Achieving Value in Medicaid Home- and Community-Based Care: Considerations for Managed Long-Term Services and Supports Programs

CHCS Center for Health Care Strategies, Inc.

CONTENTS

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IN BRIEF

This guide describes considerations for states seeking to adopt value-based payment (VBP) models for home- and community-based services (HCBS) in Medicaid managed long-term services and supports (MLTSS) programs. It examines approaches used by five states — **Minnesota**, **New York**, **Tennessee**, **Texas**, and **Virginia** — for promoting high-quality MLTSS programs while simultaneously supporting the ability of Medicaid beneficiaries who need long-term services and supports (LTSS) to live in their communities. It describes considerations for selecting quality metrics and payment models, and common challenges that these states have faced in implementing these models and strategies to address them. Recognizing the importance of stakeholder involvement in developing VBP models, this guide also brings managed care plan, provider and beneficiary engagement perspectives into state conversations.

EXECUTIVE SUMMARY

States are increasingly adopting value-based payment (VBP) models to tie payment to outcomes including quality of care, health status, and costs for their Medicaid programs. Although most Medicaid VBP models are for primary and acute care services, states are beginning to explore VBP for long-term services and supports (LTSS). Through support from the West Health Policy Center, the Center for Health Care Strategies in partnership with Mathematica Policy Research and Airam Actuarial Consulting developed *Achieving Value in Medicaid Home- and community-based Care: Options and Considerations for Managed Long-Term Services and Supports Programs* to support states that are exploring VBP models for home- and community-based services (HCBS) in managed long-term services and supports (MLTSS) programs. This guide distills insights from five leading states — Minnesota, New York, Tennessee, Texas, and Virginia — as well as national health policy experts to outline considerations for adopting VBP to promote high-quality MLTSS programs and support the ability of older adults and people with disabilities to live in their communities. The guide has four sections:

1. **Defining the state policy goals that VBP models help to achieve**. The first step for states in designing a VBP model is to clearly articulate the policy goals they want to achieve. Then, states can evaluate if VBP is the right tool to support those goals, and determine how to focus VBP efforts to support the goal(s) and achieve HCBS system improvements. States will also want to define what "value" means in the context of their MLTSS programs in order to determine which program elements to reward. MLTSS performance measures and payment model parameters are often different than those for other medical services.

2. **Selecting performance measures**. Performance measures are the foundation on which VBP models are built. Performance can be evaluated through quality of care processes and outcomes, such as improved health and functioning, or quality of life. MLTSS managed care plan and HCBS provider performance can also be measured by: how well they provide timely access to needed services and supports; whether care coordinators are available and helpful; whether there are adequate numbers of well-trained direct care workers; and whether other key components of HCBS delivery are in place. States need to consider:

- What HCBS performance measures are available?

- Which measures are relevant to policy and program goals?

- Are measures feasible to collect?

- Which performance measures can HCBS providers reasonably be held accountable for improving and which are best suited to financially reward plans and providers?

- What are appropriate improvement targets for payment bonuses or shared savings?

3. **Selecting payment models**. Payment models are an important tool that can be used by states to drive higher quality in MLTSS programs and create the right financial incentives for improved value. The payment approach taken by states and managed care plans can influence provider behavior, creating an opportunity for states and their MLTSS plan partners to help achieve program goals. Examples of payment models for HCBS include performance-based payments that often serve as a starting point to engage payers and providers, as well as risk-based approaches where providers are held accountable for the cost and outcomes of the services provided. In addition, non-financial incentives may be another lever to increase provider engagement and improve performance. States need to consider:

- How can payment models be aligned with policy goals and the state's definition of high-value HCBS?

- What payment model and incentive payment amounts will most effectively change HCBS provider behavior?

- What VBP model is most feasible in the current environment, particularly as it relates to existing VBP models operating in the state as well as providers' level of sophistication and ability to accept financial risk?

- What is the long-term sustainability of the financial model?

- What other non-financial incentives (e.g., preferred referral status, marketing, workforce training, etc.) might impact provider behavior?

4. **Working through operational considerations**. States should consider several practical and operational issues as they work on VBP design elements and engage with stakeholders. First, states need to set appropriate VBP model expectations or contract requirements for managed care plans. States and managed care plans generally agree that plans should have flexibility to develop their own payment models within some overarching standards — or "guard rails" — to ensure consistency in performance metrics and reporting requirements. States will also want to assess HCBS provider readiness and capacity to participate, as providers may have limited capital to support risk-bearing arrangements or few reserves to cover reductions in revenue resulting from missed performance benchmarks. There are several ways states can support providers through infrastructure, data and technology investments, or education and technical assistance. They may also require managed care plans to provide training and build infrastructure that can help HCBS providers prepare for, or engage in VBP. Lastly, states will want to engage stakeholders throughout the design and implementation process.

The overarching themes of this guide to advancing VBP models for HCBS in Medicaid are:

- **Set clear goals**. Clearly define the policy goal that a VBP model can help to achieve, such as reduction in nursing facility use, reduction in avoidable hospitalizations, or a broader state quality strategy. VBP is a tool to advance clearly defined policy goals.

- **Go slowly and build incrementally and iteratively**. Building these models is an incremental process, requiring iterative planning; troubleshooting; and ample input from stakeholders. Once a state sets its goals and desired outcomes, it can examine how to first build and incentivize provider and system capacity to develop the practices required to achieve them. Then, states can create incentives for good practices and finally, for good outcomes.

- **Understand which HCBS quality measures are mostly closely tied to overarching goals**. There is not a single, standard set of HCBS measures states can use to assess managed care plan performance, but there are several measures states can use for VBP models that can directly support their policy goals and for which data can feasibly be collected.

- **Commit to robust stakeholder engagement** to continually assess and improve program design and operations — including early and frequent managed care plan, provider, and beneficiary engagement — in order to ensure that programs achieve objectives.

- **Incorporate both accountability and flexibility**. Managed care plans need flexibility to develop innovative payment models, but a robust state oversight presence is key to monitoring what is and is not working well for beneficiaries and providers.

- **Support workforce development efforts for the HCBS provider community**, including targeted strategies for different types of HCBS providers.

INTRODUCTION

State Medicaid programs are pursuing various strategies to improve the quality and cost-effectiveness of long-term services and supports (LTSS), and are increasingly turning to managed long-term services and supports (MLTSS) programs to accomplish these goals. In MLTSS programs, states contract with managed care plans (i.e., MLTSS plans) to deliver LTSS either as a stand-alone benefit (i.e., institutional care and home- and community-based services [HCBS]), or as part of a comprehensive package of physical and behavioral health and LTSS. Contracting with managed care plans to deliver LTSS has the potential to: (1) increase the share of LTSS spending on HCBS relative to institutional care; (2) improve the quality of LTSS by holding managed care plans accountable; and (3) establish budget predictability and control LTSS cost growth. As of 2017, 24 states had developed MLTSS programs.[1] Some of these programs integrate LTSS through Medicare-Medicaid Plans or align MLTSS plans with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) to better coordinate care for the large number of LTSS users who are dually eligible for Medicare and Medicaid.

What is Value-Based Payment?

Alongside the growth of MLTSS programs, states are also seeking to transform how they pay for health care. Payment reform is intended to shift from fee-for-service (FFS) systems — where providers are paid for each service delivered — to value-based payment (VBP) models. VBP models tie payment to outcomes including quality of care, health status, and costs. Some states, such as Arizona and New York, require the majority of Medicaid managed care plan payments to providers be linked to quality within a set timeframe.[2,3]

Terminology Used in This Guide

Long-term services and supports (LTSS): LTSS encompass a variety of health, health-related, and social services that assist individuals with functional limitations. LTSS includes assistance with activities of daily living (e.g., eating, bathing, and dressing) and instrumental activities of daily living (e.g., housekeeping and managing money) over an extended period of time. LTSS may be delivered in institutional or community settings.[4]

Home- and community-based services (HCBS): LTSS that are delivered in the community, such as adult day services, assisted living facilities, and personal care services in someone's home.[5]

Payment: VBP models and Alternative Payment Models (APMs) are used interchangeably in some sources. Some sources define APMs more narrowly and VBP models more broadly. For purposes of this guide:

- **VBP models** include a broad set of initiatives that link provider payments to the cost and/or quality of care delivered.
- **APMs** are the specific payment methods used in VBP programs (i.e., shared savings for delivering services at lower cost, or prospective payments per beneficiary) covering services for which the provider bears some financial risk.[6]

Several frameworks are helpful for understanding VBP, but one commonly used model — created by the U.S. Department of Health and Human Services in collaboration with partners in the public, private, and nonprofit sectors — is the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model (APM) framework. This framework creates various categories of payment models and a common "language" to describe them. The LAN framework, which is used by the Centers for Medicare & Medicaid Services (CMS), states, and some private payers, establishes: (1) categories of VBP models based on different levels of provider financial risk; and (2) consistent terminology with which to describe the different VBP models.[7] See section 3 for more information about the LAN framework.

Connecting MLTSS and VBP

Although most states have developed Medicaid VBP for primary and acute care services, given the growth of Medicaid LTSS spending — $167 billion or 30 percent of all federal and state Medicaid spending in 2016 — states are beginning to explore LTSS payment reforms that incentivize quality and program outcomes.[8,9] Furthermore, states are increasingly interested in developing VBP models for HCBS, which comprised 57 percent of Medicaid LTSS spending in 2016.[10] Due to unique characteristics of HCBS financing and delivery however, adoption of VBP models in HCBS settings requires states to be innovative and address several challenges, including limitations with: (1) provider capacity to assume financial risk and build the required infrastructure; (2) HCBS quality measurement and data collection; and (3) the opportunity to achieve Medicaid savings for dually eligible beneficiaries if they are not enrolled in a Medicare-Medicaid integrated program.

Value-Based Payment Models in Nursing Facilities

Of the limited number of Medicaid VBP models focused on LTSS, most involve nursing facilities rather than HCBS providers, likely because the former typically have greater financial capacity, more sophisticated data and reporting systems, and an easily attributable patient population. For more information on VBP in nursing facilities, the Integrated Care Resource Center's brief *Value-Based Payment in Nursing Facilities: Options and Lessons for States and Managed Care Plans* provides an extensive overview of select states and Medicaid managed care plan models, presents perceived effects of VBP, and shares lessons on the design and administration of VBP programs.[11]

Overview of the Guide

This guide seeks to help states adopt VBP strategies that promote high-quality HCBS within MLTSS programs that support the ability of older adults and people with disabilities to live in their communities. The guide is comprised of four sections:

Section 1: Defining the state policy goals that VBP models help to achieve;

Section 2: Selecting performance measures used to reward HCBS providers in VBP models;

Section 3: Selecting payment models that create the right financial incentives for improved value; and

Section 4: Working through operational considerations as states, managed care plans, providers, and beneficiaries design and implement VBP models.

This guide is the culmination of the Center for Health Care Strategies' (CHCS) *Advancing Value for Medicaid Managed Long-Term Supports and Services* initiative supported by and produced in collaboration with the West Health Policy Center. For the initiative, CHCS partnered with national experts at Mathematica Policy Research and Airam Actuarial Consulting to support states adopting VBP strategies that promote high-quality MLTSS programs. This guide captures lessons from: (1) a learning collaborative that convened five leading states — Minnesota, New York, Tennessee, Texas, and Virginia — with experience operating or planning MLTSS VBP initiatives; (2) an environmental scan of states with mature MLTSS programs and managed care plans that have developed VBP models with LTSS providers; and (3) discussions with provider stakeholders and other policy experts. *(**See Exhibit 1. State MLTSS Programs and VBP Initiatives [next page]** for a description of the five states' programs.)*

Exhibit 1. State MLTSS Programs and VBP Initiatives

Minnesota	
MLTSS and Related Program Overview	**MLTSS VBP Efforts**

Minnesota Senior Health Options (MSHO)
■ Integrated Medicare-Medicaid program; aligned MLTSS/D-SNP platform
■ Age 65+
■ Statewide; voluntary enrollment
■ Covers all Medicare and Medicaid benefits, including primary and acute care, behavioral health, and LTSS (Elderly Waiver HCBS and 180 days of nursing facility (NF) care)
 	
Minnesota Senior Care Plus (MSC+)
■ Medicaid-only
■ Age 65+
■ Statewide; mandatory enrollment for beneficiaries who are not eligible for, or who choose not to enroll, in MSHO
■ Covers all Medicaid benefits, including acute care, behavioral health, and LTSS (Elderly Waiver HCBS and 180 days of NF care)
 	
Special Needs BasicCare (SNBC)
■ Integrated Medicare-Medicaid program; aligned MLTSS/D-SNP platform
■ Age 18 to 64 years with disabilities
■ Statewide; voluntary enrollment
■ Covers all Medicare and most Medicaid benefits, including acute care, behavioral health, and 100 days of NF care
	■ Requires plans serving older adults and individuals with disabilities to enter into value-based contracts with primary/acute care, behavioral health, and LTSS providers through the Integrated Care System Partnership (ICSP) initiative
	■ Operates three other VBP programs for NFs in FFS:
	  1. Performance-based Incentive Payment Program (PIPP); facilities can earn performance-based payments from the state
	  2. Quality Incentive Payment Program (QIIP); facilities receive a one-time add on based on improving one facility-selected measure
	  3. Value-Based Reimbursement; facilities receive a base rate adjustment based on a three-part quality score

New York	
MLTSS and Related Program Overview	**MLTSS VBP Efforts**
Managed Long-Term Care (MLTC) ■ MLTSS-only program (partial cap) ■ Adults with disabilities age 18+ with LTSS needs ■ Statewide; mandatory enrollment for most populations ■ Covers all Medicaid LTSS for most eligible populations; coordinates other services not in MLTC benefit package with other plans; most other services are covered via FFS **Fully Integrated Duals Advantage (FIDA)** ■ Capitated financial alignment demonstration ■ Dually eligible beneficiaries ages 21+ who have LTSS needs ■ Limited regions (NYC, Long Island, Westchester); voluntary enrollment ■ Comprehensive Medicare-Medicaid managed care program; includes all Medicare and Medicaid acute care, behavioral health, and LTSS **Medicaid Advantage Plus (MAP)** ■ Fully Integrated D-SNP ■ Dually eligible beneficiaries 18+ with LTSS needs ■ Limited regions; voluntary enrollment ■ Comprehensive Medicaid managed care program; includes Medicaid acute, behavioral health, and LTSS; some benefits covered by MAP plan and some by FFS	■ Developed a multiyear roadmap for comprehensive Medicaid payment reform, including MLTC plans, with the goal of transitioning 80 to 90 percent of Medicaid plan payments to VBP arrangements by 2020 and reducing avoidable hospital use by 25 percent over five years ■ Required every partial capitation MLTC plan to convert select provider contracts (Licensed Home Care Services Agencies (LHCSAs); Certified Home Health Agencies and SNFs) into MLTC Level 1 VBP arrangements (pay-for-performance) by 2017[12] ■ Required MLTC plans to move 5 to 15 percent of total plan expenditures to Level 2 by April 1, 2019 and April 1, 2020, respectively[13] ■ Required 10 percent of qualifying integrated plans' (FIDA, MAP, and PACE) total expenditures (Medicare and Medicaid) be transitioned to Level 1 VBP by April 2018

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Tennessee

MLTSS and Related Program Overview	MLTSS VBP Efforts
TennCare CHOICES ■ Comprehensive MLTSS program; aligned MLTSS/D-SNP platform ■ Age 65+ and adults age 21+ with physical disabilities ■ Statewide; mandatory enrollment ■ Includes all Medicaid acute care, behavioral health, and LTSS **Employment and Community First CHOICES** ■ Comprehensive MLTSS program ■ Individuals of all ages with intellectual or developmental disabilities ■ Statewide; mandatory enrollment for all new HCBS participants; optional for existing 1915(c) waiver participants ■ Includes all Medicaid acute care, behavioral health, and LTSS (e.g., employment and independent community living support services)	■ Launched Quality Improvement in Long Term Services and Supports (QuILTSS) in 2014 to promote delivery of high-quality LTSS ■ Created a new payment system (aligning payment with quality) for NFs and certain HCBS based on performance on measures most important to members and their family/caregivers ■ Includes creation of a comprehensive competency-based workforce development program and credentialing registry for direct support professionals

Texas

MLTSS and Related Program Overview	MLTSS VBP Efforts
STAR+PLUS ■ Comprehensive MLTSS program ■ Age 65+ and adults age 21+ with disabilities ■ Statewide; mandatory enrollment for most adults ■ All Medicaid benefits, including acute care, behavioral health, and LTSS **Texas Dual Eligibles Integrated Care Demonstration** ■ Capitated financial alignment demonstration ■ Age 21+ ■ Limited counties; voluntary enrollment ■ Includes all Medicare and Medicaid benefits, including acute care, behavioral health, and LTSS	■ Launched Quality Incentive Payment Program (QIPP) in 2017, a voluntary program that links additional nursing facility payments to performance on specific quality measures ■ Launched a revised managed care Pay for Quality (P4Q) program in 2018 with new managed care plan contract targets for VBP models in the STAR+PLUS program

Virginia

MLTSS and Related Program Overview	MLTSS VBP Efforts
Commonwealth Coordinated Care Plus (CCC Plus) ■ Comprehensive MLTSS program; aligned MLTSS/D-SNP platform ■ Age 65+ and adults age 21+ with disabilities and seniors age 65+, including dually eligible beneficiaries ■ Statewide; mandatory enrollment ■ Most Medicaid benefits, including primary acute care, behavioral health, and LTSS	■ Exploring and designing the development of VBP requirements for future contract years for managed care plans in CCC Plus

1. DEFINING THE STATE POLICY GOALS

Several initial policy and programmatic considerations arise when designing payment models for home- and community-based services in MLTSS programs. Some are common across most VBP programs; others are specific considerations for HCBS. This section highlights several policy and programmatic considerations for states in designing MLTSS VBP programs that focus on improving the value of HCBS.

Using Payment to Drive Outcomes at the Managed Care Plan Level

This guide focuses on how states can design MLTSS programs that promote higher-value care at the provider level. But states can also use payment incentives to drive similar outcomes at the plan level by:

✔ **Adding requirements to managed care plan contracts** that specify the percentage of total provider payments that must be made through VBP arrangements or adopting a standardized VBP model for certain providers;

✔ **Structuring the capitation payments to managed care plans** to create incentives for greater use of HCBS, such as constructing a blended rate for all covered nursing facility stays and HCBS for eligible members who meet the state's criteria for nursing facility level of care regardless of the care setting; and

✔ **Developing plan-level withhold arrangements**, in which states retain a portion of capitation payments that can be returned to plans if they meet specific quality and performance targets. The targets may make their way into VBP models between plans and providers, creating better alignment.

Is VBP the Right Tool for Achieving State MLTSS Program Goals?

The first step in designing a VBP model is to clearly articulate the policy goals that a state wants to achieve, then identify if and how VBP efforts can be focused to support the goal(s). VBP is not a goal in and of itself. These models are tools that can advance state policy goals — either system-wide goals (e.g., New York's initiative to reduce potentially avoidable hospitalizations statewide by 25 percent) or goals that are narrowly targeted to an MLTSS program (e.g., increasing access to HCBS or improving member satisfaction).

It is important to evaluate whether VBP is the right strategy to support those goals, and if so, what role it should play. For example, in 2013 Tennessee's governor launched a statewide effort to use VBP to "transform the relationship among health care users, providers and payers" in order to help achieve sustainable medical costs, and improve quality of care and outcomes.[14] While the initial focus was on primary and acute physical and behavioral health care, following this announcement and other statutory mandates to improve LTSS quality, TennCare staff conducted a comprehensive program assessment to identify: (1) gaps in the LTSS quality and delivery system in need of improvement; (2) opportunities to create financial incentives and build capacity in the LTSS system to advance the state's goal; (3) existing and needed data to measure LTSS program improvement; and (4) preferences about how to measure quality from individuals who receive LTSS and their families. Through this assessment, the state determined that a VBP model was the right tool to align incentives around the outcomes that most impact the member's experience of care and day-to-day living and meet statewide quality improvement and cost-effectiveness goals. Ultimately, the state launched the Quality Improvement in Long Term Services and Supports initiative (QuILTSS), which promotes the delivery of

high-quality, person-centered LTSS for TennCare members through payment reform and workforce development.

States should assess several factors when deciding whether to launch an MLTSS VBP program for community-based services, such as:

■ **State capacity and existing initiatives**. Considerable time and resources are needed to design, implement, and monitor VBP programs. If a state already has other payment and delivery reforms underway for acute, primary care, and specialty services, new MLTSS VBP initiatives can leverage the leadership backing, staff experience, monitoring systems, and other supports from those initiatives that are critical for program success. For example, New York, Texas, and Virginia developed VBP roadmaps or managed care quality strategies that incorporated MLTSS programs. See *Case Study: Texas Managed Care Strategy to Pay for High-Quality Care (below)* as an example of a statewide strategy that includes its MLTSS program.

CASE STUDY │ **Texas Managed Care Strategy to Pay for High-Quality Care**

The Texas Health and Human Services Commission requires VBP targets for managed care plans, including for STAR+ PLUS (its MLTSS program). Twenty-five percent of all provider payments must be in a value-based arrangement, with 10 percent of those in risk-based arrangements by 2018. Percentages increase to 50 and 25 percent, respectively, over the next four years. Texas officials hope to eventually analyze these models used to better understand: (1) which models plans and providers are using; (2) provider capacity to participate; and (3) the impact of these arrangements on quality.

In addition, Texas recently added new VBP requirements to its medical Pay-for-Quality (P4Q) Program to meet statewide goals of improving the quality and efficiency of services provided by managed care plans. This comprehensive program applies to most of Texas' Medicaid managed care programs, including STAR+PLUS. In this program, three percent of plans' capitation is at risk, based on their meeting targets for "at-risk measures" calculated against a statewide benchmark (to reward high performance) as well as an individual plan performance target (to drive plan-specific improvement). Plans may also earn incentive payments on bonus measures. Throughout 2017, Texas officials worked closely with managed care plans and other stakeholders to select measures and develop the methodology for measuring plan performance, including some targeted measures for the STAR+PLUS P4Q model to better reflect the needs of LTSS users, such as preventing avoidable readmissions, controlling chronic disease, and monitoring interactions for individuals prescribed anti-psychotics.

■ **Ability to commit to a long-term plan**. Preparing plans and providers to engage in VBP often takes many years and can require considerable state investments and continued attention across changes in leadership and administrations. States with a long-term strategic plan instill greater confidence across managed care plans and providers that their upfront financial investments and changes in clinical and business practices will pay off in the long-run.

■ **Potential to improve value for dually eligible beneficiaries enrolled in the MLTSS program**. Nearly 70 percent of Medicaid enrollees who use LTSS are dually eligible for Medicare and

Medicaid.[15] Medicare covers medical services, including hospitalizations and emergency department visits, while Medicaid covers HCBS and other LTSS. In many cases, however, savings from providing better care to Medicaid LTSS recipients may accrue primarily to Medicare.[16] States with integrated managed care plans, such as Medicare-Medicaid Plans in Financial Alignment Initiative demonstrations and/or MLTSS plans that are aligned with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), have greater potential to use VBP models to impact acute care utilization and generate savings to both programs. These plans are accountable for all services and can capture savings on the medical side achieved through investments in HCBS.

- **Availability of a stable source of funding**. VBP program start-up costs may include provider and managed care plan infrastructure and capacity building, and/or initial funding pools to cover incentive payments. Before program launch, states should assess their funding capacity, the potential for return-on-investment in other areas, whether they have access to new or repurposed funds, and if they will require managed care plans to cover some of these costs. Some states have rolled MLTSS VBP efforts into statewide budgeting efforts. For example, New York's MLTSS VBP program draws on federal funds that support the state's Delivery System Reform Incentive Payment (DSRIP) initiative, which covers workforce and other investments that help LTSS providers prepare to adopt VBP. Some states have identified other funding sources, such as restructuring the capitation rates to establish quality withholds that plans can earn back, or civil monetary penalties on nursing homes.

Key design considerations related to selecting quality measures and payment models for these programs are discussed in sections 2 and 3.

How Can States Define "Value" in MLTSS Programs?

VBP seeks to improve value, which means **improving the quality of care** provided while at the same time **reducing the costs of care** (or in some cases, achieving higher quality for similar levels of payment). VBP initiatives designed to improve the value of care can link payment incentives to a wide array of standardized quality measures. As will be discussed in sections 2 and 3, MLTSS performance measures and payment model requirements are often different than those for other services. There are few nationally standardized measures for HCBS quality, which can be defined in many different ways, such as:

- Rebalancing toward HCBS (e.g., diverting nursing facility admissions, encouraging nursing facility discharge to community living, promoting community integration, etc.);
- Transitioning individuals successfully from hospitals and nursing facilities back to home and community settings;
- Reducing potentially avoidable and unnecessary care, and improving physical health outcomes;
- Maintaining or slowing the decline of functional status;
- Improving quality of life, community integration, and person-centeredness; and
- Improving the skills, training, and stability of the HCBS workforce.

Who Does the HCBS Workforce Include?

The HCBS provider workforce includes certified nursing assistants, home health aides, home care/personal aides, direct support professionals (who serve individuals under age 65 with intellectual/developmental disabilities), and hospice or palliative care aides. These workers typically provide assistance with activities of daily living (e.g., eating, bathing, or dressing) and instrumental activities of daily living (e.g., housekeeping, meal preparation) and may perform other clinical tasks depending on licensure or certification.

As discussed in detail in section 2, as part of setting goals for MLTSS VBP programs, states need to decide which types of quality outcomes they seek to achieve through the program and which of these outcomes should be tied to payment incentives. To select specific measures for these outcomes, it is also important to consider: (1) the availability of data, or the burden of collecting new data, to construct the measures selected; (2) whether managed care plans and HCBS providers have the ability to affect quality and be held accountable for their performance on the measures; and (3) whether the measures must be risk-adjusted to reflect the age, gender, level of need for assistance, and other characteristics of the members served by each plan and provider to fairly compare their performance. It is also critical to define the targets that qualify for payment bonuses or shared savings, so that they are ambitious but still achievable.

Value is sometimes defined only in terms of quality rather than a product of both quality and cost. But most states expect VBP programs to improve quality *and* reduce LTSS costs per enrollee, or slow the annual rate of cost growth. Savings in the LTSS sector often come from substituting less expensive HCBS for more costly institutional care, and MLTSS programs may need to increase the number of hours for personal care services — which provide hands-on help with activities of daily living — to reduce nursing facility use. In addition, it would be hard to save costs by reducing payment rates to HCBS workers, who are already paid low rates. Consequently, slowing the growth of LTSS costs per beneficiary may be a more realistic goal. MLTSS plans that cover acute care services, either for Medicaid-only beneficiaries, or through an aligned Medicare managed care plan, may also be able to achieve savings through reductions in costly avoidable hospitalizations and emergency room visits. In some cases, states may want to invest *more* in one area to improve quality and outcomes. Tennessee and New York, for example, have recently made large investments in building HCBS workforce capacity to achieve better outcomes for members. Regardless of the source of the savings, it is important to ensure that savings do not come at the expense of lower quality or inappropriate service reductions, either for LTSS or medical care.

2. SELECTING PERFORMANCE MEASURES TO IMPROVE THE VALUE OF HCBS

Performance measures are the foundation on which VBP systems are built. Measures indicate which aspects of care need to be improved and how much improvement is required to qualify for VBP financial incentives. Performance is often equated with quality of care processes and outcomes, such as improved health, functional ability, or quality of life. But the performance of managed care plans and HCBS providers can be measured in other ways, such as: how well they provide timely access to needed services and supports; whether care coordinators are available and helpful; whether there are adequate numbers of well-trained direct care workers; and whether other key components of HCBS delivery are in place. This section describes:

- The types of HCBS performance measures that can be used in MLTSS VBP programs;
- Criteria and considerations for selecting the right set of performance measures to financially reward plans and providers for improvement; and
- How to set appropriate improvement targets for payment bonuses or shared savings.
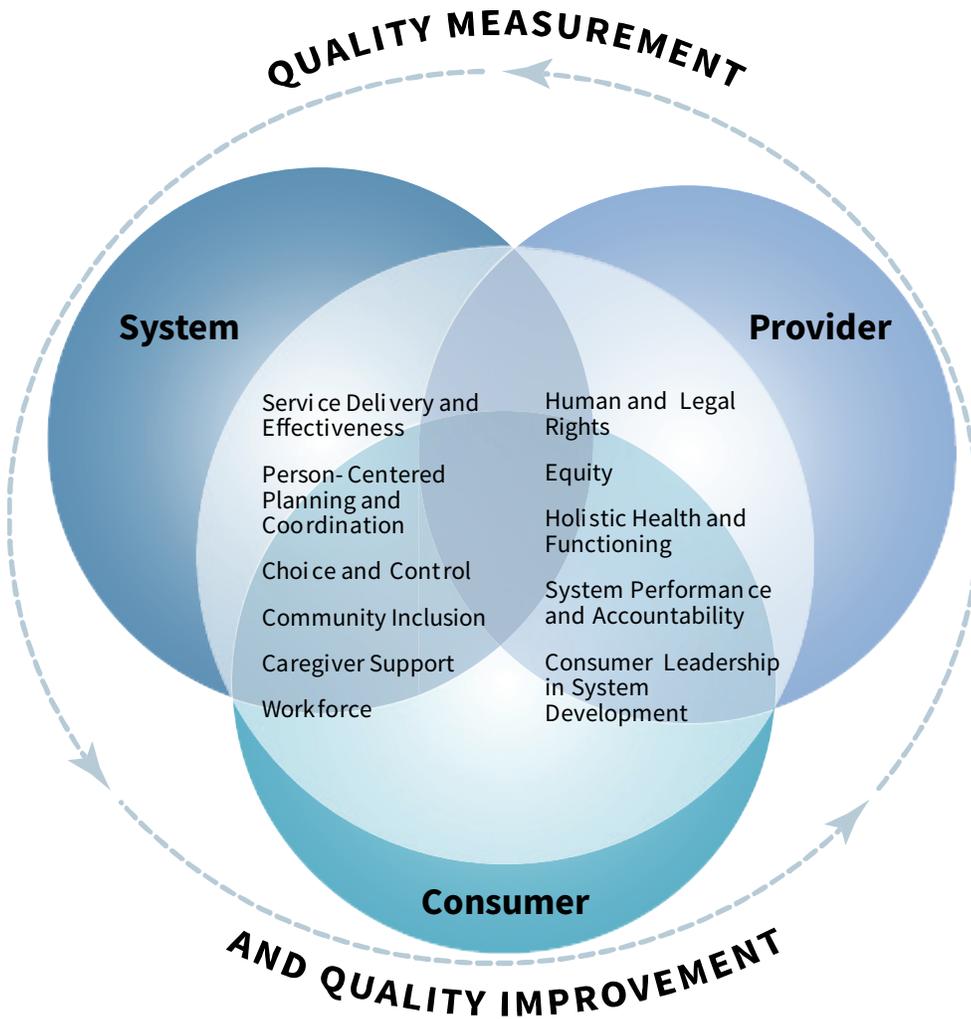
What are Different Types of HCBS Performance Measures?

States can use many types of measures to assess the performance of managed care plans and providers on how well they deliver HCBS. Measures fall into four general categories: (1) **structural measures**, which are associated with critical inputs to HCBS delivery, such as having sufficient numbers of qualified care coordinators and direct care workers to provide personal care assistance (the most common type of HCBS); (2) **access measures**, which indicate whether HCBS beneficiaries can obtain the services and supports they need on a timely basis; (3) **process measures**, such as the degree to which core elements of HCBS delivery, such as assessments and care plans, are person-centered and comprehensive; and (4) **outcome measures**, which reflect the results of care, such as improved health, maintenance of function, improved quality of life, attainment of competitive and integrated employment, and meaningful community inclusion.

Other measure typologies, such as the National Quality Forum's (NQF) HCBS quality measurement framework, sort measures into care domains (***see Exhibit 2, National Quality Forum HCBS Quality Measurement Framework, next page***).[17] In addition to aspects of care that can be measured at the person-level, such as person-centered planning and coordination, it includes system-level performance measures, as well as factors that influence outcomes for individuals using HCBS, such as human and legal rights, and equity.

Although NQF identified many examples of HCBS measures for each framework domain, it found very few standardized, nationally recognized HCBS measures. And although some state Medicaid agencies have operated MLTSS programs for a long time, there is no common set of metrics available for states to measure MLTSS performance. There may also be variations in the use of measures across programs within a single state. Nor has NQF, which is the national consensus body for health care quality measures, endorsed any measures specifically designed for MLTSS plans.

Exhibit 2. National Quality Forum's HCBS Quality Measurement Framework

QUALITY MEASUREMENT

System

Provider

Service Delivery and
Effectiveness

Person-Centered
Planning and
Coordination

Choice and Control

Community Inclusion

Caregiver Support

Workforce

Human and Legal
Rights

Equity

Holistic Health and
Functioning

System Performance
and Accountability

Consumer Leadership
in System
Development

Consumer

AND QUALITY IMPROVEMENT

Source: National Quality Forum. *Quality in Home- and community-based Services to Support Community Living: Addressing Gaps in Performance Measurement Final Report*. 2016. Available at:
https://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx.

As a consequence, states do not have a "playbook" or standard set of HCBS measures they can use to assess the performance of managed care plans for various purposes, including: monitoring access to and quality of care; publicly reporting plan performance; or rewarding plans and providers in pay-for-performance and VBP programs.

Although there are challenges with developing standardized measures to compare diverse Medicaid LTSS programs across states, there are efforts underway to develop valid, reliable measures of MLTSS quality for use by all states (***see Progress toward Nationally Standardized MLTSS Performance Measures, next page***). These measures are likely to be a small subset of those needed for VBP. Consequently, each state Medicaid agency must select a set of HCBS performance measures for use in VBP models that support its goals. Fortunately, there are several sources of existing HCBS performance

measures to use as a starting point. For example, states can apply or adapt measures that have been used to assess the performance of HCBS waiver programs, or MLTSS programs if they have been operating for some time. The NQF HCBS quality framework final report identifies examples of measures in each domain, and NQF published a compendium with over 250 measures corresponding to the 11 measurement domains.[18] The National MLTSS Health Plan Association issued recommendations for a set of measures that can be used to hold plans accountable.[19] Several states have also developed useful measure sets for MLTSS VBP programs, which will be discussed later in this section.

Progress toward Nationally Standardized MLTSS Performance Measures

Since 2012, Mathematica Policy Research and the National Committee for Quality Assurance (NCQA) have been working to fill the gap in nationally standardized measures of quality for MLTSS plans. Such measures are critical to making fair and accurate comparisons of managed care plan performance across states. In the first phase of this work, Mathematica and NCQA identified important aspects of LTSS quality for which managed care plans could be held accountable, formulated candidate measure concepts, and consulted with members of a technical expert panel who recommended a set of measures that held promise for development and testing.

In the second phase, the team rigorously tested eight MLTSS measures:

- Four measures that are related to the extent to which beneficiary **needs assessments and care plans** are comprehensive, person-centered, and shared and updated as appropriate;
- One measure that determines whether enrollees' risk of falls is fully assessed and whether appropriate steps are taken to **reduce falls risk**; and
- Three measures that are "rebalancing indicators" assessing the effectiveness of managed care plans' care coordination and HCBS delivery in helping members **remain in the community** by avoiding unnecessary admissions to nursing homes or other institutions, reducing time spent in institutions if it is needed, and transitioning back to the community after a long-term stay.

In May 2018, NCQA's Committee on Performance Measurement approved the four comprehensive assessment and care plan measures for inclusion in 2019 HEDIS, and draft technical specifications were available for review on Medicaid.gov.[20] The four remaining measures were nearing final testing and will be considered by the National Quality Forum for possible endorsement in the fall of 2018.[21]

What are Criteria and Considerations for Selecting Performance Measures for HCBS VBP?

Choosing the right mix of measures for assessing HCBS performance, which reflect the outcomes of HCBS as well as the structures and processes that lead to good outcomes, depends on two key steps. First, it is important to convene a broad group of stakeholders, including contracted managed care plans and LTSS providers who will be responsible for collecting and reporting the measures or the data needed to construct them. The group should also include consumers and advocates representing the

populations enrolled in MLTSS programs to provide input into which measures or types of measures matter most to them. Given their varying perspectives, stakeholders may not agree on all purposed measures, but it should be possible to reach consensus on a core set acceptable to all parties.

Second, once a list of potential measures is selected, states — in consultation with stakeholder groups — must decide which HCBS measures should be used for bonuses or other financial incentives (i.e., which measures should be linked to payment). See ***Case Study: New York's Clinical Advisory Groups (next page)*** for an example of how a state selected quality measures (otherwise referred to as performance measures) for plans to use in VBP models with providers.

The selection of the most appropriate performance measures can be informed by the following considerations:

Are the measures relevant to policy and program goals?

As described in section 1, measures used in MLTSS VBP models should be those that directly reflect the goals and desired results of the MLTSS program, and the overall LTSS system if managed care is the primary mode of delivering these services. For example, if one of the goals is to increase access to high-quality HCBS, managed care plans can be rewarded for providing a greater share of LTSS in home and community settings rather than in institutions. However, the design of capitated payments may already provide this incentive when rates are set based on a blend of HCBS and institutional costs, and the ratio between the two favors more HCBS.[22] At the same time, more HCBS does not necessarily mean that it is all appropriate or of high quality.

Consequently, measures used in a VBP model might award extra payment to specific types of inputs, processes, or outcomes that demonstrate better access to high-quality HCBS. These could include: (1) **structural inputs** such as well-trained direct care workers who provide most hands-on HCBS; (2) **processes** such as completion of comprehensive assessments and care plans that ensure HCBS participants receive high-quality person-centered care; and/or (3) **outcomes** such as meeting individuals' goals for care. For structural input and process measures, it is important to select those that are supported by evidence showing that better performance on the measures actually leads to improved outcomes.

Are the measures feasible to report and are data available to construct the measures? If not, how burdensome is it to report new measures or collect additional data?

Not all important program activities and related improvements are easy to measure. The feasibility of collecting complete, accurate, and timely data needed to construct measures is a key consideration when selecting measures for VBP arrangements. This applies to all types of data: claims or encounter data; health conditions; functional ability and limitations; enrollee-reported experience of care and quality of life; and assessment and care plan data derived from managed care plan or provider records.

CASE STUDY | **New York's Clinical Advisory Groups**

As part of its broad efforts to engage stakeholders in VBP Roadmap efforts, New York Department of Health (DOH) convened a series of Clinical Advisory Groups (CAGs) to provide expert opinion from various stakeholders in its measure selection processes. The CAGs — one for each VBP arrangement (e.g., pediatrics, maternity care, managed long-term care [MLTC], etc.) — are comprised of experts and representatives of providers, plans, advocates, trade associations, enrollees, and researchers. CAGs met regularly from 2015 through 2017 to provide clinical insight and make recommendations for selecting and refining VBP quality measures. The CAGs continue to meet at least annually to help the DOH prioritize care goals and continue to guide the long-term development of the state's quality measure set for VBP. The CAGs' recommendations were collected and published on the DOH website.[23]

The MLTC CAG reviewed several quality measures for inclusion, many of which were already used in other programs. It separated quality measures into three categories according to their clinical validity, reliability, feasibility, and perceived importance of the measure to the stakeholder community. The categories determine how the measures can be used: as part of VBP arrangements (Category 1); subject to further testing (Category 2); or not recommended for VBP because they are not valid, are unreliable, and/or are not feasible (Category 3). Following is a list of the 2017 measures recommended by the MLTC CAG for its MLTC VBP models.[24] Measures with an asterisk are included in the state's MLTC quality incentive measure set, which rewards MLTSS plans for their performance on quality measures.[25]

Category 1: Approved quality measures that are clinically relevant, reliable, valid, and feasible. These measures align with the existing state-plan quality incentive program that uses a quality withhold from the MLTSS capitation rate to pay plans. Plans must report on the Potentially Avoidable Hospitalization measure, with the option of including other Category 1 measures in reporting efforts.

- Potentially Avoidable Hospitalization for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection *(required measure)**
- Percentage of MLTSS members who:*(optional measures)*
  » Had no emergency department visit in last 90 days*
  » Had no falls needing medical care in last 90 days*
  » Received influenza vaccination in the last year*
  » Remained stable or improved pain intensity*
  » Remained stable or improved Nursing Facility Level of Care score*
  » Remained stable or improved urinary continence*
  » Remained stable or improved shortness of breath*
  » Did not experience uncontrolled pain*
  » Were not lonely and not distressed*

Category 2: Measures that are clinically relevant, valid, and probably reliable, but where feasibility issues require further investigation before full implementation for use in VBP arrangements is possible [measures for long-stay nursing residents are not listed].

- Care for Older Adults – Medication Review
- Use of High–Risk Medications in the Elderly
- Percentage of members who rated the quality of home health aide or personal care aide services within the last 6 months as good or excellent*
- Percentage of members who responded that they were usually or always involved in making decisions about their plan of care*
- Percentage of members who reported that within the last 6 months the home health aide or personal care aide services were always or usually on time*

Measures within each categories can change. The MLTC CAG provides annual reports to the state about the appropriate categorization of quality measures, such as relevance to the community or new evidence to improve reliability. The MLTC CAG can also consider the changing capacity of the plans, providers, and state Medicaid agency to determine whether new measures can be collected efficiently and used in the program.

New York notes although the initial MLTC CAG membership was selected by the state-appointed VBP Work Group, it did not restrict other members and its MLTC CAG membership grew to more than 80 people. As membership grew, New York reports that the quality of feedback improved too. New York also let the MLTC CAG set the meeting schedule and meeting agendas whenever possible, which increased stakeholder buy-in and ownership of the process.

However, feasibility does not mean the data must already be available; if the measures are important indicators of progress toward program goals, new data collection may be needed. If new or additional data are needed to construct important measures, states should consider the additional cost and burden such data collection imposes on plans, providers, and beneficiaries. The higher the cost and burden, the greater the risk that the data will be incomplete or inaccurate. This is particularly true for HCBS providers, many of which have limited capacity to report accurate data because they are small agencies with few administrative staff and, in some cases, because they do not use electronic record systems to keep track of beneficiary information and visits. Strategies may be used to lessen the burden, for example, by collecting data annually or quarterly, rather than monthly, or by developing a common web-based reporting system and making it available for free or at low cost to all plans or providers. Direction Home, a leading Area Agency on Aging in Ohio that participates in VBP models with some of its contracted managed care plans, suggested that, if possible, plans should align the performance measures they must report to states with those use for provider reporting. . When plans and providers are responsible for collecting and reporting the same data, the process can be simplified.

Another consideration is whether measures require Medicare data for dually eligible enrollees, to which states and managed care plans might not have access. The New York State DOH Office of Quality and Patient Safety calculates the VBP measures in Category 1 to reduce the burden on managed care plans and providers. This is a resource-intensive activity, but also provides important data for New York's MLTSS managed care plans, which cover LTSS services only and do not otherwise have access to the hospital data needed to construct the potentially avoidable hospitalization measure for dually eligible enrollees. DOH compiles hospital data for these enrollees using the Statewide Planning and Research Cooperative System, a comprehensive all-payer data reporting system, and it provides that data to plans.

The standards for assessing the completeness and accuracy of the data must be high. If managed care plans and providers' financial status depend on whether or how much they receive in VBP arrangements, the stakes increase for ensuring the data used to create measures are correct. For this reason, rigorous data validation is critical, an activity that represents another set of expenditures to factor into the overall cost. Although there may be ways to reduce the cost of data validation (e.g., by randomly selecting a set of records or measure reports from all managed care plans and providers for such checks), the greater the bonus or amount of shared savings at risk, the greater the investment should be in validating the data and measures reported.

If states are not able to construct the measures, and the feasibility for a given measure is low, such measures are not suitable for VBP. New York excluded some measures nominated for use in VBP models because of concerns about their accuracy or reliability for measuring beneficiary outcomes.

Can MLTSS plans and HCBS providers be held accountable for measure performance?

Measures used in VBP models should be those which plans or providers have the ability to control or influence, a concept known as "accountability." It is generally easier for managed care plans and providers to affect inputs and processes, such as conducting timely and comprehensive assessments, which is why they often prefer such measures. It may be harder to control outcomes, particularly those related to HCBS such as quality of life and achieving personal care goals, because such outcomes are influenced by many factors other than the services and supports covered by the managed care plan or

delivered by HCBS providers. Managed care plans and providers also have less ability to maintain individuals' functional ability, given the trajectories of some disabling conditions.

To be sure the measures used in VBP models align with accountability, it is important to understand which services and supports are covered by the managed care plans and delivered by each type of provider. For example, one of the measures derived from the CAHPS® HCBS survey is "Choosing Services That Matter to You," based on beneficiaries' responses to questions that ask them to rate the extent to which their service plan and direct care workers reflect the services that are most important to them. If the managed care plan does not cover certain services that an individual prefers because they are not in the contract, or if direct care workers do not provide certain services because they are outside the scope of their training and qualifications, then it would be unfair to hold managed care plans or HCBS provider agencies accountable for low scores on this measure.

Similarly, if managed care plans cover HCBS but not acute care services such as hospital inpatient care, emergency department visits, and physician visits, they may argue that in many cases they should not be held accountable for measures that reflect timely access to primary and preventive care or other services that are outside of covered benefits. In cases where accountability for performance is shared across providers, the measures should apply to managed care plans or accountable care organizations that contract with all of the providers with shared accountability.

Do the measures need to be risk-adjusted, at the plan or provider level, to account for LTSS population diversity?

The people enrolled in MLTSS programs have diverse health conditions, different types of disabilities, varying levels of functional limitations, and differ in age, living arrangements, and many other characteristics that affect their need for services and supports and expected outcomes of care.

Key Terms

- **Risk adjustment**: Statistical methods that adjust for differences in population characteristics or risk factors, before comparing outcomes of care across plans or providers, sometimes called "case-mix adjustment."
- **Risk stratification**: Reporting outcomes separately for different groups, unadjusted by a risk model.

This diversity means that certain outcomes measures in VBP models must be risk-adjusted to account for differences in the characteristics of people enrolled in each managed care plan or served by each provider, which influence these outcomes but are not within the plan's or provider's ability to control. These characteristics, known as risk factors, include age, health and functional status, type of disability, and many others. It may also be important to consider whether and how social, economic, or neighborhood factors influence the outcomes, and if so, whether data are available to account for such factors in risk adjustment models. Adjusting the scores for each plan and provider to take into account such risks, or stratifying the results by age or other factors if risk adjustment models cannot accurately account for all differences, levels the playing field when comparing performance of MLTSS managed care plans and HCBS providers.

How does the nature of HCBS service delivery influence the choice of VBP measures?

Many states prefer to use measures for HCBS VBP models that reflect the outcomes that matter most to beneficiaries. Examples of these outcomes include: having a good quality of life; having the autonomy to decide where to live and receive care and who will provide that care; and being able to set personal care goals and receiving the services and supports needed to achieve those goals. These outcomes can only be measured by asking beneficiaries directly, usually through telephone or in-person surveys. See: *Case Study: Minnesota's Efforts to Work with Managed care plans on National Core Indicator Data (below)* for an example of how a state is using survey data.

CASE STUDY | **Minnesota's Efforts to Work with Managed Care Plans on National Core Indicator Data**

The National Core Indicators-Aging and Disabilities (NCI-AD) initiative supports states in collecting and analyzing valid and reliable data that examines how LTSS programs for older adults and persons with physical disabilities impact quality of life.[26] A collaborative effort between National Association of States United for Aging and Disabilities and the Human Services Research Institute, the NCI-AD helps states assess beneficiary experience, including how programs support social, community, and person-centered goals. Minnesota is one of the 18 states that participate in the NCI-AD. It joined this initiative to improve its ability to assess how its LTSS programs (including MLTSS and FFS waiver programs) are improving quality of life, and to fill some gaps in existing measures that are more health care and process-focused. It collects this data across all LTSS programs, and recently decided to share data with its managed care plans to identify areas and actions for improvement for individuals enrolled in MLTSS programs.

The state contracted with the University of Minnesota to analyze the NCI-AD data by program, managed care plan, and race and ethnicity. Early results indicated minimal variation between plans, slightly higher performance for MLTSS enrollees compared to those in fee-for-service programs, and some disparities in certain quality measures across racial and ethnic groups.

Minnesota formed a work group with managed care plans participating in its Senior Health Options program to develop a collaborative analytic plan for using this data to improve performance on quality of life indicators. Initial work group efforts focus on: developing a direction and focus for future program expectations and contract requirements; cross-walking these results with other surveys that assess beneficiary experience (e.g., CAHPS); and conducting analyses to understand how Minnesota compares to other states. It will also work with managed care plans to address and develop targeted approaches to improving self-reported disparities in quality across different ethnic groups.

But surveys have some challenges. First, surveys are expensive to administer, so they are usually conducted with only a sample of enrollees and just once a year, which may be too infrequent to adequately assess provider performance. Second, the measures and scores derived from survey responses are reliable only if the sample of people who respond is representative of all members of the managed care plan, or all individuals served by a particular provider. If managed care plans or providers have relatively few members, the survey must oversample — select more respondents — from such managed care plans or providers to ensure the results are statistically valid, which adds to the cost.

In addition to outcome measures, structural measures may be important to include in VBP models for plans or providers to show increasing progress in establishing the infrastructure needed to deliver high quality HCBS. For example, some experts recommend including measures of staffing and steps to improve the stability and qualifications of the HCBS workforce,[27] because HCBS are provided by workers who may have minimal training and education, get paid near minimum wage, receive few job benefits, and have irregular schedules. As a result, there are chronic shortages of such workers, annual turnover rates are very high (over 50 percent nationally), and the HCBS workforce overall has insufficient skills and knowledge to provide high quality care to people with complex needs.[28,29]

Structural measures can create incentives to strengthen the HCBS workforce and could include quarterly or annual staff turnover rates (e.g., reductions in three-month and yearly turnover rates), completion rates for training courses, employee satisfaction scores, onsite worker injury rates, and consistency of assignment of aides to beneficiaries. These types of measures are used by several states that operate VBP programs for nursing facilities.[30] For example, Indiana's VBP program for nursing facilities uses several staffing measures that collectively comprise 25 percent of the total score required to receive incentive payments, including: average nursing hours per resident day; retention rate for RN/LPNs and CNAs; and turnover rate for RN/LPNs, CNAs, administrators, and directors of nursing.[31] Tennessee's QuILTSS nursing facility VBP program gives credit for results related to staff satisfaction, nurse hours per day, staff retention, consistent staff assignment, and initial and ongoing staff training.[32]

How can states set targets that qualify for payment bonuses or shared savings?

After selecting which measures to use for VBP models, states must determine the performance targets or benchmarks that qualify for financial bonuses, or shared savings. Targets or benchmarks can be:[33]

- **Absolute**, requiring a provider to meet or exceed a specified score on one or more measures, typically a minimum (or maximum) value;

- **Relative**, requiring the provider to achieve a score within a certain range relative to a benchmark, such as the mean, median, or a percentile, based on the performance of similar managed care plans and providers; the benchmark may be set using national or state-specific scores (sometimes called an "industry standard") for the Medicaid population or line of business; or

- **Improvement-based**, comparing a provider to its performance in the previous measurement period, or degree of improvement compared to a statewide target.

There are pros and cons to each of these methods, and states may choose a combination of these methods depending on desired outcomes and certain performance levels. Absolute targets can give all providers an incentive to improve, if the target is set near or above the score of the highest performer(s). Absolute targets can also be used to ensure minimum performance on specific types of inputs and processes that all providers are expected to achieve. However, providers already performing well can more easily reach the targets, and those that are farther away may get discouraged and not even try. Relative targets can also encourage improvement by all providers, but can create a moving target that those performing poorly may be unable to achieve. Rewarding improvement is important for the lowest performers, which gives them the incentive to do better even if they cannot achieve an absolute target or their performance is well below the median. Improvement-based targets may also be more suitable for outcomes measures, particularly those for which the "best" score is unclear.

To determine which method may be appropriate for any given measure, states should start by determining how HCBS providers currently perform on the measures. Collecting the data on these measures, at least for a sample of entities that will be part of the VBP program, will establish the baseline: average scores; highest and lowest scores; and the distribution of scores across the reporting entities. If baseline scores show that all or a majority of providers are already performing very well (e.g., in the 90th percentile) the measure may be "topped out," indicating little room for improvement. If baseline scores indicate that most providers are well below the highest performer — an outlier — it can help in deciding how far and how fast the state wants to raise the bar for everyone else. It may also be worthwhile to select a mix of measures, including those that are easily achieved by most HCBS providers to motivate all of them to participate, and those that are more of a stretch to reward those that make extra effort and improve the most.

After selecting the target or benchmarking method, the next step is to set the specific value(s) to which the HCBS provider's performance will be compared. This is easier when measures have been in wide use, and national or state benchmarks are available. Because there are few nationally standardized measures for MLTSS plans or for HCBS providers, benchmarks are also rarely available. That means, once again, that states must develop their own benchmarks. It is also very important for states to be transparent about this process so that managed care plans and providers understand at the outset the bar for which they are reaching.[34]

3. SELECTING PAYMENT MODELS TO IMPROVE THE VALUE OF HCBS

Payment models are an important tool that can be used by states to drive better value in MLTSS programs. States are continually challenged with trying to manage limited state budgets while ensuring access to high-quality HCBS services for an increasing number of people who qualify. The payment approach taken by states and managed care plans can influence provider behavior, creating an opportunity for states and their MLTSS plan partners to achieve program goals.

Most states and managed care plans pay for HCBS services on a FFS basis. FFS-based payment systems generally incent the use of more services, since the more services that are provided, the more revenue a provider receives. This may be desirable when the payer wants to encourage the use of preventive services or HCBS that promote community integration and increased independence. States and managed care plans may also reimburse some HCBS providers using bundled payments or population-based per member per month capitation payments. These payment models are designed to incent greater efficiency, since the provider is paid a set amount of money for delivering a specific set of services to a person or group of people. FFS or a bundled/capitated payment approaches typically are not linked to the quality of care delivered or the outcomes achieved. In contrast, VBP models can be used by payers to help improve the value of the services, and potentially reduce overall costs, by including incentives to deliver high quality, efficient care in the payment model.

This section describes:

- Different ways of structuring payments in VBP models for HCBS;
- Key considerations for selecting a VBP model, including determining the most appropriate approach and the incentive amount; and
- Potential non-financial incentives that can be used to complement a VBP model for HCBS.

How Can Payments Be Structured within HCBS VBP Models?

The Health Care Payment Learning and Action Network (LAN), sponsored by the U.S. Department of Health and Human Services, created a framework to establish standard terminology across both Medicare and Medicaid to describe payment models. *(See Exhibit 3, APM Framework, next page)*.[35]

The payment models described in the LAN framework vary in the level of financial risk for providers and the extent to which they incorporate quality and value. Category 1 models represent how most HCBS providers are paid: FFS with no link to quality or value. Payment models in Categories 2, 3, and 4 under this framework are considered VBP initiatives. Category 2 approaches, based on FFS and including some link to quality and value, often serve as a starting point to engage payers and providers in measuring and assessing the quality of care being delivered. APMs move towards risk-based approaches in Categories 3 and 4, where providers are held accountable for the cost and outcomes of the services provided. Categories 3 and 4 include episode-based payments, shared savings models with accountable care organizations and capitation-based payments that often require different types of providers to coordinate and organize around the beneficiary or group of beneficiaries as part of a larger team to identify efficiencies and improve effectiveness.

Exhibit 3. APM Framework

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
FEE-FOR-SERVICE - NO LINK TO QUALITY AND VALUE	FEE-FOR-SERVICE – LINK TO QUALITY AND VALUE	APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	POPULATION-BASED PAYMENT
	A	**A**	**A**
	Foundational Payments for Infrastructure and Operations (e.g., care coordination fees and payments for HIT investments)	**APMs with Shared Savings** (e.g., shared savings with upside risk only)	**Condition-Specific Population-Based Payment** (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B	**B**	**B**
	Pay-for-Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	**APMs with Shared Savings and Downside Risk** (e.g., episode-based payment for procedures and comprehensive payment with upside and downside risk)	**Comprehensive Populations-Based Payment** (e.g., global budgets or full/percent of premium payments)
	C		**C**
	Pay-for-Performance (e.g., bonuses for quality performance)		**Integrated Finance and Delivery System** (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk-Based Payment NOT Linked to Quality	**4N** Capitated Payments NOT linked to Quality

Source: Health Care Payment Learning and Action Network (HCP-LAN). *Alternative Payment Model (APM) Framework: Refresh for 2017*. The MITRE Corporation. 2017. Available at: http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

What are Key Considerations for Selecting a VBP Model for HCBS?

The use of VBP models in HCBS so far has been very limited, particularly for payment models that involve substantial downside risk if providers do not successfully manage costs, which could reduce total revenue. This is due, in part, to the many small, independent HCBS providers, who have limited capacity to take on risk in these models. Further complicating this issue is the reality that HCBS providers often do not have the administrative infrastructure needed to collect, analyze, and monitor performance data to identify gaps and areas for improvement. Nor have most HCBS providers established partnerships with hospitals and physicians that would support better care coordination across the delivery system — a critical component to improving outcomes for the HCBS population.[36] The key to determining the most appropriate payment model starts with identifying the options that are best aligned with overall policy goals, most effective at driving change, and most operationally feasible. Several questions to consider are:

Which payment models are most aligned with the policy goals?

VBP should incentivize and reinforce: (a) the care delivery processes that lead to improved outcomes (e.g., achieving: individual care goals; higher quality of life; community integration; or competitive, integrated employment); or (b) the activities that lead to better care processes and outcomes, based on how the state defines high-value HCBS.

Given the importance of a strong HCBS workforce, states may also consider payment approaches that improve workforce capacity and quality when low pay and high turnover rates have created a shortage of high-quality direct care workers. For example, some states are awarding extra dollars to community-based residential homes or directly to personal care attendants for participating in additional training, beyond the minimum requirements. Washington State established payment rates for individual direct care workers that reflect geography, credentialing, accreditation, training, education, and tenure. To help direct care workers provide higher-quality care, Washington pays qualifying providers an extra $0.50 per hour for direct care workers that successfully complete an additional training program designed to help them better serve residents with high-risk behavioral care needs, such as people with dementia.[37]

Which VBP model will be most effective in changing provider behavior?

States should examine their existing HCBS payment methodology and identify potential changes that may better align with state policy goals. For example, if payment rates differ based on acuity (level of need), there may be a disincentive to improve functional ability and increase independence because higher needs translate into more hours and higher payment. A bonus payment or higher rate tier could be paid to personal care workers or agencies who achieve better outcomes for beneficiaries for the same or fewer hours, financed by the savings to help offset any potential lost wages. With bundled payments, there may be an incentive to use fewer services, which may be a desirable outcome in some cases, but not always. For example, in its Section 1915(c) waivers for people with intellectual disabilities (carved out of managed care), Tennessee paid a bundled rate for day habilitation services that included all employment and day services within a six-hour day. The rate was higher if the person supported was working at least two hours per day in order to incentivize employment. However, upon review, the state found that individuals for which the enhanced rate was paid were working on average almost exactly two hours per day, when many people wished to work more hours. Using lessons from its new MLTSS program, Employment and Community First CHOICES, Tennessee is now unbundling the day habilitation rate in the waiver programs, and implementing VBP reforms, including

incorporating separate milestone payments related to employment outcomes. See **Case Study: Tennessee's Alternative Payment Model for Employment Services (below)**, which describes Tennessee's approach to designing a payment model for supported employment services that lower the need as appropriate for more intensive services.

CASE STUDY | **Tennessee's Alternative Payment Model for Employment Services**

Tennessee's Employment and Community First CHOICES program serves people with intellectual and developmental disabilities. When developing a VBP model for this MLTSS program, the state faced a conundrum: how to reward HCBS providers for promoting individuals' independence, which could create a situation under which an individual needs *fewer* services from that provider. The state's innovative solution was to develop a VBP model for the managed care plans in this program that links provider reimbursement to a series of deliverables and employment outcomes based on the beneficiary's identified needs.

Many of the services offered under Employment and Community First CHOICES are employment supports to help individuals identify job opportunities (e.g., employment exploration, discovery) and prepare for, obtain, and maintain competitive, integrated employment. Tennessee's model creates an actionable series of steps that must be accomplished to achieve sustainable employment and ties specific, tiered payments to "deliverables" or expected outcomes achieved after each step in the process. Examples of deliverables are: developing a job profile that meets the requirements of Vocational Rehabilitation agencies; creating a job plan that meets certain standards; getting hired; and remaining on the job for a number of months.

Tennessee also designed several payment tiers for job coaching services to create incentives for providers to support continued employment while appropriately reducing the hours of coaching required. There are also opportunities to build in natural supports and leverage technology supports to meet this goal. Lastly, payment rates are risk adjusted to reflect an individual's acuity level or needed supports, so providers may receive higher reimbursement levels if they serve beneficiaries with higher needs.

In addition, Tennessee's approach is person-centered. Staff providing employment supports are trained to learn about and examine individuals' interests and aptitude as a step in identifying and, in some cases, creating employment options that align with each person's unique interests, goals, and abilities.

Tennessee's innovative outcomes-based and beneficiary-centered approach has contributed to improved employment outcomes — in terms of the percentage of working age adults participating in competitive integrated employment, their average hourly wage, and the number of hours worked per week.

What type of VBP arrangement is most feasible in the current environment?

To identify appropriate payment models for HCBS, it can be helpful to build on existing VBP models operating in the state that include a link to quality and value, such as nursing facility VBP models or shared savings models with accountable care organizations. Several states, including Indiana, Ohio, Minnesota, Texas, and Tennessee have implemented VBP incentives for nursing facilities that could be adapted for HCBS providers.[38] Massachusetts is expanding its Medicaid accountable care organization model to require that they partner with LTSS providers.[39]

To assess which payment models are feasible for different types of HCBS providers, it is important to consider the providers' level of sophistication and ability to accept financial risk. More advanced states also emphasize the importance of going slow and rewarding incremental change. For example, some providers need to start by building capacity and infrastructure to participate in VBP arrangements and getting paid for reporting performance measures, before moving to getting paid for improved performance.

One related policy consideration for states is the use of "Any Willing Provider" (AWP) rules, which are protections that ensure Medicaid beneficiaries can receive covered services from any qualified provider willing to furnish such services. States typically include AWP requirements in new managed care programs to ensure continuity of care and minimize disruptions during program transitions. However, AWP rules could hinder VBP efforts by limiting managed care plans' ability to selectively contract with providers who demonstrate that they provide high-quality care. Some states with mature MLTSS programs have decided to remove these standards over time, or to at least elevate the floor for "qualified providers" based on quality performance.

What is the appropriate payment incentive amount to drive behavior change?

Appropriate levels for financial incentives depend on what is achievable within the program budget, policy priorities, and the measures/benchmarks used. Federal Medicaid managed care rules limit the incentive payments states can make to managed care plans to no more than five percent of the capitation rate.[40] However, there is no comparable limit on incentives that managed care plans can make to providers under VBP models.

The financial incentives should be high enough to engage providers and drive change; the bigger the incentive or penalty, the more attention it will get from providers. If the incentive is too low or achieving the threshold to qualify for it appears unattainable, providers may not be willing to make the necessary investments. The right incentive amount needed to change behavior is likely to vary from provider-to-provider based on their unique circumstances. One state official noted that for HCBS providers, they have been surprised at "how little money it takes to change provider behavior."

But there is a risk that the additional funds will not be shared with direct care workers. Most often, incentive payments go to the agency or entity that employs direct care workers, which might not be willing to pass those payments down to individual HCBS workers. To address this concern, Texas established a voluntary rate enhancement program for attendant care providers. Providers who choose to participate in the program are eligible to receive an enhanced add-on rate and agree to spend at least 90 percent of their total attendant care revenues, including the enhanced add-on rate and any VBP incentive payment, on direct care worker compensation.[41]

States that have limited funds to invest in these programs could consider a shared savings or a combined incentive/penalty model that is budget neutral to the state. For example, CMS' Medicare home health VBP program will adjust home health agency payments by a maximum of three percent (upward or downward) in the first year (CY 2018), increasing each year to eight percent by year five (CY 2022). Providers are scored based on their own performance relative to their peers in the state as well as their own past performance and improvements.[42]

Examples of VBP Models for HCBS from Innovative Managed Care Plans

Innovative managed care plans are developing VBP models for HCBS providers. At this point, the models involve upside-risk only — or performance-based incentives — but both managed care plans hope to transition to a risk-based model in the future. Following are two examples:

Mercy Care, Arizona: Working with eight attendant care agencies, Mercy Care developed an incentive program to reduce hospital readmission rates through improved member adherence to discharge plans. Mercy Care tasked participating agencies with developing a comprehensive training for attendant workers, many of whom are family caregivers employed by the agency, to guide care for plan members after hospital discharge. The trainings address several activities that attendant care workers can do that support successful discharges, such as filling prescriptions within 48 hours of discharge, assisting with appointment scheduling, and ensuring that the member is seen by a primary care physician within seven days and/or specialist as appropriate within 30 days. Agencies were eligible to receive a performance bonus if they: submitted an approved training curriculum; executed a contract with Mercy Care to offer discharge training; and completed an attestation that workers, based on a self-reported tracking tool, completed the training and adhered to discharge protocols. Mercy Care is pleased with preliminary agency participation in its first year, and is actively planning a second phase to advance this initiative that may include:

- Identifying best practices in individual agency trainings to streamline the curricula;
- Incorporating disease management elements into the training curriculum for common chronic conditions such as diabetes and *chronic* obstructive pulmonary disease;
- Developing a member questionnaire to identify specific triggers for readmissions; and/or
- Collecting benchmark data to better measure and hold providers accountable for meeting goals (e.g., percentage of members seen by a primary care physician in seven days; readmission rates by provider). Mercy Care noted that the diversity among participating agencies poses one challenge with developing benchmark data. For example, one agency serves over 4,000 members, while another serves fewer than 200. For small agencies, just a few non-compliant or clinically challenging members can disproportionately skew outcomes compared to larger agencies.

VNSNY CHOICE, **New York:** To meet New York's VBP Roadmap requirements, VNSNY CHOICE (CHOICE) executed contracts at the end of 2017 with its Licensed Home Care Services Agencies; Certified Home Health Agencies and Skilled Nursing Providers to incorporate payment arrangements that meet New York's Level 1 criteria.[43] In addition to including the required Potential Avoidable Hospitalization measure, CHOICE selected six additional measures from New York's approved MLTC Quality Incentive Category 1 measure set to include in its performance bonus process. Under CHOICE's payment methodology:[44]

- Providers must meet a performance score based on achievement of a point increase or target value for each measure, compared to a baseline.
- The Department of Health sets the baseline and calculates the providers' performance scores. CHOICE assigns a weight to each measure that is factored into the final payment amount. The weighing methodology and measure selection ties the provider incentives to CHOICE's quality improvement initiatives.
- CHOICE will calculate the bonus owed to providers based on respective measurement year performance once it receives its stimulus funds from the state's established funding pool.

In addition, CHOICE has made several investments in provider education and resources to support participation in this initiative. For example, it developed a real-time dashboard to provide visibility into the member's health status and early detection of at-risk measures to allow the provider to intervene and provide effective care in a timely manner. CHOICE also plays a leading role in a Workforce Investment Organization, and aligns trainings for its providers with the selected quality measures it is trying to improve.

What level of financial risk is appropriate?

A provider's ability and willingness to accept risk is tied to its size, sufficiency of reserves, information technology infrastructure, diversity of services, and other factors. LAN Category 2 payment models may be an endpoint for certain types of HCBS providers, particularly small or independent providers.[45] Large institutional or agency-based HCBS providers are more likely to have the ability and capacity to take on some level of financial risk. Providers with substantial cash reserves may be more willing to take risk than safety net providers who are operating on thin margins. The more diversified a provider's business is, the less risky a particular payment approach may be to their overall business and more likely they are to have direct control over the activities and services required to improve performance on the process and outcome measures.

States and plans should also be mindful of the unintended consequences of the payment model. If new payment models result in HCBS providers taking on greater financial risk than they can manage, they may go out of business, disrupting care for beneficiaries. Consequently, such risks must be weighed against the potential benefits of improving quality and access in a fragile HCBS delivery system.

Is the financial model sustainable long term? What ROI is needed?

As discussed in section 1, designing new MLTSS payment models will ideally be a long-term initiative. That is because implementing VBP models may first require the state and or managed care plans to make upfront investments in data reporting and infrastructure, provide technical support to providers, and test alternative types or levels of incentive bonuses and increased payments to see what works to engage providers. At some point, states need to consider a financing strategy to ensure the VBP model is sustainable over the long term. Financial modeling is essential for assessing the feasibility, initial investment costs, potential savings, and the potential return on investment. Performing financial modeling and holding discussions with various stakeholders can also help identify potential winners/losers and mitigate any potential unintended consequences.

What types of "non-financial" incentives can be used to improve HCBS value?

Non-financial incentives may be another lever to increase provider engagement and improve performance. While money can be a motivating factor, it may not be the only way to change an HCBS provider's behavior. States and managed care plans with limited financial resources to drive quality improvement through VBP models can use non-financial incentives as a complementary strategy to help motivate providers to take action and drive change. Potential strategies include:

- **Report cards/data reporting.** Public reporting of quality scores and health outcomes has often preceded VBP initiatives launched by CMS and states. Through public reporting, providers gain insight into their own performance relative to that of their peers. Report cards help providers identify areas for improvement and can promote healthy competition among providers, focusing them on the specific elements included in the report card. Texas publishes a report card on its website for participating MLTSS plans that includes a number of different measures and star ratings.[46] Washington State publicly reports on the performance of each Area Agency on Aging on several accountability measures as required by the legislature.[47]

- **Marketing/recognition programs.** Being publicly recognized as a high-quality provider can be a strong motivational factor. HCBS providers who achieve a certain quality score could receive preferential marketing status, "best provider" status, or other endorsements to help attract customers, retain staff, and expand services. Vermont's "gold star employer" program recognizes

the top five nursing facilities in the state with nominal monetary rewards, holding an awards ceremony for staff at each winning home and inviting the local newspaper.[48]

- **Preferred provider status/referrals.** HCBS providers could receive preferred provider status with managed care plans or preferential placements on referral lists. For example, a large home health agency in Texas partnered with a managed care plan to be the preferred provider in the region after demonstrating its ability to help reduce emergency room visits for members, a measure that is tied to an incentive payment from the state to the managed care plan. Part of the home health agency's success was attributed to the implementation of a bonus program for its direct care workers, whereby those workers who made the most difference in helping to avoid unnecessary emergency room visits were recognized and rewarded.

- **Auto assignment algorithms**. Auto-assignment algorithms are used by states with mandatory managed care programs to assign Medicaid members to a managed care plan if they do not choose one on their own. Oftentimes, these members have lower than average costs, and thus are more profitable for plans. As an incentive, states can disproportionately assign these members to its highest performing MLTSS plans through an auto-assignment process. Ten states (Arizona, California, Hawaii, Michigan, New Mexico, New York, Ohio, South Carolina, Virginia, and Washington) currently include quality or performance rankings in the auto-assignment algorithm for their Medicaid managed care programs.[49] States can also freeze enrollment for plans that are performing poorly, so that new members are not able to enroll until the plan meets minimum performance thresholds.

- **Training opportunities/workforce support.** As discussed in other sections, states can provide additional technical support and promote higher-quality training to better prepare workers and improve the overall quality of the LTSS workforce. States or plans could also provide "perks" to direct care workers who achieve certain levels of training or tenure, such as preferential placements on referral lists or recognition through public events or media.

- **Reduce administrative burden/dedicated support resources.** States could consider options that reduce administrative burden to high-performing providers such as reducing audit frequency or waiving certain administrative or compliance reports for high performing providers. States could also offer reduced license fees or provide additional technical support or dedicated support resources to those providers participating in VBP programs to encourage provider engagement.

- **Policies to expand HCBS provider responsibilities.** Some states have enacted policies to expand access to HCBS by increasing the availability of the direct care workforce to meet beneficiaries' needs. Nursing delegation, for example, is the process by which a registered nurse "directs another individual (i.e., an HCBS provider) to do something that that person would not normally be allowed to do."[50] Shifting some responsibilities from nurses to HCBS providers may create system efficiencies, and appropriately expanding HCBS provider responsibilities may also increase engagement and new career pathways for workers. However, it is important to note that making nursing delegation policy changes involves changes in licensure requirements and professional training, as well as the cultural shift needed to redistribute work.

4. WORKING THROUGH OPERATIONAL CONSIDERATIONS

This section outlines several practical and operational considerations for states as they focus on design elements and work with managed care plans, providers, beneficiaries, and other stakeholders to prepare for implementation, including:

- Setting appropriate VBP expectations or contract requirements for managed care plans;
- Assessing provider readiness and capacity to participate in VBP arrangements; and
- Engaging stakeholders throughout the design and implementation process.

What Types of VBP Requirements or Expectations Should Be Set for Managed Care Plans?

Although VBP models for MLTSS programs are implemented through contracts between managed care plans and LTSS providers, states generally use their contracts with managed care plans to set ground rules regarding the types of VBP models, acceptable level of financial risk, and quality metrics to be used in the plan-provider agreements. States may also require managed care plans to implement VBP models or participate in multi-payer or Medicaid-specific delivery system reform and provider payment initiatives. However, arrangements directing managed care plans' payments to providers are subject to written approval from CMS prior to implementation.[51]

State approaches to oversight and contracting vary, driven in part by state investments in staff capacity and availability of other resources dedicated to program oversight. They can also be driven by the managed care plan market, including size, managed care plan experience with MLTSS, states' long-standing relationships with managed care plan contractors as well as HCBS providers' comfort level with managed care. State considerations for developing MLTSS plan contract requirements and expectations include:

- **Determining the amount of flexibility given to managed care plans.** States and managed care plans generally agree that plans should have some flexibility to develop their own payment models and contracting relationships with providers. However, states should consider developing some overarching standards — or "guard rails" — to ensure consistency in performance metrics and reporting requirements across all plans and providers. For example, states could mandate a standardized list of performance measures, while allowing plans to test different, targeted payment models with specific providers. In addition, streamlining requirements around data collection and reporting can reduce burdens on providers who contract with multiple managed care plans. It can also simplify the interface between the states and multiple plans.

  States with MLTSS VBP programs have operationalized "guard rails" differently. Some require a certain percentage of provider payments to be made through VBP models each year and give plans wide latitude to meet that requirement. Other states require that payments be linked to specific performance metrics. Several examples include:

» **Arizona** requires its MLTSS plans to have 35 and 50 percent of total provider payments in a VBP model for calendar years 2018 and 2019, respectively, and choose from a state-developed list of measures and state-approved payment models to meet those targets.[52]

» **Texas** required its MLTSS managed care plans to ensure that 25 percent of provider payments are in a VBP model linked to quality metrics for 2018, and 10 percent of those payments must be in a risk-based model.

» **Minnesota** requires that managed care plans participating in its Integrated Care System Partnerships (ICSP) initiative, based on partnerships between plans and acute, primary, long-term care, and mental health providers that serve individuals in integrated programs, develop four VBP models with providers. Two must be with LTSS providers.

» **Tennessee** works with stakeholders to develop VBP models for all plans to use with LTSS providers to meet the same quality metrics, upon which the plans can build.

■ **Requesting information from managed care plans in contract bids.** States can ask managed care plans to describe their current VBP arrangements, future initiatives, and expected challenges in their Request-for-Proposals (RFP). Such information helps the state develop appropriate contract requirements related to payment models, and reasonable targets for the share of provider payments made through VBP contracts, among others. See *Case Study: Virginia's Approach to Stakeholder Input in Program Design* for an example of how a state used its RFP to collect program information.

■ **Requiring or encouraging managed care plan investments in workforce.** In addition to investments described below, states can require managed care plans to provide training and technical assistance, and build infrastructure that can help HCBS providers prepare for, or engage in, VBP. Data sharing is another important support. Direction Home, an Area Agency on Aging, noted that the investments its plan partner made in supporting data collection and reporting efforts resulted in a greater ability to make clinical and administrative improvements. Alternatively, states can create incentives for managed care plans to invest in HCBS provider networks, for example, by developing "preferred contracting" approaches to reward providers that have invested in training and other capacity-building for their workers. See section 3 for more information about these incentives.

What Can States Do to Help HCBS Providers Prepare for and Engage in VBP?

HCBS provider agencies face many challenges to participating in VBP models. These providers generally have limited capital to support risk-bearing arrangements or few reserves to cover reductions in revenue resulting from missed performance benchmarks. In addition, many HCBS provider agencies do not have other capacities important for success in VBP models, including information technology systems for measure reporting and data analysis, and many have limited experience with managed care. However, states, managed care plans, and HCBS providers understand the critical importance of direct care workers. Because of their frequent and often in-home contact with MLTSS program participants, direct care workers may often play other important roles by: (a) serving as the eyes and ears of other providers, like PCPs; (b) providing emotional support to participants; and (c) being a liaison with family caregivers, who may be paid or unpaid.

There are several ways that states can help HCBS providers engage in VBP models, including: (1) investing in and helping providers learn to use technology or systems to support data collection and reporting; (2) providing technical assistance to educate providers about VBP; or (3) directing grants to providers to build business acumen and infrastructure. States may also develop training programs that support career advancement, improve workforce retention, and pay higher wages to HCBS workers. Collecting, analyzing, and providing program data to HCBS providers — along with some technical support to help them use it — is another key strategy.

It is important to target support to the needs of different types of HCBS providers. For example, a state with many smaller providers with little experience with managed care or other payment reform activities may wish to organize educational programs and target infrastructure building to that set of providers. Large home health agencies have more familiarity with business or managed care practices and more advanced information systems and data analytic capacity. Even so, they may still need support with data collection and reporting, and technical assistance on information sharing and data analysis.

Nearly all states and HCBS providers have workforce challenges, and leading MLTSS states have made HCBS workforce investment a key component of MLTSS VBP efforts. ***Case Study: Tennessee's Approach to Workforce Development (next page)*** provides a detailed example. In addition, New York launched its Workforce Investment Program in early 2018, through which its managed care plans contract with designated workforce training centers (Long Term Care Workforce Investment Organizations) to train, recruit, and retain direct care workers. Funded by its DSRIP waiver, activities include: (1) investing in recruitment and retention initiatives; (2) developing plans to place these workers in medically underserved communities; (3) analyzing workers' training and employment needs; (4) promoting stakeholder input and engagement; and (5) supporting expansion of respite care.[53]

CASE STUDY | Tennessee's Approach to Workforce Development

A major component of the Quality Improvement in LTSS (QuILTSS) program, Tennessee's workforce development approach complements its LTSS VBP strategy by aligning the opportunities for direct care worker training and degree attainment with LTSS quality measures, and by rewarding providers that employ a well-trained workforce. In particular, after it expanded MLTSS to individuals with intellectual/developmental disabilities through Employment and Community First CHOICES, the state discovered that acute shortages of well-trained and qualified staff were making it difficult to meet its quality goals. This led Tennessee to develop a more comprehensive strategy around workforce development.

First, the program will encourage new workforce entrants and worker retention by offering high-quality training to direct care workers who participate in TennCare, Tennessee's Medicaid program, coupled with an educational initiative that creates a new career path for workers to earn credits for individual certificates, college courses, and/or degree programs. The worker training curriculum will be used in vocational-technical and trade schools, as well as community colleges. The program is competency-based, requiring workers to demonstrate learning and capacity outside of a classroom or an online course.

Second, recognizing that a strong workforce is a critical component of a system able to deliver person-centered care and improved outcomes, Tennessee decided to expand its workforce development effort and its link to payment. It is creating incentives that result in greater provider capacity to train and retain workers and, ultimately, more well-trained workers providing care to participants. Tennessee is phasing-in its workforce development model, beginning with the Employment and Community First CHOICES program in which:

- Providers will receive a one-time payment to help establish infrastructure to uniformly collect and report workforce data and fill gaps in information about current workforce development needs.

- Once areas of need are identified, Tennessee will also support provider capacity building through consultations with subject matter experts to help them understand and use their own workforce data to drive targeted improvement efforts.

- Incentives will be offered for providers that participate in state-supported trainings on evidence-based and best practices regarding recruitment, and retention (including structuring of wage scales).

- Incentives and technical assistance will be offered to providers to begin implementing these practices in their agencies, targeting improvements based on their unique workforce challenges.

- Once data collection and reporting and quality improvement efforts are underway, Tennessee can begin to incentivize changes in provider outcomes related to workforce, including worker competency, retention, and satisfaction, ultimately leading to the impact of these improvements on persons supported.

- Tennessee will monitor the impact of its workforce development efforts.

Throughout the program, Tennessee will continue engage plans and providers in the design of its workforce recruitment and retention programs.

How Can States Engage Stakeholders in Policy and Program Design Decisions?

States that have successfully launched MLTSS programs cite robust, frequent, and ongoing engagement of Medicaid stakeholders, including beneficiaries and their families, managed care plans, and providers as key to their accomplishments.[54] States now implementing VBP model in their MLTSS programs agree that gathering extensive feedback during program planning efforts about key stakeholder priorities is essential. ***Case Study: Virginia's Approach to Stakeholder Input in Program Design (below)*** provides an example of Virginia's approach to getting feedback from beneficiaries, families, providers, and plans on the most important features of its MLTSS program.

CASE STUDY | **Virginia's Approach to Stakeholder Input in Program Design**

Virginia's Department of Medicaid Assistance Services (DMAS) collected stakeholder input to design its MLTSS program, Commonwealth Coordinated Care Plus (CCC+). Virginia released a public first draft of its CCC+ RFP in 2017 to solicit input from advocates, providers, and managed care plans about various program elements, including VBP requirements.[55] Managed care plan feedback on VBP models included: a request for flexibility to design their own payment models with providers; use of existing quality measures (either nationally endorsed or used in other established state programs); and recognition that the state should play a role in supporting LTSS providers participating in VBP arrangements. This feedback helped DMAS to design the final RFP.

In the final RFP, DMAS asked bidding managed care plans to describe whether and how they have used the LAN framework to adopt successful LTSS VBP strategies in other states, and to propose similar activities for CCC+. Most of the managed care plan respondents had implemented LTSS pay-for-performance models but few were risk-bearing arrangements. DMAS also discovered variation in how managed care plans defined "VBP."

The draft RFP comments and bidders' responses identified areas of managed care plan interest, capacity and experience gaps, and informed DMAS' decision to pause VBP efforts for the first year to establish an operating "baseline" while it launched the program. DMAS is currently evaluating potential ways to advance VBP models under the CCC+ program.

Other areas of advice for states designing and launching VBP models in MLTSS programs include:

- Ensure transparency in payment methodology development and associated reporting burdens to build stakeholder's trust. Transparency also provides an opportunity for stakeholders to identify potential operational issues to help avoid the need to troubleshoot later on.

- Work closely with providers during program design. Providers can help states better understand concerns and opportunities for program involvement. They can also offer insights into: feasible measurement strategies; performance measures for which providers can be held accountable; and data that is least burdensome to collect. Including providers in these discussions demonstrates a commitment to their priorities, and can help to build program trust and buy-in.

- Communicate with managed care plans and providers early and often, such as monthly during program design planning, and then weekly during implementation to troubleshoot any issues that arise. For example, Texas has held one-on-one meetings with each managed care plan as it redesigned its P4Q Program, and will soon launch a series of regular managed care plan and provider meetings focused on quality and payment. In addition, meetings with plans or providers should be face-to-face, whenever possible.

Achieving Value in Medicaid Home- and Community-Based Care: Considerations for Managed Long-Term Services and Supports Programs

38

CONCLUSION

This guide describes common themes and lessons drawn from states' efforts to improve the value of HCBS delivered through MLTSS programs. Despite some real challenges, there is emerging interest among states to develop VBP models for community-based care in MLTSS programs. States have gained experience with VBP models for medical services and are eager to apply what they have learned to test new VBP models for HCBS. More states are interested in developing VBP models in Medicare-Medicaid integrated care programs, particularly those that provide an opportunity to integrate funding.

Based on their experiences to date, Minnesota, New York, Tennessee, Texas, and Virginia, along with the many managed care plans, providers, and other stakeholders that contributed to this guide, offered advice for other states to consider as they determine whether to advance VBP models:

- **Set clear goals**. Understand that VBP is a tool to advance clearly defined policy goals within the MLTSS program or more broadly in the Medicaid system.

- **Go slowly, and build incrementally and iteratively**. Building these models is an incremental process, requiring several fits and starts; troubleshooting; and ample input from stakeholders.

- **Understand which HCBS quality measures are mostly closely tied to overarching goals**. There is not a single, standard set of HCBS measures states can use to assess managed care plan performance, but there are several measures states can use for VBP models that can directly support their policy goals and for which data can feasibly be collected.

- **Commit to robust stakeholder engagement**. Incorporate ongoing efforts to assess and improve program design and operations — including early and frequent managed care plan, provider, and other stakeholder engagement — in order to ensure that programs achieve objectives.

- **Incorporate accountability and flexibility**. Encourage managed care plan innovation with flexible parameters around the type of models used to pay providers, but maintain a constant state oversight presence to keep a finger on the pulse of what is working and what is not — and to step in when necessary.

- **Support workforce development efforts for the HCBS provider community**. Support workforce development efforts for the HCBS provider community. This includes developing strategies to build providers' capacity, which can vary significantly across different HCBS providers, to successfully engage in VBP models.

As states gain experience with these initiatives, they are exploring the potential for LTSS to become part of other VBP initiatives, such as incorporating LTSS into "total cost of care" models that cover physical and behavioral health services, as well as LTSS; and developing new models to test in integrated Medicare-Medicaid programs. They are also designing payment models that reward HCBS providers for building capacity to participate in these models. Although it is too soon to know whether, or to what extent, VBP models for MLTSS programs yield better value, they hold great promise for improving outcomes for frail older adults and people with disabilities.

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[25] New York State Department of Health. "Managed Long Term Care Subpopulation Value Based Payment Quality Measure Set Measurement Year 2018." November 2017. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/quality_measures/docs/2018_mltc_qms.pdf.

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[31] The Indiana State Department of Health, Long Term Care Division. "Nursing Home Report Cards." Available at: https://www.in.gov/isdh/reports/QAMIS/ltccr/rptcrd1.htm.

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[33] Although these examples focus on strategies for providers, states may use the same types of benchmarks for MCO quality withholds. See "Using Payment to Drive Outcomes at the Managed Care Plan Level" for more information.

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[35] Health Care Payment Learning and Action Network, op. cit.

[36] A. Ostrovsky, A. Cisneros, and A. Morgan. "Long Term Supports and Services as a Logical Next Step in the Evolution of Bundled Payments." *Annals of Long-Term Care: Clinical Care and Aging*, 23 no. 11 (2015) 37-40.

[37] For more information about the Advanced Home Care Aide Specialist Training Pilot, see: https://www.dshs.wa.gov/altsa/training/advanced-home-care-aide-specialist-training-pilot.

[38] Libersky, J. et al., op.cit.

[39] Commonwealth of Massachusetts "Request for Responses for Accountable Care Organizations." September 29, 2016. https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-00000009207.

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