Advancing Quality and Accessibility of Home and Community-Based Services under Community HealthChoices

Juliet Marsala, Deputy Secretary

Office of Long-Term Living

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Good morning, Chairman Kinsey, Chairman Heffley, committee members, and staff. My name is Juliet Marsala, and I have the privilege of serving as the Deputy Secretary for the Office of Long-Term Living (OLTL) within the Department of Human Services (DHS). I appreciate the opportunity to testify today regarding the delivery and ongoing improvement of home and community-based services (HCBS) under OLTL's managed long-term services and supports program, Community HealthChoices (CHC). I will also highlight how DHS is committed to enhancing this critical program through quality initiatives, oversight, and monitoring.

CHC is Pennsylvania's mandatory managed care program for dually eligible individuals and individuals with physical disabilities receiving home and community-based waiver services or nursing facility services. The Department implemented CHC to enhance opportunities for individuals to live in the community, improve coordination of care, enhance quality, advance innovation, and increase efficiency. CHC aims to serve people in the community, giving them the opportunity to work, spend more time with their families, and experience an overall better quality of life.

In January 2024, OLTL served a total of 405,141 participants in the CHC program. Of these, 236,180 (58.3%) received basic health benefits in the community, 127,288 (31.4%) received both basic health benefits and HCBS services to remain in their communities, and 41,673 (10.3%) were served in nursing facilities or other institutions. We know that the majority of individuals prefer to receive their long-term care services at home and in the community. One of the primary goals of CHC is to enhance opportunities for community-based living, which means continuing to build a long-term care program that can be flexible and adaptable to support participant preference. We are proud to report that 89.7% of CHC participants are being served in communities of their choice and over 75% of the costs of the long-term services and supports

(LTSS) component of OLTL programs are delivered in home and community-based settings. OLTL recognizes the important role that provider agencies and the CHC managed care organizations (MCOs) play in achieving these results and ensuring that participants receive high-quality services and care in their preferred settings.

To further our goal of ensuring participants eligible for LTSS, HCBS, or facility services receive these services in the least restrictive and most preferred settings, CHC has built in incentives for the participating CHC-MCOs to offer HCBS as the first option and to support participants wishing to transition from facility-based care to community-based services. Additionally, we encourage CHC-MCOs to introduce health and program innovations to continually improve and increase the quality of services and health outcomes for CHC participants, while helping us remain good stewards of the limited resources available.

Historically, prior to CHC, providers were paid for each service they performed without regard to how their participants fared. With the CHC program, MCOs receive a capitated payment, which is a fixed payment, from DHS and are responsible for developing their own provider rates to meet the needs of participants. They must ensure that their provider networks are robust enough to give participants timely access to quality care through participating professionals, without the need to travel excessive distances. Through their provider contracts, CHC-MCOs can leverage value-based purchasing (VBP) strategies with their network providers, tying provider payments to participant outcomes. This approach incentivizes improvements in care and the reduction of unnecessary costs. For example, VBP might involve creating programs aimed at reducing avoidable hospitalizations or emergency department visits. This is achieved by addressing potential causes for hospital visits or stays early, enhancing preventative health

and wellness education and services, and sharing the resulting savings with the providers involved in the program's delivery.

VBP as a Quality Improvement Strategy

OLTL continues to implement best practices to enhance quality within the CHC program. Beginning with the Calendar Year 2022 agreements, CHC-MCOs were required to enter into arrangements with providers to incorporate VBP. VBP agreements between the CHC-MCO and providers specify how providers are paid for services delivered and can include several strategies with varying degrees of accountability and financial risk. VBP agreements are typically categorized as low-, medium- or high-risk arrangements. Low-risk arrangements incentivize improving quality, whereas medium- or high-risk arrangements incentivize providers to both improve quality and reduce costs. Examples of such arrangements include performance-based contracting, shared savings, shared risk, bundled payments and global payments.

For CY 2022 and 2023, CHC-MCOs were required to achieve the following through their VBP arrangements:

- At least 15% of the medical portion of the capitation payment must be expended through VBP.
    - This 15% may consist of a combination of low, medium and high-risk strategies, with at least 7.5% of LTSS payments through a VBP arrangement;
- In CY 2022, all CHC-MCOs successfully met the LTSS portion of the VBP requirements.

For CY 2024, the goal for LTSS VBP has been raised to 25% of LTSS payments through a VBP arrangement, with a minimum of 10% of the total LTSS expenditure required to be in medium- or high-risk categories.

Monitoring of VBP

OLTL measures compliance through the following reporting requirements:

- CHC-MCOs must submit a progress report to OLTL by the last workday of each quarter.
- By October 1 of every calendar year, each CHC-MCO must submit its proposed VBP plan to OLTL. This plan should outline and describe the CHC-MCO's strategy for compliance in that calendar year.
- By June 30 of the subsequent calendar year, each CHC-MCO must submit a report to OLTL detailing its accomplishments from the prior year. This annual report must include a listing of VBP arrangements by provider, an explanation of each arrangement, and the total dollar amount allocated for medical services and LTSS through these arrangements.

General Program Monitoring

OLTL has established reporting requirements to capture key program quality metrics, such as service plan changes, missed services, qualifications of providers, service denial notices, complaints and grievances, and network adequacy. OLTL staff diligently review these reports and address any arising concerns directly with the CHC-MCOs. This rigorous oversight ensures that CHC-MCOs are held accountable for meeting these standards and that participants are receiving appropriate levels of quality services.

In addition, OLTL convenes regular quarterly quality review meetings (QQRM) with the CHC-MCOs. These meetings are devoted to reviewing key quality indicators, best practices, and areas for improvement. Specifically, the QQRM provides an opportunity for the following:

- Reviewing CHC-MCO performance against stated goals;
- Examining the causes for missed goals and targets;
- Establishing new targets;
- Recommending corrective action steps for plans that missed targets;
- Identifying trends and opportunities for program improvements; and,
- Developing special studies for populations being served under CHC.

Thank you again for the opportunity to testify on DHS' home and community-based services overseen by OLTL, and thank you for your continued support of quality services for our older adults and adults with physical disabilities.