
# Pay-for-Performance Rate Methodologies in a HCBS FFS Environment

**Division of Long Term Services and Supports**

**Disabled and Elderly Health Programs Group**

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# Training Objectives

- Define fee-for-service (FFS) delivery models and pay-for-performance delivery models.
- Identify the differences between FFS and pay-for-performance in 1915(c) waivers.
- Review key considerations for states implementing pay-for-performance in a FFS environment.

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# Fee-For-Service (FFS) Delivery System

## What is a FFS Delivery System?

- Home and Community-Based Services (HCBS) are often delivered in a FFS delivery system:[1]
  - Individuals are served through a FFS delivery system, where providers are reimbursed for each service (e.g., a personal care service, respite, supported employment) based on a unit established for the delivery of that service (e.g., 15-minutes, per hour, per visit, per day).
- States may develop their payment rates based on:
  - The costs of providing the service.
  - A review of what commercial payers pay in the private market.
  - A percentage of what Medicare pays for equivalent services.

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# Fee-For-Service (FFS) Delivery System (Continued)

## What is a FFS Delivery System? (Continued)

- Payment rates are often updated based on specific trending factors, such as the Medicare Economic Index or a Medicaid-specific trend factor that uses a state-determined inflation adjustment rate (e.g., Bureau of Labor Statistics Consumer Price Index or state's Cost of Living Adjustment).

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# Pay-for-Performance

## What does pay-for-performance mean in HCBS?

- In pay-for-performance arrangements, payment initiatives are aimed at improving the quality, efficiency, and overall value of health care. These initiatives provide incentives or penalties to providers to carry out improvements and achieve optimal outcomes for individuals in HCBS programs.[2]
- Providers may be paid a fee schedule rate, but also may be eligible to receive an incentive payment based on specified events or some measurable criterion of performance, such as:[3]
  - Milestones
  - Outcomes
  - Quality-related performance measures
  - Other pre-specified criteria set by the state

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# Pay-for-Performance (Continued)

## What does pay-for-performance achieve?

- Pay-for-performance improves efficiency, quality, and value of care by:
  - Shifting the focus away from volume of care and incentivizing providers to improve coordination of care efforts.
  - Using quality metrics to measure and improve quality of care.
  - Reducing healthcare costs by reducing preventable visits and/or repeat visits to hospitals or institutions.
  - Providing financial incentives to providers for meeting stated goals, desired outcomes and/or milestones (e.g., outcome based reimbursement).
- States can begin to move towards a more proactive, population-based service delivery system rather than reactive, individual-focused care.

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# Traditional FFS vs. Pay-for-Performance

| Description | Traditional FFS | Pay-for-Performance |
|---|---|---|
| **Goals of Program** | Focuses on volume. Higher units of service equals higher revenue. | Focuses on achieving performance targets or incentives. |
| **Use of Incentives** | Typically excludes metrics of quality of service or value as part of the reimbursement. | Considers good performance or compliance as part of the payment. |
| **Risk Arrangements** | Encourages stand-alone providers. | Encourages partnerships to achieve goals or share risk. |
| **State Oversight** | States monitor using post-payment reviews but does not focus on goal achievement. | States focus on alignment of goals and oversight of reporting such achievements. |

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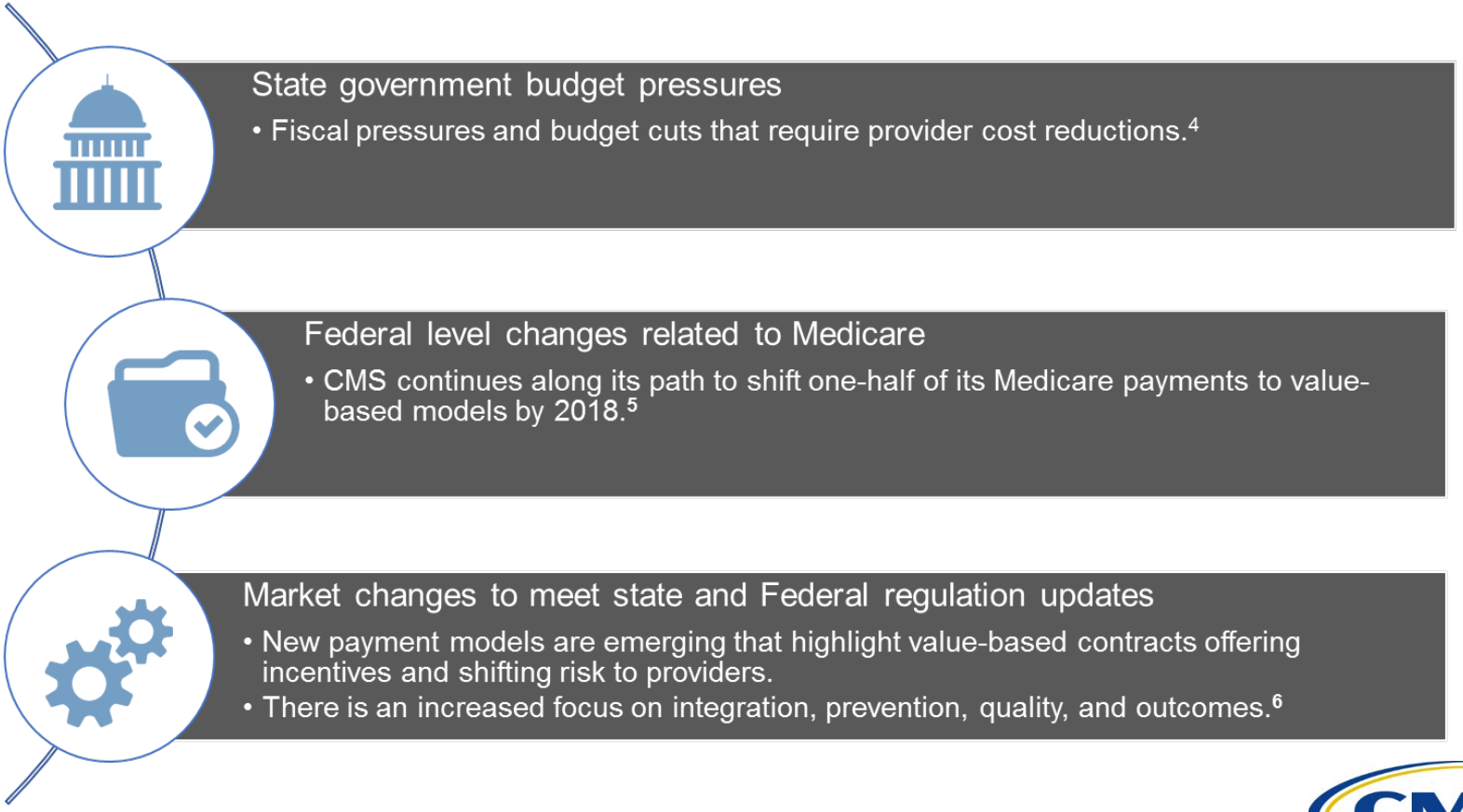
# Relevance of Pay-for-Performance

- Ongoing trends in the healthcare marketplace are towards pay-for-performance and value-based purchasing arrangements.

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# Pay-for-Performance Design Process

**Overview of the Design Process.[7]**

- Step 1: Identify the state's need.
- Step 2: Design goals and incentives to address the need.
- Step 3: Implement the incentive plan for the program.
- Step 4: Realign goals based on stakeholder feedback.

The pay-for-performance design process requires continuous collaboration and discussions between all stakeholders involved in the design and implementation.

# Step 1: Identify State's Need

- The challenge is that home and community-based services (HCBS) are complex and states standardize their own provider qualifications per defined services in each individual waiver.
- States can adopt pay-for-performance strategies in 1915(c) waivers to increase and enhance quality for individuals.
- States should determine areas where providers can be incentivized to perform better, and therefore be able to obtain cost savings. Suggestions to identify the state's need include:
  - **Obtain input** from provider association groups and individuals.
  - **Use claims data** and determine high-cost areas, services, populations, etc.
  - **Review reports** from program integrity, quality improvement systems, provider enrollment data, cost reports, and/or individual satisfaction surveys.

# Step 1: Identify State's Need (Continued)

- Example of a state's need evaluation for rural case managers.
  - **Survey individuals and Case Management Agencies:** Families and individuals in rural areas confirm the closure of multiple case management agencies. Agencies admit that it is difficult, with existing rates, to attract case managers who will work in rural areas.
  - **Review claims data:** The state noted that, across all waiver programs, case management services had the highest cost per individual and was used most often, regardless of population group. In rural areas, the cost was 90% lower than the rest of the state.
  - **Review provider enrollment data:** The state noted that an increasing number of case management providers in rural areas did not renew their Medicaid provider agreement the subsequent year.
  - **Cost Report Review:** Case management agencies report high transportation, benefit, and program support costs because the cost of living in rural areas of the state was higher.

# Step 2: Design Goals and Incentives

- States should outline the overall goal(s) of the incentive program to remediate the identified need(s).
- Once a goal is determined, decide how the state will motivate providers to participate. Typically in a pay-for-performance system, states can either incentivize or dis-incentivize providers.

| Goal | Incentive/Disincentive | Example |
|---|---|---|
| Increase number of case management agencies in rural areas. | Incentivize the creation of case management agencies in rural areas. | A case management agency that has more than 5 case managers serving a designated rural area will receive 5% of the monthly case management rate as incentive payment. |
| Limit the caseload per case manager. | Dis-incentivize any type of caseload that is greater than 25 cases per case manager. | A case management agency that reports a caseload per case manager of more than 25 will have a reduction of 5% of the incentive rate. |

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# Step 2: Design Goals and Incentives (Continued)

- When designing a goal, states should consider:
  - Is the goal achievable for most providers?
    - Provider incentives will not be used if providers recognize that the goal is unachievable.
  - Is the incentive or disincentive sufficient to interest individuals and providers?
    - When choosing measures to dis-incentivize providers, consider the fiscal impact. If the impact is too low for the provider group, then they may choose to keep the status-quo and accept the punitive measure as a cost of doing business.
  - Is the goal clear and measurable?
    - Goals and incentives must be clearly communicated to all stakeholders. Clear goals will assist the states and providers to determine how to measure success.

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# Step 3: Implement Incentive Plan(s)

- States can integrate pay-for-performance into HCBS waivers through supplemental or enhanced payments.
  - Supplemental or Enhanced Payments Definition: Any payment to a Medicaid provider that is in addition to the state's standard direct payment for services rendered to a Medicaid beneficiary and billed by a provider (per 1915(c) Technical Guide, pages 311-312).
- States must document the supplemental or enhanced payment arrangement in the 1915(c) HCBS waiver application, Appendix I-3-c.
- Payments still must meet requirements outlined in Section §1902(a)(30)(A) of the Social Security Act, which states, "payments for Medicaid services must be consistent with efficiency, economy, and quality of care."

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# Step 3: Implement Incentive Plan(s) (Continued)

- If supplemental or enhanced payments are used, states must be able to describe (per 1915(c) Technical Guide, pages 258-259):
  - The nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made.
  - The types of providers to which such payments are made.
  - The source of the non-Federal share of the supplemental or enhanced payments.
  - That providers eligible to receive supplemental or enhanced payment must be able to retain 100% of the total computable expenditure claimed by the Medicaid Agency to CMS.
  - That the basis of such payment is transparent (i.e., it is clear to the public which providers should receive the additional payments and under what circumstances).

# Step 3: Implement Incentive Plan(s) (Continued)

**Ways states can use supplemental or enhanced payments.[8]**

- Select to provide supplemental payments, or payments that are made to providers as adjustments to interim payment rates based on performance or additional activities.
- Provide an enhanced rate, which builds based on accomplishments of performance goals.

**CMS encourages states to be creative when determining ways to use supplemental or enhanced payments.**

**Regardless of the methods and processes used, it must meet the 1915(c) Technical Guide requirements discussed in the previous slide.**

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# Step 3: Implement Incentive Plan(s) (Continued)

**Ways states can measure the success of a goal.**

- States can provide incentives based on measured improvements using quality measures selected to represent goals and objectives of the waiver.
- Using quality measures can:
  - Support performance of activities that contribute to increased quality.
  - Validate the processes states have adopted for their waiver application.
  - Identify how well services are being received by individuals.
  - Highlight benefits of adopting certain processes or standards known to improve care.

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# Step 3: Implement Incentive Plan(s) (Continued)

**Ways states can measure the success of a goal (continued).**

- States should consider the following when using quality measures:
  - Measures may not be comprehensive and there may be other measures that need to be identified to understand the impact on a health outcome.
  - Measures may need to be standardized to make comparisons across programs.
- Use additional data sources to measure the outcome. Examples are:
  - Claims data submission (e.g., increase / decrease in utilization of services)
  - Providers' internal reports
  - Individual and family feedback
  - Results of the internal post-payment reviews

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# Step 3: Implement Incentive Plan(s) (Continued)

**Example of a state's enhanced payment for case management.**

- One state is proposing to provide an enhanced rate for case management providers that meet waiver-specified requirements over a two year period.
- At the end of the two years, if the provider has been able to meet additional criteria, then the enhanced rate will be made permanent.
- Should the provider not maintain compliance, then payment will revert to the basic rate.

# Step 4: Realign Goals and Incentives

- Evaluate the program and continuously monitor performance.
  - States must explain clear expectations regarding the required outcome.
  - Criteria of receiving an incentive payment must be standard and not arbitrary. States should be able to obtain evidence to determine a successful outcome.
  - Include a detailed fiscal integrity structure to review the evidence submitted by the providers and verify the subsequent outcome.
    - For example, if the state incentivizes case management agencies that achieve a certain caseload ratio, verify that submitted evidence only include the population outlined in the incentive program.
- Discuss performance with stakeholders. Incentives and goals might require continuous adjustment for the long term.
- Continue to monitor the goals and incentives using available data.

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# Key Considerations

**Key Considerations for Implementing Pay-for-Performance.**

- Set performance incentives that take into account additional administrative costs.
- Build in sufficient time to discuss and obtain buy-in from the stakeholders.
- Conduct ongoing monitoring to ensure that access to care is not being restricted.
  - States need to ensure that individuals are not being denied care by methods such as prescreening on the basis of a perceived likelihood of a lower performance score.
- Refine incentives through continuous analysis.
- Consider time and costs involved in creating system requirements for data collection.

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# Summary

- The goal of pay-for-performance is to improve care coordination, improve quality of care and reduce overall spending.
- Implementing pay-for-performance payments requires states to consider multiple items including whether the state and providers have the administrative infrastructure to properly analyze and monitor performance data.
- The switch from FFS care to integrated innovative value-based care is still fairly new and requires some experimentation and flexibility from both states and stakeholders, particularly for the HCBS population.

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# Additional Resources

- Copies of the HCBS Training Series – Webinars presented during SOTA calls are located in below link: https://www.medicaid.gov/medicaid/hcbs/training/index.html.

# Questions & Answers

# For Further Information

**For questions contact:**

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