Philadelphia MLTSS Hearing
Friday, June 26, 2015
Temple University Center City – Room 222
1515 Market Street
Philadelphia, PA 19102
1:00 to 4:00 p.m.

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My name is Stuart H. Shapiro, M.D. I am the CEO of the Pennsylvania Health Care Association and Center for Assisted Living Management (PHCA/CALM), a statewide advocacy organization for the Commonwealth's elderly and disabled residents and their care providers. Members comprise of for-profit, non-profit and government providers. Together, they represent more than 450 long-term care and senior service providers that care for more than 45,000 elderly and disabled individuals daily.

Thank you for the opportunity to appear before you today to comment on the Commonwealth's Managed Long-Term Services and Supports Discussion Document.

Introduction

While PHCA supports the Administration's commitment to a long-term care system that is person-centered, coordinated, and focused on preventative services and participant outcomes, not surprisingly, we do have some concerns with the document as drafted and look forward to working with you collaboratively and constructively, as a partner with the Wolf Administration, as we move forward.

I hope you will find our perspective helpful. My verbal comments are restricted to five minutes, so I ask that you consider my testimony to be my entire written statement. We will also submit additional written comments in a timely matter.

Throughout 2013 and 2014, I was fortunate to be part of an important Long-Term Care Commission that studied a variety of ways to improve Pennsylvania's long-term services and supports (LTSS) system. While I did not like every word, every idea, and every recommendation in the final report, in the end, I believe what we produced was a valuable compromise. That compromise outlined a roadmap to improve LTSS for Pennsylvania. Thus, I voted yes, and, the compromise was unanimously endorsed by every member of the Commission.

One of the recommendations from the Commission related to managed care for the elderly, and I am very much looking forward to working with the departments of Human Services and Aging, and the entire Wolf Administration, to make sure it is implemented in a way that protects Pennsylvania's seniors.

That is why I am here today --- to be a partner in LTSS system change and to bring my years of experience as Health Commissioner here in Philadelphia, as CEO of a managed care company, and as an advocate for the elderly. Those who know me well, say I am a perfectionist. In this case, I believe that to be a badge of honor when dealing with program revisions of the magnitude the Administration is considering. The perfectionist in me would say let's take the time to get this as close to right the first time as we can, then let's fix problems when they occur; and,

Let's always keep our eyeballs on preserving availability and access to care, preserving the quality of that care and preserving our long-term care safety net for our most vulnerable seniors by making sure we serve individuals in the most cost-effective ways commensurate with their needs, and do so in a way that does not artificially shift costs from state government to the federal government, or vice-versa.

To accomplish all that is contained in that very long last sentence is a tall order, and, I believe the Long-Term Care Commission got it right when they said: **Proceed Prudently.**

While I believe Pennsylvania is most prudent to wait for some real and consistent data from other states that show that the elderly are not hurt by so-called managed care and that managed care can actually save the state money, and not, in fact, hurt consumers, **we are prepared to expeditiously move into Phase 1**, and carefully, help design several small geographically limited projects that are developed with real stakeholder involvement so that we can collectively assure that they are person-centered, coordinated, and focused on preventive services and participant outcomes.

These should be part of an initial RFP limited to getting a couple of programs up and running. Please note that I am recommending more than a single geographically limited phase 1 project. It is essential that the initial RFP not lock the Commonwealth, and other stakeholders, into the future by the decisions made at the beginning.

For example, as an RFP is put in place for phase 1, we could explore several different phase 1 projects that utilize different models of payment, organizational structure, risk, and care management. As we design these models, the Department and a broad base of stakeholders (including the beneficiaries themselves) must assure that the models are **not** designed to drive scarce taxpayer dollars to **just** large insurance companies who may have financial incentives to deny care rather than to provide it. Later in this testimony, I will outline some novel ideas for possible demonstration projects, including provider driven models, models that don't include nursing homes in the initial wave, and perhaps programs that are voluntary rather than mandatory, **Creativity is key, and Pennsylvania should be a leader in creating programs for Pennsylvania.**

We also believe that the proposed planning period of July to October, or three months, to get ready to issue the first RFP is a bit short. This is the 6th day of testimony on this subject. There has been much interest. Over 100 people have testified and I am sure there will be 1000's of pages of comments by the July 15th deadline for submitting comments. All of these comments need to be reviewed by not just the Departments, but also other stakeholders as I am sure there is much to learn. Please note we are not asking that that deadline be moved.

Stretching out the planning phase a bit would allow for real and important stakeholder involvement to drive Pennsylvania's MLTSS program moving forward that would serve as the basis for an RFP that would be used to implement the program in phases statewide. For example, New York's managed care demonstration proposal was developed over the course of more than a year from 2011-2012 with regular stakeholder engagement.

I don't think we need a planning process of a year, but I don't believe that the process can be completed in three months.

Just as the Long-Term Care Commission recommended that several different models be tested and proven effective before the decision is made to expand the program statewide, we urge that the initial RFP be limited to getting a couple of programs up and running and not be written to include the entire commonwealth.

There is no way we can know today, what will be needed in 2018 or 2019.

Any evaluation requires sufficient data to ensure a significant analysis, and we urge Commonwealth to allow adequate testing time to capture claims and other necessary data to inform this evaluation, and to look at the softer side of analytics—impressions and acceptance of consumers, providers, plans, and other stakeholders.

That way, before we go statewide, we make sure that:

1. We have Pennsylvania specific data to evaluate which programs/models are most effective in ensuring the best outcomes for consumers and optimal cost effectiveness for the Commonwealth;
2. The Administration has time to assess whether any segments of Pennsylvania's population would be better served in an alternative model, or even held out of MLTSS altogether if the evaluation didn't show enough benefit;
3. There is time to understand and benefit from how programs just now being implemented in other states are working;
4. Careful consideration is looked at the impact of various CMS initiative like bundling, ACO, and other innovations being led by the CMS Center for Medicare and Medicaid Innovation (CMMI); and, finally;
5. The just released comprehensive CMS proposed rule on Medicare and Medicaid Managed Care which included a multitude of protections for consumers, is fully understood, and, incorporated into the Pennsylvania program.

In other words, we urge that the Administration not proceed to lock into a five year rollout, but rather: **Proceed Prudently into Phase 1 and spend the necessary time to get the initial RFP right, learn, and then move expeditiously forward Statewide.**

My testimony will now address four topics: program design, program pace, program outcomes, and program principles --- the four P's of PHCA.

Program Design

While the administration's discussion document does not speak to cost savings as a goal, we all must acknowledge the incredible pressure that the Commonwealth and providers are under to live within the Medicaid budget. We therefore believe the state should focus on the duals population where the savings and efficiencies can be achieved for the system as a whole, and partner with providers and the Centers for Medicare and Medicaid Services (CMS) to share in the savings that Pennsylvania achieves for the federal government.

There is little data to support cost savings related to stand-alone Medicaid LTSS programs, or MLTSS. In fact, Indiana's ABD Task Force report to the General Assembly in 2013 determined that MLTSS would actually have a negative impact on cost due at least in part to increase state administrative costs associated with implementation of MLTSS. While many states are moving their LTSS populations into a managed care arrangement, most are doing so under a dual financial alignment project with CMS, which allows the shared savings to occur, primarily through reduced hospital costs on the Medicare side.

In addition, Medicare is a time tested and structured program that ensures both consumer safety through long-standing policies and protections and quality through rigorous provider standards and reporting. A focus on the duals population rather than a more broad approach will enable the state, managed care plans, and providers to develop a targeted program that increases the opportunity for positive outcomes.

For example, Pennsylvania could do what several states that have implemented MLTSS programs have done. They have narrowed the scope of such programs through the exclusion of the nursing home population. We

strongly recommend that one of the demonstration projects that are utilized for learning not include nursing homes in the initial phase of any program to allow adequate time for Medicaid and the managed care organizations (MCOs) to focus on activities related to the development of a network of community-providers who are unfamiliar with the managed care environment, including the following:

- Developing MCO reports that relate specifically to MLTSS and include components of call monitoring, complaint and appeal actions, disenrollment, network adequacy, participant health and functional status, quality and performance measures tailored to the needs of those eligible for LTSS.
- Ensuring that MCO and provider data systems are capturing the necessary information to facilitate reporting of community-based LTSS for which they are currently unfamiliar.
- Allowing sufficient time for MCOs to work with community-based LTSS providers who are not sophisticated and experienced in managed care with activities such as contracting and reporting.
- Developing capacity to facilitate the additional prior authorization processes that will be necessary to manage community-based LTSS.
- Designing enhanced monitoring of MCO prior authorization to ensure it is not being over- or under-utilized.

Experience in other states implementing MLTSS indicates that while most community LTSS providers continue to be viable, they report increased administrative cost and cash management pressures. Billing issues were pervasive in Minnesota, some continued many years after implementation. A challenge when implementing managed care for new provider groups, such as community-based LTSS, is that each MCO has separate billing systems and procedures that are much different from Medicaid billing procedures. This is new and unfamiliar territory for these providers. In Minnesota, providers waited longer to get paid, and billing disputes took longer to resolve than when they billed Medicaid directly under fee-for-service.

By being proactive and ready to address provider readiness and claims payment issues, Medicaid and MCOs can prepare for many of these potential issues; however, as with any implementation there are unforeseen challenges and barriers. Therefore, states must allow time post-implementation to address and resolve provider needs before expanding programs.

Nursing homes are one of the most highly regulated groups of providers at both the state and federal levels. Integrating these existing regulations into any new program and ensuring the MCOs are competent at overseeing nursing homes adds a new layer of complexity. While nursing homes are highly skilled at ensuring the coordination of care across both Medicare and Medicaid, MCOs that concentrate on the Medicaid business are traditionally not skilled at working with the Medicare program. Even those that work with Medicare on the commercial side have siloed models that require extensive internal reorganization to build the expertise within the Medicaid program.

We urge the Commonwealth to follow the lead of states that have chosen a measured approach to allow adequate time for testing models and assessing MCO expertise in working with people with long-term care needs before adding the most vulnerable and frail population into the mix.

For example, Texas began to pilot Texas STAR+, a long-term care managed care program in 1998. Nursing homes are only now being carved into the STAR+ program over 18 years later.

Indiana's first foray into managed care for the aged blind and disabled populations, I believe, did not include nursing homes.

When New Hampshire implemented managed care, LTSS was not added until Phase 2 of the implementation.

New Jersey also waited to include MLTSS until Phase 2 of its 1115 demonstration. It has just recently been added, and, from what we have heard, there is much confusion for both consumers and providers.

While we believe that a duals program is the only viable choice for Pennsylvania and would suggest that nursing homes be carved out in the first phase, experience elsewhere has shown that there is no "one size fits all" approach and no single proven model that the Department can merely pull "off the shelf" for implementation.

The duals population is not homogenous: there are the over 65s, the under 65s, nursing home residents and community duals. Careful planning and advanced analytics to discover and target clinical approaches and interventions to the subsets of the duals population will be required for positive outcomes.

In addition to limited Commonwealth experience in managing duals, the managed care plans seeking to serve the duals populations have relatively scant experience with this complex population. For many it is a totally new population. Caring for these individuals requires expertise in evaluating not just the medical needs, but also the social needs of the person. With the current focus on serving the primary and acute needs of children and families, the existing private medical managed care model has the risk of not meeting the needs of the duals/LTSS population. This lack of experience with the ongoing complex needs of the duals populations and LTSS can undercut an MCOs' ability to administer those benefits effectively and fairly.

A study of KanCare provides a good example of too much too fast:

> *In January 2013, Kansas began phasing out the traditional fee-for-service model and enrolling low-income, disabled and frail elderly patients in a managed care program called KanCare. The administration contracted with three health insurers to coordinate care for a patient population that currently numbers about 400,000.KanCare was launched with promises, some of them written into the contracts with Amerigroup Kansas Inc., United Healthcare Community Plan and Sunflower Health Plan, a subsidiary of Centene. Medicaid eligibility would not be reduced. Payments to health care providers could not be lowered. Patients would not see cuts in benefits. More than a year and a half in, KanCare's record is spotty at best. All three of the managed care companies lost money in 2013, and the shortfalls accelerated in the first half of this year, amounting to $182.6 million total. The other big problem has been late payments of claims submitted by hospitals, nursing homes, doctors, pharmacists and other health care providers. Some have complained bitterly about having to delay paying bills and even making payroll while they're waiting for reimbursements from the managed care companies. While it does not appear that enrollee care is compromised, the tension in the program has resulted in enrollee and family insecurity and fear of reductions in services.*

Some states have backed out of the duals demonstration because they couldn't find enough MCOs to participate. The reality of the true costs and complexity of the population became clear to the plans only after capitation rates were reviewed.

- Minnesota and Tennessee said part of their reasons for withdrawing was that the plans would receive lower rates than they get under the current Medicare Advantage Dual Eligible Special Needs Plan program, known as D-SNPs.

- In Massachusetts, three of the original six managed care plans that intended to offer plans, including Blue Cross and Blue Shield of Massachusetts, dropped out over payment issues a few months before enrollment began Oct. 1. As a result, the state's One Care program pared back its goal to serving about 90,000 duals. A spokesperson for one of the Massachusetts plans said they dropped out because they "would not have been able to adequately support the complex health needs of the dual-eligible population under the proposed rates."

Further, there are no definitive studies that have shown improved health outcomes or cost savings on the frail elderly who are most likely to need the round-the-clock care that our members provide under managed care. Pennsylvania has the fourth highest proportion of residents age 65 and older and the fourth highest number of residents age 65 and older. Our proportion of the "oldest old" -- those age 85-plus -- is even higher, numbering almost 400,000 as we provide this testimony.

The challenges that Pennsylvania's aging population presents are very real—and the Administration should not assume that MCOs can magically "manage away" the chronic and ongoing care needs and costs of caring for our frail elders.

As outlined earlier, managed care plans with experience serving the Medicaid or commercial populations do not traditionally have experience with LTSS providers, and as such they would be recruiting a new class of providers to their network. With the exception of nursing facilities, many LTSS providers are not sophisticated and experienced in managed care contracting.

Traditional managed care strategies to control costs such as off-the-shelf prior authorization guidelines and telephonic care coordination strategies for members are unlikely to be sufficient for this population. Even worse, they could put the duals population at risk. For example, several Pennsylvania Medicare Advantage Plans utilize so-called outsourced utilization management companies that receive an incentive payment for reducing length of stay.

Quantifiable savings from any change in how care is delivered will be minimal until we learn what works well for this population. The only way to guarantee savings in the short term is to determine current costs and cut the capitation rate by a designated percentage. Such an approach could threaten the health and lives of the frail and disabled whom we are all committed to serving.

According to a recent study completed by Avalere Health, a nationally respected consulting firm, nursing homes in the Commonwealth are already operating on a 1.2 percent margin. Those serving the highest levels of Medical Assistance (MA) residents are in even greater financial straits, operating at 0.3 percent margins. The low margins demonstrate the current underfunding of the Medical Assistance rates for nursing homes here in Pennsylvania. They also show that the high cost of caring for a frail, old population is very real, and will make it extremely difficult for MCOs without experience in this arena to manage the cost and care of this population. Data from the Department of Human Services document that nursing homes are, on average, paid $23 per day less than the actual cost of care, or about $8,500 annually.

With such a narrow margin, any additional reductions in payments to nursing homes from the managed care plans could force a number of nursing homes to close their doors. There is NO room to cut payments to nursing homes so that a managed care company can take its "margin" for its shareholders. For those needing 24/7 care, every study has shown that a nursing home is the most cost effective setting with high quality outcomes. No one should be in a nursing home who doesn't need 24/7 care. Unfortunately, some have considered a reduction of "institutional care days" as an "outcome measure" in many states where MLTSS is already in place, with plans given nursing facility (NF) and home and community-based services (HCBS) utilization targets to hit. A number of states even put a price tag on this measure, rewarding plans financially if they get consumers out of the facility and into the community. That isn't an outcome—it is a process measure—and it's done only because it 'feels right'. And, this in all instances may not be good for consumers, as it limits rather than broadens consumer choice, while potentially placing consumers in risky community placements where they do not receive round-the-clock supervision or care. There is data that supports this position due to increased re-hospitalizations in the HCBS setting, which ultimately shifts expenditures to Medicare.

Again, as a member of the Governor's Long-Term Care Commission in 2014, I can tell you firsthand that the premise behind our recommendation that MLTSS be considered carefully and implemented only after demonstrating that MLTSS is the best option for Pennsylvania's consumers was just that—**we wanted to replace "feelings" with "facts," and move forward ONLY if the "FACTS" showed that MLTSS was the best option for consumers, and the most cost-effective option for Pennsylvania's taxpayers.**

As you know, I believe that NO ONE who doesn't need the round-the-clock care provided in a nursing home should be forced to have the NF as their only option. However, in many instances there is no substitute for nursing home care after an acute stay in a hospital for rehab, recovery from a catastrophic illness, or for persons whose frailty and needs cannot be safely served through community options.

When nursing home services are denied due to an approach that is driven by a volume based "quality" or "outcomes" measure driven by cost-containment pressure and profit motive, the results are often detrimental to the individual.

The March 5, 2014, edition of the *New York Times* published an article entitled, "Pitfalls Seen in a Turn to Privately Run Long Term Care," in which the reporter recounted what happened to one 75-year-old man with debilitating arthritis, lung disease, newly blinded and with growing dementia who was first forced from a nursing facility to inadequate services in the community, and then denied continuation of even those paltry services. This man's story is part of a report that focused on Tennessee, New York and Minnesota, all states that have been touted as states that have been successful in shifting to managed long term care services. **All have experienced serious quality, coordination and outcome problems, as illustrated in the article. We should not allow this story to repeat itself here in Pennsylvania.**

Thus, PHCA recommends that the departments **proceed prudently and consider** testing alternatives to fully capitated MLTSS as part of an extended Phase 1, in addition to the demonstration that excludes nursing homes. For example, a viable program could include a provider owned or operated program subject to some type of capitation. Make the providers part of the solution. Eliminating the "middleman" may save money and improve care.

Private Medicare and Medicaid managed care plans are not the only model that should be considered. The innovations in care supposedly provided by managed care plans (case management, counseling, care coordination) have long been delivered by providers of LTSS and can be provided, sometimes more cheaply, through provider-driven models such as primary care case management, health homes, and Accountable Care Organizations.

Recently, a number of states have begun to explore the possibility of implementing these alternatives. To date, eight states have launched Medicaid ACO programs, with New Jersey slated to begin its program in spring 2015. Oregon also is looking at a new model.

- The New Jersey Medicaid program is pursing ACOs as an opportunity to explore innovative system re-design, including: testing the ACO as an alternative to managed care; evaluating how care management and care coordination could be delivered to high-risk, high-cost utilizers; stretching the role of Medicaid beyond just medical services but to integrate social services; and testing payment reform models including pay-for-performance metrics and incentives.

- Oregon also pursued accountable care to replace their fragmented managed care delivery system with a statewide network of regionally based Coordinated Care Organizations (CCOs). CCOs are required to cover and provide all services for beneficiaries, including physical, behavioral, and oral health;

comprehensive transitional care; and linkages to community and social support services. Long-term care services are currently excluded.

According to a Center for Healthcare Studies report, states believe that Medicare-Medicaid beneficiaries could benefit greatly from an ACO model, as their care is often so poorly coordinated due to the separate Medicare and Medicaid financing streams. States such as Colorado and Alabama are particularly interested in using ACOs or versions of it to integrate physical and behavioral health care and LTSS.

- Colorado's Accountable Care Collaborative administers integrated Medicare-Medicaid services through seven Regional Care Collaborative Organizations (RCCOs). Colorado's plan is unique because it maintains their fee-for-service environment and allows clients to keep their doctors and existing network of providers. Other states are implementing the demonstration in a managed care setting, which in some cases may require a client to change providers.

- Alabama created provider-centric regional care organizations (RCOs) in 2013 to administer the Medicaid program. Alabama wisely chose not to include long-term care in the RCOs, to take time to assure that the system is functioning efficiently before moving to LTSS inclusion. Now, two years later, Alabama is moving forward a similar provider-driven model referred to as Integrated Care Networks MLTSS. These networks will be focused on serving the long-term care population in recognition of the fact that this complex population is not best served by traditional managed care approaches.

To promote quality of care rather than quantity of care, Medicaid agencies are keen to incorporate value-based purchasing principles and tie payment to quality outcomes within ACO programs. In these arrangements, provider payment is often determined by meeting specific quality standards in addition to containing costs.

However, similar to managed care, ACOs come with challenges to the state. Through their participation in CHCS's Medicaid ACO Learning Collaborative, states identified challenges to including Medicare-Medicaid enrollees in Medicaid ACO programs, including:

1. **Achieving return on investment**. States are concerned that adding Medicare-Medicaid enrollees to their Medicaid ACO programs would not produce state-level savings. States worry that the share of savings accrued to Medicaid may be insufficient to justify the added expense of investing in such an endeavor.

2. **Overcoming IT and data complexities**. Medicare and Medicaid data often have different submission requirements, fields, and other data elements, and states and ACOs would need to develop systems capable of integrating these data. Without the necessary resources and infrastructure from federal and state governments, providers would have difficulties building the needed infrastructure to participate effectively in an ACO. There are additional challenges for LTSS providers. Nursing homes were not included in the HITECH funding for electronic medical records, and are at a disadvantage for sharing information with hospital and others community providers. Secure health information sharing is basic to a collaborative managed care model. The Pennsylvania E-Health Authority has experience with these issues and should be part of any dialog as MLTSS is implemented.

3. **Addressing the diverse needs of Medicare-Medicaid enrollees**. In addition to diverse chronic, physical health needs, Medicare-Medicaid enrollees are a heterogeneous population using substantial behavioral health services and LTSS. Unless a broad range of providers are participating in a Medicaid ACO and a comprehensive set of services are provided as part of the model, states and providers will not be able to effectively manage the full range of services that these patients require. Including LTSS in Medicaid ACOs may be especially challenging, because this coordination would require primary care

and specialty medical providers to bridge potential differences in culture, quality measurement approaches, data and system capabilities, and clinical models.

Program Pace: Planning Phases and Implementation

If the Commonwealth is going to consider entering the MLTSS arena beyond the limited experience and population we have covered to date, we must learn from our history and take a more incremental approach. Move forward in prudent steps.

PHCA asks that the state take sufficient time to thoroughly review the current national landscape, especially the challenges and barriers other states have faced as they moved down this path. We believe that it is critically important to know the issues that have led the many states which have not moved to managed care for LTSS to that decision. The dual and nursing facility clinical eligible populations are both fragile and vulnerable. States that have moved precipitously to place these folks in managed care have experienced problems in each of the areas the state has listed for comment: Program Design, Planning Phases, Implementation, Oversight and Quality. For us, this is a great opportunity. The Commonwealth has the advantage of learning from those states and crafting a deliberate and incremental approach that respects the needs of MA consumers and their current providers of LTSS. Our members view themselves in an important partnership with the consumers they serve, their families, and the Commonwealth. I believe that is true for all of the provider groups you will hear from during this process. It is essential that existing consumer/provider relationships be maintained under the Administration's plans.

Thus, we do not think the timeline that the Department has laid out gives sufficient time to get it right. As I said earlier, **we recommend that the Administration replace "feelings" with "facts," and move forward ONLY if the "FACTS" showed that MLTSS is the best option for consumers, and the most cost-effective option for Pennsylvania's taxpayers. Good data is key as it will drive up quality and drive down costs.**

Therefore, as said in my introduction, we strongly urge the Commonwealth to consider moving expeditiously but carefully in the planning phase before moving forward with a request for proposal (RFP).

The proposed planning period of July to October, or three months, to get ready to issue the first RFP appears a bit short to us. This is the 6th day of testimony on this subject. There is much interest. Stretching out the planning phase a bit would allow for real and important stakeholder involvement to drive Pennsylvania's MLTSS program moving forward that would serve as the basis for an RFP that would be used to implement the program in phases statewide. For example, New York's managed care demonstration proposal was developed over the course of more than a year from 2011-2012 with regular stakeholder engagement. The program was not implemented until January 2015. **I don't think we need a planning process of a year, but I don't believe that the process can be completed in three months.**

We can learn from the experiences of others states that have too quickly moved these programs forward without extensive input from all stakeholders. KanCare, as highlighted earlier, has had a lot of negative press over their implementation of wholesale managed care in 2013.

> *Shawn Sullivan, Secretary of the Kansas Department for Aging and Disability Services, a former nursing home administrator, conceded in an interview that state officials should have done a better job interacting with families and providers from the start. "I think there are a lot of lessons learned," he said. "I would have gone and worked with families and guardians and all the providers to address their concerns and do a better job of communicating the protections we have in the system."*
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> *Debra Lipson, a senior researcher for Mathematica Policy Research, a nonpartisan think tank, cautioned that Kansas' blueprint presents "huge challenges." "They're entering into virgin territory,"*

she said. "They don't have a lot of models to follow, and it's a highly vulnerable population, and therefore you can't skimp on oversight. And there's a risk when you've got national companies that don't bring a tremendous amount of experience in this area."

The literature is clear that any MLTSS undertaking not only should—but must—begin with a comprehensive stakeholder engagement process. This would include providers, advocacy groups and potential beneficiaries of the program.

Stakeholder engagement means more than providing information about decisions that have been made, it is imperative to include all stakeholders in the discussion, planning and decision-making process in a meaningful way. We do not believe that there has been adequate stakeholder engagement to this point nor do we believe that the timeline proposed by the Commonwealth is adequate to allow that level of stakeholder involvement.

To be clear, we are also recommending that the RFP not be written to include the entire commonwealth.

An initial RFP that contains a single region or at most two regions testing a variety of models will allow for adequate evaluation and adjustments to the model before committing to a rollout to other regions of the Commonwealth. There is no way we can know today, what will be needed two or three years from now. Any evaluation requires sufficient data to ensure a significant analysis.

Therefore, we urge Commonwealth to allow adequate time to capture claims and other necessary data to inform this evaluation, and to look at the softer side of analytics—impressions and acceptance of consumers, providers, plans, and other stakeholders.

We also would suggest that the Commonwealth consider a phased approach that considers subpopulations as opposed to or in addition to geographic areas. As discussed previously, such an approach would enable the state and the MCOs, and other alternative models, to focus on developing policies and programming that meets the varying needs of the subpopulations, such as the nursing home population, within MLTSS.

It is quite ironic that during the same week that the discussion document was released, CMS issued a proposed rule addressing the Medicaid managed care regulations; this is the first update to the regulations governing Medicaid managed care plans since 2002. CMS indicates that the overarching goal of the proposed rule is to further align Medicaid managed care requirements with those of Medicare Advantage and the Affordable Care Act (ACA) Health Insurance Marketplace qualified health plans (QHPs). This alignment is intended to facilitate integration of Medicare Advantage and Medicaid managed care programs for dual eligibles, and to ease transitions for beneficiaries shifting between Medicaid and health insurance marketplace QHP coverage over the course of the plan year. **The proposed rule also marks the first time LTSS provisions have been incorporated into the Medicaid managed care regulations**

It is thus very important that before Pennsylvania locks into a long-term program that we make sure that our programs meet these important standards that should be finalized within the next year.

In this proposed rule, CMS includes 10 key principles that CMS believes are inherent in a strong MLTSS program. Several of these relate to the issues of stakeholder engagement, payment structures, beneficiary support, planning, etc. Clearly, the timeframe laid out by the department is much too quick to meet these principles (like stakeholder engagement, for example).

The 10 CMS principles are outlined below:

1. **Adequate Planning:** States would be required to conduct robust readiness reviews that are tailored to MLTSS programs and to meet additional standards for development and dissemination of LTSS enrollee educational materials

2. **Stakeholder Engagement:** States would be required to solicit and address public input on MLTSS programs. Through this proposal, CMS seeks to ensure that the views of beneficiaries, providers, and stakeholders are integrated into to design, implementation, and oversight of MLTSS programs on an ongoing basis.

3. **Enhanced Provision of Home and Community Based Services:** CMS reminds states that, under the Americans with Disabilities Act (ADA) and the Olmstead v. L.C. Supreme Court decision, MCOs must offer services in the "most integrated setting possible." In addition, the standards for providing "medically necessary services" would be revised to ensure that enrollees have the opportunity to access the benefits of community living.

4. **Alignment of Payment Structures and Goals:** States would be required to ensure that payment to MCOs support the following MLTSS program goals --- to improve the health of populations, support the beneficiary's experience of care, support community integration of enrollees, and reduce costs.

5. **Support for Beneficiaries:** States would be required provide a beneficiary support system, including choice counseling services, resources regarding grievances and appeals, etc. CMS also proposes that MCOs would no longer be able to stop any services pending determination of appeals. In addition, an enrollee would be permitted to change their MCO if their residential or institutional provider terminates their participation with the enrollee's current MCO.

6. **Person-centered Processes:** States would need to develop a process for identification, assessment, and treatment/service planning for individuals receiving LTSS (including non-medical); updates to the care plan would be required at least every 12 months or when the enrollee's circumstances or needs change significantly.

7. **Comprehensive, Integrated Service Package:** MCOs would be required to coordinate care between settings of care and across MCOs or between MCO and FFS.

8. **Qualified Providers:** States would be required to develop specific time and distance standards (and post these standards on the state website) to ensure network adequacy in managed LTSS programs, and must require that MCOs ensure that LTSS network providers have the capability to ensure physical access, accommodations, and accessible equipment for enrollees with physical and mental disabilities.

9. **Participant Protections:** States would require MCOs to participate in state efforts to prevent, detect, and remediate all "critical" incidents.

10. **Quality:** MCOs would be required to have mechanisms to assess the quality and appropriateness of care provided to LTSS enrollees including between settings of care and as compared to the enrollee's service plan. In addition, results of any re-balancing efforts would need to be included in the state's annual program review.

During the deliberations of the Long-Term Care Commission, the subject of this proposed rule from CMS was not discussed; however, the Commission's overall recommendations of careful planning, stakeholder involvement, and the use of data in decision making all are goal aligned. Given that proposed rule, when finalized, is certain to alter the regulatory landscape, it is clear that it is wise, as unanimously recommended by the Commission, to test models and prove effectiveness *before* the decision is made to expand the program statewide. This will also allow the Administration to assess whether any segments of Pennsylvania's population would be better served in an alternative model, or even held out of MLTSS altogether if the evaluation didn't show enough benefit. Put differently: **Proceed Prudently. Learn, and then move expeditiously forward.**

Program Oversight and Quality

On the issue of oversight and quality, we have two main themes that we want the Departments to be sure to address.

The first is around the delegation of functions. We believe that it is CRITICAL that the state retain responsibility for management and guidance and continue strong and aggressive oversight of the quality and care outcomes. It is critical that the state dedicate adequate resources to assure that vulnerable populations receive optimal services and supports. The Department is ultimately responsible.

The second is that the state must establish quality and outcomes measures that are true indicators of the quality of care that consumers are receiving under MLTSS, and their health outcomes. As my colleague Russ McDaid said earlier this week, we want to be very clear—reduced use of nursing homes is NOT a quality indicator or a health outcome, it is a policy goal; the same with reductions in emergency room (ER) visits, or the proportion of consumers transitioning to home and community based care.

Rather, the Department should work with experts in the field to develop a comprehensive quality strategy that is transparent and appropriately tailored to address the needs of the MLTSS population. It is our understanding that the HEDIS measures as currently configured do not address MLTSS measures. Once developed, these measures would be overseen and monitored by the Department through their External Quality Review Organization (EQRO); it is important to note that many EQROs are also inexperienced in LTSS arrangements, and will experience a learning curve that places additional pressure on state resources.

It is essential that any system of performance measurement include metrics designed to assess the ability of MLTSS to improve quality of care and consumer outcomes. Real quality measures should include the following indicators: consumer health status, including change in daily activity function over time; the incidence of injuries or secondary health conditions such as burns, falls, skin ulcers, or involuntary weight loss; and preventable serious adverse events; avoidable hospitalizations, ER visits, and nursing facility stays, risk adjusted for the unique needs of the consumer being served. An avoidable hospitalization for someone like me is far different than that which may be avoidable for a younger person living with a disability or a frail elder in need of round-the-clock care. Other so-called quality measures such as community placements and consumer satisfaction ratings, while important, are not as critical as the outcomes measures listed above. They are true indicators of whether MLTSS is doing more than getting consumers out of so-called “institutions” or saving money, and truly improving their health status over their health status under the current fee for service system.

It is in the best interest of consumers that outcomes and quality measures be weighted more heavily than process measures, such as reduced hospital or nursing facility use, when assessing the value received for dollars spent.

Principals to Ensure Access, Quality and Choice for Consumers

Earlier in this testimony, we indicated that we would address the four P’s of Managed Care for the Pennsylvania: **program design, program pace, program outcomes, and program principles --- the four P’s of PHCA.**

This final section outlines the Program Principles, which we believe the Departments of Human Services and Aging should consider when implementing MLTSS.

Among the principles:

1. **MLTSS must improve access and quality, first.** True savings should be derived from care coordination, prevention and wellness, and quality initiatives. Rate reductions, unnecessary utilization controls, or cumbersome prior authorization processes are not the answer for individuals who need these sorts of support.
2. **States and plans should possess demonstrated experience before implementing or expanding MLTSS.** When implementing or expanding such programs for the older adults, states and plans should meet federally established or approved benchmarks and both states and plans should undergo a federal readiness review.
3. **States should offer individuals meaningful opportunities to make educated decisions.** States also should have clear standards for network adequacy so beneficiaries have sufficient choice of providers. Individuals also should have choice of services as well as service setting. Plans should be required to provide materials and information so individuals can make educated decisions about their services and service settings.
4. **Independent grievances and appeals processes for individuals and providers should be established and adequately funded.** The state Medicaid agency should maintain provider liaison functions for managed care network participants to support providers in plan interactions as they deliver critical services to individuals.
5. **MLTSS arrangements should ensure access to care when patients and residents need it.** Programs should offer adequate protections, such as access to out-of-network doctors and caregivers and make provision for "any willing provider," to allow such critical relationships to continue as part of continuity of care.
6. **Ensuring administrative efficiency and consistency across plans is essential.** Administrative simplification and intra-plan consistency should be core components of any MLTSS arrangement, particularly given the possibility for opting in and out of plans.
7. **Care coordination should produce efficiencies while improving health care experiences.** Care coordination roles and responsibilities at the level where health plans and providers interface should be clearly defined, particularly with managed care entities that have less proven experience serving this population at the point of care delivery.
8. **Consider all views and perspectives when crafting MLTSS programs.** There needs to be transparency at the state level in the development of state-health plan contractual relationships. Guidance should establish stronger requirements for transparency in contract language development.
9. **Align provider reimbursements with program standards and access goals.** Rate adequacy and timely payment process standards should be clearly defined.

Conclusions

MLTSS is relatively new. The body of evidence of efficacy is still being built, and there is not enough experience with the existing duals demonstration programs to draw conclusions about whether they help or hurt seniors and whether they save money or cost more money with any certainty.

A project of the depth and breadth proposed in the Commonwealth's discussion document deserves enough time and effort to assure collaboration among Commonwealth agencies for program planning, development, with meaningful stakeholder engagement, including those individuals whose health care will depend on the decisions made during the process. To do less, just isn't prudent.

PHCA supports the Administration's commitment to a long-term care system that is person-centered, coordinated, and focused on preventative services and participant outcomes, and PHCA stands ready to work with the Commonwealth to continue to research and develop the scope of such a project and a reasonable timeline and approach for implementing any decisions that are made. As a representative of the elderly and their providers of care, we want to be part of the solution!

We thank you for this opportunity to comment and assure you we will have additional written comments.