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Advancing Value-Based Contracting in MLTSS:

A Paper to Stimulate Collaborative Discussions with Key Partners

National MLTSS Health Plan Association

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Advancing Value-Based Contracting Partnerships in MLTSS: A Paper to Stimulate Collaborative Discussions with Key Partners

Introduction

During the 2023 MLTSS Leadership Summit, key stakeholders from managed long-term services and supports (MLTSS) managed care organizations (MCOs), state government leaders, and long-term services and supports (LTSS) providers convened to discuss value-based contracting (VBC) within MLTSS. The Summit highlighted the need for a strategic shift towards VBC in the LTSS sector, including home and community-based services (HCBS), to enhance the quality of LTSS, accelerate innovation in LTSS, and to identify efficiencies and flexibilities that can help control costs. Participants recognized that, while progress has been made, significant work remains to fully integrate VBC into MLTSS programs across states.

As a result, the National MLTSS Health Plan Association launched a Value-Based Contracting Workgroup in 2024. The workgroup, comprised of member MCOs, was tasked with identifying opportunities to advance VBC within MLTSS and providing guidance on overcoming barriers to adoption. The exchange of insights and expertise shared among the workgroup members and external subject matter experts has been crucial in shaping this initiative's direction.

This paper represents the culmination of those discussions, proposing a practical guide for MCO members, their advocates, policymakers, states, and LTSS providers to engage with National MLTSS Association MCOs and collectively expand the effective use of VBC. Building on existing literature and initiatives, this paper offers recommendations to accelerate intentional partnerships and strategic adoption of VBC in MLTSS, addressing the unique challenges faced in this sector of managed care. It should serve as a starting point for future collaborations—one that supports current efforts, drives progress and establishes VBC, as a foundational element of MLTSS programs nationwide, ultimately improving quality, efficiency and member outcomes.

Long-term services and supports encompass a wide range of health, personal care, social, community integration and employment services and supports typically provided to individuals aged 3 years and older who have chronic illnesses or significant disabilities. These services are provided to individuals who require routine assistance with activities of daily living and maintaining independence, productivity and community involvement to ensure a fulfilling life. These services are delivered across various settings, from institutional environments such as nursing homes and intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) to community-based settings such as individual homes, workplaces and other community places. In 2022, half of the 8 million Americans with current LTSS needs were under age

65.[1] In addition, as of 2024, more than 6 million people under age 65 with disabilities were using paid LTSS[2] and over 500,000 people with disabilities were on waiting lists for HCBS programs that offer an alternative to institutional LTSS.[3] The growth of HCBS programs and declining use of institutional settings is expected to continue, with the number of people served in and public dollars spent on HCBS programs surpassing the respective institutional numbers more than a decade ago. As of 2021, 86.2 percent of LTSS users received HCBS, accounting for 63.2 percent of LTSS expenditures.[4] However, demand for HCBS is likely to outpace HCBS program growth. One example of rising HCBS demand is the growth of autism spectrum disorder diagnosis, with 1 in 36 children diagnosed in 2020 compared to 1 in 150 in 2000.[5]

Managed long-term services and supports integrate LTSS into managed care structures, primarily through Medicaid, to improve coordination of acute, primary and behavioral health services with LTSS. The goal is to enhance the quality and effectiveness of services while managing costs. By applying managed care principles, MLTSS programs create a more streamlined and efficient delivery system for LTSS.[6]

As the population in need of LTSS continues to grow, the role of MLTSS has become increasingly critical in managing the demand for long-term care services.[7] These programs are essential in ensuring that individuals with complex, chronic needs or permanent disabilities receive the care, services and supports necessary to maintain their independence and quality of life. MLTSS programs do not exist in a silo, as they require integration and coordination with other parts of the healthcare system. This comprehensive approach is vital for addressing the full range of needs that individuals requiring long-term services and supports have, ensuring that care is delivered in a person-centered, outcome-focused, and cost-effective manner.

In the context of MLTSS, VBC offers a framework for improving both the quality and cost-effectiveness of care. In MLTSS, like in traditional managed care, VBC shifts the focus from the quantity of services provided to the quality of the services provided and the resulting outcomes. In traditional fee-for-service (FFS) models, LTSS providers are reimbursed on the volume of service delivered, which can lead to service delivery inefficiencies, an over-serving of individuals and a lack of focus on the quality of the care and outcomes. In contrast, VBC aligns the payment model—with its financial incentives—along with key indicators of efficient and high-quality service delivery, and the achievement of specific outcomes that the service is intended to produce. By tying

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[1] AARP Blog. Most Americans Will Need Long-Term Services and Supports in Their Lifetimes; Many Will Face Economic Hardship as a Result. May 2024.
[2] KFF. 10 Things About Long-Term Services and Supports (LTSS). July 2024.
[3] The Arc. Community-Based Long Term Supports and Services
[4] Medicaid.gov. Trends in the Use of and Spending for Home and Community-Based Services as a Share of Total LTSS Use and Spending in Medicaid, 2019–2021
[5] Statista. The Rising Prevalence of Autism It should be noted that while not all individuals with ASD require LTSS or HCBS, a significant number do.
[6] HHS Office of the Assistant Secretary for Planning and Evaluation. Overview of Long-Term Services and Supports (LTSS) and Medicaid: Final Report. January 2018.
[7] Ibid.

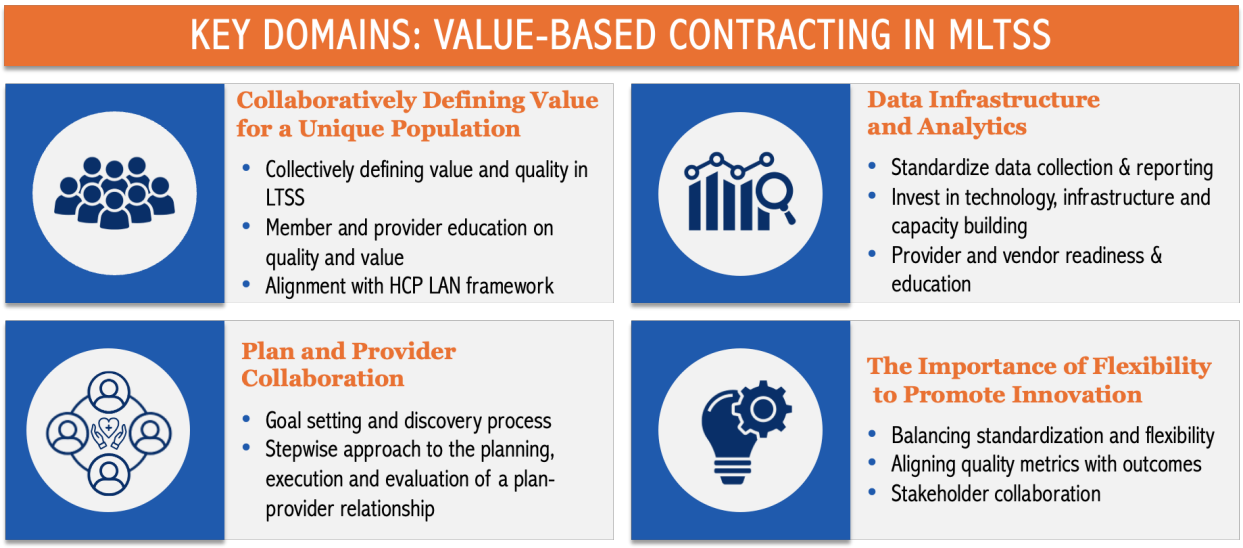
payments to outcomes, VBC encourages LTSS providers, including HCBS providers, to adopt innovative and efficient service delivery models that better address the goals of the service and the unique needs each person served.[8]

The adoption of VBC within Medicaid and specifically within MLTSS has been uneven across states. State agencies that have more developed strategies to incorporate VBC into their MLTSS programs typically utilize frameworks like the Health Care Payment Learning & Action Network (HCPLAN) Alternative Payment Model (APM) Framework to guide their efforts with VBC models prioritizing quality and efficiency.[9]

Despite these efforts, the effective and successful integration of VBC into MLTSS still involves significant challenges, particularly in defining value for LTSS programs and populations. Unlike broader Medicaid managed care programs, which often focus on acute and primary care, MLTSS often involves the provision of ongoing services for a highly diverse population with long-term support needs. MLTSS programs and the MLTSS population both require a different approach to value measurement and VBC in order to achieve success. States and MCOs, in collaboration with their LTSS beneficiaries and providers, must navigate these complexities to develop VBC models that are truly reflective of the unique needs of LTSS beneficiaries and the unique LTSS programs they utilize.

To effectively advance VBC in MLTSS, this paper provides a set of initial recommendations and best practices from the MCO perspective. We explore four key domains that MLTSS Association members believe are critical to success:

Figure 1: Key Domains for VBC in MLTSS



[8] HHS Office of the Assistant Secretary for Planning and Evaluation. Overview of Long-Term Services and Supports (LTSS) and Medicaid: Final Report. January 2018.
[9] HCPLAN APM Framework

Domain 1: Collaboratively Defining Value for a Unique Population

This domain explores how "value" is defined and measured for different populations receiving LTSS and how the definition differs when addressing institutional versus home and community-based LTSS. Value metrics may differ significantly from those in traditional healthcare when consideration is given to the unique opportunities in MLTSS programs to improve quality and efficiency without increasing costs.

Problem Statement

Value definitions vary significantly depending on the specific LTSS population considered, their needs, and the type/scope of program they are participating in. LTSS beneficiaries represent a number of distinct populations, each with their own qualifying conditions, support needs and expectations with regard to what participation in an LTSS program will afford them. The disabilities or conditions that make this population eligible for LTSS are typically expected to be permanent. Additionally, the LTSS population tends to change plans during open enrollment with significantly less frequency than traditional Medicaid populations. For all of these reasons, value will be fundamentally different for these populations than how value is defined in the acute and primary healthcare arena.

Value definitions for LTSS populations must balance goals of improving quality of life and other person-centered objectives with traditional VBC goals around cost savings. Cost savings outcomes from LTSS VBCs may be realized outside the LTSS program (e.g. a reduction in cost on the acute and primary side) and/or may accrue to organizations not directly involved in the VBC effort. Moreover, important differences exist between institutional and HCBS programs that beg the question whether a standardized set of measures across these distinct categories of LTSS settings is appropriate.

Initial Recommendations and Best Practices

In the context of VBC within an MLTSS program, MCOs and providers will need to evolve from sole reliance on traditional FFS payment models – where payment for services are based on a fee schedule tied to unit-based (e.g. encounter, visit, period of time) service delivery – to payments that also strategically incorporate value-informed reimbursement. Accordingly, the individuals served, and their natural supports (e.g. professional or personal caregivers) will also need to understand how VBC can lead to better outcomes for them than FFS has been able to deliver.

Ideally, a VBC approach should be closely aligned with and informed by broader state quality strategies and objectives, with equal importance placed on building consensus among members and providers involved with the MCO's VBC effort as to what represents increased quality and efficiency. The distinctive qualities of LTSS, such as the permanency of the population, necessitates a redefined concept of value that differs from how value is conceptualized in the traditional Medicaid managed care model. In

LTSS, value is not measured primarily by cost savings but by the attainment of person-centered, quality of life outcomes that can be achieved without cost increases. Outcomes might include:

- Maintaining or increasing independence.
- Fostering social connections which positively impacts mental health and access to natural supports, leading to decreased loneliness and associated mental health challenges as well as less reliance on paid staff, with all three positive outcomes producing tangible cost savings.
- Ensuring quality and continuity of supports through staff retention, which is one of the more highly valued outcomes for the LTSS population but has proven difficult to achieve in the traditional FFS system.

In defining value for LTSS, it is also important to acknowledge that traditional metrics of success, such as cost savings, may not reflect the goals of a VBC relationship within MLTSS. The presumptive goal should be the enhancement of one or more contributors to quality of life for LTSS beneficiaries. By prioritizing outcomes that bring the most benefit to LTSS beneficiaries, VBC can be more effectively aligned with true value for these populations.

Collaboratively Define What Value and Quality Mean in The Context of LTSS

A clear and shared understanding of what value and quality mean in the context of LTSS is essential for the success of VBC in MLTSS. To achieve this, collaboration among states, health plans, providers, beneficiaries and advocates is crucial. These stakeholders must work together to leverage resources, data and lived expertise to arrive at clear definitions of these concepts before engaging in a value-based arrangement. This collective effort helps to ensure that value and quality are not only well-defined but also interconnected in a way that supports the specific goals of VBC for the LTSS population.

Furthermore, state policymakers should prioritize explicitly defining priority areas for VBC that are specific to LTSS, rather than establishing broad, general goals such as the percentage of LTSS that is delivered through VBC contracts. These priority areas for VBC must be tailored to address the distinct challenges and opportunities within the state's LTSS system, focusing on meaningful gains in quality outcomes rather than focusing on VBC as an outcome in and of itself. By centering requirements on outcomes that are truly important for LTSS beneficiaries—improved quality of life, greater independence, and enhanced social connections—the resources, time, collaboration and coordination required to implement VBC initiatives can be leveraged to maximize positive impact for the target population.

VBC models also have the potential to address health disparities by targeting underserved populations and aligning incentives with person-centered outcomes that prioritize equitable access to care and quality of life improvements. For example, by incorporating metrics that measure and reward reductions in disparities across racial,

ethnic, geographic, and socioeconomic groups, VBC can ensure that LTSS programs serve all beneficiaries equitably.

Develop Stakeholder-Informed Goals and Values

Engaging a holistic set of stakeholders in a collaborative effort is critically important as plans develop internal MCO VBC goals. It is critical that plans engage and learn directly from beneficiaries, providers, advocates, and other stakeholders to ensure a well-rounded VBC approach.

Additionally, MCOs should more proactively include members and providers in their efforts to orient MCO staff to the various VBC models that payers can deploy (such as pay-for-performance, shared savings/risk arrangements, bundled payments and sub-capitation), highlighting the unique approaches and implications of each. Providers, just like MCO staff, need to clearly understand how these models work and how they can be leveraged to enhance the provider's and MCO's ability to improve outcomes for LTSS beneficiaries. Providers also can bring important perspectives to help identify which VBC models would be most advantageous and operationally feasible in various circumstances and scenarios.

Investing in this collaborative learning with members and providers is not just a matter of necessity but also of financial feasibility. Provider engagement and VBC model design and implementation require time, resources, and funding. It is important to address the needs of providers in this regard, to ensure that providers, just like MCOs, are adequately prepared. By financially planning for these collaborative educational, training and engagement activities, states and health plans can ensure that providers are not only informed but also motivated to adopt and excel in VBC practices.

Through prioritizing education and training on VBC for all stakeholders, states and plans can ensure that all partners are well-equipped to meet the challenges of VBC in MLTSS, ultimately leading to better outcomes for beneficiaries and more sustainable service models.

MCO INNOVATION

Humana's Family Care program, branded as Inclusa, is a long-standing Wisconsin MLTSS program, having delivered long-term services and supports since 2000. Inclusa exemplifies a proactive, stakeholder-informed approach to VBC by committing to co-create initiatives directly with its HCBS providers. Co-creation is a recognized business process involving the development of innovation in teamwork with key partners outside of the organization. The goal of Inclusa's long-standing commitment to co-creation has been to promote a culture of collaboration and the sharing diverse ideas and perspectives in order to improve outcomes for members served and to support contracted providers of services to increase the quality and efficiency of those services. To continue improving upon these outcomes, Inclusa opted to deploy a pay for performance (outcome) VBP with its residential providers that incentivized them to become actively involved in helping to divert or transition members from their group homes to their own homes whenever possible.

STATE INNOVATION

In Wisconsin, advocates and other stakeholders consistently communicated a desire to see the MLTSS program ("Family Care") achieve better competitive integrated employment outcomes. Despite many years of collaboration and pockets of innovation, the statewide competitive integrated employment rate for working-age MLTSS participants with disabilities remained low. In response, between 2018 and 2022, **Wisconsin's Department of Health Services (DHS)** implemented a pay-for-performance initiative with its MLTSS MCOs that focused on improving competitive integrated employment outcomes. The state strategically selected competitive integrated employment as an area of focus to improve outcomes that were deemed unacceptable through analysis of available data by DHS and a wide range of stakeholders and ensure DHS's active participation in implementation of the state's Employment First law.

Alignment with HCPLAN APM Framework

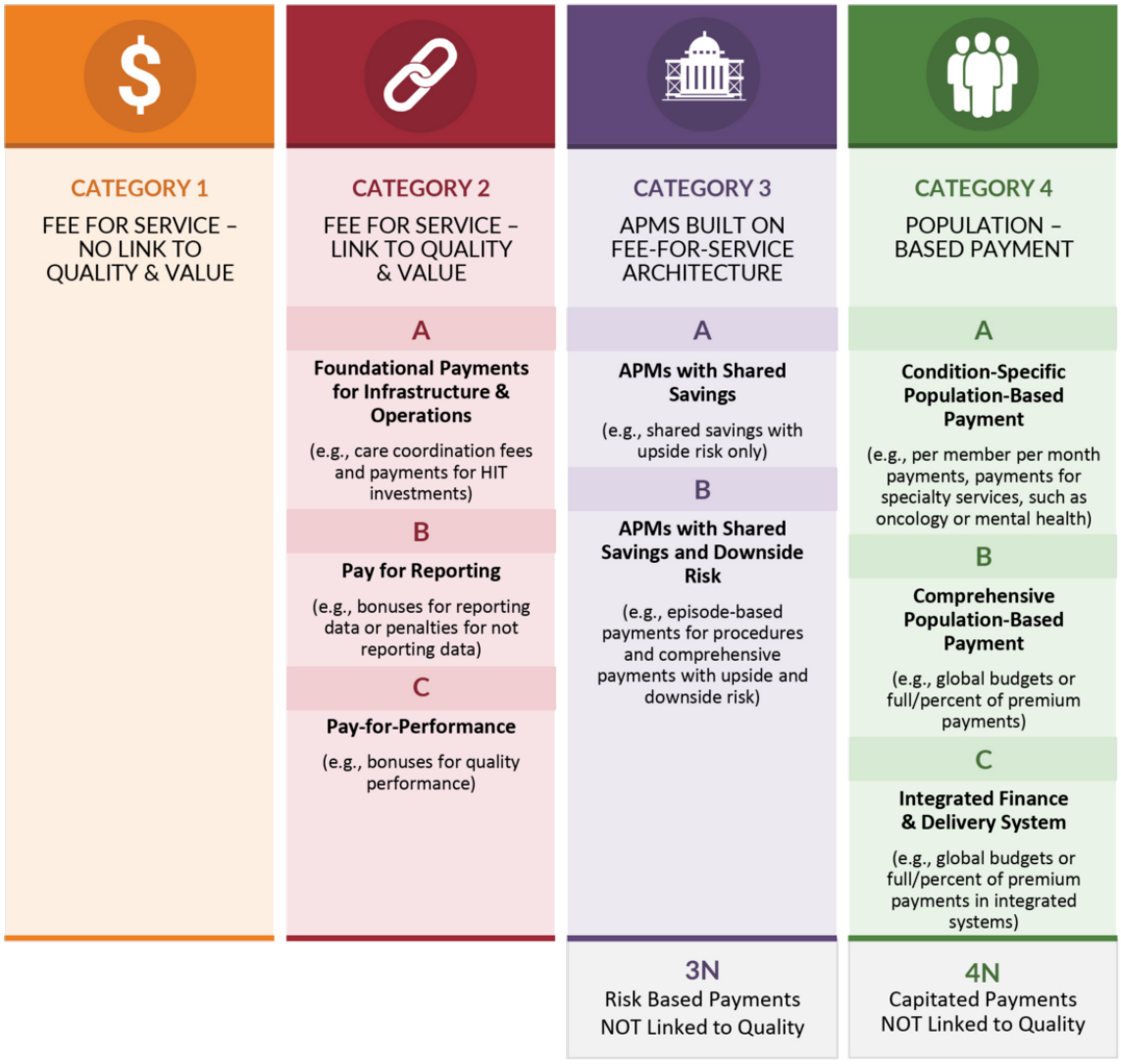
The **Health Care Payment Learning & Action Network (HCPLAN) Alternative Payment Model (APM) Framework** provides a structured approach to advancing value-based payment (VBP) models, which can be highly effective in MLTSS programs.[10] The framework categorizes payment models into four progressive categories, from FFS with no link to quality and value, to fully integrated population-based payment models. The applicability of the HCPLAN APM Framework to MLTSS VBC lies in its potential to guide states and health plans in structuring a successful, and

[10] HCPLAN APM Framework

as needed incremental, transition away from volume-based FFS to payment models that have a direct connection to value and quality.

States should be strongly encouraged to align their MLTSS VBC goals with the HCPLAN APN Framework to create a logical and easily grasped approach to VBP in LTSS programs. By doing so, they can ensure that VBC follows a consistent evolution with each phase supporting the state, MCOs and providers to be ready to successfully implement the next phase. This consistency in approach also supports MCOs that operate in multiple states by providing a unified framework that can be applied across different jurisdictions, reducing complexity and enhancing the scalability of VBC initiatives.

Figure 2: HCPLAN APM Framework



[11] HCPLAN APM Framework

MCO INNOVATION

PA Health & Wellness (PHW) rolled out its first Value Based Contract (VBC) with Centers for Independent Living (CILs) in 2018. Several CILs that had traditionally provided FFS nursing facility transition now had the choice to shift from the dated FFS model to a PMPM arrangement with built-in quality incentives tied to transition placement, reducing recidivism, visitation, vaccination support, SNAP, and LiHEAP benefit access. The results confirmed that the model could deliver on quality outcomes. PHW has since enjoyed year over year increases in nursing facility transitions while maintaining lower than required recidivism rates. Since 2019, PHW has exceeded the state metrics for nursing facility transitions. In 2023 alone, nearly 450 seniors were able to return home and age in place through the CIL partnership. This partnership exemplifies alignment with **Category 4A** of the HCPLAN APM Framework, as PHW's VBC model incorporates population-based payments with incentives directly tied to specific outcomes, such as reducing recidivism and improving access to services, ultimately driving value and improving the quality of care delivered through CILs.

STATE INNOVATION

Beginning in 2014, **TennCare** (Tennessee's State Medicaid Program) designed and implemented a two-part VBC initiative with nursing homes to increase quality in specific areas. A portion of each nursing home's per diem reimbursement became based on the provider's performance on quality measures reflecting stakeholder input. The first phase made retrospective rate adjustments to nursing homes for a range of quality improvement activities (e.g., conducting resident, family, and staff surveys; undertaking culture change initiatives), as well as measurement of actual performance where possible (**Category 2B-C** of the HCPLAN APM Framework). In the second phase, Tennessee Medicaid moved to a prospective pay-for-performance structure, continuing to transition to outcome-based measures over time (**Category 2C** of the HCPLAN APM Framework). The pay-for-performance design included requiring certain "threshold measures" to be met by a nursing home in order for it to be eligible to earn the quality payment portion of their reimbursement rate. In addition, quality performance was used to determine the amount of the quality payment the nursing home earned.

Increased Use of LTSS-specific Quality Measure Sets

Utilizing standardized measure sets and data collection methods is also vital in this context. These standardized approaches enable consistent tracking and comparison of outcomes across different MLTSS programs, state-level MCOs and providers, helping to identify areas where care and service quality can be improved. For instance, measure sets such as the CMS' Consumer Assessment of Healthcare Providers and Systems (CAHPS), the National Core Indicators (NCI), National Core Indicators for Aging and

Disabilities (NCI-AD), and the CMS HCBS measure set provide valuable benchmarks for evaluating the quality of care and support services provided in LTSS settings.

NCI focuses on developmental disability services and evaluates personal outcomes, health, and safety, while NCI-AD measures quality for older adults and individuals with physical disabilities, emphasizing community living and service satisfaction. CAHPS has a variety of versions that all measure beneficiary experiences. The CMS HCBS measure set targets home and community-based services and assesses areas such as care and service access and beneficiary experiences. These sets include key indicators for assessing access to care and services, participant outcomes, and beneficiaries' satisfaction, focusing on participant-centered outcomes. When used in VBC, these sets may provide a suitable framework for evaluating provider performance, allowing states and/or MCOs to target specific areas for quality improvement and align financial incentives with evidence of quality improvement.

By analyzing data from these standardized measures, MCOs in collaboration with other stakeholders can identify gaps in quality and take targeted actions in collaboration with their providers to address them. This approach not only supports the goals of VBC in MLTSS but also ensures that the value and quality delivered to beneficiaries are aligned with the broader objectives of the HCPLAN APM Framework.

MCO INNOVATION

Humana's Family Care program, branded as Inclusa, offers an example of how standardized quality measures and VBC incentives can improve LTSS outcomes. Using data from quality measures, Inclusa regularly assesses how many members are living in their own homes that are not owned or controlled by service providers. *"Controlling my own front door"* is a recognized outcome endorsed by Inclusa members and stakeholders and reinforced by state and federal policy. To continue improving upon these outcomes, Inclusa opted to use VBC with its residential providers to encourage these providers to become actively involved in diverting and transitioning members from their group homes to homes of their own whenever possible. Inclusa developed a pay-for-performance (outcome) payment that a contracted residential provider could earn if they demonstrated direct involvement in the diversion of a referred member, or transition of a served member, from their group home settings.

Domain 2: Data Infrastructure and Analytics to Support Value-Based Contracting Initiatives

This domain covers the development of robust data systems to support VBC in MLTSS by focusing on the relationship between MCO and provider. This domain ultimately includes the collection, integration, and analysis of data from various sources to track performance, quality, and cost outcomes. A critical focus area for MCO systems is in receiving non-traditional data from providers and system to pay providers based on non-traditional units and codes.[12] An additional critical area of focus involves strategies for supporting providers to develop and test capacity to track and submit data for VBC, overcoming challenges with standardizing data, ensuring accuracy, and enabling effective data sharing across different stakeholders to support informed decision-making.

Problem Statement

The effectiveness of VBC models in MLTSS hinges on robust data infrastructure and the ability to perform sophisticated analytics prior to, during, and after the full implementation of a new VBC model. Accurate data collection and real-time analysis are critical for tracking performance, evaluating outcomes, and ensuring financial accountability within these contracts. Without access to timely and comprehensive data, stakeholders—ranging from MCOs to providers to state policymakers—are unable to assess whether the goals of their value-based arrangements are being met and whether outcomes are directly attributable to the value-based reimbursement (VBR) model being deployed.

For MLTSS programs, the data challenges are magnified by the complexity of the services offered as well as the variety of providers and populations served. States, MCO plans, and providers must be able to collect, report and analyze data across a broad range of metrics, including eligibility, claims, person-centered service outcomes, staffing, and expenditures. Data infrastructure must also account for the needs of beneficiaries tied to multiple systems where coordination between two or more payers and/or programs introduces additional layers of complexity (examples include but are not limited to dual-eligibles that have Medicaid and Medicare coverage; children and youth who are justice-involved or being served in the child welfare program and also are HCBS waiver eligible; and individuals with a dual IDD/SMI diagnosis, who receive services through both county based mental health systems and Medicaid HCBS waiver programming). To implement successful VBC models, it is essential that states invest in integrated data systems and ensure that both plans and providers have access to timely, relevant data. This will help facilitate informed decision-making and enable accurate assessment of VBC performance within MLTSS.

[12] It remains a significant challenge that federal HCPCS codes for LTSS generally do not include codes for units other than units of service.

The data required to develop, inform, and evaluate value-based arrangements is inherently complex and costly. Without sufficient infrastructure, funds or adequate access to timely data, stakeholders (states, MCOs, providers, etc.) cannot accurately develop, report, or evaluate VBCs. Furthermore, the fragmented nature of the healthcare environment, with its mix of FFS and managed care models, sometimes complicates the attribution of costs and savings. This fragmentation challenges stakeholders to accurately track where savings are realized and to whom they should be credited, especially when positive outcomes result from a combination of interventions. The challenge of attributing improvements in quality care or health outcomes to a specific VBC initiative is further intensified when multiple, overlapping interventions are in place. This underscores the need for sophisticated data analytics and coordination mechanisms to ensure that the value created by these initiatives is appropriately recognized and rewarded.

Initial Recommendations and Best Practices

In order to implement successful VBC models, it is essential that states invest in integrated data systems and ensure that both plans and providers have access to timely, relevant data contained within the state system. This will help facilitate informed decision-making by health plans and providers with regard to VBC initiatives. However, it is also critical that health plans are able to capitalize on their own data and data analytics resources to guide preliminary decisions on VBC that can then be shared with providers as a first step to collaborating on final decisions regarding joint VBC initiatives.

Standardize Data Collection and Reporting

To effectively support value-based contracting in MLTSS, it is essential to establish standardized data collection and reporting practices. The complexity and cost associated with the data required for VBC arrangements require a streamlined approach to data management to ensure that stakeholders have the information they need without being overwhelmed by unnecessary complexity.

First and foremost, data collection should be kept as simple as possible. While the payer receivers of data may be diverse—including Medicaid FFS programs, Medicaid LTSS providers, D-SNPs, and Medicare Advantage plans with dual-eligible beneficiaries — so too are the sources. Data from (and capabilities of) a large adult community service provider will differ significantly from that of a small personal care or home health agency, which in turn will differ greatly from that of an assisted living provider, or an acute long-term nursing facility. Despite these varied service setting models, significant effort should be put into standardizing data collection files and approaches, at least among provider and payer types. Standardized data files that are uniformly structured enable more efficient data integration, analysis, and comparison, thereby facilitating the accurate development, reporting, and evaluation of VBCs.

Along with standardization, however, there needs to be some flexibility to allow VBR models to accurately capture the impact of specific services and value-based arrangements in helping LTSS beneficiaries meet person-centered milestones and goals. The National Committee for Quality Assurance (NCQA)'s work on person-centered outcome measurement[13] should be a guiding tool for MCOs and providers when creating simplified, direct methods for tracking the results of VBR arrangements.

State Health Information Exchanges (HIEs) have significant potential to contribute to this standardization process, particularly in the context of including LTSS provider information. Successful implementation of state HIE requirements that incorporate LTSS data demonstrate how coordinated, centralized data repositories can streamline data access and reporting across different sectors.

Intra-agency coordination is another critical component in developing standards for data collection and definitions of measures used in VBC. Collaboration between various state agencies is necessary to ensure that data collection methods and measure definitions are consistent and aligned with the goals of VBC across state programs. This coordination helps to eliminate discrepancies and redundancies in data reporting by providers and plans, leading to more accurate and meaningful evaluations of VBC performance.

Data standardization is also critical when risk adjustment methodologies are used in the evaluation and/or execution of VBCs. Member populations in MLTSS programs often have varying characteristics, health risks, and functional status, which can significantly impact outcomes. Risk adjustment allows for a more equitable comparison of performance across different populations by accounting for these differences, but only if appropriate information is consistently collected and report across populations.

Particularly important are standardized efforts to collect functional status data on LTSS beneficiaries, which can lead to VBCs that are more attuned to the goal and purpose of LTSS beneficiaries (as discussed in Domain 1 above). Moreover, these conscious data collection efforts ensure that evaluations of VBC initiatives are fair and reflective of the true value provided to beneficiaries, rather than being skewed by the inherent complexities of the populations served.

[13] The NCQA's Person-Centered Outcome Measurement Initiative has tested a model across providers of capturing data around goal identification, follow-up, and achievement as a way of more simplistically and accurately tracking the impact of specific services and interventions on individual outcomes in the LTSS population. https://www.ncqa.org/hedis/reports-and-research/pco-measures/

MCO INNOVATION

VNS Health engaged with Licensed Home Care Service Agencies (LHCSAs) to develop a pay-for performance VBC initiative in New York. VNS Health used a consistent set of metrics across all LHCSAs, also using a consistent methodology to measure performance on each metric on a quarterly basis, with payments for performance also occurring on a quarterly basis. Metrics related to health status of LTSS beneficiaries include flu vaccinations; no falls with injury; no ER visits; no inpatient hospitalizations, pain intensity stable or improved; urinary continence stable or improved; and shortness of breath stable or improved. To support provider success, VNS Health shared critical data via dashboards highlighting things like falls risk lists and hospitalization risk lists. They also held monthly meetings with providers to review performance, discuss interventions, educate leadership and clinical teams on the various metrics and address training for aides on how to impact specific measures in delivering home care services.

STATE INNOVATION

A successful example of integrating LTSS provider data into a Health Information Exchange (HIE) system for VBC can be seen in **Minnesota**'s electronic Long-Term Services and Supports (eLTSS) system. This initiative promotes the adoption of electronic health records (EHR) and facilitates the standardized exchange of health data, including LTSS provider information, through certified Health Information Organizations (HIOs).[14] Minnesota's oversight process ensures that HIOs adhere to both state and national standards, enabling effective coordination and data sharing between healthcare providers.[15] The integration of LTSS data within the state's HIE helps streamline care coordination and supports performance tracking, making it easier for stakeholders to meet VBC goals within the LTSS framework. This initiative demonstrates how centralized and standardized data collection can be a key asset in enabling value-based care. Minnesota's approach can serve as a model for other states aiming to align LTSS with value-based outcomes by simplifying data management and improving interoperability among healthcare providers.

Invest in Technology, Infrastructure and Capacity Building

A robust investment in technology and infrastructure is fundamental to the successful implementation of value-based contracting in MLTSS. For plans to effectively monitor key performance indicators (KPIs), track quality metrics, and assess the impact of value-based initiatives, they must have access to real-time data. This real-time access enables

[14] Minnesota Department of Health. Health Information Exchange in Minnesota. 2024.
[15] Ibid.

stakeholders to make timely decisions and interventions, ensuring that VBC goals are met, and that care delivery is optimized for LTSS beneficiaries.

One key area of investment is in integration platforms or middleware solutions that can seamlessly connect disparate data sources. These platforms should be capable of integrating electronic health records (EHRs), claims data, pharmacy data, electronic visit verification applications, care coordination and person-centered service management platforms, and member-generated data from wearables and remote monitoring devices. By connecting these diverse data streams, stakeholders can gain a comprehensive view of a beneficiary's health status, allowing for more informed decision-making and more effective management of care.

However, it is important to recognize that the upfront investment in data collection and reporting is a substantial lift for both plans and providers. Updating plan systems and ensuring providers have the necessary resources to do the same are necessary but costly endeavors. These costs should be carefully considered and factored into the planning and implementation phases of VBC initiatives. Plans and providers must have the resources to build and maintain this infrastructure. States that seek continuing advancements in VBC sophistication in LTSS must account for these types of investments on the part of both plans and providers.

States, plans, and providers all need to have a strong and consistent IT infrastructure to support these efforts. This includes the capability for automated reporting, which can reduce administrative burdens and improve the accuracy and timeliness of data submission. Additionally, enhanced access to data from elements like Electronic Visit Verification (EVV) systems and EHRs across all stakeholders can help make sure care delivery is accurately tracked, and that quality metrics are reliably reported.

When possible, waivers should be leveraged to support technology solutions that enhance access to and the effectiveness of LTSS delivery for unique populations within the MLTSS community. States should ensure waivers provide the necessary flexibility to implement innovative technology-driven solutions that address the specific needs of LTSS beneficiaries. However, as detailed in the January 2024 CMS Technical Guide, there are significant limitations around what is allowable under 1915(c) and other HCBS waivers authorities.[16] For example, these waivers typically require a clear demonstration of budget neutrality, which can limit the scope of innovative solutions. Additionally, restrictions on the types of services and supports that can be provided, and the requirements for individualized service plans, present challenges in adopting broad technology-based innovations without careful regulatory alignment. For example, the 1915(c) waiver prohibits covering general room and board costs, and the assistive technology and equipment category is carefully regulated under HCBS waivers, ensuring that only technologies deemed medically necessary and aligned with person-centered care plans can be reimbursed.[17] This excludes many advanced technologies that are not directly linked to individualized care plans. Stakeholders should ensure that proposed

[16] CMS. Technical Guidance and User Guide for the 2024 Plan Year. 2024.
[17] Ibid.

solutions comply with these limitations while seeking additional flexibilities where appropriate to meet the evolving needs of LTSS beneficiaries.

Finally, it is important to recognize the varying levels of sophistication and capacity among plans and providers. Everyone must meet each other where they are in terms of their current technological capabilities and then work to build up their capacity from there. For states and MCOs, this means assessing and accounting for provider readiness during the planning and creation of the VBC as well as consideration of targeted investments in provider capacity.

MCO INNOVATION

Humana's Family Care program, branded as Inclusa, engaged supported employment providers in 2012 around the benefits of moving from FFS to an outcome-based reimbursement model. To ensure its providers could fully participate in developing this VBC arrangement, Inclusa awarded high-performing providers who were committed to participating in the model a grant to support their leadership and program staff involvement in a workgroup and to support the providers collecting and reporting additional performance-based data that was needed to support the creation of the new reimbursement model. Inclusa used the data to identify the particular providers who were likely to struggle the most with the new performance-based reimbursement model and leveraged expert technical assistance for these providers both before and immediately following the move to the new payment model. These various investments ensured the development of a VBC arrangement that providers understood, endorsed and were prepared to succeed in, once the change was implemented.

STATE INNOVATION

Tennessee's Enabling Technology Initiative uses waiver programs like CHOICES and Employment and Community First to incorporate technologies such as remote support caregiving, smart home devices, and medication dispensers.[18] Additionally, State Medicaid Durable Medical Equipment (DME) and Assistive Technology (AT) refurbishment programs, implemented in states like Oklahoma, Kansas, and South Dakota, have significantly improved consumer access to essential equipment while generating cost savings. By reusing valuable equipment, these states have maximized Medicaid resources and ensured that LTSS beneficiaries have the tools they need for better health outcomes.

[18] Tennessee Disability and Aging. Enabling Technology.

STATE INNOVATION

Texas has implemented a Health IT Strategic Plan that promotes the sharing of electronic health records and clinical data among MCOs, providers, and the state health system.[19] This plan is part of a broader strategy to increase the use of alternative payment models (APMs) within the MLTSS space. Texas requires MCOs to meet specific targets for transitioning provider payments to value-based models, with a minimum of 50% of payments expected to be in APMs by 2021. Texas also invests in IT infrastructure by mandating MCOs to publicly report APM data, ensuring transparency and accountability.[20] This comprehensive IT strategy facilitates real-time data sharing and monitoring, which is essential for managing quality and cost in VBC models.

Provider and Vendor Readiness and Education

Provider capability and readiness to adopt value-based contracting can present a significant challenge to the broader uptake of VBC within the MLTSS space. Providers often express legitimate concerns about the variation in VBC programs from year to year and across different MCOs, which makes them hesitant to invest in necessary infrastructure and training. This variability creates unreliability, which is a significant barrier to provider participation in VBC initiatives. To address this, states and policymakers should work towards creating a degree of uniformity in VBC programs, enabling providers to plan with confidence without being discouraged by constantly shifting requirements. However, as we explore in further detail in Domain 4, this uniformity should not be so prescriptive as to preclude one of the key benefits of MLTSS, which is the value that plans can bring in innovative and tailored VBC design.

In order to achieve this balance while also bolstering provider confidence and capacity in readiness, plans and states should ensure that their VBC programs are multi-year efforts with clear stepwise approaches that allow providers to achieve appropriate levels of readiness and recoup investments made. Such long-term planning provides stability and predictability for providers, encouraging them to invest in the necessary tools and training to participate fully in VBC programs.

Health plans and states also need to be prepared to educate providers on how to utilize advanced systems and potentially invest in provider enablement tools and financial incentives. Many providers may lack the resources or in-house expertise to implement and operate the technologies required for effective participation in VBC models. Some of the best VBC models have included front-end capacity-building milestone incentives for providers—such as milestone payments for orienting and training staff to accurately capture data in a new format/model or achieving specific data reporting benchmarks (e.g., 80% of reports submitted with complete data). By offering training and support, as

[19] Texas Health and Human Services Commission. Health Information Technology (Health IT) Strategic Plan. 2019.
[20] Texas Health and Human Services Commission. Alternative Payment Models in Texas Medicaid. 2021.

well as investing in tools that enable providers to manage these systems more effectively, health plans and states can help bridge this gap and facilitate greater provider readiness.

On the vendor side, multi-state vendor solutions sometimes struggle to create unique solutions that match the specific strategies of individual states. The challenge lies in balancing the need for customization with the demand for uniformity across different jurisdictions. Vendors need to be flexible enough to adapt to varying state strategies while still providing solutions that are consistent and scalable.

MCO INNOVATION

To position providers for strategic, sustainable success, **AmeriHealth Caritas** has developed custom value-based dashboards that enable them to track performance relative to program objectives and peers. Providers can access the dashboards 24/7 and generate reports at the population, provider, or member level, which gives providers the capacity to proactively identify member quality fallouts for targeted follow-up and/or intervention. The value-based dashboard dataset is comprised of a variety of inputs, including peer-based, trend-based, and benchmark comparisons such as quality data (e.g., HEDIS metrics, CMS Star Ratings, and the MDS 3.0 assessment); benchmark data (e.g., NCQA Quality Compass); cost and efficiency metrics (e.g., TCOC and Potentially Preventable Events); and member experience feedback (e.g., via CAHPS and other surveys).

STATE INNOVATION

Virginia's Medicaid program under the Cardinal Care managed care contract includes comprehensive guidelines aimed at improving provider readiness and education within MLTSS. Specifically, the program mandates that MCOs develop detailed plans for provider engagement in value-based arrangements.[21] This includes readiness assessments that evaluate a provider's capacity to handle VBC and the methods they use for collecting and assessing performance data. Providers are also offered training and support to ensure they can meet the program's quality and performance standards. Additionally, Virginia's Nursing Facility Value-Based Payment Incentive Initiative focuses on staff education and readiness to improve care outcomes.[22] Facilities receive financial incentives based on their performance in areas like reducing pressure ulcers and hospital readmissions. The initiative directly ties financial incentives to performance metrics, ensuring that providers are prepared and equipped to deliver quality care.

[21] Commonwealth of Virginia Department of Medical Assistance Services. Cardinal Care Managed Care Contract. 2024.
[22] Commonwealth of Virginia Department of Medical Assistance Services. 2023–2025 Quality Strategy. 2023.

Domain 3: Plan and Provider Collaboration on Design and Implementation of VBC

This domain focuses on the importance of collaboration early and often between MCOs and providers to assess, design, and test value-based contracting relationships. An alignment in goals, roles, and responsibilities is necessary to successfully implement VBC models. The domain explores strategies for meeting providers where they are at and overcoming challenges related to differing capacities and resources among providers and ensuring sustained partnerships that drive effective VBC initiatives in the long run.

Problem Statement

Strong collaboration between MCOs and providers is crucial once a collaborative understanding of quality and value has been reached. The LTSS landscape consists of a variety of service providers, many of whom are smaller, community-based organizations that may lack the resources, infrastructure, or knowledge necessary to engage effectively in value-based arrangements. This fragmentation presents challenges for plans and providers alike, including difficulties in tracking and reporting metrics, managing financial risk, and aligning care goals.

To overcome these barriers, it is essential that MCOs and providers work together to build capacity, share resources, and establish clear expectations for performance. Providing technical support, training, and education for smaller providers is a critical step in this process, as it ensures that all participants in the value-based ecosystem are equipped to meet the demands of VBC contracts. Moreover, fostering strong relationships between plans and providers can help address the administrative burden associated with VBC, enabling stakeholders to focus on improving care quality and achieving better outcomes for LTSS beneficiaries. By investing in collaboration, stakeholders can help ensure that providers of all sizes are able to participate in and benefit from value-based arrangements.

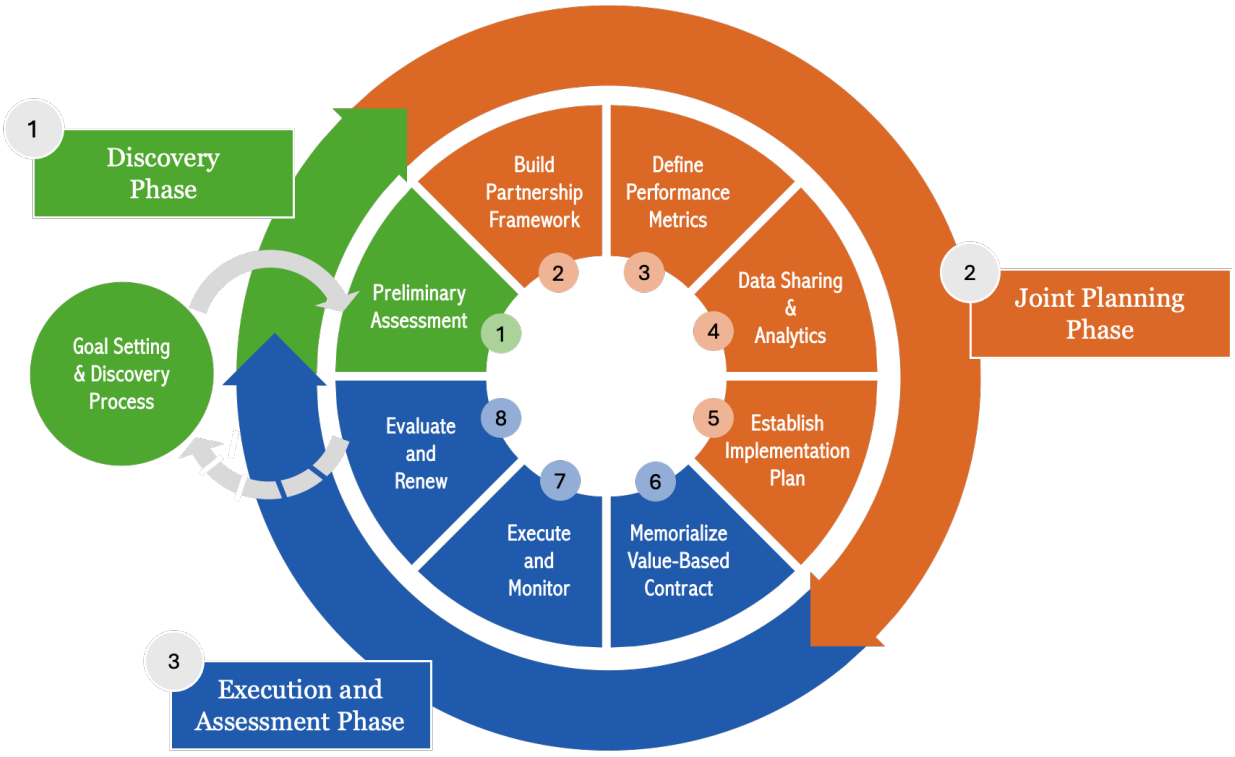
LTSS encompasses multiple service types and providers across various levels of need and conditions. Stakeholders may not have the capacity, data infrastructure, human capital or knowledge to properly implement and execute specific VBP metrics. Providers may face significant implementation costs, along with the administrative challenge of navigating diverse processes across multiple MCOs.

Initial Framework Suggested for Development of Plan and Provider Relationship

Based on input from its member plans, the National MLTSS Health Plan Association has developed the following template for a stepwise approach in the planning, execution, and evaluation of a plan-provider VBC relationship. The graphic below and explanatory text that follows is intended to illustrate what considerations should be accounted for in each step of the process as informed by the principles and recommendations outlined

throughout this document. The steps can best be understood to occur in three broad phases: Precursory steps and step 1 are the discovery phase, steps 2 through 5 are the joint planning phase, and steps 6 through 8 are the execution and assessment phase. **It is worth highlighting that in practice, many of these steps may occur in parallel, or simultaneously – particularly those in each respective phase. However, our goal is to explicitly highlight each one to ensure that they are intentionally accounted for in the development of future VBCs.**

Figure 3: Framework for Development of Plan and Provider Relationship



Precursory Steps

The initial steps in developing a successful value-based contracting relationship between plans and providers are critical for laying a strong foundation for collaboration. These steps include the goal setting and discovery processes.

Goal Setting and (Ongoing) Discovery Process

Prior to the establishment of a VBC relationship, the MCO must develop an internal VBC strategy that identifies the goals it seeks to accomplish via a VBC. As discussed in Domain 1, VBC arrangements should be tools used to help achieve strategic goals– their use should not be considered an end in itself. Plans should develop VBCs as part of broader quality and process initiatives and not simply as a means of claiming that the plan uses VBC. To ensure alignment and relevance, plans should turn to the state, the

member LTSS advisory group, providers (including workforce and family caregivers), to gather feedback on the VBC goals. This collaborative approach ensures that VBC arrangements reflect the needs and priorities of all stakeholders involved, making them more likely to succeed.

Once a plan has set an overall strategic goal and identified a VBC-related means to achieve that goal, the plan should prepare to identify a potential provider partner. Ideally this step should occur naturally through the network of providers that the plan manages. As an element of becoming a member of that network, each provider should be made aware of the MCO's strategic goals of and how the plan intends to use VBC to achieve those ends. The state also plays an important role in signaling early support for the proposed VBC and/or encouraging providers to be open and proactive in collaborating with plans to propose and implement VBC models. Just as states should clearly communicate their VBC strategy to plans, plans should, in turn, communicate their VBC strategies to providers as well as continually assess their own and their provider network's ability to implement such programs. This communication and assessment should be ongoing - not just at the point a provider(s) joins the network for the first time.[23]

Providers ideally will not adopt a passive or reactive posture to VBC. Despite MCOs typically being the predominant innovator in VBC relationships in other health care settings, the lack of VBC in LTSS generally leaves open the opportunity for providers to distinguish themselves as innovators. Providers should make it a point to understand the needs of the health plans and beneficiaries in their community and proactively bring forward ideas to health plans that the plans may not have considered. This, in turn, requires the provider to perform due discovery on health plans in the market as well as internally assess their own capacity to implement such programs.

[23] It is important to note that this recommendation assumes an ideal state where VBC in MLTSS is prolific and common practice. Currently, plans do not widely set VBC-related conditions in the management of their networks or, if they do, they are modest. Nevertheless, network requirements are a central tool for the setting of provider policy by health plans and are heavily leveraged for VBC purposes in other health care contexts outside of LTSS.

PROVIDER INNOVATION

TenderHeart Health Outcomes is the nation's leading provider of incontinence management services. They provide high-quality products and coaching to help individuals manage their incontinence at home, which results in improved health outcomes and decreased costs. Partner managed care organizations (MCOs) pay TenderHeart a case rate for each incontinence member in need of support. TenderHeart monitors quality metrics such as product utilization, cost, emergency room visits and hospital admissions related to incontinence, and patient satisfaction. Data is shared through a secure data network, and communication is enhanced through TenderHeart's portal, although health plans are still able to reach TenderHeart by phone or email. Value-based, case rate contracts include incentive metrics selected by the MCO. The success of TenderHeart's value-based program is driven by member engagement and a focus on outcomes versus unit cost. All healthcare savings from reduced hospital admissions and emergency room visits accrue to the health plan. Critically, TenderHeart's program improves the quality of life for members by allowing them to age in one place.

PROVIDER INNOVATION

CareBridge Medical Group partners with health plans through a value-based contracting approach to improve the health, experience, and increase the independence and quality of life for Medicaid and dually eligible adults living in the community. 24/7 Member Support leverages simple, cellular-enabled technology and a longitudinal, high-risk, telehealth model to provide 24/7 virtual access to health care and support at the touch of a button. The interdisciplinary care team delivers person-centered, culturally competent care to help manage chronic conditions, improve health, and avoid unnecessary utilization of emergency room and inpatient stays. The Decision Support program complements by providing health care plan care managers with person-centered, data-informed recommendations from experts trained in occupational & physical therapy to help individuals optimize the HCBS they receive to maximize their independence and safety at home. CareBridge is paid a per-member-per-month (PMPM) payment and assumes full risk for ensuring their service intervention delivers outcomes for members, which in turn creates savings for the MCOs that at least equal the PMPM payment received. Using a shared savings approach, if savings accrue above the total PMPM payments made to CareBridge, the provider shares a portion of this net savings with the MCO.

MCO INNOVATION

Elevance Health is committed to building a strong foundation for value-based contracting with their provider partners, especially those who are new to managed care. When Elevance enters a market that previously relied solely on a fee-for-service delivery system, they prefer to hold off on prematurely introducing pay-for-performance arrangements immediately. Instead, they choose to build provider relationships and assess the broader environment's readiness for more sophisticated contracting approaches. Instead of immediate performance and outcomes agreements, Elevance chooses to create arrangements that foster the development of provider capacity, capability, and trust. As those elements grow, Elevance models for providers new to managed care what reimbursement under a more sophisticated value-based arrangement would look like as compared to the fee-for-service model the providers were used to. Elevance knows that success in these types of arrangements takes time and relationship building.

Step 1: Preliminary Assessment

After a health plan has identified a potential partner(s) for a VBC initiative, it should ensure that it shares the general parameters of the goals and outline of the initiative with the provider, actively seeking their feedback and securing their buy-in. The plan can then begin to assess and update its understanding of both the provider's and its own readiness. This means performing a targeted readiness test for the health plan and the provider(s) that assesses each partner's respective ability to engage in a VBC relationship. This test should evaluate several key areas: the current technological and administrative infrastructure, including staff capabilities, data collection and reporting and analytics processes; clinical capabilities; quality outcomes produced to date; and financial stability/ability of health plan and provider to invest resources including financial resources in a VBC initiative.

Similarly, the provider should perform their own assessment of the health plan's strategic goals that have been shared, sharing their own goals and objectives in return, assessing the plan's preferred data sharing procedures and requirements, and deciding whether their own operations match to each element of the VBC parameters.

Step 2: Build Partnership Framework

After both plan and provider have completed an initial assessment of the compatibility of mutual interests and capabilities, they should begin defining the parameters of the working relationship. These conversations should outline what the general expectations are of each party including identifying the relevant subset of provider services, the target population (if relevant), the performance metrics (step 3), the data sharing and analytics cadence (step 4), and the overall implementation plan (step 5).

Throughout this process both plan and provider should be clear about the anticipated development of the VBC arrangement over time. As discussed in Domain 1, the initial VBC relationship should ideally follow the stepwise fashion exemplified by the HCPLAN APM Framework. This suggests choosing a simple starting point such as pay-for-performance or pay-for-reporting. However, over time the VBC relationships should evolve to more sophisticated (and more outcome-focused) relationships.

This development process should be discussed in the joint planning phase (steps 2-5) and milestones should be built into the arrangement that give the plan and provider opportunity to review, assess, and evolve (step 8). Eventually this pathway should be memorialized in the implementation plan (step 5) as well as in the contract itself (step 6).

Step 3: Define Performance Metrics

A necessary part of any successful VBC is an agreement on the relevant performance metrics that a plan will hold providers accountable to. Early agreement on these metrics will allow for the identification of appropriate data sharing requirements (step 4) as well as other practical administrative and operational needs (e.g. the staffing needed by each party to administer the arrangement).

A consequence of the recommended stepwise approach discussed in step 2 and Domain 1 is the likelihood that agreed upon metrics will evolve over time. At the outset of an arrangement, relevant reporting / process measures (such as EVV percentage, or completion of functional assessment, etc.) may be the focus of the arrangement. However, over time these measures may be replaced by more outcome-oriented measures such as person-centered NCI-AD measures (e.g. percentage of participants who report being able to do things they enjoy outside of home as much as they want to).[24] These metrics and the timeline of their development should be captured in the implementation plan (step 5) and ultimately the VBC arrangement itself (step 6).

If plans and providers are entering into risk-based or cost-savings agreements, careful consideration must be given to participant attribution. Particularly important is to ensure that attributed beneficiaries are not participating in multiple or competing cost-of-care models. Similarly, if clinical outcomes are being used as the target metric, attention should be paid to any competing clinical or population health initiatives seeking to achieve the same ends.

Step 4: Data Sharing & Analytics

Once relevant metrics are established (step 3), plans and providers should focus on the practical requirements of data sharing and analytics. As discussed in Domain 2, ensuring that both plan and provider have the capability and capacity to implement a VBC arrangement is of paramount importance. This should partly be identified in the

[24] 2022-23 NCI-AD Indicators. Available at: https://nci-ad.org/about/the-surveys/

discovery phase (precursory steps and step 1), but mutual troubleshooting should occur during the joint planning phase.

Common issues and problems that arise in this step include challenges in assuring interoperability and real-time bilateral communication loops; continuity in reporting template; and administrative burden on providers to collect, capture/input additional data elements.

MCO INNOVATION

CareSource engages with a contracted provider network of skilled nursing facilities to provide a comprehensive approach to care and quality outcomes for members who require these services. The program is structured to reduce avoidable hospital readmissions, ED utilization and index hospitalizations with a special focus on assisting members who wish to return to community living after the SNF stay do so in a timely manner with needed services and supports in place. The network, facility care teams, and health plan care management teams work collaboratively to provide members transitional planning for discharge post-SNF stay, supports for social determinants of health, behavioral health and substance use disorders, social work services, community health services, transportation, coaching and healthy rewards. The contracted provider is also responsible for using its data analytics capabilities to identify gaps in care and ensure these are addressed. CareSource pays the contracted provider using a PMPM and utilizes a shared savings model with the provider for savings resulting from the VBC arrangement.

Step 5: Establish Implementation Plan

As a culmination of the joint planning phase, the plan and provider should develop an implementation plan that outlines respective roles and responsibilities of each participant. This plan should outline the key elements of the arrangement (e.g. target population, metrics, relevant data components) as well as the cadence of communication, data sharing, and performance reporting. It should also anticipate regular check-in and assessment periods (steps 7 and 8) that allow for the plan and provider to review and assess progress on the plan.

Step 6: Memorialize Value-Based Contract

The execution phase of the contract can begin with the drafting and execution of the value-based arrangement itself. At this stage the relevant details of the partnership should have already been identified during the join planning phase (steps 2-5). Most of those elements should be accounted for in an implementation plan. Now the plan and provider must draft and execute the formal contractual agreement between the entities that formalizes next steps.

As with any legal document, careful consideration must be given to the agreed-upon terms. For example, while the implementation plan may outline a multi-year engagement, parties may choose not to incorporate those specifics in the final agreement, leaving instead an opportunity for annual review and update. Thus, the implementation plan and the contract should be considered as separate documents. As with any contract, each parties' attorneys should review it first to ensure it complies with appropriate laws and regulations.

Plans and providers should also ensure that any such contract complies with (or helps satisfy the requirements of) any state-set VBC requirements (Domain 4). It is therefore important to include in the contract those state-required VBC elements; it is likely insufficient to outline those components in the implementation plan.

Step 7: Execute and Monitor

Once the contract is signed and the services begin to be provided according to the terms of the arrangement, the plan and provider should follow the monitoring and assessment plans outlined in their implementation plan. This should include regular operational and administrative check-ins, with an increased cadence at the outset tapering to regular check-ins throughout. If performance or operational issues arise, they should be identified and addressed as soon as possible.

Plans and providers should perform independent outcomes assessments and connect on a regular basis to reconcile any discrepancies and prevent future payment discrepancies. Consideration should also be given to how plans and providers report the outcomes of VBC arrangements to relevant state agencies.

Step 8: Evaluate and Renew

The final step in the VBC process is to regularly evaluate the performance of each party relative to the terms of the contract. This evaluation process should be included in the implementation plan (step 5) and the contract itself (step 6). The evaluation process should outline how parties will address and ameliorate performance issues as they arise.

Separate from formal evaluation periods, the arrangement should have renewal periods that allow the parties to either stay the course on current performance outcomes/metrics or adjust the arrangement to a new set of metrics. Such periods allow the parties to revert to the joint planning phase and update their implementation plans and administrative/operational procedures. The process then resets itself and becomes cyclical.

Moreover, it is essential to reward providers who go beyond minimum compliance with VBC requirements and performance expectations. Those who actively engage in innovative practices and demonstrate exceptional outcomes should be recognized and rewarded. This approach encourages a culture of continuous improvement and excellence, where providers strive to achieve the highest quality and most innovative and responsive service models.

Working Together to Address Systemic Biases

In addition to understanding and partnering in the design of VBC models, it is equally important for plans and providers to recognize and address systemic bias that leads to certain segments of the LTSS population being underserved. Training programs for both MCO and provider staff should include strong cultural competency components that focus on identifying and mitigating these issues, ensuring that all beneficiaries receive equitable and high-quality LTSS. States, MCOs and providers must be able to identify and understand the root causes of disparities in access and quality. Each of these partners must be empowered with collaborative and role-specific strategies to overcome these disparities. MCOs and providers should learn together how to respect the cultural, linguistic, and social nuances of the populations they serve. This training not only helps in delivering more personalized and effective LTSS but also in galvanizing collaborative efforts and building trust and rapport with beneficiaries, which are all critical to the success of any VBC initiative in MLTSS.

Domain 4: The Importance of Flexibility to Promote Innovation

This domain emphasizes the importance of flexibility in VBC frameworks to foster innovation within MCOs and their network providers. It explores how states and MCOs can create adaptable VBC models that encourage experimentation and innovation while maintaining accountability. The focus is on balancing regulatory requirements with the need to develop new approaches to serving the LTSS populations that result in higher quality, increased efficiency and measurable increases in the value being delivered.

Problem Statement

Flexibility is a key consideration in the design and implementation of VBC models in MLTSS. States and MCOs must strike a delicate balance between setting clear, measurable goals for care quality and cost savings, while also allowing room for innovation. Overly rigid frameworks can stifle creativity and limit the potential for new approaches to care, whereas models that are too flexible may result in a lack of accountability or inconsistencies in performance.

To foster a culture of innovation, states should provide MCOs and providers with the flexibility to experiment with different service models, payment structures, and quality metrics. This could include piloting new approaches to service delivery that address the unique needs of the targeted LTSS beneficiaries, while also ensuring alignment with broader program goals. Flexibility also encourages the scaling of successful innovations across different regions and populations by allowing MCOs and providers to adapt best practices to their local contexts. Ultimately, promoting flexibility within VBC models can lead to more sustainable and innovative solutions that improve care for the LTSS population while maintaining financial accountability.

States have broad authority to design programs and plan contracts within their Medicaid programs, setting a wide range of measures and payment structures. States must strike a delicate balance between providing sufficient guidance and standardization for stakeholders to be successful in value-based arrangements while not imposing guardrails that limit innovation.

Initial Recommendations and Best Practices

Balancing Standardization and Flexibility

Policymakers should structure their VBC-related requirements and overall quality strategy in as informed a fashion as possible. Specifically, policymakers should understand their design choices along a spectrum of flexibility. On one hand, absolute standardization and uniformity by states requires all plans and providers to adopt the same VBC metrics and initiatives. On the other hand, maximum flexibility sets no requirements on VBC initiatives and allows plans and providers to freely create any of their own. States should understand the tradeoffs of their decisions and seek to establish

a VBC program that is standardized enough to alleviate common hurdles (e.g. data sharing) while flexible enough to leverage the innovation of health plans and providers.

Generally, increased standardization and prescription gives policymakers greater control to define preferred target populations, geographies, provider types, metrics, outcomes, degree of risk, etc. This control allows policymakers to set a VBC quality goal that meets preferred goals (as discussed in Domain 1). However, when policymakers make prescriptive choices, they risk the significant tradeoffs of increased programmatic costs on providers and health plans who lack uniform degrees of readiness and capability to administer the requirements as well as incompatibility and inflexibility in the creation of VBC arrangements that could benefit a broader set of beneficiaries and otherwise benefit the program. Moreover, such requirements run the risk of ignoring other nuances such as the differences between rural and urban providers and beneficiaries.

Overall, policymakers should strive to provide broad guidelines that offer clear connection to an overall quality strategy as well as general parameters to achieve those quality ends and trust that health plans and providers will rise to meet the challenge. For example, as discussed in Domain 1, states should generally adopt a VBC program that encourages the stepwise approach of the different categories of the HCPLAN APM Framework. The framework sets parameters of growth but is not so prescriptive as to preclude innovation. Moreover, policymakers should ensure that incentives are aligned in a way that maximizes this type of structured innovation. Plans and providers that yield continuingly improved VBC arrangements should be rewarded.

STATE INNOVATION

Arizona mandates that MCOs achieve specific levels of VBP activity but grants them the autonomy to select appropriate payment models for each provider. This approach allows MCOs to tailor VBP arrangements to the unique needs of their provider networks and the populations they serve. Arizona provides broad guidance on acceptable VBP models, including primary care incentives, performance-based contracts, bundled payments, shared savings, shared risk, and capitation with performance-based contracts. Rather than requiring MCOs to submit models for approval, the state asks them to share examples of their primary arrangements. To enforce these requirements, Arizona withholds a portion of the capitation payment, contingent upon the MCO meeting annual VBP benchmarks and state-defined quality performance standards. This flexible framework encourages MCOs to develop innovative, value-driven strategies that align with their specific operational contexts, thereby fostering a more responsive and effective MLTSS environment.[25]

[25] AHCCCS: Alternative Payment Model Initiative – Strategies and Performance-Based Payments Incentive

Aligning Quality Metrics with the Quality Outcomes VBC Seeks to Facilitate

For VBC initiatives to be truly effective, it is essential that quality metrics are closely aligned with the quality outcomes they aim to achieve or increase. This alignment ensures that VBC arrangements are focused on driving meaningful improvements in services, rather than simply meeting regulatory benchmarks for compliance. Traditional quality metrics must be accurately labeled as compliance metrics, allowing for different, authentic quality metrics to be developed to support VBC arrangements. When introducing new quality measures, policymakers should implement a phase-in approach, allowing for a smooth transition that gives MCOs and providers time to identify and adopt practices that contribute directly to high performance on these quality measures. This gradual implementation, with an initial focus on quality practices followed by a focus on quality outcomes, helps mitigate the risk of service disruption while supporting, incentivizing and rewarding the steady evolution of quality service provision practices.

Furthermore, states should develop robust measurement strategies to assess the impact of LTSS value-based contracting initiatives. These strategies should be designed to evaluate how effectively VBC models improve participant outcomes, enhance the quality of services, and promote cost-effectiveness. By regularly monitoring outcomes, quality indicators and other performance metrics, states and MCOs can identify areas for improvement, adjust strategies as needed, and ensure that VBC initiatives continue to meet their intended goals. Providers should also be expected (and supported) to track their own performance for similar reasons. States and MCOs should involve participating providers in evaluating VBC initiatives and should be transparent when sharing evaluation and monitoring results with stakeholders including providers. Ongoing evaluation is crucial for maintaining the momentum of innovation, the structure to ensure providers are able to succeed, and responsiveness to the needs of the population.

Recognizing and rewarding innovative practices is by far one of the most critical aspects of aligning quality metrics with outcomes. States and MCOs should incentivize providers who achieve outstanding results through the adoption of new service and support models, technologies, or approaches. These rewards not only encourage providers to strive for excellence but also deliver financial resources to enable high-performing providers to reinvest in growing their geographic footprint and/or service capacity, rewarding their staff appropriately, and continuing to invest in testing innovations. Financially rewarding innovative practices also serves to highlight successful strategies that can be replicated across the system, fostering a culture of continuous improvement, and placing those providers who developed the innovative practices in a position to mentor other providers.

Finally, it is important that LTSS VBC strategies are integrated into a broader, system-wide approach. VBC initiatives should not operate in isolation but should be part of a comprehensive strategy that aligns with other healthcare reforms and quality improvement efforts.

MCO INNOVATION

PA Health & Wellness, a Centene company, demonstrates how closely aligning quality metrics with intended outcomes can drive meaningful improvements in LTSS. Through its CM 2.0 initiative, the plan sought to reduce emergency department (ED) visits and increase member stability in community settings. Originally, CM 2.0 faced obstacles, such as duplicated roles within the care management team and inconsistent data sharing, which complicated its ability to focus on quality outcomes rather than simply meeting regulatory requirements. By recalibrating the model to rely more on community health workers—who educate caregivers and address member needs directly in their homes—PA Health & Wellness realigned its quality metrics with the outcome of ED diversion and long-term community living for members. To support this shift, PA Health & Wellness adopted a gradual implementation approach, allowing providers time to adjust to the new quality metrics that emphasize community-based support over traditional clinical interventions. This phased transition was crucial to the program's success, reducing ED visits by 42% without disrupting service quality. In 2025, CM 2.0 will move to a shared risk/shared savings model, providing financial rewards for providers who achieve high-performance outcomes in line with the program's goals.

Stakeholder Collaboration

The success of VBC initiatives depends on active collaboration among a diverse group of stakeholders, including providers, payers, policymakers, and consumers. States should prioritize engaging these stakeholders early in the development of guidelines, standards, and policies, gathering feedback that reflects a wide range of perspectives. This inclusive approach helps to build consensus among stakeholders, leading to greater acceptance of changes to traditional models and ensuring that the resulting policies are both practical and effective.

Collaboration among states, organizations, and experts is also key for driving knowledge sharing, replicating successful approaches, and fostering collective learning. By encouraging the exchange of best practices, lessons learned, and successful models of LTSS VBC, states can help create a learning environment that accelerates innovation and improves care outcomes. This collaborative effort also helps to build a repository of effective strategies that can be adapted and applied across different settings, enhancing the overall impact of VBC initiatives.

To support health plans and providers in navigating the complexities of VBC for LTSS including HCBS, states should provide them with the knowledge, tools, and resources needed to address challenges and seize opportunities for innovation within the scope of what CMS and the state is allowing per regulation and/or contract. This includes offering training and education that equips health plans and providers with the knowledge required to implement new, innovative and permissible service delivery

models and payment models, as well as fostering an environment that encourages experimentation and risk-taking. Engaging providers in the development of innovative solutions is particularly important, as their firsthand experience and insights are invaluable in shaping effective and sustainable VBC models.

MCO INNOVATION

UPMC Community HealthChoices has been engaging around this question of value in LTSS since the inception of our value-based work with our nursing facilities in 2022. Beyond the traditional cost savings associated with Medicaid managed care, the focus has been on identifying and addressing the issues faced by staff and partners within value-based arrangements. UPMC has also integrated the Pennsylvania Long-Term Care Learning Network into its incentive program, supporting their efforts to provide training and information to nursing facility and MCO staff, as this is seen as central to delivering high-quality care. Additionally, the program is used to collaborate with nursing facilities to accept participants with more acute care needs and maintain their placement in the facility. All value-based efforts are carefully coordinated with state regulators, who oversee the programs and have their own initiatives to improve the quality of care in facilities.

COLLABORATIVE INNOVATION

In New York, the **Coalition for Excellence in Value-Based Care at Home** partnered with **Vesta Healthcare** and **VNS Health** to address gaps in care coordination for dually eligible beneficiaries with long-term care needs. This collaborative effort demonstrates how diverse stakeholders, including nonprofit organizations, clinical care companies, and managed long-term care plans, can work together to enhance service delivery through innovative VBP arrangements. The initiative links Medicare chronic care management services with Medicaid-funded in-home supports, using a vertically aligned care model that integrates services across programs. Key features include empowering home health aides with remote-patient monitoring for real-time updates and providing virtual chronic care management services to keep beneficiaries stable at home. Stakeholder collaboration was critical to aligning this VBP model with the NYS MLTC Quality Incentive Program (QIP) Methodology, ensuring both Medicare and Medicaid activities were coordinated to achieve shared goals. This approach achieved significant results in Q4 2023, with 550 VNS Health MLTC members exceeding state average scores on key quality measures and generating $78,000 in performance payments to contracted providers. The Coalition's efforts exemplify how engaging stakeholders at multiple levels can overcome barriers to integration and advance innovative solutions, even in settings where fully aligned arrangements like FIDE-SNPs are unavailable.[26]

[26] Health Affairs. An Incremental Approach To Integrating Medicare And Medicaid. 2024.

Conclusion and Intended Next Steps

The journey toward advancing value-based contracting in MLTSS represents a crucial step in improving the quality of care and outcomes for individuals receiving long-term services. Through collaborative efforts between MCOs, providers, state agencies, and beneficiaries, we can drive innovations that prioritize person-centered care while ensuring financial sustainability.

While challenges remain in fully integrating VBC within the MLTSS landscape—particularly in areas such as data infrastructure, provider readiness, and flexible policy frameworks—the examples and recommendations presented in this paper illustrate the promising path forward. The ongoing commitment to shared learning, stakeholder engagement, and the development of robust data analytics systems will be essential in overcoming these hurdles.

This paper serves as an invitation for continued dialogue, urging all stakeholders to reflect on the insights shared and actively engage in refining and expanding these models. The real value lies in the collaborative exploration of new ideas, practices, and approaches that will shape the future of MLTSS. With the right investments in technology, education, and partnership, VBC has the potential to transform the delivery of long-term services and supports, ensuring better outcomes for all involved.

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About the National MLTSS Health Plan Association

The National MLTSS Health Plan Association ("MLTSS Association") is the leading organization in Washington, DC promoting Medicaid managed long-term services and supports (MLTSS) and integrated care. We represent health plans that contract with states to provide long-term services and supports to beneficiaries through the Medicaid program. Our members assist states in delivering high quality long-term services and supports with a focus on ensuring beneficiaries' quality of life and ability to live as independently as possible.

Members include Aetna, AlohaCare, AmeriHealth Caritas, CareSource, Centene, Commonwealth Care Alliance, Elevance Health, Florida Community Care, Humana, LA Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, United Healthcare, and UPMC Community Health Choices.

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