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DHS Issues Community HealthChoices RFP

On March 1st, the PA Department of Human Services (DHS) issued its Statewide Request for Proposal (RFP) for Community HealthChoices. Any health plans interested in being a Community HealthChoices plan (a CHC-MCO) in any of the five Community HealthChoices zones have 60 days—or until May 2nd—to submit a proposal to the Department.

As a reminder, Community HealthChoices is slated to start first in the 14 counties that make up the Southwest Zone on January 1, 2017. According to the data provided in the RFP, there are approximately 100,000 individuals in the Southwest zone who will be participating in Community HealthChoices. Two-thirds (over 67,000) of those are dual eligibles (on Medicare and Medicaid) who are **not** receiving any long term services or supports. Of the remaining one-third, approximately 20,000 are residents of nursing facilities, while the rest (nearly 12,000) are individuals receiving long term services and supports (LTSS) in the community through Home and Community-Based Services Waiver (Waiver) services administered by the Office of Long-Term Living (Aging, Attendant Care, COMMCare, Independence, and OBRA). Most individuals receiving nursing home or Waiver services are also dual eligibles.

A review of the RFP and corresponding Draft Agreement reveals that DHS did make substantial changes compared to earlier drafts of the documents. Many of the recommendations PHLP and other consumer advocates raised during the comment period were adopted.

These include:

- Revisions to the "continuity of care" rules that specify:
    - ◊ Participants receiving Waiver services at the time Community HealthChoices begins in their zone have an initial 180 day continuity of care period during which their CHC-MCO must continue to provide all existing Waiver services through existing service providers. This continuity of care right generally applies even if the individual switches CHC-MCOs during that 180 day period; however, participants who switch CHC plans during this period will not have a right to continue with their service coordinator.
    - ◊ Participants residing in a nursing facility at the time Community HealthChoices begins in their zone have a right to continue to reside in that facility for as long as they choose and as long as they are eligible for Medicaid coverage for nursing home care. This right continues even if the participant changes CHC-MCOs.
- Clarifications about requirements related to dual eligible participants (duals) since Medicare is their primary coverage:
    - ◊ CHC-MCOs cannot require prior authorization of any Medicare covered services for duals;
    - ◊ Duals are **not** required to have a Primary Care Physician who is in their CHC plan's network but are free to use their primary Medicare provider as their PCP;
    - ◊ CHC-MCOs must allow all duals to access Medicare covered products and services from the Medicare provider of their choice (regardless of whether the provider is in the CHC plan's network);
    - ◊ CHC-MCOs are responsible for duals' Medicare co-insurance and deductible amounts whether or not the Medicare provider is in network **and** whether or not the plan's prior authorization requirements were met.
- Requiring that Service Plans and Care Management Plans for participants must address how CHC-MCOs will coordinate care with **whatever** type of Medicare coverage the member has;
- CHC-MCOs must do a Comprehensive Needs Assessment not just for those who are "nursing facility clinically eligible" but also for any participants who request an assessment or who identify themselves as needing LTSS, as well as for those participants who the plan or the Independent Enrollment Entity determines have unmet needs, service gaps or a need for service coordination.

Some areas of concern raised by PHLP and others were not addressed by DHS and continue to be problematic. These include:

- An initial contract term of five years in the Southwest Zone. Advocates have argued this is too long for a new and untested program, and too long for the state to be locked in with a CHC-MCO who may not be able to comply with program requirements or serve their members well;

- An unprecedented requirement that participants report changes in their income and assets **to their CHC-MCO** as well as to their County Assistance Office;
- **No** specific CHC-MCO provider network standards for nursing facilities and wholly inadequate standards for rehabilitation facilities (a minimum of two facilities within the CHC-MCO's network only one of which is required to be located within the CHC zone);
- Exhibit CC to the Draft Agreement addresses requirements for the CHC plan's coverage of outpatient pharmacy services yet makes **no** reference to Medicare or how the plan should coordinate with Medicare Part D which is the primary payer for dual eligible participants;
- Few parameters put on the plans and inadequate consumer protections to assure that participants are not mislead or coerced into changing their Medicare coverage and enrolling into the plan's aligned Medicare D-SNP. Although the Draft Agreement specifies that CHC plan outreach materials cannot state that their members must enroll in the plan's aligned Medicare D-SNP Plan, the plan is otherwise allowed to market its Medicare D-SNP to members and include information about its Medicare D-SNP in every quarterly newsletter sent to participants;
- Regarding participant access to behavioral health services, the Draft Agreement requires coordination of services/written agreements between the CHC-MCO and HealthChoices Behavioral Health Plans (who will continue to provide behavioral health coverage to CHC participants) yet makes **no** mention of coordination with Medicare which is the primary payer of many behavioral health services for dual eligibles.

The RFP and Draft Agreement can be found here. Once the plans have submitted their proposals, DHS will then review them and eventually choose from 2-5 plans to contract with as CHC-MCOs in each Community HealthChoices zone.

Future Opportunities to Provide Input about Community HealthChoices

DHS must seek and receive federal approval to implement Community HealthChoices. This will be done by submitting a request to amend existing OLTL Waiver programs followed by a concurrent 1915 (b) and 1915(c) Waiver application to the federal government's Center for Medicare and Medicaid Services (CMS). Before submitting these documents for federal approval, however, DHS will publish them in the Pennsylvania Bulletin seeking public comment. The amendments to the existing waivers are slated to be published in the PA Bulletin on April 2nd and the 1915 (b)/(c) waiver application will be published in the Bulletin on April 16th. Each document will allow for a 30 day public comment period.

Maximus to Handle Aging Waiver Enrollments Starting April 1st

Pennsylvania's current Independent Enrollment Broker, Maximus, will begin to enroll people in the Aging Waiver starting April 1st. As of this date, individuals wishing to apply for the Aging Waiver should contact Maximus at 1-877-550-4227. Local Area Agencies on Aging will continue to process Aging Waiver enrollments started before April 1st; however, any application that is not completed by June 30th will transition to Maximus for completion.

Maximus currently handles enrollments for the Attendant Care, COMMCare, Independence, and OBRA Waivers. These Waiver programs are all administered by Pennsylvania Department of Human Services' Office of Long Term Living. After April 1st, Maximus will handle enrollments for all of the OLTL Waivers, including the Aging Waiver.

As a reminder to readers, applications for OLTL Waivers include a determination of functional eligibility as well as a determination of financial eligibility (handled by local County Assistance Offices). Maximus is responsible for shepherding waiver applications through the process to ensure that the functional eligibility determination is made within 60 days (previously it was 85 days).

Pennsylvania intends to continue to use an Independent Enrollment Entity to handle applications for Long Term Services and Supports after Community HealthChoices (CHC) begins. A Request for Proposal will be issued in upcoming months outlining the requirements for an Independent Enrollment Entity specifically for Community HealthChoices and seeking bids to handle these functions across all five CHC Zones. We'll provide readers with further information about how this enrollment process will work in future newsletters.

DHS Launches Information and Referral Tool for Home and Community Based Services

The Pennsylvania Department of Human Services (DHS) launched a new online Information and Referral Tool this month to help individuals, family members and advocates identify available programs and resources that will allow older adults and people with disabilities remain in their homes and communities.

The tool asks a series of questions. Based on the person's responses, the tool offers suggestions on county and state funded programs that provide services to help people remain living as independently as possible. The tool does **not** link individuals to services that are privately funded.

DHS started developing this tool last year. They launched a "trial run" of it earlier this year and solicited feedback from various stakeholders to make improvements and correct any problems. PHLP, and many others, participated in this trial run.

People who use the tool are not required to provide any personal identifying information and the tool does not save responses to the questions asked. The goal of the tool is to help people learn about program options available based on the person's identified needs and how to access this help. The tool is not used to apply for a specific program; however, the tool can make referrals to certain programs or connect the person to an online application, when available, if someone chooses these options.

In addition to launching the Information and Referral Tool, DHS has also made improvements to the online Medicaid application system, COMPASS, to help connect people with home and community based services Waiver programs. As of March 12th, individuals are able to apply online for the Aging, Attendant Care, COMMCare, Independence, and OBRA Waivers. COMPASS will submit the financial application information to the person's local County Assistance Office and submit information electronically to the Pennsylvania Independent Enrollment Broker (Maximus). To qualify for these Waiver programs, someone must be determined both functionally and financially eligible. Maximus handles functional eligibility while the CAO determines financial eligibility. Individuals are still able to contact Maximus directly to apply by calling 1-877-550-4227.

Contact RA-PWBIP@pa.gov with any questions or concerns or to identify any problems with the Information and Referral Tool.

DHS Issues RFP for Home Modification Brokers

DHS has issued a Request for Proposal (RFP) seeking entities interested in assisting individuals in certain Home and Community-Based Services Waiver programs with getting home modifications. Proposals are due May 9, 2016. One entity will be chosen for each of the five HealthChoices regions across Pennsylvania. The selected entities, generally referred to as "brokers," will help individuals in the following Waiver programs who are seeking home modifications:

Office of Developmental Programs	Office of Long Term Living
Adult Autism Consolidated Person/Family Directed Supports (PFDS)	Aging COMMCare Independence OBRA

*Note: Home modifications are **not** covered under the Attendant Care Waiver.*

Brokers will provide for the delivery, administration and management of the home modification Waiver services, as authorized by the waiver participant's Service Coordinator. Broker responsibilities will include:

- Establishing and maintaining an adequate network of qualified home modification contractors;
- Developing project specifications and issuing requests for bids to qualified home modification contractors;
- Submitting at least two completed bids to the participant and the Service Coordinator ("SC");

- Assisting the participant and the SC with selection of a qualified home modification contractor;
- Negotiating final specifications and terms of home modification services with the selected contractor;
- Approving detailed design, timelines, and quotes of the selected contractor;
- Entering into agreements with selected home modification contractors;
- Providing oversight of the contractor during the home modification process, including the quality and timeliness of the work;
- Performing all contract management services, including but not limited to monitoring to ensure proper permits are obtained;
- Assessing and evaluating completed home modifications with the waiver participant and the SC to determine the quality of the modifications and whether the modifications meet the needs of the participant;
- Resolving issues relating to unfinished, inadequate or poor quality work or the failure of the modification to meet the needs of waiver participant; and
- Paying home modification contractors for all modifications inspected and accepted by the broker.

Brokers will receive a monthly fixed administrative fee and will bill the actual costs of each home modification through the existing Medicaid billing system (PROMISe). Payments for the cost of home modifications will not be advanced by DHS- except for the monthly administrative fee. However, the RFP states: "Payments cannot be delayed pending the selected Offeror's [broker's] payment from the Commonwealth". The RFP also requires the broker to secure a line of credit equal to a minimum of 25% of the estimated amount of annual home modifications for the region, presumably to cover contractor payments made while the broker waits for reimbursement from DHS.

When the Aging, COMMCare and Independence Waivers are combined into Community Health Choices, the Community HealthChoices managed care plans will have the option of using the brokers selected through this RFP, contracting with another entity, or handling home modifications in-house (not likely). Please see the article on page one for more information about Community HealthChoices.

DHS Clarifies Policy Regarding Medicaid Eligibility for Pregnant Women Who Are Immigrants

Thanks to our legal service colleagues, language in the Medical Assistance Eligibility Handbook has been clarified regarding eligibility for immigrant women who are pregnant. Most immigrant adults have to reside in the US for 5 years with a qualified immigration status before they can qualify for Medicaid. However, under the current rules, lawfully present women who are pregnant can qualify for Medicaid if they meet the income limits for their family size **regardless of how long they have been in the US**. Once approved, the pregnant woman's Medicaid coverage lasts until 60 days after they give birth-even if their income or household size changes during this period.

In Southeastern Pennsylvania, legal service advocates encountered a number of clients who were being inappropriately denied Medicaid for prenatal care and for the birth of their baby and approved only for the 60 day post-partum period because of confusion over how the policy was written. Advocates raised the issue with the Department of Human Services. In response, DHS staff revised the policy to clarify its intent and reached out to each County Assistance Office to ensure they were clear about eligibility rules for pregnant women who are immigrants.

For more information about Medicaid eligibility for immigrants, please see PHLP's Health Care for Immigrants manual. Pregnant women who are denied Medicaid can call PHLP's Helpline at 1-800-274-3258 for assistance.

State Agencies Step Up Efforts to Enforce Autism Insurance Law

Following PHLP's successful lawsuit against Independence Blue Cross regarding coverage of autism services in school, and several meetings between PHLP, families, providers, the Pennsylvania Department of Human Services (DHS) and the Pennsylvania Insurance Department, there has been an expanded effort by these state agencies to ensure that commercial health insurers are covering autism service costs as required by the Autism Insurance Law (Act 62 of 2008).

Families of children with autism and other supporters of Act 62 have raised concerns about Medicaid paying for services that should be covered by commercial insurers subject to Act 62 for children that have both insurances. On April 15th, DHS will begin to recoup payments made by Medicaid for certain autism services from commercial insurers. Medicaid rules require that it be the payer of last resort.

DHS has also identified additional diagnostic and procedure codes which it believes are subject to Act 62. Starting August 1st, DHS will refuse to pay for services with those additional diagnostic and procedure codes for children on Medicaid who also have commercial insurance subject to Act 62. The goal is to have autism providers bill commercial insurers for those additional services first before billing Medicaid. It is not clear what will happen if the commercial insurer refuses to pay.

A related concern of families and advocates is what will happen to the savings generated when commercial insurers pick up more costs that had previously been paid by Medicaid. It was always the intention of the prime sponsor of the legislation that became Act 62, then Speaker of the House, Dennis O'Brien, that any savings to Medicaid realized from the mandate be used to expand services for adults with autism. Unfortunately, DHS has not yet made that commitment.

Services for adults with autism are of great concern since many supports for people with autism end at age 21. Act 62 only applies to children and youth under 21, Behavioral Health Rehabilitation Services (also known as BHRS or "wrap around" services) are only available to children and youth under 21, and public education services usually stop at the end of the school term in which the youth turns 21. Also adding to the concern is the growing numbers of individuals with autism spectrum disorders. The PA Autism Census estimates that the number of adults in our state with autism spectrum disorders will rise by 36,000 individuals between 2011 and 2020.

Our Mission

Founded in the mid-1980s and incorporated in 1993, PHLP protects and advances the health rights of low-income and underserved individuals. Our talented staff is passionate about eliminating barriers to health care that stand in the way of those most in need.

We seek policies and practices that maximize health coverage and access to care, hold insurers and providers accountable to consumers, and achieve better outcomes and reduce health disparities.

PHLP advances its mission through individual representation, systemic litigation, education, training, and collaboration.

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PHLP: Helping People in Need Get the Health Care They Deserve