Advancing Value-Based Payment in Medicaid Managed Long-Term Services and Supports: Opportunities for Community-Based Care

September 18, 2018; 1:30-3:00 pm ET

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Questions?

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Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Session Overview

- Introductions
- State Considerations for MLTSS Value-Based Payment Models: Design and Implementation for Home- and Community-Based Services
- New York’s Value-Based Payment Strategy for MLTSS
- Tennessee’s Journey: Advancing Value-Based Payment Models in Medicaid MLTSS
- Expert Insights on Advancing Value-Based Payment Models in Medicaid MLTSS
Introductions
Today’s Presenters

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About the Center for Health Care Strategies

A non-profit policy center dedicated to improving the health of low-income Americans
Overview of West Health

West Health’s mission is lowering healthcare costs and enabling seniors to successfully age in place with access to high-quality, affordable health and support services that preserve and protect their dignity, quality of life and independence.
State Considerations for MLTSS Value-Based Payment Models: Design and Implementation for Home- and Community-Based Services

Michelle Soper,
Director of Integrated Care
Center for Health Care Strategies

*Made possible through support from the West Health Policy Center*
## Context: MLTSS & VBP

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<th>Trend</th>
<th>Description</th>
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<tr>
<td>Managed long-term services and supports (MLTSS)</td>
<td>Nearly half of states have MLTSS programs to rebalance care toward the home and community; improve quality; and control costs</td>
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<td>Value-based payment arrangements</td>
<td>Public payers are driving efforts to increase VBP across most health care sectors</td>
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- Few VBP arrangements include LTSS
- Challenges with adoption of VBP models in home and community-based settings include:
  - Provider capacity
  - HCBS quality measurement and data collection
  - Opportunity for Medicaid savings for dually eligible beneficiaries
Advancing Value in Medicaid Managed Long-Term Services and Supports: Project Overview

- **Goal**: Advance the adoption of operational strategies that promote high-quality MLTSS and support individuals living in communities

- **Partners**: CHCS, with Mathematica Policy Research and Airam Actuarial Consulting; supported by West Health Policy Center

- **Main activities**
  - State learning collaborative: Minnesota, New York, Tennessee, Texas, and Virginia
  - New publication *Achieving Value in Medicaid Home- and Community-Based Care: Considerations for Managed Long-Term Services and Supports Programs* that focuses on four areas for state program design and implementation:
    - Defining State Policy Goals
    - Selecting HCBS Performance Measures
    - Selecting Payment Models
    - Working through Operational Considerations
Defining State Policy Goals: First Steps for States

- Identifying key state policy goals
- Determining whether VBP is a useful tool to achieve the state’s goals for HCBS system improvements
- Defining what “value” means in the context of MLTSS programs
Selecting HCBS Performance Measures

- Performance measures are the foundation on which VBP approaches are built

- Several HCBS measures available across state programs, but few are standardized, nationally recognized
  
  » Several ways to measure MLTSS performance
  
  » States do not have a “playbook”

- Importance of stakeholder engagement to help choose the right mix of structural, process, and/or outcome measures
HCBS Performance Measure Criteria for VBP Models

- Are the measures relevant to policy and program goals?
- Are the measures feasible for data collection and reporting?
- Can MLTSS plans and HCBS providers be held accountable for measure performance?
- How does the nature of HCBS delivery influence the choice of VBP measures?
- What are appropriate performance targets or benchmarks for use in payment models?
Examples of Payment Models

- Health Care Payment Learning and Action Network (LAN) created a framework to establish standard terminology for payment models

- **FFS with Link to Quality & Value – Pay for Performance** (Category 2C)
  - Rewards entities for achieving pre-defined targets or measures
  - Least financial risk to providers

- **APMs Built on FFS Architecture Gainsharing/Risk Sharing** (Category 3)
  - Incentivize cross-sector partnerships and improved care coordination
  - Include episode-based payment and shared savings models
  - Shifts risk to accountable entities

- **Population-Based Payment** (Category 4)
  - Provider org. responsible for a pre-defined set of services for a defined population
  - Shifts financial risk to and aligns incentives across provider organizations

- Most existing models with HCBS providers include some link to quality and value but have limited risk sharing
Considerations for Selecting Payment Models

- Alignment of payment models with policy goals
- Which models and incentive payment amounts may most effectively change HCBS provider behavior
- The type of VBP model that is most feasible in the current environment, particularly related to:
  » Existing VBP models operating in the state
  » Level of sophistication and ability to accept financial risk
- Long-term sustainability of the financial model
- Appropriateness of alternative, “non-financial” incentives
State Operational Considerations

- Several practical and operational considerations for states as they work with managed care plans, providers, beneficiaries, including:
  - Setting health plan requirements and expectations
  - Assessing provider readiness and capacity to participate in VBP arrangements
  - Supporting provider capacity efforts
  - Engaging stakeholders throughout the design and implementation process
Advice for Other States

- VBP is a tool to advance clearly defined goals
- Go slowly: Build incrementally and iteratively
- Incorporate ongoing efforts to assess and improve program design and operations
- Understand which HCBS quality measures are most closely tied to overarching goals—and are feasible for plans and providers to measure
- Encourage plan innovation within “guardrails”
- Support HCBS workforce development efforts and provider capacity-building
New York’s Value Based Payment Strategy for Managed Long Term Services and Supports (MLTSS)

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New York State Department of Health
Development and Maintenance of the Overall VBP Strategy

**VBP Governance and Stakeholder Engagement**

1. The **VBP Workgroup** is a governing body that consists of NYS Health Plans, MCOs, and representative organizations (including physicians, health plan associations, hospital associations, legal firms specializing in health care contracting, NYS HHS Agencies, CBOs, patient advocates, PPSs, and other industry experts). Its goal is to develop strategy and monitor the implementation of VBP in NYS.

2. The **VBP CAGs and SCs** were created to address the larger VBP design questions. Their charge was to produce initial recommendations for design solutions to the VBP Workgroup and to the State. As a result, a number of VBP standards and guidelines were developed (included in the current version of the Roadmap) by the Subcommittees. The scope of work for the CAG included the recommendation of an initial set of quality measures for each of the VBP arrangements.
LTSS-specific VBP Program Parameters

- LTSS-specific VBP program parameters were developed because of the uniquely different needs of the long term care dually eligible population.

- LTSS-specific VBP arrangements are total cost of the sub-population arrangements, where VBP Contractors take responsibility for the total cost of care and the total quality of care delivered to the Medicaid member.

- The goal of total cost of the sub-population arrangements is to improve population health through enhancing the quality of care for specific subpopulations that often require highly specific, intensive care needs.
MLTC Level 1 VBP Arrangement Parameters

• The State, Clinical Advisory Group, VBP Workgroup and industry experts met multiple times to develop the parameters.

• Level 1 VBP Arrangement is a performance bonus (pay-for-performance, or P4P) agreement between an MLTC plan and a provider that is based on meeting performance targets for a set of specific quality measures agreed to in a VBP contract between an MLTC Plan and a provider or group of providers (the "VBP Contractor"). A cornerstone of MLTC Level 1 VBP arrangements is monitoring and reducing potentially avoidable hospital (PAH) use. Until full total cost of care can be incorporated, the Roadmap allows a quality payment based on avoiding hospitalization as a proxy for Medicare acute care costs. This approach also applies to Level 2 VBP MLTC arrangements, with the addition of a downside risk component.

• MLTC partial capitation plans were required to implement MLTC Level 1 VBP arrangements by December 31, 2017 using the PAH measure.

• Provider contracts covered by the requirement are for covered services provided by Licensed Home Care Services Agencies (LHCSAs), Certified Home Health Agencies (CHHAs), and Skilled Nursing Facilities (SNFs).
MLTC Level 2 VBP Arrangements Parameters

• Require providers (e.g., Licensed Home Care Services Agency, or LHCSA, or Certified Home Health Agency, or CHHA) to adopt a minimum percentage downside risk of 1% of total expenditure with the contractual provider

• Plans and providers would still maintain flexibility to negotiate higher risk/shared savings

• The percentage minimum should not create a significant cost burden for plans and should neither induce them to prefer to incur penalties nor place undue pressure on LHCSAs or CHHAs to unduly reduce hours of care

• Not a target budget. Incentive payment based on quality performance only

• Quality Measures are aligned from Plan to Provider
  • Require the providers to include the PAH measure in Level 2 contracts
  • Require the providers to include at least one other long-term care measure (as pay for performance) from the MLTC Quality Incentive (MLTC QI) measures recommended by the MLTC CAG, in the Level 2 contract
Providing Hospital Data on Duals for MLTC Plans

• VBP relies on the use of quality measures to ensure high quality care is provided to members. For MLTC plans and VBP Contractors, the Potentially Avoidable Hospitalization (PAH) measures help to assess whether a reduction in potentially avoidable hospital admissions among attributed members in VBP arrangements has occurred.

• The PAH measure is calculated by Office of Quality and Patient Safety (OQPS) using Statewide Planning and Research Cooperative System (SPARCS) data. SPARCS is an all-payer hospital file that includes the primary discharge diagnosis, allowing OQPS to identify hospitalizations that were potentially avoidable.
How PAH Measures are Used in VBP

- **PAH SNF Rate**
  - Risk Adjusted – Calculated to the facility connected to the VBP arrangement

- **PAH Community Rate**
  - Risk Adjusted - Calculated to the specific group of members attributed to the VBP arrangement

- The VBP Performance Adjustment payment to the plan will be weighted by the number of members in SNF facilities and in community.

- **MLTC Plan**

- **Performance Payment**

- **PAH SNF Rate**
  - Risk Adjusted/Non-Risk Adjusted – Calculated to the facility under the VBP contract
  - Both risk-adjusted and non-risk-adjusted rates are available

- **PAH Community Rate**
  - Non Risk Adjusted - Calculated to the specific group of members attributed to the VBP arrangement

New York State

VBP Contractor

September 18, 2018
Stakeholder Engagement Efforts Relating to the Development of LTSS-specific VBP Strategies

• MLTC CAG Meetings
  • June 9, 2017
  • August 17, 2017

• VBP Readiness Survey
  • July – August 2017

• Bootcamp 2.0 MLTC Course
  • Seven Sessions
    • October 2017 (Albany, New York City, Lake Placid)
    • November 2017 (Rochester, Long Island)
    • January 2018 (New York City)
    • February 2018 (Albany)
Other State Efforts to Ensure LTSS-specific VBP Program Success

• Implementation support is interdisciplinary (contracting with OQPS, DFRS and all division and departments). Webinars, ongoing communications and bootcamps and materials including the VBP Resource Library

• **Contract Amendment Review**
  • October – December 2017

• **Individual Question & Answer Sessions by Request**
  • Ongoing

• **VBP Stakeholder’s Meeting to Discuss Level 2**
  • February 20, 2018
  • May 24, 2018

• **VBP Learning Series**
  • June 12, 2018
Health Plan Responses to LTSS-specific VBP Program Requirements

• The State is continuously receiving feedback from plans in regards to program requirements.

• Starting 12/2017 the MLTC VBP team sent a compliance survey to plans for five consecutive weeks asking for a self reporting on their Partially Capitated Level 1 provider contract conversion rates.

• After our 2/2018 and 5/2018 Level 2 Stakeholder meetings, we gave Stakeholders a two week period to provide us with their feedback. This feedback was then incorporated into a guidance document and a FAQ which is posted to an on-line NYS VBP Resource Library.

• We held a MLTC VBP Learning Series on June 12th, and sent a survey to all attendees the following day asking for their insight. The responses were documented and analyzed to ensure that their needs are being addressed.
Biggest Implementation Challenges for MLTC Plans

- Integration and alignment with Medicare for the Partially Capitated Plans
- Paucity of vetted and endorsed quality measures that are applicable to the dual population
- How to effectively engage the various different long term care providers in VBP arrangements
- Finding ways to realize savings in long term care services
- Identifying the ideal VBP Contractor characteristics and Provider ability to control the total care and quality of services
- Avoiding duplication of care management services between Plan and VBP Contractor
- Involvement of Plans with small member sizes in VBP arrangements
- Plan and providers securing the infrastructure needed to engage in VBP arrangements
- Securing financial incentives to jumpstart VBP contracting
Thank You!

• For more information, please visit:
  • https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/

• Please send any questions you may have to:
  • mltcvbp@health.ny.gov
Advancing Value-Based Payment Models in Medicaid MLTSS

Opportunities for Community-Based Care
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 dual eligibles and people with disabilities
- Three health plans (MCOs) operating statewide with aligned D-SNPs
- Physical/behavioral health integrated beginning in 2007
- Managed LTSS began with the Statewide *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 State I/DD Department
  - People *carved in* for physical and behavioral health services
- New Statewide MLTSS program for individuals with I/DD began July 1, 2016: *Employment and Community First CHOICES*
Challenges in Implementing VBP

• Defining “value”
  – More than cost (good outcomes may cost more, at least in the short term)
• Measuring value
  – Lack of standardized measures
  – Do we “value what we can measure” or find ways to “measure what we value?”
    
    *It doesn’t matter how well we can measure things that don’t matter—that don’t make a difference in people’s lives.*
    —Lisa Mills, PhD

• Program/provider capacity to achieve defined values
• Volume and diversity of LTSS (particularly HCBS) providers
• Changing payment methodologies
  – Lack of new resources/challenge of redirecting existing funds to quality
  – Ability to model rate impact
• System transformation
System Transformation through VBP

“Here’s where it gets a little challenging.”
Strategic Policy Decisions

• Focus on member experience to define, measure, 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

• 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

• Transparent
  – Clear expectations, training and feedback to providers

• Collaborative stakeholder engagement
  – Ongoing broad stakeholder input through a variety of mechanisms
  – Design and ongoing implementation
Quality Improvement in LTSS (QuILTSS)

- A TennCare initiative to **promote the delivery of high quality LTSS** for TennCare members (NF and HCBS) **through payment reform (at the provider level) and workforce development**
- Part of the State’s broader payment reform strategy (episodes of care and primary care transformation—patient centered medical homes and behavioral health homes)
- **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
- **Transform the system** by aligning incentives around the things that most impact the member’s experience of care and day-to-day living
- **Includes workforce development** as a core foundational aspect of building capacity to deliver high quality LTSS
Long-Term Services and Supports (LTSS) Overview

Value-Based Purchasing Initiatives for Nursing Facilities

- Medicaid reimbursement for Nursing Facility (NF) services based in part on resident acuity and quality outcomes that most impact residents’ experience of care
- Goal to reward providers that improve quality of care and quality of life by promoting a person-centered care delivery model
- Revised reimbursement approach for Enhanced Respiratory Care (ERC) services in a NF based on the facility’s performance on key quality outcome and technology indicators

Value-Based Purchasing Initiatives for Home and Community Based Services (HCBS)

- Align incentives with person-centered individual and program outcomes across HCBS programs and populations including:
  - Employment and Community First CHOICES MLTSS Program
  - Section 1915(c) waivers
  - CHOICES MLTSS Program
  - Behavioral Health Crisis Prevention, Intervention and Stabilization Services for Individuals with I/DD

Workforce Development

- Invest in the development of a comprehensive competency-based workforce development program and credentialing registry for individuals paid to deliver LTSS
- Value-based incentives for providers employing better trained and qualified staff
### NF QuILTSS Quality Framework

#### Phase 1 (Bridge)
Retrospective quarterly adjustments to per diem rates focused on QI activities (i.e., process measures)

#### Phase 2 (Full Model)
Component of prospective per diem payment based on quality outcome performance compared against benchmarks

Improvements in person-centered care delivery model evaluated through a point system and rewarded as part of the NF payment

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<th><strong>Satisfaction</strong></th>
<th><strong>Culture Change/Quality of Life</strong></th>
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<tr>
<td>35 points</td>
<td>30 Points</td>
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<tr>
<td>Member (15)</td>
<td>Respectful treatment (10)</td>
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<tr>
<td>Family (10)</td>
<td>Member choice (10)</td>
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<tr>
<td>Staff (10)</td>
<td>Member/family input (5)</td>
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<td></td>
<td>Meaningful activities (5)</td>
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<tr>
<th><strong>Staffing/Staff Competency</strong></th>
<th><strong>Clinical Performance</strong></th>
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<tr>
<td>25 Points</td>
<td>10 Points</td>
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<tr>
<td>RN hours per day (5)</td>
<td>Antipsychotic Medication (5)</td>
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<tr>
<td>CNA hours per day (5)</td>
<td>Urinary Tract Infection (5)</td>
</tr>
<tr>
<td>Staff Retention (5)</td>
<td></td>
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<tr>
<td>Consistent Staff Assignment (5)</td>
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<td>Staff Training (5)</td>
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**Bonus Points:** 10 QI initiatives
From Policy to Practice: VBP Approaches

**VBP components of new NF reimbursement methodology**

- **Quality incentive component** of each facility’s per diem rate
  - Annual quality incentive pool starting at no less than the greater of $40M or 4% of total projected FY expenditures for NF services
  - Will increase at 2x the rate of inflation in the index factor adjustment until quality-based component is 10% of total projected NF expenditures
  - Will remain at 10% thereafter

- **Other components of each facility’s per diem rate are quality-informed**, based on tiers of quality incentive scores:
  - Direct care (the largest rate component), including both:
    - Case-mix adjusted (based on resident acuity)—Nurse/CNA staffing
    - Non case-mix-adjusted (raw food, recreation and social services)
  - Fair rental value
From Policy to Practice: VBP Approaches

- 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
  - Implemented March 2016
  - Monthly case rate aligned to support improvement, independence
  - Additional VBP components (incentives) TBD based on:
    - Claims-based measures, e.g., ED visits for behavioral health crises, inpatient psychiatric hospitalization, behavioral respite utilization, total service expenditures, intensity/cost of HCBS
    - Non-claims-based measures, e.g., use of psychotropic medications; # of crisis events requiring intervention by SOS provider, in-person assistance by the SOS provider, out-of-home placement (including length of out-of-home placement); community tenure—days/periods without institutionalization or out-of-home placement; stability in living arrangements; participation in community activities, integrated competitive employment; perceived quality of life; satisfaction with services; perceived ability of paid/unpaid caregivers to support person, prevent/stabilize crisis events
From Policy to Practice: VBP Approaches

• **Employment and Community First CHOICES**
  - New MTLSS program for people with I/DD
  - 14 different employment services create a pathway to competitive, integrated 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.*
LTSS Workforce Development
Currently developing a comprehensive **competency based** workforce development program and credentialing registry.¹

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**Better for Workforce**

- Opportunity to both learn and earn acquiring **shorter term credentials** with clear labor market value
- Portable credentials **across providers, programs, and service settings**
- Earn college credit and certificate; apply toward degree program—**education path** for direct support professionals
- Build competencies to access **higher wages** and advanced jobs—**career path** for direct support professionals
- Learning **and relationship** management system matches worker with coach/mentors/career planning support

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**Better for Members & Providers**

- Promotes delivery of **high quality person-centered services**
- Supports **competency** and **continuity** of staff for members and providers
- **Online registry** for matching by individuals, families, providers based on needs/interests of individual
- Alignment **improves member experience**
- Agencies employing better trained and qualified staff will be **appropriately compensated** for the increased competency of staff and higher quality of care experienced by individuals they serve

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¹ for deployment through secondary, vo-tech, trade schools, community colleges, and 4-year institutions, offering portable, stackable credentials and college credit toward certificate and/or degree program
LTSS Workforce Development

- Developed in consultation with National Subject Matter Experts
- Corresponds with CMS DSW Core Competencies released in 2014*
- Worked with Tennessee Board of Regents to award college credit and a post-secondary credential (certificate) for completion
  - Embed within a variety of existing (and potential new) degree paths
- Rollout through Tennessee Community Colleges and Colleges of Applied Technology
- Leverage *Tennessee Promise* and *Tennessee Reconnect* funds
- Support achievement of Governor’s *Drive to 55* Initiative
- Added pre- and early service learning component (also developed with national SMEs under a contract with TASH and Dr. Lisa Mills)
- Launch in January 2019 with statewide rollout in the Fall 2019

Practices that would address the workforce crisis include:

- Using competency-based training models that lead to credentialing or certification of staff and yield wage increases.
- Teaching business and organization leaders skills to improve their ability to recruit, select and retain direct service employees.

Addressing Workforce Challenges

A Multi-Prong Approach *(in addition to competency-based training)*:

**Workforce Capacity-Building Investments**

- Establish processes for collection/use of workforce-related data at provider and system levels to target and measure improvement efforts over time
  - Comprehensive statewide data analysis to target investments, track improvement over time
  - Provider-specific analysis and training/technical assistance to providers in analyzing and using their own data to guide/evaluate their organization’s efforts to address workforce issues
- Engage national experts and leverage/invest MFP Rebalancing Fund to provide training and technical assistance to providers to support adoption of evidence-based and best practices that have been shown to result in more effective recruitment, increased retention, and better outcomes for people served
Addressing Workforce Challenges

A Multi-Prong Approach (in addition to competency-based training):

- **Workforce Incentives**
  - Incentivize *practices* that will lead to desired *outcomes*:
    - Data collection, reporting, and use at the provider level
    - Adoption of evidence-based and best practice approaches to workforce recruitment/retention and organization culture/business model changes
    - Ensure DSP wages are increased as they increase their level of training and competency and upon completing the certification program
  - Transition to financial incentives for specific workforce and quality of life *outcomes* once practices expected to result in the outcomes have been effectively adopted
    - DSP career ladder is essential outcome, including wage increase for worker tenure and completion of WFD program
  - Outcomes for persons served will be ultimate measure
Lessons Learned

- VBP is a tool; identify your policy goals and figure out how to leverage payment to help you achieve them
- 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)
- Be flexible, willing to adapt approach as you learn, identify needs/opportunities
- It’s easier to build than “rebuild”
- You must develop the capacity of the system to measure and improve quality
- Be at least two steps ahead of the system (or 10—lots 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!
Expert Insights on Advancing Value-Based Payment Models in Medicaid MLTSS

Debra Lipson
New Guide

- Available at: www.chcs.org/vbp-in-hcbs
Question & Answer
To submit a question online, please click the Q&A icon located at the bottom of the screen.

Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Visit CHCS.org to...

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services
- **Subscribe** to CHCS e-mail, blog and social media updates to learn about new programs and resources
- **Learn** about cutting-edge efforts to improve care for Medicaid’s highest-need, highest-cost beneficiaries

**Contact Information**
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Appendix:
QuILTSS Workforce Development (WFD)
QuILTSS Workforce Development (WFD)
# LTSS Workforce Development

## 7 Key Tenets
- Competency-Based (knowledge, skills, abilities, and intellectual behaviors)
- Require Demonstration
- Micro-Credentialing System
- Portability through Registry
- Faculty, Coach and Mentor Support
- Clear Career and College Pathways
- Credit-Bearing Framework

## Structure of Online Learning Modules
- Reading material
- Videos with examples and non-examples
- Voiceover videos with stop effects
- Pre- and post-simulations
- Journal entries
- Decision trees
- Coaching sessions
- Range of learning activities
- Formative assessments throughout*
- Summative assessments for demonstration of competency (application of knowledge)

*Include interactive videos, simulations, work-embedded activities supported by behavioral tools
# National SMEs

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<tr>
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<tbody>
<tr>
<td>Jonathan Martinis</td>
<td>Senior Director for Law and Policy, The Burton Blatt Institute at Syracuse University and Partner, Something Else Solutions, LLC</td>
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<tr>
<td>Meg Traci</td>
<td>Project Director and Research Associate Professor, Rural Institute for Inclusive Communities, University of Montana-Missoula</td>
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<td>Gail Fanjoy</td>
<td>Executive Director, KFI</td>
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<td>Allison Wohl</td>
<td>Former Executive Director, Association of Person Supported Employment</td>
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<tr>
<td>Angela Amado</td>
<td>Institute on Community Integration, University of Minnesota</td>
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<tr>
<td>Kathie Snow</td>
<td>Author, Speaker, and Trainer, Disability is Natural</td>
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# National SMEs

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<tr>
<td>Tawara Goode</td>
<td>Director, Georgetown University National Center for Cultural Competence</td>
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<td>Sonya Barsness</td>
<td>Gerontologist and Consultant, Ubuntu Dementia Consulting</td>
</tr>
<tr>
<td>Ralph Edwards</td>
<td>TASH Board of Directors, Retired from the Massachusetts Department of Development Services</td>
</tr>
<tr>
<td>Regis Obijiski</td>
<td>Former 15-year board member of NADSP, retired from various positions within New York’s developmental disability community, served on the writing and validation team for CMS’ Core Competencies.</td>
</tr>
<tr>
<td>Lisa Mills</td>
<td>Former Deputy Chief of the Division of LTSS for TennCare, instrumental role in the design of the ECF CHOICES program; advisor, consultant, advocate for numerous associations, systems, governments in the field of IDD for 28+ years</td>
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Education and Career Path

- Partner with Tennessee Board of Regents and Tennessee Higher Education Commission to offer training program through:
  - Tennessee Community Colleges (CCs)
  - Tennessee Career and Technical Colleges (TCATs)

- Award 18 hours of college credit and a post-secondary credential
  - Includes work-based learning hours

- Embed within a variety of degree paths, with new Associates Degree (in development)

- Drive to 55* and the “Last Dollar Funding” programs
  - Tennessee Promise and Tennessee Reconnect**

- Learn from other states’ workforce development efforts to appropriately incentivize training—at the provider and worker levels
  - Fits perfectly with TennCare’s value based purchasing efforts

*Governor-led initiative to get 55% of Tennessee’s adults with a post-secondary credential by 2025
**Last dollar funding programs which offer up to 2 years of post-secondary education at a CC, TCAT, or other eligible institution for students after high school or returning adult learners, respectively