Value-Based Payment in Medicaid Managed Long-Term Services and Supports: A Checklist for States

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Many state Medicaid programs seek to improve the quality and cost-effectiveness of long-term services and supports (LTSS) by transforming how they pay providers for these services. State Medicaid agencies, and their contracted managed care plans, are shifting away from fee-for-service systems that reward providers for delivering more services to value-based payment (VBP) models that tie payment to better outcomes. Although most Medicaid VBP models target medical care, states are beginning to explore payment reforms that encourage quality and outcomes for LTSS. As of 2017, nearly half of all states contracted with managed care plans to cover LTSS, including home- and community-based services (HCBS).[4]

This checklist, adapted from the guide ***Achieving Value in Medicaid Home and Community-Based Care: Options and Considerations for Managed Long-Term Services and Supports Programs***, identifies **four** issues that states may want to explore as they develop and adopt VBP models for HCBS within managed long-term services and supports (MLTSS) programs:

Why Use VBP Models for Managed Care Plans Covering HCBS?

In 2016, LTSS comprised 30 percent ($167 billion) of all federal and state Medicaid spending with 57 percent of that devoted to HCBS, increasing state interest in developing new payment models for HCBS.[1]

HCBS spending will grow, due to an anticipated 50 percent increase in individuals age 65 and older by 2030, and the ongoing needs for services among high-cost HCBS users, particularly those with intellectual and developmental disabilities.[2,3]

HCBS quality and outcomes depend on the supply and skills of direct care workers, but there are challenges with worker recruitment, retention, and career development opportunities that these models could help address.

1. **Assessing available support from the state policy environment**;
2. **Selecting the right performance measures to reward HCBS providers**;
3. **Selecting payment models that create the right financial incentives for improved value**; and
4. **Addressing operational issues faced by plans and providers.**

This checklist also suggests ways for ongoing engagement of key stakeholders (e.g., managed care plans, providers, and beneficiaries and their families) throughout the program from initial design to implementation to evaluation.

About this Resource

This tool is adapted from the guide, ***Achieving Value in Medicaid Home and Community-Based Care: Options and Considerations for Managed Long-Term Services and Supports Programs***, which shares considerations for selecting and implementing quality metrics and payment models, as well as common challenges that states may face in adopting these models. It includes lessons from five states — Minnesota, New York, Tennessee, Texas, and Virginia — that participated in ***Advancing Value in Medicaid Managed Long-Term Services and Supports***, an initiative led by the Center for Health Care Strategies (CHCS), in partnership with Mathematica Policy Research and Airam Actuarial Consulting, and supported by the West Health Policy Center. Learn more at **www.chcs.org/achieving-value-in-hcbs**.

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Made possible through support from the West Health Policy Center.

Before beginning the design of a VBP model, a state should clearly articulate its overall policy and program goals. VBP is a tool to help achieve goals, not a goal in and of itself. Desired goals may be broad (e.g., reducing potentially avoidable hospitalizations statewide) or targeted (e.g., increasing access to employment services or improving member satisfaction with assisted living facilities). Once its goals are articulated, a state can evaluate: (1) whether VBP is the right strategy to achieve them; and, if so (2) how it could direct managed care plans to use VBP arrangements with providers to support the goals. States should consider the following four key steps in program design.

1. Assessing Available Support from the State Policy Environment

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Certain state policy factors may improve the feasibility of launching a VBP model for HCBS. Affirmative responses to the following questions suggest an environment that supports VBP implementation:

- ☐ ***Are payment and delivery reforms underway for other services?***

  States may leverage leadership backing, staff experience, monitoring and information systems, and other supports to secure the considerable resources needed to design, implement, and monitor VBP models in MLTSS programs.

- ☐ ***Is there a long-term plan?***

  A multi-year plan and dedicated resources to implementing VBP can instill greater confidence in managed care plans and providers to make upfront financial investments and changes in clinical and business practices.

- ☐ ***Is there a stable source of start-up funding?***

  Start-up costs may include: state, provider, and managed care plan infrastructure; data reporting and capacity building; and initial funding pools to cover incentive payments. States will want to assess: (1) funding capacity; (2) whether they have access to new or repurposed funds; and (3) if they will require managed care plans to cover some of these costs.

- ☐ ***To what degree do managed care plans, HCBS providers, and program beneficiaries support VBP and regard it as important for improving HCBS quality and outcomes?***

  Regular meetings with stakeholders to gather feedback about their priorities during program planning efforts is critical.

2. Selecting the Right Performance Measures to Reward HCBS Providers

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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 payments. The following questions will help states to: (1) identify potential measures for use; (2) decide whether these measures are suitable for use in VBP models; and (3) determine what level of performance qualifies for a payment:

- ☐ ***What does the state want to measure?***

  States might focus MLTSS quality efforts on several broad areas or domains, and several types of measures within each domain of performance (see ***State Performance Measure Selection Decisions***, next page**)**. States can consider measures including: (1) structural measures associated with critical inputs, such as training for direct care workers; (2) access measures indicating whether beneficiaries obtain the services and supports they need on a timely basis; (3) process measures assessing the effectiveness of core elements of HCBS delivery; and (4) outcome measures reflecting the results of care.

☐ *Can the performance measures selected be used for payment?*

Once potential measures are selected, states must decide which should be linked to payment by assuring that they meet basic criteria, such as:

- ***Do the measures used for the VBP model directly reflect MLTSS program goals?***
- ***Is it feasible to collect complete, accurate, and timely data needed to construct measures?*** For example: (1) do providers already collect this data; (2) if new data are needed, what is the data collection burden for plans, providers, and beneficiaries; and (3) are measures dependent on Medicare data, to which states or Medicaid managed care plans might not have access?
- ***Can plans and providers control or influence outcomes and thus be held accountable for them?*** Performance measures should reflect the activities, processes, or outcomes that MLTSS plans and LTSS providers can affect. In addition, many Medicaid enrollees who use LTSS are dually eligible for Medicare and Medicaid.[8] Plan performance scores should not depend on services covered by Medicare, unless the managed care plans provide integrated Medicare-Medicaid benefits to dually eligible beneficiaries or are required to coordinate beneficiaries' care with Medicare plans and providers.

State Performance Measure Selection Decisions

✔ **Areas on which states may focus MLTSS quality efforts**:
- Rebalancing the share of LTSS spending from institutional services to HCBS;
- Successfully transitioning between settings;
- Maintaining or slowing functional status decline;
- Making improvements in physical health outcomes, quality of life, and person-centered care; and
- Enhancing the skills and stability of the HCBS workforce.

✔ **Examples of HCBS performance measure sources**:
- Eight new **measures** for MLTSS programs, four of which address comprehensive assessment and care plans, that will be included in NCQA's 2019 HEDIS quality measures for health plans[5].
- A set of **recommended measures** from the National MLTSS Health Plan Association[6].
- A **compendium** of HCBS measures across several domains from the National Quality Forum[7].

- ***Do the measures need to be risk-adjusted?*** Risk-adjustment can account for differences such as age, health, functional status, type of disability, and other enrollee characteristics. This is important to level the playing field when comparing performance across plans and HCBS providers.
- ***Are the unique characteristics of the HCBS delivery system addressed?*** The performance measures that often matter most to people using HCBS, quality of life and person-centeredness, rely on self-reported survey data that may be difficult or costly to collect. In addition, because most HCBS are provided by direct care workers, states might consider measures that support the stability of the HCBS workforce to link incentives to improving workforce capacity and staff retention.

☐ *What are appropriate improvement targets for payment?*

After selecting which performance measures to use, states must determine the performance targets that qualify for financial bonuses or shared savings. Targets can be absolute, for which a provider must meet or exceed a specified measure score. They can also be relative, which requires a provider to score within a certain range relative to a benchmark among similar types of providers, or they can be improvement-based, which assess performance relative to each provider's previous score or the degree of improvement compared to a specified threshold.

Opportunities to Engage Stakeholders in Selecting Performance Measures

✔ **Conduct an assessment of program priorities that are most important to HCBS beneficiaries and their families**, and focus performance measures on those elements.

✔ **Develop formal mechanisms for feedback on performance measures from managed care plans and providers** who will be responsible for collecting and reporting data; and

✔ **Publicly release and seek comment** on measure technical specifications under review.

3. Selecting Payment Models that Create the Right Financial Incentives for Improved Value

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Payment models are an important tool that can be used by states to set the right financial incentives for improved quality. Many states use the alternative payment model framework developed by the Health Care Payment Learning and Action Network (LAN) as a foundation for designing VBP models.[9] This framework defines payment models based on the level of financial risk for providers and the extent to which they incorporate quality and value. Questions for states when developing payment models for HCBS providers are:

☐ ***Which payment models align with policy goals?***

VBP models should incentivize and reinforce the activities that lead to better care processes and outcomes.

☐ ***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, such as nursing facility VBP models or shared savings models with accountable care organizations. 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.

Opportunities to Engage Stakeholders in Selecting Payment Models

- ✔ **Develop communication feedback loops** to ensure transparency in payment methodology development and associated reporting burdens.
- ✔ **Conduct meetings with different LTSS providers** to better understand implications of new payment models on specific provider types, and mitigate potential unintended consequences.

☐ ***What level of financial reward and risk is appropriate?***

Performance-based bonus payments often serve as a starting point for payers to engage providers in VBP. However, the incentive (bonus) amounts must be high enough to influence providers' behavior. If the payment structure involves downside risk, under which providers might lose revenue if they do not meet performance targets, it should be scaled to reflect providers' capacity to accept risk, which is often tied to their size, infrastructure, diversity of services, and other factors. Large institutional or agency-based HCBS providers may be able to accept more financial risk than smaller HCBS providers, for whom any loss of revenue can cause them to go out of business and result in disrupted care for beneficiaries.

☐ ***Is there a return-on-investment?***

States need to consider ways 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. States could consider a shared savings or a combined incentive/penalty model that is budget neutral to the state.

☐ ***Can non-financial incentives also increase provider engagement and improve performance?***

While money is a motivating factor, it may not be the only way to impact quality. States and managed care plans may consider non-financial incentives (e.g., public report cards that compare providers' performance on selected measures; marketing or recognition programs for high-quality providers; preferred provider status or referrals; and training opportunities or other workforce supports). These efforts can complement financial incentives to help motivate providers to drive change.

4. Addressing Operational Issues Faced by Plans and Providers

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Operational issues to address before launching VBP models in MLTSS programs include:

☐ ***How much flexibility should states give to managed care plans?***

Most states allow plans to design their own provider payment models and arrangements within limits — or "guard rails" — to ensure consistency in performance metrics and reporting requirements. The more flexibility granted to plans, the more important state oversight becomes.

☐ ***What can states do to help HCBS providers prepare for and engage in VBP?***

Challenges to HCBS provider participation in VBP models include limited capital to support risk-bearing arrangements and few reserves to cover revenue loss resulting from missed performance targets. Providers also may have limited capacity to collect and analyze data, and attract and retain high-quality workers. High-priority areas for state investments include: (1) direct data collection and analysis support for performance and cost data; (2) technical assistance on VBP, related business models, and how to use technology or systems to support data collection, sharing, and reporting; and (3) grants to build infrastructure. States can also work with managed care plans to develop training programs that support direct care workers' career advancement and improve workforce retention that can be tied to higher wages. States may also require managed care plans to provide some of these supports to HCBS providers.

Opportunities to Engage Stakeholders to Support Program Improvement

- ✔ **Regularly request information from managed care plans about current VBP arrangements, future initiatives, and challenges** to help the state set appropriate contract requirements and reasonable targets for the share of provider payments in VBP models.
- ✔ **Conduct ongoing assessments** to understand HCBS provider readiness and capacity to participate in VBP and the type of support they need to succeed.

☐ ***What is the state's plan for engaging stakeholders in policy and program assessment and evaluation?***

A robust engagement process to continually assess and improve program design and operations — including input from managed care plans, providers, and beneficiaries — is important for achieving program objectives and stakeholder buy-in.

About the West Health Policy Center

The West Health Policy Center is a nonprofit, nonpartisan organization wholly funded by philanthropists Gary and Mary West. The West Health Policy Center provides education, expertise, and policy proposals to lower health care costs and enable seniors to 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. Learn more at **westhealth.org** and follow **@westhealth**.

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The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. Learn more at **www.chcs.org** .

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