REALIZING THE VALUE IN VALUE-BASED PURCHASING OF LTSS

BRIDGING THE GAP BETWEEN THEORY AND APPLICATION

AUGUST 2017

Robert Butler, Principal
Mike Smith, MPA
Wendy Woske, RN, MHA
Mercer

Karen Llanos
Centers for Medicare and Medicaid Services

Laura Otterbourg
New Jersey Department of Human Services

Patti Killingsworth
Tennessee Division of Health Care Finance and Administration

The Health Care Payment Learning & Action Network's (LANs) Alternative Payment Models (APM) Framework

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

CATEGORY 2
FEE-FOR-SERVICE
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)

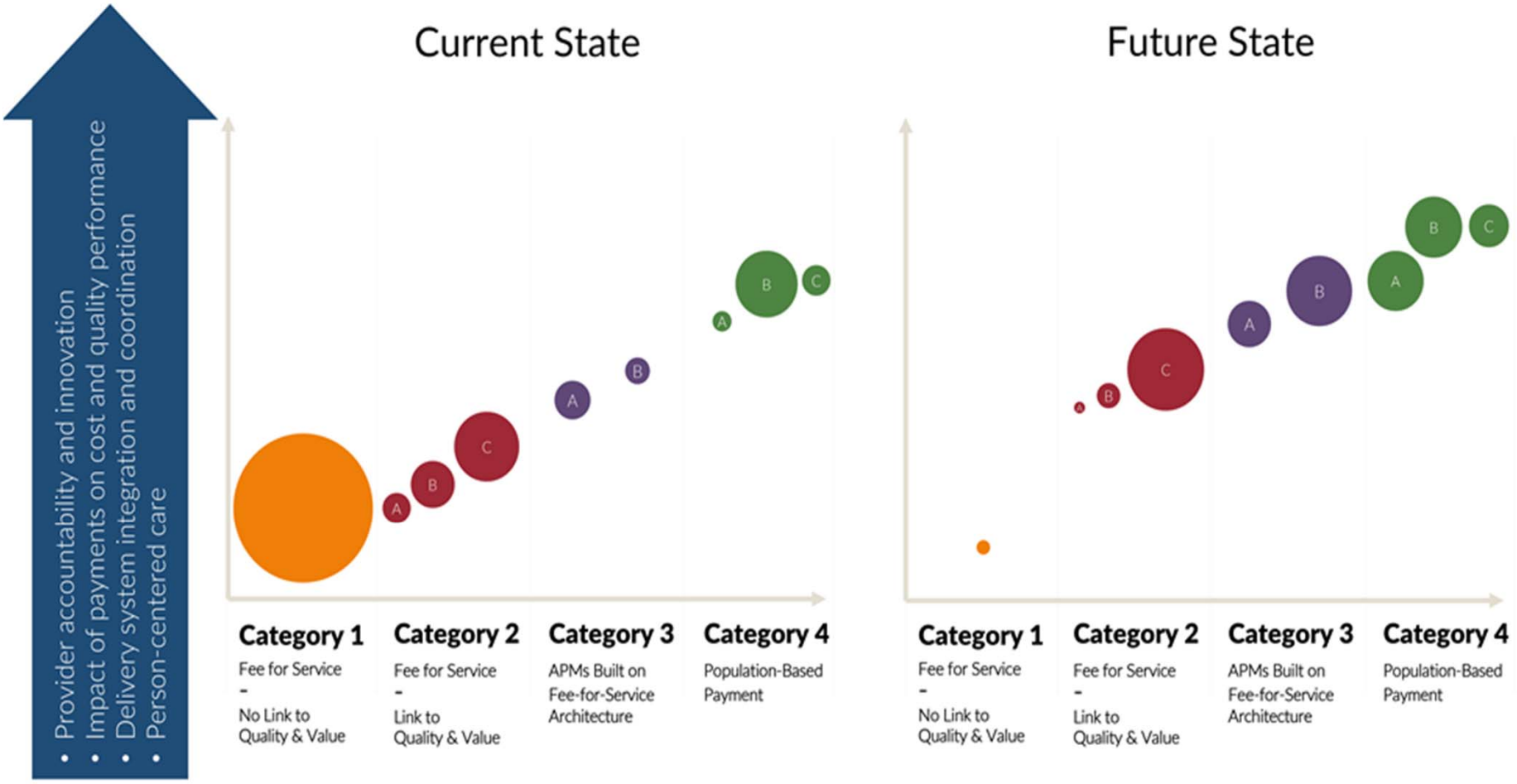
CATEGORY 3
APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE
A
APMs with shared savings with upside risk only
(e.g., shared savings with upside risk only)
B
APMs with shared savings and downside risk
(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

3N
Risk-based payments NOT linked to quality

CATEGORY 4
POPULATION–BASED PAYMENT
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 in integrated systems)
C
Integrated finance & delivery system
(e.g., global budgets or full/percent of premium payments in integrated systems)

4N
Capitated payments NOT linked to quality

PAYMENT REFORM GOALS (LAN)



DEFINITIONS

Value-based Purchasing (VBP): broad term generally translated as reimbursement strategies that reward value rather than volume.

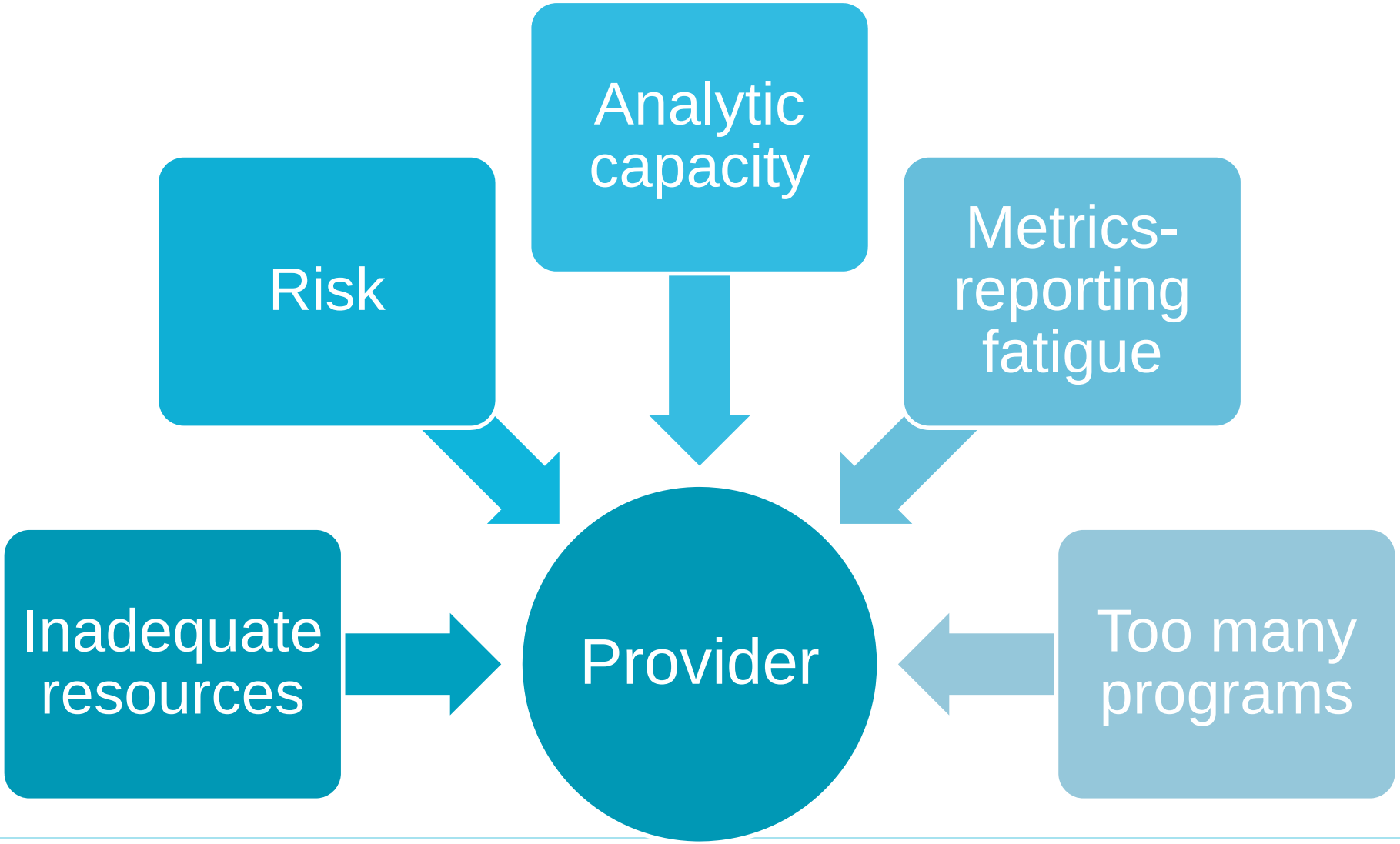
Alternative Payment Models (APM): term applied to payment models that are based upon shared risk and population-based reimbursement strategies that incentivize improvements in quality and person-centered care.

Episode-based Payments: payment model that holds providers accountable for the costs and quality of a defined and discrete set of services for a defined period of time.

Population-based Payments: payment model where one or more providers is accountable for spending targets and quality benchmarks for the vast majority of health services for a defined population.

Provider Accountability: shared risk and rewards requires collaboration, data sharing and analytics at the provider level rather than at the MCO or state level. Strategies include development of new delivery models: Accountable Care Organizations, Primary Care Medical Homes, etc.

CONCERNS IN ADMINISTERING VBP PROGRAMS



STATE NEEDS

- Determine relationship of cost impact to quality outcomes
  - How will the quality be defined and measured?
  - What is the full “cost” to be measured?

What has worked and why

What challenges do Medicaid programs face

What investments must states make to manage

What provider capabilities exist

What resources are required to implement and operate

How will integration of behavioral health and LTSS occur

How will beneficiaries be involved

PRESENTERS

Robert Butler, Mercer

Karen Llanos, CMS

Mike Smith, Mercer

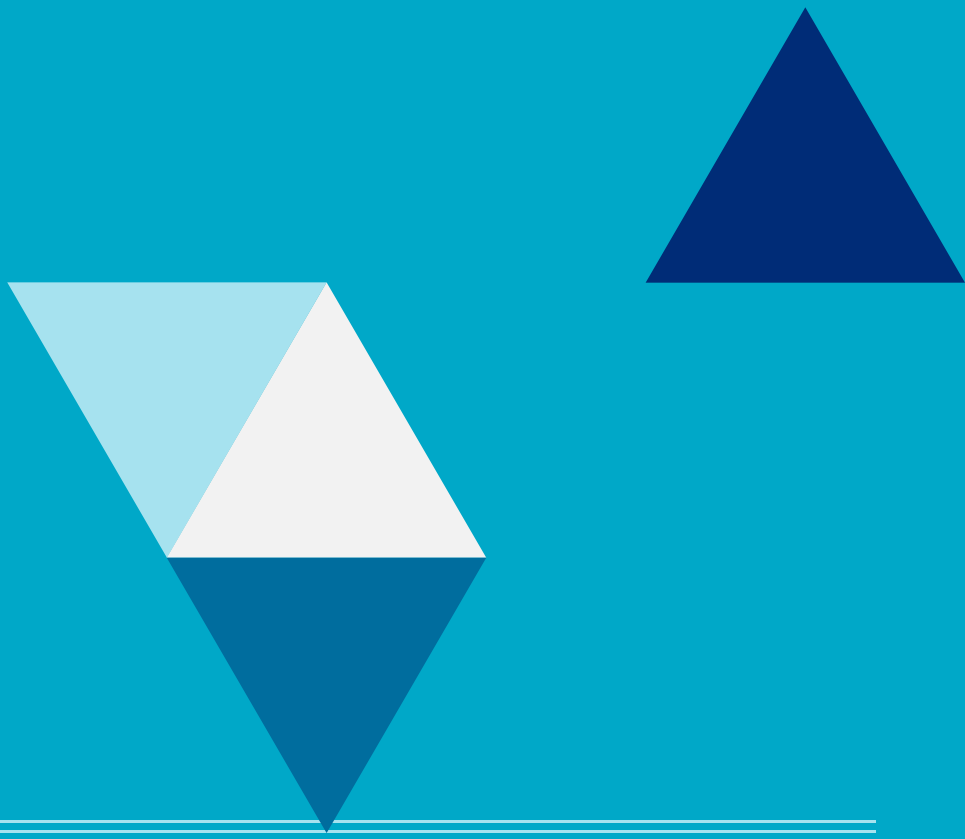
Laura Otterbourg, New Jersey

Wendy Woske, Mercer

Patti Killingsworth, Tennessee

STRATEGIES AND CASE STUDIES

CMS
NEW JERSEY
TENNESSEE



CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

Medicaid.gov
Keeping America Healthy

IAP | Medicaid Innovation Accelerator Program

VALUE-BASED PAYMENT & THE MEDICAID INNOVATION ACCELERATOR PROGRAM

NASUAD Conference

Karen LLanos, Medicaid IAP Director

Center for Medicaid and CHIP Services, CMS

August 30, 2017

VALUE-BASED PAYMENT IN RECENT YEARS

Why Important?

- Health care field is moving to rewarding better value, outcomes, and innovation instead of the volume of services
- In January 2015, The Administration set goals for value-based payments within the Medicare Fee-for-Service (FFS) system and invited private sector payers to match or exceed them:
  - Goal 1: 30% of Medicare payments are tied to quality or value through alternative payment models by the end of 2016, and 50% by the end of 2018.
  - Goal 2: 85% of all Medicare FFS payments are tied to quality or value by the end of 2016, and 90% by the end of 2018. (CMS Quality Strategy 2016)

VALUE-BASED PAYMENT IN RECENT YEARS

- **Examples of Drivers**
  - Medicare Access and CHIP Reauthorization Act (MACRA)
  - Medicare Shared Savings Program
  - Hospital and Home Health Value-Based Purchasing Programs

- **Examples of how CMS has supported VBP**
  - Imbedded in the CMS Quality Strategy
  - Health Care Payment Learning and Action Network
  - State Innovation Model grants
  - Medicaid Innovation Accelerator Program

MEDICAID INNOVATION ACCELERATOR PROGRAM (IAP)

- **Medicaid IAP**
  - Collaborative between the Centers for Medicare and Medicaid Innovation and the Center for Medicaid and CHIP Services
  - Supports states' Medicaid delivery system reform efforts
    - The IAP goal is to increase the number of states moving toward delivery system reform across program priorities
  - Not a grant program; targeted technical support

- **Value-Based Purchasing Functional Area**

- **Long-Term Services and Supports Community Integration Track - Incentivizing Quality and Outcomes (IQO)**

THEMES FROM IQO PLANNING TRACK

- **Quality measurement**
  - What are relevant measures?
  - What are examples of strategies for setting performance benchmarks?
- **Data capacity**
  - How does a state assess whether it has data and the capacity to collect a measure?
- **Value-based payment roadmap**
  - Where's the right place to start?

FOR MORE INFORMATION…

- Check out IAP's page on Mediciad.gov
www.medicaid.gov/state-resource-center/innovation-accelerator-program/index.html

- Watch for IAP's upcoming VBP national webinar series

NEW JERSEY

LAURA OTTERBOURG

DIRECTOR OF THE DIVISION OF AGING SERVICES

NEW JERSEY AND MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS): A SNAPSHOT

- In July 2014, New Jersey consolidated its four waivers under managed care through the Comprehensive Medicaid Waiver, which was approved by the Centers for Medicaid and Medicare Services (CMS) in 2012:
  - About 12,000 individuals moved to home- and community-based services (HCBS) under MLTSS
  - About 29,000 individuals were grandfathered in Medicaid Fee-for-Service (FFS) in nursing facilities (NFs)
  - PACE stayed as an HCBS option in NJ
  - 29 percent of the LTC population were being served by HCBS versus 71 percent in NFs
- As of June 2017, MLTSS is shifting the balance of long-term care (LTC) from NFs to community settings:
  - 46 percent of the NJ FamilyCare LTC population is now in HCBS
  - Number of recipients residing in NFs is down by almost 1,400 since MLTSS implementation:
    - MLTSS members in NFs has increased to about 13,500 with FFS Medicaid decreasing in NFs
  - About 6,000 individuals from the July 2014 Waiver population are still being served with MLTSS HCBS and about 1,000 have moved to NFs with MLTSS
  - PACE remains an option with a new site slated to open in fall 2017
- Any Willing Provider (AWP) provision will end
  - Requires a managed care organization (MCO) to contract with any NF who would like to contract and complies with the MCO's network participation requirements

NEW JERSEY AND THE ANY WILLING QUALITY PROVIDER (AWQP) INITIATIVE: THE BASICS

- Any Willing Qualified Provider (AWQP) is now laying the groundwork for a NF and an MCO to negotiate a payment rate based on quality of care for MLTSS members in NFs and outcomes:
  - Designed to be a foundational step in an evolving value-based purchasing (VBP) strategy to reimburse providers based on performance and encourage consumers to select high value service providers
  - Non Medicaid NFs and Special Care Nursing Facilities (SCNFs) are excluded from AWQP
- Confirmed seven quality NF measures as the initial threshold:
  - Minimum Data Set (MDS) Standards:
    - Anti-psychotropic medications
    1. Influenza vaccination (annual)
    2. Pressure ulcers
    3. Physical restraints
    4. Falls with major injury
  - Survey Standards:
    6. Resident experience survey (CoreQ)
    7. Hospitalization tracking tool

NEW JERSEY: STAKEHOLDER DRIVEN

- Collaborative approach under the leadership and purview of the NJ Department of Human Services.
- New Jersey has a robust MLTSS Steering Committee from which its Nursing Facility Quality Workgroup was reengaged for the AWQP initiative. Among the organizations involved are the following:
  - NJ Department of Human Services; NJ Department of Health; Office of the Ombudsman for the Institutionalized Elderly and its volunteer advocates; nursing home industry trade groups – NJ Hospital Association, Health Care Association of New Jersey and LeadingAge NJ; AARP; five managed care organizations; Area Agency on Aging representation; legal services organizations; various nursing facility administrators and other long-term care advocates.
- The following five guiding principles were agreed upon:
  1. Improved resident experience and quality of life
  2. Transparency and collaboration with the stakeholder community
  3. Consistent approach to quality measurement
  4. Quality monitoring and promoting continuous quality improvement
  5. Oversight and protections
- NJ will continue to rely on its relationships with stakeholder groups to inform providers and consumers as the AWQP implementation rolls out.

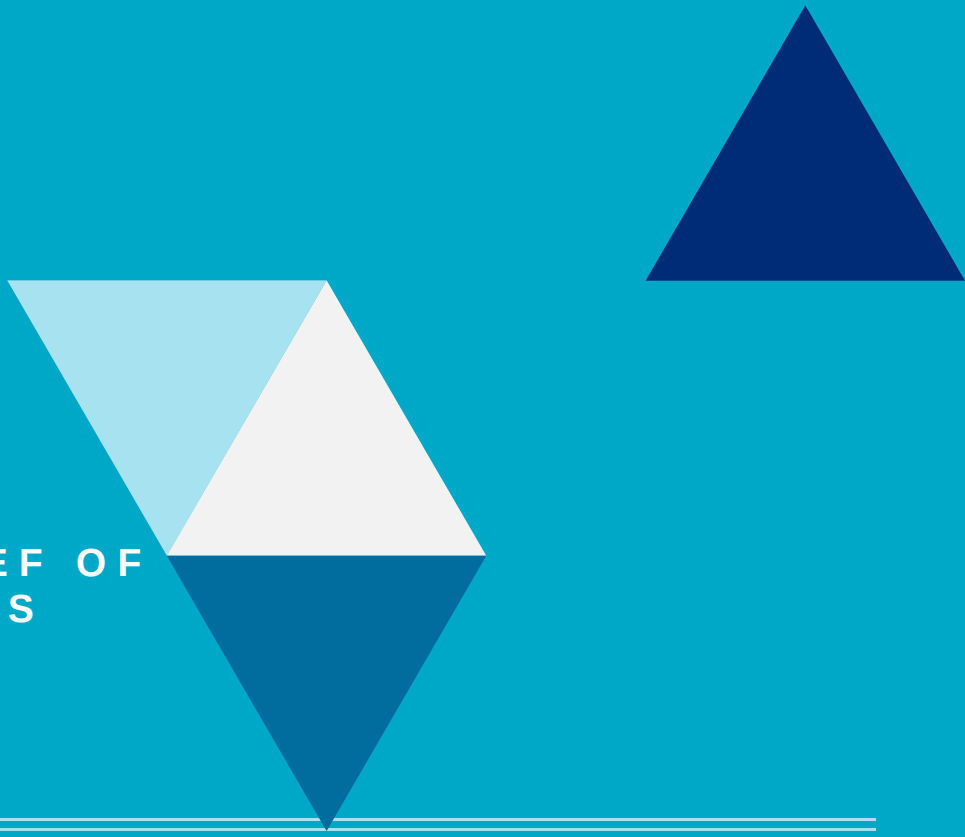
NEW JERSEY: STATE RESOURCES

- NJ Department of Human Services (DHS):
  - Division of Aging Services (DoAS)
  - Division of Medical Assistance and Health Services (DMAHS)
- NJ Department of Health (DOH) – state licensing agency for NFs
- Office of the State Long -Term Care Ombudsman
- A sampling of the required skill sets:
  - Project management
  - Communications
  - Policy development
  - Business intelligence, including MDS measures collection and data analytics
  - File transfer protocols (FTPs)
  - Quality Monitoring
  - MCO contracting
  - Training

NEW JERSEY: DETERMINATION AND ENDURANCE

- Multi-year rollout with gubernatorial election in November 2017
  - Long lead time for implementation if focus is to improve NF quality for long-stay residents
- Stakeholder buy-in for the program goals:
  - Setting the stage for VBP
  - Improving NF quality for long-stay residents:
    - Framework of continuous quality improvement to build capacity from the outset
  - Providing MCOs with a pathway towards stronger network management
- Technical assistance is indispensable:
  - Opportunity to gain from other states' experiences: NJ looked to Tennessee, Texas and New York
  - If AWQP is a step in the State's evolving VBP strategy, there needs to be an eventual link to Medicaid managed care payments

TENNESSEE



PATTI KILLINGSWORTH

ASSISTANT COMMISSIONER AND CHIEF OF LONG-TERM SERVICES AND SUPPORTS

Division of
Health Care
Finance & Administration

REALIZING THE *"VALUE"* IN LTSS VALUE-BASED PURCHASING: *TENNESSEE'S JOURNEY*

TENNESSEE'S JOURNEY TO VBP IN HCBS

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 individuals with I/DD)
- Three health plans (MCOs) operating statewide
- Physical/behavioral health integrated beginning in 2007
- Managed LTSS began with the 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 Department of Intellectual and Developmental Disabilities (DIDD) (people carved in for physical and behavioral health services)
  - New MLTSS program for individuals with I/DD began July 1, 2016: *Employment and Community First CHOICES*

WHAT IS QUILTSS

- A TennCare initiative to promote the delivery of high quality LTSS for TennCare members (NF and HCBS) through payment reform and workforce development
- Part of the State's broader payment reform strategy
- 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
- Includes creation of a comprehensive competency-based workforce development program and credentialing registry for direct support professionals, including coaching and mentoring to support continued recruitment, learning, development and retention

WHY VALUE-BASED PURCHASING FOR LTSS IN TN?

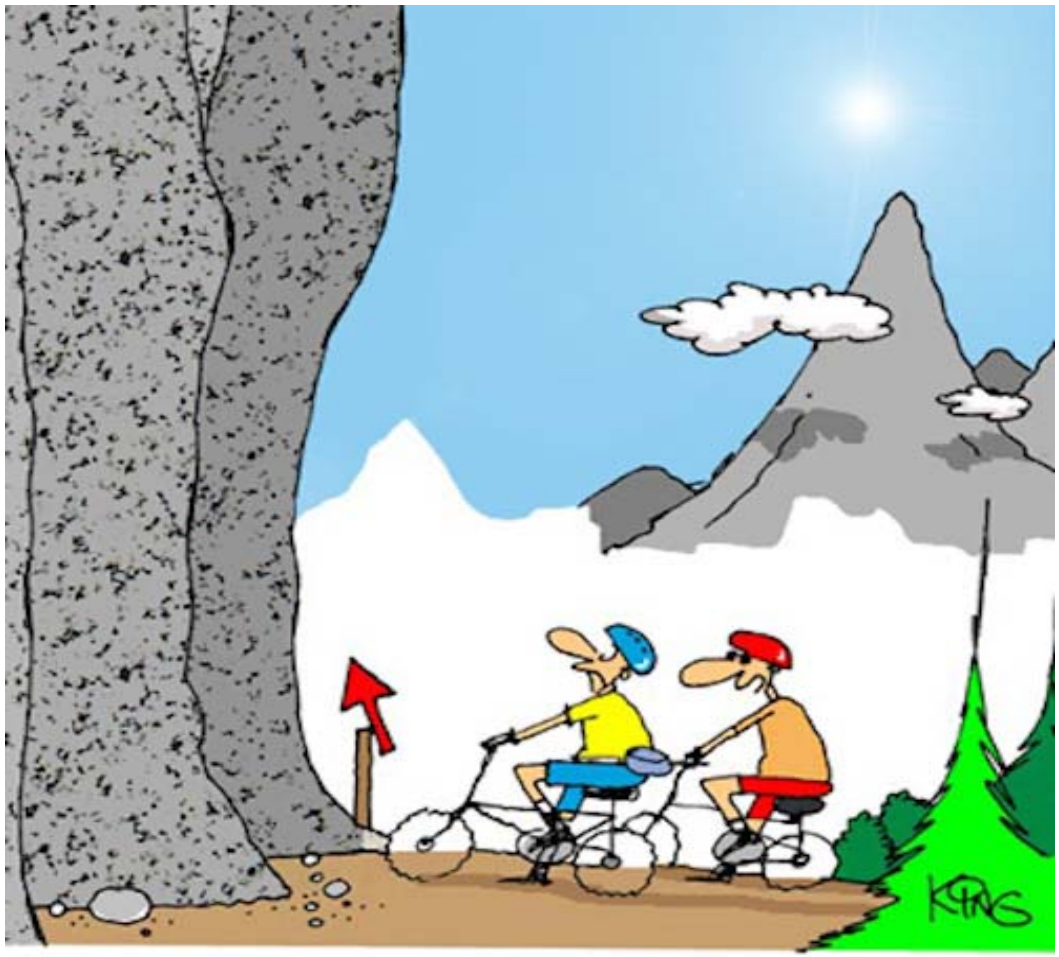
- Governor's commitment to payment reform
- Statutory commitment to change NF reimbursement methodology
- Statutory commitment to quality—from the perspective of the individuals receiving LTSS

The long-term care system shall include ***a comprehensive quality approach across the entire continuum of long-term care services and settings*** *that promotes continuous quality improvement and that* ***focuses on customer perceptions of quality****, with mechanisms to ensure ongoing feedback from persons receiving care and their families in order to immediately identify and resolve issues, and to improve the overall quality of services and the system.*

—The Long Term Care Community Choices Act of 2008

- Poor NF quality performance; low participation in AEC and QAPI
- Member satisfaction surveys identified opportunities for improvement in quality of care and quality of life (across services and settings)
- Opportunities to **transform the system** by aligning incentives around value – outcomes and other things that most impact the member's experience of care and day-to-day living

SYSTEM TRANSFORMATION



"Here's where it gets a little challenging."

WHY IS VBP FOR HCBS SO DARN CHALLENGING?

- Defining “value”
  - More than cost (good outcomes may cost more, at least in the short term)
- Measuring value
  - Do we “value what we can measure” or find ways to “measure what we value?”
- Program/provider capacity to achieve defined values
- Volume and diversity of HCBS providers
- Changing payment methodologies
  - Lack of new resources/challenge of redirecting existing funds to quality
  - Ability to model rate impact
- **System transformation**

STRATEGIC POLICY DECISIONS

- Focus on the member experience to define, measure and pay for quality
  - Other systems measure clinical quality and regulatory compliance
- Develop a statewide payment reform approach
  (Versus allowing MCOs to develop their own)
  - Reduces administrative burden for providers
  - Aligns efforts around key values/metrics across the system
- Collaborative stakeholder process
  - Ongoing stakeholder input
  - Design, implementation
- Iterative, developmental process
  - Develop infrastructure, processes and capacity—set providers up for success (for improvement); then keep raising the bar
  - Provide ongoing feedback to improve quality
- Transparency
  - Clear expectations, training and feedback to providers

FROM POLICY TO PRACTICE: STEPS ALONG THE JOURNEY

- ***Employment and Community First CHOICES***
  - New MTLSS program for people with I/DD
  - 14 different employment services create a pathway to employment
  - Outcome-based reimbursement for up-front services leading to employment
  - Tiered outcome-based reimbursement for Job Development and Self-Employment Start-Up based on person's "acuity" level and paid in phases
  - Tiered reimbursement for Job Coaching based on:
    - Person's "acuity" level;
    - Length of time person has held job; and
    - Amount of support required as percentage of hours worked

Payment is higher per hour if fading achieved is greater, and vice versa.

FROM POLICY TO PRACTICE: STEPS ALONG THE JOURNEY

- ***Cross-walk lessons learned into existing 1915(c) waivers***
  - Establish separate rates for job development/customization or self-employment start-up, coaching, and stabilization and monitoring
  - Create separate Community-Based wrap-around service with higher rates of reimbursement than Community-Based Day that does not wrap competitive integrated employment (CIE)
    - Wrap-around rates vary depending on the number of hours the person participates in integrated employment (higher rates for persons working more hours in CIE) in order to further incentivize desired employment outcomes
  - Realign existing funds with desired outcomes, i.e.,
    - Invest substantially more resources in higher rates for services that achieve CIE
    - Reduce reimbursement for services that do not support desired outcomes, including facility-based programs
  - Model provider impact and help providers plan/prepare for success, i.e., transformation

FROM POLICY TO PRACTICE: STEPS ALONG THE JOURNEY

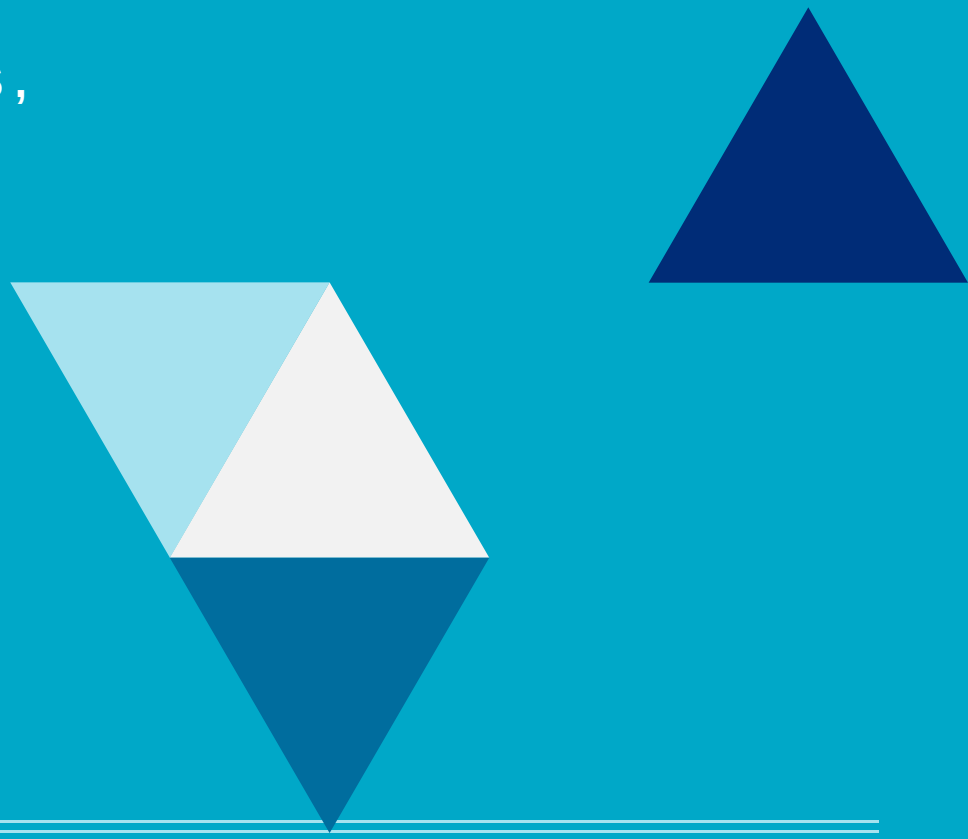
- ***New Behavioral Health Crisis Prevention, Intervention and Stabilization Services ("Systems of Support")***
  - New behavioral health service/model for individuals with I/DD who experience challenging behaviors
  - Monthly case rate aligned to support improvement and independence
  - Technology platform tracks outcome measures to establish additional VBP components
    - *Decrease crisis events requiring out-of-home placement*
    - *Decrease ER visits*
    - *Decrease inappropriate inpatient psychiatric hospitalizations (utilization and cost)*
    - *Decrease behavioral respite utilization*
    - *Decrease use of psychotropic medications (except to treat diagnosed MH conditions)*
    - *Decrease intensity/cost of HCBS (more cost-effective services/integrated settings)*
    - *Increase sustained community living (community tenure)*
    - *Increase integrated employment*

LESSONS LEARNED

- Engage stakeholders early and often (formal/informal)
- Transparency is key (nobody likes surprises)
- This is an iterative and developmental process (you cannot get there all at once; learn and move forward, then learn some more; not everything you try will work the way you thought it would)
- It's easier to build than "rebuild"
- You will need to develop the capacity of the system to measure and improve quality
- Be at least two steps ahead of the system (or 10—you need a lot of lead time for planning)
- Communication, communication, communication
- It's harder than you think. It will take longer than you think.
  And it will accomplish more than you think…***it's totally worth it!***

ROUND TABLE DISCUSSION

IDEAS, CHALLENGES, QUESTIONS, CONCERNS AND “AHA” MOMENTS



MAKE TOMORROW, TODAY