Advancing Value-Based Payment in Medicaid MLTSS: Opportunities for Community-Based Care

Michelle Soper, Director of Integrated Care, Center for Health Care Strategies
Maria Dominiak, Managing Partner, Airam Actuarial Consulting
Patti Killingsworth, Assistant Commissioner and Chief of LTSS, Bureau of TennCare

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2018 NASUAD HCBS Conference

*Made possible through support from The West Health Policy Center*
Meet the Presenters

Michelle Soper, Director of Integrated Care, CHCS

Patti Killingsworth, Assistant Commissioner and Chief of LTSS, Bureau of TennCare

Maria Dominiak, Managing Partner, Airam Actuarial Consulting
Session Overview

- Introductions and overview
- State considerations for MLTSS payment models: Design and implementation
- Overview of value-based payment models for home and community-based services
- Tennessee’s approach to advancing value-based payment models in Medicaid MLTSS
State Considerations for MLTSS Value-Based Payment Models: Design and Implementation

Michelle Soper
Director of Integrated Care
Center for Health Care Strategies

Made possible through support from The West Health Policy Center
About the Center for Health Care Strategies

A non-profit policy center dedicated to improving the health of low-income Americans
Advancing Value in Medicaid Managed Long-Term Services and Supports: Project Overview

- Advance the adoption of operational strategies that promote high-quality MLTSS and support individuals living in communities
- CHCS, in partnership with Mathematica Policy Research (Debra Lipson & Jenna Libersky) and Airam Actuarial Consulting (Maria Dominiak); supported by West Health Policy Center
- Main activities
  - Environmental scan
  - State learning collaborative with Minnesota, New York, Tennessee, Texas and Virginia
  - Publication forthcoming: *Achieving Value in Medicaid Home- and Community-Based Care: Options and Considerations for Managed Long-Term Services and Supports Programs*
  - National webinar, September 18th
Overview of West Health

West Health Mission:

To help seniors successfully age in place, with access to high-quality, affordable health and support services that preserve and protect their dignity, quality of life and independence.
## Context: MLTSS & VBP

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<thead>
<tr>
<th>TREND</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>Managed long-term services and supports (MLTSS)</td>
<td>Nearly half of states have MLTSS programs to rebalance care toward the home and community; improve quality; and control costs</td>
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<tr>
<td>Value-Based Payment Arrangements</td>
<td>Public payers are driving efforts to increase VBP across most health care sectors</td>
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- Few VBP arrangements include LTSS
- Challenges with adoption of VBP models in HCBS settings include:
  - Provider capacity
  - HCBS quality measurement and data collection;
  - Opportunity to achieve Medicaid savings for dually eligible beneficiaries
Defining State Policy Goals: First Steps for States

- Identifying key state policy goals
- Determining whether VBP is a useful tool to achieve the states goals regarding HCBS system improvements
- Defining what “value” means in the context of MLTSS programs
Types of and Benchmarks for HCBS Performance Measures

- Several measures available across state programs, but few standardized, nationally-recognized HCBS measures
  - Several ways to measure MLTSS performance
  - States do not have a “playbook”

- Importance of stakeholder engagement to help choose the right mix of structural, process and/or outcome measures
Criteria for Selecting Performance Measures for HCBS VBP

- Are the measures relevant to policy and program goals?
- Are the measures feasible to report and are data available to construct the measures?
- Can MLTSS plans and HCBS providers be held accountable for measure performance?
- How does the nature of HCBS service delivery influence the choice of VBP measures?
- What are appropriate performance targets or benchmarks for use in payment models?
Considerations for Selecting Payment Models

- Alignment of payment models with policy goals
- Which models and incentive payment amounts may most effectively change HCBS provider behavior
- The type of VBP model that is most feasible in the current environment, particularly related to:
  - Existing VBP models operating in the state
  - Level of sophistication and ability to accept financial risk
- Long-term sustainability of the financial model
- Appropriateness of alternative, “non-financial” incentives
Several practical and operational considerations for states as they work with managed care plans, providers, beneficiaries, etc. including:

» Setting health plan requirements and expectations
» Assessing provider readiness and capacity to participate in VBP arrangements
» Supporting provider capacity efforts
» Engaging stakeholders throughout the design and implementation process
Advice for Other States

- VBP is a tool to advance clearly defined goals
- Go slow
- Understand which HCBS quality measures are mostly closely tied to overarching goals—and are feasible for plans to measure
- Incorporate ongoing efforts to assess and improve program design and operations
- Encourage plan innovation within “guardrails”
- Support HCBS workforce development efforts and provider capacity-building
Visit CHCS.org to...

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services

- **Subscribe** to CHCS e-mail, blog and social media updates to learn about new programs and resources

- **Learn** about cutting-edge efforts to improve care for Medicaid’s highest-need, highest-cost beneficiaries

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Overview of Value Based Payment Models in Home and Community Based Services

August 28, 2018
Maria Dominiak, FSA, MAAA
Airam Actuarial Consulting, LLC
CMS’s Alternative Payment Model (APM) Framework
HCPLAN APM Framework

### CATEGORY 1: FEE FOR SERVICE - NO LINK TO QUALITY & VALUE

**A**
- Foundational Payments for Infrastructure & Operations
  (e.g., care coordination fees and payments for HIT investments)

**B**
- Pay for Reporting
  (e.g., bonuses for reporting data or penalties for not reporting data)

**C**
- Pay-for-Performance
  (e.g., bonuses for quality performance)

### CATEGORY 2: FEE FOR SERVICE - LINK TO QUALITY & VALUE

**A**
- APMs with Shared Savings
  (e.g., shared savings with upside risk only)

### CATEGORY 3: APMs BUILT ON FEE-FOR-SERVICE ARCHITECTURE

**A**
- Condition-Specific Population-Based Payment
  (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

**B**
- Comprehensive Population-Based Payment
  (e.g., global budgets or full/percent of premium payments)

**C**
- Integrated Finance & Delivery System
  (e.g., global budgets or full/percent of premium payments in integrated systems)

### CATEGORY 4: POPULATION-BASED PAYMENT

Value Based Payment (VBP) Models in HCBS
Category 2C: FFS with Link to Quality and Value – Pay for Performance

- Rewards accountable entities for achieving pre-defined targets or measures
- Financing model can include incentive payments, withholds or penalties
- Least financial risk to providers
- Easily understood by providers
## Category 2C: FFS with Link to Quality and Value - Pay for Performance

<table>
<thead>
<tr>
<th>Approach</th>
<th>Example</th>
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<tbody>
<tr>
<td>Aggregate or per member per month (PMPM) bonus payment</td>
<td>• Connecticut includes a performance incentive pool in its HCBS case management contract</td>
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<td>for meeting targets</td>
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<td>Vary FFS payments based on performance rating</td>
<td>• CMS Home Health Value-Based Purchasing Model adjusts Medicare payments to home health agencies by 3% upward or downward, ramping up to 8% in five years based on performance score</td>
</tr>
<tr>
<td>Enhanced payment rate for meeting specific milestones</td>
<td>• Washington pays an enhanced rate for eligible personal care workers who have completed additional training activities</td>
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</table>
Category 3: APMs Built on FFS Architecture

Gainsharing/Risk Sharing

- Incentivize cross sector partnerships and improved care coordination across providers

- Models include:
  - Episode-based payment: pays a lump sum amount for a set of services for a specific episode of care or treatment within a defined time period.
  - Shared savings model: includes performance bonus/withhold or shared savings/losses tied to “total cost of care” to encourage better efficiencies.

- Shifts risk to accountable entities
### Category 3: APMs built on FFS Architecture

**Gainsharing/Risk Sharing**

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<td>PMPM case management rate with performance bonus amount tied to savings if certain quality targets are achieved</td>
<td>• MaineHealth Accountable Care Organization contracts with Area Agency on Aging (AAA) to provide care transition services; the AAA is eligible for shared savings of up to 5%</td>
</tr>
<tr>
<td>Retroactive episode based payments for specific chronic conditions</td>
<td>• Tennessee plans to implement 75 episodes of care in next five years. Some episodes (e.g., Pneumonia care, COPD) include opportunities for HCBS providers to partner with hospitals and post-acute care providers</td>
</tr>
<tr>
<td>Accountable Care Organization (ACO) with shared risk on total cost of care, including LTSS</td>
<td>• Massachusetts ACOs include primary care providers that may partner with certified community-based behavioral health and LTSS providers</td>
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</table>
Category 4: Population-Based Payment

- Payment models where the provider organization is responsible for a pre-defined set of services for a defined population
- Shifts financial risk to provider organization and aligns incentives across providers increasing potential for greater efficiencies and improved outcomes
- May be condition-specific or population-specific
- Payment approaches may be prospective or retrospective
- Quality measures are often used to ensure quality and access are not compromised
### Category 4: Population-Based Payment

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<td>Population based payment for chronic conditions/special needs</td>
<td>• New York has specialized Medicaid managed care programs focused on people with high behavioral health care needs and another focused on people with intellectual and developmental disabilities. The models include quality measures and withholds/incentives</td>
</tr>
<tr>
<td>Sub-capitation or full risk capitation with link to quality</td>
<td>• Oregon PACE – includes five measures in quality incentive program and pays a bonus for each measure met, up to $100 pmpm</td>
</tr>
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CMS Medicaid Innovation Accelerator Program (IAP) VBP for HCBS
Collaborative initiative between the Centers for Medicare and Medicaid Innovation and the Center for Medicaid and CHIP Services

- Goal is to increase the number of states moving toward delivery system reform across program priorities
- Provides technical support to states

Ten states participating in current cohort (*through March 2019*)
Target populations include:

» Older adults
» Adults with physical disabilities
» Adults with ID/DD
» Children with physical or ID/DD
» Individuals with specific diagnoses

Target HCBS providers include:

» Agency-based home care providers
» Independent home care providers
» Assisted living providers
» Adult day providers
» Managed care plans
» Care managers

 Majority of focus is in Categories 2C and 3 of APM framework
IAP - VBP for HCBS: State Areas of Interest (Current Cohort)

- Improve quality of HCBS workforce
  - Increase training for direct care workers
  - Develop career path for direct care workers
  - Expand access/reduce turnover

- Improve member satisfaction/quality of life
  - Reduce adverse events
  - Increase stability of placement/caregiver
  - Increase independence/meaningful activities
  - Accountability for achievement of person-centered goals

- Improve care coordination across health care system
  - Increase accountability of care managers/service coordinators
  - Better integrate HCBS providers into care team; data sharing
IAP - VBP for HCBS: Key Challenges for States (Current Cohort)

- Limited state funds
- Provider capacity/engagement
- Data limitations
- Stakeholder buy-in
- Limited state resources
- Lack of standardized measures
Summary

- VBP is an important tool to improve quality and outcomes for the LTSS population
- There are many different payment approaches that can be used to link quality and value
- Best approach will be:
  » Aligned with overall policy goals and needs
  » Effective at driving change
  » Operationally feasible
Thank You!

Maria Dominiak, FSA, MAAA
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For additional information on IAP, contact CMS IAP lead Melanie Brown: Melanie.brown@cms.hhs.gov
Advancing Value-Based Payment Models in Medicaid MLTSS
Service Delivery System in Tennessee

- TennCare managed care demonstration began in 1994
- Operates under the authority of an 1115 demonstration
- *Entire* Medicaid population (1.4 million) in managed care since 1994
  - Including dual eligibles and people with disabilities
- Three health plans (MCOs) operating statewide
- Physical/behavioral health integrated beginning in 2007
- Managed LTSS began with the Statewide *CHOICES* program in 2010
  - Older adults and adults with physical disabilities only
- 3 Section 1915(c) waivers and ICF/IID services for individuals with I/DD carved out; operated by State I/DD Department
  - People *carved in* for physical and behavioral health services
- New Statewide MLTSS program for individuals with I/DD began July 1, 2016: *Employment and Community First CHOICES*
- Managed care and fee-for-service LTSS
Quality Improvement in LTSS (QuILTSS)

- A TennCare initiative to promote the delivery of high quality LTSS for TennCare members (NF and HCBS) through payment reform (at the provider level) and workforce development.
- Part of the State’s broader payment reform strategy (episodes of care and primary care transformation—patient centered medical homes and behavioral health homes).
- Quality is defined from the perspective of the person receiving services and their family/caregivers.
- Creates 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.
- Transform the system by aligning incentives around the things that most impact the member’s experience of care and day-to-day living.
- Includes workforce development as a core foundational aspect of building capacity to deliver high quality LTSS.
Long-Term Services and Supports (LTSS) Overview

**Value-Based Purchasing Initiatives for Nursing Facilities**
- Medicaid reimbursement for Nursing Facility (NF) services based in part on resident acuity and quality outcomes that most impact residents’ experience of care
- Goal to reward providers that improve quality of care and quality of life by promoting a person-centered care delivery model
- Revised reimbursement approach for Enhanced Respiratory Care (ERC) services in a NF based on the facility’s performance on key quality outcome and technology indicators

**Value-Based Purchasing Initiatives for Home and Community Based Services (HCBS)**
- Align incentives with person-centered individual and program outcomes across HCBS programs and populations including:
  - Employment and Community First CHOICES MLTSS Program
  - Section 1915(c) waivers
  - CHOICES MLTSS Program
  - Behavioral Health Crisis Prevention, Intervention and Stabilization Services for Individuals with I/DD

**Workforce Development**
- Invest in the development of a comprehensive competency-based workforce development program and credentialing registry for individuals paid to deliver LTSS
- Value-based incentives for providers employing better trained and qualified staff
LTSS Workforce Development

7 Key Tenets

• Competency-Based (knowledge, skills, abilities, and intellectual behaviors)
• Require Demonstration
• Micro-Credentialing System
• Portability through Registry
• Faculty, Coach and Mentor Support
• Clear Career and College Pathways
• Credit-Bearing Framework

Structure of Online Learning Modules

• Reading material
• Videos with examples and non-examples
• Voiceover videos with stop effects
• Pre- and post-simulations
• Journal entries
• Decision trees
• Coaching sessions
• Range of learning activities
• Formative assessments throughout*
• Summative assessments for demonstration of competency (application of knowledge)

*Include interactive videos, simulations, work-embedded activities supported by behavioral tools
LTSS Workforce Development

- Developed in consultation with National Subject Matter Experts
- Corresponds with CMS DSW Core Competencies released in 2014
- Worked with Tennessee Board of Regents to award college credit and create a post-secondary credential (certificate) for completion
- College credit also applied toward new degree program*
- Rollout through State Community Colleges and Colleges of Applied Technology
- Leverage Tennessee Promise and Tennessee Reconnect funds
- Support achievement of Governor’s Drive to 55 Initiative
- Added pre- and early service learning component (also developed with National SMEs under a contract with TASH) and Dr. Lisa Mills
- Pilot in Fall 2018; statewide rollout in January 2019

*In development
But then…
The train we didn’t see coming
The Workforce Challenge

- Escalating challenges with recruitment and retention in longstanding Section 1915(c) waivers
  - 51% based on 2018 Staff Stability Survey (NCI)
- Most significant factor impacting implementation of MTLSS program for people with I/DD
- To provide high quality services and supports, must have competent staff to deliver them
  - Recruitment
  - Retention
  - Consistent assignment
  - Training and competency
  - Wages and benefits
  - Satisfaction of workforce and people receiving services and supports
Understanding Workforce Challenges

• Pay is only one piece of the solution to the workforce crisis. It is certainly an important piece but challenges with recruitment and retention are not just about pay.

• Reimbursement rate increases are not guaranteed to result in increased wages and benefits for DSW.

• DSWs that leave agencies aren’t always leaving the field. They may be moving to another agency, often for reasons other than pay.

• If we do not have good data on workforce challenges, at both the individual provider and systems level, we will not accurately and fully understand the problem. Good data is essential to guide our efforts and to enable us to evaluate the efficacy of those efforts over time.
Understanding Workforce Challenges

President’s Committee for People with Intellectual Disabilities: 
*Report to the President 2017 – America’s Direct Support Workforce Crisis*

• Practices that would address the workforce crisis include:
  – Using competency-based training models that lead to credentialing or certification of staff and yield wage increases
  – Teaching business and organization leaders skills to improve their ability to recruit, select and retain direct service employees

Phase One: 
Build Provider Capacity to Achieve Desired Outcomes

**NON-RECURRING INVESTMENT IN CAPACITY-BUILDING SUPPORTS**
- Technical Assistance
- Training/Train the Trainer
- Expert Consultation
- Community of Practice
- Peer Mentoring
- Verifying Adoption of Required Practices

**FINANCIAL INCENTIVES FOR ADOPTING SPECIFIC PRACTICES**
- One-time payment to establish ongoing provider workforce data collection and reporting processes
- QuILTSS: Financial incentives for adopting evidence-based and best practices

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**Phase Two:** Move to incentives for specific outcomes once practices that result in these outcomes have been effectively adopted
Addressing Workforce Challenges

A Multi-Prong Approach *(in addition to competency-based training)*:

- Establish processes for collection/use of workforce-related data at provider and system levels to target and measure improvement efforts over time
  - Comprehensive statewide data analysis to target investments, track improvement over time
  - Provider-specific analysis and training/technical assistance to providers in analyzing and using their own data to guide/evaluate their organization’s efforts to address workforce issues

- Engage national experts and leverage/invest MFP Rebalancing Fund to provide training and technical assistance to providers to support adoption of evidence-based and best practices that have been shown to result in more effective recruitment, increased retention, and better outcomes for people served
Addressing Workforce Challenges

A Multi-Prong Approach
(in addition to competency-based training):

- **Category 2**
  - Foundational payments for infrastructure and operations
  - Pay for reporting
  - Pay for practices

- **Incentivize practices that will lead to desired outcomes:**
  - Data collection, reporting, and use at the provider level
  - Adoption of evidence-based and best practice approaches to workforce recruitment/retention and organization culture/business model changes
  - Ensure DSP wages are increased as they increase their level of training and competency and upon completing the certification program
Incentivize Evidence-Based and Best Practices

<table>
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<tr>
<th>Recruitment</th>
<th>Retention</th>
<th>Organizational Culture and Business Model</th>
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<tr>
<td>• Hiring Strategies</td>
<td>• Competency-based professional development, credentialing/badging</td>
<td>• Is associated with greater retention of DSPs, higher rates of satisfaction for DSW/persons served</td>
</tr>
<tr>
<td>— Targeted Marketing</td>
<td>• Career ladder/wage differential pathways</td>
<td>• Results in measurable improvements in quality of service delivery and opportunities/outcomes</td>
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<tr>
<td>— Realistic Job Previews</td>
<td>— Reward advanced training/certification and tenure</td>
<td>• Supports the delivery of more individualized HCBS</td>
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<tr>
<td>— Structured Behavioral Interviewing</td>
<td>— Align incentives at the DSW level</td>
<td>• Has strong focus on facilitating/sustaining independence, natural supports, valued social roles and access to/use of community resources</td>
</tr>
<tr>
<td>— Minimum entry/starting wage</td>
<td>• Effective support/supervision</td>
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<tr>
<td>• On-Boarding Strategies</td>
<td>• Employee engagement/satisfaction</td>
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<tr>
<td>— High quality competency-based pre/early service training</td>
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<td>— Mentoring and coaching</td>
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Value-Based Payment: Phase 2

- **Category 2**
  - Pay for performance

- Transition to financial incentives for specific workforce and quality of life outcomes once practices expected to result in the outcomes have been effectively adopted

- DSP career ladder is essential outcome
  - Includes wage increase for worker tenure and completion of WFD program

- Outcomes for persons served will be ultimate measure