Summary of Anticipated Major Changes to the Organization and Delivery of Certain Medicaid (Medical Assistance) Benefits in Pennsylvania

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Managed Long Term Supports and Services

Pennsylvania is undertaking several major changes to the organization and delivery of certain Medicaid (Medical Assistance) benefits in Pennsylvania through Community Health Choices (CHC).

CHC is a new structure for the delivery of Managed Long Term Supports and Services (MLTSS) in Pennsylvania through managed care organizations rather than fee for service paid directly by the State Medicaid Agency, the Department of Human Services (DHS) in Pennsylvania.

CHC is scheduled to impact individuals receiving care in nursing facilities, individuals enrolled in five Office of Long Term Care Waivers (i.e. the Aging, Attendant, COMMCARE, Independence, and OBRA Waivers) and adults 21 and older who are dually eligible for Medicaid and Medicare.

CHC has been in the works for roughly two years and is scheduled to enroll in several phases:

- Phase 1 (Southwest Region) January 2018
- Phase 2 (Southeast Region) July 2018
- Phase 3 (Northwest, Lehigh-Capital & Northeast Regions) January 2019

It is anticipated that the COMMCARE Waiver will be modified to become the global waiver program for CHC by being an umbrella organization for other Waiver programs, which will slowly be incorporated under COMMCARE. Other Waivers will be slowly phased out and will be transitioned over various phases.

All services previously provided under the Waivers will be provided through CHC Managed Care Organizations (MCOs) rather than through DHS directly. DHS will still handle eligibility determinations for the Medicaid benefits, but CHCs will approve and deny services, with appeal rights to be in place comparable to those already in place for Pennsylvania's Health Choices program, Pennsylvania's Managed Care Medicaid program.

Individuals who are dually eligible for Medicare and Medicaid will have a choice of enrolling in one of three CHC Medicaid Managed Plan providers: UPMC For You, Pennsylvania Health and Wellness (Centine), and AmeriHealth Caritas. Each of these three CHC MCOs is required to have a Medicare advantage plan for dual-eligibles, and a Special Needs Plan (SNP), although dually eligible individuals are not necessarily obligated to enroll in such SNP Medicare Advantage Plan.

An independent enrollment broker, currently Maximus (although bidding is out), will determine enrollment, with individuals then selecting their CHC MCO Plan. Payments for services will come directly from the CHC MCO, rather than from DHS as previously was the case with fee for services.

CHC MCOs will determine the services and amounts available to individuals. For example, for Waiver programs, the CHC MCO will determine whether an individuals gets 5 or 40 hours a week of coverage, etc. However, there is an exception whereby individuals enrolled in Waivers are to remain with their providers and their current level of services for the first 6 months after the rollout of CHC, after which time the CHC MCO is able to review and change the services, with appeal

rights as previously stated.

CHC MCOs will have the option of contracting with outside service coordinators or hiring their own. The input at this point is that CHC MCOs will hire their own services coordinators, which creates an inherent concern regarding conflict of interest and providing advocacy and for consumers.

One basis behind the centralization of managed care is better management and coordination of services, particularly for individuals whose needs and services change, for example the switch from attendant care to nursing care in a facility. Additionally, when the CHC rolls out, if an individual is in a nursing facility, the individual is entitled to stay in that nursing facility even if the nursing facility is not in-network for the selected CHC MCO. Thus, it is anticipated that not all nursing facilities will be in the network of each MCO.

Health Choices, Pennsylvania's State Medicaid Managed Care program, will remain in place, but will change for dual eligibles and those with long term supports and services delivered through the Office of Long Term Living.

CHC does not impact Medicare or the choices available to Medicare recipients. CHC is also currently **not** slated to impact:

- OBRA Waiver recipients who are not nursing facility clinically eligible;
- Adult consumers who are dual eligible between the ages of 18 and 20;
- Consumers in the Autism Waiver, Act 150 program, Options or Life Programs;
- Consumers enrolled in Waivers administered by the Office of Development Programs; which include the Consolidated and PFDS Waivers; and
- Individuals in state-run nursing facilities or veterans homes.

In addition, as part of the Governor's budget proposal, DHS has announced that it is intending to consolidate back office work into regional processing centers to enable work to be "done more quickly, accurately, and cost-effectively." The front office functions, which consist of face to face interaction with DHS, will remain in place. It is anticipated that Medicaid consumers will remain able to have face to face meetings at their local County Assistance Offices (CAOs), online or by telephone.

DHS has indicated that it will continue to have a CAO presence in each county and is proposing the creation of five processing centers to handle back office centralization of work which will result in a nominal reduction in staff throughout local CAOs. It has been indicated that the centralization and back offices are hoped to be opened in phases, initially beginning June 30, 2018.

Improved and Expedited Medicaid Appeals Process

The Centers for Medicare and Medicaid Services (CMS), per rulemaking issued on January 22, 2013, has finalized a subset of provisions to improve eligibility notices and expedite the fair hearing process. These provisions were first displayed in the Federal Register on November 21, 2016 (published November 30, 2016) and were effective January 20, 2017.

In pertinent part these provisions establish minimum standards for the content of Medicaid eligibility notices (§435.917(a)). The provisions will require DHS to improve the content of approval notices to include**:**

- Basis and effective date of eligibility;
- Benefits and services available;
- Premium and cost sharing obligations;
- Procedures for reporting changes; and
- Appeal rights.

In addition, DHS's Medicaid denial/termination notices must include a clear explanation of the reason(s) for ineligibility.

These provisions also require DHS to establish and maintain an expedited fair hearing process (§431.224). DHS's Bureau of Hearings and Appeals (BHA) is finalizing policies for implementation.

The new notice full implementation date is projected to be November 2017, with pilots starting in August with CAO Notices for the following pilot counties: Armstrong, Beaver, Butler, Cameron, Clarion, Clearfield, Clinton, Crawford, Elk, Erie, Forest, Jefferson, Lawrence, McKean, Mercer, Montgomery, Potter, Venango, Warren, Washington, Westmoreland, and York.

The provisions further establish standards for expedited fair BHA hearings to include:

- Individuals' ability to make a request "if the agency determines that the time otherwise permitted for a hearing under §431.244(f)(1) could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function;"
- A timeframe for final action of 7 days for eligibility-related matters (§431.224, 431.244(f)) and 3 days for benefit or services related matters (§431.224, 431.244(f));
- BHA fair hearing requests and expedited hearing requests available through all modalities (§431.221);
- A requirement for DHS to accept any method for withdrawal of a fair hearing request (§431.223);
- Clarifying the circumstances when an applicant or beneficiary can request a fair hearing (§431.220); and
- Providing for a fair hearing system that is accessible to individuals who are limited English proficient and individuals with disabilities that comply with antidiscrimination laws.

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