



Pennsylvania Homecare Association
Community HealthChoices (CHC) RFI Comments
April 14, 2023
Teri Henning, thenning@pahomecare.org

PHA and our members appreciate the opportunity to comment on the Department of Human Services' Request for Information (RFI) on the Community HealthChoices (CHC) procurement and identify ways to improve the quality of care and provision of home and community-based services (HCBS) in the CHC program. Our comments focus on three main principles:

1. **Homecare providers as partners.** It is critically important that home-based care providers are considered and treated as full partners in the provision of care to the more than 100,000 Pennsylvanians who are eligible for and receiving HCBS, and on the healthcare continuum more generally. Too often, decisions are made or practices are implemented without sufficient provider engagement or input, when such input would have benefitted all, and improved both policy details and efficient implementation.
2. **More transparency and increased reporting requirements.** Increased transparency and reporting would benefit the program, providers, and most importantly, quality of care.
3. **Clearer communication and Department/MCO/provider communication and engagement.** More communication and Department engagement on compliance issues, EVV, system and program changes, including the establishment of a CHC Advisory Group, would help to improve the quality of and access to care. We believe that the program would greatly benefit from an advisory group that includes providers, participants, DHS, and managed care, who can provide input on proposed program changes and implementation, including EVV and other technology-based issues. Active involvement in program design and the discussion of proposals before policy is developed would significantly improve program implementation and operation.

In addition to these, we have provided comments on specific program changes that we believe would enhance the quality of care, improve the CHC program, and create a fair, transparent system that would benefit consumers, the Department, providers, and MCOs. On the issue of number of MCOs, PHA members believe that adding to the total number of MCOs in CHC is worthy of consideration, as it could improve consumer choice and access to care. Program-specific comments are below.

Appendix A – Program Requirements.

A. Covered Services. 16. Participant Self-Directed Services. b. Agency with Choice.

We continue to have concerns with Agency with Choice, as communicated on [February 28, 2022](#), [March 25, 2022](#), and [April 29, 2022](#), as well as in PA Home Care Association v. DHS, No. 629 MD 2022.

Accordingly, we believe that the Request for Applications (RFA) should exclude AWC as currently proposed.

19. Service Delivery Innovation.

We continue to support the requirement that CHC-MCOs promote innovation in the CHC service delivery system, including: “[w]orkforce innovation that improves the recruitment, retention, and skills of direct care workers, which may include but are not limited to direct or enhanced payment and other incentives to Providers, Participant-Directed employers, and direct care workers for education, training, and other initiatives designed to enable direct care workers to become a more functional member of the PCPT.”

We believe that any such innovation efforts should be reported on and shared publicly on a regular basis, to allow others to participate in or replicate successful programs or initiatives.

B. Prior Authorization of Services.

We believe DHS should require/request consistent prior authorization practices and time frames (length of authorizations) among the managed care organizations (MCOs). Current practices vary widely, and providers are challenged by inconsistent practices and implementation. DHS should also provide clear expectations to the MCOs that new authorizations must be provided prior to expiration of an existing authorization, and monitor MCOs for compliance. In addition, providers request clear guidance from DHS on how to handle expired authorizations with no updated authorization.

Providers are challenged by authorizations of varying timeframes, some very short, authorizations that start or end in the middle of the week, as opposed to the start of a week, delays in receiving authorizations, backdating issues (particularly when ending an authorization), and more. Providers err on the side of continuing to provide care in many circumstances, risking non-payment or recoupment if authorizations don’t continue or are retroactively modified.

Providers should also receive direct notice, at the same time as participants, of any changes in eligibility, denial of services, or reduction in authorized hours. Providers are a critical partner in the provision of these services and often are not aware of denials or reductions. As a result, they continue to provide care, pay Direct Care Workers (DCWs), etc., and are later denied payment or subject to recoupment actions. This weakens the system as a whole, as it puts providers in difficult financial and care-related situations.

D. Choice of Provider.

The CHC-MCOs should be required to describe and share publicly their methods of how they “provide Participants with choice of Providers within Network,” including how and whether they refer participants to specific providers, share needs with the full network of providers, etc.

E. Comprehensive Needs Assessments and Reassessments. G. Person Centered Service Plans.

As you know, the 2023 CHC Agreement includes the following language, which is also in the RFI. We believe the following changes are necessary to satisfy the intent of the program and allow providers the necessary information to provide appropriate, quality care:

~~If requested, t~~The MCO must share ~~minimum necessary~~ **LTSS** service plan information with providers **prior to the start of care and within seven (7) days of any changes to the PCSP or LTSS Service Plan,** consistent with HIPAA rules and regulations, ~~If sufficient justification is demonstrated by a provider,~~ **that information may include including, but not limited to** the following:

- a. Total number of authorized units per week (i.e., amount);
- b. Service provision dates (i.e., service begin and end dates);
- c. Preferred schedule (i.e., duration and frequency);
- d. List of tasks detailing participant needs (i.e., ADLs/IADLs);
- e. Service coordinator name, phone, and email address, **which must be updated within three (3) days of any change;**
- f. Special conditions and instructions; and
- g. Unique circumstances (e.g., allergies, smoking, pets, children under 18 years of age, etc.)
- h. Emergency back-up plan information.**

DHS should require that the LTSS plan be provided to HCBS providers, and the default must be that all relevant information is provided prior to the start of care and when changes are made. Providers continue to struggle with having accurate, up-to-date contact information for SCs, which should be required to be updated immediately when changes in SCs occur. Providers should also be included as necessary participants in the development of the PCSP.

J. Service Coordination.

The following plans should be shared with providers, in addition to the Department.

- Individual Service Coordination staffing plans
- Plan to monitor the performance of Service Coordinators

MCOs should publicly report their caseload ratios for SCs, and the Department should specify the consequences, if any, when these caseload ratios are exceeded. We also believe that additional clarity is necessary on SC responsibilities and expectations, including, but not limited to their responsibilities relating to the development and confirmation of realistic back-up plans for participants and their obligations to respond to/return provider/participant calls or emails.

T. Provider Dispute Resolution Process.

Providers must be permitted to pursue an external appeal/review from claims denials, reductions, or attempted recoupments that are not solely decided by the MCOs. An external review process is necessary to maintain fairness and ensure that any such actions are appropriate and necessary. The Department should play a role in ensuring that appeals are handled fairly and appropriately.

MCO provider dispute and provider appeals policies should be posted and easily accessed/reviewable by all providers, including the makeup of the CHC-MCO Committee.

X. Administration. 5. Electronic Visit Verification (EVV).

We believe that the program would benefit from the Department taking a more active role in establishing/confirming EVV policies and practices on issues such as manual edits, overnight, awake caregivers, specificity of task listing per shift, and authorization timeframes. The MCOs have different

policies and expectations on a range of EVV issues, causing confusion among providers and leading to unnecessary negative outcomes and even attempted recoupments. Providers, participants, DHS and the MCOs would all benefit from clearer, consistent expectations.

In addition, any requested or required changes to the technology platforms used by DHS or the MCOs must be widely, publicly shared, including public posting on the applicable listservs, at least 90 days in advance of any proposed changes. Although notice of system changes (e.g., changes to rounding rules) have been communicated within the platforms, broader public notice would help to ensure notice of any system changes that providers need to work with third party vendors on, to prevent delayed claims or payments.

AA. Provider Services. 10. Provider Orientation and Ongoing Education.

We support broad training for providers and believe that any training materials developed or used by the MCOs should be posted and available for repeat or later viewing, in addition to any live training opportunities. Providers appreciate the live webinars, which include the opportunity to ask questions and get clarification on issues. These should be required and continued, and providers should be able to review or direct others to review recorded sessions as well. It's not always possible to make all appropriate caregivers and employees available for live webinar opportunities.

All MCO training and policy expectations should also be required to be provided in detail in the Provider Manual, and updated regularly, as necessary. This should include any audit/review expectations of the individual MCOs.

BB. Provider Network.

The Department should more clearly define network adequacy in the program, to ensure that there are an adequate number of eligible providers who can provide necessary and appropriate services within individual counties or smaller areas, including consideration of cultural, linguistic, and disability competencies and the need for services.

DHS should clearly explain how it measures network adequacy, including regular posting/sharing of aggregated statistics on consumers who have been determined to be eligible but not yet receiving services, by county, by MCO, and authorized hours vs. utilized hours, by county, by MCO, including the reasons for unfilled hours.

8. Network Changes/Provider Terminations.

See comments under Exhibit V, CHC-MCO Requirements for Provider Terminations.

Appendix B – Financial Requirements.

Payment for Personal Assistance Services.

We strongly support the Department requirement that CHC-MCOs pay for Personal Assistance Services at no less than the FFS rate and the inclusion of a provision that higher payment rates may be paid.

Appendix C – Reporting Requirements.

The Department should publicly share the annual program report produced to comply with Federal State Monitoring Requirements concurrent with its submission to the Centers for Medicare and Medicaid (CMS). The Department should also publicly report on MCO compliance with response expectations for critical and urgent issues.

To the extent that it does not already do so, the Department should collect from the MCOs and share publicly: 1) the number of individuals eligible to receive services, but not yet receiving them, by MCO, by county, including reasons why; and 2) the number of hours authorized vs. the number utilized, by MCO, by county, including reasons why.

Exhibit T – PROVIDER NETWORK COMPOSITION/SERVICE ACCESS. Network Composition.

The Department should more clearly define network adequacy in the program, to ensure that there are an adequate number of eligible providers who can provide necessary and appropriate services within individual counties or smaller areas, including consideration of cultural, linguistic, and disability competencies and need for services.

The Department should also better define “excessive distances” for purposes of HCBS when care is provided in the home, and it is the provider who is traveling.

Finally, we believe that the Department should regularly request and make publicly available geographic access maps using Participant-level data detailing the number, location, and specialties of its Provider Network in order to verify accessibility of Providers within its Network in relation to the location of its Participants.

EXHIBIT U – Provider Agreements.

We ask the Department to provide further clarification on the following restrictions, including specific examples of acceptable actions vs. prohibited ones, and make clear the consequences for violations.

- Communicating with existing CHC Participants via telephone, face-to-face or written communication for the purpose of petitioning the Participant to change Providers;
- Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential CHC Participants.

EXHIBIT V – Provider Terminations.

The Department should share its process for reviewing/accepting proposed provider terminations, whether for cause or no cause. As recommended above, providers should have an external review process to challenge proposed terminations and seek further review, and the Department should play a role in ensuring that decisions are fair and appropriate.

Participant choice should factor heavily in the determination of whether a proposed termination is in the best interest of the program and the access to/provision of quality care. Provider terminations that would negatively impact access to services for specific populations must be carefully reviewed to ensure network adequacy. Any summary of issues/reasons for termination provided to the Department or otherwise developed must be shared with the affected provider.