Value Over Volume: Payment Reform Pilots in Community I/DD Services

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Executive Summary

In 2019, ANCOR released *Advancing Value & Quality in Medicaid Service Delivery for Individuals with Intellectual & Developmental Disabilities*, our first white paper to examine the need for payment reforms in the Medicaid-funded system of services for people with intellectual and developmental disabilities (I/DD).[1] This work centered on the recognition that the current fee-for-service payment methodology was not sustainable given growing demand for services and relatively stagnant payment rates for providers.

As part of that initial white paper, ANCOR posited 14 principles for payment reform centered on the provision of quality services, choice and control for the people supported, flexibility, and stability. Together, those principles revealed that an alternative payment model should be geared toward achieving maximum impact for the most efficient cost. Striking this balance is, of course, both art and science—a delicate balancing act encompassing sometimes difficult conversations about the relative value of certain interventions or services.

Within this framework, alternative payment models, or APMs, need to emphasize that the impact on people is the most critical element—with cost efficiencies a consideration. To be successful, APMs must work for the individuals supported, their families, providers, and government.

With these principles in mind, ANCOR set out to evaluate five examples of emerging APM programs to derive best practices in the delivery of services funded under such models. Over the course of two years, we met with people with disabilities, families, funders, providers, and direct support professionals (DSPs) to learn about system effectiveness, funding stability, funding flexibility, satisfaction with services, and sustainability. Through interviews and program observations, we evaluated each emerging model within four key dimensions: Quality, Access, Finance, and System Integrity. These evaluations are highlighted in our second APM white paper, *Improving Lives, Ensuring Sustainability: Implementing Alternative Payment Models in I/DD Service Delivery*, which we issued in 2021.[2]

Following those evaluations, ANCOR's study group wanted to investigate how each of the key models had fared as we emerged from the COVID-19 pandemic. Were they able to withstand the pressures of the pandemic and emerge just as strong, if not stronger, than they were in 2021? Were the models growing or gaining traction? How were stakeholders feeling about the models after the pandemic became a more normal element of our ways of life?

The study group set out to answer these questions by reviewing all five models in the summer of 2022. As with previous reviews, we met with a wide array of stakeholders, took extensive notes that we then offered to all parties involved to assure fidelity, and documented findings of those characteristics that were consistent with our original Principles for Payment Reform. This publication is an overview of these findings.

Community Providers' Principles for Payment Reforms

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 take into account the complex array of services and the unique challenges associated with community-based services. 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 and 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.

Findings

As was to be expected, we found over the course of our study that there were qualities of each model that we would recommend as they align with our Principles for Payment Reform. We also identified components of each model that were less effective at moving the organization or system toward its goals and thus should be avoided. However, there was not one single model we would recommend in total.

The model features we most liked trend around eight key concepts and would be considered "non-negotiables" were we to design our ideal APM. These include (1) access to services, (2) individualized budgets, (3) availability of "in lieu of" services, (4) partnership between payers and providers, (5) system structures that motivate the use of technology, (6) flexibility that contributes to staff satisfaction, (7) a clear, multidisciplinary approach, and (8) emphasis on quality outcomes and personal satisfaction.

Access to Services

Since the dawn of the COVID-19 pandemic, we have seen a significant decrease in the availability of ready and willing providers with the resources to meet the needs of the people with I/DD in their communities. This, coupled with severe workforce shortages that have plagued our field for decades, has resulted in diminished access to services that should otherwise be guaranteed in the Medicaid program. For example, in *The State of America's Direct Support Workforce Crisis 2022*, ANCOR found that challenges related to recruitment and retention of DSPs have been long-standing but are now reaching catastrophic levels thanks to the pandemic.[3] This in turn is affecting access to services for many individuals with disabilities, particularly those with more significant support needs.

In two of the models we studied, families and individuals said accessing support programs has been a challenge. They cited waiting lists, limited choice of services and limited availability of providers once approved for services. In an effort to mitigate these shortages and access issues, states are turning to interventions and support models that are less staff intensive, such as shared living and paid family caregivers, as well as increased reliance on natural (unpaid) supports. While these support models are largely effective and, by design, require fewer staff hours, they are not ideal for all people seeking services and should be seen only as one part of a more comprehensive solution.

Individualized Budgets

Individualized budgets are a key feature we found in successful APMs. In the programs that include this feature, individuals are allocated funding based on their assessed needs and these funds are used to support the person for a predetermined period of time. Also important in this process is that the program considers the person as a whole and does not divide areas of need into silos. However, maintaining a rigid system of utilization of funding can be counter-productive and does not provide sufficient flexibility for the service provider to manage day-to-day fluctuations in need. We believe that individual rates should be rolled up to an aggregate rate (based on program or service(s), location of

recipients, or other reasonable factors) that can be managed across individuals served with predetermined methods of accountability. This method provides financial assurances to funders while promoting maximum service flexibility, ensuring each person gets what they need, when they need it, to be successful and have opportunities for personal growth and satisfaction.

We also observed one program that reconciled the number of service hours provided at the overall contract level and not at an individual level. This method can also be highly successful when there are predetermined quality measures in place so that the provider is accountable to the outcomes and not the discrete hours in any one person's funding or unit allocation. This method is also more efficient for funders to administer.

Although this methodology is promising, one caveat to note is that rates must be actuarily sound and updated on an annual basis. Without the ability to demonstrate cost savings or cost neutrality, the value of an APM is compromised. We also noted that when states base future rates on previous history alone, it can lead to a *downward* spiral in the actual rates and, in one case, the system reverted back to using fifteen-minute units as the method of reimbursement. Similarly, when a state leaves the process of rate setting solely to a managed care organization (MCO), there is no standardization, resulting in each provider negotiating individually with the MCO.

Availability of "In-Lieu of" Services

Another key component of successful models is the ability to use individual allocations to pay for goods and services "in lieu of" traditional Medicaid-funded long-term supports. These items may include any item or activity needed by the individual that is apart from specific service provision and is needed to help maintain the person's independence, safety, quality, or well-being.

These "in lieu of" services are starting to be incorporated into health care plans and even built into states' Medicaid waivers as systems are increasingly exploring "whole person care". It is with the recognition that preventative interventions can create savings in the long term as they lead to better health outcomes and overall quality of life. The Centers for Medicare and Medicaid Services (CMS) recently released a State Medicaid Directors' Letter issuing guidance for the inclusion of "in lieu of" services in state Medicaid programs and waivers.[4] We believe that this flexibility in the funding model must be incorporated into any APM going forward.

Partnership Between Payers & Providers

A key component we saw in all successful models was the existence of a true partnership between the payer and the provider. Successful systems relied on this collaboration to ensure quality in case management, expedited pre-authorizations, routine review of individual outcomes and the remediation of service planning disagreements, investigations, claims, and other operational requirements.

Similarly, when there is poor underlying communication or failure by the payer to acknowledge the provider as a vital member of the team, the individual's care plan and subsequent service is compromised. Additionally, it is essential to develop mutually agreed upon social determinants of health and/or quality metrics in advance that align with the pilot's goals and are person-centered. A true partnership between the individual, family, provider, and state leads to remarkable outcomes for the individual and the system.

System Structures that Facilitate & Motivate Use of Technology

With the rapid advancement of technology, there are many resources available to support the independence of individuals with I/DD and to supplement the work of support staff. APMs must embrace the use of technology as an augmentation to traditional services by enabling providers to bill for the use of it and retain any subsequent savings to be redeployed to other areas of need (e.g., workforce development, supporting people cleared from waiting lists, etc.).

The ability to use technology to mitigate the direct support workforce crisis is also imperative. With the need for new DSPs in the coming years projected to approach six-digit figures and illustrated in a recent paper, *Community Supports in Crisis: No Staff, No Services*, we must work together to increase our reliance on methods of support that do not require "eyes on" a person at all times.[5] Not only will the inclusion of these technologies support solutions to workforce challenges, but in many cases it will also provide individuals supported with an enhanced degree of independence and autonomy while enabling them to live and engage with the community as a more equal member.

Last but not least, we recommend that APMs not only permit but also incentivize the use of technology. These resources take up-front investments from payers and may challenge some organizations' level of comfort, but payers and regulators should encourage providers to embrace these new resources as technology-avoidant operations will be unsustainable in the long run.

Flexibilities that Result in High Staff Satisfaction

We spoke to staff over the years who consistently commented on their overall satisfaction with their jobs and attributed that satisfaction, at least in part, to the flexibility they experienced on the job.

Specifically, they repeatedly cited the organization's ability to pivot quickly and seamlessly when a person's needs changed. This gave the staff members a sense of autonomy and the assurance that they could respond to meet someone's needs in a timely manner.

Staff within these programs also reported feeling that they are an important and contributing member of the team and that their opinions are respected and considered. This fosters a level of job satisfaction that is often lacking in current structures that focus on providing the greatest number of units of service over the quality of service. These staff also generally reported the presence of open and respectful communication by supervisors and between coworkers, and the sense that they are all on one team.

This is a perfect example of how focusing on the needs of an individual also supports the needs of the staff delivering their services. The current regulatory system primarily focuses on compliance, often with standards that do not enhance people's lives. However, a primary focus on quality supports can contribute to a culture that is about meeting the needs of individuals, and these cultures encourage staff to be professional and responsive in each moment—when interacting with the people they support and their family members, but also with their colleagues and supervisors. When staff feel like respected professionals and are empowered to make decisions with the people they support, everyone does better.

A Clear, Multi-Disciplinary Approach

Whenever stiving to support individuals with I/DD, it is essential that the whole person is valued and considered in every support plan. It is also essential that the person and their family members have a voice in what the plan looks like and are at the center of determining what is the best way to meet the individual's needs and wants.

As services are delivered in such a system, it is important to ensure that all support personnel, from the DSP to the Case Manager and from the Registered Nurse to the Physician, are included in the coordination of service delivery. This application of integrated care ensures that there is not duplication in service and that the person's needs are being met across the board.

One key element of success in this arrangement is the availability of low service coordinator ratios that are adjusted for acuity. We found that in all cases, when the service coordinator maintains a small case load, they are able to know each person's plan and work to ensure efficacy in the delivery of the plan. This individualization also supports higher quality outcomes as the coordinator can more closely monitor and update plans as needed.

Emphasis on Quality Outcomes & Personal Satisfaction

The final key component for a successful APM is the incorporation of clearly defined quality measures. By ensuring these measures are clearly articulated from the outset, everyone involved understands expectations and service providers can be held accountable for those expectations. We found that

successful APM components included individualized quality metrics, which could then be aggregated for compliance and used to inform achievement of payment incentives. Additionally, we found that having a reasonable number of outcomes and a realistic path to achieving desired outcomes was essential.

Within the programs we studied, some reported an increase in process measures and oversight; these did not enhance quality outcomes, but instead promoted more antiquated systems of compliance. As such, the question of quality measurement in I/DD services continues to be unsettled. There are several well-regarded resources, including National Core Indicators and the Council on Quality & Leadership's Personal Outcome Measures, but each state and APM contract contains their own measures, and most do not require the use of a standardized measure set.[6]

We continue to be concerned about the lack of a nationally accepted set of quality standards, with state- and locality-specific measures added to the core set of outcome measures as desired.[7] In the absence of such standards, we continue to feel it important to emphasize that all parties involved in service delivery understand the expectations of the individual and their family, and that the success of service outcomes are regularly measured.

Finally, we find it important to emphasize the need to keep distinct measures that indicate the delivery of quality from those that are often used as stand-ins for quality but do not, in fact, indicate improved outcomes. For example, a couple of the models we examined had a focus on incident reporting. While reporting on critical incidents is important, it should not serve as an example of "quality," nor should it be used to compare providers. Likewise, we found there to be little use of value-based payments (VBP) in the models we studied. While this is a common component of provider reimbursement methodology in behavioral health and health care delivery, it is less prevalent in I/DD funding models. Many states, like some of the models we reviewed, express a desire to include VBP as a method of incentivizing quality, but we found little had been done on this goal. Several models we studied reported the intent to add value-based payments to the APM, but at the time of these reviews, no single model had a fully implemented, scalable value-based payment model in place.

Proposed Models

The culmination of our five years of research finds ANCOR committed to promoting and advancing three potential APMs, each of which reflects a set of characteristics identified in our research as critical to success. We feel these prototypes are best suited to support the transition to managed long-term supports and services (LTSS) for people with I/DD.

In particular, each of the three models ANCOR supports include:

- Measures to enhance individual choice and control.
- Measures to ensure service flexibility.
- An emphasis on performance outcomes rather than process measures.
- Providers assume an increasing degree of risk and reward over time.

- A foundation of market-based rates with the flexibility for acuity to drive the payment structure.
- Startup or transitional funding investment from states and/or the federal government.
- A robust health information exchange system or platform.
- Opportunities for direct contracting between providers and payers.
- Recognition that providers are in the best position for care coordination and provision of service.

In the remainder of this section, we lay out more thoroughly the potential structure of three model prototypes that are ripe for being piloted: (1) a prepaid inpatient health plan, (2) an "optimizing outcomes" plan, and (3) a multi-system integrated care plan for youth and adults.

Prepaid Inpatient Health Plan

A Prepaid Inpatient Health Plan (PIHP) model can be found in an organization that is responsible for managing Medicaid services related to behavioral health and developmental disabilities. A PIHP coordinates and provides medical services to individuals under a contract with the state Medicaid agency. The organization is paid based on a prepaid capitated rate and is responsible for coordinating LTSS and arranging other eligible services as needed.

The PIHP model we propose is similar to the structure used in the ACAP program in Pennsylvania, but we do not recommend a wholesale adoption of that model. One key difference is that we believe the model should be used to support people with I/DD and not just those with Autism. Furthermore, we envision a model that differs from the ACAP program in that it includes all LTSS and residential services, as well as most health care services, some contracted supports (such as psychological and behavioral health services) and the ability to support rehabilitation or assisted living stays if needed.

This model is promising because as it matures, the provider can assume a relative degree of financial risk by maintaining a risk and stabilization reserve at a predetermined level. This reserve can be used to help transition an individual to a different LTSS provider if ever needed, and stabilization reserves support the provider during times of crisis, such as those triggered by the COVID-19 pandemic.

Additionally, this structure may produce a net margin which can be reinvested in services, staff wages, and waiting list support. The services are paid with a "per member per month" (PMPM) rate, which is driven by the acuity mix of those served and service utilization. The mix of support needs can range from people needing minimal support to those receiving 24/7 assistance. We recognize that this payment model might not work to include people with significant medical support needs, a challenge that is better responded to with the third proposed model we discuss later in this section.

In this PIHP model, there is an emphasis on aggregated individual outcomes versus process outcomes and regulatory compliance. Key metrics are established between the payer and the provider, who is then held accountable for the delivery of said outcomes. There may be reluctance to veer from a highly regulated model of payment, but it is our position that predetermined metrics, reflective of both health

and HCBS measures, are necessary to ensure quality. This approach places the responsibility on the provider to ensure high-quality service is delivered and may even reduce states' oversight burden. Again, the emphasis here is on outcomes.

Another key component of this model is the integrated team approach to funded case management. In this model, all members of the team—from the physicians to the DSPs—are engaged in the care and service planning for and with each individual. This multi-disciplinary team can also determine when a service beyond those traditionally paid for by Medicaid is needed and has the flexibility to provide the "in lieu of" services, such as covering the cost of gym memberships to help people lose weight and lower their cardiovascular care costs down the road.

Optimizing Outcomes & Shared Savings

According to the Centers for Medicare & Medicaid Services (CMS), the Medicare Shared Savings Program offers providers (e.g., physicians, hospitals, and others involved in patient care) an opportunity to share in any net savings over a specified period of time through the creation of an Accountable Care Organization (ACO).[8] An ACO agrees to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population.

The program is an important innovation for moving the CMS payment system away from volume and toward value and outcomes. It is an alternative payment model that:

- Promotes accountability for a patient population.
- Coordinates items and services for Medicare fee-for-service (FFS) beneficiaries.
- Encourages investment in high-quality and efficient services.

Our second recommendation, which we call the "Optimizing Outcomes" model, centers on a version of the Medicare Shared Savings Program which offers the provider an opportunity to share in any net savings over a specified period of time, while also measuring and incentivizing performance for agreed-upon quality outcomes. Although the program this APM is modeled on originated in Medicare and is thus focused on savings in health care delivery, we see it as a model that can be customized and scaled for Medicaid LTSS service providers.

In the proposed model, provider organizations do not face downside risk or a financial penalty if actual costs exceed the benchmark. However, the model may evolve into a shared-risk model wherein the provider is accountable for a portion of the excess costs and must return funds to the payer if actual costs exceed the benchmark. For our purposes, however, this risk-bearing approach is not recommended until sufficient time and experience enables all parties to calculate the inherent risk and until providers have the financial resources to absorb such risk. It is important to note that in this model, "shared savings" should be defined across the state's Medicaid system, versus being defined specifically within the LTSS system of care. Cost savings from the increased flexibility, efficiency, and innovation within the interventions offered by HCBS/LTSS providers often are realized through reduced utilization of high-cost services such as hospitalizations and emergency department visits. In other words, states should consider the total amount spent on an individual when calculating shared savings.

In shaping this model for I/DD LTSS, we recommend either an enhanced FFS rate or an up-front financial investment to support providers' transition from a traditional payment structure to a new model that incentivizes innovation, efficiency, and flexibility. We envision a successful model would include a menu of potential interventions that would be likely to result in cost savings while achieving improved outcomes. Examples of such interventions include the use of supported living services, natural supports, employment services, "in lieu of" services (which may help to support the social determinants of health), technology-based supports such as assistive or adaptive technology and remote support services, and provision of or coordinated linkage to psychiatry and other behavioral health services, dental care, and natural supports capacity building.

Another key component of the Shared Savings model we recommend is the utilization of value-based payments (VBP) as part of the payment mix. VBP models are focused on aggregated individual outcomes and how well providers can improve quality of service or outcomes based on specific measures. VBP takes the best parts of the three traditional reimbursement methods (FFS, capitation, and bundled payments) and combines them into an approach that rewards providers financially for performing better than expected and, in some cases, sanctions them for not achieving predetermined outcomes. The caveat to this component is that VBP breaks down when the incentives are insufficient to justify effort from providers to achieve the targeted level of outcome improvement, or when the fiscal incentive is combined with insufficient FFS rates that don't support the implementation of innovative service and intervention models.

In an effort to promote participation and success in a pilot of the Optimizing Outcomes model, states will want to keep in mind some key considerations. First, a sufficient FFS payment rate (i.e., a pilot rate) would need to be developed. On top of this pilot rate, a menu of services or interventions attributed to a VBP strategy and payment could be evaluated and studied for effectiveness. Second, this model will need to be phased in over time, rather than implemented all at once. Data collection and analysis will be required to determine actual costs for interventions to achieve each eligible outcome and to estimate the savings per each eligible outcome.

Ultimately, the long-term goal of the Optimizing Outcomes model is to expand programs that (1) demonstrate improved outcomes, (2) generate systemwide savings across Medicaid, and (3) integrate fully into states' standard benefits and services plans.

Multi-System Integrated Care for Youth and Adults

This APM structure—the most intensive and integrated we propose—would create a multi-system service structure for youth and/or adults with complex medical and behavioral support needs.

We, like our partners in state and federal governments, recognize that supporting people with complex needs is a priority across the country, and we share concern for the growing inability of community-

based providers to serve the individuals whose needs are complex. We regularly hear accounts of providers struggling to support people with complex needs who are already in services, as well as providers' growing inability to take on new referrals with similar profiles. These challenges are generally due to workforce inadequacies and, relatedly, to rate structures that do not provide adequate funding for clinical training, supervision, and intervention. We believe that this model represents our best chance at serving people with complex needs in the community and ensuring that they do not languish in developmental centers and hospitals because HCBS providers do not have the resources to support them.

In this model, we envision the need for an acuity-based rate structure—one that includes sufficient funding for in-home behavioral and/or nursing supports. We see similar models already working effectively in some states. In those models, providers are partnering with hospital systems and behavioral health providers to ensure access to these critical supports. These partnerships rely on the development of an integrated team. These integrated teams include the residential program professionals as well as more specialized staff, including hospital and community-based nursing professionals and mental health and behavior intervention clinicians. Through these integrated teams, individuals receive wrap-around services, and their home life is positioned for success via continuity in direct service and adherence to identified support guidelines developed by the integrated team.

A key consideration of this model is that it does not adopt a one-size-fits-all approach. Rather, the model is hyper-focused on the specific needs of each individual and thus lends itself to a community-based setting. Those supported in such a model can realize truly individualized service plans that provide the care and support needed to meet their specific care plans and personal goals.

We envision this model could be funded in several different ways. Some potential funding models include acuity-based funding levels, adjusted for experience with a per diem or a per-member, per-month aggregate rate. This model is likely to be the most flexible, but we have also seen some promising models funded with a mixed structure that combines HCBS and ICF/IID (Intermediate Care Facilities for Individuals with Intellectual Disabilities) funding with add-on payments to support care and services.

When considering how to fund such an approach, it is important that the funding accommodates the volatility of costs associated with supporting a relatively small population of people with highly complex needs. Funding should also be positioned to support a standard set of requirements or quality measures, and having a mechanism for payment or disenrollment of significant outliers will be critical. Ideally, we envision this model to operate as a decentralized, adapted PACE-like model or like a PIHP but oriented toward community-based support. Unlike the traditional PACE model, we do not recommend the congregate day program facility typically found in PACE, but rather the use of a central hub for access to key ancillary services, specifically care coordination. In this model, people would be served in their homes and communities.

It is also essential in this model that medical and/or behavioral expertise be present and active on the interdisciplinary team. Ensuring that these components are funded in the payment structure is equally important because without this expertise, the most significant needs of the individual are not met,

resulting in hospitalization and an inability to reenter the community. VBP may also be incorporated into this model, based on achievement of improved outcomes and reduced costs associated with serving these individuals in more restrictive environments or institutional levels of care.

Conclusion

Although we believe that all three of the proposed APMs reviewed here are promising for their potential to deliver high-quality services, we recognize that each state is different in terms of their priorities and goals. These prototypes are thus not intended to be step-by-step roadmaps for program design, but rather broad structures rooted in our principles for payment reform that can help generate conversation and ideas within states considering a move to value over volume in their I/DD LTSS programs.

In offering these proposals, we emphasize the following:

- ANCOR is committed to advancing these APMs because we believe that the current FFS funding paradigm is unsustainable. As the need for community-based services grows and there is increased competition for limited resources, we believe it is essential that the Medicaid program divests itself of FFS models in I/DD LTSS and shift to a more streamlined funding mechanism with greater flexibility and the opportunity for shared savings that fuel reinvestment in the direct support workforce and service expansion.

- ANCOR supports a shift from payment for units of service to a "value over volume" strategy for HCBS services. To this end, we envision a future wherein providers are compensated using more streamlined processes and are focused on quality outcomes rather than units of service.

- ANCOR supports models that are ultra-person-centered and provide the greatest amount of flexibility possible, both for the people served and for the providers delivering services. While the FFS system can be focused on the individual, the inherent design requires providers to focus on delivering all the units of service allocated to a person—within elaborate regulatory structures. Our models focus on the person accepting services and are predicated on the attainment of personal goals rather than organizational process measures. In these models, we believe providers will be held accountable to ensuring that individual quality outcomes are met and are met within the agreed upon financial parameters.

- ANCOR recognizes there will be costs associated with change and that there is a significant role for us to play in developing data on the actual costs of producing the best outcomes for the people served. We recognize this will be challenging because the I/DD population has not been sufficiently studied and we do not have solid benchmarks on current outcomes. We expect that any state entertaining the shift from volume to value would also be involved in examining the costs of this transformation and we are anxious to support those initiatives. This requires a careful balance: ANCOR supports accountability in fiscal management but also the highest-possible quality of outcomes for people with I/DD. A guiding principle is that reform costs money to implement and our state and federal partners should support these change initiatives

with upfront investment. We also know that over time, providers will demonstrate improved outcomes and potential savings.

To advance our goals, ANCOR has created an "APM Incubator," a space for our members to study, implement, and learn about these promising APMs together as states begin to implement managed LTSS initiatives.

In short, we are working hard to be part of the solution and are prepared to commit time and resources to advancing APMs. We stand ready to support our state and federal partners in a move away from FFS financing and to share lessons learned and our own expertise as states consider placing value over volume.

Notes

[1] ANCOR, "Advancing Value & Quality in Medicaid Service Delivery for Individuals with Intellectual & Developmental Disabilities", 2019

[2] ANCOR, "Improving Lives, Ensuring Sustainability: Implementing Alternative Payment Models in I/DD Service Delivery", 2021

[3] ANCOR, "The State of America's Direct Support Workforce Crisis 2022", 2022

[4] CMS, SMD #: 23-001 RE: Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care, 2023

[5] U.S. Department of Labor, Women's Bureau, "High Demand Occupations" (with data from the U.S. Bureau of Labor Statistics, Employment Projections program, 2021; and the U.S. Census Bureau, American Community Survey, 2021.

See also NASDDDS; Institute on Community Integration, University of Minnesota; Human Services Research Institute, "Community Supports in Crisis: No staff, No Services", 2022

[6] HSRI, National Core Indicators;

See also Council on Quality & Leadership, Personal Outcomes Measures

[7] ANCOR response to CMS RFI, November 6, 2020

[8] https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/about