Improving Lives & Ensuring Sustainability:

Implementing Alternative Payment Models in Intellectual & Developmental Disabilities Service Delivery

ANCOR

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Executive Summary

In January 2019, ANCOR released its initial white paper on alternative payment models (APMs), *Advancing Value & Quality in Medicaid Service Delivery for Individuals with Intellectual & Developmental Disabilities*.[1] This report highlighted the emergence of APMs and Value-Based Purchasing (VBP) in intellectual and developmental disabilities (I/DD) programs. It considered the advantages and cautions of such endeavors and sought to identify the foundational principles of payment reform for providers operating in this sector. The report identified thirteen recommendations for the future of APMs (Appendix A) and suggested that efforts to further engage providers and other stakeholders in this process continue. As such, ANCOR's APM work group developed a plan to identify systems with promising practices/incubators for ideas that may influence national thought and spur action on I/DD alternative payment models.

The APM work group visited five key states/programs focusing on those models that most resonated from the first round of review. Between late 2019 through early 2021, members met with a diverse group of stakeholders in Arkansas, Pennsylvania, Tennessee, Vancouver (British Columbia) and Wisconsin. Interviews were held in person and virtually (as our work was delayed by the COVID-19 pandemic) and each program was evaluated on four areas: Access, Quality, Finance and System Design. The purpose of these visits was to study the APMs; talk about the models with a broad group of stakeholders and identify the models that may be scalable in other states in whole or in part. The APM work group studied what these locations were doing and planning to do and identified promising practices to inform system level thinking on the future sustainability of the I/DD system. The resulting environmental scan was drafted and shared with all participating stakeholders for accuracy and clarification.

This report identifies five "Key Components" we believe are essential in the design of alternative payment models serving people with intellectual and developmental disabilities in long-term services and supports. The Key Components include Quality Outcomes, Integrated Care/Services, Value-based Contracting with Shared Savings, Individual Control & Access, and Efficient Use of Resources.

As we participated in the meetings with states/programs, one reality became increasingly clear: no model is the same. Despite the fact that these models are structured differently, we did find common themes or characteristics that were generally consistent where models were successful. These characteristics included stakeholder involvement, flexibility to meet changing needs and clearly defined, measurable outcomes. The variability between the models however does question the scalability across states which is one of our goals in this work. Subsequently, we recommend that models be designed with scalability in mind despite state or regional differences.

We have long recognized the need for significant changes to the system of services and supports for people with intellectual and developmental disabilities. Never has this been clearer than in the shadow of the COVID-19 pandemic. From the onset of the pandemic, providers and people served grappled with dramatic changes in access to and availability of services, funding losses, significantly increased expenses, and an inability to weather the crisis without significant resources from the states and federal government. The challenge for providers to pivot to meet the crisis environment highlighted the rigid and even restrictive nature of the fiscal and regulatory environment upon which Medicaid services are built.

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[1] "Much of this paper is premised on *Advancing Value & Quality in Medicaid Service Delivery for Individuals with Intellectual & Developmental Disabilities* (Alexandria, VA: ANCOR, 2019). Consult that publication for reference.

The unexpected delay in our workplan actually highlighted the importance of our effort to identify and showcase innovative service and funding models that are transitioning this sector from a legacy fee-for-service model to one which is more person-centered, flexible, and innovative.

Our final recommendations suggest that the most successful models will include person-centered design and control with broad stakeholder involvement and shared governance; full integration of health care management and long-term services and supports; implementation of key outcome measures as indicators of quality resulting in measurable outcomes; funding stability through adequate reimbursement coupled with incentive payments for quality outcomes; a decrease in fee-for-service funding structures that incentivize volume over value; growth of value based purchasing; innovation and greater reliance on technology. Through these changes in the structure and financing of the I/DD service system, we envision greater service flexibility and individualization, and an opportunity to address our workforce and waiting list issues. As demand for I/DD home and community-based services continues to outpace the available workforce, we believe that these system changes are our best chance to meet this growing demand and address states' waiting lists.

It is essential that states ensure these elements are embedded in new models that may be developed. We present this work to serve as a resource for entrepreneurial providers and states wanting to reshape service delivery systems. We look forward to engaging with states and stakeholders as new models are developed, piloted and scaled-up.

Introduction

In January 2019, ANCOR released its initial paper titled, "Advancing Value & Quality in Medicaid Service Delivery for Individuals with Intellectual & Developmental Disabilities". The report highlighted the emergence of Alternate Payment Methods (APM) and Value-based Purchasing (VBP) in Intellectual and Developmental Disabilities (I/DD) programs. It considered the advantages and cautions of such endeavors and sought to identify the foundational principles of payment reform for providers operating in this sector. After considering the lessons learned from that report, we initiated the process of taking a deeper look into a few of the most promising alternative models we found which became the genesis of this paper. The resulting environmental scan helped to inform our thinking on the future of system sustainability.

While there has been substantial growth in the application of Alternative Payment Methods in the health care sector since the adoption of the Affordable Care Act in 2009, it has had limited use in long-term supports and services, with inclusion primarily found in elder and behavioral health services. Today, there are only eleven states that include services for people with I/DD in their Medicaid Long Term Services and Supports (MLTSS) programs. These states include Arizona, Arkansas, Iowa, Kansas, Massachusetts (in development), Michigan, North Carolina, New York, Pennsylvania, Tennessee, and Wisconsin. There are several factors that contribute to the slow expansion of APMs in this space including the ongoing challenge of establishing a widely agreed upon set of quality measures upon which value-based purchasing goals can be based.

There have been difficult lessons learned in the early application of APM principles to I/DD LTSS and as a result, some states became reticent to change their systems and implement new models, and individuals and families have expressed concern about disruptions to their long-standing supports. Despite the slow expansion in I/DD services, ANCOR believes that the thoughtful development of alternative payment models is an essential component in the stabilization of community-based services. Through the expansion of person-centered APMs that are developed and governed by stakeholders, we see a pathway to creating more flexible methods for delivering long-term supports and services, wherein resources are allocated based on individual need, are managed responsibly, and savings are shared and reinvested.

Additionally, we recommend that APM plans be implemented to augment existing programs. In the wake of the COVID-19 pandemic, states are likely to consider changes to their HCBS programs to address provider capacity to manage and ensure safety of people served during times of crisis, albeit public health emergencies, natural disasters, or other events that significantly impact operations. It is recommended that states consider adapting some of the flexibilities described herein to enable service organizations to shift resources and pivot operations as a crisis unfolds. As the vast majority of HCBS programs are currently rooted in a fee-for-service funding system, we saw agencies struggle immensely during the pandemic as revenues plummeted and expenses dramatically increased. Our assertion is that as states adopt various tenants of alternative payment models, providers will be better positioned to manage crises with less disruption to the individuals served.

As is illustrated on the following page, the foundational principles recommended are grounded in person-centered choice and control, provider flexibility to meet the changing needs of people supported, streamlined administrative systems to ensure that more time and resources are focused at the point of service, and an assurance of quality outcomes. All of which we believe is achievable through thoughtful and iterative design with the individual served at the center of the plan and with stakeholders sharing responsibility and accountability. Among these foundational principles we would like to note two points of clarification. First, in reference to principle number four, rates to ensure “adequate direct support compensation” need to include other workers and also adequate rates for general operations and fixed costs. Regarding principle number nine on system complexity and administrative burdens, it is important to specify that the fee-for-service system of billing and payment is incredibly complex and that coupled with extensive regulatory compliance and unfunded mandates exacerbates administrative burdens.

The original paper reviewed 10 APM care delivery models across eight states, including Arizona, Arkansas, Kansas, Michigan, New York, Pennsylvania, Tennessee, and Wisconsin. In this report, we take an in-depth look at five key models and recommendations built upon promising practices that are aligned with our foundational principles and recommendations.

Community providers have been and will continue to be central to advancing state and national goals of promoting community integration and individual independence. Payment reforms should support providers' role in service provision and consider the complex array of services and the unique challenges associated with community-based services.

Therefore, payment reforms should:

1. Promote continuity and stability of services, reflecting that many individuals with I/DD have needs that span their lifetimes and that services are in many cases provided on a 24/7 basis by agencies, paid caregivers and/or family caregivers.

2. Promote maximum flexibility and utilization of risk sharing and sharing of cost savings mechanisms.

3. Assure continued access to services and, where possible, expand access to individuals on waiting lists.

4. Assure payment rates fund adequate direct support compensation to attract and retain a stable, skilled, qualified workforce.

5. Achieve a high level of quality in outcomes, including outcomes that are not medical in nature (such as independence, equality of opportunity and economic self-sufficiency).

6. Promote a full range of services and supports needed to address the diverse needs of people with disabilities (including services such as competitive employment).

7. Promote coordination of physical health services with LTSS and behavioral health.

8. Support self-direction for any individual/family who opts to self-direct.

9. Reduce system complexity and administrative burdens.

10. Promote provider autonomy in the delivery of services.

11. Promote the use of technology where it is an efficient and effective means of supporting quality service delivery and delivering quality and outcomes for individuals.

12. Assure high levels of accountability and transparency to providers, individuals and governments, and assure effective and efficient use of resources.

13. Provide payments based on actuarially sound rates.

14. Promote development of direct support workforce to bolster I/DD service provision.

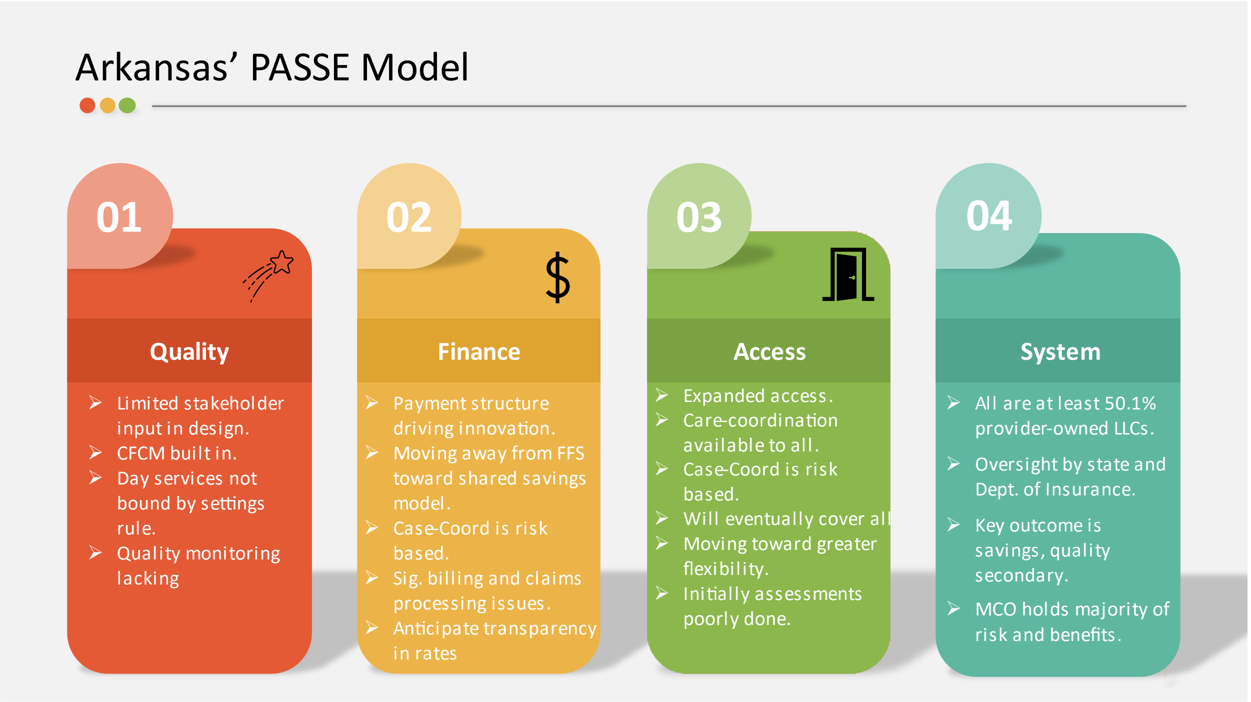
Process

Stemming from the recommendations in the January 2019 paper, the ANCOR APM work group was charged with doing a deeper dive into several of the more mature MLTSS programs to garner a better understanding of what was and was not working. The committee spent approximately 15 months (with a mid-year hiatus due to the COVID-19 pandemic) visiting five states, meeting with providers, government officials, people with disabilities and their families, and agency staff (Appendix B). In total, the project included approximately ninety stakeholders across the five states/programs, and included representatives from ANCOR, the U.S. Administration for Community Living, ARRM (Minnesota), the Centers for Medicare & Medicaid Services, the Institute on Public Policy for People with Disabilities, the New York Alliance for Inclusion & Innovation, the Ohio Health Care Association, PAR (Pennsylvania) and TNCO (Tennessee), as well as multiple state legislators and managed care organizations. Several meetings were held within each location during which participants shared information about the development of their model, the model's current status and plans for future iterations.

Extensive notes were collected during each stakeholder meeting focusing on Quality, Finance, Access, and System Design elements. Once all programs were visited, state profiles were developed and shared with the participants for any necessary clarification and editing. This process ensured that we were capturing the key elements of each program as accurately as possible and made edits as stakeholders deemed necessary. This report reflects our findings, identification of promising practices, and recommendations for state-level pilot projects.

Environmental Scan & Findings

Provider-led Arkansas Shared Savings Entity (PASSE) Model



Arkansas' PASSE Model

01 Quality

- Limited stakeholder input in design.
- CFCM built in.
- Day services not bound by settings rule.
- Quality monitoring lacking

02 Finance

- Payment structure driving innovation.
- Moving away from FFS toward shared savings model.
- Case-Coord is risk based.
- Sig. billing and claims processing issues.
- Anticipate transparency in rates

03 Access

- Expanded access.
- Care-coordination available to all.
- Case-Coord is risk based.
- Will eventually cover all
- Moving toward greater flexibility.
- Initially assessments poorly done.

04 System

- All are at least 50.1% provider-owned LLCs.
- Oversight by state and Dept. of Insurance.
- Key outcome is savings, quality secondary.
- MCO holds majority of risk and benefits.

The movement to managed care in Arkansas resulted from legislation passed in 2017 directing the creation of the "Provider-led Arkansas Shared Savings Entity (PASSE)" model. The goal was to provide fully integrated care for individuals with intellectual and developmental disabilities and people with serious mental illness, and representative of these communities were key stakeholders in the initiative. The managed care function was enabled under a Section 1915(b)/(c) waiver authority and the program was developed in two phases. The first phase was initiated in 2017 and centered on the provision of health care services through PASSEs. In 2018, care coordination was added for people enrolled in the PASSE and offered to individuals on the state's waiting list. The second phase of implementation added the functions of provider payment and full coordination of services for people enrolled. This phase began in 2020 but was delayed due to the Coronavirus pandemic.

In this model, LTSS and specialty medical providers partnered with traditional MCOs to create the provider-led entities (50.1% provider owned). The premise of the PASSE model is that better case management and care coordination will minimize more costly acute services and its global payment model includes both shared savings and incentive payments for achieving certain quality outcomes. Stakeholders participating in our review for this paper reported the following:

- **Quality**: Some stakeholders reported limited stakeholder input in design of the model. Conflict-free case management is built into the system and case coordinators are required to do at least one contact a month with every individual. This is seen as a positive component of the program. Stakeholders also reported that quality monitoring could be improved and that there needs to be better coordination between the provider and the PASSE. Additionally, some suggested there needs to be more focus on planning and payment processes.

- **Finance**: The PASSEs function on a Per-Member-Per-Month (PMPM) payment system that funds all services provided by the agency. The long-term goal is to implement a shared savings program where providers receive financial incentives for meeting certain quality outcomes. Stakeholders also report that the payment structure is encouraging providers to be more innovative. Case-coordination functions in a risk-based model within the PASSEs. The current day service model (for those who are not eligible for PASSE enrollment) is clinic-based and does not allow for billing and payment of community integration activities. However, the PASSEs can pay for more community integration which provides greater flexibility in service options for people served.

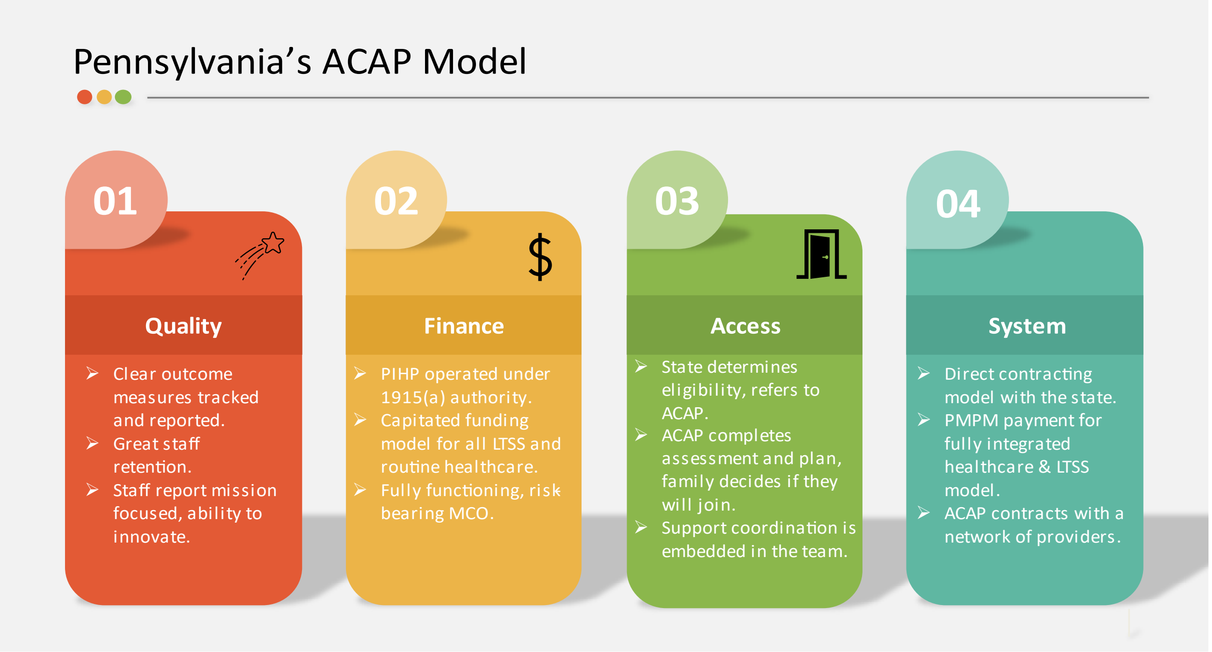
  The claims system is reported to be problematic and some suggested that smoothing out that system in advance of implementation would have helped. The model has been burdensome because of issues with payment and providers may be working with up to three different PASSEs, thereby having to manage increased billing complexities. Originally, the PASSEs adopted the rates that were being paid through the waiver, but they can modify those rates that pay for Home and Community-Based Services and Community Integration Services. Participants report they expect a high degree of transparency in rate setting. The MCOs have agreed to assume most of the financial risk and will keep most of any net revenue.

- **Access**: PASSEs provide wrap around services for those who qualify. This includes primary care, medication/pharmacy, hospitalization, and I/DD LTSS. To qualify for PASSE, a participant must meet an "institutional level of care" and complete an independent assessment. The assessment must achieve a Tier 2 or Tier 3 level of care to be enrolled in the PASSE. If a person meets these criteria, they must be enrolled in the PASSE, they cannot opt out. However, for those who are enrolled, day services are an included service. Participants report that access to service has improved and care-coordination has expanded to reach all individuals on the waiting list. These individuals were assessed and were assigned a care-coordinator; however, it was reported that there were challenges with the state's vendor in completing the assessments and some questioned the assessments' true outcomes.

Additionally, a hybrid provider model was developed with the intention of meeting both behavioral health and I/DD service needs. Participants expressed concern that this may exacerbate the workforce crisis as behavioral health services become increasingly community based. Some are also concerned that these hybrid organizations could lead to mergers and partnerships. The PASSEs will cover all populations served except those residing at state centers. Providers want to move toward flexibility in covered services. Some stakeholders fear the risk of significant service disruption if a PASSE folds as that would present a challenge for others to absorb the case load.

- **System:** The PASSEs are structured as LLCs and are 50.1% provider owned with providers active in governance of the corporation. The structure is set up to monitor that the MCOs do not have too much power and that service provision remains a key focus of the PASSEs. The state provides oversight along with the Department of Insurance (due to the MCO functions). The desired outcomes in phase one include savings and bending the cost curve in Medicaid. In phase two the focus on quality measurement will be addressed. Stakeholders report that having care-coordination has helped and that day service providers are interested in increasing supported employment. Despite a typical goal of a managed LTSS initiative being the maintenance of social determinants of health (SDOH), this is not a current component of the PASSE model. APMs allow for greater flexibility in payment for services as it relates to SDOH which then creates greater access for the individual, yet the PASSEs do not pay for these related services.

Pennsylvania's Adult Community Autism Program (ACAP) Model



Pennsylvania's ACAP Model

01 **Quality**
- Clear outcome measures tracked and reported.
- Great staff retention.
- Staff report mission focused, ability to innovate.

02 **Finance**
- PIHP operated under 1915(a) authority.
- Capitated funding model for all LTSS and routine healthcare.
- Fully functioning, risk bearing MCO.

03 **Access**
- State determines eligibility, refers to ACAP.
- ACAP completes assessment and plan, family decides if they will join.
- Support coordination is embedded in the team.

04 **System**
- Direct contracting model with the state.
- PMPM payment for fully integrated healthcare & LTSS model.
- ACAP contracts with a network of providers.

The Adult Community Autism Program (ACAP) is a provider-led, prepaid inpatient hospital plan (PIHP) which was launched in 2009 and was based on the popular CMS PACE model available across the country to those 55 and older. In Pennsylvania, PACE is known as Living Independence for the Elderly (LIFE), and provides a full continuum of acute, primary, and long-term services to several thousand older Pennsylvanians and Pennsylvanians with disabilities.

The ACAP program currently serves 200 people across four counties in Pennsylvania. The state makes referrals to ACAP, and after the program completes an assessment and program plan, individuals and their families decide if they want to join. This affirmative decision-making process is essential because those who do join the program must give up their prior health care access and providers and enroll in that which is offered by ACAP. Keystone Autism Services, a subsidiary of Keystone Human Services, is the entity that operates ACAP and is responsible for the coordination of comprehensive services including physical and behavioral health, and long-term supports and services (LTSS) to adults over 21 with a diagnosis of autism. Specific services include in home support, vocational, recreational, transportation, social, family support, crisis intervention, behavioral therapy, counseling, and 24-hour residential support in small community-based homes. The 24-hour residential support option serves a small per centage of those enrolled. The vast majority of people in ACAP are served in their own homes. Keystone also functions as the MCO and develops individual service plans through its internal case management function. The integration of case management and comprehensive services including physical health care creates a highly effective clinical treatment and support environment.

Stakeholders participating in our review for this paper reported the following:

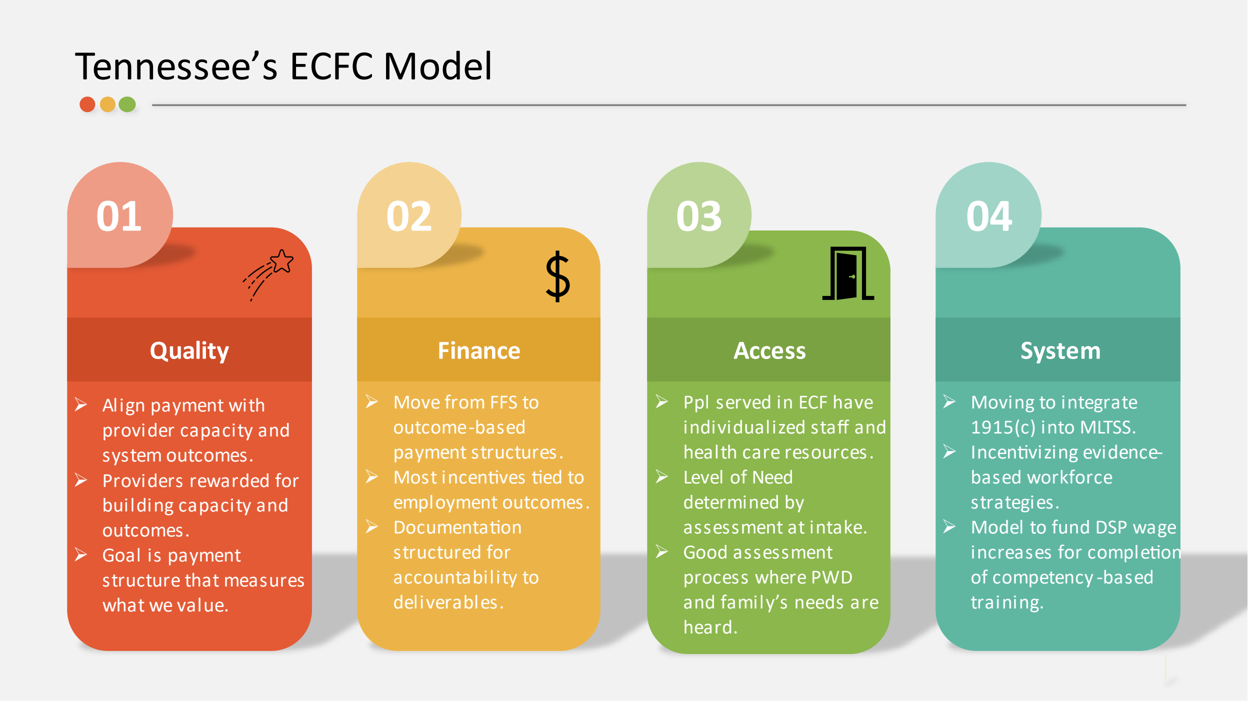
- **Quality**: ACAP has specific outcome measures built into their contract with the state and report meeting and exceeding those measures annually. All reviews are outcome based, measuring an individual's progress in several discrete areas. These outcome measures are compared year over year rather than against an individual's baseline and so are cumulative. ACAP has great retention among staff who report the program is true to its mission, provides great supervision, and offers individualized services rooted in person-centeredness. Staff also report that the model helps them to be innovative! The majority of DSPs have undergraduate degrees. This is not required but incentivized through higher wages because of the financial flexibility of the model. This flexibility also impacts recruitment by providing more attractive wages and benefits than other providers in the region. Also, of note is that the staff with enhanced qualifications are serving people in the community and in their own homes, versus the more traditional congregate residential setting. The program was designed to be community based and structured accordingly through programmatic and fiscal design.

- **Finance**: The program is paid as a Prepaid Inpatient Hospital Plan (PIHP) and operated under a 1915(a) waiver. It is a fully functioning MCO assuming risk across all participants with a capitated funding model which includes all LTSS and routine health care. There is a single per member per month (PMPM) rate that is required by CMS to be actuarily sound. The single PMPM is applied to all enrolled individuals and is set by a third party each year. There is an allowable, combined administrative cost of fifteen percent for the MCO and LTSS with a three percent cap on retained savings. Shared losses and gains run within a 3%-5% risk corridor. Less than seven percent of expenses are on traditional health care costs, allowing the vast majority of the budget to be used on LTSS needs. Additionally, ACAP was not set up under an insurance authority which reduced the set-asides that would have been required. This was a significant bonus to the design of the model but created a lot of risk.

- **Access**: All individuals must meet state eligibility requirements to participate. The state refers eligible people to ACAP, Keystone completes the initial assessments, develops the individual service plan (ISP), offers enrollment and then the person/family decide if they want to join. The assessment determines the services that are offered, and authorizations are based on “medical necessity” as determined by the team. Support Coordination is embedded in the team.

- **System**: ACAP is a full managed care contract. It cannot be overstated the power of integrating the risk function with service delivery within a service corporation. This structure allows the entity to fully manage the resources. In keeping with this model, ACAP has a direct contracting relationship with the state. They receive a per member per month (PMPM) payment and are responsible for all service and care delivery for which ACAP has built a network of providers for niche services, clinical services, medical providers, hospitals, etc. One key consideration reported by some stakeholders is the potential for scalability of the model. The provider is interested in scaling up the model, but there seems to be a lack of political interest and/or system capacity to do so. Some stakeholders appear concerned that there are no regulations governing the program as it is purely contract and outcome driven. Providers acknowledge that the program could be modified if more oversight is desired by the state, however they consistently exceed their annual targets. Finally, stakeholders commented on the flexibility demonstrated by CMS during the program design phase. They highlighted the potential in designing something from scratch rather than modifying a program that already exists.

Tennessee’s Employment and Community First CHOICES (ECFC) Model



Tennessee’s ECFC Model

01 **Quality**
- Align payment with provider capacity and system outcomes.
- Providers rewarded for building capacity and outcomes.
- Goal is payment structure that measures what we value.

02 **Finance**
- Move from FFS to outcome-based payment structures.
- Most incentives tied to employment outcomes.
- Documentation structured for accountability to deliverables.

03 **Access**
- Ppl served in ECF have individualized staff and health care resources.
- Level of Need determined by assessment at intake.
- Good assessment process where PWD and family’s needs are heard.

04 **System**
- Moving to integrate 1915(c) into MLTSS.
- Incentivizing evidence-based workforce strategies.
- Model to fund DSP wage increases for completion of competency-based training.

The Employment and Community First CHOICES (ECFC) program was launched in 2016 and uses managed care to align incentives in order to help people with intellectual and developmental disabilities achieve employment and community living goals with as much independence as possible. Enrollment in ECFC is mandatory for all new HCBS applicants. All of the employment and pre-employment services are reimbursed using value-based payment structures to incentivize competitive integrated employment (CIE). There are fourteen discrete employment and pre-employment services such as Exploration, Discovery and Job Development, which are outcome-based, wherein the payment is received upon completion of the service or deliverable. Employment Start-Up, the explicit purpose of which is to implement an Employment Plan and get the person working is paid when the person actually begins working in CIE, and paid in phases to reinforce stability in the job placement.

In essence, the provider accepts risk by providing the service until the outcome is achieved so payment can be made. In Job Coaching, payment is tiered based on the person’s level of support need and also on the hours of paid support needed as a percentage of hours worked, in order to incentivize fading of paid services and the person’s increased independence and use of enabling technology or natural supports in the work environment. The state’s strategy in developing ECFC VBP was to determine policy goals first, then develop system capacity, then pay for outcomes. They hope to apply a value-based reimbursement structure more broadly (to other service types) but anticipate that this will require incremental change.

The initial stated goals of the ECFC program were to serve more people, including those on the I/DD waiting list for services, to promote competitive integrated employment and community integration, and to improve quality. In this program, the state established preferred contracting standards which favor providers who have experience in providing integrated employment services and implementing person-centered practices. A truly unique component of this program is the state’s goal of advancing comprehensive workforce development among its providers by providing resources and incentivizing staff training and development targets. Stakeholders participating in our review for this paper reported the following:

- **Quality:** One goal of the ECFC program is to implement a value-based purchasing approach that aligns payment with provider capacity and ultimately with individual and system outcomes. It initially incentivizes process compliance, on actions that providers can take such as obtaining organizational accreditations (CQL, APSE, technology first, organizational and QuILTSS for DSPs) to support person-centered approaches, integration of technology, competitive integrated employment, increase independence, and developing a stable and qualified workforce. Providers will be rewarded for building these capacities and the state is currently considering these capacity-building metrics along with outcome metrics. Emphasis is placed on the family and the individual directing their desired supports which in turn allows for greater independence. Additionally, the individual and his or her family can readily change the plan to meet changing needs.

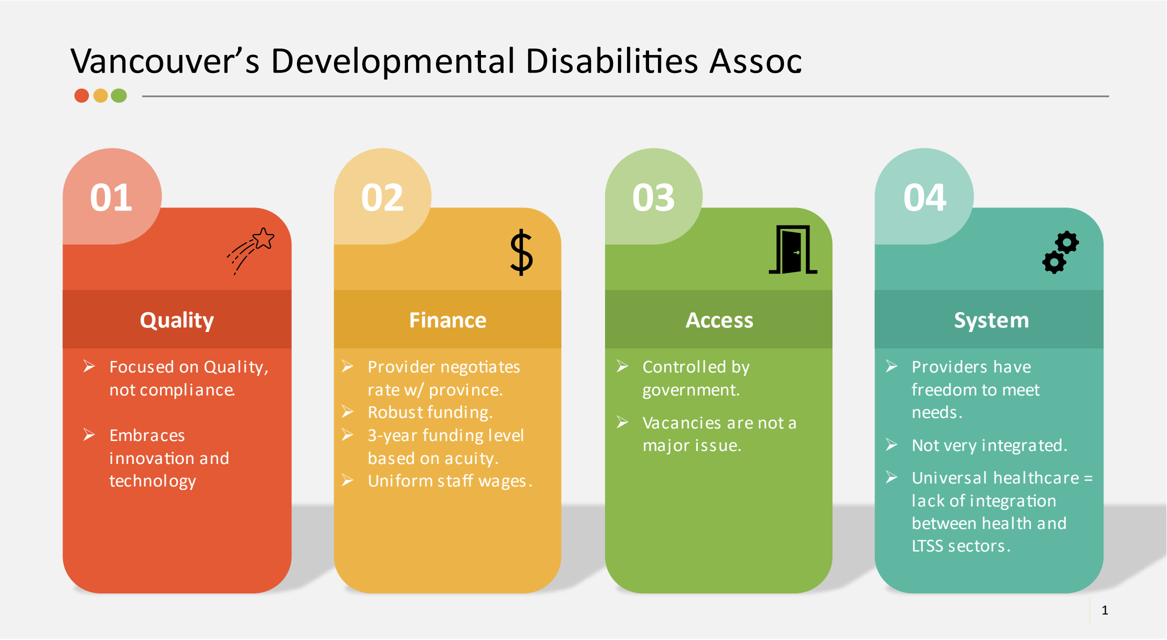
  The state is also focused on incorporating the following credentialing domains: person-centered practices, competitive integrated employment, technology, increased independence, and workforce, and they plan to create a framework that prefers providers who have achieved these credentials. A key focus is on developing a payment structure that “measures what we value”. They recognize that measuring the quality of what matters to people is difficult, but it is more important than quantitative measures alone. They are incorporating Personal Outcome Measures (developed by CQL) and are working with CQL to help define and collect relevant data. They anticipate that providers will need to understand HEDIS measures as they may be used to incentivize providers and improve health outcomes, but the primary focus is on employment, independence, and integration.

- **Finance**: The state believes that most HCBS providers are not able to take on significant risk as they move from fee-for-service to outcome-based payment structures, or value-based purchasing. Most of the current incentives are tied to employment outcomes, but future VBP plans encompass a broader range of measures aligned with system goals. Relative to "deliverables" for outcome-based payments, reporting is needed for accountability to the deliverables rather than simply payment for providing a service. This has proven challenging for some providers.

- **Access**: Most people served in ECFC do not receive full-time support but rather support is provided based on each person's individual needs. This differs from Tennessee's 1915(c) waivers where most people do receive full-time support. Additionally, people in ECFC have access to a full range of medical benefits and may qualify for home health services as appropriate. At the point of intake, a person's level of support need is determined by an assessment completed by a neutral third party (not the state or the MCO). The MCO then gives the same referral to all its available providers thereby ensuring adequate choice for the person seeking service. Stakeholders report there are good assessment processes and that the providers and payers really listen to what the individual and family want. The state also asserts that they need providers of all sizes to meet the varying needs of people served.

- **System**: Tennessee added the ECFC program through an 1115 waiver to allow broader flexibility to drive program outcomes. Today, they still support three 1915(c) waivers, but the goal is to integrate or "carve-in" the remaining LTSS for individuals with I/DD by July 1, 2021. The state is working with the University of Minnesota to collect workforce data over time to drive employee retention strategies and to incentivize evidence-based workforce strategies. They had planned a comprehensive workforce training program to launch in 2020 which would focus on changing how the workforce is trained to have skills needed to support people to live the lives they want. They were also planning to add funding to increase wages for DSPs as they complete levels of competency-based training but lost funding and attention due to the pandemic.

Vancouver, British Columbia's Developmental Disabilities Association Model



Vancouver's Developmental Disabilities Assoc

01 Quality
- Focused on Quality, not compliance.
- Embraces innovation and technology

02 Finance
- Provider negotiates rate w/ province.
- Robust funding.
- 3-year funding level based on acuity.
- Uniform staff wages.

03 Access
- Controlled by government.
- Vacancies are not a major issue.

04 System
- Providers have freedom to meet needs.
- Not very integrated.
- Universal healthcare = lack of integration between health and LTSS sectors.

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Vancouver has for many years operated its I/DD services in such a way that individuals receive annual budgets based on assessed needs which are paid on a per member per month basis. Stakeholders report that this consistent, reliable funding method enables them to focus on quality, person-centered supports and creative services. This flexibility and predictability of funding has enabled providers to invest in the development of technology that fosters independence and access for people with disabilities. Stakeholders participating in our review for this paper reported the following:

- **Quality**: Stakeholders described their system as one that enables providers to be able to focus on quality, not compliance. In Vancouver, the focus on quality creates room for innovation because providers are not using excessive personnel resources on activities of compliance and can instead spend time developing and implementing quality programs. People receiving supports seemed happy and engaged in a positive manner with staff. The professionalism of the DSPs and front-line supervisors was impressive**.** However, one observation was that some of the people in their program did not seem well integrated with other services in the community. Services providers tended to offer mostly in-house supports and were less inclined to access generic community resources.

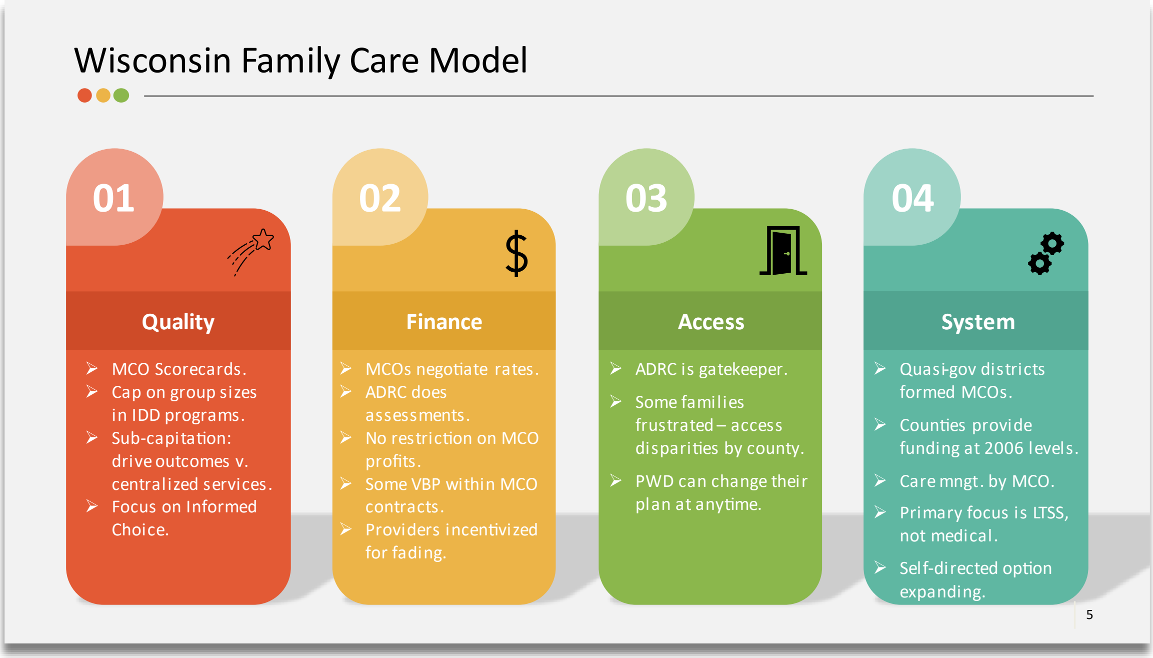
- **Finance:** The financing system in Vancouver appears to be relatively flexible with providers negotiating rates with the province which enables innovation and the ability to provide creative services. Funding generally seemed to be more robust than in the U.S., but providers are regulated on how funding is spent. For example, providers report to the province the hours of staff time provided to each individual. Individual service participants were assessed on acuity/need and a three-year funding plan was developed and administered via a monthly allocation paid to the provider. Additionally, providers may negotiate higher funding if there is a change in acuity or someone's personal situation prior to end of the three-year period which added an enhanced safety net and fostered provider creatively. DSPs seemed more satisfied with their profession and turnover was considerably lower than in the US. Staff wages are uniform due to a province-wide labor agreement.

- **Access:** All referrals are controlled by the government and passed along to providers as needed. Subsequently, vacancies are not a major issue.

- **System:** Providers have a fair amount of freedom resulting in flexibility and creativity, but services appear not as integrated as in the US. The program overall reflects a hybrid between congregate care and community-based services. Lastly, there is a lack of planning for health service integration across medical care and LTSS and may be due to the country's universal health care system. People with I/DD appear to have very few issues of access to health care services and are reported to have the same access as people without disabilities.

Wisconsin's Family Care Model

Wisconsin began its Family Care program for individuals with I/DD, older adults, and people with physical disabilities as a pilot program in 1998 and grew incrementally on a county-by-county basis until state legislation approved statewide expansion in 2015. Enrollment is mandatory for individuals using HCBS, except for a self-directed carve-out.



Wisconsin Family Care Model

01

Quality

- MCO Scorecards.
- Cap on group sizes in IDD programs.
- Sub-capitation: drive outcomes v. centralized services.
- Focus on Informed Choice.

02

Finance

- MCOs negotiate rates.
- ADRC does assessments.
- No restriction on MCO profits.
- Some VBP within MCO contracts.
- Providers incentivized for fading.

03

Access

- ADRC is gatekeeper.
- Some families frustrated – access disparities by county.
- PWD can change their plan at anytime.

04

System

- Quasi-gov districts formed MCOs.
- Counties provide funding at 2006 levels.
- Care mngt. by MCO.
- Primary focus is LTSS, not medical.
- Self-directed option expanding.

Family Care is operated by county-based and regional nonprofit MCOs responsible only for LTSS. Initially, Family Care launched with goals of ending the waiting list, improving access and quality of services, and creating a cost-effective long-term care system. As of this report, the state is on track to eliminate its waiting list by July 2021. Stakeholders participating in our review for this paper reported the following:

- **Quality**: Stakeholders report there is strong state oversight on administration and quality outcomes. The Aging and Disability Resource Centers (ADRC) maintain a “scorecard” on each MCO which is based on outcomes and other quality indicators. However, stakeholders report that improvements are needed to the scorecard process and the information provided. Stakeholders maintained that “informed choice” of participants is critical and the scorecard process helps to ensure that people seeking service have the best information possible to aid in this decision making. Family Care requires a cap on the number of people served in a group setting which applies to the I/DD services only (this cap does not apply to elders and people with physical disabilities whose services are also coordinated by the MCO). Some stakeholders suggested that sub-capitation to a specific service provider can help drive outcomes, but state representatives expressed that they see pros and cons when the MCO sub-capitates to only one provider for both community and residential services. Care plans are reviewed at least every six months.

- **Finance:** With the expansion of Family Care, the state has seen a 20% cost differential in managed care costs versus the old county-run waivers. In the Family Care structure, MCOs receive capitated payments based on an actuarily sound rate setting model and they negotiate the rates (for most programs) within a “rate range.” The ADRCs screen for eligibility, and assess attributes and costs associated with an individual’s needs. They then calculate an individual rate within the rate range. There is no restriction on how much profit an MCO can keep, and MCOs receive a small administrative percentage of 5%.

However, MCOs are expected to manage care and costs by using the Resource Allocation Decision Model to ensure authorized care and services meet member needs and are cost-effective. Some stakeholders reported that the MCO system has a lot of problems. Specifically, that rates do not keep up with service costs, particularly as an individual's need for services change. Additionally, some MCOs use value-based purchasing within their provider contracts. In these programs, as an individual need less support, the rate stays the same and the provider is rewarded for fading support. In some contracts there may also be bonuses available to providers "in good standing." Providers may also be incentivized with pay-for-performance enhancements, and reporting quality.

- **Access**: The ADRC is the gatekeeper and is run by the counties. They are the point of entry for aging and disability services and organized on a county basis with a couple exceptions. As part of the Family Care program, the state gave the ADRCs target numbers of people who could be taken off waitlist once transition to the new model started. The goal was to have eliminated the waiting list by February 2021, but likely not to be completed until July 2021 (we think that's still a remarkable accomplishment!).

  Some family stakeholders reported frustration with the new system, having been satisfied with their prior services. In the Family Care model, they had to transition to a new, and in their opinion, unknown system. In the former model, counties were very flexible, and families really liked this. Additionally, it was noted that "family frustration" varies from county-to-county based on different variables like waiting lists or service delivery. A clear benefit of the new model is that people can go back to the ADRC and change their program at any time and the addition of technology can be included in an individual's care plan.

- **System:** In 1998, the state-initiated activities to end their waiting list. They began to transition toward managed care as the vehicle to accomplish this goal and in 2000 formed the Family Care Program. The program was organized into quasi-government districts, with non-profit MCOs coordinating services. Counties had previously been the lead and were responsible to contribute funding for services Over time, counties continued to contribute funding toward the waiver match but at a static rate and the state picked up a growing percentage of the necessary funding. Through the Family Care model, MCOs can negotiate rates more effectively than individual counties could previously and are able to move people out of ICFs and nursing homes to more cost-effective, community-based alternatives as appropriate or desired. Some stakeholders feel that the Family Care model is "very prescriptive". For people with I/DD, the medical component is secondary to the long-term supports and services which is the primary focus or goal. In 2008, the state developed a self-directed service option as an alternative to participation in managed care which they call "IRIS." The IRIS program develops individual budgets and works with a consultant agency to set rates.

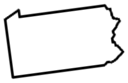
Key Features of Existing Models: What Should Be Included?

Arkansas

- Moving toward a shared savings model, and shared savings on Emergency Room diversion
- Actuarily sound rates with incentives for quality
- Expanded access to services
- Care-coordination service expanded to all individuals on the waiting lists, managing upstream

- Moving toward flexibility in covered services
- 50.1% provider owned and providers active in governance
- Increasing supported employment services
- Intended focus is to implement pay for performance, shared savings
- Involved stakeholders, families
- Actively involved Medicaid director

Pennsylvania



- Accountability is contract-based and criteria for success is based on individual outcomes
- Measuring reductions of problematic behavior in several discrete areas and increases of positive behavior in other areas
- Experiences high retention among staff; staff report program is true to its mission
- Program rooted in person-centeredness; model helps staff to be innovative
- Support coordination is embedded in the team
- PIHP does not require conflict-free case management (unlike the requirements found in HCBS programs) but the agency must demonstrate accountability between the health care and LTSS components
- Direct contracting model with the state—disintermediated structure provides potential for the greatest degree of flexibility, shared savings and shared risk
- Receives a PMPM payment and is responsible for all health care and LTSS

Tennessee

- Align payment with provider capacity and ultimately with individuals and system outcomes
- Providers will be rewarded for building these capacities
- Looking at outcome metrics
- Develop sophistication in electronic medical records
- Streamline documentation
- Goal is payment structure that measures what we value
- Individuals can readily change their plan
- Current incentives are tied to employment outcomes and CIE
- Looking to incentivize evidence-based workforce strategies and partnership with University of Minnesota to collect workforce and overtime data to drive improvement
- Planned a comprehensive workforce training program, changing how they train the workforce
- Added funding to increase wages for DSPs as they complete levels of competency-based training

Vancouver, British Columbia

- Providers have space to focus on quality, not compliance
- Innovation is key
- Providers negotiate rates with the Province and negotiate additional funding for an individual, if needed
- Individuals are assessed on acuity/need for a three-year funding cycle which is administered via a monthly allocation
- Finding ways for providers to assure value/quality while minimizing focus on compliance

- Providers and individuals are able to leverage technology to improve the quality of the individual's life experience
- DSPs seemed more satisfied with their profession and turnover was considerably lower than in the US

Wisconsin

- Aging and Disability Resource Center (ADRC) keeps scorecard on each MCO and is based on outcomes and other quality indicators
- System allows MCOs sub-capitation to a provider
- Informed choice is critical
- Negotiated rates (for most programs) within a "rate range"
- As individuals need less support, rate stays the same—provider is rewarded for fading
- Target numbers of people who could be taken off waiting list once transition started
- Individual can go back to ADRC and change their program at any time
- Technology can be included in an individual's care plan
- As of December 2020, there were 23,172 people with I/DD enrolled in Family Care and a total of 50,771 in the program overall[2]

Identification of Key Components

As ANCOR's Alternate Payment Model work group spent time visiting the five selected programs, hearing from stakeholders including state authorities, people served and their families, and provider members and staff, several clear themes resonated and were identified by the work group as promising practices. Conversely, an equal number of caveats emerged and were identified as variables to be avoided or planned for if unavoidable. With consideration of an array of program components, ANCOR is proposing the following key elements for inclusion in potential state pilot projects.

Key Component: Quality Outcomes

A key component that the successful APM projects demonstrate is measurable quality outcomes that are person-centered and drive toward greater independence and community involvement. Specifically, we heard examples of this from the ACAP program in Pennsylvania and the ECFC program in Tennessee. Both programs, while very different in their structure, can demonstrate measurable, positive outcomes. ECFC rewards providers with financial incentives for employment outcomes and ACAP has a shared savings methodology with guardrails to ensure quality is not sacrificed for savings.

One key concern we have regarding the ECFC model is that providers are only paid when a person is employed. We believe there needs to be a base payment rate with quality incentive as an add-on. Many providers do not have the capital to maintain organizational infrastructure while waiting for the end-result payment. This practice is likely to put significant strain on the provider. Additionally, there is concern that this structure may lead to "cherry picking" referrals that are easier to support and negatively impact providers who are working with people with higher acuity and increased support needs.

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[2] *Family Care, Family Care Partnership and Pace Enrollment Data* (Madison: Wisconsin Department of Health Services, 2020).

In a recent study by CQL, it was demonstrated that people with I/DD who experience continuity and security, and who participate in the life of the community, have dramatically lower rates of emergency department utilization.[3] This suggests that person-centered outcomes lead to better health outcomes.

One consideration, however, is that there is not one widely agreed-upon set of quality measures that address life outcomes and satisfaction. These variables are more subjective than health-related quality outcomes and many of the available measure sets are focused on process outcomes, not individuals' quality of life indicators. There are a few that have increasing recognition in this sector such as the Personal Outcomes Measures (POMs) by CQL and in 2020, the Medicaid & CHIP program released a draft of a voluntary measure set and requested public feedback. ANCOR's feedback regarding shortcomings of the proposed set was aligned with that of other groups and identified:

- The need to focus on person-centeredness and personal preferences and satisfaction more strongly.
- A reliance on measures which reflect the health of the system and not on recommended measures like autonomy, sense of belonging and self-determination.
- The need for I/DD-specific measures.
- The need to ensure that base payments are sufficient and reliable, and that payment incentives do not substitute for adequate base rates.
- That measures should minimize reporting burdens on providers.
- That measures should consider variation in providers' ability to report.
- The need to move toward a small but mandatory set of core measures.[4]

For the advancement of quality measures, we recommend a greater focus on quality as defined by the impact on the individual with I/DD and/or the population served by the APM. There must be a greater focus on person-centered outcomes and less of a focus on process.

Key Component: Integrated Care Over the Lifespan

Community-based I/DD services is a unique sector of Medicaid services overall. It is unlike all other Medicaid-funded services as people with I/DD can spend their entire life in one phase of service or another. Those served are unlike other populations in that they generally do not move in and out of services. They receive life-long service, and continuity for the individual requires service organizations to operate with a deep value-base and an enduring long-term perspective.

The APM should consider the whole person and ensure that both physical health and overall wellbeing are addressed in a comprehensive plan. This model will improve the coordination and integration of physical health with LTSS, behavioral health and social support needs.

Additionally, an integrated team this is led by providers and includes team members who have experience and expertise supporting individuals who have complex needs will be focused on all aspects of a person's life. The ACAP model demonstrates that when the coordinating entity is responsible for maintaining optimal health and ensuring that the person's daily needs are met; quality outcomes are

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[3] Carli Friedman, "Managed Care and Value-Based Payment: The Relationship Between Quality-of-Life Outcomes and Emergency Room Utilization." *Intellectual and Developmental Disabilities, 59*(1), 22-38.

[4] *Request for Information: Recommended Measure Set for Medicaid-Funded Home and Community-Based Services* (Alexandria, VA: ANCOR, 2020).

consistently achieved. While a focus on individual outcomes is optimal, it can present challenges in attempts to aggregate regionally, statewide or nationally because of a relatively small sample size that has a high degree of variability among acuity, individual needs and supports, desired outcomes, natural supports, etc.

Part of this paradigm includes ensuring there is a strong assessment process in which the participant's needs are clearly identified and accounted for in their service plan. In addition to such an assessment, there is a clear need for data systems to support monitoring and measurement.

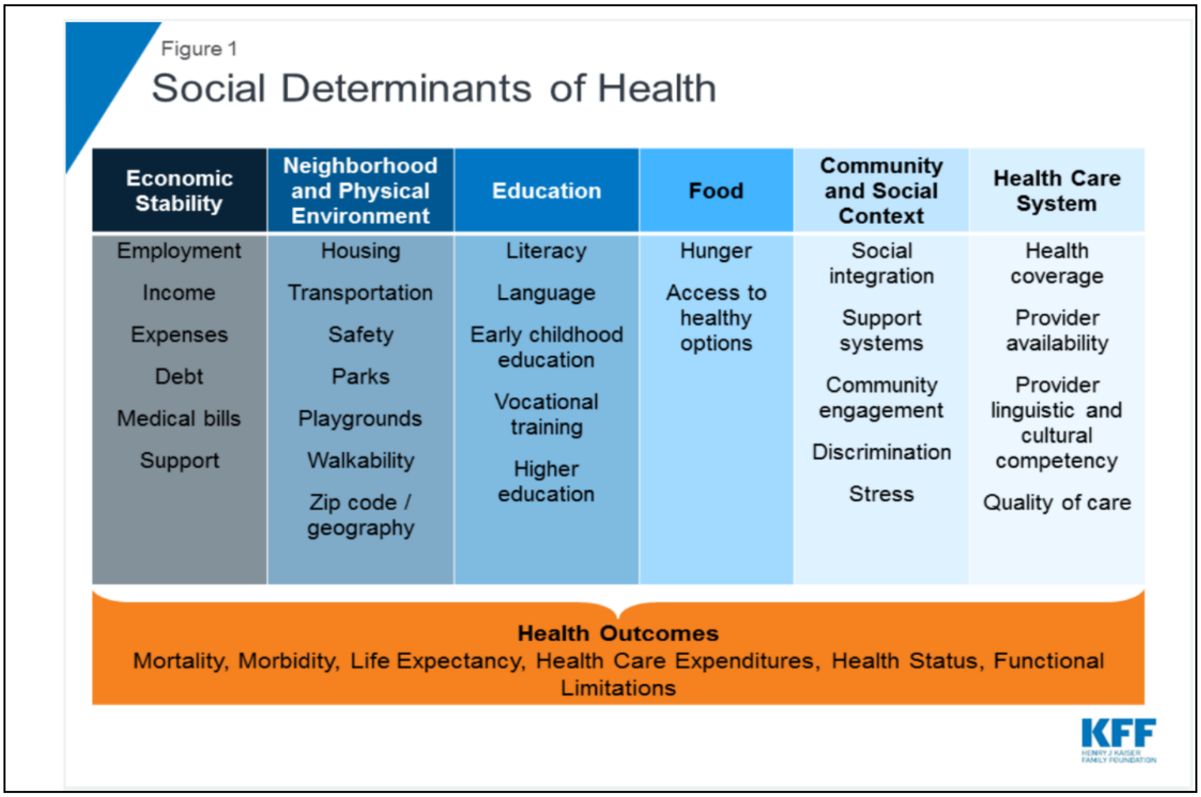

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability Zip code / geography	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination Stress	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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HENRY J KAISER FAMILY FOUNDATION

Among these systems is the inclusion of an electronic health record that is accessible by all members of the team to facilitate coordination of service and seamlessly integrate data collection on the outcomes metrics identified. Participants expressed the need to clearly define the data to be collected and how it will be used. The key element of integrated care is the inclusion of social determinants of health (SDOH). It is also essential that the program provides resources and supports for ensuring that SDOHs are incorporated and met within the design of the plan. It is through the inclusion of this framework that care becomes truly integrated and quality outcomes are achieved.[5]

Key Component: Value-based Contracting & Shared Risk

A key focus of the Centers for Medicare & Medicaid Services is the incorporation of "value-based care" (VBC) in states' contracts with providers and MCOs. In a 2020 letter to state Medicaid directors, CMS outlined the array of available waivers states can access to include VBC practices grounded in value-based purchasing. In its opening, CMS said, "Value-Based Care seeks to hold providers accountable for

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[5] *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity* (San Francisco, CA: Kaiser Family Foundation, 2018).

providing high-quality care and can also be a part of the solution to reduce health disparities in the health care system."[6]

The letter expresses support for flexible approaches to system transformation and identifies these key components:

- Moving from fee-for-service toward value-based payments
- Shared savings
- Upside and downside risk through a shared loss critical for aligning financial incentives
- Total cost of care approaches prioritizing results vs. individual billable services
- Medicaid goals that 15% of health care payments will be tied to two-sided risk arrangements by 2020 and increasing to 50% by 2025

From our conversations with representatives from the five APMs studied there was consensus that there needs to be a balance between quality and compliance. DDA in Vancouver spoke specifically about the need for this balance and that when it is achieved, individual and family satisfaction is high, provider creativity and innovation is optimized, and staff turnover is greatly decreased.

Also of concern is the possibility that providers will be required to take on downside risk or that VBP arrangements will include a withhold of funds pending achievement of a predetermined benchmark, such as in the case of Tennessee's ECF CHOICES model. In this model providers only get paid when they achieve the employment outcome for an individual. There is no base payment rate that supports essential operations. At the core of these concerns is the reality that providers have been underfunded for years and do not have the financial strength to withstand a withhold of operating revenue nor could they absorb losses driven by downside risk. It is more realistic to ensure that providers are paid a base rate to cover their cost of delivering a service, with the potential for enhanced payments for achievement of predetermined, specific outcomes.

Another consideration when developing an APM that includes provider control or governance is the number of very small providers who will not likely have the internal resources to manage in the new operating environment. These providers will need education on APM requirements and support to shift their service model from caregiving to outcome-based services. It is a concern that a number of these organizations may not withstand the transition.

Key Component: Individual Control & Access

One message that came through clearly from the participating stakeholders is the desire for individuals and their families to have the maximum amount of control possible. They want to know that their needs are recognized and represented in their care plans and that they can make changes as their life situations warrant.

In addition to individual control, expanded access to services was a key metric in Arkansas and Wisconsin. Both states identified the outcome of reducing their waiting list as a primary goal of their APM program. In Wisconsin, the ADRCs were incentivized to make the transition to the new MCO-led service system with the promise of additional state funding and the ability to expand the ADRCs' caseloads until such time as the waiting list is vacated. Similarly, Arkansas expanded access to care coordination to people on

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[6] *Federal Policy Guidance: Value-Based Care Opportunities in Medicaid* (Baltimore, MD: Centers for Medicare & Medicaid Services, 2020).

their waiting list while the program was being implemented and are expanding supported employment services and centralizing care-coordination in the PASSEs.

Embedded in this key component of an APM is the need for flexibility. Stakeholders spoke about the importance of this and how it enables services to be more person-centered. For example, Wisconsin stakeholders spoke about an individual's ability to modify their plan throughout the year and staff from ACAP spoke about how their model's flexibility enables them to easily pivot to support someone in unexpected and creative ways. DDA in Vancouver described similar flexibility afforded them through the structure of a PMPM. This assures dependable revenue for the service organization and avoids the need to chase volume over value. This flexibility has helped them unleash their creativity and provide individuals with the ability to choose their daily activities from an extensive menu of options.

Additionally, we recognize that through the advances of technology, we are better able to ensure individuals have increasing control over their lives. Through technology and innovation, there are countless ways a person's autonomy can be enhanced through both high-tech and low-tech solutions to daily life activities management. We urge stakeholders to ensure access to and inclusion of these strategies in alternative payment model design.

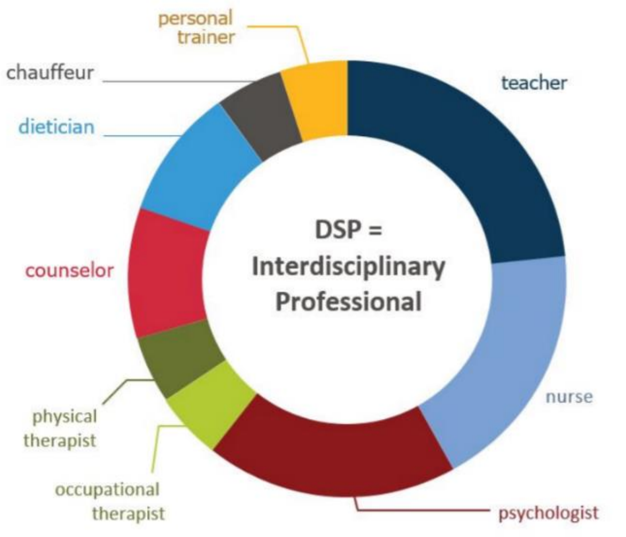
Key Component: Effective Use of Resources

In 2017 President's Committee for People with Intellectual Disabilities issued a report entitled *America's Direct Support Workforce Crisis: Effects on People with Intellectual Disabilities, Families, Communities and the U.S. Economy*. This report illustrated the growing need for direct support professionals and the critical role they play in the supports for and successes of people with I/DD.

The report illustrated the varied scope of practice [Figure 1] and made the case that "low wages, scant benefits, limited training and lack of career advancement opportunities have led over the past 30 years to the following nationwide results:

- Average DSP wages of $10.72 per hour
- Average DSP wages below the federal poverty level for a family of four
- Half of DSPs relying on government-funded and means-tested benefits
- Most DSPs working two or three jobs
- Average annual DSP turnover rates of 45 percent (range 18–76 percent)
- Average vacancy rates of more than 9 percent."[7]

Figure 1. DSP Scope of Practice



It is apparent that there are limited fiscal and personnel resources to meet the growing need for home and community-based services. Current data suggests that demand will continue to outpace investments

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[7] Report to the President 2017: America's Direct Support Workforce Crisis (Washington, DC: President's Committee for People with Intellectual Disabilities, 2018).

for the foreseeable future. The Institute for Community Inclusion at the University of Minnesota suggests that there were an estimated 1.3 million people working as DSPs in 2013 and that 574,200 new DSPs need to be hired into the workforce each year to accommodate current levels of turnover. They also projected that and additional 167,001 new DSPs would need to be hired to accommodate the 200,000 people on states' waiting lists for services. They asserted that, "Given the rising growth in demand and need, the persistent turnover rates, and a strong U.S. economy, the number of new DSPs that will need to enter the workforce is expected to grow each year between now and 2030."[8]

As we strive to address these issues, we see alternative payment models as a key component to building a more stable infrastructure where people with disabilities have control of their lives, receive person-centered services, and maintain access to robust supports from an array of natural and paid sources.

Part of the solution rests on building a more stable and qualified workforce. We see the flexibility inherent in the promising practices outlined herein as a key component. We must also consider how technology can support our workforce and even reduce the number of needed staff in a given circumstance. As we are able to provide better wages, coupled with enhanced training and ongoing support, we will deepen the skill level of our workforce and enhance their autonomy and job satisfaction. Through a structured payment model, we will be able to reinvest in the workforce and technology, have greater ability to impact DSP payrates, and as we stabilize our workforce, we will have a greater ability to reduce waiting lists. Without stabilizing our workforce, we will not be able to meet the growing demand for services.

Finally, we have only begun to scratch the surface of those advancements and economies that can be achieved through the inclusion of technology—for use by people with disabilities to increase their independence and for use by caregivers to reduce the reliance of "eyes on" supports. We believe the ability to implement these promising practices are at our fingertips and will be enabled through the advancement of alternative payment models.

Characteristics of Successful Models

We recognize that change is coming to this sector and we strive to help shape it through collaborative and creative initiatives with stakeholders. In this paper we have reviewed an array of promising practices and believe that a service delivery system which is person-centered, flexible, and achieves greater stability for all involved is possible. We recognize that APMs structured with these components can work for everyone and can lead to improved outcomes for individuals, organizations, and the overarching system.

APMs that advance these outcomes are characterized by:

- Accountability to an **effective use of public resources**, with the ability to provide the same opportunities to people served as is afforded the general population, and the assurance of optimal outcomes for people served.

- **Payment structures** that reimburse providers for their cost to deliver services, reduce administrative burdens, include the opportunity to earn quality incentives and thus incentivize

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[8] "Direct Support Workforce," *Institute on Community Integration, University of Minnesota*, accessed May 18, 2021.

value over volume. Moving away from a fee-for-service architecture will encourage provider creativity, shared responsibility, and ability to share risk.

- Models that ensure stakeholder **choice and control***,* including a role in governance, and enhance the system's accountability for the effective use of public resources to optimize outcomes for people with I/DD.

- Service organizations that are valued for their **unique expertise** in supporting people with I/DD and are key partners in collaboration with other stakeholders. We have seen numerous examples of how commercial managed care does not include I/DD-centric expertise. In these instances, the core values driving this sector are jeopardized. I/DD service organizations ensure the fundamental values associated with providing a life-long service are maintained and that the interpersonal relationships which have formed over years of service are honored. This experience is somewhat unique to this sector.

- Designs that do not necessitate a commercial MCO model to be successful. **Private-public partnerships** can be at least as successful as can integrated models with service providers leading design and development initiatives. There needs to be people in these decision-making roles that understand individuals with developmental disabilities, lifespan care, the importance of community integration, and the role that community-based organizations play in acquisition/maintenance of social determinants of health.

- **Enhanced use of technology** to support independence in people's daily lives, and to support/supplant direct support staff thereby, allowing for greater privacy for an individual and reducing the amount of time support staff have "eyes on" a person. This dual path for technology will significantly alter the current landscape of service delivery.

- **Measurable and person-centered outcomes** that evaluate individual satisfaction and attainment of personal goals, organizational innovation and performance, and system accessibility and accountability. Additionally, incentives for achieving quality outcomes can be embedded in the model design.

- The opportunity for providers to form collaboratives or coalitions to enable **economies of scale, shared resources, and shared risk.**

- **Pilot projects** that are designed for scalability, broader application and replication.

- Models that offer **full integration** of health care and long-term services and supports over a person's lifespan to drive more robust outcomes for the whole person and accountability for the providers. Where we have seen fully integrated models, there has been consistent achievement of outcomes, cost savings, enhanced satisfaction and reduced staff turnover. These models appear to offer the greatest degree of flexibility and accountability and will play a pivotal role in future model design.

Conclusion

We envision these emerging models will continue to expand in prevalence and design as states continue to look for ways to streamline systems and improve outcomes. ANCOR is among the preeminent thought leaders in alternative payment models in support of our members and people with I/DD, and we will continue to promote the key components and recommendations identified throughout this paper. As these systems evolve, we must ensure that they are aligned with the core values of this sector and we are committed to open, iterative work wherein we learn as we progress, redesign systems from what we are learning, and apply best practices.

We believe that alternative payment models are the best path forward in creating a more sustainable service system. We value partnership in our work generally but especially on this project and ANCOR looks forward to working with state provider associations, states and federal offices to implement, pilot and evaluate new models in partnership with all stakeholders.

Appendix A: ANCOR's APM Recommendations

Based on our assessment of 10 existing APMs for I/DD services, a review of analyses and literature on alternate payment approaches, and discussion with key experts from CMS and organizations that represent state officials, ANCOR makes the following recommendations on APMs for individuals with I/DD.

1. Specific value-based payment approaches should be developed to incentivize the delivery of desired lifelong outcomes for people with I/DD. Value-based payments can increase quality and efficiency. In contrast to FFS payments, APMs reward quality and value over volume. Cost savings are difficult to achieve with services for the I/DD population, and should not be a primary motivating factor behind APM development.

2. To promote outcomes, efficiency, and flexibility in service delivery, models should move toward risk-based and/or global payments to providers at a measured pace and with robust risk adjustment. Risk can encourage innovation, coordination, and efficiency better than existing FFS arrangements. But providers have small margins and low rates, and the consequences of inappropriate risk adjustment are significant for providers and people with I/DD.

3. For APMs to be successful, significant advances in measuring quality and outcomes for people with I/DD are needed. In initial stages, tying value to measures used for CQL accreditation is an example of an approach to explore. The success of APMs in meeting the needs of individuals with I/DD and promoting their health, independence, and well-being will depend on the measures of progress to which they are tied. However, currently quality measures exist to only a limited extent.

4. APMs should maintain access to necessary services and promote continuity and stability for individuals, families, and providers. People with I/DD are best served by providers who understand them as individuals and their families and make a long-term commitment to advancing their health, lifetime needs, and life goals (rather than entering and exiting the market frequently).

5. APMs should foster integration of physical health, behavioral, and LTSS and support coordination of I/DD services led by providers/interdisciplinary care teams who have experience and expertise with individuals' needs. People are better served when their services are coordinated; coordination also promotes efficiency in service delivery.

6. APMs should reduce administrative burdens, administrative layers and promote flexibility in service provision while maintaining accountability and sound stewardship of public dollars. Small, timed increments for billing are burdensome, inefficient, and do not promote self-determination or provider accountability; layering intermediaries between the state as payer and providers can be inefficient.

7. APMs should incentivize technology to promote a more efficient service delivery system and a sustainable workforce. High rates of worker turnover are a barrier to the delivery of quality services. Savings that occur through the use of technology under APMs should be reinvested to promote recruitment and retention of DSPs, reduction of waiting lists, and further advances in technology at the payer, provider and individual level.

8. APMs should promote person-centered planning and opportunities for individual choice and control in service provision and accelerate progress toward greater community integration. APMs should support key goals of individuals and their families. Provider resources and capacities can be deployed to promote self-direction.

9. Payment models for LTSS should continue to move toward fostering independence, individual well-being, and community integration. They should encompass medical services but not impose a medical model. The role of LTSS HCBS as social determinants of health needs to be analyzed and better understood. Although medical services are important for this population, the needs of and services for people with I/DD exceed the boundaries of a medical model.

10. APMs should be overseen with a diverse governance model that actively involves individuals, families, providers and state/county governments. Regardless of APM approach, a state oversight role remains important. To support success, safety and well-being, family involvement, individual self-advocacy and governance are important.

11. The transition to new models should not be rushed. Models should be developed with transparent, iterative processes. The consequences of moving too fast are significant and range from placing individuals at risk and provider dislocation to undermining broader system goals for promoting community integration. The speed of some recent managed care transitions has created significant disruption and compromised quality of care. CMS' LTSS transition principles may also inform the appropriate speed of transition for APMs.

12. Models should be responsive to individuals' changing needs and ensure access to necessary LTSS services across the lifespan. People with I/DD have LTSS needs resulting from a range of conditions and often require a lifetime of services. Their specific needs will evolve over time, as the population ages and as new health and public health challenges emerge. Evidenced-based best practices need to be studied and promulgated to result in better outcomes and a better experience of care for individuals.

13. Efforts to further engage providers and other stakeholders in this process should continue. Despite limited experience with APMs in LTSS, the number of APMs is likely to grow in the future. Community providers along with other stakeholders should be continuously engaged in the development and implementation of APMs.

Appendix B: Stakeholder Participants by State

State/Jurisdiction	Stakeholder Participant	Organization
National	Donna Martin	ANCOR
	Barbara Merrill	
	Arun Natarajan	U.S. Administration for Community Living
Arkansas	Jason Miller	Summit PASSE / Anthem
	Melissa Stone	Arkansas Department of Human Services
	Paula Stone	
	John Ryan	Arkansas Total Care PASSE / Centene
	Jack Keathley	Birch Tree Communities
	Ruth Allison	Mid-South Health Systems - BH Provider
	John Neumeier	Practice Plus / Baptist Hospital
	Robert Slattery	Empower (Beacon Health) PASSE
	Craig Cloud	Friendship Community Care
	Katie Baker	
	Doug Freeman	
	Cindy Mahan	
	Robert Wright	Quapaw House
Illinois	Kathy Carmody	Institute on Public Policy for People with Disabilities
Maine	Bonnie-Jean Brooks	OHI
	Victoria LaBelle	
Minnesota	George Klauser	Altair ACO / Lutheran Social Services of Minnesota
	Ken Bence	ARRM
	Stacy Roe	Mains'l Services, Inc.
New York	Robert Budd	Family Residences & Essential Enterprises
	Cathy Varano	New York Alliance for Inclusion & Innovation
	Daniel Brown	Racker Centers
Ohio	Debbie Jenkins	Ohio Health Care Association
	Pete Van Runkle	
Pennsylvania	Terry McNelis	Merakey
	Megan Brodsky	Access Services
	Susan Steege	
	Chris Elliott	Barber National Institute
	Carrie Kontis	
	Brian Smith	
	Jessica Colarette	CADES
	Dave Wyher	Delta Community Supports
	Stephen Bruce	Devereux Advanced Behavioral Health
	Beverly Keep	Erie Homes for Children and Adults

Pennsylvania (cont.)	Debra Niland	
	Shannon Weber	
	Rachel Murphy	InVision Human Services
	Shawn Ryan	
	Ruth Siegfried	
	Clara Thompson	JEVS Human Services
	Bob Baker	Keystone Human Services
	Stacy Buchmann	
	Julie Rizzo	
	Kim Siegfried	
	Charles Sweeder	
	Kim Sonafelt	Mainstay Life Services
	Thomas McDermott	Martha Lloyd Community Services
	Thomas Crofcheck	Melmark, Inc.
	Lisa Gavin	Merakey
	Mark Davis	PAR
	Rebekah Glick	
	Ilana Gruber	
	Lisa Mathis	
	Zachery Senft	Passavant
	Kristin Ahrens	Pennsylvania Office of Developmental Programs
	Lisa Gaylor	
	Stacy Nonnemac	
	Nina Wall	
	Patricia Parisi	SPIN
	Crisane Cook	SUNCOM Industries, Inc.
	William Harriger	Verland Foundation
	Kristen Farry	Woods Services
	Tine Hansen-Turton	
	Elizabeth Hayden	
Tennessee	Brian Dion	Community Options, Inc.
	Brandy Dix	
	Meika McClendon	
	Allison Bender	Enrich for Life
	Betty Ammons	Shelby Residential and Vocational Services
	Aseri Cook	
	Alyson Edwards	
	Denetris Grandberry	
	Tyler Hampton	
	Adrian Walker	

Tennessee (cont.)	Michell Gray	State legislator
	Missy Irvin	State legislator
	Patti Killingsworth	TennCare
	Jordan Allen	Tennessee Department of Intellectual & Developmental Disabilities
	Robin Atwood	TNCO
Vancouver, BC	Alanna Hendren	Developmental Disability Association Vancouver
	Danielle White	
Wisconsin	Jennifer Fishcer	Aging and Disability Resource Center of Dane County
	Paul Yochum	
	Tim Garrity	Inclusa, Inc.
	Mark Hilliker	
	Curtis Cunningham	Wisconsin Department of Health Services
	Christine See	