Milbank Memorial Fund

CENTER FOR EVIDENCE-BASED POLICY

EXECUTIVE SUMMARY

Bundling, Benchmarking, and Beyond: Paying for Value in Home- and Community-Based Services

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JULY 2018

Millions of children, adults, and seniors with disabling and chronic conditions receive long-term services and supports (LTSS) through Medicaid to help with the tasks of daily living.[1] The utilization of and expenditures for Medicaid's home- and community-based services (HCBS) have been growing over the last few decades because of a large shift toward HCBS as the preferred alternative to institutional care. From 1995 to 2015, the expenditures for HCBS rose from 18% to 55% of Medicaid LTSS expenditures.[2] Estimates suggest that by 2020, spending on HCBS will continue to increase and account for nearly two-thirds of Medicaid LTSS spending.[3] The increase in HCBS expenditures, attributed to several factors such as beneficiary preference and a growing emphasis from the Centers for Medicare & Medicaid Services (CMS) on expanding HCBS options, have compelled policymakers to explore new ways to reimburse for and measure the quality of Medicaid HCBS.

One alternative payment model (APM) that has received interest in recent years is "bundled payments," also known as "episode-based payments." Bundled payments are a package of health care services that are paid for as a set.[4] Although bundled payments have been in development for clinical procedures for several years and continue to be explored, they are now just being developed for HCBS. While few examples exist, bundled payments are being used in the Arkansas Medicaid Living Choices Waiver and the Colorado Medicaid Brain Injury Waiver Supported Living Program, in which assisted-living facilities or contracted home health agencies receive a daily rate to provide a bundle of HCBS to beneficiaries.[5,6] The beneficiaries receive different levels of services in their plans of care, based on their assessed severity of need, and providers receive a different daily rate based on the level of services provided.[5-7]

Policymakers should consider the lessons learned from the existing bundled payment initiatives and literature to help plan and develop bundled payments for HCBS. These lessons may be summarized in the following way:

Four Cs for Developing HCBS Bundled Payments

1. Consistency and Transparency

Medicaid programs should consider how to regularly and transparently determine the bundle of services and length of an episode, population, outcomes, data collection across providers, involvement of stakeholders, and methods to accurately predict the cost of a bundle.

2. Coordination of Care

Medicaid programs should consider the providers needed to deliver a bundle of HCBS, a locus for care coordination, beneficiary input, and the organization and infrastructure needed to promote a coordinated approach to HCBS delivery.

3. Calculating Payment

Medicaid agencies should consider how to account for beneficiary populations with different severities of need by exploring the use of claims data to predict the cost of an episode, using consistent cost-prediction methods over time, using tools to help evaluate a beneficiary's severity of need, and using risk adjustment to promote appropriate resources for providers to care for beneficiaries with differing levels of need.

4. Capacity of Medicaid Agencies and Providers

Providers' capacity regarding clinical readiness to change health care delivery models, promote care coordination, assume financial risk, and engage beneficiaries is an important consideration in bundled payments for HCBS. In addition, Medicaid agencies should consider their own capacity and their providers' business readiness, including data infrastructure and interoperability.

Quality metrics are also a critical component of APMs, including bundled payments. In recent years, CMS has emphasized measuring the quality of Medicaid HCBS.[8] But despite many efforts, HCBS currently has no standardized quality metrics. Accordingly, an important initial step for policymakers interested in a quality measurement system for HCBS is agreeing with the relevant stakeholders on a definition of high-quality HCBS in a particular state to serve as the foundation for the next steps, such as identifying specific metrics and data sources.[9]

Policymakers have several frameworks and resources to help them select measures and identify data sources such as the National Quality Forum HCBS Quality Measurement Framework, the Agency for Healthcare Research and Quality, the Truven Health Analytics HCBS Quality Measurement Framework, and the Accountable Care Organizations Quality Framework for LTSS.[10-12] Related to selecting measures is identifying data sources for quality metric data. To obtain quality metric data, Medicaid programs will likely have to use a variety of sources, including fee-for-service claims, managed care organization (MCO) encounter data, and self-reported surveys.[11]

The following Three Ms for HCBS quality assessment also consider several factors, including data limitations and the capacity of Medicaid programs, MCOs, and providers to participate in systematically collecting, analyzing, and storing HCBS quality metric data in regard to the quality assessment of HCBS.

Three Ms for HCBS Quality Assessment

1. Measures

The selection of HCBS quality measures should consider the stakeholders' engagement, the definition of high-quality HCBS, available data sources, and experts' reviews of possible quality measures.

2. Methods

For data collection, management, analysis, and reporting, Medicaid programs should consider current capacities and systems that allow for systems' interoperability and information exchange, the particular resources and capacities needed, and outreach to stakeholders.

3. Monitoring

Medicaid programs should consider a plan to continually evaluate quality measurement systems and to tie metrics to payments to providers.

HCBS continues to expand as the preferred LTSS option in Medicaid. Policymakers may consider bundling payments for HCBS and measuring quality of care to promote the Triple Aim of health.

Notes

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