Value-Based Purchasing: Opportunities in Medicaid Managed Home and Community-Based Services

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Experience with IDD Systems and Providers: MLTSS States & Non-MLTSS States
What is Value-Based Purchasing?

➢ Tying payment (or part of payment) to outcomes produced by services delivered

➢ Reducing cost for same quality or increasing quality for same cost

➢ Advancing policy goals in meaningful ways: service delivery system reform requires payment reform

➢ Rewarding providers for quality regardless of quantity of service delivered
New York’s VBP Initiative: Good Logic

“In essence, the State’s Medicaid payment reform goals attempt to move away from a situation where increasing the value of the care delivered (preventing avoidable [care], reducing administrative waste) has a *negative* impact on the financial sustainability of providers, towards a situation where the delivery of high value care can result in *higher* margins.”

Source: NY DOH Medicaid Redesign Team - A Path toward Value Based Payment: Annual Update November 2017: Year 3
Need to Move Beyond Fee for Service

“The number one thing that needs to happen as part of health care reform: We need to change incentives from doing more to being paid for performance...in other words, we need to end fee for service.” Dr. Paul Keckley, Health Care Economist

The Reality of Fee For Service in IDD World:
Providers who do exemplary work earn no more than providers who do not do exemplary work. In fact, they may earn less.
The Problem with Fee for Service: Supported Employment Case Example

The paradox when paying by hour of service.

The more capable an organization, the less hours they need to deliver a service.

The less hours of service delivered, the less billable hours.

The more capable organization receives less funding as a result of being more capable.
History of Value-Based Purchasing

➢ Major feature in health care reform

➢ Priority for CMS

➢ Most experience in acute and primary healthcare – clinical outcomes focus

➢ In LTSS, most models are focused on how states use VBP with managed care organizations, not how VBP can be used with direct service providers
Is LTSS/HCBS Valuable Part of Healthcare System?

Determinants of Health

- Traditional Medicaid
- LTSS/HCBS
- Genes & Biology (10%)
- Physical Environment (10%)
- Clinical Care (10%)
- Health Behaviors (30%)
- Social & Economic Factors (40%)
VBP and Direct Support Professionals

➢ What if provider reimbursement rates were higher if services were provided by credentialed DSPs or DSPs in process of earning credentials?

➢ What if assisting individuals to gain independence/access to natural supports was tied to financial incentives (and resulted in providers needing to recruit/retain less DSPs)?
VBP and the Direct Service Workforce Crisis

➢ Low wages and benefits are not the only factor in DSP turnover

➢ Practices that would address the workforce crisis include “teaching business and organization leaders skills to improve their ability to recruit, select and retain direct service employees.”

Source: PCPID Report to the President 2017, America’s Direct Support Workforce Crisis: Effects on People with Intellectual Disabilities, Families, Communities and the U.S. Economy
VBP and the Direct Service Workforce Crisis (2)

In **Tennessee**, HCBS providers operating in MLTSS are:

- Being paid to set up systems to collect, report and utilize data on retention/recruitment to inform their efforts to improve retention/recruitment outcomes.

- Being provided training and TA on evidence-based practices to increase retention and successful recruitment of DSPs

- Will be able to qualify for higher reimbursement rates if they implement one or more evidence-based practices.
What if providing a service in the community resulted in a higher reimbursement rate (net income) than providing it in a facility?

What if fading paid supports allowed the provider to increase net income per hour of service delivered?
Paying for Service **Does Not** Incentivize the Valued Outcomes We Desire in Individual Supported Employment Services

**01**
Increasing hours the person works (while not increasing support) does not result in any increased payment to the provider.

**02**
Increasing hours of support (while not increasing hours the person works) results in increased payment to the provider.

**03**
Allowing billing only for face-to-face service is contradictory to what we know to be good job development and worksite support strategies.

VBP and Advancing Employment First
VBP and Advancing Employment First (2)

**Paying for Job Coaching Based on Hours Worked by the Supported Employee**

- Rewards fading (more fading = greater net income; risk-adjusted fading expectations are critical)
- Rewards moving individual toward full employment (increase in income if hours worked increase)
- Incentivizes provider to prevent job loss or reduction in work hours
- Provides a sustainable way for agencies to survive by making Individual Supported Employment their primary service line

**ALIGNS PAYMENT MODEL WITH POLICY GOALS**
Does Paying for Supported Employment Based on Individual Hours Worked Improve Outcomes?

Wisconsin MCO: Outcomes and Impact

25 MONTHS LATER: 35% GROWTH in number of people employed in competitive integrated employment

6 YEARS LATER: 70.6% GROWTH in number of people employed in competitive integrated employment

Average cost/hour worked lower than average cost/hour of day or prevocational services.
Does Paying for Supported Employment Based on Individual Hours Worked Support Provider Transformation?

• Largest employment/day service provider moved to outcome-based reimbursement in mid-2012

• # of people supported in competitive integrated employment increased 300% in 8 years.

• % of agency revenue coming from competitive integrated employment services tripled in 8 years.
What if Support Coordination agencies received incentive funding for increasing # of individuals with goal of CIE who have this goal documented in their service plan?

What is Support Coordinator performance reviews factored this in and merit pay was attached.

Source: NCI, 2016-2017
VBP and Quality Monitoring

➢ What if state quality monitoring was really about measuring quality, not basic compliance?

➢ What if providers who earned high scores for quality were rewarded with higher reimbursement rates and preferred provider status?
VBP – Doing it Well

➢ There is **not** “one right way” to do VBP in MLTSS

➢ Collaboration with service providers is essential

➢ Providers need support to move away from focus on “maximizing billing by maximizing service”

➢ We (funders/government agencies) have created the current focus on maximizing the quantity of service delivered...we must own responsibility for supporting providers through the change that must occur
Risk-adjustment must be factored into VBP initiatives.

Performance measurement and data collection are critical but beware of backing into what we value, based on what we can currently measure.

There is no such thing as a payment structure that is value-neutral. Every payment structure contains incentives and disincentives.

VBP involves aligning financial incentives and disincentives with policy goals and quality indicators.
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