

Evaluation of the Community HealthChoices (CHC) Program
Medicaid Research Center (MRC)
Summary of Activities, Findings and Recommendations (2016 to 2019)
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INTRODUCTION AND OVERVIEW

Community HealthChoices (CHC) is the Commonwealth of Pennsylvania’s new Medicaid Long-Term Services and Supports (LTSS) program lead by the Pennsylvania Department of Human Services (DHS). Planning design began in 2015, and on August 30, 2016, DHS announced the managed care organizations selected as part of the CHC program. Implementation discussions occurred followed by a three-year phased-in implementation strategy beginning in January 2018. The program was fully implemented statewide by January 2020¹. The University of Pittsburgh Medicaid Research Center (MRC) was selected to conduct a comprehensive, scientifically rigorous, multi-year evaluation of CHC. This long-term, multi-method evaluation complements other oversight and quality assurance activities conducted by the DHS, Office of Long-Term Living (OLTL). The goals of the CHC program are to:

- Enhance opportunities for community-based living;
- Strengthen coordination of LTSS and other types of healthcare, including all Medicare and Medicaid services for Dually Eligible people;
- Enhance quality and accountability;
- Advance program innovation; and
- Increase the efficiency of healthcare and LTSS.

The overarching goal of the evaluation was to determine the effect of the CHC program on health outcomes, cost, use of health care and LTSS, and participant experience. The MRC has collected extensive data over the past four years to meet this objective. As of mid-2020, the MRC has conducted 227 interviews with key stakeholders, surveyed 1,022 LTSS providers, and interviewed over 4,374 participants. The MRC held 66 focus groups with 250 participants and caregivers in Phases I & II.

This report summarizes the major activities, key findings, and recommendations based on MRC’s overall evaluation, and describes the evolution of the CHC program in response to the MRC’s work. The report covers planning for the evaluation in 2016-2017, activities in the Phase I implementation in the Southwest region in 2018, Phase II implementation in the Southeast region in 2019, and initial observations of the Phase III implementation in the remainder of the state in 2020. This report is based on interviews, surveys, and focus groups conducted, collected, and analyzed by the MRC.²

<ul style="list-style-type: none">• Centers for Independent Living• Service Coordination Entities• Area Agencies on Aging• Skilled Nursing Facilities• Home Care Agencies• Home Health Agencies• Home Modification Providers• Adult Day Services Providers• Habilitation Providers• Transportation Providers• Delivered Meal Providers• Primary Care Providers• Community Health Centers• Trade Associations• Consumer Advocacy Organizations
Table 1. Examples of Stakeholders

DEVELOPMENT OF THE EVALUATION PLAN (2016-2017)

In the two years preceding the rollout of CHC (2016-2017), DHS and the MRC took a series of steps to develop a comprehensive evaluation plan using input from key informants, stakeholders, and participants. This resulted in a comprehensive plan that was designed to capture the perspectives of program participants, providers, and a wide range of stakeholders.³ A draft of the evaluation plan was published on the DHS website for public comment. Over 200 comments were received, leading to publication of a revised plan. Several common themes emerged from public comments. First, commenters were concerned about the methodology being used to conduct the evaluation and how results could be attributed to the implementation of CHC. The methodological challenges were acknowledged, and the MRC

¹ PA Department of Human Services Community HealthChoices Program: <http://www.healthchoices.pa.gov/info/about/community/index.htm>

² The MRC is in the process of analyzing administrative data from Medicaid, Medicare, the Nursing Home Minimum Data Set, the Level of Care Determination, the Functional Eligibility Determination instrument and the interRAI Home Care instrument. Due to the time lag in the availability of these data sources, findings from these sources on impact of CHC are not yet available.

³ The CHC Evaluation Plan is publicly accessible on PA Department of Human Services website: <http://www.healthchoices.pa.gov/info/resources/publications/community/evaluation-plan> .

provided assurances that best research practice would be employed to address such challenges, including use of previously validated standardized interview questionnaires as much as possible, as well as statistical techniques that allow for comparisons across different regions of the state.

Although several commenters requested that results be broken out by MCO, the focus of the MRC is on the overall program, not on the performance of specific providers or organizations. While results can be analyzed by MCO, no reports will identify the MCOs or other providers by name. This allows the MRC evaluators to operate independently of DHS and protect the privacy and confidentiality of the data collected. This also allows providers and MCO representatives the freedom to speak candidly about their experience without concern that it might affect their contract or other status. It also assures the independence of the evaluation, since the data are independent of other quality assurance efforts conducted by the DHS. At the suggestion of the commenters, to capture details of participants' physical environments, the MRC included an objective assessment of the living environment as part of in-person interviews. In addition, geographical techniques will be used to incorporate data on neighborhood quality. Finally, concern was expressed about the languages being used during evaluation activities, such as surveys, focus groups and interviews. The MRC provided assurances that it was committed to effective participation of all persons selected for interviews and surveys and would incorporate translation services as necessary. The following sections summarize findings related to the Participant and Provider Experience with the early implementation of CHC.

COMMUNITY HEALTHCHOICES: THE PARTICIPANT EXPERIENCE

The MRC undertook several activities to gauge participant experience: Phase I Participant Experience Survey; Statewide Focus Groups; and Listening Sessions

Phase I Participant Experience Survey

In order to capture the experience of participants in the Phase I implementation of CHC in the Southwest, the MRC designed and launched a prospective telephone interview survey of a random sample of people eligible for the new program. Interview questions were drawn from several valid, widely used survey instruments, including the CAHPS-HCBS⁴ and NHATS⁵ instruments. New questionnaire items were developed by the MRC to address concepts that have not been addressed in previous research or needed to be tailored to the CHC context (e.g., care coordination). Starting in late 2017, a sample of participants from the Southwest was selected at random. The sample was divided into three groups: people age 21 and older who are dually eligible for Medicaid and Medicare but do not use LTSS, people age 21-59 who use home and community-based services (HCBS), and people age 60 and older who use HCBS. A total of 1,767 baseline telephone interviews were completed from late 2017 to early 2018. From January 1 to June 30, 2018 the continuity of care rules limited the influence of CHC plans on participants medical care or HCBS. Thus, follow-up interviews were conducted 12 months after the end of the continuity of care period (July 2019). A total of 1,157 follow-up interviews were conducted: 460 with participants who were also interviewed at baseline and 697 with a new sample of randomly selected participants.

Participant Demographics

Table 2 summarizes the demographic and health status of HCBS and non-LTSS participants interviewed in the Southwest at baseline (prior to full implementation) and follow-up (after 18 months in the program). Among HCBS participants, the characteristics at baseline and follow-up were very similar. The proportion of non-Hispanic Black participants was slightly higher at follow-up, as was the proportion of people living alone and in urban areas. Similar to the HCBS sample, the proportion of non-Hispanic Black participants was slightly higher at follow-up, as was the proportion living alone and in urban areas. These differences were not statistically significant.

⁴ The Consumer Assessment of Health Providers – Home and Community Based Services (CAHPS-HCBS) instrument is available online at <https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/cahps-home-and-community-based-services-survey/index.html>.

⁵ The National Health and Aging Trends Study (NHATS) instrument is available online at <https://www.nhats.org/>.

Table 2. Demographic Characteristics of Phase I Participants

	Baseline (2018)		Follow-Up (2019)	
	HCBS (n = 1,160)	Non-LTSS (n = 607)	HCBS (n = 778)	Non-LTSS (n=379)
Age [mean (Standard Deviation)]	60.67 (15.98)	62.01 (15.80)	60.63 (14.23)	62.15 (12.76)
Gender (% Female)	68.19	64.91	64.54	63.47
Race				
Non-Hispanic White	73.49	88.63	70.80	85.97
Non-Hispanic Black	20.55	9.72	22.31	11.22
Other	5.96	1.65	6.89	2.81
Lives Alone	38.88	39.54	46.18	46.68
Urbanicity (% Metro)	76.38	46.46	85.23	66.84

Participant Engagement and Choice

An important goal of CHC is to increase the quality of life of participants. One aspect of quality of life is engagement in preferred activities. For people with disabilities who rely on caregivers and paid providers, there are substantial barriers to engaging in such activities outside the home.

The MRC interview asked participants whether they had done any of four activities in the previous month: (1) visit friends and family; (2) attend religious services; (3) attend clubs, classes or other organized activities; (4) and entertainment (going out to dinner, movies, gambling, hearing music or going to a play). Participants were asked to rate the importance of each activity (not important, somewhat important, very important). A weighted score from 1 to 10 was constructed to measure participation in preferred activities. A higher score indicates a higher level of participation, weighted by preference. Thus, improvement in participation in more highly preferred activities will have greater influence on the results. As can be seen on Figure 1, in Phase I, from Baseline to Follow-Up, there is a small, statistically significant increase among HCBS participants of about .42 points (one sided p = .002). The increase among non-HCBS participants is .45, but not statistically significant due to smaller sample size (one sided p = .09).

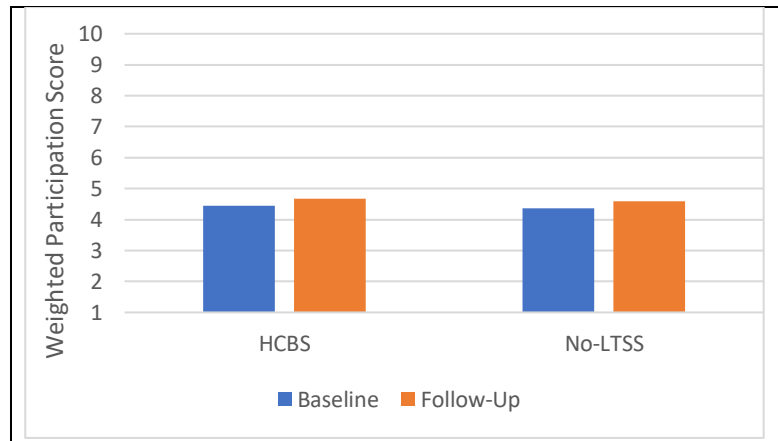


Figure 1. Participant Rating of Activities

Participant Care Coordination

An important goal of CHC is to increase care coordination for all participants, including those who do not use HCBS. This includes coordination of physical health, LTSS, and behavioral health. Participants were asked whether they had someone who helps manage their medical care, as distinct from HCBS service coordination. There was no overall change in this measure. However, since many people receive assistance from family members with managing their health care needs, we also examined just those participants who were interviewed by proxy. In other words, since proxy informants are likely to be the person who helps with medical care decisions, they might be more aware of changes in care coordination due to the implementation of CHC. When the data are restricted to proxy informants, the percent of HCBS users in Phase I reporting having help with medical care decisions increases from 65% at Baseline to 78% at Follow-Up (p = .013) and non-HCBS participants increases from 52% to 67% (p = .29). This suggests that there has been some improvement in one measure of care coordination.

Participant Self-Reported Health and Psychological Well-Being

To measure participant health status and psychological well-being the MRC used several standard interview instruments. Health status is measured with a single item, “How would you rate your health (Excellent/Very Good/Good/Fair/Poor)?” The results are on a 1-5 scale, with 5 representing better health. Psychological well-being is measured using an instrument that includes items that address mood, meaning, and control. The results are on a 1-10 scale, with 10 representing better well-being.

Table 3. Health Status and Psychological Well Being Among Phase I Participants at Baseline and Follow-Up.

HCBS Users	Baseline	Follow-Up	p-value
Health Status [1-5]	2.6	2.4	.69
Psychological Well-Being [1-10]	7.1	7.2	.10
Depressive Symptoms [% Severe]	10.9	9.75	.26
No-LTSS*			
Health Status [1-5]	2.4	2.6	.04
Psychological Well-Being [1-10]	7.4	7.6	.01
Depressive Symptoms [% Severe]	10.2	8.1	.11

*Dual eligible adults who do not receive LTSS services in HCBS or nursing facility, also known as “Nursing Facility Ineligible.”

Depressive symptoms are measured using the PHQ-9. The result is dichotomized using a clinically validated cut-point indicating need for clinical evaluation and therapy. As can be seen on Table 3, health status and well-being scores are essentially unchanged from Baseline to Follow-Up. Among people who do not use LTSS, health status and psychological well-being appeared to improve slightly from baseline to follow-up.

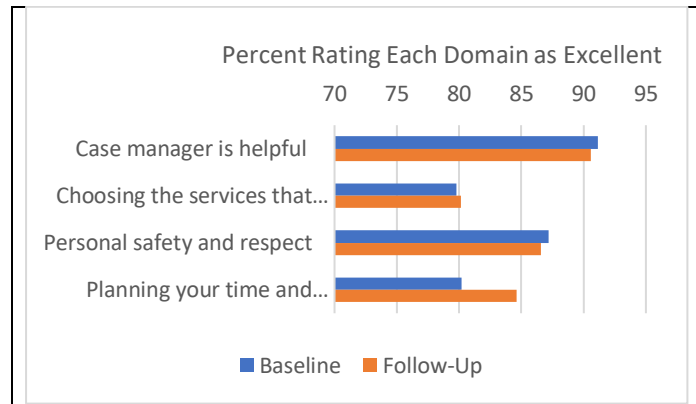


Figure 2. Service Coordination Composite Measures Before and After Implementation of CHC in the Southwest Region

Participant Experience with HCBS

To examine trends in participant experience with HCBS, the MRC used items derived from the home and community-based services version of the Consumer Assessment of Health Care Survey tool (CAHPS-HCBS).⁶ The findings from our survey are reported as composite scores that measure several key aspects of the quality of care from the perspective of the participant. Figure 2 shows that the measures of service coordination are mostly stable over time with the exception that “Planning your Time and Activities” shows improvement.

⁶ More information about the HCBS CAHPS including details of composite scores is available at <https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/cahps-home-and-community-based-services-survey/index.html>

Figure 3 shows that in Phase I, the measures of participant experience with respect to in-home workers (e.g., personal attendants) appear to decline slightly from Baseline to Follow-Up, and medical transportation appears to improve. However, these changes are not statistically significant.

Over the course of 2018, there were many concerns raised regarding non-medical transportation, for example lack of providers or inappropriate (non-accessible) vehicles being sent. In 2019, the MRC added new questions to the follow-up interview to address this issue. Overall, 51% of participants who use HCBS reported that they are usually or always able to get a ride to non-medical activities (e.g., shopping, religious services, or recreation). This issue will continue to be tracked over time.

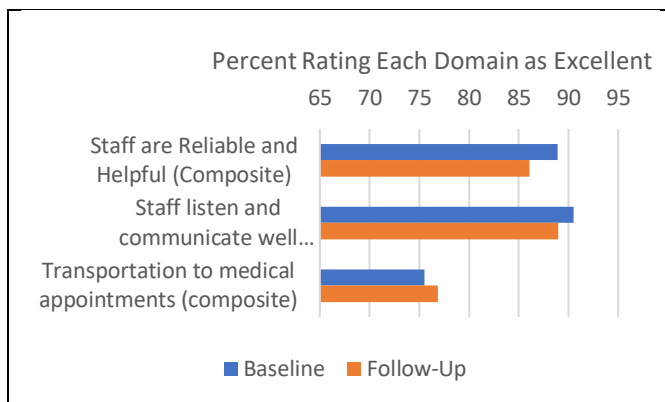


Figure 3 HCBS Service Delivery Composite Measures Before and After Implementation of CHC in the Southwest Region.

Participant Focus Groups

In early 2018, the MRC held 11 focus groups in the Southwest region to capture the perceptions of participants soon after the Phase I transition to CHC. In early 2019, 14 focus groups were conducted in the Southeast region to capture their perceptions soon after the Phase II transition to CHC. Focus groups were held with HCBS waiver clients, dually eligible individuals, and caregivers, in both urban and rural settings.

The same basic themes, with one exception, emerged from both participants and caregivers (see Table 2). The theme of receiving information on benefits and coverage did not emerge with caregivers.

Table 4. Emergent Themes from Focus Groups with Participants and Caregivers

- The process of selecting a CHC plan.
- Satisfaction with CHC enrollment.
- Receiving information on benefits and coverage. *
- Experience of CHC.
- Communication with the CHC plan.

*This theme emerged only with participants.

Participants and caregivers expressed higher levels of dissatisfaction with the early Phase I experience than with the early Phase II experience. This suggests that the CHC rollout improved between Phase I and Phase II. For example, in Phase II, more focus group respondents' participants reported feeling well-equipped to make the choice between three competing health plans, compared to Phase I. There were minor concerns related to receiving insurance

cards, but overall there was more satisfaction in Phase II regarding the enrollment process than in Phase I.

Listening Sessions

In response to concerns from participants and providers that emerged early during the Phase I implementation, the OLTL partnered with the Jewish Healthcare Foundation (JHF) to host a total of 13 listening sessions in Western Pennsylvania during 2018. In 2019, six listening sessions in the Southeast were conducted by the Pennsylvania Health Access Network (PHAN). These sessions allowed participants to voice their concerns and have them transmitted to OLTL for follow-up. The information that arose in these sessions was used by OLTL to provide additional guidance to the MCOs.

Phase I Listening Sessions: Southwest Implementation (2018)

Participants spoke of transportation problems to and from necessary appointments as well as transitions from nursing homes to community. For both seniors living in the community with LTSS and those dually eligible for Medicaid and Medicare, there were issues regarding enrollment. One common concern was that participants

were confused about the interaction between the new CHC plans that replaced Medicaid and their Medicare coverage. Many participants with disabilities had concerns regarding the assessment and reassessment process. Some people expressed high levels of anxiety and fear regarding the transition to managed care. However, many of their concerns with CHC turned out to be long-standing issues that preceded the implementation of the program but had not been adequately addressed. New concerns had to do with grievance procedures, and choice of service coordinator and providers. Many participants at the listening sessions noted that they had already attempted to have their problems resolved by calling the Participant Support telephone line or contacting their MCOs. Family members of participants were generally satisfied. Most were looking for clarity and consistency in the information they received. Common issues reported by caregivers regarding home modifications, pest remediation, and whom to contact at MCOs to resolve problems.

Phase II Listening Sessions: South East Implementation (2019)

For seniors living in the community, and people dually eligible for both Medicaid and Medicare, there were issues regarding enrollment options, home modifications, the assessment process, and how to contact the MCOs. There was also general confusion about differences between Medicare and Medicaid. For people with disabilities the level of anxiety and fear was high in almost all sessions, especially for young people. There were some attendees who were under age 21 and were going to transition onto CHC when they reached that age; these individuals expressed concern and confusion over the pending changes. Many participants at the listening sessions noted that the new system did not fix many older problems, and some newer confusion arose. For example, new CMS grievance procedures, transportation, choice of service coordinator and providers were common concerns.

Community HealthChoices: The Provider Experience

To capture the provider experience, the MRC conducted qualitative interviews and surveys with a wide range of providers. This section summarizes findings from qualitative interviews with HCBS providers, service coordination entities, nursing home administrators, and various advocacy organizations. The next sections report on findings from qualitative surveys.

Table 5. Summary of Qualitative Interviews by Phase (number of interviews)

Phase	Continuity of Care	Post-Continuity of Care
Phase I	27	66
Phase II	13	11

Qualitative Interviews

To provide an overall evaluation of CHC, the qualitative interview results from Phase I and Phase II were combined and reorganized into Continuity of Care (CoC) and post-continuity of care periods. This analysis covers a subset of 117 interviews conducted in the Phase I and Phase II regions from 2018 to 2019 (see Table 3). This allows us to examine the implementation from the provider perspective. Major themes identified during the CoC and Post-Continuity of Care periods are reported below.

Continuity of Care Period

Delays in the Provisions of Services. Delays in the provisions of services to CHC consumers during the CoC period were discussed by providers in both the Phase I and Phase II regions. Many of the service delays were specific to transportation issues. Some concerns regarding service interruptions were related to enrollment approvals or confusion regarding enrollment. Approvals at the MCO level were also noted as a cause for concern. The most commonly discussed source of problems related to delays in services was that there was a lack of information exchange regarding authorizations, processes for getting services approved, or coverage during the CoC period in general. Interestingly, providers reported that approvals for home modifications were slower under CHC but also more precise, suggesting some improvements. One of the examples given had to do with a request for a grab bar that in the past may have led to a complete bathroom remodel.

Billing Issues. Problems with billing and payment were highly salient among providers during the CoC period across all Phases. Many providers experienced disruptions in payments for services after the start of CHC. A common experience was that providers had difficulty obtaining authorizations for service, leading to missing

payments. Providers also commonly mentioned that they had to decide whether to continue providing services to specific consumers after a disruption in payment from the MCOs.

Communication with MCOs. There was a mixed picture regarding communication with MCOs during the CoC period during 2018 (Phase I) and 2019 (Phases II). In each year, at the beginning of the CoC period, many providers reported that the MCOs were often unresponsive or that the process of interacting with them was cumbersome leading increased workload. Several providers reported that their contacts at the MCOs were frequently changing. However, in each year, as the CoC period progressed across each implementation, informants reported that communication tended to improve. Thus, much of the concern seems to do with the initial transition to managed care rather than an ongoing problem.

Service Coordination. Many providers reported challenges regarding communication with service coordinators, particularly with the MCOs' internal service coordinators. Providers reported that some MCO service coordinators were not familiar with the population, creating challenges in obtaining reliable information for their organization or their participants.

Post-Continuity of Care

Delays in the Provision of Services. During the post-continuity of care period in Phases I and II, providers described delays as resulting from multiple factors, including problems with paperwork, communication, and staffing. These issues impacted the delivery of a range of services, including in-home care, home modification, dispensing and repair of durable medical equipment (DME), and transportation. Providers advised that many care delays could have been due to communication challenges between providers and MCOs. Calls between insurers and providers or beneficiaries were not always returned, or when they were returned, no action was taken. Related to communication challenges are problems with paperwork and processes, which further contribute to service delivery interruptions. Paperwork was seen as being complex, submissions were lost, and there was a lack of clarity regarding requirements. There were particular challenges with service delivery in rural areas due to availability of providers.

Billing Issues. Billing issues were significant in the post-continuity of care period throughout each phase, with many providers continuing to experience disruption in payments for services provided. Several providers reported that billing process had improved during the Post-Continuity of Care period, but that they were still actively working to recover missing payments from the CoC period. By far, the most common item of discussion regarding billing was the burden of the process itself. Respondents felt that processes were inefficient and inconsistent across MCOs. They felt inadequately prepared for the change in billing procedures and expressed a lack of clarity regarding billing requirements, which added to the difficulty of adapting to CHC billing processes. For example, some providers reported that they would receive authorization notifications for consumers and then later find out after billing for services that the authorization was absent, inadequate, or inappropriate. One factor leading to this was that they were not notified when consumers switched MCOs.

Communication with MCOs. Communication with MCOs was a concern not only as it related to billing, but also regarding service delivery. Many providers felt that representatives from the MCOs were unfamiliar with their own policies or with the needs of their beneficiaries. Often the representatives or key individuals were unavailable, leading to delays. While many providers reported improvements, concerns with communication were still reported in late 2019.

Service Coordination. The move to MCO service coordination caused many providers to worry about a loss of rapport or connection with consumers. Not knowing the consumers or having a history with them can potentially result in service disruptions. This concern was also rooted in high rates of turnover among service coordinators.

What's Working Well.

Despite the concerns that many providers expressed regarding billing, in the middle of 2018, some providers stated that billing had improved. Many providers reported



Just overall, I think if somebody would have said this is where we would be four months in, I think we would probably be happy with that in hindsight. Like I said, despite the fact I had some fairly critical things to say about a couple of pieces early on in the interview. I do think considering the size of the change, the number of participants it affected, and the short amount of time that's passed since its inception, if somebody would have told us in December this is where we'd be in April, I think we would be happy with where we're at given the complexities and size, and all those other things.

that payments were received faster than under the previous program. Collaboration among providers and agencies was seen as improving as a result of or in response to CHC. There were also some positive reflections on services and expansion of benefits. Providers also expressed that OLTL was viewed positively regarding the management of implementation, problem-solving, and maintaining transparency during each of the CHC planning and implementation processes. The last excerpt sums up the idea that, despite challenges with processes, CHC has gone better than expected for some providers.

HCBS Provider Survey

The MRC conducted a statewide online survey of HCBS providers that addressed readiness for CHC, interactions with the CHC Managed Care Organizations (CHC-MCOs), and providers' overall perspectives of CHC. Wave 1 was conducted from December 2017 to January 2018 and Wave 2 from December 2018 to January 2019. There were 359 responses to Wave 1 (response rate of 36%) and 460 responses to Wave 2 (response rate of 40%). Providers from all three regions were included in the survey.

At the time of the Wave 1 survey, HCBS providers were mainly undecided (41%) or generally positive (40%) regarding whether they believe that CHC will be successful in achieving program goals. Over 63% believed that CHC participation would be critical to their organization's future, and the vast majority of providers reported that they were planning to participate in the program. Only 8% of respondents reported that they did not need to grow private-pay clientele or to compete with other LTSS organizations. Over half of providers (57%) agreed that they would be able to continue to provide care to current consumers.

Other observations:

- Phase II providers were more positive about CHC's ability to improve HCBS in Pennsylvania, help in the receipt of timely services, better provide care coordination, and improve the quality and access of LTSS services than the first phase.
- Providers delivering personal assistant services (PAS) were more likely to report planning to increase number of employees than non-PAS providers. PAS providers were also significantly more satisfied with communication with the MCOs and OLTL and overall CHC implementation than non-PAS providers.
- Respondents from Service Coordination Entities (SCE) were less likely to anticipate increasing the number of employees than non-SCE providers. SCEs disagreed with the statement that CHC helps get services to people in a timely manner, that they would be able to serve more people under CHC, and that their agency would benefit financially. SCE providers reported greater dissatisfaction with communication with the MCOs and OLTL, and overall CHC implementation than other provider types.

At the time of the Wave 2 survey, satisfaction with communication with MCOs was significantly different across Phases I and II. Greater numbers of Phase I respondents reported dissatisfaction with MCO communication ($p=0.003$), while greater numbers of Phase II respondents were satisfied ($p<0.001$). In the Wave 2 survey, Phase I providers were more focused on daily operations, such as participant relations, claim submission, and credentialing with MCOs. By contrast, Phase II providers were discussing the infrastructure and contracts necessary to participate in CHC. As would be expected, relatively few Phase III providers reported having had communication with the CHC MCOs or with OLTL during late 2018 to early 2019.

Nursing Home Provider Survey

In 2019, the MRC conducted a statewide online survey of nursing facilities. This survey was designed to capture the experience of nursing facilities with regard to CHC, and their expectations regarding the future of the program. Personalized emails were sent to nursing home administrators using a list provided by OLTL. The overall survey response rate was 32.4%. Of the 203 surveys, 65 (32%) were from Phase I, 35 (17%) from Phase II, and 103 (51%) from Phase III. The majority 62% (126) of responses were from facilities that are part of multi-facility chains.

The survey of nursing facilities presented a mixed picture of the implementation of CHC program. There are some positive observations: respondents in Phase II reported higher levels of preparation than those in Phase I, indicating improvement in OLTLs efforts to inform providers regarding the program. The finding that facilities do not expect to benefit financially from the program is consistent with the broad policy of setting a rate minimum. However, it does suggest that facilities have a somewhat pessimistic outlook. This is reflected in the fact that fewer than 50% of facilities in Phase I and II indicated that they expected to be able to continue providing services. Slightly more than a third of administrators in Phases I and II (36%) reported that CHC plans had made efforts to transition long-stay residents to the community. In addition, about 78% of respondents stated that those residents who transitioned to the community did so as a result of MCO efforts. One of the goals of CHC is to enhance opportunities for community-based living, therefore this is an important area to continue to monitor; MCOs should be expected to improve their capacity to identify and effectively target service coordination and transition services. Finally, there are some concerns regarding access to behavioral health services. Even though nursing facility residents should have access to enhanced benefits with the implementation of CHC, only about one third (35%) of nursing facilities surveyed seemed to be aware of these new benefits.

Nursing Home Focus Study

The MRC team selected 15 nursing facilities (five from each region) for a Focused Study. The facilities were selected to represent both large and small; urban and rural; for-profit, not-for profit, and government owned facilities; in each of the three phases. In addition, the MRC recruited two facilities with a relatively high proportion of people aged 21-59 to assure that that population would be well represented in the overall analysis. At each facility, the MRC interviewed top management, as well as residents and family members.

NH Focus Study: Top Management Interviews

Interviews with top management revealed several key themes relative to CHC: transportation, behavioral health, nursing home transition, service coordination, communication with MCOs, and billing. Nursing facilities reported struggling with arranging non-emergency transportation for residents under the new payment arrangements. Confusion during the early months was somewhat resolved with changes that mostly restored the status quo. However, reports of inappropriate vehicles being used have negatively impacted confidence. With regard to nursing home transition, the nursing facilities do not report an increase in activity.

The introduction of service coordination for nursing facility residents is complex. The potential benefits are clear, such as advocacy, improved access and coverage. However, the role is not well defined and high turnover has limited impact in most facilities. There is a need for clear standards and core competencies for service coordination in the nursing facility setting that may be different than in the community. Nursing facility staff interviewed reported reasonably good levels of communication with CHC plans. However, some report that the provider service representatives are poorly trained and provide inconsistent information. This is compounded by turnover in service coordination. Finally, a consistent theme was that billing was more efficient than prior to CHC. Facilities report being paid more quickly. However, there were some reports of having to change their claims submission systems to be compatible with the new insurers.

NH Focus Study: Resident Interviews

The MRC interviewed 391 nursing facility residents in all three Phases. As expected, most nursing facility residents were not actively involved in choosing their CHC plan, although plan selection was higher in Phase II than Phase I. In addition, relatively few residents reported having been approached regarding transition to the community.

Finally, awareness of service coordination was higher in Phase II than in Phase I, but fairly low overall. It should be noted that although service coordinators are required to have regular contact with all participants, residents in each phase are assessed during the first six months of their first year of the program. Thus, the recency effect could account for higher awareness in Phase II than Phase I.

NH Focus Study: Family and Representative Interviews

The MRC completed interviews with 187 family members and representatives of residents living in eight of the facilities involved in the Focus Study. Family members and other representatives indicated that only 4% of residents had selected their own CHC plan, and only two people reported that their resident was considering nursing home transition. A majority of family members and representatives (59% in Phase I, 71% in Phase II) reported they know who their relative's service coordinator is. A very high proportion (89% in Phase I, 77% in Phase II) indicated they know how to contact them. In contrast to plan selection and transitions, the similarity in rates across phases indicates that service coordination is relatively consistent.

RECOMMENDATIONS AND RESPONSE

As part of its work, the MRC made several recommendations to OLTL for specific initiatives to improve the implementation of CHC during the past three years of the program. These recommendations are organized into several broad topics below, followed by a summary of steps OLTL took in response.

Recommendations

Improve Information for Providers

- Provider trainings could be improved by tailoring them to specific professions. Handouts that synthesize and condense more in-depth trainings would be useful. For example, it would be helpful to provide specific information on reporting and billing requirements for different lines of service and information on how to navigate the three MCO portals. This would reduce the time that providers need to spend to educate themselves about CHC.
- Information about CHC benefits, program rules, and better understanding between Medicaid and Medicare needs to be more concise, clear, and consistent. Efforts towards this end will reduce the possibility of conflicting information from different parties that can feed consumers' confusion and help them be better informed of their services and the CHC program.
- DHS should continue to work with MCOs to assure that participants and providers have accurate information.

Authorization and Billing

- Encourage MCOs to standardize and streamline billing and authorization processes and rules across plans. MCOs use different systems, creating burden for providers and leading to frustration and errors.
- Steps should be taken to reduce the burden on providers. For instance, having the same calendar billing week would simplify operations.
- Providers suggest that having an easy-to-understand notification system for authorizations would help them to stay on top of their consumers' needs while not putting their organization in harm's way by providing services they didn't realize were not authorized.

Behavioral Health

- Continue to strengthen coordination with Behavioral Health Managed Care Organizations. This will help improve an understanding among providers, especially nursing facilities, regarding the role of behavioral health plans and behavioral health services.
- Develop information on what services are offered and how to access them for providers and participants to better understand.

Transportation

- Expand outreach on which kinds of transportation resources are available, and how to go about requesting them if needed. There is continued confusion about the role of Medical Assistance Transportation Program versus CHC benefits.
- OLTL should assure that MCOs contract with transportation services that are accessible to people with disabilities. Transportation providers should have adequate supply of vehicles with appropriate accommodations are dispatched to CHC participants.

OLTL Response

The MRC provided findings summarized in this report to OLTL during each of the phases, or Phase I and II. In response to these findings and recommendations, OLTL has taken steps to improve the implementation process over time. This included greatly increasing the number of provider and participant information sessions prior to both Phase II and III. In addition, the OLTL produced a large number of explanatory flyers aimed at providers and participants that explained key aspects of CHC. OLTL clarified to providers that responsibility for participant education lies with the MCOs. Another step taken by OLTL was to conduct Listening Sessions (described above); these arose out of concern from the provider and advocacy communities that many participant concerns were not being adequately addressed. The work of the MRC helped validate this need. Over time, OLTL invested substantial effort to improve the coordination of transportation services for CHC participants and nursing home residents. This took the form of clarifying guidance to nursing facilities regarding the use of facility owned vehicles versus MCO brokered transportation. Information from the MRC helped OLTL determine that concerns were indeed widespread and not limited to specific providers. Finally, in response to findings produced by the MRC with respect to use of behavioral health in nursing facilities, the OLTL created clear expectations for MCOs to improve coordination with Behavioral Health Managed Care Organizations, requesting specific plans for outreach to nursing homes as part of ongoing quality improvement efforts.

CONCLUSION

Over the past two decades, nearly half of all states have implemented some form of Medicaid Managed Long-Term Services and Supports. These programs have generally been considered to be successful from the perspective of state spending, however there has been little credible evidence regarding the impact on participants and providers. The PA OLTL made a commitment to a comprehensive evaluation of the implementation and outcomes of the CHC program, and engaged the MRC to design and conduct an independent study. Starting in 2016, the MRC developed a detailed plan that was made available for public comment and feedback. The public process resulted in over 200 comments that strengthened the design and most importantly, assured participant voices would be a central component of the evaluation. As part of the process of developing the evaluation plan, it was recognized that much of the impact and benefit of the program on participant's lives would not be captured in administrative data such as medical claims. Thus, the MRC put substantial effort into interviews and focus groups with participants and providers.

The MRC is committed to transparency and works closely with OLTL to share findings from the evaluation as quickly as possible to help inform the program implementation. Many of the observations from Phase I were incorporated by OLTL into the implementation in Phase II and Phase III. In addition to regular meetings with OLTL staff, the MRC has shared findings with the Managed Care Organizations as part of the internal Quarterly Quality Review Meeting. This collaboration has allowed the MRC to develop deep insight into program operation, informing the evaluation and helping guide and refine the research questions in response to events. In addition, the MRC has shared findings publicly with stakeholders through annual presentations to the Managed Long-Term Services and Supports Subcommittee⁷, as well as presentations at meetings of the PA Home Care Association, the

⁷ Managed Long-Term Services and Supports Subcommittee Presentations: <https://www.dhs.pa.gov/about/DHS-Information/Pages/Stakeholders/Managed-Long-Term-Subcommittee.aspx>

PA Association of Area Agencies on Aging, as well as the Advancing States national Home and Community Based Services Conference.

This report summarizes findings with regard to participants in the Phase I of the program implementation in 2018. Future reports will cover the experience of participants in Phase II and Phase III. Data collection for the follow-up period for Phase II (18 months after initial enrollment) began in July 2020 and was impacted by the COVID-19 pandemic, and was ongoing as this report was being prepared. Follow-Up for Phase III will begin in July 2021.

The experience of providers was captured through surveys and qualitative interviews conducted from 2017 through mid-2020. This provides an up-to-date picture of program implementation from the perspective of providers in all three Phases.

The MRC evaluation of the CHC program reveals a mixed picture from the perspective of participants. Interviews and focus groups with participants and family members showed modest improvement on several measures of psychological well-being and depressive symptoms. Importantly, the MRC has not identified major declines in self-reported health or participant experience (satisfaction).

With regard to providers, there is evidence of both disruption as well as improvement. Much of the disruption experienced in the early months of each implementation phase has been resolved. For example, there is evidence of improvement with regard to payment processing, which relieves some financial strain on providers. However, there are some persistent challenges, such as confusion regarding service authorizations. Finally, we note that the OLTL has been responsive to concerns identified by the MRC and other sources and has made significant changes to improve the implementation experience for both participants and providers.

The MRC will produce subsequent reports on the experience of participants and providers, drawing on surveys conducted in 2020 and planned for 2021 and 2022. In addition, administrative data from the Medicaid and Medicare programs will become available in 2021 and 2022 that will allow comprehensive analysis of utilization and quality of care of acute care, behavioral health, and long-term services and supports.