CHC Evaluation: Update on 2021 Activities and Findings

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Medicaid Research Center

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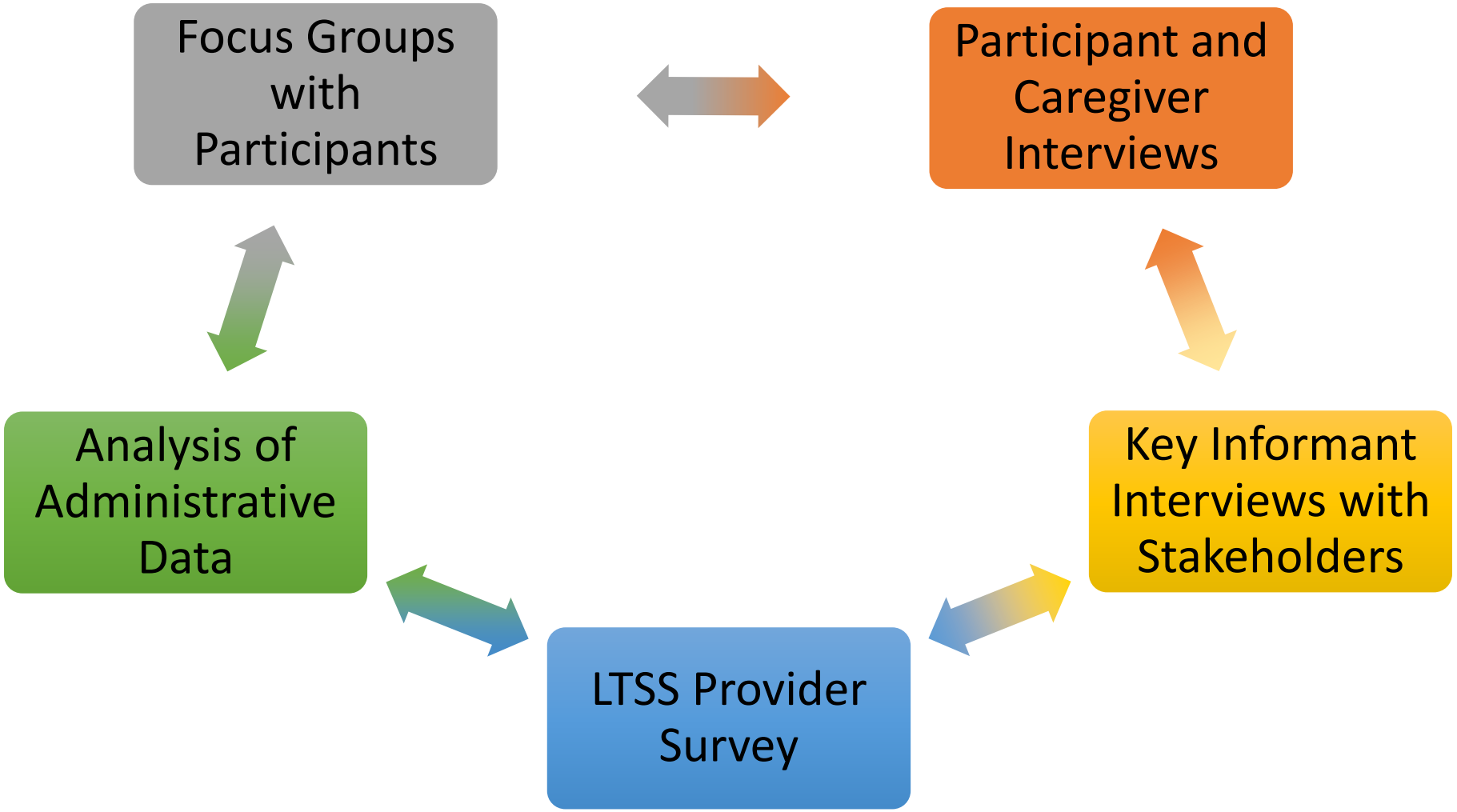
Overview

- The Medicaid Research Center is conducting a 7-year evaluation of CHC
  - Independent assessment of program implementation and impact
- Multiple methods from a wide range of data sources
- High priority on participant voice
  - Augments what we learn from administrative data
  - Focus groups and surveys
- Regular contact with OLTL on findings
  - Independent data helps verify and validate anecdotal reports OLTL hears from other sources
  - Aid decision making in real time

- Findings in this presentation:
  - Participant Experience
    - Telephone interviews 2017-2020
  - Administrative Data:
    - Rebalancing (2016-2018)
    - HCBS Use (2016-2020)
  - Provider Experience
    - Qualitative Interviews with Service Coordinators
    - HCBS Provider Survey
      - Overall Experience
      - COVID-19

Evaluation Overview



Participant Experience Telephone Interviews (2017-2020)

Methodology

- Consumer Assessment of Health Providers – Home and Community-Based Services
  - Required for all MCOs to report annually
    - MCOs required to hire an independent survey vendor to collect data
    - Assures independence of data collection
  - OLTL has presented findings on performance of each plan within each of the 5 regions
    - Plans must meet numerical targets and submit performance improvement plans
- These data can be used to gauge overall impact of CHC program at the population level
- Combine multiple surveys over past three years to produce comprehensive look
  - Medicaid Research Center Surveys
    - Population based surveys conducted before implementation in each region (SW, SE and NW/NE/LCAP)
    - Longitudinal samples re-interviewed after 18 months (SW, SE are complete)
    - Comparison group of people in NW/NE/LCAP interviewed in 2018 and 2019
  - CHC Managed Care Organization Surveys
    - Starts in SW in 2018 Q4, add SE in 2019 Q4 and Statewide in 2020 Q4
      - Data from NE/NW/LCAP regions are combined to be comparable with MRC data
    - Individual level 2018 data are not available, so not used for this analysis

Analysis

- Weighting
  - Survey data are weighted to produce population level estimates for each region
  - Focus is on the overall program, not the individual plan
  - Adjustment for non-response
  - MRC surveys stratified by age group (under/over age 60) and urban/rural
  - MCO surveys stratified by Hispanic ethnicity
- Interviews used the same CAHPS-HCBS questionnaire
  - Developed by CMS; measures of quality approved by National Committee on Quality Assurance
  - Data are used to construct multiple measures of quality from the perspective of program participants
  - MRC and MCOs added questions to the questionnaire to address other topics – we will focus on non-medical transportation
- Big picture and Deep Dive
  - To get an overall picture data from the entire state are combined to create “pre-CHC” and “post-CHC” estimates, controlling for differences in age and race/ethnicity
  - We report statistically significant differences associated with race and ethnicity

Survey Approach

Weighting	• Survey data are weighted to produce population level estimates for each region
	• Focus is on the overall program, not the individual plan
	• Adjustment for non-response
	• Account for differences between MRC and MCO surveys
	  • MRC stratified by age group (under/over age 60) and urban/rural
	  • MCO surveys stratified by Hispanic ethnicity

Interviews used the same questionnaire	• MRC included CAHPS-HCBS questions as part of longer participant interview • MCOs hired outside vendor to collect CAHPS-HCBS
Big Picture and Deep Dive	• Data from the entire state are combined to create “pre-CHC” and “post-CHC” estimates, controlling for differences in age and race/ethnicity • Statistically significant differences associated with race and ethnicity

Sample Sizes for HCBS-CAHPS Surveys (2018-2020)

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Sample Size for Combined Data:

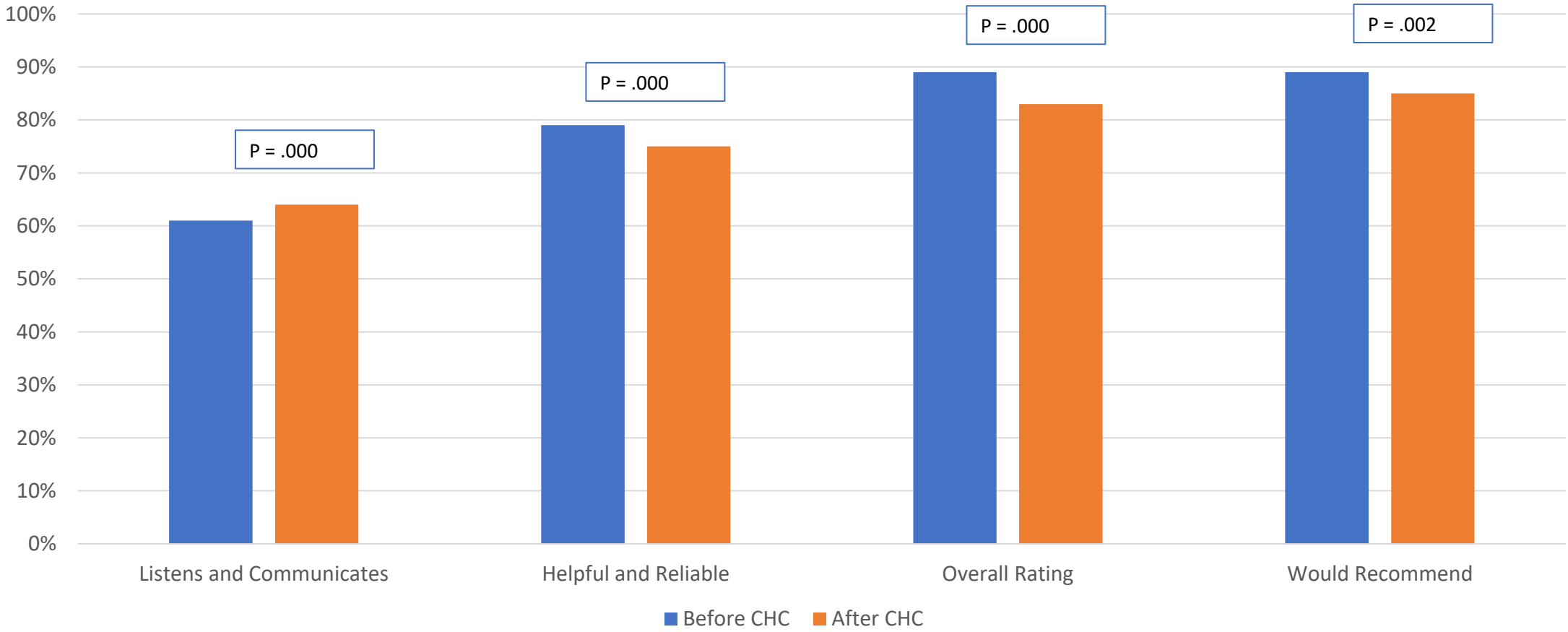
	Before	After
SW	1,256	1,097
SE	1,880	1,046
NW/NE/LCAP	2,505	1,181

- Annual HCBS-CAHPS surveys
  - Conducted by CHC MCOs with outside vendor
  - Fall of each year in active regions
    - Fall 2019: SW, SE
    - Fall 2020: All three regions
  - Data from all three CHC MCOs combined
- MRC Surveys
  - HCBS-CAHPS integrated into longer interview.
- MRC pre-CHC surveys conducted prior to implementation:
  - SW: Fall of 2017 and early 2018
  - SE: Fall of 2018 and early 2019
  - NW/NE/LCAP: Fall of 2019 and early 2020

Personal Attendant Service: Composite Quality Measures

- Listen and Communicate Well
  - PAS worker treats you with courtesy and respect
  - Explanations hard to understand because of accent or they way they spoke English?
  - Treat you the way you wanted them to
  - PAS explain things in way that was easy to understand
  - PAS listen carefully to you
  - Know what kind of help you need
- Reliable and Helpful
  - Come to work on time
  - Work as long as they are supposed to
  - Someone tells you if PAS cannot come
- Overall Rating of PAS Worker
  - 0 = worst / 10 = best
- Would you Recommend?
  - Agree / Disagree

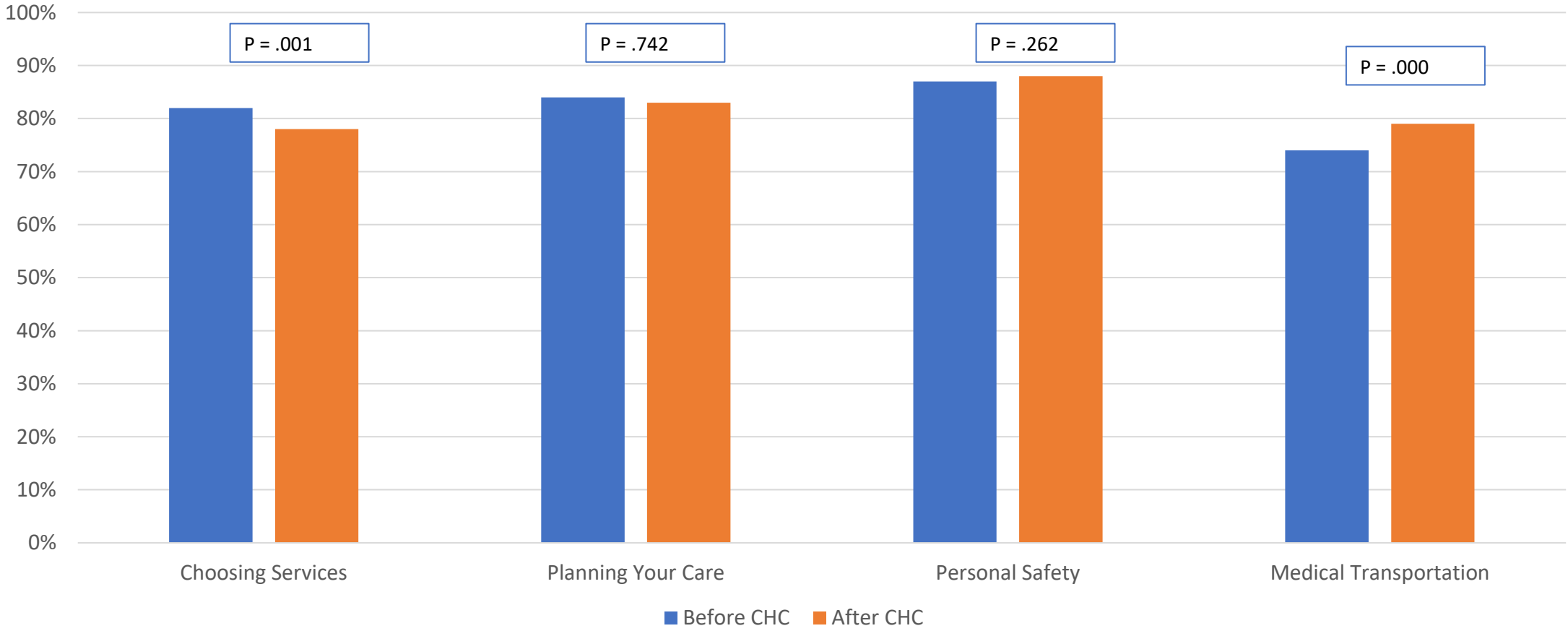
Overall Summary: Personal Attendant Services



Summary:
- 1 measure improves
- 3 measures decline

Note: Models control for race, age, and gender.

Overall Summary: Safety, Medical Transportation

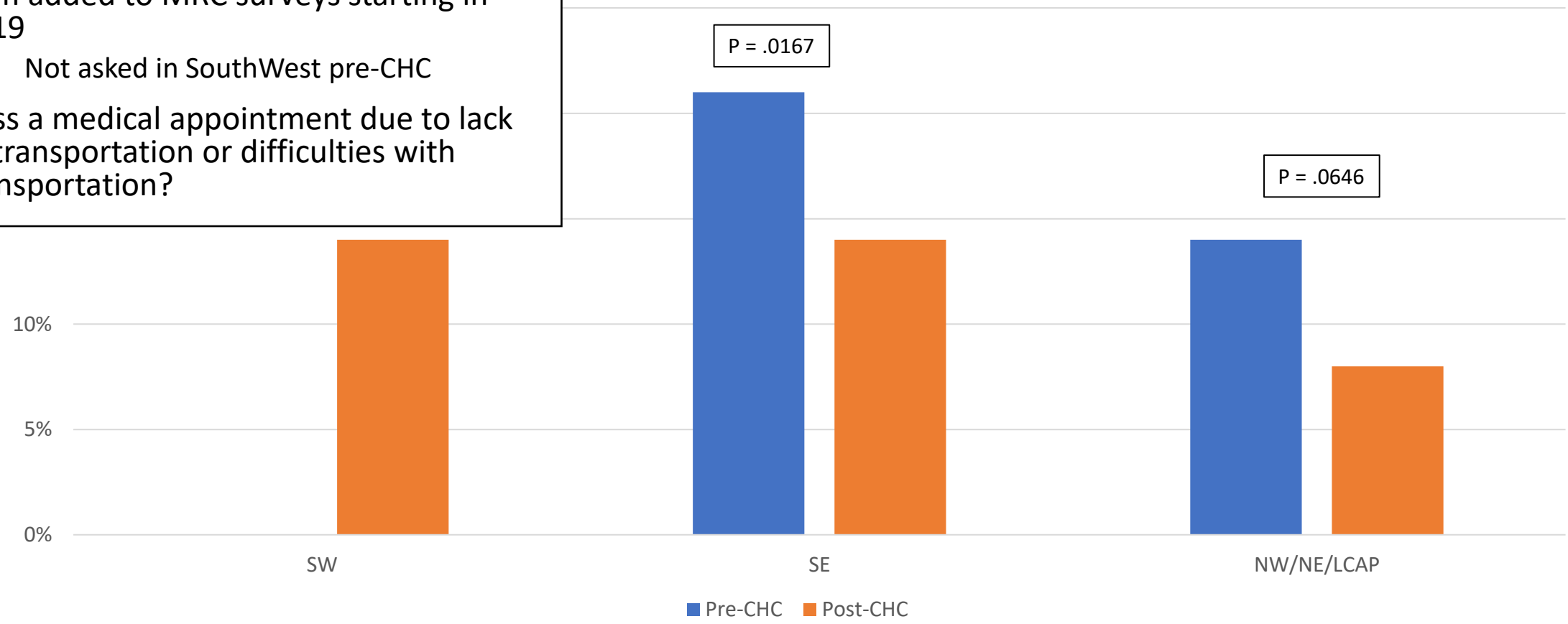


Note: Models control for race, age, and gender.

Summary:
- 1 measure improves
- 1 measures decline
- 2 measures unchanged

Missed Medical Appointments Due to Transportation

- Item added to MRC surveys starting in 2019
  - Not asked in SouthWest pre-CHC
- Miss a medical appointment due to lack of transportation or difficulties with transportation?



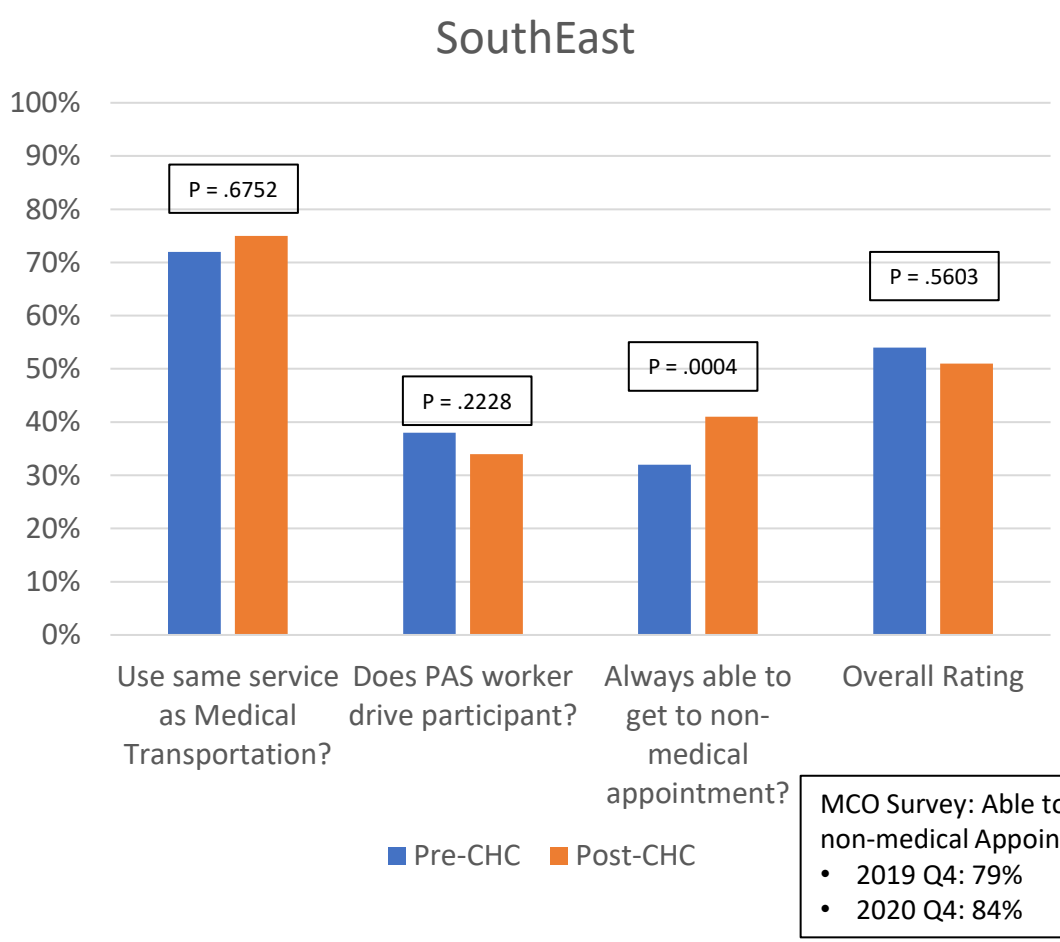
Note: Data are from MRC Surveys only. Question was not asked in SW pre-CHC.

Non-Medical Transportation

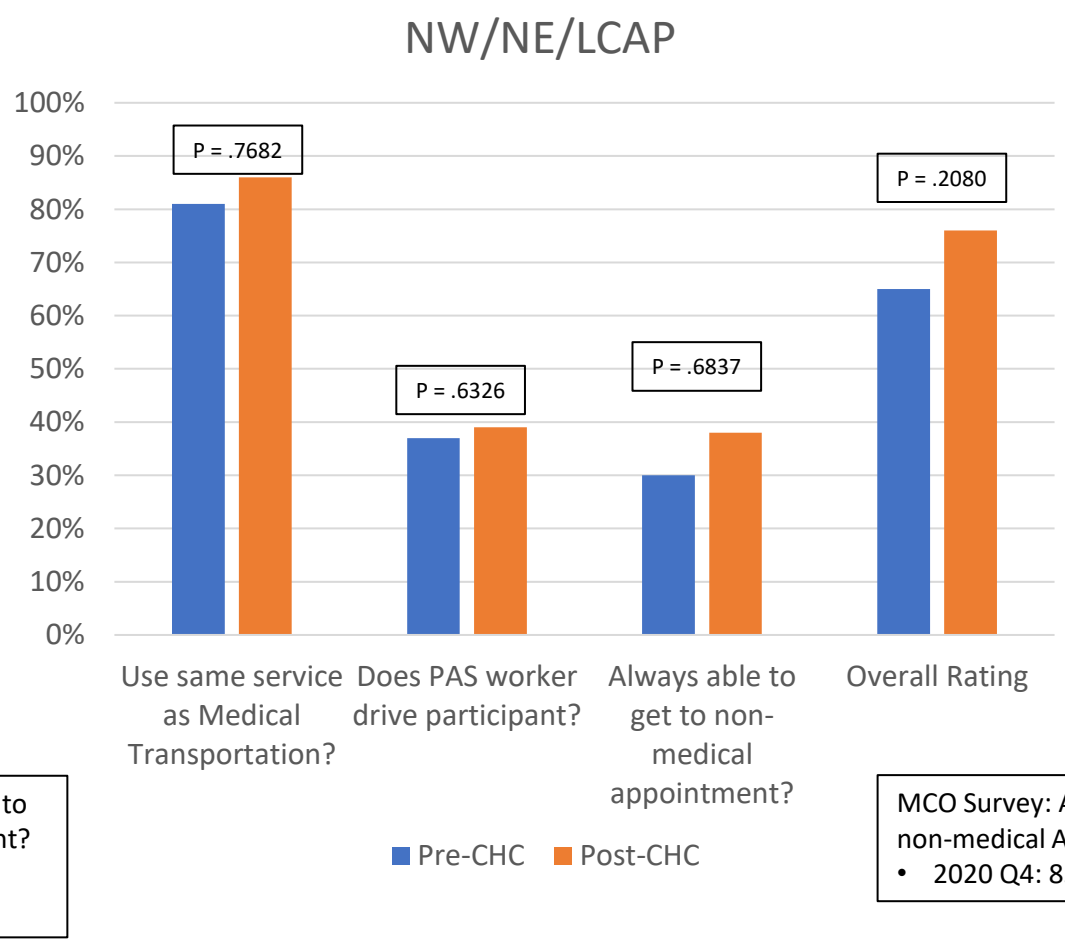
- Questions were added to MRC surveys after 2018 interviews were conducted
  - Pre-post comparisons only possible for SE and NW/NE/LCAP
- Single Question added to MCO data for 2019 and 2020 surveys
  - Wording is different than MRC survey
  - Compare trend, but direct comparison not possible

- Use same service as medical transportation?
- Does PAS worker drive?
- Able to get to non-medical appointments?
- Overall Rating of Transportation
  - 0 = worst / 10 = best

Non-Medical Transportation



MCO Survey: Able to get to non-medical Appointment?
- 2019 Q4: 79%
- 2020 Q4: 84%

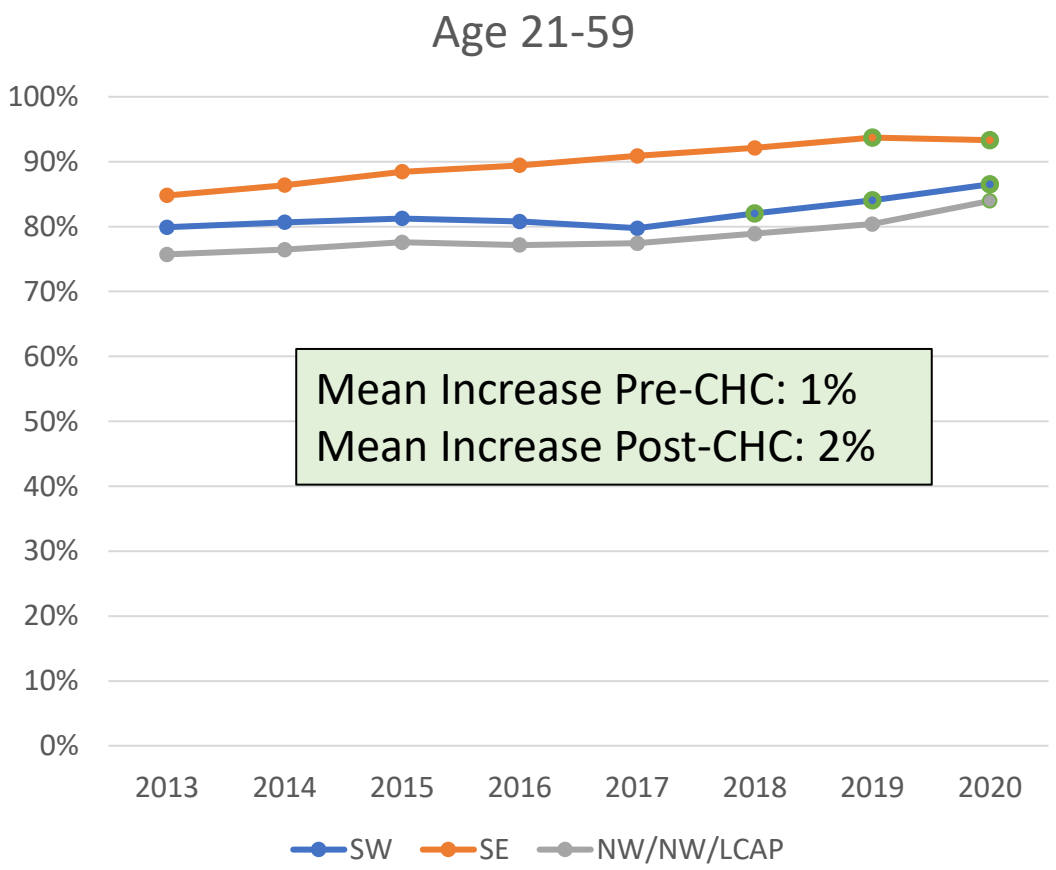


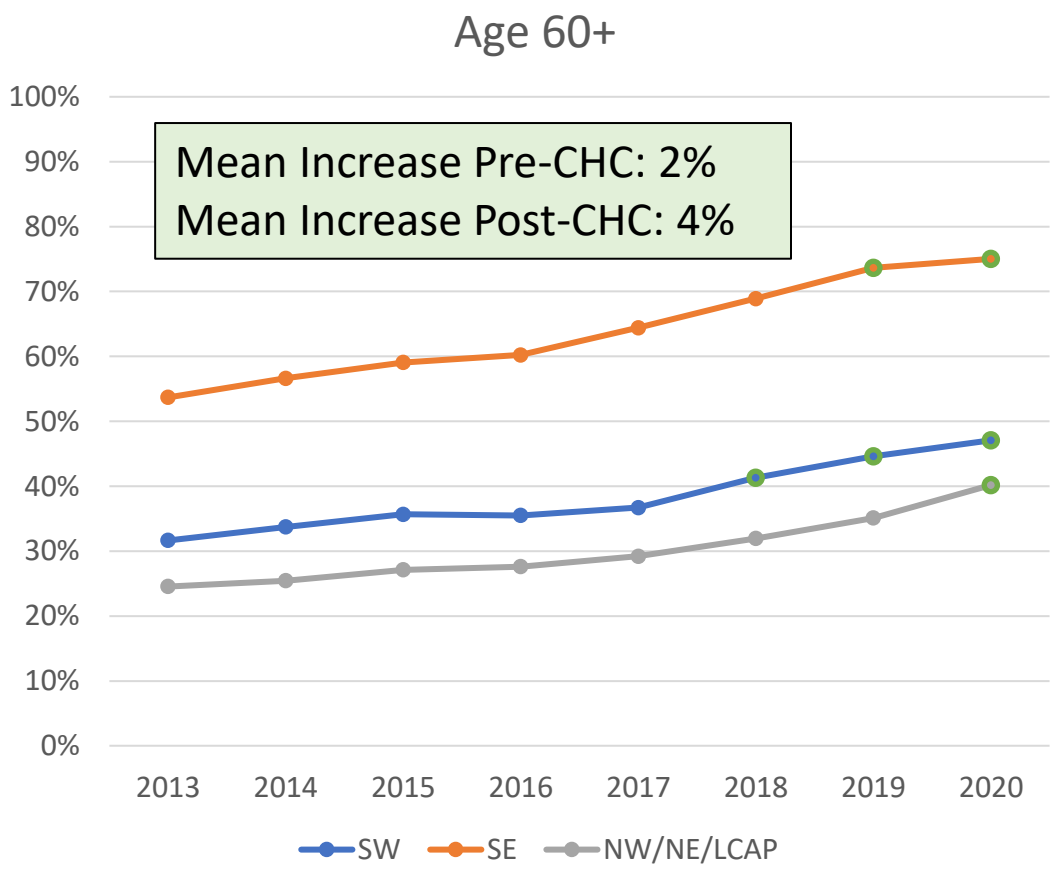
MCO Survey: Able to get to non-medical Appointment?
- 2020 Q4: 85%

Note: Data are from MRC Surveys only. Questions were not asked in SW pre-CHC.

Quantitative Analysis of Medicaid Claims Data (2016 to 2019)

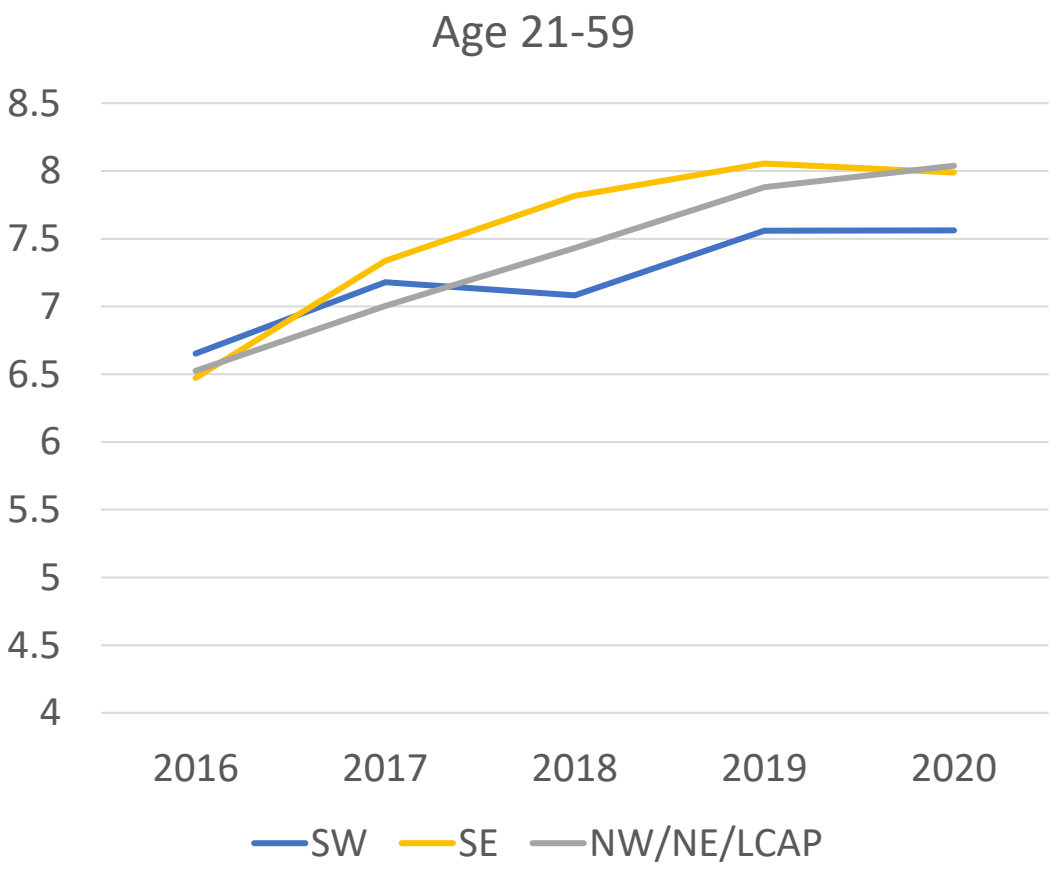
Quantitative Findings:
Percent of LTSS Participants in HCBS (2013-2020)

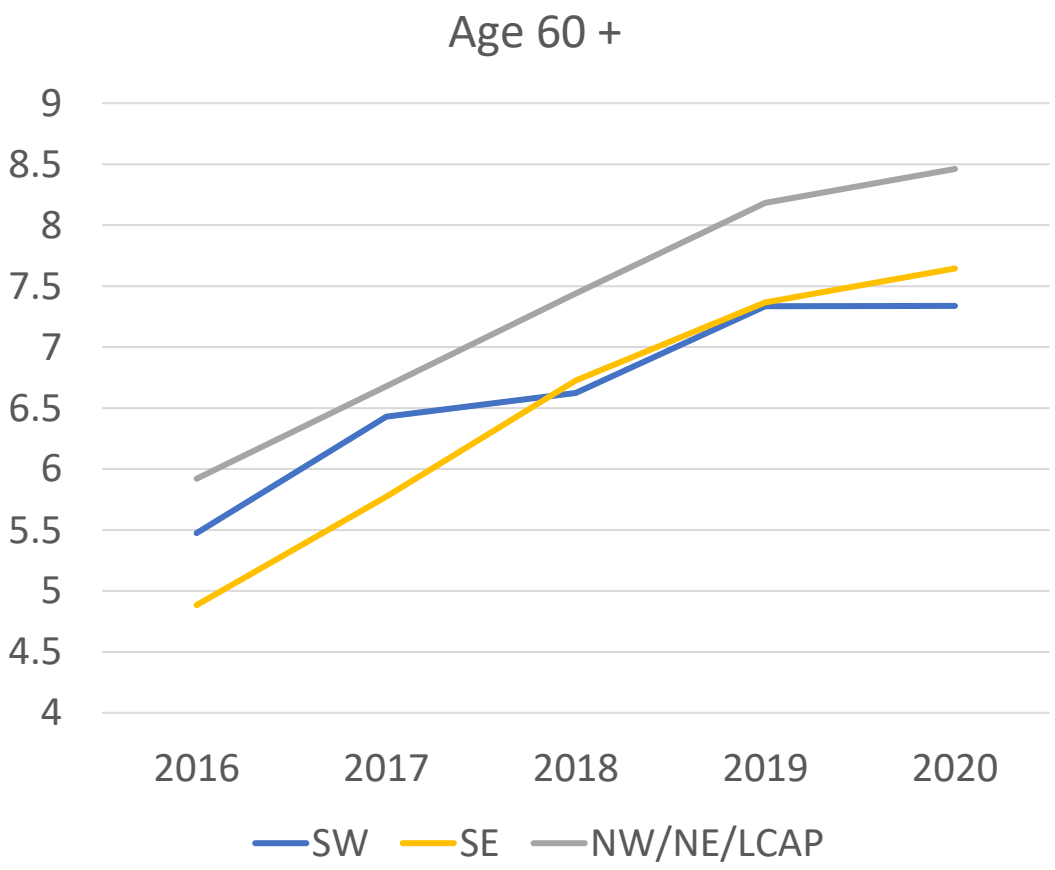




Note: Estimates based on average person-months.
Source: Medicaid enrollment data 2013 to 2020.

Average Personal Attendant Service Hours Per Person Per Day (2016 to 2020 Q2)





Source: Medicaid enrollment and claims data 2016 to 2020.

Percentage Increase in Average PAS Hours Per Person per Day: Age 21-59

	SW	SE	NW/NE/LCAP
2016 to 2017	7.9%	13.4%	7.3%
2017 to 2018	-1.3%	6.6%	6.1%
2018 to 2019	6.7%	3.0%	6.0%
2019 to 2020	0.0%	-0.8%	2.0%

Average Increase:

- Pre-CHC: 7.9%
- Post-CHC: 1.6%

Note: Pre-CHC Changes re shaded in blue. Post-CHC changes are shaded in green.

Percentage Increase in PAS Hours Per Person per Day: Age 60+

	SW	SE	NW/NE/LCAP
2016 to 2017	17.4%	18.2%	12.5%
2017 to 2018	3.0%	16.1%	11.7%
2018 to 2019	10.8%	9.9%	10.0%
2019 to 2020	0.0%	3.8%	3.4%

Average Increase:

- Pre-CHC: 5.2%
- Post-CHC: 14.3%

Note: Post-CHC changes are shaded in green.

Percent of Participants Experiencing a Decrease of at Least One Billed Hour Per Day Compared to Prior Year

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Slightly more decreases under CHC than in FFS

	2018	2019	2020*
SW	10.38%	6.4%	11.41%
SE	4.28%	6.76%	10.9%
NW/NE/LCAP	6.10%	6.82%	10.69%

Note: Shaded cells represent CHC Active Regions. * 2020 represents data through 6/30/2020.

Percent of Person-Months with An Average of > 23 Hours of Care Per Day

Slightly more people with heavy service plans under CHC than in FFS

	2018	2019	2020*
SW	1.31%	2.25%	2.14%
SE	.91%	1.40%	1.65%
NW/NE/LCAP	1.58%	2.18%	2.40%

Note: Shaded cells represent CHC Active Regions. * 2020 represents data through 6/30/2020.

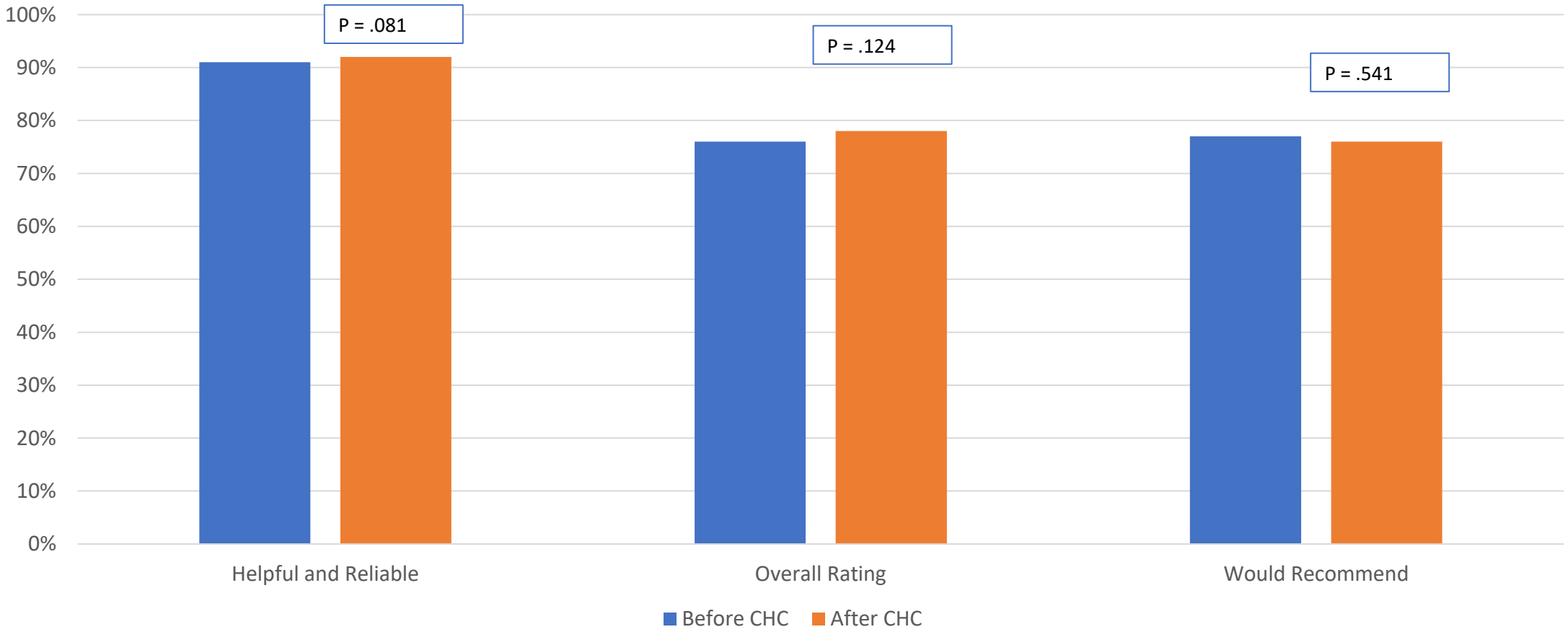
Summary

- Participant ratings of PAS workers are relatively high
  - Small declines in 3 of 4 composites
- Under CHC, there has been a slight increase in the growth of HCBS
  - Age 21-59: 2% per year compared to 1% prior
  - Age 60+: 4% per year compared to 2% prior
- Average PAS Hours were increasing every year prior to CHC:
  - Age 21-59: 7.9% per year prior to CHC
  - Age 60+: 14.3% per year prior to CHC
- Implementation associated with slowing of the rate of growth in all three phases and in both age groups
  - Age 21-59: 1.6% per year post CHC
  - Age 60+: 5.2% per year post CHC
- After implementation:
  - Some people experienced drops in the number of hours,
  - But there were more people with >23 hours of PAS per day
- Next steps:
  - Adjust for physical and cognitive function to determine if changes in use of PAS is associated with changes in disability levels

Part Two

Qualitative Interviews: Service Coordination Sub-Study

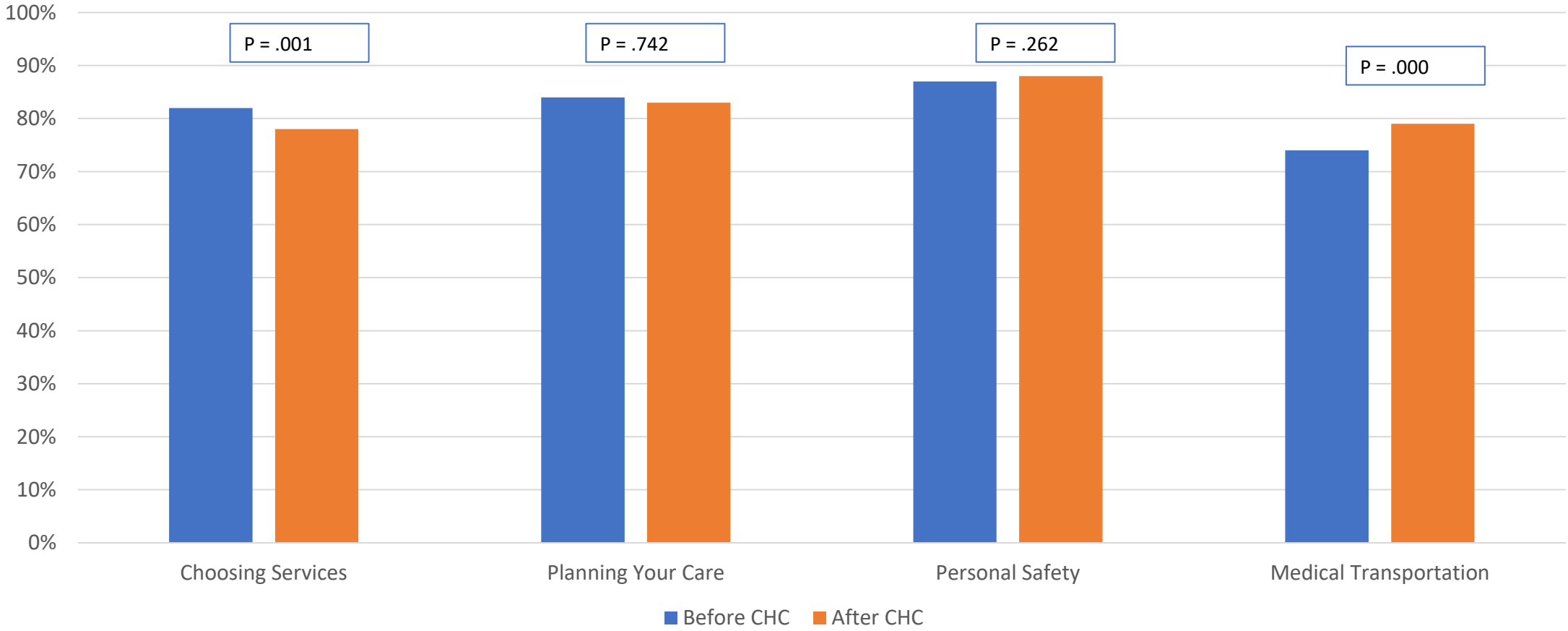
Overall Summary: Service Coordination



Summary:
- 3 measures unchanged

Note: Models control for race, age, and gender.

Overall Summary: Person Centered Service Planning



Note: Models control for race, age, and gender.

Summary:
- 1 measure improves
- 1 measures decline
- 2 measures unchanged

Qualitative Methodology

- Data Collection
  - July 2020 – April 2021
  - Statewide
  - Representative Sample of SCEs
    - Urban and rural
    - Currently and formerly contracted (at time of interview)
  - 28 semi-structured interviews
    - SCEs (22)
    - MCO executives (3)
    - MCO service coordinators (3)
- Data Analysis
  - NVivo was used for coding and analysis
  - Both deductive and inductive approaches to coding were implemented
- Findings
  - 4 Focal Areas
  - 6 Recurrent Themes
  - 4 Sets of Recommendations

Characteristics of Participating Organizations

Descriptor	n=28	
SouthWest (n = 9)	Former	Current
Rural	1	1
Urban	2	5
SouthEast (n = 7)		
Urban	2	5
NW/NE/LCAP (n = 6)		
Rural	1	
Urban		5
MCO (n = 6)		
MCO executive	3	
MCO internal service coordinator	3	

Qualitative Findings

Focus Areas			
Provider Experience	Service Coordination under CHC	Health Care, Supplies, and Services	Impact of COVID-19

Recurrent Theme 1:
Data and Documentation Requirements

Data and documentation requirements are increasing at the expense of relationships with consumers.

"And, you know, we're spending a lot more time in the portal, doing clerical work more than we are doing service coordination, case management, face-to-face interactions. We're spending a lot more time with [MCO] doing paperwork than we are anything else."

Recurrent Theme 2: Recruiting and Retaining SC Workforce

Recruiting and retaining an adequate service coordination workforce is a challenge, especially when combined with increasing caseloads.

"The caseloads are probably 30-40% larger than coordinators typically had pre-CHC, so that has thrown a lot of extra demands. Seems like any time that a coordinator kind of gets to an end of a project, there's another project thrown at them. So, you know, coordinators kind of look like, you know, 'Where's the light at the end of the tunnel?' And it seems like they get to the end of the tunnel, and the tunnel grows. I've kind of used the analogy, you know, it seemed like it would be a sprint for a while, but the sprint has turned into a marathon. So, staff have got burned out. There has been some turnover. Some that have been in this field for ten, fifteen years have just said, you know, 'I've had enough. This just isn't for me any longer.'"

Recurrent Theme 3: Person-Centered Service Plans (PCSPs)

Person-centered service plans (PCSPs) are in reality not person-centered and are focused on medical needs, neglecting other aspects of care important for quality of life.

"The plans are being looked at more from a medical standpoint than from a social standpoint because it's usually the medical team that's reviewing it if there's a discrepancy in the number of hours based on what the SC would be recommending."

Recurrent Theme 4: Cost-Cutting is a Priority

There was a pervasive perception that more importance is placed on cost-cutting than on quality of care.

"The writing's on the wall, as in, 'We're coming in here to limit services.'...But what everybody has been saying is it doesn't seem that [the MCOs] came here to actually provide better care for the consumers, more or less. It was, 'How can we save money?' ...If I assessed you at 40 hours...and you were expecting 60, I can explain to you why I gave you 40 hours. And the managed care organizations have the ability to do that. They're just choosing not to...So, they're taking [the service hours] away from [the consumers] and just saying, 'Survive--we believe that you can technically survive on less hours.' ...This was just more about saving money than anything. Not so much giving the best care for the individuals."

Recurrent Theme 5: Communication With MCOs

Communication between SC entities and MCOs is less than optimal, especially concerning authorizations, whether contracts would be renewed, and transitioning consumers to an internal SC at the MCOs.

"Our clients actually found out first via letter. They received a letter in the mail that we would no longer be their service coordinator, before we even knew that. So, we had hostile clients calling us saying, 'Okay, why didn't y'all tell us that you could no longer be our service coordinator?' And I'm like, 'What are you talking about?' "

Recurrent Theme 6: COVID-19 Concerns

COVID-19 has created new issues and exacerbated existing ones, for both SC entities and consumers.

"I think that we're already dealing with a very isolated population and then we have this pandemic which has created more isolation in that regard to folks that were already isolated and excluded from certain things because they might not have the physical ability to get there. I think it's ruined some routines for people that relied on the adult day centers. I think it's more of a hurt onto family members."

Provider Surveys: HCBS

Home and Community-Based Provider Survey Approach

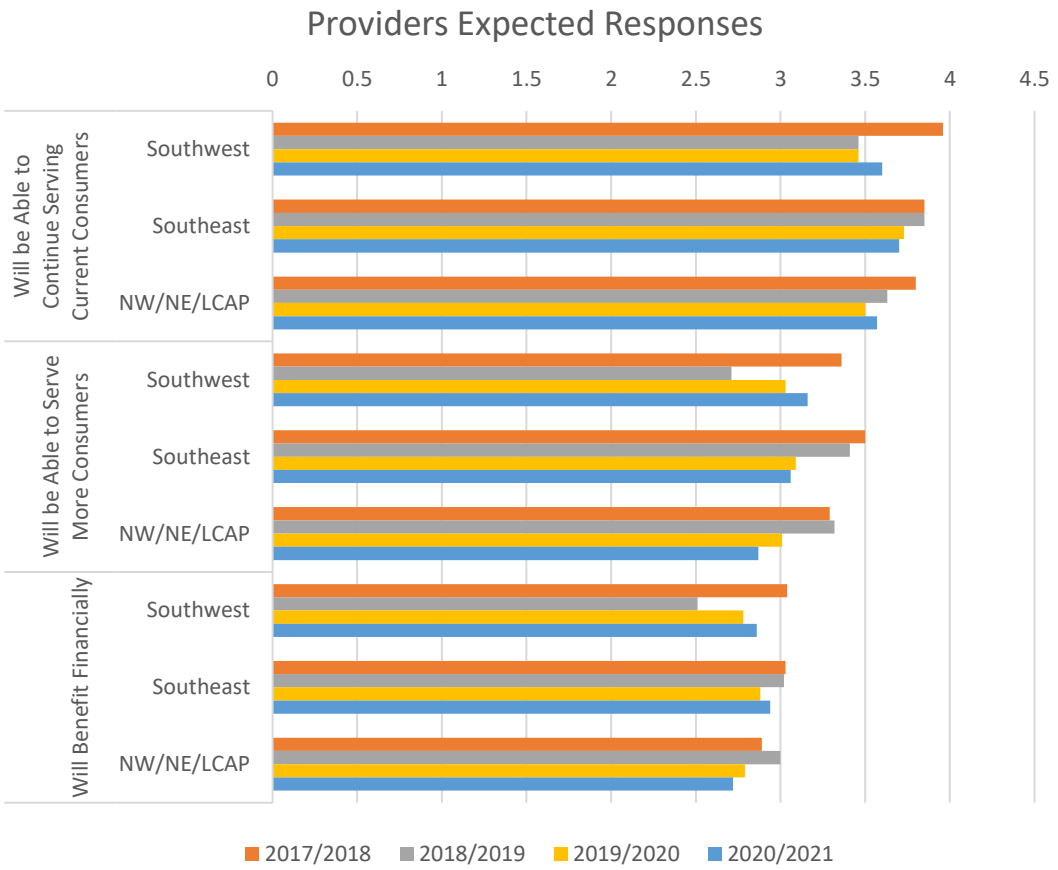
- Online survey using Qualtrics
- Email distribution to HCBS Administrators
  - Contact list obtained from OLTL
  - Telephone follow-up
- Anonymous link distributed via OLTL listserv and trade associations
- Conducted Annually

	Start Date	End Date	Sample Frame	Sample Size	Response Rate
Wave 1	9/29/2017	2/9/2018	1,003	366	36%
Wave 2	11/13/2018	2/8/2019	1,221	482	39%
Wave 3	12/19/2019	8/12/2020*	2,184	448	21%
Wave 4	12/8/2020	4/8/2021	2,380	560	24%

*Data collection interrupted by COVID-19

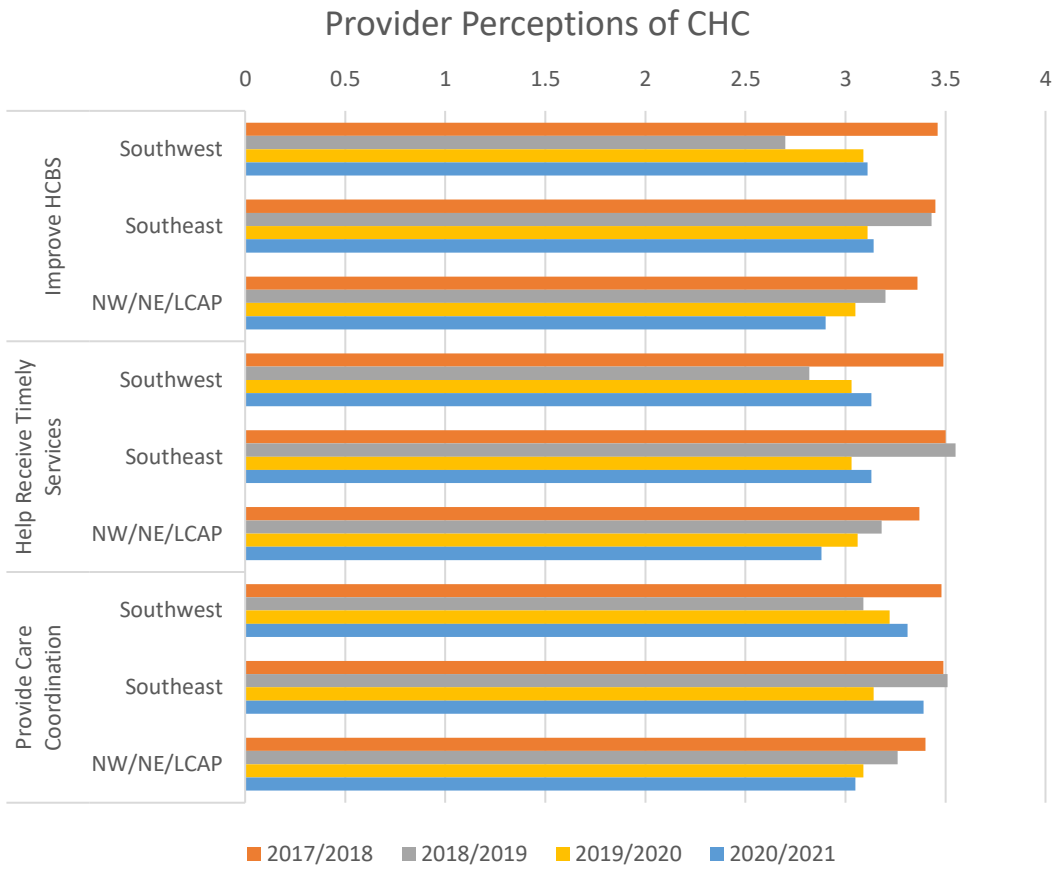
HCBS Providers: Organizational Response to CHC

- Please rate your agreement with the following statements. As a result of CHC, my site will:
  - Be able to continue providing care to our current consumers.
  - Be able to serve more people.
  - Benefit financially.
- Each item rated on 5 point scale, where 1 indicates strongly disagree and 5 indicates strongly agree.



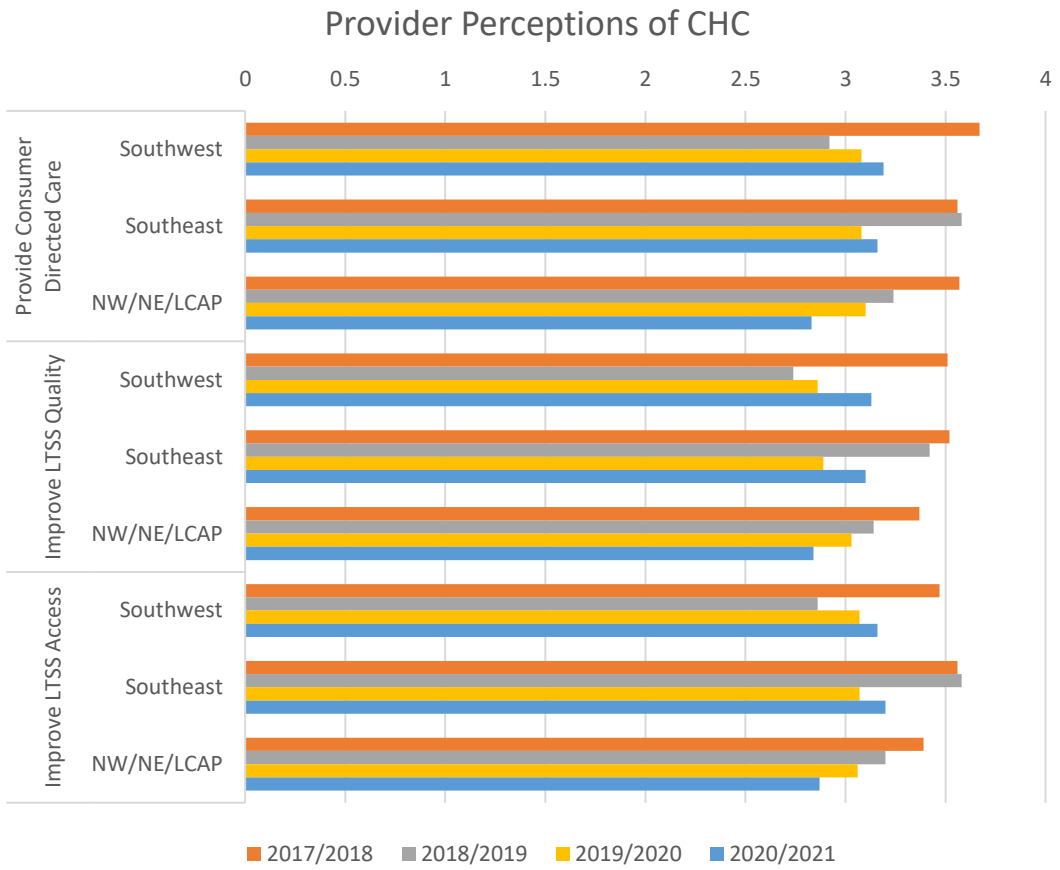
HCBS Providers' Perceptions of CHC

- Rate your agreement with the following statements. As compared to the previous system, CHC will better:
  - Improve home- and community-based services for PA
  - Help get services to people in a timely manner.
  - Provide care coordination.
- Each item rated on 5 point scale, where 1 indicates strongly disagree and 5 indicates strongly agree.



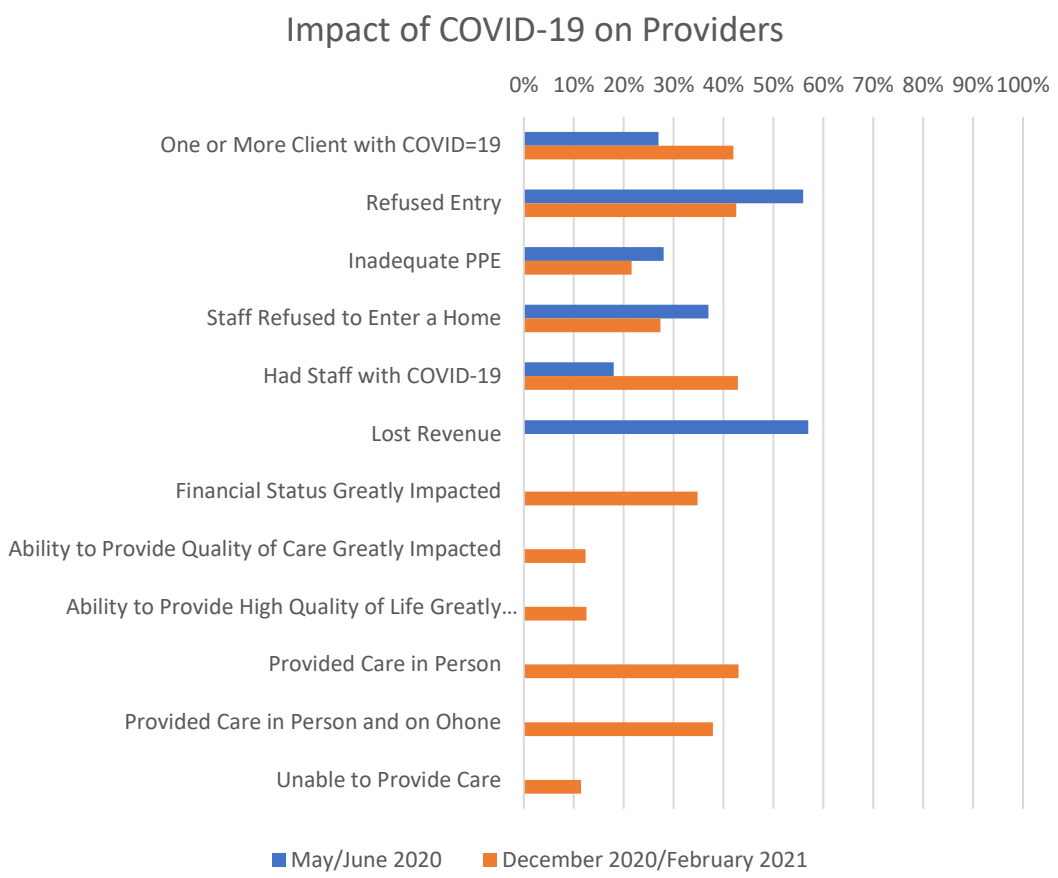
HCBS Providers' Perceptions of CHC (Part 2)

- Rate your agreement with the following statements. As compared to the previous system, CHC will better:
  - Provide consumer-directed services.
  - Improve quality of LTSS for Medicaid waiver populations.
  - Improve access to LTSS for Medicaid waiver populations.
- Each item rated on 5 point scale, where 1 indicates strongly disagree and 5 indicates strongly agree.



Impact of COVID-19 on HCBS Providers

- Questions about the impact of COVID-19 were added to the survey in May 2020. There were 90 surveys completed from May 15 to June 22 using the COVID-19 items
- The questions were modified slightly for the 2020/2021 wave.



Summary of Findings from Surveys of HCBS Providers

- The implementation improved over time.
  - In the SouthWest, 85% of providers reported receiving emails from MCOs prior to full implementation.
  - 93% of providers in the SouthEast
  - 88% of providers in the NW/NE/LCAP
- The overall outlook of providers suggest room for improvement
  - 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.
  - Providers in all three regions on average believed they were not going to benefit financially from CHC.
- In the SW and SE there is a pattern of enthusiasm pre-implementation followed by a drop during the first year of program and subsequent recovery
  - Apparent with regard to perceptions of access, quality, timeliness of service
  - Future surveys will examine whether the pattern continues in the NW/NE/LCAP region

Next Steps: 2022 and Beyond

- Participant Surveys
  - Phase I (SW) completed the 30 month follow-up
  - Phase II (SE) 30 month follow-up in the field
  - Phase III (NW/NE/LCAP) 30 month starts 3rd Qtr 2022
  - Final state-wide cross-section
- Caregiver Surveys
  - Final 6-month follow-up now
- Nursing Home Study
  - Interviews with administrators starting in February
  - Interviews with residents
    - Planning phase depending on COVID-19
- Analysis of HCBS Data
  - Working closely with OLTL on analyzing Home Care Assessment data (interRAI-HC)
- Behavioral Health
  - Outcomes for people with Severe Mental Illness
  - Access to BH for people living in nursing facilities
- HCBS Provider Survey Round 5
  - Launching in early February

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