

# Value-Based Payment for Home and Community-Based Services: Strategies, Progress and Accomplishments of Participating IAP States

## Audio Transcript

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### Welcome and Background

MELANIE BROWN: (Slides 1-3) Welcome to all of our participants. I am Melanie Brown. I'm a Technical Director at CMS within the Center for Medicaid and CHIP Services and the Medicaid Innovation Accelerator Program. (Slide 4) We'll start with a polling question—to see who is joining us on the webinar today? We're looking specifically for organizational affiliation. The choices are: state Medicaid agency; other state agency; managed care organization; advocacy organization; contractor or vendor; or other. Please select a poll option. Not surprisingly, overwhelmingly we have folks that represent the state Medicaid agencies followed by other state agencies. Thank you again for joining us today. We hope that you will find the content helpful.

(Slide 5) The purpose of today's webinar is to improve participants' understanding of value-based payment (VBP) for home and community-based services (HCBS). We also want to help identify steps to design a VBP for HCBS initiative and to share strategies, progress and accomplishments of particular states who participated in our technical support initiative regarding designing a VBP for HCBS initiative.

(Slide 6) Today's agenda:

- Overview of the IAP VBP for HCBS Technical Support Opportunity
- State Overviews
  - Louisiana: VBP for HCBS Initiative
  - Minnesota: Proposed Star Ratings for assisted living facilities
  - Missouri: VBP for HCBS Initiative
- Facilitated Q&A
- Key Takeaways

(Slide 7) Joining me today is Pat Rivard. She is a Research Leader at IBM Watson Health, and she'll be sharing part of the overview of the IAP VBP for HCBS activities. (Slide 8) To begin with, for those of you who may be unfamiliar with IAP, it stands for Innovation Accelerator Program. IAP represents a commitment from CMS to build states' capacity and accelerate ongoing innovation in Medicaid through targeted program support. (Slides 9-10) [IAP overview] (Slide 11) IAP's overall goal for the Community Integration through Long-Term Supports and Services (LTSS) Initiative, which includes the VBP for HCBS track, is to increase state adoption of strategies that tie together quality, cost, and outcomes in support of community-based LTSS. (Slide 12) So, our VBP for HCBS track really emphasized planning, designing and developing a VBP strategy for HCBS with two primary objectives. One, to build state knowledge and capacity to design a VBP strategy for HCBS. Two, to move states towards implementation of a VBP strategy. States that participated represented a continuum of VBP experience from really just beginning

to build knowledge to planning and also to actual implementation of a strategy. Now Pat Rivard will talk about the types of program support that have been provided.

PAT RIVARD: (Slide 13) I got the opportunity to be one of the coaches working with two of the states participating in this effort. We wanted to just briefly touch on the type of support provided and still being provided to the 10 states:

- First, supporting states to align financial incentives with state policy objectives. So does the plan comport with the state's overall goal for VBP?
- Next was measurement. How will you know you're meeting your objectives? The coaches supported state's efforts to review and select measures to help answer some of these questions.
- Third was stakeholders, and we can't say enough about how important it is to engage stakeholders early and often, and to be sure that your strategy is understood and ultimately supported by all stakeholders. You'll hear more about that from the states that are presenting today.
- Last, is designing a state's VBP for HCBS strategy. This could be both financial, for example incentive payments, and certainly nonfinancial, for example a Gold Star Rating. Again, you'll hear more about that during the presentation.

The support really was through site visits, regular meetings and webinars with states. Also sharing information. Most importantly was connecting states up with each other, so really to share some best practices and then certainly some bumps in the road.

(Slide 14) This next slide is a map to show the states that have been participating both in this track, as well as the previous track. It also gives you a sense of where they are in their journey to develop and implement the VBP for HCBS strategy. There are five states in blue. These are states in the planning phase. One state in pink, Massachusetts, is in the implementation phase. The seven states in purple are in a design phase. There is one state, the darker green, in both planning and implementation. Two states in a lighter green are both in the implementation and designing phase. Finally, two states in the medium green are both planning and designing. This kind of gives you a picture of where states are at and again there are 18 states highlighted on the map that show prior and current track work, and 10 have been participating in this current track that we'll be talking about today.

(Slide 15) The next slide illustrates what we refer to as the VBP for HCBS road map summary. It gives you a picture of all the components that would be covered as you think about designing, developing and then implementing a strategy. First and probably very important is your overall policy objective and your aim statement. Certainly, a successful strategy starts with this shared vision, making sure the stakeholders know what the visions are and really a strong foundation to get you to that overall aim.

Next is stakeholders. We'll keep repeating this: communicate, communicate and how important this is. Then the measurement system. Select your measures that are really important and realistic. Can you really gather the data to report on these measures, data, baseline data, data available? Availability often drives what measures you pick and again you'll hear from states about some of their experiences on this front.

The financial model, certainly money can motivate change. Performance measurement and reporting certainly can be a burden to some organizational resources but it's important to keep that in mind, and also, to keep things simple.

Last but not least, monitoring and adjusting. Ongoing monitoring and refining. Again, you'll hear some examples of that from some of your colleagues today, so ensure you're constantly monitoring to be sure that you're continuing to meet your aim statement.

As you look at this, it's certainly not a straight-line paved roadway. Certainly, there's going to be some bumps and turns along the way. We conducted a similar presentation at the recent HCBS conference in Baltimore and one of my colleagues, Robin Preston, used the term bumper cars. I think that sums it up nicely. There'll be bumps in the road, but it'll certainly be a fun ride and again you'll hear stories from your colleagues.

(Slide 16) In the next couple slides, what we wanted to do was share some initial lessons learned. This is information from both states and some of the coaches. First, data, data, data. Good data will tell you about the problems you want to address or the areas you want to improve upon. It will provide a benchmark of current performance and clearly show where the improvements are and by how much as you think about the incentives and how you want to reward those.

(Slide 17) Next is stakeholders. Take the time to identify all the stakeholders that will be affected by your strategy. Some examples include legislators, providers, provider associations, licensing bodies, participants and their families, and I'm sure you can think of others in your state. Really casting a wide net. Also, to be mindful of your colleagues in state government, if they've not been informed about your plan. Be sure to include everybody in state government as you begin to develop this whole strategy.

(Slide 18) The last lesson learned, it's okay to take interim steps. You don't have to turn around on a dime. You can start slowly, for example, paying for timely and complete reporting can help providers get used to taking the extra steps to move toward the VBP model. Sometimes we always think of financial models—it's okay to also consider nonfinancial incentives and you'll hear about that today. For example, Gold Star Ratings. Again, this can help move providers into this VBP realm.

(Slide 19) We're going to pause before we turn it over to the speakers. We have two polls. First, how prominent is community-based LTSS payment reform on the Medicaid policy agenda in your state? One of the very top priorities, near the top but not at the top, a priority but one of many, and not a priority. Complete the poll. For 19%, one of the very top; 24%, near the top; 47%, a priority but one of many; and 9%, not a priority.

(Slide 20) We have a second poll: What is the status of your state's VBP for HCBS initiative? Learning about it, planning a strategy, implementing a strategy. Half of you are learning about it: hopefully this presentation will help you think about what will work in your state; 40% planning; and 11% implementing a strategy.

## Louisiana

MELANIE BROWN: (Slide 21) First up we have Louisiana. Talking to us from Louisiana, we have Charles Ayles, the Deputy Assistant Secretary in the Office for Citizens with Developmental Disabilities at Louisiana Department of Health, and Bernard Brown, Chief of Staff in the Office for Citizens with Developmental Disabilities at Louisiana Department of Health.

BERNARD BROWN: (Slide 22) Before participating in the IAP, Louisiana was actively developing incentive-based outcome measures. Our overall goal was to develop quality measures where we actually had data to account for the typical outcome activities we were looking into. We came upon the IAP "grant" and felt it was definitely in line with what we were trying to accomplish. (Slide 23) Our overall goal and focus for our HCBS initiative was to increase the independence at home and in the community for individuals with intellectual and developmental disabilities by increasing and expanding the number and types of services used.

(Slide 24) Some of our objectives with this was, naturally we believed that based on our service definitions, successful quality delivery of those services will result in an increased service utilization mix where currently we were experiencing an overutilization just in, in-home IFS/PCA services. We felt that didn't accurately reflect the population we served so we felt like quality delivery of services would increase the service utilization mix.

We wanted to incentivize providers to take on some of those more complex needs people, some of the people with co-occurring diagnoses where they had behavioral needs as well as medically fragile needs. We wanted to incentivize providers who delivered high quality services and reduce the amount of critical incidents that were happening. And we wanted to increase the utilization of supported and competitive employment services.

(Slide 25) The original objective, originally, we had it set up where we had a rubric of measures where three provider classifications were accounted for in their own individual rubric. We broke them up into support coordination, residential services and nonresidential services. However, after conducting various stakeholder sessions, we decided we needed to make a change in how we determined the effectiveness of those service provisions. In particular, the major feedback we got was that the rubric and some of the performance indicators on the rubric weren't adequately reflecting the quality that our participants would see on a day-in, day-out basis. That was one of the pieces of homework we had to take away. To discuss the data and other things I'll pass it to Charles Ayles, our Deputy Assistant Secretary.

CHARLES AYLES: (Slide 26) On the next couple slides we'll go through and focus on our data. We looked at five years of data for utilization and for CPOCs for our various waivers and we found some very interesting things, kind of verified some things we always thought were true, but we were able to look and see, definitely, that we have a very strong bias in this state towards personal care. Over 90% of our services are in the personal care arena and that's through all four of our waivers with the exception of our Supports waiver. At one point in this state the drive was--it looks like--for everybody to have 24-hour, one-on-one, 365 days care. The system really is still geared toward that particular instance. We had almost 10-15% of our people getting 24-hour, one-on-one care of some sort or a combination of 24-

hour services between maybe PCA and skilled nursing for our medically fragile people and then a very large group that fell in between getting 0-8 hours and up to 16-24 hours. So very high usage of PCA.

(Slide 27) We also looked at five years on the planning and we saw that most of the plans when they were set did not have a lot of variation from year to year. So, the first thing we wanted to do was look and see how we could in fact change some of the service utilization mix based on the data that we found. One of the things looking at what we had and what we wished we knew now, we wished we actually had some money upfront. I know that's probably on every state's wish list that we had money to do things upfront. One of the things we discovered is it's real, real easy to plan a lot of things and then it comes down to the point of how do you pay for it. But if you already have some dollars set aside, it makes you a little more reasonable in your expectations in terms of how you set your mix, how you look at providers actually meeting the criteria, and how you're going to distribute that money towards the end.

Another thing Louisiana wishes it had upfront was a great quality framework. We don't actually have a great framework set up in place now. All our previous efforts at quality pretty much looked at processes, how effective we were, how quick we were, how fast we got people in. A lot of that had to do with the very large registry we had at one point and eliminating the registry. All of a sudden, the time frames and things and process measures that were set up became a little, I wouldn't say obsolete, but not quite as important. But in terms of looking at what are we actually getting for the dollars we were spending, that framework is not there. So even in doing so and coming to the VBP model it's forcing us to have to look at how much bang are we getting for the actual bucks that we're spending out. Close to \$500, \$600 million going out in HCBS, we're going to have a very hard time explaining how we're moving people's lives forward in terms of teaching people to care for themselves, to be more independent. Some of the plans we looked at said they were teaching people to feed themselves and had been doing so for 10, 12 years. Well at some point or another you look at it like they're either not learning or we're not adequately teaching. That's a moment where we probably need to go in and do training. But a good quality framework, we don't have at this point.

On the data infrastructure that we have, right now all of our data is siloed. It's in different places. We have one, our CPOC data, our planning data is in one system. We have the Medicaid claims payment system in another group. We have our statements of approval entry into the DD system in an entire other data system so everything is siloed. It would help a lot if all of those systems could talk to each other, or even better if it was all in one system with common fields with days that we can look at uniformly at the same time. Right now, we don't even have a system we can look at and see all of the Medicaid numbers are exactly the same across the board. We have a very difficult time matching Medicaid numbers sometimes across systems, so we wish we had all those things in place. That would help us a lot in terms of being able to get our measurements done and getting everything lined up to work with VBP, probably a lot easier than that is going to be for us.

Lastly, adequate provider rates. During one of our visits, the CMS and IBM team got to speak with some of our providers and they got a big earful about how bad our rates are. They've since gotten a rate increase, been pretty quiet on the front about all of that. But at the same time, we understand that having an adequate rate helps providers to be able to provide the kind of depth of service we would expect and are going to expect from our providers. It just eliminates some of the usual complaints about

not being able to get the kind of training and being able to get the kind of staff that they need. High staff turnover is a big problem I think all across the country, but it's amplified in places, rural areas and things, where the rate is not adequate enough to recruit the kind of people we need to provide the kind of care that we need.

(Slide 28) What are our lessons? Start simple. Be open to a phase-in strategy. As I said before, you believe you can do anything when you don't know what you're doing. We went out big. We went out to change the world upfront. We had great big plans, and as we met with our providers and spoke with our TA people, our plans started to shrink. Now we've got them down to a size where we think we can actually manage the startup of the VBP program.

We're going to phase it in instead of starting with all the providers at one time. I think by keeping it simple and moving in small steps toward a long-term goal of getting high-quality services through incentive payments, I think that's the best way to go. That would be something we learned probably after sitting in some stakeholder meetings with some providers, some families, some advocates. Start small. Move it across, phase it in to ultimately get to the goal we would like to get to. Talk with all your stakeholders, internal and external.

First, we had to get buy-in from the administrators here. They thought it was a good idea. That's one reason we've advanced as far as we have is because administrators are behind us 100% to get this program in. The stakeholders, the families, it's very difficult to explain sometimes to families that you're not coming to take something from them, that we want to improve the lives of their loved ones for the money we are providing, but we're not coming to take hours from them, which is what this could turn into, if the wrong individuals are allowed to explain the system. If an individual needs 10 hours they're still going to get 10 hours. What we're looking at is doing a good person-centered plan, taking in all the individual's considerations, and if they would like to have a job and to work, we want to give them an opportunity to work. But we're not going to do that at the expense of anybody's health and safety. We've done a good job with that so far. I think we're going to have some more work to do the further we get along, and we're going to have to work with them. And you need to get the providers to understand that in the end, all of this creates a better system.

To some, the PCA providers in particular, it looks like we're taking money out of their pockets. We very well could be, but at the same time it's all for a goal of advancing the individuals' lives, not so much those of the provider.

Lastly, consider the funding and how you're going to distribute it. We looked at maybe how we would go about doing the VBP system and it looks like the way we started it out that certain groups would be in better positions to achieve their goals than others. If the support coordinators met their goals, that would have an effect on the personal care providers, on the vocational providers, so we're looking at how we would go about distributing the funding across the system to award those providers who actually buy into what we're getting, what we're trying to provide for them, and looking at enhancing the lives of the individuals that we serve through the money. But we don't want to set up a system where all of the money dumps into one side and makes it impossible for all providers to participate in the system.

(Slide 29) Those are the three things we've learned and as we move forward, we may learn a few more things. But we're looking at doing this across the board so it's fair for everyone. We're moving forward with our funding strategy for our pilot. Hook or crook, we've managed to create some efficiencies in the system that will allow us to fund a VBP model this year. So, hurray for that. We've had an administration that have allowed us to make some changes in the system so that we could generate a few free dollars so we're going to get a chance to put our VBP model into place this year. In addition, we're going to get back out there, we're going to have more informational sessions. We're going to engage stakeholders, especially families, especially providers, and advocates so that we can get them to clearly understand what it is that we're trying to do, that we're not out to hurt the system or to hurt individuals. What we want to do is enhance the life of individuals to the good of the system and create quality services rather than just quantity of services.

So, it's going to take a lot more work. We've got to get out there. We've got to teach it, to preach it, to cheer for it, and we're going to take their questions and work on engaging them to the point that everybody across the state understands what we're doing. Might not have 100% agreement that they love it, but we do need them to understand this is the way of the future. Quality is where we're going. And hopefully through this model we'll be able to get them started in the right direction.

## Questions

MELANIE BROWN: (Slide 30) Thank you, Charles and Bernard. If you have a question for Louisiana enter it in the chat box. We got two general questions. One was whether or not this includes behavioral health HCBS. Typically, from the IAP perspective the technical support is really framed around the target population that the state selects. So, each of the states that participates in the IAP initiative can select different target populations. So, for Louisiana they focused a lot on the I/DD population. But we try to keep some of the general tenets of the technical support general enough that you could apply it to any HCBS setting. So yes, is the answer. The principles you're hearing, and ideas could be applied to HCBS for behavioral health, I believe it can.

Someone asked about the states that are participating. I'll quickly go back to slide 14 with the map. It shows all the states participating. This most recent round we worked with 10 states but prior to that we had worked with an additional four with some overlap. There were a few states that wanted to come back and get additional technical support. All this information will be available in the slide deck, which will be on Medicaid.gov in about two weeks.

We have questions for Louisiana. *Has Louisiana considered accreditation to assist with the framework for quality measures?*

BERNARD BROWN: Yeah, we looked into some of the accreditations to help with some of the quality measures. I think our focus in the state was developing quality measures that specifically use empirical data, more in particular claims data, to reflect outcomes. Again, we said what we were anticipating was if the quality of care improved eventually someone would go from needing a certain number of hours to needing less hours. That should be reflected in claims data. So, while we did consider some accreditations in already established quality measures and reports, we wanted to go to something that tied more to the long-term outcome as opposed to the day-to-day quality of delivery.

One other piece. Our initial measures are legitimately a starting point. One of the big takeaways we got from the technical assistance was you need to always be evolving in the measures that you put out and assess. So, to be in step with that we've kind of begun to build out a new electronic plan of care, our individual support plan, which will have goals and milestones built into the actual plans. That way we can measure quality and outcomes from that particular document from a holistic approach. As opposed to assuming that if there's a reduction of services then that just means the quality of care that this person is getting is good.

MELANIE BROWN: One other question for Louisiana. *What analysis or process did you do to set the pilot payment rate?*

BERNARD BROWN: Real quick, we kind of adopted the MCO model that a lot of states are using with VBP for the acute services where they're—I don't want to say holding back but they're withholding a certain percentage of the PMPM. We mimic that and instead of withholding payments from providers, we developed an incentive tool that I think it's 2.5% of whatever a provider's claimed expenditure is for the evaluation period as the incentive pool or the max incentive that a provider can get. That sounded real choppy, but pretty much instead of holding back and withholding money on the front end, we're developing a separate pool of money to be a true supplemental payment on the back end.

## Minnesota

MELANIE BROWN: (Slide 31) We will have more time for questions at the end. Our next state speaker is from Minnesota: Peter Spuit, a rate-setting policy consultant with the Minnesota Department of Human Services.

PETER SPUIT: (Slide 32) Minnesota was glad to participate in this round of the IAP project for VBP for HCBS. I am in the Minnesota Department of Human Services (DHS) in our Aging and Adult Services Division. The team that I work on supports our Elderly Waiver Program, that's what we call the waiver. That's for HCBS for people 65-plus. We also have four disability waivers in our state overseen by the Disability Services Division at the DHS. I was the project lead for our team in Minnesota for the IAP project team. We had staff actually from the Minnesota Department of Health, a separate state agency, but also a number of divisions within DHS. So, we were an inter-agency and inter-divisional team for our project.

In terms of why we participated in this IAP cohort, we especially wanted to invest in quality measurement at the provider level. This isn't so well-reflected in the slide here, but we've done lots of quality measurement at the statewide level, certainly at the county level. We also look at quality and have data at the managed care organization level, but we don't have as much data or ways to measure quality at the provider level. So that was really our interest in this project, and we decided to focus on the delivery of assisted living services in particular in looking at improvement and measurement of quality.

Two other broad reasons we participated in IAP is since we haven't done pay for performance in HCBS service delivery or VBP yet, we were particularly just interested in the nitty-gritty of designing a payment model for that. We were also really anxious to compare notes with other states in the cohort, which



there are nine other states, and also work with the coaching teams that CMS had arranged for. So, we just thought it would be a great learning experience and it would organize us so that we would actually spend time working on these topics.

(Slide 33) Our goal for the VBP project year was actually fairly narrow compared to some of the other states that looked at larger populations or multiple waivers or multiple services. For us, we really were squarely focused on looking at quality of assisted living services provided to older adults and the quality of life older adults experienced in assisted living settings or in the services they received in assisted living settings. That was the population focus and service focus for our project.

(Slide 34) In terms of objectives under that goal of measuring and improving quality of assisted living and measuring and improving older adults' quality of life for recipients of assisted living, here were some of the objectives we had. We didn't yet have in place a way to measure resident quality of life or other domains of quality in assisted living, so we wanted to work on developing measures of resident quality of life in the assisted living setting.

Beyond resident quality of life, we also thought there would be other areas of quality to measure, say around staffing or staff culture or leadership at assisted living facilities or regulatory data in terms of their compliance with rules, standards and licensing or maybe data related to abuse, neglect and exploitation that might happen in assisted living settings. So, in thinking more broadly about other data and other measures of quality we really got to talking more about developing a report card, that is to say not just measuring resident quality of life, but looking at quality in some of those other topic areas.

Then we also have a vision and are working toward developing a public website where we could eventually publicly report rating results on these different areas of quality. Then in the more distant future we really do have a vision for linking up some of the measurement results at a site-by-site or provider-by-provider basis so that we could adjust payment or have payment models based on quality in assisted living service delivery.

(Slide 35) So, in terms of implementation challenges, we really knew this going into the project, but the biggest thing is that we just have a lack of data at the provider level or that site level. I mentioned before about how we have county-level data, health plan-level data, statewide-level data, but getting down to the individual or to the provider level is something we knew we would be challenged to do. So, in the year of our IAP project we did a lot of thinking about the kinds of data we would want if there were ways to collect it and funds to support data collection and so on. So, it was helpful, but it was more hypothetical since we didn't have a lot of provider-level data.

We saw the need of developing a wider measurement framework, again not just related to say residences' experiences in those settings, as valuable as that is, but saying are there other kinds of things we would want to measure in terms of quality, say related to staff and staffing and organizational leadership and culture. So, we wanted, through the VBP, to work on that larger quality framework.

(Slide 36) Finally, as I suggested already, things like data collection at the site level are expensive or potentially expensive. We were challenged by the prospects of having funds to collect data but also funds to potentially vary payments or give additional payments for quality in the future. So, I already

noted this, but data is critical. If you're going to see what's happening at an assisted living setting and potentially vary payments based on that, you need an array of different data from that setting.

Fortunately, the timing for our project was just right because in the 2019 legislative session in Minnesota which took place between January and May 2019, assisted living received a lot of attention, and there's a lot of reason for that, a lot of local context for that. But a new assisted living license was passed, some new funding for our adult protection system was provided. Some additional funding for our ombudsman for our long-term care office through the Older Americans Act was provided and some funds to support an assisted living report card. That would include funds to collect data from residents and collect data from family and collect data from other sources to support quality ratings. So, it was a huge boon for us in terms of moving this project forward.

(Slide 37) In hindsight, while we did get a lot out of the IAP project even though we didn't have existing site level or provider level data to work with, we ended up having to do a lot of things as kind of thought experiments or hypotheticals. So, it would have been great if we did already have access to some site level data even if it was a modest data set, because then we could have actually more concretely played with potential payment model ideas. So, we really now are looking ahead to having some eventual data and then we can use that data and work with some of the hypotheticals that we developed in the last year and make it more real.

(Slide 38) So in terms of some lessons learned, a couple things I would emphasize in slide 38 are more the three lower bullet points. One, in the course of our IAP we decided to execute a small contract with some researchers at the University of Minnesota to do a national scan and national literature review of quality and quality measurement in assisted living, and that helped us tremendously to understand what are the areas of quality we would want to measure if we did in fact have funds and the means to do so, and of course the legislative session put forward some funds for that to be possible now. So, it was really well-timed. We had research results and new funding right at the same time of June 2019. So, working with an outside research partner was very helpful for us.

Second, I would say through our cohort, the other nine states, but also just through the IAP experience, we learned about some other states who were measuring quality in assisted living. Ohio and Oregon especially were looked at. We also looked some at North Carolina, and that was very helpful to look at some peers doing similar work.

Finally, while we do have our eyes on eventually having some VBP and changing payments based on quality measurement outcomes, we do feel like ratings in and of themselves can be an incentive for providers to perform better and invest in quality improvements, so the idea of having report card results or ratings we decided was of value even beyond any potential financial incentives.

(Slide 39) So, because of the great activities of 2019 legislative session, we're really able to move forward quite strongly with our work now. We are continuing under contract with the University of Minnesota (U of M) to test the findings from the quality research that they did, and U of M is going to continue to develop measures not only related to potential resident and family surveys but also other areas of quality. And since we received funding for the resident and family surveys, in the next several

months we'll be developing those surveys and pilot testing them with U of M and a forthcoming survey research vendor, an outside contractor who will help us with our survey work.

Then looking ahead to state fiscal year 2021, and our state fiscal years run from July 1<sup>st</sup> through June 30<sup>th</sup>, we will be excited to implement the first resident and family surveys because then we will have some real baseline data for all of our facilities to start really in earnest looking at potential VBP payment models. So that's where we're at.

## Questions

MELANIE BROWN: (Slide 40) Questions have come in. *There is a question about the amount of funding for the survey work, how much funding?*

PETER SPUIT: I do not have that at my fingertips, but people could contact me offline about that. It's annual and ongoing funding.

MELANIE BROWN: If you want to put your contact info in the chat box, we can share it.

PETER SPUIT: Sure.

MELANIE BROWN: *Will you be serving only families of Medicaid recipients or all residents of the assisted living facilities?*

PETER SPUIT: I didn't make that clear throughout the whole presentation. We are interested in measuring quality for all providers providing services to all payers. Because our stance in Minnesota is that families are also paying hundreds of millions of dollars a year for a fairly expensive service and making difficult choices about where they themselves or their loved ones might live. So, we will be surveying residents and family members from all payment sources, so private pay and public pay, and the ratings will be based on data, private pay and public pay.

In terms of VBP, in that case when we look at data and varying public payment, because that's what we have control over, we envision that we would use a selection of all of the measures to vary payment, so maybe not all the measures that feed into their ratings would feed into VBP. But yeah, we would be looking at all payers.

MELANIE BROWN: Related to that, *are the resident and family surveys satisfaction or perception surveys?*

PETER SPUIT: Yeah, fundamentally yes. Some of the other survey instruments we've found through our national literature review are surveys that ask questions about an individual's quality of life, their impression of their day and how things are going for them in various aspects of their life in the assisted living setting. The services they receive, the building, what daily life feels like. So, it is a lot about the residents' perceptions, and similarly the separate survey that would be for a family member, that one would be focused more on questions of satisfaction rather than obviously their experience or quality of life because they wouldn't be living in or affected by the settings. So, it would be their perceptions of how things are going for their family member.

I should say, though, when we look at existing instruments, we are definitely favoring survey questions or indicators that have already been validated, that have already been studied by outside researchers. So, as much as possible, as we construct our initial survey instruments, we are going to be building that draft instrument out of previously tested questions. And when we have our draft instruments, we will pilot test those new draft instruments, so we know there are risks in cobbling together validated questions, so we're going to fully pilot test the new draft survey so that we see how it performs as a cobbled instrument.

## Missouri

MELANIE BROWN: (Slide 41) Now Missouri. Angela Brenner is the Director of Federal Programs with the Missouri Division of Developmental Disability.

ANGELA BRENNER: (Slide 42) Missouri has really enjoyed the opportunity to participate in this IAP cohort and we definitely recommend it to other states if they have that chance. I want to give a background and the lay of the land in Missouri with our HCBS waivers for context. We have nine 1915(c) waivers in Missouri and all of them are fee for service. Our structure is set up so that we have our Medicaid operating agency, our single state Medicaid agency which is the Department of Social Services. Then we have two other operating agencies. One of those is our Department of Health and Senior Services. They operate five of our 1915(c) waivers covering the frail and elderly population. Our third department is our Department of Mental Health, Division of Developmental Disabilities, and we operate four of the 1915(c) waivers covering individuals with intellectual and developmental disabilities.

All three of our departments were really at various levels of understanding what VBP was. We had some staff that had never really heard of VBP before. Some had heard of it but not quite understanding what it entailed. Then some of us were like yes, we're ready to go, let's do this, still not understanding all that was entailed in setting up this model.

So, we decided to collaborate with this IAP request to help build basically our overall knowledge as a state and that capacity to design a VBP system for our HCBS waivers. We wanted to understand better how to move toward that implementation of the VBP strategy. Then understand what the value is for our participants and providers as well as the value to the state. Then finally we wanted to get that overall understanding of the resources that we would need between the three departments and the barriers that we would likely encounter.

(Slide 43) In order for us to get the most out of our technical assistance, the three departments looked at a service that would cross all three agencies, waiver and state plan, and one that we felt we seemed to struggle with the most. So, we chose our personal care services through again state plan and waiver. We spent a full day discussing with our coaches all the various issues and concerns that we encounter with this particular service. We kept coming back to our overall goal, to provide better quality of care for the people we serve. We really want to enhance education for the direct support staff, and then to just make a positive impact to our Medicaid system as a whole. So, by the end of our intensive two-day onsite with our coaches, our three agencies landed on our aim statement, on this slide, which is by 2021 we wanted to reduce by 20% the emergency department (ED) utilization rate of those receiving personal care services through waiver and state plan.

(Slide 44) At this point there was no science to this 20% we chose. We just knew that we needed to start somewhere, and we wanted to really challenge ourselves to make a significant impact. Again our overall objective and intent was to impact the overall health of participants by promoting healthier lives, increasing their preventative care, improving an individual's overall knowledge of their own health history, giving them some independence in their life, enhancing training and equipping our direct support professionals with knowledge of healthcare resources, and then health management techniques they can use while serving our populations.

(Slide 45) We learned through this process quite a bit about the importance of data when implementing a VBP system. We spent a significant amount of time pulling paid claims history for our waiver and state plan personal care services and even our managed care encounter data, because we have a small portion that would be in managed care. It seemed like every time we pulled our data, we realized there was something else we should have included in a data field. We also realized that because we're crossing waiver services and making an impact in our hospitalization and emergency department utilization that we needed to consider those crossover Medicare claims.

So, while we were continuing to pull that data and work on fleshing out the appropriate fields, we were also exploring national avoidable emergency department utilization criteria algorithms. During this process we had some of our own state nurses review those algorithms for appropriateness for our 1915(c) populations. We found that a lot of the national data sets really did not always include appropriate avoidable ED diagnosis for the population for intellectual and developmental disabilities. So, we had to make sure that what we were using was appropriate for our population again.

Once we gathered all the information together, we reviewed our paid claims, the ED utilization. We actually found that we were already well below our 20% of the avoidable ED utilization and we also found that we had actually improved it over the past three years. So, we thought surely there was something we were missing. So, we went back and sliced it and diced it in several different ways. We looked at it by age, by gender, by region of the state. We even took a glance at what it would be like if it was a per member per month. In most of our instances in the end we found that our avoidable ED visits were actually less than 10%. So that was a great discovery for us. We were doing better than we thought, but it kind of felt like we were having to start over. Either way we still learned a lot from the process.

(Slide 46) When we talk about our challenges, some of those challenges that really seemed to slow us down in Missouri as we were going through this process was really knowing exactly what data to pull from the initial onset of the project. Between the three agencies, we were working with several different data sets and we were looking at waiver, we were looking at the state plan, we were looking at hospital claims. So really making sure we had a good handle on what that is from the beginning. We also had some challenges in really honing in on how to analyze that data and determine the appropriateness and availability of resources that we had for pulling the data across the three agencies and through encounter claims and crossovers.

(Slide 47) So, for us our key things to think about and look at in hindsight, it really would have been helpful for us to know that those avoidable ED visits were already declining and even lower than what we expected. We could have probably started off with smaller, more simple, basic measures. Then

finally we could have met with our stakeholders in the beginning before determining our objectives. As Pat and the other states have mentioned, stakeholder communication is really key to the process. Sometimes I think as states we like to make sure we know what we're doing and we have everything laid out before we present it to stakeholders, and sometimes it's probably okay just to have those conversations upfront saying hey, this is what we're thinking about implementing, give us some of your feedback, and they can help guide you in the direction of things that they're struggling with.

(Slide 48) Some of our key lessons learned here--we would say that our team really focused in on at the end--really be leery of those assumptions based on anecdotal information. It's easy to make broad assumptions for those cases that always rise to the top for states but that doesn't mean that it's the case across the board. So, we always hear the stories of those ED visits that really weren't necessary that could have been prevented, but in the end data is key. Make sure that you're not using just those anecdotes to make the broad assumption.

We also learned to clearly identify those strategic goals and the impact on the stakeholders and those barriers. For us it was a really good experience for the three agencies to sit down and have those frank discussions and come to those agreements for us as a whole, as a state. We learned that data availability really greatly affects what we can implement and using data from the beginning helps us with that informed decision-making. Then to ensure that the appropriate individuals with the data are available from the beginning of the project. Some of our data people we weren't able to pull in until part of the way through our project so it was great for us to think back and say we should have had them in at the beginning and identify exactly who those were.

(Slide 49) So, for us looking ahead all is not lost. We're still looking up and excited that things look better than what we thought and we're going to continue to move from here. We're going to continue to explore revising our aim statement with our stakeholders. We've had several stakeholder meetings already and our stakeholders are actually really embracing this VBP concept, and some of the providers are actually presenting to other providers, and they're really engaged in exploring those future possibilities with issues that they see today in their field, such as falls and rehospitalizations.

In order for us to really continue this process, we're hoping to continue working with our coaches to assist us in what those next steps would be after our technical support ends. Our coaches have been great. We've really been able to take what we learned and think about it in other areas of our services, and I think we're going to be off to a good start when we go back and revisit our aim statement with our stakeholders.

## Questions

MELANIE BROWN: (Slide 50) Now some questions. First, specifically for Missouri. *The first is whether or not you're looking at Medicaid only for your avoidable ED visits? Or was this cross payer?*

ANGELA BRENNER: We were only looking at the Medicaid population, those that are receiving personal care services through our 1915(c) waivers and through our Medicaid state plan.

MELANIE BROWN: *There were a couple questions about how does Missouri define avoidable ED visits?*

ANGELA BRENNER: Our coaches were great resources for this. They had provided several different algorithms that are nationally recognized, and we ended up using one that was out of the state of California, and that's probably something we or our coaches could share as well. But we did use a nationally recognized algorithm.

MELANIE BROWN: [We can send it out so everyone who signed up for webinar has access.] I don't see other questions specifically for Missouri. Some are targeting any state. *One is, have any of the states finalized a financial model for VBP with vendors, and if so, could you share what the model looks like?*

PETER SPUIT: We have not. As I indicated we're at an earlier stage and we just really did lots of thought experiments about payment models and how it would work with or without additional money, if we didn't have additional money or if we did have additional money, how our model could work. We simply did that with our IAP coaches, so we didn't have separate vendors think through that with us. And it's not ready for implementation, it's really just something we captured that we can come back to when we actually have data that could be used to inform a payment model.

MELANIE BROWN: *Related to that there was a question whether Minnesota was working with vendors to provide HCBS services to residents and whether or not your surveys would target vendor participation or satisfaction outcomes?*

PETER SPUIT: I'm not sure what they mean by vendor.

MELANIE BROWN: The person who submitted that (question), if you want to offer clarification.....

PETER SPUIT: Yeah, because we would just be looking at surveying any licensed provider of assisted living services and those would be varieties of entities—nonprofit organizations, for profit organizations, publicly held assisted living facilities.

MELANIE BROWN: So, by vendor they meant third-party consultants or businesses.

PETER SPUIT: The role that third-party consultants or vendors would play in our whole project would be potentially to help implement surveys. We are prospectively going to work with a contractor who would help with survey research and actually do the data collection. The resident surveys we are planning to do in person, one-to-one interviews with trained interviewers through a third-party survey research firm, and the family surveys, our intention is to do mail surveys. That would also be conducted by a third party. That's how third parties would work. Then we would continue to work with organizations like the University of Minnesota on measure development and turning the data into ratings so that there's proper weighting and risk adjustment in comparing different providers and their results.

MELANIE BROWN: *For any state, have you considered telemedicine vendors to assist with LTSS members to save on cost?* No one's jumping in so sounds like no state is working in that area.

*For Peter, it's great you're measuring satisfaction for all payers. Will you report outcomes by payer so you can see if there are differences by payer?*

PETER SPUIT: We would probably do some analysis like that and report some things out publicly in more aggregate format. We have not discussed separating results and reporting those by site to say this particular assisted living community is having better outcomes or better results with the private pay market than the public pay market. But I do think we would be able to in the data separate that out and maybe say something about that statewide or maybe regionally, so in more of an aggregate format. We certainly would be interested to see if public pay recipients of the service are having worse experience and for what reasons or try to ask questions for what reasons if that were true. That would probably be handled through looking at the broader data set rather than looking at individual assisted living facilities.

MELANIE BROWN: *For Louisiana, has the state looked into CIE as a good area to start VBP?* I'm not familiar with that acronym. Bernard or Charles? [no response] Okay, it's Community Integrated Employment. We may have lost Louisiana so we'll come back to that if we can.

*I'm not sure of the question, it says role of internal quality improvement versus being driven by outside incentives.*

PETER SPUIT: I could comment on that. That actually comes up with our provider stakeholders quite a lot. It's really good that it comes up. A lot of our assisted living providers and the trade associations that represent them, many providers are engaged in ongoing quality improvement efforts of various kinds within their parent company, within their local organization, within their trade association, there are quality initiatives. So, there are a lot of things that can drive quality. It's fine that there are a lot of things that can drive quality. The parent organization, some organizations that provide a service are very customer service-oriented and survey their customers or the people they serve regularly and try to improve their results with them. So, none of those efforts have to preclude another effort. It's also okay for the state who licenses the service and who has been asked by the Legislature to provide oversight of the service, who we run waiver programs and pay for these services, so we have an interest in quality, too. And we want to drive and encourage quality for some of those reasons. But I love that associations want to encourage quality and that individual providers have quality initiatives. So, I think all the above is good.

MELANIE BROWN: *Peter, do you have an example of question source?*

PETER SPUIT: We'll give a plug for one of the cohort states. Two things I could say. The University of Minnesota released the report they wrote for us that was a literature review and environmental scan and in that they name lots of existing instruments and surveys that we might draw from. So, I can share a link to that and put that in the chat, because that would be the best way to show you what we found with the U of M.

So, a great example is one of the cohort states. Ohio has conducted resident and family surveys in what they call residential care facilities but are also assisted living facilities, just a different name. They have used Miami University and I believe Purdue to study their survey instruments. Those are really great instruments because for us they're right on target. They are conducting surveys with residents and families in assisted living and that's exactly what we want to do. There are other national instruments that we'll draw from but those will be really important because they're right on target with what we want to do. I can share a couple links in the chat.



## Conclusion

MELANIE BROWN: (Slide 51) We'll close out questions. We will follow up with those we didn't get to today.

Key takeaways from today's webinar:

- Participation in the IAP VBP for HCBS track helps states to use data to determine the focus and aim of their VBP for HCBS initiatives.
- It helps states to identify key stakeholders that need to be engaged to move the initiative forward.
- Consider both financial and nonfinancial incentives.

(Slide 52) Thank you for joining us and to our speakers. Please complete the short evaluation form.  
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