [strike-out "appropriateness of a"] transition from an institution to the community which gathers information about the need for health services, social supports, housing, transportation, financial resources and other needs... Comment: With the right services and supports, all facility residents can, and should be provided the opportunity to live in the community. Transition is "appropriate" for all who wish to transition. DRN has successfully advocated for young adults who have multiple and complex disabilities, including the need for 24-hour skilled nursing, ventilators, behavioral supports, and other services and supports who are now living successfully in community homes after spending years in institutions.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Exh. DDD(2) - Nursing Home Transition	Nursing Home Transition services assist institutionalized individuals that have resided in an institution for at least ninety (90) consecutive or a barrier (including but not limited to; lack of informal or family supports, housing, etc.) and	Question: Something appears to be missing. The sentence is not clear.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Exh. DDD(2) - Personal Assistance Services	Health maintenance activities provided for the Participant, such as bowel and bladder routines, ostomy care, catheter, wound care and range of motion as indicated in the individual's service plan and permitted under applicable State requirements.	Change: Health maintenance activities provided for the Participant, such as bowel and bladder routines, ostomy care, catheter (including intermittent catheterization), wound care and range of motion as indicated in the individual's service plan and permitted under applicable State requirements.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Exh. DDD(2) - Personal Assistance Services	Services to accompany the Participant into the community for purposes related to personal care, such as shopping in a grocery store, picking up medications and providing assistance with any of the activities noted above to enable the completion of those tasks.	Change: Services to accompany the Participant into the community for purposes related to personal care, such as shopping in a grocery store, picking up medications and providing assistance with any of the activities noted above to enable the completion of those tasks, and to enable the Participant to work and to otherwise engage in activities in the community. Comment: The Department's suggested language, limiting the purposes for which PAS can be used in the community, is inconsistent with the stated purpose of the service to enable the Participant to "integrate more fully into the community."	Disability Rights Network of Pennsylvania (DRN)
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Exh. DDD(2) - Personal Assistance Services	Personal Assistance Services are provided by a Home Care Agency and must be Licensed by the PA Department of Health	Change: Personal Assistance Services are provided by a Home Care Agency which must be licensed by the PA Department of Health, or by a qualified Individual Support Service Worker as defined in the current Attendant Care Waiver. Comment: This would both increase consumer control and decrease staff shortage issues.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Exh. DDD(2) - Residential Habilitation		Question: Will CARF or other accreditation be required? Comment: Residential Habilitation is a vital service to enable individuals with the most significant disabilities to live in the community, and there has been a major shortage of providers. If necessary, the Department should provide a supplemental payment, as it does in the Consolidated Waiver.	Disability Rights Network of Pennsylvania (DRN)

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Exh. DDD(2) - Service Descriptions		Add: Life Sharing and Partner Families: Life Sharing is a residential service in which Participants live in a host lifesharing home and are encouraged to become contributing members of the host lifesharing unit. The host lifesharing arrangement is chosen by the Participant, his or her family and team and with the lifesharing host and Family Living Provider Agency in accordance with the Participant's needs. Partner Families are part-time lifesharing arrangements where the Participant lives with his or her own family when not with the lifesharing host. For Participants who need continuous care and services, this arrangement provides for family life without overwhelming either family.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Exh. DDD(2) - Service Definitions		Add: Support Service Provider (SSP): A SSP provides services directly to persons who are deaf-blind. SSPs are trained in Orientation and Mobility methods, communication facilitation, and providing environmental and visual information to persons who are deaf-blind. Most SSPs are trained in American Sign Language and/or tactile interpreting. However, SSP is not a substitute for a certified interpreter when needed for effective communication. The SSP is a trained facilitator who assists the deaf-blind individual in the community. This can include, but is not limited to, activities such as grocery shopping, visiting stores and restaurants, going to doctors' appointments or other similar day-to-day activities essential to independent living. An SSP does not assist with personal care activities such as bathing or grooming. The service includes training for the Participant in how to use the service.	Disability Rights Network of Pennsylvania (DRN)
RFP	General Information	RFP, page 7	CHC will serve the following Participants: Adults age 21 or older who require MA LTSS (whether in the community or in private or county nursing facilities) because they need the level of care provided by a nursing facility or an intermediate care facility for individuals with other related conditions (ICF/ORC). Current Participants in DHS OLTL waiver programs who are 18 to 21 years old.	Comment: This provision would eliminate the current eligibility for waiver services for new 18- to 21-year-old individuals who need LTSS. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) does not cover all the services that children and adolescents need to avoid institutionalization, such as respite, home modifications and residential habilitation. An 18-21 year old with significant physical and medical conditions, whose parents can no longer care for him or her would, without a waiver, have no option but to accept placement in an nursing facility or other institutional facility. This would be a travesty and is contrary to DHS's intentions as we understand it. Also, for youth who are aging out of the child welfare system, the transition to adult services is complicated and currently uncoordinated. It is important to have an overlapping time period to ensure a smooth transition.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Participant Rights & Protections	LTSS Service Cut Reviews		Comment: DHS should require Departmental review and approval of all, or at least a large random sample of all, LTSS service cuts for the first year, and provide data about these cuts to the Participant Advisory group, and the Consumer Subcommittee of the MAAC, and to the public upon request.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Participant Rights & Protections	Notice of Appeal - PCSPs		Comment: Notice and appeal rights should be provided to Participants at every PCSP meeting and also attached to the Plan. This is in addition to the requirement of written notice of denials. It should be made clear that signing an attendance sheet does not indicate agreement with everything in the Plan.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Participant Rights & Protections	Sanctions		Comment: The document refers to a Section VIII.H. SANCTIONS, but this section is not included. It is imperative that the Department have sanctions available for any CHC-MCO violation of the Agreement that effects Participants.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Participant Rights & Protections	Ombudsman Program		Comment: An independent advocate and ombudsman program for Participants needing LTSS should be housed in Pennsylvania's protection and advocacy system.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Participant Rights & Protections	LOC determinations		Comment: Level of Care determinations must be made by an entity independent of the CHC-MCO. Participants must be notified of their right to appeal these determinations.	Disability Rights Network of Pennsylvania (DRN)
Requirements Document	Section II - Definitions	Page 1	All Definitions within the Agreement.	The Department must ensure that all definitions contained in the Agreement, RFP, as well as any other related documents are consistent with the definitions that are included in state and federal laws and regulations. In addition the definitions should contain terms that are clear and well defined. The definitions of concern include but are not limited to the following: Abuse; Abuse of a Participant; Activities of Daily Living; Actuarially Sound Rates; Advanced Healthcare Directive; Adverse Action; Certified Nurse Midwife; Certified Registered Nurse Practitioner; Complaint; Covered Pharmacy; Covered Services; Daily Participant File; Eligibility Period; Emergency Medical Condition; Emergency Participant Issue; Emergency Services; Fraud; Grievance; Information Resource Management; Instrumental Activities of Daily Living; Healthcare Provider; Lock-In; Monthly Participant File; Network Provider; Open-ended; Provider; Provider Agreement; Provider Appeal; Provider Dispute;	PHCA

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Requirements Document	Section II - Definitions	Page 1	Activities of Daily Living	In addition to the definition being inconsistent with existing ADL definitions, the last sentence of the definition should be removed from the definition. An individuals ADL score is not the sole determinate of their eligibility for NF services - it is one component of the determination.	PHCA
Requirements Document	Section II - Definitions	Page 1	Definition of Abuse and Fraud	The definitions for Abuse and Fraud do not match state or federal law and are more strident than the commonly recognized concept of fraud and abuse.	PHCA
Requirements Document	Section II - Definitions	Page 1	Definition of Abuse of Participant	Within the definition the terms verbal abuse, sexual abuse, physical and psychological abuse are listed. The Department must ensure that the definitions are consistent with the Department of Health and Federal definitions. This will eliminate confusion among the provider community.	PHCA
Requirements Document	Section II - Definitions	Page 1	Definition of Actuarially Sound Rates	PHCA urges the Department and their actuarial contractor to ensure that their work around costs and trend levels for each level of care accurately accounts for the costs of caring for a high acuity population and utilization.	PHCA
Requirements Document	Section II - Definitions	Page 2	Definition of Adverse Action	This definition does not track with the regulatory definitions in the Administrative Code or Titles 1 and 55 of the Pa.Code, nor is it consistent with the definition of "Grievance" on page 8 of this Agreement and is further compounded by the confusion of Exhibit GG. How does this coordinate with PSAEs and payment reductions? We believe all should be made consistent with MA Bulletin 03-14-08.	PHCA
Requirements Document	Section II - Definitions	Page 2	Definitions of Complaint and Grievance	This Definitions of Adverse Action and Complaint and Grievance do not encompass a provider's exclusion or expulsion from network. It would be clearer to cross reference to the provider appeal which seems to include payment decisions that might be adverse actions which are covered in complaints or grievance.	PHCA
Requirements Document	Section II - Definitions	Page 4	Definition of Consumer Assessment of Healthcare Providers and Systems (CAPHS)	We are not aware of this system- we ask that the Department provide information on this system/issue that we can review.	PHCA
Requirements Document	Section II - Definitions	Page 4	Definition of Covered Pharmacy	This should be "pharmaceutical product" or "medication". The definition does not relate to pharmacy. See also definition of Preferred Drug List - the problem may have been caused by a spell check auto correct.	PHCA
Requirements Document	Section II - Definitions	Page 9	Definition of Healthcare Provider	Does this definition of healthcare provider include licensed Assisted Living Residences and Personal Care Homes?	PHCA
Requirements Document	Section II - Definitions	Page 11	Definition of Long-Term Services and Supports	It is recommended that the definition be amended as follows: "....., a nursing facility, or other residential setting ***including a licensed assisted living residence or personal care home,…"***	PHCA
Requirements Document	Section II - Definitions	Page 14	Definition of Out of Area Covered Service	CHC "ZONE" is spelled incorrectly.	PHCA
Requirements Document	Section II - Definitions	Page 18	Definition of Provider Preventable Condition	This definition explicitly excludes PSAEs by referring only to those that should not be paid by MCOs. This whole issue must be addressed to avoid confusion going forward.	PHCA
Requirements Document	Section II - Definitions	Page 18	Definition of Restraint	This definition does not address use of restraints in NFs, which are typically not episodic/behavior based. The definition should be consistent with the definition contained in 28 Pa Code Chapter 201 Section 201.3 Restraint—A restraint can be physical or chemical. (i) A physical restraint includes any apparatus, appliance, device or garment applied to or adjacent to a resident's body, which restricts or diminishes the resident's level of independence or freedom. (ii) A chemical restraint includes psychopharmacologic drugs that are used for discipline or convenience and not required to treat medical symptoms.	PHCA
Requirements Document	Section V.A. - Covered Services	Pages 26-36		Generally, the Descriptions of the Program Requirements are not consistent, nor do they provide guidance or transparency to potential providers or Participants. Not clear what the process will be for a NF that needs to transfer a Participant to the emergency department on emergent basis- See Item 10.	PHCA

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
Requirements Document	Section V.A. - Covered Services	Page 31 Item 12b	The language requires the CHC-MCO to require that all Providers know the procedures for reporting suspected abuse and neglect in addition to the requirements for performing physical examination of Participants	How does this paragraph coordinate with DOH reporting and assessment and various protective services programs? It is recommended that there is a cross-reference to DOH/CMS and the protective service programs or an acknowledgement that the "assessment" may be done as required by other regulations. Additionally, it is important that there be coordination regarding reporting of incidents between the state agencies and the CHC- MCOs. Particularly for nursing centers who already report to multiple entities.	PHCA
Requirements Document	Section V.A. - Covered Services	Page 32 Item 15	The language requires the CHC-MCO to provide all medically necessary emergency ambulance transportation, all medically necessary non-emergency ambulance transportation and non-medical transportation.	Does this language apply to Participants residing in a nursing facility?	PHCA
Requirements Document	Section V.A. - Covered Services	Page 33 Item 17	The CHC-MCO is responsible for payment of Medically Necessary nursing facility services.	It must be clear in the Agreement what services are nursing facility services and are to be covered by the per diem payment paid to the nursing facility by the CHC-MCO. The Agreement should more closely track the NF regulations. Clarification should be provided that this provision applies to out of network and in-network providers consistently. Language should be included to ensure that NFs are not penalized financially.	PHCA
Requirements Document	Section V.A. - Covered Services	Page 33 Item 17	The CHC-MCO must allow newly enrolled Participants who are residing in a Nursing Facility on the Effective Date of Enrollment for CHC in the zone to continue to reside in the Nursing Facility on the date of their CHC-MCO enrollment for the duration of the individuals' need for nursing facility services.	If a resident is transferred to a hospital and the stay goes beyond the 15 bed hold days - is this considered a break in the resident's stay and is the CHC-MCO permitted to require the Participant, if they need to return to a nursing facility, to choose a nursing facility in network if the prior one was out of network? We believe these residents should be allowed to return to the facility whether in network or not - this will help to ensure continuity of care.	PHCA
Requirements Document	Section V.A. - Covered Services	Page 34 Item 17	The CHC-MCO is required, incoordination with the Department, to ensure that all nursing facility related processes are completed and monitored. It goes on to list the processes to include: Preadmission Screening, Specialized Service Delivery, Participants Rights, Patient Pay Liability, Personal Care Accounts or other identified processes.	It is unclear how this will be accomplished; clarification should be provided. Nursing facilities must have a clear understanding of the role of all entities in these processes and if there is a breakdown what entity is held accountable. It notes "other identified processes" who determines what these processes are and how will the information be communicated to the nursing facility?	PHCA
Requirements Document	Section V.A. - Covered Services	Page 34 Item 19	The CHC-MCO must provide health and wellness opportunities for Participants.	We understand that education can be a benefit to Participants that are functioning and able to make changes to impact their health - this education is not however as beneficial to Participants that are long term nursing facility residents - given their frail condition and comorbidities. Is it the intent of the Agreement to provide education and outreach to long term nursing facility residents? The resources may be better utilized to provide educational and outreach to the nursing facility staff that will help to ensure the provision of quality servcies to residents.	PHCA
Requirements Document	Section V.A. - Covered Services	Page 35 Item 20	The CHC-MCO must provide services in the least restrictive, most integrated setting - only settings that comply with the HCBS final rule.	It is recommended that the following language be added: The CHC-MCO must provide services in the least restrictive, most integrated setting WHICH IS PRACTICAL GIVEN THE PARTICIPANT'S CARE AND SERVICE NEEDS. THE CHC-MCO shall provide LTSS in settings that comply with the HCBS Settings final rule at 79 F.R,2948 (January 16, 2014) INCLUDING SETTINGS WHICH ARE CONSIDERED TO BE "PRESUMED NON HCBS SETTINGS" UNDER THE FINAL RULE, IF THEIR USE IS ESSENTIAL TO ENSURE AN AVOIDABLE INSTITUTIONAL PLACEMENT.	PHCA

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
Requirements Document	Section V.E. - Needs Screening	Page 40	Upon Enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or need for Service Coordination. Any Participant whose needs screening reflects unmet needs, service gaps, or a need for Service Coordination will be referred for a comprehensive needs assessment. The needs screening must be completed within the first 30 days of Enrollment, and may be conducted by phone, electronically, by mail, or in person.	Based on this language it appears the tool will not be a standard tool each MCO will develop their own tool to be reviewed and approved. We recommend that the tool be standard across all MCOs so there is consistency especially in nursing facilities where residents may be participants in different plans.	PHCA
Requirements Document	Section V.E. - Needs Screening	Page 41	The CHC-MCO must conduct a comprehensive needs reassessment no more than 12 months following the most recent prior comprehensive needs assessment or comprehensive needs reassessment unless a trigger event occurs. Reassessments must be completed as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, but in no case more than 14 days after the occurrence of any of the following trigger events:	These provisions should be coordinated with the MDS requirements that NFs must abide by to be in compliance. If there is no coordination between the CHC-MCO needs assessment requirements and the federal requirements regarding the completion of MDS assessments – the resident will go through multiple assessments with no commensurated benefit.	PHCA
Requirements Document	Section V.M.- Coordination of Services		Coordination of Care provisions	The Agreement should address privacy concerns with sharing of mental health information for NF residents. Emergency care issues for Participants and responsibilities for when prior authorization is necessary and the process for prior authorization for both in-network and out of network providers is unclear.	PHCA
Requirements Document	Section V.M.- Coordination of Services	Page 45	Item 1b. Requires the CHC-MCO and BH-MCO to work collaboratively on joint initiatives to improve health outcomes.	NFs have implemented programs and processes in their buildings that focus on the reduction of anti-psychotic medications. If a Participant is residing in a NF the CHC-MCO and BH-MCO should be required to work collaboratively with NFs in the reduction of anti-psychotic medications.	PHCA
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Page 51 Item 9	Participants may voluntarily choose to transition between CHC-MCO and LIFE - if the Participant meets the eligibility criteria for LIFE.	What are the requirements that are being referred to in this sentence? Are LIFE providers required to enroll all eligible individuals that choose this program or do they have the ability to limit enrollment and be selective in those they accept? If LIFE providers are permitted to limit enrollment, the rates for LIFE providers should be for lower acuity consumers.	PHCA
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Page 50 Item 6	Enrollment Procedures	Recommend that training be provided to nursing facility staff so they can assist residents with the enrollment and selection process. There must be extensive coordination during this process between the state, the provider and the MCOs. For at-risk elders who may not be their own decision makers it is recommended that an authorized representative have the authority to make the enrollment determination. Auto enrollment – it is recommended that for a resident in a nursing facility, the Department's algorithm for plan assignment should give priority to the CHC-MCOs that have contracted with that nursing facility. This is particularly critical if the Department does not decide to extend continuity of care protections such as an extended 'any willing provider' provision in the program.	PHCA

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Page 55 Item 15		How will the issuance of identification cards to Participants be handled for existing nursing facility residents enrolled in a CHC-MCO?	PHCA
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Page 58	Involuntary Disenrollment	What happens to a NF who has a violent or disruptive Participant and whose needs can not longer be met? Does the CHC-MCO have an obligation to help locate alternate placement? In reviewing this section - it would seem that not to be the case. It is our recommendation that the CHC-MCO have an obligation to work with the NF in these instances.	PHCA
Requirements Document	Section V.P. - Participant Services	Page 61 Item 5	CHC-MCOs are required to distribute newsletters to Participants at least 3 times per year.	The CHC-MCO should coordinate distribution of these materials with the NF if the Participant is in a NF. The materials should be shared with a residents responsible party if the resident is unable to make their own decision or understand the materials.	PHCA
Requirements Document	Section V.T. - Provider Dispute Resolution Process	Page 63	Provider Dispute Resolution Process	This section is very troubling. One of the issues that have been encoutered in the past is with interpretation of policies. For example, what happens if DHS approves a policy for a CHC-MCO that is inconsistent with federal law? The contract should not abrogate Providers' appeal rights. As written, this provision violates procedural and substantive due process rights. The program is fundamentally still a Medicaid program. DHS cannot say Providers have no right of appeal involving DHS. Also what happens if CHC-MCO is currently using an illegal policy? As written, that policy would continue until DHS says it can change, but there will be no recourse to DHS.	PHCA
Requirements Document	Section V.T. - Provider Dispute Resolution Process	Page 64	CHC-MCO Appeal Committee	The membership on this Committee is only required to be composed of 25% Providers- It is our recommendation that this percentage be set higher at 40%.	PHCA
Requirements Document	Section V.V. - Executive Management	Page 65	Director of LTSS	It is important for this individual to have experience with long term care as opposed to managed care. Experience in managed care would not qualify someone for this position with this specialized population.	PHCA
Requirements Document	Section V.X.- Administration	Page 67	Under W. Other Administrative Components	The role of the Provider Claims Educator is ill-defined and should be stated in more objective and measurable tasks. It is recommended that this individual work as a laisons with the provider trade associations representatives so they can assist their membership with issues as they arise. To support this process it is recommended that quarterly meetings be held with the trade association representatives and staff from the CHC-MCO to discuss issues and work to improve processes.	PHCA
Requirements Document	Section V.X.- Administration	Page 69-70		It is recommended that the following be added. With the exception of information otherwise protected under the exceptions to the Pennsylvania Right to Know Law, all contracts and subcontracts shall be publicly available.	PHCA
Requirements Document	Section V.X.- Administration	Page 69	Recipient Lock-In Program	Standards to identify "over-utilizers" or "misusers" of medical services should be articulated in advance of the RFP in this document.	PHCA
Requirements Document	Section V.Y. - Records Retention	Page 72		These requirements are somewhat confusing. If records are required to be retained for 5 years, they can be destroyed after that period- what is the reference to fraud and abuse meant to accomplish? We ask that the Department clarify this provision as it relates to the retention of the Agreement, medical records etc. When developing the clarification it is important to consider the retention requirements provided for under HIPAA.	PHCA
Requirements Document	Section V. Z. - Fraud & Abuse	Audit Requirements		Generally, the audit requirements are vague and confusing with little to guide providers. It is unclear how Quality Review and Reporting of suspected fraud and abuse would operate under this Agreement and coordinate with the processes described in Exhibit KK and how the new processes will coordinate with current processes in particular for LTC providers of care in residential settings. For example, how will this be coordinated with licensing, reporting and documenation requirements such as the long negotiated Preventable Serious Adverse Event Requirements of Act 1 of 2009?	PHCA
Requirements Document	Section V. Z. - Fraud & Abuse	Page 75 Item m.i.	Duty to Cooperate with Oversight Agencies	What would authorize jurisdiction of the Bureau of Program Integrity (BPI) over fraud, waste and abuse without permitting Providers to have a right of appeal? There have been instances where MCOs are "overzealous" in their identification of fraud, waste and abuse. The BPI voluntary disclosure process does not really allow for disclosure to the MCO. It is recommended that DHS-BPI clarify what the MCO's role in this should be.	PHCA

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Requirements Document	Section V. Z. - Fraud & Abuse	Page 75 Item m.i.	Department will provide the CHC-MCO with immediate notice if a provider is suspended or terminated from participation in the MA Program.	Is it the intent of the Department to notify the CHC-MCO if a NF is under an enforcement action such as a ban on new admissions, cmp etc.? Not all licensure actions result in exclusion-the majority of actions are time limited and in some instances not implemented - because the NF has come into compliance - it is recommended that the Department only report instances that result in exclusion. The exclusion provisions and process must be consistent with other federal and state laws.	PHCA
Requirements Document	Section V. Z. - Fraud & Abuse	Page 77	Overpayment Recovery	The CHC-MCO should have the ability to settle disputed claims with Providers, especially if there is no right of appeal. There have been situations currently where MCOs cannot compromise a claim, even in those instances where payment would truly constitute a financial hardship. We question the appropriateness of the CHC-MCO equally sharing in RAC recoveries with DHS.	PHCA
Requirements Document	Section V. Z. - Fraud & Abuse	Page 79	Management Information Systems	This section is not clearly articulated. There is no reference to the nature of any of the relationships in terms of workflow, data flow and privacy protections.	PHCA
Requirements Document	Section V. Z. - Fraud & Abuse	Page 80 Item 7 e	The CHC-MCO is required to have the capability to process claims consistent with timeliness and accuracy requirements identified in the Agreement,	It is unclear what requirements are being referred to. We believe that CHC-MCOs should be required to comply with the federal rule related to timely claims payments contained in 42 CFR § 447.45, which requires the payment of 90% of all clean claims within 30 days of receipt and 99% within 90 days of receipt. For clarity it will be important to clearly define "clean claim"- or define the elements necessary for payment. We also recommend that the CHC-MCOs be required to pay interest at the rate of 10% per annum on clean claims paid after 45 days of receipt	PHCA
Requirements Document	Section V.AA. - Selection & Assignment of PCPs	Page 83	If a Participant does not select a PCP within 14 days of enrollment the CHC-MCO will auto assign the Participant.	If a Participant that is residing in a NF does not select a PCP the auto assignment process should take into consideration the PCPs that have experience working with NF residents and will work with the NF to ensure the resident receives the care and services that will help them attain and maintain quality of life. PCPs for NF residents must be familiar with the policies and procedures that NFs are required to comply with.	PHCA
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	Page 84	Selection ad Assignment of Service Coordinators	The choice of service coordinators is important for Participants. Additional detail is needed on how service coordinators will work with existing providers once assigned.	
Requirements Document	Section V.DD. - Provider Network	Page 89	Provider Network	We are supportive of the provision that CHC-MCOs pay nursing facilities for all residents who reside in the nursing facility on the effective date of the zone for as long as the residents reside in the nursing facility. This is a pro-consumer measure that ensures continuity of care.	
Requirements Document	Section V.DD. - Provider Network	Page 89	A willing provider is a provider that is willing to contract with the CHC-MCO to provide services for a payment rate that is agreed upon by the provider and CHC-MCO.	This definition of willing provider is of concern. What if a NF where Participants are residing at enrollmemt cannot come to terms with the CHC-MCO- is the CHC-MCO obligated to make payment arrangements to the NF to ensure continuity of care? There are some inconsistencies regarding any willing provider definition and the continuity of care requirements. We strongly recommend that CHC-MCOs be required to contract with all current MA-certified NFs for at least three (3) years from the date of implementation of each phase or geographic 'zone'. We believe that this is essential to the success of the CHC program for those consumers who have chronic and ongoing need for intensive LTSS.	PHCA
Requirements Document	Section V.DD. - Provider Network	Page 94 Item 9	The CHC-MCO must require all network providers to be enrolled in the MA program and possess an active PROMISe number.	Will the Department develop MA participation requirements and process for Assisted Living Residences to enroll in MA?	PHCA
Requirements Document	Section V.EE. - QM & UM Program Requirements			Reference is made to Exhibits M(1), M(2) and M(4) in the document but are not available for review. It is important that we are afforded the opportunity to review these Exhibits and provide comments.	PHCA

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
Requirements Document	Section V.EE. - QM & UM Program Requirements			It is essential that these requirements be articulated and available for public comment and revision by the Department in advance of the procurement. Issues like critical incident reporting, where nursing facilities already have a myriad of reporting requirements to both the Department of Human Services and the Department of Health, must be laid out in greater detail. We recommend that the Commonwealth work across Departments, with DHS and DOH coordination to tap into existing reports required of nursing facilities. Additional requirements mandated to/by the CHC-MCOs which are duplicative in nature are an inefficient use of scarce resources at the facility and MCO level, and could jeopardize access to care rather than protect consumers. We also highly recommend that the components of the quality management program include provider feedback and surveys. The providers in network should have the opportunity to weigh in on the effectiveness of the CHC-MCO.	PHCA
Requirements Document	Section V.EE. - QM & UM Program Requirements			CHC-MCOs must be educated on the CMS quality measures and the 5 star rating system- the components of the rating system, what goes into the ratings and how the stars are determined. It is critical to note that the CMS 5 star rating system is a tool that can be used, in conjunction with others, to measure a nursing facility's overall quality efforts. However, believe that it is inappropriate for the CHC-MCO to determine a nursing centers performance solely on the 5 star system. We have significant concerns around the adoption of Pennsylvania specific quality performance measures in addition to the MA requirements of participation contained in the CMS guidance to surveyors. Nursing facilities already have multiple requirements relating to quality measurement and report on 18 measures, 11 of which are included in the 5 star rating system. We cannot support additional measures under the CHC program unless they are demonstrated to measure facilities on a domain that the current measures do not, and deemed to be essential to improving the care that consumers receive. If additional measures are developed they should be developed, reviewed and approved by a clinical workgroup comprised of clinical experts and tested with providers of care and consumers before being implemented or required.If additional measures are adopted, they should be standardized measures across all plans. If CHC-MCOs are permitted to apply different quality measures– many of which can be inconsistent or in conflict with CMS measures – nursing facilities will find it difficult and costly to comply and be at risk of contract termination, which will not be in the participants best interest.	PHCA
Requirements Document Exhibit	C - Requirements for Provider Terminations			In general this Exhibit is vague and confusing. A glaring concern is that the requirements for termination provide no recourse for either Participants or Providers. This is in violation of the administrative rights afforded Participants under the Medicaid Act and Pennsylvania Administrative Law as an adverse action. It is a violation of the substantive and procedural due process rights of providers under the Medicaid Program.	PHCA
Requirements Document Exhibit	C - Requirements for Provider Terminations	Termination by the CHC-MCO C. Notification to Participants	When a provider is terminated from the CHC-MCO network it is required that all Participants be notified that received services from the provider over the previous 12 months. This provision does not apply to a PCP or hospital.	It is our recommendation that NFs be exempt from this requirement as well. Separate notification requirements should be developed for when a NF is terminated from the network. If a NF is terminated from the CHC-MCO network what will the requirements be around the Participants that are residing in the NF? It is important to consider the federal rules regarding discharge notice etc., when developing a process for a NF provider termination from the network.	PHCA
Requirements Document Exhibit	C - Requirements for Provider Terminations	Termination by Provider B. Notification to Participants	When a provider decides to terminate its participation in the CHC-MCO network it is required that all Participants be notified that received services from the provider over the previous 12 months. This provision does not apply to a PCP or hospital.	It is our recommendation that NFs be exempt from this requirement as well. Separate notification requirements should be developed for when a NF decides to terminate its participation in the CHC-MCO network. Will Participants be required to transfer to an in-network NF or will they be permitted to continue to recieve care and services in the NF? It is important to consider the federal rules regarding discharge notice etc., when developing a process related to this provision.	PHCA
Requirements Document Exhibit	E(1) - Other Federal Requirements		Federal Citations related to provider-preventable conditions- payment and reporting.	NF providers are required to abide by the PSAE Bulletin published by the Department. It is unclear how those provisions and the provisions referred to in the chart will be implemented under CHC. The Department should provide clarification to both NFs and the CHC-MCOs.	PHCA
Requirements Document Exhibit	E(1) - Other Federal Requirements		Federal Citations related to EHR incentive payments.	As DHS OMAP/HIT staff are aware, two of the major providers of MLTSS—nursing facilities and home health agencies, were ineligible for Medicaid and Medicare funding for critical investments provided to other provider types, including hospitals, pharmacies, laboratories, and physicians. It is essential that additional funding for HIT investments be identified to maximize care coordination and the reporting and tracking of quality measures for these providers.	PHCA

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Requirements Document Exhibit	C - Requirements for Provider Terminations			In general this Exhibit is vague and confusing. A glaring concern is that the requirements for termination provide no recourse for either Participants or Providers. This is in violation of the administrative rights afforded Participants under the Medicaid Act and Pennsylvania Administrative Law as an adverse action. It is a violation of the substantive and procedural due process rights of providers under the Medicaid Program.	PHCA
Requirements Document Exhibit	C - Requirements for Provider Terminations	Termination by the CHC-MCO C. Notification to Participants	When a provider is terminated from the CHC-MCO network it is required that all Participants be notified that received services from the provider over the previous 12 months. This provision does not apply to a PCP or hospital.	It is our recommendation that NFs be exempt from this requirement as well. Separate notification requirements should be developed for when a NF is terminated from the network. If a NF is terminated from the CHC-MCO network what will the requirements be around the Participants that are residing in the NF? It is important to consider the federal rules regarding discharge notice etc., when developing a process for a NF provider termination from the network.	PHCA
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Requirements Document Exhibit	E(1) - Other Federal Requirements		Federal Citations related to provider-preventable conditions- payment and reporting.	NF providers are required to abide by the PSAE Bulletin published by the Department. It is unclear how those provisions and the provisions referred to in the chart will be implemented under CHC. The Department should provide clarification to both NFs and the CHC-MCOs.	PHCA
Requirements Document Exhibit	E(1) - Other Federal Requirements		Federal Citations related to EHR incentive payments.	As DHS OMAP/HIT staff are aware, two of the major providers of MLTSS—nursing facilities and home health agencies, were ineligible for Medicaid and Medicare funding for critical investments provided to other provider types, including hospitals, pharmacies, laboratories, and physicians. It is essential that additional funding for HIT investments be identified to maximize care coordination and the reporting and tracking of quality measures for these providers.	PHCA
Requirements Document Exhibit	K - Emergency Services			This exhibit should proscribe the CHC-MCO payment procedures for emergency services so that the billing and payment is as seamless as possible to the Participant and is not a hardship to the provider. The CHC-MCO should be required to have clear guidance for providers with regard to any Emergency Medical Treatment and Active Labor Act implications.	PHCA
Requirements Document Exhibit	L - Medical Assistance Transportation Program			This Exhibit is vague and not helpful. Who are the MATP providers, what are the Participants' responsibilities for procuring transportation service? How is need for the service determined? When is paratransit deemed to be medically necessary? How will coordination between medical and MATP providers be facilitated?	PHCA

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Requirements Document Exhibit	L - Medical Assistance Transportation Program		Provisions related to MATP under CHC Program.	The exhibit requires the CHC-MCO to arrange for non-emergency transportation for urgent appointments for Participants. Does this provision apply to Participants residing in NFs? Under the MA program NFs are responsible as part of their per diem for nonemergency transportation services- will NFs continue to be responsible for this service?	PHCA
Requirements Document Exhibit	X - Guidelines for Adverstising, Sponsorship & Outreach			This Exhibit needs to be formatted and checked for typos. Specific guidelines should be provided to the CHC-MCO on avoiding False Claims Issues. The CHC-MCO should have similar guidance to share with providers.	PHCA
Requirements Document Exhibit	CC - Data Support			Data support (including a live help-line), interoperability, integration, appropriate enhancements and upgrades should be provided, or at the very least available to all Providers as well as other Commonwealth agencies. Shared computing and value creation with revenue sharing to all parties for innovative cooperative solutions should be afforded to Providers.	PHCA
Requirements Document Exhibit	DD - Participant Handbook			The Department should require a full review of this Handbook as it does for marketing materials…similar to Exhibit X.	PHCA
Requirements Document Exhibit	DD - Participant Handbook		The CHC-MCO must provide a Participant Handbook to all Participants within 5 business days of being notified of the Participant's enrollment.	It is our understanding that all MA residents currently residing in NFs will be transitioned to CHCs. As noted above this will bring many challenges as far as coordination of care, assessments, care planning etc. Among those challenges will be this requirement - again it will be important for the CHC-MCO to work collaboratively with the NF staff when distributing information and explaining the processes - particularly those that overlap with NF compliance requirements. It is also recommended that electronic access to Participant Handbooks be made available to providers.	PHCA
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes			These three tracks are confusing and cumbersome and a waste of scarce dollars that could be used for care. None of the three potential paths to "complain", "grieve" or "appeal" meet the regulatory requirements in the Administrative Code. Complaint and grievance definitions do not encompass a provider's exclusion or expulsion from network. It would be clearer to cross reference to Provider appeal which seems to include payment decisions that might also be covered in complaints or grievance. What would be the recourse?	PHCA
Requirements Document Exhibit	KK - Reporting Suspected Fraud & Abuse to the Department			This Reporting process does not track state or federal law. It is very unclear from the Exhibit how this processes will work with current fraud and abuse reporting requirements, licensing requirements and auditing processes. There is no mention of Child Protective Services Law requirements where Adult Protective Services and OAPSA reporting are specifically referenced. The CHC-MCO is to identify providers who are "at risk" of fraud and abuse. What does that mean and how are those providers singled out?	PHCA
Requirements Document Exhibit	LL - Guidelines for Sanctions regarding Fraud, Waste & Abuse			This Exhibit does not track state or federal law and is overly broad. It is very unclear from the Exhibit how this processes will work with current fraud and abuse reporting requirements, licensing requirements and auditing processes.	PHCA
Requirements Document Exhibit	PP - Provider Manuals		CHC-MCOs are required to work with the Department to develop, distribute prior to implementation, and maintain a Provider manual. The Exhibit outlines what the manual must include.	The Department should require a full review of this Handbook and allow for full comment by the provider community. It appears that there will be one manual for all Providers - it is our recommendation that their be a manual that contains all information that crosses all Providers with subchapters that are specific to the different Provider types. This will be more user friendly to the providers and limit any confusion as to what provisions apply. Furthermore, the provider manuals should be made publicly available	PHCA
Requirements Document Exhibit	WW - Audit Clause			Generally-Audit requirements are vague and confusing with little to guide providers. It is very unclear how quality initiatives and reporting of suspected fraud and abuse would operate under this agreement and coordinate with this processes; and how this audit process will coordinate with current processes. How will these Audits impact Providers?	PHCA
Requirements Document Exhibit	XX - Encounter Data Submission & Penalty Applications			The Penalties should be subject to settlement with the Department under certain circumstances, including hardship.	PHCA

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Requirements Document Exhibit	AAA - Provider Network Composition/Service Access		Exhibit AAA Provider Network Composition/Service Access requires the CHC-MCO to ensure that it Provider Network is adequate to provide its Participants in the zone with access to quality care in a timely manner without the need to travel excessive distances. The CHC-MCO must know the capacity of the network providers at all times. Provide each Participant with a choice of at least 2 PCPs, at least one hospital and at least 2 providers for each LTSS covered service all within the travel time limits- 30 minutes urban; 60 minutes rural.	The Department should take an active role in establishing reasonable criteria for adequacy. As this exhibit reads, all research and study verification falls on the CHC-MCO. Historically, this methodology has led to inadequate networks and capacity. The standard of "at least two" does not take into account Participant density. That could be sufficient in very rural areas, and wholly insufficient in others. The Department should explore per Participant ratios as floors for provider networks or use consumer experience during an "any willing provider" timeframe to assess the correct standards. Additionally, as noted previously, for an ALR to be part of the CHC-MCO network they must be MA participating - currently there are no provisions around MA certification for a licensed ALR - will the Department develop that certification process? If so, what will be the components/requirements of the MA certification process?	PHCA
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	Item i.	Rehabiliation Facilities - the CHC-MCO must provide a choice of at lest 2 rehabilitation facilities etc.	What is the definition of a Rehabilitation Facility? Nursing facilities can be a low cost provider for rehabilitative types of services and the appropriate placement for those in need of these services, the Department should take this under consideration when establishing the facilities that meet this requirment.	PHCA
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	Item h	The CHC-MCO must ensure a choice of at least 2 dentists within the Provider Network etc.,	The CHC-MCO must ensure that there are dentists in the network that will treat residents within the NF.	PHCA
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	Item a	Choice of PCPs.	How will this work with a NF resident given that the NF has a medical director? Will the PCP be willing to go to the NF to see the resident? What will be the role of the PCP and the Medical Director?	PHCA
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	Item d.	Choice of Hospitals.	Under 28 PaCode Chapter 201 §201.31 a NF is required to have transfer agreement with 1-2 hospitals – what if the hospitals are not in the network- will the resident be required to go to the in-network hospital?	PHCA
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	Item s	Declined Provider	If a CHC-MCO declines a Providers participation in their network - does the Provider have the right to appeal that decision?	PHCA
Requirements Document Exhibit	BBB - Pharmacy Services			PHCA appreciates that the network is open for any willing pharmacy. DHS should consider reimbursement for telemedicine type pharma service carts in LTC facilities.	
Requirements Document Exhibit	BBB - Pharmacy Services	1.a.		Under the MA Program over-the-counter drugs are included in the NF's per diem rate - how will these costs be reimbursed under CHCs?	PHCA
Requirements Document Exhibit	BBB - Pharmacy Services	1.d.	All covered pharmacies must be dispensed through CHC-MCO Network providers.	NFs have pharmacies that normally service the facility. In accordance with §211.9 (f) Residents shall be permitted to purchase prescribed medications from the pharmacy of their choice. If the resident does not use the pharmacy that usually services the facility, the resident is responsible for securing the medications and for assuring that applicable pharmacy regulations and facility policies are met. How will this provision be addressed under CHCs?	PHCA
Requirements Document Exhibit	BBB - Pharmacy Services	12	Drug Utilization Review Program	This is a valuable process, however there are no provisions that speak to the timeliness in which this needs to be completed to ensure that a delay does not occur creating an adverse event and/or poor outcome for a Participant. It is recommended that standards are developed and adhered to.	PHCA
Requirements Document Exhibit	CCC - Provider Agreements			The CHC-MCO should be required to submit a draft provider agreement template to the Department and Providers given the opportunity to comment prior to finalization.	PHCA

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Requirements Document Exhibit	CCC - Provider Agreements	a.	Provider participation in needs screening etc.	It will be imperative that this coordination occurs particularly for Participants that are residing in NFs to ensure that the resident receives the care and services they need to attain and maintain quality of life. It will also important to ensure that the care plan and discharge plan meets the state and federal standards/regulations that NFs must comply with.	PHCA
Requirements Document Exhibit	CCC - Provider Agreements	e.		It is unclear what is meant by this provision- we ask that the Department clarify.	PHCA
Requirements Document Exhibit	CCC - Provider Agreements			The Provider Agreement must include payment standards regarding rate adequacy and timely payments.	PHCA
Requirements Document Exhibit	DDD(1) - Covered Services List			Participants who are in Nursing Facilities should be able to avail themselves of the same expanded services that are provided for in this exhibit.	PHCA
Requirements Document Exhibit	DDD(1) - Covered Services List		Nursing Facility Services	Under Nursing Facility Services it lists skilled nursing facility. It is unclear why this is listed in this manner. If this is referring to the provider of service it should be listed as nursing facility. If it is referring to the level of care that is covered by CHC - it should be deleted.	PHCA
Requirements Document Exhibit	DDD(1) - Covered Services List		Under Community Health Choices LTSS Benefits Nursing Facility Services and Nursing Home Services are listed.	What is the difference between these two terms? They are one in the same in the industry.	PHCA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions			Participants who are in Nursing Facilities should be able to avail themselves of the same expanded services that are provided for in this exhibit.	PHCA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Assisted Living Definition		The definition of Assisted Living does not include the provision of supplemental health care services - this is one of the provisions that enables the individual to age in place. We agree that ALRs should be part of the covered services but the definition must be consistent with the definition contained in 55 Pa. Code Chapter 2800.	PHCA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Residential Habilitation		The definition refers to licensed and unlicensed settings and specifically calls out personal care homes. It is unclear whether the personal care home will be a provider of service or is a setting where the services can be provided. This must be clarified in order to avoid confusion.	PHCA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Specialized Medical Equipment and Supplies		In reviewing the definition it is unclear as to whether this definition includes exceptional DME that a resident in a NF may need. Also it is unclear as to whether when a Participant residing in a NF needs specialized medical equipment and supplies if the payment is made outside the per diem rate paid to the NF for routine care and services. Clarification is requested.	PHCA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Respite		In reviewing the definition of Respite it is unclear whether respite services can be provided in a NF. Under the Aging Waiver NFs are automatically enrolled as a Respite Provider - it is recommended that this practice continue under CHC.	PHCA
Other	Federal Requirements			CMS is proposing significant and costly changes to the requirements of participation that NFs must meet to participate in the Medicare and Medicaid program. A provision must be included that requires CHC-MCOs to pay for all Federal mandated services that may result from changes in rules and regulations.	PHCA
Other	Network			***Provider Credentialing*** . We believe that the Department must establish standard credentialing for providers to be used by all CHC-MCOs. Inconsistent/multiple credentialing requirements with each CHC-MCO will be overly burdensome and inefficient for providers and the Department, and ultimately harm consumers. This is particularly important for nursing facilities or other LTSS providers which are in the networks of multiple MCOs, which is highly likely given the process that the Department intends to implement when phasing in CHCs. MA certification and/or Medicare certification should be adequate credentialing for NFs. There must be some coordination with the licensing agency for all licensed providers, as the requirements established by the licensing agency need to be the provider's most immediate consideration.	PHCA

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Other	Other			***Timely Provider Payments.*** The CHC-MCOs should be required to comply with the federal rule related to timely claims payments contained in 42 CFR § 447.45, which requires the payment of 90% of all clean claims within 30 days of receipt and 99% within 90 days of receipt. For clarity it will be important to clearly define "clean claim"- or define the elements necessary for payment. It is also recommend that the CHC-MCOs be required to pay interest at the rate of 10% per annum on clean claims paid after 45 days of receipt	PHCA
Other	Other			***Payments outside NF Per Diem.*** It is our recommendation that the Department continue to pay disproportionate share payments, MDOI payments, supplemental payments, HAI pass-through payment and exceptional DME payments outside the CHC-MCO per diem payment. Providing these payments outside the per diem will help to ensure access to care for consumers that rely on MA to pay for their care in a nursing center, and avoid further administrative complexity in contracting between CHC-MCOs and providers.	PHCA
Other	Other			***Medicare Coinsurance.*** We also recommend that payments for Medicare coinsurance days should be determined in accordance with the methodology currently applied to nursing facility payments under FFS. Once any protections on network inclusion or payment rates during CHC phase in have expired, we recommend that the CHC-MCOs be required to pay to an out-of- network provider at the CHC-MCOs average in-network rate or the provider's current rate under the existing fee-for-service system, whichever is higher	PHCA
Other	Other			***Adequacy of Payment Rates.*** We recommend that CHC-MCOs be required to pay nursing facilities within a CHC program 'phase' or zone at a daily rate which is not less than their annual July 1st per diem rate as currently calculated under the case mix reimbursement system defined at 55 Pa. Code Ch. 1187 beginning on the implementation date for that 'phase' or zone. We propose that those facilities be provided with an annual inflationary increase of not less than 2.4% each year for a period of three (3) years from the implementation date of the respective CHC 'Phase' or zone.	PHCA
Other				***Transitions of Care.*** There are federal transfer and discharge requirements that nursing facilities must comply with relating to the necessity of discharge, timely notice, and the health and safety of the resident. (See 42 CFR § 483.12) In any situation when there is a conflict between the CHC-MCO requirement and the federal rules, the nursing facilities must comply with the federal rules. A nursing facility should not be put in a position to potentially jeopardize their licensure status. It is recommended that DHS consult with the Department of Health on how best to accomplish the coordination of licensure requirements.	PHCA
Other	Contract Administration			***Questions:*** How will the Department effectively monitor compliance with the provisions binding the CHC-MCO Agreement?	PHCA
Other	Other			***CHC-MCO Education*** . CHC-MCOs and their staff must be trained on nursing center services and the requirements they must comply with – including the survey process, licensure requirements, participation requirements and quality measures, etc. Additionally, as noted above given the fact that CMS is proposing significant and costly changes to the requirements of participation for nursing centers, which are likely to be published as final some time during CY 2016; the Department must ensure ongoing training and flexibility in the CHC-MCOs processes and procedures to accommodate the changes.	PHCA
Other	Schedule/Timeline			***Implementation Timing.*** The program should not be implemented until all specifics are available to both the MCOs and communicated to providers. Time must be allotted for the CHC-MCOs to develop their networks and enter into agreements with providers. Managed care contracting on this scale is a new process to the vast majority of MA providers, and sufficient time will allow them to exercise due diligence and enter into real negotiations, rather than feeling forced to sign an agreement quickly or fear being left out of the network. This will allow the Department to prevent contract errors and disruptions of care for beneficiaries.	PHCA
Other	Covered Benefits			References to Assisted Living and Personal Care in the Agreement are confusing. The Department should clearly define the roles of ALR and PCH providers under CHC. As noted previously, it is recommended that the Department work with CMS to allow licensed ALRs to be part of the community based living option under CHCs. Additionally, to encourage a robust ALR industry it is recommended that the Department work with stakeholders to amend regulatory provisions related to ALR licensure that will encourage providers to seek licensure as ALRs	PHCA

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Other	Program Goals			PHCA opposes formal barriers or financial bonus payments earned specifically by keeping consumers out of a certain setting, and recommends that they not be used in the CHC program. If a CHC-MCO is able to successfully serve an enrollee with LTSS needs in a community-based setting, they will achieve the financial benefits of doing so and see a larger margin on their capitation payment. Additional financial incentives that could limit choice and potentially put consumers at risk would be very damaging and should not be part of the CHC program.	PHCA
Other	Continuity of Care			The language in the agreement continues to focus on least restrictive setting and discourages the use of institutional services. The program appears to be more geared toward consumers that are not currently receiving services in a nursing center or those that have been in a nursing center for a limited period of time. How the program will be beneficial to those individuals that are long term residents remains unclear. Careful consideration must be given to the long term residents and how to ensure continued quality of life.	PHCA
Other	Eligibility			***Process Flow Chart.*** To fully help consumers, providers, the CHC- MCOs, and other stakeholders understand the eligibility and enrollment process we urge the Department to provide a flow chart that outlines the steps in the process, timeframes for approval, and the entity at risk for the provision of services while eligibility is being finalized. Given that consumers will be enrolled from different settings- it is important to have a well-defined process. A flow chart will benefit the consumer, the provider, the Department and the CHC-MCO.	PHCA
Other	Eligibility			***MA Pending.*** The Department should be responsible for the MA pending period that is later determined to be covered by MA, as well as any retro-period covered after resolution of an appeal. The Department should pay the NF under FFS for these days of care at the nursing facility's case-mix rate. It is our recommendation that because the individual is MA eligible during a penalty period – the individual is only responsible for room and board during this period- under CHC the resident choose an MCO and the MCO be obligated to pay the nursing facility for the days of service and be responsible to collect payment for the days of care from the resident.	PHCA
Other	Eligibility			***PA 162.*** It is our recommendation that the CAO provide the PA 162 to both the nursing facility and the CHC-MCO and that the nursing facility manage the resident's patient liability dollars. Routinely, if an individual is in a nursing facility, the nursing facility will assist the resident and their family with the initial application as well as the renewal process; it is our recommendation that nursing facility have the authority to continue this practice. Nursing facilities should continue to receive eligibility information from the CAO as well- PA 162.	PHCA
Other	Eligibility			***Financial Eligibility Process*** . Historically, there have been significant delays in MA eligibility determination for residents in nursing facilities. The Department should work with their CAO staff to improve the efficiency and effectiveness of this application process. PHCA has made several suggestions on how to streamline the process and would welcome the opportunity to work with the Department to improve the process.	PHCA
Other	Other			***Ombudsman.*** The role of the Ombudsman was not addressed in the Agreement. It is important they are educated on CHC and the CHC-MCOs are educated on the role of the Ombudsman. As part of the educational program the Ombudsmans should be encouraged to work with the nursing facilities and the CHC-MCOs in the best interest of the resident/Participant.	PHCA
Other	Other			***Level of Care Tool*** . This issue is among the most important provision of the CHC program, as many ongoing care decisions will be based off of the LoC determination. It is therefore imperative that the tool be developed in a manner that ensures accuracy and consistency, addresses all components of care and support services, and is validated and tested. It is recommended that all stakeholders have an opportunity to review the tool, provide input, and work with the Departments to test it in real world situations before implementation.	PHCA
Other	Enrollment & Disenrollment			***Auto Enrollment.*** It is recommended that for a resident in a nursing facility, the Department's algorithm for plan assignment should give priority to the CHC-MCOs that have contracted with that nursing facility. This is particularly critical if the Department does not decide to extend continuity of care protections such as an extended 'any willing provider' provision in the program.	PHCA
Other	Enrollment & Disenrollment			It is recommended that the Department implement real-time monitoring of the enrollment process during the transition period – so issues and inefficiencies can be identified and addressed immediately. Prior to implementation it is recommended that the Department adopt enrollment process performance measures and monitoring techniques to evaluate transitions from FFS to CHCs.	PHCA
Other	Enrollment & Disenrollment			***Transfers between CHC-MCOs.*** A flow chart on the process with timeframes and responsibilities will be very helpful for the affected provider and the Participant and help to ensure a seamless transition.	PHCA

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Other	Other			***Bed Need Policy.*** It is recommended 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 quality NFs to be part of the CHC- MCO network without going through a need assessment. We also recommend that any nursing facility that has an existing agreement with the Department under the bed need program to meet a certain percentage of MA residents no longer be obligated to fulfill that agreement. Upon full implementation of the CHC program, they will lose their ability to ensure they meet the MA penetration requested by the Department, and cannot be held to the prior agreements.	PHCA
Other	Other			***Replacement Bed Process.*** The Replacement Bed review process should also be eliminated. The vast majority of these requests involve the reconfiguration of a facility in a manner that is designed to have a positive impact on a resident's quality of life. There is no benefit for the Department to continue to use resources to review requests that in most cases will improve the quality of life for residents and under CHC have no financial impact on the Department.	PHCA
Other	Other			***Case-Mix Rate System.*** It is our strong recommendation that case mix rates be calculated assuming that all providers remain in the FFS system throughout the phase-in of the CHC program. Once the program is fully implemented, decisions can be made regarding the ongoing calculation of rates pending other program decisions around the maintenance of a FFS rate structure for those consumers who may not be cost effective in a capitated payment structure.	PHCA
Other				It seems contrary and to border on disingenuous to solicit public comment while promoting the use of a specific template as being preferred when that template is unnecessarily confusing and unfamiliar to many of the consumers most likely impacted by the proposed changes. The use of an instrument purposely designed to aid in the compiling of data by those soliciting the public rather than facilitate the public's ability to offer comment is an offense to the spirit of the process of public review.	Farley Wright AAA resident and senior citizen
Other				The seemingly unnecessary haste in which the Commonwealth is proceeding with what amounts to a huge shift in the way in which it provides services to a large consumer group is concerning. The potential magnitude of the consequence demands a thorough and patient effort. It almost seems as though the decision was made to move forward and now, despite some acknowledged problems, we are in a race to keep pace with the pre-established timeframes rather than focusing on insuring the changes are in the best interests of the consumer.	Farley Wright AAA resident and senior citizen
Other				With the Commonwealth's prolonged budget impasse, the haste of the process is exacerbated by the limited ability of some segments of stakeholders to participate. Gutted by a lack of revenue from the state, many critical players in the Long Term Care system are short on staff and resources needed to meaningfully participate in the review and commentary sought through the current process and required by the Centers for Medicare and Medicaid Services. Being so compromised renders the intended spirit of the open and participatory process to be severely compromised. It would make sense that until the Commonwealth is able to restore funding to these critical stakeholders, the process should be put on hold.	Farley Wright AAA resident and senior citizen
RFP				The rfp defines little in the way of specifics. Many of the details are couched in the prospective MCO's response to the rfp question, "Explain how you would provide for…?" Taking an approach that has the prospective bidder provide detail to concepts expressed in the rfp render making comment difficult.	Farley Wright AAA resident and senior citizen

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Requirements Document	Section V.D. - Choice of Provider	pgs. 44 and 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	As an Area Agency on Aging administrator, I am concerned with the qualification requirements for the Service Coordinators and the Service Coordinator Supervisors. I am unaware of any concerns expressed in the past with regard to the existing qualifications and competence of SC's and/or SC supervisors. While comments regarding inconsistency of how services are applied from county to county have been made, the inconsistency was attributable to a lack of overall standards and training than to lack of individual qualification or competence. To the contrary, over recent years the DHS (formerly known as DPW) has promoted efforts to focus on cost efficiencies including converting SC or case management under the Aging waiver program (as well as other waiver programs) to a structured billable units reimbursement for services format. Critical to this change was to insure the services of the SC were brief and compacted… even allowing for phone calls as allowable contacts…and left no room for clinical observation or lengthy discussion. Actually, as the conversion was implemented less than 2-3 years ago, we were advised that nursing services were an unallowable expense and not eligible for reimbursement as a part of billable time. Our agency and I suspect others as well, ended up furloughing our RN's as a result of the changes implemented by DHS. While we believed the value of the clinical expertise was important to our provision of SC services and that appropriate time and consideration provided to a consumer is of significant value, without the cost of nursing staff being reimbursed through the waiver program, we were unable to continue their employment. Now as DHS moves to convert to Managed Care and have SC provided via contract with managed care organizations, the qualifications for SC's and SC Supervisor's include and seemingly prefer a nursing degree. We find ourselves confused with what seems to be a very arbitrary shift that by impact precludes many of the AAA's from being able to compete for SC contracts without modifying its current workforce to add the very types of positions we recently left go. We must do so while continuing to provide waiver services which don't permit the cost of nursing services to be reimbursed…effectively stifling our ability to "ramp up". The current 1951 (c) waiver application as amended and with an effective date of October 28, 2015 and as hosted on the dhs.pa.gov website, does not mention nursing qualifications for SC workers. The only mention that I am aware of is the requirement to have access to an RN consultant, either as employee of the SC organization or by virtue of a consulting contract. Further, the qualifications stipulated in the draft clearly exceeds and conflicts with PA Code, (PA Code, Chapter 52, §52.27). Our agency has made the necessary modifications to staffing to insure compliance with the requirements currently in place, and absent access to waiver reimbursement for nursing services, lacks the resources necessary to engage staff needed to meet the new standards of qualification proposed in the draft. From my perspective, this unfortunately seems to be a continuation of what appears to be an effort to displace the AAA's as providers of service under the waiver program. Moreover, by design, the proposed document will displace large numbers of public non-profit county employees that in good faith met the civil service requirements of the position as defined yet now find they are unqualified to perform the duties of the very job they've performed for years.	Farley Wright AAA resident and senior citizen
RFP	Work Statement Questionnaire	Pages 29-41		Please clarify the page limits as specified in the draft RFP. Will DHS be adjusting the page limits to reflect requirements per question? If not, will DHS consider increasing the page limit requirements given the volume of questions in each section and the requirement to include the question on the page?	Geisinger Health Plan
RFP	Proposal Requirements	Part II-B (f), page 23	Exceptions for paper and font size are permissible for project schedule (Microsoft Project) or for graphical exhibits and material in appendices which may be printed on white paper with dimensions of 11 by 17 inches.	If exhibits are provided in table format, does the font size exemption apply to tables embedded within the text response apply just as it does for graphical exhibits and material in appendices as listed in Part II-B.f.?	Geisinger Health Plan

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RFP	Criteria	Parts III-5 and III-6(c), pg. 51	The Issuing Office must select for negotiations the offerors with the highest overall scores for each zone; PROVIDED, HOWEVER, THAT AN AWARD WILL NOT BE MADE TO AN OFFEROR WHOSE PROPOSAL RECEIVED THE LOWEST TECHNICAL SCORE OF THE RESPONSIVE PROPOSALS RECEIVED FROM RESPONSIBLE OFFERORS. IN THE EVENT SUCH A PROPOSAL ACHIEVES THE HIGHEST OVERALL SCORE, IT SHALL BE ELIMINATED FROM CONSIDERATION AND AWARD SHALL BE MADE TO THE OFFEROR WITH THE NEXT HIGHEST OVERALL SCORE.	In Parts III-5 and III-6 of the RFP, the DHS outlines the final ranking and award for the program. Geisinger request clarity around the ranking and final selection process. Specifically, please define the intent of the exclusion language contained in Part III-6(C). How could a plan receiving the lowest technical score, 80% of overall weight, achieve the highest overall score?	Geisinger Health Plan
Requirements Document	Section V.A. - Covered Services	Part 7, Page 29	The CHC-MCO must coordinate with the BH-MCO as necessary to ensure that Participants receive all Medically Necessary Behavioral Health Services.	Will DHS be providing guidance to the BH-MCOs around requirements to particiapte in coordination with the CHC-MCOs? This will help plans design plans that efficiently and properly coordinate services for enrollees.	Geisinger Health Plan
Requirements Document	Section V.A. - Covered Services	Part A.21.a-d., Page 35	The CHC-MCO must promote innovation in the service delivery system. This includes innovation pursued by the CHC-MCO on its own initiative, as well as collaborative efforts involving the Department, CMS and local partners.	Must plans participate in all outlined examples of DHS initatives as well as their own or are these provided as examples?	Geisinger Health Plan
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	Part F, Page 40	The first bullet states that the comprehensive needs assessment must be completed in accordance with timelines outlined in Services Prior to Effective Dae of Enrollment.	Where do we find the timelines addressed in this section?	Geisinger Health Plan
Requirements Document	Section V.E. - Needs Screening	Part E, Page 40	Upon Enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or need for Service Coordination.	When will the approved tool be released?	Geisinger Health Plan
Requirements Document	Section V.H. - Person Centered Service Plans	Part H, Page 42	PCSPs must be developed for all Participants who have had comprehensive needs assessments.	Are PCSPs required for all Participants in the program regardless of acuity or needs?	Geisinger Health Plan
Requirements Document	Section V.M.- Coordination of Services	Part M, Page 44	The continuum of services may include the Covered Services, out-of-plan services, and non-MA Covered Services provided by other community resources.	Please confirm that coordination of out-of-plan services is limited to helping the Participant access the service and does not include payment for the services.	Geisinger Health Plan

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Part P.4., Page 60	The CHC-MCO must establish and maintain a Health Education Advisory Committee that includes Participants and Providers in the community to advise on the health education needs of Participants.	Can the activities of the Health Education Advisory Committee be combined with other committees such as the Participant Advisory Committee in cases where activities overlap?	Geisinger Health Plan
Other		General Comment		**Intent/Definition of Service Coordination**-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program. One example of where this is important is when considering the continuity of care period. If service coordination is a provider service, the continuity of care period would definitely apply. If it is an administrative function, we are not sure if that provision would apply to service coordination.	P4A
Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	P4A
Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems**- The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	P4A
Requirements Document	Section II - Definitions	p. 14	Participant Advisory Committee (PAC)- A group convened in person, at least quarterly by the CHC-MCO's governoring board which is open to all participants and which reflects the diversity of the CHC-MCO's Participant population.	**Participant Advisory Committee Makeup -** We recommend that the PAC meetings be formed for, and held in, each zone (for instances where MCO may cover more than one zone) and have representation for rural and urban counties in each particular zone.	P4A
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Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department** – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	P4A
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	P4A
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	P4A
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	P4A

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	P4A
RFP	Part I, General Information	Subsection I-4, Page 9	The CHC Program will be implemented in three phases over the next three years. Phase one is anticipated to be implemented in January 2017 and will encompass the Southwest zone; phase two is anticipated to be implemented in January 2018 and will encompass the Southeast zone; and phase three is anticipated to be implemented in January 2019 and will encompass the Lehigh/Capital zone, the Northwest zone and the Northeast zone.	We recommend a shorter implementation. We suggest 6 month phases. Phase 1 would be implemented in January 2017, Phase 2 in July 2017 and Phase 3 in January 2018. The condensed timeframe allows DHS to more quickly meet its goals of enhancing opportunities for community based living, strengthening coordination for complex populations, enhancing quality, increasing accountability and realizing appropriate cost savings. In Philadelphia, Secretary Osborne said that "Every poll that I have ever seen, it says 95 percent of folks would rather age in their home or community rather than a nursing home... I think what the governor is trying to get to is right now 95 percent or above would like to live in the community. We are a little bit above the number of 50/50 of folks who live at home and folks who reside in nursing homes." There is a very large gap between where the State is now (at 50%) and where they are trying to be (at 95%). A shorter implementation will allow more beneficiaries to be served in their homes and in their communities. Since many individuals in CHC have chronic and co-morbid conditions, the condensed implementation allows these individuals to benefit from care coordination more quickly. With person-centered care planning and LTSS coordination, outcomes and member experience will be improved more quickly. An expedited rollout will also accelerate financial savings for the State as individuals are appropriately transitioned from more costly institutional settings to more cost effective community settings. Significant savings will also be accelerated as care coordination will address avoidable hospitalizations and emergency room visits. Given the proven framework of HealthChoices, many providers and advocates are familiar with managed care. Selected MCOs will be committed to working with advocates and providers to educate and transition newly eligible individuals to the HealthChoices program in a person-centered manner that minimizes confusion and ensures continuity of care. Nationally, MLTSS programs have been implemented in multiple states where they developed and matured for a number of years. Pennsylvania can take advantage of those best practices to simplify implementation of CHC and more quickly realize its benefits.	Magellan Health
Requirements Document	Section V.EE. - QM & UM Program Requirements	Subsection 1, Page #: 94	The CHC-MCO must comply with the Department's Quality Management (QM) and Utilization Management (UM) Program standards and requirements set forth in Exhibit M(1) Quality Management and Utilization Management Program Requirements, Exhibit M(2) External Quality Review, and Exhibit M(4) Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®).	Will the Exhibit "M" Documents be released on December 14th as part of the additional draft materials? If so, please allow a period of time-at least one week-for interested parties to review and submit comments back to the Department on those additional materials.	Magellan Health

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Requirements Document	Section V.A. - Covered Services			I use a combination of consumer-driven hours and agency model hours. As far as the consumer-driven hours are concerned, I use this model at home. I have heard from other consumers that there is a possibility that some ancillary services would be removed under the new program. While sometimes my family members participate in meal preparation and ancillary tasks such as these, this is not a guarantee. Eating is still a basic human need. If such ancillary tasks as eating and cleaning are not an approved part of my service plans, am I not supposed to eat? Am I supposed to snap my fingers and suddenly be able to use the stove? This is just one example of many. On a wider scale, I use these services to survive. I have significant spastic, quadriplegic cerebral palsy and I use a motorized wheelchair for mobility. I need someone to physically transfer me on and off the toilet, shower me, dress me, feed me, and complete a lot of other daily tasks that a large majority of the population takes for granted. Should I really have to worry even more than I already do about whether I am going to have someone available to take me to the bathroom at the scheduled time. There are days when it is a matter of "when" that is going to happen. With these changes, I do not want this to turn into a matter of "if." Having said that, I also work. I currently have three jobs and I am a Licensed Professional Counselor and National Certified Counselor. I use the agency model for hours during my lunch break at work so that if my agency attendant is not coming for some reason, the agency automatically sends someone else. I would not be able to work if that was not an option because I do not have the availability to find someone else to take care me while I'm at work because I'm doing my work-related duties, which means being available to the clients to my am providing therapy services. My work is a huge part of my identity as a person and I do not know where I would be without my chosen profession. Transportation to work is a problem. I cannot use public transportation because of the location where I live. In addition to that, the "window" of pickup times that is part of the way adaptive public transportation works would not work for me because I have very specific times when I have someone available to take me to the bathroom, and if the transportation is an hour late, I would literally be urinating on myself. This cannot happen. Currently, my parents transport me to and from work, but when they are not able to do this any longer, I do not know how it will happen because I am not currently allowed to have an attendant drive my adapted vehicle as part of my service hours.	Lauren Ostrowiski Licensed Professional Counselor
Requirements Document	Section V.L. - Nursing Home Transition			How will continuity be maintained for the consumers that are in the middle of a transition home? Continuity for this population is critical to ensure that all needs and services are being met. A disruption or change in NHT provider working with them could devastate the entire process and result in a permanent or longer stay.	Stephanie Quigley Director, Nursing Home Transition Abilities In Motion
Requirements Document	Section V.L. - Nursing Home Transition			The goal of CHC is serve people in the community, therefore Nursing Home Transition is a crucial part of accomplishing that and you need to have experienced, successful providers doing this work. NHT providers are specialized and have skills that SCs do not have, i.e. working consistently in healthcare facilities. Allowing SC agencies that have no experience doing NHT will not be of benefit to the consumer, often times SCs themselves create problems and add additional barriers within the NFs.	Stephanie Quigley Director, Nursing Home Transition Abilities In Motion
Requirements Document	Section V.L. - Nursing Home Transition			NHT should be done by CILs, in keeping with WIOA, transition services are a core service of Centers For Independent Living and should remain there. There is also opportunity to explore employment services for youth transition within the framework of CHC if looking at WIOA and CILs. CILs have the ability to serve all ages and have always done so.	Stephanie Quigley Director, Nursing Home Transition Abilities In Motion
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	41	Reassessments must be completed as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participants health status and needs, but in case more than 14 days after the occurrence of any of the following trigger events.	Suggestion to change occurrence to notification of any of the following trigger events. Reason for suggestion: If Medicare parts A & B are the participant's primary coverage, we may not be aware of the actual occurrence but may receive notification following the occurrence and will then complete the assessment within the assigned timeline.	Health Partners Plans/Patricia Wright
Requirements Document	Section V.L. - Nursing Home Transition	44	Service coordinators may coordinate NHT services	Comment: the Concept Paper stated CHC-MCOs will contract with NHT providers to identify NHT-appropriate participants and coordinate their NHT services. The Draft Agreement indicates that the Service Coordinator may coordinate NHT. Is this to indicate that the MCOs are no longer required to contract with the NHT providers to perform this function?	Health Partners Plans/Patricia Wright

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Page 46 1. General	The CHC-MCO is prohibited from restricting its Participants from changing CHC-MCOs for any reason. The Participant has the right to initiate a change in CHC-MCO's plans at anytime.	• A strong participant / service coordinator relationship is critical to the success of a person-centered service planning process and ongoing coordination of services. HPP understands the importance of participant choice and protection; however, permitting a participant to switch MCOs at any time will hinder the development of a crucial Participant / Service Coordinator relationship and create a potential need for the participant to change the provider of their health care service(s), thereby affecting the time needed to fully assess and measure the impact of the services outlined in their service plan. It can also present opportunities for fraud and abuse when multiple transfers occur over a period of time. • Furthermore, a participant may be put at risk of having a disruption in their service delivery if a provider chooses to discontinue the current services once they become aware of the change in MCOs. The provider may choose to wait until they receive a new authorization from the new MCO before resuming service delivery. The MCOs will make every effort to educate providers that DHS requires them to continue service delivery in these situations with assurance that the current service will be honored and reimbursed until a new Individual Service Plan can be developed; however, we cannot control a provider's decision. • HPP supports a CHC-MCO transfer provision change to a one-year enrollment period with the ability to change CHC-MCOs within a 90 day time frame after initial enrollment. In the event that a participant expresses a desire to transfer outside the initial 90 day time frame or one-year enrollment, the Commonwealth could consider a "with cause" exception. A set of causes could be defined and available to participants at enrollment. This would enable the participant's ability to transfer, but limit the possibility of monthly transfers and minimize service delivery disruption.	Health Partners Plans/Patricia Wright
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Pest Eradication	Pest eradication services will be available to make a Participant's home fit for the Participant to live there. Pest Control Services are intended to aid in maintaining an environment free of insects, rodents and other potential disease carriers to enhance safety, sanitation and cleanliness of the Participant's residence. The service may be considered for inclusion in the Individual Service Plan (ISP) for a Participant transitioning to the community. It can also be made available on an ongoing basis if necessary as determined by the Service Coordinator (SC) and documented in the ISP. That documentation needs to include the amount, duration and scope of services as determined by the SC. The service cannot be made available as a preference of the Participant to remove something on a property that has no impact on the Participant living there.	Suggestion: to provide parameters around the benefit definition to define the following: 1) Place of service to exclude apartment that serves as the participants home as this is a service the apartment/rental complex should provide. 2) consider defining pest services (i.e. bed bugs, rodents) included in the benefit.	Health Partners Plans/Patricia Wright
Requirements Document	Section V.I. - Department Review of Changes in Service Plans	43	The Department may review and revise any Person-Centered Service Plan. The CHC-MCO must provide the Department with weekly aggregate reports on PCSP changes	Please provide clarification that this requirement is to report any change including provider changes, increase in services, and / or participant requested changes. We would like to suggest that the weekly report be required to include only service reductions that are not defined as a reduction of one service replaced by the another service (i.e. reduction in personal attendant hours so that the participant can attend a day program). In addition, please consider participant requested service changes as non-reportable.	Health Partners Plans/Patricia Wright

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Requirements Document	Section V.E. - Needs Screening	40	Upon Enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or need for Service Coordination.	Our interpretation of the Needs Screening tool is that it applies to all newly enrolled individuals and is comprised of a health risk questionnaire. Is this interpretation reflect DHS expectation?	Health Partners Plans/Patricia Wright
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	40	For Participants that are NFCE but are not receiving LTSS at the time of Enrollment, the comprehensive needs assessment must be completed in accordance with the timelines outlined inServices Prior to Effective Date of Enrollment. For Participants that are Dual Eligible and identified by the IEE as having a need for immediate services, the comprehensive needs assessment must be completed in accordance with the timelines outlined in Prior to Effective	We are unable to locate the timelines outlined in Services Prior to Effective Date of Enrollment in the draft Agreement.	Health Partners Plans/Patricia Wright
Requirements Document	Section V.H. - Person Centered Service Plans	43	• Communications Plan	Nationally this term is defined in different ways. Can you please clarify Pennsylvania's definition of Communications Plan.	Health Partners Plans/Patricia Wright
RFP	General Information			What is going to happen to all participants under the ACT 150 program and the proposal indicates these individuals will no longer be eligible for LTSS.	Casey Ball Supports Coordination, LLC
RFP	General Information			It is reported the CHC-MCO can either complete service coordination themselves or delegate it to community partners, how is this conflict free?	Casey Ball Supports Coordination, LLC
RFP	General Information			What will the new rate for service coordination be once the CHC-MCO takes effect?	Casey Ball Supports Coordination, LLC
Other		General Comment		**Intent/Definition of Service Coordination**-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program. One example of where this is important is when considering the continuity of care period. If service coordination is a provider service, the continuity of care period would definitely apply. If it is an administrative function, we are not sure if that provision would apply to service coordination.	Chester County Department of Aging Services
Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	Chester County Department of Aging Services
Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems-** The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	Chester County Department of Aging Services

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Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	Chester County Department of Aging Services
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	**Willing Provider Definition –** In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	Chester County Department of Aging Services
Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department** – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	Chester County Department of Aging Services
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	Chester County Department of Aging Services

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Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	Chester County Department of Aging Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	Chester County Department of Aging Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	Chester County Department of Aging Services
Other		General Comment		**Intent/Definition of Service Coordination**-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program. One example of where this is important is when considering the continuity of care period. If service coordination is a provider service, the continuity of care period would definitely apply. If it is an administrative function, we are not sure if that provision would apply to service coordination.	Active Aging, Inc.
Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	Active Aging, Inc.
Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems-** The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	Active Aging, Inc.
Requirements Document	Section II - Definitions	p. 15	Person Centered Planning Team- The team of individuals that will participate in Person Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT	**Person Centered Planning Team Makeup** - We recommend OLTL include the minimum acceptable required individuals and also include other suggestions/preferences for individuals on the team. We also recomment that OLTL require that if there is a behavioral health diagnosis, a behavioral health representative be required on the team.	Active Aging, Inc.

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Requirements Document	Section II - Definitions	p. 15	Person Centered Planning Team- The team of individuals that will participate in Person Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT	**Person Centered Planning Team Makeup** - We recommend OLTL include the minimum acceptable required individuals and also include other suggestions/preferences for individuals on the team. We also recomment that OLTL require that if there is a behavioral health diagnosis, a behavioral health representative be required on the team.	Active Aging, Inc.
Requirements Document	Section V.A. - Covered Services	p.26	In-Home and Community -Based Services- The CHC- MCO may not deny personal assistance services for Participants under the age of 21 based on the Participant's diagnosis or because the need for personal assistance is the result of a cognitive imparment…	**Personal Assistance Services** - We recommend removing "under the age of 21" so that no conumer could be denied personal assistance services based on the participant's diagnosis or because the need is based on a cognitive impairment	Active Aging, Inc.
Requirements Document	Section V.A. - Covered Services	p.26	The CHC-MCO may not deny a request for Medically Necessary in-home nursing services, home health aide services, or personal assistance services for a Participant under the age of 21 on the basis that a live-in caregiver can perform the task…	**In-home Nursing, Home Health Aide or Personal Assistance Services** - We recommend removing "under the age of 21" so that no consumer could be denied under these circumstances.	Active Aging, Inc.
Requirements Document	Section V.B. - Prior Authorization of Services	p. 36	B. Prior Authorization of Services 1.General Prior Authorization Requirements (4th paragraph) When the CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of denial using the appropriate notice outline in templates…	**Notice of Service Denial** - We recommend that when there is a denial of services for those in MLTSS, notification should also be sent to the Service Coordination Agency/entity to ensure continuity and follow up with consumer.	Active Aging, Inc.
Requirements Document	Section V.B. - Prior Authorization of Services	p.37	2. Time frames for notice of Decisions	**Notice of Service Decisions** - We recommend that notice decisions should also be sent to Service Coordinator (entity) if additional information is needed from an MLTSS consumer the Service Coordination Agency should also be notified so they can assist the consumer in acquiring required documentation.	Active Aging, Inc.
Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	**Continuity of Care for LTSS Participants**-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	Active Aging, Inc.
Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	**Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors**-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination supervisors be required to have the same level of education and experience as the MCO Director of Service Coordination. The requirment for an LSW or RN should not be necessary for an SC Supervisor, while the Director of the entire division does not meet that level of requirement. Such degreed staff would likely increase the cost significantly without any measureable return.	Active Aging, Inc.

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Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	**Limited English Proficiency Requirements**- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	Active Aging, Inc.
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	**Management Information Systems**-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	Active Aging, Inc.
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	Active Aging, Inc.
RFP	Criteria	Proposal Requirements. B. Small Diverse Business Submittal; II-3 Prior Experience. A Corporate Background.	A. Offerors must also abide by the Departments' conflict of interest standards identified in Appendix A, Agreement.	Recommendations for RFP: 1. Provide your organizational structure; including any affiliations or agreements with contractors and subcontractors who provide direct services. 2. Provide your procedures to remove affiliations; terminate agreements with contractors and subcontractors who provide direct services if you are awarded this bid. 3. Provide your compliancy policy that ensures future contracts are absent of any affiliations or agreements with contractors and subcontractors who provide direct services. 4. Provide your policy and procedures that ensure that choice of service offerings is made available to participants free of conflict of interest.	
RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 29-#1	1. Describe how you will employ: - Person-centered approaches. - Self-direction. - Incentives for health and wellness. - A focus on sustaining family and personal connections and community involvement. Include how the approaches were/will be measured and reported. Describe your results.	Recommendations for RFP: 1. Describe your goals for increasing consumer direction utilization and penetration. 2. Describe your procedures for providing information about consumer direction, obtaining written confirmation of interest and communicating that referral to the FMS. Please include your plan for reintroducing consumer direction annually to eligible members and confirming interest annually for participating members. 3. Describe how you will assess needs for consumer direction, include members in the development of service plans and communicate what has been authorized for consumer direction. 4. Describe how you will provide HCBS services until consumer direction enrollment is complete 5. Key staff must be assigned to work with the FMS during the implementation phase. Please provide resumes for the following key staff: a. Contract manager - Primary FMS contact. Oversight and management responsibility for FMS implementation b. Technical lead – Oversight and management for electronic transfer of data c. Clinical lead – Oversight and management for care coordination staff d. Claims lead- Oversight and management of claiming 6. Describe the responsibilities of the MCO care coordinator in consumer direction. 7. Describe the responsibilities of the MCO for FMS education. 8. Describe the content and frequency of care coordinator training on case management, person centered planning, self direction	Public Partnerships

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RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 30-#3	3. Describe your experience and approach to screening for needs, conducting assessments and reassessments, and using existing or developing new tools and ;systems to support these processes.		Public Partnerships
RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 30-#4	4. Describe your approach for using the needs screening to identify people with cognitive impairment, acquired or developed. Describe your approach to meeting the needs of this population.		Public Partnerships
RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 30-#5	5. Describe your experience and approach to Participant care management.		Public Partnerships
RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 30-#6	6. Describe your experience with and approach to using a Person-Centered planning team approach to service planning. Describe your plans for using a Person-Centered Planning Team approach in CHC.		Public Partnerships
RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 30-#7	7. Describe your process to ensure that Service Planning is a person-centered process and that Participants' needs, goals, and preferences are at the center of the process. Include the communication process with the Participant and how he or she is supported in the most integrated setting with preference and priority for supporting Participants in their own homes.		Public Partnerships

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RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 30-#8	8. Describe your process for care coordination to ensure that Participants receive adequate in-home services to divert them from entering or returning to acute or long term care facilities.		Public Partnerships
RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 30-#9	9. Describe your plans for delivering comprehensive services that: - Increase access to affordable, accessible housing. - Expand access to community-based integrated employment. - Develop the LTSS direct service workforce. - Expand use of technology among LTSS providers.	**- Develop the LTSS direct service workforce.** General Feedback: A critical aspect of value-based care delivery in managed LTSS is to optimize the full potential of LTSS staff to achieve optimal outcomes, cost effectiveness, and consumer experience for the consumer. Another critical prerequisite for successful MLTSS is to ensure a motivated, competent, and satisfied workforce. Technology can play an important role in achieving these goals. A November 2015 article in Annals of Long-term Care summarizes how technology can optimize achievement of the Triple Aim with an HCBS workforce: http://www.annalsoflongtermcare.com/article/long-term-supports-and-services-logical-next-step-evolution-bundled-payments Recommendations for RFP: 1. Demonstrate your capacity to provide a training curriculum to expand the LTSS direct service workers health literacy in the home and increase their awareness to identify red flag events such as worsening medical or social conditions to care coordination team. **- Expand use of technology among LTSS providers.** General Feedback: Unlike providers, MCO contracted technology vendors are not being held accountable for outcomes. Please see the research referenced here showing how a vast minority of technology vendors have peer-reviewed evidence for their marketing claims: http://blog.careathand.com/2015/07/digital-health-industry-slips-under.html Below are a set of 10 recommendations to ensure that MCO contracted technology vendors are accountable for supporting high-quality, consumer-centric care and achievement of the Triple Aim: Recommendations for RFP: 1. Demonstrate your use of innovative technology that addresses the unique needs of the LTSS community within a HCBS environment. Solution should include: A. Technology should have peer-reviewed evidence to support their marketing claims B. If technology is not evidence based, it needs to validate its claims through quality improvement within 6 months of deployment in order to be reimbursable C. Technology should support quality measurement along all domains of healthcare, not just medical care, such as those being developed by National Quality Forum Committee on Home and Community-based Services D. Reimbursement for technology should be tied to outcomes E. Technology should facilitate early identification of risk factors for acute care utilization using the observations of the existing non-medical workforce already providing care	Public Partnerships

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				medical workforce already providing care F. Technology should support improvement of workforce quality and satisfaction G. Providers should have choice in the technology platforms they use rather than being mandated by the state to use a single platform H. If interoperability is needed, then technology should support interoperability along all domains of healthcare, not just medical care, such as those being developed by the electronic LTSS (eLTSS) workgroup from the Office of the National Coordinator (ONC) I. MCO Technology vendors should be able to demonstrate sustainability of services by showing return-on-investment calculations J. Users of technology, especially those that don't have capacity for rapid system transformation, should be offered technical assistance to ensure they have a baseline capacity for business acumen, quality improvement, and design thinking These 10 principles can help attain CMSs goals for optimizing consumer choice as described in Section 2402(a) of the Affordable Care Act which requires the Secretary to ensure all states receiving federal funds develop service systems that are responsive to the needs and choices of beneficiaries receiving home and community based services.	
RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 30-	10. Describe how you will use community resources, such as community health workers, and natural supports to improve wellness, improve education on health options, and to improve community involvement.		Public Partnerships

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RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 30-#11	11. Describe your organization's experience and your plan for using technology such as assistive technology, telehealth, telecare, social media, electronic visit verification, and other methods to deliver services to the CHC Participants.	Organizations describing their use of technology should reflect the guiding principles listed above in section 9. Of note, the above principles are new, so it is unlikely that MCOs will have existing experience executing the guidelines above. MCOs may use the following examples of progressive HCBS providers working with MCOs to adhere to the above principles with regard to technology adoption. Evidence: Some examples of HCBS providers in Massachusetts developing peer-reviewed evidence to characterize the utility of technology to achieve the Triple Aim include the following: -$9,056 Medicare A savings/beneficiary/year (Avalere 2015 in peer-review) -39.6% reduction readmissions & 257% ROI (AHRQ 2014) -Predict admissions up to 120 days (PHIM 2016 in press) -Role of non-medical staff in bundled payment (ALTC 2015) -Leading Age Remote Patient Monitoring for LTPAC Primer (Leading Age 2015) Quality Improvement: Rigorous use of quality improvement by HCBS providers in Maryland, Washington State, and Massachusetts during times of natural disasters or civic unrest: http://www.ihi.org/communities/blogs/_layouts/ihi/community/blog/itemview.aspx?List=7d1126ec-8f63-4a3b-9926-c44ea3036813&ID=178 Quality Measurement aligned with HCBS: Emerging HCBS quality measures via National Quality Forum and how they can be applied in the context of technology evaluation (slides 20-22): http://www.healthcarefornewengland.org/wp-content/uploads/C3-Sept_Webinar_092415_final.pdf	Public Partnerships
RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 31-#12	12. Describe the techniques, policies, procedures or initiatives you have in place to effectively and appropriately control avoidable nursing facility, hospital, and emergency department admissions and other high-cost services and to increase the use of health promotion, primary care, and Home and Community Based Services (HCBS). Describe how you will determine the level of full time equivalent licensed and non-licensed telephonic and community based personnel that will be involved in these activities. Include the communication process and plan.		Public Partnerships

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RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 31-#13	13. Describe the techniques, policies, procedures, or initiatives you have in place to effectively and appropriately manage the Transition of Care (TOC) for Participants being discharged from inpatient care and how these techniques control hospital and nursing facility admissions and readmissions. Describe how you will determine the level of full time equivalent licensed and non-licensed telephonic and community based personnel that will be involved in these activities. Describe the strategy to be used if selected for award.		Public Partnerships
RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 31-	14. Describe how you encourage provider usage and exchange of interoperable health information, electronic service plans, and how you will develop and implement innovations to use these records to promote better coordination and overall health.	General Feedback: Alignment with Interoperability Standards for LTSS MCOs applying should take into account the interoperability framework for an LTSS care plan as outlined here on slide 23: http://www.healthcarefornewengland.org/wp-content/uploads/C3-Sept_Webinar_092415_final.pdf	Public Partnerships
RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 31-	16.Describe your plan's approach to identifying, reporting, and addressing social determinants of health for Participants.		Public Partnerships
RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 32-	26. Describe the procedures and processes you will have in place for coordination of care to ensure a smooth transition for CHC Participants who transfer between care settings. Specifically describe the support efforts you will use to transition Participants from institutional to community based settings.	General Feedback: Please refer to the evidence section in #11 for examples of research of HCBS providers performing effective care transitions.	Public Partnerships

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RFP	Work Statement	WORK STATEMENT QUESTIONNAIRE/PARTICIPANT SERVICE AND CARE COORDINATION/Page 32-#28	28. Describe how your person-centered service planning process will support family caregivers.		Public Partnerships
RFP	Work Statement	SERVICE INTEGRATION/ Page 33-#1	1. Describe the approaches you will use to integrate MA and Medicare services, including primary, acute and LTSS, to improve Participant experience and outcomes.		Public Partnerships
RFP	Work Statement	QUALITY IMPROVEMENT AND PERFORMANCE MEASURES/ Page 31-#1	1. Describe your strategy for achieving quality performance and outcomes.		Public Partnerships
RFP	Work Statement	QUALITY IMPROVEMENT AND PERFORMANCE MEASURES/ Page 31-#3	3. Describe your strategy for controlling chronic conditions such as high cholesterol, high blood pressure, diabetes, etc.		Public Partnerships
RFP	Work Statement	QUALITY IMPROVEMENT AND PERFORMANCE MEASURES/ Page 31-#4	4. Describe your strategy for addressing the needs of Participants with dementia in community settings.		Public Partnerships
RFP	Work Statement	QUALITY IMPROVEMENT AND PERFORMANCE MEASURES/ Page 31-#6	6. Describe your strategy for approaching service delivery in rural and urban areas including LTSS, preventive, and acute care.		Public Partnerships

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RFP	Work Statement			Draft RFP Comments General feedback: It is recommended that all MCOs agree to a consistent set of policies, procedures, and file formats with the FMS vendor to reduce impact and confusion of beneficiaries and reduce administrative errors caused with inconsistent practices across vendors: • The transition to MLTSS introduces new populations, services and waivers that MCOs may have a lack of experience serving. Billing, claiming, management and case management departments often require orientation and overall awareness of the person centered planning process and self-direction. MCOs should demonstrate a commitment to the development of a case manager/care coordinator training program focuses on the unique needs of those members that select participant direction. The training must include at minimum a person centered planning process, benefits of self-direction including independence, dignity of risk, and self determination. • Significant confusion amongst beneficiaries and their representatives is experienced when switching MCOs or transferring between fee-for-service and MCOs. We recommend the MCOs demonstrate a commitment to utilize consistent enrollment procedures and file exchanges with the FMS vendor for self-direction. MCOs should demonstrate a process to monitor eligibility and member enrollment/disenrollment with timely notification to vendors to reduce the risk of authorization overlaps, denials, billing and claiming challenges. • DHS and MCOs should establish a timeline for consumer transition that allows sufficient time for MCO outreach as well as the FMS outreach and enrollment. One common challenge experienced in consumer directed programs with the transition to MLTSS is the lack of time to complete transition and complicated FMS tax forms required for members to enroll with a FMS and direct their services. Recommendations for RFP: Please indicate your technical capability and willingness to develop and operationalize a consistent set of technical business requirements across multiple awardees: 1. Electronic data transfers between the MCO and FMS will be required for communicating referrals, member demographics, authorizations, consumer direction enrollment and consumer direction disenrollment. Please describe your experience with establishing systems interfaces and your plan for testing and implementation. 2. Please describe how the MCO would provide adequate staffing to implement consumer direction with multiple FMS at the same time as implementing the other MLTSS services. 3. Describe your experience and describe your plan to implement, 270/271 and 835/837 file transfers with the FMS. 4. Describe the process for disenrollment in consumer direction. 5. Members will transition between MCOs. Please describe the guidelines and technology solutions that you will put in place to	

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		PROVIDER NETWORK COMPOSITION AND NETWORK MANAGEMENT/Page 42-#13	Describe how you will oversee the Financial Management Services (FMS) Grantee and the administration of FMS services to Participants.	5. Members will transition between MCOs. Please describe the guidelines and technology solutions that you will put in place to ensure that there are no breaks in service. 6. DHS anticipates contracting with multiple FMS. Please describe how you will accommodate referrals, authorizations and billing when members change FMS. Please consider how late timesheets submitted after a member switches MCOs will be accommodated from an authorization and billing standpoint. 7. DHS expects MCOs to provider periodic reporting to DHS on consumer direction. Please describe how you will provide reporting on the following service elements: a. Referrals b. Enrollment c. Average time to enroll d. Disenrollment e. Utilization Security and Training Requirements: 1. Please describe the security requirements an FMS must meet to comply with the security requirements of your organization. 2. Describe the responsibilities of the MCO care coordinator in consumer direction. 3. Describe the responsibilities of the MCO for FMS education. 4. Describe the content and frequency of care coordinator training on case management, person centered planning, self direction and impact of FLSA on consumers' budgets.	
Other		General Comment		Coordination of CHC Services with Behavioral Health Services- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	Union-Snyder Agency on Aging, Inc.
Other		General Comment		Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems- The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	Union-Snyder Agency on Aging, Inc.
Requirements Document	Section II - Definitions	p. 14	Participant Advisory Committee (PAC)- A group convened in person, at least quarterly by the CHC-MCO's governing board which is open to all participants and which reflects the diversity of the CHC-MCO's Participant population.	Participant Advisory Committee Makeup We recommend that the PAC meetings be formed for, and held in, each zone (for instances where MCO may cover more than one zone) and have representation for rural and urban counties in each particular zone.	Union-Snyder Agency on Aging, Inc.
Requirements Document	Section II - Definitions	p. 15	Person Centered Planning Team- The team of individuals that will participate in Person Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT	Person Centered Planning Team Makeup - We recommend OLTL include the minimum acceptable required individuals and also include other suggestions/preferences for individuals on the team. We also recommend that OLTL require that if there is a behavioral health diagnosis, a behavioral health representative be required on the team.	Union-Snyder Agency on Aging, Inc.

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Requirements Document	Section V.A. - Covered Services	p.26	In-Home and Community -Based Services- The CHC- MCO may not deny personal assistance services for Participants under the age of 21 based on the Participant's diagnosis or because the need for personal assistance is the result of a cognitive impairment…	Personal Assistance Services - We recommend removing "under the age of 21" so that no consumer could be denied personal assistance services based on the participant's diagnosis or because the need is based on a cognitive impairment	Union-Snyder Agency on Aging, Inc.
Requirements Document	Section V.A. - Covered Services	p.26	The CHC-MCO may not deny a request for Medically Necessary in-home nursing services, home health aide services, or personal assistance services for a Participant under the age of 21 on the basis that a live-in caregiver can perform the task…	In-home Nursing, Home Health Aide or Personal Assistance Services - We recommend removing "under the age of 21" so that no consumer could be denied under these circumstances.	Union-Snyder Agency on Aging, Inc.
Requirements Document	Section V.B. - Prior Authorization of Services	p. 36	B. Prior Authorization of Services 1.General Prior Authorization Requirements (4th paragraph) When the CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of denial using the appropriate notice outline in templates…	Notice of Service Denial - We recommend that when there is a denial of services for those in MLTSS, notification should also be sent to the Service Coordination Agency/entity to ensure continuity and follow up with consumer.	Union-Snyder Agency on Aging, Inc.
Requirements Document	Section V.B. - Prior Authorization of Services	p.37	2. Time frames for notice of Decisions	Notice of Service Decisions - We recommend that notice decisions should also be sent to Service Coordinator (entity) if additional information is needed from an MLTSS consumer the Service Coordination Agency should also be notified so they can assist the consumer in acquiring required documentation.	Union-Snyder Agency on Aging, Inc.
Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	Continuity of Care for LTSS Participants- To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	Union-Snyder Agency on Aging, Inc.
Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	Union-Snyder Agency on Aging, Inc.
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	Limited English Proficiency Requirements- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	Union-Snyder Agency on Aging, Inc.

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Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following components to its MIS or the capability to link to other systems containing this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	Management Information Systems-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	Union-Snyder Agency on Aging, Inc.
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		Intent/Definition of Service Coordinator- There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	Union-Snyder Agency on Aging, Inc.
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC- MCO.	Willing Provider Definition – In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	Union-Snyder Agency on Aging, Inc.
Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	Notification to Department – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	Union-Snyder Agency on Aging, Inc.
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	Complaints and Grievances – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC- MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	Union-Snyder Agency on Aging, Inc.
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	Definition of Travel Time – In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	Union-Snyder Agency on Aging, Inc.

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	Definition for Respite Care-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	Union-Snyder Agency on Aging, Inc.
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	Responsibility of Annual Level of Care Redetermination- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	Union-Snyder Agency on Aging, Inc.
RFP	V, V	65		Director of LTSS requirements are not sepcified, should they be?	JEVS Human Services
RFP	V, W	66		Director of service coordination requirements are not specified either	JEVS Human Services
RFP	V, DD	88-89	"To minimize the disruption of services to Participants, the CHC-MCO must enroll in its Provider network all willing and qualified LTSS Providers that provide HCBS through the OLTL waivers in effect prior to CHC implementation date and through all Nursing Facilities in the assigned zone."	Does this mean the MCO must enroll in its network all willing and qualified LTSS providers, or that if it chooses to enroll a particular provider, that it does so prior to the CHC implementation date in the assigned zone?	JEVS Human Services
Other		180		6 months is too long to wait for a provider manual to be updated in response a program or policy change(s) made by the Department via M.A. bulletin or issuance of an M.A. bulletin.	JEVS Human Services
RFP		44	Supervisor's credentials to be a licensed social worker or an RN.	Some elements of supervision require experience as a service coordinator, some require business expertise and some require clinical and or medical expertise for the purpose of oversight in reviewing care plans or complex cases.	JEVS Human Services
RFP		44	Service Coordinator Credentials	We propose one year of experience if a person has a Bachelor's degree. The experience should include the coordination of services.	JEVS Human Services
RFP		44	General comment on raising quality	in addition to service coordination entities having oversight from RN's or licensed social workers, getting credentialled from a national body such as NCQA should also be considered.	JEVS Human Services
Requirements Document	Covered Benefits	V. A.19 p34	service shall also include annual preventive care reminders and caregiver resources…..	Annual preventive care reminders should be sent to caregivers also.	Allegheny County AAA
Requirements Document	Needs Assessment & Reassessment	V.F., p 40-41	for any additonal LTSS required between Service Plans……	This section should be clearer on who is responsible for the comprehensive needs assessment and who is responsible for care plan changes.	Allegheny County AAA

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Requirements Document	Needs Assessment & Reassessment	V. E p 40	Requires CHC-MCO's to conduct a needs screening….	Clarify if this will be a uniform tool used by all MCOs.	Allegheny County AAA
Requirements Document	Needs Assessment & Reassessment	V. F p 40-41	Reassessments must be conducted annually…	Clarify what entity does this and how is it coordinated with SC and MCO.	Allegheny County AAA
Requirements Document	Service Coordination	V. K p 44	All employed/contracted…….	Clarify whether the Supervisor needs to be a LSW or RN if there is an RN on care team approving the care plan?	Allegheny County AAA
Requirements Document	Service Coordination	V. L p 44	NHT services which may be coordinated by SC'S	Will NHT be a stand alone service or part of Service Coordination?	Allegheny County AAA
Requirements Document	Needs Assessment & Reassessment	V. I. p 43	The right of DHS to review and revise any Service Plan	Clarify how this process will work and can the DHS over rule changes.	Allegheny County AAA
Requirements Document	Section V.A. - Covered Services	V. A4 p27	MCO's are permitted & encouraged to offer LTSS to participants who are not yet NFCE.	MCOs should be encouraged to purchase these services.	Allegheny County AAA
Requirements Document	Section V.P. - Participant Services	Pg32	Non-Medical Transportation covers…..	We recommend eliminating the current $215 monthly cap, which is a significant barrier to successful community placement, esp. for the 60-64 population.	Allegheny County AAA
Requirements Document	Section V.P. - Participant Services	pg.34 Participant Directed Services	…who can be a family member	Current regs do not permit spouses, children under 18 or POA. Will this remain in place? If so, it should be added.	Allegheny County AAA
Requirements Document	Section V.A. - Covered Services	pg. 35 Service Delivery Innovation	Housing innovation request in 21.a	Housing services seem to be not mandatory as a piece of service coordibation. The MCO must, however, promote innovation in the delivery of housing services. More clarity on this topic along with the other services mentioned on page 35 would be helpful.	Allegheny County LINK for Disability and Homelessness Services
Requirements Document	Section V.B. - Prior Authorization of Services	Pg36 Prior Authorizatio n	Emergency Services	Add emergency Nursing Home placement & 24 hour in-home respite as emergency services.	Allegheny County AAA
Requirements Document	Section V.C. - Continuity of Care	pg39 Continuity of Care	A participant who is receiving LTSS through an HCBS Waiver, existing services…180 days or until….	This is not enough time. We recommend 18 months.	Allegheny County AAA
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Pg.50- LEP Requirement s	The CHC-MCO must provide at no cost…	Why not just add it as a LTSS service?	Allegheny County AAA
Requirements Document		Pgs. 4-18 Exhibit Exhibit GG	Participant Complaint, Grievance and DHS Fair Hearing Process	Could this be a function of the Ombudsman due to need for unbiased Prt advocate?	Allegheny County AAA
Requirements Document	Section V.X.- Administration	Pg.66 Other Admin. Components	A full-time Director of SC….	These requirements are less than those being required for a SC Supervisor.	Allegheny County AAA

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Requirements Document	Section V.AA. - Selection & Assignment of PCPs	Pg 83	If a participant does not select a PCP within 14 days of enrollment, the CHC-MCO must make an automatic asssignment…..	This isn't enough time for older adult participants to make a major choice like this. We recommend 30 days minimum.	Allegheny County AAA
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	PG.84 Selection & Assignment of SC's	The CHC-MCO must offer the participant the choice of at least 2 Service Coordinators.	Clarify whether it's individual SC or SC entities?	Allegheny County AAA
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators		If a participant does not select a SC within 14 business days of enrollment…	Clarify "automatic".	Allegheny County AAA
Requirements Document	Section V.DD. - Provider Network	Pg. 89 Provider Network	This requirement will remain in effect for HCBS Providers for the first 180 days…	This is Insufficient time. We recommend 2 years.	Allegheny County AAA
RFP	Proposal Requirements	p19 Definitions	Service Coordinator and Service Coordination: …appropriately qualified professional, etc.	Change name(s). Title will be confusing for individuals receiving Service Coordination and have a Service Coordinator on the BH side. These individuals make up a large part of those who may be eligible and enroll in this program	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	p25 Definitions	PBM - Pharmacy Benefit	Pharmacy Benefit Manager	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.A. p 26	Covered Services : ..must ensure that all PHS provider are medically necessary	Appendix provides list of minimum covered benefits, but no discussion of minimum requirements for medical necessity criterion or interepretation	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.B.. p 36	Prior Authorization	Include language of "hold harmless" to the subscriber/participant. Responsibility for prior auth should clearly remain with referring and/or receiving provider. This should not be sole responsibility of participants.	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.B.2.d p 38	..CHC-MCO must mail written notice of denial to participant	Participants should be given option of alternative/additional person(s) for notification and all correspondence should be sent to both	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.C p 39	…CHC-MCO must continue to allow the Participant to receive services for a 60 day period and must pay that provider until such time that an alternative network provider can be identified….	Suggest requirement that CHC-MCO be required to pay up to 60 days or longer, and until such time that an alternative, in-network provider be identified which is qualified to, and begins to deliver the same LTSS services as the former provider.	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.D. p.40	Participants must be afforded choice of provider	Suggest inclusion of geoaccess requirements that take into account the driving or transportation distance.	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.F. p41	Comprehensive Needs Assessments and Reassessments	Specify instead of behavioral health to use " mental health and drug and alcohol screening"	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.H. p 42	Person-centered Service Plans	Include language that requires coordination of CHC-MCO service plans with the BH-MCO service plans where indicated/appropriate	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.J. p 43	Service Coordination	Suggest different title and reference as per cell above. Community based BH service coordinators (in some regions called targeted, blended, or intensive case managers or resource coordinators) conduct same/similar functions and will cause great confusion for Participants	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.O.2 p 46	CHC-MCO Outreach Materials	Materials should be developed in coordination with the BH-MCO for this population. Additionally, they should be written in language that is lower than a sixth grade level; and consider that not all participants will be LTSS specific, but represent a range of population needs based upon disabling condition, age, etc.	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.O.3 p.47	Outreach Activities	Include specific requirements for general education and allow for clearer understanding of what this program is, and how it works. Could be an after-enrollment outreach requirement. This will be very new and confusing and overwhelming for many.	Allegheny County Office of Behavioral Health

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RFP	Proposal Requirements	Section V.O4 p. 50	Limited English Proficieny	Reading level should be considered at 4th grade consistent with what was required for the HealthChoices program	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.O8 p. 51	Transitioning Participants	Transition of care period should be explicitly stated here to be consistent with at least 60 days, and/or until such time that the Participant can be safely to transitioned ….	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.O.14 p. 55	Participant Handbook	Write at a 4th grade level	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.O.18 p. 57	Participant Advisory Committee	Must include individuals with BH needs, and representation across age/population/gender/lifestyle, etc.	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.P.1 p. 58	Participant Services: General	Program should require Ombudsman function so that Participants would have someone to go to for assistance when they believe the CHC-MCO is not serving them, or when they have a more serious concern. Position would have to exist in such a way that it is seen as an objective party and separate from services/coverage/delivery.	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.R.2 p. 62	DHS Fair Hearing	Suggest close coordination with BH-MCO fpr complaints/grievance process so that parallel processes are not occurring related to the same concern resulting in confusion, waste and inefficiency	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.W p.65	Other Administrative Components	Per abo ve, Ombudsman function should be added	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Section V.X.1 p. 69	Recipient Lock-In Program	Suggest concurrent consideration and close coordination with BH-MCO in all cases where option may be indicated	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Exhibit J.5 p J-4	EPSDT Guidelines	Include requirement for coordination with BH-MCO, and participation in Interagency Planning Meetings with multi-system involvement, e.g., JPO, CYF, OBH, IDD, etc.)	Allegheny County Office of Behavioral Health
RFP	Proposal Requirements	Exhibit L M(1)-3	MATP	Further detail requirements to plan for alternative transportation modes, e.g., across a county line, or in an area where a more immediate need has arisen, and MATP cannot be arranged or engaged in a timely enough way.	Allegheny County Office of Behavioral Health
Other		General Comment		The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	PACHSA
Requirements Document	Section V: Program Requirements	7. Behavioral Health Services p. 28	The CHC-MCO must coordinate with the BH-MCO as necessary to ensure that Participants receive all Medically Necessary Behavioral Health Services	Given coordination is the keystone of CHC, the RFP as drafted risks abandoning the collaboration that occurs at the county level. The loss of services and networks which have been woven together at the local level will have its greatest impact on counties' most vulnerable population--the elderly and disabled. The role of the county and the services provided must be acknowledged and incorparated into any procurement. At the very least, there should formalized agreements with county systems, such as Base Service Units, housing agencies, Area Agencies on Aging, local transportation agencies, and Drug & Alcohol programs, among others, clearly laying out the expectations regarding case coordination roles and responsibilities.	PACHSA
Requirements Document	Section V: Program Requirements	12. Examinations to Determine Abuse or Neglect p. 31	a. The CHC-MCO must provide Participants under evaluation as possible victims of abuse or neglect and who present for physical examinations for determination of abuse or neglect, with such services.	It is unclear how the provision of protective services by the CHC-MCO will be coordinated with the relatively recently selected Adult Protective Services vendor. The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	PACHSA
Requirements Document	Section V: Program Requirements	15. Transportation p.32	The CHC-MCO must provide all Medically Necessary emergency ambulance transportation, all Medically Necessary non- emergency ambulance transportation, and non-medical transportation.	Non-emergency medical transportation as well as most non-medical transportation for the prospective CHC population is currently provided through county managed programs. As noted previously, the continuing provision of those services by the counties must be incorporated as part of any procurement.	PACHSA

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RFP	General Information			This paper a response and suggestions on how to improve the RFP aims to ensure that the history, aims and goals of the Independent Living Movement are not only incorporated in the new vision for Pennsylvania under managed care but are sustained and developed thought-out and beyond the transition process of the next 5 years. The independent living movement has got us to where we are which is that we want to live in our own homes not be forced into institutions. We want to control, direct, recruit and dismiss the services we receive. We disabled people are innovative and cost effective, efficient and insightful about our vision, our lives, our families and our future.	Alan and Cathleen Holdsworth
Requirements Document	Section V.A. - Covered Services			The move to managed care, a capped system could be dangerous and people could die in a system that puts profit before people. However it also gives States the opportunity to put in place core values and philosophies that can be measured to bring about a system that builds on the success of the Independent Living Movement. For this to succeed we need to embrace a Social Model of Disability, understand the Independent Living Model of Disability, understand the language of disability and how to eradicate negative images of disability from marketing. Just to be clear this is not just about using the appropriate language but understanding how we talk about disabled people and the impact that can have on our services.	Alan and Cathleen Holdsworth
Requirements Document	Section V.H. - Person Centered Service Plans			We recommend that MCO must employ a person with a disability in a leadership role within their organization who can 1. Advocate the philosophy of the Social Model who understands the Independent Living Model and can advise on language and creating positive images on the people they serve. 2. Have access to all areas of the MCO's dealings so that they can assess, define and improve on the MCO's quality standards in line with the goals of Independent Living and the Social Model. 3. They should be a key component of any policy formation, complaints procedure, marketing or policy development within the organisation. 4. They should be responsible for the oversight of any training that the MCO undertakes to ensure that it includes the Social Model of Disability and helps participants understand the Independent Living Model and that the language used within the organization and the images it uses reflect disability in a positive light. 5. They should be responsible for commissioning training of executive staff within the organisation and oversight of training all key personnel in the organisation on the above. 6. MCO's must provide this at their own expense and commission only those partners willing to undertake the training below.	Alan and Cathleen Holdsworth
Requirements Document	Section V.N. - CHC-MCO Responsibility for Reportable Conditions			We recommend that all partnership organizations must also employ a person with a disability at the executive level to perform roles similar to those outlined above	Alan and Cathleen Holdsworth
RFP		Page 33 - 17		Performance measure indicators need to measure the success or failure to reduce Nursing home beds and the success or failure to transition people to the community. MCO's need agreed targets and need to report on what strategies they will employ to achieve this, how they will evaluate, learn and make progress. This is needed because this is the overarching key aim of what CHC is trying to achieve.	Alan and Cathleen Holdsworth
RFP		Page 34 - 18		FMS vendors need to accessible and responsive and operate in a way that is flexible and user driven.	Alan and Cathleen Holdsworth
RFP		pg 35 21b		The single biggest barrier to employment for disabled people is the poverty trap created by the benefits system. This leads to taking low paid jobs or working part time or not working at all. The most useful innovation would be to stop means testing benefits and services that get us to a level playing field with everyone else.	Alan and Cathleen Holdsworth
RFP		pg 35 21c		Disabled people can be employed by MCO's and partnership organizations to deliver the training described above and to assist in strategic planning and performance review. Also all MCO and Partnership Organizations should have a demonstrable strategy to employ more disabled people which may include training on how they can achieve this.	Alan and Cathleen Holdsworth

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RFP		page 40 F		We want to see in the RFP an acknowledgement of a participants right to risk. We want our assessments based on Functional need based on a person centered approach. It would also be useful if the assessment could also describe what the participants goals were in connecting to the community at large and what efforts are made by the provider to become knowledgeable about the community where the participant lives. Just to give some examples is the local church bar /nightclub/ accessible? Do any grocery stores deliver?	Alan and Cathleen Holdsworth
RFP		pg 44 K		I think you have already heard loud and clear our opposition to the qualification barriers set up here. First many excellent Service Coordinators would lose their jobs. Second there is no evidence that BA's or MA's or RNs have had any exposure to the philosophy of Independent living on their courses. Another non discriminatory way of wording this would be must have the relevant demonstrable experience to undertake the duties laid out in the Job Description and an understanding of the Independent Living model would be an advantage. We also concur with PCIL "Given the timeline for the rollout of MLTSS and given the "wealth" of existing person centered service coordination knowledge, we suggest that PA DPW take in consideration the critically important knowledge and expertise of the current service coordination the existing provider networks already employ.PCIL strongly recommends that the expertise in supports coordination that the state has so carefully developed—and paid for—over the past twenty-five years not be discarded as a result of the implementation of a new system of Managed Long Term Services and Supports. Instead, MTLSS should take advantage of this existing expertise by "grandfathering in" the existing provider network supports coordinator entities in the new system. This will insure continuity of care of consumers and as well keep the expertise of person centered service coordination intact." Finally training as described above should be rolled out to all Service Coordinators.	Alan and Cathleen Holdsworth
Requirements Document	Section V.C. - Continuity of Care			In order to ensure Continuity of Care, it is recommended that the six month period for consumers to transition to a MCO contracted provider be increased to a two year minimum. This will ensure that the consumer is informed choice, proper enrollment, that services are not interrupted. During this period, the current published rates should be maintained. With the changes in the FMS, LOCA, IEB in addition to switching to a managed care environment, it is the potential for a perfect storm that may drive consumers to agency model to ensure back up in services. The extension to two years can avoid the time concentration of these transitions to new providers.	Alan and Cathleen Holdsworth
Requirements Document		pg 57 18		The PAC should be directly involved in performance review and innovation as well as quality control and setting performance measure indicators. Each sub contracted Partnership organization should also have a similar PAC with tasks similar to those above.	Alan and Cathleen Holdsworth
Requirements Document		pg 64 V		Where possible you may want to review these qualifications to make sure we don't miss talent. You may want to include the recommendation repeated here and have such officer at this level We recommend under section page that MCO must employ a person with a disability in a leadership role within their organization who can 1. Advocate the philosophy of the Social model who understands the Independent Living Model and can advise on language and creating positive images on the people they serve. 2. They should have access all areas to the MCO's dealings so that they can assess define and improve on the MCO's quality standards in line with the goals of Independent living and the Social model. 3. They should be a key component of any policy formation, complaints procedure, marketing or policy development within the organisation. 4. They should be responsible for the oversight of any training that the MCO undertakes to ensure that it includes the Social Model of Disability and helps participants understand the Independent Living Model and that the language used within the organization and the images it uses reflect disability in a positive light. 5. They should be responsible for commissioning training of executive staff within the organisation and oversight of training all key personnel in the organisation. on the above. 6. MCO's must provide this at their own expense and commission only those partners willing to undertake the training below	Alan and Cathleen Holdsworth

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Requirements Document		pg 95 2		The quality management program should include the following: • Quality of life measures and consumer engagement - Focusing on consumer quality of life measures and consumer satisfaction - Reimbursement process efficiencies• Monitoring and evaluating activities which include peer review and Quality Management Committees• Continuous consumer involvement in the quality management process• Consumer Satisfaction• Person Center Goal Achievement and attainment• Tracking and trending participant and provider issues and resolution• Mechanism to assess the appropriateness of care and in home supports • Performance Improvement programs. • Submission of participant specific data • Reporting on designated quality measure to identify outcomes, trends and how trends will be address• Mechanism to assess the quality and appropriateness of care furnished	Alan and Cathleen Holdsworth
Requirements Document		pg 96 6		Another pay for performance could be linked to rebalancing efforts to transition from nursing home back to the community and keeping people in the community with supports.	Alan and Cathleen Holdsworth
Requirements Document Exhibit	DD - Participant Handbook			Add how participants can be involved in shaping the service how they can get involved on consumer panels.	Alan and Cathleen Holdsworth
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes			There are concerns that the plan language distinguishing between ADL's and IADL's could result in a reduction in hours in the plan. The only identified measures are around medical necessity. It is recommended that health and safety and quality of life measures be added to the medical necessity definition when considerations are made to determine eligibility for service and as grounds for appeal.	Alan and Cathleen Holdsworth
Other				Maintenance of Effort & ISPs – It is imperative that MCOs and service coordination providers in the new MLTSS system not be permitted to reduce participant personal assistance services authorized in their current individual service plans. Allowing MCOs (especially those with virtually no service coordination experience) the arbitrary ability to reduce service hours up to 25% would put participants at risk of harm and unnecessary and expensive hospital admissions or nursing facility placement.	Alan and Cathleen Holdsworth
				redacted	Redacted
Other		UNDER 21		We want 18-21 year olds who are currently eligible for the OLTL waivers to continue to be eligible for the CHC waiver unless and until the Department creates an alternative Children's waiver. We do want all children from birth on to be eligible for waiver services, and including them in the CHC would be one way of doing that, but we might prefer a Children's Waiver outside of the CHC. The Imagine Different Coalition has asked DHS to provide waiver services to all children, but did not make a recommendation regarding whether it should or should not be part of the CHC. In the meantime though, the 18-21 year olds who could potentially have no parent or service system to even give them a home, should remain eligible for CHC.	Alan and Cathleen Holdsworth
Other		Performance Measures		• Number of people out of nursing facilities/institutions • Number of people going into nursing facilities/institutions• Number of people getting face to face service coordination• Number of people getting phone service coordination• Number of people offered consumer directed services• Number of people selecting consumer directed series• Number of people living in their own home or apartment• Number of people living in assisted living• Number of people in adult foster care• Number of people living in group omes• Availability/use of architectural barrier modifications• Length of time receiving services• Length of time keeping an attendant• System of back up for attendants• Pay wages above $10.50 per hour (will vary in different areas) • Access to durable medical equipment• Access to Assistive Technology such as communication devices• Nurse delegation of health maintenance tasks to unlicensed Direct Care Attendants• Advisory Committee made up of at least 50% of people using the services and supports.	Alan and Cathleen Holdsworth
Other		General Comment		**Intent/Definition of Service Coordination**-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program. One example of where this is important is when considering the continuity of care period. If service coordination is a provider service, the continuity of care period would definitely apply. If it is an administrative function, we are not sure if that provision would apply to service coordination.	P4A JR Reed Director

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Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	P4A JR Reed Director
Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems-** The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	P4A JR Reed Director
Requirements Document	Section II - Definitions	p. 14	Participant Advisory Committee (PAC)- A group convened in person, at least quarterly by the CHC-MCO's governoring board which is open to all participants and which reflects the diversity of the CHC-MCO's Participant population.	**Participant Advisory Committee Makeup -** We recommend that the PAC meetings be formed for, and held in, each zone (for instances where MCO may cover more than one zone) and have representation for rural and urban counties in each particular zone.	P4A JR Reed Director
Requirements Document	Section II - Definitions	p. 15	Person Centered Planning Team- The team of individuals that will participate in Person Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT	**Person Centered Planning Team Makeup** - We recommend OLTL include the minimum acceptable required individuals and also include other suggestions/preferences for individuals on the team. We also recomment that OLTL require that if there is a behavioral health diagnosis, a behavioral health representative be required on the team.	P4A JR Reed Director
Requirements Document	Section V.A. - Covered Services	p.26	In-Home and Community -Based Services- The CHC- MCO may not deny personal assistance services for Participants under the age of 21 based on the Participant's diagnosis or because the need for personal assistance is the result of a cognitive imparment…	**Personal Assistance Services** - We recommend removing "under the age of 21" so that no conumer could be denied personal assistance services based on the participant's diagnosis or because the need is based on a cognitive impairment	P4A JR Reed Director
Requirements Document	Section V.A. - Covered Services	p.26	The CHC-MCO may not deny a request for Medically Necessary in-home nursing services, home health aide services, or personal assistance services for a Participant under the age of 21 on the basis that a live-in caregiver can perform the task…	**In-home Nursing, Home Health Aide or Personal Assistance Services** - We recommend removing "under the age of 21" so that no consumer could be denied under these circumstances.	P4A JR Reed Director
Requirements Document	Section V.B. - Prior Authorization of Services	p. 36	B. Prior Authorization of Services 1.General Prior Authorization Requirements (4th paragraph) When the CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of denial using the appropriate notice outline in templates…	**Notice of Service Denial** - We recommend that when there is a denial of services for those in MLTSS, notification should also be sent to the Service Coordination Agency/entity to ensure continuity and follow up with consumer.	P4A JR Reed Director
Requirements Document	Section V.B. - Prior Authorization of Services	p.37	2. Time frames for notice of Decisions	**Notice of Service Decisions** - We recommend that notice decisions should also be sent to Service Coordinator (entity) if additional information is needed from an MLTSS consumer the Service Coordination Agency should also be notified so they can assist the consumer in acquiring required documentation.	P4A JR Reed Director

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Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	**Continuity of Care for LTSS Participants**-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	P4A JR Reed Director
Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	**Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors**-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	P4A JR Reed Director
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	**Limited English Proficiency Requirements**- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	P4A JR Reed Director
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	**Management Information Systems**-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	P4A JR Reed Director
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	P4A JR Reed Director
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	**Willing Provider Definition –** In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	P4A JR Reed Director

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Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department** – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	P4A JR Reed Director
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	P4A JR Reed Director
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	P4A JR Reed Director
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	P4A JR Reed Director
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	P4A JR Reed Director
Other		General Comment		Intent/Definition of Service Coordination-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program.	Carbon Co Area Agency on Aging - Susan Zeigler, Acting Administrator

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Other		General Comment		Coordination of CHC Services with Behavioral Health Services- The Department should convene a workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining how these two systems will work together for the good of the consumer. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	Carbon Co Area Agency on Aging - Susan Zeigler, Acting Administrator
Other		General Comment		Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems- The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	Carbon Co Area Agency on Aging - Susan Zeigler, Acting Administrator
Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	Continuity of Care for LTSS Participants-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a one year period.	Carbon Co Area Agency on Aging - Susan Zeigler, Acting Administrator
Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	Carbon Co Area Agency on Aging - Susan Zeigler, Acting Administrator
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	Limited English Proficiency Requirements- to ensure all consumer's needing an iterpretor willreceive the assistance they need I recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	Carbon Co Area Agency on Aging - Susan Zeigler, Acting Administrator
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	Management Information Systems-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	Carbon Co Area Agency on Aging - Susan Zeigler, Acting Administrator
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		Intent/Definition of Service Coordinator- The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	Carbon Co Area Agency on Aging - Susan Zeigler, Acting Administrator
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	Willing Provider Definition – In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	Carbon Co Area Agency on Aging - Susan Zeigler, Acting Administrator

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Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	Notification to Department – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	Carbon Co Area Agency on Aging - Susan Zeigler, Acting Administrator
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	Complaints and Grievances – While I support the need for accommodations for those who need them, The Department Needs to recognize that some older adults may also need help presenting their case during these proceedings. A recommendation would be that the Older Adult be assigned an advocate that can attend hearings, help to prepare their case and this should be at no charge to the consumer.	Carbon Co Area Agency on Aging - Susan Zeigler, Acting Administrator
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	Definition of Travel Time – In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. A recommendation is that travel time be measured via public transportation for all types of care described in exhibit AAA.	Carbon Co Area Agency on Aging - Susan Zeigler, Acting Administrator
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	Definition for Respite Care-A recommendation is to expand the definition to allow for the provision of respite care in an institutional setting. Some older Adult have limited suppoerts / Family and if the caregiver needs Respite an instititional setting is the only option.	Carbon Co Area Agency on Aging - Susan Zeigler, Acting Administrator
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	Responsibility of Annual Level of Care Redetermination- In order to avoid any conflict of interest, A recommendation is to add language that confirms the annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	Carbon Co Area Agency on Aging - Susan Zeigler, Acting Administrator
Requirements Document	Section V.A. - Covered Services	15 pg. 32	non-medical transportation and other activities as specified in the PCSP	Language should include transportation for Adult Day Care, reshab services and employment and volunteering opportunities.	Allied Services Waiver Coordination

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Requirements Document	Section V.C. - Continuity of Care	2nd section pg. 39	For a Participant who is receiving LTSS through an HCBS Waiver program on his or her Effective Date of Enrollment, the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later.	Continuitity of care should be 1-2years. To allow for validation of provider documentation, contract changes and for through needs assesment.	Allied Services Waiver Coordination
Requirements Document	Section V.D. - Choice of Provider	pg 40	Participants must be afforded choice of all Providers within the Provider Network, including Service Coordinators. CHC-MCOs may not attempt to steer Participants to CHC-MCOs Affiliates who are Providers or interfere with the Participants' choice of Provider.	Language should be changed from Service Coordinators to service coordination unit/service coorinator	Allied Services Waiver Coordination
Requirements Document	Section V.E. - Needs Screening	pg 40	Upon Enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or need for Service Coordination. Any Participant whose needs screening reflects unmet needs, service gaps, or a need for Service Coordination will be referred for a comprehensive needs assessment. The needs screening must be completed within the first 30 days of Enrollment, and may be conducted by phone, electronically, by mail, or in person.	Service coordination for LTSS services should be required. The needs screening should only be done in person and not by phone, electonically or by mail to see the true need especially to screen for mental health conditions that impact cognative abilities as well as health and safety. Assessments should be done by SC that are not directly employed by an MCO to add a layer of advocacy of confict free status. Final review can be done at the MCO level to mantain a multi discplinary approach. Service plans can be reviewed by the PCP and signed an authorized by the RN or caremanager.	Allied Services Waiver Coordination

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Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	Second paragraph pg 41	CHC-MCO must conduct a comprehensive needs reassessment no more than 12 months following the most recent prior comprehensive needs assessment or comprehensive needs reassessment unless a trigger event occurs. Reassessments must be completed as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, but in no case more than 14 days after the occurrence of any of the following trigger events: A significant healthcare event to include but not be limited to a hospital admission, a transition between healthcare settings, or a hospital discharge. A change in functional status. A change in caregiver or informal support status. A change in the home setting or environment. A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning. As requested by the Participant or designee, the caregiver, the provider, or the PCPT or PCPT Participant, or the Department.	After a change in caregiver or informal support status changes and home setting or enviroment should have writing after it aht unly if it impacts 1 or more area of health status or functioning.	Allied Services Waiver Coordination

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Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	section k pg 44	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology or other related field and at least three years of experience in the coordination of services. All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience. Service Coordinators and Service Coordinator Supervisors must also complete Department-approved training in required training topics.	To consider ACT 22 requirements as the minimal standards and to allow current staff to be grandfathered in. We suggest a more focused training program with certification programs for minimial skill levels. Allowing a 6 month grace period to allow the department approved certifications to be obtained. Increase level of education does not directly coordinate to effective coordination. Current requirements requires a RN to review high profile cases but not necessarliy all cases.	Allied Services Waiver Coordination

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			The CHC-MCO must ensure that the process of selection and assignment of Service Coordinators for participants who require Service Coordination includes, at a minimum, the following features: The CHC-MCO must offer the Participant the choice of at least two Service Coordinators. The CHC-MCO must make contact with the Participant within seven (7) business days of his or her Enrollment for a comprehensive needs assessment indicating the need for LTSS and provide information on options for selecting a Service Coordinator unless the CHC-MCO has information that the Participant should be immediately contacted due to a medical condition requiring immediate care. If a Participant does not select a Service Coordinator within fourteen (14) business days of Enrollment for a comprehensive needs assessment, the CHC-MCO must make an automatic assignment of Service Coordinator. The CHC-MCO must consider such factors (to the extent they are known), as current Provider relationships, the person assigned to the	Language after selection of service coordinator should read service coordinator/service coordination unit	

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Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	first bullet pt pg 84	Participant for care management in the CHC-MCO's aligned D-SNP, specific medical needs, physical disabilities of the Participant, language needs, area of residence and access to transportation. The CHC-MCO must then notify the Participant by telephone or in writing of his/her Service Coordinator's name, location and office telephone number. The CHC-MCO must make every effort to determine Service Coordination choice and confirm this with the Participant 85 prior to the commencement of the CHC-MCO coverage in accordance with Participant Enrollment and Disenrollment, so that new Participants do not go without a Service Coordinator for a period of time after Enrollment begins or after assessment of needs for LTSS. The CHC-MCO must take into consideration, language and cultural compatibility between the Participant and the Service Coordinator. If a Participant requests a change in his or her Service Coordinator selection following the initial visit, the CHC-MCO must promptly grant the request and process the change in a timely manner. The CHC-MCO must have written policies and procedures for allowing Participants to select or be assigned to a new Service Coordinator whenever requested by the Participant, when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding. The policies and procedures must receive advance written approval by the Department.		Allied Services Waiver Coordination
Requirements Document	Section V.DD. - Provider Network	3rd paragraph pg 89	This requirement will remain in effect for HCBS Providers for the first 180 days that CHC is operational in each zone. Following the 180 day period, the CHC-MCO may adjust its Provider Network in accordance with the Network access and adequacy standards outlined in this agreement.	Please allow 1-2 years to help to allow stabiliation of the program and ensure appropriate service coverage.	Allied Services Waiver Coordination
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	section e pg aaa(3)-7	Ensure at least two (2) Providers for each LTSS Covered Service within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural).	To ensure at least 3-5 providers for each LTSS covered service within the travel time limits	Allied Services Waiver Coordination

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Requirements Document	Section V.A. - Covered Services	expanded services, p. 27	CHC-MCOs are permitted and encouraged to offer LTSS covered services to participants who are not yet NFCE.	Providing LTSS early not only will prove to have a considerable impact on the state financially, by preventing higher cost care, it will also introduce consumers to LTSS before they have a critical medical event. This softer introduction brings about the most success.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise
Requirements Document	Section V.A. - Covered Services	service delivery innovation, p. 35	MCOs must participate in innovation initiatives that are targeted by DHS	DHS should be required to publish notice to stakeholders of the innovation projects or target areas that are being considered for CHC-MCO initiatives prior to implementation in the MCO's annual contract renewal. If providers and consumers are made aware of possible target areas in this way, they can offer assistance and expertise to the MCOs in crafting successful innovation projects. Additionally, knowing what DHS is aiming for from a quality standpoint will help providers direct their own quality initiatives.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise
Requirements Document	Section V.A. - Covered Services	settings for LTSS, p. 35	The CHC-MCO must provide services in the least restrictive, most integrated setting.	CHC-MCO's will be well-versed in Medicare payment and billing practice, but it will be important to educate them on the nuances of serving a Medicaid population, including the fact that NFCE individuals do not need to be considered homebound to receive personal assistance and other related long term care services in their home. To receive skilled home health services, Medicare requires a physician to certify that a patient is confined to the home (meaning it would take considerable and taxing effort to leave the home without assistance) and in need of skilled services. Under our current HCBS waivers, individuals are able to receive care in their home so long as they are found to be NFCE. Other states with MLTSS found that MCOs often struggle with this distinction when it comes to homebound status. PHA suggests adding language to this section of the contract to clarify that CHC-covered LTSS, including personal assistance services, may be provided in the home regardless of the participant's homebound status.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise
Requirements Document	Section V.C. - Continuity of Care	continuity of care, p. 39	For a participant that is receiving LTSS through an HCBS waiver program on his or her effective date of enrollment, the continuity of care period for continuation of services provided under all existing PCSPs through all existing service providers will run from the effective date of enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been develop and implemented	I strongly urge DHS to extend the continuity of care period for more than 180 days to allow providers and MCOs to negotiate fair contracts, establish new systems of business and ensure participants are not put in jeopardy of losing their caregivers after six months. Homecare is a very person-centered service, provided in the individual's home and involving very intimate and personal one-on-one care. The relationship between the caregiver and participant is a critical component to the participant's health and the overall success of home care. During the Community Conversations initiative, when provider organizations heard concerns directly from current senior HCBS consumers, we learned the most important aspect of a senior's care is trust. CHC participants are not only concerned about whether they will lose access to a choice of providers after the continuity of care period ends, they are worried they will lose the relationship they've built with their own caregiver if that agency does not secure a contract or remain in an MCO's network. The continuity of care period must be extended. In most states with MLTSS, this period lasted at least one full year, sometimes two or three years. Our organiztion urges DHS to change the language in the draft agreement to create a two-year continuity of care period so we can work together to get the right system in place without fearing .	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Participant advisory committee, p. 57	Provider representation must include physical health, behavioral health, dental health and LTSS.	we encourage DHS to require representation from providers of each of the LTSS covered services. As written, the contract language could be interpreted by MCOs as only requiring one provider of any of the LTSS covered services, i.e., one nursing facility or one in-home meals provider. This would certainly not allow the PAC to consider the perspectives of LTSS providers across the sprectrum, which will be very diverse and not easily represented by just one provider. It is important that all of these perspectives are able to contribute to the work of the PAC and assist the MCOs in building programs that fit all of the unique needs of their members.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise
Requirements Document	Section V.T. - Provider Dispute Resolution Process	Provider dispute resolution process, p. 63	Establishment of a CHC-MCO Committee to process formal Provider Disputes/Provider Appeals which must provide....	We strongly believe it is essential that the department play some role in resolving provider disputes with MCOs. MCO's are in a position to exert a lot of pressure on LTSS providers when it comes to contract changes and rate decreases and these can often be all or nothing terms. It is important that the commonwealth act as a check in the provider-MCO relationship when it is necessary, most particulary when it potentially impacts consumers. To facilitate that department's participation, OLTL could add 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.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise

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Requirements Document	Section V. Z. - Fraud & Abuse	Subcontracts, p. 77	The CHC-MCO must require that all network providers and all subcontractors take such actions as are necessary to permit the CHC-MCO to comply with the fraud, waste and abuse requirements in this agreement.	MCOs must be required to monitor the FMS providers for fraud and abuse in the same way as other network providers and subcontractors. The CHC-MCOs should be required to answer for any fraudulent activity of their members that choose the participant-directed model and utilize the FMS contractors to submit timesheets for payment. The MCOs, like the FMS agency, are trusted stewards of the MA program and should be accountable for improper payments. The contract should expressly encompass the FMS agency in these required auditing activities, given that the MCO will also be required to contract with all statewide FMS agencies. Participant directed services already are afforded exceptions to the standards and regulations Licensed providers are required to meet, MCO's must not be lax in assuring these relaxed regulations do not extend to proper delivery, verification and payment of services.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise
Requirements Document	Section V.DD. - Provider Network	Provider qualifications, p. 89	All providers must meet the minimum qualification requirements established by the department and must be credentialed by the department	Home and Community based providers operate on a thin margin, requiring an Agency to credential with multiple MCO's who each may have differing requirements above the current state minimum requirements will be enormously burdensome. We strongly encourage the state requiring MCO's to establish a standardized credentialing process that is identical between all MCO's based on type of service provided.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise
Requirements Document Exhibit	C - Requirements for Provider Terminations		The CHC-MCO must notify the Department in writing of its intent to terminate a network provider and services provided by a network provider …sixty (60) days prior to the effective date of the termination.	We thank the department for maintaining oversight in the CHC program when it comes to provider terminations, but the language in this exhibit will not address providers that leave the network when they are forced to reject contract amendments containing dramatic rate decreases. In the experience of our member agencies in the physical health HealthChoices program, the reason providers leave a health plan's network is not because they are "terminated" by the plan in the general sense of that term, but their reimbursement rates are cut in the form of a contract amendment to which they are not able to agree. MCOs can avoid the provisions of this exhibit in this way, but forcing the provider's "voluntary" exit from the network rather than a termination by the MCO. In this scenario, the department would not receive advance notice of the impact the loss of this provider could have on the network and the consumers' access to care. We urge the commonwealth to strengthen oversight on providers exiting the network by requiring the same sixty-day notice from MCOs prior to any provider contract amendments that would result in a dramatic change in reimbursement rates, which could be defined by a threshold percentage change in the rates such as a 25% change in the rates from the previous twelve months. This notice will help protect providers from improper collusion from the MCOs and protect consumers from losing access to their providers for reasons other than quality concerns.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	Network composition, AAA(3) - 6	The Department may require additional numbers of specialists, ancillary and LTSS providers should it be determined that geographic access is not adequate.	As discussed in reference to the 30 minute/60 minute travel times, the geographic access to LTSS providers is not a sufficient measure of network adequacy when it comes to in-home care providers. We were pleased to see the department will have authority to require additional LTSS providers as needed, but there should be a better mechanism in place to measure the lack of homecare providers. PHA suggests requiring the MCOs to turn to the consumers and providers on their PAC to hear and process consumer-driven grievances related to narrow provider networks. The National Committee for Quality Assurance (NCQA), which provides accreditation to health plans in the federal insurance marketplace, looks to whether health plans and states have monitoring in place for network adequacy that includes the collection and analysis of consumer complaints and repetitive requests for out-of-network provider care. Other states employ this practice in the MLTSS program as well. In Arizona, MCOs must complete a network gap analysis monthly using geo-access mapping. In Minnesota, it is the state that performs a gap analysis of each MCO's network and reports to the MCO on any necessary adjustments. PHA recommends including language in Exhibit AAA to require the PAC to review and analyze participant complaints related to narrow networks and make recommendations to the department on whether it should require the addition of LTSS providers.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise

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Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	LTSS Providers, AAA(3) - 7	Ensure at least two (2) providers for each LTSS covered service within the travel time limits (thirty (30) minutes urban, sixty (60) minutes rural).	PHA and other provider organizations have continued to stress the importance of workable adequacy standards for in-home providers. Travel time measurements like those in Exhibit AAA will not measure whether there is a sufficient number of homecare agencies in the network. LTSS participants never travel from their home to the homecare agency's physical office location. Even most direct care workers travel directly from their homes to the participant's home to provide care each day and very seldom travel to the homecare agency's office. Simply measuring the geographic location of the homecare agency in relation to the MCO's LTSS population will not show any relevant information on the ability of the agency to provide care in that area. In our previous comments, we have suggested alternative ways of measuring network adequacy for in-home providers including a gap analysis that plots the location of the CHC beneficiaries in relation to the homecare provider's service area in conjunction with a measurement of staff-to-participant ratios that ensures agencies have capacity to care for the CHC population in their area. We strongly urge DHS to consider adding requirements like these in the exhibit to truly be able to measure whether the MCO's network is able to meet the needs of participants in their homes.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise
Requirements Document Exhibit	DDD(1) - Covered Services List	Home health services	Home healthcare aide services cannot be provided simultaneously with personal assistance services, adult daily living services or respite services	While we understand the importance of controlling overpayments for duplicative services, in our experience it is often very difficult to know when a home health aide and a PAS aide might be in a participant's home at the same time. As a provider who can provide both home health and PAS services, allowing us the opportunity to provide both gives us the advantage of properly scheduling each service so no overlap occurs. Because often multiple types of care are not always provided by a single agency, there are occasions when a home health aide enters a home to perform intermittent care at the same time one of our personal care aides is present for a multiple hour shift. Given the restrictions in Exhibit DDD for this type of simultaneous care, it is very important that the CHC-MCO take responsibility either for trying to give clients the first option to have a single provider provide all services (if possible) or at least notifying the participant's providers about the full care plan, including the services of other providers. The Medicare-Medicaid coordination that is envisioned in the CHC program will greatly improve the respective knowledge of the home health and homecare agencies caring for the individual, but it is important that the MCO is given responsibility for striving for streamlined, more efficient care and for keeping providers informed so simultaneous care is not inadvertently provided and providers' claims for reimbursement are rejected. When a single provider can provide both home health and PAS services, it should be pursued - it is almost always the best approach to continuous quality care.	
RFP	Work Statement	question 11, p. 30	Describe your organization's experience and you plan for using technology such as assistive technology, telehealth, telecare, social media, electronic visit verification and other methods to delivery services to the CHC participants.	Many LTSS providers already have some form of electronic medical records (EMRs) and electronic visit verification (EVV) systems in place and have invested thousands of dollars in the infrastructure and training that those systems require, we are one such Agency. The work statement questionnaire allows MCOs to decide how EMRs and EVV will be used within their network, but we urge the commonwealth to set some broad parameters in these areas rather than allowing MCOs to determine specific vendor or system requirements. Because providers will be entering contracts with multiple MCOs in their region, it is critical that we be permitted to use the same EMR system to communicate with all payers. These information management system requirements should be set at a statewide level to ensure compatibility between providers and multiple MCOs. This compatibility will lead to better outcomes for CHC participants and less cost for the network, as more providers are able to securely share patient information and better coordinate person-centered care in a streamlined, already established manner. Additionally, while EVV is the current technology generally utilized for visit verification, new approaches are evolving every year and some Providers, including us, are constantly exploring newer, more secure ways to verify service. Should we determine there is a more effective system than EVV, we would not want to be boxed in to paying only for that service, particulary if there is a more effective less expensive innovation available.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise

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RFP	Work Statement	question 5, p. 41	Describe how you will use Geo Access mapping to ensure network adequacy	Geo access mapping is the most ineffective way to evaluate network adequacy IF the points used are a Provider's physical address and the client's address. Home Care providers hire workers who live across the span of their entire service area and while coverage may be best within a 10 to 20 mile radius of a provider's physical location, it is common for home care providers to adequately cover a much broader service area. Additionally, to assure adequate choice for consumers, there must be at a minimum 10 providers for a specific service within the communities where a consumer lives and those providers must have staff with various skills and availabilities to truly meet the needs of all consumers in an area. An MCO will never, never be able to offer adequate choice and reliable coverage if only two providers per geo acces defined areas are contracted.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise
RFP	Work Statement	question 13, p. 42	Describe how you will oversee the Financial Management Services (FMS) Grantee and the administration of FMS services to participants.	Without question the participant-directed program through the new FMS procurement must be improved. As a former Service Coordinator, now independent owner of two home care agencies, I have seen gross negligence and fraud in this program - far more often than I have seen it benefit a consumer. You simply cannot expect quality service when you remove standards for employees that Agency model staff must meet, when you remove supervision and oversight and when you do not require the same skills, monitoring and training expectations as you require of Agency staff. The CHC-MCOs' role in managing the FMS contract will be a key component to the success of the participant-directed model under CHC and the state should permit MCO's to enforce higher standards at a minimum equal to those of licensed Agencies. Some suggestions: prohibit employment of any worker with a criminal background, provide some baseline healthcare training for participant-hired workers, limit the scope of practice for workers who are not trained to provide medical care such as wound care in the home, and employ EVV systems to monitor the care the participant is receiving and accurately track compensable time. In addition, MCOs must take a larger role than the state has up until now in monitoring the FMS agencies for fraud and abuse. The participant-directed model of care is an important component of HCBS in Pennsylvania if utilized in the right settings and under the right conditions, but there is much room for improvement in the way these workers are hired and trained which will lead to better quality of care for CHC participants.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise
Requirements Document	Section V.A. - Covered Services	service delivery innovation, p. 35	The CHC-MCO must promote innovation in the service delivery system. This includes innovation pursued by the CHC-MCO on its own initiative, as well as collaborative efforts involving the Department, CMS and local partners. Initial target areas for innovation are as follows.Workforce innovation that improves the recruitment, retention and skills of direct care workers, which may include but are not limited to incentives for education and training.	As I have offered in my previous feedback, transforming PA's long term continuum of care to a more home and community based focused will ONLY be successful if as much is invested into our direct care workforce as is into all the various bureaucratic, administrative and legalistic areas of our system. There is no MLTSS system success possible without a reimbursement and reward system that permits Provider Employers to attract and then pay its workforce a competitive wage, offer quality, skill building training and development that promotes our field as the valuable profession it is, and gives Employers the real opportunity to offer its employees meaningful support and benefits without needing to sacrifice quality of care measures. At present, our reimbursement rate requires us to pick and choose: have adequate administrative staff, train our staff, pay for benefits, supervise in the field, offer pto or mileage reimbursement, build relationships wiht our clients??? You cannot build a high quality home and community based system on transient, inadquately trained, supported and compensated people. Quite simply: you get what you pay for. Reward those Provider employers for investing in a viable workforce and infrastructure by giving those providers an additional add on amount to their base rate as a required "pass-through" for each identified initiative that serves to develop and build a quality workforce. It will be the most effective money the state could ever spend to reach each its goals.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise

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Requirements Document	Section V.A. - Covered Services	Choice of provider, p. 40	Participants must be afforded choice of all Providers within the Provider Network, including Service Coordinators. CHC-MCOs may not attempt to steer Participants to CHC-MCOs Affiliates who are Providers or interfere with the Participants' choice of Provider.	This is a very big concern for nearly all home and community based providers, particulary in the southwest region. We have two large MCO's who both are also competing providers - these entities essentially control the home health care market in our region. Both systematically exclude competing providers from the network as a general business practice even after a provider has demonstrated clear needs in the communities its serves (as we have repeatedly done with UPMC and now Highmark). We have had existing clients literally solicited while under our care by UPMC staff, and literally "bribed" by being given an impression that the only way they can ever expect quality, effective care is by receiving care from the same provider that provides their acute and primary care. It is unethical and immoral, but it happens to us and every other provider I have ever spoken to regularly. In the past we experienced this only with UPMC, but we are now seeing it with Highmark as they are operating identical to UPMC. It changes the concept "freedom of choice" and not for the better. There must be clear mechanisms in place for assuring and honoring choice and immediately addressing unethical measures and misrepresented dissemination of information.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise
Requirements Document	Section V.A. - Covered Services	Nursing home transition services, p. 44	CHC-MCOs must offer Nursing Home Transition (NHT) services as defined in Exhibit DDD(2), LTSS Covered Services Definitions, to Participants residing in Nursing Facilities who express a desire to move back to their homes or other community-based settings. Service Coordinators may coordinate NHT services.	We strongly implore the state to make it part of the requirement for MCO's to include any chosen home and community based provider as part of the interdisciplinary transition team. At present, the NHT program as it exists in PA miserably fails in meeting it's mission to safely, successfully give nursing home residents the opportunity to transition to the community.	Superior Home Services and Superior Home Health and Staffing/Kimberly L. Pirilla-Scalise
RFP	General Information	Deffinitions Pages 2-6	Capitation payment, certificate of authority, disability competency, Disease management, Linguistic competency, medically necessary, other related conditions	What are the measures for these services, how will we they be held accountable and outlined for participants?	United Disabilities Services
RFP	General Information	Deffinitions Pages 15-19	Participant Restriction program, Retrospective Review, Service Coordinator	What is the period (length) of time that the participant is restricted? How will the MCO determine if the service was provided?, SC-who is the MCO designated accountable point person, how is a appropriately qualified professional measured?	United Disabilities Services
RFP	General Information	Deffinitions Page 21	Utilization Management and Utilization Review Criteria	How often is the review done? Who is involved, is the participant involved in the review?	United Disabilities Services
RFP	General Information	Agreement & RFP Acronyms	Glossary of Terms/Acronyms	Will the terms/Acronyms be available for participants, supports and providers to understand, how will this information be provided to them?	United Disabilities Services

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Requirements Document	Section V.A. - Covered Services	V:A Page 26	The CHC-MCO must require that determinations of Medically Necessary Covered Services be documented in writing and that they be based on medical information provided by a Participant, the Participant's family or caretaker and PCP, as well as other Providers, programs or agencies that have evaluated the participant. A determination of Medically Necessary services must be made by qualified and trained Providers with clinical expertise comparable to the prescribing Provider.	What current waiver services fall under 'physical health'? Who would be considered 'clinical experts' from Providers? ATPs, RNs, OT/PTs?	United Disabilities Services
Requirements Document	Section V.A. - Covered Services	V:A 2 Page 26	The CHC-MCO may not deny a request for Medically Necessary in-home nursing services, home health aide services or personal assistance services for a Participant under the age of 21 on the basis that a live-in caregiver can perform the task, unless there is a determination that the live-in caregiver is actually able and available to provide the level or extent of care that the Participant needs, given the caregiver's work schedule or other responsibilities, including other responsibilities in the home	What constitutes a determination that the caregiver cannot perform the task? Does a PCP need to write a letter stating the live-in caregiver is unable to care for the participant? What is the process for a participant receiving EPSDT services who also qualifies for the waiver?	United Disabilities Services
Requirements Document	Section V.A. - Covered Services	V:A 4 Page 27	These must be services that are generally considered to have a direct relationship to the maintenance or enhancement of a Participant's health status, and may include various seminars and educational programs promoting healthy living or illness prevention, memberships in health clubs & facilities promoting physical fitness and expanded eyeglass or eye care benefits.	We appreciate this line item and see great benefit to our participants.	United Disabilities Services
Requirements Document	Section V.A. - Covered Services	V:A 12 (a) Page 31	The CHC-MCO must provide Participants under evaluation as possible victims of abuse or neglect and who present for physical examinations for determination of abuse of neglect with such services.	Will the Provider be initiating the physical exam? Where do the findings go? What if the participant declines the physical exam?	United Disabilities Services

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Requirements Document	Section V.A. - Covered Services	V:A 21 (a) Page 35	These made include but are not limited to: outreach to and engagement of Participants, housing search assistance, assistance for applying for housing & benefits, assistance with SSI eligibility processes, advocacy and negotiation with landlords and other tenants, moving assistance, eviction prevention…	We encourage assistance for paying for bed bug extermination as we see this as a common hardship for our participants. Thank you for adding this benefit.	United Disabilities Services
Requirements Document	Section V.B. - Prior Authorization of Services	V:B 1 Page 37	The Department will use its best efforts to review and provider feedback to the CHC-MCO (e.g., written approval, request for corrective action plan, denial, etc.) within sixty (60) days from the date the Department receives the request for review.	Many of our participant's needs are urgent and need reviewed within 72 hours. Could you please rethink the time frame of 60 days?	United Disabilities Services
Requirements Document	Section V.B. - Prior Authorization of Services	V:B 2€ Page 38	The CHC-MCO is not required to provide advance notice when it has factual information on the following…	We suggest adding when a SC or Provider has evidence the Participant engaged in Medicaid Fraud & Abuse.	United Disabilities Services
Requirements Document	Section V.B. - Prior Authorization of Services	V:B K Page 44	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology or other related field and at least three years of experience in the coordination of services.	The current regulation allows for 1 year in experience versus the proposed 3 years. We propose educational requirements for both SCs and supervisors that match ACT 22. We also recommend that provider organization utilize a variety of skills including LSW, RNs and other healthcare professionals to participate in monthly QA meetings that review participants with high risk behaviors, service note and documentation quality, incident management and protective service issues. These QA meetings need to include discussion on issues and development of plans to help mitigate risk. Limiting the education and breadth of experience to LSW or RN (as supervisors) is very restricting. The scope of knowledge needed for SC teams requires a broader set of skills which necessitates better training within each organization. There are a plethora of degrees and experiences that make for a great SC and Supervisor. It is our recommendation that DHS maintain the educational requirements of ACT 22 but augment the skills required for routine QA meetings that need to review key issues. Organizations should have a variety of key skills and knowledge within their organization and have processes that allow those skills to be utilized for key issues. To mitigate the risk that OLTL sees with APS issues, QA processes need to be incorporated into the business model. Applying an educational requirement over supervisors won't fix a process issue. Instead it adds costs and restricts the skills set and knowledge within an organization because a broader set of skills are needed. It will also cause greater turnover in organizations because their degree isn't fully used within the organization when they are also working on non medical situations like non medical transportation, NHT etc	United Disabilities Services

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Requirements Document	Section V.B. - Prior Authorization of Services	V:B.K Page 44	All Service Coordinators Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience of a registered nurse with at least 5 years of experience.	The current regulation allows for 1 year in experience versus the proposed 3 years. We propose educational requirements for both SCs and supervisors that match ACT 22. We also recommend that provider organization utilize a variety of skills including LSW, RNs and other healthcare professionals to participate in monthly QA meetings that review participants with high risk behaviors, service note and documentation quality, incident management and protective service issues. These QA meetings need to include discussion on issues and development of plans to help mitigate risk. Limiting the education and breadth of experience to LSW or RN (as supervisors) is very restricting. The scope of knowledge needed for SC teams requires a broader set of skills which necessitates better training within each organization. There are a plethora of degrees and experiences that make for a great SC and Supervisor. It is our recommendation that DHS maintain the educational requirements of ACT 22 but augment the skills required for routine QA meetings that need to review key issues. Organizations should have a variety of key skills and knowledge within their organization and have processes that allow those skills to be utilized for key issues. To mitigate the risk that OLTL sees with APS issues, QA processes need to be incorporated into the business model. Applying an educational requirement over supervisors won't fix a process issue. Instead it adds costs and restricts the skills set and knowledge within an organization because a broader set of skills are needed. It will also cause greater turnover in organizations because their degree isn't fully used within the organization when they are also working on non medical situations like non medical transportation, NHT etc.	United Disabilities Services
Requirements Document	Section V.B. - Prior Authorization of Services	V:B 0 (1) Page 46	The Participant has the right to initiate a chance in CHC-MCO's plans at anytime.	We appreciate keeping the choice with the Participant.	United Disabilities Services
Requirements Document	Section V.B. - Prior Authorization of Services	V:B P (1)	The CHC-MCO must have arrangements to receive, identify, and resolve in a time manner Emergency Participant Issues on a twenty-four (24) hour, seven (7) day-a-week basis.	Current Service Coordination entities provide a 24/7 on-call number which allows emergencies to be addressed at all times.	United Disabilities Services
Requirements Document Exhibit	C - Requirements for Provider Terminations	1.0 Page 1	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	What is considered a large provider? Also, shouldn't CHC MCOs be required to demonstrate network adequacy before a termination occurs. This includes showing network adequacy in all townships/counties provided by the prior organization. Further, all providers aren't the same. For example, termination of a DME company who provides rehab equipment cannot be replaced with another DME company that does not provide rehab services with qualified ATPs etc.	United Disabilities Services
Requirements Document Exhibit	C - Requirements for Provider Terminations	8.0 Page 6	Web-based provider usage-provider list	How often are providers required to update their web-based system to reflect the current provider list?	United Disabilities Services
Requirements Document Exhibit	E(1) - Other Federal Requirements	E (1) 2-E (3)	CHC-MCO will report all identified preventable conditions	What is defined as a preventable condition? Please clarity requirements.	United Disabilities Services
RFP	General Information	K Page 3	Property And Supplies CHC-MCO agrees to obtain all supplies and equipment for use in the performance of the agreement at the lowest practice cost and to purchase by means of competitive bidding.	Please define what is meant by supplies & equipment within the contract/agreement. If you are referring to DME equipment competitive bidding does not apply across all counties within PA.	United Disabilities Services

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RFP	General Information	Q-2 Page 6	The CHC-MCO's CPP approved recruiting and hiring plan shall be maintained throughout the term of the agreement and through any renewal or extension of the agreement.	Please define the recruiting and hiring plan.	United Disabilities Services
Requirements Document Exhibit	F - Family Planning Services	Pages F-1 to F-3	Family Planning Services & Procedures	There is no explanation of what medical providers are approved to provide the stated services and procedures. Some procedures could require a specialist and are the providers going to be within a reasonable distance to the living area of the participant and offer choice.	United Disabilities Services
Requirements Document Exhibit	J - EPSDT Guidelines	Page J-3	Follow-Ups and Outreach MCO's must have an established process for reminders, follow up and outreach.	Please define what the process for reminders, follow up and outreach must include and look like.	United Disabilities Services
Requirements Document Exhibit	K - Emergency Services	Pages K-2	CHC-MCO must develop a process to ensure that PCP's promptly see participants who did not require or receive hospital Emergency services for the symptoms prompting the attempted emergency room visit.	How will this process be implemented and what is meant by attempted emergency room visit?	United Disabilities Services
Requirements Document Exhibit	L - Medical Assistance Transportation Program	Page M (1) 3	When requested, the CHC-MCO must arrange non emergency transportation for urgent appointments.	Currently arranging/coordinating transportation for routine appointments is a challenge. How will the plan to arrange this urgent transportation be implemented and monitored?	United Disabilities Services
Other	Covered Benefits	Exhibit U Page U-1	Behavioral Health Services No mental health or drug and alcohol services, except ambulance, pharmacy and emergency room services, will be covered by the CHC-MCO's.	If subscribing to the disease model of chemical dependency why are drug and alcohol services not covered? It appears they are only covered through supplemental benefits? This will be a major gap to providing the right type of care to participants of the CHC. Drug and alcohol issues apply over all populations and are a major barrier to improved health outcomes. Access to providers is needed in CHC.	United Disabilities Services
Requirements Document Exhibit	X - Guidelines for Adverstising, Sponsorship & Outreach	Exhibit X-2 Page X-4	The Department's contract monitoring Core Team will review and forward to the CHC-MCO a preliminary response within 30 calendar days from the date of the receipt of the requested form.	What are the qualifications to be apart of the Core Monitoring Team?	United Disabilities Services
Requirements Document Exhibit	X - Guidelines for Adverstising, Sponsorship & Outreach	Exhibit X C Page X-6	CHC-MCO Participating in or hosting an event	Will providers be able to independently market their programs and/or services?	United Disabilities Services
Requirements Document Exhibit	CC - Data Support	CC Page 139	DHS Inquiry Access	We see this as a benefit to participants and providers, as access to Client Information System [CIS] will enhance continuity of eligibility across service system and reduce potential fraud.	United Disabilities Services
Requirements Document Exhibit	CC - Data Support	CC Pages 139-140	PROMISE Access	We see this as a benefit, enhanced access will potentially reduce denied billing and inappropriate service provision	United Disabilities Services
Requirements Document Exhibit	CC - Data Support	CC Pages 140-144	Files and Reports	We see this as a benefit, as it will potentially reduce denied billing and inappropriate service provision, as well as highlighting red flag areas.	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 145	Participant Handbook # 5 Access after-hour, non-emergency care is paramount even with a non-medical model.	Please note UDS has a documented after hours on call system that participants are currently benefitting from.	United Disabilities Services

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Requirements Document Exhibit	DD - Participant Handbook	DD Page 146	Participant Handbook # 14 Information on the availability of and how to access or received information. Participant Handbook # 16 Table of Contents	Receipt of information orally and in writing for all non-English speaking participants. UDSF has a current policy participants are benefitting from.	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 147	Prior authorization for services/service limitations for individual < age 21 # 24	We encourage third party payers such as, EPSDT, etc to be noted. What does special instructions regarding how transportation is to be provided mean?	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 147	Moral or religious grounds # 25 A description of services not covered if electing to no provide/reimburse/cover counseling or referral service because of moral objection or religious grounds.	Please define further, provide examples? Appeal process?	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 147	Guidelines # 26 Information on how to request guidelines, including utilization review and clinical practice.	What will this anticipanted process be?	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 147	Procedures # 27 Explanation of procedures for obtaining benefits and services.	What will this anticipanted process be?	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 147	Resources # 28 How to contact participant services, nurse hotline, SC, and a description of their functions.	What will this anticipanted process be and how will they be differentated to allow the participant to know whom and where to contact? We encourage a team model approach.	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 147	Provider resources # 30 How to obtain a list of all available PCPs, specialists, RXs, and providers of services.	How will this listing be kept up to date and provided with those updates? Participants often call SC entities and are provided a list of PAS providers for example to make informed decsions when transfering services. We appreciate the alternate formats for language. Will there be a braille option?	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 147	Transportation # 32 How to obtain ER and medically necessary transportation? Provide the names and numbers for county MATP providers.	Transportation is a large concern a large section of our current participants. Scheduling is especially challengeing. How will this be monitored and ensured? Will county transportation providers work together to go across county lines? This is a current concern, limiting access to the community, as well as weekends and evenign hours.	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 148	EPSDT # 33 Update handbook regarding Early Intervention and EPSDT services, including dental.	Dental access in a timely and localized area is a continuous issue for current participants.	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 148	Ancillary services # 34 How and where to access Behavioral health, family planning and visions services.	How will service coordinators and Behavioral health services work together to ensure the team approach?	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 148	County/State moves # 36	Please define a list of steps on what to do regarding out of County/out of state move and who completes them. How will continuity of care be ensured between county and or state moves for the participant?	United Disabilities Services

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Requirements Document Exhibit	DD - Participant Handbook	DD Page 148	PCP choice # 39 Notification that the selection of certain PCP sites may result in medical residents, nurse practitioners and physicians assistants providing care to participants	Please note that all medical background requirements will be ensured for those providing care.	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 148	Availability of MA out of plan services # 42	How will this information on accessing other resources be provided or accessed?	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 148	Estate Recovery #46	Currently HCBS has a packet of information on this topic provided from the CAO. Will this information be continued to use and if so, who will provide and explain further as needed?	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 149	Assessment and Reassessment # 48	Please list who will conduct and the steps for completion.	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 149	Advance directive, POA, guardians # 50	We encourage this to be addressed by PA State Law. How will this be monitiored?	United Disabilities Services
Requirements Document Exhibit	DD - Participant Handbook	DD Page 149	Rights and Responsibilities # 51-56	Please note UDS has documented forms that address each of these areas and continue to put the focus on participant choice.	United Disabilities Services
Requirements Document Exhibit	FF - Provider Directories	FF - A) Page 150	PCP and Dentists	We encourage directories need to list if PCPs and dentists are able to serve adults with developmental and/or physicial disabilities.	United Disabilities Services
Requirements Document Exhibit	FF - Provider Directories	FF - A) Page 150	PCP and Dentists	We encourage directories to Identify languages spoken and communication competencies at PCP and dental sites.	United Disabilities Services
Requirements Document Exhibit	FF - Provider Directories	FF - A) Page 150	PCP and Dentists	We encourage directories to include wheelchair accessibility information.	United Disabilities Services
Requirements Document Exhibit	FF - Provider Directories	FF - A) Page 150	PCP and Dentists	We encouarge hospital affiliations to be noted.	United Disabilities Services
Requirements Document Exhibit	FF - Provider Directories	FF - A) Page 150	PCP and Dentists	We encourage directories to include days and hours of operations, as well as after hours contacts if provided.	United Disabilities Services
Requirements Document Exhibit	FF - Provider Directories	FF - A) Page 150	PCP and Dentists	We encourage directories to note experience or expertise in serving individuals with particular conditions.	United Disabilities Services
Requirements Document Exhibit	FF - Provider Directories	FF – B) Page 151	Specialists and providers of ancillary services	Please identify which specialty areas will be included.	United Disabilities Services
Requirements Document Exhibit	FF - Provider Directories	FF – B) Page 151	Specialists and providers of ancillary services	We encourage experience or expertise in serving individuals with particular conditions be included.	United Disabilities Services
Requirements Document Exhibit	FF - Provider Directories	FF – B) Page 151	Specialists and providers of ancillary services	We encourage directories to Identify languages spoken and communication competencies at PCP and dental sites.	United Disabilities Services
Requirements Document Exhibit	FF - Provider Directories	FF – C) Page 151	LTSS Providers	Please identify the services provided by each LTSS provider listed.	United Disabilities Services
Requirements Document Exhibit	FF - Provider Directories	FF – C) Page 151	LTSS Providers	We encourage directories to Identify languages spoken and communication competencies with LTSS providers.	United Disabilities Services
Requirements Document Exhibit	FF - Provider Directories	FF – C) Page 151	LTSS Providers	We encourage directories to include experience or expertise in serving individuals with particular conditions.	United Disabilities Services
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG-A Page 152	# 4 Maintain written documentation of each complaint and grievance	UDSF has current written policies and processes for this.	United Disabilities Services
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG-A Page 152	#6 Have a data system to process, track and trend	How will this system steps for data collection be completed?	United Disabilities Services

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Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG-A Page 152	# 11 Show ability to accept complaints and grievances from individuals with disabilities in alternative formats	We encourage the following, but not limited to: TTY/TDD; Braille; tape; computer disk; and trained staff able to demonstrate patience, understanding, and respect regarding awareness of participants with disabilities and limitations.	United Disabilities Services
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG-A Page 153	# 12 Hearing impaired	We encourage the provision of qualified sign language interpreters throughout the process.	United Disabilities Services
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG - B Page 154	1.b. Toll free number	We encourage a toll free number to file a complaint be established. Partcipants are currently used to the OLTL hotline in the event that a complaint is unable to be addressed at a coordinator entity level.	United Disabilities Services
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG-B Page 158-160	4. Expedited Complaint Process	"Must be conducted at any point with proof of participant's life, health, or ability to maintain or regain maximum function would be placed in jeopardy." This requires certification from the participant's provider. Who will obtain this?	United Disabilities Services
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG-C Page 160	1.a. First level grievance	Please identify time frames for throughout the process.	United Disabilities Services
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG-C Page 160	1.d. Receipt	Will template identified on page GG7 be utilized?	United Disabilities Services
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG-C Page 161	1.g. Level of grievance	Please identify steps for first and second level committees.	United Disabilities Services
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG-C Page 161	1.h. Level one	Including a licensed physician that typically manages or consults on the service/item in question shall potentially benefit the participant and providers on need and assist in deciding in the grievance process.	United Disabilities Services
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG- C Page 162	2.a. Second level	Will template GG8 be utilized for this?	United Disabilities Services
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG- C Page 162	2.d. Review at second level	Including a licensed physician that typically manages or consults on the service/item in question shall potentially benefit the participant and providers on need and assist in deciding in the grievance process.	United Disabilities Services
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG-C Page 165	4. Expedited Complaint Process	"Must be conducted at any point with proof of participant's life, health, or ability to maintain or regain maximum function would be placed in jeopardy." This requires certification from the participant's provider. Who will obtain this?	United Disabilities Services
Requirements Document Exhibit	II - Required Contract Terms for Administrative Subcontractors	Exhibit II Page 171-172	Subcontracts must be in writing with listed minimum provisions:	We encourage the use of the language used in the OHCDS agreement. Information included in this agreement outlines what needs to be included for required contract terms for Administrative Subcontractors and documented to be working.	United Disabilities Services

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Requirements Document Exhibit	II - Required Contract Terms for Administrative Subcontractors	Exhibit II Page 172	Maintain books and records regarding subcontractors	Please identify point person / department.	United Disabilities Services
Requirements Document Exhibit	II - Required Contract Terms for Administrative Subcontractors	Exhibit II Page 173	Cooperation of subcontractors with Quality Management	Please identify point person / department.	United Disabilities Services
Requirements Document Exhibit	II - Required Contract Terms for Administrative Subcontractors	Exhibit II Page 173	Monitoring of subcontractors	Please identify point person / department and corrective action procedures.	United Disabilities Services
Requirements Document Exhibit	KK - Reporting Suspected Fraud & Abuse to the Department	A & B Pages KK-1 to KK-4	Fraud, Abuse and Waste-MCO to notify OLTL	Will the provider be involved in the resolution?	United Disabilities Services
Requirements Document Exhibit	KK - Reporting Suspected Fraud & Abuse to the Department	A & B Pages KK-1 to KK-4	Quality issues/concerns	How will suspension of payments to providers be determined? If an allegation is made is the provider suspended until the review process is completed?	United Disabilities Services
Requirements Document Exhibit	KK - Reporting Suspected Fraud & Abuse to the Department	A & B Pages KK-1 to KK-4	Network provider training	How often with this happen and how laid out?	United Disabilities Services
Requirements Document Exhibit	KK - Reporting Suspected Fraud & Abuse to the Department	A & B Pages KK-1 to KK-4	Identifying participants	The MCO will assist to identify participants who may be at risk of abuse/ neglect and take steps. Will the SC entity be involved? Restriction of services?	United Disabilities Services
Requirements Document Exhibit	LL - Guidelines for Sanctions regarding Fraud, Waste & Abuse	LL Page LL-1	Failure to implement, develop, monitor continue and/or maintain the required compliance plan.	What is the compliance plan? Do providers play a role in developing the compliance plan?	United Disabilities Services
Requirements Document Exhibit	PP - Provider Manuals	T Page PP-4	Provider performance expectations, including disclosures of Quality Management and Utilization Management Criteria and processes.	How will this be different from the current process? Will the criteria for eligibility, prior authorization, etc change?	United Disabilities Services
Requirements Document Exhibit	WW - Audit Clause	Page WW-1	Submission of MCO contract audit will be available to OLTL, OMAP, BMCo and Division of Financial Analysis.	Will the audit findings be made available to providers as well as the public? Will the guidelines used to conduct the audit be made known advance?	United Disabilities Services
Requirements Document Exhibit	WW - Audit Clause	Page WW-1	If circumstances arise in which the Commonwealth or the CHC-MCO invoke the contractual termination or determine the contact will cease the MCO will be responsible to provide MA benefits to recipients within 180 days.	What are the circumstances that this could happen? How is this being planned to ensure there are no interruptions in participants services, as well as continued choice be made during this period. How quickly can a new contract be entered offering continued choice and continuity?	United Disabilities Services

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Requirements Document Exhibit	WW - Audit Clause	Page WW-1	The commonwealth reserves the right for federal and state agencies or their authorized representatives to perform additional financial or performance audits of the CHC-MCO, its subcontractors or Providers.	Will routine audits be established to ensure a standard of care for all providers as well as the MCO? Will the guidelines be presented for audits before hand?	United Disabilities Services
Requirements Document Exhibit	WW - Audit Clause	Page WW-2	Numbers 1-3 but not limited to in audited areas of focus.	We suggest providers with documented track records of positive audits and findings be utilized. UDS has documented positive compliance, tools, and systems and has shown economic, efficient and effective program operations.	United Disabilities Services
Requirements Document Exhibit	WW - Audit Clause	Page WW-2	Corrective Action Plans from Audits	What is the process for non compliant corrective action plans and rebuttals that MCO's or providers may have?	United Disabilities Services
Requirements Document Exhibit	XX - Encounter Data Submission & Penalty Applications	Page XX-4	Failure to achieve Promise approved/paid status for 98% of all CHC-MCO paid/approved and specified encounters may result in a penalty.	Is this 98% achievable-how has this been measured, and what is the penalty defined as?	United Disabilities Services
Requirements Document Exhibit	XX - Encounter Data Submission & Penalty Applications	Page XX-5	Penalty Provision	Is this a documented table of penalties that has been used previously? If so, is this public information?	United Disabilities Services
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	Page AAA (3)-6	The CHC-MCO must ensure that its provider network is adequate to provide is participants in this CHC zone with access to quality participant care through participating professionals, in a timely manner, and without the need to travel excessive distances.	Access to care in a timely manner and without excessive travel is critical to our participant's health, safety and well being. What is defined as timely and excessive distance? A large portion of participants live in rural areas with limited transportation or utilize county transportation, which has limited service areas, as well as limited time frame and often wil not cross county lines. How will this factor into ensuring participant choice options? Further we need to add language about any willing provider. Providers willing to work within the rules of CHC should be able to participate especially DME providers. DME providers have long standing trusted relationships with participants with disabilities and should not be carved out.	United Disabilities Services
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	Page AAA (3)-6	At least 2 PCP's,2 specialists, 2 LTSS providers, and 1 hospital choice within a travel time of no greater than 30 min urban and 60 minutes rural.	The number of PCPs, specialists and LTSS providers seems limited and could result in long wait times for service especially in areas where there are greater numbers of eligible patients. This is a high risk population and access to approprite services is critical. Having a larger network of providers is never a downside and may bring unique value to participants. How will this be ensured and does this take into account public transportation?	United Disabilities Services
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	Page AAA (3)	Appointment Standards. The CHC-MCO will require the PCP, dentist or specialist to conduct affirmative outreach whenever a participant misses an appointment and to document this in the medical record.	What is the goal of tracking this? Will it be communicated as part of service communication to assist with care needs? Is there a penalty for missing appointments?	United Disabilities Services
Requirements Document Exhibit	BBB - Pharmacy Services	F Page BB-1	All proposed pharmacy programs and drug utilization management programs, such as prior authorization, step therapy, partial refills, specialty pharmacy, pill splitting, etc must be submitted to the department for review and approval prior to implementation.	Is there a timeline for review that participants can expect and grievance/appeal process?	United Disabilities Services
Requirements Document Exhibit	BBB - Pharmacy Services	Dii Page BB-14	The CHC-MCO may deny payment if a prescription has been identified as a case of fraud, abuse or gross overuse.	Who will determine if fraud, abuse or gross overuse has been found and if so, what steps will be taken after payment is denied?	United Disabilities Services
Requirements Document Exhibit	DDD(1) - Covered Services List	(1) Page 1-2	Covered services list	We would encourage no current provided service be excluded, if not more options added. Will all services listed be available to all participants that demonstrate a need? For example home delivered meals are currently only provided to those over the age of 60. For those under 60 that have a documented or assessed need- would they quality for this as well?	United Disabilities Services

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 2	Assistive Technology	Will there be a list of approved providers to choose from that ensures participant choice? Will distance from participants home be considered, as well as shipping costs if needed?	United Disabilities Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 4 & 6	Career Assessment & Employment Skills Development	Will this role not be filled by OVR or work in conjunction with OVR?	United Disabilities Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 7	FMS	How many option choices for FMS providers will participants have to choose from? How will orientation and skills training be provided to participants- especially those unable to travel? This is encouraged greatly to allow for more positive and understood consumer model arrangements. Will participants still be able to hire a DCW that is unable to pass a criminal background check?	United Disabilities Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 9	Home Adaptations Other adaptations, subject to approval, to address specific assessed needs as identified in the service plan. Also excluded are those adaptations or improvements to the home that are of general maintenance and upkeep and are not of direct medical or remedial benefit to the Participant this includes items that are not up to code.	Will kitchen appliances be included in kitchen modifications? Reasonable expectation that the participant will continue to live in the home for how long? The Appeals Process for denied Home Adaptations is not listed. Is there a maximum amount per participant or provision if the participant moves that they would be able to obtain a second home adaptation if necessary?How will this be determined? Examples? Will participants be responsible for bringing a home into code compliance, if it is not compliant prior to home modifications being approved? Does this include the whole home or just the section where the modification is needed?	United Disabilities Services
Requirements Document Exhibit	DDD(1) - Covered Services List	DDD (2) Page 10	Home Delivered Meals	In order to receive HDM's can the participant not have a PCA present when the meal is to be consumed? Will HDM's be available to those participants under 60, as well as over 60? We encourage this option, as participant under 60 would benefit for nutritional value this option.	United Disabilities Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 10	Home Health Services	Who is responsible for obtaining the prescription every 60 days?	United Disabilities Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 13	Non Medical Transportation Non Medical Transportation services include mileage reimbursement for drivers and others to transport a participant and/or the purchase of tickets or tokens to secure transportation for a Participant. Non Medical Transportation must be billed per one way trip or billed per item, for example a monthly bus pass.	Will the current cap of $215.00 maximum per month continue? Providing a monthly pass, when available would alleviate additional requests and allow greater independence, encouraging participants to access the community independently more often. This perhaps would increase socialization and independence in general.	United Disabilities Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 14	Non Medical Transportation does not cover reimbursement to the Participant or another individual when driving the participant's vehicle. An individual cannot perform both Personal Care Assistance Services and Non Medical Transportation Simultaneously.	Will it provide reimbursement in a PCA or informal supports vehicle? Will there be an exception for those participants that have an adapted vehicle to meet their accessibility needs and it is required to safely transport the participant? This would eliminate the option of PCA's providing NMT, a great deal of our participants count on their PCA's to provide transportation, which eliminates extensive wait times and allows for further community access. It is encouraged to allow PCA's to be reimbursed for NMT.	United Disabilities Services

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 14	Nursing Home Transition	Who will be providing the NHT coordination and will this be in conjunction with the SC entity. It is encouraged to provide clearer details of what provider will do each part and how communication/meetings & plan request will be completed. This is a current struggle and barrier to achieving the best results for the participant. Currently when NHT participants enter the waiver, they are considered on hold for billing purposes until there discharge. Is there a way to eliminate this, as the SC is actively working on the participants needs, often in an intensive manner. Currently an individual who resides in a NF for 180 day or greater is terminated from the waiver. Often participants require over the 180 days to get their situation coordinated, could this 180 days be removed or looked into to allow for an increase in successful NHT discharges to home.	United Disabilities Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 16	Personal Assistance Services Health Maintenance activities provided for the Participant, such as bowel and bladder routines, ostomy care, catheter care, wound care and range of motion as indicated in the individual's service plan and permitted under applicable state requirements. Services to accompany the participant into the community for purposes related to personal care, such as shopping in a grocery store, picking up medications and providing assistance with any of the activities noted to enable the completion of these tasks.	Currently PAS providers do not allow in an agency model for catheter, some bowel & bladder programs and would care. There is concern to allowing a PCA opposed to nursing to provide this invasive care in an agency situation. There is great liability to an agency provider to allow for this, as well as the safety and well-being of the participant. We encourage this be looked into further and explained in greater detail. Does this mandate that the participant must accompany the PCA into the community for all needed tasks? For example, we have participants whose PCA's complete their shopping or pick up there needed medications for them when they do not feel well enough to enter the community.	United Disabilities Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 17	Personal Emergency Response Systems (PERS)	Will all varying types of PERS be included? The type of PERS needed depends on the participants living situation, access to community and physical abilities. As a cost saving method, UDS notes that there are current PERS providers that do not charge an initial setup fee.	United Disabilities Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page	Pest Eradication	This is a current high impact concern. UDS feels very strongly this will allow for greater health, safety & well being for the participant and those providing care/services. Is there a list of what is considered "Pests" for elimination? We would encourage this to include bed bugs, fleas and any infestation or potential insect or rodent challenges in the participants living areas. Will there be a list of Pest Providers to choose from for participants needing the service? Is there a CAP on this?	United Disabilities Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 17-18	Residential Habilitation	Currently each Residential Rehabilitation has varying rates in the amount they remand from the participant's income to cover expenses for the participant, etc. This often takes a toll on the participant, leaving them with very little income for activities they wish to participant in or items they need to purchase, such as for hygiene. Can a flat rate be established across the board, taking into consideration the needs that the participant must still purchase?	United Disabilities Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 18	Respite Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or resides in the home.	A large amount of participants have paid caregivers who reside in the same home. Eliminating this for respite would decrease supports available to assist the participants at times when respite could be needed when the primary support is unavailable. We strongly request that this be removed from the respite section.	United Disabilities Services

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 18-19	Service Coordination	Current service coordination has 24 hour on call availability that is not noted, will this continue? UDS has documented success with our on call system. There is no information on incident reporting, follow up and management for service coordination. Will coordinators still complete this? There is no detail on level of contact or frequency between the coordinator and participant. There is no detail provided on assessing for needs such as home adaptations and specialized medical equipment and coordinating that these outcomes are achieved. When Managed Care rolls out, will participants have the choice to remain with an SC entity that is documented to be meeting all of the needed requirements in their area? How will rates be established, participants needs vary in intensity from low to high depending on many factors that change frequently. What role will the identified Health Choices Care Coordinator take and how will service coordination work together with the care coordinator to ensure best outcomes and that the same tasks are not being done twice.	United Disabilities Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 19-20	Specialized Medical Equipment and Supplies Non Covered Items	Items such as nutritional drinks, dentures and eye glasses are great need for current participants. Including these items would aide in ensuring the health and well-being of the participants. Hearing aides being covered as noted is a very positive item for our participants.	United Disabilities Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 21	Therapeutic and Counseling Services Counseling services are non-medical counseling services provided to participants in order to resolve individual or social conflicts and family issues.	We encourage participant choices in providers and that they be within an identified as reasonable time frame area from the participant's area and not have identified waiting periods. Counseling can currently take extensive periods of time to get an appointment and not be in the participant's area to access, which can limit needed appointments. Counseling services are a positive addition to assist in potential concerns issues as identified with the individual, socially or in the family setting.	United Disabilities Services
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	DDD (2) Page 22-23	Vehicle Modifications The vehicle must be less than 5 years old and have less than 50,000 miles for vehicle modification requests over $3,000.00	Does this mean that modifications under $3,000.00 that adhere to the approved guidelines will be approved in vehicles older than 5 years and/or with over 50,000 miles?	United Disabilities Services
Requirements document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	Page 44	all employed or contracted Service Coordinators meet the minimum requirements of bing a registered nurse or having a bachelro's degree in social work, psychology, or other field and at least three years experience in the coordination of services.	We believe that ACT 22 regulations should be the baseline for service coordinators at time of hire. Then we suggest that each service coordinator be required to become a certified service coordinator within a specified period of time. This time would be determined by which certification program would be chosen as the requirement. For existing SCs, a period of time from when their entity begins working under CHS there should be a reaonable period of time to become certified. Many that we have researched addresess DHS's current concerns around doucmentation, recognizing and reporting potential abuse and neglect and understanding people with medical needs. Ohio State University, Boston University, and University of Connecticut are just a few we have looked at. Or perhaps, the state could develop a certification using the extensive Supports Coordinator training that has been established for ODP. We do not believe that the standards for current Service Coordinating agencies that are doing well should be changed due to some that are doing so well. If requirements are not changed, we belive nearly 52% of current SCs will not be eligible to be employed under this program and invaluable experience will be lost. If a change in requirements is not considered, we beleive that there should be a grandfathering for those who have been doing this for years, who have made this their careers and who have long term working relationships with current participants.	Service Coordination Unlimited
Requirements document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	Page 44	All Service Coordinator Supervisors must be a licensed social worker with at least 5 years of experience or a registered nurse with 5 years of experience.	We believe that the baseline for SC supervisors should follow ACT 22 as well as a certifcation SC program that needs to be developed as well as 5 years SC experience. If draft requirements remain, we believe around 90% of current SC supervisors will no longer be eligible to work with current participants. This would cause a loss of many year of invaluable experience among existing supervisors. If a change in requirements is not considered, we beleive that there should be a grandfathering for those who have been doing this for years, who have made this their careers and who have long term working relationships with current participants.	Service Coordination Unlimited

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Requirements Document	Section V.D. - Choice of Provider	Page 40	Participants must be afforded choice of all Providers within the Provider network, including Service Coordinators	We recommend this be changed to say must be afforded choice with the Provider network, including Service Coordination Entities. We are concerned that real choice will not be given to participants if they must remain within the same entity whether this be with the MCO or a contracted Service Coordination Entity. More than one SCE will provide real choice for consumers. We believe in real choice for every service that a participant receives.	Service Coordination Unlimited
Requirements document	Section V.C. - Continuity of Care	Page 39	all existing providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed	We recommend the timeframe be a timeframe that is more realistic. This is a tremendous change to current participants in LTSS. Other states started with a shorter period of time and needed to adjust the timeframe. We recomment 2 years as this will allow the MCO a real opportunity to get to know the provider and to decide if that provider should be part of a newtowrk, whether this is SC or a direct service provider. We do feel a subpar provider should be able to be removed by an MCO with proper protocol.	service Coordination Unlimited
Requirements document	Section V.E. - Needs Screening	page 40	The needs screening must be conducted in the first 30 days of Enrollment, and may be conducted by phone, electronically, by mail, or in person	We believe that this must be done in person. For accuracy and to have a true assessment, in person should be required.	Service Coordination Unlimited
Requirements document	Section V.A. - Covered Services	1, amount, duration and scope	must provide services in the amount, duration, and scope	It is understood why type would no longer be needed by we believe frequency needs to be included as well	Service Coordination Unlimited
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	All	Footer states AAA(3)	Are sections AAA(1) and AAA(2) missing?	Meridian Health Plan
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	All		Will there be different standards for the different zones similar to what was seen in the HealthChoices RFP #06-15	Meridian Health Plan
Other	Covered Benefits			Will PA Medicaid cover Assisted Living Residences (ALR) and Personal Care Homes (PCH) as part of Community Health Choices? Currently these options are not a covered MA benefit.	Meridian Health Plan
Other	Other			Will the Department of Human Services recognize other non medical services in the proposed rates? These non medical services can be the most contentious if deemed "not covered" or not adding value to the overall care plan	Meridian Health Plan
Other	Other			Given the historical "payment tension" between Home Care Providers and MA MCOs in the Health Choices Program, will PA MA increase the base MA fee schedule for home health nurse and aide services? It goes without saying, if the base rates are increased for home care this would be reflected in the PMPM.	Meridian Health Plan
RFP	Work Statement Questionnaire	Provider Network Page 40	Question 3	Will the Department of Human Services support the expanded practice and use of Dental Hygienists, specifically in nursing homes? Currently only "public health" hygienists have expanded practice capabilities. This is import as the RFP highlights oral health and PA has a significant shortage of Dentists that is compounded by Medicaid reimbursement.	Meridian Health Plan
RFP	Work Statement Questionnaire	Participant Service and Care Coordination Page 30	Question 11	Since the Department of Human Services continues to emphasize the use of assistive technology, tele-health, telecare, social media, e-visits, and the like; will the Department of Human Services update its base fee schedule to reflect this care model? Will the Department of Human Services coordinate this effort with the Department of Health which regulates telemedicine in PA?	Meridian Health Plan
Other	Other			What is the Department of Human Services media and outreach strategy? When will it be shared with the MCOs?	Meridian Health Plan
Other	Other			With the status of the budget still in process do you expect an impact on Community Health Choices program?	Meridian Health Plan
Requirements Document Exhibit	BBB - Pharmacy Services	Formularies and Preferred Drug Lists (PDLs) pg BBB-3	a.The CHC-MCO may use a Formulary or a PDL. All drugs must be Covered Pharmacies.	a.The CHC-MCO may use a Formulary or a PDL. All drugs must be **dispensed by contracted pharmacies.**	Meridian Health Plan

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RFP	Work Statement Questionnaire	Participant Service and Care Coordination Page 29	2. Describe how your CHC-MCO will work with each of the different CHC populations and their different needs with particular emphasis on the different strategies for the nursing facility clinically eligible population and nursing facility ineligible population.	2. Describe how your CHC-MCO currently works with different populations and their different needs with particular emphasis on the different strategies for the nursing facility clinically eligible population and nursing facilility ineligible. Describe how your CHC-MCO will work with each of the different CHC populations in the Commonwealth	Meridian Health Plan
RFP	Work Statement Questionnaire	Participant Service and Care Coordination Page 30	3. Describe your approach for using the needs screening to identify people with cognitive impairment, acquired or developed. Describe your approach to meeting the needs of this population.	3. Describe your experience and approach for using the needs screening to identify people with cognitive impairment, acquired or developed. Describe your experience and approach to meeting the needs of this population.	Meridian Health Plan
RFP	Work Statement Questionnaire	Participant Service and Care Coordination Page 30	7. Describe your process to ensure that Service Planning is a person-centered process and that Participants' needs, goals, and preferences are at the center of the process Include the communication process with the Participant and how he or she is supported in the most integrated setting with preference and priority for supporting Participants in their own homes.	7. Describe your experience and your process to ensure that Service Planning is a person-centered process and that Participants' needs, goals, and preferences are at the center of the process Include the communication process with the Participant and how he or she is supported in the most integrated setting with preference and priority for supporting Participants in their own homes.	Meridian Health Plan
RFP	Work Statement Questionnaire	Participant Service and Care Coordination Page 30	8. Describe your process for care coordination to ensure that Participants receive adequate in-home services to divert them from entering or returning to acute or long term care facilities.	8. Describe your current process for care coordination to ensure that Participants receive adequate in-home services to divert them from entering or returning to acute or long term care facilities. How will your process be applied to the CHC program.	Meridian Health Plan
RFP	Work Statement Questionnaire	Participant Service and Care Coordination Page 30	9. Describe your plans for delivering comprehensive services that:	9. Describe your experience in delivering comprehensive services that: … and describe your plans for delivering these services to the CHC population.	Meridian Health Plan
RFP	Work Statement Questionnaire	Participant Service and Care Coordination Page 30	10. Describe how you will use community resources, such as community health workers, and natural supports to improve wellness, improve education on health options, and to improve community involvement.	10. Describe how you currently use community resources, such as community health workers, and natural supports to improve wellness, improve education on health options, and to improve community involvement. How will you replicate and/or improve these efforts for the CHC population?	Meridian Health Plan
RFP	Work Statement Questionnaire	Participant Service and Care Coordination Page 32	19. What is your plan for the collection of Participants' payment obligation for the cost of nursing facility care?	19. What is your experience and plan for the collection of Participants' payment obligation for the cost of nursing facility care?	Meridian Health Plan
RFP	Work Statement Questionnaire	Participant Service and Care Coordination Page 32	20. Describe how you will consider feedback from your Participant Advisory Committee (PAC) into your operations and policies.	20. Describe how you currently use feedback from your Participant Advisory Committee (PAC) into your operations and policies. How will you use this feedback in the Commonwealth?	Meridian Health Plan

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RFP	Work Statement Questionnaire	Service Integration pg 33	5. Describe how your plan will coordinate with each Participant's Medicare Part D coverage.	5. Describe how you currently coordinate Medicare Part D coverage and your plan to coordinate CHC's Medicare Part D coverage.	Meridian Health Plan
RFP	Work Statement Questionnaire	Quality Improvement and Performance Measures pg 34	1. Describe your strategy for achieving quality performance and outcomes.	1. Describe your experience and strategy for achieving quality performance and outcomes.	Meridian Health Plan
RFP	Work Statement Questionnaire	Quality Improvement and Performance Measures pg 34	3. Describe your strategy for controlling chronic conditions such as high cholesterol, high blood pressure, diabetes, etc.	3. Describe your experience and strategy for controlling chronic conditions such as high cholesterol, high blood pressure, diabetes, etc.	Meridian Health Plan
RFP	Work Statement Questionnaire	Quality Improvement and Performance Measures pg 34	4. Describe your strategy for addressing the needs of Participants with dementia in community settings.	4. Describe your experience and strategy for addressing the needs of Participants with dementia in community settings.	Meridian Health Plan
RFP	Work Statement Questionnaire	Quality Improvement and Performance Measures pg 34	5. Describe your strategy for addressing the needs of Participants with acquired brain injuries in community settings.	5. Describe your experience and strategy for addressing the needs of Participants with acquired brain injuries in community settings.	Meridian Health Plan
RFP	Work Statement Questionnaire	Quality Improvement and Performance Measures pg 34	6. Describe your strategy for approaching service delivery in rural and urban areas including LTSS, preventive, and acute care.	6. Describe your experience and strategy for approaching service delivery in rural and urban areas including LTSS, preventive, and acute care.	Meridian Health Plan
RFP	Work Statement Questionnaire	Quality Improvement and Performance Measures pg 34	9. Describe how you will engage your PAC in quality improvement.	9. Describe how you currently engage your PAC in quality improvement and how will you use the PAC with the CHC populations to improve quality.	Meridian Health Plan
RFP	Work Statement Questionnaire	Provider network Compostition and Network Management pg 41	8. Describe how you monitor and evaluate PCPs and other provider compliance with availability and scheduling requirements outlined in the agreement? Describe your plan to maintain PCP-to-Participant ratio requirements throughout the term of the agreement.	8. Describe your experience and how you monitor and evaluate PCPs and other provider compliance with availability and scheduling requirements outlined in the agreement? Describe your plan to maintain PCP-to-Participant ratio requirements throughout the term of the agreement.	Meridian Health Plan

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Requirements Document	Section V.A. - Covered Services	Subsection 3, Pg. 27	The CHC-MCO is required to establish a program exception process, reviewed and approved by the Department, whereby a Provider or Participant may request coverage for items or services, which are included in the Member's benefit package but are not currently listed on the MA Program Fee Schedule.	In some of the similar programs that we are currently managing, members will often request that a spouse or other live- in caregver is compensated for their services if the amount of time they spend delivering these services prevents them from regular employment. Oftentimes, they do not want a caregiver provided to them because they are more comfortable with the live-in caregiver. Is it at the discretion of the CHC- MCO to establish a review process for exceptions as it relates to members requesting personal assistance services from a live-in caregiver that meets this criteria?	Meridian Health Plan
Requirements Document	Section V.A. - Covered Services	Subsection 4, Pg. 27	CHC-MCOs are permitted and encouraged to offer LTSS Covered Services to Participants who are not yet NFCE. These services will not be reimbursed by the Department.	Is there a timeframe in which the CHC-MCO can expect to receive Nursing Facility eligibility after submission to the Department? We suggest that coverage for LTSS services offered to those who are not yet NFCE is limited to those who are deemed "high risk" after a clinical review process; otherwise.	Meridian Health Plan
Requirements Document	Section V.A. - Covered Services	Subsection 6, Pg. 28	A Participant may self-refer for vision, dental care, Indian Healthcare Providers, obstetrical and gynecological (OB/GYN) services, providing the Participant obtains the services within the Provider Network.	For dual eligible members, will the provider network for dental and vision be contracted directly with the CHC-MCO?	Meridian Health Plan
Requirements Document	Section V.A. - Covered Services	Subsection 19, Pg. 34	The CHC-MCO must contract with the Commonwealth-procured FMS entities, of which there are three that operate statewide.	Does the CHC-MCO have an obligation to contract with all three providers and offer each of these options to all personal assistance providers?	Meridian Health Plan
Requirements Document	Section V.A. - Covered Services	Subsection 20, Pg. 35	The CHC-MCO must provide services in the least restrictive, most integrated setting. The CHC-MCO shall only provide LTSS in settings that comply with the HCBS Settings final rule at 79 F.R. 2948 (January 16, 2014).	We suggest that a comprehensive list of approved LTSS settings is available via sharepoint or other data sharing tool for use by all CHC-MCOs to avoid duplicate visits	Meridian Health Plan
Requirements Document	Section V.A. - Covered Services		The CHC-MCO must conduct a comprehensive needs reassessment no more than 12 months following the most recent prior comprehensive needs assessment or comprehensive needs reassessment unless a trigger event occurs. Reassessments must be completed as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, but in no case more than 14 days after the occurrence of any of the following trigger events:	Suggest that participating CHC-MCOs agree upon standard list of trigger events that warrant the need for a Comprehensive needs reassessment that aren't otherwise outlined in this section.	Meridian Health Plan

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RFP	General Information	Section I-4	Population projections for the CHC Program can be uncertain and can be affected by changes in the economy, law and regulations, and policies. The Department publishes monthly and historical enrollment reports capturing many specific geographic and statistical elements.	Will these reports be added monthly prior to the first of each month? If so, will an updated report be provided the event enrollment information changes after new membership becomes effective?	Meridian Health Plan
RFP	General Information	Section I-4	Pay for Performance: For 2017, the Department will implement a Pay for Performance Incentive to CHC-MCOs that helps Participants successfully complete the financial eligibility redetermination process with their local CAOs. The Department may implement additional Pay for Performance Incentives in later years.	Suggest that data is submitted by each MCO that outlines success in reaching out to all members who are due for redetermination.	Meridian Health Plan
RFP	Proposal Requirements	Section II-B	The CPP requires entities entering into agreements with the Department make a commitment to fill vacancies and new positions with individuals currently receiving TANF cash assistance. The CPP will work cooperatively with entities to assist in these efforts by coordinating the resources of local service providers to assist in the identification of qualified individuals for employment opportunities. While the CPP will provide assistance, the selected CHC-MCO is ultimately responsible for meeting its goal.	Is there any literature avilable that will offer additional information and guidance regarding this program?	Meridian Health Plan
RFP	Proposal Requirements	Section II-3 A	Corporate Background. The Offeror must describe the corporate history and relevant experience of the Offeror and any subcontractors. This section must detail information on the ownership of the company (names and percentage of ownership), the date the company was established, the date the company began operations, the physical location of the company, and the current size of the company.	Suggest that testimonies are submitted to display past success in launching new product line in a new territory or state.	Meridian Health Plan
RFP	Proposal Requirements	Section II-3 C	References. The Offeror must provide a list of at least three (3) relevant contracts within the past three (3) years to serve as corporate references. These references may not be DHS contracts. This list shall include the following for each reference:	LTSS or any other specific reference preferred?	Meridian Health Plan

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RFP	Work Statement Questionnaire	Participant Service and Care Coordination, Q1	Decribe how you will employ Person-centered approaches and Self-direction.	MCOs who are currently managing populations that require Care Coordination should be required to submit training materials and/or external training experiences they've attended regarding Person-Centered planning	Meridian Health Plan
RFP	Work Statement Questionnaire	Participant Service and Care Coordination, Q3	Describe your experience and approach to screening for needs, conducting assessments and reassessments, and using existing or developing new tools and systems to support these processes.	May be valuable to submit data supporting an increase in success as a result of the development of a new tool or implementation of a new resource (such as a subcontractor)	Meridian Health Plan
RFP	Work Statement Questionnaire	Service Integration- Q5	Describe how your plan will coordinate with each Participant's Medicare Part D coverage.	May be helpful to request data displaying the number of Part D providers that each MCO is currently working with and how Rx care is being coordinated for members	Meridian Health Plan
RFP	Work Statement Questionnaire	Management Information Systems- Q1	Describe the capacity and security of your systems and its ability to handle the CHC population.	Request data displaying clean claims approved wtihin timeframe during onboarding periods	Meridian Health Plan
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments			Is it a requirement for these assessments to be completed in person? Is there specific stratification logic that should be incorporated into the assessment? No timeframes indicate for regular follow up visits or phone calls	Meridian Health Plan
Requirements Document	Section V.A. - Covered Services	Item #7, P28	All Participants who need behavioral health services will obtain these services from the Behavioral Health Managed Care Organizations (BH-MCOs).	Due to issues with learning, memory, and transfer of skills to daily life, it is important that all services for individuals with brain injury be carefully coordinated and specialized. Traditional behavioral health providers do not have the expertise to provide these services to individuals with brain injury. It would be detrimental for behavioral health services, defnied as mental health and substance and substance use services, to be provided by an entity that is separate from that which provides HCBS. These need to be integrated for this population in order to be effective.	Brain Injury Association of Pennsylvania/Monica Vaccaro
Requirements Document	Section V.B. - Prior Authorization of Services	P 36	When the CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of denial using the appropriate notice outlined in templates N(1), N(2), (N)3, and N(7) found on the Intranet site supporting CHC. In addition, the CHC-MCO must make the notice available in accessible formats for individuals with visual impairments and for persons with limited English proficiency.	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.	Brain Injury Association of Pennsylvania/Monica Vaccaro
Requirements Document	Section V.E. - Needs Screening	P 40	Upon Enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or need for Service Coordination.	The needs assessment tool needs to take into account the impact of cognitive impairment on function. Individuals with brain injury may lack awareness of their impairments, 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.	Brain Injury Association of Pennsylvania/Monica Vaccaro

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Requirements Document	Section V.J. - Service Coordination	P 44	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology or other related field and at least three years of experience in the coordination of services. All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience. Service Coordinators and Service Coordinator Supervisors must also complete Department-approved training in required training topics.	The requirements for those providing Service Coordination for individuals with brain injury should be based on disability specific training rather than field of study or licensed discipline. It is recommended that Service Coordinators working with individuals with brain injury obtain training through the American Academy for Certification of Brain Injury Specialists - www.biausa.org/acbis/cbis. This is a national certification, includes an exam to demonstrate learning, and requires ongoing education to maintain certification.	Brain Injury Association of Pennsylvania/Monica Vaccaro
Requirements Document	Section V.DD. - Provider Network	90	All Providers must meet the minimum qualification requirements established by the Department and must be credentialed by the Department.	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.	Brain Injury Association of Pennsylvania/Monica Vaccaro
Requirements Document	Section V.A. - Covered Services		• How to get those in need to services providers seamlessly. • This seamless system being developed before the Program is offered. • Consumers who will need, or can use information to help others, should be identified, including caregivers, families, providers and the general population that can provide natural supports, along with how they best can be reached before government attempts to sell a Program. • Continual tracking of "How are we doing?" as it relates to consumer awareness and services delivery effectiveness.		Casey Jones Transformation Initiative
Requirements Document	Section II - Definitions	9	HCBS definition	LeadingAge PA recommends revising the definition to include the concept of safety while residing in their homes "…which promote the ability for older adults and adults with disabilities to live independently to the greatest degree and remain SAFELY in their homes." LeadingAge PA recognizes and supports the concepts of consumer direction, with services reflecting the consumer's goals and preferences, but also recognizes that promoting the participant's safety is an important component of HCBS.	LeadingAge PA

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Requirements Document	Section II - Definitions	12	Medically Necessary is missing "documented in writing based on medical information and based on determination by a qualified and trained health care provider."	Consider adding Medically Necessary documentation where appropriate. May need to have two definitions; one for medical services, which should be medically necessary and documented/approved by a health care professional and necessary social services, which need not be approved and documented by a medical professional. May want to retain an approval mechanism like the Medical Necessity documentation required within Physical Health HealthChoices (PH-HC).	LeadingAge PA
Requirements Document	Section II - Definitions	12	MIPPA Agreement defined	LeadingAge PA recommends that the MIPPA agreements be made publicly available.	LeadingAge PA
Requirements Document	Section II - Definitions	14 and see page 57	Participant Advisory Committee	The discussion of the PAC on page 57 of the agreement indicates that providers are also included, so that should be reflected in the definition. Moreover, LeadingAge PA recommends that CHC-MCOs be required to have a provider advisory committee.	LeadingAge PA
Requirements Document	Section V.A. - Covered Services	33-34	Nursing Facility Services - Does the Department intend to hand over the field operations function to the CHC-MCO or a third party?	Please clarify that DHS will continue to provide field operations (FO) oversight. It will be duplicative and administratively complex if each CHC-MCO will impose its own FO requirements.	LeadingAge PA
Requirements Document	Section V.A. - Covered Services	35	Service Delivery Innovation - Housing Innovation	As noted in the letter accompanying this excel document, LeadingAge PA appreciates the interest expressed in the draft RFP and agreement regarding innovative housing programs. We believe the discussion around housing in the agreement reveals that the department recognizes that the need for affordable, accessible housing far exceeds the supply and that the current subsidy programs available are not adequate to meet this need, even though housing providers would be willing to expand their offerings. We encourage the departments to pursue additional funding opportunities so that the supply can be increased and also to recognize and assist providers in identifying and implementing sustainable funding strategies to provide service coordination in affordable senior housing properties. Our members have expertise in helping seniors to manage chronic conditions and in finding and accessing the community resources available to help them remain at home while improving their quality of life. LeadingAge PA members would be pleased to meet with DHS and share their expertise and insights into developing and maintaining housing and programs that allow people to successfully age in place at home, and would like to explore ways that these innovative models can be supported and replicated under CHC.	LeadingAge PA
Requirements Document	Section V.B. - Prior Authorization of Services	38	Time Frames for Notice of Decisions must be very quick for hospital discharges	CHC-MCOs will need to be able to quickly make and communicate decisions on prior authorization for LTSS for participants being discharged from a hospital. The hospital will not be willing to wait up to 21 days for service authorization, creating pressure for providers to accept admissions without having the preauthorization from the MCO. Also, prior authorization decisions should be communicated to all providers involved, not just the prescriber.	LeadingAge PA
Requirements Document	Section V.C. - Continuity of Care	39	Current residents of nursing facilities will be able to continue to reside in their home. Clarification requested on subsequent discussion.	LeadingAge PA appreciates DHS/PDA's recognition that nursing facility residents have already selected their LTSS provider and consider the nursing facility to be their home. Bullet 3 references LTSS Providers, which includes both HCBS and nursing facility providers. We believe that bullet 3 on page 39 should refer to HCBS providers only rather than to both HCBS providers and nursing facility providers. Please clarify that the third bullet applies to HCBS participants only. Additionally, we request clarification that current residents of nursing facilities who spend down to eligibility for Medical Assistance will be included in this provision and discussion regarding how the process will work for them.	LeadingAge PA
Requirements Document	Section V.C. - Continuity of Care	39	180 day continuity of care requirement for HCBS is inadequate to assure a safe transition to CHC.	LeadingAge PA believes that the 180 day continuity of care requirement for HCBS is much too brief and urges the department to provide a minimum of two years for the continuity of care provisions to allow for a smooth transition and ensure that consumers will not have their services disrupted.	LeadingAge PA
Requirements Document	Section V.C. - Continuity of Care	39	Seniors who have selected a Continuing Care Retirement Community have already chosen their LTSS provider, but there are no specific continuity of care provisions to protect them and support this choice.	The department must require CHC-MCOs to work with all CCRCs who participate in the Medical Assistance program so that consumer choices in selecting a CCRC are respected. Further, since CCRC residents have selected a package of services that may contain nursing facility, home health, assisted living residence, etc., the CHC-MCO should be required to contract with all services components within a given CCRC so that the CCRC residents can remain in the community using the services that they have selected.	LeadingAge PA

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Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	40	Needs assessment using a tool approved by the department	LeadingAge PA commends the departments on requiring that the needs assessment tools be approved by the departments, however, we recommend that the needs assessment tool be developed by the departments, working with stakeholders, including LeadingAge PA.	LeadingAge PA
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	40-42	Development of the comprehensive needs assessment and reassessment	LeadingAge PA commends the departments on the requirement that CHC-MCOs conduct a comprehensive needs assessment that is conducted in person. LeadingAge PA should be included as a stakeholder in the development and testing of the comprehensive needs assessment.	LeadingAge PA
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	46	Participant enrollment and disenrollment - participants can change CHC-MCOs for any reason at any time.	LeadingAge PA is concerned that participant changes in CHC-MCOs will be difficult to track and will lead to confusion in providing and billing for services. The department must assure that participant CHC-MCO changes can be managed smoothly because this population is likely to need services on a daily basis, with little or no lag in provision of services.	LeadingAge PA
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	48, 55, 56, 57	Marketing of companion D-SNPs	LeadingAge PA has concerns there may be undue pressure upon participants to accept the CHC-MCO's companion D-SNP program and urges the departments to provide oversight to prevent this.	LeadingAge PA
Requirements Document	Section V.R. - Participant Complaint, Grievance & DHS Fair Hearing Process	62	Language from PH-HC regarding policies and procedures for resolving participant complaints is not included in CHC-HC agreement.	LeadingAge PA suggests that the agreement for CHC include the following language from the PH-HC agreement: The CHC-MCO must have written policies and procedures approved by the Department, for resolving Participant Complaints and for processing Grievances and DHS Fair Hearing requests, that meet the requirements established by the Department and the provisions of 40 P.S. 991.2101 et seq. (known as Act 68, Pennsylvania Department of Health regulations (28 Pa. Code Chapter 9), Pennsylvania Insurance Department regulations (31 Pa. Code CHs. 154 and 301) and 42 CFR 431.200 et seq. of the Federal Regulations. The PH-MCO must also comply with 55 Pa. Code 275 et seq. regarding DHS Fair Hearing Requests and 42 CFR 438.406(b).	LeadingAge PA
Requirements Document	Section V.T. - Provider Dispute Resolution Process	63	Provider Dispute Resolution Process is not within the jurisdiction of the Department's BHA.	LeadingAge PA supports the requirement that CHC-MCOs must develop, implement and maintain a provider dispute resolution process. However, LeadingAge PA strongly urges the departments to reconsider this proposal to include provider access to the Bureau of Hearings and Appeals. Providers must have access to the Bureau of Hearings and Appeals or another independent body as suggested in our attached letter.	LeadingAge PA
Requirements Document	Section V.V. - Executive Management	65	Director of LTSS	LeadingAge PA commends the department on requiring that the CHC-MCO executive management team includes a full time Director of LTSS; however, we also urge the inclusion of executive management staff who have experience working with seniors.	LeadingAge PA
Requirements Document	Section V.V. - Executive Management	67	Claims Administrator to ensure timely and accurate processing of claims, encounter forms, etc.	LeadingAge PA appreciates that the CHC-MCO agreement requires a person on the CHC-MCO staff who is responsible to ensure timely and accurate claims processing; however, the definition of timely and accurate claims should be specified by DHS and be consistent for all CHC-MCOs.	LeadingAge PA
Requirements Document	Section V. Z. - Fraud & Abuse	78	Overpayment recovery does not describe process for provider appeal.	LeadingAge PA requests that DHS provide and describe a process for providers to appeal any CHC-MCO overpayment recovery actions.	LeadingAge PA
Requirements Document	Section V.AA. - Selection & Assignment of PCPs	83	Selection and Assignment of PCPs	Please address how PCP selection will be conducted if a dual-eligible participant's PCP accepts Medicare but does not participate in the Medical Assistance program or clarify that the assignment of a PCP applies only to non-duals.	LeadingAge PA
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	84	notify the Participant by telephone or in writing of his/her Service Coordinator's name.	Suggest that the language require that the CHC-MCO "notify the Participant by telephone AND in writing of his/her Service Coordinator's name..."	LeadingAge PA
Requirements Document	Section V.CC. - Provider Services	85	Providing to PCPs a monthly list of participants.	Will a list updated monthly be accurate enough? LeadingAge PA suggests that PCPs and other providers must have access to information that is updated and shared on a daily basis.	LeadingAge PA

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Requirements Document	Section V.CC. - Provider Services	85	Developing a process to respond to Provider inquiries regarding current Enrollment.	This process must be easy to access, even after the hours of 9-5 weekdays, and must be up-to-date.	LeadingAge PA
Requirements Document	Section V.EE. - QM & UM Program Requirements	96	HEDIS data is not necessarily pertinent to LTSS.	As we have noted in prior comments, several of the HEDIS measures are not necessarily relevant to the MLTSS population, so irrelevant measures should be screened out. LeadingAge PA encourages the departments to work with stakeholders and with accrediting and quality measure development entities to identify and develop measures appropriate to MLTSS.	LeadingAge PA
Requirements Document	Section V.EE. - QM & UM Program Requirements	97	Delegated QM and UM functions	LeadingAge PA appreciates that the contract prohibits CHC-MCOs from structuring payment arrangements to provide incentives to deny limit, or discontinue Medically Necessary services.	LeadingAge PA
Requirements Document Exhibit	U - Behavioral Health Services	U-1	Behavioral Health Services listing does not include discussion of which entity is responsible to provide services related to dementia.	Please clarify which entity (BH-MCO or CHC-MCO) will provide services related to dementia.	LeadingAge PA
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG-4	16, 17, 18 and 19 - Notification should include provider.	The CHC-MCO should notify the provider as well as the participant when it fails to decide a first level complaint or grievance within the time frames specified. The CHC-MCO should also notify the affected provider when it denies payment after a service has been delivered.	LeadingAge PA
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG-18	Fair Hearing can be accessed whether or not Grievance or Complaint Process has been completed.	LeadingAge PA commends the departments on allowing participants access to the DHS Fair Hearing process without having to exhaust the complaint or grievance process first.	LeadingAge PA
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	GG-21	Provision of and Payment for Services/Items following decision - clarification is needed.	Please clarify how this process will work, once the CHC-MCO or BHA reverses a decision to deny authorization of services. How will the payment be provided?	LeadingAge PA
Requirements Document Exhibit	PP - Provider Manuals	PP-4	Items Q, Billing Instructions and T, Performance Expectations should be consistent across CHC-MCOs.	To promote efficiency of operations for providers and reduce unnecessary costs and administrative burden, freeing resources for participant care, the departments should require consistent billing, quality management, utilization management practices among the CHC-MCOs.	LeadingAge PA
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3) - 7	The special circumstance of participants who have selected Continuing Care Retirement Communities is not addressed in the discussion of provider network composition/service access.	The department should consider adding CCRCs as either a separate category of provider, or as a subcategory of LTSS provider. The access requirements for CCRC should be that the CHC-MCO should assure that participants who have selected a CCRC have services covered at the CCRC they have chosen.	LeadingAge PA
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA(3)-7	Provider Network access standards are not sufficient and do not apply well to LTSS.	Please see our letter for additional discussion of this point. A comprehensive provider network is crucial to assuring participants have choice. The drive time limits are not sufficient for families/spouses who wish to visit every day, for those participants in a residential setting (or needing to provide transportation to services, such as adult day services). Please provide an access standard different from time and distance for home-based services that would better reflect the capacity of the CHC-MCO provider network to deliver LTSS services, for example, services delivered/services planned.	LeadingAge PA
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA(3) - 9	Absence of geriatricians in the list	Please include geriatricians in the list of appropriately qualified providers who should be in the network.	LeadingAge PA
Requirements Document Exhibit	DDD(1) - Covered Services List	DDD(1)	Inclusion of ALR	LeadingAge PA, as stated in the attached letter commends the departments for including Assisted Living Residences (ALRs) as a covered service and encourages the inclusion of personal care homes (PCHs) as well.	LeadingAge PA

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RFP	General Information	13	Pay for Performance incentives	LeadingAge PA appreciates DHS/PDA providing encouragement to the CHC-MCOs to address issues with the financial eligibility redetermination process. When the Department implements additional P4P incentives in future years, the P4P incentives should be announced through public notice, with the opportunity for comment.	LeadingAge PA
RFP	Work Statement Questionnaire	page 30 item 7	person-centered planning process	The person-centered planning process must also recognize and promote the member's preferences and safety concerns.	LeadingAge PA
RFP	Work Statement Questionnaire	page 31 items 12, 13 & 17	LeadingAge PA has concerns that the participants' safety and preferences for living arrangements and providers will be given less consideration than the departments' priority for HCBS and moving people out of hospitals and nursing facilities.	LeadingAge PA recommends that language be included in the questions that asks how the CHC-MCO will assure that the participant receives the right services in the right setting and at the right time, to meet the participant's needs, safety concerns and preferences.	LeadingAge PA
RFP	Work Statement Questionnaire	39 item 16	Describe plan to comply with standards for claims timeliness.	While LeadingAge PA appreciates the discussion of claims timeliness, it is crucial that DHS require and specify consistent processes and standards for timely and accurate payment of claims.	LeadingAge PA
RFP	Work Statement Questionnaire	page 34 item 4	Strategy for addressing the needs of Participants with dementia in community settings.	This critically important issue of addressing the needs of participants with dementia, especially how to address these needs in the community, should receive more focus and public discussion than it is receiving in the CHC process.	LeadingAge PA
RFP	Work Statement Questionnaire	Page 42 item 12	Educating provider network about services and administrative issues.	LeadingAge PA appreciates that CHC-MCOs will provide information to DHS regarding how they will educate providers. LeadingAge PA asserts that CHC-MCOs would also benefit from education by providers about the services they offer.	LeadingAge PA
RFP	General Information	Page 14	Proposal submitted for multiple zones	As referenced in more detail in our attached letter, LeadingAge PA reiterates our serious concern that the time frame envisioned for implementing CHC is much too aggressive. This is a significant change to a system that is already complex and that provides services relied upon by some of the Commonwealth's most vulnerable citizens to meet their most basic needs. LeadingAge PA urges the department to take the time necessary to get this system right, to obtain the stakeholder input that will help formulate a plan that will work, and to use lessons learned from the first regional implementation of CHC in the Southwest to guide and improve implementation in later regional expansions. Such a phased-in process was employed for implementation of the successful HealthChoices programs, and we believe CHC should follow a similar approach.	LeadingAge PA
RFP	General Information	Page 14	Proposal submitted for multiple zones	As referenced in more detail in our attached letter, LeadingAge PA reiterates our serious concern that the time frame envisioned for implementing CHC is much too aggressive. This is a significant change to a system that is already complex and that provides services relied upon by some of the Commonwealth's most vulnerable citizens to meet their most basic needs. LeadingAge PA urges the department to take the time necessary to get this system right, to obtain the stakeholder input that will help formulate a plan that will work, and to use lessons learned from the first regional implementation of CHC in the Southwest to guide and improve implementation in later regional expansions. Such a phased-in process was employed for implementation of the successful HealthChoices programs, and we believe CHC should follow a similar approach.	LeadingAge PA
Requirements Document	Section II - Definitions	II. (Definitions), Page 1	Actuarially sound rates- rates that reflect the historical and projected future medical costs expected to be incurred…	This RFP should be focused solely on long term services and supports (LTSS). As a result, rates should and must include the long term services and supports costs.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section II - Definitions	II. (Definitions), Page 1	Current definitions do not include ABI	Acquired Brain Injury (ABI) - An injury to the brain secondary to either trauma, stroke (including aneurysms), post surgical complications, and/or certain acquired disease processes.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section II - Definitions	II. (Definitions), Page 3	Current definitions do not include CARF	Commission on Accreditation of Rehabilitation Facilities (CARF) - An international, non-profit organization that provides accreditation standards and surveyors for organizations working in the human services field worldwide in areas such as Aging, Behavioral Health, and Medical Rehabilitation (which includes Brain Injury, Spinal Cord Services, Stroke Specialty, Cancer and Home and Community Services).	Success Rehabilitation,Inc/Joanne Tangney

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Requirements Document	Section II - Definitions	II. (Definitions), Page 4	Current definitions do not include CRT	Cognitive Rehabilitation Therapy (CRT) - The process of relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section II - Definitions	II. (Definitions), Page 11	Long-Term Services and Supports (LTSS)- Definition does not include Residential Habilitation	Residential habilitation provides an individual with the opportunity to acquire or advance their skills in the areas of self-advocacy, communication, mobility/transportation, community-based living, educational, self-care, personal resource management, and community/social participation.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section II - Definitions	II. (RFP Acronyms), Page 23	List of acronyms does not include ABI, CARF or CBIS	ABI- Acquired Brain Injury; CARF- Commission on Accreditation of Rehabilitation Facilities; CBIS- Certified Brain Injury Specialist	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section V.A. - Covered Services	V. Program Requirements (A. Covered Services, 2.), Page 26	In-Home and Community-based Services: The CHC-MCO may not deny personal assistance services… because the need for personal assistance is the result of a cognitive impairment..	This program requirement appears to solely focus on personal assistance services (PAS). PAS is one of many long term services and supports. The other services should be included as well.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section V.A. - Covered Services	V. Program Requirements (A. Covered Services, 7.), Pages 28-29	Behavioral Health Services: "All participants who need behavioral health services will obtain these services from the Behavioral Health Managed Care Organizations (BH-MCOs)."	Please clarify that the Long Term Services and Supports (LTSS) "Therapeutic and Counseling Services" are not to be covered under this section. These are specialized services that are not available under Behavioral Health Services.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section V.B. - Prior Authorization of Services	V. Program Requirements (B. Prior Authorization Requirements, 1.), Page 36	General Prior Authorization Requirements: "When the CHC-MCO denies a request for services….the CHC-MCO must make the notice available in accessible formats for individuals with visual impairments and for persons with limited English proficiency"…	It is recommended that if any individual has a Cognitive Impairment, the CHC-MCO must make the notice available in a format that the person can understand and include using a cognitive facilitator for this process.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section V.B. - Prior Authorization of Services	V. Program Requirements (B. Prior Authorization Requirements, 1.), Page 37	General Prior Authorization Requirements: "When the CHC-MCO denies a request for services… CHC-MCOs must conditionally approve Covered Services that are pending Medicare decisions in the event that these services are not covered by Medicare."	Please clarify that the Long Term Services and Supports (LTSS) "Therapeutic and Counseling Services" are not to be covered under this section. These are specialized services that are not available under Behavioral Health Services. Please include explicit language here that if Medicare is the TPR, the CHC-MCO will honor the Annual Cap published by Medicare for PT/SP services, and for OT services as exhaustion of TPR, and if the service continues to be medically necessary, the CHC-MCO will provide the service according to the Service Definitions.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section V.C. - Continuity of Care	V. Program Requirements (C. Continuity of Care, Bullet 2), Page 39	For a participant who is receiving LTSS through an HCBS Waiver program on his or her Effective Date of Enrollment….the continuity of care…will run from the Effective Date of Enrollment into the CHC-MCO for 180 days…	It is recommended that this timeframe be increased to a 24-month period of continuity of care. Many of the consumers have had their existing service model for years, so any changes need to be carefully transitioned.	Success Rehabilitation,Inc/Joanne Tangney

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Requirements Document	Section V.E. - Needs Screening	V. Program Requirement (E. Needs Screening), Page 40	Upon enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department… "The needs screening must be completed … and may be conducted by phone, electronically, by mail or in person."	The screening must be done using a tool that the Department specifies, and that is capable of 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 Form/Tool, Version 2.0, which can be used for all disability groups. (Link to the form/tool is below) Furthermore, for individuals with cognitive impairment, this screening must be conducted face-to-face and with additional information gathered by family/support system for those with cognitive needs. http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury%20Assessment%20(CBIA)%20Version%202.0.pdf	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	V. Program Requirement (F. Comprehensive Needs Assessments and Reassessments), Page 40-42	The CHC-MCO must conduct a comprehensive needs reassessment no more than 12 months following the most recent prior comprehensive needs assessment … unless a trigger event occurs	Trigger events should include changes in cognitive status and other issues related to cognitive impairment.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	V. Program Requirement (F. Comprehensive Needs Assessments and Reassessments), Page 40-42	The Comprehensive needs assessment and reassessment processes developed by the CHC-MCO must also capture the following…	The list of what must be addressed should also include need for Personal Assistance Services, Therapies and Counseling in consideration of the level of cognitive impairment.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section V.G. - Person Centered Planning Team Approach	V. Program Requirement (V. G Person Centered Planning Team Pg. 42)	The CHC/MCO must develop a PCPT policy for the Person Centered Service Plan development and implementation.	To meet the needs of specific populations with cognitive impairments and properly identify services needed and covered in existing HCBS Waivers, this can only be done by professionals that are experienced and credentialed to work with these specific populations. The team should include, but not be limited to, a neuropsychiatrist, neuropsychologist, OT/PT/Speech Therapists, Cognitive Rehabilitation Therapists, Nutritionists, Case Managers and Social Workers. The CHC/MCO should have such professionals available.	Success Rehabilitation,Inc/Joanne Tangney
	Section V.G. - Person Centered Planning Team Approach	V. Program Requirement (H. Person Centered Service Plans) Pg 42-43	PCSPs for Participants needing or receiving LTSS must also address: ...	The PCSP for participants with cognitive impairments must also include a plan for PAS, therapies and counseling and cognitive rehabilitation therapy as described in the waivers to be provided by a practitioner with demonstrated competency in dealing with this population. To facilitate this, specialty providers, such as for Acquired Brain Injury, who have the knowledge and experience necessary should be part of the PCSP process	Success Rehabilitation,Inc/Joanne Tangney

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Requirements Document	Section V.I. - Department Review of Changes in Service Plans	V. Program Requirement (I. Department Review of Changes in Service Plans), Page 43	The Department may review and revise any Person-Centered Service Plan. The CHC-MCO must provide the Department with weekly aggregate reports on PCSP changes.	It is recommended that a change in PCSP that would result in a 5% change of services would trigger a review by the Department. Relying on reviews of aggregate data does not afford adequate protections to the Participant.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	V. Program Requirement (K. Service Coordinator and Service Coordinator Supervisor Requirements), Page 44	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of RN, BS and at least three years of experience..All Service Coordinator Supervisors must be LSW or RN with 5 years of experience. Both must complete Department- approved training in required training topics.	Long-Term Services and Supports are by definition provided to participants with specific disability needs that are unable to be met in the regular health care system. Therefore, it is critical that disability-specific training be required for all Service Coordinators and Service Coordinator Supervisors. Disability-specific training and certification specific to the area of disability can be accessed through: "People with Physical Disability": www.cdms.org; "People with Dementia": www.ncdp.org; and "People with Brain Injury": www.biausa.org/acbis. 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 Department should utilize these organization's standards and certification process rather than asking for/relying on each MCO how they would guarantee an unspecified type and level of training. The Department could grandfather existing Service Coordinators but require that they become certified by the relevant area for the participants they will be serving within a set time frame, such as 2 years.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section V.M.- Coordination of Services	V. Program Requirement (M. Coordination of Services, 1. CHC-MCO & BH-MCO Coordination), Pages 44-45	To facilitate efficient adminstration and to enhance the treatment of Participants who need both Covered Services and BH Services…	The document needs to clarify that the Covered Services includes "Therapeutic and Counseling Services," which are specialized services that are not available under Behavioral Health Services, and as such should not be expected to be provided by BH Services.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V. Program Requirement (O. Participant Enrollment and Disenrollment, 18. Participant Advisory Committee), Page 57	Provider representation must include physical health, behavioral health, dental health and LTSS.	It is recommended that this language be revised: "Provider representation on the PAC must include physical health, behavioral health, dental health and all disability-specific groups receiving LTSS services."	Success Rehabilitation,Inc/Joanne Tangney

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Requirements Document	Section V.CC. - Provider Services	V. Program Requirement (CC. Provider Services 2. Provider Education), Pages 86-87	The CHC-MCO must submit an annual Provider education and training workplan to the Department that outlines its plans to educate and train Network Providers.	It is recommended that the RFP require that content of training for disability specific areas be developed by experts in the field, and not left up to the CHC-MCO to devise their own training content. At a minimum, this would include that the training be developed by a person trained in and certified for the specific area of disability to be covered, to include: "People with Physical Disability," www.cdms.org; "People with Dementia," www.ncdp.org; and "People with Brain Injury," www.biausa.org/acbis. The RFP should indicate that this training could be subcontracted to an outside agency with the appropriate expertise to provide said training.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section V.CC. - Provider Services	V. Program Requirement (CC. Provider Services 2. Provider Education), Pages 86-87	At a minimum, the CHC-MCO must conduct the Provider training, as appropriate, in the following areas…	It is recommended that an area be added: "Information around Brain injury and Cognitive Impairments and how to recognize and effectively work with individuals with cognitive impairments;" "i. Sensitivity training should also include how to effectively recognize and work with individuals with cognitive impairments."	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section V.DD. - Provider Network	V. DD. Provider Network; #1. Provider Qualifications, pg. 89	All providers must meet the minimum qualification requirements established by the Department and must be credentialed by the Department.	Currently, Provider Qualifications are specified in the Waivers as approved by CMS, specifically for CommCare and OBRA serving people with brain injury, it is required that Providers be CARF accredited in Brain Injury. For Residential Services, CARF accreditation for Residential Rehabilitation is required and for Structured Day Services, CARF accreditation for Home and Community Services is required. These are CMS approved regulations that should be included as minimum requirements of Providers in the CHC RFP, so that MCOs are not asked how they would guarantee an unspecificed type of training and qualification of providers.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document	Section V.EE. - QM & UM Program Requirements	V. Program Requirements (EE. QM and UM Program Requirements 2. Quality Management/Performance Improvement), Page 95	The CHC-MCO shall have a written Quality Management/Quality Improvement program that clearly defines its quality improvement structures and processes…	It is recommended that the RFP include language that recognizes the Quality Management programs 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,Inc/Joanne Tangney
Requirements Document Exhibit	DDD(1) - Covered Services List	V. Program Requirements (Exhibit DDD (1), Covered Services List)	Residential Habilitation; Structured Day; Cognitive Rehabilitation Therapy	Residential Habilitation and Structured Day Services must also include provisions for Enhanced 1:1 staffing and Enhanced 2:1 staffing; these services are currently available in the Waiver Service definitions. Cognitive Rehabilitation Therapy should be added to the list. See Pages 53, 84 and 87 in the waiver: http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_216913.pdf	Success Rehabilitation,Inc/Joanne Tangney

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	V. Program Requirements (Exhibit DDD (2) Covered Services LTSS Definitions)	Residential Habilitation; Structured Day; Cognitive Rehabilitation Therapist	The RFP should include the following as the Service Definition for Enhanced Staffing for Residential Habilitation and Structured Day Services: Individual considerations may be available for those individuals that require continual assistance as identified on their needs assessment to ensure their medical or behavioral stability. By nature of their behaviors or medical needs, individuals are not able to participate in activities or are unable to access the community without direct staff support. Residential Enhanced staffing/Structured Day Enhanced staffing is treated as an add-on to the Residential Habilitation/Structured Day Services and is only available when the participant requires additional behavioral or medical supports. The language in the Covered Services should be changed to match the language in the Waiver. See pages 53, 84 and 87 in the waiver: http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_216913.pdf	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	V. Program Requirements (Exhibit DDD (2) Covered Services LTSS Definitions)	Therapeutic and Counseling Services: Cognitive Rehabilitation Therapy services: Services include consultation, ongoing counseling, and coaching/cueing performed by a certified Cognitive Rehabilitation Therapist.	It is critical that the full definition of the Provider Qualifications in the current waiver be included in this document; specifically that a Cognitive Rehabilitation Therapist has a Certified Brain Injury Specialist (CBIS) Certificate, or Certification by Society for Cognitive Rehabilitation. The current waiver goes on to specify: Masters or Bachelors degree in an allied field with licensure, certification or registration where applicable. If credentialing is not available, a Bachelors or Masters degree professional must be supervised by a licensed psychologist, a CBIS or a professional certified by the Society for Cognitive Rehabilitation.	Success Rehabilitation,Inc/Joanne Tangney
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	V. Program Requirements (Exhibit DDD (1) Covered Services LTSS Definitions)	CHC Covered LTSS Benefits	PT, OT and Speech and Language should be covered under Therapies and Counseling Services not under Home Health Services to assure that practitioners with the appropriate experience necessary to successfully work with participants with cognitive impairments provide these services.	Success Rehabilitation,Inc/Joanne Tangney
Other	Target Populations	Requirements Document	Entire document	In the Agreement document, the brain injury population (as well as other specific populations, i.e. autism) is not identified in the general definitions, acronyms, and within the Program Requirements of the Agreement. There is great concern that the draft RFP is medically focused and based largely on the physical health agreement due to the minimal inclusion of LTSS within some of the sections. The acquired brain injury population has specific challenges and the specific qualifications and expertise to properly care for, interact with, and serve this population are inadequate in the Draft RFP, e.g., screening and assessment, service plan development, care coordination, and provider qualifications. It is difficult to know how the potential MCOs are to describe a strategy for brain injury without any guidelines on what that has to include, or for any of the other populations covered under waivers.	
Other	Target Populations			In the Agreement document, the brain injury population (as well as other specific populations, e.g. autism) is not identified in the general definitions, acronyms, and within the Program Requirements of the Agreement. There is great concern that the draft RFP is medically focused and based largely on the physical health agreement due to the minimal inclusion of LTSS within some of the sections. The acquired brain injury population has specific challenges and requires specific qualifications and expertise to properly care for, interact with, and serve this population. The language in the Draft RFP is inadequate in both describing and ensuring how these specializeds needs will be met, e.g. screening and assessment, service plan development, care coordination, and provider qualifications. It is difficult to know how the potential MCOs are to describe a strategy for "addressing the needs of Participants with acquired brain injuries in community settings" (pg 34, item #5), without any guidelines as to what should be included to do so, or for any of the other populations covered under the waivers. Given that most MCOs will not be familiar with LTSS, much less the specialty services required for the brain injury population, it is critical that guidelines for providing these services be included throughout the document.	ReMed; Vicki Eicher

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Requirements Document	Section II - Definitions	II Definitions, pg 1	"Actuarially Sounds Rates" based on "the historical and projected future medical costs expected to be incurred…"	Rates should not just be based on "medical costs" - this RFP should be focued on Long Term Services & Supports. As a result, rates should and must include the long term services and supports costs that are to be expected given changes or declines in functional and/or cognitive changes".	ReMed; Vicki Eicher
Requirements Document	Section II - Definitions	II Definitions, pg 1	Current Definitions do not include ABI, Acquired Brain Injury.	It is recommended that the term "Acquired Brain Injury" be added to this document as most MCOs will not be familiar with this diagnosis or realize that CHC-MCO services will need to include services for this population. An Acquired Brain Injury is defined as: "An injury to the brain secondary to either trauma, stroke (including anuerysms), post surgical complications, and/or certain acquired disease processes.	ReMed; Vicki Eicher
Requirements Document	Section II - Definitions	II Definitions, pg 3	Current Definitions do not include CARF.	Commission on Accreditation of Rehabilitation Facilities (CARF) - an international private, nonprofit organization that provides accreditation standards and surveyors for organizations working in the human services field wordwide in such areas as Aging, Behavioral Health, and Medical Rehabilitation (which includes Brain Injury, Spinal Cord Services, Stroke Specialty, Cancer and Home & Community Services).	ReMed; Vicki Eicher
Requirements Document	Section II - Definitions	II Definitions, pg 3	Current Definitions do not include Cognitive Rehabilitation Therapy.	Cognitive Rehabilitation Therapy (CRT) - The process of relearning cogniive skills that have been lost or altered as a resul of damage to brain cells/chemistry.	ReMed; Vicki Eicher
Requirements Document	Section II - Definitions	II Definitions, pg 11	Long Term Supports and Services definition does not include Residential Habilitation	Residential Habilitation provides an individual with the opportunity to learn or advance their skills in the areas of self-advocacy, communication, mobility/ transportation, community -based living, eucational, self-care, person resource management, and community/social participation. It is critical that Residential Habilitation be included in the definition of services included in LTSS, since this service is not one with which MCOs may be familiar as being included in the menu of possible LTSS services.	ReMed; Vicki Eicher
Requirements Document	Section II - Definitions	II RFP Acronyms, pg 23	Current Acronyms do not include ABI, CARF, CBIS, or CRT	ABI - Acquired Brain Injury; CARF - Commission on Accreditation of Rehabilitation Facilities; CBIS - Certified Brain Injury Specialist; CRT - Cognitive Rehabilitation Therapy	ReMed; Vicki Eicher
Requirements Document	Section V.A. - Covered Services	In-Home and Community Based Services; Item #2, pg 26	The CHC-MCO may not deny personal assistance services due to a cognitive impairment…	It is appreciated that this explanation include the provision that services cannot be denied due to cognitive impariments. However, this Program Requirement appears to solely focus on personal assistance services; since PAS is but one of LTSS services, the other services should be included as well.	ReMed; Vicki Eicher
Requirements Document	Section V.A. - Covered Services	In-Home and Community Based Services; Item #7.; pg 28 & 29	Behavioral Health Services: "All Participants who need behavioral health services will obtain these from the BH-MCOs".	It is recommended that the document clarify that the LTSS "Therapeutic and Counseling Services" are not to be covered under this section. These are specialized services that are not available under Behavioral Health Services.	ReMed; Vicki Eicher
Requirements Document	Section V.B. - Prior Authorization of Services	Item 1, General Prior Auth Req, Paragraph 4, pg 36	When the CHC-MCO denies a request for services…, the CHC-MCO must make the notice available in accessible formats for individuals with visual impairments or with LEP…"	It is recommended that if any individual has a Cognitive Impairment, the CHC-MCO must make the notice available in a format that the person can understand, to include using a cognitive faciltator for this process.	ReMed; Vicki Eicher
Requirements Document	Section V.B. - Prior Authorization of Services	Item 1, General Prior Auth Req, Paragraph 7, pg 37	The CHC-MCO may not require prior authorization of Medicare services for Participants with Medicare. CHC-MCOs must conditionally approve Covered Services that are pending Medicare decisions in the event that these services are not covered by medicare.	Medicare does not provide a prior authorization of services; neither will they give a denial letter. The CHC-MCO should expect the provider to bill up to the annually published Medicare therapy cap for rehabilitation services for PT, OT, SP; and if the service continues to be medically necessary, the CHC-MCO will provide the therapy service according to the Service Definitions.	ReMed; Vicki Eicher

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Requirements Document	Section V.C. - Continuity of Care	Paragraph 2, pg 39	For a participant who is receiving LTSS services…continuity of care will run from the Effective Date of enrollment into the CHC-MCO for 180 days…."	It is recommended that this time frame be increased to a 24 month period of continuity of care. Many of the Participants have had their existing service model for years, so any change needs to be carefully transitioned.	ReMed; Vicki Eicher
Requirements Document	Section V.E. - Needs Screening	Page 40	"Upon enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department….". "The needs screening must be completed…and may be conducted by phone, electronically, by mail or in person".	The Screening must be done using a tool that the Department specifices, 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, Version 2.0, which can be used for all disability groups (link to the tool is below). Furthermore, for individuals with cognitive impairment, this screening must be conducted face to face, and with additional information gathered by family/support system for those with cognitive needs. http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury%20Assessment%20(CBIA)%20Version%202.0.pdf	ReMed; Vicki Eicher
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	Page 40- 42; paragraph 3	"The comprehensive needs assessment and reassessments…must also capture the following: functional limitations and supports required to perform ADLs and IADLs …". "The Department will designate a tool to be used for comprehensive needs assessment and reassessments".	The list of areas which the needs assessment and reassessments must capture need to include: "Cognitive and behavioral needs and limitations that impact ADLs, IADLs, and that impact the the participant's ability to access and participate in the community. Again it is strongly recommended that the Department adopt Utah's Intake, Screening and Assessment tool, 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	Section V.H. - Person Centered Service Plans	Page 42; paragraph 2	"Each PCSP must address how the Participant's physical and behavioral health needs and conditions will be managed by the CHC-MCO….".	It is recommended that cognitive need be added to this statement: "…each PCSP must address how the Participant's physical, Cognitive and behavioral health needs…".	ReMed; Vicki Eicher
Requirements Document	Section V.H. - Person Centered Service Plans	Page 43, paragraph 2	List of areas that must be addressed in a LTSS assessment needs to include Personal Assistance Services, Therapies and Counseling and Level of Cognitive Impairment.	Add: Personal Assistance Services; Therapies and Counseling; Cognitive Needs (Level of Cognitive Impairment)	ReMed; Vicki Eicher
Requirements Document	Section V.H. - Person Centered Service Plans	Page 43; paragraph 6	"PCSPs for Participants who require LTSS will be developed by the Service Coordinator, the Participant and the Participant's PCPT".	Participants with physical disabilities are knowledgeable and know how to participate in and help develop their PCSP. For Participants with significant cognitive disabilities (e.g. dementia or brain injury), it is essential that providers with the appropriate expertise be included as part of the PCSP team. The team could include: neuropsychiatrist, neuropsychologist, PT, OT, SP, Cognitive Rehabilitation Therapist, Behavior Analyst, Case Mangers, Social Workers and Nutritionists.	ReMed; Vicki Eicher
Requirements Document	Section V.I. - Department Review of Changes in Service Plans	Page 43	The Department may review and revise any PCSP. The CHC-MCO must provide the Department with weekly aggregate reports on PCSP changes.	It is recommended that a change in a PCSP that would result in a 5% change of services would trigger ar eview by the Department. Relying on reviews of aggregate data does not afford adequate protection to the Participant.	ReMed; Vicki Eicher
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	Page 44	The CHC-MCO must require all employed or contracted Service Coord.to meet minimum requirements of RN, BS and at least 3 years experience; Service Coord Supervisors must be SW or RN with 5 years experience. Both must complete Department approved training in required topics.	Long term supports and services are by definition provided to participants with specific disability needs that are unable to met in the regular health care system. Therefore, it is critical that disability-specific training be required for all Service Coord. and Service Coord. Supervisors. Disability-specific training and certification specific to the area of disability can be accessed through: "People with Physical Disability, www.cdms.org"; People with Dementia, www.ncdp.org"; and People with Brain Injury, www.biausa.org/acbis". 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 utlize these organization's standards and certification process rather than asking for/relying on each MCO how they would guarantee an unspecified type and level of training. The State could grandfather exisiting Service Coordinators but require that they become certified by the relevant area for the participants they will be serving within a set time frame, such as 2 years.	ReMed; Vicki Eicher

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Requirements Document	Section V.M.- Coordination of Services	1. CHC-MCO and BH-MCO Coordination ; pg 44-45	"To facilitate efficient administration and to enhance the treatment of Participants who need both Covered Services and BH services…"	The document needs to clarify that the Covered Services includes "Therapeutic and Counseling Services", which are specialized services that are not available under Behavioral Health Services, and as such should not be expected to be provided by BH services.	ReMed; Vicki Eicher
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	#17 Provider Directories; pg 56	For Provider Directories: The CHC-MCO must utilize the file layout and format specified by the Department. The format must include….	It is recommended that the Provider Directory also include the following information: Provider Specialty or Disability Specific Services; Provider Licensure or Accreditation. This would allow Participants to seek specialty services as needed and to ensure that chosen Providers had the expertise necessary to provide those specialty services.	ReMed; Vicki Eicher
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	#18 Participant Advisory Cmte; pg 57	Provider representation on the PAC must include physical health, behavioral health, dental health and LTSS.	It is recommended that this language be revised: "Provider representation on the PAC must include physical health, behavioral health, dental health and all disability-specific groups receiving LTSS services."	ReMed; Vicki Eicher
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	Page 85	The CHC-MCO must take into consideration language and cultural compatibility between the Participant and the Service Coordinator.	It is recommended that this language also include that the CHC-MCO take into consideration the expertise of the Service Coordinator and ensure that the Service Coordinator have the expertise needed should disabilty-specific services be indicated, e.g. for individuals with acquired brain injury or other cognitive impairments.	ReMed; Vicki Eicher
Requirements Document	Section V.CC. - Provider Services	Item #2. Provider Education; Page 86-87	The CHC-MCO must submit an annual Provider education and training workplan to the Department that outlines its plans to educate and train Network Providers.	It is recommended that the RFP require that content of training for disability specific areas be developed by experts in the field, and not left up to the CHC-MCO to devise their own training content. At a minimum, this would include that the training be developed by a person trained in and certified for the specific area of disability to be covered, to include: "People with Physical Disability, www.cdms.org"; People with Dementia, www.ncdp.org"; and People with Brain Injury, www.biausa.org/acbis". 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 RFP should indicate that this training could be subcontracted to an outside agency with the appropriate expertise to provide said training.	ReMed; Vicki Eicher
Requirements Document	Section V.CC. - Provider Services	#2. Provider Education, pg. 86-87	At a minimum, the CHC-MCO must conduct the Provider training, as appropriate, in the following areas: …	It is recommended that an area be added: "Information around Brain injury and Cognitive Impairments and how to recognize and effectively work with individuals with cognitive impairments"; "i. Sensitivity training should also include how to effectively recognize and work with individuals with cognitive impairments". It is recommended that on-going education provided be specific to the area of disablity being servied. For Physical Disability providers, education should be focused on physical disability issues; for Dementia providers, education should be focused on the management of dementias; for Brain Inury providers, education should be focused on cognitive, behavioral and physical impairments related to brain injury. The CARF requirements, CBIS requirements and State licensing requirements already require such on-going continuing education of Providers, so any requirement of MCOs should be coordinated with other required on-going educational requirements, and not be in addition or in conflict of such requirements.	ReMed; Vicki Eicher
Requirements Document	Section V.DD. - Provider Network	#1. Provider Qualifications, pg. 89	All Providers must meet the minimum qualification requirements established by the Department and must be credentialed by the Department.	Currently, Provider Qualifications are specified in the Waivers as approved by CMS, specifically for CommCare and OBRA serving people with brain injury, it is required that Providers be CARF accredited in Brain Injury. For Residential Services, CARF accreditation for Residential Rehabilitation is required and for Structured Day Services, CARF accreditation for Home and Community Services is required. These are CMS approved regulations that should be included as minimum requirements of Providers in the CHC RFP, so that MCOs are not asked how they would guarantee an unspecificed type of training and qualification of providers.	ReMed; Vicki Eicher
Requirements Document	Section V.EE. - QM & UM Program Requirements	#2.QM/ Performance Improvement, pg. 95	The CHC-MCO shall have a written Quality management/Quality Improvement program that clearly defines its QI structures and processes…."	It is recommended that the RFP include language that recognizes the Quality Management programs 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.	ReMed; Vicki Eicher

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Requirements Document Exhibit	DD - Participant Handbook	Item #47	At a minimum, the Participant Handbook shall include: …..47. Information about LTSS.	It is recommended that the Department outline the information that should be included about LTSS. Most of the items listed in the Participant Handbook are about the structure and organization of the MCO. The most important part of this Handbook is information about the types of services included in LTSS (such as services for people with brain injury, cognitive rehabilitation therapy, residential habilitation, etc.), this information should be included in the Participant Handbook.	ReMed; Vicki Eicher
Requirements Document Exhibit	FF - Provider Directories	C. LTSS Providers	The CHC-MCO shall be required to provide its Participants with LTSS Provider directories upon request, which include at a minimum…."Experience or expertise serving individuals with particular conditions".	It is recommended that the Provider Directory also include any Licensure or Accreditation a Provider may have to substantiate their experience or expertise serving individuals requiring disability-specific services.	ReMed; Vicki Eicher
Requirements Document Exhibit	DDD(1) - Covered Services List	Covered Services List	Residential Habilitation; Structured Day	Residential Habilitation and Structured Day Services must also include provisions for Enhanced 1:1 staffing and Enhanced 2:1 staffing; these services are currently available in the Waiver Service definitions. Cognitive Rehabilitation Therapy should be added to the list. See pages 53, 84 and 87 in the waiver. http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_216913.pdf	ReMed; Vicki Eicher
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Covered Services Definitions	Residential Habilitation; Structured Day	The RFP should include the following as the Service Definition for Enhanced Staffing for Residential Habilitation and Structured Day Services: Individual considerations may be available for those individuals that require continual assistance as identified on their needs assessment to ensure their medical or behavioral stability. By nature of their behaviors or medical needs, individuals are not able to participate in activities or are unable to access the community without direct staff support. Residential Enhanced staffing/Structured Day Enhanced staffing is treated as an add-on to the Residential Habilitation/Structured Day Services and is only available when the participant requires additional behavioral or medical supports. The language in the Covered Services should be changed to match the language in the Waiver. See pages 53, 84 and 87 in the waiver. http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_216913.pdf	ReMed; Vicki Eicher
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Covered Services Definitions	Therapeutic and Counseling Services: Cognitive Rehabilitation Therapy services: Services include consultation, ongoing counseling, and coaching/cueing performed by a certified Cognitive Rehabilitation Therapist.	It is critical that the full definition of the Provider Qualifications in the current waiver be included in this document; specifically that a Cogntive Rehabilitation Therapist has a CBIS Certificate (Certified Brain Injury Specialist), OR Certification by Society for Cognitive Rehabilitation. The current waiver goes on to specify: Masters or Bachelors degree in an allied field with licensure, certification or registration where applicable. If credentialing is not available, a Bachelors or Masters degree professional must be supervised by a licensed psycholoist, a CBIS or a professional certified by the Society for Cognitive Rehabilitation.	ReMed; Vicki Eicher
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Covered Services Definitions	Employment Skills Development: Waiver funding is not available for the provision of Employment Skills Development (e.g. sheltered work performed in a facility) where Participants are supervised in producing goods or performing services under contract to third parties.	It appears that both CMS and the Department are intent on not allowing the existence of sheltered work for people with disabilities. When the Department held input meetings during the Summer of 2014, many consumers and their families spoke up strongly about the critical role a participant's employment in a sheltered workshop played in his/her stable activity plan, feeling of productivity, socialization, etc. It is very disheartening to see that the Department is unable to recognize the importance of this resource and determine how to support it rather than disallow it. There are some participants for whom community employment is not an option due to their cognitive, behavioral or medical needs. For those individuals, sheltered employment provides the supportive enviornment necessary so that they too can have a productive activity plan. Unless the Department changes the definition of Job Coaching to allow for ongoing full time support in a community employment setting, it is unreaslistic and unsupportive to take this option away from consumers.	ReMed; Vicki Eicher
Other	Service Coordination	2.4 pg 14	CHC-MCOs will be required to implement care transition protocols whenever participants are admitted to or discharged from hospitals, nursing facilities or residential settings.	What will be the process for allowing current service coordination entities to continue providing service coordination under the new MCO plan?	Trish Wommer/ Casey Ball Supports Coordination, LLC

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Requirements Document	Section V.C. - Continuity of Care	Subsect K, Pg 44	....all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology, or other related field and at least 3 years experience in the coordination of services.	This standard will eliminate many qualified and competent Service Coordinators who have worked with these programs - and the individuals enrolled - since their inception. It will result in tremendous disruption in services for consumers by eliminating SC's they know and trust. Many SC's have as much as 20 years experience working in this precise capacity and meet Act 22 Requirements, but do not have the proposed degree. There should be an opportunity for experience as a substitute for education. If that is not acceptable, I propose a "grandfathering period" for those currently employed and possibly some other type of benchmark or credentialling with an appropriate time period for accomplishing the new standard.	Diane L. Cagey MS, CRC, LPC
Requirements Document	Section V.C. - Continuity of Care	Subsect K, Pg 44	All Service Coordination Supervisors must be employed with the CHC-MCO or a SC entity under contract with the CHC-MCO and must eb a licensed social worker with at least 5 years experience or a registered nurse with at least 5 years experience.	This standard will also eliminate many qualified and competent individuals. The qualifications for Supervision are far too narrow and medically based. For example, I hold a Master of Science degree in Rehabilitation Counseling, have been a Certified Rehabilitation Counselor since 1982, a Pennsylvania Licensed Professional Counselor since 2002, and have worked in the field of Rehabilitation Serivces with individuals with disabilities (in various capacities) for 35 years, with the last 17 years in supervision and management. Yet because the qualification requirements are so narrow and so medically focused, I do not qualify to be a SC Supervisor. In reality, my training and experience have likely prepared me better than those with the degrees you are requiring. Further, there are many RN's who would have no interest in focusing on the details of the countless Community Based services we provide. There must be a way for agencies to allow experience, or comparable levels of training to substitute for this requirement. At the very least, there should be some type of "grandfathering process" with time allotted to achieve other benchmarks. This requirement will drive up costs, put many Pennsylvanians out of work and will not result in a better standard of care for participants.	Diane L. Cagey MS, CRC, LPC
Requirements Document	Section V.E. - Needs Screening	Subsect E, Pg 40	The needs screening must be completed within the first 30 days of Enrollment and may be conducted by phone, electronically, by mail, or in person.	The initial needs screening MUST be done IN PERSON if an accurate assessment is desired. ONLY be assessiing an individual in their home, can a true assessment of capabilities and needs be determined. Individuals may not know what they need, and many unsafe situations could exist (that could easily be remediated) when identified by a home visit. This is oparticularly true for individuals who are newly disabled and in need fo in home Personal Assistance Services. If Service Coordinators are to be responsible for the health and safety of participants, we must have multiple opportunities to see them in their home environments.	Diane L. Cagey MS, CRC, LPC
Requirements Document	Section V.A. - Covered Services	Subsect A 1, Pg 26	Amount Duration and Scope.	Type and Frequency are not mentioned, yet in recent years, this has been a major concern to DHS. It is understood that since all Waivers are being eliminated, that Type may no longer be needed. However, I bleieve the requirement for Frequency should remain. This should be addressed in the RFP.	Diane L. Cagey MS, CRC, LPC
Requirements Document	Section V.A. - Covered Services	Subsect A 2, Pg 26	The CHC-MCO may not deny personal assistance serbvices for Participants under the age of 21 based on the Participant's diagnosis or because the need for personal assistance services is the result of a cognitive impairment…	There is no mention in this entire section of individuals OVER the age of 21, and what Home and Community Based Serivces they may not be denied.	Diane L. Cagey MS, CRC, LPC
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Item 8, Pg 51	The CHC-MCO must follow the Department's established proceduire as outlined in Exhibit BB…	Exhibit BB was not included	Diane L. Cagey MS, CRC, LPC
Requirements Document	Section V.X.- Administration	Item 2D (5th para), Pg 71	On accordance with Exhibit D…	Exhibit D was not included	Diane L. Cagey MS, CRC, LPC
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	Sect BB, first bullet	The CHC-MCO must offer the Participant of at least two Service Coordinators.	In the philosophy of person-centered services, participants should be offered the choice of multiple Service Coordination AGENCIES, not just a choice of coordiantors from one agency. In order to provide an open service market, and to truly provide choice to participants, multiple SC agencies must be offered.	Diane L. Cagey MS, CRC, LPC

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Requirements Document Exhibit	DDD(1) - Covered Services List	Service Coord		There is no language to discuss the minimum frequency or types of SC contacts. If SC's are to work to prevent abuse, neglect, fraud, etc. (and will be held accountable for reporting such), there should be some minimum standard of contacts defined. I believe that a minimum of at least two FACE-TO-FACE contacts should be required per year, in addition to additional telephone contacts. This will help agencies remaain alert to possible problems and will help to minimize neglect, fraud, and abuse, etc.	Diane L. Cagey MS, CRC, LPC
Requirements Document	Section V.DD. - Provider Network	Sect DD, 3rd para, Pg 89	This requirement will remain in effect for HCBS providers for the first 180 days that CHC is operational in each zone…	The 180 day time period is TOTALLY INSUFFFICIENT to ensure a seamless transition for participants. The transition period should be at least 2 years, UNLESS there is proof of substandard care on the part of the provider. (Substandard providers should be cited and eliminated if unable to provide the quality of services required.) In many cases, participants and their family members have long-established (i.e., 20 year) relationships with provider agencies and specific Direct Care Workers. These workers are experienced, trusted, and highly competent in assisting participants in their daily routines and personal care. When participants are enrolled with new agencies or caregivers, the potential for injury to participants and workers is increased, until daily routines are well practiced. For example: Even during a routine transfer, each participant has their own unique home environment, furnishings, equipment, preferences, and techniques. This is not like a facility enviropnment, where many factors are quite similar. In order to truly provide Person Centered services, these must all be taken into consideration. States that originally had shorter periods of transition (such as 180 days) with providers, have (after many problems and much public outcry) extended those to as much as 2 years, to provide necessary and desired continuity of care.	Diane L. Cagey MS, CRC, LPC
Requirements Document	Section V.DD. - Provider Network		This requirement will remain in effect for HCBS providers for the first 180 days that CHC is operational in each zone…	There is little specific mention throughout regarding providers of Durable Medical Equipment. I am aware of some small, privately owned DME companies, that provide excellent products and exemplary servicing of those products. They have been working with our participants for decades and understand the unique needs and challenges of those they serve. These small, local, family-owned companies could be forced out of business, by large companies with better regional or even national advertising, but who may provide a lower standard of service. The same is true of many other types of Provider agencies. There should be some effort and requirement that locally-owned companies are included in Provider Networks so that Pennsylvania's small businesses are protected from large outside corporations taking jobs from our state to corporate offices elsewhere, as we have seen in recent years with other OLTL contracts.	Diane L. Cagey MS, CRC, LPC
Other		General Comment		**Intent/Definition of Service Coordination**-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program. One example of where this is important is when considering the continuity of care period. If service coordination is a provider service, the continuity of care period would definitely apply. If it is an administrative function, we are not sure if that provision would apply to service coordination.	CMAOI
Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	CMAOI
Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems-** The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	CMAOI

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Requirements Document	Section II - Definitions	p. 14	Participant Advisory Committee (PAC)- A group convened in person, at least quarterly by the CHC-MCO's governoring board which is open to all participants and which reflects the diversity of the CHC-MCO's Participant population.	**Participant Advisory Committee Makeup -** We recommend that the PAC meetings be formed for, and held in, each zone (for instances where MCO may cover more than one zone) and have representation for rural and urban counties in each particular zone.	CMAOI
Requirements Document	Section II - Definitions	p. 15	Person Centered Planning Team- The team of individuals that will participate in Person Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT	**Person Centered Planning Team Makeup** - We recommend OLTL include the minimum acceptable required individuals and also include other suggestions/preferences for individuals on the team. We also recomment that OLTL require that if there is a behavioral health diagnosis, a behavioral health representative be required on the team.	CMAOI
Requirements Document	Section V.A. - Covered Services	p.26	In-Home and Community -Based Services- The CHC- MCO may not deny personal assistance services for Participants under the age of 21 based on the Participant's diagnosis or because the need for personal assistance is the result of a cognitive imparment…	**Personal Assistance Services** - We recommend removing "under the age of 21" so that no conumer could be denied personal assistance services based on the participant's diagnosis or because the need is based on a cognitive impairment	CMAOI
Requirements Document	Section V.A. - Covered Services	p.26	The CHC-MCO may not deny a request for Medically Necessary in-home nursing services, home health aide services, or personal assistance services for a Participant under the age of 21 on the basis that a live-in caregiver can perform the task…	**In-home Nursing, Home Health Aide or Personal Assistance Services** - We recommend removing "under the age of 21" so that no consumer could be denied under these circumstances.	CMAOI
Requirements Document	Section V.B. - Prior Authorization of Services	p. 36	B. Prior Authorization of Services 1.General Prior Authorization Requirements (4th paragraph) When the CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of denial using the appropriate notice outline in templates…	**Notice of Service Denial** - We recommend that when there is a denial of services for those in MLTSS, notification should also be sent to the Service Coordination Agency/entity to ensure continuity and follow up with consumer.	CMAOI
Requirements Document	Section V.B. - Prior Authorization of Services	p.37	2. Time frames for notice of Decisions	**Notice of Service Decisions** - We recommend that notice decisions should also be sent to Service Coordinator (entity) if additional information is needed from an MLTSS consumer the Service Coordination Agency should also be notified so they can assist the consumer in acquiring required documentation.	CMAOI
Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	**Continuity of Care for LTSS Participants**-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	CMAOI

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Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	**Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors**-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	P4A
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	**Limited English Proficiency Requirements**- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	CMAOI
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	**Management Information Systems**-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	CMAOI
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	CMAOI
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	**Willing Provider Definition –** In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	CMAOI
Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department** – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	CMAOI
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	CMAOI

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Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	CMAOI
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	CMAOI
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	CMAOI
Requirements Document	Section II - Definitions	Throughout	Throughout this entire document, you are asking the MCO to "describe their process for this" or "describe how you plan to handle that". Throughout the document you are intermingling concepts that have only to do with physical health - Health Choices, and concepts that have to do with LTSS - Community Health Choices. ***You must distinguish requirements that are only germaine to Community Health Choices from those that pertain to physical Health Choices.*** Otherwise you are inviting the MCO to handle LTSS in the same manner they would handle physical health, which is not appropriate. That is why there were MA Waivers created in the first place.	For each section where you are asking the potential MCO for a response, preface it by saying either: ***"For Health Choices, describe how you would . . . " or "For Community Health Choices, describe how you would . . ."*** In this manner you will encourage the MCO how to think differently about how they will manage the requirements of the LTSS part of the program, and to not think of it as just one big health care bucket. You cannot manage LTSS in the same manner you manage acute health care services.	Beechwood NeuroRehab/Deb Cerra-Tyl

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Requirements Document	Section II - Definitions	Page 2	Throughout all documents, the brain injury population (as well as other specific populations, i.e. autism, dementia) is not identified in the general definitions, acronyms, and within the Program Requirements of the Agreement. There is great concern that the draft RFP is medically focused and based largely on the physical health agreement and there is minimal inclusion of LTSS and the unique needs of these populations, which is why these specialty waivers were developed in the first place. The acquired brain injury population has specific challenges and requires specific qualifications and expertise to properly care for, interact with, and serve this population. References to these specific needs are inadequate in the Draft RFP, e.g., the need for specialized screening and assessment, service plan development, care coordination, and provider qualifications. MCOs cannot describe a strategy for Acquired Brain Injury without any guidelines on what that has to include, or for any of the other populations covered under waivers.	Therefore, the following Definition and Acronym for ABI should be included: ***Acquired Brain Injury (ABI) - An injury to the brain secondary to either trauma, stroke (including aneurysms), post surgical complications, and/or certain acquired disease processes, which results in substantial functional limitations in major life activities, such as self-care, communication, learning, mobility, self-direction and capacity for independent living.***	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section II - Definitions	Page 4	Current Definitions do not include a major form of long term service and support for those who have cognitive impairments - Cognitive Rehabilitation Therapy.	Include Definition and Acronym for Cognitive Rehabilitation Therapy (CRT) - ***The process of retraining cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry, that results in improved functioning in everyday life activities such as life activities, such as self-care, communication, learning, mobility, self-direction and capacity for independent living.***	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section II - Definitions	Pages 3 and 23	Current Definitions do not include CARF, and should, because the current 1915c Waivers utilize CARF standards for brain injury in several regulations.	Add Definition and Acronym - ***Commission on Accreditation of Rehabilitation Facilities (CARF) - an international private, nonprofit organization who accredits rehab providers, ensuring that quality standards are met and programs focus on enhancing the lives of the persons served. CARF has program specific standards for Aging Services, Medical Rehabilitation (which includes Brain Injury, Spinal Cord Services, Stroke Specialty, Cancer and Home & Community Services).***	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section II - Definitions	Page 11	Long Term Services and Supports does not specify Res Hab or Therapeutic & Counseling services, which are core service for LTSS and its omission here implies you don't want the MCO to provide it	Include ***Residential Habilitation, Therapeutic & Counseling Services*** in this definition	Beechwood NeuroRehab/Deb Cerra-Tyl

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Requirements Document	Section II - Definitions	Page 21	Utilization Management and Utilization Review are common procedures for acute health care, but are not common, and should not be lumped into LTSS. There needs to be far different approaches for management of LTSS which is why you need to have Service Coordinators trained in the needs of your major population buckets (physcial disability, cognitive disability, and dementia	Clarify that these definitions apply to Health Choices and that Community Health Choices will be handled in a different manner	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.A. - Covered Services	Page 26	The CHC-MCO may not deny personal assistance services for Participants under the age of 21 based on the Participant's diagnosis or because the need of personal assistance services is the result of a cognitive impairment	All services under CHC-MCO cannot be denied based on a person's cognitive disability. This is the whole basis of the 1915c Waiver, that a person with a cognitive disability may not be able to get their needs met under the regular health care system, and so this clause should apply to all covered services under CHC.	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.A. - Covered Services	page 28	Behavioral Health Services - this section should be noted to apply to Health Choices only. Behavior Services (later listed as Therapeutic and Counseling Services) as defined by LTSS are not within the expertise of traditional Behavioral Health providers, and the MCO should not be confused by this language to think that they have to coordinate BH Services first, because the Behavior services needed by waiver clients are different and are provided for under the Waiver	Clarify that this section does not pertain to Behavior Services such as Therapeutic and Counseling Services, which are specialized and provided under CHC.	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.B. - Prior Authorization of Services	page 36	When CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of deinal using the appropriate notice templates . . . Must make the notice available in accessible formats for people with visual impairments and for persons with limited English proficiency	Add: ***Must make the notice available in accessible formats with persons with cognitive disabilities.*** It would be a civil rights violation to only consider formats for people with a physical or a language disability, you must also consider persons with cognitive disabilities and how they can understand the notice you are giving them. This may require the use of a Cognitive Facilitator, who understands the nature of the particular cognitive disability and is trained on how to ensure that the information is understood by the person served.	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.B. - Prior Authorization of Services	page 37	The CHC-MCO may not require prior authorization . . . Service Coordinators are required to work with the Participant's Medicare plan to ensure expeditious decision making and communication of decisions made.	That is good, because Medicare won't give a prior authorization. Neither will they give a denial letter. Please include explicit language here that ***if Medicare is the TPR, the CHC-MCO will honor the Annual Cap published by Medicare for PT/SP services, and for OT services as exhaustion of TPR, and if the service continues to be medically necessary, the CHC-MCO will provide the service according to the Service Definitions***	Beechwood NeuroRehab/Deb Cerra-Tyl

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Requirements Document	Section V.C. - Continuity of Care	page 39	Continuity of care period for continuation of PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days . . .	This is not a sufficient time period for Participants or for Service Coordinators or for Providers to become acclimated to this new business model, and will harm people who have been served by LTSS for some time. Change to: ***Continuity of care period for continuation of PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 730 days . . .***	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.E. - Needs Screening	Page 40	"The CHC-MCO will conduct a needs screening using a tool approved by the Department….". "The needs screening must be completed…and may be conducted by phone, electronically, by mail or in person".	The 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, which can be used for all disability groups. 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	Section V.F. - Comprehensive Needs Assessments & Reassessments	page 40-41-42	Comprehensive Needs Assessments . . . The Department will designate a tool to be used for comprehensive	The Department must consider the unique needs of people with cognitive impairment. This would be true for people with dementia and people with acquired brain injury, a significant portion of the total to be served under CHC. A tool has been recommended (Utah tool) that requires the evaluator to assess functional abilities, not just ask the person what they think they can do. This is absolutely required for people with cognitive impairment, because they may not know what they can do ***because of their cognitive disability.*** Furthermore, the assessors must be trained in cognitive disability as demonstrated by a National Cerification program - www.acbis.pro for brain injury and National Council of Certified Dementia Providers - www.nccdp.org for People with Dementia	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.G. - Person Centered Planning Team Approach	Page 43	Person Centered Service Plans for Participants who require LTSS will be developed by the Service Coordinator, the Participant, and the Participant's Person Centered Planning Team (PCPT)	If the PCSP is to include the provision of habilitation/rehabilitation services, a Service Provider must be part of the PCPT. For people with Cognitive Impairment, a Service Provider, including a transdisciplinary team (consisting of neuropsychiatrist, neuropsychologist, PT, OT, SP, Cognitive Rehabilitation Therapist, Behavior Analyst, Case Mangers and Social Workers), must be consulted to determine the feasibility of the desired Service Plan, and the best way to execute it. Failure to include a Service Provider with experience and training in cognitive disability will result in unrealistic service plans and will waste the state's money and fail to provide the necessary services and supports to accomplish the Participant's objectives	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.I. - Department Review of Changes in Service Plans	Page 43	The Department may review and revise any PCSP. The CHC-MCO must provide the Department with weekly aggregate reports on PCSP changes.	It is recommended that a change in a PCSP that would result in a 5% change of services would trigger a review by the Department. Relying on reviews of aggregate data does not afford adequate protection to the Participant.	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.J. - Service Coordination	page 44	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse . . .	For Community Health Choices, a registered nurse does not provide the kind of training and experience required to manage LTSS - this is more appropriate for Health Choices. If a standard bar of education is being required for CHC, such as the Bachelors degree, then the requirement should be: ***BSN, BSW, BA or BS in Psychology. In addition, training and experience should be specific to the population being served:*** ***• 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. 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. The state could grandfather existing Service Coordinators but require that they become certified by the relevant area for the people they will be serving within a set period of time, such as 2 years.	Beechwood NeuroRehab/Deb Cerra-Tyl

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Requirements Document	Section V.M.- Coordination of Services	page 44-45	Department requires CHC-MCO and BH-MCO Coordination	While this is fine for psychiatric inpatient hospitalization services, it should again be clarified that outpatient Behavior Services as defined by LTSS (later listed as Therapeutic and Counseling Services) are not within the expertise of traditional Behavioral Health providers, and the MCO should not be confused by this language to think that they have to coordinate BH Outpatient Services first, because the Behavior outpatient services needed by waiver clients are different, and are provided for under the Waiver as Therapeutic and Counseling services	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Page 57	Participant Advisory Committee (PAC)	While the PAC is a great requirement, it would not make sense for there to be mix PACs for Health Choices and for Community Health Choices. The issues for people in LTSS are going to be so different from those receiving acute health care, that it will be ineffective to have CHC people volunteer their time to sit through lengthy discussions about the experiences of people getting acute health care. Please require MCOs to create a separate PAC for HC and a separate PAC for CHC.	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.V. - Executive Management	page 65	A full-time Director of LTSS who is resonsible for	The 5 years of experience in Long Term Care is fine, but given the population being served by CHC, this person should also have designated experience in the management of populations with cognitive impairement, including dementia and acquired brain injury	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.X.- Administration	page 65-67	QM/QI/UM requirements	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. The Waivers already require that QM/QI be dictated by the requirements of CARF, so don't let MCOs think they can develop their own separate system for CHC. UM is really an inappropriate concept for LTSS, but rather should be managed by the Service Coordinators who need sufficient training 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. 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	Section V.CC. - Provider Services	page 86-87	Provider Education . . . . Training plan must be developed in conjunction with the department and must cover all topic areas identifed by the department	There should be a similar requirement for Service Coordinator Education, that requires a training plan must be developed in conjunction with the department and must cover all topic areas identifed by the department. ***These areas should include training on cognitive impairment and the long term needs of people with acquired brain injury.*** Sensitivity training on the diverse needs of persons with disabilities, such as persons who are deaf or hard of hearing, how to obtain sign language interpreters, how to wokr effectively with sign language interpreters***, and how to communicate in cognitively accessible formats.***	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.DD. - Provider Network	page 89	. . . Enroll in its provider network all willing and qualified LTSS providers that provide HCBS through the OLTL Waivers . . . . This requirement will remain in effect for the HCBS providers for the first 180 days	should specify somewhere that the current OLTL Waivers require these providers to be CARF certified in brain injury for CommCare and OBRA services to be provided to that population. . . . ***This requirement will remain in effect for the HCBS providers for the first 730 days***	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.DD. - Provider Network	page 90	Cultural Competency. CHC-MCOs and Network providers must understand . . . Cannot be permitted to present barriers to accessing and receiving quality services . . .	CHC-MCOs and Network providers must understand . . . Cannot be permitted to present barriers to accessing and receiving quality services . . . ***And must make reasonable accommodations for people with cognitive impairments so that they have the opportunity to access and receive quality services. For example, if a Participant is perceived as having a cognitive disability, a NeuroCognitive Facilitator should be utilized to communicate necessary information, and treatment must be formulated in such a manner so as to be accessible to people with cognitive impairments.***	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.EE. - QM & UM Program Requirements	page 95	The quality management proram should include the following:	The quality management proram should include the following: ***should reference existing CARF requirements for Waiver providers for brain injury programs***	Beechwood NeuroRehab/Deb Cerra-Tyl

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Requirements Document	Section V.EE. - QM & UM Program Requirements	page 9	Utilization Management and Utilization Review	Utilization Management and Utilization Review are common procedures for acute health care, but are not common, and should not be lumped into 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. 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	DDD(1) - Covered Services List		Residential Habilitation; Structured Day	Residential Habilitation and Structured Day Services must also include provisions for Enhanced 1:1 staffing and Enhanced 2:1 staffing; these services are currently available in the Waiver Service definitions.	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Residential Habilitation; Structured Day	The RFP should include the following as the Service Definition for Enhanced Staffing for Residential Habilitation and Structured Day Services: Individual considerations may be available for those individuals that require continual assistance as identified on their needs assessment to ensure their medical or behavioral stability. By nature of their behaviors or medical needs, individuals are not able to participate in activities or are unable to access the community without direct staff support. Residential Enhanced staffing/Structured Day Enhanced staffing is treated as an add-on to the Residential Habilitation/Structured Day Services and is only available when the participant requires additional behavioral or medical supports.	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Employment Skills Development: Waiver funding is not available for the provision of Employment Skills Development (e.g. sheltered work performed in a facility) where Participants are supervised in producing goods or performing services under contract to third parties.	There are some Participants for whom community integrated employment remains elusive due to their cognitive, behavioral, or medical needs. For those individuals, sheltered employment provides the supportive environment necessary so that they can continue to build skills towards a productive activity pattern. This service should continue to be offered if there are other options for productive daily activity pattern available, and if it can be demonstrated that a person is working towards another community integrated productive daily activity pattern.	Beechwood NeuroRehab/Deb Cerra-Tyl
Requirements Document	Section V.T. - Provider Dispute Resolution Process			Currently, providers involved in payment disputes with the Department of Human Services (DHS) in the long-term care program have the right to an impartial administrative hearing before the DHS Bureau of Hearings and Appeals (BHA). CHC does not provide the same protection. Specifically, the draft RFP prohibits BHA from hearing disputes between providers and the managed care organizations (MCO) administering the CHC program. While the draft RFP does include an internal dispute resolution process, this process falls short of the protections currently available to providers through BHA.	Jeffrey W. Bechtel Senior Vice President Health Economics and Policy

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Other	Rates and Reimbursement			HAP previously noted that DHS should ensure that the CHC program has sufficient funds to adequately compensate skilled nursing facilities and other long-term services and support providers. The final RFP and contract should, at a minimum, require that MCO pay providers existing Medicaid rates and provide for annual cost increases. In addition, the draft RFP's payment methodology does not appear to require that MCOs consider the acuity of the patients when establishing reimbursement rates. A failure to properly incorporate these acuity levels could result in underpayments to providers and penalize providers treating consumers with complex medical conditions. The CHC program should do more to ensure providers are adequately compensated for treating complex patients.	Jeffrey W. Bechtel Senior Vice President Health Economics and Policy
Other	Provider Protection			DHS should require that MCOs' policies are generally consistent. To the greatest extent possible, critical components of the program such as credentialing, utilization review, and payment should be aligned to prevent the imposition of unnecessary administrative burdens on providers. If each MCO has its own approaches, it will create a significant administrative burden for providers and add cost to the program.	Jeffrey W. Bechtel Senior Vice President Health Economics and Policy
Other		General Comment		**Intent/Definition of Service Coordination**-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program. One example of where this is important is when considering the continuity of care period. If service coordination is a provider service, the continuity of care period would definitely apply. If it is an administrative function, we are not sure if that provision would apply to service coordination.	AAA32
Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	AAA32
Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems-** The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	AAA32
Requirements Document	Section II - Definitions	p. 14	Participant Advisory Committee (PAC)- A group convened in person, at least quarterly by the CHC-MCO's governoring board which is open to all participants and which reflects the diversity of the CHC-MCO's Participant population.	**Participant Advisory Committee Makeup -** We recommend that the PAC meetings be formed for, and held in, each zone (for instances where MCO may cover more than one zone) and have representation for rural and urban counties in each particular zone.	AAA32
Requirements Document	Section II - Definitions	p. 15	Person Centered Planning Team- The team of individuals that will participate in Person Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT	**Person Centered Planning Team Makeup** - We recommend OLTL include the minimum acceptable required individuals and also include other suggestions/preferences for individuals on the team. We also recomment that OLTL require that if there is a behavioral health diagnosis, a behavioral health representative be required on the team.	AAA32

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
Requirements Document	Section V.A. - Covered Services	p.26	In-Home and Community -Based Services- The CHC- MCO may not deny personal assistance services for Participants under the age of 21 based on the Participant's diagnosis or because the need for personal assistance is the result of a cognitive imparment…	**Personal Assistance Services** - We recommend removing "under the age of 21" so that no conumer could be denied personal assistance services based on the participant's diagnosis or because the need is based on a cognitive impairment	AAA32
Requirements Document	Section V.A. - Covered Services	p.26	The CHC-MCO may not deny a request for Medically Necessary in-home nursing services, home health aide services, or personal assistance services for a Participant under the age of 21 on the basis that a live-in caregiver can perform the task…	**In-home Nursing, Home Health Aide or Personal Assistance Services** - We recommend removing "under the age of 21" so that no consumer could be denied under these circumstances.	AAA32
Requirements Document	Section V.B. - Prior Authorization of Services	p. 36	B. Prior Authorization of Services 1.General Prior Authorization Requirements (4th paragraph) When the CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of denial using the appropriate notice outline in templates…	**Notice of Service Denial** - We recommend that when there is a denial of services for those in MLTSS, notification should also be sent to the Service Coordination Agency/entity to ensure continuity and follow up with consumer.	AAA32
Requirements Document	Section V.B. - Prior Authorization of Services	p.37	2. Time frames for notice of Decisions	**Notice of Service Decisions** - We recommend that notice decisions should also be sent to Service Coordinator (entity) if additional information is needed from an MLTSS consumer the Service Coordination Agency should also be notified so they can assist the consumer in acquiring required documentation.	AAA32
Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	**Continuity of Care for LTSS Participants**-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	AAA32
Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	**Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors**-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	AAA32
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	**Limited English Proficiency Requirements**- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	AAA32

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Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	**Management Information Systems**-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	AAA32
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	AAA32
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	**Willing Provider Definition –** In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	AAA32
Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department** – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	AAA32
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	AAA32
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	AAA32

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	AAA32
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	AAA32
Other		General Comment		**Intent/Definition of Service Coordination**-Please clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program.	Wayne County AAA
Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- Respectfully suggest that The Department convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	Wayne County AAA
Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems-** Please clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	Wayne County AAA
Requirements Document	Section II - Definitions	p. 5	Disease Management- An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as ...	**Disease Managemnent-**An integrated treatment approach that utilizes **evidence based programs** that includes the collaboration and coordination of patient care delivery systems and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as ...	Wayne County AAA
Requirements Document	Section II - Definitions	p. 14	Participant Advisory Committee (PAC)- A group convened in person, at least quarterly by the CHC-MCO's governoring board which is open to all participants and which reflects the diversity of the CHC-MCO's Participant population.	respectfully suggest that it be required that PAC's meetings need to be formed for and held in each zone (for instances where MCO may cover more than one zone) and have representation for rural and urban counties in each particular zone.	

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Requirements Document	Section II - Definitions	p. 15	Person Centered Planning Team- The team of individuals that will participate in Person Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT	suggest that you include the minimum acceptable required individuals and also include other suggestions/preferences for individuals on the team. Include requirement that if there is a BH dx that behavioral health representative be required on the team.	
Requirements Document	Section II - Definitions	p. 19	Service Coordination Entity	add description and clarify if this is an administrative function	Wayne County AAA
Requirements Document	Section II - Definitions	p.19	Services My Way (SMW)- The Budget Authority model of service, which provides participants with a broader range of opportunities for Participant-Direction under which participants have the opportunity to hire and manage staff that performs personal assistance type services manage a flexible spending plan, and purchase allowable goods and services through their spending plan.	include oversight and training requirements of this service in the definition	Wayne County AAA
Requirements Document	Section V.A. - Covered Services	p.26	In-Home and Community -Based Services- The CHC- MCO may not deny personal assistance services for Participants under the age of 21 based on the Participant's diagnosis or because the need for personal assistance is the result of a cognitive imparment…	consider removing "under the age of 21" so that no consumer could be denied personal assistance services based on the participants dx or because the need is based on a cognitive impairment	Wayne County AAA
Requirements Document	Section V.A. - Covered Services	p.26	The CHC-MCO may not deny a request for Medically Necessary in-home nursing services, home health aide services, or personal assistance services for a Participant under the age of 21 on the basis that a live-in caregiver can perform the task…	again, consider removing "under the age of 21" so that no consumer could be denied under these circumstances.	Wayne County AAA
Requirements Document	Section V.A. - Covered Services	p.27	Expanded Services- The CHC-MCO may provide expanded services subject to advance written approval by the Department. These must be services that are generally considered to have a direct relationship to the maintenance or enhancement of a Participants health status	Expanded Services-The CHC-MCO may provide expanded services subject to advance written approval by the Department. These must be services that are **evidence based** and are generally considered...	Wayne County AAA
Requirements Document	Section V.A. - Covered Services	p.34	Health and Wellness Education and Outreach for Participants and Caregivers-The CHC-MCO must provide health and wellness opportunities for participants. This may include providing classes, support groups, and workshops, disseminating educational materials and resources...	Health and Wellness Education and Outreach for Participants and Caregivers-The CHC-MCO must provide health and wellness opportunities for participants. This may include providing classes, support groups, and workshops, disseminating educational materials and resources **(add requirement for evidence based programming to be available and require either specific evidence based programs or a % of evidence based programs). If other programs are not having a positive impact they need to be replaced by evidence based programs.**	Wayne County AAA

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Requirements Document	Section V.B. - Prior Authorization of Services	p. 36	B. Prior Authorization of Services 1.General Prior Authorization Requirements (4th paragraph) When the CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of denial using the appropriate notice outline in templates…	denial of services for those in MLTSS should also be sent to Service Coordination Agency/entity to ensure continuity and follow up with consumer.	Wayne County AAA
Requirements Document	Section V.B. - Prior Authorization of Services	p.37	2. Time frames for notice of Decisions	notice decisions should also be sent to Service Coordinator (entity) if additional information is needed from an MLTSS consumer the Service Coordination Agency should also be notified so they can assist the consumer in acquiring required documentation.	Wayne County AAA
Requirements Document	Section V.B. - Prior Authorization of Services	p.38	If the Participant is currently receiving……..the CHC-MCO must mail the written notice of denial at least 10 days prior…..	Time Frames for Notice of Decisions - The respective denial notices should specify "business" days, rather than permitting calendar days.	Wayne County AAA
Requirements Document	Section V.C. - Continuity of Care	p.39	The CHC-MCO must provide continuity of care to participants who are receiving LTSS as follows:	add wording for if the consumer is in a NF but wishes to be returned to the community, this transition is the responsibility of the CHC-MCO.	Wayne County AAA
Requirements Document	Section V.C. - Continuity of Care	p. 39	For a participant who is receiving LTSS through an HCBS Waiver program on his or Effective Date of Enrollment, the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until the comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later.	**Continuity of Care for LTSS Participants**-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	Wayne County AAA
Requirements Document	Section V.C. - Continuity of Care	p.40	E. Needs Screening	add allowance/requirement for consumer to be offered option(and/or request) to have a comprehensive needs assessment if initial screening comes up as not needed so that participants in need of services are not eliminated prematurely. Have a protocol for monitoring effectiveness of needs screening. Current wording for needs screening timeframes should not be more then timeframes for the comprehensive needs assessment.	Wayne County AAA
Requirements Document	Section V.C. - Continuity of Care	p. 42	G. Person Centered Planning Team Approach Required	include minimum team requirements and suggested/preference team members.	Wayne County AAA

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Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	**Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors**- Service coordinators are not currently required to have 3 years of experience (in the PA CODE 52.27) and we hold that one year of related experience, in addition to the bachelor's degree should be sufficient for the position of service coordinator. We believe that the Service Coordinator Supervisor current requirements (in the PA CODE 52.27) of a bachelor's degree and three years of experience is sufficient and would reccomend that adding that they have the oversight and consultation of a licensed social worker or R.N.available. To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements, as long as they remain at their current employ and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	Wayne County AAA
Requirements Document	Section V.V. - Executive Management	p.66 should be section V.W Other Administrative Components (was not available in drop down)	A full-time Director of Service Coordination oversees all Service Coordination functions of the CHC plan and who shall have the qualifications of a service coordinator and a minimum of 5 years of management/supervisory experience in the healthcare field.	Respectfully submit that this position be either an R.N. or Licensed Social Worker with 5 years of experience (instead of that requirement being on the S.C. Supervisor of the SC Agency) current wording has them meeting Service Coordinator requirements and having 5 yrs experience (which is less experience than the draft sc supervisor requirement)	Wayne County AAA
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	p. 46	O. Participant enrollment and disenrollment (4th paragraph) The Department will enroll participants transferring from one CHC zone to another with the same CHC-MCO, provided that the CHC-MCO operates in both CHC zones, unless the participant chooses to enroll in LIFE in the new zone.	Participant should be offered the choices available in the new zone, if those choices are different from the zone they are leaving.	Wayne County AAA
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	**Limited English Proficiency Requirements**- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	Wayne County AAA
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	p.53	12. Enrollment and disenrollment updates c. Discharge transition planning	are both the discharging and receiving plan paid for the participant for the 6 month transition time? Looking for clarification of which MCO (the ending or beginning or both) would be paying the providers working with consumers and/or service coordinator (s) may be different as well.	Wayne County AAA
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	p.57	18. Participant Advisory Committee	PAC for each zone, made accessible	Wayne County AAA
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	p.58	20. Involuntary Disenrollment	who would be involuntarily disenrolled and for what length of time would Service Coordination be authorized to continue.	Wayne County AAA

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Requirements Document	Section V.P. - Participant Services	p.59	2. CHC-MCO Internal Participant Dedicated Hotline	Notification to all parties calling in that calls are being monitored by an outside agency	Wayne County AAA
Requirements Document	Section V. Z. - Fraud & Abuse	p. 73	b. Written Policies	recommend listing the current citations for State Fraud and Abuse Mandates and the current Federal. Still agree wording should be inclusive of all.	Wayne County AAA
Requirements Document	Section V. Z. - Fraud & Abuse	p.75-76	m. Duty to notify	delineate whose responsibility it is to notify subcontractors/ service coordinators etc.	Wayne County AAA
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	**Management Information Systems**-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	Wayne County AAA
Requirements Document	Section V.AA. - Selection & Assignment of PCPs	p.82	The CHC-MCO must honor a Participants selection of a PCP through the IEE upon commencement of CHC-MCO coverage.	non participating PCP can be selected and must be honored, correct?	Wayne County AAA
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 84-85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE) or Service Cooridination Agency (SCA). Please clarify/define service coordinator specifically refers to an agency,entity or an individual. For example page 84 CHC-MCO must offer choice of Service Coordinators... This should read choice of two Service Coordination Agencies and, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE/SCA, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity."/ and/or "Service Coordination Agency" (This would also require an additional definition for "Service Coordinating Entity and/or Agency.") Is this then describing informed selection as opposed to randomized? If informed will it also be looking at new consumers who are NFI and already involved with AAA or other service providers outside of CHC-MCO?	Wayne County AAA
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p.85	If a participant requests a change in his or her Service Coordinator selection following the initial visit, the CHC-MCO must promptly grant the rquest and process the change in a timely manner	**On cases where selection made for participant they must be informed of their right to change Service Coordination Agency (again clarification needed here) and given information on who to contact if/when they wish to initiate change with an impartial party (independent enrollment broker?)**	Wayne County AAA
Requirements Document	Section V.CC. - Provider Services	p.88	q.information on the Complaint, grievance and Fair hearing and Appeals process including but not limited to expectations a Provider representing a Participant at a Grievance hearing	**clarify what provider type is expected (required?) to represent a participant and payment source for said provider**	Wayne County AAA
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	**Willing Provider Definition –** In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period. Also reccommend extending the term to two years, unless the consumer requests a change or the provider disenrolls.	Wayne County AAA

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Requirements Document	Section V.EE. - QM & UM Program Requirements	p. 96	6. Pay for Performance Programs-The Department may establish a pay for Performance Program to provide financial incentives for CHC-MCO's that meet quality goals. An initial P4P program may be established for CHC_MCO's that assist Participants to remain financially eligible for redetermination.	consider for LTSS and retired individuals only need to check a box on what has changed, if the same nothing needs to be sent other than signature agreeing to such.	Wayne County AAA
Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department** – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	Wayne County AAA
Requirements Document Exhibit	C - Requirements for Provider Terminations	1.B.	Unless the provider is being terminated for cause…	If not terminated for cause participant should still be able to continue service with provider at no decrease in compensation to provider. Consumer choice	Wayne County AAA
Requirements Document Exhibit	C - Requirements for Provider Terminations	B. Supporting Documentation	B. Supporting Documentation 1) Background Information a) Submit a summary of issues/reasons for termination	Can/will Department deny termination of provider and can a participant grieve to continue with said provider, as long as provider is willing and able to serve. Clarify participant rights to choice, if due cause of termination of provider not sufficient	Wayne County AAA
Requirements Document Exhibit	CC - Data Support			CHC MCO needs to have accurate breakdown by county of who is available to provide specifc service in the **participants** current area/county so that participant can easily select an accessible provider for them. (leaving the wording as listing all providers within the network will make the selection pool to be too large and will include providers who are not available to provide service to those consumers) Data Support should also include Service Coordination/provider access to specific participant information so that service coordination can truly be coordinated and integrated.	Wayne County AAA
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, we also recognize that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	Wayne County AAA
Requirements Document Exhibit	L - Medical Assistance Transportation Program			add provision for escort on transportation. Require CHC-MCO to work with MATP, (instead of strongly encourage)integrate IT system so that computer system can be used to request and verify medical necessity/approval. Ultimate responsibility should be with CHC-MCO to provide, not neighbors, volunteers, community services etc.	
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	Wayne County AAA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Home Delivered Meals	menus should be approved by a registered dietician or pa Licensed dietician /nutritionist	Wayne County AAA

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Therapeutic and Counseling Services	A provider of nutrition services should be a registered dietitian /nutritionist or a PA licensed dietitian / nutritionist. (current wording is inconsistent and conflicting)	Wayne County AAA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	Wayne County AAA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	Wayne County AAA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Home Delivered Meals only during those times when…	Revise wording to allow for extunuating circumstances. Who will determine if other household members are able or available (may not be willing etc.). Ultimate responsibility of provision needs to be the CHC- MCO not community/volunteer agenices or third parties . In addition to the DRI reccomendation, the menu needs to be consistent with the US Dietary guidelines for American's	Wayne County AAA
RFP	General Information			All consumers should receive education regarding their right to appeal, access to the Ombudsman program, and Protective Services to assist those at risk for abuse, neglect, financial exploitation and abandonment. Contracts with MCOs should mandate proper education regarding consumer rights and protection from abuse. Additionally, MCO contract must mandate adherence to applicable statutory and state program directives regarding reporting.	Wayne County AAA
RFP	General Information			To ensure person-centered service planning can increase opportunities for HCBS, enrollment must be culturally sensitive and maintain expeditious timelines. Expedited program enrollment provides a viable alternative to institutionalization by eliminating the interruption between the immediate need and start of services. Allowing consumer presumptive eligibility determinations at the local level, and random consumer care plans reviews from the state, could expedite supports while maintaining appropriate state oversight and monitoring.	Wayne County AAA
RFP	Proposal Requirements			Should a consumer's budget exceed the capitated amount, DHS needs to ensure that consumers will not be forced into Nursing Homes nor will their services be reduced in order to come under the established capitated amount	Liberty Community Connections

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RFP	Proposal Requirements	Exhibit DDD (2), Assistive Technology	An independent evaluation of the Assitive Technology nees of a participant. This includes a functional evaluation of the Assitive Technology needs and appropriate services for the participant in his/her customary environment.	We recommend that DHS not require an independent evalulation or physican script for pieces of low tech equipment (ie. signature stamps) in the instance where the evaluation or PCP visit would exceed the actual cost of the requested equipment.	Liberty Community Connections
RFP	Proposal Requirements	EE. QM and UM Program Requirements, number 2. Quality Management/Performance Improvement, page 95	The CHC-MCO shall have a written Quality Management/Quality Improvement program that clearly defines its quality improvement structures and processes and assigned responsibility to appropriate individuals.	We recommend that DHS consider mandating several audits/quality assurance measurements to ensure compliance with the regulations/waiver standards. We recommend mandatory audits such as Waiver Regulations Review, Contact Compliance, Participant Record Review, Critical Incident Reporting, Complaint Management, Hearings/Appeals, Fraud and Abuse, Billing and Payment Record Review, Recurring Incidents and Hospitalizations, TSADF and Documentation, Service Authorization and Physician scripts, Non Medical Transportation utilization and continued appropriateness, Service Note Documentation and Enterprise Incident Management Systems. We also recommend that DHS require Service Coordinators to enter service notes and document in "real time." This will assist with accuracy of documentation and ensure that identified issues and unmet needs are addressed more consistently.	Liberty Community Connections
RFP	Proposal Requirements	Service Delivery Innovation, page 35	These may include but are not limited to: outreach to and engagement of Participants, housing search assistance, assistance and applying for housing and benefits, assistance wih SSI eligibility processes, advocacy and negotiation with landlord and tenants, moving assistance, eviction prevention, motivational interviewing, and incorporating social determinants of health into the person-centered planning process.	To be included in the list of possible housing innovations, we recommend that DHS extend financial options and assistance with obtaining community resources to allow for housing placement/assistance. For example, the implementation of Nursing Home transition funds resulted in an increase in the number of annual transitions as the financial assistance mitigated the financial obstacles in regards to transition.	Liberty Community Connections
RFP	Proposal Requirements	Comprehensive Needs Assessments and Reassessments, pg. 41	The CHC-MCO must conduct a comprehensive needs reassessment no more than 12 months following the most recent prior comprehensive needs assessment unless a trigger event occurs	We recoomend that Service Coordinators complete the yearly reassessment with the participant as they have had the ongoing contact with the consumer over the year. If the language was intended to place responsibility on the Service Coordinator and not the CHC-MCO, we recommend that it is clearly defined in the RFP.	Liberty Community Connections
RFP	Proposal Requirements	Service Coordinator and Service Coordinator Requirements, page 44	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology, or other related field and at least three years of experience	We recomend that the educational requirements for Service Coordinators and Supervisors remain reflective of ACT 22 with a mandated service coordination certification program completion with annual continued educational requirements. We would like to recomend that the department utilize Case Management Certification program through The Ohio State University model whereas the Service Coordinator and supervisor would have to complete and successfully pass the certification program within their first 6 months of employment.	Liberty Community Connections

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Requirements Document	Section II - Definitions	II. Pg. 22	Medically Necessary	This definition should be updated to include the following language from proposed 42 C.F.R. § 438.210(a)(5)(iii)(D) as bullet point: "The opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living." This is important in order to ensure that participants can access services needed to achieve the underlying community integration and person-centered planning goals of CHC. More broadly, we are concerned that the draft agreement does not make clear what the criteria will be for determining who may receive the various LTSS benefits. Is this medical necessity definition intended to establish the eligibility criteria for particular LTSS benefits? "Medical necessity", even broadly defined, utilizes a medical –rather than social - model as its frame of reference. One of consumers' greatest concerns is that CHC will result in a medicalization of LTSS, especially because most MCOs are accustomed to delivering medical services and lack experience with Home and Community Based Services (HCBS). To make sure this does not happen, the qualifying criteria for particular HCBS benefits should be framed in terms of LTSS' broad goals rather than in terms of medical necessity. This is a crucial issue which should be developed with stakeholder input by a work group.	Community Legal Service of Philadelphia
Requirements Document	Section II - Definitions	II. Pg. 22	Vital Document	The definition of vital documents in Section II should mirror the definition provided in O.4, p.50. "Vital documents" should also extend to electronic material, such as information on a CHC-MCO's website. In addition, the definition should clarify that vital documents include, <u>but are not limited to</u>: provider directories, participant handbooks, appeal and grievance notices, and other notices that are critical to obtaining services. Service plans and service denial/reduction notices, for example, are certainly vital documents and should be included in the definition.	Community Legal Service of Philadelphia
Requirements Document	Section II - Definitions	II, pg. 22	Definitions	The Definitions section should also define language access. We can recommend specific language at a later date.	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A. p.26	Covered Services	The first paragraph should be revised to make clear that the references to "medically necessary services" which must be based on "medical information" refer to physical health services and not to LTSS, for which the medical necessity standard does not apply and for which eligibility often will not determined based on purely medical information.	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.1, pg. 26	Amount Duration and Scope	Add "or the CHC 1915(c) waiver" after "At minimum, the CHC-MCO must provide Covered Services in Exhibit DDD in the amount, duration and scope available in the Medical Assistance FFS Program", to make clear that LTSS are included in this requirement.	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.2, pg.26	In-Home and Community Based Services	In the first sentence of the second paragraph, we are concerned about referring to personal assistance services as "medically necessary". We would suggest deleting this language. As stated previously (definitions section), the goal of personal assistance services is generally not to address a medical need, but rather to allow the participant to perform daily functions and to access the full range of experiences available to people who do not have a disability. We are very concerned that framing the eligibility criteria for LTSS in terms of medical necessity will result in a medicalization of these services or even denials of services where they do not achieve a "medical" result.	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.2, p. 27	In-Home and Community Based Services	Language should also be added to the draft contract stating that "the CHC-MCO may not deny a request for LTSS to a Participant of any age on the basis that an informal caregiver (whether live-in or not) can perform the task, unless there is a determination that the informal caregiver is actually able and available to provide the level or extent of care that the Participant needs, given the caregiver's work schedule or other responsibilities, including other responsibilities in the home, and own sleep schedule and self-care needs."	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.4, pg. 27		In second sentence, add "or functional" after "These must be services that are generally considered to have a direct relationship to the maintenance or enhancement of a Participant's health".	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.4, pg. 27		In addition to a 60 day notice, where a CHC-MCO plans to eliminate or change expanded services, CHC-MCOs should be required to obtain approval from the Department. In the Medicare setting, CHC-MCOs use expanded services to entice participants into their plans; we suspect this is what will occur in the CHC-MCO setting. Allowing plans to unilaterally eliminate or change expanded services will result in harm to participants who have grown to rely on the additional services.	Community Legal Service of Philadelphia

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Requirements Document	Section V.A. - Covered Services	V.A.4, p.27		Additionally, all participants must be made aware prior to enrollment which services are expanded and that they could lose these services if plans decide not to provide them anymore. The CHC-MCO must be required to disclose that if a participant is leaving a plan to enter a new one that they may encounter problems with provider networks and prior authorization rules and will have to change service coordinators. Additionally, participants should have appeal rights if denied expanded services or if the services are reduced or eliminated.	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.6, p. 28	Self-Referral/Direct Access	We assume that referrals will not be necessary for LTSS, since it will be approved as part of the Person-Centered Service planning process.	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.7 page 27-28	Behavioral Health Services	More detail is needed here about what steps the CHC-MCO must take to coordinate with the BH-MCO and which staff is required to do it. A work group is urgently needed to create guidelines concerning which entity is responsible for behavioral health services in various possible scenarios and settings, and what specific coordination activities the CHC-MCO will be responsible for. See more detailed comments below in response to Exhibit U (Behavioral Health Services).	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.15, pg. 32	Transportation	We strongly support requiring the CHC-MHO to pay for medical and non-medical transportation. Dual-eligibles and recipients of LTSS are by definition elderly, low-income, or severely disabled. Many participants would not be able to afford to safely leave their homes to perform routine tasks, such as grocery shopping, community activities, and religious activities. The provision of these services will help participants maintain important connections with their community, and will contribute to positive health outcomes.	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.17, pg. 33	Nursing Facility Services	the wording in the clause "including bed hold days and up to fifteen (15) per hospitalization…" is confusing. Are bed hold days separate from the hospitalization and therapeutic leave days, as the word "and" suggests?	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.17, pg. 33	Nursing Facility Services	The second paragraph appears to require CHC-MCOs to provide nursing facility services for a participant if the Level of Care Determination Entity decides that the participant requires it. We support such a requirement, in situations where nursing facility care is the participant's preference. This is an important safeguard to ensure that CHC-MCOs do not unreasonably deny access to nursing facility care for participants who need and desire to be served in that setting. If the participant disagrees with this locus of care decision by the Level of Care Determination Entity, he or she must have the right to appeal it and to receive services in the least restrictive, most integrated setting. It should be noted that Level of Care Determination Entity is not defined in the definitions section and should be.	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.17, pg. 33	Nursing Facility Services	In the third paragraph, language should be added to make clear that leaving the nursing facility for hospitalizations or therapeutic leave does not mean that the participant's stay has ended for the purposes of the continuity of care provision, and that the participants may return to the nursing facility and continue to reside there.	Community Legal Service of Philadelphia

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Requirements Document	Section V.A. - Covered Services	V.A.17, pg. 33	Nursing Facility Services	The fourth paragraph raises a number of questions. It states that the CHC-MCO is responsible, in coordination with the Department, to ensure that processes relating to the PASSR and specialized service delivery process are completed and monitored. More explanation is needed about how this will work. Specialized services, in this context, refer to behavioral services needed by individuals for whom the PASSR screen indicates a need. How will this be funded, given that the CHC-MCOs are not responsible for behavioral health services and their capitated rates do not include funding for it? This paragraph also states that the CHC-MCO will ensure that patient pay liability processes are completed and monitored. Will the patient pay liability be subtracted from the rates which the CHC-MCO would otherwise pay to the nursing facility? And will the patient pay liability be paid to the MCO or the nursing facility? What will happen if a participant fails to pay their patient pay liability? Will the nursing facility be permitted to discharge the resident? If so, what steps will the CHC-MCO be required to take to ensure that they receive a safe discharge with the services they need? What will be the CHC-MCO's role in personal care accounts? Language is also needed to explain what the CHC-MCO's role will be in care planning in the nursing facility. Will the service coordinator participate in care planning conferences?	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.17, pg. 33	Nursing Facility Services	We strongly urge the Department to require the CHC-MCO to be involved in ensuring that NF residents receive quality care, specifically with regard to the enforcement of resident rights and care requirements. We would like to see a detailed prescription of what CHC-MCOs must do to protect NF residents, how the Department will monitor the CHC-MCOs compliance, and how the Department will collaborate with the CHC-MCO to ensure the provision of quality care to residents	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.18, p. 34	Participant Self-Directed Services	Personal Assistance Services should be defined in Section II	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.18 p. 34	Participant Self-Directed Services	CHC-MCOs must introduce and provide information on self-direction during the initial needs assessment process and in subsequent reassessments. In addition to Personal Assistance Services, participants should also be able to self-direct community integration, non-medical transportation, respite, and supported employment services.	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.18 p. 34	Participant Self-Directed Services	While the contract states that CHC-MCOs must offer participants who are eligible for HCBS the opportunity to self-direct personal assistance services, Section V, B.F, p. 41 says that the CHC-MCO must assess the ability of the participant to manage and direct services and finances independently. Will a CHC-MCO be able to deny a participant the option of self-directed care if the CHC-MCO judges that he/she cannot manage services? If so, the participant should be able to contest the denial with due process appeal rights. The participant must also be given the option of appointing a surrogate to assume self-direction responsibilities on the participant's behalf. (See for example Hawaii Contract 40.770, p.148.) The surrogate must not be paid to take on these responsibilities.	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.18 p. 34	Participant Self-Directed Services	The CHC-MCO must also support participants (and surrogates) in self-directing care through appropriate training on topics including, but not limited to: developing budgets based on PSCPs; recruiting, hiring, managing, and dismissing employees; evaluating employee performance; developing back-up plans; and reporting abuse.	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.18 p. 34	Participant Self-Directed Services	Language should also be added stating that CHC-MCOs may not interfere with the right of participants who self-direct to employ the personal assistance worker of their choice, despite any criminal convictions or background that the personal assistance worker may have.	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.19 p. 34	Health And Wellness Education	LTSS-related topics should be added to the topics on which CHC-MCOs are to provide educational programs and outreach	Community Legal Service of Philadelphia
Requirements Document	Section V.A. - Covered Services	V.A.20 p. 35	Settings for LTSS	We strongly support these provisions. Language should be added to make clear that "the Department has the right to and shall determine which settings comply with the HCBS Settings final rule at 79 F.R. 2948 (January 16, 2014)".	Community Legal Service of Philadelphia

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Requirements Document	Section V.B. - Prior Authorization of Services	V.B.1. p. 36	Prior Authorization	We strongly oppose the Department allowing CHC-MCOs to require prior authorization for services. It contradicts the overall goal of service coordination and CHC-MCO involvement in treatment. The collaborative nature of the Agreement (between provider, patient, and the CHC-MCO) is seriously undermined by allowing the CHC-MCO to require prior authorization (which amounts to allowing the CHC-MCO to deny coverage for services deemed necessary by the participant's physician).Prior authorization is a mechanism most frequently used by insurance companies to deny care or to prescribe care and treatment different from the participant's treating physician has deemed necessary. It directly contradicts a model of person centered care. Prior authorization requirements will inevitably undermine the relationship between the consumer and the CHC-MCO, and result in a reluctance on the behalf of the consumer to work with her service coordinator. Further, it creates a conflict of interest, as the service provider, a supposed advocate for the participant, is ultimately beholden to the CHC-MCO. A 2013 study of LTSS providers noted that one of the major problems they faced was significant delays in obtaining prior authorization . Delays result in participants going without care and will result in negative health outcomes. Further, prior authorization requirements increase administrative for providers, resulting in less incentive for them to participate in a CHC-MCO network. http://www.ahcancal.org/facility_operations/medicaid/Documents/MLTSS%20Analysis.pdf	Community Legal Service of Philadelphia
Requirements Document	Section V.B. - Prior Authorization of Services	V.B.1. p. 36	Prior Authorization	In the event that the Department allows prior authorization we urge it to make the process as transparent as possible. Here are suggestions: 1) 24/7 hotline where a real person answers and is capable of authorizing care 2) Information on policy and procedural requirements should be provided to both providers and participants. 3) Strict oversight by the Department to identify patterns and practices with which to monitor the CHC-MCO's denial of prior authorization requests. 4) A participant advocate that, if requested by the participant, works with the participant and provider to navigate the prior authorization system 5) A list of medically necessary services that cannot be subject to prior authorization	Community Legal Service of Philadelphia
Requirements Document	Section V.B. - Prior Authorization of Services	V.B.1. p. 37		This paragraph is confusing, as the Agreement suggests that dual eligibles will be placed in a SNP, which would cover all of their needs. This paragraph seems to suggest that a recipient could be in a Medicare Part C plan as well as a CHC-MCO. How care is coordinated between Medicare and Medicaid is discussed later in the proposal, but significant clarification needs to be made. How does the Department envision coordinating coverage between two different managed care plans? How will participants know which CHC-MCO covers which services? We see the coordination of coverage as a major problem for participants. It is going to result in confusion and frustration for participants. We strongly urge the Department to make a clear statement of how it expects CHC-MCOs to coordinate coverage with Medicare.	Community Legal Service of Philadelphia
Requirements Document	Section V.B. - Prior Authorization of Services	V.B.2 pg. 37-38	Time Frames	We strongly oppose the time limit of two (2) business days. The limit should be 24 hours or less. Requiring very ill and vulnerable participants to wait 2 business days for necessary care will put their health at risk. In some instances this could mean a delay of 5 days before necessary care is approved	Community Legal Service of Philadelphia
Requirements Document	Section V.B. - Prior Authorization of Services	V.B.2 pg. 37-38	Time Frames	Plans should not be allowed 21 days to make decisions on prior authorizations. The 21 day limit will result in a dragged out process, while very sick participants go without care prescribed by their physician	Community Legal Service of Philadelphia
Requirements Document	Section V.B. - Prior Authorization of Services	V.B.2 pg. 37-38	Time Frames	Additionally, we oppose allowing the CHC-MCO to forgo any notice for the reasons stated in Section (e). This is bad policy and arguably unconstitutional. It is not uncommon for our clients to be falsely reported as dead, incarcerated, or institutionalized. The possibility of agency error in all of the scenarios listed in (e) is present, therefore notice should be required	Community Legal Service of Philadelphia

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Requirements Document	Section V.A. - Covered Services	V.A.21, pg. 35	Service Deliver Innovation	We strongly support the requirement that CHC-MCO's "promote innovation in the service delivery system." However, we would like to see further information on how DOH will monitor "innovation" and how much "innovation" is enough. The mandatory language in this section should set baselines and goals as to what services are expected to be provided.	Community Legal Service of Philadelphia
Requirements Document	Section V.C. - Continuity of Care	V.C., pg. 39	Continuity of Care	First bullet point: Language should be added stating CHC-MCOs must pay non-network nursing facilities the higher of the rate that they pay network facilities or the Medicaid fee for service rate, to ensure that they do not interfere with participants' right to remain in their nursing facility by setting insufficient rates that the facility will not accept.	Community Legal Service of Philadelphia
Requirements Document	Section V.C. - Continuity of Care	V.C., pg. 39	Continuity of Care	The last sentence of this bullet point could be read to mean that a participant who changes CHC-MCOs during the 180 continuity of care period will only receive a 60 day continuity of care period after changing plans. Language should be added to clarify that the 180 day period continues to apply even if the participant changes CHC-MCOs during the 180 day time period. If this sentence is intended to mean that a participant who changes CHC-MCOs *after the 180 continuity of care period* will receive a 60 day continuity of care period, it should be placed into a separate bullet point, in order to avoid confusion.	Community Legal Service of Philadelphia
Requirements Document	Section V.D. - Choice of Provider	V.D., pg 40	Choice of Provider	Limiting provider choice to provider's in the CHC-MCO's network runs counter to the self-direction model. CHC-MCOs must be required to try and contract with an participant's existing Medicaid providers. In other states that have switched to a managed care LTSS model, one of the chief problems has been limited provider networks. We are gravely concerned that CHC-MCO provider networks will exclude current recipients treating physicians. Additionally, a failure on behalf of CHC-MCOs to create robust provider networks will result in long delays for appointments and will take away from the participant's right to self-direction.	Community Legal Service of Philadelphia
Requirements Document	Section V.D. - Choice of Provider	V.D., pg. 40	Choice of Provider	If a provider refuses to contract with the CHC-MCO, and the provider is a Medicaid provider, the Department must require the CHC-MCO to pay the provider at the current fee for service rate or arrange for direct payment to the provider for as long as the participant sees that provider and the provider participates in Medicaid.	Community Legal Service of Philadelphia
Requirements Document	Section V.D. - Choice of Provider	V.D., pg. 40	Choice of Provider	Medicare beneficiaries have the choice to see any provider who takes their Medicare coverage, regardless of whether that provider is in their CHC-MCO network. This fact, as well as the CHC-MCO's responsibility for paying deductibles and coinsurance for Medicare-covered services, even where the provider is out of network, and the prohibition on balance billing must be made clear in the CHC Program Requirements and all provider and participant information	Community Legal Service of Philadelphia
Requirements Document	Section V.D. - Choice of Provider	V.D., pg. 40	Choice of Provider	The Financial Requirements VII.D.9 section of the Standard HealthChoices Physical Health Agreement in effect in 2002 (when duals were in HealthChoices) must be added to the RFP/Program Requirements:Financial Responsibility for Dual Eligibles The [CHC-MCO] must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for qualified Medicare beneficiaries in accordance with Section 4714 of the Balanced Budget Act of 1997. If no contracted CHC-MCO rate exists or if the Provider of the service is an Out-of-Network Provider, the [CHC-MCO] must pay deductibles and coinsurance up to the applicable MA fee schedule for the service. For Medicare services that are not covered by either MA or the [CHC-MCO], the [CHC-MCO] must pay cost-sharing to the extent that the payment made under Medicare for the service and the payment made by the CHC-MCO do not exceed eighty percent (80%) of the Medicare-approved amount. The [CHC-MCO], its subcontractors and providers are prohibited from balance billing members for Medicare deductibles or coinsurance. The CHC-MCO must ensure that a member who is eligible for both Medicare and Medicaid benefits has the right to access a Medicare product or service from the Medicare Provider of his/her choice. The CHC-MCO is responsible to pay any Medicare coinsurance and deductible amount, whether or not the Medicare provider is included in the [CHC-MCO's] Provider Network and whether or not the Medicare Provider has complied with the authorization requirements of the [CHC-MCO].	Community Legal Service of Philadelphia

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Requirements Document	Section V.E. - Needs Screening	V.E. p. 40	Needs Screening	A definition of "Needs Screening" should be added to the definitions section. Much more detail needs to be added about this process. The tool should be developed with stakeholder input. Conducting needs screenings by mail or electronically is very problematic. As part of the Healthy PA implementation last year, a needs screening was conducted to sort MA recipients into high and low needs groups. Our experience was that many recipients were nervous about and unwilling to share private medical information, especially behavioral health or substance abuse issues or sensitive diagnoses such as HIV or hepatitis, on a form they received in the mail from a state-related bureaucracy. The same is likely to be true of electronic screenings. Moreover, much of the population to be enrolled in CHC do not have access to the Internet. Thought should be given to supplementing interviews or questionnaires with reviews of diagnoses and health care utilization patterns.	Community Legal Service of Philadelphia
Requirements Document	Section V.E. - Needs Screening	V.E. p. 41	Needs Screening	Add to the bullet points at the bottom of page 41 (issues which the comprehensive needs assessment must capture): "Employment or educational goals".	Community Legal Service of Philadelphia
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	V.F., pg. 40	Compehensive Needs Assessments	It is not clear from the draft agreement what the complete process is for a participant to obtain LTSS. Neither this section nor any other seems to explain how and under what circumstances an individual is referred to the Level of Care Determination Entity which is referenced at page 33. How does the level of care determination process relate to the Comprehensive Needs Assessment? How and through which process will it be decided which participants will be referred for a level of care assessment? What are the MCO's obligations in coordinating with the Level of Care Determination Entity (besides abiding by its decision, as stated on page 33)? Does the Comprehensive Needs Assessment take place before or after the level of care determination? It is also not clear how and whether Comprehensive Needs Assessments will function for individuals who do not need LTSS but do have unmet needs or otherwise need service coordination. It appears that some participants who are not NFCE but who do have unmet needs or a need for service coordination will receive a Service Coordinator, but this is not clearly stated. It is also not clear what the time frames are in the first two bullet points because they reference other documents which do not appear to be part of what was released to the public. What are these timeframes?	Community Legal Service of Philadelphia
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	V.F, pg. 40	Compehensive Needs Assessments	We are also concerned about the potential use of the reassessment as a tool to deny participants receiving LTSS necessary care. Although we support the proper assessment of all participants, we are concerned that reassessments will be used to reduce services or find participants ineligible. We urge DOH to limit reassessments to one per year, absent a request by a participant or a triggering event. Without limiting reassessments, what is to prevent the CHC-MCO from coming out monthly? It should be made clear that the reassessment is about needs and not eligibility. Participants will be unlikely to request a reassessment if they know it could lead to a loss or decrease in services.	Community Legal Service of Philadelphia
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	V.F, pg. 40	Compehensive Needs Assessments	We strongly encourage DOH to require the CHC-MCOs to incorporate into the reassessment process a satisfaction survey for participants to complete. Participants should be able to express their approval or disapproval of services and the CHC-MCO should work with the participant to achieve maximum satisfaction	Community Legal Service of Philadelphia
Requirements Document	Section V.G. - Person Centered Planning Team Approach	V.G. p. 42	Person Centered Planning	Federal regulations establish a participant's right to person-centered planning, and this should be made clear in the agreement. 42 C.F.R. §441.301(c)(1) through (3) (describing minimum requirements for the planning process, the written service plan, and review of the plan).	Community Legal Service of Philadelphia

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Requirements Document	Section V.G. - Person Centered Planning Team Approach	V.G. p. 42	Person Centered Planning	The CHC-MCO's PCPT policy must specify how the CHC-MCO plans to educate and support participants so that they can direct the person-centered planning process and make informed decisions. The CHC-MCO must provide training on self-advocacy, self-determination, and person-centered principles, and this training should be available for caregivers as well as legal representatives. (See for example Wisconsin's Contract, Addendum X §(A)(6), p.287.) In addition, CHC-MCOs must provide participants with information about services and supports before any service planning meetings in order to allow participants enough time to meaningfully review their options. New Jersey, for example, requires its care managers to engage in options counseling with participants so that they receive guidance in making informed choices. This counseling must be documented. Care managers in New Jersey must also pass the state's options counseling training program. (New Jersey Contract, Article 1 (Definitions) p. 21; Article 9.6.3; Article 9.6.4(C)).	Community Legal Service of Philadelphia
Requirements Document	Section V.G. - Person Centered Planning Team Approach	V.G. p. 42	Person Centered Planning	The CHC-MCOs should ensure that they train not only participants/caregivers/legal representatives, but also service coordinators and other professionals involved in the development of PCSPs so that all are equipped with knowledge and training on person-centered principles.	Community Legal Service of Philadelphia
Requirements Document	Section V.H. - Person Centered Service Plans	V.H., p. 42-43	PCSPs	This section needs stronger language clarifying that the participant must have a meaningful opportunity to participate in and direct the development of PCSPs. This means that that the participant must have control over where and when service planning meetings will be held, as well as who will attend (and to what extent). The agreement must also explicitly acknowledge that participants may choose to receive care through home and community-based services rather than through nursing facilities even when HCBS would be more expensive.	Community Legal Service of Philadelphia
Requirements Document	Section V.H. - Person Centered Service Plans	V.H., p. 42-43	PCSPs	This section must also make clear that unpaid natural supports are voluntary. CHC-MCOs must not reduce paid services by assuming that qualified caregivers are available and willing to provide care. If a participant plans to rely on natural supports, PCSPs must incorporate caregivers' abilities, needs, and preferences. Minnesota, for example, uses a Caregiver Questionnaire to inform the person-centered planning process. (See Caregiver Questionnaire: DHS-6914-ENG, Minneosta Department of Human Services, *available at* https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6914-ENG)	Community Legal Service of Philadelphia
Requirements Document	Section V.H. - Person Centered Service Plans	V.H., p. 42.43	PCSPs	The PCSP must be written in plain language that avoids jargon. It must also be accessible to individuals with disabilities and persons who are limited English proficient. Further, the PCSP must be agreed to through the written informed consent of the participant and also signed by parties who will help implement the plan. Service coordinators must ensure that 1) participants do not feel pressured to sign finalized plans; and 2) participants understand they have the right to appeal part or all of their service plans, even after service planning meetings are over. Service coordinators must explain the procedures for filing an appeal. If the participant disagrees with the service plan, the service coordinator must document this disagreement. The service coordinator must then provide a written notice of the action and the participant's appeal and fair hearing rights. (See for example New Jersey Contract, Article 9.6.4(K); Arizona Contract, p.52.). Federal regulations establish a participant's right to person-centered planning, and this should be made clear in the agreement. 42 C.F.R. §441.301(c)(1) through (3) (describing minimum requirements for the planning process, the written service plan, and review of the plan).	Community Legal Service of Philadelphia
Requirements Document	Section V.H. - Person Centered Service Plans	V.H., p. 42.43	PCSPs	Participants should receive copies of their service plans, along with any assessments the CHC- MCO/service coordinator used to determine the participants' needs and develop the plan.	Community Legal Service of Philadelphia
Requirements Document	Section V.I. - Department Review of Changes in Service Plans	V.I., p. 43	Department Review of SP Changes	This is a crucial protection for participants. We appreciate the Department's decision to eliminate the 25% threshold for Department review. The circumstances which will trigger review must be thoughtfully determined with stakeholder input. The Department should also consider whether more detail is needed in this section about what must be included in weekly aggregate reports, to ensure that it receives all of the information needed to track and identify any inappropriate trends.	Community Legal Service of Philadelphia

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Requirements Document	Section V.J. - Service Coordination	V.J., p. 43	Service Coordination	The participant, not the service coordinator, should lead the person-centered planning process. This clarification is critical because a planning process that is truly driven by the participant minimizes the conflict of interest raised by having service coordinators who are employed or contracted by the CHC-MCO. This potential conflict, which is a natural result of incentives built into the system, should be addressed explicitly in the agreement. The service coordinator must maximize the participant's self-determination (including participants with diminished capacities) while ensuring that the care provided meets the participant's needs. Further, the service coordinator must facilitate the use of substituted judgment and supported-decision making when legal representatives are involved. The participant must be allowed to request a change in service coordinator, as mentioned in Section BB, p.85.	Community Legal Service of Philadelphia
Requirements Document	Section V.J. - Service Coordination	V.J., p. 43	Service Coordination	CHC-MCOs must also be required to submit and obtain Department approval of plans to monitor the performance of service coordinators. The CHC-MCO must track participant experience with measures that capture the quality of care coordination.	Community Legal Service of Philadelphia
Requirements Document	Section V.J. - Service Coordination	V.J., p. 43	Service Coordination	We believe that service coordinators should be independent of and not employed by the MCOs, to avoid a conflict of interest. The interests of the participant must come first for service coordinators and participants must be able to trust their service coordinator to approve the services they need, and file appeals, push for prior authorizations, and advocate on behalf of the client where necessary. A service coordinator employed by the CHC-MCO has mixed loyalties and an incentive not to oppose her employer. Currently, an LTSS recipient's service coordinator has no financial interest in whether her participant receives a service. Eliminating that neutrality undermines the very concept of service coordination. Accordingly, service coordination should be delegated to a third party entity, or CHC-MCOs should be required to contract with non-affiliated service coordination agencies such as Centers for Independent Living or AAAs.	Community Legal Service of Philadelphia
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Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	V.K., pg. 44	SC and SC Supervisor Requirements	Requiring service coordinators to be a nurse or have a bachelor's degree in all cases will preclude individuals who are currently performing this job and who have extensive experience and long relationships with their consumers from continuing to work as service coordinators. In order to avoid this, there should be an option to allow current service coordinators to substitute lengthy work experience for the degree requirement. There is also a history of people who have disabilities becoming service coordinators. While some do not have degrees, they have been able to be very effective by drawing on their own experiences navigating the system and living with a disability. Service coordinator requirements should be drawn so as not to preclude this career path. Training requirements for service coordinators and supervisors should be added to the agreement.	Community Legal Service of Philadelphia

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Requirements Document	Section V.L. - Nursing Home Transition	V.L., p. 44	NH Transition Services	Add the following language after "who express a desire": "or are identified as potentially able". Nursing Home Transition programs should not be limited to participants who express a desire to move, as many may not know that they have a choice or to whom to communicate that they wish to move. Rather, the Nursing Home Transition program must have processes to identify participants who may be able to transition from a nursing facility to the community. Language should be added requiring MCOs to develop and implement processes to identify participants who may have the ability and/or desire to transition from a nursing facility to the community. These processes should include but not be limited to acceptance of referrals (including but not limited to referrals from treating providers, nursing facilities, community-based organizations, family and participants); identification through the service coordination process, and review and analysis of Minimum Data Set (MDS) data from nursing facilities. The processes must be subject to the Department's review and approval.	Community Legal Service of Philadelphia
Requirements Document	Section V.L. - Nursing Home Transition	V.L., p. 44	NH Transition Services	Much more detail is needed, either here or in another appropriate place in the draft agreement, about specific requirements concerning nursing facility transition. Time frames for various steps and other requirements should be added, such as those suggested below: 1) Within 14 days of referral or other identification a transition coordinator visit the participant to determine the member's interest in and potential ability to transition to the community, and provide orientation and information to the participant regarding transition activities. The coordinator should be required to document in the participant's record that transition was discussed with the participant and the participant's wishes and potential for transition; 2) The MCO may not require a participant to transition from a nursing facility to the community against their wishes; 3) Within 14 days of the initial visit, if the participant wishes to transition to the community, the transition coordinator shall conduct an in-facility assessment of the participant's ability to transition, using tools and protocols approved by the Department, as well as any barriers to a safe transition; 4) Any participants whose transition assessment indicates that they are not candidates for transition to the community shall be provided with written notice explaining the decision and the specific factual reasons for the decision. The notice shall also provide the participant with the right to appeal; 5) For participants whose transition assessment indicates that they are candidates for transition to the community, the transition coordinator shall develop and complete a transition plan within 14 days of the participant's transition assessment; 6) The transition coordinator shall include the participant in the transition planning process, as well as other individuals the participant wishes to include such as family members or caregivers; 7) As part of transition planning and prior to the participant's move to the community, the transition coordinator shall visit the residence where the participant will live to conduct an on-site evaluation of the resident and meet with the participant's family or other caregiver who will be living with the participant. The transition coordinator shall assess any environmental or other risks in the residence and plan for any services needed to mitigate those risks; 8) The transition plan shall address all services necessary to safely transition the participant to the community, including needs related to housing, transportation, medical care, LTSS, availability of caregivers and other transition needs and supports. The transition plan shall also identify any barriers to a safe transition and strategies to overcome those barriers; 9) The MCO must approve the transition plan and authorize any services included in the plan within 10 business days of completion of the plan. The transition plan must be fully implemented within 90 days from approval of the transition plan, except under extenuating circumstances which must be documented in writing.	Community Legal Service of Philadelphia

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Requirements Document	Section V.L. - Nursing Home Transition	V.L., p. 44	NH Transition Services	A section should be added here or in another appropriate place outlining requirements for transitions to avoid unnecessary nursing facility admissions and ensure that participants who need a short-term nursing facility stay are able to transition home with the services they need. This section should require the MCO to develop and implement a nursing facility diversion process, to be approved by the Department, describing: 1) How the MCO will identify and target participants who are at risk for nursing facility placement, including at a minimum participants waiting for placement in a nursing facility; participants living in the community who experience deterioration in health or functional status and who request or are at risk for nursing facility placement; participants who are admitted to the hospital or inpatient rehabilitation who are not residents of a nursing facility; and participants who are placed in a nursing facility for short-term care; 2) How the nursing facility diversion process will be tailored to meet the needs of each of the above groups; 3) How the MCO will ensure appropriate communication among providers and between providers and the MCO; 4) • How the MCO will ensure that its providers, particularly hospitals and nursing facilities, engage in timely transition planning which thoroughly assesses the participants' needs and presents participants with the full range of appropriate and available options; 5) How the MCO will ensure that its providers, particularly hospitals and nursing facilities, engage in timely transition planning which thoroughly assesses the participants' needs and presents participants with the full range of appropriate and available options; 6) How the MCO will coordinate with providers, including hospitals and nursing facilities, to develop and implement the transition plan; 7) How transition planning will follow person centered service planning requirements and provide participants with appeal rights; 8) Specific timeframes for each activity; 9) Processes to ensure that appropriate LTSS are available immediately upon discharge; 10) Processes to ensure that participants are able to retain their housing during a hospitalization or nursing facility stay (e.g, by ensuring that a home maintenance deduction is made available in the computation of any patient pay liability so that the participant is able to pay rent/mortgage payments and utilities during a nursing facility stay); and 11) Follow-up activities to help the participant sustain community living, including in-home visits by the service coordinator within 24 hours of the participant's move to home, if the participant will be living alone or there is other indication of high risk.	Community Legal Service of Philadelphia
Requirements Document	Section V.L. - Nursing Home Transition	V.L., p. 44	NH Transition Services	When a participant enters a nursing facility and is not ready to return to the community after a short stay, the MCO must be required to continue to monitor the participant's situation or periodically reassess to see if changed circumstances now allow for a return to the community.	Community Legal Service of Philadelphia
Requirements Document	Section V.M.- Coordination of Services	V.M., p. 44	Coordination of Services	Revise the first sentence to read "The CHC-MCO must coordinate all necessary Medicare, BH-MCO and CHC-MCO covered services and other services for its participants." If not all participants will have person centered service plans, the language needs to be clarified to state that the CHC-MCO must coordinate all necessary covered services for all of its participants, not just those with a PCSP.	Community Legal Service of Philadelphia
Requirements Document	Section V.M.- Coordination of Services	V.M.1, pg. 44	CHC-MCO and BH-MCO Coordination	Because Medicare will be the primary payor for many participants' BH services, the Department	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O., p 46-58	Participant Enrollment and Disenrollment	We support the overall approach of the Department toward marketing in this section. We discuss this more below. However, we strongly encourage the Department to develop a robust review system of all marketing materials and to adopt a strong penalty system that discourages marketing violations by plans.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O., p. 46-58	Participant Enrollment and Disenrollment	We strongly support the prohibition on direct marketing activities. We have significant experience representing clients in Medicare Advantage plans. We have often seen clients change Medicare Advantage plans after a marketing agent enticed them with promises of additional benefits, only to learn that the plan did not include their providers in network or had prior authorization requirements that interfered with their care. Further, unlike Medicare Advantage plans, where you can pay more for smaller copays or additional services, the CHC-MCOs will generally be offering the same packages of services. By allowing plans to offer additional, non Medicaid required services, DOH is inviting competition between plans. These "extras" will become the focal point of differentiation of plans and will result in participants making selections based not on provider availability, etc., but on the promise of additional, non- mandatory benefits. That is why it is extremely important that any marketing materials make clear the repercussions of switching CHC-MCOs.	Community Legal Service of Philadelphia

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.3.d, pg. 48	Participant Enrollment and Disenrollment	We oppose the exception of allowing CHC-CHC-MCOs to market plans at "health fairs" or "community events." It is not clear why DOH has banned marketing in all other areas, some very similar to these settings, but are allowing it here. The purpose of marketing is to enroll new participants into their plans. Incentives, gifts, and promises can result in participants making changes that affect their care. A health fair is not an appropriate setting for a participant to make a decision about changing plans, especially when it could affect what providers she may use, what services require pre-authorization, and other significant care issues.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.3.f, pg. 48	Participant Enrollment and Disenrollment	The Department should require full disclosure about additional benefits. There should be informational materials provided to participants that compare plans and what "extra" services they offer. It should be made clear that changing providers could result in a change in providers, treatment, and pre-authorization requirements. It should be noted that the CHC-MCO can stop offering those extras at any time	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.3.f., pg. 48	Participant Enrollment and Disenrollment	Transparency in plan choice must be the keystone to accommodating participant selection. Because of the small number of CHC-MCOs, this is easily achievable by providing a complete description of all benefits offered by each plan.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.4, p. 50	LEP Requirements	CHC-MCOs must develop language access plans with comprehensive policies for serving LEP participants. Structured language access plans support an MCO's efforts to meet LEP participants' needs by establishing clear, standard procedures for interacting with LEP individuals. Policies must meet the Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS standards). These policies must be publicly available, and CHC-MCOs must educate staff members on procedures and periodically re-train staff.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.4., p. 50	LEP Requirements	This section should also clarify that oral interpretation must be provided for all languages. Further, in-person interpretation (whether through contracted interpreters or qualified bilingual staff) should be used whenever possible for face-to-face interactions. Telephonic interpretation, which is generally less preferred by LEP participants, should only be used when in-person interpreters are unavailable or when a participant calls a hotline. CHC-MCOs should document how they have provided interpretation for an LEP participant whenever the participant interacts with the CHC-MCO.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.4., p. 50	LEP Requirements	During all interactions with LEP participants, CHC-MCOs must generally be prohibited from using participants' friends and family members as interpreters, and the CHC-MCO must never use minor children under the age of 18 as interpreters. A participant may elect to use his or her own interpreter, but only after acknowledging that the CHC-MCO explained the participant's right to free interpretation provided by the CHC-MCO. This acknowledgement should be documented by the CHC-MCO for each encounter in which a participant uses his or her own interpreter. Further, the CHC-MCO must develop procedures for cases where there is reason to doubt the effectiveness of a third party interpreter (including not only a participant's own interpreter, but also a contracted interpreter)	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.4., p. 50	LEP Requirements	As for translated materials, how will the Department decide which languages are prevalent? We recommend that the Department define a "prevalent" language to be a non-English language spoken by 5% or 500 persons, whichever is less, of potential participants in a service area. This threshold, which combines guidance and regulations from federal agencies, would ensure that smaller but significant minority populations have access to documents in their languages. Further, when a CHC-MCO is aware that an LEP participant speaks a prevalent language, the CHC-MCO must automatically send translated materials. CHC-MCOs should also document requests for materials in non-English languages.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.4., p. 50	LEP Requirements	All notices and written information in English, meanwhile, must include large print taglines and information on how to request materials in alternative formats, as well as taglines in at least 15 languages informing individuals of the availability of oral interpretation and written translations.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.6. p. 51	Enrollment Procedures	While we agree with the Department that the CHC-MCO must have in effect written administrative polices for new enrollments, we strongly encourage the Department to provide more guidance to CHC-MCOs. As stated in the Agreement, it is unclear what the Department thinks is necessary policy for new enrollments. It seems strange to allow CHC-MCOs to each adopt their own policies, which will result in a lack of uniformity, which in turn may lead to participant confusion.	Community Legal Service of Philadelphia

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.11, p. 52-53	Participant Files	It is unclear in the "Daily File" section whether the CHC-MCO's inability to "reconcile" the daily file with its own information will lead to the loss of services or a delay in services for participants. If so, we oppose allowing the CHC-MCO 30 business days to notify the Department of the discrepancy. Irreconcilable information resulting in coverage gaps, loss, or cuts should be prioritized and fixed within 24 hours.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.12 p. 53	Enrollment and Disenrollment Updates	We strongly urge DOH to require CHC-MCOs to have safeguards in place to ensure participants are not erroneously disenrolled.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.14. p 54	New Participant Orientations	We strongly suggest adding educational information on the prohibition against balance billing and how to file a complaint if a participant is balance billed.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.15. p 55	CHC-MCO Identification Cards	Identification cards for dual eligibles should reflect that providers may not balance bill participants. Currently, balance billing is a significant and widespread problem for dual-eligibles. Protections must be worked into identification cards and CHC-MCO provider contracts. A clear statement on the back of an insurance care will notify providers of the balance billing prohibitions.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.15. p 55	CHC-MCO Identification Cards	This section also highlights the obvious confusion that will result for participants. They could have as many as 5 different insurance cards, if they are on Medicare Parts A ,B, and D. As we noted before, the Agreement does not provide enough information on just how the Department expects coverage to be coordinated when the participant is a Medicare recipient.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.17 p. 56	Provider Directories	Many LTSS recipients will not have access to the internet. CHC-MCOs must be required to provide provider directories in paper form. These directories should be updated more than annually and mailed to LTSS recipients. Only requiring directories to be online, will cause many participants to be denied access to providers. Requiring the participant to request it will result in participants not receiving the directory.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.17 p. 56	Provider Directories	Medicare beneficiaries may see any provider that accepts their Medicare coverage. This must be made clear in the provider directory and in the participant handbook.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.0.18 p. 57	Participant Advisory Committee	We strongly support the creation of PACs. However, we urge the Department to take an active role in these committees. The attendance of Department staff at committee meetings, especially in the early period of the CHC program, will help to ensure that participants concerns are being addressed, and also that the Department is overseeing the CHC-MCOs compliance with this requirement. Member representation should be required to include all of the various populations served by the CHC-MCO, including older adults who utilize LTSS, younger individuals who utilize LTSS and dual eligibles.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.18 p. 57	Participant Advisory Committee	The Department should create a training curriculum for participants on PACs to ensure that they are educated about Community HealthChoices and feel comfortable providing feedback to CHC-MCOs and the state. Managed long-term supports and services is a complex topic, and participants will likely be unfamiliar with managed care jargon and issues such as Medicaid regulations and quality improvement measures. Participants without training might have difficulty understanding the information the CHC-MCOs report and feel hesitant raising their questions or concerns. Training will help empower individuals to participate fully in advisory committees.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.18 p. 57	Participant Advisory Committee	CHC-MCOs must also ensure that information they report out at PAC meetings are written and/or presented in accessible language and alternative formats. Interpreters should be available for those participants who are limited English proficient and/or have hearing impairments.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.18 p. 57	Participant Advisory Committee	An ombudsman should be established and participate in PACs. In its reports to the Department and public, the ombudsman should include an evaluation of CHC-MCOs' PAC meetings and how well CHC-MCOs address participant concerns.	Community Legal Service of Philadelphia

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.18 p. 57	Participant Advisory Committee	Further, PAC meetings should be facilitated by a participant, participant representative, or the ombudsman and include a fixed minimum time for participant questions and concerns.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.18 p. 57	Participant Advisory Committee	Minutes of the PAC should be provided to the Department and made public on the CHC-MCO website promptly after every meeting. Additionally, the CHC-MCO must copy the Department on all correspondence with the PAC.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.18 p. 57	Participant Advisory Committee	We are pleased that travel expenses for participants or their family members will be reimbursed, and that reasonable accommodations must be made to ensure in-person access to PAC meetings.	Community Legal Service of Philadelphia
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V.O.20 p. 58	Involuntary Disenrollment	We support the ban on involuntary disenrollment of participants in the cases cited in the contract. However, we strongly urge the Department to make clear the instances where involuntary enrollment is allowed. What are these situations? If the Department does allow involuntarily disenrollment it must detail what reasons are allowed. Additionally, the CHC-MCO must be made to demonstrate the facts supporting the disenrollment and the steps taken by the CHC-MCO to address the behavior or issue. A participant must have an opportunity for a fair hearing challenging the disenrollment.	Community Legal Service of Philadelphia
Requirements Document	Section V.P. - Participant Services	V.P., p. 59	Participant Services	The first sentence of last paragraph is missing words and does not make sense as written. This paragraph should further provide that in the event that the participant is calling about an urgent situation or an emergency, the service coordinator or other MCO staff must respond as quickly as is necessary in order to address the issue.	Community Legal Service of Philadelphia
Requirements Document	Section V.P. - Participant Services	V.P., p. 60	Participant Services	We recommend that the Department clarify that 85% of calls being answered within 30 seconds must be answered by a person and not a recording, and that the person be an one who can address the caller's issue (as opposed to placing the caller on hold).	Community Legal Service of Philadelphia
Requirements Document	Section V.X.- Administration	V.X.7.p, pg. 81	Program Outcomes and Deliverables	V.X.7.p. references Section VI of the agreement, concerning Program Outcomes and Deliverables, which was not included in the material released for review. This section should be released for public comment and review, since CHC program outcomes and deliverables are a key element.	Community Legal Service of Philadelphia
Requirements Document	Section V.AA. - Selection & Assignment of PCPs	V.AA., pp. 82-84	Selection and Assignment of PCPs	We are very concerned that participants with established and long term relationships with their PCPs will have to sacrifice those relationships because their PCP is not a CHC-MCO network provider. These relationships are extremely important to participants who have chronic and severe disabilities. The Department must create a mechanism that allows newly enrolled participants keep their PCP, if the PCP was a Medicaid provider. Requiring the CHC-MCO to attempt to contract with that provider is not enough. If the provider does not wish to contract with the CHC-MCO, the Department must have a process that allows the participant to maintain that relationship indefinitely.	Community Legal Service of Philadelphia
Requirements Document	Section V.AA. - Selection & Assignment of PCPs	V.AA., pp. 82-84	Selection and Assignment of PCPs	The problem of provider loss also highlights the necessity of requiring CHC-MCOs to match or increase current provider payments in order to create an incentive for providers to contract with the CHC-MCO. The increased costs for providers of navigating new prior authorization and billing systems will discourage them from contracting with a CHC-MCO, unless the payment they receive covers those costs.	Community Legal Service of Philadelphia
Requirements Document	Section V.AA. - Selection & Assignment of PCPs	V.AA., pp. 82-84	Selection and Assignment of PCPs	Additionally, it must be made clear that Medicare recipients may see any provider that accepts their Medicare coverage.	Community Legal Service of Philadelphia

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Requirements Document	Section V.DD. - Provider Network	V.DD., pp 88-94	Provider Network	We strongly support requiring MCOs to enroll in its provider network all willing and qualified LTSS providers that provide HCBS through the current waivers. As noted in the agreement, this is crucial to allow participants to maintain their current services with their current provider, with whom many participants have built long-term relationships of trust and mutual understanding. It will be essential for the Department to monitor the rates set by MCOs in relation to this provision, to ensure that it is not nullified by unreasonably low rates. **Thus any willing provider provision must remain in effect for longer than 180 days,** as the 180 day limit will simply postpone disruptions in services which will occur if the MCOs are permitted to drop providers at its expiration. This period should remain in effect for at least one year, and we urge the Department to follow Wisconsin's lead in requiring MCOs to contract with any qualified LTSS provider who will meet the guidelines and accept the rates of the MCO. In particular, MCOs should be required to contract with community-based organizations such as Area Agencies on Aging and Centers for Independent Living which are well integrated into local communities and have long been a crucial and trusted part of Pennsylvania's LTSS infrastructure for large numbers of consumers.	Community Legal Service of Philadelphia
Requirements Document	Section V.DD. - Provider Network	V.DD., pp 88-94	Provider Network	"For NF… accord": should be clarified to make clear that hospitalizations or brief absences to stay with family do not count as leaving the facility. The Department should scrutinize rates set by the MCOs for out of network nursing facilities to ensure that they are adequate and at least as high as in-network nursing facility rates or fee for service Medicaid payments, so that participants are not driven from their nursing homes because the facility will not accept an insufficient rate. Language should also be added to make it clear that the right to remain in a nursing facility for the duration of the participant's need continues to apply if the participant later switches to a different MCO.	Community Legal Service of Philadelphia
Requirements Document	Section V.DD. - Provider Network	V.DD., pp 88-94	Provider Network	"The CHC-MCO must establish and maintain adequate Provider Networks to serve all of the eligible CHC population in each CHC zone covered by this greement (sic). Provider Networks must include all Covered Services": add "and capacity must be adequate to ensure that LTSS, including HCBS, are available 7 days per week, at any hour of the day and for any number or combination of hours, as dictated by participants' needs".	Community Legal Service of Philadelphia
Requirements Document	Section V.DD. - Provider Network	V.DD., pp 88-94	Provider Network	Add "The CHC_MCO must provide a comprehensive network to ensure that its membership has access at least equal to, or better than community norms. Services shall be equally accessible to CHC-MCO participants in terms of timeliness, amount, duration and scope as those available to non-CHC-MCO participants within the same service area."	Community Legal Service of Philadelphia
Requirements Document	Section V.DD. - Provider Network	V.DD.3, p. 90	Provider Network	Edit to read: "CHC-MCOs and Network Providers must [understand] ensure that racial, ethnic, linguistic, and cultural differences between Provider and Participants [cannot be permitted to] do not present barriers…"	Community Legal Service of Philadelphia
Requirements Document	Section V.DD. - Provider Network	V.DD.5, p. 91	Provider Network	There appear to be missing words in text preceding the bullet points.	Community Legal Service of Philadelphia
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access		Provider Network Comp/Service Access	Require significant outreach to providers and education by providers.	Community Legal Service of Philadelphia
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access		Provider Network Comp/Service Access	Language should be added requiring plans to undertake a comprehensive LTSS needs and capacity assessment prior to implementation of CHC and update it annually, to provide information on community health and LTSS needs, health disparities, existing resources, typical patterns of service utilization, and barriers to living safely and independently in the community. The plan should be submitted to the Department for review and approval, and should be made publicly available. The needs and capacity assessment and any resulting transitional plans should be conducted and developed with input from the Participant Advisory Committee. Plans should then be required to use this information to assess whether their provider networks are sufficient to meet members' needs in their local communities. Where capacity is underdeveloped, MCOs should be required to develop transitional plans with specific targeted timelines to strengthen network capacity as needed beyond the stated minimum standards. These plans might require CHC-MCO activities to stimulate and support provider workforce development to address barriers over time. The needs assessment must be updated annually to determine whether access to providers, as well as contracted providers' capacity to provide all necessary services, remains adequate and/or improves over time, and to what degree contracted HCBS providers are integrated in the community.	Community Legal Service of Philadelphia

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Requirements Document Exhibit	C - Requirements for Provider Terminations		Requirement for Provider Terminations	Our greatest concern in this section is the harm to participants as the result of one of their providers being terminated. There is no discussion at all in this section, or in the Agreement, as to why and when an CHC-MCO may terminate a provider. We strongly urge the Department to create a narrow list of situations where a provider may be terminated and to put the burden on the CHC-MCO to prove to the Department that the provider meets one of the criteria. Allowed situations should only be fraud and inadequate or harmful care. Unless the Department imposes strict and specific criteria, participants will constantly be at risk of losing providers because the CHC-MCO has decided to terminate them from their plan.	Community Legal Service of Philadelphia
Requirements Document Exhibit	C - Requirements for Provider Terminations		Requirement for Provider Terminations	Unless the provider has been terminated for fraud or poor/harmful care, the participant must be allowed to keep that provider indefinitely, as long as that provider continues to participate in Medicaid. Alternatively, if the provider continues to be in the network of another CHC-MCO the terminating CHC-MCO must work with the participant to have her transferred to the other CHC-MCO, if she so chooses.	Community Legal Service of Philadelphia
Requirements Document Exhibit	C - Requirements for Provider Terminations		Requirement for Provider Terminations	The Department should monitor all proposed terminations and analyze the affect it will have on participants within that CHC-MCOs network. The ultimate decision to terminate a provider should be reserved for the Department, so it is ensured that the best interests of participants are considered	Community Legal Service of Philadelphia
Requirements Document Exhibit	C - Requirements for Provider Terminations		Requirement for Provider Terminations	Additionally, it needs to be made clear that Medicare recipients may see any provider that accepts their Medicare coverage, regardless of whether the provider is participating in the network or was terminated from the network.	Community Legal Service of Philadelphia
Requirements Document Exhibit		Exhibit U	Behavioral Health Services	A work group is urgently needed to create guidelines describing which entity is responsible for behavioral health services in various possible scenarios and settings, and what specific coordination activities the CHC-MCO will be responsible for. For example, who will be responsible for providing behavioral health services to participants in nursing facilities? Since no mental health or drug and alcohol services will be covered by the CHC-MCOs, it is not at all clear that their payments to nursing facilities will cover these services. Indeed, since no funding for these services is included in the capitated rate paid to CHC-MCOs, their payments to nursing facilities cannot be expected to cover them at a level which will ensure meaningful access to behavioral health care. On the other hand, BH-MCOs generally do not provide services to nursing facility residents. Which entity and funding source will be responsible for providing behavioral health services in this situation? If the BH-MCO will be responsible, will the CHC-MCO be responsible for coordinating those services? Will procedures be created so that BH-MCOs will be prepared to provide behavioral health services for nursing facility residents? These are critically important issues to resolve, since the CHC-MCO population includes many nursing facility residents with behavioral health needs, as well as behavioral health consumers who need nursing facility care but have not been able to find a facility willing to admit them.	Community Legal Service of Philadelphia
Requirements Document Exhibit	DD - Participant Handbook	7	Participant Handbook	One of the greatest challenges facing dual eligibles is balance billing. Despite recent CMS guidance, providers continue to illegally balance bill dual eligibles. We appreciate the inclusion of a statement that no balance billing is allowed. We urge the Department to require an in depth explanation of what balance billing is and how it is prevented. Further, participants should be provided with educational documents they can bring to providers who continue to illegally balance bill. The Department needs to create a complaint mechanism and a penalty system for balance billing. Currently, providers balance bill, even knowing that is illegal, because they face no penalties for doing so. Oftentimes, these balances end up in collections. Balance billing causes stress to dual eligibles, as they are low-income and cannot afford to pay. It leads to negative health outcomes.Both the department and the CHC-MCO must create educational materials to provide to providers and also strictly enforce the federal protections afforded to dual eligibles.	Community Legal Service of Philadelphia
Requirements Document Exhibit	DD - Participant Handbook	14	Participant Handbook	When a CHC-MCO is aware that a participant is limited English proficient, the CHC-MCO must send translated materials automatically rather than just at the affirmative request of the participant.	Community Legal Service of Philadelphia
Requirements Document Exhibit	DD - Participant Handbook	25	Participant Handbook	We strongly oppose allowing an CHC-MCO to deny payment for medically necessary care based on moral or religious grounds. What current Medicaid services could be denied because of moral or religious grounds? If an CHC-MCO denies coverage based on moral or religious grounds the Department must immediately cover the service, and not require the participant to become involved in a moral or religious dispute with the CHC-MCO. Strong guidelines and procedures must be in place beforehand to ensure protection of participants	Community Legal Service of Philadelphia

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Requirements Document Exhibit		Exhibit EE	Confidentiality	Participants should be able to designate another party to receive copies of the notices and information that the participant receives from the CHC-MCO and to speak with plan staff about the participant's coverage, services, care needs or other issues. This is important in cases where a participant has a cognitive impairment and needs the assistance of a family member or other trusted person designated by the participant to manage their health care, LTSS or coverage. Policies will also be needed to allow surrogate decision makers such as agents under a power of attorney, guardians, or health care proxies to receive information and take actions on behalf of participants.	Community Legal Service of Philadelphia
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes		Appeals and Grievances	We are pleased that the Department will form a stakeholder focus group on the grievance and appeals process, and we hope to provide more input at a later date through that group.	Community Legal Service of Philadelphia
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	A	Appeals and Grievances	We recommend that this section include an explanation of due process and why it is important. Advocates' and consumers' experiences in other states show that MCOs routinely violate participants' due process rights, possibly due to a lack of understanding of constitutional due process requirements. (We can recommend specific language at a later date.)	Community Legal Service of Philadelphia
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	A	Appeals and Grievances	This overview of general requirements should also explicitly state that in all situations involving aid paid pending, continued benefits should not be limited by the length of the original authorization period. A frequent problem seen in other states is MCOs only continuing services through the end of a pre-existing authorization rather than through the resolution of an appeal.	Community Legal Service of Philadelphia
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	A	Appeals and Grievances	This section should also note that CHC-MCOs must not take punitive action against the participant because he or she files a complaint or grievance.	Community Legal Service of Philadelphia
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	A	Appeals and Grievances	Additionally, advocates and participants should be able to review templates for notices, which must meet the requirements of 42 C.F.R. §§431.210 and 438.404 (specifying information that must be included in notices), as well as 438.10(c), (d), and 438.404(a) (explaining language and format requirements). Notices should also include information on how participants can access legal help for their appeals.	Community Legal Service of Philadelphia
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	D.1.d	Appeals and Grievances	Again, the agreement should make clear that CHC-MCOs must continue services pending a fair hearing decision regardless of whether an authorization period has expired. Because current federal regulations only require plans to continue services through the end of an authorization period (42 C.F.R. §438.420), a troubling but common practice among MCOs in other states has been to wait to reduce/terminate services until an authorization period is over, then fail to provide aid paid pending. Or, as previously mentioned, MCOs sometimes do continue services, but only until the end of an original authorization. These recurring problems violate a participant's constitutional right to receive continued services while waiting for a hearing decision.	Community Legal Service of Philadelphia
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	E.2	Appeals and Grievances	We appreciate that participants will not be liable for services that were continued during the complaint/grievance/fair hearing process.	Community Legal Service of Philadelphia
Requirements Document Exhibit	PP - Provider Manuals		Provider Manuals	We are concerned that there is nothing in this section requiring CHC-MCOs to educate providers on the prohibition of balance billing. Language should also be added regarding the freedom of choice for Medicare beneficiaries. It should also explain more about the interaction of Medicare and Medicaid, particularly Part D.	Community Legal Service of Philadelphia
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access		Provider Network/Service Area	In developing its provider networks, CHC-MCOs should also track the accessibility and language needs of its participants. CHC-MCOs should build its provider networks accordingly so that participants' needs will be met. Provider directories should note for each provider any languages spoken or available accommodations, and CHC-MCOs should verify that this information is accurate. CHC-MCOs must also ensure that all network providers meet their obligations under Title VI of the Civil Rights Act; Section 1557 of the Affordable Care Act; Title II of the Americans with Disabilities Act; Section 504 of the Rehabilitation Act of 1973; and other relevant laws and regulations. (The CHC-MCO itself, of course, must meet these obligations as well.)	Community Legal Service of Philadelphia

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Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	(3)-(6)	Provider Network/Service Area	Amend second bullet point: "The expected utilization of services, taking into consideration the characteristics and needs, including the language access needs, of specific Medical Assistance populations represented in the CHC-MCO.Add to the list of bullet points: "The preferences and existing provider relationships of participants in the service area".	Community Legal Service of Philadelphia
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	(3)-(6)	Provider Network/Service Area	AAA(3)-(6) Add to last paragraph: "For the purposes of the time frames set forth in this exhibit, a provider is to be considered available only if she or he is actively accepting employment or patients and can meet the participant's needs".	Community Legal Service of Philadelphia
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	(3)-(10)		ADA Accessibility Guidelines: Add requirement that CHC-MCO ensure that providers' offices are also programmatically accessible, e.g., in terms of equipment such as examination tables.	Community Legal Service of Philadelphia
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	(3)-(11)		Appointment Standards: "The CHC-MCO will require the PCP, dentist, [or] specialist or LTSS provider to conduct affirmative outreach...".	Community Legal Service of Philadelphia
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access			This section should be amended to add network adequacy standards other than time or distance for LTSS provider types that travel to the enrollee to provide services, as provided in proposed 42 C.F.R. §438.68(b)(2)(ii). While this proposed regulation is not yet in effect, it represents CMS' current thinking on best practices and make sense, since participants do not travel to these providers. These standards should include adequate capacity to ensure that LTSS, including HCBS, are available 7 days per week, at any hour of the day and for any number or combination of hours, as dictated by participants' needs. The timeliness of starting services is another element of LTSS network adequacy. The LTSS network adequacy standard should also consider travel distances from the homes of direct care workers to participants' homes, where the services will be provided.	Community Legal Service of Philadelphia
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access			A specific standard for nursing facilities should be added. While two providers may be reasonable for remote rural areas, it is insufficient in urban areas. The Department should consider setting a standard based on numbers of nursing facility beds per CHC-MCO enrollee. The standard should also require that MCOs contract with nursing facilities which meet specified quality standards, such as the Medicare star ratings.	Community Legal Service of Philadelphia
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access			An additional section requiring CHC-MCOs to ensure access to home visiting doctors (or nurse practitioners) should be added, because many LTSS consumers are homebound and rely upon practitioners who perform home visits for their primary or specialist medical services.	Community Legal Service of Philadelphia
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access			Add language explicitly stating that professional qualification standards and credentialing practices cannot supplant or interfere with the participant's right to hire, train and supervise personal assistance providers of his or her choice.	Community Legal Service of Philadelphia
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	(4)c		references Section VIII.H of the agreement, concerning Sanctions, which is not included in the material which was released for review. This section should be released for review. It is crucial that the agreement contain a range of remedies, including intermediate remedies, capable of ensuring compliance by the CHC-MCOs with all requirements.	Community Legal Service of Philadelphia
Requirements Document Exhibit	CCC - Provider Agreements	1st Paragraph		1st para: "The CHC-MCO is required to have written Provider Agreements with a sufficient number of Providers to ensure Participant access to all Medically Necessary services and all LTSS benefits covered by the Community HealthChoices Program".	Community Legal Service of Philadelphia
Requirements Document Exhibit	CCC - Provider Agreements	d		A requirement that the CHC-MCO must not exclude a Provider from the CHC-MCO's Provider Network because the Provider advocated on behalf of a Participant for Medical Necessary and appropriate healthcare or for needed LTSS services….	Community Legal Service of Philadelphia
Requirements Document Exhibit	CCC - Provider Agreements	g		"The definition of Medically Necessary and the eligibility criteria for LTSS as defined in Section II of this agreement, Definitions".	Community Legal Service of Philadelphia

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Requirements Document Exhibit	CCC - Provider Agreements	h.		Add language extending this protection to providers discussing participants concerning needed LTSS.	Community Legal Service of Philadelphia
Requirements Document Exhibit	CCC - Provider Agreements			Provisions should be added requiring participating hospitals and nursing facilities to ensure that participants' needs are appropriately assessed prior to discharge and that a transition plan has been developed, in cooperation with the MCO, which meets all of the agreement's requirements for proper transition planning.	Community Legal Service of Philadelphia
Requirements Document Exhibit	CCC - Provider Agreements			We also urge the Department to require CHC-MCOs to include in the provider agreements an agreement that the provider will not balance bill. Provider education is the cornerstone in preventing this illegal practice. The agreement should also contain what penalties to which a provider will be subject, if she does balance bill a participant.	Community Legal Service of Philadelphia
Requirements Document Exhibit	CCC - Provider Agreements			The agreement should require CHC-MCOs to fully disclose the billing and prior authorization processes for the CHC-MCO. The Department should require these processes to be as uniform as possible. One of the chief findings of a study done in December 2013 by the US Department of Health and Human Services, was that providers had increased costs because of administrative red tape, the variety of different billing systems and procedures for different Medicaid MCOs, and problems obtaining prior authorization. See: https://aspe.hhs.gov/basic-report/how-have-long-term-services-and-supports-providers-fared-transition-medicaid-managed-care-study-three-states. Providers must be educated on these procedures.	Community Legal Service of Philadelphia
Requirements Document Exhibit	CCC - Provider Agreements			All provider agreements should be made public by the Department and accessible online or as a result of a request.	Community Legal Service of Philadelphia
Requirements Document Exhibit	DDD(1) - Covered Services List		Covered Services	Covered Services List: "Nursing Facility Services" and "Nursing Home Services" are both listed on the list, but Nursing Home Transition is not listed. Perhaps the latter is a typo, since Nursing Home Transition is defined and described further on in the exhibit.	Community Legal Service of Philadelphia
Requirements Document Exhibit	DDD(1) - Covered Services List		Covered Services	We are very pleased that Pest Eradication has been added as a service.	Community Legal Service of Philadelphia
Requirements Document Exhibit	DDD(1) - Covered Services List		Covered Services	We suggest adding assistance and coordination with the SSA funded benefits counselor/Certified Work Incentives Counselor (CWIC)- this could be added as part of the career assessment or job finding. Fear of losing benefits is a huge barrier to employment. Allowing payment to employment providers to connect people to the CWICs and assist with follow through with CWICs could be very helpful.	Community Legal Service of Philadelphia
Requirements Document Exhibit	DDD(1) - Covered Services List		Covered Services	We also suggest adding Education Support Services - tuition/fee for classes or apprenticeships for an employment related goal (when funding though IDEA or OVR doesn't cover)	Community Legal Service of Philadelphia
Requirements Document Exhibit	DDD(1) - Covered Services List		Covered Services	We also recommend adding moving assistance and home maintenance, as Hawaii has done. See: http://www.justiceinaging.org/wp-content/uploads/2015/05/Hawaii-RFP.pdf. Hawaii's managed long term care program provides moving assistance in rare instances when it is determined that a participant needs to relocate due to their home becoming unsafe due to deterioration, being wheelchair-bound in a building with no elevator, being evicted, or no longer being able to afford their current living environment. Covered moving expenses include packing and moving of belongings, where family or other third party resources are not available to provide these services without charge. Home maintenance services are services necessary to maintain a safe, clean and sanitary environment which are not included in personal assistance, such as heavy duty cleaning (to bring home up to acceptable standards of cleanliness at the inception of service to a participant) and minor repairs to essential appliances such as stoves, refrigerators and water heaters. This service is provided to participants who cannot perform cleaning and minor repairs without assistance and are determined, through an assessment, to require the service in order to prevent institutionalization.	Community Legal Service of Philadelphia

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Requirements Document Exhibit	DDD(1) - Covered Services List		Assisted Living	we are concerned that MCOs must not be permitted to place participants in assisted living facilities if the participants need and prefer nursing facility services. While assisted living facilities are allowed to serve some individuals who are nursing facility clinically eligible under their state licensure, they do not have the ability to safely serve all individuals who need nursing home level care. To that end, MCOs must be required to abide by the decision made by the Level of Care Determination Entity concerning a participant's need for nursing facility services, as is provided for on page 33 of the draft agreement. This decision must be appealable by the participant. We also feel extremely strongly that MCOs must not be permitted to place or serve nursing facility clinically eligible individuals in personal care homes, as the licensing regulations for personal care homes do not require the staff training, staffing, level of care, or building safety features needed to serve this higher need population. Moreover, personal care homes are prohibited by law from serving individuals who require the services in or of a nursing facility. 62 P.S. § 1001.	Community Legal Service of Philadelphia
Requirements Document Exhibit	DDD(1) - Covered Services List		Home Adaptations	We have routinely seen consumers who waited years for repairs to be made to stairglides, lifts and other equipment which was installed in their home through waiver programs. These consumers were trapped in their homes, unable to obtain regular medical care, isolated from community activities and at great risk in the event of fire. To prevent this from continuing to happen, we request that language be added requiring that repairs be made promptly, and that equipment be replaced (also on a timely basis) where it cannot be repaired. We would suggest one month as a reasonable period of time for repairs, except where more immediate repairs are needed due to urgent need	Community Legal Service of Philadelphia
Requirements Document Exhibit	DDD(1) - Covered Services List		Nursing Home Transition	The second sentence appears to be missing words after "that have resided in an institution for at least ninety (90) consecutive", probably "days" and then perhaps the verb "face" prior to "a barrier". The rest of this sentence is also confusing and perhaps is missing words. The first sentence of the second paragraph has an extra clause at the beginning (it's either mean to describe transition or pre-transition activities of the Nursing Home Transition Coordinator, but it says both). This whole definition appears to need some editing. It says that the Transition Coordinator is to work with Participants enrolled in Money Follows the Person – is this the full universe of individuals the coordinator would work with? It references the "Independent Enrollment Broker", which is pre-CHC terminology and not a term defined in the draft Agreement. Also, if these services are to be provided to individuals who are already enrolled in a CHC-MCO, it is not clear why the Transition Coordinator would need to act as a liaison with the Independent Enrollment Broker. Rather, language should be added about arranging for LTSS to be provided by the CHC-MCO after the transition. There is a reference to developing a "Community Living Plan", but this term is not defined, and there is no mention of it including LTSS. We are pleased, however, with the detailed language concerning the Transition Coordinator's role in helping to obtain housing and benefits. Peer support should be added to the Nursing Facility Transition service. Heavy duty cleaning and minor repairs to essential appliances such as stoves, refrigerators and water heaters should be provided, to the extent necessary to make the home safe and sanitary for the participant to return to.	Community Legal Service of Philadelphia
Requirements Document Exhibit	DDD(1) - Covered Services List		Personal Assistance Services	Home support services should be permitted as part of PAS, including light cleaning and laundry (beyond towels from bathing), where the participant is unable to perform these tasks and has no one else to do them for him or her. Also, we recommend the following edit to the last sentence: "Personal Assistance Services are provided by a Home Care Agency which must be licensed by the PA Department of Health, or by a qualified Individual Support Service Worker as defined in the current Attendant Care Waiver." This edit is intended to retain current practice in the consumer directed model and avoid staff shortage issues	Community Legal Service of Philadelphia

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Requirements Document Exhibit	DDD(1) - Covered Services List		Service Coordination	We support defining the support coordination function to include facilitating access to non-Medicaid funded medical, social, housing, educational and other services and supports. The service coordinator may be the sole person available to the participant to identify needs which threaten the participant's ability to remain in the community (such as utility shut-offs or threatened eviction or foreclosure) and connect the participant to community resources to try to resolve those threats. The service coordination role should accordingly be drawn broadly enough to include these crucial functions. We also support including assisting the participant with activities necessary to maintain Medicaid eligibility, since these processes can be confusing and difficult for functionally-impaired individuals. We would suggest adding language stating explicitly the Service Coordinator's role in coordinating coverage and services with a participant's Medicare Advantage plan or fee for service Medicare. Language should also be added requiring minimum contacts between the service coordinator and the participant of at least one telephone call or face-to-face visit per calendar quarter, and at least two face-to-face visits per year. The Department should also consider whether a ratio of participants to service coordinators should be utilized.	Community Legal Service of Philadelphia
Other		General Comment		Intent/Definition of Service Coordination-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program. One example of where this is important is when considering the continuity of care period. If service coordination is a provider service, the continuity of care period would definitely apply. If it is an administrative function, we are not sure if that provision would apply to service coordination.	Terry Barley, Director
Other		General Comment		Coordination of CHC Services with Behavioral Health Services- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	Terry Barley, Director
Other		General Comment		Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems- The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	Terry Barley, Director
Requirements Document	Section II - Definitions	p. 14	Participant Advisory Committee (PAC)- A group convened in person, at least quarterly by the CHC-MCO's governoring board which is open to all participants and which reflects the diversity of the CHC-MCO's Participant population.	Participant Advisory Committee Makeup - We recommend that the PAC meetings be formed for, and held in, each zone (for instances where MCO may cover more than one zone) and have representation for rural and urban counties in each particular zone.	Terry Barley, Director
Requirements Document	Section II - Definitions	p. 15	Person Centered Planning Team- The team of individuals that will participate in Person Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT	Person Centered Planning Team Makeup - We recommend OLTL include the minimum acceptable required individuals and also include other suggestions/preferences for individuals on the team. We also recomment that OLTL require that if there is a behavioral health diagnosis, a behavioral health representative be required on the team.	Terry Barley, Director
Requirements Document	Section V.A. - Covered Services	p.26	In-Home and Community -Based Services- The CHC- MCO may not deny personal assistance services for Participants under the age of 21 based on the Participant's diagnosis or because the need for personal assistance is the result of a cognitive imparment…	Personal Assistance Services - We recommend removing "under the age of 21" so that no conumer could be denied personal assistance services based on the participant's diagnosis or because the need is based on a cognitive impairment	Terry Barley, Director

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Requirements Document	Section V.A. - Covered Services	p.26	The CHC-MCO may not deny a request for Medically Necessary in-home nursing services, home health aide services, or personal assistance services for a Participant under the age of 21 on the basis that a live-in caregiver can perform the task…	In-home Nursing, Home Health Aide or Personal Assistance Services - We recommend removing "under the age of 21" so that no consumer could be denied under these circumstances.	Terry Barley, Director
Requirements Document	Section V.B. - Prior Authorization of Services	p. 36	B. Prior Authorization of Services 1.General Prior Authorization Requirements (4th paragraph) When the CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of denial using the appropriate notice outline in templates…	Notice of Service Denial - We recommend that when there is a denial of services for those in MLTSS, notification should also be sent to the Service Coordination Agency/entity to ensure continuity and follow up with consumer.	Terry Barley, Director
Requirements Document	Section V.B. - Prior Authorization of Services	p.37	2. Time frames for notice of Decisions	Notice of Service Decisions - We recommend that notice decisions should also be sent to Service Coordinator (entity) if additional information is needed from an MLTSS consumer the Service Coordination Agency should also be notified so they can assist the consumer in acquiring required documentation.	Terry Barley, Director
Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	Continuity of Care for LTSS Participants-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	Terry Barley, Director
Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	Terry Barley, Director
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	Limited English Proficiency Requirements- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	Terry Barley, Director
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	Management Information Systems-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	Terry Barley, Director

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Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		Intent/Definition of Service Coordinator-There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	Terry Barley, Director
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	Willing Provider Definition – In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	Terry Barley, Director
Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	Notification to Department – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	Terry Barley, Director
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	Complaints and Grievances – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	Terry Barley, Director
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	Definition of Travel Time – In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	Terry Barley, Director
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	Definition for Respite Care-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	Terry Barley, Director

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	Responsibility of Annual Level of Care Redetermination- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	Terry Barley, Director
RFP	General Information	p. 7, I-4: Problem Statement	Dual Eligibles age 21 or older	We request DHS please clarify the types of dual eligibles that will be included in the program, and if possible provide a list of Program Status Codes and Category of Need combination codes for those duals to be included. We will be submitting our internal eligibility crosswalk used for dual status verification prior to D-SNP enrollment.	UPMC Health Plan
RFP	General Information	p. 10, Enrolled Population	Projected enrolled population	We would request updated/more recent information in order to better inform planning, enrollment projections, staff head counts, etc. If possible please include detailed information by current waiver program and county, such as the distribution of participants across waivers, # of service coordinators, and overall spend.	UPMC Health Plan
RFP	Proposal Requirements	p. 27, Board Members	one-third of the board's membership must be "subscribers" of the CHC-MCO.	We would like clarification around what constitutes a subscriber. We would also recommend the one-third subscriber membership requirement apply to the licensed entity offering the CHC benefit.	UPMC Health Plan
RFP	Proposal Requirements	p. 27, Subcontracts	Provide a description of each subcontractor with responsibilities related to the provision of services to Participants including, but not limited to, the provision of medical services and LTSS, and Participant services and administrative support	Please provide clarification of when the subcontracts will need to be executed by (e.g. RFP due date, readiness review, etc.)	UPMC Health Plan
RFP	Work Statement	p. 33, Service Integration	Provide your model of care and an explanation as to how it aligns with your Dual Eligibles Special Needs Plans (D-SNP) model of care. Please attach your D-SNP model of care.	We would like clarification that this refers to the D-SNP model of care as the MOC to be submitted. We would recommend one MOC for both D-SNP and the CHC, or an LTSS addendum to the D-SNP MOC, rather than requiring an entirely new MOC.	UPMC Health Plan
RFP	Work Statement	p. 49, B. Small Diverse Business Participation	A significant commitment is a minimum of 5% of the average Administrative PMPM	Since many current HCBS providers are diversity-owned, we would recommend spend on direct care providers count as Small Diverse Business spending.	UPMC Health Plan
Requirements Document	Section V.A. - Covered Services	p. 29, 8. Pharmacy Services	The CHC-MCO must provide pharmacy services for all other Participants	Please confirm Medical Assistance capitation will include pharmacy.	UPMC Health Plan
Requirements Document	Section V.A. - Covered Services	p. 32, 15. Transportation	The CHC-MCO must provide all Medically Necessary emergency ambulance transportation, all Medically Necessary non- emergency ambulance transportation, and non-medical transportation.	We would request DHS provide additional clarification around Medicaid-covered non-medical transportation. Will there be any limits e.g. distance or # of trips? Is there any criteria around which activities may be specified in the PCSP? How will this be capitated?	UPMC Health Plan

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Requirements Document	Section V.A. - Covered Services	p. 32, 15. Transportation	All other medical transportation for Participants to and from Medicare and/or CHC Covered Services must be arranged through the MATP.	Please confirm that MATP funding will continue to flow through counties. We also wish to express concern MATP may be problematic for some of the population, who may require special accommodation or door-to-door service. We also request that DHS provide clarification around the new service requirement for non-medical transportation. This is of particular importance since transportation is currently not offered across all waivers consistently.	UPMC Health Plan
Requirements Document	Section V.E. - Needs Screening	p. 40, E. Needs Screening	Upon Enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department…	Please provide further clarification around the assessments. Will DHS or MCOs develop the assessment tool? Which needs assessment would determine participant level of care? We recommend a core set of questions set by the Commonwealth, so data can be standardized and easily shared across CHC MCOs, but plans should be able to add additional questions as needed. The comprehensive needs assessment should flow seamlessly from the original needs screening to avoid redundancy.	UPMC Health Plan
Requirements Document	Section V.E. - Needs Screening	p. 40, E. Needs Screening	Any Participant whose needs screening reflects unmet needs, service gaps, or a need for Service Coordination will be referred for a comprehensive needs assessment.	We would like further guidance around the possible scenarios or participant characteristics that would trigger a "need for Service Coordination."	UPMC Health Plan
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	p. 40, F. Comprehensive Needs Assessments and Reassessments	The comprehensive needs assessment will be completed by a Service Coordinator…	What is the time frame for a comprehensive needs assessment? Would it be possible to get a table summarizing all required screening time frames?	UPMC Health Plan
Requirements Document	Section V.G. - Person Centered Planning Team Approach	p. 43, J. Service Coordination	Service Coordinators are responsible for assisting Participants in obtaining the services that they need.	We would like clarification on whether or not service coordination is considered a service and if it would be subject to the continuity of care requirements. We recommend it be treated separately and delicately. First and foremost, many SCEs will know participant needs very well and have invaluable insight during the continuity period. However, a 6 month continuity period may not be the best and only mechanism for knowledge transfer. CHC-MCOs will be at full risk for program costs. A 6 month continuity period where CHC-MCOs do not have full service planning responsibility could greatly undermine the integrity of the system and create duplicative investment in ramp-up without additional funding. Moreover, the feasibility of each SCE adopting each CHC-MCOs unique model of care when many may not be offered long-term contracts may prove expensive and untenable. Effective knowledge transfer may be accomplished through a shorter period of time and is best early in implementation, as staff retention will be especially difficult during this 6 month period for SCEs that are not continuing services. If DHS ultimately decides to move forward with a no change policy in service coordination and service plan for 6 months, the payment to CHC-MCOs needs to be FFS.	UPMC Health Plan

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	p 44, K. Service Coordinator and Service Coordinator Supervisor R equirements	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology or other related field and at least three years of experience in the coordination of services. All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience.	We ask that DHS reconsider the minimum requirements of this section and take into account that other relevant experience will allow individuals lacking these specific requirements to be just as successful in the role of service coordinator. In addition, it's important to note the service coordinator will be a part of the CHC-MCO's interdisciplinary care team which will contain individuals with experience and background that will cover all applicable disciplines (e.g. physical health, mental health, pharmacy, lifestyle changes, etc.).	UPMC Health Plan
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	p. 46, 1. General	The Participant has the right to initiate a change in CHC-MCO's plans at anytime.	Please clarify what is meant by "anytime." We feel some consideration could be given to members switching their Medicare plans to improve alignment, which is permitted monthly for duals. However, the ability to switch anytime will most certainly result in service disruption, provider issues, and undo continuity burdens.	UPMC Health Plan
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	p. 46, 2. CHC-MCO outreach materials	The CHC-MCO must develop outreach materials	Will the materials be educational or marketing? Are the PCP outreach materials intended to focus beyond the Medicaid-only membership? Where possible, the Commonwealth should avoid duplicating Medicare functions and rules.	UPMC Health Plan
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	p. 50, Limited English Proficiency Requirement s	CHC-MCO must make all vital documents … available in the prevalent languages.	Please confirm CHC prevalent languages will mirror those currently in HealthChoices.	UPMC Health Plan
Requirements Document	Section V.P. - Participant Services	p. 59, Participant Services	The Service Coordinator must return the call as soon as possible but no longer than two (2) business days from the receipt of the call.	We recommend that this be generalized so that any service coordinator or plan representative may return the call. Otherwise the requirement could be difficult to satisfy if there's a team based system, an extended leave of absence by a given SC, etc.	UPMC Health Plan
Requirements Document	Section V.P. - Participant Services	p. 60, 4. Education and Outreach/He alth Education Advisor Committee	The CHC-MCO must establish and maintain a Health Education Advisory Committee that includes participants and providers	Similar to the participant advisory board, we recommend this requirement apply to the licensed entity offering the CHC benefit.	UPMC Health Plan
Requirements Document	Section V.CC. - Provider Services	p. 85 CC Provider Services p. 86, 1. Provider Education	Provider	As a general rule, the Commonwealth should duplicate Medicare requirements for like Medicaid-covered CHC benefits and minimize adding different rules to areas already covered by Medicare or HealthChoices. The Commonwealth should clearly define provider when used interchangeably between CHC-covered Medicaid medical services, Medicaid HCBS services, and Medicare services. It is unclear when a requirement would apply to all areas or those contained within this RFP.	UPMC Health Plan

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Requirements Document Exhibit	DD - Participant Handbook	p. DD-, CHC-MCO Participant Handbook	CHC-MCO must ensure that the Participant handbook contains…	We request the Commonwealth provide model documents.	UPMC Health Plan
Requirements Document Exhibit	DDD(1) - Covered Services List	Exhibit DDD(1)	Covered Services List	Will there be any new covered services in CHC that are not currently covered in the waiver programs?	UPMC Health Plan
Other				Due to the close alignment with D-SNP, we request whenever possible DHS uses already established Medicare requirements (e.g. MOC, NCQA, etc.) to avoid unnecessary duplication of work.	UPMC Health Plan
Other	Brain Injury			My comments are general in nature and do not fit the Excel spreadsheet format that has been designed. I hope that they will still be considered. I would like to focus on the obstacles that this RFP presents to a considerable number of Pennsylvanians because of the unique nature of both their challenges and their needs. One of the major concerns that I have is that this document, and the process that it defines offers insurmountable barriers to those Pennsylvanians who deal with the cognitive and communication difficulties created by a brain injury. Yet there is no obvious effort to offer the supports that would aid these citizens in identifying and qualifying for appropriate short and long term care choices. The RFP contains the definitions of a number of terms that indicate a need for clear and concise communication. Terms such as "Enrollment Brokers", "Grievance Process Personnel", "Independent Enrollment Entity", "Service Coordinators", "Person Centered Planning Team", Prior Authorization Review Panel"; and processes such as the "Participant Complaint, and Grievance .." indicates that this entire process is, of necessity, rampant with a need for the participant to be able to understand and . comprehend a considerable amount of information. Without having personnel in the processes of enrollment, selection, grievance etc., who are trained in how to effectively communicate with persons who have sustained a brain injury these persons will likely not be able to connect with needed services. Persons who have sustained an ABI offer unique individual capabilities and challenges . Each person is unique in their ability to communicate and in their needs, medical and rehabilitative (long term and short term). An appropriately trained person will be able to effectively communicate and identify the qualifications and needs of the client. However, this RFP does not indicate that these critical people will receive any training on how to communicate with persons who have sustained an ABI. The RFP states, in a number of places, that participants must be provided with access to all relevant documentation. Iam certain that this documentation will be available to a number of disability groups who require accommodations to read and understand it, and to persons who speak languages other than English, however, I see no mention of assistance for persons who have sustained an Acquired Brain Injury.	Pennsylvania Brain Injury Coalition Michael J. Miller, Chairman

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Requirements Document	Section V.D. - Choice of Provider			Despite the extensive and complex interplay of programmatic factors already identified in the Draft CHC Agreement, we believe further amplification is necessary regarding the role of the informal family caregiver, who will be in the home on a dayto-day basis silently assisting the Community HealthChoices Managed Care Organizations (CHC-MCOs) in a multitude of untold and critically necessary ways. The proposal contains no definition of "family caregiver" and we fervently believe this type of voluntary and totally "free" care from family and friends will be paramount to the success of the CHC program. Our goal at the United Way of SW PA continues to be focused on ensuring that informal family caregivers are acknowledged and given a significant voice in the rollout and implementation of the CHC program, as well as to support caregivers programmatically for the sacrifices they make while taking care of their loved ones	Heather Sedlacko Director, Programs for Seniors and People with Disabilities
RFP	Proposal Requirements			The Term of Agreement provides that the SW zone agreements will commence on 1/1/17 and will have a five (5) year term, with an option to extend. The SE Zone agreements will have a four (4) year term. The LC, NW and NE zone agreements will This pilot phase is of particular interest to the United Way of Southwestern PA, since our community will be the first to implement Community HealthChoices. Locking in a five year term for the SW could hamper the ability of the CHC-MCOs to evolve and improve service delivery in SW PA as the Commonwealth learns more about how the program actually works. Additional flexibility is required so information gained through this formative process can be implemented in the SW zone through modifications to original program design. Due to the quick nature of the rollout, many first-impression gains are anticipated, which will be critical to the success of local and statewide implementation. By serving as the "test" zone, Allegheny County and the entire SW Zone do not want to be hampered by requirements that ultimately prove inadequate or outdated. An allowance for program improvements discovered or devised going forward must be ensured, especially since SW zone agreements have a lengthier five (5) year term. have a term of three (3) years	Heather Sedlacko Director, Programs for Seniors and People with Disabilities
Requirements Document	Section V.J. - Service Coordination			With regard to Service Planning and Coordination, we are pleased to note that service plan development and implementation must be "person-centered." We believe this will be crucial to achieving acceptance and effectiveness within the program. We also note that the choice of provider includes "choice of service coordinator." We continue to urge that the Area Agencies on Aging be eligible to perform this work, which they currently do extremely well in many areas of the Commonwealth. We also recommend that the Area Agencies on Aging be authorized to conduct "Needs Screening and Needs Assessment" through the standardized tool approved by the Department of Human Services. We believe the AAAs have invaluable expertise and experience that will help facilitate the assessment process	Heather Sedlacko Director, Programs for Seniors and People with Disabilities
Requirements Document	Section V.E. - Needs Screening			As part of the Needs Identification and Screening Process, we are gratified that the comprehensive needs assessment must include the Participant's caregiver needs, as well as the availability of informal supports and supports for unpaid caregivers. We recommend that the assessment be further revised to include a review of the physical and behavioral health needs of the caregiver, due to the extreme physical and mental toll that caregiving can take on the caregivers themselves.	Heather Sedlacko Director, Programs for Seniors and People with Disabilities

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Requirements Document	Section V.G. - Person Centered Planning Team Approach			With regard to the direct impact that the CHC Long Term Services and Supports Benefits have on family caregivers, we were pleased to see that Home Delivered Meals, Non-Medical Transportation and Respite Services were included on the list. We do, however, have some concerns with the limited scope and definition of those services. Home delivered meals are rightfully available for participants, but there is no mention of their caregivers, who may be so exhausted from providing care that they fail to properly nourish themselves	Heather Sedlacko Director, Programs for Seniors and People with Disabilities
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments			We would suggest that some assessment of necessity and appropriate accommodation be made in these types of situations, as this will enable continued delivery of care to the Participant. It is also unclear whether Non-Medical Transportation is available for a family caregiver who needs to accompany a Participant in connection with a specified objective identified on the Participant's service plan. Respite services are made available but only in quarter hour units to support individuals on a short term basis due to the absence or need for relief of unpaid caregivers normally providing care. It would seem more reasonable to regularly schedule respite services for family caregivers on a weekly or biweekly basis, so they can plan ahead for completing necessary personal tasks and to replenish themselves emotionally	Heather Sedlacko Director, Programs for Seniors and People with Disabilities
Other	Covered Benefits			Another CHC LTSS benefit we would like to address is the availability of Therapeutic and Counseling Services on behalf of the participant as a means of resolving individual or social conflicts and family issues. We suggest that these types of therapeutic and counseling services be made available to family caregivers if necessary, particularly those who are providing care for family members with Alzheimer's Disease and other Related Cognitive Disorders. Providing care of this nature can often have debilitating effects	Heather Sedlacko Director, Programs for Seniors and People with Disabilities
RFP	Work Statement Questionnaire			The Work Statement Questionnaire for the CHC-MCOs is a comprehensive compilation of required elements, but it does not adequately seek enough information regarding the needs of family caregivers. In order to maintain Participants in the most integrated setting with preference and priority for their own homes, it is critical to understand family caregivers and the extent of their individual capabilities and limitations. The Participant depends on his or her family caregiver each and every minute of the day and the Commonwealth depends on that caregiver to be there each and every day or the CHC program won't work. From everyday tasks of daily living to more complex tasks of administering medications and assisting with disease management, family caregivers are a critical cog along this spectrum of care. We need to ensure that the family caregiver is given appropriate consideration and support and has adequate coping skills in order to maintain an effective level of care that avoids hospitalization and prevents long-term institutional care for the Participant	Heather Sedlacko Director, Programs for Seniors and People with Disabilities
Other				Finally, while the CHC-MCO is required to maintain a 24/7 dedicated Hotline for problems regarding service delivery and a 24/7 Nurse Hotline for urgent health matters, we would recommend a pre-identified and direct MCO Contact person for the informal caregiver to discuss any and all other issues related to the Participant's care as they arise. This will ensure the delivery of consistent and streamlined information over the course of that Participant's affiliation with a particular CHCMCO.	Heather Sedlacko Director, Programs for Seniors and People with Disabilities
Requirements document		page 9	Only says IEE shall be conflict free.		Chi Bon

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Requirements Document	Section V.A. - Covered Services	p. 27, Expanded Services	CHC-MCOs are permitted and encouraged to offer LTSS covered services to participants who are not yet NFCE.	PHA appreciates that DHS is offering this flexibility to the MCOs, which will help participants get the care they need in the community without the barriers that can flow from strict interpretation of NFCE status. We hope MCOs will take advantage of this flexibility by offering homecare services to individuals that will help prevent or directly mitigate their condition from progressing to the need for skilled services. For instance, an hour of non-medical homecare services can be just what a diabetic patient needs to help with meal preparation that follows a proper diet. With some creativity and flexibility, MCOs can really maximize the use of homecare services as preventative care to keep participants' conditions from declining to the NFCE level.	Pennsylvania Homecare Association (PHA)
Requirements Document	Section V.A. - Covered Services	p. 35; Service Delivery Innovation	MCOs must participate in innovation initiatives that are targeted by DHS.	PHA requests DHS be required to publish notices to stakeholders of the innovation projects or target areas that are being considered for CHC-MCO initiatives prior to implementation in the MCO's annual contract renewal. Much like the practice of the Centers for Medicaid and Medicare Services (CMS) in publishing its list of quality measures under consideration (MUC list) each year, DHS should identify the quality and efficiency innovation projects that are under consideration by the department for potential inclusion in the MCO contract renewals each year. If providers and consumers are made aware of possible target areas in this way, they can offer assistance and expertise to the MCOs in crafting successful innovation projects.	Pennsylvania Homecare Association (PHA)
Requirements Document	Section V.A. - Covered Services	p. 35; Settings for LTSS	The CHC-MCO must provide services in the least restrictive, most integrated setting.	In order to become a CHC-MCO, health plans must also be operating a companion D-SNP product which is focused on providing care for Medicare beneficiaries with special healthcare needs. These organizations will be well-versed in Medicare payment and billing practice, but it will be important to educate them on the nuances of serving a Medicaid population, including the fact that NFCE individuals do not need to be considered homebound to receive personal assistance services in their home and that the majority of providers offering non-medical personal assistance services are not Medicare-certified and cannot obtain Medicare coverage denials. To receive skilled home health services, Medicare requires a physician to certify that a patient is confined to the home (meaning it would take considerable and taxing effort to leave the home without assistance) and in need of skilled services. Under our current HCBS waivers, individuals are able to receive care in their home as long as they are found to be NFCE. We have learned from our colleagues in other states with MLTSS that MCOs often struggle with this distinction when it comes to homebound status. PHA suggests adding language to this section of the contract to clarify that CHC-covered LTSS, including personal assistance services, may be provided in the home regardless of the participant's homebound status.	Pennsylvania Homecare Association (PHA)
Requirements Document	Section V.C. - Continuity of Care	p. 39	For a participant that is receiving LTSS through an HCBS waiver program on his or her effective date of enrollment, the continuity of care period for continuation of services provided under all existing PCSPs through all existing service providers will run from the effective date of enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been develop and implemented	PHA once again **strongly disagrees** with this provision. DHS should extend the continuity of care period for more than 180 days to allow providers and MCOs to negotiate fair contracts and ensure participants are not put in jeopardy of losing their caregivers after six months. Homecare is a very person-centered service, provided in the individual's home and involving very intimate and personal one-on-one care. The relationship between the caregiver and participant is a critical component to the participant's health. During the Community Conversations initiative, when provider organizations heard concerns directly from current senior HCBS consumers, we learned the most important aspect of a senior's care is trust. CHC participants are not concerned about whether they will lose access to a choice of providers after the continuity of care period ends, they are worried they will lose the relationship they've built with their own caregiver if that agency does not secure a contract in time. The continuity of care period must be extended. In most states with MLTSS, this period lasted at least one full year, sometimes two or three years. **PHA implores DHS to change the language in the draft agreement to create a two-year continuity of care period.**	Pennsylvania Homecare Association (PHA)

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Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	p. 44	The CHC-MCO must require that all employees or contracted Service Coordinators meet the minimum standards of being a registered nurse or having a bachelor's degree...	PHA understands the department will be revising this language in the final RFP to allow for more flexibility for MCOs to hire service coordinators that are already part of the waiver programs and provide greater opportunity for employment for persons with disabilities that might not be able to obtain the academic degrees in the draft provision. We also understand the need to ensure service coordinators are well-trained in the independent living philosophy and experienced with working with the CHC-covered population to not only address their medical needs but also their emotional, social and economic needs. MCOs should be able to hire any individual that either possesses an RN license, a bachelor's degree, **or comparable work experience**. So many of the current service coordinators in the waiver program are doing a tremendous job caring for individuals in their home, but do not have the type of academic background contained in the draft agreement. It would be a shame not to allow this work to transition into the CHC program. In addition, service coordinators just like any other network service providers, should be monitored by the MCOs for quality in terms of responsiveness, documentation standards, and quick communication and resolution of participant's needs. Increased hiring flexibilty coupled with quality standards will help guarantee MCOs can employ and contract with the best qualified providers, regardless of academic achievement.	Pennsylvania Homecare Association (PHA)
Requirements Document	Section V.M.- Coordination of Services	p.44	N/A	The draft requirements do not mention a very important piece of service coordination: the transition of Medicaid-eligible children who reach the age of 21 and can no longer receive care under the physical health HealthChoices program. CHC-MCOs should be required to work with the PH-MCOs to share information and to have transitional care providers as part of their network that can create a smoother transition of services for these participants. Some of our members that offer pediatric care in HealthChoices are already providing transitional care services to patients from age 18 through 21 that helps ensure a seamless transition into the next phase of that patient's life. These simple steps could help the CHC program improve care coordination for all participants, even before they enter the program.	Pennsylvania Homecare Association (PHA)
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	p. 57; Participant Advisory Committee	Provider representation must include physical health, behavorial health, dental health and LTSS.	While we appreciate the inclusion of LTSS representation on the participant advisory committee (PAC), we encourage DHS to require representation from providers of each of the LTSS covered services. As written, the contract language could be interpreted by MCOs as only requiring one provider of any of the LTSS covered services, i.e., one nursing facility or one in-home meal provider. This would certainly not allow the PAC to consider the perspectives of LTSS providers as a whole, which can be very diverse and not easily represented by just one provider. **PHA suggests adding language as follows:** "Provider representation must include physical health, behavioral health, dental health and at least one provider representing each of the LTSS covered services including homecare, adult day services and skilled nursing facilities. Taken together, the Provider members of the PAC should be those that care for at least 65% of the MCO's total covered population." Although there are more than twenty LTSS covered services in the draft agreement, this provision certainly wouldn't require the PAC to add twenty provider members as many LTSS providers offer more than one of these services to participants. For instance, many home health agencies are also offering personal assistance services. It is important that all of these perspectives are able to contribute to the work of the PAC and assist the MCOs in building programs that fit all of the unique needs of their members.	Pennsylvania Homecare Association (PHA)
Requirements Document	Section V.T. - Provider Dispute Resolution Process	p. 63; Provider Dispute Resolution Process	Establishment of a CHC-MCO Committee to process formal Provider Disputes/Provider Appeals which must provide…	As discussed in our previous comments on the Concept Paper and Discussion Document, we strongly believe it is important for the department to play some role in resolving provider disputes with MCOs. These large and sophisticated health plans are in a position to exert pressure on LTSS providers when it comes to contract changes and rate decreases. The CHC-MCOs will be entrusted to provide care to more than 450,000 participants and responsibly spend millions of taxpayer dollars. It is important that the commonwealth act as a check in the provider/MCO relationship when it is necessary. To facilitate that department's participation, PHA suggests 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 (PHA)

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Requirements Document	Section V. Z. - Fraud & Abuse	p. 77; Subcontracts	The CHC-MCO must require that all network providers and all subcontractors take such actions as are necessary to permit the CHC-MCO to comply with the fraud, waste and abuse requirements in this agreement.	Since each MCO will be required to contract with the selected statewide FMS agencies, PHA reads this language as requiring MCOs to monitor the FMS providers for fraud and abuse in the same way as other network providers and subcontractors. The CHC-MCOs should be required to answer for any fraudulent activity of their members that choose the participant-directed model and utilize the FMS contractors to submit timesheets for payment. The MCOs, like the FMS agency, are trusted stewards of the MA program and should be accountable for improper payments. The contract should expressly encompass the FMS agency in these required auditing activities, given that the MCO will also be required to contract with all statewide FMS agencies.	Pennsylvania Homecare Association (PHA)
Requirements Document	Section V.CC. - Provider Services	p. 85	The CHC-MCO must operate provider services functions at a minimum during regular business hours.	Many LTSS network providers will be providing care to participants in the evening and weekend hours and the need may arise to contact the MCO right away. PHA suggests requiring the MCOs to offer after-hours provider services communication options to include at least a few evening hours per week and one day during the weekend. This compromise allows providers that work atypical business hours, like homecare aides, more opportunities to reach the MCO directly when they need it.	Pennsylvania Homecare Association (PHA)
Requirements Document	Section V.DD. - Provider Network	p. 89; Provider Qualifications	All providers must meet the minimum qualification requirements established by the department and must be credentialed by the department	PHA looks forward to learning more about the MCO's provider credentialing requirements with the December 14 document release containing Exhibit M(1) Quality Management and Utilization Management Program Requirements. For purposes of this comment period, we want to highlight the need for the CHC-MCOs to understand that homecare providers in Pennsylvania are licensed by the Department of Health and enrolled by OLTL as MA providers, but they are not required to become Medicare-certified providers. One of the lessons learned from providers in other states with MLTSS is the MCOs' lack of knowledge when it comes to non-medical homecare providers. MCOs will ask homecare agencies to present them with a claim denial from Medicare before covering services for a patient, when in reality that agency is not able to bill Medicare and should not be required to enroll in Medicare billing systems. Some states do not have licensure regulations for this type of care while others, like Pennsylvania, do. It can be confusing for health plans that operate in multiple states such as those looking to bid on the CHC program contract. It is critically important to add clarifying language to this provision of the draft agreement to reiterate that LTSS providers that currently hold a license to operate in the state and are enrolled in the MA program should not be required as a condition of entering the CHC-MCO network to dually enroll as a Medicare provider.	Pennsylvania Homecare Association (PHA)
Requirements Document Exhibit	C - Requirements for Provider Terminations	Notification to Department	The CHC-MCO must notify the Department in writing of its intent to terminate a netowrk provider and services provided by a network provider ...sixty (60) days prior to the effective date of the termination.	We thank the department for maintaining oversight in the CHC program when it comes to provider terminations, but the language in this exhibit will not address providers that leave the network when they are forced to reject contract amendments containing dramatic rate decreases. In the experience of our member agencies in the physical health HealthChoices program, the reason providers leave a health plan's network is not because they are "terminated" by the plan in the general sense of that term, but their reimbursement rates are cut in the form of a contract amendment to which they are not able to agree. MCOs can avoid the provisions of this exhibit in this way, by forcing the provider's "voluntary" exit from the network rather terminating them. In this scenario, the department would not receive advance notice of the impact the loss of this provider could have on the network and the consumers' access to care. PHA urges the commonwealth to strengthen oversight on providers exiting the network by requiring the same sixty-day notice from MCOs prior to any provider contract amendments that would result in a dramatic change in reimbursement rates, which could be defined by a threshold percentage change in the rates such as a 25% change in the rates from the previous twelve months. This notice will help protect providers from improper collusion from the MCOs and protect consumers from losing access to their providers for reasons other than quality concerns.	Pennsylvania Homecare Association (PHA)
Requirements Document Exhibit	E(1) - Other Federal Requirements	(not numbered) O. CHC-MCO's Conflict of Interest	The CHC-MCO hereby assures that it presently has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder	The standard contract language in this exhibit should be amended to clarify that a CHC-MCO operating as a provider within its own network will be considered a conflict of interest in violation of the agreement. MCOs need to focus on the business of coordinating care rather than providing care. As the steward of MA funds in the commonwealth, it would not be appropriate or in the best interest of the participants for the MCO to be a provider of services thereby making payment to its own bottom line. The commonwealth should have auhtority to closely monitor the MCO's conflict-free operation.	Pennsylvania Homecare Association (PHA)

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Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA(3)-6; Network Composition	The Department may require additional numbers of specialists, ancillary and LTSS providers should it be determined that geographic access is not adequate.	As discussed in reference to the 30 minute/60 minute travel times, the geographic access to LTSS providers is not a sufficient measure of network adequacy when it comes to in-home care providers. We were pleased to see the department will have authority to require additional LTSS providers as needed, but there should be a better mechanism in place to measure the lack of homecare providers. PHA suggests requiring the MCOs to turn to the consumers and providers on their PAC to hear and process consumer-driven grievances related to narrow provider networks. PHA members that operate in HealthChoices zones providing home health care often have difficulty entering provider networks and are turned away by MCOs that say they already have enough providers to offer consumer choice. However, it is important to not only consider choice of provider by service type but also by the kind of specialty programs the provider offers. For instance, a network might have several homecare agencies already serving a given area but none of those agencies are able to offer specialty dementia care or caregivers specifically trained to care for certain conditions such as ALS. The National Committee for Quality Assurance (NCQA), which provides accreditation to health plans in the federal insurance marketplace, looks to whether health plans and states have monitoring in place for network adequacy that includes the collection and analysis of consumer complaints and repetitive requests for specialty provider care. Other states employ this practice in the MLTSS program as well. In Arizona, MCOs must complete a network gap analysis monthly using geo-access mapping. In Minnesota, it is the state that performs a gap analysis of each MCO's network and reports to the MCO on any necessary adjustments. PHA recommends including language in Exhibit AAA to require the PAC to review and analyze participant complaints related to narrow networks and make recommendations to the department on whether it should require the addition of LTSS providers.	Pennsylvania Homecare Association (PHA)
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA(3)-7 LTSS Providers	Ensure at least two (2) providers for each LTSS covered service within the travel time limits (thirty (30) minutes urban, sixty (60) minutes rural).	PHA and other provider organizations have continued to stress the importance of workable adequacy standards for in-home providers. Travel time measurements like those in Exhibit AAA will not measure whether there is a sufficient number of homecare agencies in the network. LTSS participants never travel from their home to the homecare agency's physical office location. Even most direct care workers travel directly from their homes to the participant's home to provide care each day and very seldom travel to the homecare agency's office. Simply measuring the geographic location of the homecare agency in relation to the MCO's LTSS population will not show any relevant information on the ability of the agency to provide care in that area. In our previous comments, we have suggested alternative ways of measuring network adequacy for in-home providers including a gap analysis that plots the location of the CHC beneficiaries in relation to the homecare provider's service area in conjunction with a measurement of staff-to-participant ratios that ensures agencies have capacity to care for the CHC population in their area. We strongly urge DHS to consider adding requirements like these in the exhibit to truly be able to measure whether the MCO's network is able to meet the needs of participants in their homes.	Pennsylvania Homecare Association (PHA)
Requirements Document Exhibit	DDD(1) - Covered Services List	Home Health Services	Home healthcare aide services cannot be provided simultaneously with personal assistance services, adult daily living services or respite services	While we understand the importance of controlling overpayments for duplicative services, in our members' experience it is often very difficult to know when a home health aide and a PAS aide might be in a participant's home at the same time. Many homecare participants that receive non-medical care for help with activities like bathing and dressing are also receiving home health services to care for their medical needs. This care is not always provided by one agency and there are occasions when a home health aide enters a home to perform intermittent care at the same time that a personal care aide is present for a multiple hour shift. Given the restrictions in Exhibit DDD for this type of simultaneous care, it is very important that the CHC-MCO take responsibility for notifying the participant's providers about the full care plan, including the services of other providers. The Medicare-Medicaid coordination that is envisioned in the CHC program will greatly improve the respective knowledge of the home health and homecare agencies caring for the individual, but it is important that the MCO is given responsibility for keeping providers informed so simultaneous care is not inadvertently provided and providers' claims for reimbursement are rejected. PHA suggests adding language to this provision and similar provisions throughout this exhibit to indicate that such care "cannot be knowingly provided simultaneously."	Pennsylvania Homecare Association (PHA)

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RFP	Work Statement	p. 30; Question 11	Describe your organization's experience and your plan for using technology such as assistive technology, telehealth, telecare, social media, electronic visit verification, and other methods to deliver services to the CHC Participants.	Many LTSS providers already have electronic medical records (EMRs) and electronic visit verification (EVV) systems in place and have invested thousands of dollars in the infrastructure and training that those systems require. The work statement questionnaire allows MCOs to decide how EMRs and EVV will be used within their network, but PHA urges the commonwealth to set some broad parameters in these areas rather than allowing MCOs to determine system requirements. For example, an MCO should not be permitted to require all network providers to contract with the same electronic visit verification (EVV) system provider, rather the commonwealth should set parameters for acceptable EVV systems and allow providers to choose their own vendor. Similarly, providers will be entering contracts with multiple MCOs in their region and it is critical that they be permitted to use the same EMR system to communicate with all payers. These information management system requirements should be set at a statewide level to ensure compatibility between providers and multiple MCOs. This compatibility will lead to better outcomes for CHC participants, as more providers are able to securely share patient information and better coordinate person-centered care.	Pennsylvania Homecare Association (PHA)
RFP	Work Statement	p. 41; Question 5	Describe how you will use Geo Access mapping to ensure network adequacy.	PHA reiterates the need to accommodate the unique needs of in-home providers when it comes to using geo-access mapping to determine network adequacy. Simply mapping the location of the homecare agency and the participant's home will not paint the whole picture. This mapping needs to be supplemented with participant questionnaires and staff-to-participant ratios in order to gather trusted information on whether the network can serve the participants that need care in their homes.	Pennsylvania Homecare Association (PHA)
RFP	Work Statement	p. 42; Question 13	Describe how you will oversee the Financial Management Services (FMS) Grantee and the administration of FMS services to Participants.	PHA recently submitted feedback on the commonwealth's RFI on FMS agencies and offered our suggestions for improving the participant-directed program through the new FMS procurement. The CHC-MCOs' role in managing the FMS contract will be a key component to the success of the participant-directed model under CHC. Suggestions from our comments included requiring the FMS to: prohibit employment of any worker with a criminal background, provide some baseline healthcare training for participant-hired workers, limit the scope of practice for workers who are not trained to provide medical care such as wound care in the home, and employ EVV systems to monitor the care the participant is receiving and accurately track compensable time. MCOs will be responsible for credentialing homecare agencies prior to joining the network and so participant-directed employees should be held to the same credentialing standards to ensure participants are receiving quality care in their homes regardless of their choice of delivery model. In addition and as discussed above, PHA suggested in our RFI comments that the MCOs play a large role in monitoring the FMS agencies for fraud and abuse. The participant-directed model of care is an important component of HCBS in Pennsylvania, but there is room for improvement in the way these workers are hired and trained that will lead to better quality of care for CHC participants.	Pennsylvania Homecare Association (PHA)
Other		General Comment		**Intent/Definition of Service Coordination**-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program.	Warren/Forest AAA
Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	Warren/Forest AAA
Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems**- The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	Warren/Forest AAA

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Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	**Continuity of Care for LTSS Participants**-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	Warren/Forest AAA
Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	**Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors**-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	Warren/Forest AAA
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	**Limited English Proficiency Requirements**- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	Warren/Forest AAA
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	**Management Information Systems**-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	Warren/Forest AAA
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	Warren/Forest AAA
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	**Willing Provider Definition –** In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	

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Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department –** We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	Warren/Forest AAA
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	Warren/Forest AAA
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	Warren/Forest AAA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	Warren/Forest AAA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	Warren/Forest AAA

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RFP	Work Statement Questionnaire	Planned Approach Subsection 1, pg 29	Describe in detail how you will develop your network and set up operations capable of supporting the Participant population and meeting requirements of the agreement, no later than three months prior to the anticipated implementation dates for each zone.	Describe in detail how you will develop your network and set up operations, including a technology platform, capable of supporting the Participant population and meeting requirements of the agreement, no later than three months prior to the anticipated implementation dates for each zone.	HHAeXchange/Payer Management Solutions
RFP	Work Statement Questionnaire	Participant Svs & Care Coordination Subsection 1, pg 29	Describe how you will employ self direction	Describe how you will employ self direction including scheduling can confirmation of services. Describe how your technology platform will support self directed services	HHAeXchange/Payer Management Solutions
RFP	Work Statement Questionnaire	Participant Svs & Care Coordination Subsection 8, pg 30	Describe your process for care coordination to ensure Participants receive adequate inhome svs to divert them from entering or returning to acute care or LTC facilities.	Describe your process for care coordination, including third party monitoring solutions, to ensure Participants receive adequate inhome svs to divert them from entering or returning to acute care or LTC facilities. How will you determine which Providers in the network drive the most and least admissions?	
RFP	Work Statement Questionnaire	Participant Svs & Care Coordination, Subsection 9, pg 30	Describe your plans for delivering comprehensive services that: expand the use of technology amonst LTSS providers	Describe your plans for delivering comprehensive services that: expand the use of technology amonst LTSS providers and solves for providing real time communication between the MCO and the LTSS providers	HHAeXchange/Payer Management Solutions
RFP	Work Statement Questionnaire	Participant Svs & Care Coordination, Subsection 11, pg 30	Describe your organization's experience and your plan for using technology such as assistive technology, telehealth, telecare, social media, electronic visit verification, and other methods to deliver services to the CHC Participants.	Describe your organization's experience and your plan for using technology such as assistive technology, telehealth, telecare, social media, electronic visit verification, chronic health monitoring tools and other methods to deliver services to the CHC Participants.	HHAeXchange/Payer Management Solutions
RFP	Work Statement Questionnaire	Participant Svs & Care Coordination, Subsection 12, pg 31	Describe how you will determine the level of full time equivalent licensed and non-licensed telephonic and community based personnel that will be involved in these activities. Include the communication process and plan.	Describe how you will determine the level of full time equivalent licensed and non-licensed telephonic and community based personnel that will be involved in these activities. Include the communication process, plan of care monitoring, and the documentation and sharing of background checks, licensures and necessary trainings credentials.	HHAeXchange/Payer Management Solutions
RFP	Work Statement Questionnaire	Participant Svs & Care Coordination, Subsection 14, pg 31	Describe how you encourage provider usage and exchange of interoperable health information, electronic service plans, and how you will develop and implement innovations to use these records to promote better coordination and overall health.	Describe how you encourage provider usage and exchange of interoperable health information, electronic service plans, plans of care and schedules and how you will develop and implement innovations to communicate real time with providers regarding these records to promote better coordination and overall health.	HHAeXchange/Payer Management Solutions

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RFP	Work Statement Questionnaire	Participant Svs & Care Coordination, Subsection 21, pg 32	Specify how you will coordinate with your care management programs to establish a person-centered approach is taken for disease and care management activities for all Participant populations, including the use of any technology to stratify and track Participants most in need of disease management. Identify and describe the programs that will be used if selected for award.	Specify how you will coordinate with your care management programs to establish a person-centered approach is taken for disease and care management activities for all Participant populations, including the use of any technology to stratify and track Participants in the top three chronic disease categories that are most in need of daily disease management monitoring. Identify and describe the programs that will be used if selected for award.	HHAeXchange/Payer Management Solutions
RFP	Work Statement Questionnaire	Participant Svs & Care Coordination, Subsection 28, pg 32	Describe how your person-centered service planning process will support family caregivers.	Describe how your person-centered service planning process will support family caregivers including scheduling, monitoring time & attendance and billing.	HHAeXchange/Payer Management Solutions
RFP	Work Statement Questionnaire	Quality Improvement & Performance Measures, Subsection 3, pg 34	Describe your strategy for controlling chronic conditions such as high cholesterol, high blood pressure, diabetes, etc.	Describe your strategy for controlling chronic conditions such as high cholesterol, high blood pressure, diabetes, etc. and the technology/tools that apply	HHAeXchange/Payer Management Solutions
RFP	Work Statement Questionnaire	Quality Improvement & Performance Measures, Subsection 6, pg 34	Describe your strategy for approaching service delivery in rural and urban areas including LTSS, urban and acute.	Describe your strategy (including technologies you will provide) for approaching service delivery in rural and urban areas including LTSS, urban and acute to ensure the services authorized were delivered.	HHAeXchange/Payer Management Solutions
RFP	Work Statement Questionnaire	Program Incentives & Program Integrity Subsection 3, pg 35	Describe the types of fraud, waste & abuse detection methods you will use to detect and prevent potential provider and participant FWA.	Describe how you will proactively reduce fraud, waste & abuse by describing the prevention and detection methods you will use to detect and prevent potential provider and participant FWA .	HHAeXchange/Payer Management Solutions
RFP	Work Statement Questionnaire	Management Information Systems Subsection 1, pg 37	Provide a general systems description including how each component will support the major functional areas of CHC…	Provide a general systems description including how each component will support the major functional areas of CHC including the exchange and sharing of information between the MCO and the provider…	HHAeXchange/Payer Management Solutions

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RFP	Work Statement Questionnaire	Provider Network Composition Subsection 1, pg 47	Describe how you will collect and address the language and communication needs for participants	Describe how you will collect and address the language, communication and special request needs(for example, caregiver must be able to operate a Hoyer lift) for participants and how you will match those needs to an established inventory of providers that are qualified to staff the case	HHAeXchange/Payer Management Solutions
RFP	N/A	N/A	N/A	Please provide a Table of Contents and an introductory section outlining the target populations for Community HealthChoices.	Centene Corporation/ Pennsylvania Health & Wellness
RFP	Work Statement	All p 29-42	N/A	We recommend an expansion of page limits based on the content requested in each question. We recommend no less than 2 pages per sub question in each section. Sub questions that have bullets that require additional clarifications should allow for a larger page limit, when appropriate (e.g., one page per each sub-bullet) to ensure bidder has the ability to appropriately respond to each question.	Centene Corporation/ Pennsylvania Health & Wellness
RFP	Work Statement	PARTICIPANT SERVICE AND CARE COORDINATION (Maximum 30 Pages) P 31	12. Describe the techniques, policies, procedures or initiatives you have in place to effectively and appropriately control avoidable nursing facility, hospital, and emergency department admissions and other high-cost services and to increase the use of health promotion, primary care, and Home and Community Based Services (HCBS). Describe how you will determine the level of full time equivalent licensed and non-licensed telephonic and community based personnel that will be involved in these activities. Include the communication process and plan	Please confirm the focus and target audience for the "communication process and plan."	Centene Corporation/ Pennsylvania Health & Wellness
RFP	Work Statement	QUALITY IMPROVEMENT AND PERFORMANCE MEASURES (Maximum 20 Pages) p 34	2. Describe all physical health and HCBS quality and performance measures that you currently track and your performance in these measures. Specifically detail any LTSS quality measures and your performance. Address how you measure utilization, timeliness of service delivery and rebalancing (HCBS vs Nursing Facility). Describe, out of all of the measures you collect, which three would be most meaningful in measuring HCBS quality and performance and why.	Please confirm your definitions of "quality measures" and "performance measures" so the respondent can appropriately answer this question. We recommend that you include quality definitions in your Section II, Definitions.	Centene Corporation/ Pennsylvania Health & Wellness
RFP	Work Statement	QUALITY IMPROVEMENT AND PERFORMANCE MEASURES (Maximum 20 Pages) p 34	7. Describe your plans to measure preventive care services and diagnosis based improvement.	Please define "diagnosis-based improvement."	Centene Corporation/ Pennsylvania Health & Wellness

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RFP	Work Statement	QUALITY IMPROVEMENT AND PERFORMANCE MEASURES (Maximum 20 Pages) p 34	10. Describe the role your service coordinators will play in HCBS quality assurance and improvement. Describe the relationship between care coordination and service coordination as it relates to quality assurance.	Please include, in Section II, Definitions, definitions for Care Coordination and Service Coordination	Centene Corporation/ Pennsylvania Health & Wellness
Requirements Document	N/A	N/A	N/A	Please provide a Table of Contents and an introductory section outlining the target populations for Community HealthChoices.	Centene Corporation/ Pennsylvania Health & Wellness
Requirements Document	SECTION V: PROGRAM REQUIREMENTS	A. Covered Services p 26	1. Amount, Duration and Scope At a minimum, the CHC-MCO must provide Covered Services in Exhibit DDD in the amount, duration and scope available in the Medical Assistance FFS Program unless otherwise specified by the Department. The CHC-MCO must provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. If services are added to the Pennsylvania Medical Assistance Program or the CHC Program, or if Covered Services are expanded or eliminated, implementation by the CHC-MCO must be on the same day as the Department's, unless the CHC-MCO is notified by the Department of an alternative implementation date.	A December 2015 Issue Brief for the Center for Health Care Strategies (Spencer, Lloyd, and McGinnis) reported that "Health-related supportive services and other non-medical interventions that address... social determinants of health can both improve outcomes among Medicaid beneficiaries and reduce health care spending." This report describes innovative models to meet the unique needs of members. More specifically, Oregon Health Authority (OHA)'s Coordinated Care Organization model includes a global payment approach with a flexible spending "other" category to allow care teams to provide tailored services on an as-needed basis. We recommend, in addition to CHC-MCOs providing value adds, that DHS consider including similar "other" option in its overall capitation rate to CHC-MCOs.	Centene Corporation/ Pennsylvania Health & Wellness
Requirements Document	SECTION V: PROGRAM REQUIREMENTS	A. Covered Services p 39	C. Continuity of Care If a Participant chooses to transfer to a different CHC-MCO, the receiving CHC-MCO must continue to provide the previously authorized services for 60 days or until a comprehensive needs assessment has been completed and a PCSP been developed and implemented, whichever date is later.	Please consider the administrative burden, continuity of care challenges, and cost associated with allowing Participants to change MCOs on a monthly basis. Please consider open enrollment periods (e.g., first 90 days) and appropriately aligned continuity of care requirements except for unique pre-determined exceptions to this policy.	Centene Corporation/ Pennsylvania Health & Wellness
Requirements Document	SECTION V: PROGRAM REQUIREMENTS	A. Covered Services P 34	18. Participant Self-Directed Services. The CHC-MCO must contract with the Commonwealth-procured FMS entities, of which there are three that operate statewide.	Please confirm that the CHC-MCO is contracting directly with FMS, and that as a result, will have choice in FMS selection	Centene Corporation/ Pennsylvania Health & Wellness

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Requirements Document	SECTION V: PROGRAM REQUIREMENTS	B. Prior Authorization of Services p 37	2. Timeframes for Notice of Decisions a. The CHC-MCO must process each request for Prior Authorization of a service and notify the Participant of the decision as expeditiously as the Participant's health condition requires, or at least orally, within two (2) business days of receiving the request, unless additional information is needed. If no additional information is needed, the CHC-MCO must mail written notice of the decision to the Participant, the Participant's PCP, and the prescribing Provider within two (2) business days after the decision is made. The CHC-MCO may make notification of coverage approvals via electronic notices as permitted under 28 PA Code §9.753(b). If additional information is needed to make a decision, the CHC-MCO must request such information from the appropriate Provider within forty-eight (48) hours of receiving the request and allow fourteen (14) days for the Provider to submit the additional information. If the CHC-MCO requests additional information, the CHC-MCO must notify the Participant on the date the additional information is requested, using the template, N(7) Request for Additional Information Letter on the Intranet supporting CHC.	We recommend 2 business days or 72 calendar hours from receipt of a request from a provider to request additional information on prior authorizations to account for holidays/weekends	Centene Corporation/ Pennsylvania Health & Wellness

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Requirements Document	SECTION V: PROGRAM REQUIREMENTS	A. Covered Services p 39	C. Continuity of Care. This continuity of care period shall continue so long as the Participant remains a resident of the same NF and shall apply to each enrollment into a CHC-MCO, whether at the first effective date of enrollment or at some time later in the operation of the CHC program if the Participant chooses to transfer to a CHC-MCO. AND For a Participant who is receiving LTSS through an HCBS Waiver program on his or her Effective Date of Enrollment, the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later.	Please consider changing this requirement to whichever date is earlier to allow MCOs to implement changes requested by consumers during the comprehensive needs assessment.	Centene Corporation/ Pennsylvania Health & Wellness
Requirements Document	SECTION V: PROGRAM REQUIREMENTS	E. Needs Screening p 40	Any Participant whose needs screening reflects unmet needs, service gaps, or a need for Service Coordination will be referred for a comprehensive needs assessment. The needs screening must be completed within the first 30 days of Enrollment, and may be conducted by phone, electronically, by mail, or in person	Please confirm that the initial screening and comprehensive assessment can occur at the same time, if appropriate.	Centene Corporation/ Pennsylvania Health & Wellness
Requirements Document	SECTION V: PROGRAM REQUIREMENTS	F. Comprehensive Needs Assessments and Reassessments P 40	For Participants that are NFCE but are not receiving LTSS at the time of Enrollment, the comprehensive needs assessment must be completed in accordance with the timelines outlined in Services Prior to Effective Date of Enrollment. · For Participants that are Dual Eligible and identified by the IEE as having a need for immediate services, the comprehensive needs assessment must be completed in accordance with the timelines outlined in Prior to Effective Date of Enrollment.	Please confirm the location of "timelines outlined in Services Prior to Effective Date of Enrollment" and "timelines outlined in Prior to Effective Date of Enrollment" within the Community HealthChoices Agreement	Centene Corporation/ Pennsylvania Health & Wellness

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Requirements Document	SECTION V: PROGRAM REQUIREMENTS	F. Comprehensive Needs Assessments and Reassessments P 40-41	Participants without existing Person-Centered Service Plans who are identified through a needs screening as requiring a comprehensive needs assessment shall have a comprehensive needs assessment conducted within 15 days of the completion of the needs screening.	We recommend a 30 day period following needs screening at start up for comprehensive assessments with each MCO accountability for an appropriate prioritization process based of risk and continuity of care policies firmly in place.	Centene Corporation/ Pennsylvania Health & Wellness
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	CHC-MCO Outreach Activities p 47	b. The CHC-MCO may market its approved, companion D-SNP product to its Full Dual Eligible CHC-MCO Participants.	This is the first section in the Contract Agreement (beyond definitions and acronyms) where the SNP requirement is mentioned, and this section is relevant to marketing. Please provide more information on D-SNP as a covered service and all requirements for MCOs' implementation of D-SNPs (including timelines and network development).	Centene Corporation/ Pennsylvania Health & Wellness
Requirements Document	SECTION V: PROGRAM REQUIREMENTS	O. Participant Enrollment and Disenrollment, 12. Enrollment and Disenrollment Updates p 53	When any Participant is disenrolled from the CHC-MCO the CHC-MCO from which the Participant disenrolled remains responsible for participating in discharge/transition planning for up to six (6) months from the initial date of Disenrollment. The CHC-MCO must remain the Participant's CHC-MCO upon discharge (upon returning to the CHC zone covered by this agreement), unless the Participant chooses a different CHC-MCO or is determined to no longer be eligible for participation in CHC, provided that the Participant is discharged within six (6) months of the initial CHC-MCO Disenrollment date. If the Participant chooses a different CHC-MCO, the receiving CHC-MCO must participate in the discharge/transition planning upon notification that the Participant has chosen its CHC-MCO.	Please confirm that the CHC-MCO rate will account for the cost of supporting (for up to six months) Participants who have disenrolled from the CHC-MCO.	Centene Corporation/ Pennsylvania Health & Wellness
Requirements Document	SECTION V: PROGRAM REQUIREMENTS	Selection and Assignment of Service Coordinators p 84	BB. The CHC-MCO must make contact with the Participant within seven (7) business days of his or her Enrollment for a comprehensive needs assessment indicating the need for LTSS and provide information on options for selecting a Service Coordinator unless the CHC-MCO has information that the Participant should be immediately contacted due to a medical condition requiring immediate care.	Please note that the "within 7 business days" is not consistent with the 30 days listed on p 40. We recommend a 30 day period following needs screenings at start up for comprehensive assessments with each MCO accountability for an appropriate prioritization process based of risk and continuity of care policies firmly in place.	Centene Corporation/ Pennsylvania Health & Wellness

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Requirements Document Exhibit		e .Network adequacy indicated travel time for LTSS services p AAA (3) -7	e. LTSS Providers Ensure at least two (2) Providers for each LTSS Covered Service within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural).	Important to recognize that most Participants will not be travelling to their LTSS providers (instead most LTSS providers will be travelling to the Participant). Can Commonwealth review this requirement and consider county-based access as a measure of availability?	Centene Corporation/ Pennsylvania Health & Wellness
Other		General Comment		**Intent/Definition of Service Coordination**-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the CHC-MCO. Please clarify that if the CHC-MCO makes a decision to provide Service Coordination directly, will the MCO be required to contract with another Service Coordination Entity to ensure participants have choice?	SWPA AAA
Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining specific protocols.	SWPA AAA
Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems-** The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk management be coordinated between the MCO and the protective services entity?	SWPA AAA
Requirements Document	Section II - Definitions	p. 14	Participant Advisory Committee (PAC)- A group convened in person, at least quarterly by the CHC-MCO's governing board which is open to all participants and which reflects the diversity of the CHC-MCO's Participant population.	**Participant Advisory Committee Makeup -** We recommend that the PAC meetings be formed for, and held in, each zone (for instances where the MCO may cover more than one zone) and have representation from rural and urban counties in each CHC zone.	SWPA AAA
Requirements Document	Section II - Definitions	p. 15	Person Centered Planning Team- The team of individuals that will participate in Person Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT	**Person Centered Planning Team Makeup** - We recommend OLTL include the minimum acceptable required individuals and also include other suggestions/preferences for individuals on the team. We also recommend that OLTL require that if there is a behavioral health diagnosis, a behavioral health representative be a required team member.	SWPA AAA
Requirements Document	Section V.B. - Prior Authorization of Services	p. 36	B. Prior Authorization of Services 1.General Prior Authorization Requirements (4th paragraph) When the CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of denial using the appropriate notice outline in templates…	**Notice of Service Denial** - We recommend that when there is a denial of services for those in MLTSS, notification should also be sent to the Service Coordination Entity to ensure continuity and follow up with the participant.	SWPA AAA
Requirements Document	Section V.B. - Prior Authorization of Services	p.37	2. Time frames for notice of Decisions	**Notice of Service Decisions** - We recommend that notice decisions should also be sent to Service Coordinator (entity) if additional information is needed from an MLTSS consumer to assist the consumer in acquiring required documentation, if needed.	SWPA AAA

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Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	**Continuity of Care for LTSS Participants**- The requirements document should include an extension of the 180-day transition period from existing providers to network providers if an adequate network provider within the participant's geographic area cannot be obtained.	SWPA AAA
Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	**Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors**-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	SWPA AAA
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	**Limited English Proficiency Requirements**- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	SWPA AAA
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following components to its MIS or the capability to link to other systems continuing this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	**Management Information Systems**-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	SWPA AAA
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically as to if it refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity.")	SWPA AAA
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	**Willing Provider Definition –** In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	SWPA AAA

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Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department** – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	SWPA AAA
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	SWPA AAA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting. This is a cost effective alternative to long-term placement when the informal support system becomes overwhelmed.	SWPA AAA
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	SWPA AAA
Other		General Comment		**Intent/Definition of Service Coordination**- To avoid confusion, the Department should clarify if Service Coordination is a provider service or administrative function in Community HealthChoices (CHC).	Bucks County Area Agency on Aging
Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination, and potential service gaps, between behavioral health services and long term care services. Outside the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining the specifics of this process.	Bucks County Area Agency on Aging

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Requirements Document	Section V.B. - Prior Authorization of Services	p. 38	If the Participant is currently receiving a requested service and the CHC-MCO denies the prior authorization request……..the CHC-MCO must mail the written notice of denial at least 10 days prior…..	**Time Frames for Notice of Decisions** - The respective denial notices should specify "business" days, rather than permitting calendar days, to provide adequate time for the participant to receive and respond to the denial.	Bucks County Area Agency on Aging
Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	**Continuity of Care for LTSS Participants**-To ensure consumers have adequate choice of qualified service providers, and avoid a rapid disruption of the consumer's current LTSS providers, the transition period for qualified providers should be extended to a minimum of two years.	Bucks County Area Agency on Aging
Requirements Document	Section V.C. - Continuity of Care	p. 40	RE: Needs Screening and Needs Assessments	**Needs Screening and Needs Assessment -** the needs screening plus needs assessment combined can total greater than 45 days to complete. Due to permitting completion of needs screenings by phone, electronically, mail, or in person, the timeline should mimic the maximum time allowed for the needs assessment (15 days, for a total combined maximum timeline of 30 days).	Bucks County Area Agency on Aging
Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	**Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors**-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements. Additionally, Service Coordination entities should be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	Bucks County Area Agency on Aging
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	**Limited English Proficiency Requirements**- We recommend the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	Bucks County Area Agency on Aging
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment		Services For New Participants (pg. 53)	To ensure person-centered service planning can increase opportunities for HCBS, enrollment must maintain expeditious timelines. Expedited Home and Community Base Service enrollment provides a viable alternative to institutionalization by eliminating the interruption between the consumer's immediate need and start of services. Allowing consumer presumptive eligibility determinations at the local level could expedite supports while maintaining appropriate state oversight and monitoring.	Bucks County Area Agency on Aging
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following components to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	**Management Information Systems**-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	Bucks County Area Agency on Aging

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Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define when service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	Bucks County Area Agency on Aging
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	**Willing Provider Definition –** In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	Bucks County Area Agency on Aging
Requirements Document	Section V.DD. - Provider Network	p. 94	The CHC-MCO must enroll a sufficient number of Providers qualified to conduct the speciality evaluations necessary for investigating alleged physical and/or sexual abuse.	**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems-** The Department should clarify the responsibility of the CHC-MCO, *and their monitoring of network providers* , related to reporting Older Adult Protective Services and Adult Protective Services issues. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	Bucks County Area Agency on Aging
Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department –** We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	Bucks County Area Agency on Aging
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances –** While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	Bucks County Area Agency on Aging
Requirements Document Exhibit	DD - Participant Handbook			All consumers should receive education (and language in their Participant Handbooks) regarding: their right to appeal, access to the Ombudsman program, and access to Protective Service programs (to assist those at risk for abuse, neglect, financial exploitation and abandonment).	Bucks County Area Agency on Aging
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	Bucks County Area Agency on Aging

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend this definition be expanded to allow for the provision of respite care in an institutional setting.	Bucks County Area Agency on Aging
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	Bucks County Area Agency on Aging
Requirements Document Exhibit	C - Requirements for Provider Terminations		B.1.a Supporting documentation for provider terminations (pg 104)	Clear provider standards, outcome measurements, and performance improvement should be measured consistently among all CHC-MCOs to ensure quality service is delivered. Dashboards should be made available to providers to track performance using a uniform tracking tool, and performance improvement plans as well as corrective action plans should be documented prior to a network provider being terminated.	Bucks County Area Agency on Aging
Requirements Document Exhibit	KK - Reporting Suspected Fraud & Abuse to the Department		Reporting Suspected Fraud and Abuse to the Department (pg 174)	In addition to complying with applicable reporting requirements (related to potential incidents of abuse), CHC-MCO's must also be empowered to increase care plan costs in attemps to mitigate risk. Filing a Report of Need with the respective Protective Service agency does not negate the MCO's obligation, which possibly includes increased services and supports to the consumer, to help mitigate risk.	Bucks County Area Agency on Aging
RFP	General Information	pg 12		Agreement Pricing - The Department plans to provide CHC-MCO's with capitation rates prior to annual negotiations. Service providers should be adequately reimbursed in order to pay competitive salaries within the region's market area, and to support recruitment and retention of a qualified workforce.	Bucks County Area Agency on Aging
Other		General Comment		Intent/Definition of Service Coordination-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program. One example of where this is important is when considering the continuity of care period. If service coordination is a provider service, the continuity of care period would definitely apply. If it is an administrative function, we are not sure if that provision would apply to service coordination.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Other		General Comment		Coordination of CHC Services with Behavioral Health Services- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Other		General Comment		Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems- The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone

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Requirements Document	Section II - Definitions	p. 14	Participant Advisory Committee (PAC)- A group convened in person, at least quarterly by the CHC-MCO's governoring board which is open to all participants and which reflects the diversity of the CHC-MCO's Participant population.	Participant Advisory Committee Makeup - We recommend that the PAC meetings be formed for, and held in, each zone (for instances where MCO may cover more than one zone) and have representation for rural and urban counties in each particular zone.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document	Section II - Definitions	p. 15	Person Centered Planning Team- The team of individuals that will participate in Person Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT	Person Centered Planning Team Makeup - We recommend OLTL include the minimum acceptable required individuals and also include other suggestions/preferences for individuals on the team. We also recomment that OLTL require that if there is a behavioral health diagnosis, a behavioral health representative be required on the team.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document	Section V.A. - Covered Services	p.26	In-Home and Community -Based Services- The CHC- MCO may not deny personal assistance services for Participants under the age of 21 based on the Participant's diagnosis or because the need for personal assistance is the result of a cognitive imparment…	Personal Assistance Services - We recommend removing "under the age of 21" so that no conumer could be denied personal assistance services based on the participant's diagnosis or because the need is based on a cognitive impairment	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document	Section V.A. - Covered Services	p.26	The CHC-MCO may not deny a request for Medically Necessary in-home nursing services, home health aide services, or personal assistance services for a Participant under the age of 21 on the basis that a live-in caregiver can perform the task…	In-home Nursing, Home Health Aide or Personal Assistance Services - We recommend removing "under the age of 21" so that no consumer could be denied under these circumstances.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document	Section V.B. - Prior Authorization of Services	p. 36	B. Prior Authorization of Services 1.General Prior Authorization Requirements (4th paragraph) When the CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of denial using the appropriate notice outline in templates…	Notice of Service Denial - We recommend that when there is a denial of services for those in MLTSS, notification should also be sent to the Service Coordination Agency/entity to ensure continuity and follow up with consumer.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document	Section V.B. - Prior Authorization of Services	p.37	2. Time frames for notice of Decisions	Notice of Service Decisions - We recommend that notice decisions should also be sent to Service Coordinator (entity) if additional information is needed from an MLTSS consumer the Service Coordination Agency should also be notified so they can assist the consumer in acquiring required documentation.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	Continuity of Care for LTSS Participants-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone

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Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	Limited English Proficiency Requirements- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	Management Information Systems-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		Intent/Definition of Service Coordinator-There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	Willing Provider Definition – In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	Notification to Department – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	Complaints and Grievances – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone

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Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	Definition of Travel Time – In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	Definition for Respite Care-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	Responsibility of Annual Level of Care Redetermination- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	Catholic Charities of the Diocese of Pittsburgh/ Amy Cervone
Requirements Document	Section V.C. - Continuity of Care	C & 39	For a Participant who is receiving LTSS through an HCBS Waiver program on his or her Effective Date of Enrollment, the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC- MCO for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later. If a Participant chooses to transfer to a different CHC-MCO, the receiving CHC-MCO must continue to provide the previously authorized services for 60 days or until a comprehensive needs assessment has been completed and a PCSP been developed and implemented, whichever date is later.	Continuity of Care: The draft RFP only allows for a 180 day period of continuity of care. We recommend a 24 month period of continuity of care, to give both participants and providers a chance to adjust to the major changes being proposed for this major systemic change.	RCPA/Richard Edley

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	232	This service will be provided to meet the Participant's needs, as determined by an assessment, in accordance with Department requirements and as outlined in the Participant's service plan. Personal Assistance Services are aimed at assisting the individual to complete tasks of daily living that would be performed independently if the individual had no disability.	Participant Service Plan: The language does not explain how consumers will account for their non-medical care. Consumers receiving PAS will not have adequate protection on appeal if appeals are required to be medically necessary.	RCPA/Richard Edley
Requirements Document	Section V.E. - Needs Screening	E & 40	Upon Enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or need for Service Coordination. Any Participant whose needs screening reflects unmet needs, service gaps, or a need for Service Coordination will be referred for a comprehensive needs assessment. The needs screening must be completed within the first 30 days of Enrollment, and may be conducted by phone, electronically, by mail, or in person.	The state should establish a directive on one tool. This will create consistency between plans and provide for some predictability.	RCPA/Richard Edley
Requirements Document	Section II - Definitions	232	Activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and communication. The extent to which a person requires assistance in performing IADLs is often assessed in conjunction with the evaluation of level of care.	Future waiver language should recognize consumer control, the language in the draft RFP represents a regressive approach.	RCPA/Richard Edley

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Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirem	K & 44	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology or other related field and at least three years of experience in the coordination of services. All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience. Service Coordinators and Service Coordinator Supervisors must also complete Department approved training in required training topics.	Service Coordinator Qualifications: While RCPA applauds the Department's effort to improve quality and agrees that additional qualifications would be appropriate and beneficial to all stakeholders, the proposed qualifications have unintended consequences. The state can achieve these same goals by: • Utilizing one of the many organizations and universities that provide standards and a national certification exam. • Adopting one standard statewide, rather than asking each MCO to develop their own. • Grandfathering existing Service Coordinators but require that they become certified within a set period of time, such as 2 years. In addition, PAPCA surveyed their membership for the impact the draft RFP SCE qualifications would have on their organizations. The results are drastic increases in cost and significant unemployment. This includes 86% of SCE supervisors and nearly 50% of SCs not meeting draft RFP standards.	RCPA/Richard Edley
Requirements Document	Section V.C. - Continuity of Care	C & 39	For a Participant who is receiving LTSS through an HCBS Waiver program on his or her Effective Date of Enrollment, the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later. If a Participant chooses to transfer to a different CHC-MCO, the receiving CHC-MCO must continue to provide the previously authorized services for 60 days or until a comprehensive needs assessment has been completed and a PCSP been developed and implemented, whichever date is later.	Continuity of Care: The draft RFP only allows for a 180 day period of continuity of care. We recommend a 24 month period of continuity of care, to give both participants and providers a chance to adjust to the major changes being proposed for this major systemic change.	RCPA/Richard Edley
Requirements Document	Section V.D. - Choice of Provider	D & 40	Participants must be afforded choice of all Providers within the Provider Network, including Service Coordinators. CHC-MCOs may not attempt to steer Participants to CHC-MCOs Affiliates who are Providers or interfere with the Participants' choice of Provider.	Choice of Providers: Please clarify the choice of provider provision as to whether this is choice of Service Coordinator or Service Coordination Entity. If choice is limited to the service coordinator as an individual employed by the MCO, consumer choice is illusory.	RCPA/Richard Edley
Requirements Document	Section II - Definitions	II. (Definitions), Page 1	Actuarially sound rates- rates that reflect the historical and projected future medical costs expected to be incurred…	This RFP should be focused solely on long term services and supports (LTSS). As a result, rates should and must include the long term services and supports costs.	RCPA/Melissa Dehoff

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Requirements Document	Section II - Definitions	II. (Definitions), Page 1	Current definitions do not include ABI	Acquired Brain Injury (ABI) - An injury to the brain secondary to either trauma, stroke (including aneurysms), post surgical complications, and/or certain acquired disease processes.	RCPA/Melissa Dehoff
Requirements Document	Section II - Definitions	II. (Definitions), Page 3	Current definitions do not include CARF	Commission on Accreditation of Rehabilitation Facilities (CARF) - An international, non-profit organization that provides accreditation standards and surveyors for organizations working in the human services field worldwide in areas such as Aging, Behavioral Health, and Medical Rehabilitation (which includes Brain Injury, Spinal Cord Services, Stroke Specialty, Cancer and Home and Community Services).	RCPA/Melissa Dehoff
Requirements Document	Section II - Definitions	II. (Definitions), Page 4	Current definitions do not include CRT	Cognitive Rehabilitation Therapy (CRT) - The process of relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry.	RCPA/Melissa Dehoff
Requirements Document	Section II - Definitions	II. (Definitions), Page 11	Long-Term Services and Supports (LTSS)- Definition does not include Residential Habilitation	Residential habilitation provides an individual with the opportunity to acquire or advance their skills in the areas of self-advocacy, communication, mobility/transportation, community-based living, educational, self-care, personal resource management, and community/social participation.	RCPA/Melissa Dehoff
Requirements Document	Section II - Definitions	II. (RFP Acronyms), Page 23	List of acronyms does not include ABI, CARF or CBIS	ABI- Acquired Brain Injury; CARF- Commission on Accreditation of Rehabilitation Facilities; CBIS- Certified Brain Injury Specialist	RCPA/Melissa Dehoff
Requirements Document	Section V.A. - Covered Services	V. Program Requirements (A. Covered Services, 2.), Page 26	In-Home and Community-based Services: The CHC-MCO may not deny personal assistance services… because the need for personal assistance is the result of a cognitive impairment..	This program requirement appears to solely focus on personal assistance services (PAS). PAS is one of many long term services and supports. The other services should be included as well.	RCPA/Melissa Dehoff
Requirements Document	Section V.A. - Covered Services	V. Program Requirements (A. Covered Services, 7.), Pages 28-29	Behavioral Health Services: "All participants who need behavioral health services will obtain these services from the Behavioral Health Managed Care Organizations (BH- MCOs)."	Please clarify that the Long Term Services and Supports (LTSS) "Therapeutic and Counseling Services" are not to be covered under this section. These are specialized services that are not available under Behavioral Health Services.	RCPA/Melissa Dehoff
Requirements Document	Section V.B. - Prior Authorization of Services	V. Program Requirements (B. Prior Authorization Requirements, 1.), Page 36	General Prior Authorization Requirements: "When the CHC-MCO denies a request for services….the CHC-MCO must make the notice available in accessible formats for individuals with visual impairments and for persons with limited English proficiency"…	It is recommended that if any individual has a Cognitive Impairment, the CHC-MCO must make the notice available in a format that the person can understand and include using a cognitive facilitator for this process.	RCPA/Melissa Dehoff

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Requirements Document	Section V.B. - Prior Authorization of Services	V. Program Requirements (B. Prior Authorization Requirements, 1.), Page 37	General Prior Authorization Requirements: "When the CHC-MCO denies a request for services… CHC-MCOs must conditionally approve Covered Services that are pending Medicare decisions in the event that these services are not covered by Medicare."	Please clarify that the Long Term Services and Supports (LTSS) "Therapeutic and Counseling Services" are not to be covered under this section. These are specialized services that are not available under Behavioral Health Services. Please include explicit language here that if Medicare is the TPR, the CHC- MCO will honor the Annual Cap published by Medicare for PT/SP services, and for OT services as exhaustion of TPR, and if the service continues to be medically necessary, the CHC- MCO will provide the service according to the Service Definitions.	RCPA/Melissa Dehoff
Requirements Document	Section V.C. - Continuity of Care	V. Program Requirements (C. Continuity of Care, Bullet 2), Page 39	"For a participant who is receiving LTSS through an HCBS Waiver program on his or her Effective Date of Enrollment….the continuity of care…will run from the Effective Date of Enrollment into the CHC-MCO for 180 days…"	It is recommended that this timeframe be increased to a 24- month period of continuity of care. Many of the consumers have had their existing service model for years, so any changes need to be carefully transitioned.	RCPA/Melissa Dehoff
Requirements Document	Section V.E. - Needs Screening	V. Program Requirement (E. Needs Screening), Page 40	"Upon enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department…" "The needs screening must be completed … and may be conducted by phone, electronically, by mail or in person."	The screening must be done using a tool that the Department specifies, and that is capable of 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 Form/Tool, Version 2.0, which can be used for all disability groups. (Link to the form/tool is below) Furthermore, for individuals with cognitive impairment, this screening must be conducted face- to-face and with additional information gathered by family/support system for those with cognitive needs. http://dspd.utah.gov/pdf/Comprehensive%20Brain%20Injury %20Assessment%20(CBIA)%20Version%202.0.pdf	RCPA/Melissa Dehoff
Requirements Document	Proposal Requirements	V. Program Requirement (F. Comprehensive Needs Assessments and Reassessments), Page 40-42	"The comprehensive needs assessment and reassessment processes developed by the CHC-MCO must also capture the following: Functional limitations in performing ADL and IADLs and level of care supports required by the Participant…." " The Department will designate a tool to be used for comprehensive needs assessments and reassessments."	The list of areas in which the needs assessment and reassessments must capture need to include: "Cognitive and behavioral needs and limitation that impact ADLs, IADLs, and that impact the participant's ability to access and participate in the community. It is recommended again 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	Section V.H. - Person Centered Service Plans	V. Program Requirement (H. Person-Centered Service Plans), Page 42	"Each PCSP must address how the Participant's physical and behavioral health needs and conditions will be managed by the CHC-MCO.."	Cognitive needs should be added: "….each PCSP must address how the Participant's physical, cognitive, and behavioral health needs…."	RCPA/Melissa Dehoff

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Requirements Document	Section V.H. - Person Centered Service Plans	V. Program Requirement (H. Person-Centered Service Plans), Page 43	List of areas that must be addressed in a LTSS assessment needs to include Personal Assistance Services, Therapies and Counseling and Level of Cognitive Impairment.	Add: Personal Assistance Services; Therapies and Counseling; Cognitive Needs (Level of Cognitive Impairment)	RCPA/Melissa Dehoff
Requirements Document	Section V.H. - Person Centered Service Plans	V. Program Requirement (H. Person-Centered Service Plans), Page 43	"PCSPs for Participants who require LTSS will be developed by the Service Coordinator, the Participant, and the Participant's PCPT."	Participants with physical disabilities are knowledgeable and know how to participate in and help develop their PCSP. For participants with significant cognitive disabilities (ex: dementia or brain injury), it is essential that providers with the appropriate expertise be included as part of the PCSP team. The team could include: neuropsychiatrist, neuropsychologist, physical therapist, occupational therapist, speech language pathologist, cognitive rehabilitation therapist, behavior analyst, case managers, social workers, and nutritionists.	RCPA/Melissa Dehoff
Requirements Document	Section V.I. - Department Review of Changes in Service Plans	V. Program Requirement (I. Department Review of Changes in Service Plans), Page 43	"The Department may review and revise any Person-Centered Service Plan. The CHC-MCO must provide the Department with weekly aggregate reports on PCSP changes."	It is recommended that a change in PCSP that would result in a 5% change of services would trigger a review by the Department. Relying on reviews of aggregate data does not afford adequate protections to the Participant.	RCPA/Melissa Dehoff
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	V. Program Requirement (K. Service Coordinator and Service Coordinator Supervisor Requirements), Page 44	"The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of RN, BS and at least three years of experience..All Service Coordinator Supervisors must be LSW or RN with 5 years of experience. Both must complete Department- approved training in required training topics."	Long-Term Services and Supports are by definition provided to participants with specific disability needs that are unable to be met in the regular health care system. Therefore, it is critical that disability-specific training be required for all Service Coordinators and Service Coordinator Supervisors. Disability-specific training and certification specific to the area of disability can be accessed through: "People with Physical Disability": www.cdms.org; "People with Dementia": www.ncdp.org; and "People with Brain Injury": www.biausa.org/acbis. 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 Department should utilize these organization's standards and certification process rather than asking for/relying on each MCO how they would guarantee an unspecified type and level of training. The Department could grandfather existing Service Coordinators but require that they become certified by the relevant area for the participants they will be serving within a set time frame, such as 2 years.	RCPA/Melissa Dehoff

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Requirements Document	Section V.M.- Coordination of Services	V. Program Requirement (M. Coordination of Services, 1. CHC- MCO & BH-MCO Coordination), Pages 44-45	"To facilitate efficient adminstration and to enhance the treatment of Participants who need both Covered Services and BH Services…"	The document needs to clarify that the Covered Services includes "Therapeutic and Counseling Services," which are specialized services that are not available under Behavioral Health Services, and as such should not be expected to be provided by BH Services.	RCPA/Melissa Dehoff
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V. Program Requirement (#17. Provider Directories), Page 56	"The CHC-MCO must utilize the file layout and format specified by the Department. The format must include…"	It is recommended that the Provider Directory also include the following information: Provider Specialty or Disability Specific Services; Provider Licensure or Accreditation. This would allow Participants to seek specialty services as needed and to ensure that chosen Providers had the expertise necessary to provide those specialty services.	RCPA/Melissa Dehoff
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	V. Program Requirement (O. Participant Enrollment and Disenrollment, 18. Participant Advisory Committee), Page 57	"Provider representation must include physical health, behavioral health, dental health and LTSS."	It is recommended that this language be revised: "Provider representation on the PAC must include physical health, behavioral health, dental health and all disability-specific groups receiving LTSS services."	RCPA/Melissa Dehoff
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	Page 85	"The CHC-MCO must take into consideration language and cultural compatability between the Participant and the Service Coordinator."	It is recommended that this language also include that CHC- MCO take into consideration the expertise of the Service Coordinator and ensure that the Service Coordinator have the expertise needed should disability-specific services be indicated, e.g. for individuals with acquired brain injury or other cognitive impairments.	RCPA/Melissa Dehoff

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Requirements Document	Section V.CC. - Provider Services	V. Program Requirement (CC. Provider Services 2. Provider Education), Pages 86-87	"The CHC-MCO must submit an annual Provider education and training workplan to the Department that outlines its plans to educate and train Network Providers."	It is recommended that the RFP require that content of training for disability specific areas be developed by experts in the field, and not left up to the CHC-MCO to devise their own training content. At a minimum, this would include that the training be developed by a person trained in and certified for the specific area of disability to be covered, to include: "People with Physical Disability," www.cdms.org; "People with Dementia," www.ncdp.org; and "People with Brain Injury," www.biausa.org/acbis. The RFP should indicate that this training could be subcontracted to an outside agency with the appropriate expertise to provide said training.	RCPA/Melissa Dehoff
Requirements Document	Section V.CC. - Provider Services	V. Program Requirement (CC. Provider Services 2. Provider Education), Pages 86-87	"At a minimum, the CHC-MCO must conduct the Provider training, as appropriate, in the following areas…"	It is recommended that an area be added: "Information around Brain injury and Cognitive Impairments and how to recognize and effectively work with individuals with cognitive impairments;" "i. Sensitivity training should also include how to effectively recognize and work with individuals with cognitive impairments."	RCPA/Melissa Dehoff
Requirements Document	Section V.DD. - Provider Network	V. DD. Provider Network; #1. Provider Qualifications, pg. 89	"All providers must meet the minimum qualification requirements established by the Department and must be credentialed by the Department."	Currently, Provider Qualifications are specified in the Waivers as approved by CMS, specifically for CommCare and OBRA serving people with brain injury, it is required that Providers be CARF accredited in Brain Injury. For Residential Services, CARF accreditation for Residential Rehabilitation is required and for Structured Day Services, CARF accreditation for Home and Community Services is required. These are CMS approved regulations that should be included as minimum requirements of Providers in the CHC RFP, so that MCOs are not asked how they would guarantee an unspecificed type of training and qualification of providers.	RCPA/Melissa Dehoff
Requirements Document	Section V.EE. - QM & UM Program Requirements	V. Program Requirements (EE. QM and UM Program Requirements 2. Quality Management/Performance Improvement), Page 95	"The CHC-MCO shall have a written Quality Management/Quality Improvement program that clearly defines its quality improvement structures and processes…"	It is recommended that the RFP include language that recognizes the Quality Management programs 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.	RCPA/Melissa Dehoff
Requirements Document Exhibit	DD - Participant Handbook	#47	"At a minimum, the Participant Handbook shall include:….47. Information about LTSS. "	It is recommended that the Department outline the information that should be included about LTSS. Most of the items listed in the Participant Handbook are about the structure and organization of the MCO. The most important part of this Handbook is information about the types of services included in LTSS (such as services for people with brain injury, residential habilitation, etc.), this information should be included in the Participant Handbook.	RCPA/Melissa Dehoff

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Requirements Document Exhibit	FF - Provider Directories	C. LTSS Providers	"The CHC-MCO shall be required to provide its Participants with LTSS Provider directories upon request, which include, at a minimum…"Experience or expertise serving individuals with particular conditions."	It is recommended that the Provider Directory also include any Licensure or Accreditation a Provider may have to substantiate their experience or expertise serving individuals requiring disability-specific services. This would allow Participants to seek specialty services as needed and to ensure that chosen Providers had the expertise necessary to provide those specialty services.	RCPA/Melissa Dehoff
Requirements Document Exhibit	DDD(1) - Covered Services List	V. Program Requirements (Exhibit DDD (1), Covered Services List)	Residential Habilitation; Structured Day; Cognitive Rehabilitation Therapy	Residential Habilitation and Structured Day Services must also include provisions for Enhanced 1:1 staffing and Enhanced 2:1 staffing; these services are currently available in the Waiver Service definitions. Cognitive Rehabilitation Therapy should be added to the list. See Pages 53, 84 and 87 in the waiver: http://www.dhs.pa.gov/cs/groups/webcontent/documents/d ocument/c_216913.pdf	RCPA/Melissa Dehoff
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	V. Program Requirements (Exhibit DDD (2) Covered Services LTSS Definitions)	Residential Habilitation; Structured Day; Cognitive Rehabilitation Therapist	The RFP should include the following as the Service Definition for Enhanced Staffing for Residential Habilitation and Structured Day Services: Individual considerations may be available for those individuals that require continual assistance as identified on their needs assessment to ensure their medical or behavioral stability. By nature of their behaviors or medical needs, individuals are not able to participate in activities or are unable to access the community without direct staff support. Residential Enhanced staffing/Structured Day Enhanced staffing is treated as an add-on to the Residential Habilitation/Structured Day Services and is only available when the participant requires additional behavioral or medical supports. The language in the Covered Services should be changed to match the language in the Waiver. See pages 53, 84 and 87 in the waiver: http://www.dhs.pa.gov/cs/groups/webcontent/documents/d ocument/c_216913.pdf	RCPA/Melissa Dehoff
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	V. Program Requirements (Exhibit DDD (2) Covered Services LTSS Definitions)	Therapeutic and Counseling Services: Cognitive Rehabilitation Therapy services: Services include consultation, ongoing counseling, and coaching/cueing performed by a certified Cognitive Rehabilitation Therapist.	It is critical that the full definition of the Provider Qualifications in the current waiver be included in this document; specifically that a Cognitive Rehabilitation Therapist has a Certified Brain Injury Specialist (CBIS) Certificate, or Certification by Society for Cognitive Rehabilitation. The current waiver goes on to specify: Masters or Bachelors degree in an allied field with licensure, certification or registration where applicable. If credentialing is not available, a Bachelors or Masters degree professional must be supervised by a licensed psychologist, a CBIS or a professional certified by the Society for Cognitive Rehabilitation.	RCPA/Melissa Dehoff
Other	Target Populations			In the Agreement document, the brain injury population (as well as other specific populations, i.e., Autism) is not identified in the general definitions, acronyms, and within the Program Requirements of the Agreement. There is great concern that the Draft RFP is medically focused and based largely on the physical health agreement due to the minimal inclusion of LTSS within some of the sections. The acquired brain injury population has specific challenges and requires specific qualifications and expertise to properly care for, interact with, and serve this population are inadequate in the Draft RFP, e.g., screening and assessment, service plan development, care coordination, and provider qualifications. It is difficult to know how potential Managed Care Organizations are to describe a strategy for brain injury without any guidelines on what that has to include, or for any of the other populations covered under waivers.	RCPA/Melissa Dehoff
Other		General Comment		**Intent/Definition of Service Coordination**-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program.	Jefferson County Area Agency on Aging
Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	Jefferson County Area Agency on Aging

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Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems-** The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	Jefferson County Area Agency on Aging
Requirements Document	Section V.C. - Continuity of Care	p. 39	...the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	**Continuity of Care for LTSS Participants**-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	Jefferson County Area Agency on Aging
Requirements Document	Section II - Definitions	p. 14	Participant Advisory Committee (PAC)- A group convened in person, at least quarterly by the CHC-MCO's governoring board which is open to all participants and which reflects the diversity of the CHC-MCO's Participant population	**Participant Advisory Committee Makeup -** We recommend that the PAC meetings be formed for, and held in, each zone (for instances where MCO may cover more than one zone) and have representation for rural and urban counties in each particular zone.	Jefferson County Area Agency on Aging
Requirements Document	Section II - Definitions	p. 15	Person Centered Planning Team- The team of individuals that will participate in Person Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT	**Person Centered Planning Team Makeup** - We recommend OLTL include the minimum acceptable required individuals and also include other suggestions/preferences for individuals on the team. We also recomment that OLTL require that if there is a behavioral health diagnosis, a behavioral health representative be required on the team.	Jefferson County Area Agency on Aging
Requirements Document	Section V.A. - Covered Services	p. 26	In-Home and Community -Based Services- The CHC- MCO may not deny personal assistance services for Participants under the age of 21 based on the Participant's diagnosis or because the need for personal assistance is the result of a cognitive imparment...	**Personal Assistance Services** - We recommend removing "under the age of 21" so that no conumer could be denied personal assistance services based on the participant's diagnosis or because the need is based on a cognitive impairment	Jefferson County Area Agency on Aging
Requirements Document	Section V.A. - Covered Services	p. 26	The CHC-MCO may not deny a request for Medically Necessary in-home nursing services, home health aide services, or personal assistance services for a Participant under the age of 21 on the basis that a live-in caregiver can perform the task...	**In-home Nursing, Home Health Aide or Personal Assistance Services** - We recommend removing "under the age of 21" so that no consumer could be denied under these circumstances.	Jefferson County Area Agency on Aging
Requirements Document	Section V.B. - Prior Authorization of Services	p. 36	B. Prior Authorization of Services 1.General Prior Authorization Requirements (4th paragraph) When the CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of denial using the appropriate notice outline in templates...	**Notice of Service Denial** - We recommend that when there is a denial of services for those in MLTSS, notification should also be sent to the Service Coordination Agency/entity to ensure continuity and follow up with consumer.	Jefferson County Area Agency on Aging

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Requirements Document	Section V.B. - Prior Authorization of Services	p. 37	2. Time frames for notice of Decisions	**Notice of Service Decisions** - We recommend that notice decisions should also be sent to Service Coordinator (entity) if additional information is needed from an MLTSS consumer the Service Coordination Agency should also be notified so they can assist the consumer in acquiring required documentation.	Jefferson County Area Agency on Aging
Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	**Continuity of Care for LTSS Participants**-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	Jefferson County Area Agency on Aging
Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	**Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors**-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers. We also recommend that a Service Coordination Supervisor only need the same requirements as the Director of Service Coordination of the MCO's, and not need to be an RN or LSW	Jefferson County Area Agency on Aging
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	**Limited English Proficiency Requirements**- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	Jefferson County Area Agency on Aging
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	**Management Information Systems**-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	Jefferson County Area Agency on Aging
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	Jefferson County Area Agency on Aging
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	**Willing Provider Definition –** In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	Jefferson County Area Agency on Aging

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Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department** – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	Jefferson County Area Agency on Aging
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	Jefferson County Area Agency on Aging
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	Jefferson County Area Agency on Aging
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	Jefferson County Area Agency on Aging
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	Jefferson County Area Agency on Aging

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RFP	General Information	I.5 Type of Agreement p.12	The Department's actuary will provide to the Department a set of actuarially sound rate ranges for the calendar year 2017 program for the SW zone in spring 2016. The Department anticipates that the initial agreements will include: -- Capitation rates. -- Individual Stop-Loss Reinsurance. -- Specialty Drug Risk Sharing. -- Pay For Performance Incentives	How will rates take into account the expanded list of services for CHC members? When will detailed information be made available on the individual stop loss reinsurance and specialty drug risk sharing. Given the newness of the program and therefore the lack of reliable data to base rates on and the potential for "pent-up" demand, is DHS willing to consider a risk corridor program as additional protection for participating CHC-MCOs? Will any benefit limits be added to the CHC program?	Gateway Health Plan
RFP	Proposal Requirements	A. p.22	Offerors must submit their proposals in the format, including heading descriptions, outlined below. To be considered, the proposal must respond to all requirements in this part of the RFP. Offerors should provide any other information thought to be relevant, but not applicable to the enumerated categories, as an appendix to the proposal. Small Diverse Business cost data relating to the proposal should be kept separate from and not included in the Technical Submittal. Each proposal shall consist of the following two (2) separately sealed submittals. Offers must submit in hard copy the Signed Domestic Workforce Utilization Certification Form identified as Tab 10.	Please clarify what DHS is designating for submission in Tab 10.	Gateway Health Plan
RFP	Proposal Requirements	II4.A p.26	Full time positions for executive management mean full time positions dedicated to CHC program in Pennsylvania including a CFO.	Is it possible that existing personnel oversee administration of this function? For example, is it acceptable to have a financial "leader" who acts as the CFO for the CHC program?	Gateway Health Plan
RFP	Proposal Requirements	II4.B p.27	one-third of the Board's membership must "subscribers" of the CHC-MCO.	Gateway Health, as a licensed HMO under the DOH regulations, already complies with the requirement that 1/3 of its Board Director positions are subscribers in some line off business. We object to the requirement as written in the RFP at II-4(B) to the extent it is interpreted to limit the pool of Subscriber Directors to only LTSS subscribers. This population should be included in the pool of eligible members to be considered for open Board positions, but the HMO should not be required by the LTSS contract to fill all Subscriber Director positions with all LTSS members.	Gateway Health Plan
RFP	Work Statement Questionnaire	Q.5 p.30	Describe your experience and approach to Participant care management.	Could you please define participant care management? Is this different from person centered care?	Gateway Health Plan
RFP	Work Statement Questionnaire	Q.19 p.32	What is your plan for the collection of participants' payment obligation for the cost of nursing facility care?	Do you mean in the event of participant cost sharing?	Gateway Health Plan
RFP	Work Statement Questionnaire	Service Integration p.33	Questions 1 and 8	Can these two questions be consolidated as they appear to be asking for the same things except for the D-Snp distinction in Q.8	Gateway Health Plan
RFP	Work Statement Questionnaire	Q.19 p.39	What is your plan to communicate outcome measures with Network and Out-of-Network Providers?	What is DHS's expectation for communications w/OON providers given a CHC-MCO has no contractual obligations w/these entities?	Gateway Health Plan

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RFP	Work Statement Questionnaire	Q.20 p.39	Describe your system for providing access to all network providers to enrollment, service coordinator contact, and service plan information.	Does this include non-medicall LTSS providers?	Gateway Health Plan
RFP	Work Statement Questionnaire	Q.1 p.40	Describe how you will achieve appointment access standards, including when Participants cannot access care within your provider network and must go to an Out-of-Network provider.	What are the access standards for non-medical LTSS providers?	Gateway Health Plan
RFP	Work Statement Questionnaire	Q.1 p.40	Describe how you will provide choice of medical, LTSS, and service coordination providers for Participants.	For service coordinators, it will be difficult to offer a choice for the initial assignment if a CHC-MCO wants to maintain its case load ratios. We therefore recommend that Participant choice only be allowed in the event of "friction" between them and the service coordinator.	Gateway Health Plan
RFP	Work Statement Questionnaire	Q.3 p.40	Describe how your organization will establish a dental provider network to meet or exceed compliance levels for dental needs of Participants through the use of incentives or other provider attraction techniques. Provide recent examples of dental network improvements made by your organization. Specifically describe how your network is prepared to meet the dental needs of Participants in nursing facilities or requiring accommodations to access dental services.	What are the access standards for dental care provided to nursing home residents?	Gateway Health Plan
RFP	Work Statement Questionnaire	Q.6 p.41	Explain your plan to manage contracted skilled nursing facility health providers, non-skilled home care providers , and other LTSS providers to meet Participants' needs for access to HCBS and innovative housing options.	What will be the access standards to innovative housing solutions and HCBS services?	Gateway Health Plan
RFP	Work Statement Questionnaire	Q.5 p.41	Describe how you will use Geo Access mapping to ensure network adequacy.	Will DHS allow CHC-MCOs the flexibility to use the software they wish to ensure the adequacy of its provider networks?	Gateway Health Plan
RFP	Work Statement Questionnaire	Q. 11 p.42	Explain how you will provide Participants with access to in-home services if scheduled services are not available.	Is this in the event of a last minute cancellation?	Gateway Health Plan
RFP	Work Statement Questionnaire	II-6.B. 7-10 p.43	Offeror must provide the following information: bond rating, A.M. Best rating for life/health, Standard and Poor rating and Dun and bradstreet rating, Weiss rating	As these ratings do not apply to all Offerors, we suggest adding the phrase if applicable before each rating request.	
RFP	Work Statement Questionnaire	II-10 p.47	Identify the number of employees that will be assigned to this project.	A definitive number cannot be provided initially as requested here as staffing is dependent upon CHC enrollment. .	Gateway Health Plan
RFP	Work Statement Questionnaire	p.29	Maximum 30 pages	We suggest raising maximum to 60 pages	Gateway Health Plan
RFP	Work Statement Questionnaire	p.33	Maximum 15 pages	We suggest raising maximum to 25 pages	Gateway Health Plan
RFP	Work Statement Questionnaire	p.34	Maximum 20 pages	We suggest raising maximum to 40 pages	Gateway Health Plan

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RFP	Work Statement Questionnaire	p.35	Maximum 15 pages	We suggest raising maximum to 30 pages	Gateway Health Plan
RFP	Work Statement Questionnaire	p.37	Maximum 20 pages	We suggest raising maximum to 40 pages	Gateway Health Plan
RFP	Work Statement Questionnaire	p.39	Maximum 25 pages	We suggest raising maximum to 40 pages	Gateway Health Plan
Requirements Document	Section V.A. - Covered Services	A.11 p.30	The CHC-MCO must limit charges to Participants for Post-Stabilization Services to an amount no greater than what the CHC-MCO would charge the Participant if he or she had obtained the services through the Provider Network.	Will the absorption of these charges by the CHC-MCO be limited to emergency situations? Otherwise this could promote the use of OON providers which would greatly hamper the ability to properly coordinate the Participant's care. Will any of these absorbed CHC-MCO costs be considered when rates are being developed?	Gateway Health Plan
Requirements Document	Section V.A. - Covered Services	V.A.17 p.34	The CHC-MCO must, in coordination with the Department, ensure that all Nursing Facility related processes are completed and monitored. This includes but is not limited to: Preadmission Screening Resident Review (PASRR) process, specialized service delivery, Participant's rights, patient pay liability, personal care accounts or other identified processes.	Please define the expectations for monitoring as the NF is required to do this and there is a survey process and auditing process in place for the NF. To have the CHC-MCO staff involved in collecting and monitoring members' finances appears inappropriate and duplicative of present, in place DHS/CMS auditing procedures.	Gateway Health Plan
Requirements Document	Section V.A. - Covered Services	V.A.18 p.34	Participants may elect the Budget Authority model called Services My Way, in which the Person-Centered Service Plan is converted to a budget and the Participant develops a spending plan to purchase needed goods and services. Participants in this model may elect to receive personal assistance through an agency and/or to employ their own personal assistance providers.	Please provide more detail regarding how the participant and the providers receive payment under the Services My Way option. Does the option to select Services My Way optionapply to all participants?	Gateway Health Plan
Requirements Document	Section V.C. - Continuity of Care	V.C. p.39	For a Participant who is receiving LTSS through an HCBS Waiver program on his or her Effective Date of Enrollment, the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later."	Does this apply to Service Coordination if the CHC-MCO provides Service Coordination directly?	Gateway Health Plan
Requirements Document	Section V.D. - Choice of Provider	V.D. p.40	Participants must be afforded choice of all Providers within the Provider Network, including Service Coordinators	Please clarify this requirement for CHC-MCOs that provide Service Coordination directly. Also by choice does this include the initial care coordinator assignment or afterwards in the event the CHC member would like to change care coordinators?	Gateway Health Plan

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Requirements Document	Section V.E. - Needs Screening	V.E. p.40	Upon Enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or need for Service Coordination. Any Participant whose needs screening reflects unmet needs, service gaps, or a need for Service Coordination will be referred for a comprehensive needs assessment. The needs screening must be completed within the first 30 days of Enrollment, and may be conducted by phone, electronically, by mail, or in person.	Please clarify which participants would require a Needs screening. For example, would a participant that was required to have a Comprehensive Needs Assessment completed within 7 days (Section BB.) be required to also have a Needs Screening within 30 days of enrollment?	Gateway Health Plan
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	V.F. p.40	For Participants that are NFCE but are not receiving LTSS at the time of Enrollment, the comprehensive needs assessment must be completed in accordance with the timelines outlined in Services Prior to Effective Date of Enrollment.	The Services Prior to Effective Date of Enrollment document was not referenced or attached.	Gateway Health Plan
Requirements Document	Section V.H. - Person Centered Service Plans	V.H. p.43	PCSPs must be completed no fewer than 30 days from the date the comprehensive needs assessment or reassessment is completed.	Please clarify that “no fewer” is accurate.	Gateway Health Plan
Requirements Document	Section V.I. - Department Review of Changes in Service Plans	V. I. p.43	The Department may review and revise any Person-Centered Service Plan. The CHC-MCO must provide the Department with weekly aggregate reports on PCSP changes.	Due to the volume of participants and often changing needs, this will be a significant administrative burden to CHC-MCOs.	Gateway Health Plan
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	1. General	Allowing participants to change plans “at anytime”.	Please consider offering an annual enrollment/re-enrollment period, with exceptions.	Gateway Health Plan

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	12. c p.53	When any Participant is disenrolled from the CHC-MCO the CHC-MCO from which the Participant disenrolled remains responsible for participating in discharge/transition planning for up to six (6) months from the initial date of Disenrollment. The CHC-MCO must remain the Participant's CHC-MCO upon discharge (upon returning to the CHC zone covered by this agreement), unless the Participant chooses a different CHC-MCO or is determined to no longer be eligible for participation in CHC, provided that the Participant is discharged within six (6) months of the initial CHC-MCO Disenrollment date.	Please clarify this requirement.	Gateway Health Plan
Requirements Document	Section V.X.- Administration	X.7.h	References Exhibit M for provider certification standards	Exhibit M could not be found.	Gateway Health Plan
Requirements Document Exhibit	DDD(1) - Covered Services List	p. 217	Home health aide services	Please clarify how these services are different from Personal Care Services? We recommend an hourly limit not to exceed 16 hours per day. We also recommend either adding limits to certain services such as home and vehicle modifications, HH Aide, Nursing, Personal Care OR preferably adding an individual "cost-neutrality" threshold for HCBS (with exceptions if the CHC-MCO is willing to exceed the threshold in certain cases).	Gateway Health Plan
Requirements Document	Section V.A. - Covered Services	V.B.1 p.36	The CHC-MCO may not require prior authorization of Medicare services for Participants with Medicare. CHC-MCOs must conditionally approve Covered Services that are pending Medicare decisions in the event that these services are not covered by Medicare. Service Coordinators are required to work with the Participant's Medicare plan to ensure expeditious decision-making and communication of decisions made.	What does it mean to "conditionally approve Covered Services that are pending Medicare decisions in the event that these services are not covered by Medicare"? Does this mean that the approval is conditional because approval requires that Medicare to cover the service/item first? Or approval is required in case Medicare does not cover the service/item? How does DHS envision a conditional approval being done by the CHC-MCO? Is DHS going to assist CHC-MCOs in establishing some coordination efforts with the potential Medicare plans?	Gateway Health Plan
Requirements Document Exhibit	DDD(1) - Covered Services List	p. 217	Job coaching, Job finding and Employment skills	Does DHS expect the CHC-MCO to directly provide these services to CHC Participants or may it subcontract out for them?	Gateway Health Plan
Requirements Document	Section V.V. - Executive Management	V. p.64	Full time positions dedicated to CHC including a program manager, medical director, pharmacy director, director of quality management, director of LTSS, CFO and IS coordinator.	Please define the difference between the program manager duties and that of the LTSS director as there appears to be overlap. And is it possible to leverage the full-time positions already in place for the HealthChoices program until CHC membership reaches a certain membership level?	Gateway Health Plan
Requirements Document	Section II - Definitions	Stop Loss Protection p. 20	Coverage designed to the limit the loss of a provider.	Language should be changed to "limit the loss of a CHC-MCO".	Gateway Health Plan
Requirements Document	Section V.A. - Covered Services	Expanded Services p.20	The CHC-MCO may provide expanded services subject to advance written approval of DHS.	Does every expanded service require advance approval? What circumstances could allow for services provided w/o DHS approval? The delay this likely will cause will result in members not receiving the appropriate services when needed potentially causing an unnecessary change in the level of care required.	Gateway Health Plan

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Requirements Document	Section V.I. - Department Review of Changes in Service Plans	p. 43	The CHC-MCO must provide the Department with weekly aggregate reports on PCSP changes.	The requirement for weekly aggregate reports will take time away from care cordinators essential duties and therefore we ask that it be required on a monthly or quarterly basis.	Gateway Health Plan
Requirements Document	Section V.A. - Covered Services	A.4 p.27	CHC-MCOs are permitted and encouraged to offer LTSS Covered Services to Participants who are not yet NFCE. These services will not be reimbursed by the Department.	Does this mean services should be provided when a member qualifies but isn't yet eligible? Can we give LTSS benefits to someone who doesn't meet LTSS eligibility standards? When it is said that these services will not be rembursed by the Department does this mean that these individuals will not be included in one of the rate ranges being developed?	Gateway Health Plan
Requirements Document	Section V.A. - Covered Services	A. 17 p. 33	The CHC-MCO is responsible for payment for Medically Necessary nursing facility services (including bed hold days and up to fifteen (15) per hospitalization and up to thirty (30) Therapeutic Leave Days per year) if a Participant is admitted to a Nursing Facility or resides in a Nursing Facility at the time of Enrollment.	What are the requirements or definition of a Therapeutic Leave Days? What if the MCO strongly disagrees with the LOC decision and need for Nursing Facility services? What is the appeal or redetermination process?	Gateway Health Plan
Requirements Document	Section V.A. - Covered Services	A. 17 p. 33	The CHC-MCO must allow newly enrolled Participants who are residing in a Nursing Facility on the Effective Date of Enrollment for CHC in the zone to continue to reside in the Nursing Facility on the date of their CHC-MCO Enrollment for the duration of the individuals' need for Nursing Facility services	If the member wants to transition to the community but still meets NF LOC, will he/she be allowed to make this transition?	Gateway Health Plan
Requirements Document	Section V.A. - Covered Services	A.18 p.34	In addition to the traditional agency model, CHC-MCOs must offer Participants who are eligible for HCBS the opportunity to self-direct Personal .	Please clarify which LTSS benefits may be self-directed. If there will be three statewide FMS vendors, how does the MCO pick a provider? Member's preference if they have one? If they are currently receiving services through a FMS vendor, does the MCO have to continue with them? Is it up to the MCO's discretion?	Gateway Health Plan
Requirements Document	Section V.B. - Prior Authorization of Services	B.1 p.36	If the CHC-MCO wishes to require Prior Authorization of any services, the CHC-MCO must establish and maintain written policies and procedures, which must have advance written approval by the Department.	Typically, all LTSS services require an authorization and prior approval from the MCO's service coordinator or medical director before service initiation. Is this provision related to a LTSS written policy?	Gateway Health Plan
Requirements Document	Section V.C. - Continuity of Care	C. p.39	The CHC-MCO must enter into a contract or payment arrangement with the resident's NF to make payments for the Participant's Nursing Facility services, whether or not the Nursing Facilities is in the CHC-MCO network	At what rate would the NF be paid in this circumstance?	Gateway Health Plan

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Requirements Document	Section V.E. - Needs Screening	E. p.40	Upon Enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or need for Service Coordination. Any Participant whose needs screening reflects unmet needs, service gaps, or a need for Service Coordination will be referred for a comprehensive needs assessment. The needs screening must be completed within the first 30 days of Enrollment, and may be conducted by phone, electronically, by mail, or in person.	If the needs screening reflects unmet needs, the member must then have a F2F comprehensive needs assessment by a service coordinator. Is this requirement for members only receiving or in need of LTSS services? Or, do all CHC members regardless of having LTSS services have to have a service coordinator?	Gateway Health Plan
Requirements Document	Section V O. Participants Enrollments and Disenrollments	O.11.b p.52	The file contains demographic changes, eligibility changes, Enrollment changes, Participants enrolled through the automatic assignment process, and TPL information.	Will the file contain an indicator on whether the member is in a NF or in the community?	Gateway Health Plan
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	O. 12 a. p.53	The Department will provide, every week by electronic file transmission, information on Participants enrolled or disenrolled. This file also provides dispositions on alerts submitted by the CHC-MCO.	How will this information differ from the Daily and Monthly Files?	Gateway Health Plan
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	O. 12 c. p.53	When any Participant is disenrolled from the CHC-MCO the CHC-MCO from which the Participant disenrolled remains responsible for participating in discharge/transition planning for up to six (6) months from the initial date of Disenrollment.	The six month timeframe seems excessive, Instead we recommend two to three months, if a person was still eligible, and not transitioning to a new CHC. What other situations would there be? If they are disenrolling and transitioning to another program, i.e. LIFE- having the CHC Service Coordinator involved for six months is excessive.	Gateway Health Plan
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	O.18 p.57	The meeting schedule must be no less than quarterly with in-person meetings, and travel expenses for Participants or their family members need to be reimbursed.	Will family members still need to be reimbursed if it is determined by the MCO that the Participant does not require their help?	Gateway Health Plan
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	O.20 p.58	The CHC-MCO may not request Disenrollment of a Participant because of an adverse change in the Participant's health status, or because of the Participant's utilization of Covered Services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her condition, disability, diagnosis, or needs.	Under what circumstanceswill DHS allow a CHC-MCO to voluntary disenroll a Participant?	Gateway Health Plan

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Requirements Document	Section V.B. - Prior Authorization of Services	P.4 p.60	The CHC-MCO must establish and maintain a Health Education Advisory Committee that includes Participants and Providers in the community to advise on the health education needs of Participants. Provider representation includes physical health, LTSS, behavioral health, and dental health Providers. The CHC-MCO must provide the Department annually with the membership (including designation) and meeting schedule of the Health Education Advisory Committee.	What will be the ratio of Participants and Providers on this Committee?	Gateway Health Plan
Requirements Document	Section V.X.- Administration	BB p.84	The CHC-MCO must offer the Participant the choice of at least two Service Coordinators.	Is this choice to be made available from the Participant's start in the program or only in the event of a requested change in a assigned service coordinator?	Gateway Health Plan
Requirements Document Exhibit	FF - Provider Directories	C p.151	The CHC-MCO shall be required to provide its Participants with LTSS Provider directories upon request, which include, at a minimum, the following information:	Is the requirement to have a separate LTSS provider directory or can it be a section within the provider directory as long as it meets all the requirements listed?	Gateway Health Plan
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	36:55.2	Nursing Home Transition services assist institutionalized individuals that have resided in an institution for at least ninety (90) consecutive or a barrier (including but not limited to; lack of informal or family supports, housing, etc.) and; are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained	Can a participant be transitioned to the community if they have been istitutionalized for less than 90 days?	Gateway Health Plan
Requirements Document	Section V.A. - Covered Services	10, page 29 & Exhibit K	The CHC-MCO must comply with the program standards regarding Emergency Services that are set forth in Exhibit K, Emergency Services.	Does this include emergency LTSS?	COSA, Sheelah Weekes
Requirements Document	Section V.A. - Covered Services	10, page 32	Should a PCP determine that a mental health assessment is needed, the PCP must inform the Participant or the APS or OAPS representative how to access mental health services and coordinate these services, when necessary.	When PS (or likely APS) is involved and there is a question of competency, the PCP is always the 1st contacted re: evaluation if need for guardianhip is in question. If the PCP is not in in a position to determine competency, will competency evaluation now be covered under mental health services, vs. PS or APS being responsible for cost?	COSA, Sheelah Weekes

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Requirements Document		15, page 32	The CHC-MCO must provide…non-medical transportation. Non-Medical Transportation includes transportation to community activities, grocery shopping, religious services, and other activities as specified in the Participant's Person-Centered Plan.	Does this apply to all participants whether or not they are in need of receiving other LTSS, including Service Coordination? This seems to be a huge undertaking…curious about the details re: how this will work, scheduling, cost, etc.	COSA, Sheelah Weekes
Requirements Document		21.a.i, page 35	a. Housing innovation that includes, but is not limited to: i. Pre-Tenancy and tenancy supports…	Does this apply to all participants whether or not they are in need to receiving other LTSS, including Service Coordination? What type of support will be available to those participants who do end up being evicted and have no where to go due to lack of resources, waiting lists, etc...will short term or long term NFS be approved for those in LTSS who qualify? What about those who are not in LTSS and may not qualify for NFS but need more care than a homeless shelter will provide?	COSA, Sheelah Weekes
Requirements Document		D, page 40	Participants must be afforded choice of all Providers within the Provider Network, including Service Coordinators. CHC-MCOs may not attempt to steer participants to CHC-MCOs Affiliates who are Providers or interfere with the Participants' choice of Provider.	If the CHC-MCO is a direct provider of Service Coordination, this would seem to be a potential conflict of interest? Does choice of Service Coordination Provider pertain to the choice of agency or choice of individual? If it pertains to individual, what factors will the choice be based on other than name? There is concern about potential for discrimination if based on gender &/or name and nothing else?	COSA, Sheelah Weekes
Requirements Document		E, page 40	Needs Screening	Curious re: tool that will be used for Needs Screening that will determine need for comprehensive needs assessment. If need for comprehensive needs assessment is determined, will CHC-MCO refer to Assessment Entity or IEE? If would seem that CHC-MCO would refer to Assessment Entity, who would then refer to IEE once the comprehensive needs assessment has determined the need for Service Coordination and LTSS?	COSA, Sheelah Weekes
Requirements Document		F, page 40	Comprehensive Needs Assessments and Reassessments…The comprehensive needs assessment will be completed by a Service Coordinator…	Unclear re: at what point Assessment Entity will be conducting assessment? Will Assessment Entity be conducting Assessments only on those who are expected to need LTSS? If so, then at what point and how does IEE get involved since this would be prior to participant selecting a Service Coordinator, and the Service Coordinator will be conducting this comprehensive needs assessment?	COSA, Sheelah Weekes
Requirements Document		F, page 40	The CHC-MCO must conduct a comprehensive needs assessment or reassessment no more than 12 months following the most recent comprehensive needs assessment or reassessment unless a trigger event occurs…Reassessments must be completed...in no case more than 14 days after the occurrence of any of the following trigger events: hospital admission, a transition between healthcare settings, or a hospital discharge, a change in functional status, a change in caregiver or informal support status, a change in the home setting or environment, a change in diagnosis that is not temporary or sporadic and the impacts one or more are of health status functioning, as requested by the Participant or designee, the caregiver, the provider, or the PCPT or the PCPT Participant, or the Department.	This will result in frequent, in some cases, constant comprehensive needs reassessments. Some of these trigger events are likely to occur simultaneously &/or within 14 days of each other. There should be some allowance for professional, clinical judgment...maybe consider need for a reassessment in all these situations but leave some room for decision to be based on individual circumstances? What is anticipated caseload for each Service Coordinator...will it be based on number of participants with consideration of the number of comprehensive needs assessments & reassessments being completed? What does PCPT stand for? It is not listed in the "Agreement and RFP Acronyms"	COSA, Sheelah Weekes

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Requirements Document		H, page 43	PCSPs for Participants needing or receiving LTSS must also address…How technology and telehealth will be used…	The technology and telehealth would seem to be beneficial.	COSA, Sheelah Weekes
Requirements Document		H, page 43	PCSPs for Participants needing or receiving LTSS must also address…How to accommodate preferences for leisure activities, hobbies, and community engagement.	Wonder about impact and restriction re: cost	COSA, Sheelah Weekes
Requirements Document		I, page 43	The Department may review and revise any PCSP.	While the Department "may" review and revise any PCSP, question what circumstances will warrant Department reviewing &/or revising a PCSP?	COSA, Sheelah Weekes
Requirements Document		K, page 44	Service Coordinators …meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology or other related field and at least 3 years experience in the coordination of services…Service Coordinator Supervisors...must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience.	The level of experience required for both SCs and SC Supervisors, and the need for SC Supervisors to be either a licensed Social Worker (or registered nurse) are steep and would seem much more costly than current requirements. Agree with need for qualified and experienced SCs and SC Supervisors. Consider using Civil Service METs...equivalent of ACM 2 for SCs which necessitates a bachelor's degree in sociology, social welfare, psychology, gerontology or other related social sciences; and 6 months as a Civil Service ACM 1 or 1 year experience in public or private social work. Equivalent of ACM Supervisor 1 for SC Supervisors which necessitates a bachelor's degree and 3 years of experience in public or private social work.	COSA, Sheelah Weekes
Requirements Document		O.1, page 46	The Participant has the right to initiate a change in CHC-MCO's plans at anytime.	Putting no restrictions on this will seem to result in a lot of chaos. Recommend limits of no more than once a month, with effective date at beginning of following month. Page 51.9. re: Transitioning Participants Between CHC-MCOs and LIFE Programs, specifies that all transitions to the LIFE Program will be effective on the date specified by the Department. It would seem that things should be consistent with LIFE and the CHC-MCOs.	COSA, Sheelah Weekes
Requirements Document		O.3.a, page 47	The CHC-MCO must not engage in outreach activities associated with Enrollments at the following locations and activities…	This seems to be very restrictive?	COSA, Sheelah Weekes
Requirements Document		O.3.k, page 49	The CHC-MCO may not, under any circumstances use the Department's eligibility system to identify and market to individuals participating in the LIFE Program or enrolled in another CHC-MCO.	How will this be monitored? What are the consequences?	COSA, Sheelah Weekes
Requirements Document		O.4, page 50	The CHC-MCO must provide at no cost to Participants, oral interpretation services in the requested language or sign language interpreter services to meet the needs of Participants…must also include all services…designated to the CHC-MCO Providers if the Provider is unable or unwilling to provide these services.	Questions re: cost and reimbursement	COSA, Sheelah Weekes
Requirements Document		11.b, page 52	CHC-MCO **an** Daily…	Typo, should be CHC-MCO **a** Daily	COSA, Sheelah Weekes
Requirements Document		11.b, page 52	either CHC, PH or BH…	What is PH? It is not listed in the "Agreement and RFP Acronyms"	COSA, Sheelah Weekes

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Requirements Document		14, page 54	The role of the PSPT…	What does PSPT stand for? It is not listed in the "Agreement and RFP Acronyms"	COSA, Sheelah Weekes
Requirements Document		18, page 57	Participants who are representative of the population being served as well as family caregivers. Provider representation must include physical health, behavioral health, dental health and LTSS…The PAC membership must be composed of at least 60% of CHO-MCO Participants, with 25% of the total membership receiving LTSS.	Is the 25% of LTSS Participants on PAC equivalent to the ratio of Participants receiving LTSS?	COSA, Sheelah Weekes
Requirements Document		20, page 58	Involuntary Disenrollment...The Service Coordinator will provide assistance to the disenrolled Participant to access other resources in order to ensure continuity of care.	Are there restrictions re: time &/or cost involved?	COSA, Sheelah Weekes
Requirements Document		P. 1, page 58-59	The CHC-MCO's Participant services functions must be operational at a minimum during regular business hours (9:00AM - 5:00PM, Monday through Friday) and one (1) evening per week (5:00PM - 8:00PM) or one (1) weekend per month to address non-emergency problems encountered by Participants. The CHC-MCO must have arrangements to receive, identify, and resolve in a timely manner Emergency Participants Issues on a twenty-four (24) hour, seven (7) day-a-week basis...The Service Coordinator must return the call as soon as possible but no longer than two (2) business days from the receipt of the call.	Service Coordnitors returning all calls within 2 buisness days seems reasonable.	COSA, Sheelah Weekes
Requirements Document		P. 1, page 59	The CHC-MCO must forward call calls received by the Participant **tservice** area in which the caller requests their Service Coordinator…	Typo & confusing, should be The CHC-MCO must forward call calls received by the Participant **to service** area in which the caller requests their Service Coordinator?	COSA, Sheelah Weekes
Requirements Document		P.2, page 60	Be staffed with adequate service representatives so that at least 85% of all calls are answered within thirty (30) seconds.	This seems to be a bit unrealisitc? What if call goes to voice mail? Is there a penalty?	COSA, Sheelah Weekes
Requirements Document		W, page 67	The CHC-MCO's staffing should represent the racial, ethnic, and cultural diversity of the Participants being served by CHC and comply with all requirements of Exhibit D.	I did not see Exhibit D in between Exhibit C and Exhibit E (1)? How strict is this? Will on-going changes in the racial, ethnic and cultural diversity of Participants being served by MCO necessitate on-going changes in the staffing, and be the basis for employee(s) losing their job, which might be considered a discrimitory practice?	COSA, Sheelah Weekes
Requirements Document		X,1, page 69	Recipient Lock-in Program…necessary to restrict Participants…	I don't quite understand this concept?	COSA, Sheelah Weekes

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Requirements Document		Y, page 72	The CHC-MCO will comply with the program standards regarding records retention, which are set forth in federal and state law and regulations and in Exhibit D…	I did not see Exhibit D in between Exhibit C and Exhibit E (1)?	COSA, Sheelah Weekes
Requirements Document		BB, page 84	The CHC-MCO must offer the Participant the choice of at least two Service Coordinators.	Does choice of Service Coordinators pertain to the choice of agency or choice of individual? If it pertains to individual, what factors will the choice be based on other than name? There is concern about potential for discrimination if based on gender &/or name and nothing else?	COSA, Sheelah Weekes
Requirements Document		BB, page 85	The CHC-MCO must take into consideration, language and cultural compatibility between the Participant and the Service Coordinator...The CHC-MCO must have written policies and procedures for allowing Participants to select or be assigned to a new Service Coordinator whenever requested by the Participant.	Is the Participant allowed to select or not selcect someone based on language or cultural compatibility alone? If the Participant does not want a Service Coordinator who speaks same language, will an Interpeter have to be provided?	COSA, Sheelah Weekes
Requirements Document		3, page 90	Both the CHC-MCOs and Network Providers must demonstrate Cultural Competency, Linguisitc Competency, and Disability Competency…CHC-MCOs and Network Providers must understand that racial, ethnic, linguistic, and cultural differences between Provider and Participant cannot be permitted to present barriers to accessing and receiving quality services... must demonstrate consistency in providing quality care across a variety of races, ethnicities and cultures...	I agree that there must be understanding & accomodations of cultural, racial, ethnic, linguistic and disability differences so that these do not serve as barriers (to quality services). However, will on-going changes in the cultural, racial, ethnic and disabilities of Participants being served by MCO necessitate on-going changes in the staffing, and be the basis for employee(s) losing their job, which might be considered a discrimitory practice?	COSA, Sheelah Weekes
Other	Contract Administration	I, 2nd page, under TRAVEL AND PER DIEM EXPENSES	**DEPARTMENT OF HUMAN SERVICES ADDENDUM TO <u>STANDARD CONTRACT TERMS AND CONDITIONS</u>**…The CHC-CMO shall not be allowed or paid travel of per diem expenses except as provided for in CHC-MCO's Budet and included in the agreement amount.	Will mileage accrued to and from field visits to Participants be reimburseable?	COSA, Sheelah Weekes
Requirements Document Exhibit		Exhibitt DDD(1)	Covered Services List…Community Choice Health Choices LTSS Benefits…Assisted Living...Pest Eradication…	Glad to see Assisted Living covered, is there any consideration of covering Personal Care Home &/or Dom Care? Also glad to see Pest Eradication covered.	COSA, Sheelah Weekes
RFP	Criteria	12	No fewer than two and no more than five.	If more than five MCO's meet the qualifications in a Zone and are interested in serving in such Zones, how will the selection be made? Will it be by scoring instrument (including cost) and is it appealable if an MCO is not selected?	COSA, Steve Gamble
RFP	Criteria	24	Offerors must also abide by the departments conflict of interest standards identified in Appendix A, Agreement	Please specify what the specific standards are going to be. I was not able to locate an Appendix A	COSA, Steve Gamble
RFP	Criteria	27 C.	The organizational Chart must clearly indicate any functions that are subcontracted along with the names of the entities and services.	At the time that the submissions are due, the MCO's will not have had adequate time to develop their provider network for LTSS and be able to document actual subcontracts. The wording could include indication of who they plan to subcontract with and requirmeernt that the information be updated prior to actual launch.	COSA, Steve Gamble

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RFP	Work Statement	32	19. Plan for collection of Participant obligation for NF care	Will the MCO's also be required to provide an accounting to the member of all costs associated with their care for Estate Recovery purposes? Additional information should be made available to members who are concerned with Estate Recovery and how the costs for LTSS will be broken out for Est Rec versus the Physical Health services.	COSA, Steve Gamble
RFP	Work Statement	41	6. Plan to manage contracted snf health providers… and access to innovative housing options	Will MCO's be required to explain how they will reimburse NF's when members who presently reside there choose to remain and what would be the responsibiility of the MCO in finding alternative placement for the individual if the NF is unable to remain viable?	COSA, Steve Gamble
RFP	Work Statement	49	Small Diverse Business Participation- criterion for this RFP as 20% of the total points	While the Commonwealth has mandated this requirement in contracts, there are few registered SDB's providing LTSS type services presently registered and will not likley be able to do so by the RFP due date. OLTL should keep in mind and help educate the existing LTSS service providers to allow more serious inclusion of such businesses.	COSA, Steve Gamble
RFP	Work Statement	54	IV-4 all agreements containing SDB participation must include a provision requiring … at least 50% of the subcontracted work.	This requirement seems a bit steep and not likley achievable. A more realistic number is 25% of the subcontracted work.	COSA, Steve Gamble
Requirements Document		11	Living Independently for the Elderly (LIFE)	PACE/LIFE Programs are not available as an alternative option to CHC members in all counties or zip codes throughout the Commonwealth. OLTL should work with existing providers of LIFE and/or solicit new providers to expand the availablity as a viable consistent alternative to selecting a CHC-MCO for LTSS.	COSA, Steve Gamble
Requirements Document		32 Sec 12	Should a PCP determine that a mental health assessment is needed, the PCP must inform the Participant or the APS or OAPS representative how to access mental health services and coordinate these services, when necessary.	Will the CHC-MCO be responsible for paying for a capacity evaluation, generally conducted in the home and or office, or be responsible for medical evaluations necessary for determining capacity or guardianship? This is usually associated with a OAPS or APS referral.	COSA, Steve Gamble
Requirements Document		32 Sec 15	Transportation- CHC-MCO must provide all medical and non-medical transportation as specified in the participants PCSP.	Will the CHC-MCO be responsible for paying the full fare through MATP for medical appointments and for those over age 65 only the 15 % co-pay required under the PA Lottery for non-medical trips? How about if the MCO can find a responsible provider that is more cost effective to include in the provider network who is not the designated MATP provider? This is often a very costly service and innovation and creativity should be considered, especially as this service continues to score highest on barriers to community connectedness.	COSA, Steve Gamble
Requirements Document		34 Sec 18	Self Directed Services- Participants may elect to receive PAS through a …employs his or her own personal assistant who can be a family member, a friend…	Please clarify if 'family member' includes a spouse, adult child, or POA acting as the Caregiver while receiving PAS services.	COSA, Denise Stewart
Requirements Document		39 Sec C	Continuity of Care- will run from the effective date of enrollment for 180 days…	We would suggest that the words: 'at no less than the present reimbursment rate at time of enrollment' be added to insure the continued provision of services be provided uninteruppted.	COSA, Steve Gamble
Requirements Document		40 Sec F	The needs screening must be completed within the first 30 days and may be conducted by phone, electronically, by mail, or in person.	We would suggest this process be examined for efficacy during the initial implementation period and then determined if an in-person screening is more warranted.	COSA, Steve Gamble
Requirements Document		89	Provider Network- A willing LTSS Provider is a Provider that is willing to contract with the CHC-MCO to provide services for a PAYMENT Rate that is agreed upon by the Provider and the CHC-MCO.	Allowing each of the CHC-MCO's to establish rates for the same service has the potential for great disparity. At a minimum, we would suggest creating a floor for the rate MCO's must pay, especially during the continuity of care period.	COSA, Steve Gamble
Requirements Document Exhibit		AAA (3) -6	All Providers operating within the Providers Network who provide services to Recipients must be enrolled in the Commonwealth's Medical Assistance program and possess an active PROMISE Provider ID	Will this limit current providers registered for a specific service such as 'service coordination' only, to contract with CHC-MCO's to provide other services which address the social determinates of health such as health promotions, wellness activities, or care transition services?	COSA, Steve Gamble

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Requirements Document Exhibit			DDD(2) Covered Services- Employment Skills Development	Is there any indication the CHC-MCO would utilize SCSEP Title V Senior Employment or at least coordinate with this service?	COSA, Steve Gamble
Requirements Document Exhibit			DDD(2) Covered Services- Financial Management	While not included under this section thus far, it's in the interest of the CHC-MCO and OLTL to include assistance with bill pay, budgeting, and/or credit counseling as a service avaible under CHC. This service has allowed many seniors to remain in a home or apartment setting they would have otherwise lost due to eviction or foreclosure.	COSA, Steve Gamble
Requirements Document Exhibit			DDD(2) Covered Services- Residential Habilitation - Licensed settings may not exceed capacity of more than 8 unrelated individuals.	We applaud the inclusion of Assisted Living services under this RFP, but encourage you to include Personal Care Boarding Homes and Domiciliary Care Homes as options for housing. There are so few accredited Assisted Living residences in the area and particpants should have as many options as possible to transition to the least restrictive enviroment. The restriction of maximum 8 person homes will eliminate many decent facilities.	COSA, Steve Gamble
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	Page 44	… Service Coordinators meet the minimum requirements … at least three years of experience in the coordination of services. All Service Coordinator Supervisors … must be a licensed social worker with at least 5 years of experience…	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology or other related field and: at least two years of experience in the coordination of services OR attain certification in a relevant discipline which would include Service Coordination certification, Case management certification, Psychiatric Rehabilitation Certification within 18 months of employment.	Abilities in Motion
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements			All SC Supervisors must be required to have a bachelor's degree in social work, psychology or other related field, 2 years of experience and a certification in Case Management (note 2 years of experience is needed to become certified), TBI certification, Psychiatric Rehabilitation Certification, OR a Master's degree in social work, psychology or other related field and one year of experience in the coordination of services.	Abilities in Motion
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements			Each CHC-MCO must require SCOs to employ at least two licensed social workers for every 25 FTE Service Coordinators.	Abilities in Motion
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements			Each CHC-MCO must either have on staff or contract an RN for the following activities: Review of the CMI or equivalent assessment, home visits for medical RON, reconcile in conjunction with pharmacist and or Physician medications, review nursing notes from Home health care agencies monthly.	Abilities in Motion
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements			Service Coordinators and SC Supervisors employed by SCOs as of the date CHC is implemented in their region are grandfathered in. However they must meet core competencies through testing, such as the service coordination certification classes.	Abilities in Motion
Other		General Comment		Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems- clarification on the roles and responsibilities of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will risk issues be coordinated and guidance when issues regarding consumers require involvement of protective services entities?	GECAC AAA Erie

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Other		General Comment		Definition of Service Coordination-A clear and precise definition and guidance on what service coordination entails and its interaction between other ancillary services and supports should be provided. The draft RFP appears to have ambiguity in the definition of service coordination. The Department should clarify if service coordination will be classified as a provider service or as an administrative function under the Community Health Choices (CHC). One example of where this is important is when considering the continuity of care period. If service coordination is a provider service, the continuity of care period would definitely apply. If it is an administrative function, will continuity apply to service coordination.	GECAC AAA Erie
RFP	Section V.C. - Continuity of Care	General Comment	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	Continuity of Care for LTSS Participants-6 months is a short time to identify the impacts of implementing a whole new system as comprehensive as CHC and the participants should be able to maintain their services with the trusted professionals they are accustomed to, unless there is justification for a change. To assure participants the most seamless transition for long term care services and supports, the RFP should establish this time frame at a minimum of a two year (24 month) period.	GECAC AAA Erie
Other		General Comment		Coordination of CHC Services with Behavioral Health Services- The Department should provide specific guidance for the coordination between behavioral health services and long term care services. Local experience through County Aging and IDD teams are that many difficult issues can mitigated with regular meetings of multi-disciplinary teams with representatives from CILs, AAAs, BH, MCO and other supportive services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. To determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks, this regular meeting of stakeholders is critical.	GECAC AAA Erie
Requirements Document	Section II - Definitions	p. 14	Participant Advisory Committee (PAC)- A group convened in person, at least quarterly by the CHC-MCO's governing board which is open to all participants and which reflects the diversity of the CHC-MCO's Participant population.	Participant Advisory Committee Makeup -PAC meetings should be formed in each region due to issues and solutions that are specific to each region. Also these meetings should be held in each zone (for instances where MCO may cover more than one zone) to enable representation for all types of participants such as rural and urban counties, older adults, individuals with disabilities, and others in each particular zone.	GECAC AAA Erie
Requirements Document	Section II - Definitions	p. 15	Person Centered Planning Team- The team of individuals that will participate in Person Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT	Person Centered Planning Team Makeup - The RFP should include the minimum acceptable required individuals and the stakeholder groups mandated for the PCPT. The RFP should also include other suggestions/preferences for individuals on the team. The RFP should require that if there is a behavioral health diagnosis, a behavioral health representative be required on the team.	GECAC AAA Erie
Requirements Document	Section V.B. - Prior Authorization of Services	p. 36	B. Prior Authorization of Services 1.General Prior Authorization Requirements (4th paragraph) When the CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of denial using the appropriate notice outline in templates…	Notice of Service Denial - The RFP should mandate that when there is a denial of services for those in MLTSS, notification should be sent to the Service Coordination Entity to ensure continuity and follow up with consumer.	GECAC AAA Erie
Requirements Document	Section V.B. - Prior Authorization of Services	p.37	2. Time frames for notice of Decisions	Notice of Service Decisions - The RFP should include that notices of service decisions also be sent to Service Coordinator and SC Entity. if additional information is needed from an MLTSS consumer the Service Coordination Entity should also be notified so they can assist the consumer in acquiring required documentation.	GECAC AAA Erie

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Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	Continuity of Care for LTSS Participants-To assure participants the most seamless transition for long term care services and supports, the RFP should establish this time frame as a minimum of a two year (24 month) period.	GECAC AAA Erie
Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, the RFP should include a provision that all current Service Coordinators and Service Coordinator Supervisors be 'grandfathered' and maintain their current requirements and the proposed minimum staff training requirements be imposed as service coordination entities through the contracting / certification standards of each MCO to achieve compliance with the new requirements. Performance goals in the contracting process could be used to attrition "poor performing" and "low quality" SC entities without disrupting the current continuity. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	GECAC AAA Erie
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	Limited English Proficiency Requirements- The RFP reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	GECAC AAA Erie
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following components to its MIS or the capability to link to other systems containing this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	Management Information Systems-The RFP should require that complaints and appeals be included as one of the minimum components for a technology / MIS or other linked-in system that all MCO's provide to oversight entities.	GECAC AAA Erie
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		Intent/Definition of Service Coordinator-There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	GECAC AAA Erie
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	Willing Provider Definition – In the interest of continuity of care, the RFP should change the 'any willing provider' definition to reflect that the payment rate must meet a minimum criteria of the current existing payment rate for the entire duration of the continuity of care period. MCO's should be able to dictate providers through the contracting requirements and performance goals.	GECAC AAA Erie

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Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	Notification to Department – The RFP should mandate the CHC-MCO to notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	GECAC AAA Erie
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	Complaints and Grievances – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. The RFP should include an advocate that can attend hearings with older adults. The RFP should mandate that CHC-MCO assure that participants are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior. AAAs and CILs can fulfill this mediation role and have many years experience in this capacity.	GECAC AAA Erie
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	Definition for Respite Care-The RFP should include in the definition of Respite the provision of respite care in an institutional setting when safe Home and Community options do not exist.	GECAC AAA Erie
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	Responsibility of Annual Level of Care Redetermination- In order to avoid any conflict of interest, the RFP should have language added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	GECAC AAA Erie
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements			I hereby submit that the qualifications for service coordinators will be detrimental to our quality of life as consumers of. HCBS. While I agree that something must be done to increase accountability and quality of this critical role, there are better ways to achieve this outcome. Conducting regular audits and sanctioning providers that fail to provide necessary documentation of consumer concerns is a welcome step. Please adapt the qualifications to allow for flexibility so that experience can substitute for education.	Brenda Dare/Consumer

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RFP	Proposal Requirements	D. Department's fair hearing requirements, page GG-18	The denial, in whole or part, of payment for a requested service/item if based on lack of Medical Necessity	The language in regards to Hearings/Appeals outlines denials based on lack of medical necessity. We recommend that reasons for denial of service to allow for a Fair Hearing/Appeal are also based on (1) health and safety and (2) quality of life aspects be added	Liberty Community Connections
Other	Target Populations			In the Agreement document, the brain injury population (as well as other specific populations, i.e. autism) are not identified in the general definitions, acronyms, and within the Program Requirements of the Agreement. There is great concern that the draft RFP is medically focused and based largely on the physical health agreement due to the minimal inclusion of LTSS within some of the sections. Individuals with acquired brain injury face specific treatment challenges that require specialized training, qualifications and expertise in order to properly meet their needs. Language relating to this is inadequate in the Draft RFP, e.g., screening and assessment, service plan development, care coordination, and provider qualifications. It is difficult to know how the potential MCOs are to describe a strategy for brain injury without any guidelines on what that has to include, or for any of the other populations covered under current waivers.	Main Line Rehab Associates (MLRA); Bridget Lowery
Requirements Document	Section II - Definitions	II Definitions, pg 1	"Actuarially Sounds Rates" based on "the historical and projected future medical costs…"	Rates should not just be based on "medical costs" - this RFP is for Long Term Services & Supports and so should focus solely on the long term services and supports costs.	MLRA; Bridget Lowery
Requirements Document	Section II - Definitions	II Definitions, pg 1	Current definitions do not include ABI	Acquired Brain Injury (ABI) - An injury to the brain as a result of either trauma, stroke (including aneurysms), post surgical complications, and/or certain acquired disease processes.	MLRA; Bridget Lowery
Requirements Document	Section II - Definitions	II Definitions, pg 3	Current Definitions do not include CARF.	The Commission on Accreditation of Rehabilitation Facilities (CARF) - an international private, nonprofit organization that provides accreditation standards and surveyors for organizations working in the human services field worldwide in areas such as Aging, Behavioral Health, and Medical Rehabilitation (including Brain Injury, Spinal Cord Services, Stroke Specialty, Cancer and Home and Community Services). Accredits providers, ensuring that quality standards are met and programs focus on enhancing the lives of the persons served.	MLRA; Bridget Lowery
Requirements Document	Section II - Definitions	II Definitions, pg 4	Current Definitions do not include CRT	Cognitive Rehabilitation Therapy (CRT) - Therapy that focuses on the process of relearning or compensating for cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry.	MLRA; Bridget Lowery
Requirements Document	Section II - Definitions	II RFP Acronyms, pg 23	Current Acronyms do not include CARF, ABI or CBIS.	CARF - Commission on Accreditation of Rehabilitation Facilities; ABI - Acquired Brain Injury; CBIS - Certified Brain Injury Specialist	MLRA; Bridget Lowery
Requirements Document	Section V.A. - Covered Services	Section V: A. Program Requirements, 2.; pg 26	In-Home & Community-Based Services: The CHC-MCO may not deny personal assistance services due to a cognitive impairment…	This Program Requirement appears to focus solely on denial of personal assistance services (PAS) because of cognitive impariments. However, this is only one of many services that should be included since cognitive impairments could impact someone in a variety of ways and could result in their need for nursing home placement without the proper supports available.	MLRA; Bridget Lowery
Requirements Document	Section V.A. - Covered Services	Section V: A. Program Requirements, 7.; pg 28 & 29	Behavioral Health Services: "All Participants who need behavioral health services will obtain these from the BH-MCOs".	Please clarify that the LTSS "Therapeutic and Counseling Services" are not to be covered under this section. These services are specialized services that are not available under Behavioral Health Services.	MLRA; Bridget Lowery

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Requirements Document	Section V.B. - Prior Authorization of Services	Section V: B. Prior Authorization of Services; Item 1, General Auth Req, paragraph 4, pg 36	General Prior Authorization Requirements: "When the CHC-MCO denies a request for services…, the CHC-MCO must make the notice available in accessible formats for individuals with visual impairments or with LEP…"	Because cognitive impairments also require specialized accessibility considerations, it is recommended that if any individual has a Cognitive Impairment, that the CHC-MCO must make the notice available in a format that the person can understand, to include using a cognitive faciltator for this process.	MLRA; Bridget Lowery
Requirements Document	Section V.B. - Prior Authorization of Services	Section V: B. Prior Authorization of Services; Item 1, General Auth Req, paragraph 4, pg 37	General Prior Authorization Requirements: "When the CHC-MCO denies a request for services…, the CHC-MCO must conditionally approve Covered Services that are pending Medicare decisions in the event that these services are not covered by Medicare."	Please clarify that the Long Term Services and Supports (LTSS) "Therapeutic and Counseling Services" are not to be covered under this section. These are specialized services that are not available under Behavioral Health Services. Please include explicit language here that if Medicare is the TPR, the CHC-MCO will honor the Annual Cap published by Medicare for PT/SP services, and for OT services as exhaustion of TPR, and if the service continues to be medically necessary, the CHC-MCO will provide the service according to the Service Definitions.	MLRA; Bridget Lowery
Requirements Document	Section V.C. - Continuity of Care	Section V: C. Continuty of Care; bullet 2, pg 39	For a participant who is receiving LTSS services…continuity of care will run from the Effective Date of enrollment into the CHC-MCO for 180 days…."	It is recommended that this time frame be increased to a 24 month period of continuity of care. Many of the consumers have had their existing service model for years, so any change needs to be carefully transitioned.	MLRA; Bridget Lowery
Requirements Document	Section V.E. - Needs Screening	Section V: E. Needs Screening; pg 40	"The CHC-MCO will conduct a needs screening using a tool approved by the Department….". "The needs screening must be completed…and may be conducted by phone, electronically, by mail or in person".	The Screening must be done using a tool that the Department specifices, 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, which can be used for all disability groups. 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 and/or who lack insight into their deficits.	MLRA; Bridget Lowery
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	Section V: F. Comprehensive Needs Assessments & Reassessments; pg 40-42; paragraph 3	"The comprehensive needs assessment and reassessments…must also capture the following: functional limitations and supports required to perform ADLs and IADLs …". "The Department will designate a tool to be used for comprehensive needs assessment and reassessments".	The list of areas which the needs assessment and reassessments must capture need to include: "Cognitive and behavioral and psychosocial needs and limitations that impact ADLs, IADLs, and that impact the the participant's ability to access and participate in the community. Again it is strongly recommended that the Department adopt Utah's Intake, Screening and Assessment tool, which can be used for all disability groups.	MLRA; Bridget Lowery
Requirements Document	Section V.H. - Person Centered Service Plans	Section V: H. Person-Centered Plan; pg 42; paragraph 2	"Each PCSP must address how the Participant's physical and behavioral health needs and conditions will be managed by the CHC-MCO….".	Cognitive Needs should be added here. It is recommended that this language be revised to state: "…must address how the Participant's physical, Cognitive and behavioral health needs…".	MLRA; Bridget Lowery

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Requirements Document	Section V.H. - Person Centered Service Plans	Section V: H. Person-Centered Plan; pg 43; paragraph 6	List of areas that must be addressed in a LTSS assessment needs to include Personal Assistance Services, Therapies and Counseling and Level of Cognitive Impairment.	Add: Personal Care needs, Therapy needs and Cognitive Needs (Level of Cognitive Impairment)	MLRA; Bridget Lowery
Requirements Document	Section V.H. - Person Centered Service Plans	Section V: H. Person-Centered Plan; pg 43; paragraph 6	"PCSPs for Participants who require LTSS will be developed by the Service Coordinator, the Participant and the Participant's PCPT".	Participants who only have physical disabilities are capable of participating in and helping to develop their PCSP. For Participants with significant cognitive disabilities (those with dementia or brain injury), it is essential that providers with the appropriate expertise be included as part of the PCSP team. The team could include: neuropsychiatrist, neuropsychologist, PT, OT, SP, Cognitive Rehabilitation Therapist, Behavior Analyst, Case Mangers and Social Workers.	MLRA; Bridget Lowery
Requirements Document	Section V.I. - Department Review of Changes in Service Plans	Section V: I. Department Review of Changes in Service Plans; pg 43	The Department may review and revise any PCSP. The CHC-MCO must provide the Department with weekly aggregate reports on PCSP changes.	It is recommended that a change in a PCSP that would result in a 5% change of services would trigger a review by the Department. Relying on reviews of aggregate data does not afford adequate protection to the individual Participant.	MLRA; Bridget Lowery
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	Section V: K. Service Coordinator & Service Coord. Supervisor Requirments ; pg 44	The CHC-MCO must require all employed or contracted Service Coord.to meet minimum requirements of RN, BS and at least 3 years experience; Service Coord Supervisors must be LSW or RN with 5 years experience. Both must complete Department approved training in required topics.	Long term supports and services are by definition provided to participants with specific disability needs that are unable to be met in the regular health care system. Therefore, it is critical that disability specific training be required for all Service Coordinators and Service Coordination Supervisors. Disability specific training and certification specific to the area of disability can be accessed through: "People with Physical Disability": www.cdms.org; "People with Dementia": www.ncdp.org; and "People with Brain Injury": through www.biausa.org/acbis. 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 Department should utilize these organization's standards and certification process rather than asking for/relying on each MCO how they would guarantee an unspecified type and level of training. The Department could grandfather existing Service Coordinators but require that they become certified by the relevant area for the participants they will be serving within a set time frame, such as 2 years.	MLRA; Bridget Lowery
Requirements Document	Section V.M.- Coordination of Services	Section V: M. Coordination of Services; 1. CHC-MCO and BH-MCO Coordination ; pg 44-45	"To facilitate efficient administration and to enhance the treatment of Participants who need both Covered Services and BH services…"	The document needs to clarify that the Covered Services includes "Therapeutic and Counseling Services", which are specialized services that are not available under Behavioral Health Services, and as such should not be expected to be provided by BH services.	MLRA; Bridget Lowery

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Section V: O. Participant enrollment & Disenrollment, #18 Participant Advisory Cmte; pg 57	Provider representation on the PAC must include physical health, behavioral health, dental health and LTSS.	It is recommended that this language be revised to state: "Provider representation on the PAC must include physical health, behavioral health, dental health and all disability-specific groups receiving LTSS services.".	MLRA; Bridget Lowery
Requirements Document	Section V.CC. - Provider Services	Section V: CC. Provider Services; #2. Provider Education, pg. 86-87	The CHC-MCO must submit an annual Provider education and training workplan to the Department that outlines its plans to educate and train Network Providers.	It is recommended that the RFP require that content of training for disability specific areas be developed by experts in the field, and not left up to the CHC-MCO to devise their own training content. At a minimum, this would include that the training be developed by a person trained in and certified for the specific area of disability to be covered, to include: "People with Physical Disability": www.cdms.org; "People with Dementia": www.ncdp.org; and "People with Brain Injury": www.biausa.org/acbis. The RFP should indicate that this training could be subcontracted to an outside agency with the appropriate expertise.	MLRA; Bridget Lowery
Requirements Document	Section V.CC. - Provider Services	Section V: CC. Provider Services; #2. Provider Education, pg. 86-87	At a minimum, the CHC-MCO must conduct the Provider training, as appropriate, in the following areas: …	It is recommended that an area be added: "Information around Brain injury and Cognitive Impairments and how to recognize and effectively work with individuals with cognitive impairments"; "i. Sensitivity training should also include how to effectively recognize and work with individuals with cognitive impairments".	MLRA; Bridget Lowery
Requirements Document	Section V.DD. - Provider Network	V. DD. Provider Network; #1. Provider Qualifications, pg. 89	"All providers must meet the minimum qualification requirements established by the Department and must be credentialed by the Department."	Currently, Provider Qualifications are specified in the Waivers as approved by CMS, specifically for CommCare and OBRA serving people with brain injury, it is required that Providers be CARF accredited in Brain Injury. For Structured Day Services, CARF accreditation for Home and Community Services is required. These are CMS approved regulations that should be included as minimum requirements of Providers in the CHC RFP, so that MCOs are not asked how they would guarantee an unspecificed type of training and qualification of providers.	MLRA; Bridget Lowery
Requirements Document	Section V.EE. - QM & UM Program Requirements	Section V: EE. QM & UM Program Requirements, 2. QM/Performance Improvement, pg. 95	The CHC-MCO shall have a written Quality management/Quality Improvement program that clearly defines its QI structures and processes…."	It is recommended that the RFP include language that recognizes the Quality Management programs 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.	MLRA; Bridget Lowery
Requirements Document	DDD(1) - Covered Services List	Section V: Exhibit DDD(1), Covered Services List	Structured Day; Cognitive Rehabilitation Therapy	Structured Day Services must also include provisions for Enhanced 1:1 staffing and Enhanced 2:1 staffing for times when enhanced staffing is needed due to the medical or behavioral condition of the individual; these services are currently available in the Waiver Service definitions. Cognitive Rehabilitation Therapy is perhaps the most important service being provided to individuals with acquired brain injury and should be added to the list of covered services. See Pages 53, 84 and 87 in the waiver: http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_216913.pdf	MLRA; Bridget Lowery

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Requirements Document	Section V: Exhibit DDD(2), Covered Services Definitions	Section V: Exhibit DDD(2), Covered Services Definitions	Structured Day; Cognitive Rehabilitation Therapy	The RFP should include the following as the Service Definition for Enhanced Staffing for Structured Day Services: Individual considerations may be available for those individuals that require continual assistance as identified on their needs assessment to ensure their medical or behavioral stability. By nature of their behaviors or medical needs, individuals are not able to participate in activities or are unable to access the community without direct staff support. Structured Day Enhanced staffing is treated as an add-on to the Structured Day Services and is only available when the participant requires additional behavioral or medical supports. The language in the Covered Services section should be changed to match the language in the Waiver. See pages 53, 84 and 87 in the waiver: http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_216913.pdf	MLRA; Bridget Lowery
Requirements Document	Section V.DD. - Provider Network	Section V: Exhibit DDD(2), Covered Services Definitions	Therapeutic and Counseling Services - Cognitive Rehabilitation Therapy	Given past problems with confusion between two services with similar names, it is critical that the full definition of the Provider Qualifications for Cognitive Rehabilitation services in the current waiver be included in this document; specifically that a Cognitive Rehabilitation Therapist has a Certified Brain Injury Specialist (CBIS) Certificate, or Certification by the Society for Cognitive Rehabilitation. The current waiver goes on to specify: Masters or Bachelors degree in an allied field with licensure, certification or registration where applicable. If credentialing is not available, a Bachelors or Masters degree professional must be supervised by a licensed psychologist, a CBIS or a professional certified by the Society for Cognitive Rehabilitation.	MLRA; Bridget Lowery
Other	Target Populations	pg. 29 #9 - EPSDT Services		Limiting services to those over 21 for all services, including those not available in EPSDT will create a service gap. If they need Structured Day services (which are not included in EPSDT) and typically get that structure through school but graduate at age 18, they will not be able to access Structured Day services through EPSDT and will therefore have a service gap until they turn age 21 and can access the service through CHC. If they need CRT, they can not access that through EPSDT because the state has used the wrong credentials for providing CRT (they require it be an OT), essentially leaving everyone unable to access this service because there is no one who can provide it under the current credentials. The program should lower the age to 18 years or make allowances for specialized services that are not available through EPSDT.	MLRA; Bridget Lowery
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	Page 84	The CHC-MCO must offer th Participant the choice of at least two Service Coordinators	To ensure consumer choice recommend change to: The CHC-MCO must offer the Participant the choice of at least two Service Coordination **Entities**.	Chester County Department of Human Services
Requirements Document	Section V.M.- Coordination of Services	Subsection 1 page 45, M1a	References BH inforamtion data to be provided to PH MCO.	Recommend that a requirement that PH MCO data will also be provided to BH MCO	Chester County Department of Human Services
Requirements Document		Section W page 66		Coordination with the BH-MCO to ensure Integrated Care Planning should be added to list of BH Coordinator's primary functions.	Chester County Department of Human Services
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Subsection 16 & 17, pages 55 and 56		Both should include requirement that this information is provided to the local Apprise programs or include how this information will be provided to local Apprise programs.	Chester County Department of Human Services
Requirements Document	Section V.CC. - Provider Services		Coordinating Behavioral Helath Services by working with BH-MCOs as spedified in Exhibit U: Behavioral Health Services	Statement should be expanded to also include BH MCO provider network e.g. - Coordinating Behavioral Health Services by working with BH-MCOs **and their BH network of providers** as spedified in Exhibit U: Behavioral Health Services	Chester County Department of Human Services
	Other		General Comment	Currently our Aging Care Managers provide a great deal of hands on support for consumers including trouble shooting for them when they experience lapses in MA coverage for preventable reasons. This includes assisting them obtaining documentation, working with the CAO, and continuing to provide services during the appeal process while they assist the consumer in getting their MA reinstated with no break in coverage. We understand that there will be a state contracted enrollment broker who is expected to fulfill this role when initially establishing eligibility but it is not clear who will fill this role thereafter. Will this be an Service Coordination expectation?	Chester County Department of Human Services

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Other		General Comment		Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems- The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	Chester County Department of Human Services
Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	Chester County Department of Human Services
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		Intent/Definition of Service Coordinator-There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	Chester County Department of Human Services
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	Willing Provider Definition – In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	Chester County Department of Human Services
Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department** – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	Chester County Department of Human Services
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	Chester County Department of Human Services
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	Chester County Department of Human Services

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Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	Chester County Department of Human Services/ Kim Bowman Director
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	Chester County Department of Human Services/ Kim Bowman Director
RFP	II-5 Work Statement	30	11. Describe your organization's experience and your plan for using technology such as assistive technology, telehealth, telecare, social media, electronic visit verification, and other methods to deliver services to the CHC Participants.	11. Describe your organization's experience and your plan for assuring access to assistive technology, telehealth, telecare. Include a description of how you will assure access to the full array of AT from highly specialized, customized and modified devices and generic commercially available items used to meet a specific disability-related need. Describe your plan for obtaining products from outside of network when unavailable in network.	Pennsylvania Assistive Technology Foundation (PATF)
RFP	II-5 Work Statement	30	11. Describe your organization's experience and your plan for using technology such as assistive technology, telehealth, telecare, social media, electronic visit verification, and other methods to deliver services to the CHC Participants.	Add New # - Describe your organization's experience and your plan for using social media and electronic visit verification, and other methods to deliver services to the CHC Participants.	Pennsylvania Assistive Technology Foundation (PATF)
Requirements Document	Section V.A. - Covered Services	Assistive Technology P219-20	Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized...	The description should clarify that both the AT service and the AT DEVICE are a covered benefit.	Pennsylvania Assistive Technology Foundation (PATF)
Requirements Document	Section V.A. - Covered Services	Assistive Technology P219-20	Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized...	ADD a bullet "Devices that would otherwise be considered Durable Medical Equipment but are not included in the State Plan definition for DME and meet a specific disability-related need"	Pennsylvania Assistive Technology Foundation (PATF)

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Requirements Document	Section V.A. - Covered Services	Assistive Technology P219-20	Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized...	Include smart home tech, apps for electronic devices and generators in definition. Suggested language - mirrors ODP's definition. Assistive Technology includes independent living technology or smart home technology devices that promote the independence of participants and decrease their need for assistance from others such as; medication dispensers, electric stove sensors, water sensors, and panic pendants. This list is instructive and not intended to be an all-inclusive description of allowable items, devices or services. Documentation of the participant's informed consent must be obtained prior to authorization of these devices. The monthly monitoring fees for these devices are also covered under Assistive Technology. Electronic devices are included under Assistive Technology when there is documentation that the device is a cost effective alternative to a service or piece of equipment. The device must be the least expensive and most effective device to meet the participant's need as documented by the evaluation. Assistive Technology also includes applications for electronic devices that assist participants with a need identified through the evaluation described below. Generators are covered for participants residing in private homes when the following has been documented: • The generator purchased is the most cost-effective to ensure the health and safety of the participant; AND • The neighborhood has a history of unreliable power as documented in a letter from the power company; OR • The participant's health and safety is dependent upon electricity as documented by a physician.	Pennsylvania Assistive Technology Foundation (PATF)
Requirements Document	Section V.A. - Covered Services	Assistive Technology P219-20	Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized...	ADD a clause explaining that mainstream devices may be allowed if they otherwise meet the definition of AT device and are a less costly alternative to specialized device	Pennsylvania Assistive Technology Foundation (PATF)
Requirements Document	Section V.A. - Covered Services	NHT (p230)	assessing the need for any home modifications that may need to be complete prior to the Participant transitioning to the community;	ADD PHRASE "assessing the need for any home modifications <u>or acquisition of assistive technology</u> that may need to be complete prior to the Participant transitioning to the community..."	Pennsylvania Assistive Technology Foundation (PATF)
Other			In relation to telecare, smart home technology	We recommend that OMAP develop participant protection policies for telecare/smart home technology that are standardized across departments related to confidentiality, consent and privacy and applicability of these poliices for certain uses/situations	Pennsylvania Assistive Technology Foundation (PATF)
RFP	General Information	I-4	Adults age 21 or older who require MA LTSS (whether in the community or in private or county nursing facilities) because they need the level of care provided by a nursing facility or an intermediate care facility for individuals with other related conditions (ICF/ORC). Current Participants in DHS OLTL waiver programs who are 18 to 21 years old.	An 18- to 21-year-old with LTSS needs, whose parents can no longer care for him or her would, without access to Community Health Choices for LTSS, have no option but to accept placement in a nursing or other institutional facility. This policy seems counter-intuitive. We recommend 18-21 year olds will LTSS needs can enroll in CHC.	Pennsylvania Assistive Technology Foundation (PATF)
Requirements Document	Section V.A. - Covered Services	#18 Participant Self-Directed Services	CHC-MCOs must offer Participants who are eligible for HCBS the opportunity to self-direct Personal Assistance Services	We urge DHS not to limit self-direction to Personal Assistance Services. **This would actually be reducing access to this service model.** Respite is currently available as a self-directed service in the Aging, Commcare, OBRA and Independnce waivers. People should have the option to self-direct additional services like Community Integration, Non-Medical Transportation, Respite and Supported Employment.	Pennsylvania Assistive Technology Foundation (PATF)

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Requirements Document	Section V.R. - Participant Complaint, Grievance & DHS Fair Hearing Process			**Add**: We strongly urge additional language both here and in other sections (i.e., Participant Handbooks and Provider Manuals) that CHC-MCOs that deny any Participant services must inform him or her that **free legal** help with complaints, grievances, and Fair Hearings is available. **Comment**: One of the strongest consumer protections for a Participant denied a service is access to free legal help with complaints, grievances, and Fair Hearings. Participant access to legal representation provides a level playing field in the appeal process, which will result in fairer adjudications, and fair adjudications benefit all concerned. In PH-HealthChoices MCOs are required to use a standard denial notice for any service or item being reduced, changed, or denied.	Pennsylvania Assistive Technology Foundation (PATF)
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes			1. **Change**: The General Requirements Section should include, "The CHC-MCO must allow anyone the Participant requests to participate in a complaint or grievance meeting on their behalf. Participants can provide this information verbally to the plan." 2. **Change**: "A Participant denied a service by a CHC-MCO must be informed in writing or when they contact the CHC-MCO that free legal help with complaints, grievances, and Fair Hearings." In HealthChoices, free legal help is available from either the Pennsylvania Health Law Project or the Pennsylvania Legal Aid Network. **Comment**: One of the strongest consumer protections for a Participant denied a service is access to free legal help with complaints, grievances, and Fair Hearings. Participant access to legal representation provides a level playing field in the appeal process, which will result in fairer adjudications, and fair adjudications benefit all concerned. In PH-HealthChoices MCOs are required to use a standard denial notice for any service or item being reduced, changed, or denied.	Pennsylvania Assistive Technology Foundation (PATF)
RFP	II-5	30	11. Describe your organization's experience and your plan for using technology such as assistive technology, telehealth, telecare, social media, electronic visit verification, and other methods to deliver services to the CHC Participants.	11. Describe your organization's experience and your plan for assuring access to assistive technology, telehealth, telecare. Include a description of how you will assure access to the full array of AT from highly specialized, customized and modified devices and generic commercially available items used to meet a specific disability-related need. Describe your plan for obtaining products from outside of network when unavailable in network.	Institute on Disabilites, Temple University
RFP	II-5	30	11. Describe your organization's experience and your plan for using technology such as assistive technology, telehealth, telecare, social media, electronic visit verification, and other methods to deliver services to the CHC Participants.	Add Requirement New # - Describe your organization's experience and your plan for using social media and electronic visit verification, and other methods to deliver services to the CHC Participants.	Institute on Disabilites, Temple University
Requirements Document	Section V.B. - Prior Authorization of Services	F Assessments (p41)	"Use of adaptive devices"	Replace language to read "Use of Assistive Technology"	Institute on Disabilities, Temple University
Requirements Document	Section V.A. - Covered Services	Assistive Technology P219-20	Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized…	The description should clarify that both the AT SERVICE and the AT DEVICE are a covered benefit.	Institute on Disabilites, Temple University
Requirements Document	Section V.A. - Covered Services	Assistive Technology P219-20	Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized…	ADD a bullet "Devices that would otherwise be considered Durable Medical Equipment but are not included in the State Plan definition for DME and meet a specific disability-related need"	Institute on Disabilites, Temple University

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Requirements Document	Section V.A. - Covered Services	Assistive Technology P219-20	Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized…	Include smart home tech, apps for electronic devices and generators in definition. Suggested language - mirrors part of ODP's definition. "Assistive Technology includes independent living technology or smart home technology devices that promote the independence of participants and decrease their need for assistance from others such as; medication dispensers, electric stove sensors, water sensors, and panic pendants. This list is instructive and not intended to be an all-inclusive description of allowable items, devices or services. Documentation of the participant's informed consent must be obtained prior to authorization of these devices. The monthly monitoring fees for these devices are also covered under Assistive Technology. Electronic devices are included under Assistive Technology when there is documentation that the device is a cost effective alternative to a service or piece of equipment. The device must be the least expensive and most effective device to meet the participant's need as documented by the evaluation. Assistive Technology also includes applications for electronic devices that assist participants with a need identified through the evaluation described below. Generators are covered for participants residing in private homes when the following has been documented: • The generator purchased is the most cost-effective to ensure the health and safety of the participant; AND • The neighborhood has a history of unreliable power as documented in a letter from the power company; OR • The participant's health and safety is dependent upon electricity as documented by a physician."	Institute on Disabilities, Temple University
Requirements Document	Section V.A. - Covered Services	Assistive Technology P219-20	Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized…	ADD a clause explaining that mainstream devices may be allowed if they otherwise meet the definition of AT device and are a less costly alternative to specialized device	Institute on Disabilites, Temple University
Requirements Document	Section V.A. - Covered Services	Home Modifications (p225)	a speech, hearing and language therapist	The correct term for this practioner is Speech Language Pathologist	Institute on Disabilites, Temple University
Requirements Document	Section V.A. - Covered Services	NHT (p230)	assessing the need for any home modifications that may need to be complete prior to the Participant transitioning to the community;	ADD PHRASE "assessing the need for any home modifications <u>or acquisition of assistive technology</u> that may need to be complete prior to the Participant transitioning to the community…"	Institute on Disabilites, Temple University
Other			In relation to telecare, smart home technology	We recommend that OMAP develop participant protection policies for telecare/smart home technology that are standardized across departments related to confidentiality, consent and privacy and applicability of these poliices for certain uses/situations	Institute on Disabilites, Temple University
RFP	General Information	I-4	Adults age 21 or older who require MA LTSS (whether in the community or in private or county nursing facilities) because they need the level of care provided by a nursing facility or an intermediate care facility for individuals with other related conditions (ICF/ORC). Current Participants in DHS OLTL waiver programs who are 18 to 21 years old.	An 18- to 21-year-old with LTSS needs, whose parents can no longer care for him or her would, without access to Community Health Choices for LTSS, have no option but to accept placement in a nursing or other institutional facility. This policy seems counter-intuitive. We recommend 18-21 year olds will LTSS needs can enroll in CHC.	Institute on Disabilites, Temple University
Requirements Document	Section V.A. - Covered Services	#18 Participant Self-Directed Services	CHC-MCOs must offer Participants who are eligible for HCBS the opportunity to self-direct Personal Assistance Services	We urge DHS not to limit self-direction to Personal Assistance Services. **This would actually be reducing access to this service model.** Respite is currently available as a self-directed service in the Aging, Commcare, OBRA and Independnce waivers. People should have the option to self-direct additional services like Community Integration, Non-Medical Transportation, Respite and Supported Employment. services are currently available in both traditional agency models and self-direction in the Consolidated and P/FDS waivers.	Institute on Disabilities, Temple University
Requirements Document	Section V.A. - Covered Services	#21 Service Delivery Innovation		To promote rebalancing of our system, we recommend adding institutional diversion and NH transition to this list.	Institute on Disabilities, Temple University

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RFP	Work Statement Questionnaire	Participant Service and Care Coordination		ADD: In the Office of Long Term Living home and community based waivers, 35% of waiver participants self-direct at least one service. This percentage ranges from 16% in Fayette County to 67% in Wyoming County. Describe how you will reach benchmarks or enrollment targets for numbers of participants using self-directed options.	Institute on Disabilities, Temple University
Requirements Document	Section V.R. - Participant Complaint, Grievance & DHS Fair Hearing Process			Add: We strongly urge additional language both here and in other sections (i.e., Participant Handbooks and Provider Manuals) that CHC-MCOs that deny any Participant services must inform him or her that free legal help with complaints, grievances, and Fair Hearings is available. Comment: One of the strongest consumer protections for a Participant denied a service is access to free legal help with complaints, grievances, and Fair Hearings. Participant access to legal representation provides a level playing field in the appeal process, which will result in fairer adjudications, and fair adjudications benefit all concerned. In PH-HealthChoices MCOs are required to use a standard denial notice for any service or item being reduced, changed, or denied.	Institute on Disabilities, Temple University
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes			1. Change: The General Requirements Section should include, “The CHC-MCO must allow anyone the Participant requests to participate in a complaint or grievance meeting on their behalf. Participants can provide this information verbally to the plan.” 2. Change: "A Participant denied a service by a CHC-MCO must be informed in writing or when they contact the CHC-MCO that free legal help with complaints, grievances, and Fair Hearings." In HealthChoices, free legal help is available from either the Pennsylvania Health Law Project or the Pennsylvania Legal Aid Network. Comment: One of the strongest consumer protections for a Participant denied a service is access to free legal help with complaints, grievances, and Fair Hearings. Participant access to legal representation provides a level playing field in the appeal process, which will result in fairer adjudications, and fair adjudications benefit all concerned. In PH-HealthChoices MCOs are required to use a standard denial notice for any service or item being reduced, changed, or denied.	Institute on Disabilities, Temple University

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Requirements Document	Section V.C. - Continuity of Care	39	For a Participant who is a NF resident on his/her Effective Date of Enrollment and the First Enrollment Effective Date of any Enrollment into the CHC program in the zone in which the Participant resides, the continuity of care period will run from the Participant's Effective Date of Enrollment into the CHC-MCO for the duration of the Participants' residency in the Nursing Facility. The CHC-MCO must enter into a contract or payment arrangement with the resident's NF to make payments for the Participant's Nursing Facility services, whether or not the Nursing Facilities is in the CHC-MCO network The CHC-MCO must provide services and payment for all Participants who are in an NF on the date of Enrollment even if the NF does not enroll as a provider.Provider. The CHC-MCO is prohibited from interfering with a Participant's choice of NF. This continuity of care period shall continue so long as the Participant remains a resident of the same NF and shall apply to each enrollment into a CHC-MCO, whether at the first effective date of enrollment or at some time later in the operation of the CHC program if the Participant chooses to transfer to a CHC-MCO.	MCOs should be required to pay, at a minimum, the current nursing facility rates to out-of-network facilities during the continuity of care period.	PALPA

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Requirements Document	Section V.C. - Continuity of Care	39	For a Participant who is receiving LTSS through an HCBS Waiver program on his or her Effective Date of Enrollment, the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later. If a Participant chooses to transfer to a different CHC-MCO, the receiving CHC-MCO must continue to provide the previously authorized services for 60 days or until a comprehensive needs assessment has been completed and a PCSP been developed and implemented, whichever date is later.	MCOs should be required to pay, at a minimum, the current waiver rates to out-of-network providers during the continuity of care period.	PALPA
Requirements Document	Section V.C. - Continuity of Care	39	For a Participant who is receiving LTSS but whose LTSS Provider leaves the CHC-MCO Provider Network, the CHC-MCO must continue to allow the Participant to receive services for a 60 day period and must pay that Provider until such time as an alternative Network Provider can be identified and begins to deliver the same LTSS services as the former Provider.	MCOs should be required to pay, at a minimum, the rates stipulated in the terminated or expired contract during the continuity of care period.	PALPA
Requirements Document	Section V.EE. - QM & UM Program Requirements	96	The Department may establish a Pay for Performance (P4P) Program to provide financial incentives for CHC-MCOs that meet quality goals. An initial P4P program may be established for CHCMCOs that assist Participants to remain financially eligible through redetermination.	Assisting Participants to remain financially eligible through redetermination does not indicate quality or effective care coordination and should not be the basis for a payment increase.	PALPA
RFP	Other	I-V Type of Agreement. Pg. 12	The Department anticipates that the initial agreements will include: Capitation rates; Individual Stop-Loss Reinsurance; Specialty Drug Risk Sharing; Pay For Performance Incentives.	Is the referenced reinsurance provided by the state, or is it a requirement that MCOs purchase such reinsurance?	PALPA

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RFP	I-5, Type of Agreement	N/A; 12	I-5 Type of Agreement Regardless of the number of Zones which are awarded to a CHC-MCO, the Department will have one agreement with the CHC-MCO that covers all awarded Zones. Please see Appendix A for a draft agreement. I-24 Term of Agreement For CHC-MCOs approved to operate in multiple zones, the Department and the CHC-MCO will execute a separate agreement for each zone in which the CHC-MCO is approved.	RFP Section I-5, Type of Agreement, states that the Department will have one agreement with the CHC-MCO covering all awarded Zones. In seeming contradiction to Section I-5, Section I-24, Term of Agreement, provides that the CHC-MCO will execute separate agreements for each zone in which the CHC-MCO is approved. Please clarify or eliminate this apparent contradiction in the final draft.	Aetna Better Health® of Pennsylvania
RFP	I-21 Restriction of Contact	N/A; 18	From the issue date of this RFP until the Department selects proposals for award; the Project Officer is the sole point of contact concerning this RFP. Any violation of this condition may be cause for the Department to reject the offending Offeror's proposal. If the Department later discovers that the Offeror has engaged in a violation of this condition, the Department may reject the offending Offeror's proposal or rescind its award. Offerors must not distribute any part of their proposals beyond the Department. An Offeror who shares information contained in its proposal with other Commonwealth personnel or competing Offeror personnel may be disqualified.	Please consider adding language to RFP Section I-21, Restriction of Contact, clarifying that questions posed or discussions had during the pendency of the RFP regarding the Small Diverse Business Program and/or the Contractor Partnership Program using the contact information specified in RFP Sections I-13, Small Diverse Business Information, and Section I-14, Contractor Partnership Program (CPP), are permissible and do not violate Section I-21, Restriction of Contact or any federal or state statutory or regulatory provision or other governing law or rule regarding black out periods or no contact rules during the pendency of a government procurement.	Aetna Better Health® of Pennsylvania
RFP	I-25 Offeror's Representations and Authorizations	A; 20	The Commonwealth shall treat a misstatement, omission or misrepresentation as fraudulent concealment of the true facts relating to the proposal submission, punishable pursuant to 18 Pa.C.S. § 4904.	Please consider adding the words "made with the intent to mislead" after the word "misrepresentation" as shown in capital letters below to more accurately reflect the State of mind required by 18 PA.C.S. Section 4904. The Commonwealth shall treat a misstatement, omission or misrepresentation MADE WITH THE INTENT TO MISLEAD as fraudulent concealment of the true facts relating to the proposal submission, punishable pursuant to 18 Pa.C.S. § 4904.	Aetna Better Health® of Pennsylvania

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RFP	Part II Proposal Requirements	A; 22	A. Technical Submittal, which shall be a response to RFP Part II, Sections II-1 through II-7 and Sections II-9 through II-11. Offerors must submit their technical response using the following guide: Tab 1 Table of Contents Tab 2 Zones of Operation Tab 3 Management Summary Tab 4 Prior Experience Tab 5 Personnel Tab 6 Work Statement and Work Statement Questionnaire Tab 7 Financial Capability Tab 8 Objections to Standard Terms and Conditions Tab 9 Corporate Reference Questionnaire (Appendix G) Tab 10 Domestic Workforce Utilization Certification (Appendix J) Tab 11 Lobbying Certification and Disclosure Tab 12- Contractor Partnership Program	The response to Section IV-3B, Emergency preparedness, directly follows the Work Statement Questionnaire in the RFP; however, there is no separate tab for this response. We recommend that this response have its own tab and either be placed after the Work Statement Questionnaire (with subsequent tabs renumbered) or moved to another location in the tab sequence.	Aetna Better Health® of Pennsylvania
RFP	Part II Proposal Requirements	A; 22	A. Technical Submittal, which shall be a response to RFP Part II, Sections II-1 through II-7 and Sections II-9 through II-11. Offerors must submit their technical response using the following guide: Tab 1 Table of Contents Tab 2 Zones of Operation Tab 3 Management Summary Tab 4 Prior Experience Tab 5 Personnel Tab 6 Work Statement and Work Statement Questionnaire Tab 7 Financial Capability Tab 8 Objections to Standard Terms and Conditions Tab 9 Corporate Reference Questionnaire (Appendix G) Tab 10 Domestic Workforce Utilization Certification (Appendix J) Tab 11 Lobbying Certification and Disclosure Tab 12- Contractor Partnership Program	The response to Section II-11, Lobbying Certification and Disclosure, is to be placed behind Tab 11. However, Section II-11 follows Section II-10, Contractor Partnership Program, which is to be placed behind Tab 12. We recommend this assignment be swapped so that the response to Section II-10 goes behind Tab 11 and the response to Section II-11 goes behind Tab 12.	Aetna Better Health® of Pennsylvania

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RFP	Part II Proposal Requirements	II-3, Prior Experience; 24	Note that this issue appears throughout the RFP and supporting documents. Two such examples are below, but please consider editing throughout to eliminate all such issues. II-3(A) Corporate Background Offerors must also abide by the Department's conflict of interest standards identified in Appendix A, Agreement. Exhibit D, Standard Terms and Conditions for Services, and Exhibit F, Department of Human Services Addendum to Standard Terms and Conditions. II-7 Objections and Additions to Standard Contract Terms and Conditions The Offeror will identify which, if any, of the terms and conditions (contained in Exhibits E and F to Appendix A Draft Agreement).... Regardless of any objections set out in its proposal, the Offeror must submit its proposal on the basis of the terms and conditions set out in Appendix A, Draft Agreement and its Exhibits E and F.	There appear to be inconsistent appendix and exhibit letters applied to the Draft Community Health choices Agreement, Standard Terms and Conditions, and the Department of Human Services Addendum to Standard Terms and Conditions throughout the RFP and supporting documents. To avoid confusion, in the final RFP, please label each document with the appropriate letter and edit the RFP and supporting documents throughout to insure that the proper appendix and exhibit letters are used when referencing these documents.	Aetna Better Health® of Pennsylvania
RFP	Part II Proposal Requirements	II-4; 27-28	In Section II-4 (Personnel) of the Draft RFP, the following subsections are included: A: Executive Management B: Key Administrative Positions C: Staffing Plans D: Subcontracts	Section II.4-D, Subcontracts follows Section II-4.A through C, which addresses Personnel requirements. The response to II-4 is to be placed behind Tab 5; however, "Subcontracts" does not seem to be a Personnel topic, rather, an independent one. We recommend that the response to II-4.D, Subcontracts be put behind a separate tab and that the rest of the subsequent tabs be renumbered accordingly.	Aetna Better Health® of Pennsylvania
RFP	Part II Proposal Requirements	II-5. Work Statement and Work Statement Questionnaire: (Soundness of Approach); 29-42	Page numbering for: • Participant service and care coordination • Service integration • Pharmacy • Management information systems • Provider network composition and network management	Due to the number, type and complexity of the questions asked, we are recommending revising the page limits as follows: • Participant service and care coordination – current limit is 30 pages with 30 questions; we recommend this be increased to 50 pages. • Service integration – current limit is 15 pages with 11 questions; we recommend this be increased to 25 pages. • Pharmacy – current limit is 15 pages; while there are 8 questions, some have several subparts; we recommend this be increased to 30 pages. • Management information systems – current limit is 20 pages with 20 questions; several of these questions address complex issues; we recommend this be increased to 40 pages. • Provider network composition and network management – current limit is 25 pages with 14 questions; some of those questions have several subparts; we recommend this be increased to 35 pages.	Aetna Better Health® of Pennsylvania

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Requirements Document	Section V.A. - Covered Services	2. In-Home and Community-Based Services; 26	The CHC-MCO may not deny personal assistance services for Participants under the age of 21 based on the Participant's diagnosis or because the need for personal assistance services is the result of a cognitive impairment. The personal assistance services may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self. The CHC-MCO may not deny a request for Medically Necessary in- home nursing services, home health aide services, or personal assistance services for a Participant under the age of 21 on the basis that a live- in caregiver can perform the task, unless there is a determination that the live-in caregiver is actually able and available to provide the level or extent of care that the Participant needs, given the caregiver's work schedule or other responsibilities, including other responsibilities in the home.	This language appears to remove the ability to modify services if they meet the individual's needs and are cost effective. Is this the intent?	Aetna Better Health® of Pennsylvania
Requirements Document	Section V.A. - Covered Services	Program Exceptions; 27	The CHC-MCO is required to establish a program exception process, reviewed and approved by the Department, whereby a Provider or Participant may request coverage for items or services, which are included in the Member's benefit package but are not currently listed on the MA Program Fee Schedule.	Please provide a list of the HCPCs/CPT codes that will be used.	Aetna Better Health® of Pennsylvania
Requirements Document	Section V.A. - Covered Services	Program Exceptions; 27	The PH-MCO must also apply the program exception process to requests to exceed limits for items or services that are on the Fee Schedule if the limits are not based in statute or regulation. These requests are recognized by the Department as a Program Exception and are described in 55 PA Code §1150.63.	Please provide a list of the HCPCs/CPT codes that will be used.	Aetna Better Health® of Pennsylvania

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Requirements Document	Section V.A. - Covered Services	Referrals; 27-28	The CHC-MCO must establish and maintain a referral process to effectively utilize and manage the care of its Participants. The CHC-MCO may require a referral for any medical services that cannot be provided by the PCP except where specifically provided for in this agreement.	Is a CHC-MCO required to mandate that participants obtain referrals, or would this be optional at each CHC-MCO's discretion? The second sentence of the RFP language above suggests this is optional. Please clarify.	Aetna Better Health® of Pennsylvania
Requirements Document	Section V.A. - Covered Services	Pharmacy Services; 29	Full Dual Eligible Participants are not eligible for Pharmacy services under Medicaid; they will receive their pharmacy services through their Medicare Part D coverage. The CHC-MCO must provide coverage of prescriptions and over-the-counter medicines for Full Dual Eligibles that are not otherwise covered by the dual eligible's Part D prescription drug plan.	Given the timeframes necessary to apply for a SNP, would the Department consider allowing MCOs to obtain necessary SNPs within 1 year of go-live for the Southwest Zone? If not, by which date would the SNP have to be effective? We recommend that SNPs not be required until the first MA contract year following the first year of implementation due to the application cycle timeframe.	Aetna Better Health® of Pennsylvania
Requirements Document	Section V.A. - Covered Services	Pharmacy Services; 30	Full Dual Eligible Participants are not eligible for Pharmacy services under Medicaid; they will receive their pharmacy services through their Medicare Part D coverage. The CHC-MCO must provide coverage of prescriptions and over-the-counter medicines for Full Dual Eligibles that are not otherwise covered by the dual eligible's Part D prescription drug plan.	Is a SNP required in every county within the Zone?	Aetna Better Health® of Pennsylvania
Requirements Document	Section V.A. - Covered Services	Nursing Facility Services; 33	The CHC-MCO is responsible for payment for Medically Necessary nursing facility services (including bed hold days and up to fifteen (15) per hospitalization and up to thirty (30) Therapeutic Leave Days per year) if a Participant is admitted to a Nursing Facility or resides in a Nursing Facility at the time of Enrollment.	We recommend that the Department change the language above to "...12 days per year for hospitalization and 9 days per year for therapeutic leave with bed hold days being paid to the Nursing Facility at a lesser rate.".	Aetna Better Health® of Pennsylvania

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Requirements Document	Section V.A. - Covered Services	Service Delivery Innovation; 35	b. Employment innovation that supports Participants to seek, find and maintain employment. c. Workforce innovation that improves the recruitment, retention and skills of direct care workers, which may include but are not limited to incentives for education and training. d. Technology innovation that supports Participants to lead healthy and independent lives in the community, which may include but not be limited to home monitoring and telemedicine applications.	Could the MCO provide personal care services in an Assisted Living environment as a reimbursable covered benefit?	Aetna Better Health® of Pennsylvania
Requirements Document	Section V.C. - Continuity of Care	Continuity of Care; 39	For a Participant who is receiving LTSS through an HCBS Waiver program on his or her Effective Date of Enrollment, the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later.	We recommend that the Department remove the words "whichever is later." in the above Draft RFP language. This is because if the participant's needs are adequately being met, based on the assessment tool, with decreased services it seems inappropriate to pay for any services the member no longer needs. Per the requirements indicated in the Draft RFP, the Department will be notified of changes in service plans, thus protecting the participant.	Aetna Better Health® of Pennsylvania

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Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	Comprehensive Needs Assessments and Reassessments; 41	Reassessments must be completed as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, but in no case more than 14 days after the occurrence of any of the following trigger events: • A significant healthcare event to include but not be limited to a hospital admission, a transition between healthcare settings, or a hospital discharge. • A change in functional status. • A change in caregiver or informal support status. • A change in the home setting or environment. • A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning. • As requested by the Participant or designee, the caregiver, the provider, or the PCPT or PCPT Participant, or the Department	We recommend that the Department change the language in this Section which currently reads "...no more than 14 days after the 'occurrence' of any of the following trigger events." to "...no more than 14 days after NOTIFICATION of the occurrence of any of the following trigger events".	Aetna Better Health® of Pennsylvania
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	Comprehensive Needs Assessments and Reassessments; 41	The Department will designate a tool to be used for comprehensive needs assessments and reassessments. CHC-MCOs are permitted to gather additional information not included in the designated tool to supplement but not supplant the Department-designated tool.	Is the comprehensive needs assessment/reassessment tool the same as the Level of Care Determination tool being used by the AAAs currently?	Aetna Better Health® of Pennsylvania
Requirements Document	Section V.H. - Person Centered Service Plans	Person Centered Service Plans; 41-42	Specifies the right of DHS to review and revise any service plan. Requires the CHC-MCOs to submit weekly reports on service plan changes. (Section V.I)	In what circumstances would DHS revise a service plan?	Aetna Better Health® of Pennsylvania
Requirements Document	Section V.H. - Person Centered Service Plans	Person Centered Service Plans; 42	How technology and telehealth will be used. How to accommodate preferences for leisure activities, hobbies, and community engagement.	Is it the expectation that each participant's PSCP include technology, telehealth, leisure activities, hobbies, and community engagement or only to be included when appropriate for the participant?	Aetna Better Health® of Pennsylvania
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Participant Enrollment & Disenrollment; 53	c. Discharge/Transition Planning When any Participant is disenrolled from the CHC-MCO the CHC-MCO from which the Participant disenrolled remains responsible for participating in discharge/transition planning for up to six (6) months from the initial date of Disenrollment.	What kind of activities would the discharge/transition planning include? Would this be considered a HIPAA violation if providing/receiving confidential information considering that the participant would be dis-enrolled from the CHC-MCO?	Aetna Better Health® of Pennsylvania

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Requirements Document	Section V.X.- Administration	2. Contracts and Subcontracts ; 71	The CHC-MCO must make all Subcontracts available to the Department within five (5) days of a request by the Department…	Please consider adding language to this provision and any other provision in the RFP or supporting documents that requests copies of, or access to, subcontracting or intercompany agreements confirming that (1) pricing in these agreements is confidential and proprietary and therefore not subject to disclosure by the Department in response to a Right to Know Law request or other such request for information; and (2) when providing this information to the Department the CHC-MCO may redact pricing information.	Aetna Better Health® of Pennsylvania
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	Selection & Assignment of Service Coordinators ; 84	The CHC-MCO must offer the Participant the choice of at least two Service Coordinators.	If a CHC-MCO handles the Service Coordination role, does the above requirement of providing the Participant a choice of two Service Coordinators or Service Coordination Entitles still apply?	Aetna Better Health® of Pennsylvania
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	Selection & Assignment of Service Coordinators ; 84-85	The CHC-MCO must make every effort to determine Service Coordination choice and confirm this with the Participant prior to the commencement of the CHC-MCO coverage in accordance with Participant Enrollment and Disenrollment, so that new Participants do not go without a Service Coordinator for a period of time after Enrollment begins or after assessment of needs for LTSS.	Is the expectation that the CHC-MCO outreach participants prior to the effective date?	Aetna Better Health® of Pennsylvania

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Requirements Document Exhibit	J - EPSDT Guidelines	EPSDT Guidelines; J2	The family shall be informed in writing of the plan, and the right to use complaint procedures if they disagree. As part of the initial assessment, the PCP shall make a recommendation regarding whether case management services should be provided to the child, based on medical necessity, and with the families or custodial agency's consent, this recommendation shall be binding on the CHC-MCO. 3. Tracking The CHC-MCO must establish a tracking system that provides information on compliance with EPSDT service provision requirements in the following areas: • EPSDT screen and reporting of all screening results. • Diagnosis and/or treatment, or other referrals for children. • Other tracking activities include: Number of comprehensive screens (reported by age); hearing and vision examinations; dental screens; age appropriate screens; complete age appropriate immunizations; blood lead screens; prenatal care for teen mothers; provision of eyeglasses to those in need of them; dental sealants; newborn home visits; referral of very low birth weight babies to early intervention; referral of Participants under the age of 21 with elevated blood lead levels to early intervention; routine evaluation for iron deficiencies; and timely identification and treatment of asthma.	Please advise whether the tracking will occur in real time or be claims based?	Aetna Better Health® of Pennsylvania
Requirements Document Exhibit	K - Emergency Services	Emergency Services; K2	The CHC-MCO must also develop a process to ensure that PCPs promptly see Participants who did not require or receive hospital Emergency Services for the symptoms prompting the attempted emergency room visit.	Please define "attempted emergency room visits". How would a CHC-MCO identify participants with attempted emergency room visits, assuming no claim would be submitted?	Aetna Better Health® of Pennsylvania

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Requirements Document		N/A	N/A	Would the Department be willing to include the following language in the Community HealthChoices Agreement: The PH-MCO considers its financial reports and information, marketing plans, Provider rates, subcontractor rates, trade secrets, information or materials relating to the PH-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 PH-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. In each such instance, the Department will notify the PH-MCO when it determines that disclosure of information is necessary for the administration of the HC Program. The PH-MCO will be given the opportunity to respond to such a determination prior to the disclosure of the information, and the information will not be disclosed until it is finally determined by a court of competent jurisdiction, including after any and all appeals, that the information is subject to disclosure under the Pennsylvania Right-to-Know-Law, 65 P.S. Section 67.101 et seq. or other applicable law or rule.	Aetna Better Health® of Pennsylvania
Requirements Document	Section V.D. - Choice of Provider	Page 40	Participants must be afforded choice of all Providers within the Provider Network, including Service Coordinators.	Participants must be afforded choice of all Providers within the Provider Network, including Service Coordination Entities.	Service Coordination Resources
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	Page 44	All Service Coordinator Supervisors must be a licensed social worker with at least 5 years of experience or a registered nurse with 5 years of experience.	All Service Coordinator Supervisors must be a certified Professional Service Coordinator (https://aasc.osu.edu/help/requirements) with at least 5 years of experience or a registered nurse with 5 years of experience.	Service Coordination Resources
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	Page 44	Service Coordinators must meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychoogy or other related field and at least three years of experience in the coordinatin of services.	Service Coordinators must meet the minimum requirements of being a registered nurse, or having a bachelor's degree in social work, psychoogy or other related field, or at least five years of experience in social services or a related health care field (qualifications matching Professional Service Coordinator Certification - https://aasc.osu.edu/help/requirements).	Service Coordination Resources
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Page 2	"Financial Management Services" is not listed.	List "Financial Management Services"	Service Coordination Resources
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Page 2	"Nursing Home Transition" is not listed	List "Nursing Home Transition"	Service Coordination Resources
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Page 2	"Participant-Directed Community Supports" is listed twice.	List "Participant-Directed Community Supports" once.	Service Coordination Resources
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		"Nursing Facility Services" is not defined.	Define "Nursing Facility Services".	Service Coordination Resources
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Page 2	"Nursing Home Services" is not defined.	This should be "Nursing Home Transition"	Service Coordination Resources

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Requirements Document	Section V.C. - Continuity of Care	Page 39	The continuity of care period for continuation of services provided under al existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later.	The continuity of care period for continuation of services provided under al existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 2 years or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later.	Service Coordination Resources
Requirements Document	Section V.W.- Other Administrative Components	Page 67	The CHC-MCO's staffing should represent the racial, ethnic, and cultural diversity of the Participants being served by CHC and comply with all requirements of Exhibit D, Standard Terms and Conditions for Services.	Quantitatively, what representation is required?	Cigna-HealthSpring
Requirements Document	Section II - Definitions	Page 4	Complaint — A dispute or objection regarding a participating Provider or the coverage, operations, or management policies of a CHC-MCO, which has not been resolved by the CHC-MCO and has been filed with the CHC-MCO or with the Department of Health or the Pennsylvania Insurance Department, including but not limited to: - a denial because the requested service/item is not a Covered Service; or - a failure of the CHC-MCO to meet the required time frames for providing a service/item; or - a failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames; or - a denial of payment by the CHC-MCO after a service has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or - a denial of payment by the CHC-MCO after a service has been delivered because the service/item provided is not a covered service/item for the Participant. The term does not include a Grievance.	Is this definition more applicable as a definition of an appeal? Does this definition of complaint apply for Participating Providers only? Therefore, does it not apply to a participant complaint and also excludes Non-Participating Providers? Is there a definition for a Participant complaint?	Cigna-HealthSpring

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Requirements Document	Section II - Definitions	Page 8	Grievance - A request to have a CHC-MCO or utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a healthcare service. A Grievance may be filed regarding a CHC-MCO decision to 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level of service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item but approve an alternative service/item. 5) deny a request for a benefit limit exception (BLE). This term does not include a complaint.	Does this definition of grievance apply to Providers only? Also, does this pertain more to a Provider Appeal for Medical Necessity or Provider Reconsideration for a Claim?	Cigna-HealthSpring
Requirements Document	Section II - Definitions	Page 18	Provider Dispute - A written communication to a CHC-MCO, made by a Provider, expressing dissatisfaction with a CHC-MCO decision that directly impacts the Provider. This does not include decisions concerning medical necessity.	Is there a Participant Dispute Definition?	Cigna-HealthSpring
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	12. Enrollment and Disenrollment Updates - Page 53	c. Discharge/Transition Planning When any Participant is disenrolled from the CHC-MCO the CHC-MCO from which the Participant disenrolled remains responsible for participating in discharge/transition planning for up to six (6) months from the initial date of Disenrollment. The CHC-MCO must remain the Participant's CHC-MCO upon discharge (upon returning to the CHC zone covered by this agreement), unless the Participant chooses a different CHC-MCO or is determined to no longer be eligible for participation in CHC, provided that the Participant is discharged within six (6) months of the initial CHC-MCO Disenrollment date. If the Participant chooses a different CHC-MCO, the receiving CHC-MCO must participate in the discharge/transition planning upon notification that the Participant has chosen its CHC-MCO.	When during the month will the department provide names of those Participants who disenroll from the program? Can we call these Participants to determine why they have disenrolled before they leave our plan?	Cigna-HealthSpring

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	19. Voluntary Disenrollment - Page 58	Participants may only voluntarily disenroll from the CHC program if - They are eligible for and transition to LIFE or - They are choosing to no longer receive any Medicaid-covered services.	Can a Participant choose another MCO if they are unable to voluntarily disenroll? If so, when, and how often?	Cigna-HealthSpring
Requirements Document	Section V.P. - Participant Services	1. General - Page 58	The CHC-MCO's Participant services functions must be operational at a minimum during regular business hours (9:00 a.m. to 5:00 p.m., Monday through Friday) and one (1) evening per week (5:00 p.m. to 8:00 p.m.) or one (1) weekend per month to address non- emergency problems encountered by Participants. The CHC-MCO must have arrangements to receive, identify, and resolve in a timely manner Emergency Participant Issues on a twenty-four (24) hour, seven (7) day-a-week basis.	How is the general line, which is open from 9am to 5pm, different from the internal Participant dedicated hotline? Is the general line also subjected to the same call center metrics?	Cigna-HealthSpring
Requirements Document	Section V.P. - Participant Services	2. CHC-MCO Internal Participant Dedicated Hotline - Page 60	The CHC-MCO must maintain and staff a twenty-four (24) hour, seven (7) day-a-week toll-free dedicated hotline to respond to Participants' inquiries, issues and problems regarding services.	How is the internal dedicated line, which is open 24 hours/day, 7 days/week, different from the general services line?	Cigna-HealthSpring
Requirements Document	Section V.P. - Participant Services	2. CHC-MCO Internal Participant Dedicated Hotline - Page 60	The CHC-MCO must maintain and staff a twenty-four (24) hour, seven (7) day-a-week toll-free dedicated hotline to respond to Participants' inquiries, issues and problems regarding services.	Given that each MCO has different call center Automatic Call Distributor (ACD) technology for call monitoring, how does the Department plan on integrating monitoring capabilities? Does monitoring have to be real time? At what frequency will the monitoring be performed and how will results be reported if monitoring capabilities can be established?	Cigna-HealthSpring
Requirements Document	Section V.P. - Participant Services	3. Nurse Hotline - Page 60	The CHC-MCO must maintain and staff a twenty-four (24) hour, seven (7) day-a-week toll-free dedicated nurse hotline to respond to Participants' urgent health matters.	Are there call center metrics that the Nurse Hotline will be required to meet?	Cigna-HealthSpring
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	A. General Requirements - Page GG-4	18. The CHC-MCO must notify the Participant when it denies payment after a service has been delivered because the service or item provided is not a Covered Service for the Participant, using the required template (template GG(12)). The CHCMCO must mail this notice to the Participant on the day the decision is made to deny payment.	Is there ever a potential for financial responsibility on the part of the Participant?	Cigna-HealthSpring

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Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	A. General Requirements - Page GG-5	20. The CHC-MCO must, at a minimum, hold in-person reviews of Complaints and Grievances (at all levels) at one location within each of its zones of operation. If a Participant requests an in-person review, the CHC-MCO must notify the Participant of the location of the review and who will be present at the review using the required template (template GG(14)).	What is the expected timeframe, turn-around time, and frequency of a requested in-person review?	Cigna-HealthSpring
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	B. Complaint Requirements, 1. First Level Complaint Process - Page GG-5	a. A CHC-MCO must permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a Complaint either in writing or orally. The CHCMCO must commit oral requests to writing if not confirmed in writing by the Participant. The CHC-MCO must provide the written confirmation to the Participant or the Participant's representative for signature. The signature may be obtained at any point in the process, and failure to obtain a signed Complaint may not delay the Complaint process. If the Complaint disputes the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames; challenges the failure to meet the required time frames for providing a service/item; disputes a denial made for the reason that a service/item is not a covered benefit; disputes a denial of payment after the service(s) has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or disputes a denial of payment after a service(s) has been delivered because the service/item provided is not a covered benefit for the Participant, the Participant must file a Complaint within forty-five (45) days from the date of the incident complained of or the date the Participant receives written notice of the decision. For all other Complaints, there is no time limit for filing a Complaint.	Does the failure to obtain a signed complaint void or dismiss a Participant's complaint if by day 30 it is not received? What happens if the signature is ultimately not obtained?	Cigna-HealthSpring

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Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	B. Complaint Requirements, 1. First Level Complaint Process - Page GG-6	d. Upon receipt of the Complaint, the CHC-MCO shall send the Participant and Participant's representative, if any, an acknowledgment letter using the template (templates GG(2a) and GG(2b)).	In general, are there stated complaint, grievance, provider appeal, and provider dispute acknowledgement timeframes after they are initially received?	Cigna-HealthSpring
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	B. Complaint Requirements, 1. First Level Complaint Process - Page GG-6	f. The first level Complaint review for Complaints involving a clinical issue shall be performed by a first level Complaint review committee, which shall include one or more employees of the CHC-MCO who were not involved in any previous level of review or decision making on the issue that is the subject of the Complaint. The Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Complaint.	Can the review committee medical staff for decision making be outsourced by the MCO?	Cigna-HealthSpring
Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes	B. Complaint Requirements, 3. External Review of Second Level Complaint Review Decision- Page GG-9	a. If a Participant files a request for an external review of a second level Complaint decision to dispute a decision to discontinue, reduce, or change a service/item that the Participant has been receiving on the basis that the service/item is not a covered benefit, the Participant must continue to receive the disputed service/item at the previously authorized level pending resolution of the external review, if the request for external review is hand-delivered or post-marked within ten (10) days from the mail date on the written notice on the CHC-MCO's second level Complaint decision.	If the DHS Fair Hearing and the External Review of the Second Level Complaint run concurrently, who has the final authority?	Cigna-HealthSpring
Requirements Document	Section V.A. - Covered Services	18. Participant Self-Directed Services- Page 34	Personal assistance workers employed by Participants under either self-directed model become qualified and receive payment through a financial management services (FMS) vendor, which processes timesheets, makes payments, and manages all required tax withholdings, including FICA taxes. The CHC-MCO must contract with the Commonwealth-procured FMS entities, of which there are three that operate statewide.	Is it the Department's expectation that this vendor will be treated as a participating provider in the network, or are there additional expectations?	Cigna-HealthSpring

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Requirements Document	Section V.A. - Covered Services	21. Service Delivery Innovation- Page 35	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 first report must be submitted on June 1, 2017 and each report submitted annually thereafter.	What parameters would the Department use to determine which CHC-MCO will participate in the initiatives?	Cigna-HealthSpring
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	Page 42	The Department will designate a tool to be used for comprehensive needs assessments and reassessments. CHC-MCOs are permitted to gather additional information not included in the designated tool to supplement but not supplant the Department-designated tool.	Will we be provided with these tools during the RFP response process?	Cigna-HealthSpring
Requirements Document	Section V.A. - Covered Services	10. Emergency Services - Pages 29-30	The CHC-MCO must limit the amount to be paid to Non-participating Providers of Emergency Services to no more than the amount that would have been paid for such services under the Department's FFS Program. The Department will determine the amount of payment after consideration of the payment proposed by the CHC-MCO, the amount sought by the Non-participating Provider, the payment rates established by the Department for equivalent services under the Department's FFS program, and the assumptions used to develop the Department's Actuarially Sound Rates paid to the CHC-MCO, along with supporting documentation submitted by the parties and information otherwise available to the Department.	Does this language require Department approval for all payments for Emergency Services to non-participating providers? Given the large volume of claims for these services, please clarify the process that will be used to resolve these issues. Also, please clarify the time frames for resolution as these will not be clean claims during this process.	Cigna-HealthSpring

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Requirements Document	Section V.A. - Covered Services	11. Post-Stabilization - Page 30	The CHC-MCO must cover Post-Stabilization Services without authorization, and regardless of whether the Participant obtains the services within or outside its Provider Network if any of the following situations exist: a. The Post-Stabilization Services were administered to maintain the Participant's stabilized condition within one hour of Provider's request to the CHC-MCO for pre-approval of further Post-Stabilization Services. b. The Post-Stabilization Services were not pre-approved by the CHC-MCO because the CHC-MCO did not respond to the Provider's request for pre-approval of these Post-Stabilization Services within one (1) hour of the request. c. The Post-Stabilization Services were not pre-approved by the CHC-MCO because the Provider could not reach the CHCMCO to request pre-approval for the Post-Stabilization Services. d. The CHC-MCO and the treating physician could not reach an agreement concerning the Participant's care and a CHC-MCO physician is not available for consultation. In this situation, the CHC-MCO must give the treating physician the opportunity to consult with a CHC-MCO physician and the treating physician may continue with the care of the patient until a CHC-MCO physician is reached or one of the criteria applicable to termination of a CHC-MCO's financial responsibility described below is met.	Do these services, when provided by non-participating Providers, have to go through the same pre-payment review as those in Subsection 10?	Cigna-HealthSpring

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Requirements Document	Section V.A. - Covered Services	15. Transportation - Page 32	Transportation Subsection 15 page 32 states: The CHC-MCO must provide all Medically Necessary emergency ambulance transportation, all Medically Necessary non- emergency ambulance transportation, and non-medical transportation. Non-Medical Transportation includes transportation to community activities, grocery shopping, religious services, and other activities as specified in the Participant's Person-Centered Service Plan.	The breadth of this benefit, including transport to the grocery store and religious services, implies that the type of activities to which the MCO would be required to transport a member are unlimited. This implies that trips to the movies or family picnics could be covered. There are no specified mileage limitations or frequency limitations. This language then leads to a consideration of the other LTSS benefits such as personal attendant services, meals on wheels, ERS, etc. Is there a dollar cap, for example 200% above the cost of nursing facility care, above which services would no longer be covered? Is there a budgeted dollar amount for the delivery of the LTSS package? If so, please provide the details of how this is calculated and administered. If not, does this mean that the MCO is exposed to unlimited open-ended cost determined solely by the member's desire not to reside in a nursing facility or assisted living facility?	Cigna-HealthSpring
Requirements Document	Section V.A. - Covered Services	15. Transportation - Page 32	Transportation Subsection 15 page 32 states: The CHC-MCO must provide all Medically Necessary emergency ambulance transportation, all Medically Necessary non- emergency ambulance transportation, and non-medical transportation. Non-Medical Transportation includes transportation to community activities, grocery shopping, religious services, and other activities as specified in the Participant's Person-Centered Service Plan.	Is non-medical transportation covered outside of the service area?	Cigna-HealthSpring
Requirements Document Exhibit	L - Medical Assistance Transportation Program	M(1) - 3	When requested, the CHC-MCO must arrange non-emergency transportation for urgent appointments for their Participants through the MATP. MATP agencies have been instructed to contact the CHC-MCO for verification that a Medical Assistance Participant's services request is for transportation to a Medical Assistance compensable service.	Is there a current process under FFS to verify that a request for transportation is to a valid MA compensable service? If so, please provide details of the current process. If not, is the MCO free to create its own process?	Cigna-HealthSpring
Requirements Document	Section V.B. - Prior Authorization of Services	1. General Prior Authorization Requirements - Page 37	The CHC-MCO may not require prior authorization of Medicare services for Participants with Medicare. CHC-MCOs must conditionally approve Covered Services that are pending Medicare decisions in the event that these services are not covered by Medicare. Service Coordinators are required to work with the Participant's Medicare plan to ensure expeditious decision-making and communication of decisions made.	This language seems to prohibit utilization review for Medicare services and then extend that prohibition to Medicaid covered services. 1. Please clarify the Medicaid position if the services are denied by Medicare as not medically necessary. 2. The "conditional approval" requires the MCO maintain an open authorization for which there is no timeframe for a response from Medicare. How will the open authorization timeframe be balanced against the MCOs prior authorization response timelines? 3. If utilization review is prohibited the MCO will be unable to manage care. In this case, will the cost of these services be excluded from MCO responsibility under the contract? 4. If a Participant is a Medicare Advantage member, can Medicare Advantage prior authorization rules prevail?	Cigna-HealthSpring

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Requirements Document	Section II - Definitions	Page 4	Covered Pharmacy - In accordance with 42 U.S.C.A. 1396r-8(k)(2) and 55 PA code Chapter 1121, the term means a brand name drug, a generic drug, or an over-the-counter drug (OTC) which: 1. Is approved by the Federal Food and Drug Administration. 2. Is distributed by a manufacturer that entered into a Federal Drug Rebate Program agreement with the Centers for Medicare and Medicaid Services (CMS). 3. May be dispensed only upon prescription in the Medical Assistance Program. 4. Has been prescribed or ordered by a licensed prescriber within the scope of the prescriber's practice. 5. Is dispensed or administered in an outpatient setting. The term includes biological products and insulin.	Please consider replacing Covered Pharmacy with Covered Outpatient Drug to remain congruent with 42 USC 1396r-8(k)(2).	Cigna-HealthSpring
Requirements Document	Section II - Definitions	Page 7	Formulary - A Department-approved list of pharmacies determined by the CHC-MCO's Pharmacy and Therapeutics (P&T) Committee to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, and cost for the CHC-MCO Participants.	Please consider replacing the term pharmacies with drugs or medications. Can more detail be provided as to how the formulary differs from the preferred drug list(PDL)? Are these separate lists?	Cigna-HealthSpring

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Requirements Document	Section II - Definitions	Page 13	Ongoing Medication — A medication that has been previously dispensed to the Participant for the treatment of an illness that is chronic in nature or for an illness for which the medication is required for a length of time to complete a course of treatment, until the medication is no longer considered necessary by the physician/prescriber, and that has been used by the Participant without a gap in treatment. If the current prescription is for a higher dosage than previously prescribed, the prescription is for an Ongoing Medication at least to the extent of the previous dosage. When payment is authorized due to the obligation to cover pre-existing services while a Grievance or DHS Fair Hearing is pending, a request to refill that prescription, made after the Grievance or DHS Fair Hearing has been finally concluded in favor of the MCO, is not an Ongoing Medication.	To prevent variability among CHC-MCOs separately applying the definition of ongoing medications to Exhibit BBB, item 4, will the Department provide a list of medications that should be considered as necessary for ongoing therapy?	Cigna-HealthSpring
Requirements Document	Section II - Definitions	Page 16	Preferred Drug List — A list of Department-approved pharmacies designated as preferred products because they were determined to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness and cost for the CHC-MCO Participants by the CHC-MCO's Pharmacy and Therapeutics (P&T) Committee.	1. Please consider replacing the term pharmacies with drugs or medications. 2. Will more detail be provided as to how the formulary differs from the preferred drug list(PDL)? Are these separate lists?	Cigna-HealthSpring
Requirements Document	Section V.X.- Administration	1. Recipient Lock-In Program - Pages 68-69	A Centralized Recipient Lock-in Program is in place for the Medical Assistance FFS and the managed care delivery systems and is managed by the Department's Bureau of Program Integrity (BPI).	Are CHC-MCOs to understand the Department will provide pharmacy lock-in criteria for use in referring members meeting such?	Cigna-HealthSpring
Requirements Document	Section V. Z. - Fraud & Abuse	o. Subcontracts - Page 77	ii. To the extent that the CHC-MCO delegates oversight responsibilities to a third party (such as a Pharmacy Benefit Manager), the CHC-MCO must require that such third party complies with sections 6a. – 6h. above, of this agreement.	Please provide additional clarification as to which sections are being referred to. We are unable to identify where sections 6a - 6h are found.	Cigna-HealthSpring

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Requirements Document Exhibit	BBB - Pharmacy Services	1. General Requirements - Page BBB-1	a. The CHC-MCO must cover all Covered Pharmacies listed on the Center for Medicare and Medicaid Services (CMS) Quarterly Drug Information File when determined to be Medically Necessary, unless otherwise excluded from coverage. (Sec. 2. Coverage Exclusions below for exclusions.) This includes brand name and generic drugs, and over-the-counter drugs (OTCs), prescribed by licensed Providers enrolled in the Medical Assistance program, and sold or distributed by drug manufacturers that participate in the Medicaid Drug Rebate Program.	Please consider replacing the term pharmacies with drugs or medications.	Cigna-HealthSpring
Requirements Document Exhibit	BBB - Pharmacy Services	1. General Requirements - Page BBB-1	c. Unless financial responsibility is otherwise assigned, all Covered Pharmacies are the payment responsibility of the Participant's CHC-MCO. The only exception is that the BH-MCO is responsible for the payment of methadone when used in the treatment of substance abuse disorders and when prescribed and dispensed by BH-MCO Service Providers.	Please consider replacing the term pharmacies with drugs or medications.	Cigna-HealthSpring
Requirements Document Exhibit	BBB - Pharmacy Services	1. General Requirements - Page BBB-1	d. All Covered Pharmacies must be dispensed through CHC-MCO Network Providers. This includes Covered Pharmacies prescribed by both the CHC-MCO and the BH-MCO Providers.	Please consider replacing the term pharmacies with drugs or medications.	Cigna-HealthSpring
Requirements Document Exhibit	BBB - Pharmacy Services	1. General Requirements - Page BBB-1	e. Under no circumstances will the CHC-MCO permit the therapeutic substitution of a pharmacy by a pharmacist without explicit authorization from the licensed prescriber.	1. Please consider replacing the term pharmacy with drug or medication. 2. Also, please confirm this statement does not preclude generic substitution, as long as the prescriber notates such on the prescription.	Cigna-HealthSpring
Requirements Document Exhibit	BBB - Pharmacy Services	1. General Requirements - Page BBB-1	f. All proposed pharmacy programs and drug Utilization Management programs, such as Prior Authorization, Step Therapy, partial fills, specialty pharmacy, pill-splitting, etc. must be submitted to the Department for review and approval prior to implementation.	Does this include quantity limits based on FDA-approved labeling? Does this include DUR edits such as drug-drug interactions, high dose edits, refill too soon edits, etc.? What is the timeframe for the Department to respond to requests for edits?	Cigna-HealthSpring

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Requirements Document Exhibit	BBB - Pharmacy Services	1. General Requirements - Page BBB-1	g. The CHC-MCO must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for Covered Pharmacies, such as, but not limited to, Prior Authorization (including Step Therapy), medical necessity guidelines, age edits, drug rebate Encounter submission, reporting, notices of decision, etc. will: i. Apply, regardless of whether the Covered Pharmacy is provided as a pharmacy benefit or as a "medical benefit" incident to a medical service and billed by the prescribing Provider using codes such as the Healthcare Common Procedure Coding System (HCPCS). ii. Ensure access for all medically accepted indications as documented by package labeling, nationally recognized pharmacy compendia, peer-reviewed medical literature, and FFS guidelines to determine medical necessity of drugs that require Prior Authorization in the Medical Assistance FFS Program, when designated by the Department.	Please consider replacing the term pharmacies and pharmacy with drug(s) or medication(s).	Cigna-HealthSpring
Requirements Document Exhibit	BBB - Pharmacy Services	1. General Requirements - Page BBB-2	i. The CHC-MCO must comply with Section 2117 of Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2117 regarding continuity of care requirements and 28 PA Code Ch. 9. The CHC-MCO must also comply with the procedures outlined in Medical Assistance Bulletin 99-03-13 and Medical Assistance Bulletin # 99-96-01. The CHC-MCO policy and procedures for continuity of care for pharmacies, and all subsequent changes to the Department-approved policy and procedures, must be submitted to the Department for review and approval prior to implementation. The policy and procedures must address how the CHC-MCO will ensure no interruption in drug therapy and the course of treatment, and continued access to pharmacies that the Participant was prescribed before enrolling in the CHC-MCO.	Please consider replacing the term pharmacies with drugs or medications.	Cigna-HealthSpring

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Requirements Document Exhibit	BBB - Pharmacy Services	3. Formularies and Preferred Drug Lists (PDLs) - Page BBB-3	a. The CHC-MCO may use a Formulary or a PDL. All drugs must be Covered Pharmacies.	Please consider replacing the term pharmacies with drugs or medications.	Cigna-HealthSpring
Requirements Document Exhibit	BBB - Pharmacy Services	3. Formularies and Preferred Drug Lists (PDLs) - Page BBB-3	g. The CHC-MCO must receive written approval from the Department of the Formulary or PDL, quantity limits, age edits, and the policies, procedures and guidelines to determine medical necessity of drugs that require Prior Authorization, including drugs that require Step Therapy and drugs that are designated as non-formulary or non-preferred, prior to implementation of the Formulary or PDL and the requirements.	Please clarify this language, specifically the possible redundancy to that of item 1(f) in Exhibit BBB: "All proposed pharmacy programs and drug Utilization Management programs, such as Prior Authorization, Step Therapy, partial fills, specialty pharmacy, pill-splitting, etc. must be submitted to the Department for review and approval prior to implementation."	Cigna-HealthSpring
Requirements Document Exhibit	BBB - Pharmacy Services	3. Formularies and Preferred Drug Lists (PDLs) - Page BBB-4	k. The CHC-MCO must allow access to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a Covered Pharmacy either by addition to the Formulary or PDL, or through Prior Authorization, within ten (10) days from their availability in the marketplace.	1.Please consider replacing the term pharmacy with drugs or medications. 2. Also, how does the Department handle this issue today while having P&T review? Are all new drugs added to the formulary automatically, prior to P&T review?	Cigna-HealthSpring
Requirements Document Exhibit	BBB - Pharmacy Services	4. Prior Authorization of Pharmacies - Page BBB-5	g. The CHC-MCO must establish and maintain written Prior Authorization policies, procedures, and guidelines to determine medical necessity of Covered Pharmacies that require Prior Authorization, including drugs that require Step Therapy and drugs that are designated as non-formulary or non- preferred.	Please consider replacing the term pharmacies with drug(s) or medication(s).	Cigna-HealthSpring
Requirements Document Exhibit	BBB - Pharmacy Services	9. Pharmacy Encounters - Page BBB-9	e. The Department will review the pharmacy Encounters and remove applicable 340B covered entity Encounters from the drug rebate invoicing process. i. The Department does not recognize 340B contracted pharmacies as 340B Providers and will not remove Encounters billed by contract pharmacies from the rebate invoicing process	How will the Department identify 340B claims on the encounter file? Can the Department provide examples of how 340B claims are tracked and identified today?	Cigna-HealthSpring

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Requirements Document Exhibit	BBB - Pharmacy Services	11. General Reporting Requirements - Page BBB-10,11	c. The CHC-MCO shall conduct and submit to the Commonwealth a monthly audit of pharmacy claims accuracy. The audit shall be conducted by an entity or CHC-MCO staff independent of pharmacy claims management. d. The audit shall utilize a statistically valid, random sample of all processed or paid pharmacy claims upon initial submission in each month. The minimum attributes to be tested for each claim selected shall include…	May the person charged with completing this monthly audit be an employee of the CHC-MCO if the PBM is a separate entity? If not, could the PBM complete the audit itself with oversight by the CHC-MCO? Will the Department define what a statistically valid sample would be?	Cigna-HealthSpring
Requirements Document Exhibit	BBB - Pharmacy Services	14. Requirements for CHC-MCO and BH-MCO Interaction and Coordination of Pharmacy Services - Page BBB-13	b. The BH-MCO will be required to issue an initial list of BH-MCO Providers to the CHC-MCO, and quarterly updates that include additions and terminations. Should the CHC-MCO receive a request to dispense medication prescribed by a BH Provider not listed on the BH-MCO's Provider file, the CHC-MCO must work through the appropriate BH-MCO to identify the Provider. The CHC-MCO is prohibited from denying prescribed medications solely on the basis that the BH-MCO Provider is not clearly identified on the BH-MCO Provider file.	In the case outlined in item (b), can the Department provide processing timeframes in which CHC-MCOs given for verifying a given provider's status with the BH-MCO?	Cigna-HealthSpring
Requirements Document Exhibit	BBB - Pharmacy Services	14. Requirements for CHC-MCO and BH-MCO Interaction and Coordination of Pharmacy Services - Page BBB-14	d. The CHC-MCO may deny payment of a Claim for a Covered Pharmacy prescribed by a BH-MCO Provider only if one of the following occurs: i. The drug is not being prescribed for the treatment of substance abuse/dependency/ addiction or mental illness and any side effects of psychopharmacological agents. Those drugs are to be prescribed by the CHC-MCO's PCP or specialists in the Participant's CHC-MCO Network.	Please consider replacing the term pharmacy with drug or medication. Can the Department explain how CHC-MCO's will be expected to make this determination? It would appear that all pharmacy claims written by BH-MCO providers would have to require prior authorization for the CHC-MCO to ensure appropriate use.	Cigna-HealthSpring
Other	Other	N/A	N/A	How will high cost pharmaceutical agents such as hepatitis C therapies be managed? How will pharmacy rates be analyzed and adjusted as new high cost pharmaceuticals are made available?	Cigna-HealthSpring

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Requirements Document	Section V.T. - Provider Dispute Resolution Process	Page 64	Establishment of a CHC-MCO Committee to process formal Provider Disputes/Provider Appeals which must provide: – At least one-fourth (1/4th) of the membership of the Committee must be composed of Providers/peers. – Committee members who have the authority, training, and expertise to address and resolve Provider Dispute/Provider Appeal issues. – Access to data necessary to assist committee members in making decisions. – Documentation of meetings and decisions of the Committee.	Will this committee be expected to process disputes or appeals related to payment, medical necessity, or denial of coverage? What should be done in cases where provider representation is not sufficient or we are unable to find providers to serve on the committee?	Cigna-HealthSpring
Requirements Document	Section V.X.- Administration	Page 68	The CHC-MCO must have an administrative office within each CHC zone covered by this agreement. The Department may grant exceptions to this requirement on an individual basis if the CHC-MCO has administrative offices elsewhere in Pennsylvania and the CHC-MCO is in compliance with all standards set forth by the DOH and PID.	Does the office need to be dedicated solely to administering LTSS?	Cigna-HealthSpring
Requirements Document	Section V.AA. - Selection & Assignment of PCPs	Page 83	If the Participant has not selected a PCP through the IEE for reasons other than cause, the CHC-MCO must make contact with the Participant within seven (7) business days of his or her Enrollment and provide information on options for selecting a PCP, unless the CHC-MCO has information that the Participant should be immediately contacted due to a medical condition requiring immediate care. To the extent practical, the CHC-MCO must offer freedom of choice to Participants in making a PCP selection.	How many unsuccessful attempts to make contact are allowed before a participant may be auto assigned to a PCP?	Cigna-HealthSpring

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Requirements Document	Section V.CC. - Provider Services	2. Provider Education - Page 86	The CHC-MCO must demonstrate that its Provider Network is knowledgeable and experienced in treating and supporting Participants in the program. The CHC-MCO must submit an annual Provider education and training work plan to the Department that outlines its plans to educate and train Network Providers. The format for this work plan will be designated by the Department through its operations reporting requirements found on the intranet supporting CHC. This training plan must be developed in conjunction with the Department, and must cover all topic areas identified by the Department. The CHC-MCO must also include Participants, advocates and family members in designing and implementation of the training plan.	How should participants, advocates and family members be involved; either through a committee process or can the CHC MCO allow for stakeholder comment on our training material?	Cigna-HealthSpring
Requirements Document	Section V.DD. - Provider Network	Page 89	If the CHC-MCO's Provider Network is unable to provide necessary Covered Services covered under the agreement, to a Participant, the CHC-MCO must adequately and timely cover these services out-of-network, for the Participant for as long as the CHC-MCO is unable to provide them and must coordinate with the Out-of-Network Provider with respect to payment.	Quantitatively, what is considered 'timely'?	Cigna-HealthSpring
RFP	General Information	I-4. Problem Statement p. 7	"CHC will serve the following Participants: …Current Participants in DHS OLTL waiver programs who are 18 to 21 years old"	UHC requests further clarification of this sentence. We read it to mean that no additional 18-21 year olds other than those referenced in the cited language will participate in the CHC program.	UnitedHealthcare | Community and State/Julie Weinburg
RFP	Work Statement Questionnaire	Participant Service and Care Coordination	Items 1 - 30	We notice that the Participant Service and Care Coordinator section has 30 questions with a 30-page limit. These important questions merit concise and thorough responses that cannot be achieved with the current page limitation. Can the page limits for this section be expanded?	UnitedHealthcare | Community and State/Julie Weinburg

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Requirements Document	Section V.A. - Covered Services	Section 4. Expanded Services p.27	"The CHC-MCO may provide expanded services subject to advance written approval by the Department. These must be services that are generally considered to have a direct relationship to the maintenance or enhancement of a Participant's health status … These services must be generally available to all Participants and must be made available by all appropriate Network Providers..."	1) UHC supports the benefits of expanded services but believes that the requirement as written is too narrow for an MLTSS program, specifically the requirement that expanded services "...must be generally available to all Participants...". In an MLTSS program in particular, some expanded services should be targeted to certain populations in order to promote person-centered goals and improved outcomes for certain populations of Participants. However, the services would not make sense for other Participant populations. For example, an expanded service could be used to help certain disabled Participant populatins achieve fuller integration in the community, but it would be unlikely to benefit the broader Participant population. As such, UHC suggests the language "...must be generally available to all Participants..." be modified so that expanded services can be generally available to all Participants and targeted to specific Participant populations. 2) UHC hopes that as the CHC program matures, the Department will consider the value of expanded services in achieving overall program goals during rate development.	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document	Section V.A. - Covered Services	17. Nursing Facility Services p.33	"The CHC-MCO must allow newly enrolled Participants who are residing in a Nursing Facility on the Effective Date of Enrollment for CHC in the zone to continue to reside in the Nursing Facility on the date of their CHC-MCO Enrollment for the durations of the individuals need for Nursing Facility services.	1) UnitedHealthcare Community and State (UHC) supports this requirement. 2) UHC suggests that nursing facility rates for the CHC program be set at the Medicaid rates and that payments can only exceed Medicaid rates when they are part of a value-based contract arrangement. This will protect Participants, nursing facilities and the CHC-MCOs, and will provide for a smooth implementation. 3) UHC assumes that this requirement does not restrict a CHC-MCO plan's ability to transition individuals out of the Nursing Facility into the community. Can the Department please clarify this?	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document	Section V.A. - Covered Services	Section 18. Participant Self-Directed Services p. 34	"The CHC-MCO must contract with the Commonwealth-procured FMS entities, of which there are three that operate statewide"	UHC supports this requirement to contract with the State's chosen FMS entities.	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document	Section V.C. - Continuity of Care	Continuity of Care p. 39	"For a Participant who is a NF resident on his/her Effective Date of Enrollment and the First Enrollment Effective Date of any Enrollment in the CHC program in the zone in which the Participant resides….The CHC-MCO must enter into a contract or payment arrangement with the resident's NF to make payments for the Participant's Nursing Facility services, whether or not the Nursing Facility is in the CHC-MCO network.	UHC understands the importance of continuity of care in the case of nursing facility residents and supports this requirement. UHC strongly suggests that nursing facility rates for the CHC program be set at the Medicaid rates and that payments can only exceed Medicaid rates when they are part of value-based contract arrangement between the provider and the MCO.	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document	Section V.C. - Continuity of Care	Continuity of Care p. 39	"For a Participant who is a NF resident on his/her Effective Date of Enrollment …if the Participant chooses to transfer to a CHC-MCO"	We believe that the word "different" was intended to be between "…transfer to a..." and "...CHC-MCO"	UnitedHealthcare | Community and State/Julie Weinburg

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Requirements Document	Section V.C. - Continuity of Care	Continuity of Care p. 39	"For a Participant who is receiving LTSS through an HCBS Waiver program on his or her Effective Date of Enrollment, the continuity of care period…will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented...whichever date is later."	As written, this language does not allow the CHC-MCO to change a PCSP for 180 days even though a comprehensive needs assessment (CNA) is required to be conducted within 180 days of enrollment. Should the CNA identify additional needs or inappropriate services, the requirement does not allow the CHC-MCO to change the PCSP until the 180-day period is up. UHC recommends the continuity of care period run for 180 days or until a comprehensive needs assessment has been completed and a PCSP implemented, *whichever date is sooner*. This assures that 6 months after post-implementation, the CHC-MCOs will have assessed their existing HCBS Participants promptly and that the Participants are receiving all needed services in the appropriate amounts in order to be safe and to meet the goals of the Participant and the CHC program. Another option could be a staggered continuity of care period for Participants receiving HCBS so that those with the oldest PCSPs (those expiring in the near future) are assessed sooner and those with newer PCSPs are assessed later.	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	Comprehensive Needs Assessments and Reassessments p.40	"For Participants the are NFCE but are not receiving LTSS at the time of Enrollment, the comprehensive needs assessment must be completed in accordance with the timelines outlined in Services Prior to Effective Date of Enrollment."	UHC is unable to find language in the Requirements document, Requirements Exhibit and the RFP labeled as "Services Prior to Effective Date of Enrollment."	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	Comprehensive Needs Assessments and Reassessments p.41	"Participants with existing PCSPs in place at the time of enrollment will have a comprehensive needs assessment within 180 days of their enrollment."	UHC is bringing up this language because it conflicts with the requirement that PCSPs resulting from comprehensive needs assessments are implemented no sooner than 180 days from the Effective Date of Enrollment. Please see our comments on Line 15.	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	p. 44	"The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology or other related field and at least three years of experience in the coordination of services."	1) UHC supports the Department's position in setting minimum qualifications for Service Coordinators. UHC suggests that the Department revisit the minimum qualifications as currently stated in the RFP in order to allow time for workforce development and to avoid shortages of qualified Service Coordinators during the first few years of the program. UHC is *not* suggesting that minimum qualifications be removed altogether. 2) UHC suggests that the Department allow the CHC-MCOs to use a case-by-case exception process based on an individual's experience and other qualifications	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	1. General p. 45	"The Participant has the right to initiate a change in CHC-MCO plans at any time."	Given the investments of time, effort and caring that Participants and their MCOs make in building a relationship, UHC strongly believes that the best thing for the Participant is plan continuity after the first 90 days of enrollment. UHC suggests, therefore, that Participants be allowed to change their CHC-MCO plan once in the first 90 days after the original Effective Date of Enrollment in the plan. If the Participant does not change within the first 90 days, the Participant is then committed to the plan for 1 year (12 months) from the original Effective Date of Enrollment. If the Participant changes plans within the first 90 days, then the Participant is committed to the new plan for 1 year (12 months) from the Effective Date of Enrollment in the new plan. UHC suggests that Participants be allowed to change "for cause" during the lock-in period, with the Department's approval based on Department-developed criteria, and also be allowed to change plans annually during the Participant's open enrollment period that occurs just prior to completing one year in his or her CHC-MCO plan.	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Section 12. Discharge/Transition Planning p. 53	"When any participant is discharged from the CHC-MCO the CHC-MCO from which the Participant disenrolled remains responsible for participating in discharge/transition planning for up to six (6) months from the initial date of Disenrollment."	UHC requests clarification of this section as we are unsure what the Department is seeking to achieve in this section. In general, UHC recommends a 90-day discharge/transition period after a participant is disenrolled from the CHC-MCO. The Participant's CHC-MCO should not have 180 days of responsibility for these activities after the participant has been disenrolled.	UnitedHealthcare | Community and State/Julie Weinburg

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Section 14. New Participant Orientation p. 54	"The role of the PSPT"	UHC cannot determine what a PSPT is. There is no other mention of PSPT in the RFP or Requirements documents.	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p.84	"The CHC must offer the Participant the choice of at least two Service Coordinators"	UHC objects to this requirement as it will unnecessarily complicate the CHC-MCO's ability to manage caseloads and meet comprehensive needs assessment timelines. UHC instead suggests that the Participant be assigned a Service Coordinator based on the factors (provider relationships, language, etc.) described later in this section.	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 84	"The CHC-MCO must make contact with the Participant within seven (7) days of his or her Enrollment for a comprehensive needs assessment indication the need for LTSS…"	UHC requests clarification of the language in this section.	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document	Section V.CC. - Provider Services	Section 2. Provider Education p.86		The ambitious requirements for provider training in this section, while important, are unrealistic for many provider types as they are unlikely to attend trainings for many, if not all, of the topics listed. CHC-MCOs will not have much success in helping to achieve the Department's goals in this important area given the requirements as written. UHC suggests that the Department change language to allow training alternatives such as provider bulletins, emails, and on-line courses in lieu of direct training. UHC also suggests that webinars and on-line, self-service training modules be allowed in lieu of on-site, face-to-face trainings in order to achieve better attendance and educate a larger number of providers.	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document	Section V.DD. - Provider Network	p. 89	"For NF, the CHC-MCO must ensure payment for participants who are in a NF on the day that they become CHC eligible until the time that they leave the NF on their own accord. This includes payment to NFs that are either enrolled or not enrolled as Provider with the CHC-MCO."	UHC again suggests that the Department set Nursing Facility payment rates at the Medicaid rates. This will protect Participants, the Nursing Facilities and the CHC-MCOs, and provide a smooth transition to CHC. Please see our full discussion on line 12.	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document	Section V.DD. - Provider Network	Section 5, Specialists as PCPs, p. 91	"The CHC-MCO must adopt and maintain procedures by which a Participant CHC: …"	UHC requests clarification or correction of this language	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions			UHC strongly supports the inclusion of such benefits as career assessment and other employment-related services, home-delivered meals, pest controls, telecare, and vehicle modifications in LTSS covered services.	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Page 224 Home Adaptations		UHC suggests an annual expenditure limit on home adaptations. The annual limit could be based on historical use of this benefit. This will "level set" the CHC-MCOs and reduce adverse selection and MCO shopping. Additional spending over the annual limit could be considered a value-added service that the MCO could use to differentiate itself.	UnitedHealthcare | Community and State/Julie Weinburg
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Page 238 Vehicle Modifications		UHC suggests an annual expenditure limit on vehicle modifications. This will "level set" the CHC-MCOs and reduce adverse selection and MCO shopping. Additional spending over the annual limit could be considered a value-added service that the MCO could use to differentiate itself.	UnitedHealthcare | Community and State/Julie Weinburg
Other				UHC strongly suggests that the Department continue to maintain a Medicaid fee schedule for all covered services that the CHC-MCOs must adhere to. We suggest that rates can exceed the fee schedule when they are part of a value-based purchasing arrangement between the provider and the CHC-MCO. UHC also suggests that, when appropriate, case rates or PMPMs can be used in lieu of the fee schedule.	UnitedHealthcare | Community and State/Julie Weinburg

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	RFP	Section II 5		Add: Describe the approaches you will use to coordinate with Medicare for dual eligible members to improve Participant experience and outcomes. Specifically, how will care be coordinated? --for Participants with Medicare FFS? -for Participants in any Medicare Advantage plan not affiliated with your Insurance company? -- for Participants in a Medicare Special Needs Plan affiliated with your insurance Company?	PHFC/Ann Torregrossa
Requirements Document	Definitions	p. 8 Definitions	Grievance — A request to have a CHC-MCO or utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a healthcare service.	Grievance--A request to have a CHC-MCO or utilization review entity reconsider a decision concerning, in the case of physical health care, the Medical Necessity and appropriateness of a healthcare service, or in the case of a long-term services and supports, services needed for indepent living, including assistance with Instrumental Activities of Daily Living and to assist the recipient to realize their social and vocational goals.	PHFC/Ann Torregrossa
	Definitions	p.12	Medical Necessity	add: and not experience deterioration.	PHFC/Ann Torregrossa
	Definitions	p.16	Physician Incentive Plan	add CRNPs and Phyician Assistants	PHFC/Ann Torregrossa
	Covered Services	pp 26-27 In-Home and Community-Based Services	The CHC-MCO may not deny a request for Medically Necessary in- home nursing services, home health aide services, or personal assistance services for a Participant under the age of 21 on the basis that a live- in caregiver can perform the task, unless there is a determination that the live-in caregiver is actually able and available to provide the level or extent of care that the Participant needs, given the caregiver's work schedule or other responsibilities, including other responsibilities in the home.	The CHC-MCO may not deny a request for Medically Necessary in- home nursing services, home health aide services, or personal assistance services for a Participant underor over the age of 21 on the basis that a live- in caregiver can perform the task, unless there is a determination that the live-in caregiver is actually able and available to provide the level or extent of care that the Participant needs, given the caregiver's work schedule, sleep schedule or other responsibilities, including other responsibilities in the home and realizing social and vocational goals.	PHFC/Ann Torregrossa
		p.28 Behavioral Health Services	All Participants who need behavioral health services will obtain these services from the Behavioral Health Managed Care Organizations (BH-MCOs). The CHC-MCO must coordinate with the BH-MCO as necessary to ensure that Participants receive all Medically Necessary Behavioral Health Services.	All Participants who need behavioral health services will obtain these services from the Behavioral Health Managed Care Organizations (BH-MCOs). The CHC-MCO must coordinate with the BH-MCO and the Medicare Behavioral Health providers as necessary to ensure that Participants receive all Medically Necessary Behavioral Health Services.	PHFC/Ann Torregrossa
		p.29 EPSDT	The CHC-MCO must comply with the requirements regarding EPSDT services as set forth in Exhibit J, EPSDT Guidelines.	Start sentence with: "For participants under the age of 21 years	PHFC/Ann Torregrossa
		p. 29 Emergency services	The CHC-MCO is responsible for all Emergency Services including those categorized as mental health or drug and alcohol except for emergency room evaluations for voluntary and involuntary commitments pursuant to 50 P.S.§§7101 et seq., which shall be the responsibility of the BH-MCO.	Clarify not Medicare covered emergency services	PHFC/Ann Torregrossa

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	Service Delivery Innovation	p. 35 Housing Innovation		Add: Obtaining a list of 30-day utility shut offs, doing home safety audits, assisting with LIHEAP applications,arranging for pest control and plumbing and roof repairs.	PHFC/Ann Torregrossa
	Service Delivery Innovation	p. 35 Housing Innovation		Add: iii. CHC-MCOs may not use personal care homes as a placement for participants, but should utilize other appropriate and innovative housing solutions.	PHFC/Ann Torregrossa
	Service Delivery Innovation	p. 35 Innovation		Add: e. Innovation to meet quality metrics. Innovation to support quality metrics provided by the Department, based on best evidence, for nursing-facilty level of care participants receiving services in nursing facilities and in the community.	PHFC/Ann Torregrossa
		pp35-36	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	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 five areas, lessons learned, and plans for the following year.	PHFC/Ann Torregrossa
	B. Prior Authorization of Services	p.36 1. General Prior Authorization Requirements		Add: and shall notify the Ombudsperson of the denial and contact information for the participant.	PHFC/Ann Torregrossa
		p. 37 Prior authorization last paragraph	35	Service Coordinators are required to work with the Participant's Medicare Advantage plan or Medicare FFS to ensure expeditious decision-making and communication of decisions made.	PHFC/Ann Torregrossa
		Continuity of care nf		Add: The CHC-MCO must continue to pay non-network nursing facilities the rate they would have received under MA fee-for-service.	PHFC/Ann Torregrossa
		p. 39 Continuity of Care	36	Add: During the continuity of care period, the CHC-MCO must continue to pay for all services in the participant's service plan with the original service providers. If the CHC MCO does not continue the provider in the network and the participant expresses the desire to remain with that provider, the MCO shall advise the participant about the participant self-directed option.	PHFC/Ann Torregrossa
		P. 40 Choice of Provider		Add: "Where the participant is receiving services from a Medicare provider and the participant is in need of additional services from CHC that could be provided by that Medicare provider, the CHC-MCO should advise the participant of that option to foster continuity of care." This section needs to make clear that a Medicare beneficiary can see any providerwho accepts their Medicare card, even if the provider is not in the CHC-MCOs network.	PHFC/Ann Torregrossa
		P. 40 E. Needs Screening	year.	Add: Upon 48 hours of notification of a new participant enrollment, the CHC-MCO shall do triage screening of all information about the participant from the Department, the Indpendent Enrollment Counselor or other sources to triage which participants need to screened immediately and which can be screened within the 30-day period.	PHFC/Ann Torregrossa
		P. 40 Needs Screening	Upon Enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or need for Service Coordination.	Add: The screening tool shall include questions to determine the physical, mental, and emotional and substance abuse needs of the enrollee. If unmet needs are identified, the MCO shall work with the participant, the particpant's Medicare coverage and BH-MCO to identify the appropriate providers to meet those needs.	PHFC/Ann Torregrossa

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	F. Comprhensive Needs Assessments and Reassessments	p.40	For Participants that are NFCE but are not receiving LTSS at the time of Enrollment, the comprehensive needs assessment must be completed in accordance with the timelines outlined inServices Prior to Effective Date of Enrollment.	For Participants that are NFCE but are not receiving LTSS at the time of Enrollment, the comprehensive needs assessment must be completed within 72-hours upon notification by the Department or the Independent Enrollment Counselor that the participant has selected the MCO, even if the enrollment date is subsequent. Services must be provided upon date of enrollment, if the plan has had at least 72 hours notice of the need of services prior to the enrollment date or 72-hours from the enrollment date, if the did not have prior information indicating the need for such services. This shall include referral for Behavioral Health Services.	PHFC/Ann Torregrossa
		p.40	For Participants that are Dual Eligible and identified by the IEE as having a need for immediate services, the comprehensive needs assessment must be completed in accordance with the timelines outlined in Prior to Effective Date of Enrollment.	For Participants that are Dual Eligible and identified by the IEE as having a need for immediate services, the comprehensive needs assessment must be completed within 72 hours of notice by the IEE, even if the enrollment date is subsequent. Services must be provided upon date of enrollment, if the plan has had at least 72 hours notice of the need of services prior to the enrollment date or 72-hours from the enrollment date, if the did not have prior information indicating the need for such services. This shall include referral for Behavioral Health Services.	PHFC/Ann Torregrossa
		Pages 40-41	Reassessments must be completed as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, but in no case more than 14 days after the occurrence of any of the following trigger events: A significant healthcare event to include but not be limited to a hospital admission, a transition between healthcare settings, or a hospital discharge. A change in caregiver or informal support status. A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning.	The CHC-MCO must conduct a comprehensive needs reassessment no more than 12 months following the most recent prior comprehensive needs assessment or comprehensive needs reassessment unless a trigger event occurs and in the case of nursing facility eligibles, a face-to-face assessment must occur every 90 days. Reassessments must be completed as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, but in no case more than 24 hours after the occurrence of any of the following trigger events:	PHFC/Ann Torregrossa
		p.42 H Person-Centered Planning Tool Requirements		The CHC-MCO must develop a PCPT policy for Person-Centered Service Plan development and implementation consistent with the requirements established by the Department.	PHFC/Ann Torregrossa
		p.42 H Person-Centered Planning Tool Requirements		Add for both types of plans: How Medicare and Medicaid-funded behavioral health services will be integrated into the care plan and how continuity of care needs will be addressed.	PHFC/Ann Torregrossa
		p.43	Service Coordinators are responsible for assisting Participants in obtaining the services that they need	Add at the end of the sentence: "by co-ordinating all necessary Medicare, BH-MCO, CHC-MCO and other services for the Participant.	PHFC/Ann Torregrossa

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	Service Co-ordinator and Service Co-0rdinator Supervisor Requirements	p.44	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology or other related field and at least three years of experience in the coordination of services. All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience.	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology, aging and geriatrics or other related field and at least three years of experience in the coordination of services. All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience. Service Coordinators and Service Coordinator Supervisors must also complete Department- approved training in required training topics. Existing Service Coordinators and Supervisors may be grandfathered and given 2 years to meet the requirements.	PHFC/Ann Torregrossa
	L. Nursing Home Transition Services	Page 44	CHC-MCOs must offer Nursing Home Transition (NHT) services as defined in Exhibit DDD(2), LTSS Covered Services Definitions, to Participants residing in Nursing Facilities who express a desire to move back to their homes or other community-based settings. Service Coordinators may coordinate NHT services.	CHC-MCOs must offer Nursing Home Transition (NHT) services as defined in Exhibit DDD(2), LTSS Covered Services Definitions, to Participants residing in Nursing Facilities who express a desire to move back to their homes or other community-based settings. Service Coordinators may coordinate NHT services. The Independent Enrollment Counselor will meet with new MA applicants to facilitate plan selection prior to eligibility determination. The CHC-MCOs shall meet in person with those who have chosen their plan prior to eligibility determination to advise of possible transion services and to help plan for care upon enrollment in the plan should they be determined eligible.	PHFC/Ann Torregrossa
		M.1 CHC-MCO and BH-MCO Coordination		Most participants will have Medicare coverage which will pay for most of their physical and behavioral health needs as the primary insurer. This section needs to acknowledge that and clearly state how the CHC-MCO and the BH-MCO will coordinate with either the participant's Medicare FFS or Advantage plan.	PHFC/Ann Torregrossa
		P. 44	To facilitate the efficient administration of the Medical Assistance Program and to enhance the treatment of Participants who need both Covered Services and BH services, the CHC-MCO must develop and implement written agreements with each BH-MCO in the CHC-MCO's zone(s) regarding the interaction and coordination of services provided to Participants enrolled in the Community HealthChoices Program. These agreements must be submitted and approved by the Department. The CHC-MCOs and BH-MCOs are encouraged to develop uniform coordination agreements to promote consistency in the delivery and administration of services.	To facilitate the efficient administration of the Medical Assistance Program and to enhance the treatment of Participants who need both Covered Services and BH services, the CHC-MCO must develop and implement written agreements with each BH-MCO in the CHC- MCO's zone(s) regarding the interaction and coordination of services provided to Participants enrolled in the Community HealthChoices Program, which agreement shall include language provided by the Department to foster uniformity in co-ordination. These agreements must be submitted and approved by the Department.	PHFC/Ann Torregrossa

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		p.45	The CHC-MCO must, and the Department will require Health Choices Behavioral Health Managed Care contracts to submit to independent binding arbitration in the event of a dispute between the CHC-MCO and a BH-MCO concerning their respective obligations under this agreement and the Behavioral Health HealthChoices agreement. The mutual agreement of the CHC-MCO and a BH-MCO to such an arbitration process must be evidenced by and included in the written agreement between the CHC- MCO and the BH-MCO.	The CHC-MCOs must advise the Department of failure of the BH-MCO concerning its obligations under the agreement within 30 days of such failure. The Department will enforce the agreements between the parties and will use warning, fines, penalties and contract termination, if needed to enforce the contracts and the requirements of this Agreement.	PHFC/Ann Torregrossa
		p. 46 Participant enrollment/ disenrollment	The Department will enroll Participants transferring from one CHC zone to another with the same CHC-MCO, provided that the CHC- MCO operates in both CHC zones, unless the Participant chooses to enroll in LIFE in the new zone.	The Department will enroll Participants transferring from one CHC zone to another with the same CHC-MCO, provided that the CHC-MCO operates in both CHC zones, unless the Participant chooses to enroll in a different CHC-MCO or in LIFE in the new zone.	PHFC/Ann Torregrossa
		p.50		Add: The CHC-MCO must send representatives to the Zone Community Committee Meetings, which will start in each CHC Zone shortly after the selection of bidders and will include CHC BH plans, provider representatives, consumers, advocate and foundations to facilitate implementation and to further communication and coordination. The groups will meet monthly and once MCH is running smoothly in the zone, will meet quarterly.	PHFC/Ann Torregrossa
	14. New Participant Orientation	p.54		Need to add clear information on the role of the CHC PCP vs. the Medicare PCP	PHFC/Ann Torregrossa
	14. New Participant Orientation	p. 54		Add: 1. information on CHC_MCOs payment for Medicare deductibles and co-insurance even if not in the CHC-MCO networks and how that works. 2. Those with Medicare coverage may access all Medicare covered services from Medicare providers of their choice and 3. No balance billing by the CHC-MCOs	PHFC/Ann Torregrossa
	15. CGC-MCO Identification Cards	p. 55	The CHC-MCO must issue a single identification card to Participants enrolled in the aligned D-SNP for both the CHC-MCO and the D-SNP.	Two (2) cards are necessary to get services, especially when multiple, non-resident caregivers are responsible for assisting the participant to receive covered services.	PHFC/Ann Torregrossa
	P. Particiipant Services	Pages 58-60		Three different toll-free numbers are unmanageable. A single, toll-free number staffed with appropriately trained professionals should be able to triage the needs of the consumer and connect them with the appropriate MCO resource.	PHFC/Ann Torregrossa
	P. Participant Services General	P. 59		What is missing is defing how quickly the MCO must provide services in an emergency if a critical provider does not show up. Add the following language: "MCOs must make arrangements through their providers or otherwise to have back up staffing to arrive at the participants house within 90 minutes of notice that the service provider is ill or otherwise unable to attend the participant, where the lack of services could cause an urgent or emergent problem.	PHFC/Ann Torregrossa
		P. 62		CHC MCOs may not delegate the Complaint, Grievance and Fair Hearing Process and must have the unit staffed with personnel authorized to immediately remedy denials or quality complaints where necessary to prevent harm to the participant.	PHFC/Ann Torregrossa
		p.62		Add: The MCO must immediately advise a participant filing a complaint of the availability of assistance of the Ombudsperson and the relevant legal services program, including contact information.	PHFC/Ann Torregrossa

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		p. 68 Office		Add: The office must be staffed with employees authorized to do face-to-face problem resolution and to monitor local provider network compliance with CHC requirements.	PHFC/Ann Torregrossa
		p.66	A Behavioral Health Coordinator who is a behavioral health professional and is located in Pennsylvania. The Behavioral Health Coordinator shall ensure that the CHC-MCO adhere to behavioral health requirements in this agreement.	A full-time Behavioral Health Coordinator who is a behavioral health professional and is located in Pennsylvania. The Behavioral Health Coordinator shall ensure that the CHC-MCO adhere to behavioral health requirements in this agreement.	PHFC/Ann Torregrossa
				Add: If the existing providers are not adequate to meet the Access requirements, the CHC MCO must enroll additional providers to meet these requirements.	PHFC/Ann Torregrossa
		pp.88-89		Need to define "timely". Within 48 hours of development of the care plan.	PHFC/Ann Torregrossa
	Exhibit L MATP		When requested, the CHC-MCO must arrange non emergency transportation for urgent appointments for their Participants through the MATP.	When requested, the CHC-MCO must arrange non-emergency transportation for non urgent appointments for their Participants through the MATP.	PHFC/Ann Torregrossa
	Exhibit GG	3	1. The CHC-MCO must have written policies and procedures approved by the Department for registering, responding to and resolving Complaints and Grievances (at all levels) as they relate to the Medical Assistance population and must make these policies and procedures available upon request.	Add: Procedures must require advising the participant of the availability of assistance by the Ombudsperson and appropriate legal services program and contact information.	PHFC/Ann Torregrossa
		5		Add: The CHC-MCO must provide Participants,their attorneys, and the Ombudsperson with access and copies to all relevant documentation pertaining to the subject of the Complaint or Grievance.	PHFC/Ann Torregrossa
		12	The CHC-MCO must notify the Participant when it denies payment after a service has been delivered because the service or item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program using the required template (template GG(11)). Templates located on the CHC Intranet site. The CHC-MCO must mail this notice to the Participant on the day the decision was made to deny payment	Add: and the CHC-MCO must assure that the Participant is not billed for the denial of payment. Put same language for 18 and 19	PHFC/Ann Torregrossa
		20	The CHC-MCO must, at a minimum, hold in-person reviews of Complaints and Grievances (at all levels) at one location within each of its zones of operation. If a Participant requests an in-person review, the CHC-MCO must notify the Participant of the location of the review and who will be present at the review using the required template (template GG(14)).	Add: For nursing home eligibile participants the in-person review must be done in the participant's house or nursing facility.	PHFC/Ann Torregrossa
	Exhibit DD	21		Add: and how to obtain assistance from the Ombudsperson and/or appropriate legal services program.	PHFC/Ann Torregrossa
				Add: 58. A list of long-term services and supports that may be available to qualifying participants.	PHFC/Ann Torregrossa
				Add: 59. For nursing home eligible level of care recipients receiving services in the community, what to do if a service provider fails to come to the house at the schedulded time.	PHFC/Ann Torregrossa

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	Exhibit GG	5		Add: 5. The CHC-MCO must provide Participants, their attorney and the Ombudsperson with access to and copies of all relevant documentation pertaining to the subject of the Complaint or Grievance.	PHFC/Ann Torregrossa
	Exhibit GG			Add: The CHC-MCO must advise the participant of the availability of assistance by the Ombudsperson and appropriate legal services program and contact information.	PHFC/Ann Torregrossa
	Exhibit GG			g. The Participant and/or attorney must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The CHC-MCO shall be flexible when scheduling the review to facilitate the Participant's and attorney's attendance. The Participant and attorney shall be given at least seven (7) days advance written notice of the review date. If the Participant or attorney cannot appear in person at the review, the CHC-MCO must provide an opportunity to communicate with the first level Complaint review committee by telephone or video conference. The Participant may elect not to attend the first level Complaint meeting but the meeting must be conducted with the same protocols as if the Participant was present.	PHFC/Ann Torregrossa
	Exhibit AAA			The CHC-MCO must ensure that its Provider Network is adequate to provide its Participants in this CHC zone with access to quality Participant care through participating professionals, in a timely manner, and without the need to travel excessive distances, or in the case of services provided in the home, provided in a timely manner according to the service plan.	PHFC/Ann Torregrossa
				The vast majority of participants will have a Medicare PCP. The language should work to assure that the Medicare and CHC PCP are the same. It is the Medicare PCP who will be handeling the participants physical health needs.	PHFC/Ann Torregrossa
		e. LTSS Providers		Ensure at least two (2) Providers for each LTSS Covered Service listed in Exhibit DDD1 within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural) or in the case of MLTSS services provided in the home, sufficient to staff the service plan in a timely manner.	PHFC/Ann Torregrossa
	Exhibit AAA	f. Out-of-Network Access		Add: 90% are Medicare providers	PHFC/Ann Torregrossa
		Rehab Facility	Ensure a choice of at least two (2) rehabilitation facilities within the Provider Network, at least one (1) of which must be located within this CHC zone.	Ensure a choice of at least two (2) rehabilitation facilities within the Zone.	PHFC/Ann Torregrossa
		Nursing Facilities		At least one nursing facility located in each county in the Zone.	PHFC/Ann Torregrossa
	Exhibit DDD1			Add: Geriatricians, palliative care, respite services, dementia care and nutrition assessment	PHFC/Ann Torregrossa
	Add			The [CHC-MCO] must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for qualified Medicare beneficiaries in accordance with Section 4714 of the Balanced Budget Act of 1997. If no contracted CHC-MCO rate exists or if the Provider of the service is an Out-of-Network Provider, the [CHC-MCO] must pay deductibles and coinsurance up to the applicable MA fee schedule for the service. For Medicare services that are not covered by either MA or the [CHC-MCO], the [CHC-MCO] must pay cost-sharing to the extent that the payment made under Medicare for the service and the payment made by the CHC-MCO do not exceed eighty percent (80%) of the Medicare-approved amount. The [CHC-MCO], its subcontractors and providers are prohibited from balance billing members for Medicare deductibles or coinsurance. The CHC-MCO must ensure that a member who is eligible for both Medicare and Medicaid benefits has the right to access a Medicare product or service from the Medicare Provider of his/her choice. The CHC-MCO is responsible to pay any Medicare coinsurance and deductible amount, whether or not the Medicare provider is included in the [CHC-MCO's] Provider Network and whether or not the Medicare Provider has complied with the authorization requirements of the [CHC-MCO].	PHFC/Ann Torregrossa

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			• allow Scranton to, upon termination of its distressed municipality status, levy up to a $156-per-year local services tax if its pension system remains in moderate or severe distress with any amount over $52 to be applied solely to the city's unfunded actuarial accrued pension liability;		PHFC/Ann Torregrossa
Requirements Document	Section V.C. - Continuity of Care	Pg. 39, Sect. C, 2nd bullet	Continuation of services….180 days or until a comprehensive needs assessment	In order to ensure Continuity of Care, it is recommended that the six month period for consumers to transition to a selected Managed Care Organization (MCO) be increased to a two year minimum. This will ensure that the consumer is properly enrolled, that services are not interrupted and that the consumer is educated on the new process of the managed care organization.	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
Requirements Document	Section V.C. - Continuity of Care	Page 39, 3rd Bullet	For a Participant who is receiving LTSS but whose LTSS Provider leaves the CHC-MCO Provider Network, the CHC-MCO must continue to allow the Participant to receive services for a 60 day period and must pay that Provider until such time….	The rates especially for PAS continue to be at an all time low for sustaining a quality program. This will hinder the MCO and other providers in hiring a quality staff and pay them a decent livable wage. Without the increase in rates, it assures constant turnover in a position that is critical to keeping the consumers in the community. It is strongly recommended that OLTL reconsider increasing rates for all services,especially PAS, that are below the standard. It is also recommended that MCO be required to contract with all providers at the OLTL increased published rate in the region for a minimum of two years.	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions	Personal Assistance Services	(Description of ADL/IADL) PAS primarily provide hands on assistance to participants that are necessary……..PAS may include assistance with the following when incidental to PA and necessary to complete ADL's	There are concerns regarding the plan language delineating between ADL's and IADL's. It is recommended that health and safety and quality of life concerns be added to the medical necessity definition when considerations are made to determine eligibility of such service. Additionally, the state should ensure that the appeals process accounts for these factors and not solely "medical necessity".	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	55 a.	Consumer Rights and Independent Living	The RFP should require that the MCO's be familiar with and trained on the topics of consumer rights, the independent living philosophy, consumer choice and the social model of attendant care in conjunction with the medical model approach. MCO's should be responsible for training all staff working having direct/indirect contact with coordination of care. There should also be standardized training requirements for the MCO to train consumers on the above topics.	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
Requirements Document	Section V.EE. - QM & UM Program Requirements	94	Utilization Review –	The RFP does not detail a proposed utilization review system. It is important for the stakeholders to be able to review the proposed utilization review process and be able to comment on its format. It is recommended that the utilization review not be solely based on a medical model but consider social/quality of life factors. It is further recommended that the state leverage the MCO infrastructure to provide providers or make a utilization review report available electronically on a quarterly basis for each consumer.	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
Requirements Document	Section V.C. - Continuity of Care	Pg 39, Bullet 3	….but whose LTSS provider leaves the network….	The RFP includes several hidden costs. It is recommended that the state review the RFP for any hidden cost when setting the state MCO rates.	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
Requirements Document	Section V.C. - Continuity of Care	39	Caution	With the changes in the FMS, LOCA, IEB in addition to switching to a managed care environment, it is the potential for a perfect storm that may drive consumers to agency model to ensure back up in services. With that in mind, current rates do not support a hiring of an adequate workforce therefore it is once again suggested that the PAS rate be increased to ensure continuity of care, in the event that consumers should need to change services.	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)

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Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	Pg 44-k		Need: Standardization of Training among all SCEs. Comply with ACT 22 and set educational benchmarks. Also, new proposed standards exclude too many degrees. Example of deficiency: Master's in Healthcare Administration would be excluded. Suggested Solution: OLTL should require SCEs to have an RN on staff, or to contract out to RNs, and to use RNs for consultation with SCs. OLTL can set requirements that RNs are more involved in long-term-care planning of patients with the medical need. Suggested Solution: OLTL should require SCEs to have an RN on staff, or to contract out to RNs, and to use RNs for consultation with SCs. OLTL can set requirements that RNs are more involved in long-term-care planning of patients with the medical need. Support Coordination Group's addition: RNs working with SCEs should be required to sign-off on ISPs agreeing that the participant's level of care meets NFCI and that the hours the SC suggests are correct to meet the participant's needs. SCs and RNs should work together. Benchmark of all of SC should be certified within 2 year, and SC Supervisors should have 5 years' experience in the human service field and are all required to be certified. Should receive certifications from an association identified by OLTL there should be one or a few to choose from such as the CDIS, CRC, CAC. Therefore the Act 22 requirements could still be following for educational requirements.	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
				Benchmark of all of SC should be certified within 2 year, and SC Supervisors should have 5 years' experience in the human service field and are all required to be certified. Should receive certifications from an association identified by OLTL there should be one or a few to choose from such as the CDIS, CRC, CAC. Therefore the Act 22 requirements could still be following for educational requirements.	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
				In addition to the RN consulting requirement, adding LSW/LPC consulting assess as a requirement for SCE's.	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
Requirements Document	Section V.A. - Covered Services	Page 26, A-1	Program Requirements lists only the Amount, Duration and Scope of care.	Need: OLTL should add language, or address the Frequency of care, as all five aspects of care are stressed by Quality Reviewers. (Is Type being eliminated due to the elimination of Waivers?)	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
Requirements Document	Section V.A. - Covered Services	Page 26., A-2		Need: Language should be added for participants above the age of 21-years old.	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	Page 51, Number 8		Exhibit BB is referenced, but not found. Where might they be found, or was this a typing error?	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
Requirements Document	Section V.X.- Administration	Page 71, Number 2-D, 3rd para		Exhibit D is referenced, but not found. Where might they be found, or was this a typing error?	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Issue: Regulations for DCWs working 100+ hours per week	Currently, there is no regulation to limit PAS hours in the consumer model worked per direct care worker.	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
				Suggested Solution: Create a regulation: A Direct Care Worker can work no more than 60 hours per week for a single participant, with exceptions only from OLTL.	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
			Extension of the 180 day Continuity of Care	Suggested Solution: Extend the 180 day continuity of care clause to a full two-years for service coordination, allowing time for SCEs to make sure staff meet training benchmarks within that 2 year period.	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
			???	Documented formal partnerships and agreements with community partners and SCE's ie. Crisis services and housing coordination.	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
				How to address QA Concerns?- having caseload capacity at 50, Sanctions for noncompliance, Sanctions and deficiency should be public record similar to those of NF so consumers are aware of their choices	Matthew Perkins, President, on behalf of the PA Providers Coalition Association (PA-PCA)
Other		General Comment		**Intent/Definition of Service Coordination**-There is currently ambiguity in the definition of service coordination. The Department should clarify if service coordination is intended to be classified as a provider service or as an administrative function under the Community HealthChoices (CHC) program. One example of where this is important is when considering the continuity of care period. If service coordination is a provider service, the continuity of care period would definitely apply. If it is an administrative function, we are not sure if that provision would apply to service coordination.	p4 a Pike Co. AAA concurs/ Robin LoDolce

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Other		General Comment		**Coordination of CHC Services with Behavioral Health Services**- The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like. Specific scenarios should be discussed to determine potential gaps in the service systems and create a safety net so that people with behavioral health needs do not fall through the cracks.	p4 a Pike Co. AAA concurs/ Robin LoDolce
Other		General Comment		**Coordination of MCO Activities with Existing Adult and Older Adult Protective Services Systems**- The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity? How will information flow from and to the appropriate reporting authority and what safe guards for confidentiality will be provided?	p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document	Section II - Definitions	p. 14	Participant Advisory Committee (PAC)- A group convened in person, at least quarterly by the CHC-MCO's governoring board which is open to all participants and which reflects the diversity of the CHC-MCO's Participant population.	**Participant Advisory Committee Makeup -** We recommend that the PAC meetings be formed for, and held in, each zone (for instances where MCO may cover more than one zone) and have representation for rural and urban counties in each particular zone.	p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document	Section II - Definitions	p. 15	Person Centered Planning Team- The team of individuals that will participate in Person Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT	**Person Centered Planning Team Makeup** - We recommend OLTL include the minimum acceptable required individuals and also include other suggestions/preferences for individuals on the team. We also recomment that OLTL require that if there is a behavioral health diagnosis, a behavioral health representative be required on the team.	p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document	Section V.A. - Covered Services	p.26			p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document	Section V.A. - Covered Services	p.26	The CHC-MCO may not deny a request for Medically Necessary in-home nursing services, home health aide services, or personal assistance services for a Participant under the age of 21 on the basis that a live-in caregiver can perform the task…	**In-home Nursing, Home Health Aide or Personal Assistance Services** - We recommend removing "under the age of 21" so that no consumer could be denied under these circumstances.	p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document	Section V.B. - Prior Authorization of Services	p. 36	B. Prior Authorization of Services 1.General Prior Authorization Requirements (4th paragraph) When the CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of denial using the appropriate notice outline in templates…	**Notice of Service Denial** - We recommend that when there is a denial of services for those in MLTSS, notification should also be sent to the Service Coordination Agency/entity to ensure continuity and follow up with consumer.	p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document	Section V.B. - Prior Authorization of Services	p.37	2. Time frames for notice of Decisions	**Notice of Service Decisions** - We recommend that notice decisions should also be sent to Service Coordinator (entity) if additional information is needed from an MLTSS consumer the Service Coordination Agency should also be notified so they can assist the consumer in acquiring required documentation.	p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document	Section V.C. - Continuity of Care	p. 39	…the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed...	**Continuity of Care for LTSS Participants**-To assure participants the most seamless transition for long term care services and supports, we recommended that this time frame be established at a minimum of a two year period.	p4 a Pike Co. AAA concurs/ Robin LoDolce

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Requirements Document	Section V.D. - Choice of Provider	p. 44 & p. 66	K. Service Coordinator and Service Coordinator Supervisor Requirements- …All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience...	**Experience/Training Requirements for Service Coordinators and Service Coordination Supervisors**-To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers. *That the 5 year requirement be removed to remove any barriers from skilled professionals who may have worked in different careers with people with disabilities and or aging consumers.	p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document	Section V.D. - Choice of Provider	p. 50, Exhibit DDD1	4. Limited English Proficiency (LEP) Requirements	**Limited English Proficiency Requirements**- We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document	Section V. Z. - Fraud & Abuse	p. 79	7. a. The CHC-MCO must have at a minimum the following ocmponents to its MIS or the capibility to link to other systems contining this information: Participants, Provider, Claims processing, Prior Authorization, Reference.	**Management Information Systems**-We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	p. 85, Exhibit BB		**Intent/Definition of Service Coordinator-**There are instances where it is unclear if the term "Service Coordinator" is referring to the individual Service Coordinator or the Service Coordination Entity (SCE). Please clarify/define service coordinator specifically refers to an entity or an individual. For example, page 85, in section BB, it states in the last bullet "…when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding…" The first instance of Service Coordinator appears to refer to the SCE, not an individual service coordinator. The Department should clarify if they are referencing the service coordinator or the service coordination entity wherever the term "Service Coordinator" is used to reflect "Service Coordinator" or "Service Coordinating Entity." (This would also require an additional definition for "Service Coordinating Entity."	p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document	Section V.DD. - Provider Network	p. 89	A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO.	**Willing Provider Definition –** In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document Exhibit	C - Requirements for Provider Terminations	1. A.	The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.	**Notification to Department** – We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document Exhibit	DD - Participant Handbook	Section A point 12	The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant.	**Complaints and Grievances** – While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, and their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	p4 a Pike Co. AAA concurs/ Robin LoDolce

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Requirements Document Exhibit	AAA - Provider Network Composition/Service Access	AAA (3)-7	This travel time is measured via public transportation, where available.	**Definition of Travel Time –** In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Respite Care -Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.	**Definition for Respite Care**-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	p4 a Pike Co. AAA concurs/ Robin LoDolce
Requirements Document Exhibit	DDD(2) - Covered LTSS Service Definitions		Service Coordination - Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements...	**Responsibility of Annual Level of Care Redetermination**- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	p4 a Pike Co. AAA concurs/ Robin LoDolce
	DDD(2) - Covered LTSS Service Definitions	227	Home Delivered Meals are provided only during those times when neither the Participant nor anyone else in the household is able or available to provide them, and where no other relative, caregiver, community/volunteer agency or third-party payer is able to provide, or be responsible for, their provision	Provider not contracted with current community organization or volunteer group	p4 a Pike Co. AAA concurs/ Robin LoDolce
	DDD(2) - Covered LTSS Service Definitions	237 Therapeutic & Counseling Services	Nutritional counseling services are limited to 90-minutes (6 units) of nutritional consultations per month. Home health agencies that employ licensed and registered dieticians may provide nutritional counseling	Add that participants with newly diagnosed chronic diseases, as identified in Academy Of Nutrition and Dietetics with relating to medical nutrition therapy, may require more than one 90 minute counseling per month to promote adherance to care plan and nutritional therapy and prevent further hospitalizations. Also services may be provided by other nutritional professionals not employed by Home HEalth agencies but hold the appropriate licenses and provider/registration numbers.	p4 a Pike Co. AAA concurs/ Robin LoDolce
RFP	Criteria	p7 1-4	Community Well Duals	Comment: good to include upstream population for interventions; should know that among that group, those who qualify for Independence at Home (hosp prior year, post-acute care prior year, 2+ chronic conditions, and 2+ ADL difficulties requiring some human help) represent 24% of ALL incident LTI among Medicare beneficiaries, but 4% of the pool, a greater concentration than community duals, and should be a stratum for population planning	American Academy of Home Care Medicine/Bruce Kinosian
RFP	Proposal Requirements	p 11, I-5	Timing of Agreements	If there may be substantial changes in the RFP as a result of the roll-out in SW (for example, requirements around network breadth and stability), it might make more sense to obtain bids on the other regions (at least NW, NE, and LC) after the initial year's experience.	American Academy of Home Care Medicine/Bruce Kinosian
RFP	Criteria	p12 i-5	p4p	good choice of re-enrollment as target; P4P has limited role in a capitated arrangement, other than as a potential downward adjustment for poor quality	American Academy of Home Care Medicine/Bruce Kinosian

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RFP	Work Statement Questionnaire	p31 12	describes integrated model w medicare	Good to have intention to integrate care regardless of whether participants are in a dual plan or not. The RFP is unclear if the state will be building in some shared savings with the state for these activities when it sets it's rates? Should you make explicit the intent to look at integrated outcomes leveraged off Medicaid program in the scope of work?	American Academy of Home Care Medicine/Bruce Kinosian
RFP	Work Statement Questionnaire	p30 9	access to integrated housing	Will the department accept proposals for novel forms of integrated housing for individuals typicall in NHs now-- such as group homes?	American Academy of Home Care Medicine/Bruce Kinosian
RFP	Work Statement Questionnaire	p32 21	disease management	The presumption is that disease management programs are effective, despite their near-universal failure in demonstrations (the exception being HQP); engagement of patients and providers is key, yet there is nothing in the list of questions that requires involvement of a patient's providers (who may well not be a plan provider, being paid on the Medicare side)	American Academy of Home Care Medicine/Bruce Kinosian
RFP	Work Statement Questionnaire	p33 30	service coordinators	The RFP is unclear about the traditional LTSS service coordinator roles and the traditional MCO service coordinator roles, and how (or if) they can be dealt with through a subcontract (say, for the LTSS SC role)	American Academy of Home Care Medicine/Bruce Kinosian
RFP	Work Statement Questionnaire	p33 3	data access for Medicare coordination	You should also ask what the MCO considers the data necessary to coordinate care; this has been extremely frustrating as a provider in obtaining data on one's patients from current MCOs.	American Academy of Home Care Medicine/Bruce Kinosian
RFP	Work Statement Questionnaire	p40 a (3rd bullet)	any willing provider	Describe how you will enroll any current willing and qualified HCBS, nursing facility, and LTSS providers into your network. This sounds like the very welcome approach of requiring "any willing provider" and then using reasonable quality measures to ensure ongoing participation, rather than letting the MCOs narrow their networks for ease of management. Is that the intention here?	American Academy of Home Care Medicine/Bruce Kinosian
RFP	Work Statement Questionnaire	p40 1	accessiblity	Are home limited individuals included in the accessibility standard (e.g., providing home based primary care and/or flexible and affordable transportation options?	American Academy of Home Care Medicine/Bruce Kinosian
RFP	Work Statement Questionnaire	p41 7	pcp contracting and incentives	Shoould include how MCOs intend to incorporate new and effective aspects of Medicare Program (e.g., Independence at Home) into their primary care offerings, and how they will share those savings with the state. PA MCOs have been very resistant to altering their traditional practices in this area.	American Academy of Home Care Medicine/Bruce Kinosian
				The transitional period for maintaining one's own network, if only 6 months, is unreasonably short, unless the "any willing provider" clause on p. 40 would mean those grandfathered networks would be maintained, except "for cause".	American Academy of Home Care Medicine/Bruce Kinosian
RFP	Work Statement	p52 2	strengthen coordination	There's no requirement for willingness on the part of MCOs to coordinate with medicare providers; tranditionally the MCOs have been very internally focused on their coordination; we've had difficulty getting patient-level coordination with several of the major MCOs in SE PA for our LTSS patients.	American Academy of Home Care Medicine/Bruce Kinosian
RFP	Work Statement Questionnaire	p 11, I-5	areas for integration	Triple - eligible veterans--duals who get care from VA have a menu of non-institutional care that need to be coordinated with the MCOs. Veterans receiving waiver-equivalent non-institutional care account for over 14% all waiver consumers, and 20% of all Pennsylvanians who current have integrated LTSS and coordinated primary care (LIFE outside VA and combination of HBPC+non-institutional services and supports) within VA)	American Academy of Home Care Medicine/Bruce Kinosian
				related to above, a recent IG invetigation suggestion over $1B in cost shifting from MCOs to VA, so it's also a sensitive issue.	American Academy of Home Care Medicine/Bruce Kinosian
RFP	Work Statement	p31 12	integrated model with Medicare and accessibility	With recent IAH results with respect to LTI (25% reduction) should making home based primary care avaiable to home limited, frail elders (for example, defined by IAH criteria) be included in the accessibility standards?	American Academy of Home Care Medicine/Bruce Kinosian

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Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	Page 44	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology or other related field and at least three years of experience in the coordination of services. All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience. Service Coordinators and Service Coordinator Supervisors must also complete Department-approved training in required training topics.	**Suggested Change:** The CHC-MCO must require that all employed or contracted Service Coordinators and Service Coordinator Supervisors meet the minimum requirements established by Act 22 and that every Service Coordinator and Service Coordinator Supervisor obtain Service Coordinator Certification through a Standardized Training Program approved by OLTL. **Comments: 1)** The Great Need of the State, SCEs and participants is to have a **standardization of training** to set a guaranteed standard of care and of education for Service Coordinators in long-term-living services and supports. There are already existing Training Materials for Service Coordinators which are not required but would be extremely beneficial to increase quality of care. Examples: Ohio State Service Coordination Training. Boston University Service Coordination Training. Long-Term-Living Training Institute Service Coordination Training. **SCEs would pay the cost of the trainings and have stricter monitoring for Preventative Care and Detailed Service Notes.** In Addition, current Service Coordinators and Service Coordinator Supervisors meeting the Act 22 requirements and who meet new educational requirements should be authorized to continue, as their experience is invaluable for participants and SCEs	Supports Coordination Group / Bailey Carey
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	Page 44	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology or other related field and at least three years of experience in the coordination of services. All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience. Service Coordinators and Service Coordinator Supervisors must also complete Department-approved training in required training topics.	**2) Statistics. Loss of Jobs.** from the Pennsylvania Providers Coalition Association show the extensive loss of jobs that would occur if such change in position requirements takes place. 23 SCEs out of 120 SCEs in the State of Pennsylvania completed a survey with the following results. From those 23 SCEs, there are 81.5 full-time Service Coordinator Supervisors, out of which 85% (70 Service Coordinator Supervisors) would not meet the new proposed regulations in the Draft RFP. From those 23 SCEs, there are 407 Service Coordinators, out of which 51% (209 Service Coordinators) would not meet the new proposed regulations into he Draft RFP. Applying these percentages to all SCEs in Pennsylvania shows that approximately 1,000-1,100 Service Coordinators would no longer qualify and 280 Service Coordinator Supervisors would no longer qualify. In Addition, too many degrees are excluded from the new provisions. For example, a Service Coordinator with a Master's in Healthcare Administration would not meet the new proposed regulations in the Draft RFP. **3) Additional Costs.** From the above mentioned survey, the average increase in cost per Service Coordinator will be $4,100. The total increase in cost for a total of 180 Service Coordinators will be $856,900.	Supports Coordination Group / Bailey Carey

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Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	Page 45	The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology or other related field and at least three years of experience in the coordination of services. All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience. Service Coordinators and Service Coordinator Supervisors must also complete Department-approved training in required training topics.	**4) SCEs must employ or have contracted RNs for consultation. Suggestion: Change and clarify CMI and RN requirements.** The RN must be required to review each participant's CMI to verify whether the participant is NFCE or NFI, as per current requirements, but must also conduct quarterly reviews to ensure that participant's Individual Service Plan (ISP) meets their medical needs. the Service Coordinator Supervisor continually reviews each participant's ISP to ensure the participant's social needs are met and meets the RN for consultation for the participant's medical needs. In this way, the medical and social aspect of a participant's case are more seamlessly monitored.	Supports Coordination Group / Bailey Carey

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Requirements Document	Section V.DD. - Provider Network	Pages 88 - 89	To minimize the disruption of services to Participants, the CHC-MCO must enroll in its Provider network all willing and qualified LTSS Providers that provide HCBS through the OLTL waivers in effect prior to CHC implementation date and through all Nursing Facilities in the assigned zone. This will allow participants who are receiving LTSS as of the date of their enrollment in the CHC to maintain their current services with their current service provider. A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO. A qualified Provider is a Provider that meets applicable MA program participation or waiver requirements for the Provider's provider type. **This requirement will remain in effect for HCBS Providers for the first 180 days that CHC is operational in each zone. Following the 180 day period, the CHC-MCO may adjust its Provider Network in accordance with the Network access and adequacy standards outlined in this agreement.**	**Suggested Change:** This requirement will remain in effect for HCBS Providers for the first **2-years** that CHC is operational in each zone. Following the 180 day period, the CHC-MCO may adjust its Provider Network in accordance with the Network access and adequacy standards outlined in this agreement. **Comments:** Along with maintaining Act 22 regulations, the State should set a benchmarks for Service Coordinators and Service Coordinator Supervisors to reach each 3-month period to reach a Standard Service Coordination Certification.	Supports Coordination Group / Bailey Carey
RFP	General Information			What is going to happen to all participants under the ACT 150 program and the proposal indicates these individuals will no longer be eligible for LTSS.	Casey Ball Supports Coordination, LLC
RFP	General Information			It is reported the CHC-MCO can either complete service coordination themselves or delegate it to community partners, how is this conflict free?	Casey Ball Supports Coordination, LLC
RFP	General Information			What will the new rate for service coordination be once the CHC-MCO takes effect?	Casey Ball Supports Coordination, LLC
RFP	General Information			What will be the process for allowing current service coordination entities to continue proviidng service coordination under the MCO?	Casey Ball Supports Coordination, LLC
Requirements Document	Section II - Definitions		Disability Competetency	1.How is the OLTL going to evaluate disbility competency 2. I suggest that this eveaulted on a yearly basis	Casey Ball Supports Coordination, LLC Lester Bennett Executive Assistant
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements	43	All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience	1. Will current Service Coordinator Supervisors be grandfathered in ? 2. I suggest those with Bachelor's degrees in Rehabiliation Science be able to be Supersvisors aslo because the have taught about People with disabilites and the services that are avaailable to them .	Casey Ball Supports Coordination, LLC Lester Bennett Executive Assistant

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Other			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. When reviewing other states that have implemented MLTSS, they provided a full year for transition. Why is Pennsylvania being so aggressive in its timeframe?	Jennifer Poole /Alma Health Skilled Services and MedStaffers
Other			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 /Alma Health Skilled Services and MedStaffers
Other			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 /Alma Health Skilled Services and MedStaffers
Other			Adequacy of Home Care Providers	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 /Alma Health Skilled Services and MedStaffers
Other			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. We urge the DHS to rewrite this process and to reconsider remaining a part of the solution.	Jennifer Poole /Alma Health Skilled Services and MedStaffers
Other			Prior Authorization Requirements	We find the vagueness of direction for prior authorizations disturbing. Having each of the CHC-MCO's propose and establish timeframes can lead to confusion for providers. We would prefer that the Commonwealth establish these guidelines for the CHC-MCO to ensure that the timeframes in each region is consistent across the state. Being a provider in each county, we are concerned that if each region has a different timeframe it would be confusing and difficult to manage approvals for our participants; leading to delayed services.	Jennifer Poole /Alma Health Skilled Services and MedStaffers
Other			Clean Claim	During the OLTL meetings on November 4 and 5 there were extensive conversations regarding the term "clean claim." The RFP also references a "clean claim." We would expect that there be a very detailed and clear definition of what the CHC-MCO requires of a clean claim so that providers understand the expectation. Having a point by point list of what each claim needs to include would be the best scenario so that there is no room for deviation or gray areas for providers. In addition, we would like to see a financial penalty to the CHC-MCO if the claims aren't paid timely. We feel that accountability should be held to both ends in this process.	Jennifer Poole /Alma Health Skilled Services and MedStaffers

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Other			Provider Network	In section DD of the draft RFP there is a 180 day window that mandates the CHC-MCO to continue all contracts with willing and qualified LTSS Providers that provide HCBS through the OLTL waivers. The reason cited is to permit participants who are receiving LTSS as of the date of their enrollment in the CHC-MCO to maintain their current services with their current service provider. The draft continues to state, "Following the 180 day period, the CHC-MCO may adjust its provider network in accordance with the Network access and adequacy standards outlined in this agreement." We would like to be reassured that there will be no limits on the number of qualified providers that can contract with the CHC-MCO's and that service coordination contracts will remain with the current providers versus being absorbed as an internal process by the CHC-MCO. We want to see this written as part of the RFP. Service Coordination entities have been providing the coordination of services for decades in Pennsylvania. They thoroughly understand how HCBS are designed, how to do person centered planning, and are patient advocates. We feel that they are the best candidates to perform this job and should remain in their current positions as service coordinators. Requiring CHC-MCO's to contract this service with providers will also keep a conflict free environment. We are requesting that the DHS seriously considers this suggestion and the positive implications that will result from such a mandate.	Jennifer Poole /Alma Health Skilled Services and MedStaffers
Requirements Document			Workforce Development	The Community HealthChoices RPF highlights the need for service delivery innovation. It is important that these innovations include initiatives that MCOs pilot on their own as well as coordinated initiatives that DHS drives across MCOs. We applaud the inclusion of workforce innovations as one of the four target areas needing attention. Innovations that improve the recruitment, retention, and skills development of direct care workers will be a vital component for ensuring that there is a large enough workforce of capable providers to meet the growing demand for community-based long-term services and supports. We also applaud the requirement that MCOs have policies and procedures around new participant orientations and suggest that the direct care workers also receive similar support to program and policies.	United Home Care Workers of Pennsylvania
Requirements Document			Promoting efficiency, quality and consistency through a limited number of FMS providers.	Any changes to the current FMS system should limit the number of FMS providers to no more than 3 state-wide entities, allowing for both choice as well as the kind of consolidation that allows for economies of scale, transparency, accountability, innovation, quality, and efficiency.	United Home Care Workers of Pennsylvania
Requirements Document			Promoting efficiency, quality and consistency through a limited number of FMS providers.	Efficient and effective FMS services—with the lowest possible administrative overhead costs—plays an important role in the satisfaction of the direct care workforce. Improving direct care worker job satisfaction helps with both the retention and expansion of the direct care workforce, thereby providing consumers greater access to the most important element of choice—who provides the services one receives in one's home. This focus on quality and expanding the workforce also gives the consumer more options to change their worker and/or supports as they see fit.	United Home Care Workers of Pennsylvania
			Promoting efficiency, quality and consistency through a limited number of FMS providers.	The consolidated approach to the number of FMS providers also allows for the Commonwealth to ensure greater transparency and accountability in the programs, ensuring access to consistent data. This consolidation also promotes greater simplicity and consistency for consumers and/or workers who end up moving between FMS entities and/or multiple MCOs.	United Home Care Workers of Pennsylvania
Requirements Document			Promoting efficiency, quality and consistency through a limited number of FMS providers.	Finally, state-wide consolidation to a very limited number gives FMS entities the scale and resources to promote the latest innovations and technology around data, payroll, enrollment, and other needs. It also ensures that these entities are large and sophisticated enough to deal with important changes, like the implementation of the new rules regarding the Fair Labor Standards Act for home care workers.	United Home Care Workers of Pennsylvania
Requirements Document			Promoting efficiency, quality and consistency through a limited number of FMS providers.	Ensure that any FMS providers are truly "conflict free" in that they and/or any of their related entities are focused on delivering FMS services and promoting participant directed home care services, not providing other services under the CHC program. As mentioned previously, being "conflict free" ensures that FMS providers are focused on enabling and empowering participant directed services and highly invested in the details of promoting the most efficient and effective provision of FMS services. This also ensures greater consumer independence and choice, ensuring that FMS providers do not have any incentive to try "shift" consumers to other types of services or related entities.	United Home Care Workers of Pennsylvania

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Requirements Document			Promoting efficiency, quality and consistency through a limited number of FMS providers.	Finally, promoting accountability for state and federal monitoring of the program as well as the ability to produce and analyze benchmark statistics requires a limited number of high functioning, state-wide FMS entities who can collect and produce similar data in similar formats; this requires FMS entities with the focus, capacity, and track record of engaging with the latest data and technology advancements. The Commonwealth should ensure that any FMS entities both have this capacity and are required on a regular basis to provide this data and analysis to the state, including information on workforce like turnover, pay rates, hours worked, demographics of workforce, and other relevant data.	United Home Care Workers of Pennsylvania
Requirements Document			Maintaining a direct contracting relationship between the Commonwealth and the limited number of state-wide FMS entities	The Commonwealth should maintain a contractual relationship with FMS vendors and, at a minimum, the Commonwealth should develop standard language that must be used in any additional contract between an MCO and an FMS vendor. This language should outline the basic requirements that will be universal across all FMS vendors. MCOs could add supplemental language that is specific to their networks so long as it does not conflict with the model language provided by the Commonwealth.	United Home Care Workers of Pennsylvania
Requirements Document			Maintaining a direct contracting relationship between the Commonwealth and the limited number of state-wide FMS entities	There should be basic consistency across FMS vendors and this should include things like qualification standards, consumer and worker enrollment procedures, and administrative and reporting requirements. Additionally, FMS vendors should be required to adhere to consumer-directed rate standards set by the Commonwealth. MCOs could still be responsible for payments, but rate standards would be set by the Commonwealth. All of this will help to ensure that consumers are receiving similar services regardless of which FMS vendor they choose, help the state and MCOs in measuring accountability across FMS vendors, and ensuring the Commonwealth's ability to directly improve the quality of services and the workforce.	United Home Care Workers of Pennsylvania
Requirements Document			Experience should be taken into consideration when determining the Service Coordination Entity qualification standards.	There is a substantial amount of knowledge in the current person-centered service coordination program and that expertise should be taken into consideration when the Commonwealth transitions to Community HealthChoices.	United Home Care Workers of Pennsylvania
Requirements Document			Experience should be taken into consideration when determining the Service Coordination Entity qualification standards.	While there is real value in increasing the education requirements for personcentered service coordination, there is also real value in experience and expertise in the work of service coordination. In order to ensure continuity of care of consumers and maintain the expertise of person-centered service coordination, the Commonwealth should consider how to "grandfather" the existing supports coordinators into the new system and/or ensure that any changes in qualification requirements are supported by the resources for furthering training and education of the current workforce.	United Home Care Workers of Pennsylvania
Requirements Document	Section V. A. Covered Services			We thank you for acknowledging the value of Behavioral HealthChoices in serving individuals in long-term care by maintaining the behavioral health carve out.One issue is the need to address in the design of the service system the need to meet the Targeted Case Management Services requirements as stated in Pennsylvania Chapter 1247 and in federal regulation 33 42 C.F.R. §441.18(a). The standard states that only one Medical Assistance funded targeted case manager per recipient is permitted for any given period of time.	Deb Neifert Deputy Director/PACA
Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators			In regard to supports coordination, the approach referenced in the RFP, is equal in definition to targeted case management. PACA MH/DS believes that if the issue is left unaddressed the result will be delays in individual's planning for and accessing services and supports. An administrative approach which addresses these concerns prior to the implementation of the program can assure access and continuity of care to all individuals and ultimately assure the success of the program. Resolution of these concerns will facilitate collaboration between programs.	Deb Neifert Deputy Director/PACA

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Requirements Document	Section V. A. Covered Services	Section V. L.		Another transition issue is the ability of the programs to quickly and efficiently serve individuals transitioning from nursing homes. Traditionally individuals move from nursing homes into Fee- for-Service prior to enrollment into HealthChoices. Once an individual leaves a facility and is eligible for Medical Assistance, we recommend they immediately be enrolled in HealthChoices, and remain eligible for HealthChoices for all services. Understandably a timely and commensurate rate adjustment will be needed in funding for the respective HealthChoices plans. This will require a detailed approach to planning, which will include addressing targeted service management and service coordination roles and standards. In addition, continuity for pharmacy services must be included in transition planning. Addressing these concerns prior to implementation will permit programmatic and financial soundness of the program. To strengthen the integration of behavioral health and other needs, behavioral health must be included in the Needs Identification, Service Planning and Service Coordination sections of the RFP. The previously identified issues will need to be resolved to assure continuity of care and appropriate supports. We would recommend that specific standards such those reflected in previous behavioral HealthChoices RFPs be incorporated into the CHC RFP as they would lead to effective outcomes. Finally, again PACA MH/DS appreciates the Department of Human Services acknowledgement of the viability of Behavioral HealthChoices in maintenance of the community behavioral health carve out. Our local systems of care continue to meet or exceed goals regarding access and quality of care. In order to promote continued cross-systems collaboration and effectiveness, PACA MH/DS is available for further discussion as the department works to shape the development of an effective integrated approach to community services, supports and treatment. We are willing and able to provide representatives to assist in the RFP review, in vendor selection or to help in any other way to facilitate our mutual goal: a viable integrated approach for individuals involved with community services and supports.	Deb Neifert Deputy Director/PACA
Draft RFP	Personnel			To ensure that executive management is in place prior to implementation, we recommend that Executive Management positions, as specified in section II-4A, are hired and identified to the commonwealth no later than six months prior to the applicable implementation timeframe(s), as identified on page nine of the draft RFP, based on the proposed zone(s). Due to the staggered implementation dates, we recommend that for proposal submission purposes the requirement for II-4A be changed to job descriptions only.	Dave Boim, Vice President Molina Healthcare
Draft RFP	Agreement Pricing			To achieve the intended results of the pay for performance program as well as ensure adequate processes and resources are planned for, we recommend that the commonwealth provide a detailed description of the pay for performance program.	Dave Boim, Vice President Molina Healthcare
Draft RFP	Corporate Experience			Due to the specialized nature of this procurement, we recommend that the department replace the requirement in II-3B2 from "Qualifications and experience operating any managed care program" to “Qualifications and experience operating any dual eligible managed care program.”	Dave Boim, Vice President Molina Healthcare
Agreement	Emergency Services			To ensure the integrity of presepctive CHC_MCOs we recommend the follwoing requierement be added to this section of the RFP: To maintain the financial integrity of the program and lessen the administrative burden on the commonwealth, we recommend language be modified to reflect a change that the CHC-MCO pays up to Medicaid FFS allowable rate and addresses requests for additional non-participating ER payment upon appeal.	Dave Boim, Vice President Molina Healthcare
Agreement	Continuity of Care			To maintain the financial integrity of the program, we recommend that the agreement be modified to limit the CHC-MCO payment to the Nursing Facility to Medicaid allowable. In addition, we recommend that this is the department’s position for any Medicaid providers that refuse to contract with the CHC-MCO.	Dave Boim, Vice President Molina Healthcare
Agreement	CHC-MCO Outreach Activities			To further promote Medicare-Medicaid integration and seamless healthcare delivery, we recommend changing the agreement language to: b. The CHC-MCO may market its approved, companion D-SNP product to its Full Dual Eligible CHC-MCO Participants including assisting member in contacting IEE regarding CHC-MCO selection of member’s choice.	Dave Boim, Vice President Molina Healthcare

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Agreement	Selection and Assignment of Service Coordinators			To enhance care coordination, for members that do not have assigned service coordinators, we recommend the department allows CHC-MCOs to assign a service coordinator upon enrollment In addition, we recommend the choice to select from two or more service coordinators is offered when the participant is reached to complete the comprehensive needs assessment. Furthermore, participants should be allowed to change service coordinators at any time. Finally, to ease the transition, we recommend the department review and revise contractual timelines for assessing and reassessing participants when program transitions from FFS to CHS due to one-time volumes associated with transition. To ensure that service coordinators have the appropriate experiences to support the members, we recommend adding "Or equivalent experience" after the word "fields" in the following statement.	Dave Boim, Vice President Molina Healthcare
CHC Draft Requirements	Needs Identification, Service Planning, and Service Coordination			*"Delineates service coordinator, supervisor qualifications, and training requirements. All employed or contracted service coordinators must be an RN or have a bachelor's degree in social work, psychology or other related fields and at least three years of experience in the coordination of services." For clarity of evaluation, we recommend that the department provide detailed information regarding the approach and scoring of the technical response by question.*	Dave Boim, Vice President Molina Healthcare
RFP	General Information			The RFP asks for extensive information from MCOs, but there is very little in here by way of program standards. While that is not necessarily required, a lot of the questions and concerns we have are around those standards that have been yet to be developed such as specific expectations, timeframes and numbers around transition of participants, authorizations, coordination of care, billing requirements, etc. While I am certain these will be dealt with in contracts between DHS and the MCOs, it would be helpful to hear the MCOs intentions to meet these standards when they are identified.	Kelly Andrisano, J.D., Executive Director PACAH
RFP	General Information			Problem Statement – Implementation: We have stated before and continue to feel that a January 2017 implementation date is too soon. There needs to be more time for DHS to address issues and questions that have been presented by providers and consumers, and to effectively prepare those in the Southwest zone for the changes. We also need more time for providers to be able to potion themselves as innovative, cross-system providers. Which is not going to happen over the next year without significantly more information about CHC. Extending the Continuity of Care period as addressed below would help with this as well.	Kelly Andrisano, J.D., Executive Director PACAH
Requirements Document	Section V.A. - Covered Services			Adequate in-home services/Smooth Transition: The RFP asks MCOS to describe the process for care coordination to ensure that Participants receive adequate in-home services to divert them from entering or returning to acute or long term care facilities. There should also be a requirement or plan to comply with federal and state regulations that require "safe and orderly" discharges from nursing facilities. How will this be accomplished? What if the discharge results in readmission? Who is responsible for making these determinations?	Kelly Andrisano, J.D., Executive Director PACAH
Other	Other			Licensure Requirements: There should be discussion on how knowledgeable the MCO is on licensure requirements of nursing facilities in Pennsylvania and how they will determine that their policies and procedures comply with these requirements.	Kelly Andrisano, J.D., Executive Director PACAH
Requirements Document	Section V.C. - Continuity of Care			Continuity of Care: As we have raised in our previous comments, we are very concerned about the short period provided for the continuity of care. We believe that this time frame be established at a minimum of a two year period, as was done in many of the other states implementing long-term care managed care. Extend the any willing provider requirement to 2 years and expand to include all ancillary services (Pharmacy, Lab, Diagnostics, and Physicians). Requiring participants and providers to adapt to a system change of this magnitude in just six short months is unrealistic. There will be numerous changes being made from billing to rate setting. Providers and consumers need more than six months to educate themselves and transition. We once again ask that the state take a serious look at this provision, and that it be extended for all providers including ancillary providers like therapists and pharmacists.	Kelly Andrisano, J.D., Executive Director PACAH
Requirements Document	Section V.C. - Continuity of Care			Overall Care Coordination and Nursing Facility Issues: As this process progresses, we would strongly encourage the state to insure that a workgroup is formed between the MCOs and nursing facility providers to address some of the smaller details and issues that they may not be aware of. Things such as MA pendings, billing issues, discharge issues, etc. I think this would be a prudent practice to insure that these issues are all addressed.	Kelly Andrisano, J.D., Executive Director PACAH

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Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments			Coordination of Behavioral Health Services: Other than a requirement for the CHC-MCOs to "coordinate" with BH-MCOs, there are few directives or language clearly defining what this will mean. Currently our Behavioral Health HealthChoices program, is a successfully run managed care program, often overseen by the counties. There are concerns that without additional input from the BH-MCOs some important and critical issues will be missed impacting coordination of these services. We would recommend that the state take some time to work with the BH-MCOs on how coordination will be achieved, as well potential issues that may result, and address these more clearly in the RFP process.	Kelly Andrisano, J.D., Executive Director PACAH
RFP	Criteria			Notification to Department – We would recommend that the notification period be at least 90 days. Transitions to new providers can take longer than this, and to insure a "safe and orderly discharge," the provider must have adequate time to insure that the consumer is being transitioned into adequate care.	Kelly Andrisano, J.D., Executive Director PACAH
Requirements Document	Section V.A. - Covered Services			Respite Care: The definition for Respite Care needs to include care in an institutional setting. Many nursing facilities are currently providing this service and to eliminate them from the definition would limit services that families and consumers are currently utilizing and are happy with.	Kelly Andrisano, J.D., Executive Director PACAH
Requirements Document	Section V.D. - Choice of Provider			Any Willing Provider: In order to allow "any willing provider," to continue to serve in this system, we believe that there should a rate floor implemented. Rates for nursing facilities should not fall below the current rates. Rates are already much lower than the cost of providing care, and to cut them further will force many providers to serve fewer Medicaid consumers.	Kelly Andrisano, J.D., Executive Director PACAH
Other	Other			In addition, for our county nursing facilities who by nature of being public homes have historically served the safety-net population, we need to determine how MCOs can build incentives into their rates to continue as safety-net providers. Not only are county homes required to take Medicaid patients on day one, but according to December 2013 cost reports, the average MA occupancy rate of county nursing facilities was 80 percent while the average MA occupancy rate of all skilled nursing facilities in the state of Pennsylvania (including county homes) was just 65 percent1. Because of this, county homes are not just providers of long-term care services, but instead, are partners with the state in insuring that the needs of the community's most vulnerable individuals are met.	Kelly Andrisano, J.D., Executive Director PACAH
Other	Other			In the past, to encourage and support county homes taking on the role of the safety-net, they have been carved out of the traditional skilled nursing facility payment system. Their rates are not based on their CMI as private nursing facility rates are, and instead, only fluctuate if there is an increase in rates as part of the state budget.	Kelly Andrisano, J.D., Executive Director PACAH
Other	Other			As safety-net facilities, how will the new payment system recognize and support the county homes? Will counties continue to be "carved out" of the payment system? With rates being set by MCO's, how will the high Medicaid population of these homes and unique history of county payments be reflected? Where will the incentive be for county homes to continue to fulfill this role of safety-net facilities? How will unique payments available to public facilities continue to be maximized (the IGT, CPE, etc.)? We have not heard answers to these questions yet.	Kelly Andrisano, J.D., Executive Director PACAH
Other	Other			We strongly believe that counties should not be expected to negotiate rates in direct competition with for-profit nursing homes, some owned by national companies who already have existing relationships with managed care entities and experience in a managed care environment. Forcing this upon our public, safety-net facilities who have partnered with the state for decades would jeopardize their ability to continue to provide much-needed services. In addition, the costs of providing service within the county nursing homes are unique for the following reasons:	Kelly Andrisano, J.D., Executive Director PACAH
Other	Other			Medicaid populations nearing 85%-95%	Kelly Andrisano, J.D., Executive Director PACAH
Other	Other			Significant population without any Part B type coverage, These numbers come from a 2012 study done by Avalere Health LLC Of those that have Part B type coverage, it is rare that any coinsurance coverage exists, Unionized facilities, High cost of care factors that cause non-county homes to avoid similar admissions, Expensive specialty units that service specific populations. As previously stated, we continue to strongly recommend, due to the unique population served and the nature of services provided by county nursing facilities, that there be incentives included in rates (prior to any negotiations) for county facilities due to their status as safety-net providers. We would also ask the state to explore the possibility of setting aside funding for the MCOs to allocate specifically to safety-net	Kelly Andrisano, J.D., Executive Director PACAH
Requirements Document	Section V.A. - Covered Services			Respite Care should be expanded to include the provisions of overnight care in an institutional setting	John Mehler, Norhthampton AAA

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Requirements Document	Section V.A. - Covered Services			CHC and BH must be expanded on and strengthened, perhaps a workgroup could be created.	John Mehler, Norhthampton AAA
Requirements Document	Section V.A. - Covered Services			Limited English Proficiency requirements need to be strengthened. We support adding interpretation services for individuals who are blind, deaf, or have limited english proficiencey as a covered benefit under MLTSS	John Mehler, Norhthampton AAA
Requirements Document	Section V.R. - Participant Complaint, Grievance & DHS Fair Hearing Process			Provisions for complaints and grievences need to be strengthened. We believe that an advocate should be able to attend hearings at the request of an older adult or person with a disability. If a participant seeks an advocate, it should be a requirement of the MCO to connect them with the same, and at no cost to the participant.	John Mehler, Norhthampton AAA
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements			To assist with ensuring continuity of care, we recommend all current service coordinators and supervisors be grandfathered into the CHC system, with SC Organizations achieving compliance with the new standards via staff attrition. This will all staff who are currently familiar with participants to continue to be availalbe to them.	John Mehler, Norhthampton AAA
RFP	General Information			Provision for coordination of MCOs and Adult/Older Adult Protective Services is needed, MCO responsibilites need to be clarified.	John Mehler, Norhthampton AAA
Requirements Document	Section V.E. - Needs Screening			Responsibility of annual level of care determinations should be with the entity conducting level of care determinations and not be the function of service coordinators.	John Mehler, Norhthampton AAA
Requirements Document	Section V.A. - Covered Services		Expanded Services: Program requirements state that the CHC-MCO may provide "expanded services subject to advance written approval by the Department. These must be services that are generally considered to have a direct relationship to the maintenance or enhancement of a Participant's health status, and may include various seminars and educational programs promoting healthy living or illness prevention, memberships in health clubs and facilities promoting physical fitness and expanded eyeglass or eye care benefits. These services must be generally available to all Participants and must be made available by all appropriate Network Providers."	We recommend that this policy clearly indicate that covered programs may enhance or maintain social, emotional, or cognitive health, in addition to physical, and that should a general list of programs and/or curriculum providers such as Silver Sneakers, Arthritis Foundation, The Y, or Weight Watchers be provided, we suggest a policy that allows the participant to substitute another program, should his or her medical provider certifies will provide the same benefits.	Christy Ayala Alliance on Aging Facilitator United Way of the Greater Lehigh Valley
Requirements Document	Section V.M.- Coordination of Services			National Council on Aging developed BenefitsCheckUp!, a program to screen for eligibility for all federal, state and local benefits in one simple 5-minute screener. It is vitally important that all seniors receive a similar benefit screen that is comprehensive and informs the consumer of all possible benefits, rather than expecting the consumer to understand that only benefits from one particular funding source were discussed and that they should go to a different office to be screened for federal benefit programs, for example. Whether this should be part of the OPTIONS training from the state through PA LINK, part of No Wrong Door or Balancing Incentive Plan as a precursor to entry to the MCOs or part of the MCO care manager duties is a matter of debate. The thing that is not of debate, though, is that all seniors need to receive a standardized screen for all federal, state and local benefits every time they enter the system of supportive services.	Christy Ayala Alliance on Aging Facilitator United Way of the Greater Lehigh Valley

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Requirements Document	Section V.P. - Participant Services		Nurse Hotline: The draft states, "The CHC-MCO must maintain and staff a twenty-four (24) hour, seven (7) day-a-week toll-free dedicated nurse hotline to respond to Participants' urgent health matters,"	but doesn't indicate a target maximum wait-time/hold-time, nor does it address communication barriers. (see internal Participant hotline staff requirements)	Christy Ayala Alliance on Aging Facilitator United Way of the Greater Lehigh Valley
Requirements Document	Section V.AA. - Selection & Assignment of PCPs			Mandate and institutionalize a transparent evaluation system allowing beneficiaries to make meaningful comparison between providers. The state often encourages self-directed care but does not give consumers the tools they need to make an informed and educated decision. In addition, programs are evaluated, but not always provided the information they need to improve. Beyond evaluation of service providers, MCOs will also be evaluated and those ratings should be publicly available.	Christy Ayala Alliance on Aging Facilitator United Way of the Greater Lehigh Valley
Other	Quality Assurance & Performance Improvement			Comonwealth's evaluation of MCOs. 1. Required Mechanisms for Handling Complaints, Grievances, Appeals, and Associated Reporting. The State of Pennsylvania should apply more stringent guidelines for appeal processes, handling complaints, grievances, and appeals. The management of this and determination of how it is implemented can be the responsibility of each MCO, but the state-wide guidelines should be designed and implemented by the state. 2. Ombudsman. Ideally, Pennsylvania should incorporate reporting of relevant issues into the existing Long Term Care Ombudsman program. The reported concerns will be evaluated and used, in part, as one of the criteria for evaluation of both MCOs and home and community based services. These processes are best handled by the EQRO or a state-wide entity to ensure there is a check and balance of power, and that issues are recorded and reported correctly. 3. Critical Incidents Reporting/Investigation Requirements. These issues could be collected and reported by the ombudsman program as part of their normal functioning. Some critical events, such as death or hospitalization of the customer should be required to be reported by the MCO to ensure that there is accurate tracking of events. We also caution that in addition to measuring and analyzing outcomes, which is requested as part of the draft RFP, MCOs should be required to explain how they will reinvest dollars to launch needed services from a percent of their profit margin as they are in managed care for behavioral health in Pennsylvania	Christy Ayala Alliance on Aging Facilitator United Way of the Greater Lehigh Valley
Other	Other			An active and ongoing commitment to rebalancing our long term care system away from nursing homes and other institutional care for adults with physical disabilities and seniors (age 18 and older). This would be demonstrated through policy and budget systems with ongoing reports to PA DHS MAAC MTLSS and other stakeholder groups. • Greater Incorporation of prior comments made by PA SILC, PCIL (PA Council for Independent Living) and other disability stakeholders that would improve access to Home & Community Based Services (HCBS) in RFP Summary, RFP, and RFP Requirements.	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)
Other	Schedule/Timeline			Slow down the CHC rollout and implementation process for a slower rollout by starting implementation in January 2018 and adding one region each year for 5 years (or more), depending on the number of regions in PA.	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)
Other	Other			Protect and Preserve the existing system of CILs and other OLTL HCBS providers. Many CILs and other OLTL HCBS providers have done a strong job of providing necessary supports in these challenging times. Consumers rely on these strong network- direct service providers, supports coordination and other types of assistance. • Independent Living (IL)- The proposed CHC system should, at a minimum, empower consumers to maintain and potentially improve IL options that they currently have and increase it where preferred. • Independent Enrollment Broker (IEB)- It is our understanding the Maximus will continue as the current IEB for 2016 and that Aging Waiver consumers will be served by the current IEB in March 2016. We ask for IEB(s) that are able to meet or exceed current deadlines and empower individuals with greater acceleration to become enrolled in HCBS where possible.	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)

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RFP	General Information			Fiscal Management Services (FMS)- We ask that CHC has a stronger local or regional as well as increased quality in the future FMS system as well as provide choice of FMS agencies. Consumers currently have no choice on FMS currently in PA. This is inconsistent with IL and offering choice. We also ask for strengthening collaboration between future FMS provider and all other CHC stakeholders, particularly consumers.	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)
RFP		7		For age of eligibility (p. 7, RFP), we suggest that the age for individuals be age 18 instead of age 21 in all CHC programs (under age 60). There would address service gaps for consumers who may not be currently eligible in the current system.	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)
Requirements Document	Section V.CC. - Provider Services			Many CILs and other OLTL providers have struggled with low rates for reimbursements for services and supports. Like other organizations, these organizations incur increased costs through maintaining facilities, transportation, insurances, staffing, utilities and other standard business costs. We ask that rate adjustments be increased for sustaining services and help for increasing wages of attendants and professionals supporting disability and aging services	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements			On Service Coordination (SC) and SC Entities (SCE), please empower consumers by permitting the option of keeping their existing SC provider if they are content. Many consumers are satisfied; let's keep the status quo where it is working and improve the options where SC performance has been substandard for the consumer and state government. A number of CILs and like-minded SC / SCEs provide an existing life-line. Let's not jeopardize that. Instead, we would ask that DHS and Aging to: - Improve training for SC Entities and staff with a time period for improving compliance before forcing unwarranted changes which disrupt everyday lives, particularly for areas where OLTL / Aging says there are information gaps (HCIS information, etc.) - Revise the SC Supervisor and future staff standards- Please allow for other education and life experience substitutions (such as an Associates or BA, BSW degrees) combined with work (example: work experience in MH, ID, OLTL, Aging systems) and life experience, course trainings in filling SC Supervisors and other staff positions. Allow for a time period to permit to be able to meet these requirements. - Separation of SC from MCOs- We believe that this would help consumers to receive stronger supports in a conflict free manner and help PA to maintain safety in terms of adhering to CMS' conflict of interest concerns in both OLTL and Aging systems. More importantly, this would avoid further disruptions of support for consumers.	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)
Requirements Document	Section V.A. - Covered Services	Home mods		Increasing access to housing that accessible (or at least visitable), affordable, integrated and healthy/ non-toxic. Lack of housing for individuals with disabilities and seniors exists in every region of PA, particularly accessible housing. There are waiting lists (where kept) with Public Housing Authorities for accessible units and with community agencies or Area Agencies on Aging for home modifications. • Home Modifications- Access to home modifications is a challenge for many individuals. Not all consumers are in a waiver who receive long term care (Act 150, Options) or are in a waiver that doesn't provide home modifications as a covered benefit (Attendant Care Waiver and previously AIDS Waiver). State funding has been greatly reduced for PA Accessible Housing Program, now a combined line item in DCED's Keystone Communities. Home Modifications needs to be clearly defined in the glossary section of RFP's requirements. The roles of brokers needs to improve with additional and larger regions than has been proposed in prior Home Modification Discussion Documents and related communications from DHS/ Aging. MCOs also need to be educated, particularly on the differences between home modifications and other similar terms with different meanings (home remodeling, home renovations, environmental, energy efficiency upgrades, etc.).	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)

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Requirements Document Exhibit	AAA - Provider Network Composition/Service Access			Any Willing Provider - There has been discussion about support for allowing any willing provider to participate for CHC. As long as a provider is in compliance with OLTL/ Aging policies and has no outstanding issues, we support this policy for Direct Service Providers, Supports Coordination Entities, DME Providers and others organizations that promote HCBS for people with disabilities of all ages. • In most instances, managed care has been used as a cost savings measure. It is also generally agreed that HCBS is usually more cost effective than nursing facilities and other types of institutional care. We ask that these savings be placed into serving additional consumers who may be more expensive to serve in the community with complex / multiple needs and serving individuals who are on various disability and aging waiting lists in PA.	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)
Requirements Document	Section V.L. - Nursing Home Transition			Nursing Home Transition (NHT)- CILs and other OLTL providers have been doing NHT successfully for thousands of individuals across the state and need to continue to receive strong support. This includes timely payments from the state and soon to be MCOs. This has been an ongoing issue for several years and is unfair to organizations serving consumers that are savings government millions of dollars.	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)
Requirements Document	Section V.A. - Covered Services	DME		Durable Medical Equipment (DME) – DME protections need to be spelled out strongly in the requirements. It is a life line for individuals to remain or come back into the community. DME needs to be defined in the beginning of the glossary. There is also no mention of DME in the Summary or RFP draft documents. Here are the following suggestions for DME: - There should be one sentence in the Summary document just to touch on MCO role here. DME protections need to be spelled out strongly in the requirements.	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)
Requirements Document	Section V.A. - Covered Services	Assistive Technology		Assistive Technology (AT)- AT is a vital component for many persons with disabilities toward maintaining independence. We suggest additional training and making the definitions separate and distinct so as to clearly differentiate between AT and DME. AT should also be a covered benefit under CHC for both OLTL and Aging populations. It has not been included in Attendant Care and AIDS Waivers or in Act 150 with limited AT options for seniors in the current system and that needs to be changed.	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)
Requirements Document	Section V.R. - Participant Complaint, Grievance & DHS Fair Hearing Process			Consumer Appeals and streamlined process- There needs to be a clear and streamlined process for consumer appeals and rights. The process needs to have guidance for those with more than 2 health insurance policies (consumers living with family members and included additional policies).	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)
Requirements Document	Section V.A. - Covered Services	Dental		Increased access to dental care and medical specialists- Access to dental care and medical specialists has been a challenge for the existing Medical Assistance system in PA, particularly in rural and low income (un/underserved) areas. How will CHC improve access to dental care and overall oral health? We suggest improving care and coordination, particularly for individuals who are dual eligible (Medicare and Medicaid) and also where additional / secondary health coverage (2 or more health insurances) are part of the individual's plan. Additional cost savings in the system could also be redirected here, particularly where it would reduce the future need for advanced dental and medical specialty care in the future which is more costly.	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)
Requirements Document	Section V.A. - Covered Services	Transportation		Transportation- PA SILC believes that this is an opportunity to increase access to transportation for medical, employment and other community opportunities. We believe that MCOs should be working with all transportation stakeholders to improve current options and add new ones for accessible community transportation that is available for community life. This will empower more individuals toward access to healthcare (including wellness activities, add language to page 129 in RFP Requirements), employment, volunteerism and community activities. There also needs to be modernization that includes, but is not limited to transportation systems used by people with disabilities and seniors, particularly the Medical Assistance Transportation Program (MATP) where there is no standardized system across counties for submitting, billing and reimbursements received by consumers and providers. Too much is in a paper format. Reimbursement rates need to be increased for MATP (now at .12 cents per mile) and faster reconciliations should occur for all parties.	Jeffrey L. Iseman Program Analyst Pennsylvania Statewide Independent Living Council (PA SILC)

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Requirements Document	Section V.J. - Service Coordination			1. I strongly urge you to revert to utilizing the Act 22 background requirements for Service Coordinators and Managers as had been promised during the development of the RFP. An important aspect of Home and Community Based Services had always been that they are a non-medical model and the persons receiving the services are Consumers playing an active role in planning and directing their care not patients receiving services. Requiring managers to be nurses and social workers and service coordinators to be overqualified specialists really makes the Consumers take on the role of passive patients.	Jeff Parker serving as Administrative Entity in Western Pennsylvania for the Office of Social Programs, serving on the Pennsylvania Developmental Disability Council including as chair, serving on the board of a service coordination agency and most importantly as an ongoing Consumer utilizing attendant care under Act 150.
Other	Service Coordination			2. A provision to allow paying for in home training of a Consumer's new attendant by one of their preexisting attendants is a much needed feature to assure the quality and safety of services for the Consumer. This means the Program would allow and pay for a very short period of time when two attendants would be at a Consumer's house at the same time. This would allow the Consumer and the experienced attendant to work with a new attendant and let them practice the Consumer's desired way to do the routines required for their assistance with dialing living activities.	Jeff Parker serving as Administrative Entity in Western Pennsylvania for the Office of Social Programs, serving on the Pennsylvania Developmental Disability Council including as chair, serving on the board of a service coordination agency and most importantly as an ongoing Consumer utilizing attendant care under Act 150.
Requirements Document	Section V.J. - Service Coordination			3. The most profound and distressing challenge presented by the draft RFP and program requirements is that another element of Consumer's choice is being taken away. Consumers currently after having been determined eligible choose a service coordinator provider. The current service coordinator providers have been meticulously vetted by the State to be conflict free and performing all the services in the manner expected by the State. Under this RFP, one of the scenarios is that the MCO could be the sole service coordinator. In this case, Consumer choice to find and work with other agencies that can best assist them is gone. The State should take advantage of the time and commitment that not only the State but the existing service providers have invested in seeing that the current providers are well qualified at this task. Instead of literally discarding the expertise of the current providers that the State itself supported and developed, the MCO's should be required to offer Consumers the option of also choosing the other already existing providers. Allowing this option is the only way to be responsive to the recurring theme that Pennsylvanians want a choice in their care.	Jeff Parker serving as Administrative Entity in Western Pennsylvania for the Office of Social Programs, serving on the Pennsylvania Developmental Disability Council including as chair, serving on the board of a service coordination agency and most importantly as an ongoing Consumer utilizing attendant care under Act 150.

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RFP	General Information	pages 7-11		CARIE continues to have major concerns with the timeline and the plan to fully implement the proposed Community HealthChoices (CHC) program statewide and recommends delaying the start date as well as limiting CHC to the SW region until problems are resolved. (The rationales for these concerns were highlighted in comments we submitted concerning the CHC Concept paper that we hope will be reviewed and considered.) The draft RFP and program requirements have not relieved our trepidations about the problems that will inevitably occur by moving too quickly through the planning process and implementing a program statewide before it is tested and modified on a smaller scale. If the Commonwealth continues this course, vulnerable consumers will no doubt be harmed as a result, despite the well-meaning intentions of the Department of Human Services (DHS). DHS should take the time needed to develop a well-conceived plan with a more realistic timetable for implementation. In recent years, there have been many examples of the state having disastrous outcomes implementing changes to its Medicaid Waiver program and this change is certainly of a much greater magnitude. The Centers for Medicare & Medicaid Services (CMS) identifies adequate planning and transition strategies as an essential element for MLTSS programs. CMS advises, "The most effective MLTSS systems are the result of a thoughtful and deliberative planning process that permits enough time to develop a clear vision for the program. An adequate planning process includes the solicitation and consideration of stakeholder input; education of program participants; assessments of readiness at both the state and managed care plan level; and development of quality standards, safeguards, and oversight mechanisms to ensure a smooth transition and effective ongoing implementation of MLTSS." A recent Health Management Associates white paper, The Value of Medicaid Managed Care, echoes CMS' recommendation, "States should thoughtfully plan RBMC (risk-based managed care) implementations, allowing time to build state infrastructure, define state contracting requirements and priorities, and ensure plan readiness." Community Catalyst's issue brief, Promising Practices for Medicaid Managed Long-Term Services and Supports, indicates "adequate planning" as a way for states to minimize risks and maximize benefits in MLTSS programs and further states that CMS recommends a minimum of a two-year planning process. As proposed, CHC is scheduled to begin in the Southwest zone in slightly more than a year. Many details of the program need to be finalized and this should be done through a meaningful stakeholder process to have the best possible plan in place before a RFP is issued. Even disregarding having a thoughtful plan in place, DHS needs to issue a formal RFP, review proposals, negotiate rates with the MCOs, complete readiness reviews, and educate the public among other tasks. The managed care organizations (MCOs) will also have much to do to ramp-up and be prepared to serve the thousands of consumers in need of long-term services and supports (LTSS). The tasks at hand cannot be successfully or thoroughly completed by January 2017. One example of a state that rushed the process occurred when Florida began enrolling consumers into its MLTSS program and the MCOs were still in the process of developing their provider networks. This led to many serious problems for consumers. We are concerned that there is not enough time to ensure adequate provider networks in Pennsylvania. We encourage Pennsylvania to pursue a MLTSS demonstration project as recommended by the Pennsylvania Long Term Care Commission. Ideally, Pennsylvania could test two different MLTSS models to see what works best in Pennsylvania and resolve any problems on a smaller scale before expanding statewide.	Diane A. Menio/ Executive Director/ CARIE
RFP	General Information	19		CARIE strongly opposes DHS issuing the RFP for the entire state at one time. DHS should release a RFP for the SW zone as a start and later release another RFP for the remaining regions of the state once problems are identified and resolved so the subsequent RFP can reflect any needed changes. Even if this recommendation is disregarded, the proposed 5-year contract term for the SW zone and the 4-year contract term for the SE zone are far too long for a brand new, untested program. Any initial contract should be no longer than 2-3 years.	Diane A. Menio/ Executive Director/ CARIE

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RFP	Work Statement Questionnaire			One grave overall concern upon reviewing the draft RFP and program requirements is that too many details are left to the MCOs to develop. This is problematic for a variety of reasons. There is no meaningful way for consumers and other stakeholders to provide input, it is likely that there will be a lack of consistency among the plans, and there will be inconsistent data making comparisons among plans and measuring the success of the program impossible. Hopefully, DHS will engage stakeholders to discuss and develop plans before a RFP is released so the responses to the questions asked throughout this section will be more to ensure the MCO has the capacity to comply with the program requirements. The "Participant Service and Care Coordination" section of the work statement questionnaire that begins on page 29, only allows for a maximum of 30 pages. To get a needed level of detail, this maximum should be increased by at least 5 pages. Question 16 in this topic area should be expanded to include mental health. For example ask, "Describe your plan's approach to identifying, reporting, and addressing social determinants of health and mental health for Participants." Question 23 should be expanded to include participants "who do not speak English" and participants with "low literacy levels." The "Service Integration" section on pages 33-34 is confusing. Will Medicare and Medicaid be fully integrated? Questions should reflect different scenarios such as when a consumer chooses to receive their Medicare coverage through Original Medicare or Medicare Part C. Questions should be added to have the MCOs explain how they will handle complaints, what provider information will be collected by the MCO and publically shared so participants can make informed choices about the best provider for them, as well as plans for marketing. MCOs should be required to describe their cultural competency plan. It is important to have a plan that ensures culturally and linguistically competent care and treatment for participants. Lesbian, gay, bisexual and transgender (LGBT) individuals and people living with HIV/AIDS often feel unwelcome at health or human services organizations and more needs to be done to ensure their inclusion and access to care. For consumers who opt out for their Medicare coverage, information should be gathered from MCOs as to how they will coordinate with Medicare's hospice coverage and hospice drug coverage. This should include descriptions of how the MCO will help beneficiaries who need to transition out of Medicare hospice coverage.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document	Section V.A. - Covered Services	26		This section references the CHC 1915(c) Waiver and illustrates a conundrum for stakeholders to provide meaningful input. DHS should develop its CHC 1915(c) Waiver before proceeding with releasing the RFP. It is important that stakeholders understand how the current 5 OLTL Waivers will be combined and what the criteria will be for getting LTSS. Regardless of how DHS proceeds, stakeholders should be given ample opportunity to provide comment on any CHC Waiver proposals before submission to CMS.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document	Section V.A. - Covered Services	28-29		Since counseling and therapy are covered LTSS services (per Exhibit DDD) and behavioral health services may also be provided through Medicare, this section should reflect the inclusion of needed behavioral health services that may not be provided by the BH-MCOs.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document	Section V.A. - Covered Services	28		Pharmacy Services:.....This section needs further clarification as not all full dual eligible participants who need prescriptions and over the counter medications will need LTSS or require a service plan. In addition, there is no reference to hospice in this section or in Exhibit BBB, Pharmacy Services. There is a need for coordination with the Medicare hospice benefit in that not all prescriptions needed by consumers are covered under the hospice benefit.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document	Section V.A. - Covered Services	31-32		V.A.12. – Examinations to Determine Abuse or Neglect (pages 31-32) MCOs should also know about the procedures for reporting financial exploitation in 12b.	Diane A. Menio/ Executive Director/ CARIE

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Requirements Document	Section V.A. - Covered Services	Hospice		V.A.13. – Hospice Services Language should be added to require MCOs to coordinate with hospice services for those who choose to use Original Medicare or Medicare Part C.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document	Section V.A. - Covered Services	33-34		V. A.17. - Nursing Facility Services (pages 33 and 34) MCOs should not be allowed to force consumers to be admitted to a nursing facility if the cost of their care plan is equal or more than the cost of care in a nursing home. Once assessed as NFCE< consumers should be able to choose whether they want to receive their care in a nursing facility or at home. This option should be extended to family caregivers when the consumer lacks th capacity to make this decision	Diane A. Menio/ Executive Director/ CARIE
Requirements Document	Section V.A. - Covered Services	34		V.A.18. - Participant Self-Directed Services (page 34) Earlier this year, the Legislative Budget and Finance Committee issued a report, Family Caregivers in Pennsylvania's Medicaid Home and Community-Based Waiver Programs, which documents a problem related to fraud and abuse that occurs at times in the Aging Waiver. The report concludes, "Paying family members to be caregivers can help overcome some of the challenges people face finding qualified, reliable, and continuous caregivers. However, family members often have access to financial and other personal data that would not generally be available to an agency-sponsored caregiver. There may also be a higher degree of trust between a beneficiary and a family member that could be exploited by an unscrupulous family caregiver. CMS requires states to take steps to address these issues, but family members are the largest category of financial exploiters of the elderly, so the concerns are warranted." It is important that MCOs are vigilant in monitoring the care of older consumers who choose to self-direct their services. There are some welfare-to work programs that encourage their clients to find an older person to take care of and this has led to consumers being neglected in some circumstances. Protocols need to be established to address situations when a caregiver is getting paid but is not providing services or if they are abusing, neglecting, or exploiting the consumer in other ways. There are situations where these circumstances would not involve OAPS intervention such as in cases where the consumer has capacity but refuses OAPS intervention. However, DHS and the MCO cannot be complicit in the neglect of an older participant and other options should be implemented to allow the consumer to receive the care they need.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document	Section V.C. - Continuity of Care	39-40		If we interpret the first bullet point correctly, we strongly support DHS proposal to allow nursing facility residents to remain in the facility upon enrollment to CHC. This is particularly important to those who spend down their life savings, those whose rehabilitation stays become more permanent or longer than anticipated, and others who would otherwise need to endure transfer trauma. It should also be noted that federal and state law protects those who are residents of nursing homes from improper discharge. This should be monitored very closely. In terms of continuity of care during the transition to CHC, it should be clear that no reductions along with the continuation of all services be provided for a minimum of 180 days. Any service reductions during the first year of each phase of the CHC rollout, must be reviewed by OLTL BEFORE notice is issued. (Appeal rights should still apply.)	Diane A. Menio/ Executive Director/ CARIE

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Requirements Document	Section V.E. - Needs Screening			A participant, their family, or responsible party should be able to request a needs assessment at any time. It is encouraging to see that OLTL plans to develop a standardized needs screening tool. It is important to have a tested tool that provides consistent results throughout the state.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments			It is important that DHS ensure both the medical and non-medical needs of consumers are met and there should be an equal focus on all needs in any MLTSS program. The MCO must demonstrate the capacity and protections to ensure that home and community-based services are treated equally with medical services and that the medical model not be used for home and community-based service planning and delivery. The section states that the comprehensive needs assessment will be conducted by a Service Coordinator. It is important that the service coordinator is independent of the CHC-MCO to avoid conflict of interest. OLTL should standardize the assessment and reassessment tools so all MCOs are required to use one uniform tool to ensure consistency and enable better data collection. Any tool should be tested to ensure validity and consistency throughout the state. It is vital that DHS ensure the transparency of the data collected and that it be shared with the public, especially in regard to cost, quality measurements and outcomes. Any algorithms used to authorize services should be made public so it is clear how any tool is used to determine eligibility and level of services as well as the number of service hours.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document	Section V.H. - Person Centered Service Plans			The participant should be the lead in developing PCSPs and it should be clear that signing the plan only means they participated in the process and not that they necessarily agree with the plan. PCSPs should also identify how the service coordinator will assist the participant in accessing covered services through their Medicare, BH-MCO and CHC-MCO identified in the PCSP. There is no mention of veteran's benefits throughout the draft documents. It is important that participants be screened and connected to any veteran's benefits they may be entitled to receive. It is also vital that PCSPs address the needs of participants with dementia and encourage their participation to the greatest extent possible. Participants and caregivers should be guided towards dementia capable services to help meet their needs.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document	Section V.I. - Department Review of Changes in Service Plans			If DHS revises a PCSP, participants should still have the same appeal rights and notice as if the MCO made the decision.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements			Service Coordinators and Service Coordinator Supervisors should be independent entities and not be employed by the MCOs to avoid any conflict of interest. They should also be required to demonstrate competency after completing DHS approved training. This could take the form of passing a post test.	Diane A. Menio/ Executive Director/ CARIE
Other	Other	46		O.2. - CHC-MCO Outreach Materials (page 46) Outreach materials should meet the needs of those with low literacy levels.	Diane A. Menio/ Executive Director/ CARIE

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	54-55		V.O.14 - New Participant Orientation (page 54-55) The CHC-MCOs written policies and procedures for new Participants or written orientation plan or program must also include more detailed information for Medicare beneficiaries so they understand their rights, how their benefits will be coordinated, and cost sharing benefits	Diane A. Menio/ Executive Director/ CARIE
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment	55-56		V.O.16.a - Participant Handbook-Handbook Requirements (page 55-56) The handbook must also provide clear information to dual eligible members need about Medicare and Medicaid and how their care will be coordinated.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document		61		V.Q - Additional Addressee (page 61) This is a positive component of the proposal but should be expanded to develop protocols to allow Participants who may not be able to give consent the ability to have a responsible third party receive information. This would be particularly helpful for participants who have dementia.	Diane A. Menio/ Executive Director/ CARIE
	Section V.R. -			V.R.1 - Participant Complaint, Grievance and Fair Hearing Process, page 62 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 program or any independent consumer advocate to assist consumers with problems and complaints. Consumers should have access to an independent ombudsman as well as free legal services to help them through the grievance and appeal process. These procedures are critical particularly when consumers are subject to service denials, reductions, and terminations. Without these resources, the process is stacked against the consumer. It is important that CHC consumers have access to independent, free ombudsman services to help with issues such as understanding their rights, enrollment, accessing care, and appealing adverse decisions regarding their care. Ombudsman can also help identify systemic issues and should have access to state and MCO officials to resolve these problems in an expeditious manner. It would be prudent to build upon Pennsylvania's long term care ombudsman program rather than creating a new entity. Combining ombudsman services into the current program will be more cost effective, seamless for consumers regardless of how they may transition through settings or payers. Illinois is a state that has successfully combined its ombudsman program. It is important that any ombudsman program have adequate funding to be able to respond to the needs and concerns of MLTSS consumers. All consumers should receive information about ombudsman services upon enrollment, in any correspondence from the MCO or DHS about their plan or services and periodically throughout the year. DHS should conduct focus groups with legal service providers and other advocates to develop the recommendations for a comprehensive grievance and appeals process. This process should be followed by an opportunity for all stakeholders to provide comments. DHS and the public should receive regular data updates on the number of denials, appeals and grievances filed, and the decisions.	Diane A. Menio/ Executive Director/ CARIE

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Requirements Document	Participant Complaint, Grievance & DHS Fair Hearing Process	62		Further data should be compiled and shared about the outcomes to those who were denied services. All templates and other materials used to inform Participants about service denial decisions and the process to challenge those decisions should informing of their right o to free legal help with complaints, grievances, and Fair Hearings.	
Requirements Document	Section V. Z. - Fraud & Abuse	72-73		DHS should have a verification system that prohibits any MCO or provider from participating in the CHC program that has or have owned a company that previously defrauded the government. If DHS is planning to reimburse providers based on a risk score (reimbursing health plans based on a calculated fee paying higher rates for sicker consumers) DHS needs to monitor for "upcoding" by plans. DHS also needs to monitor that consumers are receiving the services they are entitled to receive as there are incentives for MCOs to deny or limit services to keep their costs down.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document	Section V.EE. - QM & UM Program Requirements	94-98		V.EE. - QM and UM Requirements (pages 94-98) Under the "Quality" heading on page 9 of the RFP and draft agreement summary, there is a reference to Exhibit GGG, "requires CHC-MCOs to report on an array of quality measures outlined in Exhibit GGG." We could not find this exhibit but would recommend adding it and allowing for stakeholder input. The lack of measures to help a consumer select a quality LTSS plan is a major problem. We hope that DHS will create a focus group to discuss what measures should be collected and how the data should be disseminated.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document Exhibit	L - Medical Assistance Transportation Program			Exhibit L – Medical Assistance Transportation Program (page M(1)-3 MCOs should also provide feeder information and support mobility management.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document Exhibit	LL - Guidelines for Sanctions regarding Fraud, Waste & Abuse			Exhibit LL – Guidelines for Sanctions Regarding Fraud and Abuse The document refers to a Section VIII.H. SANCTIONS, but this section is not included. It is imperative that the Department have sanctions available for any violation of the Agreement that effects Participants.	Diane A. Menio/ Executive Director/ CARIE
Requirements Document Exhibit	AAA - Provider Network Composition/Service Access			Exhibit AAA - Provider Networks: Network Composition" and is replacing the following text: "DHS must establish and enforce clear standards to ensure all CHC-MCOs have an adequate network in place so consumers have real choice among qualified providers in all categories of service, that they or their caregivers will not have to travel excessive distances to access them, and that they will not have to wait for care due to a lack of provider capacity to serve their needs."	Diane A. Menio/ Executive Director/ CARIE
Other	Other			CARIE hopes there will be more opportunities for feedback when more details are available and before decisions are finalized. We hope that Pennsylvania will create a thoughtful and deliberative state planning process and take the time needed to create a MLTSS system that promotes person-centered care, independence and dignity. The current timeline should be scrapped since it does not allow enough time to ensure meaningful consumer input, avert risks, optimize opportunities, or ensure a smooth transition for consumers. Stakeholder input should not be constrained by the procurement process. This historic change could be positive if all stakeholders are actively engaged in an ongoing, transparent process that includes significant discussion before formalizing or implementing any plan. DHS should continue to engage with stakeholders regularly in the monitoring and oversight of its MLTSS program. Should this process be instituted, CARIE is pleased to participate.	Diane A. Menio/ Executive Director/ CARIE

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Requirements Document Exhibit	DDD(1) - Covered Services List			Exhibit DDD(2) - Covered Services," also on the last page, CARIE is adding the following language: CARIE appreciates and supports the inclusion of "Pest Eradication" services	Diane A. Menio/ Executive Director/ CARIE
Requirements Document	Section V.A. - Covered Services	Section V.A: Covered Services-4: Expanded Services (Page 27)	CHC-MCOs are permitted and encouraged to offer LTSS Covered Services to Participants who are not yet NCFE. These services will not be reimbursed by the Department.	AmeriHealth Caritas supports the flexibility the state is allowing to support CHC-MCOs offering LTSS covered services to CHC Participants who are not yet NCFE. As part of the person-centered assessment process, we work to identify gaps and needs for our members, including some services that are not covered in the Medicaid benefit package. We choose to provide these supplemental, non-reimbursed services when they help our members stay healthy and independent. However, to support our ability to provide these additional, uncompensated services, the commonwealth should ensure that the Community HealthChoices program is based on actuarially sound rates with rigorous risk adjustment to ensure program stability and that CHC-MCOs have the appropriate incentives to drive high quality care in the community. These rates should not only be based on historical state spending as well as the intensity of services and innovation needed to manage care for nursing facility certified eligible participants as well as providing expanded uncompensated services to those who currently would not quality for LTSS. To encourage innovation and address... (continued on next page)	AmeriHealth Caritas
Requirements Document	Section V.A. - Covered Services	Section V.A: Covered Services-4: Expanded Services (Page 27)	CHC-MCOs are permitted and encouraged to offer LTSS Covered Services to Participants who are not yet NCFE. These services will not be reimbursed by the Department.	(continued from last page)...longstanding care fragmentation and the social determinants of health impacting participants, the commonwealth should be thoughtful when considering setting rates for CHC-MCOs to ensure that they reflect and support the overarching goals of the program.	AmeriHealth Caritas
Requirements Document	Section V.A. - Covered Services	Section V.A: Covered Services-17: Nursing Facility Services (Page 33-34)	The CHC-MCO is responsible for payment for Medically Necessary nursing facility services (including bed hold days and up to fifteen (15) per hospitalization and up to thirty (30) Therapeutic Leave Days per year) if a Participant is admitted to a Nursing Facility or resides in a Nursing Facility at the time of Enrollment.	Requiring CHC-MCOs to cover up to fifteen (15) bed hold days and up to thirty (30) Therapeutic Leave Days per year may align incentives in the wrong direction which can lead to an increase in unnecessary hospital admission. We recommend that the commonwealth should allow CHC-MCOs to cover seven (7) bed hold days with the flexibility to approve additional days on a situational basis. Additionally, we recommend that the commonwealth allow CHC-MCOs the flexibility to cover bed hold days and therapeutic leave days at a reduced rate or at a lower percentage of the normal per diem rate.	AmeriHealth Caritas
Requirements Document	Section V.A. - Covered Services	Section V.A: Covered Services-20: Settings for LTSS (Page 35)	The CHC-MCO must provide services in the least restrictive, most integrated setting. The CHC-MCO shall only provide LTSS in settings that comply with the HCBS Settings final rule at 79 F.R. 2948 (January 16, 2014).	Allowing Participants to remain or move into the least restrictive setting (to be in compliance with the HCBS final rule) is the main goal of program; however, there may certain times that this results in cost prohibitive situations. The impending request for proposal should address needs to address this area to ensure that the program remains stable and sustainable.	AmeriHealth Caritas

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Requirements Document	Section V.A. - Covered Services	Section V.A: 21: Service Delivery Innovation- a. Housing (Page 35)	Housing innovation that includes, but is not limited to: i. pre-tenancy and tenancy supports that help Participants at risk of homelessness or institutionalization to obtain and maintain homes in the community. These may include but are not limited to: outreach to and engagement of Participants, housing search assistance, assistance and applying for housing and benefits, assistance with SSI eligibility processes, advocacy and negotiation with landlords and other tenants, moving assistance, eviction prevention, motivational interviewing, and incorporating social determinants of health into the person-centered planning process. ii. Participation in local and statewide housing collaboratives, which may include local and state housing agencies and social service organizations.	Housing is a key issue affecting many Participants who will be in the CHC program. AmeriHealth Caritas is committed to working collaboratively with other stakeholders in the commonwealth to increase housing options for Participants. We recommend that the commonwealth allow flexibility and support collaboration and initiatives around housing that impact CHC Participants.	AmeriHealth Caritas
Requirements Document	Section V.B. - Prior Authorization of Services	Section V.B: Prior Authorization of Services - 1. General Prior Authorization Requirements (Pages 36 - 37)	The CHC-MCO may not require prior authorization of Medicare services for Participants with Medicare. CHC-MCOs must conditionally approve Covered Services that are pending Medicare decisions in the event that these services are not covered by Medicare. Service Coordinators are required to work with the Participant's Medicare plan to ensure expeditious decision-making and communication of decisions made.	Coordination with Medicare is an important feature of the CHC program. We request additional clarifications about how a CHC-MCO would coordinate Medicare services if their member is enrolled in another health plan's Dual Eligible Special Needs Plan (D-SNP) and would appreciate guidelines from the commonwealth around operational and/or policy parameters for coordination and engagement between the CHC-MCO and a Participant's D-SNP if it is not affiliated with the CHC-MCO's D-SNP.	AmeriHealth Caritas
Requirements Document	Section V.C. - Continuity of Care	Section V.C: Continuity of Care (Page 39-40)	The CHC-MCO is prohibited from interfering with a Participant's choice of NF.	Continuity of care protections are critical during the implementation of the CHC program. For Participants who reside in a nursing facility at the time of program implementation, we recommend that care managers or others for the CHC-MCO be allowed to share state, federal or CHC-MCO quality data comparisons with members to ensure that Participants have enough information to make an informed choice.	AmeriHealth Caritas
Requirements Document	Section V.E. - Needs Screening	Section V. E: Needs Screening (Page 40)	The needs screening must be completed within the first 30 days of Enrollment, and may be conducted by phone, electronically, by mail, or in person.	The initial needs screening process is unclear and thus may be problematic for MCOs. We request additional clarification as to the specific screening and assessment process the state is recommending. We support utilizing a short, telephonic screening tool to outreach to new member within the first 30 days of enrollment, but allowing CHC-MCOs a longer period of time, for example 90 days from enrollment, to perform more comprehensive assessments. This allows us to quickly identify Participants with pressing and/or unmet needs as quickly as possible, which triggers a more comprehensive, multi-dimensional in-person assessment. This timeframe allows CHC-MCOs to triage assessments based on risk level to better target the most urgent members as soon as possible. Additionally, we recommend that the state provide data on incoming members if available on recent utilization history so that MCOs can perform predictive modeling to identify and prioritize the most needy members as soon as possible.	AmeriHealth Caritas

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Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments	Section V. F. Comprehensive Needs Assessments and Reassessments (Page 40-42)	Participants without existing Person-Centered Service Plans who are identified through a needs screening as requiring a comprehensive needs assessment shall have a comprehensive needs assessment conducted within 15 days of the completion of the needs screening.	We would like more clarity around comprehensive assessment requirements. Typically, a CHC-MCOs will triage Participants into different risk levels (such as high, medium and low) based on a Participant's individual needs. We have found in our work in other states that there may need to be additional time granted to CHC-MCOs to perform these assessments and reassessments given the number of individuals that may be designated high-risk. Thus, we believe that the 15 day timeframe required by the commonwealth may be too short to allow us to perform these critical functions and recommend that the commonwealth allow for increased flexibility and additional days with which to meet these requirements. Additionally, the criteria for determining who receives a needs assessment are not specific enough and may trigger a large number of individuals who may not necessarily need a comprehensive risk assessment.	AmeriHealth Caritas
Requirements Document	Section V.I. - Department Review of Changes in Service Plans	Section V.I: Department Review of Changes in Services Plans (Page 43)	The Department may review and revise any Person-Centered Service Plan. The CHC-MCO must provide the Department with weekly aggregate reports on PCSP changes.	While we believe that oversight of the CHC program by the commonwealth is important, we feel that weekly aggregate reporting requirements may be administratively burdensome and would recommend more flexibility around reporting requirements in general.	AmeriHealth Caritas
Requirements Document	Section V.M.- Coordination of Services	Section V.M: Coordination of Services- 1. CHC-MCO and BH-MCO Coordination (Page 44)	To facilitate the efficient administration of the Medical Assistance Program and to enhance the treatment of Participants who need both Covered Services and BH services, the CHC-MCO must develop and implement written agreements with each BH-MCO in the CHC-MCO's zone(s) regarding the interaction and coordination of services provided to Participants enrolled in the Community HealthChoices Program.	Coordination between CHC-MCOs and BH-MCOs will be essential in the Community HealthChoices program. We believe this coordination could be strengthened by not just declaring which entity is liable for claims (CHC-MCO versus BH-MCO) but also to assign primary service coordination role based on whether mental illness is primary diagnosis or not.	AmeriHealth Caritas
Requirements Document	Section V.AA. - Selection & Assignment of PCPs	Section V.AA: Selection and Assignment of PCPs (Page 83)	If a Participant has not selected a PCP within fourteen (14) business days of Enrollment, the CHC-MCO must make an automatic assignment. If the Participant is enrolled in the D-SNP aligned with the CHC-MCO, the CHC-MCO must assign the PCP who the Participant uses in the D-SNP. The CHC-MCO must consider such factors (to the extent they are known) as current Provider relationships that may be identified through Encounters, existing Service Plans, or any CHC-MCO contacts with the Participant, specific medical needs, physical disabilities of the Participant, language needs, area of residence and access to transportation.	To support PCP assignment for Participants who do not select a PCP within fourteen days, AmeriHealth Caritas recommends that the commonwealth share with the CHC-MCO any previous encounters, claims history and historical provider relationships that the Participant may have had under the fee-for-service program when transitioning Participants to the CHC Program during the implementation period. The sharing of this information in a timely manner will facilitate more successful assignments and ease Participant disruption.	AmeriHealth Caritas

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Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	Section V. BB Selection and Assignment of Service Coordinators (Page 84-85)	The CHC-MCO must offer the Participant the choice of at least two Service Coordinators.	Ensuring Participant choice is very important and to that end we support and maintain comprehensive provider panels, including Service Coordinators, that meet the needs of our members. Because of other network adequacy requirements, we do not believe that the commonwealth should specifically require that CHC-MCOs provide Participants with the choice of at least two Service Coordinators. Requirements supporting Participant choice should remain around cultural competency and language and continue to support allowing Participants to change Service Coordinators if desired.	AmeriHealth Caritas
Other	Quality Assurance & Performance Improvement	N/A	N/A	The commonwealth should work closely with the Bureau of Managed Care Operations within the Pennsylvania Department of Human Services to coordinate both the quality standards they plan to use as well as reports (where applicable) they will require for the CHC Program. This will not only align resources, efforts and initiatives for dual eligible participants, but will also ease administrative efforts for state agencies and for any MCOs who may be participating in both the HealthChoices Program and the CHC Program.	AmeriHealth Caritas
Other	N/A	N/A	N/A	AmeriHealth Caritas supports increased integration of Medicare and Medicaid services to 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 timelines for implementation of the zones and the federal D-SNP timelines that must be followed to bring up a D-SNP, we recommend that the commonwealth increase the flexibility for compliance with having a companion D-SNP in the counties of each zone to ensure alignment with federal application timelines, such as allowing CHC-MCOs eighteen (18) months after zone implementation to fully develop D-SNPs in each of the counties of the awarded zones.	AmeriHealth Caritas
RFP	Work Statement	Work Statement Questionnaire - Participant Service and Care Coordination (Page 29)	Maximum 30 Pages	In this section, the commonwealth is asking 30 questions with a limit of 30 pages. Based on the number, type, and complexity of information being asked in this section, we recommend that the commonwealth increase the page limit for this section to 50 pages.	AmeriHealth Caritas
RFP	Work Statement	Work Statement Questionnaire - Service Integration (Page 33)	Maximum 15 Pages	In this section, the commonwealth is asking 11 questions with a limit of 15 pages. Based on the number, type, and complexity of information being asked in this section, we recommend that the commonwealth increase the page limit for this section to 25 pages.	AmeriHealth Caritas
RFP	Work Statement	Work Statement - Pharmacy (Page 35)	Maximum 15 Pages	In this section, the commonwealth is asking 8 questions with a limit of 15 pages. However, some of the questions have multiple parts. Based on the number, type, and complexity of information being asked in this section, we recommend that the commonwealth increase the page limit for this section to 30 pages.	AmeriHealth Caritas
RFP	Work Statement	Work Statement - Management Information Systems (Page 37)	Maximum 20 Pages	In this section, the commonwealth is asking 20 questions with a limit of 20 pages. Several of these questions address complex issues. Because of this, we recommend that the commonwealth increase the page limit for this section to 40 pages.	AmeriHealth Caritas

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RFP	Work Statement	Work Statement - Provider Network Composition and Network Managemen t (Page 39)	Maximum 25 Pages	In this section, the commonwealth is asking 14 questions with a limit of 25 pages. Based on the number, type, and complexity of information being asked in this section, we recommend that the commonwealth increase the page limit for this section to 35 pages.	AmeriHealth Caritas
RFP	General Information	Other		We believe that AAAs that opt not to contract with MCOs to perform service coordination could play the vital role of quality assurance with regard to these services.	Montgomery County Aging and Adult Services/Barbara O'Malley
RFP	Proposal Requirements	Page 44		the MCO will need to submit a plan include contacts, caseload, in-person contact. As this may vary by MCO, AAAs that are not providing service coordination can help determine if there is a best practice among the varying service coordination staffing plans.	Montgomery County Aging and Adult Services/Barbara O'Malley
RFP	General Information	Other		The Department should convene a special workgroup to discuss the coordination between behavioral health services and long term care services. Other than the requirement for CHC-MCOs to coordinate with BH-MCOs, there is no further language outlining what this looks like.	Montgomery County Aging and Adult Services/Barbara O'Malley
RFP	General Information	Other		The Department should clarify the responsibility of the CHC-MCO as related to Older Adult Protective Services and Adult Protective Services. How will the responsibility of risk issues be coordinated between the MCO and the protective services entity?	Montgomery County Aging and Adult Services/Barbara O'Malley
RFP	General Information			To ensure the most effective continuity of care for consumers throughout the phased-in approach for CHC, we recommend that all current Service Coordinators and Service Coordinator Supervisors be grandfathered into the proposed minimum staffing requirements and that service coordination entities be required to achieve compliance with the new requirements through the process of staff attrition. This ensures that the currently certified and experienced workforce can be immediately deployed to meet the diverse and complex needs of CHC service consumers.	Montgomery County Aging and Adult Services/Barbara O'Malley
RFP	General Information			We recommend that the reference of specialized interpreter services should also include those consumers who have Limited English Proficiency and that interpreter services for the blind, deaf and Limited English Proficiency consumers be added as a MLTSS Benefits within the list of covered services at the end of the draft agreement.	Montgomery County Aging and Adult Services/Barbara O'Malley
RFP	General Information			We recommend that complaints and appeals be included as one of the minimum components for a MIS or other linked-in system.	Montgomery County Aging and Adult Services/Barbara O'Malley
RFP	General Information			We recommend the CHC-MCO notify the Department of its intent to terminate a Network Provider 90 days prior to the effective date of the termination. The transition from a provider can take longer than 60 days when ensuring that participants experience no lapse in service.	Montgomery County Aging and Adult Services/Barbara O'Malley
RFP	General Information	Section A of the Complaint, Grievance and DHS Fair Hearing		Section A of the Complaint, Grievance and DHS Fair Hearing Processes outlines the basic responsibilities of CHC-MCOs in complaints, grievances, and hearings. Point 12 in Section A states that "the CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant." While we support the need for accommodations for those who need them, the AAA network also recognizes that some older adults may also need help presenting their case during these proceedings. We recommend that there be an advocate that can attend hearings with older adults. We recommend that the CHC-MCO be mandated to assure that older adults are connected to an advocate or someone who can help them prepare and/or give the presentation of their case, that if an older adult chooses to have such an advocate, their case should not be heard without this assistance, and that it should also occur at no charge to the senior.	Montgomery County Aging and Adult Services/Barbara O'Malley
RFP	General Information			In the interest of continuity of care, we recommend that any willing provider definition be changed to reflect that the payment rate must be no lower than the current payment rate for the entire duration of the continuity of care period.	Montgomery County Aging and Adult Services/Barbara O'Malley

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RFP	General Information			In the explanation of travel time under a., "travel time is measured via public transportation, where available." In reading this section, it would appear that this definition of travel time being measured via public transportation only applies to PCPs. We recommend that travel time be measured via public transportation for all types of care described in exhibit AAA.	Montgomery County Aging and Adult Services/Barbara O'Malley
RFP	General Information			Definition of Respite Care-We recommend that this definition be expanded to allow for the provision of respite care in an institutional setting.	Montgomery County Aging and Adult Services/Barbara O'Malley
RFP	General Information			Responsibility of Annual Level of Care Redetermination- In order to avoid any conflict of interest, we recommended that language be added that confirms that these annual redeterminations be completed by the entity that is conducting the level of care determinations and not service coordinators.	Montgomery County Aging and Adult Services/Barbara O'Malley
RFP	General Information	Page 39/ Continuity of Care		In order to ensure Continuity of Care, it is recommended that the six month period for consumers to transition to a MCO contracted provider be increased to a two year minimum. This will ensure that the consumer is informed choice, proper enrollment, that services are not interrupted. During this period, the current published rates should be maintained. With the changes in the FMS, LOCA, IEB in addition to switching to a managed care environment, it is the potential for a perfect storm that may drive consumers to agency model to ensure back up in services. The extension to two years can avoid the time concentration of these transitions to new providers.	Fady Sahhar
RFP	General Information			There are concerns that the plan language distinguishing between ADL's and IADL's could result in a reduction in hours in the plan. The only identified measures are around medical necessity. It is recommended that health and safety and quality of life measures be added to the medical necessity definition when considerations are made to determine eligibility for service and as grounds for appeal.	Fady Sahhar
RFP	General Information			Throughout the draft RFP, there are indications of consumer advisory committees and materials to be provided for consumer enrollment and orientation, as well as provider and staff training. The recommendation is that consumer committees and CBO's like CIL's should actively participate in the preparation and review of these materials to assure the inclusion and presentation of consumer control and independent living.	Fady Sahhar
RFP	General Information			The RFP does not detail a proposed utilization review system. It is important for the stakeholders to be able to review the proposed utilization process and be able to comment on its format. It is recommended that the utilization review incorporate the social model to complement the medical model.	Fady Sahhar

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RFP	General Information		The RFP states "CHC will serve adults age 21 or older who require MA LTSS (whether in the community or in private or county nursing facilities) because they need the level of care provided by a nursing facility or an intermediate care facility for individuals with other related conditions (ICF/ORC), and current Participants in DHS' OLTL waiver programs who are 18 to 21 years old." RFP at 7 We object to limiting participation for individuals age 18 to 21 only if they are currently participating in DHS' OLTL waiver programs when CHC begins and encourage the Department to allow participation for any 18- to 21-year-old who needs LTSS at any time. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) does not cover all the services that children and adolescents need to avoid institutionalization, such as respite, home modifications and residential habilitation. An 18- to 21-year-old with significant physical and medical conditions, whose parents can no longer care for him or her would, without the availability of a waiver or the ability to enroll in Community Health Choices for LTSS, have no option but to accept placement in a nursing or other institutional facility. This is contrary to DHS' intentions, as we understand them. The transition to adult services for young adults with special health care needs is complicated and currently uncoordinated. Including 18- to 21-year-olds with LTSS needs in CHC on an ongoing basis (rather than just those who meet this criteria at the beginning of CHC) would provide an overlapping time to ensure a smooth transition for youth transitioning from Medicaid's children benefits with LTSS to adult benefits with LTSS as well as those who age out of the child welfare system and need LTSS.	Pa Council for Independent Living's	

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RFP	Work Statement Questionnaire		Question 11 (RFP at 30) should be changed: "Describe your organization's experience and your plan for assuring access to assistive technology, telehealth, telecare … Include a description of how you will assure access to the full array of assistive technology from highly specialized, customized and modified devices and generic commercially available items used to meet a specific disability-related need. Describe your plan for obtaining products from outside of network when unavailable in network." Add a new question: "Descri be you r organizati on's ex peri ence and your plan for using social media and electronic visit verification, and other methods to deliver services to CHC Participants	Pa Council for Independent Living's	
RFP	Work Statement Questionnaire		Under "Service Integration" 1. This section implies Medicare will be integrated with CHC-MCO coverage. However, information describing the program elsewhere indicates that Medicare will continue to operate separately although the CHC-MCO will coordinate care with the member's Medicare coverage. Since Medicare remains separate, the first question should be revised to read "Describe the approaches you will use to integrate Medicaid A and Medicare services, including primary and acute services and LTSS, to improve Participant experience and outcomes." Since Medicare is NOT integrated with Medicaid and LTSS this needs to be corrected. Medicare does not belong here. CHC integrates Medicaid and LTSS. Then, the CHC will coordinate with Medicare. ▯	Pa Council for Independent Living's	

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			2. A new question should be added: Describe the approaches you will use to coordinate with Medicare for dual eligible members to improve Participant experience and outcomes. Specifically, how will care be coordinated o For Participants with Original Medicare? o For Participants in any Medicare Advantage plan not affiliated with your Insurance Company? o For Participants in a Medicare Special Needs Plan affiliated with your Insurance Company? 3. Question 7 of the same section (RFP at 33) asks CHC-MCOs with affiliated D-SNP plans to describe how the CHC model of care will align with the D-SNP's model of care. We support this inquiry and encourage much more specifics be given about how a CHC-MCO's model of care would coordinate with any type of Medicare coverage a member would have. Specific to D-SNPs that will be aligned with CHC-MCO, the Department should be concerned about the		

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RFP	Work Statement Questionnaire		quality of care and services provided by these D-SNPs. We urge the Department to require CHC-MCOs with affiliated D- SNPs to submit Medicare past performance information to the state, including submission of CMS warning letters, corrective action plans, deficiency notices, and/or notices of low Medicare star ratings. We also urge the Department to require CHC-MCOs with companion D-SNPs to submit D-SNP grievance and appeals data (including the outcome of those appeals) as a quality check on D- SNP processes and results. This is important since most of the services CHC-MCO Participants will receive will be covered on the Medicare side rather than the Medicaid side. Future MIPPA agreements between Pennsylvania and D-SNPs should require the same. According to the Integrated Care Resource Center at the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office, Massachusetts requires D-SNPs to submit detailed monthly reports on enrollee complaints and appeals, specifying the quantity, types, solutions, and timeframes they were resolved. D-SNPs are also required to cooperate with the state to implement improvements based on the findings of these reports. See Massachusetts, Senior Care Organizations Contract, 2013, Sec 2.14.d. Finally, the performance of the D-SNP aligned with each CHC-MCO applicant should be strongly considered when determining whether a CHC-MCO is offered a CHC contract. And during Community HealthChoices, the Department should actively monitor the performance of each D-SNPs aligned with chosen CHC-MCOs. CHC Participants should be informed about the performance of their CHC-plan's affiliated D-SNP.	Pa Council for Independent Living's	

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RFP	General Information		1. Much to our disappointment, these program requirements seem to have been lifted whole cloth from the current HealthChoices- RFP with little thought given to the population that will be served by the CHC-MCOs: dual eligibles. Dual eligibles have not been in the HealthChoices program since prior to 2006. Over 90 percent of the Community Health Choices target population will have Medicare, yet the draft RFP and Program Requirements contain very few references to Medicare. This lack of reference to Medicare in several key sections, plus questions raised in sections where Medicare is referenced, causes concern that that the Administration does not fully understand how dual eligibles receive coverage or access care now. Even though the CHC program will change how dual eligibles receive their Medicaid coverage, it will not change the fact that Medicare will continue to be someone's primary coverage with Medicaid paying second for most services.	Pa Council for Independent Living's	

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RFP	Proposal Requirements		Financial Responsibility for Dual Eligibles The [CHC-MCO] must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for qualified Medicare beneficiaries in accordance with Section 4714 of the Balanced Budget Act of 1997. If no contracted [CHC-MCO] rate exists or if the Provider of the service is an Out-of-Network Provider, the [CHC-MCO] must pay deductibles and coinsurance up to the applicable MA fee schedule for the service. For Medicare services that are not covered by either MA or the [CHC-MCO], the [CHC-MCO] must pay cost-sharing to the extent that the payment made under Medicare for the service and the payment made by the [CHC-MCO] do not exceed eighty percent (80%) of the Medicare-approved amount. The [CHC-MCO], its subcontractors and providers are prohibited from balance billing members for Medicare deductibles or coinsurance. The [CHC-MCO] must ensure that a member who is eligible for both Medicare and Medicaid benefits has the right to access a Medicare product or service from the Medicare Provider of his/her choice. The [CHC-MCO] is responsible to pay any Medicare coinsurance and deductible amount, whether or not the Medicare provider is included	Pa Council for Independent Living's	

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Requirements Document	Section V.A. - Covered Services		In this section (Requirements Document at 26-27) and Exhibit DDD(2) we suggest additional language about Assistive Technology: 1. The description of Assistive Technology in Exhibit DDD(2) should clarify that both Assistive Technology services and Assistive Technology devices are covered benefits. 2. An additional bullet following the first paragraph at Exhibit DDD(2) (describing Assistive Technology) should state "Devices that would otherwise be considered Durable Medical Equipment but are not included in the State Plan definition for DME and meet a specific disability-related need"	Pa Council for Independent Living's	

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Requirements Document	Section V.A. - Covered Services		V.A.2. In-Home and Community Based Services What is this section (Requirements Document at 26-27) referring to? Is it referring to medically necessary services available through the Medicaid state plan for individuals under age 21 as required by EPSDT or in-home community based LTSS services? This needs to be clarified. We are very concerned that framing the eligibility criteria for LTSS in terms of medical necessity will result in a medicalization of these services or even denials of services where they do not achieve a “medical” result. We urge the Department to have this section refer to all CHC participants, regardless of age, who receive in- home and community based services, and suggest the following changes: The first sentence of the first paragraph (Requirements Document at 26-27) should be changed: “The CHC-MCO may not deny personal assistance services for Participants under the age of 21 based on the Participant’s diagnosis or because the need for personal assistance services is the result of a cognitive impairment.” The second paragraph should be changed to: “The CHC-MCO may not deny a request for Medically Necessary in- home nursing services, home health aide services, or personal assistance services for a Participant under the age of 21 on the basis that a live- in caregiver can perform the task, unless there is a determination that the live-in caregiver is legally responsible for the care of the Participant and is actually able and available to provide the level or extent of care that the Participant needs, given the caregiver’s work schedule, sleep schedule or other responsibilities, including other responsibilities in the home.”	Pa Council for Independent Living's	

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Requirements Document	Section V.A. - Covered Services		V.A.4. xpanded Services In the first paragraph (Requirements Document at 27), we are concerned about DHS' ability to allow plans to provide extra services to only certain Participants who meet performance goals In the second paragraph (Requirements Document at 27), revise the second sentence to add the words underlined: "Upon sixty (60) days advance notice to the Department, and with Department approval, the CHC-MCO may modify or eliminate any expanded service." The last two sentences in this section encourage CHC-MCOs to provide LTSS services to those not yet NFCE but goes on to say " these services will not be reimbursed by the Department." (Requirements Document at 27) The last sentence seems unnecessary. Does this mean that the Department will be paying for LTSS services to the MCOs via a reimbursement vs. an enhanced capitation?	Pa Council for Independent Living's	
Requirements Document	Section V.A. - Covered Services		The section (Requirements Document at 27-28) should specify that the CHC-MCO must not apply its referral process to Medicare services for Participants on Medicare.	Pa Council for Independent Living's	
Requirements Document	Section V.A. - Covered Services		V.A.6. Self-Referral/Direct Access Specify that the CHC-MCO may not use either the referral process or Prior Authorization process to manage the utilization of Medicare services for Participants with Medicare and may not restrict the right of Participants with Medicare to choose the provider of their Medicare services.	Pa Council for Independent Living's	

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Requirements Document	Section V.A. - Covered Services		Revise the last sentence (Requirements Document at 28-29) to read "The CHC-MCO must coordinate w it h the Part ici pant 's Medicare as well as with the BH-MCO as necessary to ensure that Participants receive all Medically Necessary Behavioral Health Services."This provision should also be added to this section: "The CHC-MCO must send one or more representatives to attend nd participate in the PH/BH Committee meetings DHS establishes in each CHC zone in which it is doing business."	Pa Council for Independent Living's	
			The information included in this section (Requirements Document at 29) should be separated into two paragraphs. The first paragraph should discuss full dual eligible Participants and the second paragraph should discuss pharmacy services for people who do not have Medicare. The second sentence says the CHC-MCO must provide coverage of prescriptions for full duals that are not otherwise covered by their Medicare Part D plan. Does the Department really mean this? Currently, Medicaid does not cover prescriptions for duals (other than "Over The Counter" meds because these are excluded from Part D coverage). The individual must deal with their Medicare Part D plan for all medication except for OTC meds. How would the CHC-MCO "coordinate pharmacy services" for duals across Medicare Part D when it does not provide coverage for those services? Also, this same sentence discusses coordination to "ensure that the Participant receives the pharmacy services outlined in the Participant's Person-Centered Service Plan". Will all CHC-MCO Participants have a service plan? If not, then this	Pa Council for Independent Living's	

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Requirements Document	Section V.A. - Covered Services		Participants have a service plan? If not, then this language needs to be removed or clarified as it implies that the CHC-MCO has no responsibility in coordinating pharmacy services for people who do not have a service plan.		
Requirements Document	Section V.A. - Covered Services		The first sentence (Requirements Document at 29) should be revised to read "For Participants under the age of 21, the CHC-MCO must comply…."	Pa Council for Independent Living's	
Requirements Document	Section V.A. - Covered Services		The CHC-MCO may not apply case management protocols to limit or restrict Participants with Medicare from accessing services or providers of their choice for Medicare covered services. In the last paragraph (Requirements Document at 30), specify that the CHC-MCO may not deny payment of inappropriate emergency room use for Participants on Medicare when Medicare has covered the services and that the CHC-MCO may not apply Participant lock-in methodology to any Participant on Medicare.	Pa Council for Independent Living's	

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			The first sentence (Requirements Document at 33) states the CHC-MCO is responsible for payment for medically necessary nursing facility services. If the CHC-MCO decides that nursing facility services are no longer medically necessary, there should be a requirement that the CHC-MCO help find and connect a Participant with resources needed upon discharge from a nursing facility; this includes services available through the CHC-MCO as well as those that are beyond the scope of CHC-MCO coverage. The third paragraph, first sentence needs to be clarified to assure that this right to reside in a SNF for the duration of someone's need applies does not just apply to the original MCO but also if that Participant later switches to another CHC-MCO. We do not understand the point of the second sentence of the third paragraph. We also do not understand the first sentence of the fourth paragraph that says that CHC-MCOs must ensure Nursing Facility processes are	Pa Council for Independent Living's	

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Requirements Document	Section V.A. - Covered Services		completed and monitored for Participants. We recommend that CHC-MCOs have a designated NH unit and care managers to help Participants with these issues. The language in the fourth paragraph is also vague. There are no standards for each of these processes and no reference to the applicable laws and regulations that contain the standards. There are no standards for the monitoring that needs to occur, for example, what the monitoring entails, the frequency of monitoring, or how violations are corrected. Particularly with respect to specialized service delivery, it is unclear what role CHC-MCOs are expected to play.		
Requirements Document	Section V.A. - Covered Services		In addition to Personal Assistance Services, Participants should be able to self-direct community integration, non-medical transportation, respite and supported employment services.	Pa Council for Independent Living's	
Requirements Document	Section V.A. - Covered Services		In the second paragraph (Requirements Document at 31), there seems to be a typo "The Department will consider P.A policies and procedures approved under previous Community HealthChoices agreements approved under this agreement" (emphasis added). What previous CHC agreements? In the last paragraph, the last sentence should be revised to read, "Service Coordinators are required to work with the Participant's Original Medicare or Medicare Advantage plan to ensure expeditious decision-making and communication of decisions made."	Pa Council for Independent Living's	

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Requirements Document	Section V.B. - Prior Authorization of Services		Delete the second sentence of the first paragraph (Requirements Document at 38) that reads, "If probable Participant fraud has been verified, the period of advance notice is shortened to five (5) days." The 4th bullet seems problematic and should be deleted. Would a Prior Authorization request to continue services be submitted for someone whose whereabouts would be unknown? Just because previous mail was returned to the CHC-MCO does not mean the Participant may not have since contacted the CHC-MCO with a new address.	Pa Council for Independent Living's	

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			The first paragraph (Requirements Document at 39) is hard to follow but again we want to ensure that anyone in a SNF initially enrolling into Community Health Choices has continuity of care for the duration of their stay even if they later switch to another CHC-MCO. The first bullet includes a sentence that the CHC-MCO is prohibited from interfering with a Participant's choice of nursing facility. This should include setting insufficient rates that nursing homes may not accept. Therefore, there should be a requirement that, at a minimum, CHC-MCOs must pay non-network nursing facilities the fee- for-service rate for nursing home care. The first sentence of the second bullet point should be revised to read, "For a Participant who has been approved for or who is receiving LTSS	Pa Council for Independent Living's	

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Requirements Document	Section V.C. - Continuity of Care		has been approved for or who is receiving LTSS through an HCBS Waiver Program on his or her Effective Date of Enrollment …" The second bullet should clarify that for the first 180 days of the program's implementation in each region, CHC-MCOs are required to cover all services provided under existing PCSPs through all existing service providers. This can be extended if the CHC-MCO does not complete a comprehensive needs assessment and develop and implement a PCSP within this timeframe. However, the 180-day period for continuity of services cannot be shortened during the first 6 months of the CHC program operation in each region, even if a Participant chooses to change their CHC-MCO within this timeframe. Only after the first 6 months of the program's operation in each region can CHC-MCOs impose the shortened continuity of care timeframe (60 days or until a needs assessment and PCSP is developed and implemented, whichever is later).		
Requirements Document	Section V.D. - Choice of Provider		Individuals who have Medicare have the choice to see any provider that takes their Medicare coverage. Those in Original Medicare as well as those in Medicare Advantage Plans have the freedom to see any doctor who accepts their Medicare regardless of whether that doctor is also in their CHC plan network. Previous versions of the HealthChoices agreement included information about what a plan's responsibility is in this situation. The same rules should apply to CHC plans and this should be detailed in the CHC Program Requirements (Requirements Document at 40).	Pa Council for Independent Living's	

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Requirements Document	Section V.E. - Needs Screening		This should be inserted after the first sentence (Requirements Document at 40): "The needs screening tool must include questions regarding the mental and emotional needs and substance abuse treatment needs of Participants. If the screening identifies unmet behavioral health needs, the CHC-MCO is responsible for working with the Participant and other insurance providers (Original Medicare, Medicare Advantage Plan and/or BH-MCO) to identify appropriate provider resources t o meet those needs." The second sentence should be changed to: "Any participant whose needs screening reflects unmet needs, service gaps, or a need for Service Coordination, or who requests a comprehensive needs assessment will be referred for a comprehensive needs assessment."	Pa Council for Independent Living's	

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			The first sentence of this section (Requirements Document at 40) should be changed: "The comprehensive needs assessment will be conducted by a Service Coordinator (or other individual with equal or higher qualifications) who is independent of the CHC- MCO… " This is critical to avoid a conflict of interest to counter the financial disincentives for the CHC-MCO to identify expensive needs that can and should be provided in the community. The third bullet of the first paragraph should be changed: "Participants without existing Person-Centered Service Plans who are identified through a needs screening as requiring a comprehensive needs assessment, or who request a comprehensive needs assessment, shall have a comprehensive needs assessment conducted within 15 days of the completion of the needs screening or of the request."	Pa Council for Independent Living's	

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Requirements Document	Section V.F. - Comprehensive Needs Assessments & Reassessments		the needs screening or of the request. The second full paragraph describes when reassessments need to occur and says they must happen within 14 days of a trigger event but it is not clear how the CHC-MCO would know of a trigger event. The sentence before the list of trigger events should be revised to read: "Reassessments must be completed as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participants' health status and needs, but in no case more than 14 days from the plan receiving a report of, or otherwise becoming aware of, the occurrence of any of the following triggering events…."		

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Requirements Document	Section V.G. - Person Centered Planning Team Approach		Federal regulations establish a participant's right to person- centered planning, and this (at Requirements Document at 42) should be made clear in the agreement. 42 C.F.R. §441.301(c)(1) through (3) (describing minimum requirements for the planning process, the written service plan, and review of the plan). The CHC-MCO's PCPT policy must specify how CHC-MCO will educate and support participants so that they can direct the person- centered planning process and make informed decisions. CHC-MCOs must train on self-advocacy, self-determination, and person-centered principles. This training should be available for caregivers as well as legal representatives. In addition, CHC-MCOs must provide Participants information about services and supports before any service planning meetings to allow Participants enough time to meaningfully review their options. New Jersey, for example, requires its care managers to engage in options counseling with Participants to make informed choices. This counseling must be documented. Finally, CHC-MCOs should ensure that they train not only participants, caregivers, and legal representatives, but also service coordinators and other professionals involved in the development of PCSPs so that all are equipped with knowledge and training on person- centered principles.	Pa Council for Independent Living's	

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Requirements Document	Section V.G. - Person Centered Planning Team Approach		This section (Requirements Document at 42) needs stronger language clarifying that the Participant must have a meaningful opportunity to participate in and direct the development of PCSPs.	Pa Council for Independent Living's	

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			This section must also make clear that unpaid natural supports are voluntary. CHC-MCOs must not reduce paid services by assuming that qualified caregivers are available and willing to provide care. If a Participant plans to rely on natural supports, PCSPs must incorporate caregivers' abilities, needs, and preferences. PCSP must be written in plain language that avoids jargon. It must also be accessible to individuals with disabilities and persons who are limited English proficient. Further, PCSP must be agreed to through written consent of the Participant and also signed by parties who will implement the plan. Service coordinators must ensure that 1) Participants do not feel pressured to sign finalized plans; and 2) Participants understand they have the right to appeal part or all of their service plans, even after service planning meetings are over. Service coordinators must explain the procedures for filing an appeal. If the Participant disagrees with the service plan, the service coordinator must document this disagreement. The service coordinator must then provide a written notice of the action and the Participant's appeal and fair hearing rights. Participants should receive copies of their service		

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			Participants should receive copies of their service plans, along with any assessments the CHC-MCO/service coordinator used to determine the Participants' needs and develop the plan. The second paragraph (Requirements Document at 42) should be revised to read: "Each PCSP must address how the Participant's physical and behavioral health needs will be managed by the CHC-MCO and how services and Medicare coverage (if the Participant is a dual eligible) will be coordinated by the Service Coordinators." The last bullet in the list of what PCSPs must identify should be revised to read: "how the Service Coordinator will assist the Participant in accessing covered services through their Medicare, their BH-MCO and their CHC-MCO identified in the PCSP. We also strongly recommend that notice and appeal rights, including access to free legal help, be provided to Participants at every PCSP meeting and also attached to the PCSP Plan. This is in addition to the requirement of written notice of denials. Moreover, it should be made clear to Participants that signing an attendance sheet does not indicate agreement with everything in the Plan.		
Requirements Document	Section V.I. - Department Review of Changes in Service Plans		We appreciate the Department's decision to eliminate the 25 percent threshold for Department review. The circumstances which will trigger review must be thoughtfully determined with stakeholder input. The Department should also consider whether more detail is needed in this section about what must be included in weekly aggregate reports, to ensure that it receives all of the information needed to track and identify any inappropriate trends.	Pa Council for Independent Living's	

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			The Participant, not the service coordinator, should lead the person-centered planning process. This clarification is critical because a planning process driven by the Participant minimizes the conflict of interest raised by having service coordinators who are employed or contracted by the CHC-MCO. This potential conflict, which is a natural result of incentives built into the system, should be addressed explicitly in the agreement. The service coordinator must maximize the Participant's self- determination (including Participants with diminished capacities) while ensuring that the care provided meets the Participant's needs. Further, the service coordinator must facilitate the use of substituted		

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Requirements Document	Section V.J. - Service Coordination		judgment and supported-decision making when legal representatives are involved. The Participant must be allowed to request a change in service coordinator. CHC-MCOs must also be required to submit and obtain Department approval of plans to monitor the performance of service coordinators. A CHC-MCO must track Participant experience with measures that capture the quality of care coordination. Service coordinators should be independent and not employed by CHC-MCOs to avoid a conflict of interest. Participants need to trust their service coordinator to approve the services they need. A service coordinator employed by the CHC-MCO has mixed loyalties and an incentive not to oppose her employer. Currently, an LTSS recipient's service coordinator has no financial interest in whether her participant receives a service. Eliminating that neutrality undermines the very concept of service coordination. Accordingly, service coordination should be delegated to a third party entity, or CHC-MCOs should be required to contract with non-affiliated service coordination agencies such as Centers for Independent Living or AAAs. Additionally, having CHC-MCOs function as service coordinators inhibits Participant choice. Participants will not want to change service coordinators every time they switch CHC-MCOs. This fact will cause Participants to be reluctant to switch to a plan that may be better for their needs.	Pa Council for Independent Living's	
Requirements Document	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements		Service Coordinators and Service Coordinator supervisors should be independent of, and not employed directly by, the CHC-MCOs to avoid a conflict of interest.	Pa Council for Independent Living's	

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Requirements Document	Section V.L. - Nursing Home Transition		Add (Requirements Document at 44): "The CHC-MCO must ensure that all nursing facility residents are informed at admission and at least annually thereafter, of the availability and meaning of NHT services, and how to request them." Many persons will not express a desire to move to the community if they do not know that leaving is an option, that home and community-based services are available, or that someone is available to help them with housing and other issues.	Pa Council for Independent Living's	
			Because Medicare will be the primary payer for many of the Participant's BH services, the Department must specify how the CHC- MCO and the BH-MCO will coordinate with the Participant's Original Medicare or Medicare Advantage plan. This section (Requirements Document at 44) must include language that acknowledges the vast majority of CHC-MCO Participants will have Medicare as their primary insurance. This section only speaks to the coordination of CHC-MCO and BH-MCOs without acknowledging the Participants' Medicare insurance as primary to these plans. For example, how will the CHC-MCO work on the "development of specific coordination mechanisms to assess and, where appropriate, reduce the use of psychotropic medications prescribed for Participants"? The vast majority of CHC-MCO Participants who will be prescribed psychotropic medications will have	Pa Council for Independent Living's	

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Requirements Document	Section V.M.- Coordination of Services		them paid for by Medicare Part D. How will the CHC-MCO even know their Participant is taking a psychotropic medication or any other medication? These CHC-MCO Program Requirements repeatedly lack acknowledgement of Original Medicare or a Medicare Advantage plan not aligned with the CHC-MCO as the Participant's primary health insurance. It is not possible to meet the state's goals for managed long terms services and supports without recognizing all types of Medicare coverage that a Participant might have.		
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment		Revise the last paragraph (Requirements Document at 46) in this section to read: "The Department will enroll Participants transferring from one CHC zone to another with the same CHC-MCO, provided that the CHC-MCO operates in both CHC zones, unless the Participant chooses to enroll into a different CHC-MCO or to enroll in LIFE in the new zone." Add the CHC-MCO must coordinate with the IEE and county child welfare agencies to ensure that each CHC-eligible young adult with LTSS needs has the opportunity and information to choose a CHC-MCO and is provided a smooth transition from the child welfare system to community based LTSS.	Pa Council for Independent Living's	

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment		V.O.2. CHC-MCO Outreach Materials Under (b) (Requirements Document at 46), the CHC-MCO is allowed to market its companion D-SNP product to its Full Dual Eligible Participants. DHS must approve exactly how the CHC-MCO "markets" its D-SNP product and all the marketing materials the CHC-MCO uses to do this.	Pa Council for Independent Living's	
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment		V.O.6 CHC-MCO Enrollment Procedures The second paragraph (Requirements Document at 50-51) should be revised to add the following sentence: "If u pon enrollment i nto CHC t he Part icipant has designated with the IEE a third party to receive copies of information, notices and other written materials sent by the IEE and the CHC-MCO, the CHC-MCO must honor that designation without requiring a written release from the Participant for the first 180 days of enrollment in the CHC-MCO."	Pa Council for Independent Living's	
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment		V.O.7. Enrollment of Newborns This section (Requirements Document at 51) should be removed as newborns are not included in the CHC target populations.	Pa Council for Independent Living's	
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment		V.O.8 Transitioning Participants Between CHC-MCOs Change the second sentence to read, "Participants should must be assisted by their Service Coordinators…" to mirror the "must" in Section V.O.9 (Requirements Document at 51) when someone transitions from a CHC-MCO to LIFE.	Pa Council for Independent Living's	

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment		V.O.14 New Participant Orientation The CHC-MCO's written policies and procedures for new Participants and written orientation plan or program must also include: * Information that for those Participants on Medicare, the CHC-MCO will pay Medicare deductibles and co-insurance for any Medicare covered service. * Information that the CHC-MCO will pay the Medicare deductibles and co-insurance whether or not the Medicare provider is in their network and whether or not the Medicare provider complied with the CHC's authorization requirements. * Information that the CHC-MCO, its subcontractors and providers cannot balance bill Participants with Medicare for Medicare deductibles and co-insurance * Information that Participants with Medicare have the right to access all Medicare covered services from any Medicare provider they choose. * Information on who qualifies for a Service Coordinator and how the Service Coordinator will coordinate care for dual eligible Participants with Original Medicare, with a Medicare plan not	Pa Council for Independent Living's	

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment		V.O.15 CHC-MCO Identification Cards It seems needlessly cumbersome that the Participant must carry and produce an ACCESS card when they are enrolled in a CHC-MCO. Providers should be able to access EVS and verify Participant eligibility either through the CHC-MCO or EVS. The last sentence (Requirements Document at 55) states that the CHC-MCO must issue a single identification card to Participants enrolled in the aligned D-SNP for both the CHC-MCO and the D-SNP. Although we understand that having one card is easier for consumers, one card cannot be issued because the consumer is in two plans- a D-SNP providing their Medicare coverage, and a CHC-MCO providing their Medicaid and long-term care coverage. Currently, when a dual eligible is enrolled in a D-SNP for Medicare coverage, they must use two cards: the D-SNP ID card AND their ACCESS card for Medicaid coverage when accessing all health care services and the provider must bill each system for its services.	Pa Council for Independent Living's	

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			V.O.16.a rticipant Handbook-Handbook Requirements The Handbook (Requirements Document at 55) must provide clear information to dual eligible members about Medicare and Medicaid, what each insurance covers and what insurance cards must be shown when the Participant is accessing: health services covered by Medicare and the CHC-MCO; health services covered by Medicare and the person's BH-MCO; health services covered only by the CHC-MCO. The Handbook must provide clear information on how a dual eligible Participant's care will be coordinated with Original Medicare, with whatever Medicare Advantage plan the Participant chooses, and with whatever D-SNP plan a Participant chooses	Pa Council for Independent Living's	

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment		The second paragraph states all Handbooks must include a link to the handbook for the aligned D-SNP. There is no reason the state should require or encourage this and the requirement should be deleted as unnecessary and misleading. Participants who are enrolled in the D-SNP will already be getting the D-SNP Handbook and those not enrolled will be confused and mislead by this information and think it applies to them when it does not. V.O.16.b Department Approval The second paragraph (Requirements Document at 56) requiring a reference and a link to the aligned D-SNP Handbook should be deleted for the same reasons noted in section V.O.16.a above		

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment		Provider Directories The Directory (Requirements Document at 56) should clearly state that Participants with Medicare may get their Medicare-covered services from any provider of their choice and that they are not required to go to CHC-MCO network providers for those services. This must be clarified throughout the directory, especially for those providers where Medicare typically pays primary (i.e., hospitals, physicians, diagnostic testing). It also must be clarified that for other services that are not generally covered by Medicare such as dental, however, the Participant is required to use network providers unless the CHC-MCO allows them to use an out-of-network provider. The last paragraph requires the plan to link to their D-SNP provider directory. Again, that requirement should be deleted as unnecessary and misleading for the reasons noted in section V.O.16.a above.	Pa Council for Independent Living's	

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Requirements Document	Section V.O. - Participant Enrollment & Disenrollment		Involuntary Disenrollment The second paragraph (Requirements Document at 58) in this section should be included in the previous section as well. It seems the only involuntary disenrollment of a CHC-MCO member would arise from that individual no longer qualifying for Medicaid since the CHC-MCO is prohibited from involuntarily disenrolling members. Therefore, the second paragraph in this section should be revised to say, "In situations where a CHC-MCO is disenrolled because they no longer qualify for Medicaid benefits, the Service Coordinator…"	Pa Council for Independent Living's	
Requirements Document	Section V.O. - Participant Enrollment & Disenrollment		Participant Services (Requirements Document at 58-59) must include explaining to dual eligible Participants: how they access Medicare covered services; their right to obtain these services from any provider they choose whether or not the provider is in the CHC-MCO's network; that the CHC-MCO will pay the Medicare deductibles and co- insurance to the Medicare provider; and that the CHC-MCO's subcontractors and providers cannot balance bill the Participant for Medicare deductibles or co-insurance.	Pa Council for Independent Living's	

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Requirements Document	Section V.P. - Participant Services		V.P.2 CHC-MCO Internal Participant Dedicated Hotline The list of topics the Hotline staff (Requirements Document at 59- 60) must be trained in must also include: Medicare covered services and to address questions that relate to Original Medicare, to the Participant's Medicare Advantage Plan (both when it is and is not affiliated with the CHC-MCO); the dual eligible Participant's right to access Medicare–covered services from the provider of their choice, whether or not the provider is in the CHC-MCO network; and, that the dual eligible Participant may not be balance billed for Medicare deductibles or co-insurance.	Pa Council for Independent Living's	

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Requirements Document	Section V.P. - Participant Services		The sentence in the first paragraph (Requirements Document at 61) that states: "The CHC-MCO should also provide information about its aligned D-SNP including the services covered, the enhanced Service Coordination available to those enrolled in both, and how to request enrollment" should be deleted as unnecessary and misleading. Dual eligible Participants have the right to access their Medicare services however they choose and they have several options. We see no reason for the Department to encourage the CHC-MCO to provide information only on one option and not the others. It is misleading to imply that the CHC-MCO will provide "enhanced service coordination" for some Participants and not others. (See Exhibit DD Member Handbook, #55 that specifies Participants are free to exercise their rights [which includes their choice of how they receive their Medicare coverage] and the services and treatment of Participants by the CHC-MCO must be the same regardless). Without any information about Service Coordination requirements related to D-SNPs, Original Medicare, or other Medicare Advantage plans, it is not clear that individuals who have coverage through a CHC-MCO's corresponding D- SNP will have enhanced service coordination.	Pa Council for Independent Living's	

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Requirements Document			We are pleased to see this included (Requirements Document at 61); however, we urge the Department to allow Participants the right to designate individuals to receive copies of information, notices and other written materials and to allow them to do this in the least burdensome way for them. We understand the need to maintain confidentiality; however, we are concerned about Participants who may not be physically able to sign a release form and who may not have a third party with legal authority to make the request. Suggested ways to allow someone to designate a third party to receive information as well as receive information to help the person navigate the insurance system include: asking for a designated person as part of enrollment process; or taking a recorded verbal statement from the individual. CHC-Participants, especially older adults, should be able to designate a second party to receive the notices and information the Participant receives from the CHC-MCO. All CHC-MCOs should honor the designation. Welcome calls from CHC-MCOs to members should encourage designating a second party if a member has not yet done so. For seniors already enrolled in an OLTL waiver at the time of their enrollment into Community Health Choices, the person's primary	Pa Council for Independent Living's	

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Requirements Document	Section V.R. - Participant Complaint, Grievance & DHS Fair Hearing Process		This section (Requirements Document at 61-63) recognizes that CHC-MCOs must use state templates to inform CHC-Participants about service denial decisions and the process to challenge those decisions. We strongly urge additional language both here and in other sections (i.e., Participant Handbooks and Provider Manuals) that CHC-MCOs that deny any Participant services must inform him or her that free legal help with complaints, grievances, and Fair Hearings is available. In the HealthChoices system the Pennsylvania Health Law Project and the Pennsylvania Legal Aid Network provide such help. See Exhibit N(1) of the PH-HealthChoices Agreement proscribing the format of the Standard Denial Notice. See also our comments below about Exhibit GG - Complaints, Grievances and Fair Hearings.	Pa Council for Independent Living's	

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			The Behavioral Health Coordinator should be a full-time position. At the end of the list (Requirements Document at 65-68) of BH Coordinator functions this sentence should be added: "The CHC-MCO must detail how it will fulfill the identified primary functions of the Behavi oral Healt h Coordi nat or". This section lists out administrative functions that the CHC-MCO must provide for including Behavioral Health Coordinator, Director of Service Coordination, a Government Liaison, and Participant Services Manager. We'd recommend including a Medicare liaison or similar type position that would be responsible for overseeing the plans interaction with Medicare for its members. This person would also be responsible for overseeing plan's communications regarding dual eligibles, developing and providing training for CHC-MCO	Pa Council for Independent Living's	

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Requirements Document			staff and providers, and resolving problems that arise for dual eligible members. Care Coordination Manager (or similar title) also seems to be missing from the list of required functions. Perhaps this function could include responsibilities related to dealing with care coordination between the member's Medicare coverage and CHC-MCO plan as well as troubleshooting any problem that arises for a dual eligible related to their coverage. In previous comments to V.A.17, we recommended that the CHC- MCO have a designated NH unit and care managers to help Participants with nursing facility service issues and we reiterate that recommendation here. We also recommend that a Manager of this unit be added to the list of administrative components.		
Requirements Document	Section V.X.- Administration		The CHC-MCOs should have an administrative office within each zone in which they operate and the Department should not grant exceptions to this requirement	Pa Council for Independent Living's	
Requirements Document	Section V.X.- Administration		It must be clarified that the CHC-MCO's Recipient Lock In Program may not be imposed on any Participant who has Medicare and Medicaid.	Pa Council for Independent Living's	

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Requirements Document	Section V.AA. - Selection & Assignment of PCPs	82-84	This entire section (Requirements Document at 82-84) lacks any reference to individuals who have Medicare aside from the sentence that discusses assigning individuals to a PCP that the person uses in the aligned D-SNP, if applicable. The individual's Medicare coverage (especially if they have Original Medicare) may not have any requirement about needing a PCP. Since Medicare is someone's primary coverage, it is the rules for that coverage that determines whether a PCP is needed, and whether any referrals are needed in order for services to be covered. Having a CHC-MCO PCP cannot restrict a Medicare beneficiary's ability to see any provider that accepts their Medicare coverage. Information about how this will work for people on Medicare (especially in Original Medicare or in a Medicare Advantage plan that is not a D-SNP aligned with the CHC-MCO) is needed throughout this entire section.	Pa Council for Independent Living's	

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			This section (Requirements Document at 84-85) should clarify who gets service coordination services. Is it only people who are determined to need LTSS? Others? All members? The second bullet in this section discusses timeframes for contact with a Participant in need of service coordination. What happens if someone has a service plan in place prior to joining the CHC-MCO (either because they have been receiving Waiver services prior to start of CHC or as a result of receiving LTSS from one CHC-MCO and then switching to a different plan)? Per continuity of care rules, services must stay in place for 180 days at outset of program and then		

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			place for 180 days at outset of program and then for 60 days after that. The third bullet in this section discusses automatic assignment of a service coordinator and discusses what factors to consider when making this auto-assignment including the person assigned to the Participant for care management in the CHC-MCO's aligned D-SNP. This seems problematic for a number of reasons including: 1) not everyone in a D-SNP may have an assigned care manager 2) care management is different than service coordination. We recommend removing this language. If this language is included in the final program requirements however, then some explanation of why this is a factor should be included. The list of factors should include the person who provided service coordination services in the past, if relevant. The fifth bullet requires the CHC-MCO to promptly grant a request to change the service coordinator selection if the Participant requests this change after the initial visit. Does this mean that someone cannot choose to change his or her Service Coordinator at any time? The following bullet seems to indicate that people can request a change at any time. Participants should be able to change their Service	Pa Council for Independent Living's	

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Requirements Document	Section V.BB. - Selection & Assignment of Service Coordinators	84-85	Coordinator at any time, and CHC-MCO must promptly grant the request (as is currently allowed by the OLTL Waiver programs). The initial visit language should be removed. We encourage the Department to provide a timeframe (referenced in the 6th and final bullet) for when the change must be processed by the CHC-MCO's. "In a timely manner" is too vague. We suggest within 14 days or whatever the current expectation is now under the current OLTL Waiver programs. People should have the option to select an out of network option for service coordination if they can show that the in-network options cannot meet their needs.		
Requirements Document	Section V.CC. - Provider Services		We recommend adding (Requirements Document at 85) under provider service functions: "assisting providers with questions related to dual eligibility, including Medicare balance billing protections that exist."	Pa Council for Independent Living's	
Requirements Document	Section V.CC. - Provider Services	86-88	In general, provider training (Requirements Document at 86-88) should include information about dual eligibility and how Medicaid works when someone has Original Medicare, a Medicare Advantage Plan not aligned with the CHC-MCO, and the aligned D-SNP as their primary insurance. Information should also include the Medicare balance billing rules that apply.	Pa Council for Independent Living's	
Requirements Document	Section V.DD. - Provider Network	88-89	Revise the third paragraph (Requirements Document at 88-89) to read, "This requirement will remain in effect for HCBS providers and Nursing Facilities for the first year that CHC is operational in each zone."	Pa Council for Independent Living's	

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Requirements Document	Section V.DD. - Provider Network	90-91	This section (Requirements Document at 90-91) needs to include reference to Medicare and what is expected of a CHC-MCO primary care practitioner for members who have Medicare as their primary insurance. This should include information about when people have Original Medicare (and therefore no PCP on the Medicare side) as well as when people have Medicare Advantage plans not aligned with the CHC-MCO where the PCP through that plan might be different than the CHC-MCO PCP.	Pa Council for Independent Living's	
Requirements Document	Section V.EE. - QM & UM Program Requirements		CHC Needs Policies and Practices That Allow Participants to Give Verbal Authorization for CHC-MCOs To Talk To A Second Party (e.g., Adult Children, Or Their Caregiver Or Other Advocate) CHC-Participants, especially older adults, should be able to designate a second party to receive the notices and information the Participant receives from the CHC-MCO. All CHC-MCOs should honor the designation. Welcome calls from CHC-MCOs to members should encourage designating a second party if a member has not yet done so. For seniors already enrolled in an OLTL waiver at the time of their enrollment into Community Health Choices, the person's primary caregiver should be recorded and that person be allowed to act for the senior regarding contacts with their CHC-MCO, and for filing appeals, without being required to file formal legal paperwork.	Pa Council for Independent Living's	

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			Exhibit C - Requirements for Provider Terminations 1.B. Continuity of Care There should be information included here (Requirements Document at Exhibit C) about the 180 timeframe immediately following the implementation of CHC in each region (including dates here would be helpful-for example, if SW PA starts 1/1/2017, then until 6/30, the timeframe for continuity of care is 180 days. After this date, the 60-day rules should apply). This section should include information about how dual eligibles may be impacted by provider terminations such as the fact that the person may be able to continue to see a provider who accepts their Medicare coverage. Language		

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Requirements Document Exhibit	C - Requirements for Provider Terminations		accepts their Medicare coverage. Language included in our beginning General Comments from an earlier HealthChoices PH Agreement about the Financial Responsibility for Dual Eligibles should be included to clarify that the CHC-MCO is responsible for paying a non-network provider as secondary coverage when the provider accepts the person's Medicare and the Medicare covers a service.. Also, templates should include language about "If you have Medicare..." Department of Human Services Addendum to Standard Contract Terms and Conditions B. Confidentiality This section requires written consent of Participant for information to be disclosed. However, CHC needs policies and practices that allow Participants to give verbal authorization for CHC-MCOs to talk to a second party (e.g., adult children, or their caregiver or other advocate). CHC-Participants, especially older adults, should be able to designate a second party to receive the notices and information the Participant receives from the CHC-MCO. All CHC-MCOs should honor the designation. Welcome calls from CHC-MCOs to members should encourage designating a second party if a member has not yet done so. For seniors already enrolled in an OLTL waiver at the time of their enrollment into Community Health Choices, the person's primary caregiver should be recorded and that person be allowed to act for the senior regarding contacts with their CHC-MCO, and for filing appeals, without being required to file formal legal paperwork.	Pa Council for Independent Living's	
Requirements Document Exhibit	K - Emergency Services		Exhibit K - Emergency Services This section (Requirements Document at Exhibit K) needs to reference Medicare; specifically, that the CHC-MCO is required to pay as secondary payer when a member's Medicare coverage has paid for Emergency Services. Again, language from previous HealthChoices PH Agreement regarding Financial Responsibility for Dual Eligibles would be helpful to include here.	Pa Council for Independent Living's	

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Requirements Document Exhibit	L - Medical Assistance Transportation Program		Exhibit L - MATP MATP is instructed to contact the CHC-MCO for verification that a Medical Assistance covered service. If the MATP needs to verify that the service is covered by Medicare and needs assistance doing that, the CHC-MCO must help get this information as part of its responsibility to coordinate care for its members.	Pa Council for Independent Living's	
Requirements Document Exhibit	X - Guidelines for Adverstising, Sponsorship & Outreach		Exhibit X – Community HealthChoices CHC – MCO Guidelines for Advertising, Sponsorship & Outreach II.B.3. Criteria for Review of CHC-MCO Outreach Materials This section (Requirements Document at Exhibit X) should include a reference to ensure that outreach materials do not lead someone to believe that they must enroll in the aligned D-SNP in order to get the CHC-MCO coverage, or that enrolling them in the aligned D- SNP will provide them with vastly superior benefits than if they chose other Medicare choices for coverage. A sentence should be added to say "In addition, outreach materials cannot include statements or assertions that a dual eligible Participant must enroll in the plan's aligned D-SNP as a condition of CHC-MCO enrollment or to receive better benefits from the CHC-MCO".	Pa Council for Independent Living's	

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			Exhibit DD – CHC-MCO Participant Handbook The handbook (Requirements Document at Exhibit DD) should include information for dual eligibles about how the CHC-MCO works with Medicare and there should be references to: Original Medicare, Aligned D-SNP, and other Medicare Advantage plan. CHC-MCOs should provide clear written information to their members about the two insurances (Medicare and Medicaid), who cover which services, and what insurance cards must be shown when accessing health care services. For example: "If you need to go to the dentist, this is not a Medicare-covered service and you will need to use your (CHC-MCO's) card to pay for those services and go to a dentist within the network of your CHC-MCO". Under 2, the Role of PCP in directing and managing care and as a Participant Advocate should include additional language: in situations where person has Medicare as well as when they do not. Under 7, it should be revised to say that no	Pa Council for Independent Living's	

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Requirements Document Exhibit	DD - Participant Handbook		Medicare or Medicaid balance billing is allowed. Under 9, it must be clarified that full dual eligibles must get their prescription meds through Part D. In addition, reorder the bullets describing the exceptions so that the bullet that is currently second (non-network provider is the Participant's Medicare providers) is moved to be the first bullet (and move the current first bullet about arrangements approved in advance or prior authorization given to be the second bullet). Under 32, the handbook should also specifically state that the CHC-MCO must arrange non-emergency transportation through the MATP for urgent care appointments upon request of the Participant. Under 35, this should include a reference to someone on Medicare needing to get prescription drug coverage through Medicare Part D. Refer people to APPRISE or other resource for help. Under 41, this should include reference to Medicare. Language from past HealthChoices agreement regarding financial responsibility for Dual Eligibles could be used here. See General Comment #2. Under 55, clarify that each participant is free to choose how they get their Medicare coverage (Original, any D-SNP, any other Medicare Advantage Plan) and what provider they use to access Medicare services. Language should also be included that those choices won't adversely affect their treatment or services thru the CHC-MCO.		

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			Exhibit GG - Complaints, Grievances and Fair Hearings We are pleased that this section (Requirements Document at Exhibit GG) mirrors the process and protections currently in PH- HealthChoices. We have the following suggestions: 1. The General Requirements Section should include, "The CHC-MCO must allow anyone the Participant requests to participate in a complaint or grievance meeting on their behalf. Participants can provide this information verbally to the plan." 2. The General Requirements Section should also specify "CHC-MCOs are required to use a standard denial notice for any service or item being reduced, changed, or denied." See Exhibit N(1) of the PH- HealthChoices Agreement proscribing the format of the Standard Denial Notice. 3. Moreover, a Participant denied a service by a		

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			CHC-MCO or its contractor must be informed in writing that they may obtain free legal help with complaints, grievances, and Fair Hearings. In HealthChoices, free legal help is available from either the Pennsylvania Health Law Project or the Pennsylvania Legal Aid Network and denial notices include contact information for both organizations. Participant access to legal representation provides a level playing field in the appeal process, which will result in fairer adjudications, and fair adjudications benefit all concerned. Research shows (and PHLP's experience in the HealthChoices system bears out) that Participants are much more successful in appealing service denials when they receive expert guidance. Medicaid fair hearings are formal appeals to an Administrative Law Judge (ALJ) where the rules of evidence and the right to cross-examine (and be cross examined) apply. Insurers usually have an attorney represent them at these hearings. Consequently, Participants unfamiliar with the rules of evidence and subject to cross examination by an Insurer's attorney, are often intimidated and struggle with arguing their position. Furthermore, Participants and families often have a high level of emotional involvement that can impede the concise and logical	Pa Council for Independent Living's	

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Requirements Document Exhibit	GG - Complaint, Grievance & DHS Fair Hearing Processes		can impede the concise and logical presentation of their appeal. Representatives who understand rules of due process, who know the rules of the insurance programs and who know how to obtain evidence that proves the Participant's need for a service or treatment can clarify the issues and focus the testimony on the relevant issues. This reduces confusion and gives the Administrative Law Judge a clearer picture of the grounds for the appeal and the relevant supporting evidence. Individuals with the best set of facts to overturn a service denial are often overwhelmed by appeals given the myriad of other concerns they are balancing. Many feel they need to "pick their battles". Legal representation increases the number of Participants able and willing to exercise their appeal rights. 4. We urge the Department to form a "Complaint, Grievances and Appeals Workgroup" that 1) reviews future and current OLTL policies, procedures and resources in this area and 2) suggests additional pathways to help CHC Participants seeking to challenge service denials by either Community HealthChoices or Medicare		

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Requirements Document Exhibit	PP - Provider Manuals		Exhibit PP - Provider Manuals E. Should include information pertaining to when someone has Medicare (Original Medicare, Medicare Advantage Plan not aligned with CHC-MCO, and aligned D-SNP) and when they do not. F. Should include information for people who have Medicare (Original Medicare, Medicare Advantage Plan not aligned with CHC-MCO, and aligned D-SNP). I. Should include information explaining how dual eligibles access drug coverage, including use of Part D and resources for help for duals who need help (i.e., APPRISE). Information should include a description of dual eligibles and how their coverage works, including information about the Medicare Balance Billing protections that apply. AA-school-based/school-linked services in CHC zone-needed? Should be very minimal if included BB. Explanation of Recipient Restriction Program should reference how the program would work (or if it could or could not work) for people with Medicare.	Pa Council for Independent Living's	

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Requirements Document Exhibit	AAA - Provider Network Composition/Service Access		Exhibit AAA - Provider Networks: Network Composition i. Rehabilitation Facilities Rehabilitation is something many in the CHC target population are likely to need at some point and assuring choice and close access to providers is critical. Requiring the CHC-MCO to only have 1 Rehabilitation Facility within the zone is totally inadequate and gives Participants no choice of providers for this service. The standard should be changed to ensure a choice of at least 2 providers who are accepting new patients within the travel time limits (30 minutes urban, 60 minutes rural) There must be specific Nursing Facility network standards. At minimum, the CHC's network must include at least one facility in each county in the zone.	Pa Council for Independent Living's	

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			Exhibit BBB – Pharmacy Services 5. Provider and Participant Notification Add a sentence at the end of (a) which states: "This notification must also be issued to the psychiatrists in the BH-MCOs." Additional general comment: We encourage the Department to consider allowing CHC-MCOs to offer LTSS to people who have chosen to live in a Personal Care Home (PCH). In many cases, individuals who reside in a PCH are forced to go into a nursing home when their health declines and their needs increase beyond what the PCH can provide. Offering LTSS in these situations can prevent this and allow individuals to age in place, if this is the preference of the Participant. Of course, there are numerous protections that must be in place should the Department allow this to ensure that Participants are not forced into a Personal Care Home, or forced to stay in a PCH when they want to leave, or to stay in a PCH that provides poor quality care, as well as policies and procedures to prevent the CHC-MCO from covering services that a PCH should already be providing to a resident.	Pa Council for Independent Living's	

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Requirements Document Exhibit	BBB - Pharmacy Services		We appreciate the Department's including Assisted Living among the covered services (Exhibit DDD) although the information included is unclear and needs clarified. Will CHC-MCOs help pay for people to be in Assisted Living Residences, if they choose to live in one, that then furnish the range of services listed? Or, will CHC-MCOs pay for additional services beyond what the Assisted Living Residence provides? Or something else? The reality is that there are few licensed Assisted Living Residences in Pennsylvania and these residences are typically unaffordable for the dual eligible population. Furthermore, protections, including those noted in the previous paragraph, are needed should CHC allow for people living in Assisted Living Residences to receive services or housing support from CHC-MCOs.		
RFP	General Information	I-13	The Department encourages … all MCO's to make a significant commitment to use small diverse businesses as subcontractors and suppliers.	I think it is important to keep getting health care supplies from people I know and trust. The local small businesses I have dealth with for years. I don't want to see them go out of business.	Participant / Delores Cunningham
RFP	Proposal Requirements	II-4 B	… one-third of the board's membership must be "subscribers" of the CHC-MCO.	The MCO should be required to have people receiving services on their governing board at all times.	Participant / Delores Cunningham
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 6	… a Person-centered planning team approach…	As a participant I want to be included in the meetings and have anyone I want with me for support. I want to make sure I get a copy of my plan in writing.	Participant / Delores Cunningham
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 7	… Participants' needs, goals, and preferences are at the center of the process.	The Team should have final say regarding the services that are best for and preferred by the client. The plan should not be vetoed by the MCO for monetary reasons.	Participant / Delores Cunningham
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 20	Describe how you will consider feedback from your participant advisory committee into your operations and policies.	It is important to know that people who are being served have a voice about what is happening in the day to day services.	Participant / Delores Cunningham
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 30	Describe your process for establishing caseloads for service coordinators.	My SC always looks overworked. If they didn't have too many people on their caseload they would have more time for me. The MCO should be mandated to limit the SC caseload numbers to no more than 30 clients in any program /service.	Participant / Delores Cunningham

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RFP	Work Statement Questionnaire	Service Integration 4	Describe your plan to …improve collaboration across all participant's providers including those that are not part of the CHC-MCO network.	I need to know that I can choose any agency I want for my services.	Participant / Delores Cunningham
RFP	Work Statement Questionnaire	Quality Improvement and Performance Measures 1	Describe your strategy for achieving quality performance and outcomes.	It is important for the department to make one statewide quality program that all MCOs and providers follow. There needs to be more quality and performance measures recorded for home care services because sometimes the service could be better and I think this will help.	Participant / Delores Cunningham
				Redacted	Redacted
RFP	Work Statement Questionnaire	Management Information Systems 20	Describe your system for providing access to all network providers to enrollment, service coordinator contact, and service plan information.	It is important for me to know that my SC knows what services I need and the home health agency. The MCO should not be the SC organization or it would be more difficult for me to get the services I need.	Participant / Delores Cunningham
RFP	Work Statement	Goal 4	Advance program innovation … enhance the LTSS direct care workforce…	The LTSS direct care workforce does not get paid enough. I constantly have to put up with turnover of people giving me care. I don't like getting used to new people all the time. Sometimes a good person works with me and then goes to get another job because the pay is too low.	Participant / Delores Cunningham
RFP	General Information	I-5	The Department will implement a Pay for Performance Incentive to CHC-MCOs … and may implement additional Pay for Performance Incentives in later years.	How will the Pay for Performance Incentives be passed down to the provider who is providing the quality services?	Acme Providers Inc. / Kathie Hoffer
RFP	General Information	I-12	Offerors should not include any costing information in the Technical Submittal.	Why is the Department not requesting or allowing costing information to gain more useful information.	Acme Providers Inc. / Kathie Hoffer
RFP	General Information	I-13	The Department encourages … all MCO's to make a significant commitment to use small diverse businesses as subcontractors and suppliers.	MCO's should also use small business providers. It is important to keep this focus on protecting small businesses because MCOs could easily put a small business out of business by taking only a few consumers away.	Acme Providers Inc. / Kathie Hoffer
RFP	General Information	I-13	The Department encourages … all MCO's to make a significant commitment to use small diverse businesses as subcontractors and suppliers.	It is important that small business providers will be utilized by an MCO and not discharged because of not making the MCO enough profits.	Acme Providers Inc. / Kathie Hoffer
RFP	General Information	I-14	The CPP … wants to maximize the recruitment, hiring, and retention of those individuals (receiving TANF) by Commonwealth contractors, subcontractors, providers, and grantees. The CPP requires entities entering into agreements with the Department make a commitment to fill vacancies and new positions with TANF individuals.	This RFP should not require that providers / subcontractors of MCOs hire people with TANF first in order to fulfill the MCOs responsibility to meet this goal.	Acme Providers Inc. / Kathie Hoffer

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RFP	General Information	I-23	Prior to the enrollemnt of any individuals in a CHC-MCO, the Department will conduct a readiness review. …At its discretion, the Department may commence monitoring before the effective or operational dates of the agreement, and before the formal readiness review period.	The Department should not rush past any Readiness Review process in place in order to make agreements and skip this important quality measure.	Acme Providers Inc. / Kathie Hoffer
RFP	General Information	I-24	For CHC-MCO's approved to operate in multiple zones, the Department and the CHC-MCO will excecute a separate agreement for each zone in which the CHC-MCO is approved.	The separate agreements should not facilitate contracts with disparate rates and payment differences for different zones.	Acme Providers Inc. / Kathie Hoffer
RFP	General Information	I-28	Technology standards. Unless DHS, in its sole discretion, determines that it would be in the best interest of the Commonwealth to waive the pertinent ITP or Business and Technical Standard.	All MCOs should have to at minimum follow the established standards instead of have that requirement waived.	Acme Providers Inc. / Kathie Hoffer
RFP	Proposal Requirements	II-4	For those (personnel) functions, an Offeror may propose to combine functions or split the responsibility across multiple CHC zones, as long as it can demonstrate that the duties of the function will be ccarried out.	It will be difficult for providers to have personnel functions in zones far from their business location if they are not able to access the location easily.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 3	… screening for needs, conducting assessments and reassessments, and using or developing new tools and systems to support these processes.	The Department needs to continue using 1 assessment of their choice and reassessment tools. If every MCO uses different assessment tools that will cause much confusion for providers to learn many different assessment tools. The current ones could be improved. Also the assessment timelines and due dates should be the same statewide so all MCOs have equivalent expectations and services will not be interrupted because of different MCO timelines. For example yearly assessments should be the same date for a client every year. The assessment should be due 30 days (or applicable number of days) before that date. This should be the same for every MCO so that if a client changes MCOs 45 days before their yearly and the new MCO requires the assessment 60 days before, the provider is already out of compliance.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 7	… Participants' needs, goals, and preferences are at the center of the process.	The Team should have final say regarding the services that are best for and preferred by the client. The plan should not be vetoed by the MCO for monetary reasons.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 14	Describe how you encourage provider usage and exchange of interoperable health information, electronic service plans, and how you will develop and implement innovations to use these records to promote better coordination…	The MCO should have to allow the provider to use whatever electronic health record and client record software they currently have in practice. If each MCO has a different requirement and the client chooses a different MCO then the provider would have to restructure often and it would reduce quality. A statewide suggested platform would create more uniformity and quality of service.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 15	Describe your approach to utilization management…	The utilization review process must be simple for new providers to be able to report to MCOs. The processes should be the same state wide to avoid issues with switching between MCOs.	Acme Providers Inc. / Kathie Hoffer

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RFP	Work Statement Questionnaire	Participant Service and Care Coordination 22	Describe your approach for training staff and providers in the submission and review of letters of medical necessity…	All information should be standardized statewide and be submitted from the provider to the Department so the Department can issue this paperwork to all MCOs. This would avoid multiple resubmissions by providers to each MCO, saving time and enhancing continuity of care, and enhanced quality.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 25	Describe your approach for authorizing LTSS services in accordance with the requirements of 1915(c) waivers.	The OBRA waiver implemented in 2013 required unlicensed facilities (less than 3 people) serving people with other related conditions (ORC) to be CARF accredited. That accreditation does not coincide well with the judgement of quality residential practices. The MCO and other Department surveys and inspections are a better indicator of quality services. The CARF requirement should be rescinded. If an accreditation is required it should be the same statewide for all providers of all types of services.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 27	Describe the procedures and processes you have in place to ensure continuity of care to ensure smooth transitions for Participants transitioning between service delivery systems…	There must be one informational clearinghouse which lists all the information of paired clients and MCOs and it must be accessisble to the provider. This would enable the provider to know which date the client switched MCOs to provide cleaner billing. This will help with continuity of care.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Service Integration 4	Describe your plan to …improve collaboration across all participant's providers including those that are not part of the CHC-MCO network.	It is vital that out of network providers are a priority of the MCO because the client can and will switch at any time and in return a provider will find themselves an out of network provider. The MCO must make it easy and quick to become an in network provider or risk putting providers out of business because of reduced rates.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Service Integration 6	Describe how your plan will ensure that eligible individuals have Medicare Part D coverage.	The department should provide a statewide information bank that lists all client coverage and is available for access by Providers and MCOs.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Service Integration 10	Describe your experience and approach in coordination among physical health, behavioral health, and LTSS.	This component is critical for long term well being. At this time it is not well integrated or easy to achieve interworking components of these three needs.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Quality Improvement and Performance Measures 1	Describe your strategy for achieving quality performance and outcomes.	The department should assign one statewide quality program that all MCOs and providers follow.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Management Information Systems 5	Explain your process for subcontractors to meet the same MIS requirements … including incentives and assessments that are utilized.	All MCOs should pay providers incentives if they meet management standards. If the MCOs are not using the same management and quality assessments then a copy of each MCOs assessment must be made available in one location for all providers to access in order to stay informed.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Management Information Systems 5	Describe how you will verify that providers … submit timely data… including frequency of verification.	All MCOs should be required to have the same frequency schedule and reporting dates so providers have consistency in reporting standards across MCOs.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Management Information Systems 14	Explain your process for maintaining your provider file …	This provider information should be maintained by the Department. Billing should still be done through PROMISe. Having to maintain information with multiple different MCOs will require a great deal of provider time just for this process.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Management Information Systems 16	Describe your plan to comply with the standards for claims timeliness and the timely and correct payment of providers…what dates will be used.	All MCO's should have the same standards for timely payment of providers. They should also use the same definitions of payment processing dates. Specifically how they will be measured and the dates used should be the same statewide.	Acme Providers Inc. / Kathie Hoffer

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RFP	Work Statement Questionnaire	Management Information Systems 20	Describe your system for providing access to all network providers to enrollment, service coordinator contact, and service plan information.	The MCO should not be the SCO organization. It is imperative that the provider have access to service plan information. The SC needs access to all plan information also.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Provider Network Composition 1	… (bullet 3) Describe how you will enroll any current willing and qualified HCBS, …LTSS providers into your network.	There should be primary requirements that are the same between all MCOs state wide for enrollment.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement Questionnaire	Provider Network Composition 2	… Explain the circumstances that would result in providers not being approved to participate in your network.	The Department should have a definitive process in place to detail why a provider is not approved to participate. It should be the same across all MCOs. The Department should also have an appeal process for unjustified grievances regarding disapprovals and other issues.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement	Goal 4	Advance program innovation … enhance the LTSS direct care workforce…	In order to enhance the LTSS direct care workforce there will have to be better pay rates for staff. They are currently undre paid and that is one reason for the lack of quality workers recruited and poor retention which translates to poor quality services.	Acme Providers Inc. / Kathie Hoffer
RFP	Work Statement	IV-4 Agreement Requirements - Small Diverse Business Participation	All agreements containing SDB participation …	The MCOs should be incentivised to contract with SDBs that are headquartered / located in Pennslyvania.	Acme Providers Inc. / Kathie Hoffer
RFP	General Information	I-4	May include additional populations	What additional populations may be served in the future?	Acme Providers Inc. / Justina Cunningham
RFP	General Information	I-5	This RFP does not require a cost proposal. The Department's actuary will provide to the Department a set of actuarially sound rate ranges for the calendar year. … (Link)	It would be more actuarially sound with actual cost reporting and a viable link to check the historical data of the department. How does the Department know the costs of the provider and determine what type of rate the provider will be paid?	Acme Providers Inc. / Justina Cunningham
RFP	General Information	I-5	The Department will implement a Pay for Performance Incentive to CHC-MCOs … and may implement additional Pay for Performance Incentives in later years.	How will the Pay for Performance Incentives be passed down to the provider who is providing the quality services?	Acme Providers Inc. / Justina Cunningham
RFP	General Information	I-12	Offerors should not include any costing information in the Technical Submittal.	Why is the Department not requesting or allowing costing information to gain more useful information.	Acme Providers Inc. / Justina Cunningham
RFP	General Information	I-13	The Department encourages … all MCO's to make a significant commitment to use small diverse businesses as subcontractors and suppliers.	It is important to keep this focus on protecting small businesses because MCOs could easily put a small business out of business by taking only a few consumers away.	Acme Providers Inc. / Justina Cunningham
RFP	General Information	I-13	The Department encourages … all MCO's to make a significant commitment to use small diverse businesses as subcontractors and suppliers.	Since the provider will be a subcontractor of the MCO does that mean that we are not responsible for …	Acme Providers Inc. / Justina Cunningham

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RFP	General Information	I-14	The CPP … wants to maximize the recruitment, hiring, and retention of those individuals (receiving TANF) by Commonwealth contractors, subcontractors, providers, and grantees. The CPP requires entities entering into agreements with the Department make a commitment to fill vacancies and new positions with TANF individuals.	This RFP should not require that providers / subcontractors of MCOs hire people with TANF first in order to fulfill the MCOsresponsibility to meet this goal.	Acme Providers Inc. / Justina Cunningham
RFP	General Information	I-23	Prior to the enrollemnt of any individuals in a CHC-MCO, the Department will conduct a readiness review. …At its discretion, the Department may commence monitoring before the effective or operational dates of the agreement, and before the formal readiness review period.	The Department should not rush past any Readiness Review process in place in order to make agreements and skip this important quality measure.	Acme Providers Inc. / Justina Cunningham
RFP	General Information	I-24	For CHC-MCO's approved to operate in multiple zones, the Department and the CHC-MCO will excecute a separate agreement for each zone in which the CHC-MCO is approved.	The separate agreements should not facilitate contracts with disparate rates and payment differences for different zones.	Acme Providers Inc. / Justina Cunningham
RFP	General Information	I-28	Technology standards. Unless DHS, in its sole discretion, determines that it would be in the best interest of the Commonwealth to waive the pertinent ITP or Business and Technical Standard.	All MCOs should have to at minimum follow the established standards instead of have that requirement waived.	Acme Providers Inc. / Justina Cunningham
RFP	Proposal Requirements	II-4	For those (personnel) functions, an Offeror may propose to combine functions or split the responsibility across multiple CHC zones, as long as it can demonstrate that the duties of the function will be ccarried out.	It will be difficult for providers to have personnel functions in zones far from their business location if they are not able to access the location easily.	Acme Providers Inc. / Justina Cunningham
RFP	Proposal Requirements	II-4 B	… one-third of the board's membership must be "subscribers" of the CHC-MCO.	The MCO should be required to continue to have at least that many subscribers on their governing board at all times.	Acme Providers Inc. / Justina Cunningham
RFP	Proposal Requirements	II-5	Offerors new to MA managed care in PA should … describe how they would adapt their current lines of business to the CHC Program.	The MCO should also be required to understand the function and process of how the Pennsylvania system has worked and functioned prior to the CHC Program. And work within precedent of The Deparment of Health past services.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 3	… screening for needs, conducting assessments and reassessments, and using or developing new tools and systems to support these processes.	The Department needs to continue using 1 assessment of their choice and reassessment tools. If every MCO uses different assessment tools that will cause much confusion for providers to learn many different assessment tools. The current ones could be improved. Also the assessment timelines and due dates should be the same statewide so all MCOs have equivalent expectations and services will not be interrupted because of different MCO timelines. For example yearly assessments should be the same date for a client every year. The assessment should be due 30 days (or applicable number of days) before that date. This should be the same for every MCO so that if a client changes MCOs 45 days before their yearly and the new MCO requires the assessment 60 days before, the provider is already out of compliance.	Acme Providers Inc. / Justina Cunningham

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RFP	Work Statement Questionnaire	Participant Service and Care Coordination 6	… a Person-centered planning team approach…	The client must be included in the meeting as stated. The provider must be included in this team and receive information as freely as the client. At this time the Department does not give the provider a copy of the Individual Service Plan that the provider is required to implement.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 7	… Participants' needs, goals, and preferences are at the center of the process.	The Team should have final say regarding the services that are best for and preferred by the client. The plan should not be vetoed by the MCO for monetary reasons.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 9	…1. Expand access to community-based integrated employment. 2. Develop the LTSS direct service workforce. 3. Expand use of technology among LTSS providers.	1. Expanding community-based integrated employment will cost additional money for additional 1:1 supports. Make sure the MCO is willing to spend enough much money to make it work safely for the client. Also the MCO should work with existing workshops and transitional work programs to address needs of clients who do not prefer or are not ready to work independently in the community. 2. There are many good educational opportunities already in existance for the development of the LTSS workers is already. PA has done a good job making sure there is access and subsidized Elsevier College of Direct Support, My Learning Center, HCQU etc. We do not need MCOs to create their own and require different trainings. 3. The Department should have a standard requirement of trainings not changed by each different MCO. If each MCO expects different training curriculums then the provider will have difficulty keeping up with changes in different training and quality of care will suffer.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 11	… Electronic visit verification, and other methods to deliver services to the CHC participants.	Electronic documentation is helpful to increase efficiency. However, the Department should not encourage the MCO to choose their own documentation system. The providers who have an acceptable system in place should be allowed to continue with their choice of electronic record. However if the provider needs to update, there should be one common system used state wide so switches from MCO to MCO will not require system changes for providers, which would reduce quality of care.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 14	Describe how you encourage provider usage and exchange of interoperable health information, electronic service plans, and how you will develop and implement innovations to use these records to promote better coordination…	The MCO should have to allow the provider to use whatever electronic health record and client record software they currently have in practice. If each MCO has a different requirement and the client chooses a different MCO then the provider would have to restructure often and it would reduce quality. A statewide suggested platform would create more uniformity and quality of service.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 15	Describe your approach to utilization management…	The utilization review process must be simple for new providers to be able to report to MCOs. The processes should be the same state wide to avoid issues with switching between MCOs.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 20	Describe how you will consider feedback from your participant advisory committee into your operations and policies.	This is an extremely important factor in keeping the MCO to provide quality services and have checks and balances. This PAC information should be overseen by the state and an entire state repository of information regarding all PACs records should be kept by the Department and reviewed before renewing MCO contracts.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 22	Describe your approach for training staff and providers in the submission and review of letters of medical necessity…	All information should be standardized statewide and be submitted from the provider to the Department so the Department can issue this paperwork to all MCOs. This would avoid multiple resubmissions by providers to each MCO, saving time and enhancing continuity of care, and enhanced quality.	Acme Providers Inc. / Justina Cunningham

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RFP	Work Statement Questionnaire	Participant Service and Care Coordination 25	Describe your approach for authorizing LTSS services in accordance with the requirements of 1915(c) waivers.	The OBRA waiver implemented in 2013 required unlicensed facilities (less than 3 people) serving people with other related conditions (ORC) to be CARF accredited. That accreditation does not coincide well with the judgement of quality residential practices. The MCO and other Department surveys and inspections are a better indicator of quality services. The CARF requirement should be rescinded. If an accreditation is required it should be the same statewide for all providers of all types of services. The CQL accreditation has interrated reliable quality indicators geared toward HCBS services.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 27	Describe the procedures and processes you have in place to ensure continuity of care to ensure smooth transitions for Participants transitioning between service delivery systems…	There must be one informational clearinghouse which lists all the information of paired clients and MCOs and it must be accessisble to the provider. This would enable the provider to know which date the client switched MCOs to provide cleaner billing. This will help with continuity of care.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Participant Service and Care Coordination 30	Describe your process for establishing caseloads for service coordinators.	Currently the Service Coordinators I work with are operating larger caseloads than are conducive to quality care. The MCO should be mandated to limit the SC caseload numbers to no more than 35 or 40 clients in any program /service.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Service Integration 4	Describe your plan to …improve collaboration across all participant's providers including those that are not part of the CHC-MCO network.	It is vital that out of network providers are a priority of the MCO because the client can and will switch at any time and in return a provider will find themselves an out of network provider. The MCO must make it easy and quick to become an in network provider or risk putting providers out of business because of reduced rates.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Service Integration 6	Describe how your plan will ensure that eligible individuals have Medicare Part D coverage.	The department should provide a statewide information bank that lists all client coverage and is available for access by Providers and MCOs.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Service Integration 10	Describe your experience and approach in coordination among physical health, behavioral health, and LTSS.	This component is critical for long term well being. At this time it is not well integrated or easy to achieve interworking components of these three needs.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Quality Improvement and Performance Measures 1	Describe your strategy for achieving quality performance and outcomes.	The department should assign one statewide quality program that all MCOs and providers follow. A change in quality and performance outcomes each time a client changes from one MCO to the next would be nearly impossible to keep up with for providers. The quality incentives paid to MCOs should also be handed down to providers because we will be the ones doing the work of maintaining quality programs.	Acme Providers Inc. / Justina Cunningham
				Redacted	Redacted
RFP	Work Statement Questionnaire	Pharmacy 5	With regard to outpatient drug claims…	It is important to know if MCOs will allow the current provider and pharmacy relationships to continue as they are currently functioning. We don't want to make multiple changes and risk medication administration errors.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Management Information Systems 5	Explain your process for subcontractors to meet the same MIS requirements … including incentives and assessments that are utilized.	All MCOs should pay providers incentives if they meet management standards. If the MCOs are not using the same management and quality assessments then a copy of each MCOs assessment must be made available in one location for all providers to access in order to stay informed.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Management Information Systems 5	Describe how you will verify that providers … submit timely data… including frequency of verification.	All MCOs should be required to have the same frequency schedule and reporting dates so providers have consistency in reporting standards across MCOs.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Management Information Systems 14	Explain your process for maintaining your provider file …	This provider information should be maintained by the Department. Billing should still be done through PROMISe. Having to maintain information with multiple different MCOs will require a great deal of provider time just for this process.	Acme Providers Inc. / Justina Cunningham

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RFP	Work Statement Questionnaire	Management Information Systems 16	Describe your plan to comply with the standards for claims timeliness and the timely and correct payment of providers…what dates will be used.	All MCO's should have the same standards for timely payment of providers. They should also use the same definitions of payment processing dates. Specifically how they will be measured and the dates used should be the same statewide.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Management Information Systems 20	Describe your system for providing access to all network providers to enrollment, service coordinator contact, and service plan information.	The MCO should not be the SCO organization. It is imperative that the provider have access to service plan information. The SC needs access to all plan information also.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Provider Network Composition 1	… (bullet 3) Describe how you will enroll any current willing and qualified HCBS, …LTSS providers into your network.	There should be primary requirements that are the same between all MCOs state wide for enrollment.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement Questionnaire	Provider Network Composition 2	… Explain the circumstances that would result in providers not being approved to participate in your network.	The Department should have a definitive process in place to detail why a provider is not approved to participate. It should be the same across all MCOs. The Department should also have an appeal process for unjustified grievances regarding disapprovals and other issues.	Acme Providers Inc. / Justina Cunningham
RFP	Criteria	III - Evaluation	The department has selected a committee of qualified personnel… to be most advantageous to the Commonwealth …	The committee should have advisory counsel from a knowledgable individual who has been through an MCO changeover in another successful state to help with wise decision making. The outcome of this process also needs to be advantageous for the people being served and the providers who are responsible to serve the residents of the commonwealth.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement	Goal 4	Advance program innovation … enhance the LTSS direct care workforce…	In order to enhance the LTSS direct care workforce there will have to be better pay rates for staff. They are currently undre paid and that is one reason for the lack of quality workers recruited and poor retention which translates to poor quality services.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement	IV - B Emergency Preparedness	… One part of this strategy is to ensure that entities providing critical services to MA beneficiaries have planned for such an emergency and put contingencies in place to provide services.	It would be helpful for a state wide plan for emergency preparedness to be developed so smaller agencies who do not have the resources could follow a well desigend plan with strategic forethought.	Acme Providers Inc. / Justina Cunningham
RFP	Work Statement	IV-4 Agreement Requirements - Small Diverse Business Participation	All agreements containing SDB participation …	The MCOs should be incentivised to contract with SDBs that are headquartered / located in Pennslyvania.	Acme Providers Inc. / Justina Cunningham
RFP	Service Plan			The RFP should included, that If the services plan of an individual living in the community costs more than cost of an individual living in a nursing facility, the individual living in the community can remain in the community without having there services cut so it cost equal or less than the cost of living in a nursing facility. Cost should not impact an individuals with a disabilities right to live in the community and receive the services they need to maintain there health and safety.	Richard Duckson/Consumer

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RFP Requirements	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements			Support coordinator training does not need to require a higher education degree or license. There currently is no higher education degree or license that is specific enough to this field. A RN, PT, SW, degree is not specific enough and does not include training on working with individuals with disabilities. Changing the education system around to include a degree that is specific to support coordination is expensive, a long term process, and is not necessary.	Richard Duckson/Consumer
RFP Requirements	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements			Support coordinators should receive there training from individuals with disabilities in partnership with Center's for independent living that follow the independent living philosophy. CIL's have unique knowledge to help prepare those who work with individuals with disabilities. Additionally Support Coordinators would benefit from receiving training in specific areas that individuals with a disabilities like my self deal with on a regular basis, including indent living philosophy, specific disabilities, TBI, domestic violence, alcohol & drug abuse, etc.	Richard Duckson/Consumer
RFP Requirements	Section V. A. Covered Services			We support the requiremens that emphasize the importance of the involvement of and coordinatin with the behavorial health managed care organizations (BHMCOs) and providers in order to provide comprehensive care for the CHC targe populations. This includes, but is not limited to, the following: Written agreements with the BHMCOs outlining coordination of care processes : behavorial health presentation on the particiapant advisory committeee and the partipant education and outreach health education advisory committee. CHC-MCO hiring a behavorial health coordinator to foster integration and collaboration.	Brandi Phillips CEO Alleghany Health Choices
RFP Requirements				What will be the process for allowing current service coordination entities to continue providing service coordination under the new MCO plan?	Trish Wommer Director of Aging Waiver Casey Ball Supports Coordination, LLC
RFP				Living (OLTL). The sole point of contact in the Commonwealth for this RFP shall be Michelle Herring, RA-PWRFPQUESTIONS@PA.GOV, the Project Officer for this RFP. Please refer all inquiries to the Project Officer. Can we talk with her in an open meeting to get updates on what proposers are asking and or saying? 2. The Department will share the rate ranges and supporting documentation with selected Offerors prior to negotiations over financial terms. Does this mean the winners of the contracts after they have been picked or does it mean the state will tell a few friendly privileged offerors only so as to cut out others so they have no chance of winning their request and if that's the case then why? 3. The Department may, in its sole and complete discretion, reject any proposal received as a result of this RFP. Who makes this decision this board or who? 4. Eligibility Requirements In order for a CHC-MCO to get credit for meeting its CPP commitment, it must hire individuals currently receiving TANF cash assistance, including but not limited to individuals currently participating in any of the Department's employment and training programs such as Employment, Advancement, and Retention Network (EARN), 17 Supported Work, Supported Engagement, Industry Specific Initiatives, Keystone Education Yields Success (KEYS), as well as, those individuals in self-initiated activities at the CAO. Individuals receiving medical assistance or foods stamps only are not eligible. What about individuals with disabilities can they be included in this hiring practice?	Fred Hess/Consumer