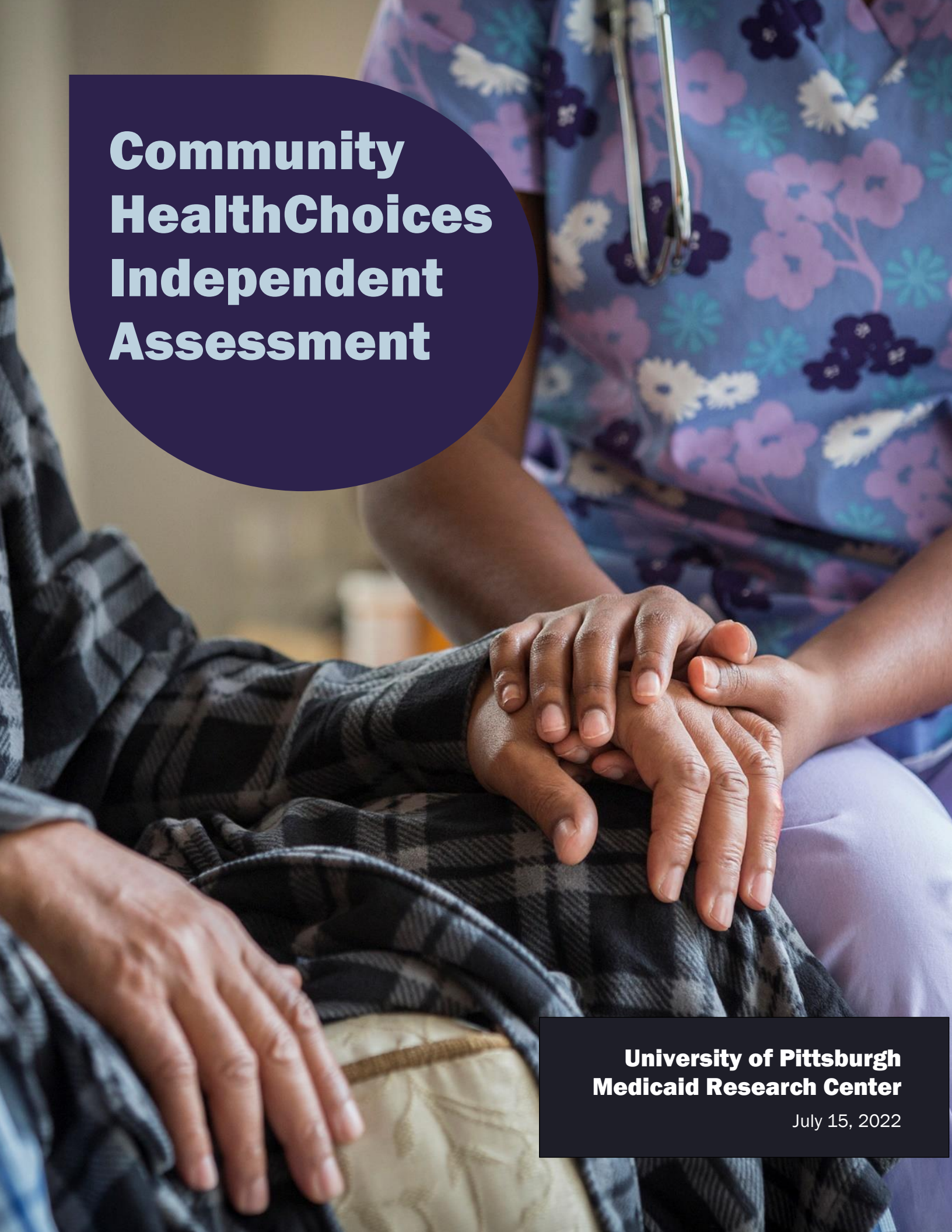

Community HealthChoices Independent Assessment

University of Pittsburgh Medicaid Research Center

July 15, 2022

This report comprises an Independent Assessment (IA) of Pennsylvania's Community HealthChoices (CHC) managed long-term services and supports (MLTSS) program. An IA is required as part of the 1915(b) waiver under which the program operates.

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LIST OF ACRONYMS

AAA	Area Agency on Aging
ACSC	Ambulatory Care Sensitive Conditions
AHC	AmeriHealth Caritas
BBA	Balanced Budget Act
BH-MCO	Behavioral Health Managed Care Organization
CAHPS-HCBS	Consumer Assessment of Healthcare Providers and Systems - Home and Community Based Services
CAHPS-HP	Consumer Assessment of Healthcare Providers and Systems - Health Plan
CAP	Corrective Action Plan
CHC	Community HealthChoices
CHC-MCO	Community HealthChoices Managed Care Organization
CIL	PA Centers for Independent Living
CMS	Centers for Medicare & Medicaid Services
DHS	Department of Human Services
EBR	Evidence Based Report
EQRO	External Quality Review Organization
FED	Functional Eligibility Determination
FFS	Fee-for-service
HCBS	Home and Community-Based Services
IA	Independent Assessment
ICI	Individual Consumer Interviews
IEB	Independent Enrollment Broker
IPRO	Island Peer Review Organization
JHF	Jewish Healthcare Foundation
KF	Keystone First
LC	Lehigh/Capital
LIFE	Living Independence for the Elderly
LTSS	Long-Term Services and Supports
MLTSS	Managed Long-Term Services and Supports
MDS	Minimum Data Set
MRC	Medicaid Research Center
NFCE	Nursing Facility Clinically Eligible
NFI	Nursing Facility Ineligible
NHT	Nursing Home Transitions
NE	Northeast
OLTL	Office of Long-Term Living
PA	Pennsylvania
OPS	Operations Reports
PAPM	PA-specific performance measures
PAS	Personal Assistance Services

PCP	Primary Care Practitioner
PCSP	Person-Centered Service Plan
PHAN	Pennsylvania Health Access Network
PHW	Pennsylvania Health & Wellness
PIA	Pennsylvania Individualized Assessments
PIP	Performance Improvement Project
PMPM	Per Member Per Month
PPE	Personal Protective Equipment
QM/UM	Quality Management/Utilization Management
RFA	Request for applications
SCE	Service Coordination Entity
SC	Service Coordinator
SE	Southeast
SNF	Skilled Nursing Facilities
SW	Southwest
WAM	Waiver Activity Monitoring

EXECUTIVE SUMMARY

This report comprises an Independent Assessment (IA) of Pennsylvania's Community HealthChoices (CHC) managed long-term services and supports (MLTSS) program performed by the University of Pittsburgh Medicaid Research Center (MRC). An IA is required as part of the 1915(b) waiver under which the program operates. The Centers for Medicare & Medicaid Services (CMS) guidance provides that the IA address the following:

1. The effect of the program on access to care;
2. The effect of the program on quality of care; and,
3. The cost-effectiveness of the program.

In addition, this report describes the early implementation of the program. In particular, the report describes many of the steps to prepare participants and providers for the implementation of the program, as well as many of the operational components of the program. This report covers the waiver period from January 1, 2018, through December 31, 2021.

Summary of Findings

Access To Care

During the implementation of CHC, the PA Department of Human Services Office of Long-Term Living (OLTL) engaged in robust outreach to stakeholders, providers, and program participants. The phased rollout of the program over a three-year period allowed for opportunities to engage in process improvement between phases. Though initial public information sessions for participants and providers were met with some confusion, OLTL was able to strengthen the content, format, frequency and reach of these sessions over time.

A key component of the implementation of the program was the role of the Independent Enrollment Broker (IEB). The function of enrolling eligible individuals into the new program fell to the IEB. In each year of the implementation, the IEB provided information and assistance to individuals enrolling in CHC, including choice counseling to help individuals select a CHC-MCO. This information included charts comparing available benefits, and directories to help participants identify which providers are included in-network at each CHC-MCO. The percent of participants who received information on CHC increased during each phase of implementation, but there was minimal variation in the level of satisfaction with the materials over that same period. In the initial years of the CHC implementation, the IEB's ability to consistently meet its contractual obligations for customer service and application processing each quarter varied considerably. However, OLTL's efforts to improve IEB performance and address issues have been effective. Since the second quarter of 2020, the IEB has consistently met its targets. In addition, OLTL has repeatedly engaged stakeholders and sought input on ways to streamline and strengthen the enrollment process, as well as implemented specific changes to IEB requirements to improve performance.

Clinical eligibility for CHC is determined through a functional eligibility determination administered by a trained assessor. The Independent Assessment Entity (IAE) contracted to perform the eligibility determinations has not had significant issues meeting its contractual obligations, outside of minor (but recurring) errors in documentation. Since the implementation of a new eligibility determination tool intended to improve accuracy in determinations in early 2019, the number of individuals found nursing facility clinically eligible (NFCE) has increased slightly each year.

The phased implementation of CHC allows for comparison of access to care indicators across CHC and non-CHC zones during the early phases of CHC implementation (i.e., comparing the SW and SE zones to the combined LC, NE, and NW zones). MRC analysis of data from the pre- and post-CHC implementation period indicates some concern in several areas. While more participants had a

primary care or specialist visit, the number of visits per person declined. Further research is needed to determine if that represents increased efficiency without impacting access to needed services. Other trends seen, including a reduction in emergency room and hospice utilization, could not be attributed to the impact of CHC based on current data.

Under CHC, the participating MCOs have the option to use internal staff to perform service coordination (SC) or rely on external providers (also referred to as 'partner SCs'). This allowed some legacy SC agencies to continue operating and facilitated the transition to the new program. Over time, however, the CHC-MCOs have brought the bulk of SC in-house, and reliance on partner SCs is the exception. For example, the CHC-MCOs use some partner SCs to serve rural communities where staffing is potentially a challenge, and also use several large legacy providers with specific clientele (e.g., younger disabled adults).

With respect to behavioral health, overall utilization of community behavioral health services did not change during the period immediately pre- and post-CHC implementation, but different service utilization impacts occurred for different subpopulations of LTSS users in different zones. A longer time period is needed to determine the impact of improved coordination between behavioral health, physical health and LTSS.

Access to medical appointments and ratings of medical transportation improved while per capita non-medical transportation spending declined following CHC implementation. This is notable, as the number of non-medical transportation providers declined over time, yet the number of authorized visits has increased. This implies that CHC-MCOs have increased satisfaction while improving access and lowering unit cost.

Other indicators of access to care reviewed for this report include data from the Health Plan version of the Consumer Assessment of Health Providers (CAHPS-HP) surveys submitted to OLTL by each MCO and ongoing monitoring of complaints regarding lack of providers and uncovered services, as well as Home and Community-Based Provider (HCBS) enrollment ratios conducted by OLTL. According to CAHPS-HP data, participants have relatively high rates of satisfaction with access to physical health services, with at least 85 percent reporting that needed care is available right away, routine and specialist appointments are available as soon as needed, and it was easy to acquire care, tests, or treatment. During the first four years of CHC operation, OLTL monitoring indicated that missed services, complaints and grievances ratios, and provider enrollment ratios were within acceptable levels, and OLTL was able to engage with MCOs to remediate problems.

Following the implementation of CHC, the annual rate of increase in the proportion of individuals utilizing HCBS accelerated, increasing from 1% to 2% per year among those 21 to 59 years old and from 2% to 4% per year among those 60 and older. The number of individuals utilizing personal assistance services (PAS) also increased steadily from 2017 to 2020, with a slight drop in 2020 (potentially due to the COVID-19 pandemic). Utilization of participant directed PAS was decreasing prior to CHC implementation, but the rate of decrease slowed following CHC implementation. In all zones, PAS hours per participant were increasing prior to CHC, but the rate of growth declined in the SW and SE zones following CHC implementation. One area to note is the percent of individuals who experienced a decrease in PAS hours from the prior year nearly doubled post-CHC implementation, from 5.7 to 9.4 percent.

Quality Of Care

Under the Department of Human Services (DHS) Quality Strategy, initial goals for CHC included ensuring contract compliance, CHC-MCO accountability and performance, and ensuring adequate data collection to support successful program implementation. With full implementation of CHC complete, moving forward, DHS is increasingly focusing on steady state monitoring and quality improvement strategies.

State Medicaid programs are required to have an External Quality Review Organization (EQRO) to evaluate all Medicaid managed care plan performance. DHS engaged Island Peer Review Organization (IPRO) to serve as the EQRO for CHC. IPRO serves as the EQRO for PA's other Medicaid managed care programs. The EQRO has responsibility to review a range of quality measures submitted by each CHC-MCO and provide annual reports to DHS. In addition, each CHC-MCO is required to conduct Performance Improvement Projects (PIPs) on topics that are nominated by the plans and approved by OLTL. Progress on PIPs is reported to the EQRO and reviewed by OLTL.

OLTL works directly with the three CHC-MCOs, holding regular telephone calls and quarterly meetings. OLTL has a 'monitoring team' of internal staff dedicated to oversight of the three CHC-MCOs. This team collaborates across all relevant program areas in OLTL, including program integrity, quality, participant supports, and monitoring and compliance. When collaborative monitoring activities are not adequate to correct concerns or non-compliance with program requirements, OLTL can place the CHC-MCOs under a corrective action plan (CAP). OLTL has utilized CAPs to address several high priority areas, including person-centered service plans (PCSP), data privacy, insufficient notice of denial of services, and the accuracy and integrity of data submissions.

CHC-MCOs have had several challenges meeting OLTL's requirements regarding PCSPs. Several factors include communication challenges with external Service Coordination Entities (SCEs), inadequate staff training regarding the required elements of the PCSP, and staff turnover. Interviews with SCs indicated additional challenges, including those assessments and the PCSPs failed to adequately capture behavioral health needs and variability among participants. In addition to formal corrective action, OLTL held technical assistance sessions, developed a detailed checklist that outlines the required elements of PCSP, and provided feedback specific to each CHC-MCO. Though monitoring is ongoing, all CHC-MCOs have improved PCSP compliance scores as a result of these interventions.

OLTL monitors grievances and appeals by collecting data on the total number of denials, the time required to resolve grievances and complaints, and by performing clinical case review of HCBS, pharmacy, dental, home modification and physical health denials. Though MCOs generally met the compliance benchmarks for grievance and appeals, additional remediation was required to address challenges related to resolving the increase in the volume of complaint and grievance requests as a result of the end of the continuity of care period and the expiration of OLTL's moratorium on service reductions and denials due to COVID-19. Though performance has improved, MCOs are not consistently meeting performance targets for clinical case review of denials. OLTL has held meetings with the MCOs to discuss compliance issues and provide assistance and may provide further clarification of requirements in the CHC Agreement.

On indicators of quality of care, rates of individuals returning to the community following hospitalization decreased in the SW and SE zones following CHC implementation for all HCBS users and non-LTSS users, with the exception of HCBS users in the SW zone ages 21-59. In the SE zone, 30-day hospital readmission rates increased from 2018 to 2019, while in the SW zone, readmission rates increased for all groups except nursing facility (NF) residents aged 21-59. Following CHC implementation, the rate of ambulatory care sensitive hospitalizations rose then declined for HCBS participants and rose sharply and remained high for NF participants in the SW zone, and in the SE zone, the rate of ambulatory care sensitive hospitalizations rose for all groups except HCBS users from ages 21-59. Hospitalizations for heart failure rose between 2017 and 2019 in the SW and SE zones and then leveled off in NW/NE/LC zone. Rates of depression and fall risk screening rose in all zones between 2017 and 2019, with the largest increases seen in the SW zone.

Antipsychotic medication adherence rates rose slightly in the SW following CHC implementation, then declined. Trends in rates of antidepression adherence were similar across all zones between 2014 and 2019.

Cost-Effectiveness

The COVID-19 pandemic had a global impact on health care use and spending leading to decreases in nearly every provider category and payor including commercial, Medicare and Medicaid. Thus, we focus our attention primarily on the first two years of experience from 2018 to 2019. Analysis of Medicaid spending found that overall program expenditures have increased dramatically over time. However, this trend can be attributed in part to a long-term pattern that pre-dates CHC, as well as growth of the program. Under CHC, only about 16% of Medicaid spending (based on provider payments) is for physical or behavioral health; the vast majority is spent on LTSS. Analysis of spending on non-LTSS found that cost per person increased very slightly. In the LTSS category, per person spending on NF care was essentially unchanged. This is not surprising, given that there was no change to NF reimbursement rates during this time period. This was in part by design: NFs were guaranteed that CHC-MCOs could not reduce reimbursement. In addition, to prevent residents from needing to relocate, CHC-MCOs were required to continue covering NF in any facility where a participant was living.

Over the time period of this report, the absolute number and fraction of CHC participants using HCBS increased. CHC has appeared to have an impact on per person HCBS spending. In the SW, per person spending in 2018 and 2019 was essentially held at 2017 levels. In the SE, the rate of increase in HCBS spending was dramatically reduced. Thus, while total Medicaid spending in 2019 was $8.475 billion, we estimate that it might have been $8.742 billion had historical trends in HCBS continued.

BACKGROUND

CHC is Pennsylvania's mandatory Medicaid MLTSS program. CHC provides physical health and LTSS to individuals who are over age 21 in two populations: individuals who are dually eligible for Medicaid and Medicare and individuals who qualify for Medicaid LTSS, both in the community and in NFs. Physical health services and LTSS are provided by three MCOs: Vista Health Care (doing business as AmeriHealth Caritas in the SW, NW, NE and LC zones and doing business as Keystone First in the SE; hereafter referred to as AmeriHealth Caritas/Keystone First), Pennsylvania Health & Wellness, and UPMC. CHC-MCOs are required to coordinate with Behavioral Health MCOs (BH-MCOs) for the provision of behavioral health services.

Prior to implementation, DHS and the Pennsylvania Department of Aging (PDA) released a concept paper describing the primary goals of CHC, which are:

- Enhance opportunities for community-based living, including enhancing HCBS options and improving person-centered planning;
- Strengthen coordination of LTSS and other types of health care, including all Medicare and Medicaid services for dual eligible;
- Enhance quality and accountability through approaches such as holding CHC-MCOs accountable for outcomes and quality data transparency that supports informed decision making;
- Advance program innovation, including new approaches to housing, technology use, and direct care workforce enhancement; and,
- Increase efficiency and effectiveness through strategies such as reducing preventable hospitalizations and emergency room visits and increased use of primary care and HCBS.[1]

The implementation of CHC occurred between 2018 and 2020 in the following three phases:

- Phase I: SW Zone Implementation (January 1, 2018)
- Phase II: SE Zone Implementation (January 1, 2019)
- Phase III: LC, NW, and NE Zone Implementation (January 1, 2020).

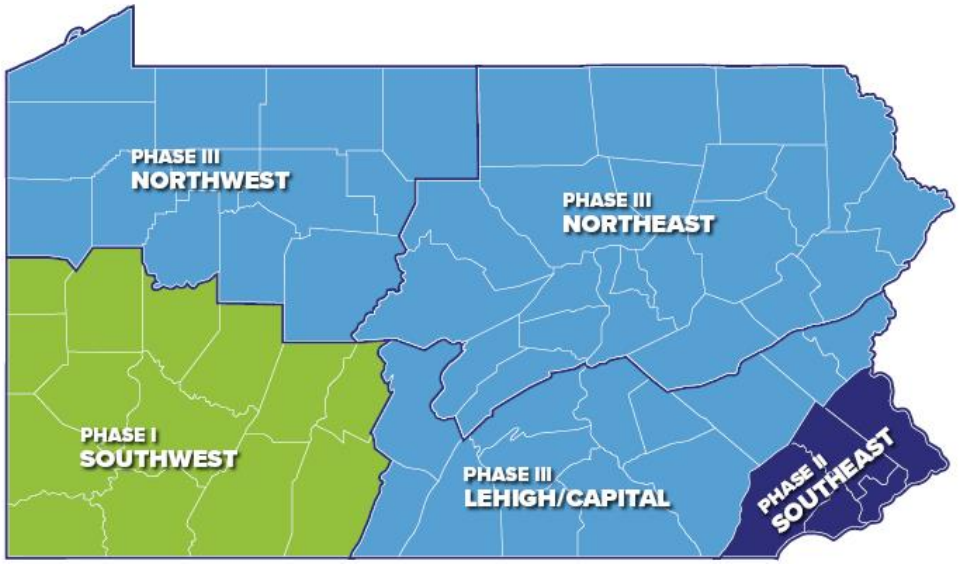


Figure 1. CHC Implementation Phases and Zones

[1] https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/CHC%20Concept%20Paper.pdf

Waiver Authority

The CHC program operates under combined 1915(b) and 1915(c) waiver authority. 1915(b) waiver authority permits the mandatory enrollment of individuals into managed care for physical health and LTSS, and the 1915(c) waiver permits individuals who are eligible for an institutional level of care to be served in the community. OLTL received approval for CHC on July 24, 2017. The concurrent approval of the CHC 1915(b) and 1915(c) waivers was for a five-year period, beginning January 1, 2018, through December 31, 2022. In its waiver approval letter, CMS included certain data reporting requirements, which are discussed further below.

Prior to the implementation of CHC, OLTL operated several 1915(c) waivers to provide HCBS to eligible populations:

- Aging waiver (serving individuals with LTSS needs age 60+)
- Attendant Care waiver (serving individuals with physical disabilities ages 18-59)
- OBRA waiver (serving individuals with developmental disabilities ages 18-59)
- Independence waiver (serving individuals with physical disabilities ages 18-59)
- COMMCARE waiver (serving individuals with traumatic brain injury age 21+)

With the implementation of CHC, nearly all "legacy" waivers were consolidated into a single 1915(c) HCBS waiver, which authorizes HCBS for all individuals who qualify for LTSS. The legacy waivers served populations in need of LTSS due to age, traumatic brain injury, and physical disability or developmental disability.

The OBRA waiver continues to serve individuals ages 18-59 with developmental disabilities. As part of CHC implementation, OBRA waiver participants were reassessed to determine if they met Nursing Facility clinical eligibility. If so, they were enrolled in CHC. Because not all individuals served by the OBRA waiver are eligible for CHC due to age or functional status, the OBRA waiver remains in operation. For all waivers other than OBRA, the phased implementation of CHC required these legacy waivers to terminate operations in zones where CHC was active and continue operation in other zones until CHC was implemented statewide.

Pennsylvania's Experience with Medicaid Managed Care

DHS operates a total of five Medicaid managed care programs: Physical HealthChoices, Behavioral HealthChoices, CHC, the Children's Health Insurance Program (CHIP), and the Office of Developmental Programs (ODP) Adult Community Autism Program (ACAP). Physical HealthChoices is a mandatory Medical Assistance (MA) program that provides medical, surgical, and prescription drug benefits to eligible individuals. Behavioral HealthChoices provides mental health, substance use, and other behavioral health services to eligible children and adults. CHIP covers physical health, behavioral health, and prescription services for eligible children under the age of 19. ACAP is an integrated program that provides physical, behavioral, and community and specialized supports to adults with autism. Except for ACAP, which operates in four counties only, the PA Medicaid managed care programs are available statewide in all 67 counties. Like Physical HealthChoices and Behavioral HealthChoices, CHC was incrementally implemented by zone across the state over a period of three years. The five HealthChoices zones are designated by geographic region and county as follows:

- SW Zone: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, and Westmoreland
- SE Zone: Bucks, Chester, Delaware, Montgomery, and Philadelphia
- LC Zone: Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York

- NE Zone: Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming
- NW Zone: Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, and Warren

In addition to the five Medicaid managed care programs, DHS also operates the Living Independence for the Elderly (LIFE) program (known nationally as the Program of All-Inclusive Care for the Elderly or "PACE"). It was available in 52 counties across the state as of the time period of this report. LIFE provides comprehensive medical and supportive services to qualifying individuals aged 55 or older. LIFE is an alternative to the CHC program's 1915(c) waiver. Participants who qualify for CHC may choose to enroll in LIFE.

CHC had a significantly shorter rollout period when compared with the other HealthChoices programs. The rollout of Physical HealthChoices occurred in all five zones between 1997 and 2013, and the rollout of Behavioral HealthChoices occurred between 1997 and 2007. By the time the CHC rollout began in 2017, DHS had extensive experience with Medicaid managed care. CHC was able to draw on the procedures, strategies, and expertise available from the fully matured HealthChoices program.

DATA SOURCES AND METHODOLOGY FOR THIS REPORT

This report draws from a wide range of data sources and data collection methodologies. The first source was data collected by DHS as part of its contract monitoring processes. These data, described below, were made available for review and inclusion.

Primary Data Collection

Key Informant Interviews

The MRC conducted qualitative interviews with key informants from provider and participant advocacy organizations and other stakeholders in PA. The first interviews were conducted in Q4 of 2016. This report incorporates findings from interviews conducted through the end of 2021.

Interviews were conducted with representatives from the following categories:

- Adult Day Centers
- Advocacy organizations
- Area Agencies on Aging
- Behavioral Health Providers
- Centers for Independent Living
- Habilitation providers
- Home Care providers
- Home Delivered Meal provider
- Home modification providers
- LIFE providers
- Nursing Facilities
- Senior Centers
- Service Coordination Entities
- Trade associations
- Transportation providers

The goal of the key informant interviews was to gain an understanding of how organizations prepared for CHC and how the impact of CHC changed over time. Organizations in all three phases of CHC were interviewed, with a focus on completing interviews at various time points – pre-CHC, during implementation, and post-implementation.

Each interview was transcribed verbatim. Names and identifying information were removed from the transcripts before analysis. The transcripts were imported into a qualitative data analysis software program for data management and analysis. The analysis process incorporated both deductive and inductive approaches to identify themes and categories. A codebook was developed, and each transcript was coded twice. The first round of coding applied *a priori* codes that segmented the text into categories directly derived from the interview guide. The second round of coding involved a codebook composed of inductively derived concepts that emerged from the responses of interviewees. The findings from this process are incorporated into this report in context.

Home and Community Based Provider Survey

The Home and Community Based Provider Survey was conducted annually from 2017 to 2021. The survey was constructed using the Qualtrics web-based survey system and distributed via email using a contact list provided by OLTL. In each wave of the survey, multiple email reminders were sent followed by telephone follow-up. In Wave 4 (2021), telephone follow-up was interrupted by the COVID-19 pandemic. The effort ceased in March 2020 and was re-started in June 2020. Data collection was kept open to assure a sufficient sample size. In Wave 4, reminder calls continued until a sufficient sample size was achieved (April 8, 2021). Waves 3 (2020) and 4 (2021) were impacted by the COVID-19 pandemic, which placed an extraordinary strain on all categories of providers. As described below, the MRC incorporated questions about the impact of COVID-19 into the survey. The data were extracted from Qualtrics and analyzed using Stata. The responses to each survey item were analyzed for trends across zones and waves of the survey.

Nursing Facility Provider Survey

The survey instrument was developed by the MRC in conjunction with DHS and OLTL by modifying the instrument used for the annual HCBS provider survey conducted in 2018 and 2019. The HCBS survey addressed communication with OLTL, experience with CHC-MCOs, and the providers' strategic outlook. The modified version for NFs included specific topics relevant to that population including the transition to the community and interaction with Behavioral HealthChoices MCOs. In 2018, 2019, and 2020, the MRC obtained an electronic file with the names of all NFs that accept Medicaid from DHS. This file contained the name of the administrator of record, his or her email address, and the phone number of the facility. The survey was distributed two ways. First, a personalized email was sent to each administrator identified which contained a custom link to complete the survey for each facility. Reminder emails were sent to non-respondents after one week. Additional reminders were sent during weeks three and four to encourage a higher response rate. The OLTL also sent emails to the Nursing Facility Listserv that contained a general link to the online survey. The four NF trade associations were asked to re-post that message to their respective memberships.

Nursing Facility Focus Study (2019)

The 2019 Nursing Facility Focus Study was designed to collect quantitative and qualitative data on a small number of facilities. NFs were randomly sampled to represent different types of facilities in all three Phases: large vs. small (under and over 120 beds), for-profit vs. nonprofit, government ownership, and urban/rural. A total of 19 facilities participated in the study. Two facilities with a relatively high proportion of people aged 21-59 were included to assure that that population would be well represented in the overall analysis. In each of the 19 facilities, qualitative interviews were conducted with top management and any staff that interacted with the CHC-MCOs. In 17 out of 19

facilities, the MRC interviewed residents – stratified by age (21-59/60+). In 6 facilities, a sample of family members and representatives were also interviewed.

Nursing Facility Sub-Study (2020)

In 2020, the MRC conducted a sub-study of NFs to address several critical issues that emerged regarding SC and access to behavioral health. From June through December 2020, the MRC conducted 22 interviews with administrators of 21 skilled nursing facilities (SNFs). In one case, evaluators conducted two separate interviews with representatives from a single SNF.

All interviews were conducted remotely during the COVID-19 pandemic and were recorded using either Microsoft Teams or Zoom. Each interview was transcribed verbatim. Names and identifying information were removed from the transcripts before analysis. All 22 transcripts (totaling 288 pages) were imported into NVivo 12 for data management and analysis.

The analysis process incorporated both deductive and inductive approaches. Each transcript was coded twice. The first round of coding applied *a priori* codes that segmented the text into categories directly derived from the interview guide. The second round of coding used a codebook composed of inductively derived concepts that emerged from the responses of the interviewees. In addition, the qualitative data analyst crafted memos within NVivo to document emergent patterns across all transcripts.

Participant Experience Surveys

The MRC conducted a prospective, longitudinal, telephone-based survey of community-dwelling program participants. Prior to each implementation phase, a stratified random sample of individuals enrolled in the legacy program was selected and recruited. In addition, contemporaneous comparison samples were recruited in 2018 and 2019 from the final implementation zone. All sampled individuals were followed for up to 30 months (up to four interviews). To account for attrition, supplemental cross-sectional samples were drawn in 2019, 2020 and 2021.

Participants were stratified into three main categories: individuals who do not use LTSS, younger HCBS users (age 21-59) and older HCBS users (60+). These age groups reflect the different legacy waiver programs that operated prior to 2018. Samples were drawn from each of the three zones of PA and were further stratified by urban or rural residents. The exception was the SE zone which does not have any non-metropolitan counties.

Survey recruitment was conducted by sending a personalized letter followed by a telephone call. There were no financial incentives to participate in the survey. The content for the interviews was drawn mainly from previously validated instruments, including the Consumer Assessment of Healthcare Providers and Systems-Home and Community Based Services (CAHPS-HCBS), the National Health and Aging Trends Study, and the Medicare Current Beneficiary Survey. Data from the CAHPS-HCBS items were combined with surveys conducted by CHC-MCOs to generate pre- and post-implementation estimates of key quality constructs.

Participant and Caregiver Focus Groups

To capture participants' early experience with the transition to CHC, the MRC conducted a series of focus groups in each implementation zone. These 'rapid' focus groups were designed to provide quick insight into key issues.

SW Implementation (2018)

In 2018, 11 consumer focus groups were conducted in 2018. The team also held four focus groups with caregivers. One of the groups was in an urban/rural setting (Washington County) and the other three took place in rural settings (Greene, Indiana, and Lawrence Counties).

SE Implementation (2019)

In 2019 the MRC conducted 14 focus groups with participants. Due to the extreme cold in the Phase II zone in early February 2019, many focus group participants were unable to participate. In order to interview participants from the Phase II zone who were unable to make it to a focus group, the MRC conducted 17 Individual Consumer Interviews (ICI) using the same questions as the focus group guide. Individuals were contacted via telephone, and interviews lasted approximately 10 to 15 minutes.

NW/NW/LC Implementation (2020)

From February through June 2020, qualitative evaluators conducted 14 focus groups with 68 consumers in the Phase III zone of CHC implementation. Focus group participants were recruited by staff members from the MRC team, who attended each of the CHC participant meetings to inform consumers about the opportunity to take part in focus groups at a later date. Names and contact information of interested consumers were recorded, and the MRC staff called those individuals when focus groups were scheduled in their areas. Those who were interested but not available and those who were interested after the beginning of the COVID-19 pandemic in March 2020 were invited to participate in virtual focus groups. Eligible consumers and caregivers included those living in the Phase III zone and recently enrolled in CHC, including consumers from Dauphin, Erie, Huntingdon, Lycoming, Mercer, Venango, Wayne, and York counties. Recruitment and focus group activities were paused in April and May 2020 as a result of the COVID-19 pandemic. Focus groups resumed virtually in June, during which five consumers participated in two virtual focus groups hosted via Zoom video conferencing. Each focus group participant was provided a $25 gift card for participating in the focus groups.

Service Coordination Sub-Study

From July 21, 2020, through April 1, 2021, the MRC's team conducted 28 semi-structured interviews with service coordinators (SCs) and other representatives from SCEs and each of the three CHC-MCOs. In this method of data collection, open-ended questions are developed within a thematic framework. Order and specific phrasing of the questions is not fixed. This structure permits comparison among respondents while allowing the interviewer the flexibility to follow the natural order of the conversation and to explore specific concepts. Interviews were intended to elicit the perspectives of SCE providers regarding CHC implementation and its effect on their practices and the participants they serve. All interviews were conducted remotely during the COVID-19 pandemic adhering to rigorous qualitative processes. NVivo 12 was utilized for data management and analysis. Several recurrent themes emerged that were examined in depth.

Analysis of Secondary Data and Reports

The MRC obtained and analyzed multiple sources of secondary data as well as reports generated by DHS quality management and compliance processes.

Administrative Data

Under a data use agreement (DUA) with DHS, the MRC has access to a wide range of administrative data sources. Note that each data source is available for slightly different time periods.[2] This includes:

- Medicaid Enrollment and Claims (2013 to 2020)
- Nursing Home Minimum Data Set Assessments (2013 to 2021)
- HCBS Participant assessments (InterRAI-HC) (2018 to 2021)
- Functional Eligibility Determination assessments (2019 to 2021)
- Medicare Enrollment and Claims (2013 to 2019)

The MRC used the DHS enterprise data warehouse to access data tables on Medicaid participants who were potentially eligible for CHC during the years prior to implementation. The enterprise data warehouse was also used to access CHC specific enrollment data elements during post-implementation.

The MRC developed an extensive set of measures and indicators of use and quality, drawing from published and validated sources (e.g., NCQA, HEDIS, AHRQ, CMS, Chronic Condition Warehouse) and the peer review literature. Original approaches were developed to combine Medicaid and Medicare claims data for dually eligible individuals.

MCO CAHPS Surveys

DHS requires that each MCO conduct annual participant surveys using the Health Plan (HP) and HCBS versions of the CAHPS. The following table summarizes the regions where each survey was used in each year.

[2] For this report, claims data prior to 2016 were used to examine long-term trends. The primary focus is from 2016 onward.

Table 1. CAHPS Surveys by Region and Year

	2018	2019	2020	2021
CAHPS-HCBS	SW	SW SE	SW SE NW/NE/LC	SW SE NW/NE/LC
CAHPS-HP		SW	SW SE	SW SE NW/NE/LC

DHS provided aggregated reports for all rounds of CAHPS-HP and CAHPS-HCBS surveys. In addition, raw data files for the CAHPS-HCBS and selected years of the CAHPS-HP were provided to the MRC for direct analysis.

Department of Human Services Monitoring Reports

The CHC program utilizes a managed care model to provide a more strategic care delivery system and improve health outcomes for seniors and individuals with disabilities. By contracting with MCOs, DHS created a capitated model that is intended to improve care coordination and health outcomes while allowing more individuals to live in their communities. DHS also contracts with external vendors to support eligibility, enrollment, and quality oversight activities in CHC.

As noted above, the CHC program operates under a concurrent 1915(b)/(c) waiver authority. Consistent with the Quality Improvement Strategy required by the 1915(c) waiver, OLTL engages in ongoing monitoring of the six 1915(c) waiver assurances: level of care, service plan, health and welfare, qualified providers, administrative authority, and financial accountability. The 1915(c) waiver includes specific performance measures for CHC-MCOs and vendors across each waiver assurance.[3] The data collected by OLTL on each waiver assurance is reported to CMS in their Evidence Based Report (EBR) as part of the 1915(c) waiver renewal.

OLTL also reports CHC program data to CMS via the regular submission of the Waiver Activity Monitoring (WAM) report. When OLTL received 1915(b)/(c) waiver approval from CMS, reporting was required across several key topic areas, including:

- Availability and Accessibility of Covered Service
- Beneficiary Support System (BSS) Entity Services
- Case Manager to Participant Ratios
- Case Management, Care Coordination, and Service Planning
- CHC-MCO Call Center Statistics
- Claims Processing Times
- Critical Incident Reporting
- CHC-MCO Staffing and Resources
- Enrollee and Provider Communications
- Grievances and Appeals
- Member Services and Outreach
- Program Integrity
- Provider Network Management
- Utilization Management

The full list of EBR and WAM measures are included as Attachments 1 and 2.

[3] CHC 1915(c) waiver. https://www.dhs.pa.gov/HealthChoices/HC-Providers/Documents/2021%20CHC%20Waiver%20PA.0386.R04.04.PDF

Beginning in 2023, the WAM, and its reporting elements will be replaced by the Managed Care Program Annual Report required by CMS regulations at 42 CFR § 438.66(e). Under the regulation, each state must submit to CMS, no later than 180 days after each contract year, a report on each managed care program administered by the state and will contain data from all involved plans. The initial CHC submission is due June 29, 2023, for the calendar year 2022 data.[4]

OLTL submitted the Evidence Based Report (EBR) for the CommCare waiver[5] in September 2018 to cover the period July 1, 2015-June 30, 2018. With that submission, OLTL failed to submit data for the period January 1, 2018, through June 30, 2018, or address the correlation of the performance measures in the CommCare and CHC waivers. As a result, OLTL was placed on a CAP and required to submit quarterly reporting data and information for the newly approved performance measures in the CHC Waiver beginning on January 1, 2018. OLTL received notification from CMS in October 2021 that OLTL met all requirements related to the development and implementation of the CAP for the CHC Waiver. The WAM was submitted quarterly for the first five quarters of the program, and annually thereafter.

To support the EBR, WAM, and other monitoring priorities identified by DHS, CHC-MCOs and vendors are required to submit data through a range of Operations (OPS) and Quality Management/Utilization Management (QM/UM) Reports. Upon submission, OPS and QM/UM Reports are reviewed by OLTL staff with appropriate expertise. CHC-MCOs and vendors are required to document remediation activities if EBR and WAM performance standards are not met. For ongoing performance problems or high priority issues, OLTL engages with the CHC-MCO or vendor to analyze and address the problem. Depending on the nature and severity of the issue, follow-up activities may include more frequent meetings, additional data reporting requirements, site visits, CAPs, or formal sanctions.

External and Contract Monitoring Reports

This section describes data obtained through external monitoring of MCO performance, including contractual requirements. These data were submitted to OLTL and made available to the MRC for analysis.

The Balanced Budget Act (BBA) of 1997 requires that state agencies contract with an EQRO to conduct an annual external quality review (EQR) of the services provided by the contracted Medicaid MCOs. This EQR must include an analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that the MCO furnishes to Medicaid beneficiaries.

DHS contracted with its EQRO, IPRO, to conduct the EQRs for the CHC-MCOs and to prepare the annual statewide technical reports required by CMS. The MRC incorporated data and analysis conducted by the EQRO into the construction of this report.

Definitions of Key Sub-Populations of Interest

Most analyses in this report are stratified by age and LTSS category. The age groupings were selected to maintain continuity with legacy waiver programs operating in Pennsylvania prior to 2018. To reduce confusion for multiple audiences, the following categories were used to define LTSS and Non-LTSS participants.

[4] Medicaid and CHIP Managed Care Monitoring and Oversight Informational Bulletin

Table 2. Definitions of Key Sub-Populations

	Definition
Non-LTSS	Participants who are dually eligible for both Medicaid and Medicare and do not receive LTSS (i.e., do not live in a nursing facility or receive HCBS services). Internal documentation from Pennsylvania DHS refers to these individuals as 'Nursing Facility Ineligible' (NFI) to differentiate them from people who are enrolled in a HCBS waiver or live in a nursing facility.
HCBS Age 21-59	Individuals aged 21 to 59 living in a community-based setting receiving HCBS Waiver services. Prior to CHC, they could be served by the Attendant Care, Independence, COMMCARE, or OBRA waiver. May include people who are eligible for Medicaid only. Internal documentation from Pennsylvania DHS additionally refers to these individuals as 'Nursing Facility Clinically Eligible' (NFCE) to indicate that they have been determined eligible for nursing facility level of care. This is necessary to receive waiver services.
Nursing Facility Age 21-59	People aged 21 to 59 living in a nursing facility. May include people who are eligible for Medicaid only. Internal documentation from Pennsylvania DHS additionally refers to these individuals as 'Nursing Facility Clinically Eligible' (NFCE) to indicate that they have been determined eligible for nursing facility level of care.
HCBS Age 60 and older	Individuals aged 60 and older living in a community-based setting receiving HCBS Waiver services. Prior to CHC, they were served by the Pennsylvania Department of Aging (PDA) waiver. Some individuals enrolled in waiver programs prior to turning age 60 may have stayed on those programs (see above) rather than transition to the PDA waiver. May include people who are eligible for Medicaid only. Internal documentation from Pennsylvania DHS additionally refers to these individuals as 'Nursing Facility Clinically Eligible' (NFCE) to indicate that they have been determined eligible for nursing facility level of care. This is necessary to receive waiver services.
Nursing Facility Age 60 and older	People aged 60 and older living in a nursing facility. May include people who are eligible for Medicaid only. Internal documentation from Pennsylvania DHS additionally refers to these individuals as 'Nursing Facility Clinically Eligible' (NFCE) to indicate that they have been determined eligible for nursing facility level of care.

FINDINGS: ACCESS TO CARE

During the implementation of CHC, OLTL engaged in robust outreach to stakeholders, providers, and program participants to support awareness of CHC and successful enrollment in managed care. This section discusses OLTL's approach to ensuring that information needed to support access to care, such as eligibility and enrollment procedures, available benefits, and CHC-MCO provider network composition, was available to participants. This section also reviews efforts to inform providers about CHC and support the continued availability of services as implementation moved forward. Finally, this section evaluates the thoroughness and effectiveness of OLTL's outreach and implementation activities, as well as OLTL's ongoing oversight of the external vendors facilitating eligibility determinations and enrollment activities for participants in CHC.

Participant and Provider Outreach

Pre-Enrollment Outreach to Participants

Prior to implementation and in partnership with PDA, DHS worked with local Area Agencies on Aging (AAAs) to hold participant education meetings in a wide variety of locations across the geographic area served for each phase. Sites included rural and urban areas. Meeting organizers learned from challenges encountered in early sessions and adapted processes and content to better address the needs of the participants. The PA Centers for Independent Living (CILs) also completed additional education sessions throughout the Phase III implementation zones.

During the Phase II and Phase III implementations, DHS contracted with the Mendoza Group to conduct a communication campaign in collaboration with local community organizations with links to racially, culturally, and linguistically diverse populations. These outreach efforts included electronic media, print media, and community roundtables.

The methods of participant outreach included hard copy via regular mail, documents (usually PDFs) available for review and download from the CHC website, and a video embedded on the website. During Phase III of CHC implementation, more extensive video trainings were made available as another educational source for participants and their caregivers.

Participants received pre- and post-informational enrollment packets that were sent via regular mail. Individuals who self-selected their MCO received a confirmation letter, which includes instructions on how to change MCOs or their primary care practitioner (PCP). Those who did not make a selection, received a letter informing them about the MCO to which they were assigned, instructions on PCP selection, and information on how to change their MCO.

Outreach and Education Vendor

The Outreach and Education vendor provided educational and outreach support during each of the three phases of implementation. The vendor was Aging Well, a consortium of AAAs. The Outreach and Education contractual obligation was in effect only for the implementation stage for each of the three phases. Performance was reported under AA-3 of the EBR in Q1 each year, 2018-2020, all of which were reported at 67%. The vendor faced some challenges related to delays in contracting with DHS in 2018, which delayed subsequent outreach activities. The vendor did not meet the contractual obligation in 2019 and 2020. The contract with this vendor ended after CHC Phase III implementation and waiver performance measure AA-3 was removed in the approved CHC waiver amendment effective 1/1/2021.

MRC Evaluation of Participant Outreach

Participant Community Information Sessions.

The OLTL offered community meetings to participants to learn more about CHC and provide an opportunity for participants to ask questions. Aging Well hosted the informational sessions in all three phases. The MRC attended a large portion of these sessions to provide feedback and utilized the meetings as a forum to recruit participants for focus groups and to schedule interviews with key informants. In Phase I, these meetings were challenging: the messages were complex and confusing, and consumers wanted clear answers to their questions, particularly around how CHC affected their Medicare benefits. However, as the sessions rolled out in the SW zone, OLTL was able to revise its presentations and improve the quality and messaging.

OLTL incorporated the feedback received and observations during Phase I to enhance Phases II and III implementation. OLTL increased the number of participant and provider information sessions and revised the content presented in those sessions. OLTL started offering information meetings earlier in the process and offered more opportunities for participants and their family members to attend. These meetings were well attended by both providers and participants. Another step taken by OLTL was to conduct listening sessions (described below); these arose out of concern from the provider and advocacy communities that many participant concerns were not being adequately addressed.

Participant Listening Sessions

In response to concerns that were raised by participants, advocates, and providers during the Phase I implementation, DHS partnered with the Jewish Healthcare Foundation (JHF) to host a total of 13 listening sessions in the SW zone during 2018. In 2019, six listening sessions in the SE zone 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 was shared in these sessions was used by OLTL to provide additional guidance to the MCOs.

Outreach and Educational Materials

Early in the Phase II implementation, the MRC conducted a review and assessment of communication and outreach methods to providers and participants. The assessment was a point-in-time review of materials available in June 2019. Several channels of communication were examined: online, hard copy, video, social media, and in-person experiences. The assessment explored communications in the domains of background, readiness, enrollment, general resources, and ongoing communication.

The assessment concluded that the CHC communications materials are of high quality, although somewhat overwhelming in volume. In qualitative interviews, providers reported that in the early implementation phase, some participants had such difficulty navigating the amount of information that they felt it would be easier to auto-enroll. There are many concise and focused documents that answer specific questions while carrying through key messages about the CHC program. High quality information is available on the website, although the lack of a CHC-specific search function poses a challenge to locating a specific document or finding specific information. A commitment to educate and apprise participants and providers through open and frequent communication was apparent.

Ongoing Participant Access to Information and Support

Several opportunities exist for individuals to stay informed about CHC via ongoing communication, including a webinar series, a listserv, and a Medical Assistance Advisory Committee (MAAC) subcommittee specific to MLTSS. The listserv provided a vehicle for meeting notification as well as

for the distribution of fact sheets and other informational pieces at scheduled intervals prior to and during each implementation phase. In addition, social media also has been used as an outreach technique. Most of the pages on the CHC website include icons for Facebook, Twitter, and YouTube. WAM #6.d.4 measures percent of newly enrolled participants who received new participant orientation. For 2018 through 2020, all MCOs surpassed the 86% benchmark at 99-100%.

The CHC program provides call centers to assist both participants and providers. There is a TTY line for individuals who are hearing or speech impaired. In addition, the state maintains an email mailbox that stakeholders can use at any time to ask questions or make comments about CHC.

Customer Service

OLTL has an extensive monitoring system in place to assure effective customer service. CHC participants can utilize OLTL's previously existing participant hotline number to obtain assistance and MCOs are required to report call center metrics quarterly. For example, responsiveness to telephone calls from participants is an important aspect of customer service. Both WAM #6.a.3 and WAM #6.d.1 measure the percent of participant calls answered by the MCOs in 30 seconds. While there was some variation across quarters, the MCOs met the contractual performance standard of 85% for answering participant calls within 30 seconds in most quarters. The exception was in 2019 Q3, one MCO reached 82% in the SW zone and 84% in the SE zone. To address this discrepancy, the MCO hired additional staff. It should be noted that the aggregated annual performance, both for individual MCOs and combined MCOs, met the performance for all three years. Annual MCO trends are illustrated below.

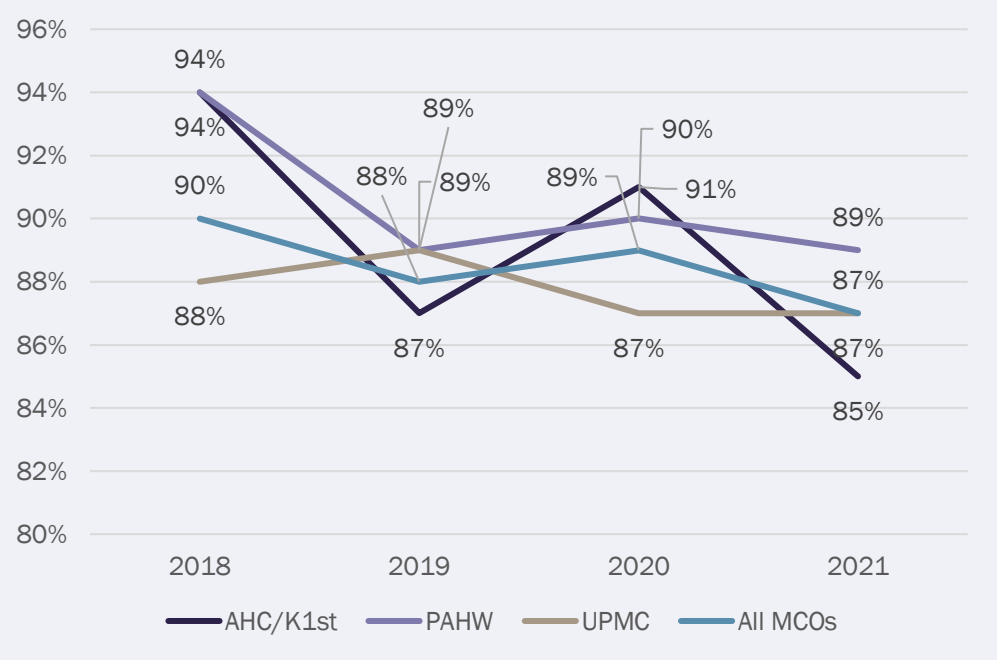


Figure 2. Percent of Participant Calls Answered in 30 Seconds
Sources: WAM, MCO Staffing, and Resources (#6.a.3); WAM, Member Services and Outreach (#6.d.1)

Monitoring reports also measure the percentage of participant abandoned calls. Both WAM #6.a.4 and WAM #6.d.2 address this issue. All MCOs met the benchmark in all quarters.

Additional qualitative findings addressed issues with the CHC-MCO helplines. Providers noted that it was difficult to contact a participant's service coordinator, making it challenging for caregivers or

family members to call on behalf of participants who are unable to speak on the telephone themselves. They also reported receiving conflicting information on separate calls about the same issue. Finally, providers reported difficulty in reaching consistent MCO staff regarding specific issues. Provider-MCO communication improved to some extent by the end of 2021.

Limited English Proficiency and Alternate Format Communication

CHC-MCOs are required to submit data on all fulfilled and unfulfilled participant requests for alternate format materials and language interpretation services. Several WAM measures address language interpretation requests for telephone calls, in-person, and material modes of communication (WAM #6.b.2 through #6.b.5). There are no benchmarks for these measures, but OLTL engages in routine monitoring to identify any significant variations that may require analysis and follow-up. Q2 (ending 3/31/2019) and Q3 (ending 6/30/2019) showed increases in the need for language interpretation (phone and materials) reflecting greater diversity in the SE zone. In 2020, AHC worked with their language services vendor to increase the pool of available interpreters, reducing the number of unfulfilled in-person language interpreter requests from 32 in Q1 to zero in Q4. WAM #6.b.1 measures the number of TTY/PA relay/videophone/sign language requests per 10,000 participants. UPMC reported a high number of requests for Q1 due to a printing error in the materials that published the TTY number incorrectly. UPMC corrected this publication error. There were minimal complaints regarding language interpretation noted in the WAM. The benchmark for training MCO customer service staff on disability, cultural, and linguistic competency (WAM #6.b.8) is 86%. All MCOs met the benchmark for Calendar Year 2018 through 2020.

Effectiveness and Development and Distribution of DHS Marketing Materials

The communication materials supporting the CHC process are comprehensive in media and content. Information is available as mailed hard copy, printable PDF, online, video, and in-person meetings. One issue is that individuals who do not use the Internet and do not have help in accessing online information may not be aware of resources that could be helpful to them. However, the pre-and post-enrollment packets, which are hard copies and sent via regular mail, did contain the most vital information. Most documents are available on the website in several languages. Regarding using DHS's CHC website, www.healthchoices.pa.gov, the user must know to click through a page with the three HealthChoices options to get to the actual CHC landing page. Also, the user may have difficulty finding specific information as there is not a search function on the website. The biggest challenge is that the amount of online information could be overwhelming and may be daunting for individuals who are not seasoned, Internet users. That said, it is commendable that transparency, through access to all materials, is a priority in the administration of the CHC program.

In terms of accessibility, TTY contact numbers were available on most CHC documents. In addition to the availability of educational materials in audio formats, Computer Assisted Realtime Transcription services were provided when a participant submitted an accommodation request with their listening session registration. Multiple American Sign Language education sessions were also conducted in a live online format. Finally, information about alternative formats for individuals with visual impairments are widely disseminated.

Pre-Implementation Outreach to Providers

Provider Summits

Prior to the CHC launch in each phase, DHS hosted provider summits which were attended by the CHC-MCOs along with provider organizations. The purpose of these summits was to prepare the providers for the transition to CHC. DHS discussed the transition from fee- for-service (FFS) Medicaid to managed care Medicaid, quality strategy, communications, covered services, continuity of care,

care planning, needs assessment, service coordination, and provider payments. The MCOs followed up with their strategies for CHC, onboarding/credentialing, and network adequacy. Breakout sessions covered behavioral health, physical health, HCBS, SC, and NFs.

MRC staff observed provider summits for Phase I during 2017 and provided feedback to OLTL. Findings from these observations included significant confusion among providers regarding the transition, requirements to 'apply' to MCOs to become providers and the continuity of care period. Prompted by feedback from the MRC during Phase I, DHS decided to host the provider summits in Phases II and III earlier in the calendar year. Also, due to the confusion surrounding changes to non-medical transportation, including the implementation of CHC-MCO contracted brokers to provide transportation services, transportation summits were added to the Phase III provider summits.

To improve provider readiness after Phases I and II, OLTL conducted a series of in-person provider summits across the Commonwealth. In preparation for the Phase III roll-out, nine summits were held in May and June 2019, three in each of the Phase III zones of LC, NW, and NE. The first part of each day-long provider summit was plenary sessions that included an overview and discussions of quality, communications, and the current state of the program. Each of the MCOs had an opportunity to discuss their approach to CHC implementation. In the afternoon, attendees selected breakout sessions most relevant to their provider domain: Behavioral Health, Hospital-Based and Physical Health, HCBS, NFs, and SC. All provider summit presentations are available on the CHC website under Provider Resources. To be responsive to emerging needs in preparation and education, a second day was added at one 2019 Provider Summit site in each of the three Phase III zones to discuss CHC implications for transportation providers.

Other lessons learned from Phase I that were implemented in Phase II and Phase III include:

- Development of information sheets for providers to be distributed through trade associations;
- Sharing of specific information for NFs regarding payment policies (e.g., Medicare cost-sharing); and
- Improved information sheets for participants regarding continuity of care and selection of PCP (e.g., that participants do not need to select a new Medicare PCP).

Provider Resources

A wide array of PDF documents suitable for printing are available on the Provider pages of the CHC website, many of which also are on the general Helpful Resources page. Provider documents support two main purposes: 1) increasing providers' understanding of the general CHC process and its implications for their clients; and 2) improving providers' delivery of services and general business processes. Some documents align with one of these purposes or the other, but for many of the resources, the line is not as clear. Provider resources include information on a diverse array of topic areas critical to meeting the health care and LTSS needs of CHC participants. Also available for review are documents directed to other professionals and organizations on which CHC has an impact. Topic areas include, but are not limited to:

- CHC eligibility
- Benefits
- Addition of behavioral health services for certain populations
- Service coordination processes
- Continuity of care
- Billing

Findings from Provider Surveys

As part of the evaluation, the MRC conducted online surveys of HCBS providers on an annual basis. The first wave of the HCBS survey was conducted statewide starting in late 2017 and ending in early 2018. This is referred to as "Wave 1 (2018)". The survey was repeated annually in 2019, 2020, and 2021. Since each wave of the survey was conducted statewide, it is possible to capture the baseline experience of HCBS providers in each zone before CHC was implemented, as well as their post-implementation experience.

These surveys reveal a complex picture of providers' perceptions of CHC. Over the four waves of the survey, there was evidence that aspects of the implementation improved over time. However, the overall outlook of providers should indicate some concern. Providers agree that CHC is critical to their organizations' future and are positive about their ability to continue to serve their current clients. Providers are neutral regarding whether CHC will improve HCBS overall. In addition, on average, providers in all three zones believe they are not going to benefit financially from CHC.

Providers were asked about the extent to which they believed that CHC will improve HCBS in Pennsylvania, improve the timeliness of services, provide care coordination, and improve the quality of and access to LTSS. In each year, during the period before implementation, providers were relatively optimistic. After the first implementation year, that optimism appeared to decline, followed by a shift towards being more positive in subsequent years. This pattern was observed in the first implementation in the SW zone and again in the SE zone.

For example, in early 2018, in response to the question about whether CHC would improve the quality of LTSS, providers in the SW zone rated this issue as 3.5 on average (scale ranged from 1= strongly disagree to 5 = strongly agree), implying moderate agreement (see figure). In 2019, providers in the SW zone rated the issue as 2.74 on average, suggesting they did not expect CHC to improve quality. However, by early 2021, the average rating was about 3.13, indicating a more positive attitude.

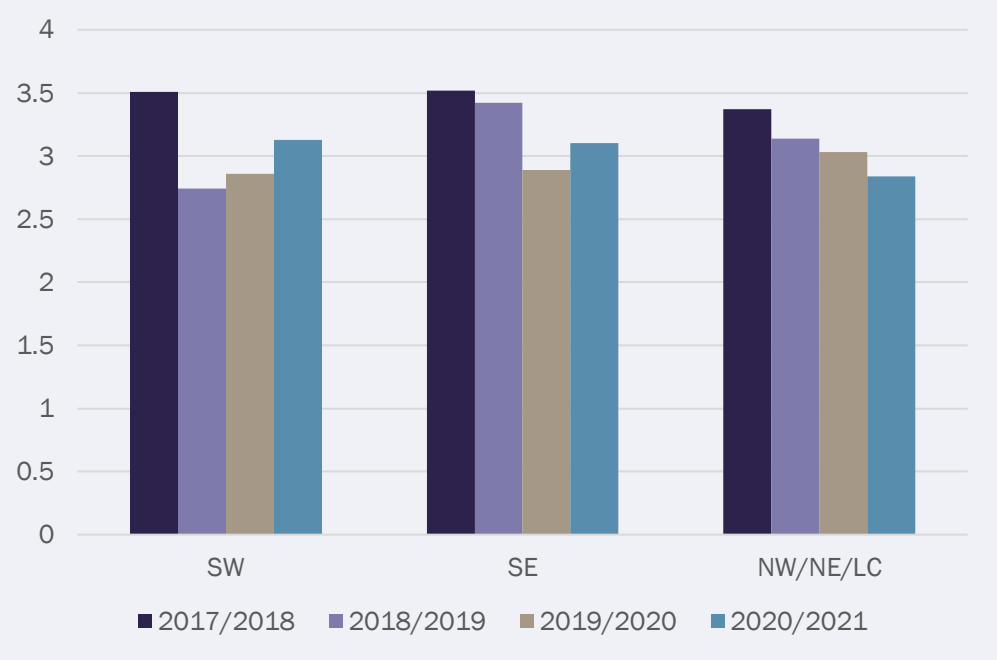


Figure 3. HCBS Provider Ratings of Whether CHC will Improve Quality of LTSS (2017 to 2021)

Note: Response on 5-point scale with 1 = Strongly Disagree to 5 = Strongly Agree.

The same pattern was observed in the NW/NE/LC zone. Surveys completed in early 2021 found that providers in the third implementation phase reported lower levels of optimism than in the prior year. For example, providers' ratings of whether CHC helps participants receive services in a timely manner declined *before* the program was implemented and increased *after* the program was implemented. Future survey reports will examine whether the same pattern of improvement is observed in this region.

Eligibility and Enrollment

Initial Enrollment Process

As noted above, DHS reached out to participants via multiple communication channels several months prior to the implementation of their respective phases. Participants also had the opportunity to participate in informational sessions conducted at numerous locations around the state.

A key component of outreach during CHC implementation was the enrollment process. The actual CHC enrollment process is done through the IEB, which helps participants compare and select a CHC-MCO. The IEB contact information – website, toll-free telephone number, and toll-free TTY number – is included liberally in pre-enrollment materials and in other available information and meeting content. The IEB's ability to address diverse communication needs is critical. The IEB is required to provide oral interpretation services in all requested languages at no cost to the participant. The MRC reviewed the IEB website (www.enrollchc.com) and concluded that it is clear and comprehensible. The IEB website directs individuals in a step-by-step process to enroll in the CHC program. The website also includes online tools that provide county specific information to assist the enrollee in selecting an MCO and PCP and in locating participating hospitals and other providers, including LTSS. During the enrollment period, the IEB also conducted several phone campaigns to assist participants with plan registration or questions about the program. Participants who did not select their MCO were auto enrolled in an MCO based on an objective algorithm. In these cases, the participant was free to change their assigned MCO, an option available to all participants. Although qualitative findings revealed some problems with the Phase I enrollment in 2018, processes were seen as improving with each roll-out.

According to the focus group sessions that were completed at the beginning of each implementation roll-out, improvements were made over the course of the three rollouts, but some concerns were noted. Issues with the insurance cards like inaccurate information; providers not joining the CHC network; confusion over what is and is not covered; perceived lack of person-centeredness; lack of responsiveness from the MCOs; transportation problems such as missed or late rides and inappropriate (not accessible) vehicles; and high turnover at the SC level. Other participants reported positive feedback relating to lower co-payments, more robust coverage, and good communication with the MCOs. Most found the pre-implementation participant meetings to be helpful. Some caregivers expressed concern over SC with delays in authorizations and the loss of an advocacy role in SCs.

The following figures are based on interviews with participants conducted prior to CHC implementation. As can be seen, the proportion of participants who reported receiving any information increased each year. The overall level of participant satisfaction with that information was relatively stable over time.

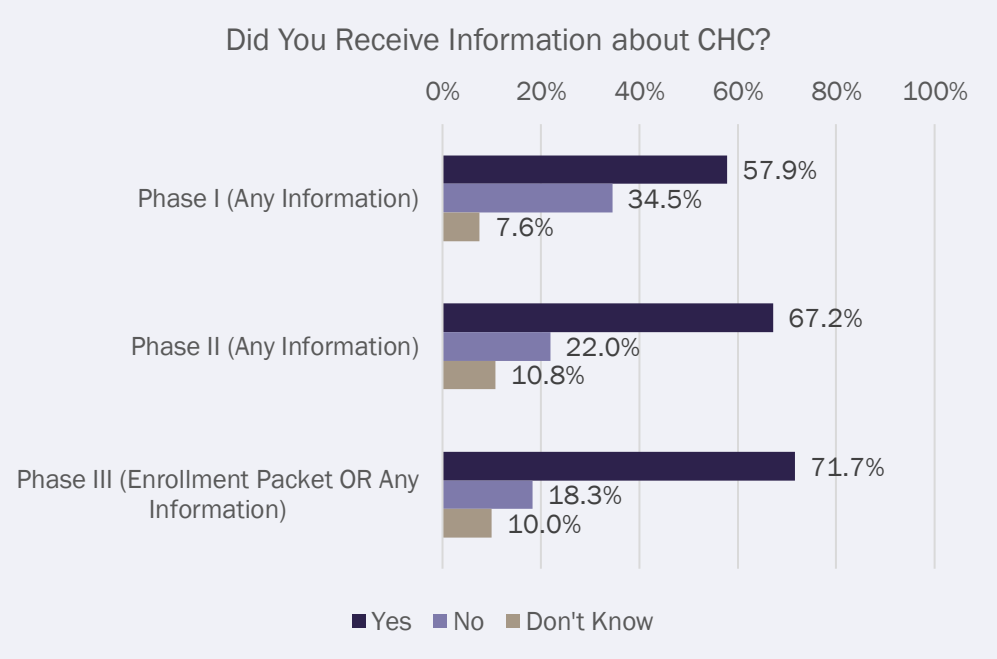


Figure 4. CHC Information Received by Participants

Figure 5. Participant Satisfaction with CHC Information Received

Availability and Quality of Enrollment Information

The IEB provides information and assistance to individuals enrolling in CHC. Individuals begin by calling the IEB for assistance in choosing an MCO and PCP and in applying for LTSS through CHC. CHC-MCOs are required to meet the standards for provider network adequacy defined in the CHC Agreement. All three MCOs offer the same basic benefits, such as office visits, blood tests, and X-rays. CHC-MCOs are also able to offer additional benefits, such as wellness programs and phone services. To serve CHC participants, providers must be enrolled in Medicaid and meet the criteria set by each CHC-MCO to join the CHC-MCO's provider network. As a result, CHC-MCOs may have different Medicaid-enrolled providers in-network. To support informed choice on plan enrollment, participants need information about which benefits, and providers are accessible in each MCO. The IEB offers various Health Plan Comparison Charts detailing the physical health and LTSS benefits each CHC-MCO offers, including "added" or "other" benefits, to help participants determine which plan best meets their needs. Provider directories let participants know which providers are available in each MCO's network. The provider directories for each CHC-MCO are available on their respective CHC program websites. AHC/Keystone First has two separate websites – one for its Phases I and III CHC participants covered by AHC, and one for its Phase II participants covered by Keystone First. Each website has a multi-step process to locate a provider. Typical filters in the provider directory search include location of service, type of network (physical health, behavioral, HCBS), provider type, and specialty. Two of the CHC-MCOs (AHC/KF and UPMC) have downloadable documents of their provider directory, which are easy to find on their websites. All three CHC-MCOs can accommodate participants who are visually impaired by offering the provider directory in Braille, large print and other formats. Participants can make special requests through the helpline phone numbers listed on the CHC websites, including requests for services in languages other than English.

The following table summarizes the availability and functionality of provider directories from each CHC-MCO. Separate directories are available for different categories of providers. The MRC reviewed the directories for readability, clarity, languages available, literacy, and accessibility.

Table 3. Provider Directories

	AHC/KF	PHW	UPMC
Physical health	Downloadable Document and Searchable Webpage, can have results emailed	Searchable Webpage	Downloadable Document and Searchable Webpage
HCBS	Searchable Webpage based on LTSS, can have results emailed	Searchable Webpage	Searchable Webpage
Service Coordination	Downloadable Document	Searchable Webpage	Searchable Webpage
Dental	Downloadable Document and Searchable Webpage, can have results emailed	Searchable Webpage	Searchable Webpage
Pharmacy	Downloadable Document and Searchable Webpage, can have results emailed	Searchable Webpage	Searchable Webpage
Medicines	Downloadable Document, TXT format, and Searchable Webpage for LTSS participants. Medicare formulary and OTC medicines for duals are searchable webpages	Downloadable document and searchable webpage	Searchable Webpage
Vision	Downloadable Document and Searchable Webpage, can have results emailed	Searchable Webpage	Searchable Webpage
Other	Downloadable Document, Searchable Webpage, option to get results emailed	Searchable Webpage- location first, detailed search- filter by name, type of provider, services offered	Searchable Webpage

Overall, accessing the provider directories via the CHC-MCO websites seems to be user-friendly for a person experienced using the Internet to find information. However, the task may be confusing for parts of the CHC population and less sophisticated users. For example, finding a provider via the CHC-MCO websites involves a multistep process. Beginning with the main webpage, users must navigate to the provider directory, then to location of service, and then to type of service, etc. For example, if a CHC participant wants to find a primary care physician, they would go to the main page of the CHC-MCO website and click on 'find a provider' or 'find a doctor', then enter their zip code, and enter the specialty they are searching for ('primary care'); which will generate a list of primary care physicians. The need to navigate several steps may pose a barrier to people with memory impairments.

Efforts to Preserve Current Beneficiary/Provider Relationships

The provider directories allow CHC participants to determine the MCOs in which their PCPs and other health care and HCBS providers are participating. Participants are free to select the CHC-MCO that will allow them to maintain existing provider relationships.

The CHC Agreement includes provisions to help maintain continuity of care and avoid interruptions of service for participants when they are first enrolled, as well as when choosing to switch from one MCO to another. The CHC Agreement contains specific requirements for continuity of LTSS providers that applied during the first 6 months of each implementation year (2018 to 2020). Each MCO was required to include in its networks all willing, qualified and Medicaid enrolled LTSS service providers. If the CHC participant resides in a NF, the participant will be permitted to continue receiving care at

that facility until the participant leaves the facility or is disenrolled from CHC, or if the facility drops out of the Medicaid program. For participants receiving HCBS through a waiver program, the CHC-MCO must continue providing care under the existing service plan using the participant's existing providers, including SCEs, for 180 days or until a comprehensive needs assessment is performed and a PCSP is created (whichever is later). During the first 180 days, if a participant transfers to a different MCO, the receiving MCO must provide previously authorized services for: 1) the greater of 60 days or the remainder of the 180 days; or, 2) until a comprehensive needs assessment is performed and a PCSP is created (whichever is later). All other services not categorized as NFs or HCBS will follow the standard 60-day continuity-of-care period.

Performance of IEB During Initial Implementation and Interaction with Service Coordination

The IEB showed variation in meeting standards from program initiation forward. For Q1 and Q2 of 2018, the vendor did not meet contractual obligations due to backlog of financial and clinical eligibility determinations from prior to 2018, as well as internal policy, procedural, and staffing issues. In response, DHS implemented more frequent meetings with and reporting from the IEB to address these issues. Q3 2018 showed dramatic improvement, but the standard was still not met. By Q4 2018, the standard was met at 86%. Performance of 71% in Q1 2019 did not meet the standard, but by Q2 2019, the performance of 100% exceeded the required standard of 86%. However, Q3 2019 performance was down to 57%. At that point, there was extensive state analysis, remediation, and quality improvement activities implemented. Performance improved to 100% for Q3 and Q4 2020. Figure 2 provides the percent of contractual obligations met by IEB during CY 2018 through Q3 CY 2021.

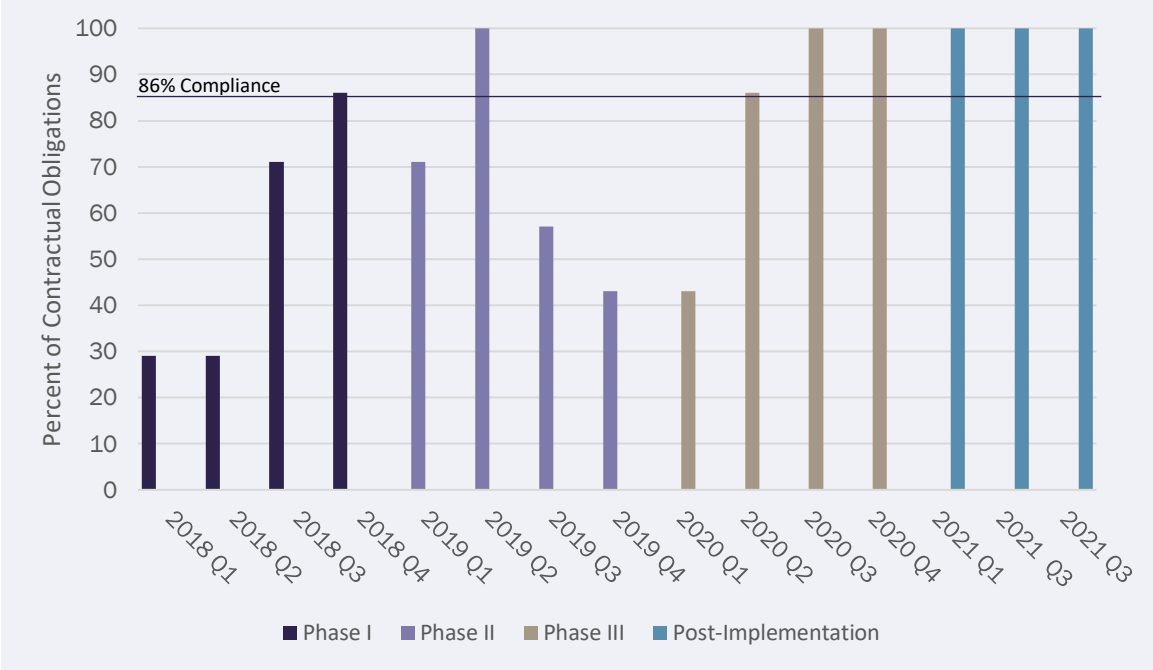


Figure 6. Percent of Contractual Obligations Met by the IEB

Based on key informant interviews conducted by the MRC, several provider organizations expressed dissatisfaction with enrollment into CHC. These providers claimed that enrollment was taking too long and causing major delays in the needed services and supports for participants. Providers also

did not approve of the automated telephone enrollment technology, which was challenging for some individuals who are older or hearing impaired.

DHS's efforts to improve IEB performance and address issues are ongoing. DHS has repeatedly engaged stakeholders and sought input on ways to streamline and strengthen the enrollment process. In addition to formal public requests for information and activities described below, DHS has also implemented specific changes to IEB requirements to improve performance. In response to concerns raised by homebound participants who were not appropriately informed about CHC implementation in their zone, in September 2019, in-home visits by the IEB were moved to the beginning of the enrollment process. This initial visit provides an opportunity for participants to make a more informed decision about whether CHC will meet their needs, understand the steps of the enrollment process, and complete the required enrollment paperwork. The following section provides additional detail on DHS's efforts to improve the IEB performance.

Changes in IEB Contract to Improve Performance

Prior to April 2016, the AAAs were responsible for enrolling participants into various Medicaid programs for the over 60 population, while the IEB enrolled participants younger than 60. Transitioning to CHC brought about changes to the enrollment process because AAAs provided direct services to participants, which was deemed a conflict of interest. Beginning in April 2016, a single statewide IEB vendor was used for all participants enrolling in CHC regardless of age.

On October 28, 2016, DHS released a draft request for applications (RFA) for public comment to solicit interest in a new IEB that was designed to provide choice counseling and assistance with eligibility and enrollment for individuals seeking LTSS and cover the following programs: Pennsylvania's existing HCBS waiver programs, the LIFE program, and CHC. Bidders were able to submit proposals for any combination of three geographic subdivisions[6] which coincided with the three phases of CHC implementation.

On April 10, 2017, DHS issued a request for applications RFA seeking an IEB to serve the CHC MLTSS program and other LTSS programs. This RFA was subsequently canceled in August 2018, to reconsider the scope of the procurement and services a vendor could provide. Because of the canceled procurement, DHS continued to work with current vendors for IEB services and long-term care clinical assessments.

On March 19, 2019, DHS issued a request for information (RFI) seeking information to assist DHS in determining how it may improve its LTSS application and enrollment process, including services provided by the IEB to individuals who apply for and enroll in CHC, the LIFE program, the Aging Waiver, the Attendant Care Waiver, the Independence Waiver and the OBRA Waiver (collectively the "OLTL HCBS Waivers"), and the state-funded Act 150 Attendant Care Program. In June 2019, DHS released a draft version of the IEB RFA for additional public comment. DHS issued a new IEB RFA on August 3, 2020, with bids due December 4, 2020. As of the end of 2021, this procurement was in a blackout period. This process is still pending as of this report.

Functional Eligibility Determination

Once participants select their MCO, they undergo a functional eligibility determination (FED), which is conducted under contract by the Independent Assessment Entity (IAE, currently Aging Well). The FED tool is a determination of an individual's long-term care needs and focuses on whether the individual needs assistance with essential activities of daily living, thus identifying whether the individual is

[6] Pennsylvania Medicaid has five zones. The Phase I implementation covered the SW zone, Phase II covered the SE zone, and Phase III covered the NW, NE and LC zones. CHC-MCOs were able to bid on any combination of Phases but could not sub-divide the Phase III region.

clinically eligible (NFCE) for MA LTSS. The FED is used to determine clinical eligibility for MA LTSS, which includes NF services as well as HCBS under the CHC waiver. To be clinically eligible for LTSS under CHC, an individual must need the level of care provided in a NF. Such individuals are referred to as NFCE. If the individual is not NFCE, then the individual is referred to as Nursing Facility Ineligible (NFI).

The FED tool captures personal and demographic information about the individual, as well as the assessor's observations and the individual's answers to questions, in five categories: (1) cognition, (2) mood and behavior, (3) functional status, (4) continence, and (5) treatment and procedures. An assessor must perform the FED assessment in person within 10 days of receiving a request for an assessment through the Pennsylvania Individualized Assessments (PIA) computer application. The request may be entered into PIA by the IEB or by another appropriate referral source that has access to PIA (e.g., the CHC-MCO). The FED tool generates a score that determines NFCE status. Individuals who are assessed to be NFCE at the time of their MA application and receive HCBS must be reassessed at least every 12 months thereafter. NF residents are not required to have a functional redetermination. HCBS users may be reassessed earlier than 12 months if a trigger event as identified in the CHC Agreement, such as a change in functional status or significant health care event, occurs.

If the applicant is determined to be NFI, OLTL will issue a notice with an explanation for why the individual is not NFCE and appeal rights. If the applicant is determined to be NFCE, the application will continue through the financial eligibility process. In addition to the FED, a physician must certify all NFCE determinations using form MA-570.[7] In circumstances where a certification submitted by the individual's physician or the assessor's opinion differs from the FED tool process, an OLTL physician will make the final determination.

OLTL has a review process whereby a team of nurses under the direction of the medical director reviews the case and addresses any discrepancies. Many cases arise because the MA-570 form was completed incorrectly by the physician (i.e., the FED indicates NFCE, but the physician did not certify that the participant needed NF level of care). In addition, the IAE assessor can disagree with the FED tool score, which triggers a medical review by OLTL. An examination of OLTL medical reviews from April 2019 – January 2020 indicated that medical review was requested in 6% of 80,908 FED assessments during that time period. For participants receiving HCBS, 94% of assessors and 89% of medical reviews agreed with FED outcomes for waiver services whether NFCE or NFI. For medical director reviews in NFs, 75% of assessors and medical reviews agreed with FED outcomes. NF short term stays drove the majority of the 25% disagreements with FED outcomes due to needs close to the NFCE threshold.

The OLTL has several measures in place to monitor the assessment process. EBR AA-2 measures the number and percent of FED assessments completed in a timely manner by the IAE. EBR LOC-1 measures the number and percent of new enrollees who have an FED completed prior to receipt of waiver services. For both measures, the performance standard was consistently met at 99-100%. EBR LOC-2 measures the number and percent of FEDs that were completed in accordance with policies and procedures. Other than two quarters in 2019, the vendor completed FEDs in accordance with policies and procedures.

In Q2 2019, the IAE identified that their subcontractors, the local AAAs, were not correctly utilizing the reference date. The reference date is the three days prior to the assessment that the assessor can look back to determine functional eligibility. Most of the AAAs were using the reference dateline as the date of the assessment, while the reference date should be three days prior to the FED being completed. This was a documentation error and did not impact eligibility determinations. In Q3 2019, performance improved from Q2 2019. Aging Well identified that the AAAs were not correctly

[7] MA-570 https://paieb.com/doc/Physicians_Certification_Form.pdf

documenting additional information when there is cognitive impairment. The AAAs also continued to incorrectly utilize the reference date. Aging Well has discussed these items on regional conference calls, individually with the AAAs, and in emails to the AAA network. DHS and the IAE regularly monitor the issue and provide guidance to AAAs. These errors were rectified, and the vendor continued to perform at an acceptable level.

The MRC conducted independent analysis of FED assessment data using records April 2019, when the new assessment was implemented, through June 2021. There was a total of 220,280 assessment records available for analysis. The following table summarizes the final assessment status. Overall, the proportion of people determined to be NFCE has increased over time.

Table 4. Summary of FED Assessment Results (2019-2021)

	Total	NFCE	NFI
2019	82,679	65,626 (79.37%)	17,053 (20.63%)
2020	93,226	75,249 (80.72%)	17,977 (19.28%)
2021	44,373	37,009 (83.40%)	7,364 (16.60%)

Note: January 1 through June 30, 2021

Enrollment Trends

The following table summarizes enrollment trends prior to CHC implementation through 2020. These data are based on raw enrollment data obtained by the MRC via the PA DHS enterprise data warehouse. The numbers represent the total person-months enrolled in each category. In the years prior to implementation in each Phase, the enrollment counts are based on an estimated eligible model developed by OLTL (shaded cells), referred to as the 'historical simulation.' These data were published by OLTL to facilitate the MCO planning and bidding process and serve as an important basis for comparative analyses. However, it is important to note that there is a disjunction between the pre-program years and the actual enrollment. For example, in Phase I, there was an estimated 977,416 person-months among eligible individuals in 2017. In 2018, the first year of the live program, there were 955,893 person-months among actual participants. The difference is due to disparities in the historical simulation file which was developed in 2016 by OLTL staff and the final CHC eligibility criteria as implemented in 2018. For example, this makes it difficult to distinguish enrollment trends that might be due to marketing and promotion of CHC by OLTL or the MCOs from pre-program population trends. As can be seen from Table 1, some categories *decrease* between pre-program estimates and actual enrollment, and other categories *increase*. For consistency in analysis, we therefore, focus on growth in post-implementation enrollment.

From 2018 to 2019, overall enrollment in the Phase I zone increased by 2.1%. The increase was 13.9% among HCBS participants (dual and non-dual), while the NF population declined by .7%. By contrast, between 2016 and 2017, overall growth in the Phase I zone was 1.2%, and growth among HCBS participants was only 3.1%. From 2019 to 2020, overall enrollment in Phase II grew by 3.3%. This is lower than the estimated pre-CHC growth rate from 2016 to 2018 of 4.8%. The same is seen for HCBS participants. Pre-CHC growth was about 18% per year, however from 2019 to 2020 growth was 8.6%.

This suggests that even though the implementation of CHC in Phase I and Phase II is associated with growth in enrollment, there is no large spike that might indicate a 'woodwork' effect.

Table 5. Enrollment (Total Person-Months, 2016-2020)

	2016	2017	2018	2019	2020
Total Enrollment					
SW	965,562	977,416	955,893	976,100	1,000,951
SE	1,467,633	1,536,583	1,610,104	1,623,816	1,677,476
NW/NE/LC	1,722,936	1,759,168	1,797,671	1,782,481	1,812,454
CHC-HCBS DUAL					
SW	93,857	95,223	104,370	117,424	132,199
SE	290,870	334,673	393,537	431,985	470,790
NW/NE/LC	153,213	159,865	175,746	191,348	221,365
CHC-HCBS NON-DUAL					
SW	27,806	30,210	34,749	40,998	44,339
SE	115,704	144,030	177,219	202,850	218,427
NW/NE/LC	38,597	42,219	49,163	56,409	72,783
CHC-LTC DUAL					
SW	135,024	134,296	124,814	123,789	120,749
SE	166,760	163,965	160,793	145,258	134,034
NW/NE/LC	312,584	310,875	309,779	301,940	271,534
CHC-LTC NON-DUAL					
SW	10,816	11,393	10,605	10,707	10,147
SE	19,816	20,187	20,335	18,202	18,204
NW/NE/LC	16,791	16,813	16,783	16,930	14,301
CHC-NFI					
SW	698,059	706,294	681,355	683,182	693,511
SE	874,483	873,728	858,220	825,521	836,019
NW/NE/LC	1,201,751	1,229,396	1,246,200	1,215,854	1,232,465

Additional Benefits Under Community HealthChoices

Through CHC, participants have access to all Medicaid State Plan services. The physical health benefits of the three MCOs are the same, with the exception of copays for prescription drugs. All three charge a $3 copay for brand name prescriptions. However, AHC charges $1 for generic drugs while UPMC and PHW have a $0 copay for generic prescriptions.

There are some expanded benefits related to HCBS. Building on the success of the Money Follows the Person grants to states, CHC-MCOs offer expanded benefits for NF to community transition, including rental assistance. In addition, the CHC-MCOs introduced a Home Modification Brokerage model that was intended to improve access to services.

CHC-MCOs have the option of offering additional benefits to participants to distinguish the plans from their competitors. Specific benefits that appear to be new or enhanced include dental and vision allowances, smartphone services for talk and text, increased support for assistive technology and exceptional durable medical equipment, Personal Emergency Response System (PERS), and pest eradication. The following table summarizes additional benefits identified by each of the MCOs as above and beyond the standard Medicaid or waiver services.

Table 6. Additional Benefits Offered by CHC-MCOs

	AmeriHealth Caritas/ Keystone First	PA Health and Wellness	UPMC CHC
Adult Dental	Oral hygiene kit	Oral hygiene kit	$500 yearly allowance for certain services
Adult Vision		$100 yearly allowance for glasses/contacts for NFCE members	$100 yearly allowance for glasses/contacts and one fitting every 12 months
Phone Services	Free smartphone w/ 350 minutes of talk and unlimited texts	Free SafeLink wireless phone with unlimited texts and calls	
Wellness Programs	Home provider visits, lab draws and testing for qualified participants; Video visits with care manager; Bright Start® maternity program	After hospital stay: 14 days of home delivered meals; After hospital stay: 14 days of respite care; Smart Start for Baby; Health library Community Connect community resource; 90-day prescription refill for those not on Medicare	Free health coaching services based on health needs and goals; Online program to ease stress
Other Benefits	Bright Start Care Mgmt. and pregnancy program; tobacco cessation; Nurse call line; employment services; service coordination	Nurse Advice line- 24/7 access to RNs for health questions; pregnancy and newborn services; employment services; caregiver access and supports; care coordination;	Pathways to Work employment service; therapeutic and counseling services; vehicle modifications; telecare; UPMC Anywhere Care; UPMC mobile app; stress mgmt.

Source: https://www.enrollchc.com/plans?location=2&program=1&plans%5b0%5d=44&plans%5b1%5d=45&plans%5b2%5d=46

Physical Health Provider Capacity

MRC examined data from CAHPS-HP surveys submitted to OLTL by each MCO. Each MCO is required to use an outside vendor to conduct annual CAHPS-HP surveys. The following table summarizes selected data elements related to physical health provider capacity.[8] The columns refer to the year the survey was conducted, however, the respondents are asked to refer to the prior six-month period. As can be seen, the first two items, getting needed care right away and getting appointments for routine care, decline from 2019 to 2020 but improve in 2021. The third item, getting care tests or

[8] CHC-MCOs are required to provide survey data to OLTL for the following sub-populations: (1) Medicaid only, (2) participants who are eligible for Medicare and enrolled in a plan sponsored by the same company as the CHC-MCO (aligned), and (3) participants who are eligible for Medicare but aligned in a different Medicare plan or fee-for-service. Data for sub-populations 1 and 2 are combined in such a way that it is not possible to report statistics for Medicaid-only participants compared to those dually eligible for both Medicaid and Medicare. It is also not possible to stratify by zone.

treatments declined over time. The last item, regarding specialist care, declined from 2019 to 2020, and improved slightly in 2021. Declines from 2019 to 2020 are likely due to the impact of the COVID-19 pandemic which was associated with significant reductions in use of medical care. Notably, none of the measures had returned to pre-COVID-19 levels by the time of the 2021 survey.

Table 7. Participant Reported Access to Medical Care

How often…*	2019	2020	2021
Did you get needed care right away?	87.5%	86.0%	87.0%
Did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?	87.7%	85.1%	86.0%
Was it easy to get the care, tests, or treatment you needed?	89.1%	88.0%	86.9%
Did you get an appointment to see a specialist as soon as you needed?	85.3%	83.5%	84%

*Note: *Percent Usually or Always*

LTSS Provider Capacity

Service Coordination

The implementation of CHC brought significant changes to the delivery of service coordination. Prior to April 2016, the local AAAs were performing several duties for Medicaid HCBS waiver participants, which included enrolling them into Medicaid, completing the level of care eligibility assessments, and coordinating their services according to the care plan. Beginning in April 2016, Pennsylvania sub-contracted enrollment to the IEB. AAAs continued to complete the level of care assessments and provide service coordination for many HCBS waiver participants who were aged 60 and over.

Prior to the CHC Phase I launch, the Pennsylvania Association of Area Agencies on Aging launched a new subsidiary, named C3. C3 was intended to act as a coordinating entity for all CHC business between the MCOs and the AAAs. In January 2018, C3 was working with many AAAs as the coordinating entity, where the MCOs would bill C3 for the services of the local AAAs. This arrangement was steady during the continuity of care period (January 1, 2018 – June 30, 2018). Beginning July 1, 2018, the MCOs had full authority to negotiate contracts with Phase I providers. At this time, one of the MCOs decided to discontinue contract negotiations with C3; another MCO drastically reduced rates, making it unfeasible for C3 to continue the partnership, and the third MCO continued contracting with C3. Moving into Phase II in January 2019, only two AAAs were contracted with the MCOs to provide service coordination. Because of this, and the fact that C3 was only working with one MCO, C3's involvement in CHC was severely diminished and eventually dissolved. At the start of calendar year 2021, there were no AAAs providing service coordination under CHC.

The number of non-AAA SCEs working as partner agencies to the CHC-MCOs has dwindled as well. Most SCEs that were in operation prior to 2018 were approved to provide service coordination for CHC participants. Since January 2018, all three MCOs have moved the bulk of service coordination to an internal staff function. During the last six months of 2020, there were 35 distinct SCEs contracted by the CHC-MCOs, but as of early 2021, there were only 17 SCEs providing service coordination for CHC.

Table 8. Service Coordination Entity Partnerships

Contracted with:	As of 12/31/2020	As of 1/1/2021
3 MCOs	2	2
2 MCOs	6	6
1 MCO	27	9

Table 9. Number of partner SCEs with Contracts with Each CHC-MCO

MCOs	AmeriHealth Caritas/ Keystone First	PA Health and Wellness	UPMC
2018	45	129	34
2019	39	73	6
2020	29	10	65
2021	11	10	6

Note: these numbers reflect the number of SCEs in January of each year

Qualitative interviews with SCs revealed several key themes. In the pre-implementation period, many SCEs allocated substantial resources to get ready for CHC, but soon found their staff members hired by the MCOs. During the post-implementation period, when most service coordination shifted internally to the MCOs, SCEs observed that there was a high level of turnover among internal SCs at the MCOs. Providers widely reported poor communication with MCO SCs. SCEs reported that they had to educate the MCOs about the services they provide since the MCOs seemed to be unfamiliar. At the same time, SCs described overly lengthy processes to request information from the MCOs in order to provide services to participants.

Overall, many processes have improved since the initial rollout of CHC in Phase I. For the rollouts in Phases II and III, processes and procedures were much smoother. Many SCs and SCEs felt that the MCOs were unprepared and dismissive during the launch in Phase I, but by the Phase II and III rollouts, MCOs elicited more advice from the SCEs, especially concerning service coordination in rural areas. Challenges of providing service coordination in rural areas included: lack of providers (especially PAS), spotty Internet and cell phone connectivity, insufficient transportation options, and onerous travel distances for both consumers and providers.

Other aspects of the rollouts that were challenging included: billing and payment, authorizations, navigating the three billing systems, and adjusting to new payment models. These processes took time to get acclimated to, and improvements were seen in these areas over time. The CHC-MCOs transitioned away from the legacy FFS payment model to other payment approaches at various times.[9] This led to changes (increases) in SC caseloads. However, SC agency representatives reported being reluctant about raising concerns over this and other issues out of fear of losing their contracts.

According to several SCEs during qualitative interviews, communication with the MCOs was insufficient. Many SCEs claimed they never received notices of termination from the MCO, instead hearing about it from their clients, whom they described as confused. Those SCEs who secured long-term contracts with the MCOs reported improvements in communication.

[9] At the end of the continuity of care period in each zone, UPMC transitioned from to an FTE model where partner SCEs are paid for a specific number of staff. AmeriHealth Caritas/Keystone First transitioned to a per-member-per-month (PMPM) model in 2021. In July of 2019, PHW transitioned to PMPM payments in the SW and SE Zones. The PMPM model was implemented in the NW/NE/LC zone after the end of the continuity of care period in 2020. There are only two SCEs that had contracts with all three MCOs by the end of 2021.

SCEs and the MCOs also reported that the CHC-MCOs trimmed their service coordination network. The CHC-MCOs and contracted SCEs reported this as a way to 'weed out' underperforming and fraudulent SCEs. This resulted in the contracted SCEs inheriting an influx of new participants, thus hiring more SCs to keep up with the rising caseloads. To build up their internal SC workforce, the CHC-MCOs also hired many SCs from the external SCEs. Transferring participants to internal SCs was challenging; poor communication was cited, as well as difficulty establishing rapport with new participants.

Two WAM measures (6.a.1 and 6.k.1) address the HCBS SC staffing ratio. The compliance benchmark of at least 1 SC per 75 HCBS participants is specified in the CHC-MCO's approved SC staffing plans. In the first two phases of implementation, the CHC-MCOs faced several challenges - performance of legacy SCs, SCEs choosing not to contract or ceasing operations, CHC-MCO ability to hire qualified staff, and HCBS enrollment growing faster than the CHC-MCOs expected. AHC and PHW met the compliance benchmark throughout the first three years of CHC. UPMC has faced ongoing staffing challenges and did not meet the HCBS staffing ratio in the SW, LC, and NW zones in 2020. However, UPMC met the statewide aggregate measure in 2020. All CHC-MCOs continued to meet the performance standard in 2021. OLTL discussed staffing ratio concerns with UPMC and issued a CAP for ongoing performance concerns in 2020. UPMC hired the necessary staff to improve SC ratios. CHC-MCOs are required to submit proposed staff to participant ratios to OLTL for review and approval. However, as of 2022, OLTL lowered the required HCBS SC ratio from 1:75 to 1:70 in response to concerns about SC staffing adequacy.

In some cases, participants are matched with SCs based on health needs and the level of expertise of the SC. Because some higher need participants require more attention, the staffing ratios tend to be lower, about 25 to 1 instead of 75 to 1. Some MCOs also have rapid deployment SCs in case there is an emergency or need to address complex needs quickly.

Table 10. HCBS Service Coordinator Staffing Ratio

Statewide (by plan)	2018	2019	2020	2021
AmeriHealth Caritas /Keystone First	1 to 24.7	1 to 54.7	1 to 58.6	1 to 74.6
PA Health and Wellness	1 to 70.3	1 to 27.9	1 to 64.2	1 to 69.6
UPMC	1 to 77.5	1 to 75.8	1 to 74.9	1 to 67.4
All MCOs	1 to 57.5	1 to 49.4	1 to 66.1	1 to 71.5

Sources: WAM, MCO Staffing, and Resources (#6.a.1); WAM Service Coordinator to HCBS Participant Ratio (#6.k.1)

Nursing Facilities

The transition to CHC included all Medicaid participants living in NFs except for the state operated NFs. All free-standing NFs (i.e., not hospital-based) that accept Medicaid in PA were considered in-network with all three MCOs. The continuity of care period for these NFs was 18 months, beginning on January 1, 2018, however, the MCOs contracted with all facilities for three years. As the continuity of care period neared expiration on December 31, 2020, there was no plan to eliminate any NFs as providers for CHC participants. This section integrates findings from qualitative interviews conducted with NF administrators and statewide surveys conducted in 2019 and 2021. In 2019, NF respondents were fairly pessimistic about the implementation of CHC, with only about 25% reporting being 'somewhat' or 'extremely' satisfied. This increased to 32% in 2021, however, the majority of NF survey respondents (68%) indicating that they were neutral or not satisfied, suggesting that there are significant concerns in this sector.

Rate negotiations and rate settings became a critical topic for these facilities. Initially, many were reimbursed at the same rate as they received in FFS Medicaid. This was known as the "rate floor" and was the average of the NFs four quarterly average case-mix rates in effect prior to the implementation of the applicable CHC phase. The rate floor did not preclude NFs and CHC-MCOs from negotiating an alternative rate or payment methodology. OLTL did not require quarterly case-mix acuity adjustments but some MCOs agreed to this adjustment, meaning the reimbursement rate could fluctuate. Based on qualitative interviews with County-owned nursing home administrators, County-owned NFs received the rate floor.

In 2021, the MRC conducted a statewide survey of NF administrators. The survey included a set of questions regarding payment models. The findings, summarized in the following table, show considerable variability in the rate model within each MCO. In addition, only a minority of NF administrators indicated that they had much choice in either the model or in negotiating their rates.

Table 11. Nursing Facility Rate Models

Rate Model:	AHC/KF	PHW	UPMC
Rate Floor without Quarterly Case Mix Index Adjustment	34.4%	23.6%	33.8%
Rate Floor with Quarterly Case Mix Index Adjustment	47.1%	56.7%	47.8%
Other	18.5%	18.8%	18.5%
Choice:			
Choice of Rate Model (Yes)	23.2%	23.2%	27.8%
Negotiate Rate (Yes)	25.2%	25.2%	29.1%

Note: Survey conducted April to July 2021. N = 200; 36% response rate.

Qualitative interviews with NF representatives addressed a range of issues regarding interaction with MCOs. First, during the initial period after the implementation in 2018, there were problems reported with billing. Over time, these issues were resolved, and NFs reported that they get paid quicker by CHC-MCOs than under FFS. Second, NFs offered a spectrum of responses regarding the overall financial impact of CHC: some noticed improvements while others reported significant financial loss. Frozen reimbursement rates under CHC were of great concern given the rise in operating costs; an observation reflected in qualitative interviews with other types of providers. Many NFs reported that MCOs were unwilling to negotiate reimbursement rates once contracts are up for renewal. During the COVID-19 pandemic, NF costs were up as SNFs combated the virus through personal protective equipment (PPE), testing, and other preventative procedures, while NF census rates were down with fewer short-stay residents.

The qualitative findings regarding the financial impact are consistent with surveys conducted in 2019 and 2021. In 2019, about 10% of NFs reported that they expected to benefit financially from CHC. While this rose to 20% in 2021, this represents a minority of providers.

Surveys of NFs conducted in 2019 and 2021 consistently found that about 38% reported being 'somewhat' or 'extremely' satisfied with communication with MCOs. Based on qualitative interviews, some NFs reported positive working relationships with MCO representatives. Others, however, had difficulty building relationships with MCO representatives because there were unclear roles. For example, there was confusion over a range of issues regarding transportation, transitioning to the community, and cell phone distribution programs. There was lack of clarity about whether eyeglasses and dentures are covered under CHC. Finally, NFs reported paying for PPE when residents visited medical specialists, such as dentists. This came at a time when NFs were handling their own rising costs during the pandemic (e.g., PPE, testing, etc.).

Transportation for NF residents was a significant issue, in large part because MCOs attempted to relieve NFs of the financial burden. Prior to CHC, many NFs had their own vehicles they used to

transport residents to appointments for social activities. When necessary, they contracted with external transportation providers, often paying for these services directly with no additional reimbursement from Medicaid since transportation is part of the Medicaid nursing facility per diem rate. Early in implementation, NFs were told that CHC would cover transportation costs. However, in the early months of 2018, there were many problems with transportation such as rides not arriving for scheduled medical appointments and the dispatching of inadequate and inaccessible vehicles. Subsequently, CHC-MCOs stopped covering non-medical transportation costs, returning this responsibility to the NFs under their per diem reimbursement.

One of the goals of CHC was to increase transitions to the community among long-stay participants. Interviews with NFs suggested that nursing home transitions (NHTs) were much more common for short-stay residents than long-term residents. Long-stay residents who don't have financial, social, or other resources to facilitate the process of NHT were at a disadvantage. NF representatives interviewed stated that the CHC-MCOs have not been proactive in promoting NHTs and that there were significant delays in completing NHTs. NF representatives stated that finding appropriate housing was a significant challenge. Qualitative interviews revealed that the housing waiting list for CHC participants seeking NHT was discouragingly long.

Qualitative interviews identified the lack of behavioral health providers as a concern, especially in rural areas. In addition, respondents indicated it was difficult to identify behavioral health providers who specialize in geriatric care. Many NFs contracted with behavioral health providers and were aware of local hospitals where they could refer residents. Getting behavioral health consultants to become "approved providers" was described as a lengthy process that increased costs for the NFs. Most NFs interviewed were unaware of the BH-MCOs. Many stated they would like to learn more about behavioral health services offered under CHC. To place this in context, in 2019 only about 36% of providers surveyed indicated they understood how to access behavioral health services from the BH-MCO. In 2021, 12% of respondents indicated that access to behavioral health had improved over the prior year.

CHC introduced a requirement for NF residents to have a CHC-MCO SC. Based on interviews conducted in 2018-2019, MCO service coordination processes were seen as complicated and time consuming. SNF staff said that working with the MCO SCs increased their workloads significantly. This was exacerbated by the COVID-19 pandemic because of the need to share data while working remotely. Communication with MCO SCs was mostly centered around data exchange, rather than conversations and interactions with CHC participants. It was relatively rare for MCO SCs to participate in the care conferences arranged by the NFs. Also, NFs reported that MCO SCs were duplicating efforts by creating separate care plans for residents.

Home and Community-Based Services

DHS used several measures to evaluate CHC-MCO networks to ensure network adequacy for CHC participants who receive LTSS. The following table shows an annual summary of the number of HCBS provider agencies per 1,000 HCBS participants as measured by WAM 6.e.1 and WAM 6.i. There is no explicit standard from CMS for this metric and OLTL has not set a benchmark.

Table 12. HCBS Providers Enrolled at the End of Each Quarter per 1000 HCBS Participants

Statewide (by plan)	2018	2019	2020	2021
AmeriHealth Caritas/Keystone First	434	101	131	144
PA Health and Wellness	330	213	164	199
UPMC	188	242	259	246
All MCOs/Combined	265	162	173	182

Source: WAM, Availability and Accessibility of Covered Services (#6.e.1) and (#6.i.3)

Provider licensure, certification, and training

Several measures in the EBR monitor whether providers are qualified to provide services. EBR standard QP-1 measures the number and percent of newly enrolled providers who meet licensure and/or certification standards prior to service provision. EBR standard QP-2 measures the number and percent of enrolled licensed/certified waiver providers who continue to meet regulatory and applicable waiver standards. EBR standard QP-3 addresses the number and percent of newly enrolled non-licensed or non-certified waiver providers who meet regulatory and applicable waiver standards. EBR standard QP-4 measures the number and percent of non-licensed or non-certified waiver providers who continue to meet regulatory and applicable waiver standards. Performance on these measures was 100% across MCOs and phases and as a result remediation and quality improvement activities were not necessary

To become an HCBS provider for CHC, the organization must be enrolled in the Pennsylvania Medicaid program. In addition, the provider must also be contracted with one or more CHC-MCOs and be approved by the CHC-MCO's credentialing committee to be enrolled and get reimbursed for services rendered to a CHC participant.

During the continuity of care period, the MCOs were required to accept all willing HCBS providers into their networks for the 180-day period. If a CHC-MCO decides to terminate a contract with a provider, they must provide written notification to OLTL 90 days prior to the termination date. In addition, they must provide written notification to the participant 45 days prior to the termination date. The provider network for HCBS services within CHC have been open since the beginning of CHC. In 2020, at least one of the CHC-MCOs closed its network to new providers.

To further assure qualifications of providers, training of new providers was monitored via EBR QP-5, the number and percent of new HCBS providers meeting provider training requirements. In Q2 2018, one MCO did not capture the necessary information to support complete and accurate reporting for new providers. In Q2 2019, new providers for another MCO did not receive the full new provider orientation. These two instances brought the statewide (combined MCOs) performance below the applicable standard for those two quarters. In both cases, performance standards were met by the next quarter. Otherwise, the performance standard was met in 2018-2020.

Capacity and Service Provision

The percentage of home health, home health aide, and PAS that could not be provided because the agency was unable to staff the service had a benchmark of <14%. All MCOs consistently met benchmarks. According to the WAM, this indicates that "CHC participants have necessary access to home health, home health aide, and PAS services."

WAM 6.i.2 monitors the percent of non-medical and non-emergency medical transportation services that were not provided. All CHC-MCOs met the compliance benchmark of <14% of services not provided.

WAM measure 6.i.4 in the Availability and Accessibility of Covered Services section is a measure of complaints related to lack of providers per 10,000 participants that has no benchmark. This includes being able to find in-network providers to deliver needed services and complaints related to participant's PCP or specialist not participating in a CHC-MCO's network. Rates are consistent at <1%. OLTL regularly monitors complaints along with missed services and HCBS providers per 1000 to monitor accessibility of services.

The measure of complaints related to a requested physical health item or service not covered by the CHC program per 10,000 participants has no benchmark. For the quarter ending 12/31/2019, UPMC showed significant increase in complaints regarding non-covered physical health services, which was primarily due to non-covered dental services, such as dentures. This included out of

network (OON) provider use, as some participants chose to remain with OON providers. Other cases involved benefit limitations and providers billing for non-covered services. UPMC explained the Benefit Limit Exception process to participants and followed up on the billing errors to have providers write off charges and the providers were referred for provider education. OLTL deemed no remedial actions necessary.

HCBS Provider Experience

The MRC conducted four waves of surveys of HCBS providers. These surveys reveal a complex picture of provider's perceptions of CHC. Overall, providers were relatively optimistic about CHC prior to implementation. In the first year after implementation in the SW and SE zones, that optimism faded. However, in subsequent years, providers grew more positive over time. This pattern was seen regarding perceptions regarding improving care coordination, access and LTSS quality. In addition, providers overall satisfaction with communication with MCOs, OLTL and the overall implementation process also improved over time.

There are a couple ongoing areas of concern. First, HCBS providers report that they are not benefiting financially from CHC. Second, although the transition to CHC has required providers to use new billing systems, few report that technology upgrades are a high priority. These issues could benefit from better coordination between OLTL and CHC-MCOs.

Impact on Access and Use of Services

Physical Health

The MRC analyzed Medicaid and Medicare FFS claims for the years 2013 to 2019 to identify trends in use of physical health care before and after implementation of CHC.[10] The following section summarizes selected broad indicators of use.

Inpatient Hospitalizations

There has been an overall decline in the rate of inpatient hospitalization in the SE and the NW/NE/LC zones from 2013 to 2017.[11] In the SW zone, there was a slight upward trend from 2015 to 2017. In the SW zone, the rate of hospitalizations began to decline in 2018 and 2019, dropping to 424.9 per 1,000 person-years to 508.3 in 2018 and 497.8 in 2019 (See Figure below. Dashed lines indicate Phase I (2018) and Phase II (2019) implementation). In the SE zone, the rate was essentially unchanged from 2017 to 2019 at about 487 per 1,000 person-years. In the NW/NE/LC zone, the rate declined slightly from 441.3 in 2016 to 439.8 in 2018 and 423.6 in 2019. Although this changed does not reach statistical significance, the trend suggests that CHC may have had a modest impact on hospitalization rates in the SW zone.

[10] As of the timing of this report, Medicare FFS claims were only available through 2019.
[11] The rate per 1,000 person years is calculated as the total number of hospitalizations divided by the number of participants, multiplied by proportion of months enrolled by the year, and multiplied by 1,000. This is comparable to member months but scaled up to the adjusted person-year. The MRC combined Medicaid claims for non-duals and Medicare FFS for duals. This approach differs from the HEDIS calculations reported by the EQRO (published online https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/CHC-Publications.aspx). In those reports the Inpatient Utilization (IPU) rate is calculated for each MCOs non-dual enrollees on a 1,000 member month basis.

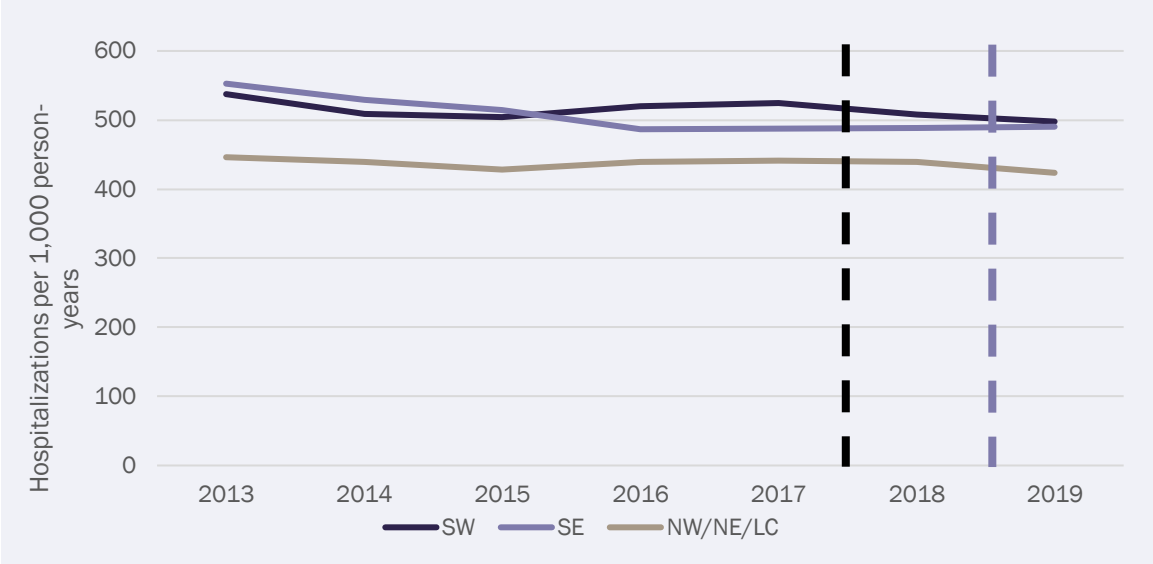


Figure 7. Acute Inpatient Hospitalizations

Urgent/Emergent Care

The use of the emergency department (ED) for acute, physical health visits was calculated for all three zones over the years 2013 to 2019 as the rate per 1,000 person-years. The following chart shows that there was a generally declining trend from 2015 to 2017. The dashed lines represent the Phase I (2018) and Phase II (2019) implementations. In the first year after the CHC implementation in the SW zone, ED visits decline, but then the rate increases slightly in 2019. In the SE zone, there is a marked drop in the first year after implementation. By contrast, the NW/NE/LC zone demonstrates a general downward trend. It is difficult, therefore, to attribute changes in ED use to CHC implementation.

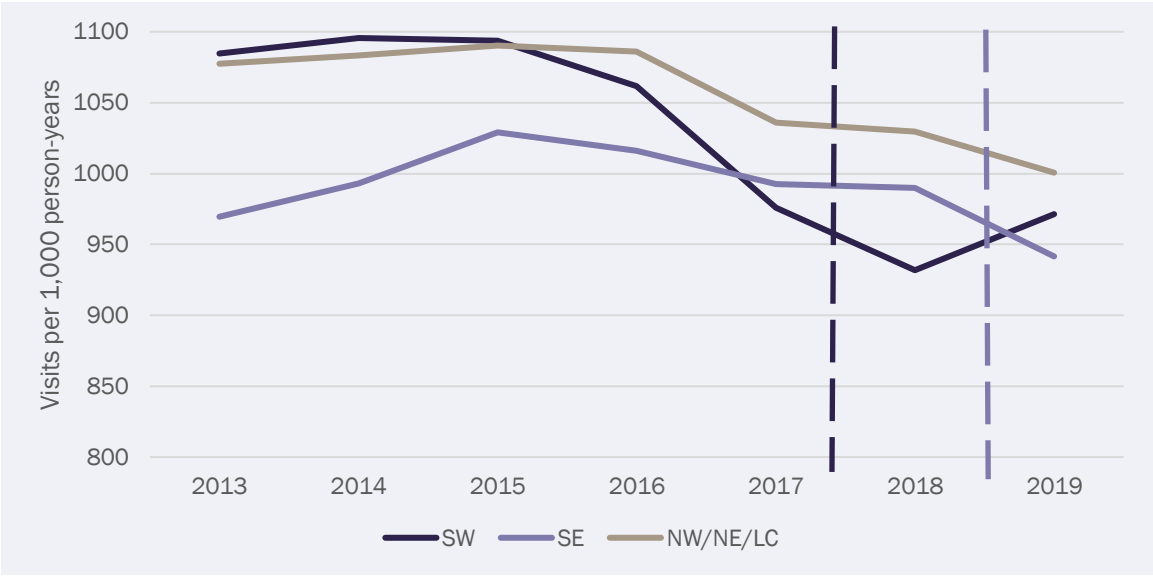


Figure 8. Acute Emergency Department Visits

Primary Care Visits

To capture primary care use, the MRC constructed a measure that includes visits to hospital outpatient clinics or rural health clinics, or federally qualified health centers for evaluation and management as well as ambulatory visits to general practitioners, family practice, internal medicine pediatrician, geriatrician, nurse practitioners or physician's assistants. The following chart shows a slight downward trajectory in all three zones prior to CHC implementation. The dashed lines represent the Phase I (2018) and Phase II (2019) implementations. In the SW zone, the rate increased slightly from 3.8 visits per person to 3.9 in 2019.

In the SE zone, there is an apparent drop off from 4.2 in 2018 to 3.6 in 2019. Given the slower decline in the NW/NE/LC zone and slight increase in the SW zone, it is possible that this drop in the SE zone may be due to changes associated with CHC implementation.

The MRC examined the percentage of CHC participants with any PCP visit in 2018 and 2019. In the SW, the percentage with any PCP visit increased from 67.9% to 69%. In the SE, the percentage with any PCP visit increased from 73.5% to 74.5%, and in the NW/NE/LC region, the percentage with any PCP visit increased from 76% to 77.7%.

Taking both statistics into account it appears that the changes in the number of visits per person are not due to people failing to receive an annual PCP visit.

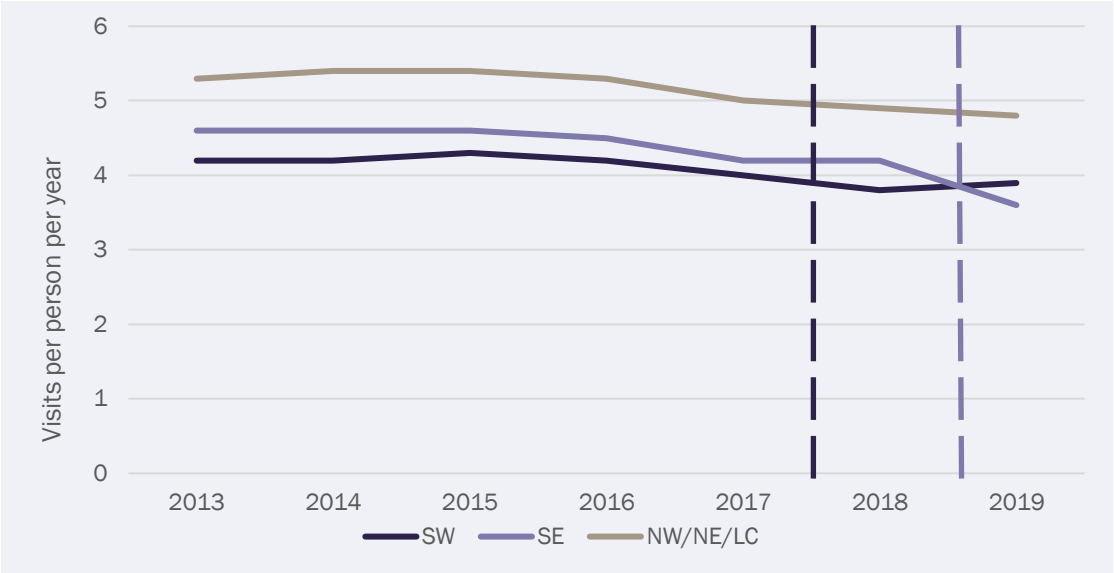


Figure 9. Primary Care Visits

Specialist Visits

Specialist visits were defined as any outpatient or ambulatory visit to a provider other than a PCP as defined above. The following chart shows a general downward trend in use of specialists in the SE and NW/NE/LC zones from 2013 to 2017. The dashed lines represent the Phase I (2018) and Phase II (2019) implementations. In the SW zone, there was a slight increase from 2013 to 2014, followed by a downward trend. From 2017 to 2018, in the SW zone, use continued to drop from 3.7 to 3.5 visits per person. A somewhat sharper drop was seen in the SE zone from 2018 to 2019, from 4.5 to 4.0 visits per person. By contrast, in the NW/NE/LC zone, the use of specialists was unchanged during these years. The timing of the change in the trend in the SE suggests that drops in the number of specialist visits per person may be due to changes implemented as part of CHC.

The MRC examined the percentage of CHC participants with any specialist visit in 2018 and 2019. In the SW, the percentage with any specialist visit increased from 58.3% to 60%. In the SE, the percentage with any specialist visit increased from 63.8% to 67.3%, and in the NW/NE/LC region, the percentage with any specialist visit increased from 59.2% to 63.4%.

Taking both statistics into account it appears that the changes in the number of visits per person are not due to people failing to receive any specialist visits.

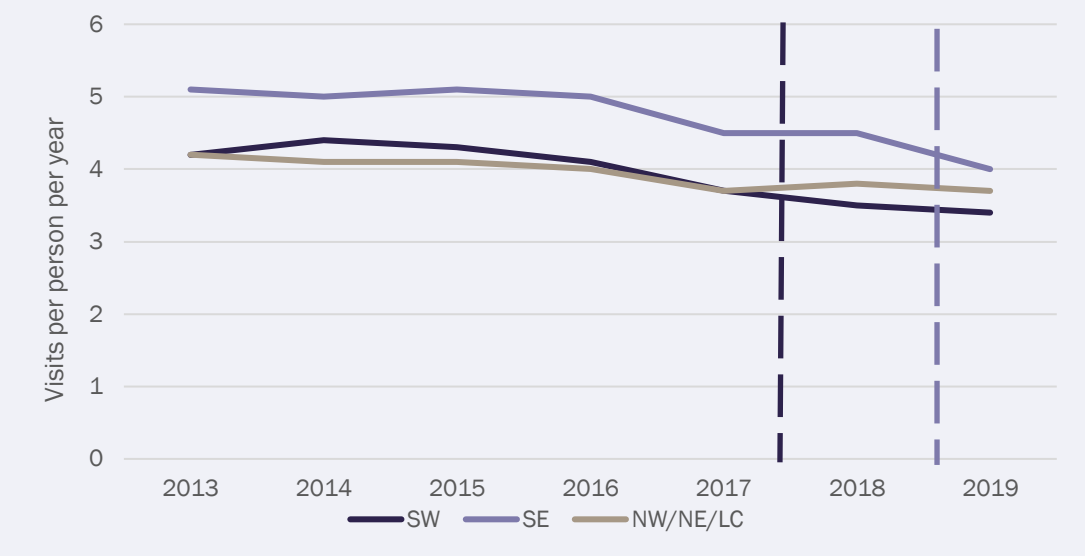


Figure 10. Specialist Visits

Hospice Use in Last 6-Months of Life

As a measure of access to end-of-life care, the MRC identified individuals who died during each calendar year. Next, Medicare and Medicaid claims were searched for hospice utilization. Both inpatient and home hospice were considered. The following chart suggests that hospice use was generally flat during the time period from 2013 to 2019 in the SW zone. The dashed lines represent the Phase I (2018) and Phase II (2019) implementations. However, there is a drop in the SE zone from 52.5% to 46.8% of decedents that appears to be associated with CHC implementation.

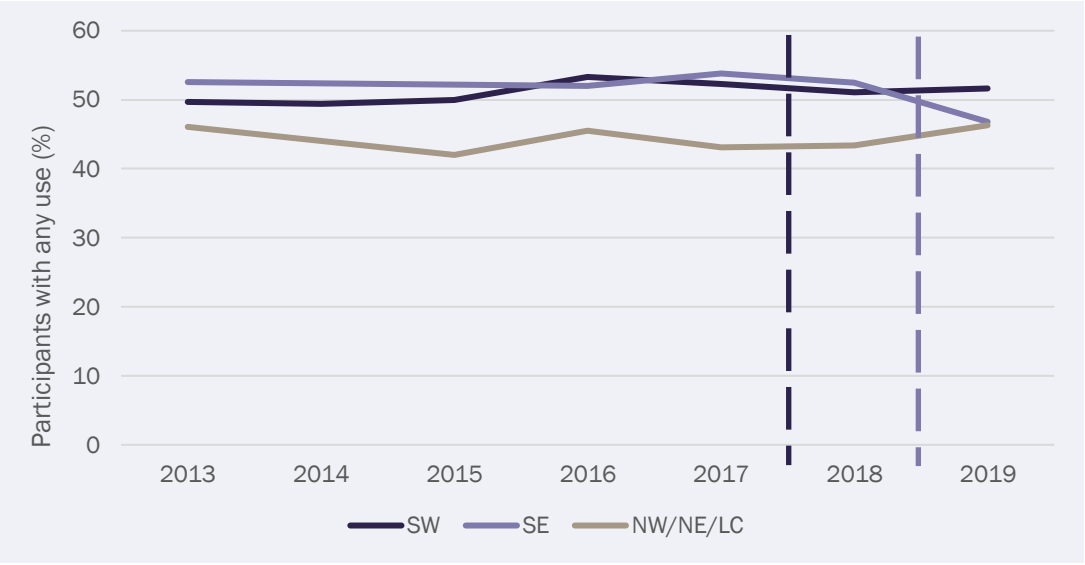


Figure 11. Hospice Use in the Last 6 Months of Life

Medical Transportation

Medical transportation is a covered benefit under both Medicare and Medicaid. However, it is very complex to track using claims data. Therefore, the MRC included survey questions about use of medical transportation to interviews conducted before and after implementation. These items were first asked in the SE zone in 2019, so there was no data available to track this issue in the SW zone. Specifically, participants were asked if they had missed a medical appointment due to transportation problems. A decline in missed appointments reflects an improvement in quality. The percentage of people in the SE zone who reported missing a medical appointment declined from 21% to 14% ($p = .0167$), and in the NW/NE/LC zones declined from 14% to 8% ($p = .0646$). Finally, participants' overall rating of medical transportation increased from 74% people rating it as at least nine out of 10 to 79% ($p = .000$).

Behavioral Health

This section presents findings related to the use of behavioral health services. Improved coordination of behavioral health services for participants is a focal goal of Community HealthChoices. All three CHC-MCOs have behavioral health coordinators to interact with the BH-MCOs. The MRC analyzed Medicaid and Medicare claims data, including data from Medicaid Behavioral HealthChoices MCOs (Pennsylvania's Behavioral Health carve out). In addition, qualitative interviews were conducted with LTSS providers to capture their perception of changes in the system.

Concurrent with the implementation of CHC, there was a change in behavioral health benefits for older adults living in NFs and receiving HCBS. As each zone was transitioned to CHC, these individual's behavioral health transitioned to the Behavioral HealthChoices Managed Care Organization system. This system carves out behavioral health and places regional managed care organizations to manage and deliver the benefits. The carve out system has been in place for other populations covered by Pennsylvania Medicaid but is new for these groups. A critical aspect of this change is the introduction of a behavioral health care manager who is responsible for assuring that all individual behavioral health needs are met.

Inpatient Psychiatric Hospitalization

The MRC examined the overall trend in use of inpatient psychiatric hospitalization, drawing on both Medicaid and Medicare claims data. (See following Figure; dashed vertical lines indicate Phase I and Phase II implementation.) This was calculated as the number of overnight stays per 1,000 person-years. In the SW zone, the rate increased sharply from 2016 to 2017, but then at a slower pace from 2017 and onward. In the SE zone, there was a decline from 2018 to 2019, but the drop was smaller than from 2017 to 2018. In the NW/NE/LC zone, the pattern is similar to the other zones, but the decrease from 2017 to 2019 is steady.

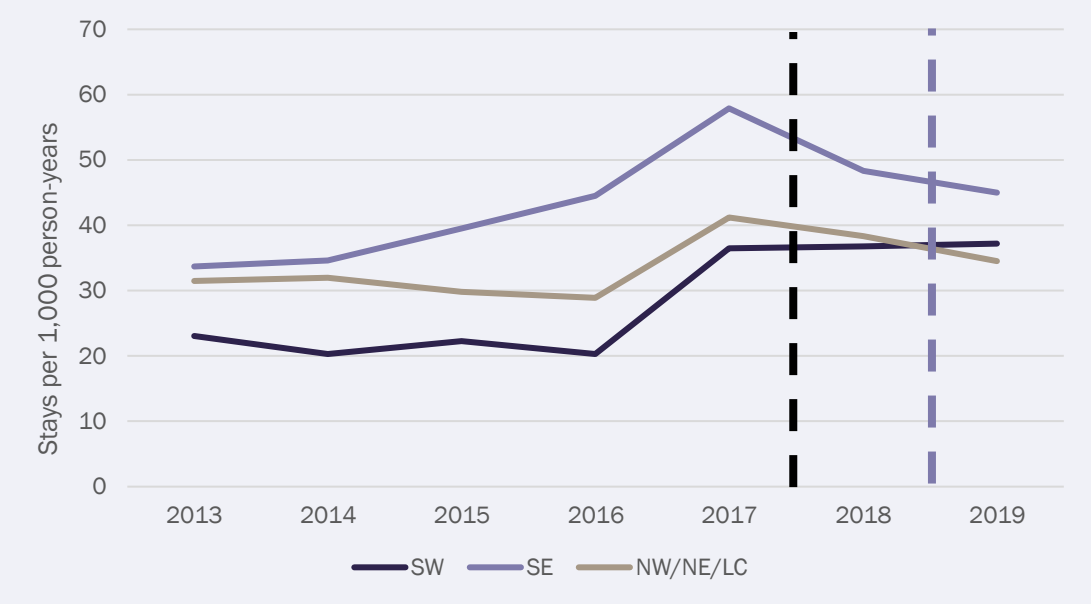


Figure 12. Inpatient Psychiatric Stays

The MRC examined the period from 2017 to 2019 for LTSS users in the SW and SE zones. There seems to be a drop in use of inpatient psychiatric care among NF residents aged 21-59 after CHC implementation in both zones. Next, in the SW zone, there is an increase in inpatient psychiatric care among NF residents aged 60 and older in 2019, but in the SE zone, there is a downward trend. In the SW zone, there is a slight increase in use of inpatient psychiatric care among HCBS users of all ages after 2017. In the SE zone, there was a slight drop from 2017 to 2018, followed by an increase in 2019 among HCBS users.

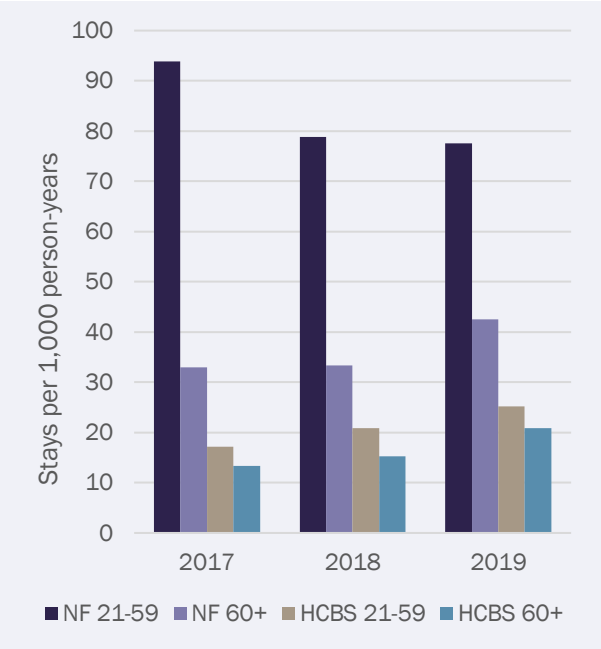


Figure 13. Inpatient Psychiatric Stays among LTSS Users (SW)

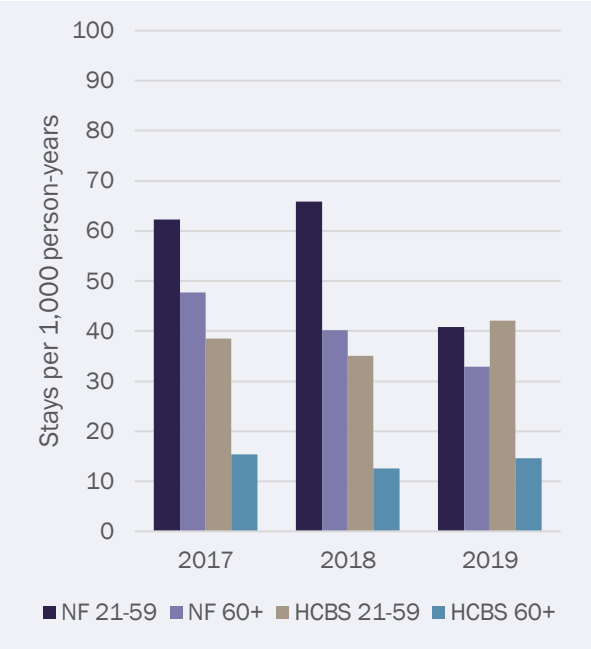


Figure 14. Inpatient Psychiatric Stays among LTSS Users (SE)

Community Behavioral Health

Looking at all sub-populations combined, the use of community behavioral health services (i.e., psychiatry, psychology) was unchanged over the four-year period from 2016 to 2019. However, when focusing on the LTSS populations, there are some apparent trends. In the SW zone, there is an increase in the use of community behavioral health from 2018 to 2019 among all HCBS users. In the SE zone, however, younger HCBS users aged 21-59 experience a slight drop, while older HCBS users aged 60 and older experience a slight increase. In the SW zone, all NF residents experienced a slight increase, while in the SE zone, NF residents experienced a slight drop.

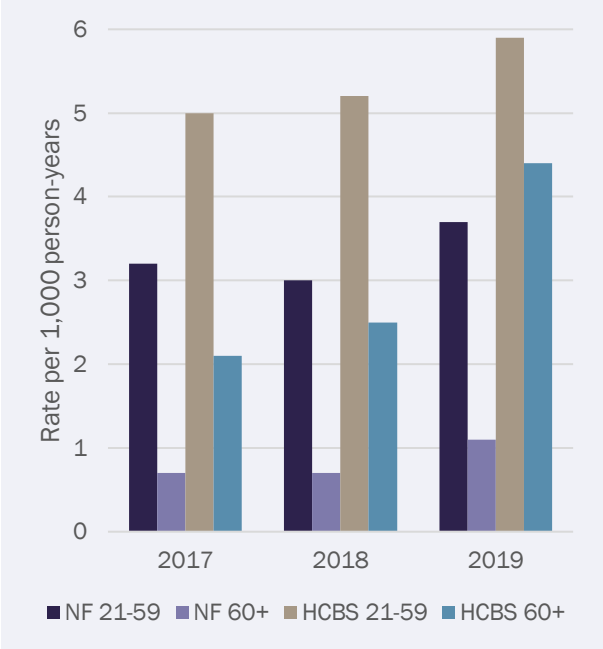


Figure 15. Community Behavioral Health among LTSS Users (SW)

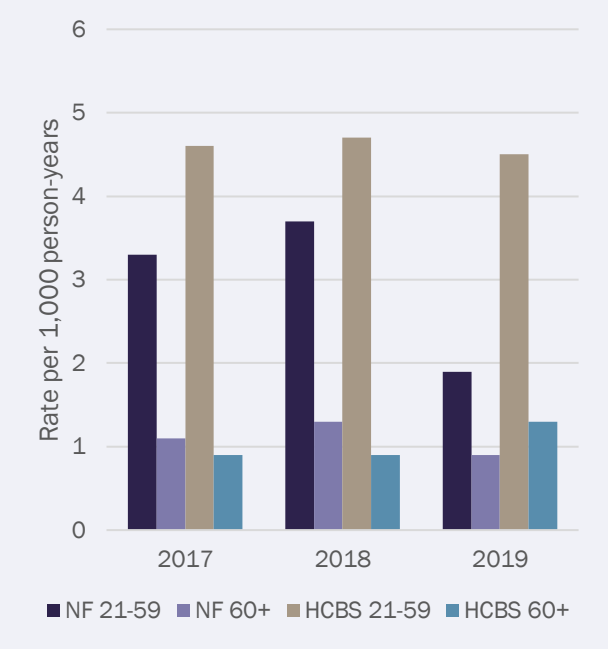


Figure 16. Community Behavioral Health among LTSS Users (SE)

Summary of Behavioral Health Utilization

Overall, there appears to be a mixed pattern with regard to behavioral health use. In general, avoiding inpatient psychiatric hospitalization is considered an indicator of high-quality care, however, there are some individuals who benefit from intense treatment. In addition, it is not clear that access to inpatient psychiatric care was ideal prior to CHC. The pattern of inpatient and community-based services suggests that there has been some increase in access to behavioral health, for example older HCBS users in the SW appear to have increased use of both inpatient and community-based services.

In qualitative interviews, LTSS providers noted a lack of communication between the CHC-MCOs and Behavioral Health MCOs. They also mentioned that providing behavioral health services in rural areas was particularly challenging because of the lack of providers. Thus, strong evidence of improved behavioral health care coordination remains unclear.

Further research is needed to understand the interaction between the CHC MCOs, the Behavioral Health MCOs and the behavioral health provider networks to understand whether the CHC has led to beneficial changes.

Nursing Facility Use

This section summarizes changes in the use of NF over the time period of this report. The first metric is the number of CHC participants with any NF admission in each year. The second metric is based on admissions that lead to long-stays (at least 100 days). The third is discharge to the community.

Nursing Facility Stays

The following figure presents the number of community-dwelling participants who had a NF stay during the year. Community-dwelling was defined as people whose first month of participation in the calendar year was not in a NF. As can be seen, the absolute number of participants with a NF stay has declined over time in all three zones. There appears to be a sharp drop in each zone concurrent with each year of CHC implementation.

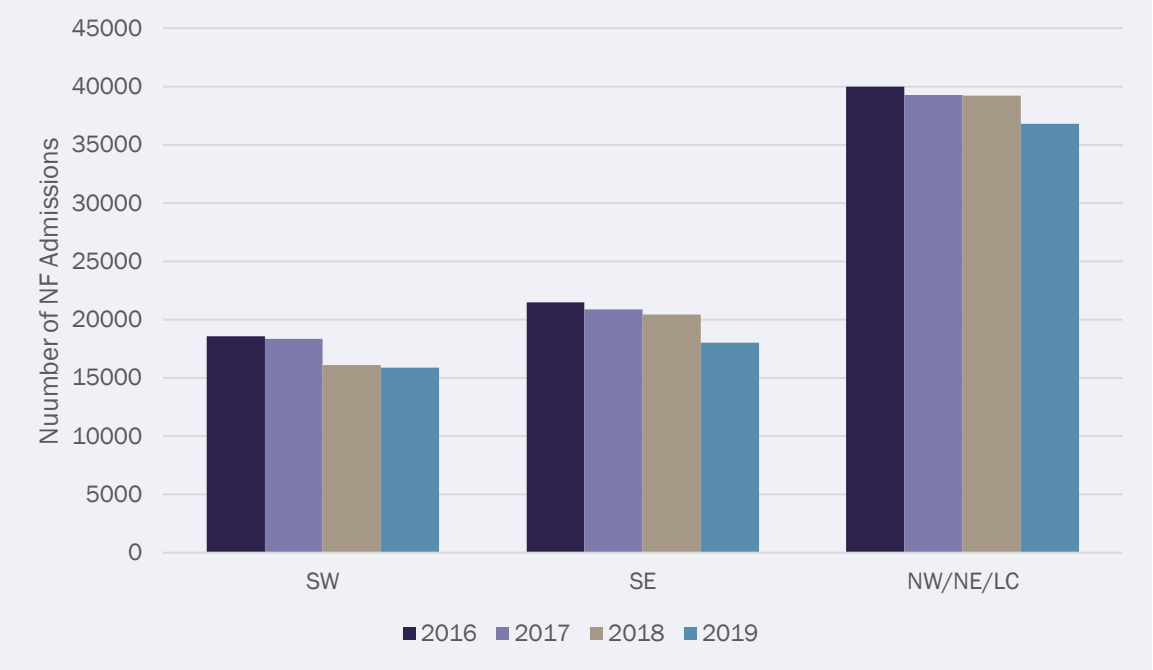


Figure 17. Nursing Facility Stays Among Community-Dwelling Participants (2016-2020)

To adjust for changes in the size of the CHC population, the following chart presents the percentage of participants with a NF admission. The dashed vertical lines indicate implementation in Phase I (2018), Phase II (2019) and Phase III (2020). The proportion of people with a NF admission declined each year.

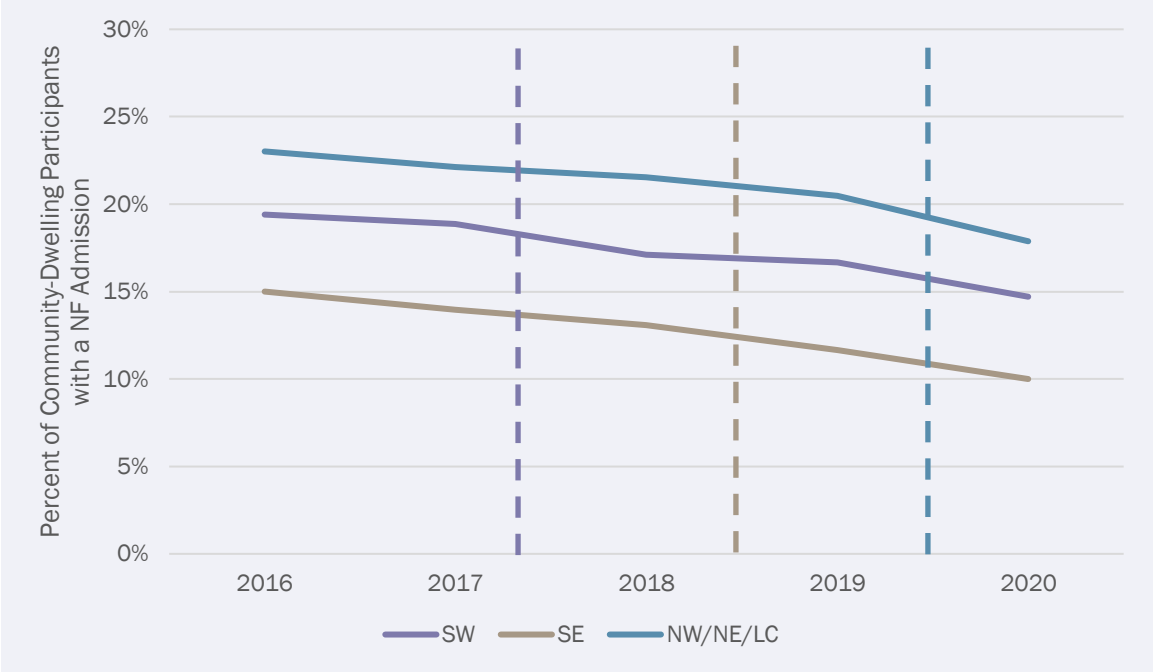


Figure 18. Percent of Community-Dwelling participants with a NF Admission (2016-2020)

Long-Stay Nursing Facility Admissions

Among CHC participants admitted to a NF, we examined the percentage of admissions that led to stays longer than 100 days. As can be seen on the following figure, the proportion of admissions in the SW zone leading to a long stay increased from about 40% in 2017 to about 60% in 2019. Similarly, the same pattern is seen in the SE zone, with an increase from 2017 to 2018.

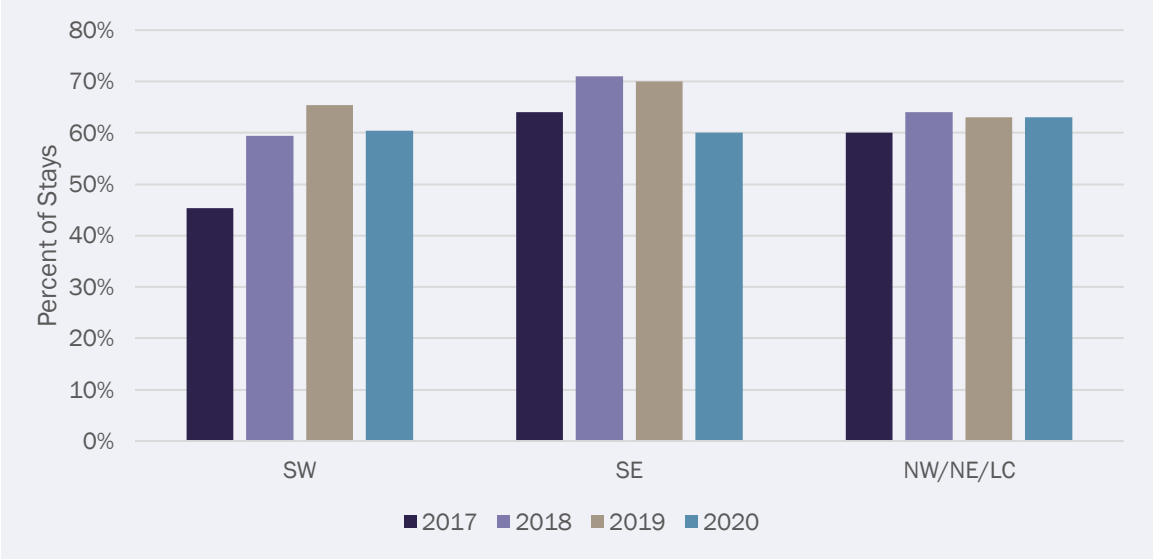


Figure 19. Nursing Facility Admissions Lasting > 100 Days

Nursing Facility Length of Stay

Consistent with the finding that there is an increasing concentration of long-stays among people admitted to a NF, the number of days spent in a facility also increased over time. There is a notable drop off in the average number of days in the SE zone in 2020, likely due to the COVID-19 pandemic.

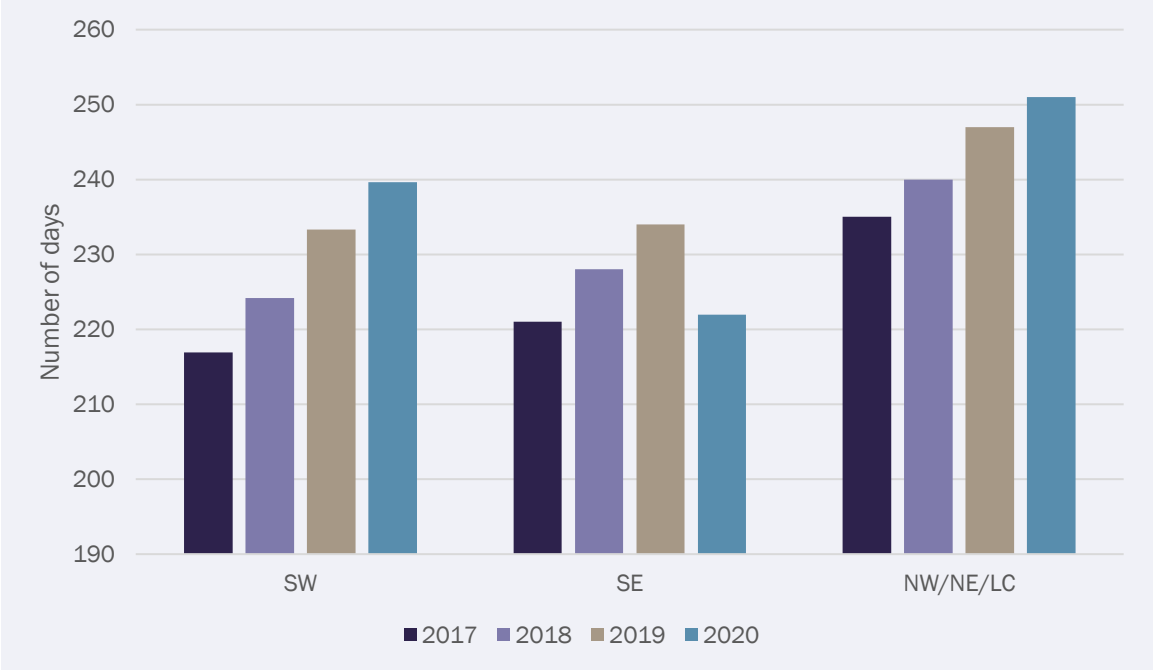


Figure 20. Nursing Facility Average Length of Stay (2017-2020)

Discharge to the Community

Another aspect of this is whether participants are more likely to be discharged to the community after a nursing facility stay. This measure is based on people with a new nursing facility admission during the calendar year. As can be seen, the percentage of admissions with a discharge to the community decreases in 2018 in the SW, in 2019 in the SE and in 2020 in the NW/NE/LC zone. While this appears to be contrary to the expectation, in the context of the previous findings, it suggests that people who are being admitted to nursing facilities may have exhausted their resources to remain in the community.

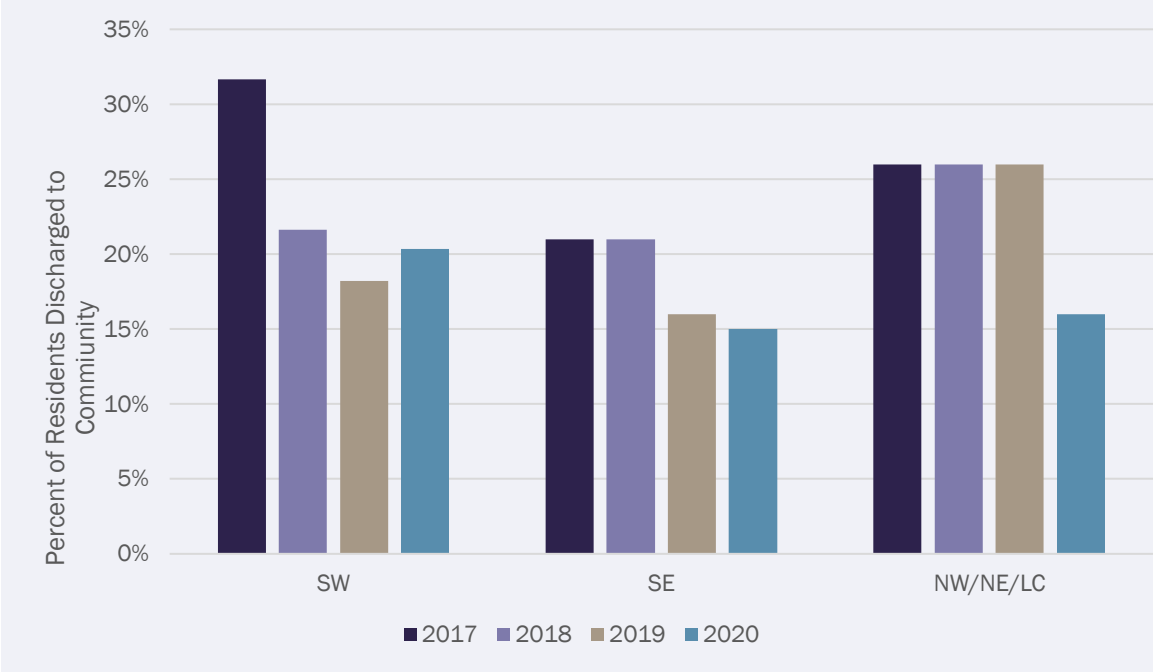


Figure 21. Discharge to Community from Nursing Facility (2017-2020)

Summary

In summary, there appears to have been a long-term trend towards decreasing use of nursing facilities overall. In the SW, there appears to be a large drop in 2018, coincident with the implementation of CHC, as well as in the SE in 2019. However, it does appear that people admitted to nursing facilities are more likely to have longer stays, and the rate of discharges has declined. Further research with other data sources should be conducted to examine whether the composition of the NF population is changing over time. Qualitative interviews with NF administrators and MCOs should examine whether this is due to changes in the care delivery system or the demographics of the population (i.e., population aging).

Home and Community-Based Services

This section summarizes changes in the use of HCBS over the time period covered by the report. We draw on data from as early as 2013 to identify pre-CHC trends. This provides some context to determine if changes observed in 2018, 2019 and 2020 are attributable to the implementation, or if they might have occurred in the absence of CHC.

Increasing Access to Community Living

The MRC conducted independent analysis of Medicaid enrollment data to determine the percentage of people receiving LTSS in a community-based setting. This analysis was stratified by two age groups: age 21-59 and age 60 and older. This cut point was selected to maintain continuity with legacy programs. Specifically, the Aging 1915(c) Waiver served people aged 60 and older, and the other waiver programs that were incorporated into CHC served people up to age 59. Notably, people who aged 'out' of one the legacy programs could elect to switch to the Aging waiver or remain in their

current program. Analysis of these data reveal substantial differences between the two populations, with much higher proportions of younger adults receiving HCBS.

The following figure summarizes the trend from 2013 to 2020 for people aged 21-59. Prior to the implementation of CHC, the proportion of people aged 21-59 receiving LTSS in a community setting increased by 1% per year on average (combining all three zones). After the implementation of CHC, this rate increased to 2% per year (combining all three zones). The vertical dashed lines indicate the Phase I (2018), Phase II (2019) and Phase III (2020) implementations.

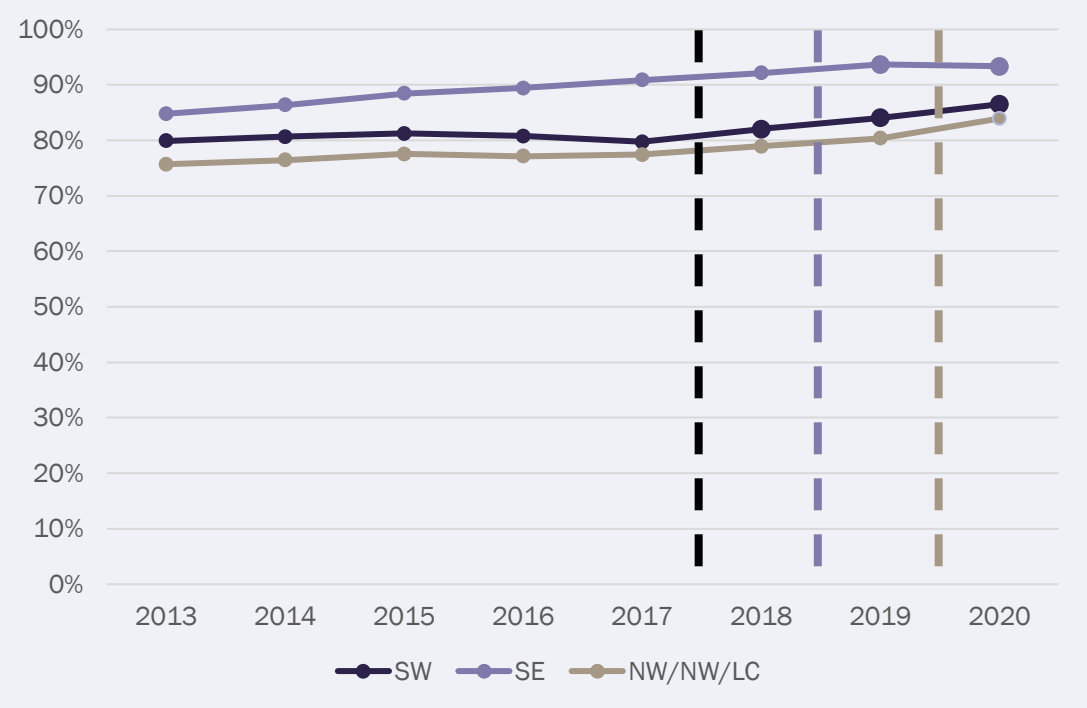


Figure 22. Percentage of LTSS users Receiving HCBS vs. NF. (Age 21-59)

The following figure summarizes the trend for people aged 60 and older. The vertical dashed lines indicate the Phase I (2018), Phase II (2019) and Phase III (2020) implementations. As noted above, this population starts at a much lower baseline – in 2013, only 32% of older adults in the SW were receiving HCBS. Notably, the proportion of LTSS users receiving HCBS increased steadily prior to CHC. The mean increase across all zones was 2% per year. However, after the implementation of CHC, the average increase doubled to 4% per year. Additional research is needed to determine whether the increase is due to changes in the initial assessment of newly eligible people or changes in the use of LTSS among dual eligible after implementation. These are not exclusive pathways; CHC may have increased both pathways into HCBS.

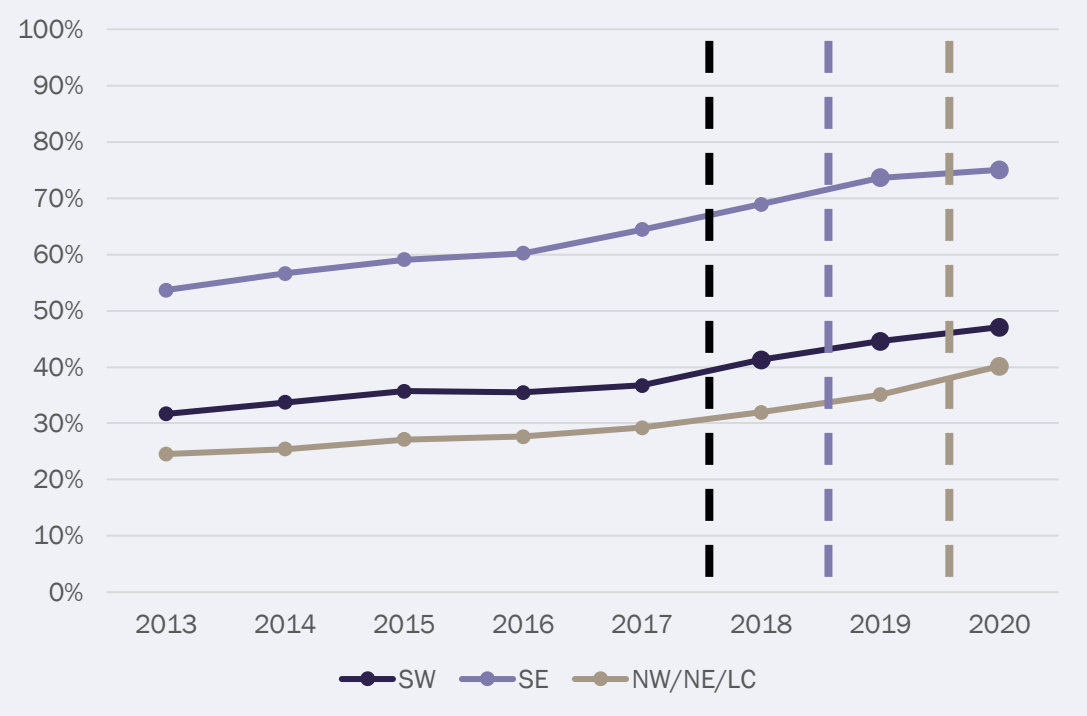


Figure 23. Percentage of LTSS users receiving HCBS vs. NF (Age 60 +)

Personal Assistance Services

Consistent with the overall trend towards increasing use of HCBS among LTSS users, the absolute number of HCBS participants using Personal Assistance Services (PAS) has increased over time. The following table summarizes the number of unique participants in each zone over the years 2017 to 2020. Note that there is a slight drop from 2019 to 2020 in all three zones. This is most likely due to the COVID-19 pandemic.

Table 13. Total Unduplicated PAS Users by Zone (2017 to 2020)

Zone	2017	2018	2019	2020
SW	11,225	12,311	13,684	13,337
SE	40,857	49,734	55,967	54,769
NW/NE/LC	18,190	20,341	22,694	22,594
Total	70,272	82,386	92,345	90,700

Note: Shaded cells represent pre-CHC periods.

Participants can choose to have PAS provided by an agency or through the participant-directed model. The participant-directed model allows individuals to hire, train and manage their own worker, which can be a family member.[12] Qualitatively, providers observed that a benefit of the participant-directed model is that it provides services to participants living in rural areas, where there are fewer providers. They presented the opportunity for fraudulent activity as a possible drawback. We tabulated the proportion of participants using any participant-directed service. The following table summarizes our findings.

[12] Family members who are powers of attorney, legal guardians, and spouses cannot be hired as a PAS worker.

Overall, the proportion of participants using participant direction declined steadily from 23% in 2017 to 14% in 2020. In the SW zone, the decline is about 2% per year prior and after implementation. In the SE, the decline was about 4% prior to CHC and about 2% per year after. In the NW/NE/LC zone, the decline was about 5% per year prior to CHC and 4% in the first implementation year. It is not clear what is accountable for the overall trend, however, it seems that CHC may have somewhat slowed the decline in use of the participant-directed model.

Table 14. Percentage of PAS Users using Participant-Directed Services (2017-2020)

Zone	2017	2018	2019	2020
SW	28%	26%	23%	21%
SE	16%	12%	10%	8%
NW/NE/LC	36%	32%	26%	23%
Total	23%	19%	16%	14%

Note: Shaded cells represent pre-CHC periods.

The MRC examined use of PAS to determine whether there were changes in the amount of care people were receiving. To construct a meaningful measure of PAS, we identified paid claims for agency and participant-directed PAS. Next, we converted the total number of 15-minute units to total hours per month by multiplying by 4/20. Finally, we divided by the number of days the person was enrolled during that month (up to 31 days). The following figures present the PAS hours per person per day for people aged 21-59 and 60 and older. This calculation assumes that participants may receive PAS any day of the week (i.e., all seven days).

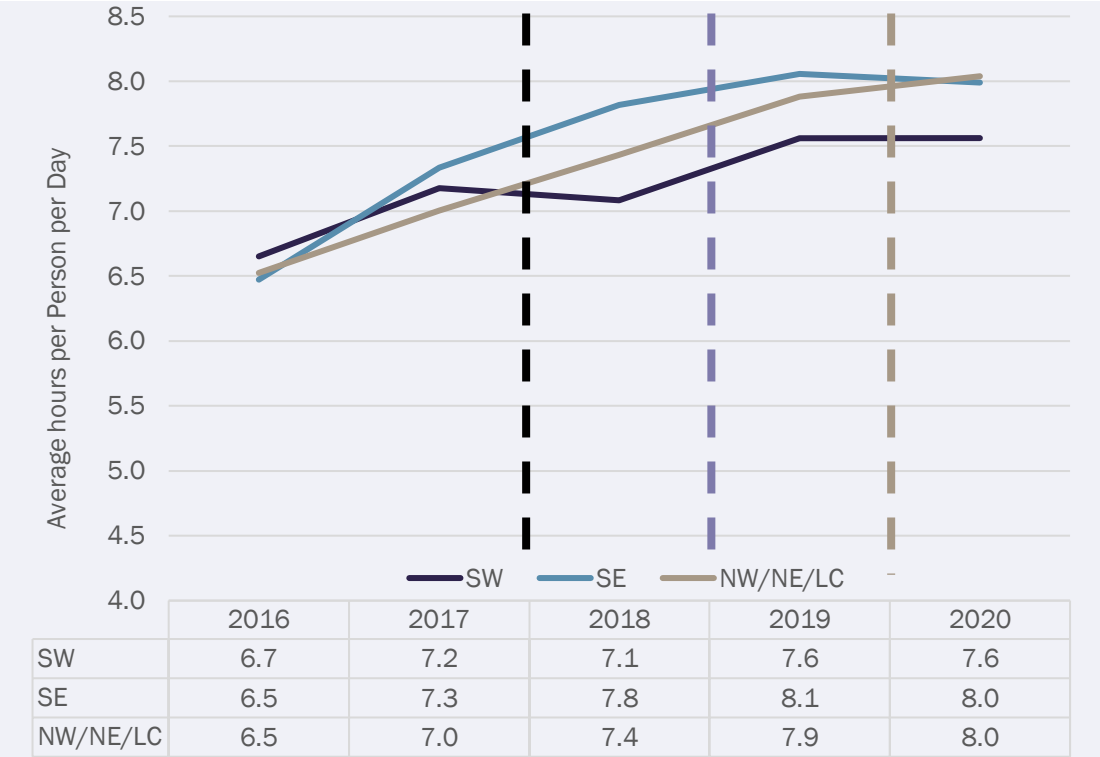
In the time period before the implementation of CHC, the average hours per person per day of PAS steadily increased in all three zones (see following table for percent change in hours). In the SW zone, hours increased from 6.6 to 7.3 from 2016 to 2017; an increase of 7.6%. In the SE, the increase was from 6.5 to 7.3 hours in 2017 and to 7.8 hours in 2018; increases of 8.7% and 6.5%. In the NW/NE/LC zone, hours increased steadily from to 7.0 in 2016 to 7.9 in 2019; increases of 7.3%, 6.1% and 6%.

Table 15. Change in PAS Hours, HCBS Users Aged 21-59 (2016 to 2020)

Zone	2016 to 2017	2017 to 2018	2018 to 2019	2019 to 2020	Pre-CHC Average	Post-CHC Average
SW	7.6%	-1.5%	6.8%	0.0%	7.6%	1.8%
SE	8.7%	6.5%	2.8%	-0.8%	7.6%	1.0%
NW/NE/LC	7.3%	6.1%	6.0%	1.9%	6.5%	1.9%

Note: Shaded cells represent pre-CHC periods.

In 2018, when CHC was implemented in the SW zone, the average hours per person per day decreased slightly from 7.2 to 7.1 (a drop of 1.5%), followed by a 6.8% increase in 2019, and no change in 2020. In 2019, in the SE, hours increased from 7.8 to 8.1 (a 2.8% increase) and actually decreased slightly in 2020 to 8.0. In the NW/NE/LC zone, hours increase to 8.0, but as can be seen, the slope of line decreases, indicating a drop in the rate of increase to 1.9% from the historical pattern. Further research is needed to determine if the change in PAS hours is associated with participant need (e.g., physical and cognitive function, unpaid caregiver support).



	2016	2017	2018	2019	2020
SW	6.7	7.2	7.1	7.6	7.6
SE	6.5	7.3	7.8	8.1	8.0
NW/NE/LC	6.5	7.0	7.4	7.9	8.0

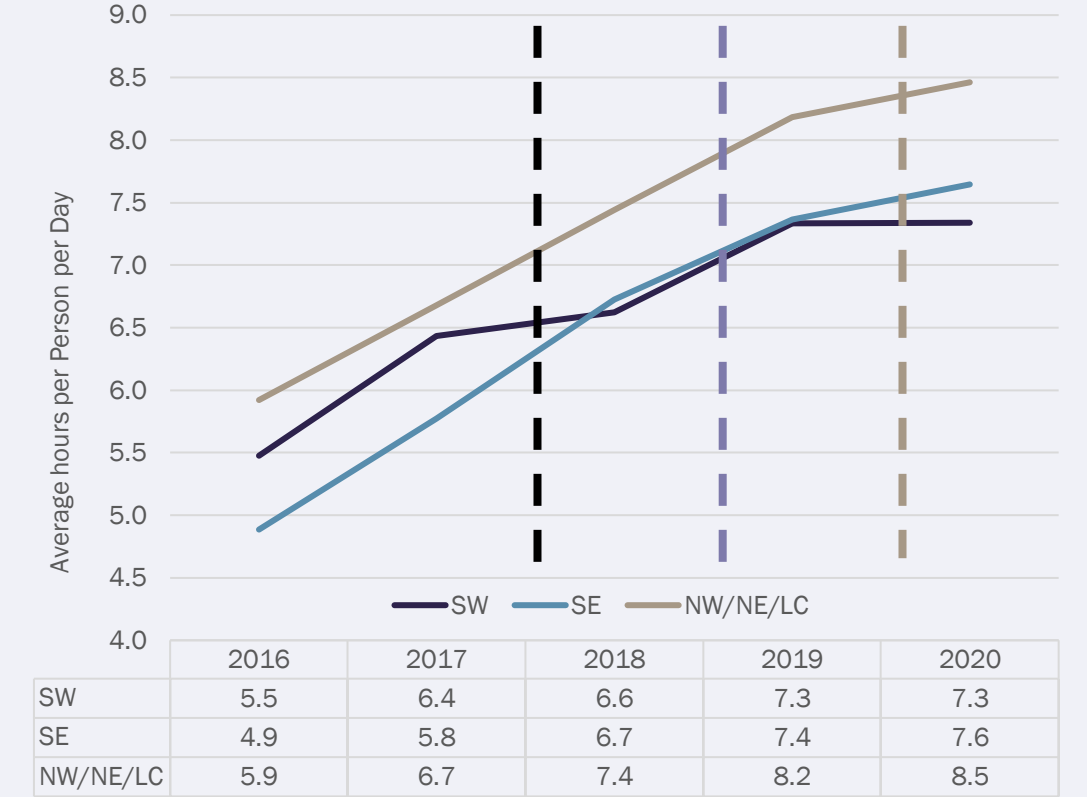
Figure 24. Average Hours of PAS (Age 21-59)

The following chart shows the same analysis for participants aged 60 and older. In the SW, there was a 17% increase from 2016 to 2017 (see following table for percent change). From 2017 to 2018, this dropped to 3%. This was followed by a 10.8% increase from 2018 to 2019, but no change in 2020. In the SE zone, historical increases of 18.1% and 16.2% were followed by an increase of only 9.3% in the first year of implementation and a 3.8% increase from 2019 to 2020. Finally, in the NW/NE/LC zone, historical increases of 12.8%, 11.7% and 10.0% dropped to 3.1% in 2020, the first year of implementation in that zone.

Table 16. Change in PAS Hours, HCBS Users Aged 60+ (2016 to 2020)

Zone	2016 to 2017	2017 to 2018	2018 to 2019	2019 to 2020	Pre-CHC Average	Post-CHC Average
SW	17.6%	2.7%	10.8%	0.0%	17.6%	4.5%
SE	18.1%	16.2%	9.3%	3.8%	17.2%	6.5%
NW/NE/LC	12.8%	11.7%	10.0%	3.1%	11.5%	3.1%

Note: Shaded cells represent pre-CHC periods.



	2016	2017	2018	2019	2020
SW	5.5	6.4	6.6	7.3	7.3
SE	4.9	5.8	6.7	7.4	7.6
NW/NE/LC	5.9	6.7	7.4	8.2	8.5

Figure 25. Average Hours of PAS (Age 60+)

Next, we examined whether these changes were due to changes in use of PAS by the same people over time. To analyze this, we examined all individuals who were enrolled and using PAS over each two-year period from 2017 to 2020. This allowed us to identify individuals who experienced drops in hours in the SE and NW/NE/LC zones in the years prior to implementation of CHC. On average, about 5.7% of CHC participants (all ages) experienced a decrease of at least one billed hour compared to the prior year. By contrast, in the post-implementation periods, across all zones and ages, 9.4% of individuals experienced a decrease. While these overall trends in PAS hours are an important indicator, aggregate increases or decreases cannot provide a complete picture of whether service hour assignment is adequate and appropriate for each individual participant's needs and circumstances. Further discussion of OLTL's service planning quality oversight and monitoring activities is below.

Home Modification

Home modification is an important benefit for adults with physical disabilities to remain independent in their homes. Prior to CHC, there were long-standing concerns regarding the home modification process. Many participants experienced long wait times for projects to be approved, then long waits for actual construction to take place. Under CHC, all three MCOs implemented a new brokerage model that was intended to streamline the process. The MRC examined claims data for Home Modifications and constructed two indicators: the percentage of participants who had any claims for home modification and the average monthly spending in this category. Note that this category was dramatically impacted by the COVID-19 pandemic, as people were reluctant to have workers in their homes, and tradespeople were severely restricted.

Table 17. Percentage of Participants with any Claim for Home Modification (2017 to 2020)

	2017		2018		2019		2020	
Zone	% Any Claim	Mean Spending	% Any Claim	Mean Spending	% Any Claim	Mean Spending	% Any Claim	Mean Spending
SW	7.6%	$780	2.1%	$235	4.3%	$393	2.5%	$318
SE	6.6%	$351	7.4%	$549	2.7%	$87	2.1%	$147
NW/NE/LC	8.0%	$848	6.9%	$810	7.8%	$1,133	0.3%	$29
Total	7.1%	$551	6.4%	$560	4.1%	$372	1.7%	$142

Note: Shaded cells represent pre-CHC periods.

As can be seen in the table, the fraction of participants with any home modification claims drops in the SW in 2018 and in the SE in 2019. In 2020, all three zones dropped precipitously, however, the NW/NE/LC zone decreased much greater than the other zones, even accounting for COVID-19 related restrictions. The dollar amount, calculated as the average spending per month among people with any claims, drops substantially from $780 in 2018 to $235 in 2018. In the SE zone, the drop is even more dramatic from $549 in 2018 to $87 in 2019. Setting aside 2020, the first two implementation years of CHC can be summarized as fewer and smaller (less expensive) home modification projects.

The MRC surveyed participants who use HCBS post-implementation in the SW and SE to gain some insight into the types of home modifications that participants are requesting. In the SW, 30.2% of participants surveyed in 2019 reported having requested a home modification; 70.1% of those indicated their SC was helpful in that process. In the SE, 25% of participants interviewed in 2020 indicated they had requested a home modification; 59.7% reported that their services coordinator had been helpful. For comparison, in the NW/NE/LC zone, 24.1% reported requesting a home modification in 2019, and 66.1% stated their SC was helpful.[13] The following chart shows the distribution of modifications requested (combined across all zones and time periods).

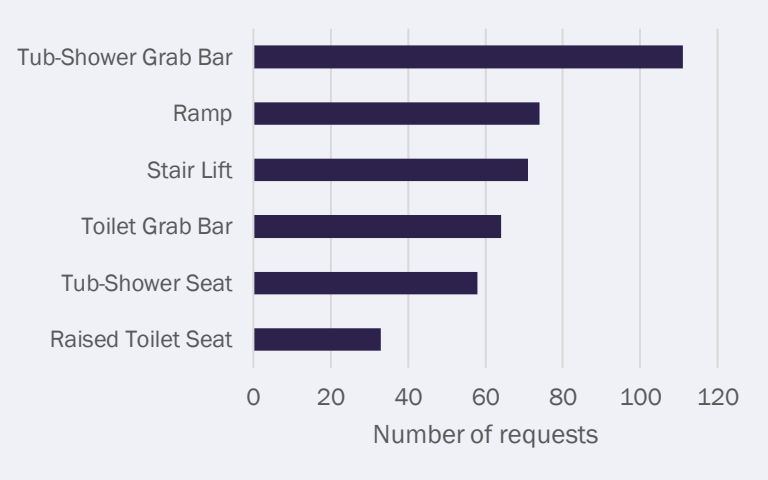


Figure 26. Home Modification Requests

The changes in home modification are important to monitor. Based on the data available, the MRC is not able to determine if the change in the number and size (dollar amount) of projects was due to

[13] Post-implementation interviews with participants in the NW/NE/LC region have not been completed as of the time of this report.

changes in the way projects are identified, planned, and approved. Nor is it possible to determine if projects are being completed in a timelier way. Future research should investigate whether CHC-MCOs are denying projects or simply moving more slowly than in the past.

Pest Eradication

CHC offers pest eradication services for participants in their own homes. Qualitative interviews uncovered some misunderstanding among providers and participants, who perceived that the CHC-MCOs were reluctant to provide this service to participants who were renting housing and who were referred to their landlords. Under CHC, pest eradication can be provided only if the landlord does not address the problem.

Adult Daily Living

There is considerable regional variation in use of Adult Daily Living services. Qualitative interviews with providers revealed a concern that MCOs, SCs, and CHC participants at times did not appear to be familiar with what Adult Daily Living services entailed. The SE zone has traditionally had much higher use compared to the SW or NW/NE/LC zones. The following chart shows the use of any Adult Daily Living service among older HCBS participants. In the SW, there was a declining trend in use of Adult Daily Living from 2016 to 2017 (about .6%). From 2017 to 2018, there is a drop of about .46%, and a decline of about .28% from 2018 to 2019. In the SE, use of Adult Daily Living is unchanged from 2016 to 2017, declines slightly in 2018, but actually increases slightly in 2019; a difference of about .20%.

In 2020, use of Adult Daily Living dropped across the entire state because of the COVID-19 pandemic. Notably, it did not drop to zero use, as providers were able to bill for 'virtual' services.

Overall, it is clear that the implementation of CHC did not lead to increase in use of Adult Daily Living, but the downward trend in the SW and SE may be due to other factors that preceded the shift to MLTSS.

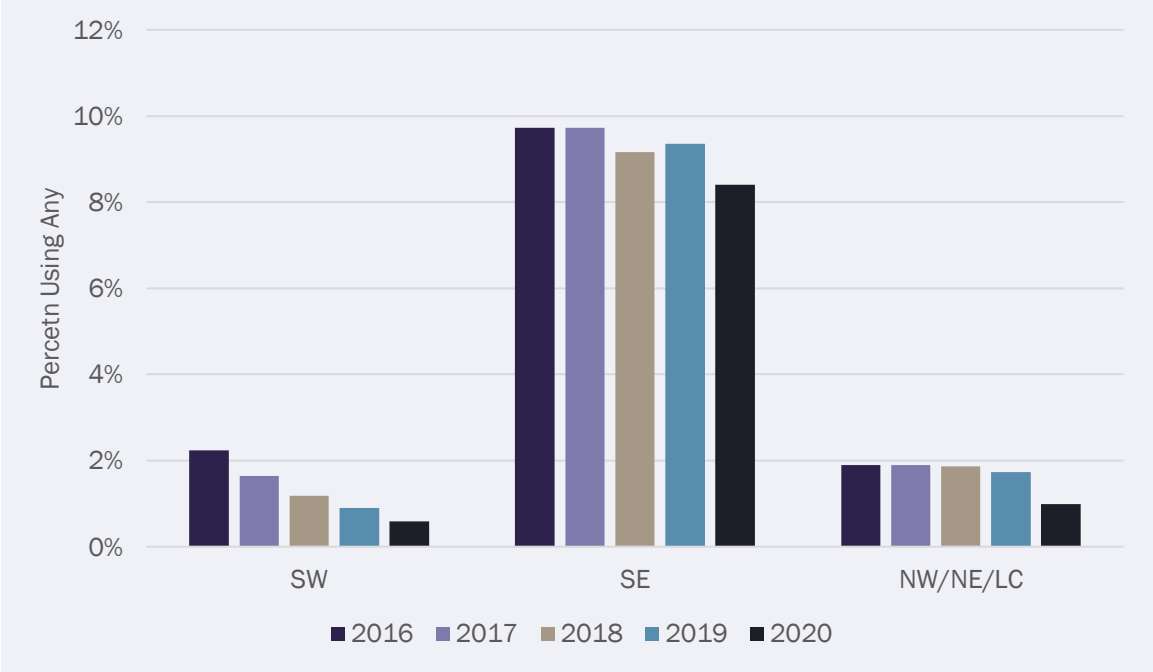


Figure 27. Adult Daily Living Service use Among HCBS Users by Region and Year (2016 to 2020)

Non-Medical Transportation

There have been significant changes in the organization of transportation services under CHC. Emergency medical and non-emergency medical transportation is covered by Medicaid under State Plan authority, while non-medical transportation is covered under the Medicaid waiver authority. Each CHC-MCO utilizes a transportation broker to coordinate non-emergency medical and non-medical transportation for participants. Initially, the brokerage model was confusing for participants who had been accustomed to being able to contract their preferred transportation provider directly.

During 2018, there were substantial complaints about non-medical transportation. Qualitative interviews with providers align with participant survey findings. They reported participants' lack of awareness about non-medical transportation. Providers also noted particular challenges in scheduling rides across county lines. The MRC incorporated several interview questions about transportation into the participant surveys. Since the Phase I baseline interviews had already taken place, the additional interview questions were used for Phase II and Phase III only. The following chart reports findings for the SE zone, before and after implementation.

Participants were asked if they use the same transportation provider for medical and non-medical transportation. This was about 75% both before and after implementation. Participants were also asked if their PAS worker transports them; this was also unchanged at about 35%. When asked whether they were always able to get to non-medical appointments, the percent of participants who agreed with the statement increased from 32% to 41% after CHC implementation ($p = .0004$). Participants overall rating of their non-medical transportation was unchanged, with about half reporting that it was 'nine or 10' on a 10-point scale.

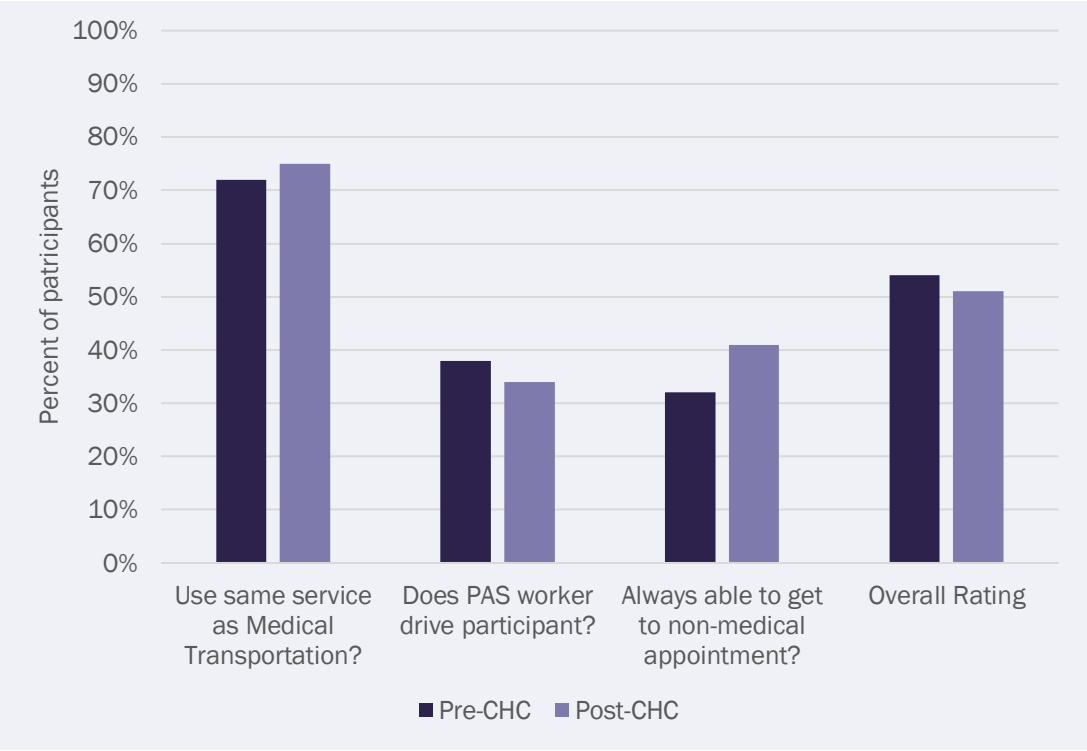


Figure 28. Participant Ratings of Non-Medical Transportation (SE)
Note: Pre-CHC interviews conducted in the SE in late 2018 and early 2019. Post-CHC interviews conducted in the SE in late 2019 and 2020.

Similar patterns were observed in the Phase III implementation as shown in the chart below, however the finding on being able to get to non-medical appointments was not statistically significant.

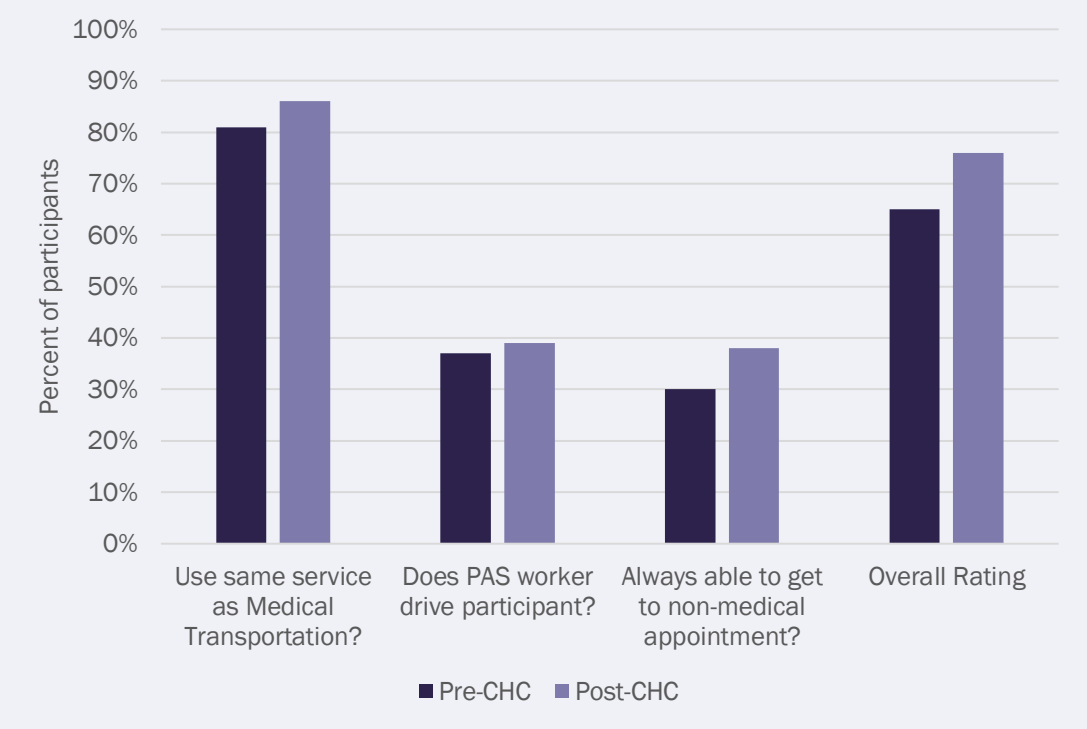


Figure 29. Participant Ratings of Non-Medical Transportation (NW/NE/LC)
Note: Pre-CHC interviews conducted in the NW/NE/LC in late 2018 and early 2019. Post-CHC interviews conducted in the NW/NE/LC in 2020.

Some communities in Pennsylvania have extensive public transportation. In these communities, people with disabilities and older adults can use public transportation or paratransit services. In other areas, public transportation is not as common, and people need to rely exclusively on paratransit or private vehicles. The Medicaid claims data capture different transportation modes, however, it is difficult to determine the number of trips or miles travelled, since some individuals have a monthly transit pass while others have a certain number of paratransit trips. Thus, we calculated the per person per month spending for each zone over time. This approach makes it possible to look at trends within each zone.

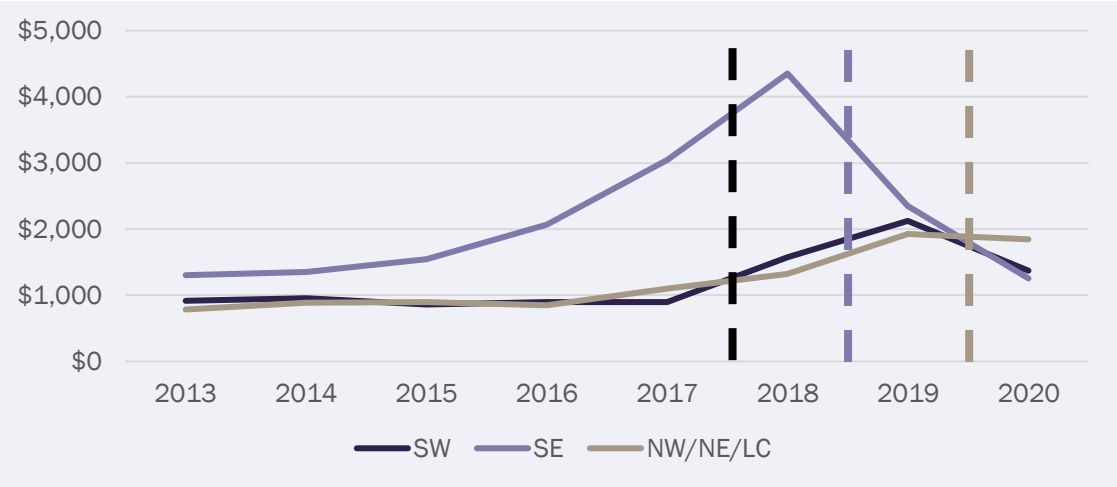


Figure 30. Average Monthly Spending on Non-Medical Transportation

As can be seen on the figure above, average spending increased in the SW from 2017 to 2018 concurrent with the implementation of CHC with a subsequent drop in 2020; likely due to COVID-19 (dashed lines represent implementation in Phase I (2018) and Phase II (2019) and Phase III (2020)). In the SE zone, there was a steady increase from 2013 until 2018, however, with the implementation of CHC there was a fairly sharp drop in average spending. Finally, in the NW/NE/LC zone, there was a long-term increasing trend that appears to have levelled off after implementation. Setting aside 2020 to avoid misinterpreting the impact of COVID-19, a clear conclusion is that the CHC program has led to standardization of spending on non-medical transportation at about $2,000–$2,300. It is noteworthy that the drop in spending in the SE was associated with an *increase* in participant positive experience.

FINDINGS: QUALITY OF CARE

This section presents findings regarding the quality of care for CHC participants. In this section, we provide an overview of the DHS Quality Strategy and present findings from a range of CHC Quality Monitoring Activities conducted by OLTL. Next, we present findings from analysis conducted by the MRC drawing on a range of data sources.

DHS Quality Strategy

Per 42 CFR §438.340, Medicaid managed care programs must have a written quality strategy. The Pennsylvania DHS Quality Strategy includes all Medicaid managed care programs: Physical HealthChoices, Behavioral HealthChoices, CHC, CHIP, and ACAP. The first iteration of the DHS-wide quality strategy was released in 2017.

In this pre-CHC implementation period, OLTL listed the key goals for CHC, and prioritized strategies needed to support successful program implementation. Many of these initial goals focused on ensuring contract compliance, CHC-MCO accountability and performance, and ensuring adequate data collection to support successful program implementation. At CHC implementation, OLTL focused on ensuring continuity of services and provider payment. To support these goals, OLTL engaged in more frequent data collection following the launch of CHC in each zone.

The most current version of the quality strategy was released in December 2020. With the full implementation of CHC complete, moving forward, DHS is increasing focus on longer term quality

improvement strategies, such as collection of national and state quality measures; continuing PIPs focused on strengthening care coordination and transition of care from LTC settings into the community; expanding social determinants of health strategies; and development of value-based purchasing initiatives. Additionally, OLTL plans to integrate CHC monitoring data into an interactive dashboard for improved access and analysis of key program quality indicators.

CHC Quality Monitoring Activities

This section summarizes findings drawn from quality monitoring activities conducted by DHS. Data from multiple sources were made available to the MRC for analysis.

EQRO Performance and Findings

Island Peer Review Organization (IPRO) is the contracted EQRO. IPRO incorporates quality monitoring into all Medicaid products in Pennsylvania. The vendor has a standard approach for CHC that builds on experience and has incorporated the new LTSS measures recently released by NCQA.

The EQR-related activities that must be included in detailed technical reports are:

- Review to determine MCO compliance with structure and operations standards established by the State (42 CFR §438.358);
- Validation of performance improvement projects; and
- Validation of MCO performance measures.

CHC-MCOs are required to submit select Medicaid and Medicare HEDIS measures, as well as PA-specific performance measures (PAPMs). Due to the age of eligibility for CHC and the carve out of behavioral health services, CHC-MCO Medicaid HEDIS reporting excludes childhood-related, pregnancy-related, and behavioral health measures. Each CHC-MCO was subject to a HEDIS compliance audit for measurement years 2018 through 2020. PAPMs were not subject to a separate onsite review for validation, as these measures rely on the same systems and staff as the HEDIS measures. CHC-MCOs also submitted four LTSS measures, which were constructed using HEDIS LTSS standards as available. NCQA does not require audit of LTSS measures.

For 2018 data, IPRO highlighted measures for which each CHC-MCO was performing below the statewide average. IPRO also identified opportunities for CHC-MCOs to strengthen data reporting, including possible biased rates and validation problems related to the timeliness and accuracy of requested information.

As part of the vendor oversight process, DHS monitors IPRO's compliance with due dates for deliverables. IPRO did not meet deliverable due dates in one quarter of each year, 2018-2020. Several of the deliverables were reliant upon the CHC-MCOs providing necessary information, data, and documentation to IPRO. A barrier to the MCOs providing necessary input and data to IPRO was impacted by IPRO not providing clear and consistent direction to the CHC-MCOs. To improve compliance, OLTL implemented bi-weekly meetings and quarterly workplan reviews.

MRC Assessment of EQRO

The MRC assessed OLTL's management of the EQRO. In general, OLTL is to be credited for consolidating the EQRO for CHC with the same vendor that provides that function for other PA Medicaid Managed Care programs. This allows OLTL and DHS to have consistency in metrics and reports across different programs, and also streamlines the administrative burden. One concern is that metrics for MLTSS plans are relatively new to the industry, thus there is less experience in constructing these measures at both the EQRO and the CHC-MCOs. For example, as noted, NCQA does not require an audit of LTSS measures. A challenge in this domain can be seen with attention

to the PCSP. The quality strategy is primarily about process – assuring that all participants have a PCSP conducted within a specified time frame.

Performance Improvement Projects

The two required PIPs address both clinical and non-clinical areas for improvement: strengthening care coordination and transition of care from the NF to the community. The first PIP proposals were due from the MCOs in 2018. The PIPs are three-year initiatives, with a target start date of 2019 in the SW, 2020 in the SE, and 2021 in the remainder of the state. Two years of PIP data were available as of 2021.[14]

CHC-MCOs were required to submit data representing baseline, interim, and final measurement years for each PIP. For the strengthening care coordination PIP, indicators included notification of inpatient admission, receipt of discharge note, engagement after inpatient discharge, and hospitalization follow-up indicator for seven-day follow up behavioral discharge. For the transition of care PIP, indicators included receipt of discharge note, engagement after inpatient discharge, medication reconciliation, and an indicator for remaining in home or community post-discharge. Preliminary data collection for PIPs included only Medicaid-enrolled (non-dual) participants and dual eligible participants enrolled in an aligned D-SNP, but eligible populations were later expanded.

Across CHC-MCOs, initial feedback on PIP proposals and early implementation called for stronger association between PIP activities and the intended outcomes or goals of the PIP. With the onset of COVID-19, IPRO noted the need for tracking of telehealth/telephonic activities in PIP interventions. As of 2021 reporting, IPRO documented that these PIP concerns had been addressed by all three CHC-MCOs.

Overall, in Year 2 of the PIP demonstration, all MCOs were determined to have achieved compliance with the PIP measures for strengthening care coordination, but all three MCOs had at least one area of only partial compliance for the NF transitions of care PIP, relating to the Aim Statement (AHC/KF), Results Table (AHC/KF and UPMC), or Discussion (PHW). AHC/KF was not able to submit a PIP to IPRO within the required timeframes, and as a result, IPRO evaluated AHC/KF's PIP submissions as only partially compliant.

MRC Assessment of PIPs

MRC assessed the overall PIP effort. The overall strategy of allowing CMC-MCOs to identify target areas for improvement is strong and allows the plans to focus their efforts on high priority areas. One concern is that the specific projects tend to be small in scope. OLTL modified the program to require that successfully PIPs be expanded to all eligible participants after 18 months.

Readiness Review

CHC-MCO readiness review was conducted at each phase of CHC implementation. During calendar year (CY) 2017, CHC-MCOs were assessed on structure and operations standards. Prior to the enrollment of CHC participants and the start date for each zone, OLTL determined the CHC-MCO's ability to provide required services. If readiness was not sufficiently demonstrated, DHS would not permit the enrollment of CHC participants.

Readiness to operate and commence enrollment of CHC participants was ascertained through on-site reviews, which is a required methodology for standardized determinations on CHC-MCO capacity and capability. OLTL conducted on-site readiness visits in 2017 for initial implementation in the SW zone, in 2018 for the SE zone, and 2019 for the remainder of the state.

[14] Current PIPs have been extended through December 2023.

Information was collected using a formalized and standardized readiness review tool, which was adapted from an existing readiness review tool used for the Physical HealthChoices readiness review process. Collected information was used to identify strengths and opportunities for improvement. The readiness review reports provided an evaluation of structural systems for CHC claims processing by zone. Additionally, the following operational domains were evaluated:

- Organizational overview
- Participant services contact center
- Overview of the case management system
- Provider services
- Overview of the provider directory
- Provider dispute process
- Subcontracting and oversight
- Service coordination

In addition, the CHC-MCOs had to successfully test their claims processing systems prior to the implementation of CHC in each zone. Findings on the structural systems and operational domains for each of the CHC-MCOs were provided to the EQRO and included multiple reports for each CHC-MCO, including justifications and integrations using supplemental readiness documentation. The EQRO reviewed the findings with orientation and support from DHS and confirmed determinations were in alignment with the readiness review documentation.

IPRO confirmed OLTL's determination that all CHC-MCOs were compliant across all operational domains in review year 2019 (SE zone implementation) and review year 2020 (NW/NE/LC zone implementations).

Contract Monitoring

In addition to the Ops and QMUM Reports discussed previously, DHS uses an electronic tool, "SMART," to monitor MCO compliance with certain contractual terms. The SMART tool stores information related to contract compliance and allows the contract manager to assess whether an MCO is compliant on a given requirement. The frequency of monitoring (from monthly up to annually) depends on the nature and significance of the requirement. If an MCO is non-compliant, DHS will engage in outreach to address the issues with the MCO and may enact a CAP as needed.

Starting in 2021, the SMART tool was utilized to support EQRO analysis of CHC-MCO regulatory compliance. Prior to 2020, compliance was assessed via onsite review. For review year 2020, all three CHC-MCOs were found to be compliant across major BBA regulatory compliance areas (availability of services, coordination and continuity of care, coverage and authorization of services, provider selection, confidentiality, grievance systems, sub contractual relationships and delegation, practice guidelines, health information systems, and quality assessment and performance improvement). No MCO was evaluated on assurance of adequate capacity and services in 2020. Though provider network composition and access standards are included in the Agreement between OLTL and the CHC-MCOs, review of IPRO materials indicated that no standards in OLTL's SMART contract monitoring tool were available for this indicator.

Contractual Performance Indicators

One of the performance measures contained in the EBR is the CHC-MCO's compliance with six key contractual obligations. Per EBR data, the MCOs met the performance standard for most quarters in 2018-2020. In all quarters where the measure was not met, it was due to untimely submission of encounter data. In all cases, the MCO addressed the cause of the delay. As illustrated in the figure below, statewide performance (combined MCOs) met the performance standard in all quarters.

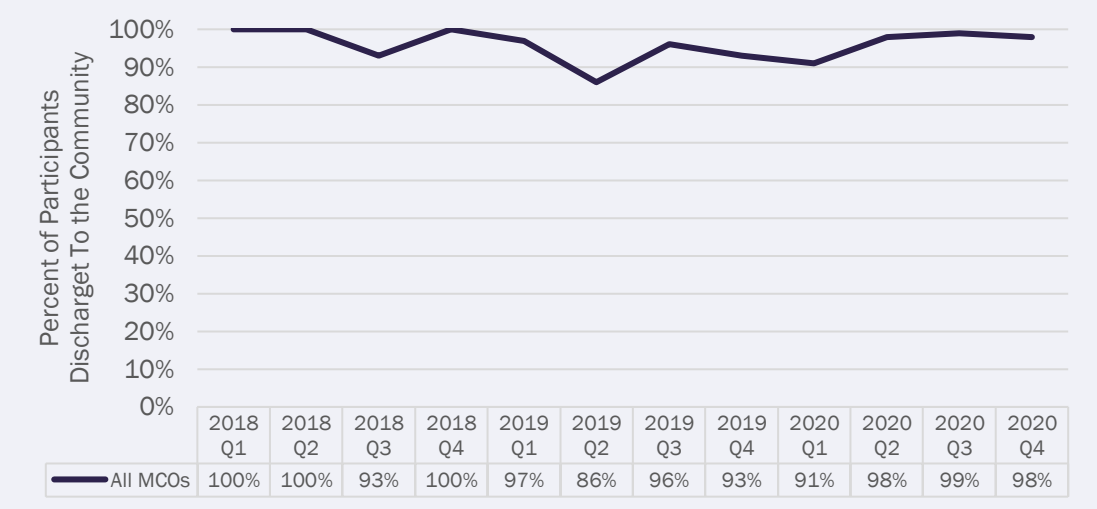


Figure 31. Statewide Performance on Contractual Obligations Met by MCOs
Source: EBR (AA-1)

Corrective Action Plans

CAPs are powerful tools that allow OLTL to assist MCOs to come into compliance with non-compliant contract requirements. A CAP is a formal resolution process which can be used after other attempts to resolve the CHC-MCO's contract non-compliance have been unsuccessful. The decision to initiate a CAP is discretionary for OLTL management; there is no automatic trigger that requires a CAP.

When it is determined that a CHC-MCO does not meet the terms of its contract, the CHC-MCO is notified in writing of the specific deficiencies and instructed to submit a CAP. OLTL's standard operating procedure outlines the specific actions, timeframes, and responsible party for each step of the CAP process. OLTL has utilized CAPs to address several high priority areas, including person-centered service planning (PCSP), data privacy, insufficient notice of denial of services, and the accuracy and integrity of data submissions.

In 2018, OLTL became aware that the MCOs were not personalizing PCSPs as required under the CHC agreement. The MCOs were conducting assessments using algorithms and check boxes on forms. In addition, the notices of service denials or reductions issued to participants were not specific to participant situations and did not include details regarding services requested, assessments conducted, and the reasoning for denial or reduction in services.

At the June 27, 2018, Consumer Subcommittee of the MAAC, OLTL announced that all three CHC-MCOs had been issued CAPs for the lack of appropriate person-centered service planning and deficient notices reducing or denying services. As a result, all three MCOs were required to retrain SCs on person-centered planning and service plan reviews. OLTL also helped the MCOs redesign the PCSP forms and processes.

In addition, OLTL assigned staff to review every service denial or reduction decision the MCOs were intending to issue to ensure that such decisions were clearly written and adequately explained the reasoning for the decision. All CHC-MCOs remained under CAPs through the remainder of 2018.

A variety of other CAPs were issued by OLTL since the CHC program began. One resolved CAP related to delays by one MCO in the mailing of denials and grievances. As of this report, an active CAP involves disclosure by an MCO of unauthorized protected health information that did not rise to the level of a breach but that must be addressed in a certain manner. Another active CAP as of the date of this report relates to one MCO's data submissions and data integrity. With all CAPs, OLTL works with the MCOs to assist with correcting the identified deficiency.

Clinical Review of Utilization Patterns

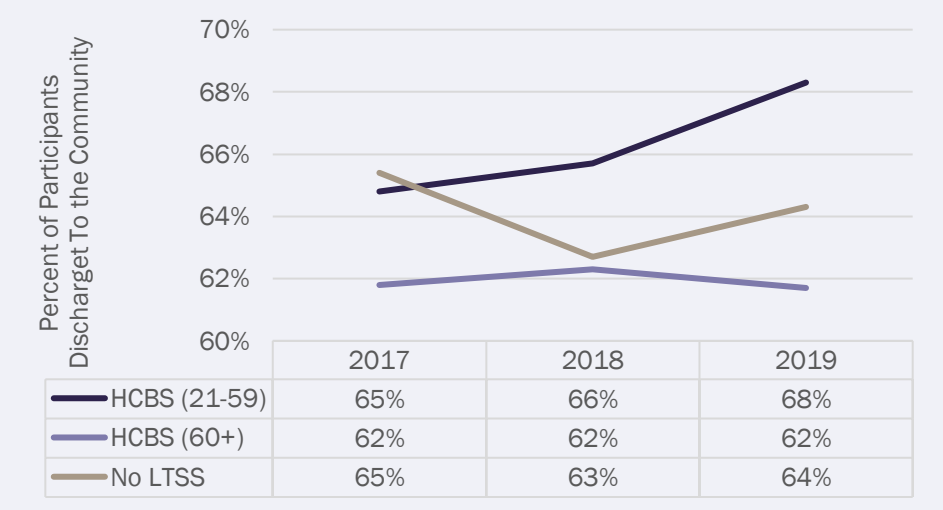
This section presents analysis of quality of care conducted by the MRC. Findings are organized by Physical Health, Behavioral Health, and LTSS.

Physical Health

A range of quality-of-care measures were constructed using Medicaid and Medicare claims data for CHC participants.

Return to Community after Acute Stay

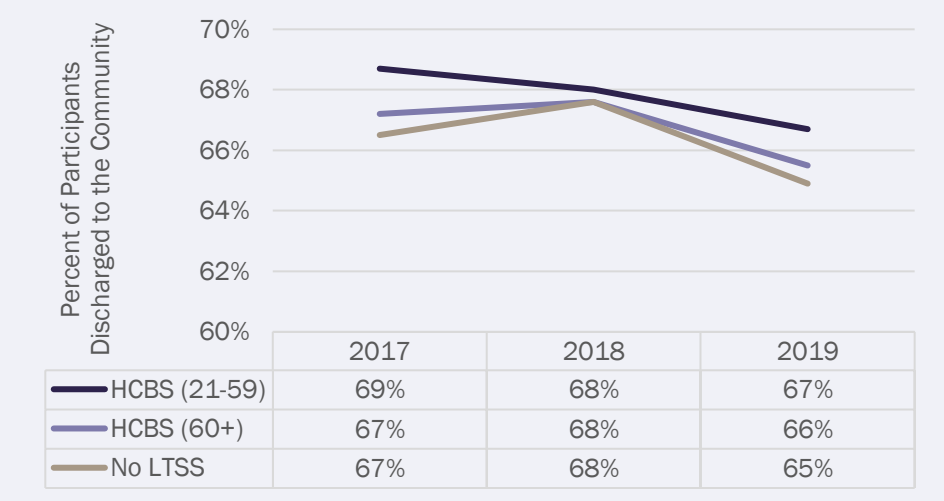
An indicator of the continuity of care is whether people who are hospitalized return to the community post-discharge, or whether they are discharged to an institutional setting for post-acute care. This indicator is limited to people who are living in a community setting prior to an index hospitalization, defined as the first hospitalization in a given calendar year. As can be seen on the following two charts, in the SW, there was a slight trend towards increasing return to the community among HCBS users aged 21-59, but not for HCBS users aged 60 and older. Among people not using any LTSS, the return to community rate dropped from 2017 to 2018, but then recovers in 2019. The trend among HCBS users is inconsistent, but suggests that CHC may have played a role for participants in the SW.



	2017	2018	2019
HCBS (21-59)	65%	66%	68%
HCBS (60+)	62%	62%	62%
No LTSS	65%	63%	64%

Figure 32. Return to Community after Hospitalization (SW)

In the SE zone, there is a decline in return to community in all three groups from 2018 to 2019. By comparison, in the NW/NE/LC zone, there was no discernable trend over this time period (no figure).

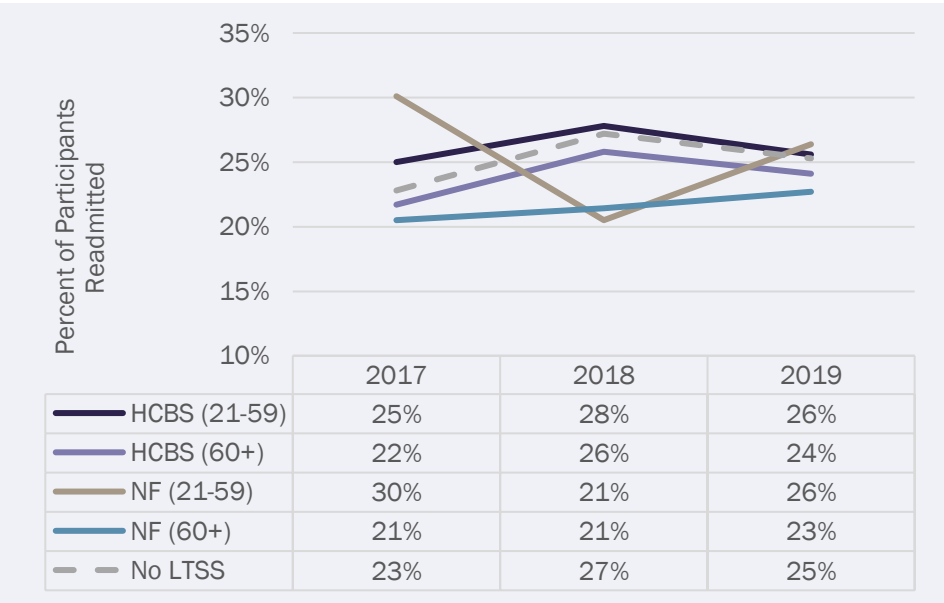


	2017	2018	2019
HCBS (21-59)	69%	68%	67%
HCBS (60+)	67%	68%	66%
No LTSS	67%	68%	65%

Figure 33. Return to Community after Hospitalization (SE)

All Cause 30-Day Readmission

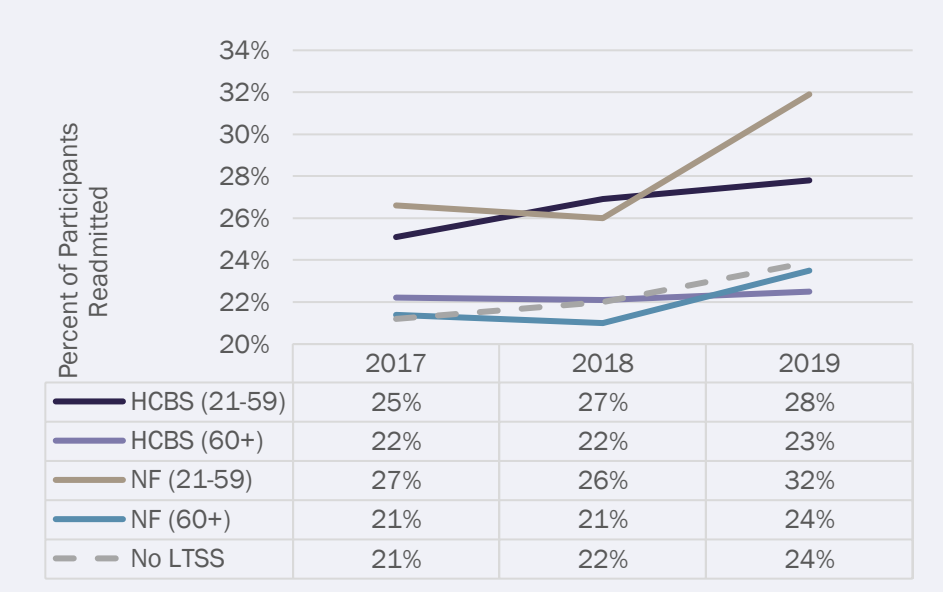
Readmission within 30 days after an acute, inpatient stay is another measure of continuity of care. This measure was calculated for HCBS, NF, and non-LTSS participants. As can be seen in the following chart, in the SW, there is an increase in readmissions in the HCBS and No LTSS groups from 2017 to 2018. Among NF residents aged 21-59, there was a sharp drop in readmission rates, however, the rate increased in 2018. Likewise, the rate increased for the No LTSS group.



	2017	2018	2019
HCBS (21-59)	25%	28%	26%
HCBS (60+)	22%	26%	24%
NF (21-59)	30%	21%	26%
NF (60+)	21%	21%	23%
No LTSS	23%	27%	25%

Figure 34. All Cause 30-Day Hospital Readmission (SW)

In the SE zone, the readmission rate increased for all groups from 2018 to 2019. This is most pronounced for NF residents aged 21-59, increasing from 26% to 31.9%.



	2017	2018	2019
HCBS (21-59)	25%	27%	28%
HCBS (60+)	22%	22%	23%
NF (21-59)	27%	26%	32%
NF (60+)	21%	21%	24%
No LTSS	21%	22%	24%

Figure 35. All Cause 30-Day Hospital Readmission (SE)

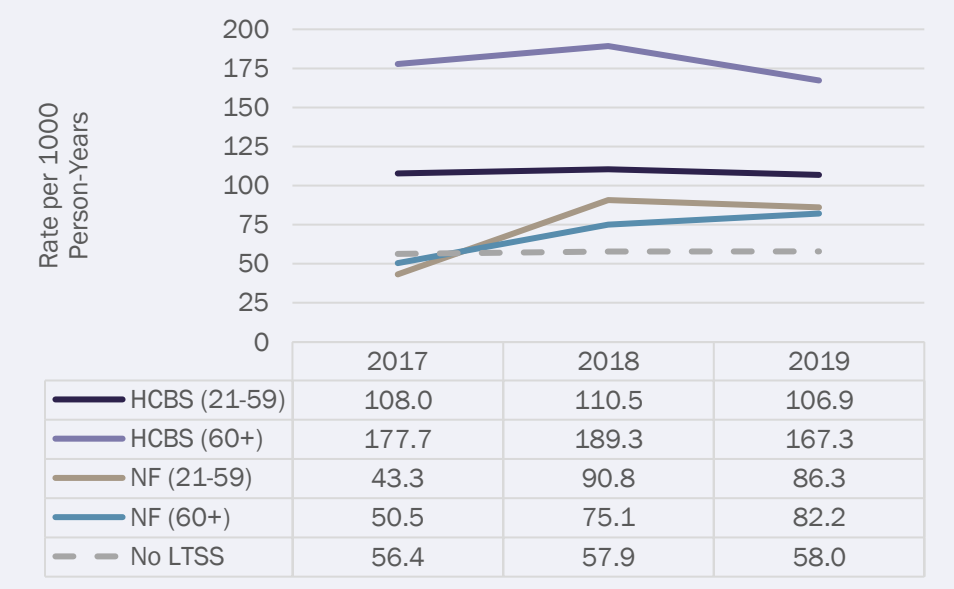
Hospitalization for Ambulatory Care Sensitive Conditions

To capture hospitalization for Ambulatory Care Sensitive Conditions (ACSC), the MRC used the AHRQ composite measure. The composite can be interpreted as the hospitalization rate per 1,000 person-years.

This measure captures the following indications:

- Short-Term Complications of Diabetes
- Long-Term Complications of Diabetes
- Chronic Obstructive Pulmonary Disease
- Hypertension
- Heart Failure
- Dehydration
- Urinary Tract Infection
- Angina Without Procedure
- Uncontrolled Diabetes
- Lower-Extremity Amputation Among People with Diabetes

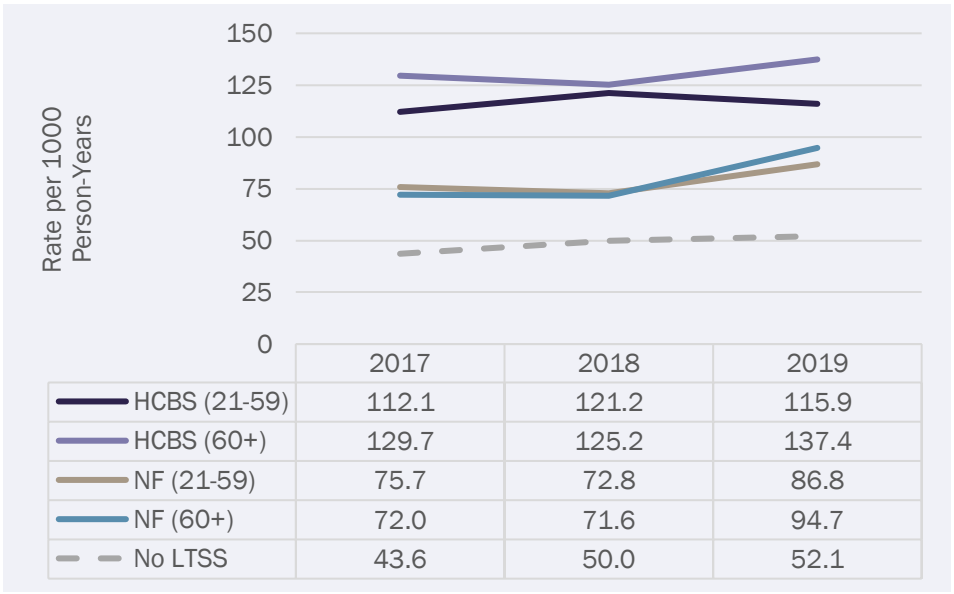
As can be seen on the following chart, the rate at which participants are hospitalized for ACSC trended differently by sub-group. The rate rose slightly, then declined for HCBS participants from 2017 to 2019. However, for NF participants, the rate increased dramatically from 2017 to 2018, and remained high in 2018. The rate for people who do not use LTSS increased slightly over this time period.



	2017	2018	2019
HCBS (21-59)	108.0	110.5	106.9
HCBS (60+)	177.7	189.3	167.3
NF (21-59)	43.3	90.8	86.3
NF (60+)	50.5	75.1	82.2
No LTSS	56.4	57.9	58.0

Figure 36. Ambulatory Care Sensitive Hospitalization (SW)

In the SE zone, there was an increase in the rate of hospitalization for ACSC from 2018 to 2019 in every sub-group except the HCBS age 21-59.

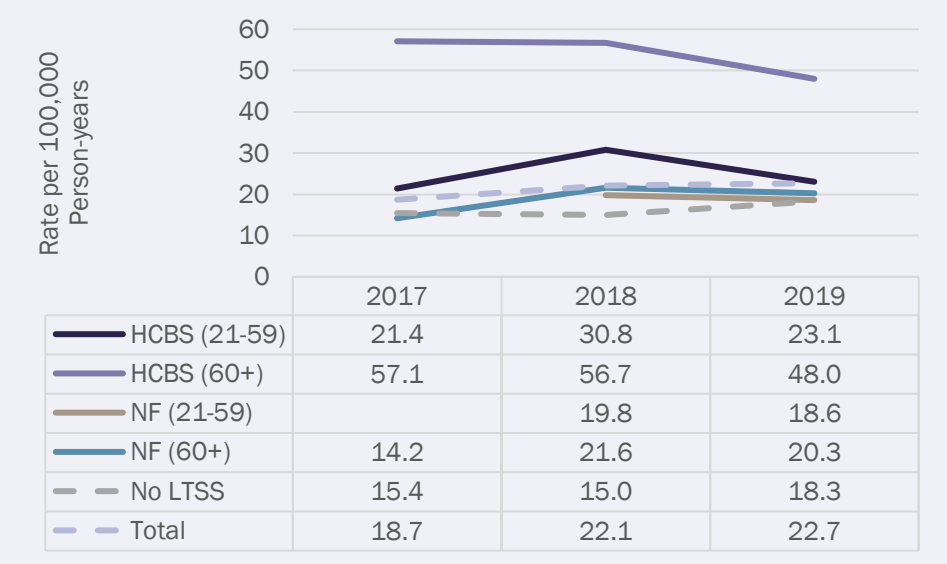


	2017	2018	2019
HCBS (21-59)	112.1	121.2	115.9
HCBS (60+)	129.7	125.2	137.4
NF (21-59)	75.7	72.8	86.8
NF (60+)	72.0	71.6	94.7
No LTSS	43.6	50.0	52.1

Figure 37. Ambulatory Care Sensitive Hospitalization (SE)

Hospitalization for Heart Failure

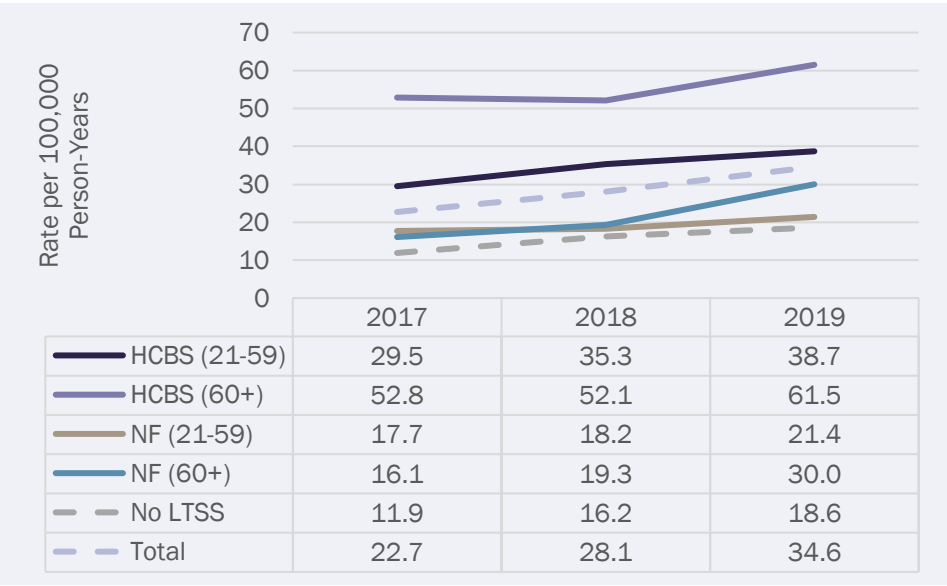
The AHRQ heart failure indicator was calculated separately to provide information on this specific condition. The following charts summarize the rates for the SW and SE. As can be seen, the rate appears to increase from 2017 to 2018 for the HCBS 21-59 group, but then declines in 2019. By contrast, the rate trends down for the HCBS 60 and older group. By contrast, the NF 60+ group has an increase from 2017, followed by a slight decrease. The non-LTSS duals group is basically unchanged from 2017 to 2018 but increases in 2019.



	2017	2018	2019
HCBS (21-59)	21.4	30.8	23.1
HCBS (60+)	57.1	56.7	48.0
NF (21-59)		19.8	18.6
NF (60+)	14.2	21.6	20.3
No LTSS	15.4	15.0	18.3
Total	18.7	22.1	22.7

Figure 38. Hospitalization for Heart Failure (SW)
Note: 2017 data for the NF 21-59 group are suppressed due to small number of cases.

In the SE zone, the rate increases in all sub-groups from 2018 to 2019. By contrast, in the NW/NE/LC zone, the rate increases overall from 2017 to 2018, but is unchanged in 2019.



	2017	2018	2019
HCBS (21-59)	29.5	35.3	38.7
HCBS (60+)	52.8	52.1	61.5
NF (21-59)	17.7	18.2	21.4
NF (60+)	16.1	19.3	30.0
No LTSS	11.9	16.2	18.6
Total	22.7	28.1	34.6

Figure 39. Hospitalization for Heart Failure (SE)

Depression Screening in Primary Care

Primary care providers are encouraged to screen for depression as part of routine office visits. Medicare will reimburse for annual depression screening; thus, the MRC constructed an indicator for people who are eligible for both Medicaid and Medicare. As can be seen on the following chart, there were significant regional differences prior to CHC, with the SW zone performing at a much

higher rate. After implementation, the screening rate increased in all three zones. However, the large increase in the SW zone is notable because of the higher starting point.

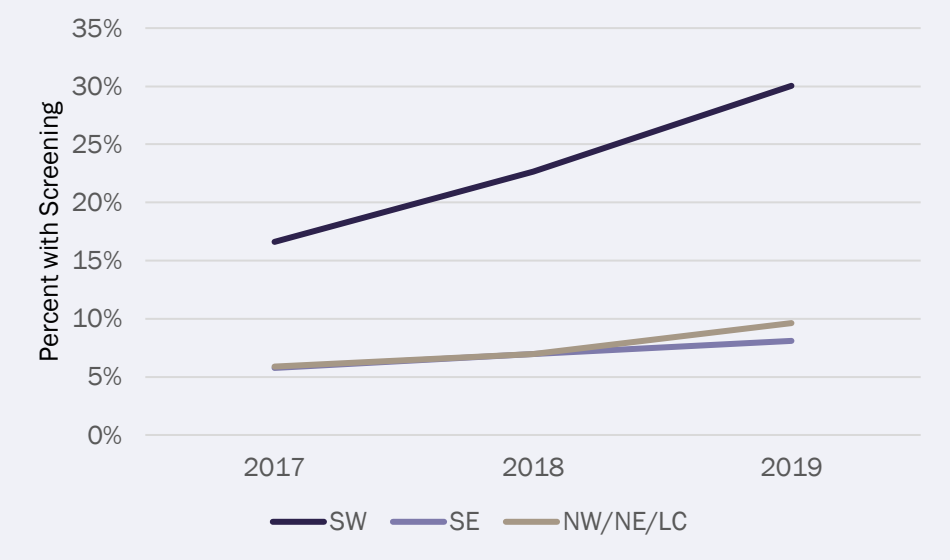


Figure 40. Depression Screening in Primary Care

Screening for Fall Risk Among Older Adults

Falls are a significant driver of cost, need for LTSS, and poor quality of life. Screening for fall risk as part of formal care can identify opportunities to modify people's home environment to reduce the risk of an injurious fall. The following chart presents the overall trend in screening for falls among adults over age 65. The SW and NW/NE/LC zones had much higher screening rates prior to CHC than the SE zone. In the SW, the screening rate increased from 2017 to 2019. In the SE, there was a small increase from 2018 to 2019, however, the increase in the NW/NE/LC zone was larger than in the SE.

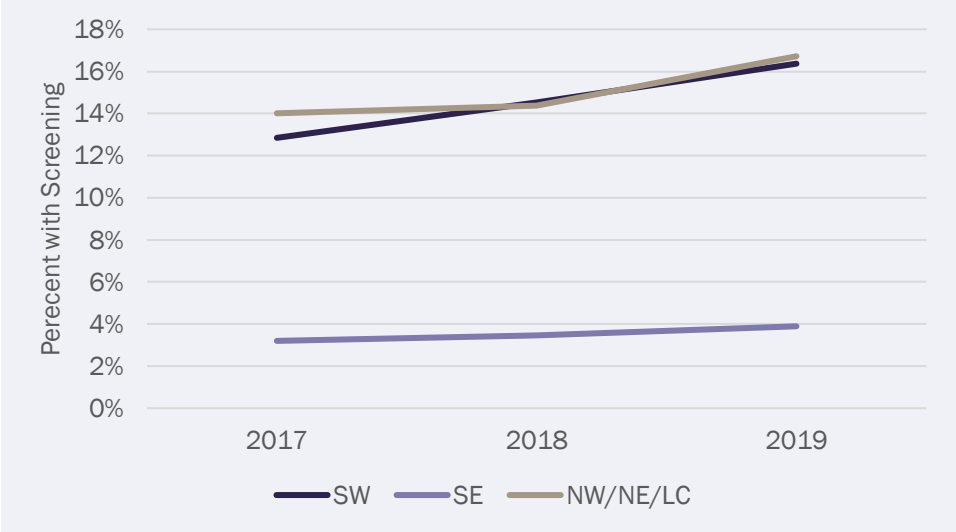


Figure 41. Fall Screening in Primary Care

Drugs to Avoid in Older Adults

A widely accepted measure of quality of prescription drug prescribing is the rate in which drugs to avoid in the elderly are prescribed. This list is constructed for adults aged 65 and older. The figure below shows a long-term downward trend in terms of the percentage of older adults with one or more drugs to avoid. Dashed vertical lines show the Phase I (2018) and Phase II (2019) implementations. From 2017 to 2018, there is a large drop in the SW and the SE zones. There is no drop in the NW/NE/LC zone, however, the fact that decrease is similar in the SW and the SE in the year prior to the implementation of CHC suggests that some other factor might be responsible for this change.

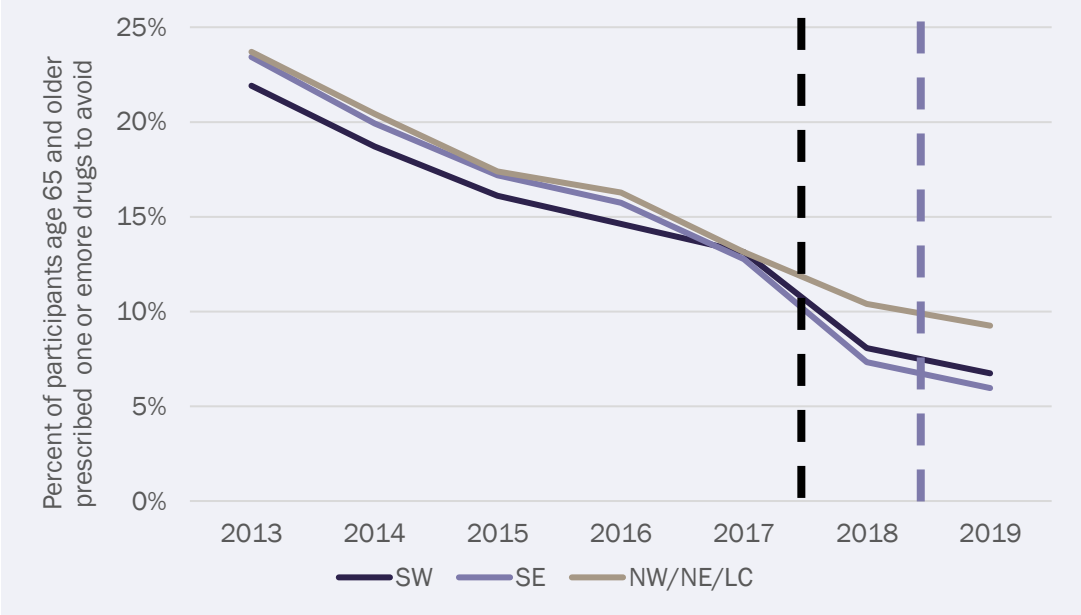


Figure 42. Drugs to Avoid in the Elderly

Participant Experience

An important aspect of quality of care is participant experience. Selected items from the CAHPS-HP were extracted to capture participant ratings of primary care. The following table summarizes five aspects of participants' experience with primary care. Overall, there is a trend toward improvement in participants' ratings.

Table 18. Participant Experience with Primary Care (2019-2021)

Item	2019	2020	2021
Clear Explanations (Usually or Always)	92.1%	93.3%	93.0%
Personal Doctor Listens Carefully (Usually or Always)	92.1%	93.9%	94.3%
Respect from Providers (Usually or Always)	93.4%	94.3%	95.3%
Doctor Spends Enough Time with You (Appointment Length) (Usually or Always)	91.6%	92.6%	92.2%
Satisfaction with personal doctor (8-10)	84.4%	86.5%	86.1%

Behavioral Health

Antipsychotic Adherence

Adherence to antipsychotic medication is used as a measure of quality behavioral health care. The MRC adapted the HEDIS measure to use both Medicaid and Medicare Part D claims. The following chart shows the trend for all three zones. Dashed vertical lines show the Phase I (2018) and Phase II (2019) implementations. From 2017 to 2018, adherence increased slightly in the SW, but then declined in 2019. In the SE zone, adherence increased from 2018 to 2019, however, the increase was smaller than in the NW/NE/LC zone.

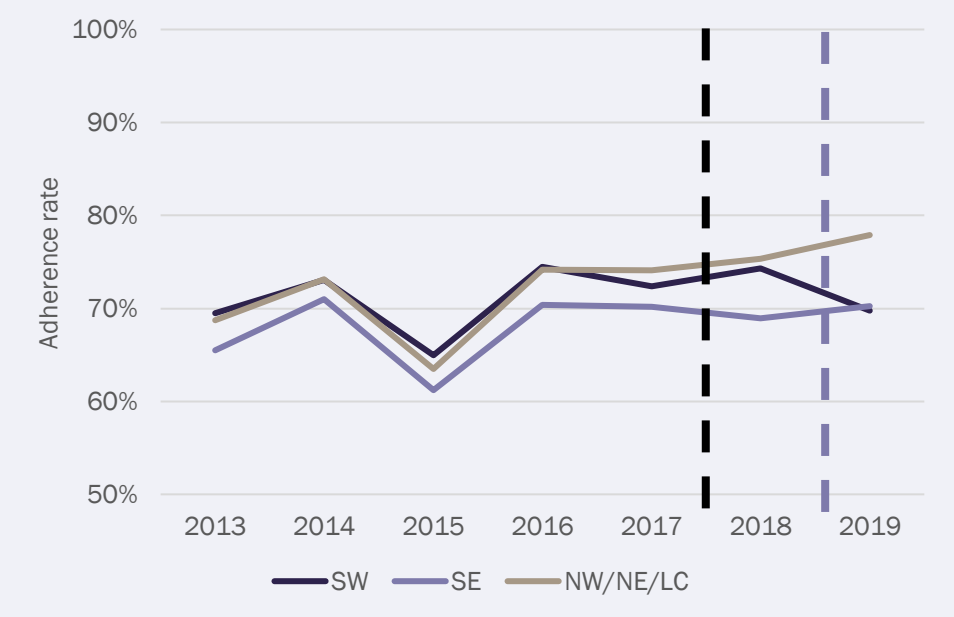


Figure 43. Antipsychotic Adherence

Antidepressant Adherence

The MRC implemented the HEDIS measures for acute and chronic antidepressant adherence. See charts below. Dashed vertical lines show the Phase I (2018) and Phase II (2019) implementations. In all three zones, adherence increases for both measures from 2017 to 2018, then declines slightly in 2019. Given the similarity of the trend, it is difficult to attribute these changes to the implementation of CHC.

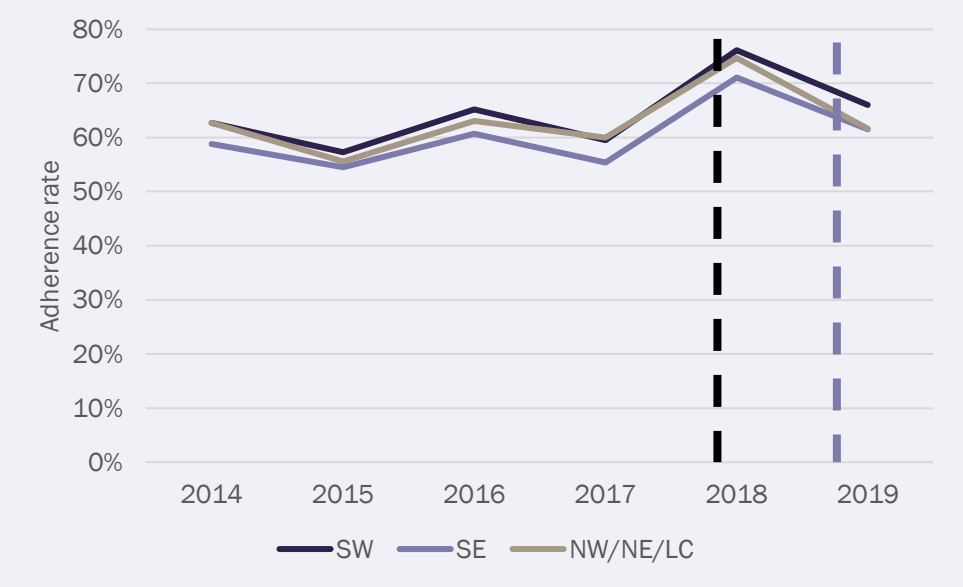


Figure 44. Antidepressant Adherence (Acute Phase)

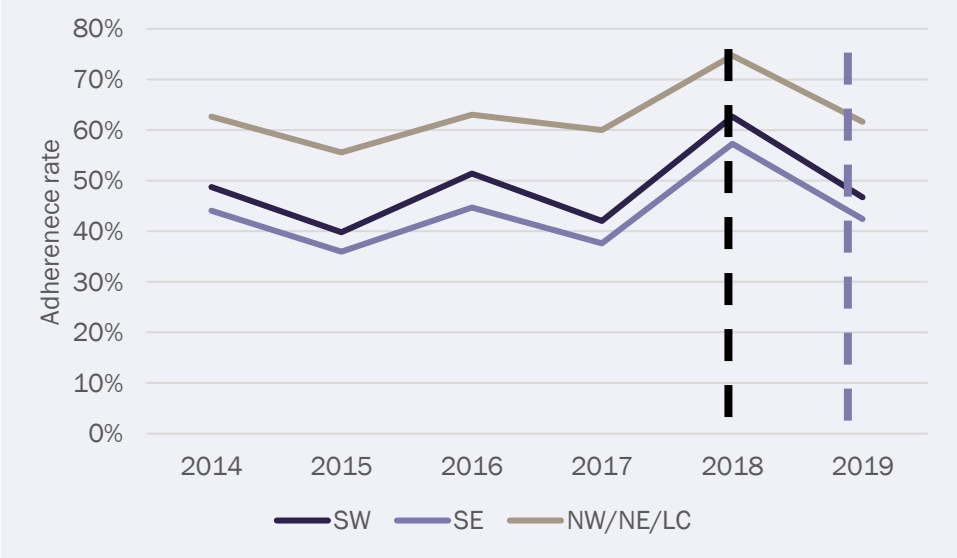


Figure 45. Antidepressant Adherence (Chronic Phase)

Outpatient Follow Up After Psychiatric Hospitalization

The MRC adapted the HEDIS measure for follow-up after inpatient psychiatric stay to incorporate both Medicaid and Medicare claims data. Two versions of the measure were constructed. The first captures follow-up within seven days of discharge from a psychiatric hospitalization with any type of provider for a mental health or substance abuse condition. The second version limits follow up to mental health providers; this version is comparable to the HEDIS Follow-up after Psychiatric Hospitalization (FUH) measure.

As can be seen on the first chart below, the rate of follow-up appears to decline in the SW and NW/NE/LC zones from 2017 to 2018 but increases in the SW in 2019. The SE zone follows an opposite trend and declines from 2018 to 2019.

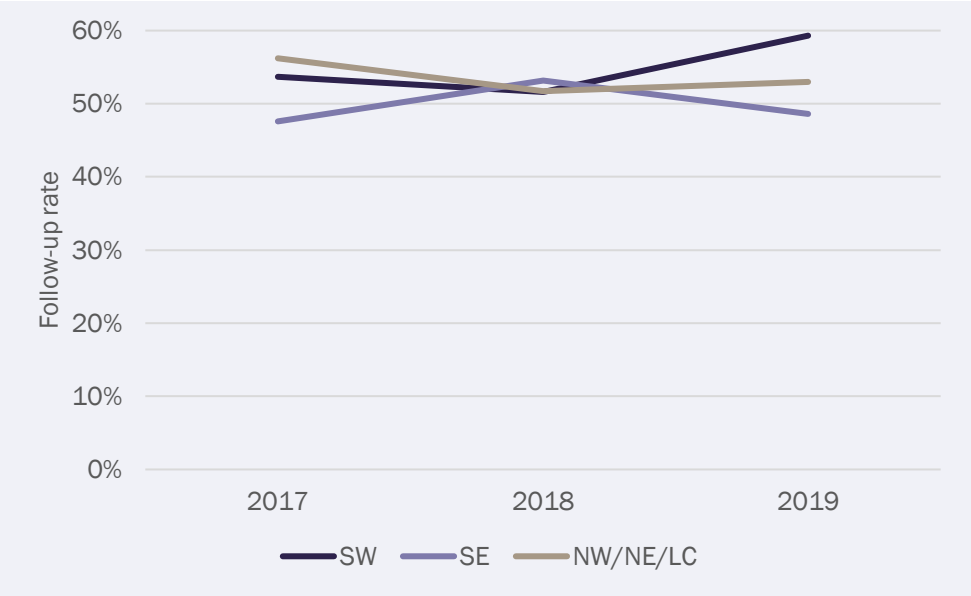


Figure 46. Follow-Up After Psychiatric Hospitalization (Any Provider)

When focusing on mental health providers, the trend in the NW/NE/LC zone is clearly downward over time. In the SW, there is no change from 2017 to 2018, followed by a slight increase. By contrast, follow up rates in the SE zone decline after implementation of CHC.

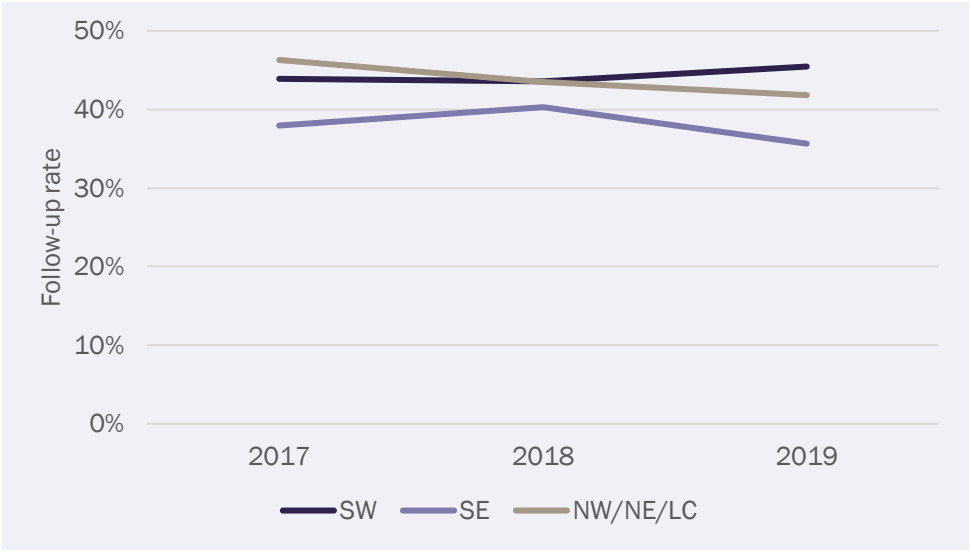


Figure 47. Follow-Up After Psychiatric Hospitalization (Mental Health Provider)

Long-Term Services and Supports

The MRC examined the quality of care provided in nursing facilities to determine whether CHC had a positive or negative impact. The likely mechanism for changes in quality of care is changes in nursing facility revenue that might adversely affect staffing levels. A comprehensive analysis of staffing levels in all free-standing nursing facilities in PA for the years 2017 to 2019 did not reveal

any changes in staffing levels.[15] Several indicators of nursing facility quality were constructed using definitions from CMS Nursing Home Compare. Nursing Home Compare reports quality of care for all residents regardless of payor. The MRC calculated selected measures for the Medicaid population. Except as noted, the following analyses include all nursing facility residents aged 21 and older.

The following figure shows Seasonal Influenza Vaccination rates by year for each zone. Since people can obtain seasonal influenza vaccinations at very low cost and without a physician visit, it is difficult to obtain population level estimates of vaccination rates. The nursing facility population is at high risk from seasonal influenza, and vaccination is tracked on the Minimum Data Set (MDS) assessment. There is no apparent time trend in this measure for this population over the time period studied.

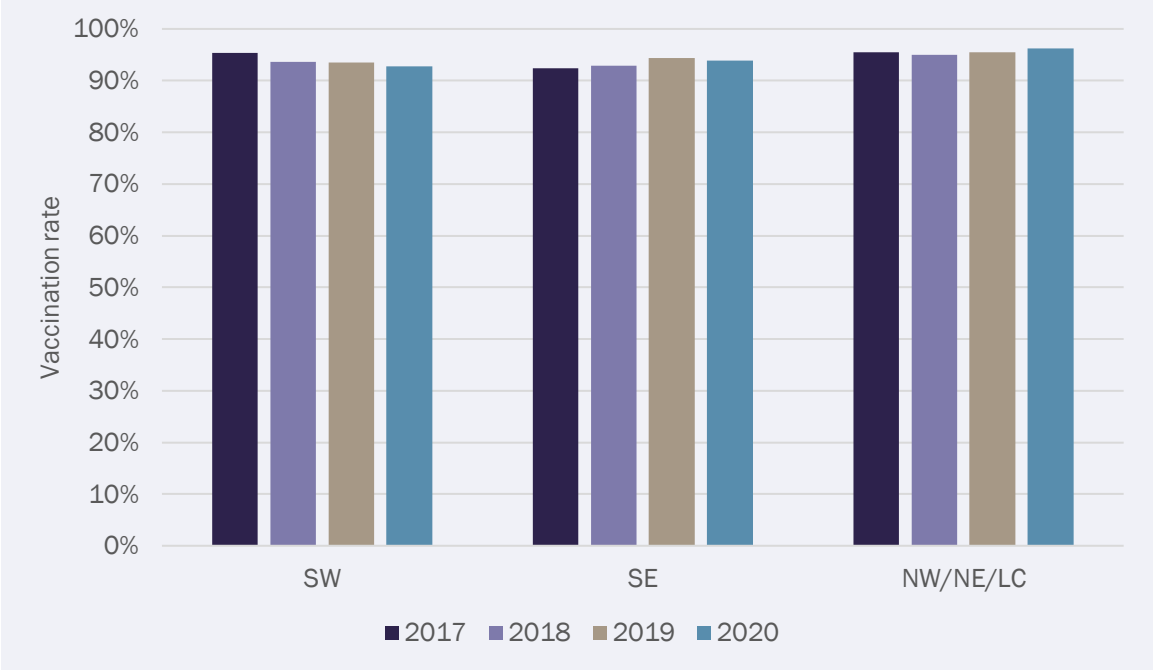


Figure 48. Seasonal Influenza Vaccination in Nursing Facilities

The following figure shows the rate of pneumonia vaccination among older nursing facility residents. There is a slight downward trend in all three zones prior to CHC, thus it is not clear that it can be attributable to the implementation of CHC. A similar trend is seen in national data published by the CDC.[16]

[15] Analysis of CMS Payroll Based Journal Data for registered nurse, licensed practical nurse, nurse aide, physical therapy, activities staff, and use of agency staff did not show any trend over time or changes concomitant with implementation of CHC in the SW or SE.

[16] Source: https://www.cdc.gov/flu/fluvaxview/interactive.htm

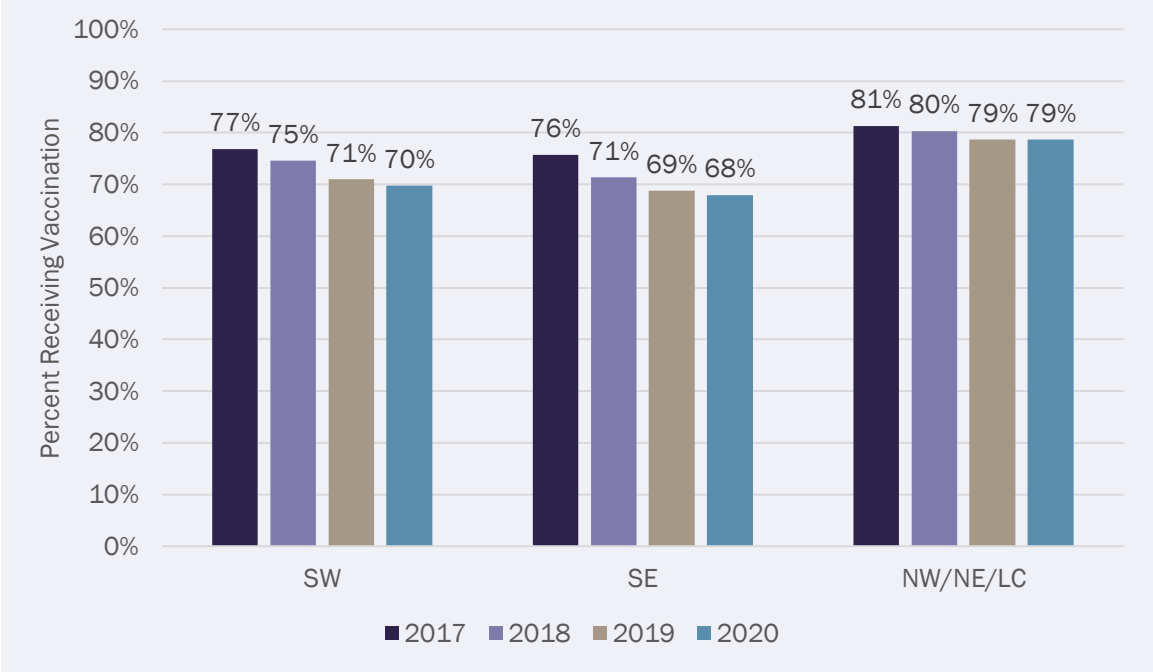


Figure 49. Pneumonia Vaccination Rate in Nursing Facilities

The rate of injurious falls among nursing facility residents is very low. However, there are apparent differences across the different zones. While there appears to be a downward trend in the SW and SE, in the NW/NE/LC zone, the rate appears to increase in 2019. It is not clear that the observed trends can be attributed to the implementation of CHC.

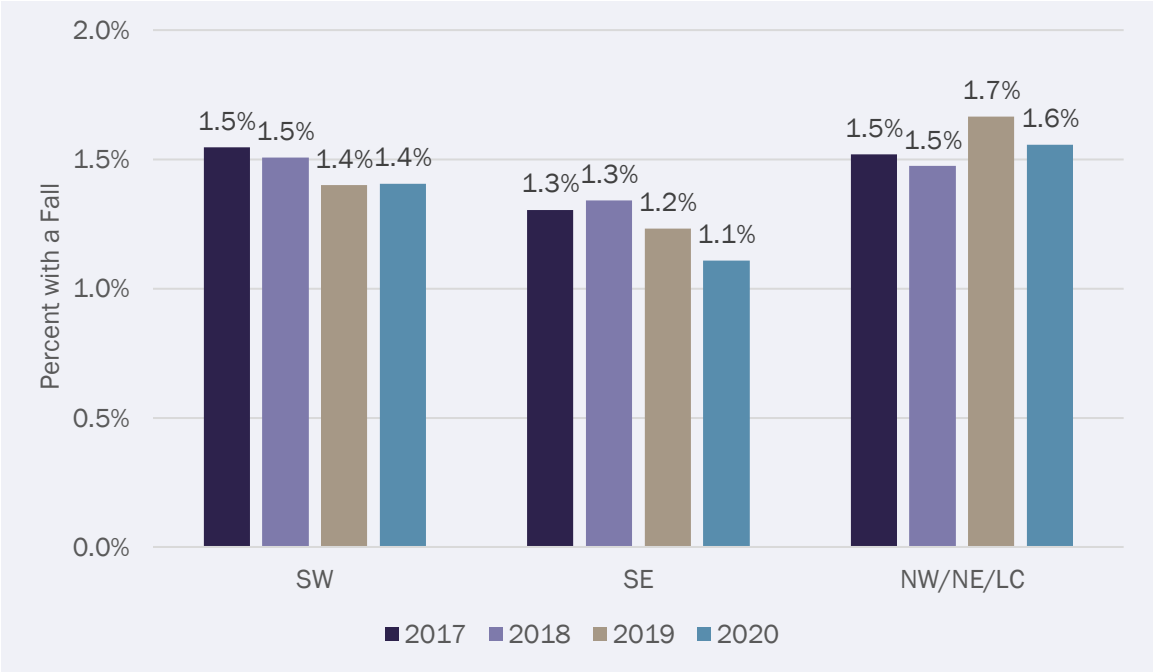


Figure 50. Injurious Falls in Nursing Facilities

Pressure ulcers among high-risk nursing facility residents varied across zone, with the highest rate seen in the SW and the lowest in the NW/NE/LC zone. There is a general downward trend, implying that this aspect of quality is improving. However, there does not appear to be an association with the implementation of CHC.

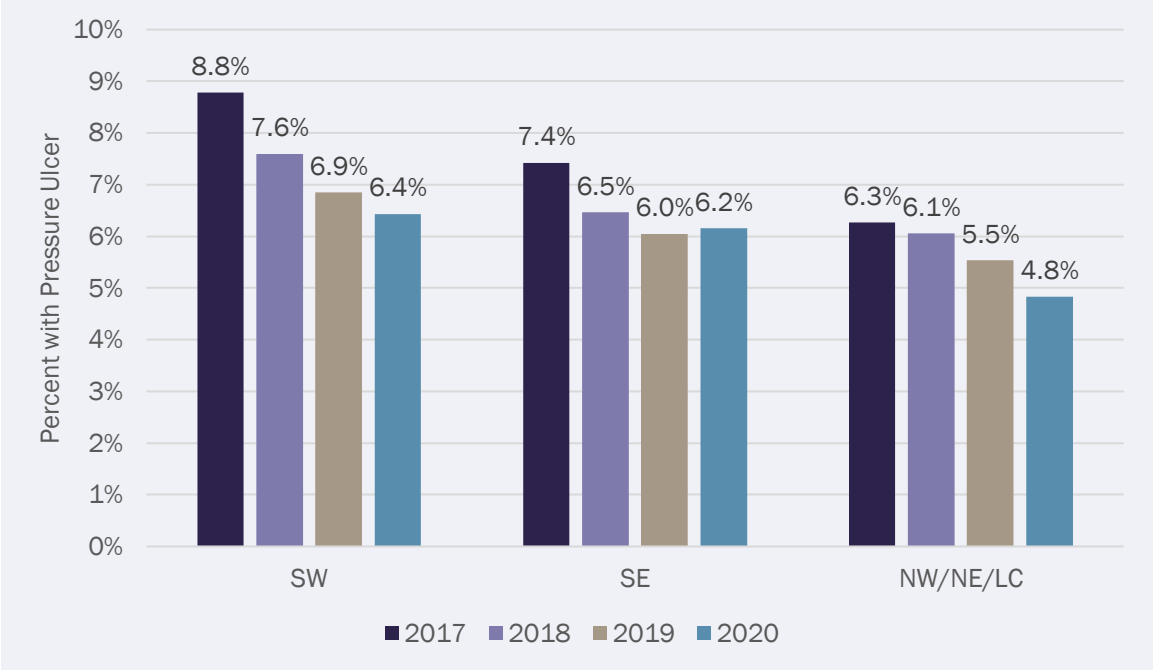


Figure 51. High Risk Nursing Facility Residents with Pressure Ulcers

The rate of pressure ulcers varies significantly with the age of CHC participants. Younger nursing facility residents (age 21-59) are much more likely to have a pressure ulcer than those over age 60. In the SW, the rate of pressure ulcers among younger residents in 2018 was 12.3%, and 7.3% among those age 60 and older. The same pattern was seen in all three zones. Although there is a large drop in the SW from 2017 to 2018, there is a similar drop in the SE and the NE/NW/LC zones. Thus, there does not appear to be a strong association with the implementation of CHC in either age group.

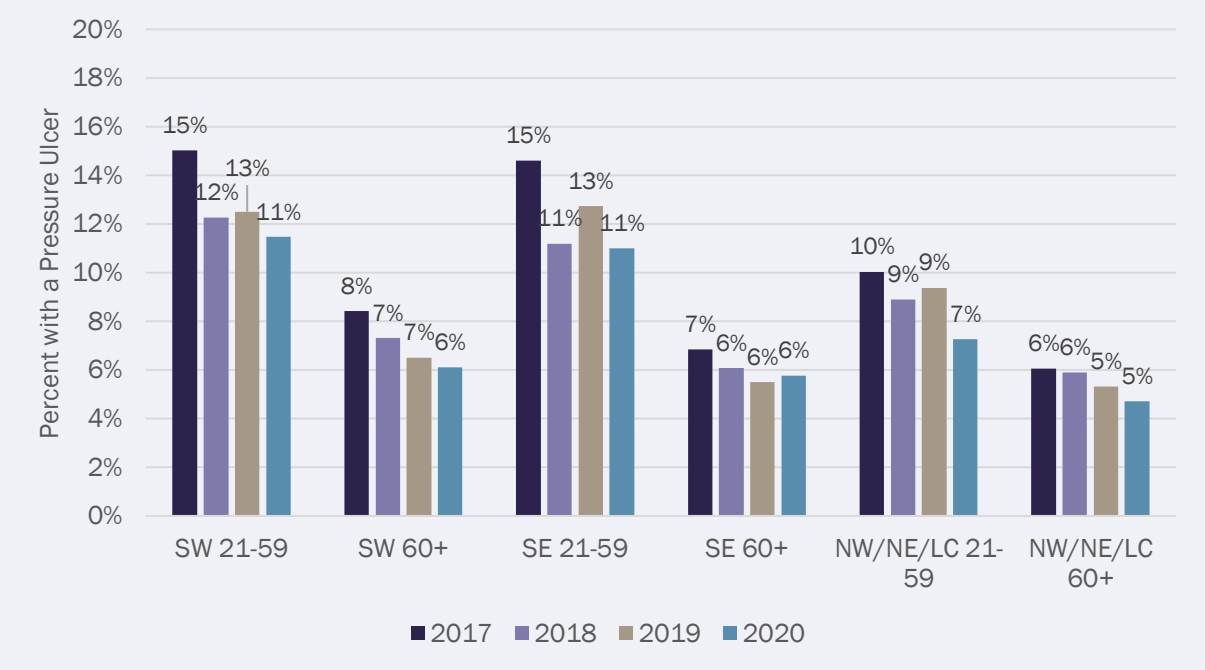


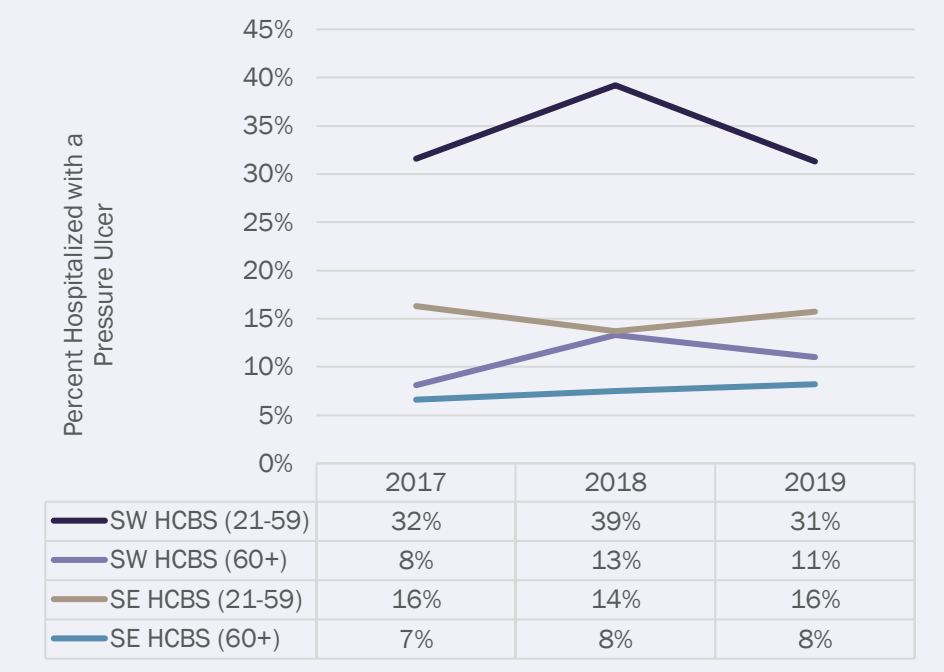
Figure 52. High Risk Nursing Facility Residents with Pressure Ulcers by Age Group

Hospitalization for Pressure Ulcers

In this section we report the rate of hospitalizations for pressure ulcer as a separate indicator of quality for HCBS users. This is based on the AHRQ Prevention Quality Indicator that is not part of the overall composite. Specifically, this measure captures the presence of a pressure ulcer as the primary or secondary diagnosis for an acute hospitalization. The chart below shows the trend for HCBS users in the SW and SE. From 2017 to 2018, the rate of hospitalization for pressure ulcer in the SW increased for both age groups, however it declined in 2019.

The rate in the SE zone increased for both age groups from 2018 to 2019. Notably, among HCBS users aged 21-59 in the SE, the rate declined prior to CHC, but increased after implementation. Among older HCBS users aged 60 and older, the rate continued on an upward trajectory.

For comparison purposes, the rate in the NW/NE/LC zone increased from 19.4 in 2017 to 33.2 in 2019 among HCBS users aged 21-59, and from 12.0 to 13.2 among HCBS users aged 60 and older over the same time period (not tabled).



	2017	2018	2019
SW HCBS (21-59)	32%	39%	31%
SW HCBS (60+)	8%	13%	11%
SE HCBS (21-59)	16%	14%	16%
SE HCBS (60+)	7%	8%	8%

Figure 53. Hospitalization for Pressure Ulcer

Person-Centered Service Planning

The PCSP is a strategy for selecting and organizing the services and supports that an individual needs to live in the community. This process is directed by the person who receives the support, providing a more meaningful care experience. The CHC program optimizes the PCSP by in-depth monitoring to assure that services are being provided in accordance with the participant's PCSP. All three CHC-MCOs are required to develop PCSPs that are informed by the interRAI™ Home Care Assessment Form along with other internal proprietary tools to develop the PCSP. The PCSPs are delivered to the participant in written form and require the participant's signature. All three CHC-MCOs store PCSPs electronically. Access to the PCSP is limited to the participant, SC, PCP, and whomever the participant deems necessary. SCs are required to monitor participants on a monthly basis and review the PCSP at least annually. If a trigger event, such as change in functional status or significant health care event occurs, SCs are required to conduct a comprehensive needs assessment and update the PCSP. Based on the assessed need, participants are able to choose service options, with the help of those on the person-centered planning team. SCs are responsible for managing the process and updating the PCSP based on the participants needs and preferences. Examples of the state's monitoring of the PCSP are discussed below.

During qualitative interviews with service coordinators and service coordination entities in 2020/2021, there was mixed feedback on the PCSP. Some felt the PCSP was very comprehensive, individualized, and encompassed all aspects of life. According to some other SCs interviewed, PCSPs are in reality not person-centered and are focused on medical needs, neglecting other aspects of care important for quality of life. Behavioral health was not adequately featured either. Some interviewees said that the PCSP is based on averages, rather than on individuals' experiences and needs. Among older adults and people with disabilities and complex health needs, health and wellbeing can vary from day to day and some SCs felt this variability was not adequately captured. Thus, PCSPs are thought to undermine the very thing they were designed to achieve -- person-centeredness.

Some SCs viewed the PCSP as a bureaucratic exercise rather than as a tool to enhance interactions with consumers and design more individualized care plans. In addition, the PCSP process was time consuming; many interviewees estimated up to six hours to complete. According to some SCs, the software used for the PCSP was not user-friendly. Specifically, they noted that the PCSP template has some redundant questions. Additionally, from the SCEs' perspective, the MCOs were more focused on cost-cutting measures than on developing relationships with consumers in a way that provided insight into their quality of life and service needs. The perspective of the MCOs was that they were distinguishing "needs" from "wants." SCEs expressed the view that the MCOs were more focused on data-driven decisions than on person-centered service coordination. This was reflected in the work that SCs were taking on. Many SCs reported they were spending increasing amounts of time on compliance and reporting rather than interacting directly with clients.

Finally, home care providers reported that SCs did not share PCSPs with them, which led to a lack of clarity about authorized services. Because SCs were not sharing assessment results with providers, some providers felt the need to conduct their own independent assessments of their clients, creating duplication of effort and the potential for conflicting information. As of this report, OLTL is taking steps to address this concern with a revision to the MCO contract agreement.

Based on findings from some of the qualitative interviews, many SCEs viewed CHC as reducing participant choice because they could select from only three MCOs. The MCO representatives who were interviewed interpreted CHC as broadening services and increasing options for HCBS. There was broad agreement among SCEs that participants were confused during the transition to CHC. According to SCs, frequent sources of confusion among participants included not knowing who one's SC was and having a reassignment in SC. SCs interviewed by the MRC stated that participants were concerned that their service plans would be cut, and they would experience a reduced number of hours approved, especially concerning PAS. Navigating the hearing and appeals process was challenging for participants as well. Delayed notification about hearings made it extremely difficult for consumers to attend their hearings. Other areas of concern included: lack of awareness about adult daily living services, and approval delays for home modifications and durable medical equipment.

PCSP Quality Indicators and Oversight

OLTL has recognized the importance of complete and effective PCSPs. To that end, WAM measure 6.g.1 and EBR SP-1 addresses the percent of waiver participants with PCSPs adequate and appropriate for their needs, capabilities, and desired outcomes. The CHC-MCOs faced some challenges in reaching the compliance benchmark of 86%, most notably:

- CHC-MCOs had difficulty integrating external SCEs into CHC-MCO activities and obtaining their cooperation during the continuity of care period
- SCs did not understand all the required elements of the PCSP and did not document all the necessary information
- Staff turnover was highest in the NE and the legacy PCSPs had the lowest compliance rate among the Phase 3 zones, particularly in the lack of back up plans and incomplete emergency evacuation plans

All three CHC-MCOs were placed on CAPs and were required to develop Quality Improvement Projects (QIPs) to address service planning barriers. Some of the CHC-MCO activities included:

- Evaluating processes
- Developing policy and procedures
- Automating processes
- Developed training materials

- Implementing monitoring procedures

To further support the improvement process, OLTL:

- Held technical assistance sessions
- Developed a checklist that outlines the required elements of a PCSP
- Provided feedback specific to each CHC-MCO

By 2021, all CHC-MCOs surpassed the performance standard of 86%. OLTL continues to monitor this process to ensure adequate performance and improvement where necessary.

Table 19. Percent of Waiver Participants with Appropriate PCSPs

Statewide (by Plan)	2018	2019	2020	2021
AmeriHealth Caritas/Keystone First	39%	73%	74%	88%
PA Health and Wellness	59%	79%	86%	96%
UPMC	5%	60%	46%	97%
All MCOs/Combined	24%	68%	69%	94%

Source: WAM, Case Management, Care Coordination, & Service Planning (#6.g.1)

The responsiveness of the PCSP is measured in part by the percentage of waiver participants with PCSPs that were revised when warranted by a change in participant needs (WAM 6.g.3). The CHC-MCOs completed QIPs when the benchmark of 86% was not met in various quarters through the first three years. QIPs included training on the need to modify the PCSPs when warranted and checking with participants during monthly calls to identify the need to modify the PCSPs. The MCOs also developed automated systems to assist in identifying trigger events. This benchmark was also part of the CAPs that addressed the development of the PCSPs. All CHC-MCOs met the performance standard in 2021.

Table 20. Percent of Waiver Participants with PCSPs Revised as Appropriate

Statewide (by plan)	2018	2019	2020	2021
AmeriHealth Caritas/Keystone First	95%	85.8%	68%	97%
PA Health and Wellness	72%	98%	100%	99.9%
UPMC	97%	94%	84%	99%
All MCOs/Combined	91%	93%	84%	99%

Source: WAM, Case Management, Care Coordination, & Service Planning (#6.g.3)

Regarding the percent of waiver participants who received authorized services in the type, scope, amount, frequency, and duration specified in the PCSP (WAM 6.g.4 and 6.h.1), the CHC-MCOs faced the same challenges that emerged regarding the development of the PCSPs. As with the other performance challenges related to PCSPs, when this benchmark was not met throughout the first three years, all three CHC-MCOs were placed on CAPs and were required to develop QIPs to address service planning barriers. The QIPs included activities such as training SCs on PCSP requirements, addressing needs identified through the comprehensive needs assessment, establishing audit procedures, and providing necessary documentation. As illustrated in the table below, two CHC-MCOs met the performance standard in 2021 and one did not. OLTL continues to monitor this process to ensure adequate performance and improvement where necessary.

Table 21. Percent of Waiver Participants who Received Services per Their PCSP

Statewide (by Plan)	2018	2019	2020	2021
AmeriHealth Caritas/Keystone First	89%	95%	75%	78%
PA Health and Wellness	70%	88%	100%	99.8%
UPMC	89%	92%	60%	98%
All MCOs/Combined	84%	90%	78%	92%

Sources: WAM, Case Management, Care Coordination, & Service Planning (#6.g.4); Utilization Management Activities (#6.h.1)

Participant Experience Regarding Person Centered Service Planning

The following figure presents participant ratings regarding the PCSP. The MRC compared responses from interviews conducted in the SW and SE prior to implementation to responses to interviews conducted after implementation. The composite measures of choosing services, planning care and personal safety were based on NCQA definitions. As can be seen, participant ratings of the PCSP decline very slightly, however the difference is not significant. The overall rate of about 80-82% suggests room for improvement.

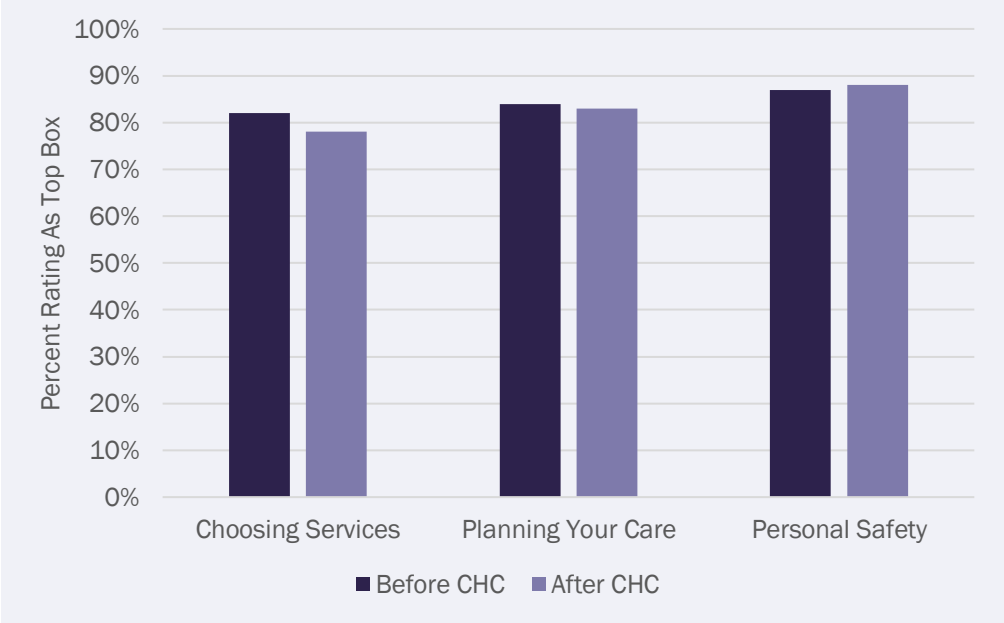


Figure 54. Participant Experience with Person-Centered Service Planning
Note: Top-box score is the percentage of participants rating each item as 9 or 10 on a 10- point scale.

Complaints, Grievances and Appeals

The project team reviewed the effectiveness of MCO grievance and appeal process; beneficiary, provider, and subcontractor understanding/knowledge of grievance processes; and state efforts to monitor grievance patterns for MCOs and providers. Measures include (tables below):

- Complaints per 10,000 participants
- Grievances per 10,000 participants
- Average days to resolve a complaint review
- Average days to resolve a first level complaint
- Average days to resolve a second level complaint
- Average days to resolve a grievance

There is no explicit standard from CMS for the metric of complaints per 10,000 participants (WAM 6.c.1). OLTL has not set a benchmark but is monitoring trends. During 2018 and 2019, the complaint rates for AmeriHealth Caritas/Keystone First were comparatively low because of a process that sought to resolve concerns while the participant was on the telephone in an effort to avoid the need for participants to file a formal complaint. By 2020 and 2021, rates were more consistent across CHC-MCOs. Types of complaints include but are not limited to: complaints about CHC-MCO SCs, participants not understanding services were now being provided by the CHC-MCOs, and non-covered LTSS items.

***Table* 22. Total Complaints per 10,000 Participants**

Statewide (by plan)	2018	2019	2020	2021
AmeriHealth Caritas/Keystone First	9.8	3.8	72.3	109.8
PA Health and Wellness	93.0	93.1	51.3	62.0
UPMC	100.2	110.3	80.6	102.4
All MCOs/Combined	79.6	61.6	70.0	96.5

Source: WAM, Grievances and Appeals (#6.c.1)

Regarding the metric of grievances per 10,000 participants (WAM 6.c.2), there is no explicit standard from CMS. OLTL has not set a benchmark but continues to monitor trends. All three CHC-MCOs showed an increase in grievances per 10,000 over the first three years of CHC. Contributing to that increase, there are several possible reasons for the variation in rates among plans across years, including the following as examples. In Q2 2019, PHW experienced an increase due to increases in denials related to pharmacy. Q3 2019 saw an increase across CHC-MCOs primarily driven by grievances for PAS services. In Q4 2019, UPMC's increase was due to the annual reassessments of SW participants and determinations about necessary services. However, across the three years, the main grievance category for all the CHC-MCOs was PAS. As the CHC-MCOs began reassessing participants after the continuity of care period, they began adjusting PCSPs accordingly and issuing denials, which increased the number of grievances filed. OLTL determined no remediation was necessary.

***Table* 23. Total Grievances per 10,000 Participants**

Statewide (by plan)	2018	2019	2020	2021
AmeriHealth Caritas/Keystone First	29.7	15.1	474.3	379.0
PA Health and Wellness	79.4	143.3	160.9	607.4
UPMC	46.2	111.6	187.1	195.5
All MCOs/Combined	52.1	79.3	300.0	368.2

Source: WAM, Grievances and Appeals (#6.c.2)

WAM 6.c.3 monitors the length of time it takes to resolve a complaint. In 2018 and 2019, the reporting metric was the average number of days to resolve a complaint review. This measure was modified starting January 1, 2020, to identify the percent of complaint reviews resolved within 30

calendar days or less. The new benchmark is resolving 86% or more complaint reviews within 30 calendar days. PA Health and Wellness did not have any complaint reviews in 2020 or 2021. AmeriHealth Caritas/Keystone First and UPMC reported missing the benchmark for occasional quarters regionally but met the benchmark when aggregated for both 2020 and 2021. Because performance improved in subsequent quarters, remediation was not necessary.

Table 24. Timeliness of Complaint Resolution

Statewide (by plan)	2018	2019	2020	2021
AmeriHealth Caritas/Keystone First	26 days	7 days	93%	98%
PA Health and Wellness	29 days	7 days	N/A	N/A
UPMC	23 days	20 days	99%	95%
All MCOs/Combined	26 days	11 days	97%	97%

Source: WAM, Grievances and Appeals (#6.c.3)

Note: For years 2018-2019 this was measured as the average days to resolve a complaint. In 2020 and 2021, this was measured as the percent of complaints resolved within 30 calendar days or less.

WAM 6.c.4 monitors the length of time it takes to resolve a first level complaint. In 2018 and 2019, the reporting metric was the average number of days to resolve a first level complaint. This measure was modified starting January 1, 2020, to identify the percent of first level complaints resolved within 30 calendar days or less. The new benchmark is resolving 86% or more first level complaints within 30 calendar days.

PA Health and Wellness did not meet the measure in any zone for Q3 and Q4 of 2020. They experienced an increase in the volume of complaint and grievance requests because of the end of the continuity of care period and the expiration of OLTL's moratorium on service reductions and denials due to COVID-19. The MCO implemented a QIP to increase staffing; and to increase timeliness monitoring, training, and process enhancements. The CHC-MCOs also increased non-clinical and Medical Review staff to handle the increased volume of complaints and grievances. Real-time reporting was enhanced to track complaint and grievances through each stage of the process. A peer review process was instituted to ensure timely communication and notification to participant. All CHC-MCOs met the benchmark at the aggregate level for 2020 and 2021.

Table 25. Timeliness of 1st level Complaint Resolution

Statewide (by plan)	2018	2019	2020	2021
AmeriHealth Caritas/Keystone First	24 days	8 days	97%	100%
PA Health and Wellness	25 days	29 days	90%	91%
UPMC	23 days	22 days	99%	99%
All MCOs/Combined	24 days	20 days	96%	98%

Source: WAM, Grievances and Appeals (#6.c.4)
Note: In 2018-2019 this was measured as the average days to resolve a 1st level complaint. In 2020-2021 this was measured as the percent of 1st level complaints resolved within 30 calendar days or less.

WAM 6.c.5 monitors the length of time it takes to resolve a second level complaint. In 2018 and 2019, the reporting metric was the average number of days to resolve a second level complaint. This measure was modified starting January 1, 2020, to identify the percent of second level complaints resolved within 45 calendar days or less. The new benchmark is resolving 86% or more second level complaints within 45 calendar days.

All three CHC-MCOs met the benchmark in 2020 and 2021. There were some instances where CHC-MCOs did not meet the benchmark at the zone quarter level, although they met at the aggregate

annual levels. The CHC-MCOs identified the barriers as difficulty with scheduling timely second level complaint meetings due to increased volumes, difficulty reaching participants, and the timeliness of issuing outcome letters. As a remedial action, the CHC-MCOs implemented process improvements to expand capacity to handle meetings and issue decision notices.

Table 26. Timeliness of 2nd Level Complaint Resolution

Statewide (by plan)	2018	2019	2020	2021
AmeriHealth Caritas/Keystone First	N/A	2 days	89%	100%
PA Health and Wellness	24 days	22 days	100%	100%
UPMC	37 days	21 days	100%	98%
All MCOs/Combined	31 days	15 days	96%	99%

Source: WAM Grievances and Appeals (#6.c.5)
Note: In 2018-2019 this was measured as the average days to resolve a 2nd level complaint. In 2020-2021 this was measured as the percent of 2nd level complaints resolved within 45 calendar days or less.

WAM 6.c.6 monitors the length of time it takes to resolve a grievance. In 2018 and 2019, the reporting metric was the average number of days to resolve a grievance. This measure was modified starting January 1, 2020, to identify the percent of grievances resolved within 30 calendar days or less. The new benchmark is resolving 86% or more grievances within 30 calendar days.

AmeriHealth Caritas/Keystone First and UPMC met the benchmark at the aggregated level for 2020. PA Health and Wellness did not meet the aggregate level for 2020 or in any zone for Q3 and Q4 2020. The CHC-MCO experienced an increase in the volume of complaint and grievance requests as a result of the end of the continuity of care period and the expiration of OLTL's moratorium on service reductions and denials due to COVID-19. As a remedial action, this CHC-MCO implemented a QIP to increase staffing; and to increase timeliness monitoring, training, and process enhancements. The CHC-MCO increased non-clinical and Medical Review staff to handle the increased volume of complaints and grievances. Real-time reporting was enhanced to track complaints and grievances through each stage of the process. A peer review process was instituted to ensure timely communication and notification to participants. Training, peer review, and volume oversight were implemented in Q4 2020. OLTL has implemented more frequent reporting for this CHC-MCO to better monitor performance. All CHC-MCOs met the benchmark in 2021.

Table 27. Timeliness of Grievance Resolution

Statewide (by plan)	2018	2019	2020	2021
AmeriHealth Caritas/Keystone First	22 days	10 days	97%	100%
PA Health and Wellness	23 days	25 days	57%	88%
UPMC	23 days	23 days	99%	88%
All MCOs/Combined	23 days	19 days	92%	95%

Source: WAM, Grievances and Appeals (#6.c.6)
Note: In 2018-2019 this was measured as the average days to resolve a grievance. In 2020-2021 this was measured as the percent of 1st level grievances resolved within 30 calendar days or less.

Reversed Denials

Beginning in 2019, CHC-MCOs reported on the percent of pharmacy denial cases reviewed that OLTL determined to be compliant with CHC requirements, as illustrated in WAM 6.h.2. Although each CHC-MCO failed to meet the performance benchmark of 86% once or twice in separate zones within Q1

and Q2 of 2019, the annual performance exceeded the benchmark. OLTL worked with the CHC-MCOs to address non-compliant areas, and performance continued to improve in 2020 as illustrated in the chart below.

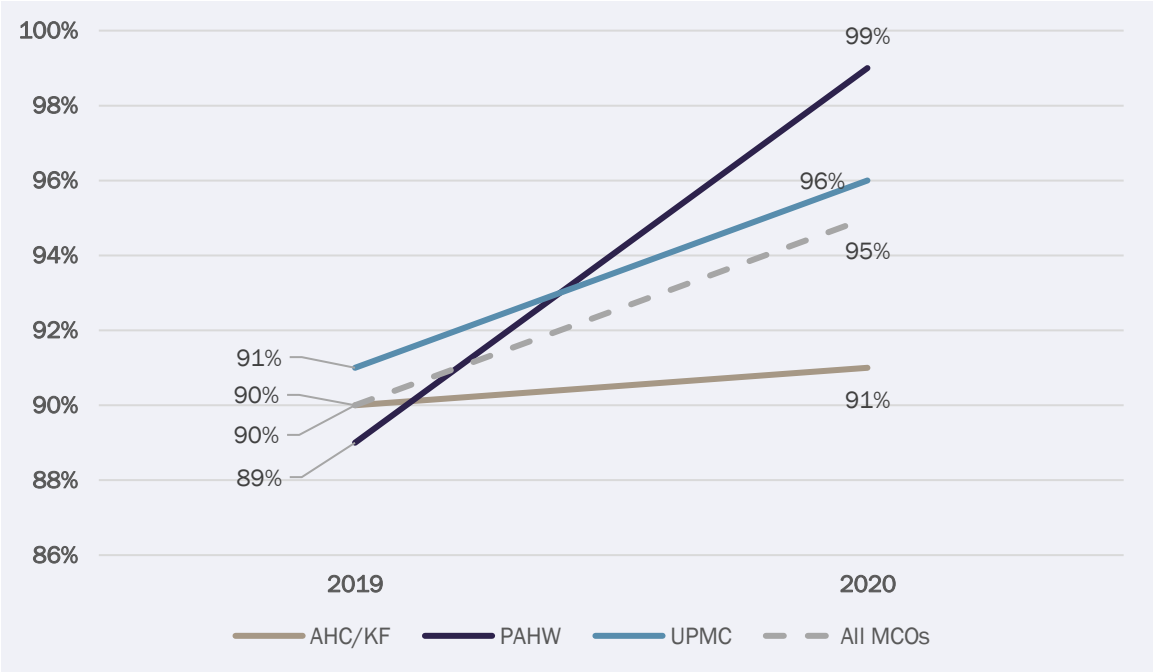


Figure 55. Percent of Pharmacy Denial Cases Reviewed that were Determined to be Compliant
Source: WAM, Utilization Management Activities (#6.h.2)

In 2019, OLTL implemented a measure of the physical health denial cases that were reviewed and subsequently determined compliant (WAM 6.h.3). AmeriHealth Caritas/Keystone First and PA Health and Wellness did not meet the benchmark of 86% in both zones in most quarters of 2019. Areas of non-compliance included readability of the denial notice, meeting the required timeframes, incomplete and inaccurate documentation, and appropriateness of denial. To remediate performance, these CHC-MCOs implemented QIPs to develop policy and procedures and train staff to improve documentation, readability, and appropriateness of decisions. UPMC met the benchmark statewide and in all zones and all quarters of 2019. Statewide performance met the benchmark in 2020 and 2021 as illustrated in the table below.

Table 28. Percent of Physical Health Denial Cases Reviewed that Were Determined Compliant

Statewide (by Plan)	2019	2020	2021
AmeriHealth Caritas/Keystone First	82%	87%	91%
PA Health and Wellness	67%	93%	97%
UPMC	92%	95%	99%
All MCOs/Combined	79%	91%	96%

Source: WAM, Utilization Management Activities (#6.h.3)

In 2019, OLTL implemented a measure of HCBS denial cases that were reviewed and subsequently determined compliant (WAM 6.h.4). UPMC met the benchmark of 86% statewide in all quarters for 2019-2021. AmeriHealth Caritas/Keystone First and PA Health and Wellness met the benchmark intermittently. Areas of non-compliance included readability of the denial notice, meeting the required timeframes, incomplete and inaccurate documentation, and appropriateness of the denial.

To remediate performance, PA Health and Wellness implemented QIPs to develop policy and procedures and train staff to improve documentation, readability, and appropriateness of decisions; performance improved substantially and the CHC-MCO met the benchmark in 2020 and 2021. AmeriHealth Caritas/Keystone First implemented QIPs to accurately document information, use of templates, allowing the necessary time for providing additional information, providing necessary documentation, and properly documenting PCSPs. The CHC-MCO continued to underperform on this measure statewide in all quarters of 2020 and in Q1, Q2 and Q3 of 2021, reaching the benchmark in Q4 of 2021; however, annual performance was just below the benchmark. OLTL's clinical review team held meetings with the MCOs to discuss compliance issues and assist the MCOs.[17]

Table 29. Percent of HCBS Denial Cases Reviewed that were Determined Compliant

Statewide (by Plan)	2019	2020	2021
AmeriHealth Caritas/Keystone First	87%	80%	85%
PA Health and Wellness	47%	96%	96%
UPMC	92%	95%	98%
All MCOs/Combined	74%	90%	93%

Source: WAM, Utilization Management Activities (#6.h.4)

Critical Incidents

The MRC reviewed data on critical incidents reported by the CHC-MCOs. This is based on aggregate statistics that capture the number of events and the proportion of events where appropriate actions have been document. Selected measures are summarized here. The MCOs are required to track substantiated cases of abuse, neglect or exploitation and report whether appropriate action has been taken (EBR HW-9). This measure was introduced in mid-2020, and two of the three MCOs addressed 100% of cases in every quarter from 2020 Q2 to 2021 Q3 (the most recent quarter with available data). One MCO (AmeriHealth Caritas/Keystone First) missed the 86% benchmark in 2020 Q2 and 2020 Q4. While AmeriHealth Caritas/Keystone did not address 100% of cases in either year, they met the 86% benchmark in 2021 Q1-Q3.

[17] In 2022, OLTL revised the 2022 CHC Agreement to clarify required timeframes for notifying participants on decisions around service requests. In addition, OLTL revised the reporting directions and templates to ensure more consistent and accurate data collection.

One measure, "Percent of unexplained deaths for which review/investigation occurred" (WAM 6.m.1) was revised in 2020 to "Percent of unexplained deaths where appropriate follow-up or steps were taken." In 2019, AmeriHealth Caritas/Keystone First did not meet the performance measure in some quarters due to lack of documentation by the individual entering incidents into the Enterprise Incident Management (EIM) system as to whether a death was unexplained or due to natural causes. AmeriHealth Caritas/Keystone First subsequently implemented a written standard procedure, requiring the entry of information into EIM that has been substantiated through the investigation process when making determinations. All MCOs met the annual benchmark in 2020 and 2021.

Table 30. Percent of Unexplained Deaths with Appropriate Follow-Up (2018-2021)

Statewide (by Plan)	2018	2019	2020	2021
AmeriHealth Caritas/Keystone First	50%	86%	93%	100%
PA Health and Wellness	100%	100%	100%	100%
UPMC	100%	100%	100%	100%
All MCOs/Combined	92%	95%	93%	100%

Source: WAM, Critical Incident Reporting (#6.m.1)
Note: For 2018 and 2019, chart represents the percentage of participants for which review, or investigation occurred. In 2020 and 2021, percentage represent whether appropriate follow-up steps were taken

For this report, we focus on a different measure for HCBS participants (WAM 6.m.2) that captures critical incidents more broadly. In 2018, the measure was defined as "Percent of waiver participants with more than 3 reported critical incidents within last 12 months based on trend analysis." In 2020, the measure was redefined as the "Percent of incidents for CHC waiver participants each month with more than 3 reported incidents within past 12 months where results of trend analysis were addressed by the CHC-MCO." AmeriHealth Caritas/Keystone First faced some challenges and identified that the barrier was the lack of SC follow up and understanding how to do a trend analysis. The CHC-MCO addressed the problem by establishing a process where quality staff checked on the status with the SC every five days. The CHC-MCOs also trained SCs on what is necessary to address the results of participant barriers and how to complete a trend analysis. All MCOs met the annual benchmark in 2019-2021.

Table 31. Critical Incidents Among HCBS Participants Resolved Appropriately (2018-2021)

Statewide (by plan)	2018	2019	2020	2021
AmeriHealth Caritas/Keystone First	74%	89%	90%	93%
PA Health and Wellness	100%	100%	100%	100%
UPMC	100%	100%	100%	100%
All MCOs	97%	97%	95%	97%

Source: WAM, Critical Incident Reporting (#6.m.2).
Note: For years 2018-2019, chart reflects the percent of waiver participants with more than 3 reported critical incidents within last 12 months for which results were addressed/investigation occurred. For 2020-2021, chart reflects the percent of incidents for CHC waiver participants each month with more than 3 reported incidents within past 12 months where results of trend analysis were addressed by the CHC-MCO.

Cultural Competency

The CHC-MCOs have addressed cultural competency through various means, including offering correspondence in languages other than English including Spanish, Russian, Mandarin, Arabic,

Korean, Cambodian, and American Sign Language. PCSPs are required to include cultural considerations of the participant. One of the MCOs provides a list of resources for the LGBTQ community. Other resources exist on the CHC-MCO websites like the Americans with Disabilities Act, resources on assistive technology, and accolades for companies which demonstrate a strong commitment to diversity in the workplace.

FINDINGS: COST-EFFECTIVENESS

To examine the impact of CHC on cost-effectiveness, the MRC conducted several analyses. First, we report total Medicaid spending over time, by zone. Next, we report total per person per month (PMPM) spending and PMPM spending in LTSS vs. all other spending. We then decompose LTSS spending into Nursing Facility vs. HCBS spending. We use difference-in-difference models to test whether changes in spending are statistically significant. One strength of the difference-in-difference model is that each zone is compared to itself over time, thus differences in acuity or historical levels of spending between zones does not affect the results. However, it is possible that the acuity might change within a zone over time. Therefore, secondary analyses (see Attachment 3) were conducted for all spending measures in this section to determine if there such changes occurred that may have affected use or spending. That analysis revealed that there were no changes in acuity over time and also that adjusting for acuity did not change the overall conclusions about Medicaid spending. The results presented here are therefore based on the unadjusted analysis. Finally, we use the results of these analyses to estimate the counterfactual: what would Medicaid spending have been in the absence of CHC?

Total Medicaid Spending

Total Medicaid spending was calculated using the sum of provider payments based on claims and encounter data.[18] In 2016, total Medicaid spending was $6.30 billion. This rose to $8.58 billion in 2020 (See Figure below). The dashed vertical lines indicate the Phase I implementation in 2018, Phase II in 2019 and Phase III in 2020. Spending in the SW zone increased from $1.26 billion to $1.33 billion over this time period.[19] By contrast, spending in the SE zone increased from $2.68 billion to $4.45 billion.

[18] Claims data were used for years prior to CHC implementation. MRC did not examine capitation rates.

[19] Total spending in the SW declined from $1.26 billion in 2016 to $1.24 billion in 2017 and $1.21 billion in 2018 but increased to $1.3 billion in 2019. This dip was not seen in other regions.

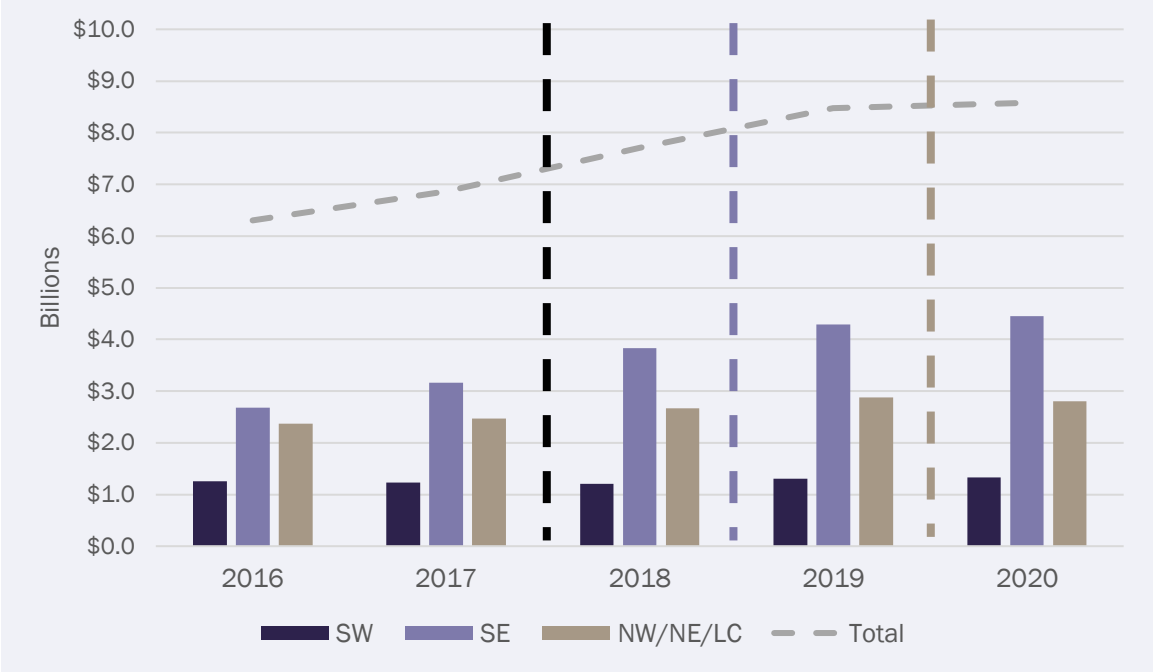


Figure 56. Total Medicaid Spending, Billions (2016 to 2020)

Total Medicaid Spending (Per Person Per Month)

Over the time period from 2016 to 2020, the number of people eligible for and participating in CHC grew substantially. Thus, to understand whether the CHC program is having an impact on spending, it is important to examine the average spending per person per month.

As can be seen in the figure below, the average Medicaid PMPM spending in the SW increased slightly from $1,313 in 2016 to $1,444 from 2016 to 2020. By contrast, Medicaid spending in the SE was $1,853 in 2016 and increased by nearly $1,000 to $2,707 in 2020. The dashed lines indicate each implementation in Phase I (2018), Phase II (2019) and Phase III (2020).

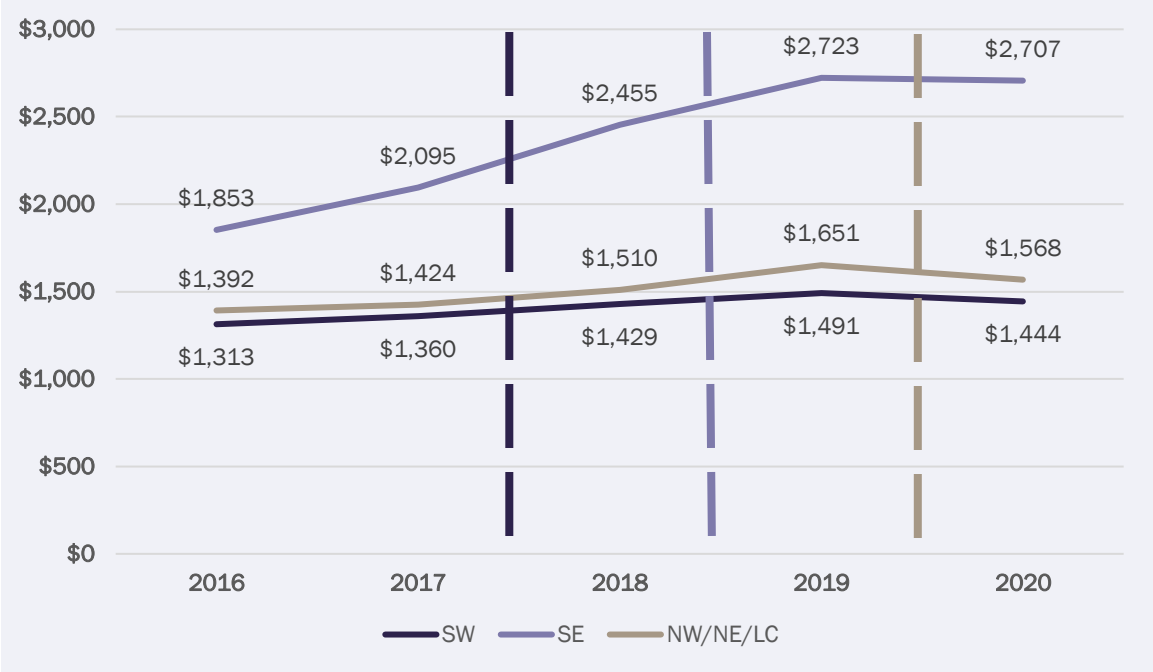


Figure 57. Average Medicaid Spending (PMPM, 2016 to 2020)

Medicaid Spending by Category (2016 to 2020)

We examined average spending in broad categories (Nursing facility, HCBS, and Non-LTSS) over the years 2016 to 2020. For this analysis, the denominator was the entire CHC population. In other words, we calculated the average Nursing Facility spending for the entire population. The following figure shows how spending was distributed across these categories. In general, the proportion of spending on non-LTSS and nursing facilities declined over time, while the proportion of spending on HCBS increased. The proportion of spending on non-LTSS declined from 15.7% of total spending in 2016 to 16.2% in 2019. The proportion of spending on nursing facilities decreased from 47% to 32% in 2019. The proportion of spending on HCBS increased from 37% to 52% in 2019.

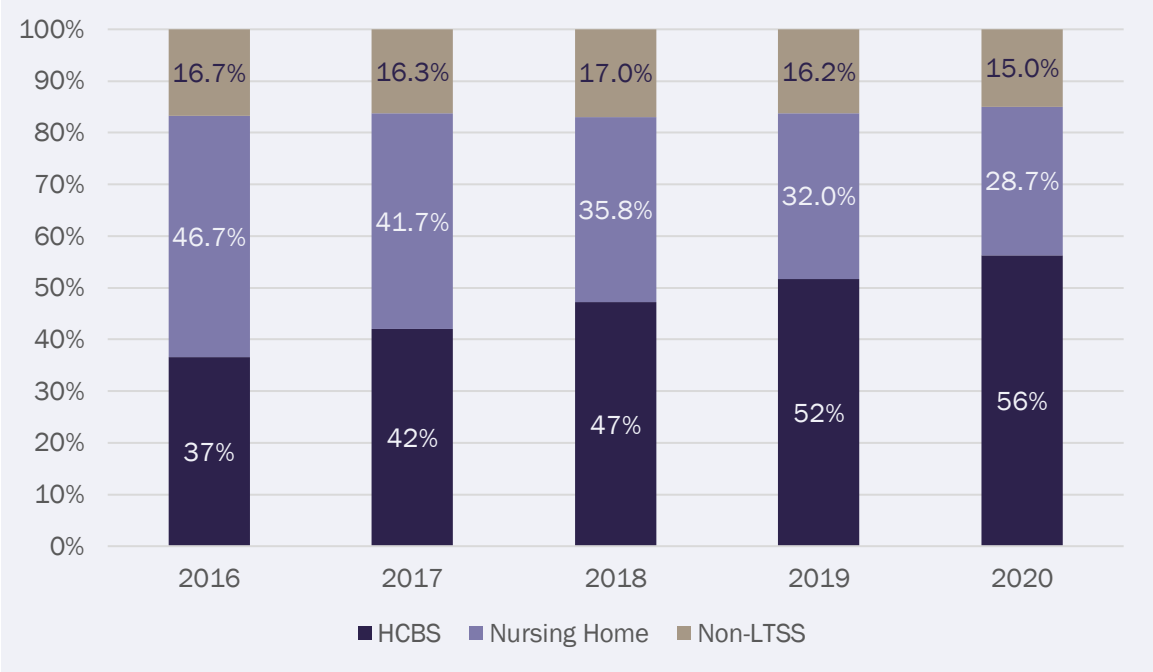


Figure 58. Distribution of Medicaid Spending by LTSS Category (2016 to 2020)

Average NFI Spending PMPM (2016 to 2020)

In the SW and NW/NE/LC zones, the average PMPM non-LTSS spending was essentially unchanged in 2016 and 2017. By contrast, as seen on the following figure, in the SE, non-LTSS spending was increasing by an average of $37 each year. The vertical dashed lines represent the implementation in Phase I (2018), Phase II (2019), and Phase III (2020). In 2018, spending increased in the SW somewhat faster relative to the NW/NE/LC zone, at about $47 PMPM. Compared to the SE, the relative increase in the SW was only $24, owing in part to the steady increase in the SE. In the SE, non-LTSS spending increased relative to the NW/NE/LC zone by about $58 PMPM.

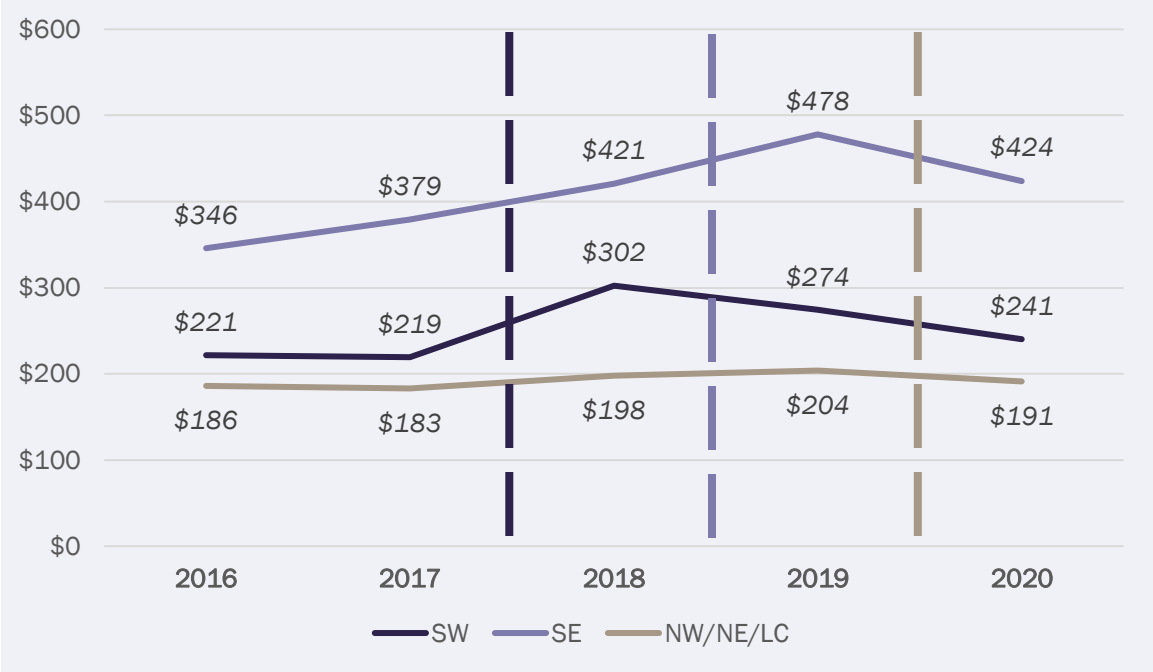


Figure 59. Average PMPM Non-LTSS Spending (2016 to 2020)

Average Nursing Facility Spending PMPM (2016 to 2020)

Average spending on NF care was essentially unchanged over the entire time period. The following figure shows the average spending PMPM on nursing facility care for CHC participants living in a nursing facility that month. The vertical dashed lines represent the implementation in Phase I (2018), Phase II (2019), and Phase III (2020). There was essentially no change in PMPM spending associated with the implementation of CHC.

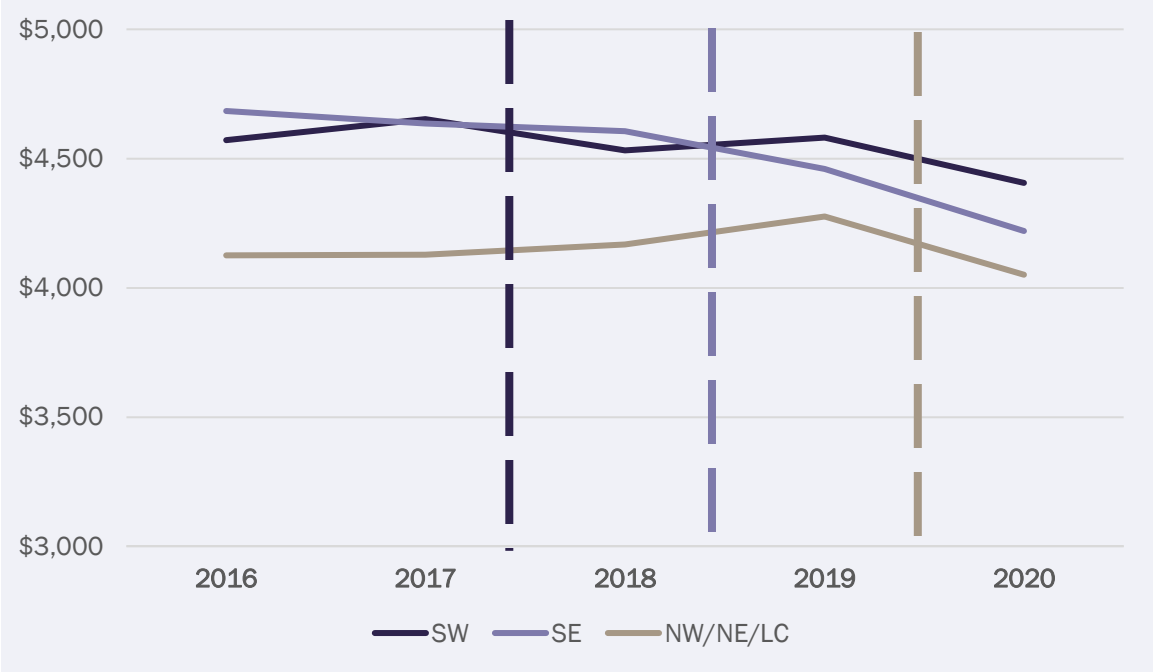


Figure 60. Average Medicaid Nursing Facility Spending (PMPM, 2016 to 2020)

Average HCBS Spending PMPM (2016 to 2020)

We first examine HCBS spending for people aged 21-59. As seen on the following figure, in 2016 to 2017, average spending was quite consistent across all three zones, at around $3,700 PMPM. The vertical dashed lines represent the implementation in Phase I (2018), Phase II (2019), and Phase III (2020). Spending increased to about $4,000 PMPM in 2017. However, with the implementation of CHC in the SW in 2018, spending was $3,684 PMPM. We note that there is a global drop in PMPM spending in 2020 due to the COVID-19 pandemic.

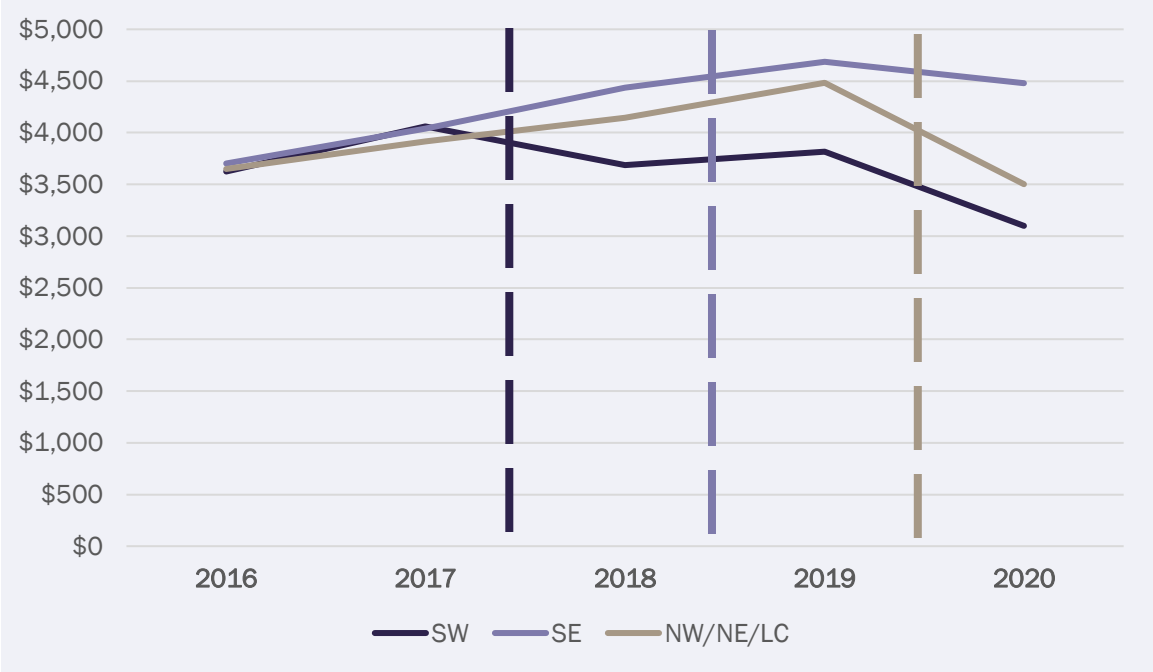


Figure 61. Average HCBS Spending, Age 21-59 (2016 to 2020)

The following figure presents the average HCBS spending for CHC participants aged 60 and older. The vertical dashed lines represent the implementation in Phase I (2018), Phase II (2019), and Phase III (2020). In all three zones, spending was about $2,900 PMPM in 2016, increasing to about $3,500 in 2017. In 2018, after the implementation of CHC, spending in the SW declined slightly from $3,362 in 2017 to $3,176 in 2018, and increased slightly to $3,403 in 2019.

To determine if the change in spending is different from the underlying trend, we compared the change in the SW to the NW/NE/LC zone. Compared to the NW/NE/LC, the implementation of CHC in the SW was associated with a decrease of $647 PMPM. Compared to the SE, the implementation of CHC in the SW was associated with a decrease of $749. The implementation of CHC in the SE was associated with a decrease of $105 compared to the NW/NE/LC zone.

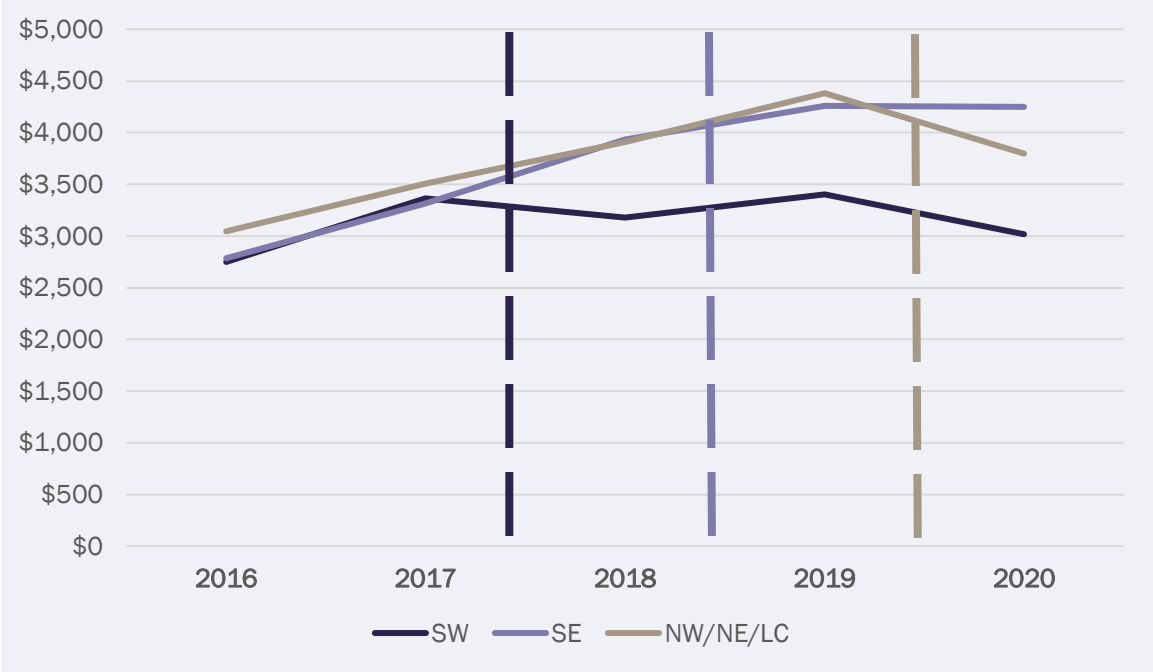


Figure 62. Average HCBS Spending, Age 60+ (2016 to 2020)

Projected HCBS Spending the Absence of CHC

As a measure of the overall cost-effectiveness of CHC, we focused on HCBS spending. As noted above on Figure 58. Distribution of Medicaid Spending by LTSS Category (2016 to 2020), LTSS consumed 85% of CHC spending in 2020. Over the time period from 2016 to 2020, average PMPM non-LTSS spending increased very slightly and average PMPM nursing facility spending was unchanged. Thus, change in HCBS spending is the critical measure of the efficiency of the program. This analysis is limited to the SW and SE zones to avoid confounding the effect of the COVID-19 pandemic with savings that are attributable to CHC.

To estimate savings, we used the average pre-implementation trend in the SW and SE zones (see table below) for each age group.[20] As can be seen on the table below (column labelled pre-implementation trend), PMPM spending was increasing in both age groups every year from 2016 to 2017 (SW) and 2016 to 2018 (SE). Projection of PMPM spending in each age group and zone for 2019 suggests PMPM in the range of $4,466 to $4,938. The actual 2019 PMPM spending was lower in the SW by $1,123 among people ages 21-59 and $1,186 among people ages 60 and older. Based on the actual number of person-months in 2019 in each age group, it is estimated that spending was about $267 million lower than it would have been in the absence of CHC.

[20] As noted above and in Attachment 3, there were no substantive changes in average acuity, therefore the unadjusted trend is used for this projection analysis.

Table 32. Projected HCBS PMPM

	Pre-Implementation Trend	Projected 2019	Actual 2019	Difference	Person Months	Spending Impact
Age 21-59						
SW	$439	$4,938	$3,814	-$1,123	51,855	$58,245,455
SE	$367	$4,775	$4,686	-$89	219,363	$19,584,729
Age 60+						
SW	$613	$4,589	$3,403	-$1,186	89,142	$105,695,669
SE	$576	$4,466	$4,259	-$207	402,483	$83,324,043

FINDINGS: RESPONSE TO THE COVID-19 PANDEMIC

Response of OLTL

In response to the COVID-19 Public Health Emergency (PHE), OLTL submitted and received CMS approval of an Appendix K waiver, which provided a number of flexibilities related to service delivery, provider qualifications, provider payment, data reporting, and needs assessments. These flexibilities were available for CHC participants impacted by COVID-19 infections, childcare disruptions, and provider closures and will continue throughout the duration of the federal PHE. CMS approved an amendment to the Appendix K waiver in 2021 to allow certain flexibilities to extend six months beyond the end of the federal PHE. These Appendix K flexibilities helped to minimize service disruption, expanded access to in-home and remote services, and enhanced access to PPE.

In addition to the Appendix K waiver activities, OLTL also distributed federal funds to support providers and issued guidance and operational recommendations to providers to address the COVID emergency. To support accurate data reporting, OLTL added a COVID specific missed shift reporting code for network providers which allowed for enhanced oversight of the impact of COVID on home care access.

As COVID-19 vaccines became available, DHS, CHC-MCOs and Rite Aid Pharmacy leadership worked collaboratively across the entire state to stand up COVID vaccine clinics for CHC participants and their caregivers. Driven by the new flexibilities offered through OLTL's Appendix K waiver, CHC-MCOs also took action to support continued access to medications and essential services and to provide resources for COVID-19 testing and vaccination during the COVID-19 PHE,

Provider Perspectives

The following section summarizes findings from qualitative interviews and quantitative surveys of HCBS and NF providers conducted in 2020 and 2021 with respect to the impact of the COVID-19 pandemic.

HCBS Providers

The COVID-19 pandemic presented considerable and unexpected challenges for the provider community. During qualitative interviews, providers described staffing problems due to laying off or furloughing employees during the COVID-19 health crisis. Lack of PPE impeded service provision and was most challenging during the early stages of the pandemic in the spring of 2020. Testing for COVID-19 was expensive and did not assure the safety of either staff or participants. Although a vaccine became available for front-line workers in late 2020, providers characterized staff as hesitant to receive it.

A survey of HCBS providers conducted in the summer of 2020 found that about 27% had at least one client with COVID-19, and over 50% had been refused entry. Over one third (26%) had staff refuse to enter a home, and over 55% reported lost revenue. HCBS providers surveyed in early 2021 reported greatly improved ability to deliver care. Only about 10% (typically Adult Daily Living Services) reported being unable to provide any care, however about 48% of providers reported providing services using the telephone as well as in person. About 35% reported that their financial status had been greatly impacted.

Nursing Facilities

The 2021 NF survey conducted by the MRC incorporated several questions about the impact of the COVID-19 pandemic. This survey found that at the time of the survey, 59% of NFs had at least one

resident and 62% had one or more staff diagnosed with COVID-19. On a positive note, 99% of NFs reported adequate PPE and onsite testing. However, only 15% of NFs reported that all residents were vaccinated and only 6% reported that all staff had been vaccinated. Finally, NFs reported that the financial impact was very high. The average response to a question that ranged from '0 – no impact' to '10-substantial impact' was an 8.

Impact on Participants

The COVID-19 pandemic presented severe negative repercussions for the health, well-being, and mobility of participants. During the social distancing restrictions of the COVID-19 health crisis, qualitative interviewees perceived that CHC participants were suffering the effects of isolation. Providers observed that participants' health and wellbeing declined during this time. When a vaccine became available for participants in early 2021, providers noted that CHC participants were eager to receive it.

In May-June 2020, the MRC conducted interviews with 345 CHC participants in the NW/NE/LC zone. These interviews are considered 'pre-implementation' since they took place prior to the end of the continuity of care period (6/30/2020). The MRC was able to take advantage of a pause in data collection to add questions about the impact of COVID-19 on people's lives. We found that about half had cancelled a doctor's appointment, and about 21% had declined in-home services during this time period. We found substantial increases in the use of telehealth, however, older dual-eligibles (non-HCBS) had lower use of telehealth than other groups, suggesting that some outreach may be required for this group. Finally, consistent with public health guidance at the time, we found substantial impact on preferred activities (i.e., outside the home), with large decreases in visiting as well as attending religious and other activities.

CONCLUSION AND RECOMMENDATIONS

A tremendous amount of thoughtful and persistent work went into launching the CHC program across the state of Pennsylvania. Though this report has highlighted a significant number of challenges, uncertainties, and areas for improvement associated with the first four years of the CHC program, the efforts of OLTL should be commended. OLTL's engagement in stakeholder and participant outreach prior to and during CHC implementation, willingness to leverage lessons learned to improve CHC between phases, and ongoing efforts strengthen oversight are all positives that have led to an overall successful implementation that minimized disruption. The experience documented in this report should provide insights for other MLTSS program implementations.

The following are specific recommendations for ongoing program improvement.

- Qualitative and quantitative findings revealed broad agreement among providers that both provider and participant communication with the CHC-MCOs could be improved.

- Oversight of CHC-MCOs could be strengthened by setting specific performance targets for CHC-MCOs. Historical data collection could be used to evaluate whether increases to minimum performance benchmarks may be appropriate for certain indicators of high importance or sensitivity, such as the creation of a specific target for service coordinator staff to participant ratios enacted in 2022 (See *Service Coordination*, page 41).

- Defined standards are needed to monitor network adequacy. EQRO review of the SMART contractual compliance oversight tool indicates that monitoring metrics to assess compliance with contractual network adequacy standards were not available for review across all CHC-MCOs prior to 2022 (See discussion on *Contract Monitoring*, page 73). OLTL has generated and is requiring MCO adherence to specific metrics for 2022 and beyond.

- OLTL should investigate approaches to enhance experience of care data collection to allow for better comparisons across Medicaid only participants and aligned and unaligned D-SNPs (See *Physical Health Provider Capacity*, page 38).

- Consider strategies to improve the accessibility of the CHC website, such as the addition of a search feature and simplified navigation (See *Availability and Quality of Enrollment Information*, page 31-32).

- Over the first four years of CHC operation, the number of external entities contracted with CHC-MCOs to provide service coordination has fallen significantly (See Table 9). This is a result of CHC-MCOs bringing service coordination in-house, using employees rather than independent provider agencies. As of 2021, no AAAs and few SCEs are providing service coordination to CHC participants. The bulk of SC activities are now performed in-house by MCO staff. In interviews, SCEs noted high rates of turnover among MCO SCs and delays with receiving requested participant information from MCOs. DHS should work with CHC-MCOs to improve communication between internal and external SCs and clarify training requirements and competencies for new CHC-MCO SCs.

- OLTL should work with CHC-MCOs to educate SCs providing support to participants in NFs on NF specific issues such as NHT, as well as PCSP requirements to improve service and eliminate duplication of effort. In interviews, nursing facilities noted that the efforts of CHC-MCO SCs for NF residents can be duplicative and time consuming, and communication from these SCs is often focused on data exchange rather than interaction with CHC participants (See *Nursing Facilities*, page 43).

- OLTL should identify partnerships across state, county, and local government to improve availability of low-income housing in general to specifically support NHT (See *Nursing Facilities*, page 43).

- Steps should be taken to address the reduced rate of home modification claims (See Table 17). First, it is important to validate that the decrease in the proportion of participants with a claim corresponds to a decline in the rate of actual home modification projects. Suggestions for increasing the number of available vendors could include regional information sessions and convening of stakeholders. OLTL should work with the CHC-MCOs to identify potential pilot projects that could be expanded.

- OLTL should continue to monitor PCSPs with particular attention to the degree of personalization. (See *Participant Experience Regarding Person Centered Service Planning*, page 92). The current approach to assessing participant satisfaction with service planning relies on analysis of CAHPS-HCBS survey data which provides self-report of choice and related topics but does not address whether the PCSPs are personalized. The OLTL should continue to audit samples of PCSPs and refine approaches to evaluating personalization.

- The implementation of CHC has apparently slowed the long-term trend of increasing hours of PAS. (See Table 13, Table 16, Figure 24-25). The OLTL should continue to monitor service plans and determine if participants are receiving sufficient services to meet their daily needs. Further analysis of HCBS use should be conducted with adjustment for acuity.