



MCO Meet and Greet Presentations

November 4th and 5th, 2015



MCO Meet and Greet Morning Session

November 4, 2015

Agenda

- PA LTSS Access
- Nursing Facility System
- Nursing Home Transition
- Home and Community Based Services System
- Medicare/Medicaid Coordination through MIPPA
- Facilitated Discussion
- Consumer Protections
- Home Modifications
- Medical vs. Social models of service delivery
- Olmstead
- PA State funded LTSS programs

▶ Long-Term Services and Supports (LTSS)

- **Long-Term Supports and Services (LTSS)** – A broad range of supports and services designed to assist an individual with ADLs and IADLs which can be provided in a home and community-based setting, a nursing facility, or other residential setting. LTSS may include, but are not limited to: self-directed care; adult day health; personal emergency response systems; home modification and environmental accessibility options; home and personal care; home health; nursing services; specialized medical equipment and supplies; chore services; social work and counseling; nutritional consultation; home delivered meals and alternative meal service; and nursing facility services.

How to Access the PA LTSS System

Components of the Enrollment process

Assessment

- The local AAA performs a Level of Care Determination (LCD) to determine nursing facility clinical eligibility (NFCE) based on specific activities of daily living and medical conditions for which the person needs support.
- The LCD is performed within 15 calendar days of the request and is required for all of the following but not for Private Pay:
 - Nursing Facilities (Medicaid)
 - HCBS Waivers
 - Act 150 Program
 - LIFE Program

Components of the Enrollment process (cont'd)

- Physician's Order
 - Medicare requires a physician's order for short-term rehabilitative services provided in a nursing facility. For Medicare funded nursing facility stays, no LCD or MA-51 is required.
 - A physician must certify that an individual needs nursing facility services.
- Financial Eligibility Determination – The County Assistance Office (CAO) determines the person's financial eligibility.
- Program Eligibility – The Office of Long-Term Living determines the HCBS Waiver program for which the person is eligible.

After Enrollment in HCBS Waiver

- **Service Coordination** – The person selects a Service Coordination Entity (SCE). The SCE is responsible for developing the Individual Service Plan (ISP) and informing the person of their options for selecting a service model:
 - **Agency Directed** – The individual selects a provider agency, which supplies the direct-care worker (DCW).
 - **Participant Directed** – The individual becomes a Common Law Employer, hiring their direct care provider with the assistance of a Fiscal/Employer Agent (F/EA).
- When the ISP is approved, the participant is authorized to receive the services it outlines.

–The participant can begin receiving services!

Financial Eligibility Application Process

- **Medical Assistance LTC Services Can Be Provided in:**
 - A nursing facility enrolled in MA
 - In the Community
- **Application is submitted:**
 - LTC facility submits application to CAO
 - Individual mails application to CAO
 - COMPASS
 - AAA/Other Agency/IEB submits application to CAO
 - CAO office/Interview
- **Process Times:**
 - 30 days from date of receipt of Application in CAO;
an additional 15 days can be granted as necessary

Current Barriers in LTSS Access

- No single point of entry – confusion on where to start
- System is difficult to navigate, particularly when transitioning between care delivery systems.
 - Lack of coordination between primary, acute, and LTSS organizations
 - Limited coordination between Medicare Special Needs Plans and LTSS organizations
- Consumers show a tendency to under-plan and under-insure for long term care until there is a crisis.
- There is limited availability of long-term care insurance products. Available products limit coverage and are costly



Nursing Facilities and Transition

Nursing Facility

Population Served	Eligibility Requirements
<p>Project to serve 84,500 MA recipients in FY 15-16.</p>	<ul style="list-style-type: none"> • Nursing Facility Level of Care • Income <ul style="list-style-type: none"> • Non-Money Payment (NMP): 300% of the Federal Benefit Rate • Medically Needy Only (MNO): \$2,550 less certain medical costs, including 6 months of LTC services • Resource Limits • NMP: \$2,000 • MNO: \$2,400 (usually excludes primary residence) • Assessed by local AAA as in need of nursing facility level of care.
Program Statistics	Federal and State Policies
<p>The proposed budget for FY 15-16 nursing facility care is \$ 3.8 billion</p>	<p>Unlike Medicaid Waiver programs, nursing facility care is defined as an entitlement by the federal government for all individuals who are found eligible for services.</p>

Nursing Facility Participation and Reimbursement

- Program regulated by 55 PA Code Chapter 1187 and 1189
 - Facility participation review process
 - Case mix and Rate Methodology
- Supplemental Payments
- Provider Trade Associations
 - Pennsylvania Healthcare Association (PHCA)
 - LeadingAge PA
 - Pennsylvania Coalition of Affiliated Healthcare and Living Communities (PACAH)

Nursing Home Transition

Population Served

- Nursing facility residents who express a desire to relocate from the facility or who have a documented barrier that was overcome through Transition Coordination services.

Goals and Objectives of the NHT Program

- Rebalance long-term living system to ensure people have a choice of where they live and receive services.
- Develops the necessary infrastructure and supports in the community by removing barriers so that individuals receive services and supports in settings of their choice.

Program Statistics

- More than 10,000 Pennsylvanians have been transitioned through the NHT Program since 2006.

Eligibility Requirements

An individual is considered an NHT participant if they:

1. are not scheduled to leave the facility through the normal discharge process (including short-term rehabilitative services);
2. have expressed a desire to relocate from the facility; and
3. meet one of the following criteria:
 - S/he has resided in an inpatient facility for a period of 90 consecutive days and is receiving MA services for one day and transition is coordinated through Transition Coordination activities. This individual would be considered an MFP target. OR
 - S/he has a documented barrier that was overcome through Transition Coordination activities regardless of nursing facility payer source.



Home and Community Based Services System

Home and Community Based Services

- Federal requirements were established to ensure that a person can be served in the community if they:
 - are qualified for a waiver;
 - choose to receive services in the community;
 - and can be safely served in the community with available services
- The overarching goal is to provide services and supports to individuals in the most integrated, least restrictive setting of their choice.

▶ HCBS in Pennsylvania

Five waivers allow Pennsylvania to spend federal dollars on HCBS for individuals who would otherwise qualify for Medicaid-funded institutional care.

Aging
Independence

Attendant Care

OBRA

CommCare

Living Independence for the Elderly (LIFE): Pennsylvania's version of the national PACE program. A fully integrated model delivering services through a fully managed risk-based capitation model.

The ACT 150 program: state-funded program that provides home and community based services to Pennsylvanians who are clinically eligible for nursing facility care but do not meet the financial eligibility test for Medicaid.

Attendant Care Waiver

Population Served	Eligibility Requirements
<ul style="list-style-type: none"> ▪ 10,695 individuals enrolled as of September 30, 2015 ▪ Average Cost Per Individual was \$24,000 for state fiscal year 14-15 ▪ Just over 80% of individuals in the program as of December 2013 were under age 60 ▪ Services for individuals over 60 years of age are paid from the PennCare appropriation in the Department of Aging budget 	<ul style="list-style-type: none"> ▪ PA resident age 18-59 ▪ Nursing facility level of care ▪ Income below 300% of the federal poverty level ▪ Countable resources below \$8,000 (excluding primary residence) ▪ Have a medically determinable physical impairment expected to last at least 12 months ▪ Be capable of a) hiring, firing and supervising an attendant care worker(s); b) managing one's own financial affairs; and c) managing one's own legal affairs.
Program Statistics	Federal and State Policies
<p>Personal assistance services accounted for \$160.3M in FY 12-13. This amount represented 95% of all Attendant Care spending.</p> <p>Consumer Directed: \$102.1M</p> <p>Agency Directed: \$58.2M</p>	<ul style="list-style-type: none"> ▪ Waiver originally approved by CMS on July 1, 1995. ▪ The Attendant Care Waiver is authorized under 1915(c). ▪ The current waiver period is 7/1/13 – 6/30/18.

Independence Waiver

Population Served	Eligibility Requirements
<ul style="list-style-type: none"> ▪ This waiver is for adults with severe physical disabilities affecting three or more major life activities. ▪ 10,796 individuals were enrolled in the Independence Waiver as of September 30, 2015. ▪ The average cost per individual receiving services under the Independence Waiver in FY 14-15 was \$39,203. 	<ul style="list-style-type: none"> ▪ PA resident age 18-59 ▪ Nursing facility level of care ▪ Income below 300% of the federal poverty level ▪ Countable resources below \$8,000 (excluding primary residence) ▪ Three or more substantial limitations in major life activities
Program Statistics	Federal and State Policies
<ul style="list-style-type: none"> ▪ Personal assistance services accounted for \$235.3M. This amount represented 80% of Independence Waiver spending in FY 12-13. ▪ Consumer Directed: \$100.4M ▪ Agency Directed: \$135.9M 	<ul style="list-style-type: none"> ▪ Waiver approved by CMS on July 1, 1997, authorized through 1915(c) of the Social Security Act ▪ Current waiver period is 7/1/15 to 6/30/20

CommCare Waiver

Population Served	Eligibility Requirements
<ul style="list-style-type: none"> ▪ This waiver serves individuals with traumatic brain injury. ▪ 713 individuals were enrolled in Waiver as of September 30, 2015. ▪ The average cost per individual receiving services under the CommCare Waiver was \$76,300 for FY 14-15. 	<ul style="list-style-type: none"> ▪ PA resident at least 21 years of age ▪ Nursing facility level of care ▪ Income below 300% of the federal poverty level ▪ Countable resources below \$8,000 (excluding primary residence) ▪ Medically determinable diagnosis of traumatic brain injury ▪ Three or more substantial limitations in activities of daily living
Program Statistics	Federal and State Policies
<ul style="list-style-type: none"> ▪ Personal assistance services and residential habilitation together accounted for \$19.9M. This amount represented 43% of all Compare Waiver spending in FY 12-13. ▪ Residential Habilitation: \$15.5M ▪ Consumer Directed PAS: \$8.8M ▪ Agency Directed: \$11.1M 	<ul style="list-style-type: none"> ▪ Waiver approved by CMS on April 1, 2002, authorized through 1915(c) of the Social Security Act. ▪ Current waiver period is 7/1/15 to 6/30/20.

OBRA Waiver

Population Served	Eligibility Requirements
<ul style="list-style-type: none"> ▪ The purpose of this waiver is to prevent inappropriate and unnecessary institutionalization for adults with physical disabilities. ▪ 1,347 individuals were enrolled in Waiver as of September 30, 2015. ▪ The average cost per individual receiving services under the OBRA Waiver was \$61,000 for FY 14-15. 	<ul style="list-style-type: none"> ▪ PA resident age 18-59 ▪ Physical developmental disability assessed as needing an intermediate care facility for people with Other Related Conditions (ICF/ORC) level of care ▪ Income below 300% of the federal poverty level ▪ Countable resources below \$8,000 (excluding primary residence) ▪ Physical disability manifested prior to age 22
Program Statistics	Federal and State Policies
<ul style="list-style-type: none"> ▪ Personal assistance services and residential habilitation together accounted for \$54.3M. This amount represented 69% of OBRA Waiver spending in FY 12-13. ▪ Consumer Directed : \$28.7M ▪ Agency Directed: \$25.6M 	<ul style="list-style-type: none"> ▪ Waiver approved by CMS on April 1, 1992, authorized through 1915(c) of the Social Security Act. ▪ Current waiver period is 7/1/10 to 6/30/15.

Aging Waiver

Population Served	Eligibility Requirements
<ul style="list-style-type: none"> ▪ Provides services for Pennsylvanians age 60 and older to allow them to maintain independence and remain in their community. ▪ 27,235 individuals were enrolled in Waiver as of September 30, 2015. ▪ The average cost per individual receiving services under the Aging Waiver was \$21,763 for FY 14-15. 	<ul style="list-style-type: none"> ▪ PA resident age 60 or older ▪ Income below 300% of the federal poverty level ▪ Countable resources below \$8,000 (excluding primary residence) ▪ Nursing facility level of care
Program Statistics	Federal and State Policies
<ul style="list-style-type: none"> ▪ Personal assistance services accounted for \$411.7M. This amount represented 81% of Aging Waiver spending in FY 12-13. ▪ Consumer Directed : \$134.6M ▪ Agency Directed: \$277.1M ▪ For FY 13-14 it is projected that Service Coordination will account for \$73M or 13% of spending for the Aging waiver. Service coordinating was a new waiver service as of July 1, 2012. Prior to that time, AAAs were paid a monthly stipend for “Care Management” through their Title XIX agreement. 	<ul style="list-style-type: none"> ▪ Waiver approved by CMS on July 1, 1995, authorized through 1915(c) of the Social Security Act. ▪ Current waiver period is 7/1/13 to 6/30/18.

Service Delivery of HCBS

- Enrolled individuals have choice and select a service coordinator (SC)
 - The SC administers the needs assessment to measure participant's functional limitations
 - The SC and the participant work together to develop a service plan based on the needs identified in the needs assessment
 - Participants are offered options in the delivery model of their services and then choose a provider
 - Agency Model
 - Participant directed model

HCBS Participation and Reimbursement

- Program regulated by 55 PA Code Chapter 52
- Provider Enrollment and Credentialing
- Reimbursement rate set by commonwealth in fee schedule as determined by actuarially sound rate setting methodology
- Provider Trade Associations
 - Pennsylvania Homecare Association (PHA)
 - Pennsylvania Provider Coalition Association (PAPCA)
 - Pennsylvania Adult Day Services Association (PADSA)
 - Pennsylvania Council on Independent Living (PCIL)
 - Pennsylvania Association of Area Agencies on Aging (P4A)
 - Rehabilitation & Community Providers Association (RCPA)

Medicare-Medicaid Enrollees (Dual Eligibles)

- There are just over 393,000* dual eligible individuals in Pennsylvania.
 - Pennsylvania's Medicaid expenditures for individuals age 65 and older who are eligible for both Medicaid and Medicare total approximately \$3 billion.
 - About half of these individuals are under age 65 and include people with disabilities.
 - These individuals are not enrolled in Pennsylvania's managed care program (Health Choices), but instead currently receive their physical health care benefits through the Medicaid-Fee-for-Services system.
 - Many dual eligible individuals receive their Medicare benefits through the Medicare Special Needs Plans (SNPs).
- *2009 Beneficiary Annual Summary File (BASf) as provided to us by the Centers for Medicare & Medicaid Services (CMS). Figure includes both full- and partial-duals.

Act 150

Population Served	Eligibility Requirements
<ul style="list-style-type: none"> ▪ This state-funded program provides services to adults who would not otherwise qualify for Medicaid. ▪ 1,700 individuals enrolled as of September 2015 ▪ Average Cost Per Individual was just over \$27,200 for state fiscal year 14-15 ▪ Services for individuals over 60 years of age are paid from the Penncare appropriation in the Department of Aging budget 	<ul style="list-style-type: none"> ▪ PA resident age 18-59 ▪ Nursing facility level of care ▪ No income test ▪ Have a medically determinable physical impairment expected to last at least 12 months ▪ Be capable of a) hiring, firing and supervising an attendant care worker(s); b) managing one's own financial affairs; and c) managing one's own legal affairs.
Program Statistics	Federal and State Policies
<p>Personal assistance services accounted for \$30.8M in FY 12-13. This amount represented 97% of all Act 150 spending.</p> <p>Consumer Directed: \$17.7M</p> <p>Agency Directed: \$13.1M</p>	<ul style="list-style-type: none"> ▪ State-funded program implemented in 1987 based on the Attendant Care Services Act (P.L. No. 150). Services had actually started through budget funding by the legislature in 1984, followed by supporting legislation in 1987. The funding enabled demonstration grants to provide services and to test models of service, including the Consumer Employer Model. ▪ The participant is not required to meet nursing facility level of care requirements, and there is no income test.
Services	
<ul style="list-style-type: none"> ▪ Personal Assistance ▪ Service Coordination ▪ Personal Emergency Response System (PERS) 	

PA Department of Aging – OPTIONS Program

Eligibility

- Nursing facility clinically eligible *and* nursing facility ineligible
- Age 60 or over
- No income limit
- Service plan is subject to mandatory cost share for those with income from over 133% of current Federal Poverty Level.

Funded by: PA Lottery

Stay up to date on CHC

- Sign up to receive email updates and webinar invitations here:
<http://listserv.dpw.state.pa.us/>
- Previous webinars are posted on the CHC website here:
<http://www.dhs.state.pa.us/foradults/communityhealthchoices/index.htm>
- Or through the CHC YouTube page:
<https://www.youtube.com/playlist?list=PLXN-I5nj4bwzf2ip2SBju-xei8QiHcjCd>

Questions or Comments?

Submit further questions or comments via email to:

RA-MLTSS@pa.gov

Home and Community Based Service Provider Session



Value of Home & Community-Based Services

November 4, 2015





Together

We believe **Community HealthChoices** Managed Long-Term Services & Supports must:

- Be consumer-focused
- Address excessive eligibility process
- Ensure continuity of care
- Allow for adequate, fair & reasonable rates to support quality care and a qualified workforce
- Be transparent
- Evaluate performance & reimbursement yearly

PA's Home Health & Homecare Community

- Members provide innovative and valued services in the most cost efficient manner in people's *HOMES*
- Licensed by the Pennsylvania Department of Health
 - 518– Home Health Agencies
 - 1,438 – Homecare Agencies
 - 191 – Hospices
- Medicare Home Health & Hospice, and State Homecare Regulations - disconnect between “needs” vs. rules



Your
partner in
bringing care
home

Ensuring Success for Homecare

Now

- No coordination with skilled home health, hospice & LTSS
- No incentive for innovation
- No standardization for LOC or service authorizations – no shared data
- Fragmented communication, fight for information, unclear lines of responsibilities



CHC-MCOs

- Share D-SNP plans of care with CHC-MCO plans
- Incent and reward for best practices – DCW turnover, consumer satisfaction, keeping people out of SNFs & hospitals
- Set up data standards & review to determine best practices
- Provider & Consumer Meetings – Work together to solve issues including rising costs, poor outcomes

More than just bringing care home...

- Whole Person
 - Guest in their home
 - Family dynamics
 - Chronic Care Management – Teaching
 - Together for long periods of time
 - Medication Compliance, Exercise, Nutrition, Safety, Socialization
- Housing Alternatives – *Brookside Homes, shared living*
- Technology
 - Electronic Visit Verification
 - TeleCare
 - My Learning Center (LMS)
 - Point of Care Documentation



*Your
partner in
bringing care
home*

About RCPA

- Rehabilitation and Community Providers Association (RCPA) is a statewide organization of over 325 members that provide services to one million Pennsylvanians annually
- RCPA members offer mental health, substance use disorder, intellectual and developmental disabilities, criminal justice, medical rehabilitation, brain trauma, long term care and other related human services for both children and adults in every setting including inpatient and outpatient, residential and vocational
- RCPA advocates for those in need of human services, works to advance effective state and federal public policies, and provides professional support to members



Challenges

For Acquired Brain Injury

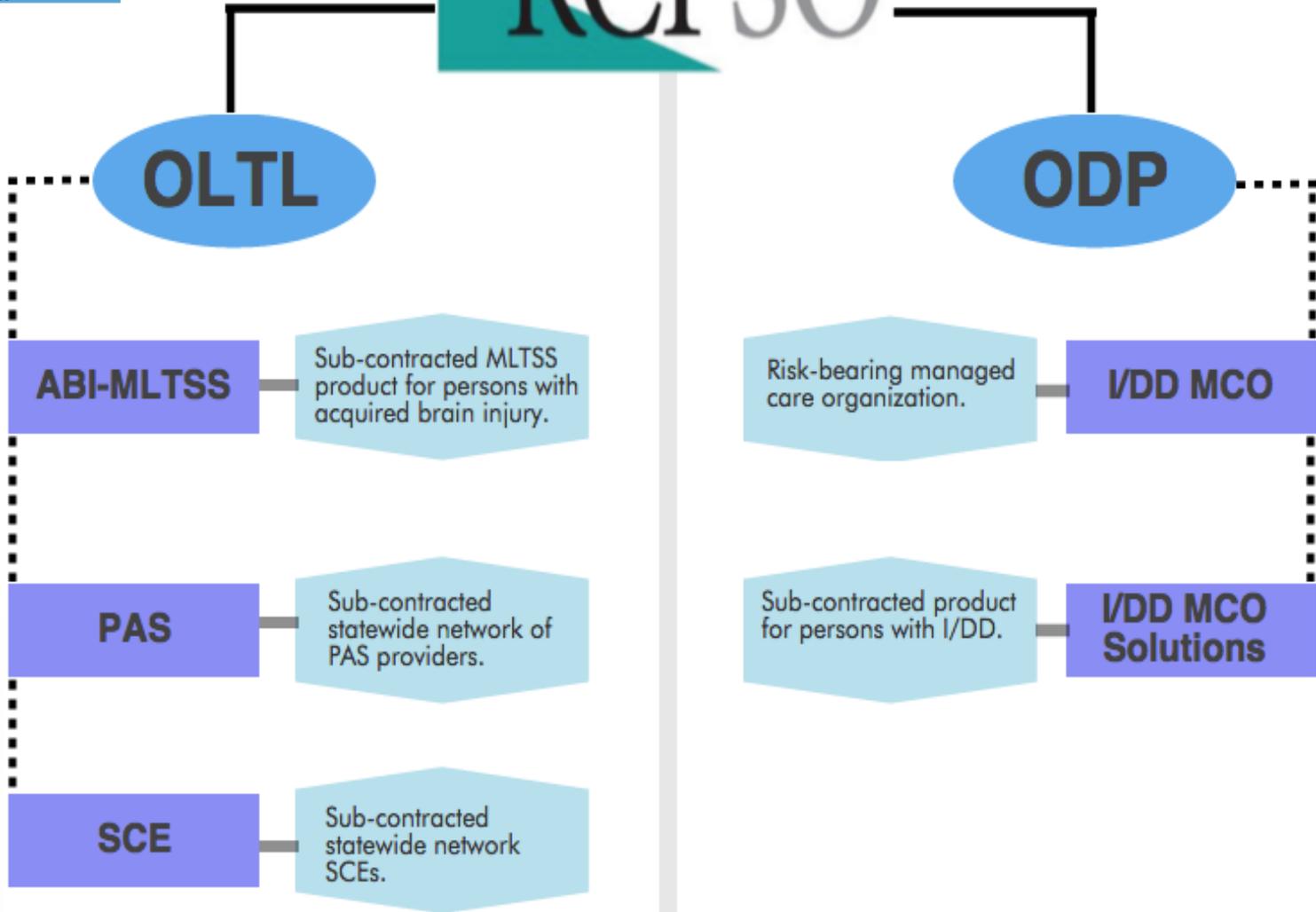
- Vastly Unlike Frail and Elderly
- 50-75% of the ABI Population are Between ages 19 and 44
- Specialized Rehabilitative and Habilitative Services
- Many Individuals with Mental Health and Substance Abuse Issues
- < 2% of OLTL HCBS Dollars
- Definable by a Finite Set of Diagnostic Codes
- Lifelong Support Needs

For Personal Assistance Services

- Many Providers, Disparate Capabilities & Managed Care Readiness
- Data Collection Across PAS Agencies
- Preserving Member Choice
- Local, Timely Delivery of Service
- Responsive to NHT
- Knowledge of Local Landscape & High Value Networks
- Member Trust and Established Relationships



RCPSO



Formation:

- Stand alone company formed by RCPA with by-laws and Board of Directors
- Based on CBHNP, a provider based solution for BH managed care.

Contracting & Compliance:

- Single Signature Authority
- Risk-based/Performance Contracts
- Statewide Network
- Centralized Reporting & Data Infrastructure with Utilization Management

For Acquired Brain Injury

- Experienced and Certified Post-Acute BI Providers
- Risk-Based and Performance Contracts, Using Clear Standards and Best Practices
- Member Services Managed Based on Functional Needs of the Member with Assessments Performed by Certified Brain Injury Specialists (CBIS)
- Centralized Conflict-Free, CBIS In-House Care Managers and Statewide Referral Coordination
- Required Home Visits, Periodic Review of PCP Adequacy, and Coordination with Medicare and PH and BH Providers
- Quality Oversight and Utilization Management
- Standardized Data Collection and Analysis
- Credentialing & Training Using CARF Brain Injury Standards



For Personal Assistance Services

- Statewide Network with SSA
- Risk-based & Performance Contracts
- Shared Function Care Management, Responsive to NHT, Unnecessary Nursing Home Placement, and Preventable ED Visits and Hospital Readmissions
- Local Service Delivery
- Centralized IT Infrastructure, Fiscal Support, and Training
- Consistent Quality and Network Adequacy
- Consistent, Standardized Data Collection and Reporting

About Adult Day Services

- Pennsylvania's 274 Adult Day Service programs serve 15,000+ adults with:
 - Medical complexities
 - Chronic and post acute illness
 - Physical disabilities
 - Functional limitations
 - Dementia



About Adult Day Services

Licensed/Certified Center Services include:

- Person Centered Care with individualized care plans
- 5-7 days per week; up to 11 hours per day
- Skilled Nursing Services/treatments, medication administration
- Diabetes management and insulin administration
- Rehab, Therapy, Wellness & Restorative Nursing Programs
- Personal care - bathing, hygiene, & other ADL assistance
- Nutrition Therapy Management (including nutritious meals)
- Therapeutic Social Environment
- Best value-based (hourly cost of a day of service) LTSS program



Ensuring Success for Adult Day

- Continuity of Care – two-year minimum for transition or modification of services
- Timely access to HCBS will:
 - Ensure the right service is provided at the right time
 - Decrease the number of people defaulting to nursing home placement
- Appropriate reimbursement rates to keep pace with inflation and provide for high-quality health care



About Pennsylvania CILs

- PCIL's network of Centers for Independent Living cover all 67 counties in Pennsylvania
- Consumer-controlled, community-based and cross age & disability CBOs that provide an array of independent living services and supports including: advocacy, nursing home transition and diversion, self-directed care, information and referral, and skills training on self-direction
- PA Centers for Independent Living have existed for over 35 years and have functioned as the HCBS providers network since their inception
- CILs are trusted providers of service for people with disabilities as well as seniors
- CIL's have the ability to provide home care, supports coordination and fiscal management services, all under the person-centered model



About Pennsylvania CILs

- The Core Services that each Center are required to do can translate into a variety of support services needed to increase quality of life and positive health outcomes (i.e. safety assessment of home, med management, home modifications, etc.)
- The PA Centers of Independent Living functions with a “boots to the ground” approach working with their consumers at their home



Ensuring Success for CILs

- Consumers must be guaranteed choice of existing providers during transition to MLTSS
- Person-centered planning should be based on the functional and social needs of participants rather than “medical necessity”
- Stakeholder Engagement should also include that regional participant committees that feed into the statewide CHC MCO Participant committee
- NHT services should adequately cover the true costs of this time intensive transition work. Incentives should also be established to motivate all providers to work towards the universal goal of reduced nursing facility care.

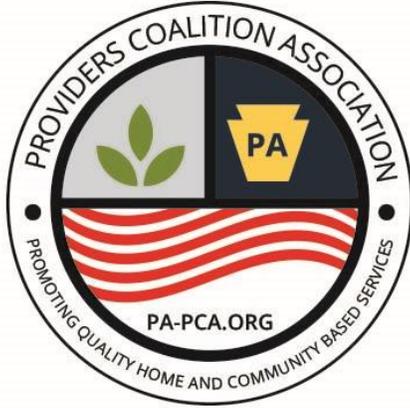


Thank you!

Questions & Discussion



Service Coordination Entities Session



Pennsylvania Providers Coalition Association
Promoting Quality Home and Community Based Services

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Presenters:

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Kristy Dovichow, Service Coordination Resources
Kelsey Miller, United Disabilities Services
Jennifer Rogers, Jevs Human Services
Barbara Polzer, Liberty Community Connections



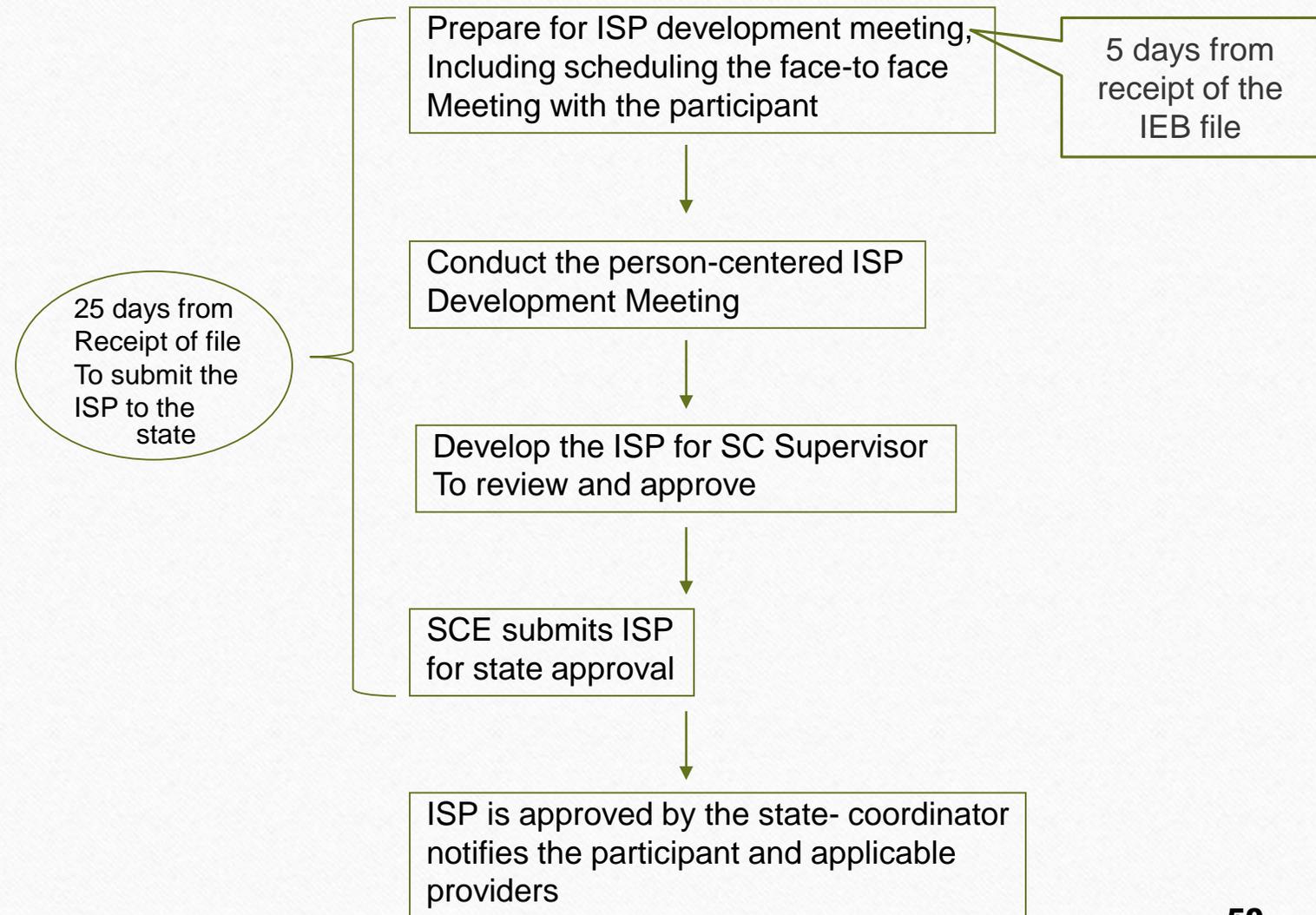
Service Coordination Entities (SCEs)

Agenda:

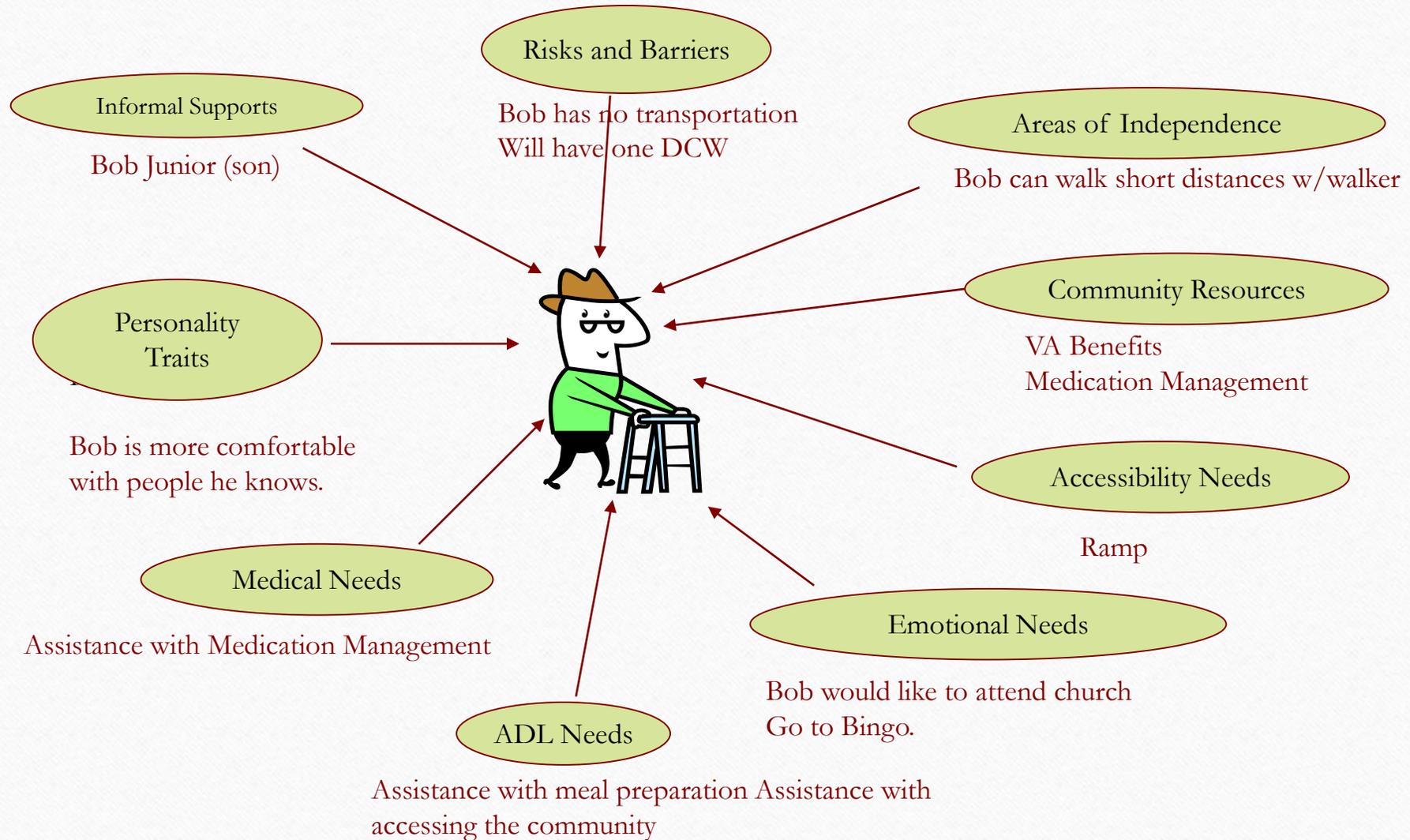
- SCEs role in ISP Development and Monitoring
- SCEs as a liaison between the Participants and other Providers
- SCEs role in protecting Participant Health/Welfare

SCEs & ISP Development

- SCEs are responsible for the assessment of need and development of the Individualized Service Plan (ISP) for new starts who were found eligible by IEB
- SCEs educate the participants about their rights & responsibilities while on the program, as per OLTL standards
- SCEs assist the participants with developing an interim plan of care which will be implemented as the participants wait for formal services.



Person Centered Assessment- ISP Meeting



Service Models

Who manages.....	Workers	Payroll	Plan Budget
Participant Directed model	Participant (<i>SCE must monitor</i>)	FEA/Participant (<i>with SCE assistance</i>)	SCE
Agency model	Agency	Agency	SCE
Services my Way	Participant (<i>SCE must monitor</i>)	FEA/Participant (<i>with SCE assistance</i>)	Participant

- Service Coordinators will assist their participants with the selection of a service model by explaining each model's advantages and disadvantages.
- Service Coordinators may restrict a participant from the use of participant directed model services if they demonstrate inability to self-direct services or engage in MA fraud.
- Service Coordinators will facilitate switches from one model to another and will coordinate referrals to providers that may be associated with the switch..

SC responsibilities with Participant Model participants:

Service Coordinators (SCs) assist their participants with set up and facilitation of consumer model services. These tasks include:

- Referral Process To Fiscal Employer/Agent *(FEA)- Medicaid funds cannot be released directly to consumers. Due to this requirement, a fiscal provider will be set up by the SC to perform all payment related employer responsibilities on behalf of consumers.
- Communication of changes
 - Demographic (i.e. Change of address, phone number).
 - Services on hold due to hospitalization, nursing home admission or incarceration.
 - Designation of Power of Attorney (POA) or new Common Law Employer (CLE).
 - Loss of Eligibility/ Termination of Services/ Switch to agency model
- Communication of concerns to the FEA
- Monitoring of service usage and restriction to agency model if the consumer demonstrates that they cannot self-direct services.

SC responsibilities with Agency Model participants:

SC is the liaison between the participant and the direct services providers (agencies that provide attendant care). SC will perform the following tasks:

- Complete the Referral Process
- Communicate changes in services (permanent increase/decrease in hours, temporary increase/decrease, termination, addition of new services)
- Communicate demographic/eligibility/employer changes (i.e. Change of address, hospitalization, designation of Power of Attorney)
- Assist with reporting complaints (i.e. concerns regarding attendant care workers etc.)

Monitoring of Services

OLTL REGULATIONS

SCE TASKS

Ensure Services are furnished in accordance with the ISP.

Verify DCW schedule, review PPL Web Portal, request usage reports from agency model providers.



Respond to and assess emergency situations and incidents to assure consumer's health and safety.

Report and investigate incidents, implement changes in the ISP when needed.



Monitor the effectiveness of back-up plans.

Ask follow up questions about people who will be included in the Crisis support Plan (do they live close by, do they work etc).



Review provider documentation of service provision and coordinate team meetings/discussions when desired outcomes are not being achieved.

Meet with agency model & non-waiver service providers to discuss alternative options that will meet consumer's needs.



Arrange for modifications in services & in service delivery if needed, to address the needs of your consumer.

Assess for increases and decreases (temporary or permanent), service model changes, provider changes, new services etc.



Advocate for continuity of services, system flexibility, proper utilization of facilities, accessibility and participant rights

Assist with Hospital and Nursing Home discharge planning, provide consumers with the OLTL Participant Packet



Participate in all Department identified activities related to quality oversight.

Attend OLTL and Program Regulated trainings.



SCEs play a vital role in the referral process:

Agency Model

- If a participant chooses to receive services from an **Agency Model** attendant (Direct Care Worker), a referral will need to be made by the **SCE** to make the provider aware of participant's choice
- SCEs communicate with providers regarding the participants specific needs and assist with meet- and-greets as needed.
- Coordinators communicate changes in consumer status during the referral process and communicate authorization information.

Participant Directed Model

- Participants who wish to **Self-Direct** will rely on their **SCE** to electronically initiate their referral on PPL's Web Portal.
- SCEs act as a liaison between the FEA and the participant during this process and often assist with the following tasks:
obtaining paperwork for the CLE and the DCW, completion of the paperwork, calls to the IRS to obtain the EIN number.
- SCEs assist with coordinating care as the participant awaits completion of enrollment.

Mandatory Contacts

- SC's are required to complete a minimum of 6 contacts per year with each of their participants:
- They are completed to monitor participant's health/welfare, proper use of MA funding and to make sure that the ISP is being implemented as it was intended



Reassessment Visit (RV) – Completed once a year

Monitoring Visit (MV) - completed once a year



Monitoring Telephone Call (MTC) – completed minimum 4 times a year

Who SCEs work with:

Communicate with CAOs:

- Nursing Home Admissions/Discharge
- Death
- Address changes (within the same county of not)
- Waiver Transfers
- Withdrawal from Waivers
- Termination of services
- Changes in Financial Status

Communicate with AAA:

- Referrals for Level of Care Determination
- Reports of Need for over 60/OAPS

Cooperate with BHA during the Appeal/Hearing Process.

Communicate with BPI:

- Report Suspected MA Fraud

Communicate with Vendors /providers in the area to coordinate:

- Housing Referrals
- Medical Supplies/ accessibility adaptations
- Funding from other sources (MS Society, OVR, VA etc.)



Communicate with Mental Health Providers:

- Regarding cognitive/metal health changes
- Suicidal attempts

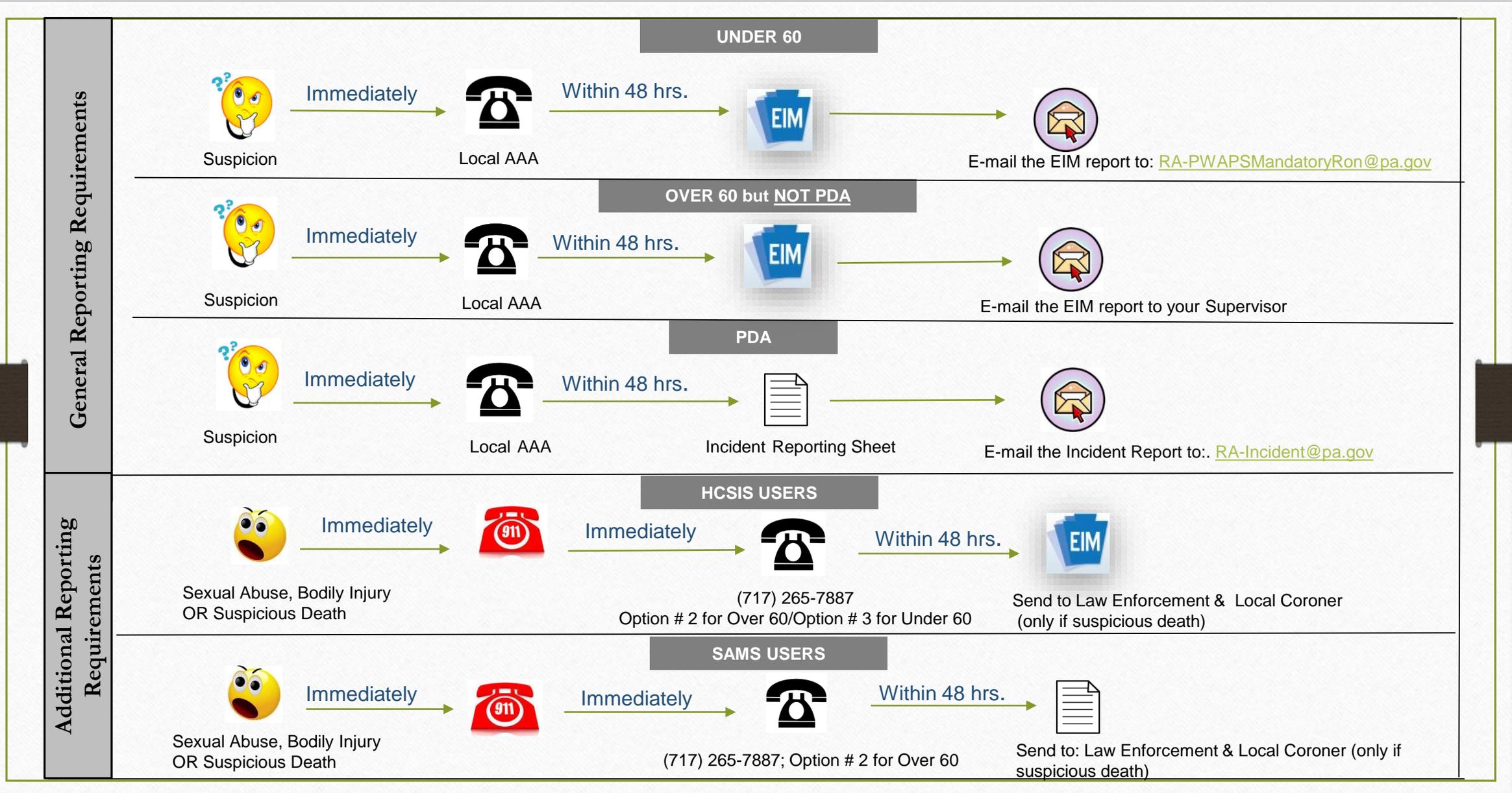
Communicate with APS Provider:

- Suspected Abuse/Neglect or Exploitation

Communicate with medical professionals:

- Obtain Physician Certification (PCP)
- Communicate regarding health risks/non-compliance issues
- Obtain scripts
- Nursing Facilities/Hospitals
- Vendors

SCEs play an important role in reporting of adult abuse:



Benefits of SCE involvement:

SCEs are viewed by their participants as trusted partners and advocates.

SCEs offers 24/7 assistance to their Participants.

SCEs have community relationships with local entities that assist in supporting the health, safety, welfare and independence of each participant currently being served through MLTSS

SCEs have years of experience working with OLTL regulations and assessing participant needs

SCEs are invaluable in preventing and stopping the abuse /neglect and exploitation of the elderly and vulnerable populations.

SCEs oversee the use of MA funding. Due to frequent contact with participants, they are invaluable in the process of spotting and stopping MA Fraud.

SCEs are geographically located across the Commonwealth resulting in the ability to have a physical presence in the home

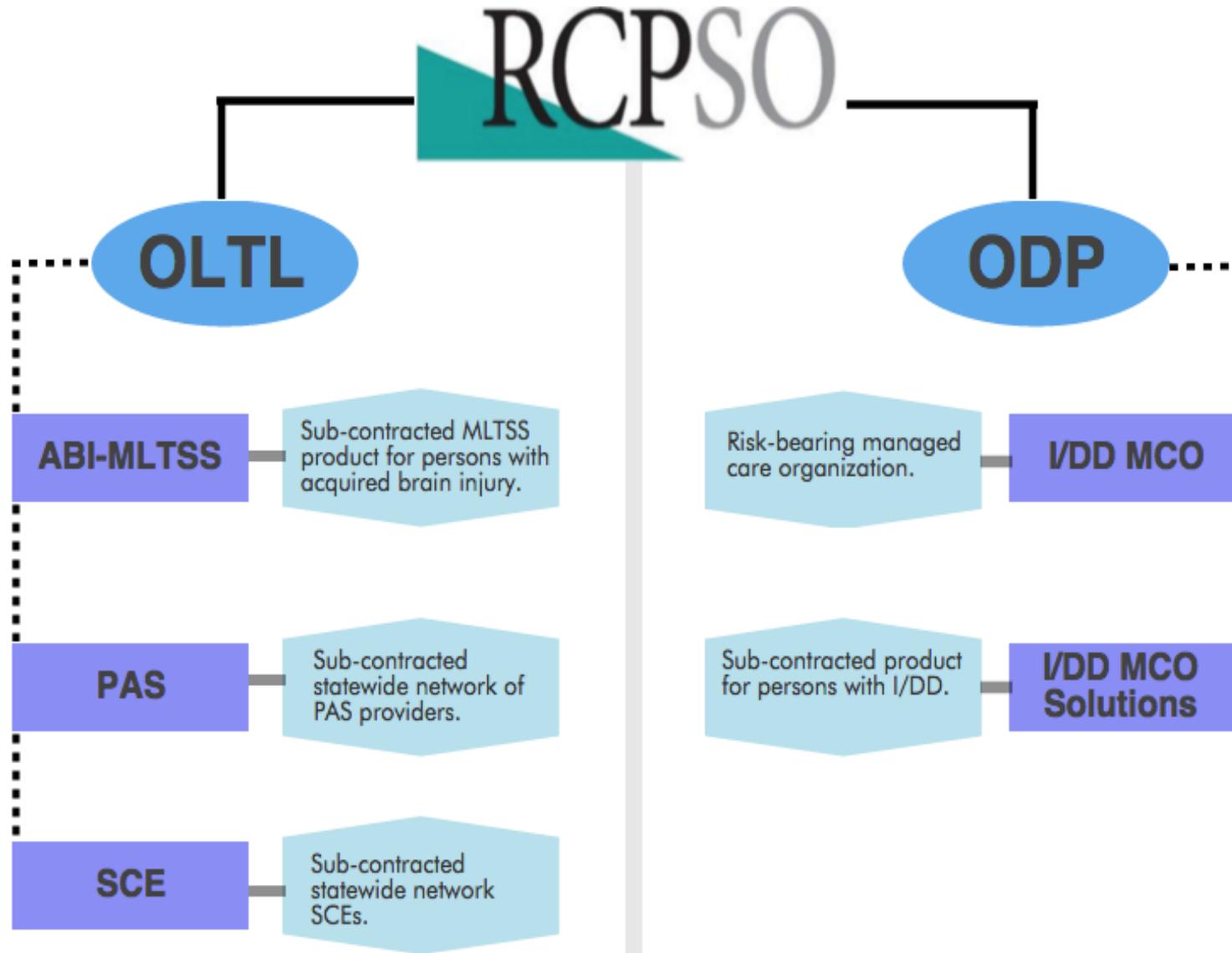
Acronym	Full Name	Acronym	Full Name
AA	Accessibility Adaptation	ISP	Individualized Service Plan
ACW	Attendant Care Waiver	IW	Independence Waiver
APS	Adult Protective Services	LCD	Level of Care Determination
AT	Assistive Technology	MDME	Miscellaneous Durable Medical Equipment
BPI	Bureau of Program Integrity	MTC	Monitoring Telephone Call
BHA	Bureau of Appeals and Hearings	MV	Monitoring Visit
CI	Community Integration	NHT	Nursing Home Transition
CLE	Common Law Employer	NMT	Non-Medical Transportation
CMI	Care Management Instrument	OAPS	Older Adults Protective Services
CMS	Centers for Medicaid/Medicare Services	ON	Office Note
CT	Community Transition	OW	OBRA Waiver
DCW	Direct Care Worker	PAS	Personal Assistance Services
DHS	Department of Human Services	PDA Waiver	Pennsylvania Department of Aging Waiver
DME	Durable Medical Equipment	PERS	Personal Emergency Response System
DMES	Durable Medical Equipment and Supplies	POA	Power of Attorney
DNR	“ Do not Resuscitate” (advanced medical directive)	QMET	Quality Management Efficiency Team
EM	Environmental Modification	RV	Reassessment Visit
EVS	Eligibility Verification System	SME	Specialized Medical Equipment
F/EA	Fiscal/Enrollment Broker	TCI	Telephone call Incoming
FMS	Fiscal Management Services	TCO	Telephone call Outgoing
HA	Home Adaptation	TCS	Telephone call from/to another Source
HCBS	Home and Community Based Services	VO	Visit Other
ICD-10	International Classification of Diseases 10 th Revision	WPT	Waiver/Program Transfer
IEB	Independent Enrollment Broker	IW	Independence Waiver

Rehabilitation and Community Providers Association (RCPA)

- Rehabilitation and Community Providers Association (RCPA) is a statewide organization of over 325 members that provide services to one million Pennsylvanians annually.
- RCPA members offer mental health, substance use disorder, intellectual and developmental disabilities, criminal justice, medical rehabilitation, brain trauma, long-term care and other related human services for both children and adults in every setting including inpatient and outpatient, residential and vocational.
- RCPA advocates for those in need of human services, works to advance effective state and federal public policies, and provides professional support to members.

Challenges with Providing Effective Service Coordination

- The many Service Coordination Entities have disparate capabilities, size, service areas, capacities for change or growth, and readiness for MLTSS
- Data collection and reporting is not standardized across Service Coordination Entities
- Members expect consistency and quality of interaction and plan development
- Members are accustomed to choice of SCE provider with swift and seamless transitions when exercising their right to make a change
- Members expect and value local access and timely response to problems
- Person-Centered Plan development and home visits require a local interface with the member, his family and his service providers
- Members who experience mental health and/or substance abuse issues have encountered problems with coordination of critical services in conjunction with LTSS
- Members who have been institutionalized have experienced delays and inconsistent coordination of a return to community living
- The service and support needs vary greatly across the OLTL populations requiring broad experience and expertise plus knowledge of local culture and resources for effective service coordination
- Members place high value in service coordinators who support their independent living and employment goals as well as health and wellness outcomes



Formation:

- Stand alone company formed by RCPA with by-laws and Board of Directors
- Based on CBHNP, a provider based solution for BH managed care.

Contracting & Compliance:

- Single Signature Authority
- Risk-based/Performance Contracts
- Statewide Network
- Centralized Reporting & Data Infrastructure with Utilization Management

RCP-SO Service Coordination Solution

Vision: “To improve quality, expand access, and drive LTSS innovation.”

- Statewide network via one at-risk contract featuring member choice of at least four service coordination entities; swift and seamless transitions between entities; increased focus on nursing home transitions and diversions, and standardized data and reporting to the MCO
- Member Services provided by well-trained service coordinators experienced with the OLTL populations and familiar with the independent living philosophy and aging in place
- Infrastructure/IT/fiscal support and training provided to SCEs for consistency, quality and adequacy of RCP-SO network across Pennsylvania
- Re-assessments of need for LTSS performed by experienced personnel
- Conflict-free service coordinators work in close partnership with the MCO care management team for appropriate Person-Centered Plan approvals and service authorizations
- Close coordination with Medicare and physical health and behavioral health providers to meet each member’s assessed needs
- Development of Person-Centered Plan for appropriate services and supports with providers and the member and his/her family; local presence and knowledge of culture and resources
- Quality oversight of Person-Centered Plan adequacy and compliance with required home visits
- Consistent, standardized data collection and reporting; analysis of goal achievement for performance incentives
- Training to Community HealthChoices partners on independent living, aging in place, efficient transition from institutions, effective use of assistive technology and telemedicine

Nursing Facility Session

MCOs & Providers Discussion of Community HealthChoices

Paul M. Winkler, President & CEO, Presbyterian SeniorCare

Anne Henry, Senior VP & Chief Government Affairs Officer, LeadingAge PA

Alicia Titus, Senior Director Member Engagement, LeadingAge PA

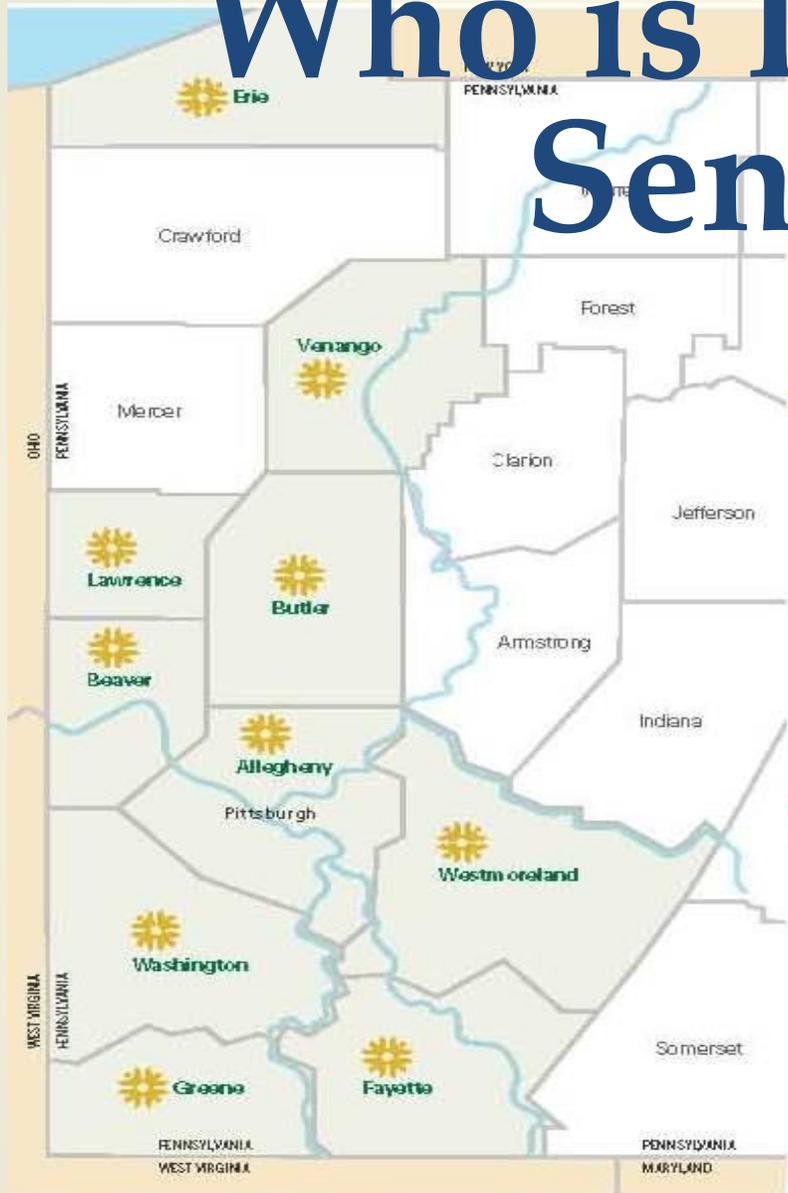
November 5, 2015



Who is LeadingAge PA?

- **More than 370 not-for-profit senior services providers**
- **Members represent the full array of senior care services and settings**
- **Members dedicated to making Pennsylvania a better place to age**

Who is Presbyterian SeniorCare



Facts-at-a-Glance

- **Western PA**
 - ✓ 56 communities/services
 - ✓ 44 locations
 - ✓ 10 western PA counties
- **Serving more than 6,500 annually**
- **Approximately 2,200 employees**
- **First in Pennsylvania and third in the U.S. to earn accreditation by CARF-CCAC as an Aging Services Network**

The Not-For-Profit Difference

- **Emphasis on caring**
- **Placing needs of individual and families served above all else**
- **Faith-based, mission-focused care**

Core Values Inform This Process

Benevolence

- Serve people of all faiths / no faith affiliation
- Serve people of all income levels
- Benevolent Care program – SeniorCARE Fund

Innovation

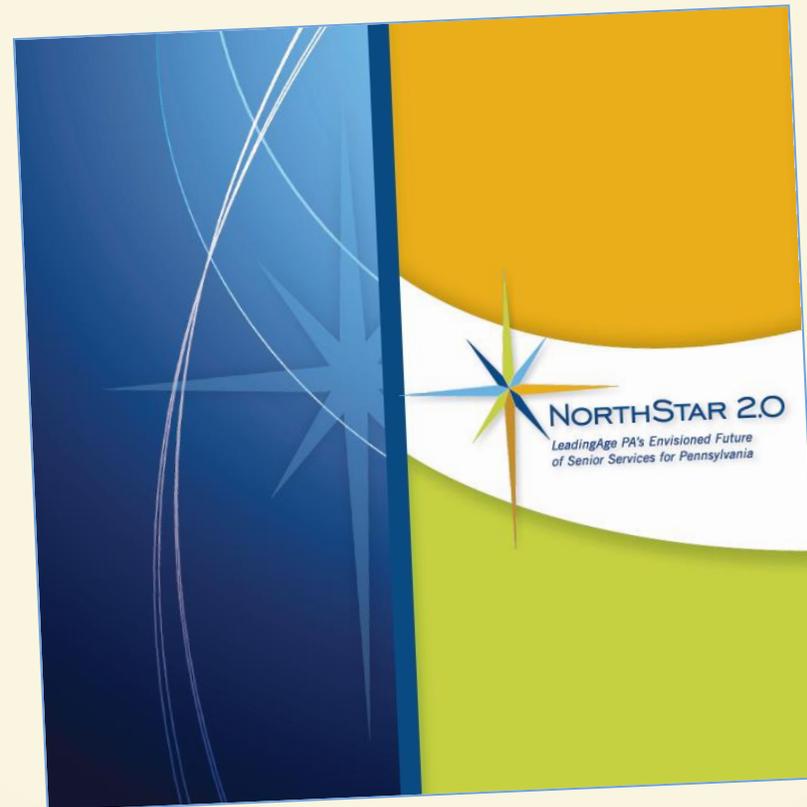
- Create products / services people want / need
- Create future of aging services

Collaboration

- Partner with peers
- Partner across the continuum (hospitals, physicians, etc.)

NorthStar 2.0

LeadingAge PA's Envisioned Future of Senior Services for Pennsylvania



Consumer-Focused Points

Seniors are living with purpose and meaning

Services are “home” centered

Choices are consumer centered

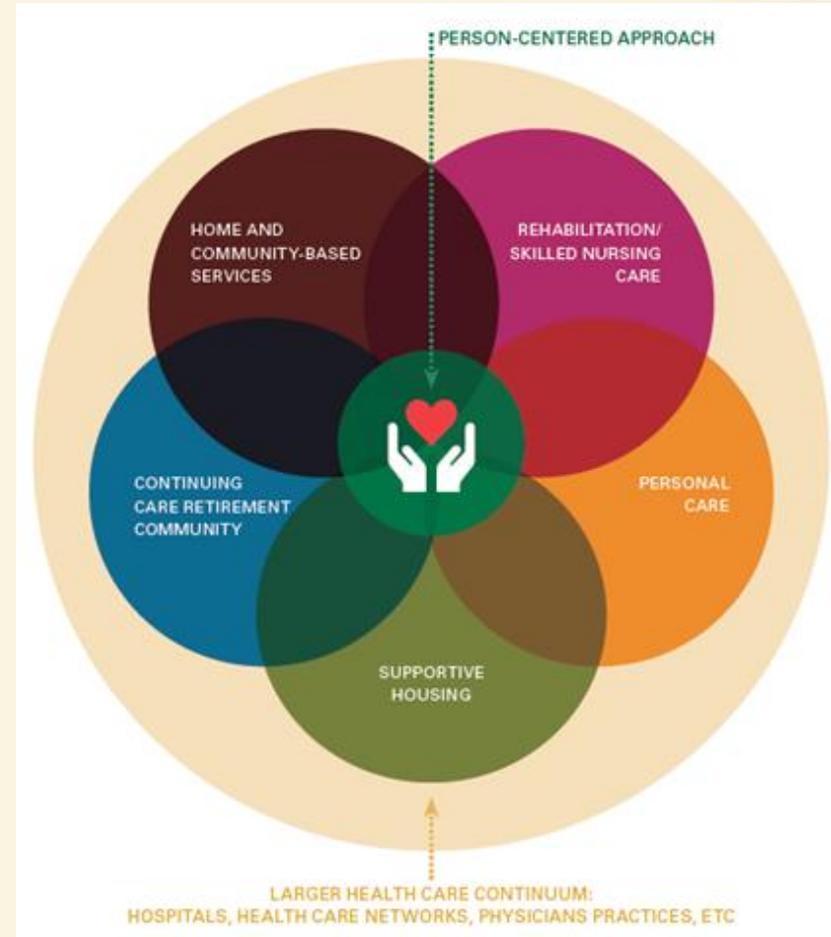
Services are easy to access and navigate

Leading Age PA Members Provide the Following:

- **Continuing Care Retirement Communities/Independent Living (CCRC)**
- **Assisted Living Residences and Personal Care Homes**
- **Post-acute Nursing Facilities**
- **Low Income Housing with Services**
- **Home Care Services**
- **Home Health Care Services**
- **Hospice**
- **Adult Day Care/Services**
- **LIFE (Living Independence for the Elderly)**

Presbyterian SeniorCare Provides the Following:

We build and deliver a continuum of living and service options for older adults and their families throughout western Pennsylvania.



Presbyterian SeniorCare Provides the Following:

- **Skilled Nursing Communities**
 - ✓ 8 communities / 404 beds
- **Personal Care Communities**
 - ✓ 7 communities / 795 beds
- **Continuing Care Retirement Communities**
 - ✓ 2 communities / 404 units
- **Affordable Housing**
 - ✓ 35 communities / 1,923 units
- **Home and Community-Based Services**
 - ✓ Dementia Day Care
 - ✓ Community LIFE (partnership with UPMC and Jewish Association on Aging)
 - ✓ Longwood at Home (Continuing Care at Home)
 - ✓ Presbyterian SeniorCare at Home

Right Service, Right Time, Right Place

- **Programs and services from consumer perspective to ensure they are accessible, seamless, and easy to navigate**
- **Coordinate services with other healthcare providers and community based organizations to ensure seamless delivery of services and care**
- **Measure consumer satisfaction and improve programs and services that do not meet consumer expectations**

SNF/Nursing Communities

Centers of Excellence

Rehabilitation Services

- Short-stay rehab program—*MyLife*
- Bundled Payment Program (5 of 8 nursing communities participating)
- Complex Patient Management (focus on CHF and COPD)

Dementia Care

- 75% of residents with a diagnosis of dementia
- 2014 LeadingAge “*Great Minds Award*”

End of Life Care

- Collaboration with Family Hospice and Palliative Care
- 2007 ANA/AHA “*Circle of Life Award*”

PCH/ALR

Alternative to Nursing Facilities

- **Pennsylvania needs to include PCH/ALR in the provider network for Community HealthChoices**
- **Older adults who require 24-hour supervision and supports would not have to have their needs met in a nursing facility**
- **Not all seniors who need care can safely reside in their own home but could be safely cared for in the PCH/ALR setting**

CCRC Difference

- **Unique blend of services, housing and insurance.**
- **Offers formal or informal services focused on prevention and supporting seniors with chronic conditions**
- **Residents have already made their choice when moving to a CCRC**
- **CHC must recognize this choice and contract with the services provided by the CCRC**

Affordable Supportive Housing (Service Enriched Housing Model)

Importance of Affordable Housing with Services

- PA has thousands of low/moderate seniors in affordable housing—many are dual eligible
 - ✓ HUD, public housing, tax credit programs
- Significant % of senior residents are frail or at risk (typically 2/3) in our aging services network of more than 2,000 residents
- A proactive service enriched program has made an impact on this population
- Monitoring, coordination of services and wellness programs have extended the length of stay and quality of life

Affordable Supportive Housing

(Service Enriched Housing Model)

Importance of Affordable Housing with Services (cont.)

- Number of discharges to personal care and nursing homes have decreased dramatically in the past 10+ years
- Many communities have “death” as their #1 reason for discharge due to care coordination and hospice services
- Programs like the “SASH” program in Vermont (Medicare demonstration) show results of proactive care coordination

Questions?

Contact Information

- **Paul Winkler, pwinkler@srcare.org**
- **Anne Henry, anne@leadingagepa.org**
- **Alicia Titus, alicia@leadingagepa.org**

Long-Term and Post-Acute Providers

Nursing Facility Availability and Role Community Health Choices Program

November 5, 2015
DHS Provider/MCO Meetings
Harrisburg, PA

W. Russell McDaid, MHA
President & COO
rmcdaid@phca.org



NURSING FACILITIES: RESIDENT PROFILE

- **‘Average NF Resident:**
 - **88 yr old female**
 - **Has 4 or more ADL impairments (62% of all residents—In PA, it’s 71% of all residents)**
 - **Is experiencing moderate to severe cognitive impairment (64% of all residents)**

PA’s population is older and sicker. There are very few people residing in our nursing facilities on a daily basis who do not need the 24/7 skilled care they provide, and ALL need some type of care and services on a 24/7 basis.

Source: CMS Nursing Home Data Compendium, 2013.

Nursing Facility Availability

- **703 Nursing Facilities Statewide**
 - 673 Non-Public NFs (367 For-Profit; 306 Non-Profit)
 - 30 Public (23 County owned/operated & 7 VA)

- **Medicaid pays for the majority of PA's nursing home care:**
 - Medicaid—65% of days
 - Medicare— 13% of days
 - Private Pay—15% of days
 - Private Ins—5% of days
 - Other—2% of days

Source: DOH Statistical Report, 12/31/13

Medicaid Nursing Facility Availability

- Of the 703, **625 participate in Medicaid**, 78 do not. (*73% of those that do not participate in Medicaid are Non-Profits*)
- **For-Profit Nursing Facilities (350), providing 60% of PA's Medicaid Days of Care**
 - Medicaid—60% of statewide days/occupancy
 - Medicare— 56% of statewide days/occupancy
 - Private Pay—32% of statewide days/occupancy
 - Private Ins—70% of statewide days/occupancy
 - Other—18% of statewide days/occupancy

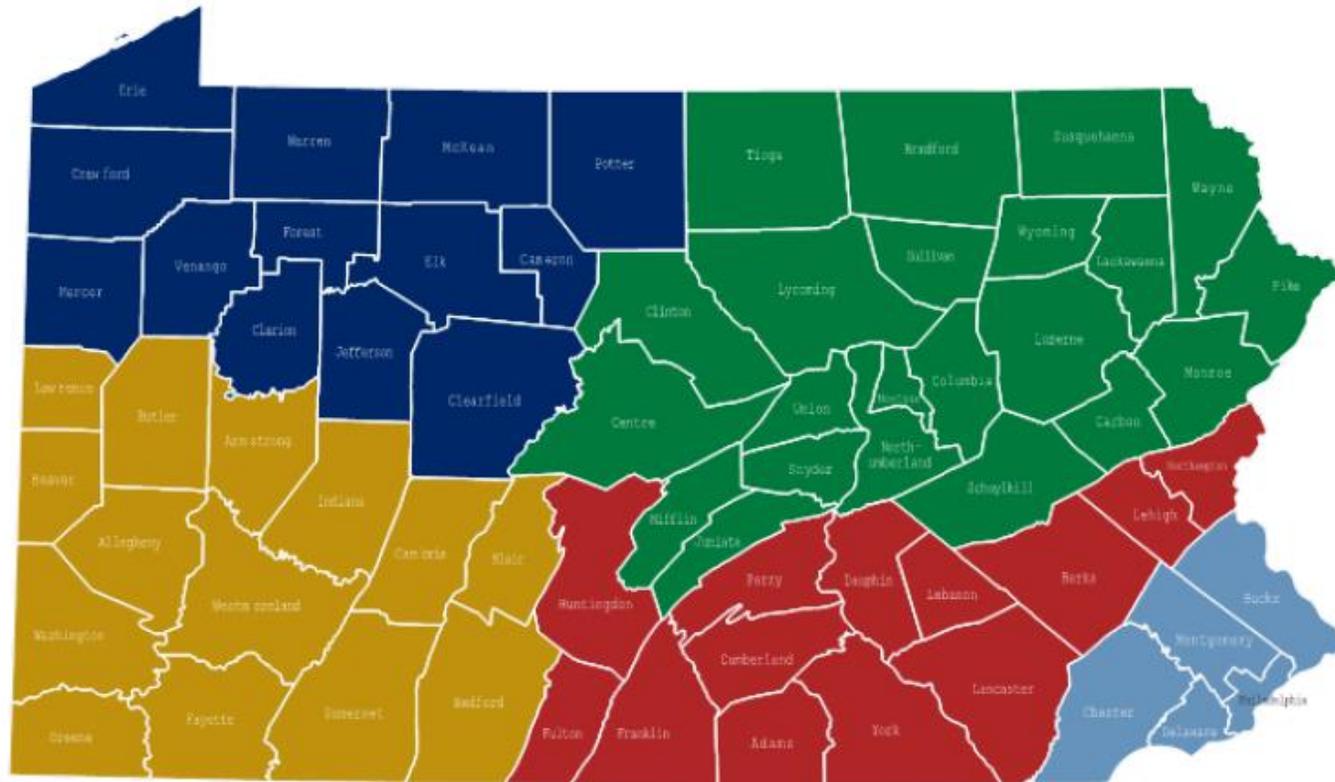
Source: DOH Statistical Report, 12/31/13

Nursing Facilities: Current Rates

- **Current Medicaid FFS system is cost-based, case mix adjusted, calculated based on Regs at 55 Pa. Code Ch. 1187**
 - ***For-Profit***: Statewide Avg. Full Rate: **\$228.83**
(before BAF applied)
 - ***For-Profit***: Statewide Avg. BAF Rate: **\$194.36**
(What they actually get paid by DHS)
 - ***Non-Profit***: Statewide Avg. Full Rate: **\$232.39**
(before BAF applied)
 - ***Non-Profit***: Statewide Avg. BAF Rate: **\$196.42**
(What they actually get paid by DHS)

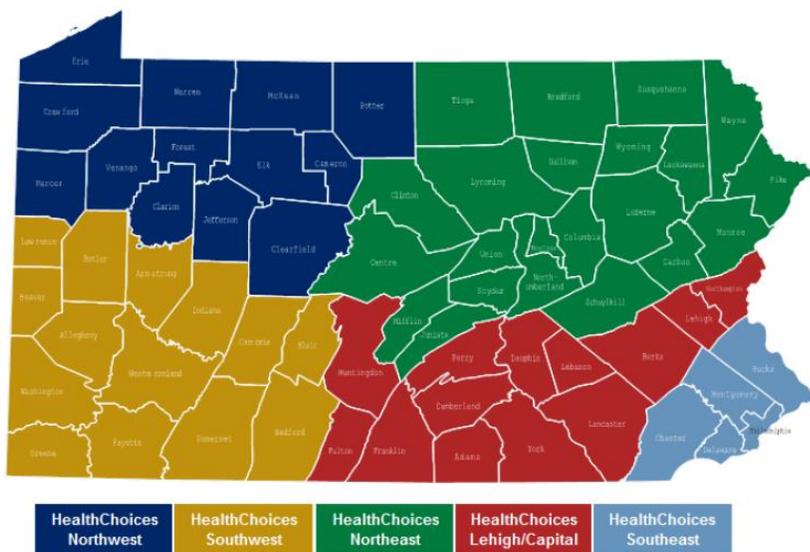
Nursing Facility Availability

HealthChoices Regions



Nursing Facility Availability

HealthChoices Regions



➤ Licensed Nursing Facilities by CHC ‘Phase’

- Phase I:
 - 153 MA Facilities w/ 19,774 beds
 - (25% of statewide/24% of statewide)
 - Average Medicaid mix 65%
- Phase II:
 - 149 Facilities w/ 22,658 beds
 - (24% of statewide/27% of statewide)
 - Average Medicaid mix 66%
- Phase III:
 - 320 Facilities w/ 41,183 beds
 - (51% of statewide/49% of statewide)
 - Average Medicaid mix 65%

Nursing Facility Services Covered under Per Diem Rate

- **Medicaid Nursing Facility Per Diem Rate includes funding for the following services:**
 - 1) **Regular Room**
 - 2) **Dietary Services**
 - 3) **Nursing Services**
 - 4) **Social Services**
 - 5) **Other Services required to meet certification standards**
 - 6) **Medical and Surgical Supplies**
 - 7) **General Nursing Services, including administration of oxygen, medications, feeding, incontinency care, etc.**

Nursing Facility Services Covered under Per Diem Rate

- **Medicaid Nursing Facility Per Diem Rate includes funding for the following services (Cont'd):**
 - 8) Items furnished routinely and uniformly to residents, such as gowns, water pitchers, bed pans**
 - 9) Items furnished to residents or used individually in small quantities like alcohol, applicators, cotton balls, bandaids, antacids, aspirin (and other non-legend drugs), suppositories, tongue depressors**
 - 10) Reusable items such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, other DME.**

Nursing Facility Services Covered under Per Diem Rate

- **Medicaid Nursing Facility Per Diem Rate includes funding for the following services (Cont'd):**
 - 11) Special dietary supplements used for tube feeding or oral feeding, even if written as a prescription by a physician**
 - 12) Basic Laundry Services**
 - 13) Nonemergency Transportation**
 - 14) Beauty and Barber Services**
 - 15) Other special medical services of a rehabilitative, restorative, or maintenance nature, designed to restore or maintain the resident's physical and social capacities.**

Long-Term and Post-Acute Providers

Nursing Facility Availability and Role Community Health Choices Program

CONTACT:

W. Russell McDaid, MHA

President & COO

rmcdaid@phca.org

Direct: 717 221 7930

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Provider Topics for MCO's and OLTL

➤ Topics for MCO's

- Safe and Orderly Discharges for NF Residents
- Medical Assistance Eligibility
- Administrative Issues
- Provider Network Standards
- Payment Issues

➤ Topics for the Office of Long Term Living (OLTL)

- Enrollment
- Level of Care Determination



Safe & Orderly Discharges of Nursing Facility Residents



Safe and Orderly Discharges

- Care Transition protocols must be consistent with state and federal requirements.
- NFs responsible for assuring safe & appropriate discharge. How will resolution be obtained when CHC-MCOs want a discharge but resident/family or state entities might not?
- Safeguards must be in place to minimize unnecessary re-hospitalization of NF residents.

Safe and Orderly Discharges

- What is the ongoing role of Ombudsman in the CHC discharge process?
- What is the ongoing role of Nursing Home Transition staff in the CHC discharge process?

Medical Assistance (MA) Eligibility



MA Eligibility

- Coordination between the County Assistance Office (CAO), Level of Care (LOC) entity, MCO and provider must occur.
- MA pending—who is at risk – MCO, State or Provider?
- Initial determinations must be processed timely
- Redetermination process needs to be coordinated with families, MCOs and providers.
- Timely appeals
- Eligibility and authorization processes and requirements must be uniform, streamlined, and coordinated

"The future of long term care"

PHCA
PENNSYLVANIA
HEALTH CARE
ASSOCIATION

 **LeadingAge™ PA**

PACAH
Pennsylvania Coalition of Affiliated
Healthcare & Living Communities

Administrative Issues



Provider Credentialing

- Credentialing should be consistent across all CHC-MCOs
- Maximize the use of Federal and State Medicare and Medicaid participation requirements, as well as any other provider accreditation requirements to avoid redundancies/duplication

CHC-MCO Transfers

- Clear and well-defined process for the transfer of consumers between CHC-MCOs
- Safeguards for the continuity of care and payment for out-of-network providers due to transfers
- Consistent process/procedures for transfers across all CHC-MCOs
- Established timeframes for transitions
- Timely notification to providers of changes
- Deadlines for care management staff assignments

Reporting Requirements

- Avoid duplicative reporting requirements
 - The State, CHC-MCOs, and providers need to work together to limit the redundancy of requirements to report incidents and the incidents/definitions of what is to be reported.
 - Recognition of different reporting requirements for different provider types must be made clear to the CHC-MCOs.



Provider Network Standards



Provider Network Standards

- Consistent standards across all CHC-MCOs
- Requirements placed on providers by CHC-MCOs must be consistent with existing state and federal laws and regulations.
- Additional provider requirements and failure to streamline processes will take resources away from care and services.
- Providers must be assured of payments if a consumer chooses an out-of-network provider.



Provider Network Standards

Assisted Living Residences & Personal Care Homes

- The role of assisted living residence and personal care homes in CHC must be defined.
- The impact of the CMS Home and Community-Based Services (HCBS) characteristics and settings final rule on the inclusion of ALR/PCH must be understood and communicated.



Payment Issues



Sufficient Rates to Ensure Quality Care

- Rates for all long term services and support providers must be adequate so that participants continue to receive quality care.
- NF Rates must include recognition of all payments that NF providers currently receive including supplemental payments funded by the provider assessment.
- CHC-MCOs must recognize the costs for various types of individuals including those needing short post-acute stays and those needing long stays.

Timely and Accurate Payment is Critical

- Current FFS requirements serve as the floor
 - Pay 90% of clean claims within 30 days
 - Pay 99% of clean claims within 90 days

- Accuracy of payments is essential to avoid costly appeals



Provider Issues for OLTL



Provider Issues for OLTL

CHC Participant Enrollment Process

- A flow chart that outlines the steps, timeframes for approval, and entity at risk for the provision of services during each step of the process should be provided.
- Providers must be trained/educated on the enrollment and selection process in order to effectively assist residents and family members.
- Extensive coordination between the Department of Human Services (DHS), the provider and the MCO is imperative.

Provider Issues for OLTL

Level of Care Determination

- Will the Level of Care tool be developed and tested in time for Phase I of CHC?
- Will the new tool be phased-in by region or implemented across the state?
- How will the Department ensure consistent application of the level of care tool across the state?



Discussion and Questions

- We look forward to working with OLTL and the CHC-MCOs to implement a smooth transition to this new system for Pennsylvania's seniors.
- Contact information:
 - LeadingAge PA – Anne Henry, Sr VP & Chief Government Affairs Officer – anne@leadingagepa.org
 - Pennsylvania Health Care Association (PHCA)- Russ McDaid, Present & rmcdaid@phca.org
 - Pennsylvania Association of County Affiliated Homes (PACAH) -Kelly Andrisano, J.D., Executive Director, kandrisano@pacounties.org





Pennsylvania Coalition of Affiliated
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PACAH MCO “MEET AND GREET” PRESENTATION

Kelly Andrisano, JD, PACAH Executive Director

November 5, 2015



Pennsylvania Coalition of Affiliated
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WHO IS PACAH?

- 143 members
- 85 Facility Members
- 23 County Nursing Homes
- Six State Veterans Homes
- Remainder are associated businesses (pharmacies, therapy companies, etc.)



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Nursing Homes in PA, an Overview:

- Non-Public Nursing Facilities
- 6 Veterans Facilities (exempt)
- County Nursing Facilities
 - 7,680 Beds
 - 23 Facilities
 - Several 4 and 5 Star rated facilities



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WHAT DO COUNTY NURSING FACILITIES DO?

Answer: What do all nursing facilities do?

County facilities offer the same services

- Short-term skilled nursing
- Long-term skilled nursing
- Hospice Care
- Complex care for coexisting disorders
- Rehabilitative care
- Dementia Units
- Respite Care
- Ventilator Care
- Dialysis



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COUNTY HOMES = SAFETY NET

- Required to take your MA Day One individuals
- Average MA Occupancy of counties as a group is greater than 80%, with many homes falling between 85-95%
 - MA Occupancy of all nursing homes in PA, including counties, is just 65%
- Largest nursing home in PA – Fair Acres, DE County, over 900 beds
- Carved out of traditional payment system (Chapter 1189 Regulations)



Pennsylvania Coalition of Affiliated Healthcare & Living Communities

Chapter 1189 Regulations:

- Instituted because of unique population concerns
- Purpose was to give counties ability to take wide variety of patients
- For each rate year beginning on or after July 1, 2007, the per diem rate paid to a county nursing facility for a rate year will be the facility's prior rate year per diem rate multiplied by a budget adjustment factor determined in accordance with subsection (d). The budget adjustment factor for the rate year will be determined in accordance with the formula in the Commonwealth's approved State Plan.



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Chapter 1189 Regulations (continued):

- What this means: counties are paid the rates set in 2007 plus any increase that was included in the Commonwealth budget.
- Increases have been minimal over the past 8 years, with several years of flat funding
- No opportunity to increase rate based on population acuity or other factors



1189 (CURRENT FUNDING)

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Healthcare & Living Communities

SHORTFALLS

- **Agree that all nursing facility rates fall short of covering cost of care; shortfalls in both funding mechanisms**
- Comment from PACAH in 2006 “We have a concern about payment for county nursing facilities if the CPE method is not a viable payment mechanism in subsequent years. How will this be addressed?”
- County rates that have not kept up with the cost of care – set in 2006 and not altered since, CPE continues to decrease
- Seen in rates of privatization of county homes – 13 in last 5 years



Pennsylvania Coalition of Affiliated Healthcare & Living Communities

Important note - Independent study done showing former county home MA rates increase significantly after privatization

- CMIs go up ↑↑↑↑
- Rates go up ↑↑↑↑
- If all county homes privatize, this cost to the state is significant (\$29 million annually PLUS the cost of lost federal funding)

Conclusion - counties are providing quality safety-net care in an extremely efficient manner



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Healthcare & Living Communities

Unique Funding Mechanisms:

- Available only to Public Homes:
 - Intergovernmental Transfer (IGT)
 - Certified Public Expenditure (CPE)
- Potential of bringing in millions of additional dollars to public nursing facilities and LTC system
- Must continue to be maximized in a managed care environment



OTHER COUNTY

Pennsylvania Coalition of Affiliated
Healthcare & Living Communities

CONSIDERATIONS

- Collaborative nature of county human services system
- Accountability to local community
- Significant population without any Part B type coverage, and minimal coinsurance
- Specialty Units
- Unique populations:
 - Low CMI individuals
 - Complex care requirements
- High cost of care factors that cause non-county homes to avoid similar admissions
- Expensive specialty units that service specific populations.
- Medicaid populations nearing 85%-95%

**Counties have provided safety-net
care in partnership with the state...**



Pennsylvania Coalition of Affiliated
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OTHER GENERAL IMPLEMENTATION CONSIDERATIONS FOR NURSING FACILITIES:

- Timely Billing and payment, minimization of payment delays
- Authorization and enrollment concerns, pre-authorization uniformity and retroactive payment considerations
- Small facilities that feel as though they may be “cut-out” in a managed care environment
- Funding Floor – restrictions on drastic cuts to rates
- Safe and orderly discharge options
- Robust provider network
- Credentialing standards
- Quality measure uniformity
- Coordination with licensure standards
- Continuity of Care period
- Provider accountability
- Excess administrative and paperwork requirements



Pennsylvania Coalition of Affiliated Healthcare & Living Communities

RESOURCES:

- www.pacahpa.org
- CHC Comments, this presentation, County Home study:
 - <http://www.pacahpa.org/Pages/Resources.aspx>
- Information on CCAP:
 - www.pacounties.org
- Contact Information
 - PACAH Executive Director, Kelly Andrisano, JD, kandrisano@pacounties.org or (717) 736-4740
 - CCAP Government Relations Associate, Adrienne Hodson, ahodson@pacounties.org or (717) 736-4718