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DEPARTMENT OF HUMAN SERVICES

Legislative report

Value-Based Payment for Home and Community-Based Services in State Disability Waivers

Study Findings

Disability Services Division

February 2022

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Contents

I. Executive summary

Purpose of the report

In 2019, the Minnesota Legislature directed the Department of Human Services (DHS) to study how value-based payment (VBP) models and outcome-based payment strategies could be used in the four Medicaid disability waiver programs that deliver home and community-based services (HCBS) to people with disabilities:

- Brain Injury (BI) Waiver
- Community Access for Disability Inclusion (CADI) Waiver
- Community Alternative Care (CAC) Waiver
- Developmental Disabilities (DD) Waiver.[1]

VBP is an approach for paying health care providers based on the quality and efficiency of services, rather than the volume of services provided, as is the case with traditional fee-for-service (FFS) reimbursement.

This study was motivated, in part, by the growing cost of services provided through Minnesota's disability waivers. This report summarizes the study's findings and proposes the next steps for DHS to design and implement a VBP model for these waiver programs.

[1] DHS is in the process of consolidating its four HCBS waiver programs for people with disabilities into two waivers (Minnesota Department of Human Services Disability Services Division 2019). For more information, see DHS – Waiver Reimagine.

Proposed VBP models

Figure 1. Components of VBP

All VBP models are designed to achieve certain goals, which are defined as measurable improvement on specific aspects of care or quality of life. VBP models:

- Set benchmarks that specify the measure value or threshold a provider must meet to receive a payment incentive
- Establish an amount and timing of payment to encourage providers to improve care or outcomes (Figure 1).

Pay for performance (P4P) is a type of VBP model in which providers receive bonus payments for demonstrating measurable improvements in quality or outcomes. Based on the principles identified in this study and feedback from DHS staff, HCBS providers, lead agencies, people who use HCBS, their families and advocates, DHS proposes developing P4P models for two categories of service: (1) residential services that provide community residential and family residential services and (2) employment services.

The components of the proposed models are as follows:

- **Goals and principles:** VBP models offer DHS a tool to achieve the Legislature's goals in Minn. Stat. §256B.4914, subd. 10. Specifically, the models will be designed to (1) support the goals of people who use HCBS in quality of life and community integration, (2) improve quality of services in a measurable way and (3) deliver services more efficiently and use the cost savings to serve more people as well as enhance person-centered services. DHS would allow providers to participate in VBP on a voluntary basis. Those who participate would be asked to do so for at least one year, after which they could opt in for future years.
- **Measures:** DHS would allow providers to select a reasonable number of measures (e.g., 1–5 measures) from a pre-specified menu. Measures would assess performance and quality using data already collected by DHS.
    - **For residential services:** DHS would use any of three available measures on safety (i.e., the use of restraints) it currently calculates by using Behavior Intervention Reporting Forms (BIRF) data collected for Olmstead reporting. DHS also could calculate three measures related to quality of life and community integration using data collected in the MnCHOICES Long-Term Services and Supports (LTSS) Improvement Tool.

    - **For employment services:** DHS would consider any of three available measures of employment outcomes it currently calculates for the Employment First dashboard. DHS also would consider two measures related to personal goals for employment it could potentially calculate using data collected in the LTSS Improvement Tool.
- **Benchmarks:** DHS would measure progress based on improvement goals set by each provider, within predetermined bounds. It would calculate performance thresholds for incentive payments and measure provider progress toward the thresholds using one year of data. Where possible, DHS would stratify performance results by socioeconomic or demographic characteristics to identify disparities.
- **Payment:** DHS could allow a pay-for-reporting (P4R) system for some or all measures in the first year and P4P in the second year. The P4R model would offer incentive payments to providers who opt to report high quality data related to relevant measures. This phased approach would help providers build capacity for quality improvement (QI) and provide baseline data to DHS that allow it to set appropriate benchmarks for specific providers. Providers that submit high-quality data could switch tracks and be paid for performance sooner. If the data allow, DHS could distribute payments to individual providers, or it could explore grouping performance of multiple providers under certain conditions. Payments to providers could be in the range of 1–10% of annual Medicaid revenue, though the ultimate amount would depend on the state's budget commitment.

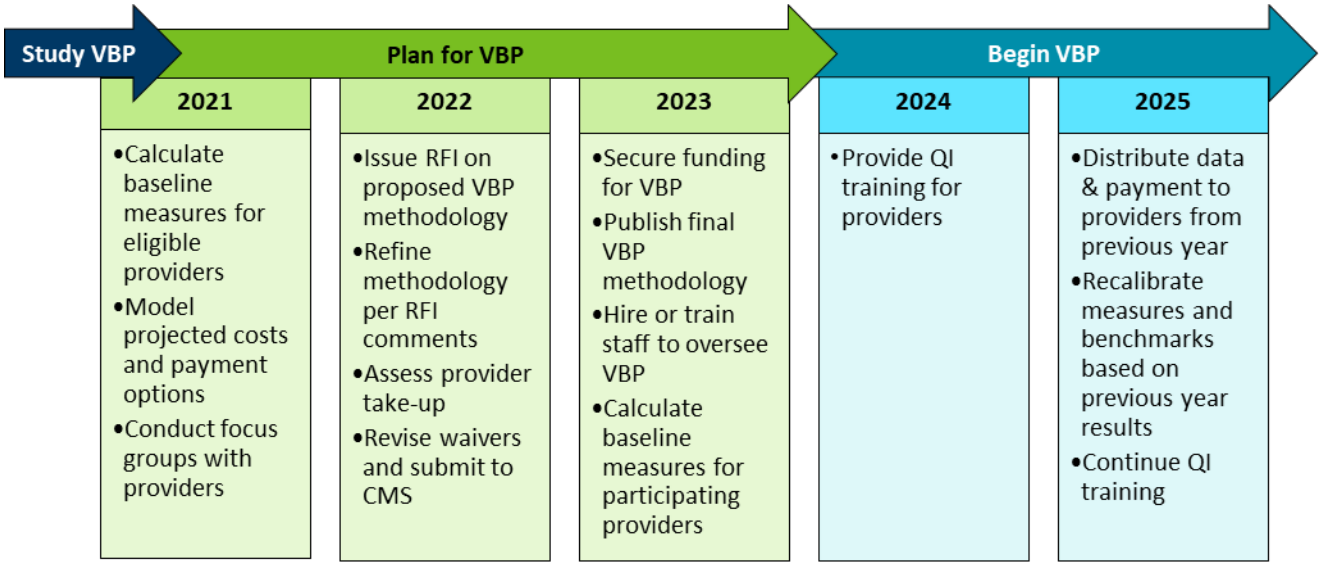
Implementation timeline

Developing a VBP model for HCBS would be a multiyear effort of at least four years. This effort would require

- Iterative (i.e., continual) revisions to the methodology
- Dedicated funding for provider payments and for staff to run the program
- Guidance and buy-in from stakeholders.

Figure 2 summarizes the key activities DHS would conduct over the next three years and the activities that would begin once providers are eligible for VBP.

Figure 2. Summary of activities required to implement VBP, 2021–2025



CMS = Centers for Medicare & Medicaid Services; QI = quality improvement; RFI = request for information; VBP = value-based payment

Next steps

Although DHS believes VBP represents a useful strategy to improve service quality, more work is needed to design and implement a VBP program in ways that will maximize its effectiveness.

If the Legislature agrees to continue planning for VBP, DHS will:

- Identify and specify statistically valid measures and benchmarks
- Estimate the amount of additional funding required for full implementation of the program
- Gain buy-in from providers who will participate in the program
- Develop plans to support providers improve the quality of their services.

II. Legislation

Minn. Stat. §256B.4914, subd. 10 (h) requires the following:

> The commissioner, in consultation with stakeholders, shall study value-based models and outcome-based payment strategies for fee-for-service home and community-based services and report to the legislative committees with jurisdiction over the disability waiver rate system by October 1, 2020, with recommended strategies to: (1) promote new models of care, services, and reimbursement structures that require more efficient use of public dollars while improving the outcomes most valued by the individuals served; (2) assist clients and their families in evaluating options and stretching individual budget funds; (3) support individualized, person-centered planning and individual budget choices; and (4) create a broader range of client options geographically or targeted at culturally competent models for racial and ethnic minority groups.

III. Introduction

The Minnesota Department of Human Services (DHS) administers services and supports that help people with disabilities live independently in their homes and communities. These services and supports are known as home and community-based services (HCBS). Many people receive HCBS through Minnesota's four section 1915(c) disability waivers:

- Brain Injury (BI) Waiver
- Community Access for Disability Inclusion (CADI) Waiver
- Community Alternative Care (CAC) Waiver
- Developmental Disabilities (DD) Waiver.[2]

A. Purpose of the study

In 2019, the Minnesota Legislature directed DHS to study value-based payment (VBP) models and outcome-based payment strategies for home and community-based services (HCBS) provided to people with disabilities through the BI, CAC, CADI and DD Waivers.

Between January 2020 and June 2021, DHS contracted with Mathematica to conduct this study. The study team included staff from both DHS and Mathematica. The purpose of the study was to provide DHS and the Legislature with a better understanding of fiscal policy options to improve outcomes, efficiency of care and quality of life for people who use the HCBS disability waivers.

Though the study team made significant strides toward determining the most appropriate VBP models, DHS needs to conduct additional analyses and engage stakeholders to design the VBP models and plan for their implementation. This report summarizes findings from the study and outlines next steps for DHS to design and implement these VBP models.

B. Definition of VBP

VBP is an approach to paying providers based on the quality and efficiency of services, rather than on the volume of services provided, as is the case with traditional fee-for-service (FFS) reimbursement.

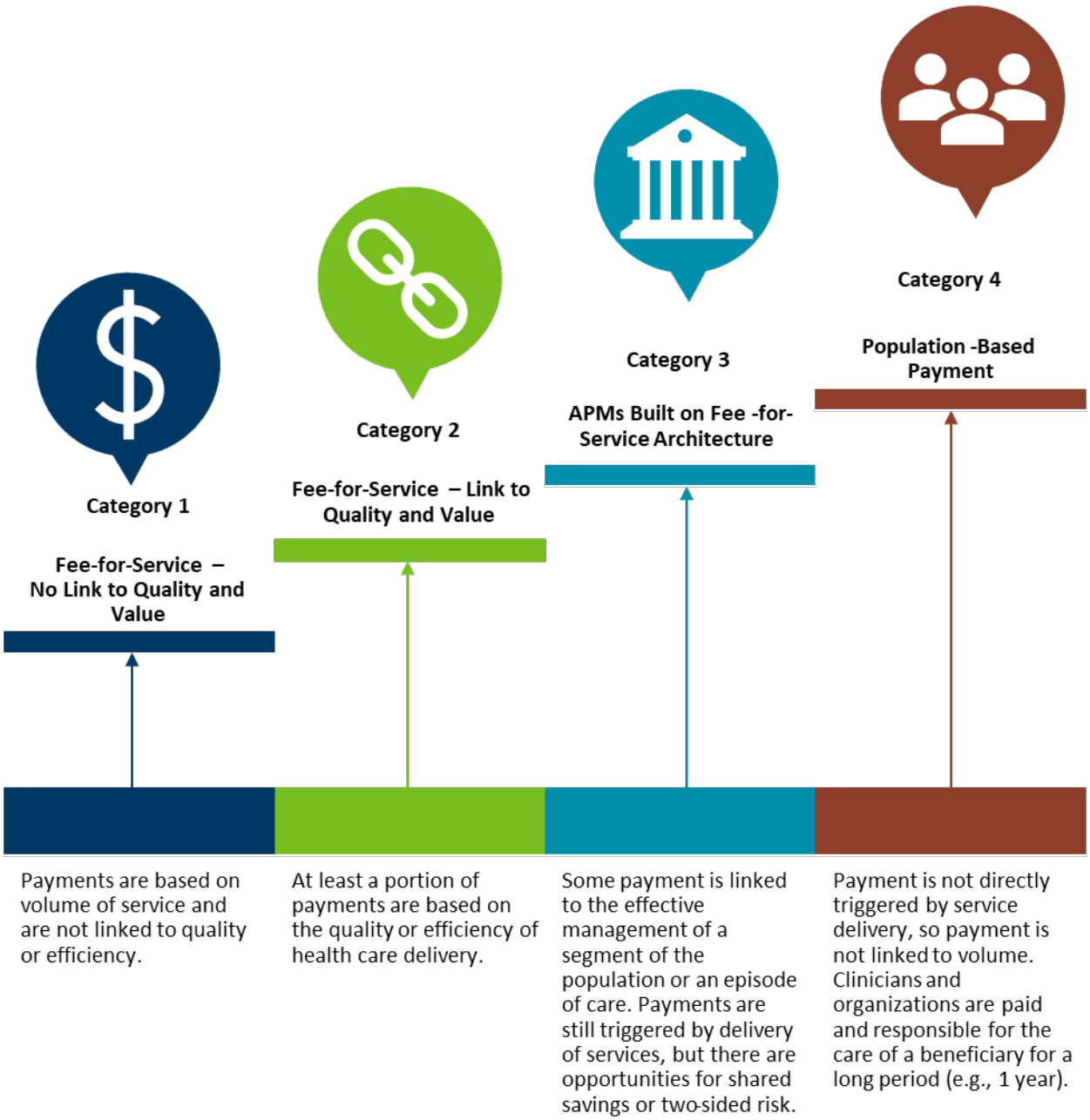
[2] DHS is in the process of consolidating its four HCBS waivers for people with disabilities into two waivers (Minnesota Department of Human Services Disability Services Division 2019). For more information, see DHS – Waiver Reimagine. Because the consolidation is still in process, this report refers to all four waivers as the scope of waivers targeted for VBP.

VBP models can be used in FFS or managed care payment environments. They can include a broad set of performance-based payment strategies that link financial incentives to performance on a set of defined measures of quality, cost or resource use (Damberg et al. 2014). Payment strategies range from paying providers who invest in infrastructure for quality improvement (QI), to alternative payment models (APMs), to comprehensive population-based payments (Medicaid Innovation Accelerator Program 2017).

The Centers for Medicare & Medicaid Services (CMS) and the Health Care Payment & Action Network (HCPLAN)[3] both use a four-category framework to summarize the range of payment models states might pursue (Alternative Payment Model Framework and Progress Tracking [APM-FPT] Work Group 2017; Figure 3).

[3] Launched by the U.S. Department of Health and Human Services in 2015, HCPLAN is a preeminent group of public and private health care leaders dedicated to providing thought leadership, strategic direction and ongoing support to accelerate the adoption of VBPs and APMs. For more information, see HCPLAN.

Figure 3. CMS and HCPLAN payment framework



APM = alternative payment model; CMS = Centers for Medicare & Medicaid Services; HCPLAN = Health Care Payment Learning & Action Network.

C. Study components

The team conducted this study in five phases:

1. **Provide background information (January to March 2020):** The team examined VBP models, structures and strategies, including those used in Minnesota and in other states, to understand the VBP models, system and data elements required to implement value- or outcome-based payment models. The team examined the available data, potential measures for such a system, stakeholder concerns and the risks and possible limitations of the models. The team also documented ways other states transitioned or planned to transition to VBP models. This activity helped the team understand situations in which new payment models were created and worked successfully. Appendix A documents federal guidelines for VBP. Appendix B summarizes VBP programs in Minnesota and other states.

2. **Propose methodologies (May 2020 to March 2021):** Based on research, best practices and available data, the team developed preliminary designs for the VBP models, including measures for the value of services reimbursed in a way that supports addressing social determinants of health. Chapter IV: Preliminary VBP models describes the proposed models.

3. **Analyze policy and implementation concerns (March to April 2021):** The team examined options for calibrating the model(s) over the long term, how to respond to changing service needs and innovation, inherent conflicts that exist within Minnesota's HCBS programs that could make it challenging to implement new payment models and how to manage financial risks to providers and the state. Chapter IV: Preliminary VBP models describes the strengths of and challenges to the models. Appendix E identifies other HCBS initiatives that influence VBP.

4. **Assess alignment or impact (June 2020 and April 2021):** The team analyzed HCBS claims data to identify characteristics of people who use HCBS waivers and providers. Then, the team reviewed existing literature and used claims data to create a preliminary model to estimate the service and fiscal impact for each proposed policy change, compared to current models. Chapter IV: Preliminary VBP models describes the preliminary model. Appendix C describes the characteristics of people who use HCBS waivers and providers.

5. **Engage stakeholders (October 2020 and February 2021):** The team conducted two web-based surveys to identify key implementation issues, potential measures, key performance indicators, e-health infrastructure (e.g., electronic medical records, care management software) and other topics. Survey respondents included providers and lead agencies that deliver HCBS, people who use HCBS waivers and their families and advocates. Appendix D includes a summary of survey findings.

IV. Preliminary VBP models

This section of the report describes potential VBP models for two sets of HCBS services:

- Residential services
- Employment supports.

A primary objective of this study was to identify VBP options that could help advance the state's goals—to improve outcomes, efficiency of care and quality of life for people who use HCBS. The models were informed by current federal requirements (Appendix A); background information gathered for this study (Appendix B); characteristics of people who use HCBS waivers and providers (Appendix C); input from providers, lead agencies, people who use HCBS waivers and their families and advocates (Appendix D); and other HCBS data, payment and quality initiatives that influence VBP (Appendix E).

A. Guiding principles for designing a VBP methodology

To achieve its goals, the design of any VBP model should follow the principles of effective VBP models. These principles emerged from discussions with program managers both inside and outside Minnesota who shared recommendations and lessons learned (see Appendix B, section 4). Specifically, they recommended DHS use the following principles to inform its VBP models:

1. Align any new VBP program for HCBS providers with existing QI efforts. The VBP model should allow providers to propose or select QI topics and measures that are meaningful to them and the people they serve. It should also use established HCBS measures that can be calculated by using data providers already collect.

2. Use an incremental approach to VBP for HCBS providers that increases in scope over time. DHS can apply this incremental approach by involving most (or all) providers early on with a few measures and adding measures over time, or by involving a limited set of provider types early on and expanding the model to additional providers over time.

3. Track performance and potential adjust payments to providers to reflect differences in the characteristics and level of need of people served.

4. Dedicate resources or state staff (or both) to support implementation and provide technical assistance to providers. Support should include clear, timely information. It should view providers as partners and, where possible, connect providers to their peers working on similar QI topics.

5. Generate evidence on the value of VBP and the change it produces.

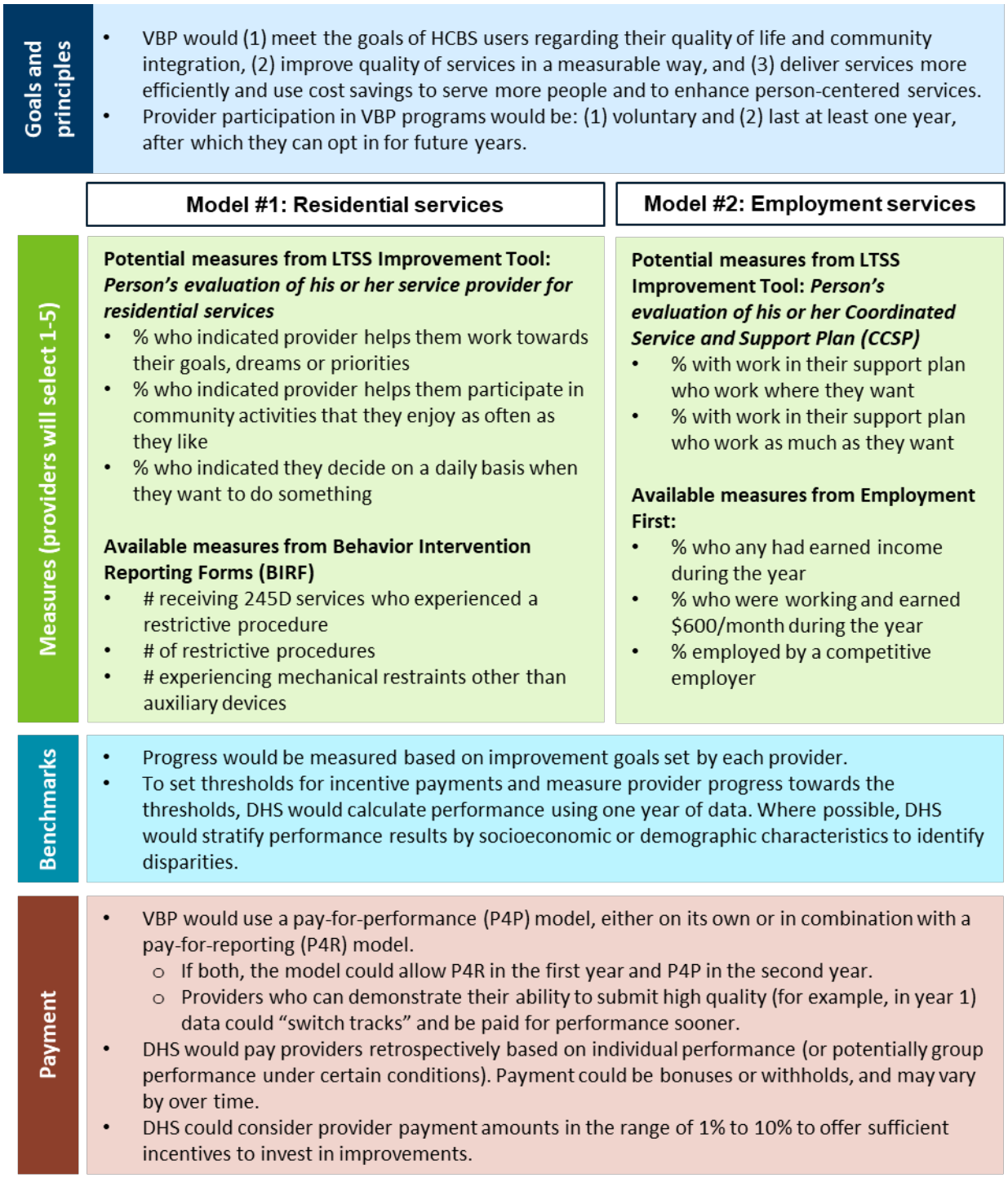
B. Preliminary VBP models for residential and employment services

All VBP models are made up of measures, benchmarks and payment approaches informed by the specific goals and intent of VBP (Figure 1):

- **Quality or performance measures** assess specific aspects of care, such as the number and type of services people use, functional status, outcomes, experience of care or administrative compliance or efficiency of a facility. Currently, there is no set of agreed-upon measures for states to use to assess quality and performance of HCBS, but CMS has sought feedback on developing these measures (CMS 2020b).
- **Benchmarks** specify the measure value or threshold a provider must reach to receive an incentive. Such values are usually pre-established for a given measurement period and can be:
    - Absolute, requiring a provider to meet or exceed a pre-specified value that is set based on a state or national standard or past performance among a similar group of providers
    - Relative, requiring a provider to score within a certain value range relative to other providers' facilities
    - Self-improvement based, comparing a provider's performance to itself in prior years.
- **Payment** offered to providers that achieve specified quality benchmarks can help create an incentive for improvements. Payments can take the form of one-time add-ons (i.e., bonuses or withholds) or recoupments, and they can be distributed prospectively or retrospectively.

Figure 4 considers each of the above components and proposes potential models for VBP in HCBS for two sets of services: residential services, which provide community residential and family residential services, and employment services. The two models use different measures and target different providers, but they share the same goals and approaches to benchmarking and payment.

Figure 4. Preliminary VBP models for residential services and employment services



C. Strengths and challenges of the proposed VBP models

The proposed VBP models have both strengths and challenges. This section of the report weighs these factors for each model component—goals and principles, measures, benchmarks and payment.

1. Goals and principles

VBP models offer DHS a tool to achieve the state's goals. Specifically, the models will be designed to:

- Support quality of life and community integration goals of people who use HCBS
- Improve the quality of services in a measurable way
- Deliver services more efficiently and use the cost savings to serve more people and enhance person-centered services.

DHS would allow providers to participate in VBP on a voluntary basis. Providers who participate would be asked to do so for at least one year, after which they could opt in for future years.

Strengths

- **The proposed models support two of the three goals identified by the Legislature and DHS.** Specifically, these models create incentives to meet the goals of people who use HCBS regarding their quality of life and improve the quality of services in a measurable way. These goals align with the legislative objectives related to this study.

Challenges

- **The proposed models do not explicitly meet the third goal of promoting efficiency (i.e., cost savings).** VBP programs often require a significant investment of time and resources in the initial years, and the degree to which improved quality of care, quality of life and person-centered care will offset overall costs to the state is not known.

2. Measures

DHS would allow providers to select a reasonable number of measures (e.g., 1–5) from a pre-specified menu. Measures would assess performance and quality using data already collected by DHS:

- **For residential services:** DHS could use any of the three available measures on safety (i.e., the use of restraints) it currently calculates by using Behavior Intervention Reporting Form (BIRF) data collected for Olmstead reporting. DHS also could calculate three measures related to quality of life and community integration using data collected in the MnCHOICES Long-Term Services and Supports (LTSS) Improvement Tool.

- **For employment services:** DHS could consider using any of three available measures of employment outcomes it currently calculates for the Employment First dashboard. DHS also could consider two measures related to personal goals for employment that it could potentially calculate using data collected in the LTSS Improvement Tool.

Strengths

- **The proposed measures support several key goals of VBP.** DHS would like the VBP models to use existing data to calculate quality measures. For residential services, existing data can measure how people receive support from providers on personal goals, community integration and decision making. They also capture use of restrictive procedures or mechanical restraints. For employment services, existing data can measure income, employment type and satisfaction with employment.
- **Drawing on existing measures helps ensure baseline data is available and stakeholders are familiar with the results.** Because both the available and proposed measures use established data sources, DHS would have ready access to aggregate performance information and would be measuring concepts currently used for other purposes.
- **Selecting measures from a menu aligns with provider preferences and precedent from other VBP programs in Minnesota.** Allowing providers to select the measures from a pre-specified menu helps balance providers' need to have control and flexibility with DHS' need for standardization.

Challenges

- **Existing data on employment does not capture key aspects of community integration and quality of life.** Measures from the Employment First dashboard assess whether a person had any paid employment for any duration, whether the payment reached a minimum threshold and whether the payment was competitive. However, the dashboard does not include employment outcomes that are more likely to reflect meaningful employment and higher quality of life (e.g., staying in the same job for 6 months or one year).
- **Providers may select measures that demonstrate more favorable outcomes and hide unintended consequences or negative outcomes.** However, requiring providers to select measures from a set menu (rather than create their own) helps limit the extent to which they can selectively influence their performance. DHS also could limit selection bias by negotiating with providers to select measures, improvement targets and payment amounts, as they have done in previous VBP programs (Minnesota Department of Human Services 2019b; Minnesota Department of Human Services, Health Care Administration 2018).

3. Benchmarks

DHS would measure progress based on improvement goals set by each provider, within predetermined bounds. DHS would calculate performance thresholds for incentive payments and measure provider progress toward the thresholds using one year of data. Where possible, DHS would stratify performance results by socioeconomic or demographic characteristics to identify disparities.

Strengths

- **Measuring providers based on individual improvements, instead of absolute or relative benchmarks, is in line with their preferences as well as the approaches used in other VBP programs.** Nearly half of providers that responded to the October 2020 survey (46%, n = 56) preferred individual improvement goals. This measurement approach also allows providers to make improvements each year, in line with trends.
- **Having DHS calculate performance from provider reports or surveys alleviates the potential burden on providers and ensures consistency and accuracy.** DHS already calculates performance results in several of its other VBP programs.
- **A one-year measurement period aligns with the way current MnCHOICES LTSS Improvement Tool, Olmstead and Employment First measures are calculated.** Stakeholders also report this period is frequent enough for providers to observe changes but not too frequent to be a burden on providers and/or DHS.
- **Using stratification as a form of risk adjustment allows DHS to examine patterns in the data and identify early whether provider performance is influenced by their characteristics.** Strata could include characteristics of people who use HCBS, such as waiver enrollment, age, disability status, income, county or region of residence and race or ethnicity. If data exist, strata could also include provider characteristics, such as minority ownership. Disaggregating the data in this way will allow DHS to examine differences in performance:
    - Between regions that are economically different
    - Over time because, in the case of employment agencies, the provider's ability to succeed in helping people secure competitive employment is highly sensitive to the economy overall.

Challenges

- **Providers may identify improvement targets that maximize payment and minimize investment.** DHS would need to set appropriate bounds or negotiate targets with providers to encourage a level of improvement that warrants the level of investment.

4. Payment

DHS would allow pay-for-reporting (P4R) for some or all measures in the first year and pay for performance (P4P) in the second year. This phased approach would help providers build capacity for

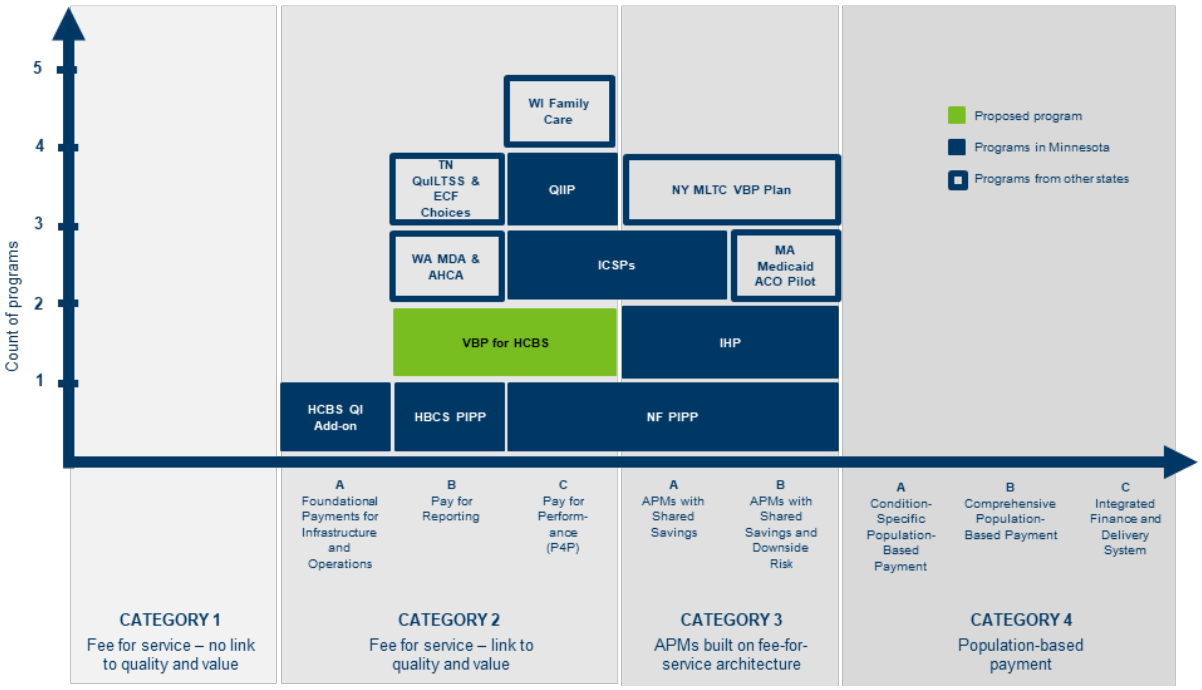
quality improvement (QI) and provide baseline data that allow DHS to set appropriate benchmarks for specific providers. Providers that submit high-quality data could switch tracks and be paid for their performance sooner. If the data allow, DHS could distribute payments to individual providers, or it could explore grouping performance of multiple providers under certain conditions. Payments to providers could be in the range of 1–10% of annual Medicaid revenue, though the ultimate amount would depend on the state's budget.

Strengths

- **A P4P model for HCBS aligns with existing VBP models in Minnesota and elsewhere**.[4] As shown in Figure 5, among the 10 VBP programs serving people with disabilities in Minnesota and other states (Appendix B), many use more than one payment model. However, the majority (i.e., eight programs) use category 2 payment models, with P4R and P4P being the most prevalent type in that category.

[4] In considering the most appropriate payment model for VBP in HCBS, the study team excluded some options for the following reasons. First, the team excluded foundational payments (category 2A), like those used in the HCBS QI add-on program, because Minnesota has already invested in QI infrastructure and therefore can progress to rewarding providers for demonstrating actual QI. Second, the team excluded population-based payments (category 4A) because they are exceptionally complex and may involve a degree of risk that HCBS providers and other organizations are not positioned to take on. Third, the team excluded alternative models that would offer the opportunity to share in savings (category 3A) and/or losses (category 3B) for a defined beneficiary group because Minnesota's existing IHP and ICSP programs already offer HCBS providers the opportunity to share in savings and losses. Rather than build a new program for HCBS providers, DHS might expand the incentives in the two partnership programs that encourage HCBS providers to participate.

Figure 5. Existing and proposed VBP programs serving people with disabilities, by HCPLAN category



ACO = accountable care organization; AHCA = add-on rate for advanced home care aides; APM = alternative payment model; ECF = Employment and Community First; HCBS = home and community-based services; HCPLAN = Health Care Payment Learning & Action Network; ICSP = Integrated Care Systems Partnerships; IHP = Integrated Health Partnerships; MA = Massachusetts; MDA = Meaningful Day Activities; MLTC = managed long-term care; NF = nursing facility; NY = New York; PIPP = Performance-based Incentive Payment Program; QI = quality improvement; QIIP = Quality Improvement Incentive Program; QuILTSS = Quality Improvement in LTSS; TN = Tennessee; VBP = value-based payment; WA = Washington; WI = Wisconsin.

- **Working toward full participation in P4P by initially using P4R for some providers or measures encourages robust participation.** The October 2020 survey of providers suggested there are two categories of providers: (1) those interested in VBP and ready to receive payment for performance and (2) those unsure whether they will participate in VBP but would like the opportunity to measure their performance and learn how to improve quality of care (see Appendix D).

  P4R is attractive to providers who are not experienced with quality measurement or who need to make significant investments to make quality gains. In contrast, P4P is more attractive to providers who understand how to modify the services they deliver to demonstrate changes in quality measures. Combining P4R and P4P in the initial years of VBP would allow DHS to support providers at different levels of readiness, especially those who have less experience with and resources for QI. However, DHS will need more information on baseline performance

and provider preferences to determine which measures and providers to encourage through P4R versus P4P. An example of the sequencing of these steps is shown in the box below.

Example of a phased approach to VBP for employment services

To ensure successful implementation, DHS could introduce VBP to employment services providers through three phases.

Phase 1: Select measures

DHS uses feedback from stakeholders and baseline measurement values to select the outcome measures that best reflect the state's goals for employment services. For example, DHS may choose existing measures of earned income or competitive employment and new measures of satisfaction with actual employment related to a person's support plan (Figure 4).

DHS uses existing data to create baseline measurement values and share them with providers who would like to participate in VBP.

Phase 2: Allow pay-for-reporting (P4R)

DHS uses the first year of VBP to collect data and share measurement results with participating providers. In exchange for reviewing their performance results, providers receive a bonus payment to help them improve the quality of their services, in line with measurement objectives. For example, they could train staff on aligning employment with personal goals or increase outreach to competitive employers.

Phase 3: Require pay-for-performance (P4P)

After providers see their performance over time and understand how the way they deliver services can influence employment outcomes, DHS starts to make bonus payments to providers who meet predetermined values for each measure. For example, a provider might receive payment when 60% of people they serve are employed by a competitive employer. DHS may raise the benchmark value or modify the amount of the bonus payment over time to encourage continual improvement in outcomes.

- **Value-based payments (i.e., rewards for achieving improvement targets) in the range of 1–10% of annual Medicaid revenue are in line with provider preferences reported in the October 2020 survey and Minnesota's existing VBP programs.** Specifically, among providers who submitted usable data, the average share of total Medicaid revenue providers would like to receive for achieving performance or QI was 5–25%. Among Minnesota's existing VBP programs that include providers who serve people with disabilities, payments ranged from 1% in the HCBS QI Add-On Rate Increase program to 5% in the Nursing Facility Performance-based Incentive Payment Program (PIPP) (see Table B.1). When setting an amount, DHS should balance the need to provide enough of an incentive to encourage providers to invest in making measurable QI with the current funding amount available, combined with additional sources. Additional feedback from providers can help inform the most appropriate payment amount.
- **Providing retrospective payments to providers will mitigate risk to the state.** Offering VBP to providers can create a financial risk to the state if there are no limits to the amount of payments available to providers, or if the amount of payments made to providers does not yield significant returns to justify the initial investment (in terms of financial savings generated or improvements to the quality of supports). For this reason, DHS should set an annual budget for total potential payments to providers and retrospectively allocate payments to providers who meet or exceed quality goals. This approach will prevent total provider payments from growing too large if there are unexpected increases in provider participation or quality gains. DHS can determine this budget based on state and federal funds designated for VBP, or DHS can attempt to quantify savings that VBP may encourage from other parts of the Medicaid or state budget (see the challenges section below). Retrospective payments could take the form of bonuses in the early years and move to withholds as providers demonstrate quality gains.

Challenges

- **Paying for performance may cause providers to selectively serve people with better health and fewer functional needs who make it easier to achieve or maintain high performance.** Stratification will help DHS watch for changes in enrollee mix among providers at various levels of performance. Benchmarks that measure improvements toward provider-specific targets will also mitigate this concern.
- **Holding individual providers accountable ignores the role of other entities in helping people find and maintain meaningful employment.** The ability to find and maintain competitive, paid work is related to the actions and quality of employment service providers, as well as the employers and all other providers supporting the person's ability to function in the community (e.g., activities of daily living [ADL] supports). All services interact to influence employment outcomes, but only employment service providers will receive payment and have incentives for improvement.

- **DHS can use rough estimates to set the maximum allowable budget for annual payments to providers through VBP. However, DHS will need additional information to project expected costs based on provider take-up and achievement, or offsets to the budget.** Table 1 estimates the total amount of additional funds required per year for provider payments under various percentage increases, excluding costs for administering the program or providing technical assistance to providers on QI. Such costs could be supported through a combination of state funds and federal matching funds. To determine the most appropriate percent increase, DHS would consult with stakeholders (see Chapter IV: Preliminary VBP models – outstanding questions about payment).

Table 1. Estimated funding for provider payments required under VBP scenarios that increase payment by 1–10%

Category	Residential services [b]	Employment services [b]
Total disability waiver spending in 2018 [a]	$473,831,441	$6,424,766
Number of unique providers [a, c]	1,307	242
Average spending per provider [a]	$362,534	$26,549
Potential annual payment per provider, by percentage increase [d]		
1%	$3,625	$265
2%	$7,251	$531
5%	$18,127	$1,327
10%	$36,253	$2,655
Total additional funds required per year for provider payments, by percentage increase [d, e]		
1%	$4,738,314	$64,248
2%	$9,476,629	$128,495
5%	$23,691,572	$321,238
10%	$47,383,144	$642,477

[a] Source: Mathematica analysis of 2018 HCBS claims, conducted April 2021

[b] Estimates include all four disability waivers (i.e., Brain Injury, Community Access for Disability Inclusion, Community Alternative Care and Developmental Disabilities waivers).

[c] The number of providers represents the number of unique providers based on National Provider Identifiers offering residential or employment services.

[d] Estimates reflect modelling performed under Task 4 of this study.

[e] This assumes all potential providers participate and receive the maximum percentage increase.

- **Increasing payments to provider "entities" does not require providers to share gains with the frontline staff who deliver services.** To ensure all staff have an incentive to meet the improvement targets, DHS might consider requiring providers who choose to participate in VBP to spend some portion of total enhancements on staff salary increases or bonuses, as Texas has done (Soper et al. 2018).

D. Outstanding questions

DHS recommends developing an initial approach to VBP in HCBS that builds on the goals, principles and models listed in previous section. As it begins the process, the state will need to address several outstanding questions to refine the details of the model.

1. Goals

- **Is VBP the right tool to achieve the state's objectives?** If the objectives for VBP shift to cost savings, the state may need to reexamine the measures used in these models and analyze their full range of cost impacts. For example, DHS could search for evidence and gather input from providers and people who use residential and employment services to estimate the potential for and magnitude of savings produced by improvement in the measures, as well as barriers to achieving these improvements (e.g., the extent to which meaningful employment reduces depression-related health care costs).
- **Are there approaches outside of VBP that could support QI?** In the October 2020 survey of providers and lead agencies, several respondents suggested that improved wages and training for the HCBS workforce are needed to support service improvements. These changes could reduce turnover, which has been shown to contribute to poorer quality of care in nursing facilities and, theoretically, could influence care in HCBS settings as well (Stone 2017). The proposed VBP models would collect, analyze and provide program data to HCBS providers—along with some technical support to help them use it—to improve quality. However, given the likely relationship between better job quality and improved quality of HCBS, the state could consider separate policies that support career advancement, improve workforce retention and build the supply of HCBS workers.

2. Measures

- **How many measures should DHS include?** Some of the proposed measures appear to cover similar topics. DHS would need to collect baseline data for the proposed measures and examine performance across providers to understand any meaningful differences among providers or overall suboptimal performance. As a result, DHS may want to narrow the list of measures to reduce the burden of data collection and analysis. DHS also may want to gather comments from people who use HCBS and providers to understand if there are important differences among

the measures and whether some are better suited to VBP. For example, providers might prefer measures with evidence-based performance improvement strategies or opportunities for peer learning.

- **How many measures should DHS allow providers to select?** In the first year, it might be sufficient for providers to work on progress toward one or two measures. Baseline data on the measures may help DHS identify which measures have the most variance and can, therefore, better identify progress across providers or areas most in need of overall performance improvement.
- **Could DHS create reliable and valid provider-level quality measures using the MnCHOICES Long-Term Services and Supports (LTSS) Improvement Tool?** DHS designed the LTSS Improvement Tool to gather data that inform regular service assessments. The degree to which its data can inform VBP is not yet known. All people on disability waivers have the opportunity to answer the LTSS Improvement Tool questions at least once a year. DHS aggregates and analyzes data collected from the LTSS Improvement Tool at the state, lead agency and program levels. However, it is unclear whether there is enough data to support reliable and valid provider-level payment rates. Therefore, DHS may wish to explore the average number and range of assessments completed for residential service and employment service providers and determine the minimum number of completed tools needed to support reliable performance measurement for each outcome.

3. Benchmarks

- **What minimum expectations or "guard rails" (i.e., minimum and maximum of expected percentage of change) will DHS set to encourage providers to improve?** Existing VBP programs set expectations in different ways. For the Performance-based Incentive Payment Program (PIPP), DHS negotiates improvement targets with each participating nursing facility, within allowable bounds. In the Quality Improvement Incentive Program (QIIP), DHS provides the maximum payment amount to facilities that improve by one standard deviation or reach the statewide 25th or 75th percentile, whichever represents more improvement. DHS may choose to mirror one of these approaches. It also may consider calculating baseline measure values to understand the range of provider performance, then convene providers to understand what levels of improvement are ambitious but achievable.
- **How will performance expectations change over time?** DHS will likely want to drive improvements over time, either by raising the level of performance it expects individual providers to achieve or by moving to an absolute or statistically derived approach to benchmarking. Stakeholders suggested an approach in which providers begin by being paid for reporting data and receiving performance reports to help provide a foundation to work toward P4P.

- **Does DHS have existing staff that can collect the data, calculate and distribute results, develop educational materials, respond to stakeholder questions and adjust associated payments? Or, will it need to train or hire new staff or contractors for this role?** DHS would consider both approaches as it considers the total cost of implementation.

4. Payment

- **Which providers or measures will use P4P versus P4R? Under what conditions can providers switch from P4R to P4P?** To establish appropriate tracks for P4R and P4P, DHS may need to examine baseline performance on the measures it intends to include in VBP across various provider groups. DHS also might consider working with providers to understand the investments in infrastructure and staff time needed to improve reporting or demonstrate progress on certain measures. Measures that do not have adequate data are better candidates for P4R during the initial years. Measures that require more investment and/or show greater room for improvement are better candidates for P4P.
- **Do individual providers serve enough people to make measurement feasible? If not, are there other ways to group providers to measure collective performance?** It may be possible to group providers together for measurement purposes (e.g., by requiring a minimum number of people served and encouraging providers to come together in formal arrangements to be held accountable for their collective performance on the measures). However, DHS would need to explore natural groupings that exist between providers and gather input from providers on whether a grouped approach is wanted and feasible.
- **How will DHS fund initial costs for provider payment and implementation support?** This study found that federal funds played a large role in facilitating VBP programs in Minnesota and other states. A limitation of the two previous VBP programs for HCBS is that they relied solely on state funds, which restricted the amount and duration of support for providers. For these reasons, DHS should structure payment to providers in a way that is transparent, allowing DHS to secure federal matching funds.
- **Will increased payments to providers result in long-term cost savings to the state?** VBP will require significant and ongoing funding. It should be viewed as an investment in provider quality. However, stakeholders suggested DHS should consider creating a funding pool that sets aside savings from quality gains to be redistributed to providers. To explore whether such a pool is feasible, DHS would need to select the measures providers will work toward, determine if there is evidence to estimate the amount of expected savings and consult with providers to understand system-wide changes in costs that occur as they improve quality according to the measures. DHS could use this information to forecast cost implications for the Medical Assistance and state budgets (including other programs that may be affected, such as income assistance and housing).

E. Implementation considerations

Designing and implementing a VBP model for HCBS would be a multiyear effort that requires:

- Iterative (i.e., continual) changes to the methodology
- Dedicated funding for provider payments and for staff to run the program
- Guidance and buy-in from stakeholders.

The proposed timeline in Figure 6 explains the key activities and timeline. The timeline proposes two years for planning and implementation, to align with:

- Minnesota's legislative and budget cycles
- The transition to the Disability Waiver Rate System (DWRS), which was fully implemented in January 2021
- The transition to statewide use of the MnCHOICES assessment and support planning process for LTSS
- Compliance with the HCBS settings rule
- Reconfiguration of the HCBS disability waivers through the Waiver Reimagine project, which is expected to happen in 2024. (For information about these activities and initiatives, see Appendix E.)

The planning time would be followed by two years of operation, during which DHS would monitor the implementation closely and make corrections as needed.

Previous VBP programs in Minnesota and other states have taken a slow, phased approach to implementation. Staff involved with those programs have reported that an incremental approach to implementation was helpful (see Appendix B).

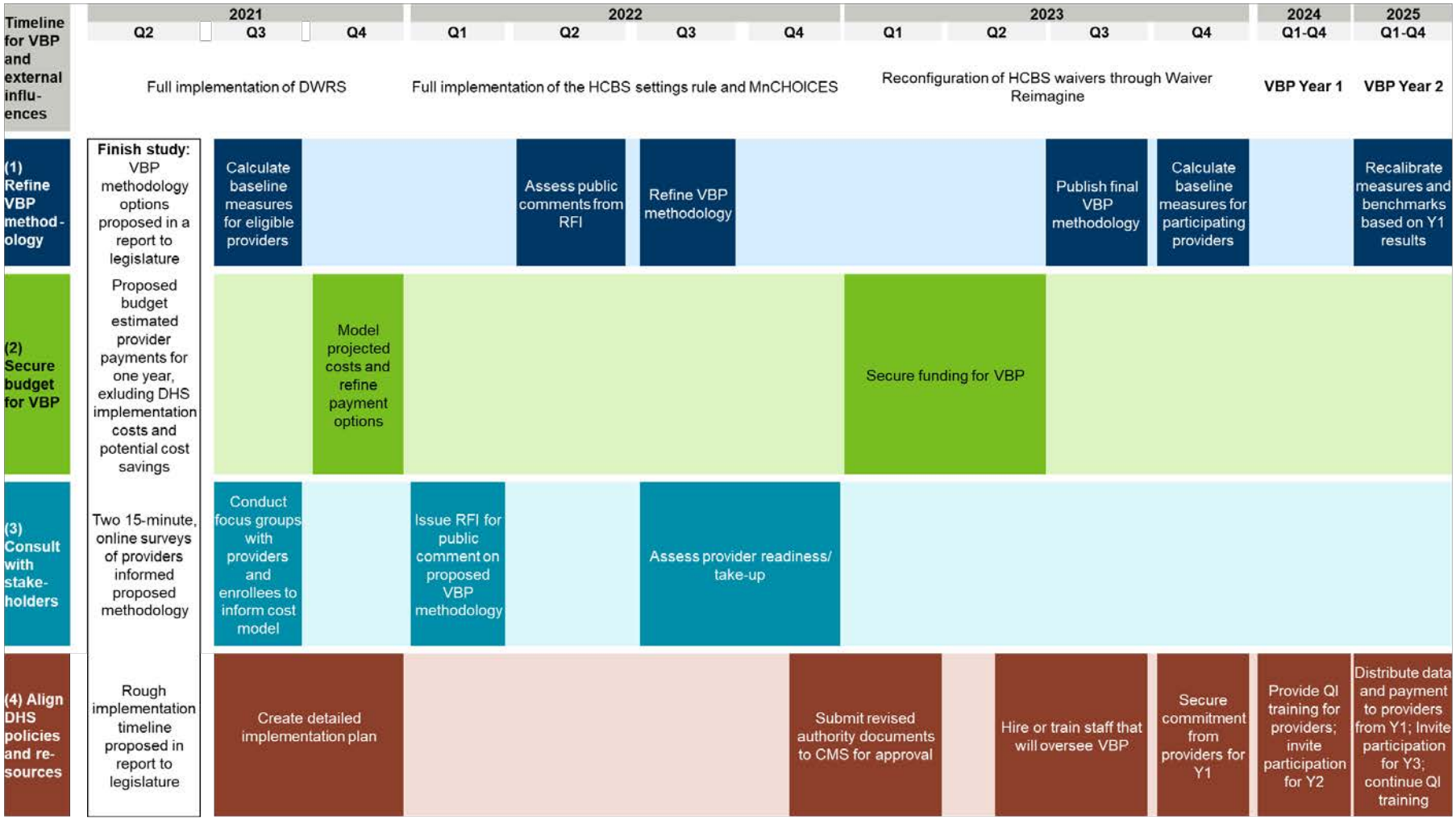
In addition to the questions on methodology and funding raised in Chapter IV: Preliminary VBP models – outstanding questions, DHS will consider the following:

- **How can DHS support providers in QI?** Across its existing VBP programs, DHS provides a range of implementation support activities, including (1) convening providers in person for learning opportunities, (2) providing one-on-one technical assistance (TA) for identifying, measuring and transforming practices to facilitate QI, (3) connecting providers to peers who are also working on QI and (4) giving providers access to data and help in reviewing the implications of VBP (see Table B.1).
  At a minimum, DHS could prepare performance reports for providers in user-friendly formats so providers will understand how their actions affect their performance and related payments. DHS could also consider expanding or adapting existing conferences (i.e., "boot camps"), QI webinars and/or peer-to-peer exchanges offered through other VBP programs to include HCBS

providers. Also, DHS could consider requiring providers to participate in TA as a condition of receiving VBP payment.

- **Do providers have the resources and interest for VBP?** In the October 2020 survey of providers and lead agencies, less than one quarter of respondents were interested in VBP and had staff and funds to support the work (Appendix D). Nearly half of respondents indicated an interest in VBP but did not have or were unsure about having staff and funds to participate. Respondents from large organizations (i.e., serving more than 100 people each month) and organizations with recent experience in QI were more likely to have the resources available to support their participation in VBP. Given this response, DHS should consider surveying providers once it further refines the VBP methodology to assess their readiness and willingness to participate. DHS could also review current state and federal HCBS-related initiatives that may already strain providers and consider how VBP might worsen current disparities across providers.
- **How can DHS build long-term commitment to the goals of VBP and support the long-term plan for implementation?** To implement a well-defined VBP program that has been thoroughly vetted with stakeholders, DHS recommends at least two years from the time of authorization to the first year of data reporting and provider payments. DHS also recommends paying providers for at least two years to facilitate change. This means DHS would make a four-year commitment to VBP, at minimum. The state would need to decide whether the upfront investment justifies the quality gains and potential savings.

Figure 6. Activities required to implement VBP, 2021–2025



V. Potential impact on key outcomes

A. Introduction

Mathematica designed an impact assessment tool that allows DHS to modify inputs, such as the percentage of providers expected to participate in VBP, and observe the subsequent changes in outcomes. This tool will help DHS predict the likely effects of implementing a VBP program for residential and employment services, including the cost of the program to Medical Assistance.

The tool produces low, medium and high estimates that differ based on the following factors:

- Data and implementation years, which establish the dates for VBP implementation and how far forward the inputs must trend
- The number of people receiving the service
- The number of providers who deliver the service, assumptions about the year-to-year change in the number of providers and estimates of the percentage of providers who will participate in VBP
- Total expenditures, assumptions about how much expenditures will increase each year and assumptions about the size of VBP payments to providers.

The study team used the VBP impact assessment tool and waiver claims data from 2018[5] to estimate the range of realistic impacts of a VBP program for residential and employment services. This section of the report presents the team's findings, with the assumption that VBP starts in 2024.

The tool provides a useful framework for considering the cost implications of VBP. However, it is only the starting point for understanding the potential effects of VBP. If the Legislature agrees to move forward with VBP for HCBS, DHS will consider expanding the impact assessment tool to add new features. For example, once DHS selects performance metrics and identifies a reasonable range of expected performance among providers, DHS could modify the tool to add performance outcomes when calculating provider payments. DHS may also add other types of impacts beyond HCBS expenditures, such as accounting for decreased non-waiver state support services to people who are competitively employed or measuring the effect of the VBP program on medical costs for people who receive services from participating providers.

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[5] At the time this report, 2018 was the most recent complete year of waiver claims data available to Mathematica. These data were used as the starting point for several inputs. Whenever possible, the study team also used 2016 data to inform their analysis.

B. Residential services

Using waiver claims data, the study team calculated the number of people receiving residential services (11,622); the number of providers offering residential services to people enrolled in waivers (439);[6] the average number of people served per provider (26); the total annual waiver expenditures on these services ($998,482,059); the average annual increase in the number of providers from 2016 to 2018 (3.1%); and the average annual increase in per-provider expenditures from 2016 to 2018 (4.4%).

Inputs that varied by scenario were chosen to represent very small impacts (the low scenario) and very high impacts (the high scenario). For example, the percentage of providers participating in VBP in the first implementation year ranged from 5% (low scenario) to 90% (high scenario). Table 2 includes the results of the analysis.

Given the substantial amount of waiver spending on residential services, it is important to note that these ranges are the extreme expected ranges for the two-year implementation period. The high end of the range represents additional spending if nearly all residential providers participated in VBP and performed sufficiently well to receive the largest possible payment increase.

Table 2. Expenditure analysis of residential services over first two years of VBP implementation

	Scenario	
Two-year totals	**Low**	**High**
Total expenditures		
Expenditures ($)	3,246,795,026	3,935,934,519
Increase relative to counterfactual (%)	22,767,509 (0.7)	711,907,001 (22.1)
Per provider expenditures		
Expenditures ($)	3,030,797	3,448,952
Increase relative to counterfactual (%)	21,052 (0.7)	439,208 (14.6)
Per beneficiary expenditures		
Expenditures ($)	114,483	130,278
Increase relative to counterfactual (%)	795 (0.7)	16,590 (14.6)

[6] The study team calculated the number of providers using Federal Employer Identification Numbers (FEINs) instead of National Provider Identifiers (NPIs). There are multiple NPIs per FEIN because multiple providers are structured (by NPI) under the same employer framework (by FEIN). The team chose FEIN because it is the level at which VBP payments are likely to be made.

Source: Mathematica analysis of 2016–2018 Minnesota HCBS waiver claims and VBP impact assessment tool

C. Employment services

Using waiver claims data, the study team calculated the number of people receiving employment services (2,898); the number of providers offering employment services to people enrolled in waivers (242); the average number of people served per provider (12); and the total annual waiver expenditures on these services ($6,424,766).

Inputs that varied by scenario were chosen to represent very small impacts (the low scenario) and very high impacts (the high scenario).[7] Table 3 shows the results of the analysis.

Employment services represent a much smaller percentage of HCBS waiver expenditures than residential services. Even in the most expensive possible scenario, an employment services VBP program likely only increases Medicaid spending by less than $4 million in the first two years of implementation.

Table 3. Expenditure analysis of employment services over first two years of VBP implementation

	Scenario	
Two-year totals	**Low**	**High**
Total expenditures		
Expenditures ($)	14,650,613	18,395,028
Increase relative to counterfactual (%)	25,923 (0.2)	3,770,338 (25.8)
Per provider expenditures		
Expenditures ($)	28,373	32,430
Increase relative to counterfactual (%)	50 (0.2)	4,107 (14.5)
Per beneficiary expenditures		
Expenditures ($)	2,369	2,708
Increase relative to counterfactual (%)	4 (0.2)	343 (14.5)

[7] The study team was unable to use waiver claims data to calculate the pre-VBP annual percent change in the number of providers or the per-provider expenditures. This is because DHS added employment services to the four waivers in July 2018. For more information, see DHS – Employment services.

Source: Mathematica analysis of 2016–2018 Minnesota HCBS waiver claims and VBP impact assessment tool

VI. Recommendations

The conditions are right for Minnesota to explore VBP for HCBS. DHS has considerable experience implementing VBP programs for providers that serve people with disabilities. In addition, many HCBS providers have recent experience working to improve the quality of their services. However, certain characteristics of residential and employment providers (e.g., serving a small number of people) will make it challenging to measure progress and distribute payments. In addition, the quality of data DHS would use for measurement has not yet been fully validated.

Although DHS believes VBP is a valuable tool to achieve its goals, more work is needed to identify and specify statistically valid measures, identify funding to support payments to providers and staff who will implement the program and gain buy-in from providers who will participate in the program.

If the Legislature approves support for VBP, DHS would take the following steps to design and implement a VBP model for HCBS providers:

- **Calculate baseline measures for eligible providers.** DHS would use Olmstead, LTSS Improvement Tool and Employment First data to calculate baseline measure values and identify the average annual sample size across all eligible providers. This would help DHS assess which measures to include in VBP, set benchmarks and minimum expectations for improvement and calculate a more accurate budget for VBP that accounts for the proportion of providers expected to earn payments based on the performance targets.
- **Conduct focus groups with providers and people who use services to select measures and establish reasonable benchmarks.** After calculating baseline measure values and determining the range in performance across providers (e.g., a minimum, 25th percentile, mean or median), DHS would convene a stakeholder work group to provide input on the best measures to include in VBP and their benchmarks. Although it would be possible for DHS to analyze the range in performance, providers and people who use services should have the opportunity to provide feedback on how difficult it will be to create meaningful change and how to identify acceptable performance levels. Ideally, defining high or low performance for the proposed measures should include a mix of analytic and qualitative feedback.
- **Model projected costs and payment options.** The VBP impact assessment Mathematica developed for this study (described in Chapter V) allows DHS to predict costs based on a

range of assumptions about the effects of the VBP arrangements on average, per-provider expenditures. After confirming the VBP model characteristics, DHS would estimate the effects. For instance, if DHS identifies a set of 3–5 quality measures to use for VBP in residential services, it could use those measures and their baseline values (as well as reasonable assumptions about the change in provider performance) to better estimate how those improved measures could impact Medicaid costs and other outcomes. It may also be possible to integrate other information (e.g., estimates of the percentage of providers who choose to participate in VBP) in the revised model.

In the longer term, DHS also could explore ways to connect improvement in provider quality with other costs to the state. This could include calculating the effect of:

- Securing competitive employment for a person enrolled in a waiver on other state-funded economic assistance programs
- Improving the quality of residential services on medical care use and related Medicaid expenditures.

References

Adult Family Home Council. "Collective Bargaining Agreement, 2019–2021." Washington State Office of Financial Management. November 27, 2019. Accessed March 19, 2020. Collective Bargaining Agreement (PDF).

Alternative Payment Model Framework and Progress Tracking (APM-FPT) Work Group. "Alternative Model Framework: Final White Paper." Health Care Payment Learning & Action Network. The MITRE Corporation. July 22, 2017. Accessed March 27, 2020. Alternative Payment Model Framework (PDF).

Bailit Health Purchasing. "Integrated Care System Partnerships: Final Report and Recommendations." Bailit Health and Minnesota Department of Human Services. August 2016. Accessed March 13, 2020. Integrated Care System Partnerships: Final Report and Recommendations (PDF).

Bir, Anupa, S. Ohri Gandhi, N. Berkman, S. Brown, J. Burton, D. Clayton, A. Cool, et al. "State Innovation Models Round 2: Model Test Annual Report Three." Centers for Medicare & Medicaid Services. RTI International. June 22, 2018. Accessed March 5, 2020. State Innovation Models Round 2: Model Test Annual Report Three (PDF).

BlueCare Tennessee. "Employment and Community First CHOICES: Working Together to Make Integrated Employment and Community Living First in Tennessee." BlueCare Tennessee. Accessed March 19, 2020. Employment and Community First CHOICES: Working Together to Make Integrated Employment and Community Living First in Tennessee (PDF).

Burns and Associates Inc. *Analysis of Utilization by Service by Waiver/Agency/Residential Placement: Attachments 1–4.* Phoenix, AZ: Burns and Associates, June 18, 2018.

Centers for Medicare & Medicaid Services. "Request for Information: Recommended Measure Set for Medicaid-Funded Home and Community-Based Services." Centers for Medicare & Medicaid Services. September 18, 2020. Accessed May 4, 2021. Request for Information: Recommended Measure Set for Medicaid-Funded Home and Community-Based Services (PDF).

Centers for Medicare & Medicaid Services, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations. "Application for a §1915(c) Home and Community-Based Waiver, Version 3.6; Instructions, Technical Guide, and Review Criteria." Centers for Medicare and Medicaid Services. January 2019. Accessed March 11, 2020. Instructions, Technical Guide and Review Criteria (PDF).

Centers for Medicare & Medicaid Services, Division of Long Term Services and Supports. "Pay for Performance in a Fee for Service System—Paying for the Outcomes Everyone Wants." Advancing States. August 2018. Accessed March 11, 2020. Pay for Performance in a Fee for Service System—Paying for the Outcomes Everyone Wants (PDF).

Costello, Anne Marie and Brad Smith. "Value-Based Care Opportunities in Medicaid." Centers for Medicare & Medicaid Services. September 15, 2020. Accessed April 26, 2021. Value-Based Care Opportunities in Medicaid (PDF).

Damberg, C., M. Sorbero, S. Lovejoy, G. Martsolf, L. Raaen, and D. Mandel. "Measuring Success in Health Care Value-Based Purchasing Programs; Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions." *Rand Health Quarterly* 4, no. 3 (2014): 9. PMID: 28083347; PMCID: PMC5161317.

Davila, Heather, Kathleen Abramson, Laura Kirk, Greg Arling, and Brian Abery. *Home and Community-Based Service Performance-Based Incentive Payment Program (HCBS PIPP): Preliminary Summary of HCBS PIPP Provider Progress and Final Reports*. Report to the Minnesota Department of Human Services. University of Minnesota and Purdue University, June 30, 2016.

Feldman, Stacie, Martha Kovac, Michael Levere, Jason Markesich, and Karen CyBulski. "Conducting a Mixed-Mode Web and Telephone Survey with an Adult Population with Disabilities: Descriptive Findings from the POD Follow-Up Survey." Presentation at the American Association for Public Opinion Research (AAPOR) Virtual Annual Conference, June 2020.

Fox, S. *The Social Life of Health Information, 2011*. Pew Research Center Report. Washington, DC: Pew Internet and American Life Project, 2011.

Killingsworth, Patti. "Memorandum of Understanding between the TN Dept of Human Services, Division of Rehabilitation Services, Vocational Rehabilitation Program and the State of TN, Division of Health Care Finance and Administration, Bureau of TennCare, Division of Long Term Services and Supports." Memorandum to Paula Knisley, Department of Human Services, Division of Rehabilitation Services, Vocational Rehabilitation Program, March 20, 2017. Accessed March 19, 2020. Memorandum of Understanding (PDF).

Massachusetts Executive Office of Health and Human Services. "MassHealth Delivery System Restructuring: Overview." Commonwealth of Massachusetts. April 14, 2016. MassHealth Delivery System Restructuring: Overview (PDF).

Medicaid Innovation Accelerator Program. "Medicaid Value-Based Payment Approaches and Key Design Considerations National Learning Webinar." Medicaid.gov. October 5, 2017. Accessed March 5, 2020. Medicaid Value-Based Payment Approaches and Key Design Considerations National Learning Webinar (PDF).

Minnesota Board on Aging. "Status Check: Service Quality and Standards." Minnesota Board on Aging. August 8, 2017. Accessed March 13, 2020. Status Check: Service Quality and Standards (PDF).

Minnesota Department of Human Services. "Integrated Health Partnerships (IHP)." Minnesota Department of Human Services. June 7, 2019. Accessed March 13, 2020. Integrated Health Partnerships (IHP). Accessed March 13, 2020.

Minnesota Department of Human Services. “Nursing Facility Performance-Based Incentive Payment Program (PIPP) Request for Proposals." Minnesota Department of Human Services. February 2019. Accessed March 27, 2020. Nursing Facility Performance-Based Incentive Payment Program (PIPP) Request for Proposals (.doc).

Minnesota Department of Human Services, Disability Services Division. *2019 Biennial Report on Long-Term Services and Supports for People with Disabilities.* St. Paul, MN: Minnesota Department of Human Services, January 2019. 2019 Biennial Report on Long-Term Services and Supports for People with Disabilities (PDF).

Minnesota Department of Human Services, Health Care Administration. “Request for Proposals for a Qualified Grantee to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnerships (IHP) Demonstration.” Minnesota Department of Human Services. June 11, 2018. Accessed March 27, 2020. Request for Proposals for a Qualified Grantee to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnerships (IHP) Demonstration (PDF).

SEIU 775 Benefits Group. “Advanced Home Care Aide Specialist.” SEIU 775 Benefits Group. Accessed March 19, 2020. Advanced Home Care Aide Specialist.

Soper, Michelle, Debra Lipson, Maria Dominiak, and James Lloyd. *Achieving Value in Medicaid Home and Community-Based Care: Considerations for Managed Long-Term Services and Supports Programs*. Hamilton, NJ: Center for Health Care Strategies, September 2018.

Stone, Robyn. “Developing a Quality Direct Care Workforce: Searching for Solutions.” *Public Policy and Aging Report* 27, no. 3 (2017): 96–100. Developing a Quality Direct Care Workforce: Searching for Solutions.

Taylor, Brittany, Yoshi Kardell, John Agosta, Mary Sowers, and Mary Lee Fay. *Waiver Reimagine: Feasibility & Recommendation Report, Minnesota Waiver Reimagine Project Study 1, Tasks A.6 & A.7*. Tualatin, OR: Human Services Research Institute and Alexandria, VA: National Association of State Directors of Developmental Disabilities Services, September 14, 2018.

Volunteers of America, Western Washington. “Meaningful Day Provider.” Volunteers of America, Western Washington. Accessed March 19, 2020. Meaningful Day Provider.

Washington State Department of Social and Health Services. “Adult Family Homes—Meaningful Day.” Washington State. October 2019. Accessed March 19, 2020. Adult Family Homes—Meaningful Day (PDF).

Washington State Department of Social and Health Services. “Advanced Home Care Aide Specialist Pilot Project (AHCAS).” Washington State. Accessed March 19, 2020. Advanced Home Care Aide Specialist Pilot Project (AHCAS).

Washington State Department of Social and Health Services, Aging and Long-Term Support Administration, Home and Community Services Division. "H19-035 – Policy & Procedure." Washington State. July 1, 2019. Accessed March 19, 2020. Available at H19-035 – Policy & Procedure (.doc).

Welch, S. and S. Snyder. *February 2021 Forecast*. St. Paul, Minnesota: Minnesota Department of Human Services, Reports and Forecasts Division, 2021.

Wisconsin Department of Health Services. "Medicaid Managed Care Quality Strategy." State of Wisconsin. June 2018. Accessed March 19, 2020. https://www.dhs.wisconsin.gov/publications/p02156.pdf.

Wisconsin Department of Health Services. "Medicaid Managed Care Quality Strategy." January 1, 2018. Accessed March 19, 2020. Medicaid Managed Care Quality Strategy (PDF).

Wisconsin Department of Health Services. "Program Contract between Wisconsin Department of Health Services Division of Medicaid Services and MCO." State of Wisconsin. January 1, 2020. Accessed March 19, 2020. Program Contract between Wisconsin Department of Health Services Division of Medicaid Services and MCO (PDF).

Appendix A: Federal guidelines for VBP in HCBS

Requirements for services authorized under Section 1915(c) waivers

DHS is considering value-based payment (VBP) strategies that would apply to home and community-based services (HCBS) provided through four section 1915(c) waivers. As such, DHS must follow requirements that apply to section 1915(c) waivers.

To increase and enhance quality in service provision, the Centers for Medicare & Medicaid Services (CMS) allows states to adopt pay for performance (P4P) strategies in their section 1915(c) HCBS waivers through supplemental or enhanced payments (CMS 2018). To do so, states must ensure the payment methodologies are consistent with statutory requirements, per section 1902(a)30(A). In their application to CMS, states also must include the following information:

- Nature of the supplemental or enhanced payments and the waiver services for which these payments are made
- Provider types receiving these payments
- Source of the nonfederal share of the supplemental or enhanced payments
- Requirement that providers eligible for the additional payment will retain 100% of the total computable expenditure claimed by the state to CMS
- Transparency of the payment, meaning it is clear to the public which providers should receive the additional payments and under what circumstances (CMS 2018, 2019)

The final requirement is particularly important for DHS to consider for potential VBP programs that use many different measures for performance across similar provider types. The HCBS Performance-based Incentive Payment Program (PIPP), which was implemented in 2013 and 2014, used measures that were applied differently to various providers. In exploratory conversations about a payment strategy for this program, CMS indicated it would not approve federal matching funds for VBPs that were not equitable across providers. This program and its funding are discussed in more detail in Appendix B.

Requirements for other services

In September 2020, CMS published guidance for states interested in adopting value-based care for Medicaid services covered by any authority, including but not limited to section 1915(c) waivers (CMS 2020a). If DHS becomes interested in a model that would add VBP to state plan services or enhance or limit services in a way that would require section 1115 demonstration authority, it should consult with CMS on the most appropriate legal and operational pathways.

Appendix B: Background information on VBP programs in Minnesota and other states

Appendix B provides a summary of findings from an environmental study conducted between January and March 2020. The purpose of the scan was to identify:

- Federal requirements related to value-based payment (VBP)
- State VBP models that would inform DHS' development of VBP for home and community-based services (HCBS) disability waivers.

State VBP models of interest included those used for HCBS providers who serve people with disabilities, as well as models that relate to other LTSS people with disabilities use (e.g., nursing facilities) or HCBS delivered under managed care models (which might use different incentive structures but likely involve similar providers).

Methods

The study team gathered information through a review of public documentation and interviews with state Medicaid staff involved in developing or overseeing VBP programs, both inside and outside of Minnesota. The team conducted six interviews in February and March 2020 by using a semi-structured discussion guide. Then, they analyzed the interview notes and documented the context for each program, lessons learned and advice for DHS as it explores VBP for its HCBS disability waivers.

1. VBP within Minnesota's Medical Assistance programs

As of March 2020, the study team identified six VBP programs Minnesota uses or has used to encourage quality improvement (QI) among providers who serve people with disabilities, including but not limited to HCBS providers. These programs demonstrate DHS' considerable experience with VBP for people with disabilities. The programs are summarized in the following sections and in Table A.1.

A. Nursing Facility Performance-based Incentive Payment Program (NF PIPP)

Since July 1, 2006, the NF PIPP has allowed nursing facilities to apply individually or in collaboration with other nursing facilities for a time-limited rate increase in exchange for implementing a project to improve the nursing facility's quality of care. A nursing facility may request a performance-based incentive payment of up to 5% of its operating payment rate, but

providers must achieve measurable program outcomes to retain full funding. The rate add-on amount, duration and outcomes are negotiated with DHS.

Through this program, DHS has funded projects to improve staff recruitment and retention, reduce the rate of falls among residents, improve clinical care and provide meaningful activities (Minnesota Board on Aging 2017).

B. Integrated Health Partnerships (IHP)

The 2010 Minnesota Legislature required DHS to develop and implement a demonstration to test alternative health care delivery systems, including accountable care organizations (ACOs). Through IHP (the resulting program), DHS contracts with innovative health care delivery systems to provide high-quality, efficient care to Minnesota's Medicaid population.

Participating providers enter into an arrangement with DHS and are held accountable for the costs and quality of care provided to their Medicaid patients. Providers who show an overall savings across their population while maintaining or improving the quality of care receive a portion of the savings. Providers who show an increased cost over time may be required to pay back a portion of the losses (Minnesota DHS 2019). Though the program is aimed at primary care and medical providers, HCBS providers are encouraged to participate in IHP.

C. Quality Improvement Incentive Program (QIIP) for nursing facilities

Building on the success of PIPP, the 2013 Minnesota Legislature directed DHS to develop a Quality Improvement Incentive Program (QIIP) to give Medicaid-certified nursing facilities the opportunity to receive funds if they improve their quality. Beginning in 2015, nursing facilities can select one quality measure to improve. The amount of a nursing facility's rate increase is based on the amount of improvement in the quality indicator relative to the previous year.

Unlike NF PIPP, QIIP does not have a competitive application process. To participate, a nursing facility only needs to select a single quality indicator and work to improve that measure (Minnesota Board on Aging 2017).

D. Integrated Care System Partnerships (ICSP)

In 2013, DHS added a provision to its contracts for managed care organizations (MCOs) that serve older adults (Minnesota Medicaid Senior Health Options/Minnesota Senior Care Plus [MSHO/MSC+]) and people with disabilities (Special Needs BasicCare [SNBC]). This provision requires MCOs to implement VBP models with their providers.

Inspired by partnerships between health plans and providers that already exist through MSHO, the ICSP initiative is designed to explore new payment and delivery system models that promote better care coordination for older adults across multiple provider types and care settings (Bailit Health Purchasing 2016). Under the program, MCOs must develop and implement a minimum number of ICSP projects each year. The MSHO/MSC+ contract for 2020 required a minimum of four ICSP projects, two of which must focus on LTSS. MCOs identify projects they find meaningful and select measures from a list, or they propose alternatives. Projects are funded from existing capitation payments, and payment arrangements are negotiated directly between the MCO and its contracted providers.

E. HCBS Performance-based Incentive Payment Program (HCBS PIPP)

The 2013 Minnesota Legislature authorized DHS to implement a one-time HCBS PIPP. The intention of the HCBS PIPP program was to improve the quality of life of people who use HCBS, improve the quality of services and deliver high-quality services more effectively.

DHS selected participating providers through a competitive application in which providers were required to identify a problem, take risks, implement innovations, develop goals and show evidence that their plan improved HCBS (Minnesota Board on Aging 2017).

F. HCBS Quality Improvement (QI) Add-On Rate Increase

The 2014 Minnesota Legislature authorized a 5% rate increase for continuing care providers and other services. The 2015 Minnesota Legislature authorized another 1% increase. These increases are referred to as the HCBS QI Add-On Rate Increase program.

To keep the portion of the rate increase related to quality, providers were required to submit plans to DHS for QI on topics and measures meaningful to them. The program provided an opportunity for DHS and the state's community of providers to collaboratively work toward improving the lives of older adults and people with disabilities (personal communication with J. Cowan, March 2, 2020).

2. VBP for HCBS outside of Minnesota

As of March, 2020, the study team identified three states with VBP models similar to DHS' proposed HCBS VBP program. The programs are summarized in the following sections and in Table A.2.

Details of two additional programs (Massachusetts's ACO program and New York's Managed Long Term Care program) are not included in this report because they did not inform the P4P/P4R model proposed in this study.

A. Tennessee QuILTSS and Employment and Community First (ECF) CHOICES

Tennessee encourages VBP through its QuILTSS initiative. This initiative is designed to promote high-quality LTSS for people who use Medicaid in nursing facilities and the community through provider-level payment reform and workforce development. QuILTSS includes outcome-based reimbursement for services such as nursing facility care, enhanced respiratory care, HCBS, behavioral health crisis prevention intervention and stabilization services (SOS) and workforce development. Tennessee's work on the QuILTSS initiative began in 2013 with support from a Robert Wood Johnson Foundation grant (Bir et al. 2018). The program initially focused on nursing facilities. However, through the state's participation in the State Innovation Model (SIM) initiative, the state extended it to HCBS providers.

Since 2010, Tennessee has provided HCBS to older adults and many people with disabilities though its CHOICES in Long-Term Services and Supports managed care program (or CHOICES, for short). However, in 2016, the state began serving most people with intellectual and developmental disabilities (I/DD) through a managed care program called ECF CHOICES. Tennessee built VBP methodologies into the ECF CHOICES reimbursement model, which provides pay for reporting of key activities, including:

- Exploration of a person's goals
- Discovery of options
- Benefits counseling
- Situational observation
- Plans and start-up activities for job development or self-employment
- Employment discovery and customization
- Career objective plans.

During the employment discovery and customization phase, payments to employment services staff are based, in part, on whether the person has achieved competitive, integrated employment (Killingsworth 2017; BlueCare Tennessee n.d.).

A 2018 report documented the successes and challenges with the implementation of VBP for HCBS providers through QuILTSS (Bir et al. 2018). The authors reported that implementing VBP in the ECF CHOICES from the start promoted employment and pre-employment services for people with I/DD. However, implementing QuILTSS among HCBS providers who served people in the state's three fee-for-service section 1915(c) waivers for people with I/DD was challenging because of the large number and differences in providers involved, as well as provider concerns about how the proposed changes would affect their financial status and business models.

Section 1915(c) waiver providers agreed on a new reimbursement structure that incentivized certain outcomes, and the state submitted the section 1915(c) waiver amendments in July 2018 (Bir et al. 2018).

B. Washington Meaningful Day Activities Add-On Rate and Advanced Home Care Aide Specialist Training

Washington State implemented two approaches to incentivize QI for HCBS providers. First, the Meaningful Day Activities program uses Medicaid and state-funded long-term care program funds to offer adult family homes an add-on rate of $30 per day to provide individualized, self-directed day activities for residents with high behavioral health needs (Adult Family Home Council 2019; Washington State Department of Social and Health Services 2019). Providers work with people to identify their strengths, interests and abilities and to develop goals and meaningful activity plans, which are updated twice a year. Activities should be relevant to people's interests, choices and abilities and be routinely available and planned by the provider. They should include opportunities for individual and group activities, such as swimming, music therapy and art (State of Washington Department of Social and Health Services, Aging and Long-Term Support Administration, Home and Community Services Division 2019; Volunteers of America, Western Washington n.d.).

Second, the Advanced Home Care Aide Specialist Training Program offers a raise of $0.75 per hour for home care aides who complete a 70-hour classroom- and web-based training on person-centered care. The state-funded training runs one day per week for eight weeks for individual providers who provide personal, in-home care to a person with high or complex needs, including high behavioral health needs (Washington State Department of Social and Health Services n.d.; SEIU 775 Benefits Group Washington State Department n.d.).

C. Wisconsin Family Care P4P component

Wisconsin instituted a P4P component in contracts with MCOs that participate in its Family Care program. The state withholds and returns up to 0.5% of an MCO's capitation rate and pays an incentive of up to 0.3% of the capitation rate, based on performance on member satisfaction surveys and competitive integrated employment metrics. Member satisfaction surveys, which are distributed and measured by the state, assess performance on four questions:

1. Person's access to services
2. Person's participation in the care planning process
3. Person's satisfaction with the care plan and team
4. Person's overall satisfaction with services.

These items are rated on a four-point scale, with question-specific benchmarks set for each MCO based on previous performance. MCOs that meet the minimum performance standards for all four questions earn back the entire withheld rate. MCOs also earn a 0.05% performance enhancement to their rate for each question-specific performance benchmark they meet (Wisconsin Department of Health Services Program Contract 2018, 2020).

MCOs also report competitive integrated employment metrics that the state Medicaid agency validates. Under the current contract, MCOs will have all capitation payments returned if 90–100% of people age 18 to 45 who are employed in competitive integrated employment in January 2020 are similarly employed in December 2020. They will have 0.125% of their capitation returned if the rate is between 80–89.9%. They will have none of their capitation returned if the rate drops below 80%.

If MCOs increase the percentage of people they serve in competitive integrated employment in 2020, they earn incentive payments of up to 0.10% of their capitation rates for an increase of 4% employed and 0.05% for an increase of 2–3.9% employed (Wisconsin Department of Health Services Program Contract 2020).

Wisconsin also uses public reporting on people's satisfaction and competitive integrated employment metrics through report cards to drive provider QI and support other QI initiatives (Wisconsin Department of Health Services 2018).

3. Themes across VBP models that include people with disabilities

Theme 1: Most programs surveyed attempted to link quality to value by offering HCPLAN category 2 payment models to providers

All programs in other states and in Minnesota (with the exception of the IHP program) offer category 2 payment models to providers. Two of Minnesota's programs (NF PIPP and ICSP) also allow providers to choose to participate in category 2 or category 3 alternative payment models (APMs) that involve shared savings and potential downside risk.

Two of Minnesota's past projects that attempted VBP for HCBS providers—the HCBS PIPP and HCBS QI add-on rate increase—used category 2 models that paid providers to begin building the capacity to measure and respond to quality targets. Both programs were an opportunity for DHS and providers to collaborate around a shared goal, build on existing provider

Category 2 VBP models dominate because:

- Category 2 models thought to be most appropriate for HCBS providers
- Medically focused category 3 payment models struggled to include HCBS providers.

capacity and create a community and culture focused on QI. At the time, DHS saw models that used foundational payment and pay for reporting (P4R) as the most appropriate for HCBS providers because many of them had never been involved in formal QI work and needed to build capacity to take on more risk in payment. In the words of one program manager, the programs and their authorizing legislation attempted to "prime the provider field for future VBP efforts."

Minnesota's two other programs that focus on medical care (ICSP and IHP) offer Category 3 population-based payment models that can include HCBS providers. However, both programs had limited participation from HCBS providers. IHP, the most advanced payment model, only includes one IHP focused on HCBS. The program has struggled to include other HCBS providers, even though program managers reported that they offered more advantageous risk terms to IHPs that partner with HCBS providers and other community-based organizations to address social determinants of health (Minnesota DHS 2019; Minnesota DHS 2020). Program managers reported it was challenging to include HCBS providers in IHPs because the populations they serve represent a relatively small proportion of an IHP's overall population. In addition, many HCBS users are dually eligible for Medicaid and Medicare.[8] This makes it difficult for DHS to calculate the total cost of care for these people because many claims are contained in Medicare data. In addition, HCBS waivers cover care coordination services similar to what is covered under the population payment, so DHS has to adjust its payment algorithms to ensure care coordination is not counted twice. One group of HCBS providers who applied for an IHP have required special accommodations (e.g., modified payment attribution) to avoid these payment challenges.

As in Minnesota, category 2 models are the most common type seen in other states that include HCBS providers in VBP. The Tennessee, Washington and Wisconsin models offer category 2 P4P payments to providers. The model used by VNSNY CHOICE in New York's MLTC

[8] For people who qualify for both Medicare and Medicaid (i.e., dually eligible beneficiaries), Medicare is the primary payer for most acute care services, including hospital, physician and short-term skilled nursing facility services. For full-benefit dually eligible beneficiaries, Medicaid pays for Medicare Parts A and B premiums and enrollee cost sharing, long-term nursing facility and other institutional services, community-based LTSS and many non-Medicare-covered services such as dental, vision and transportation. For partial-benefit dually eligible beneficiaries, Medicaid pays Medicare premiums and, depending on household income, either all or a share of Medicare deductibles and cost sharing. Partial-benefit dually eligible beneficiaries do not qualify for state Medicaid benefits.

VBP plan is a category 3 payment model that provides shared savings with upside risk only, whereas the Partners ACO in Massachusetts shares in both upside and downside risk.

Theme 2: All of Minnesota's programs are voluntary for providers, who are allowed to propose or choose VBP models relevant to them (sometimes within established parameters).

The six programs in Minnesota analyzed by the study team share the philosophy that providers are in the best position to identify their needs and to design projects that improve quality in target areas.

In each program, providers have flexibility to identify QI projects and measures that align with the goals of the program. Four programs (NF PIPP, QIIP, ICSP and IHP) provide a menu of measures from which providers can choose. Two programs (HCBS PIPP and HCBS QI add-on) allow providers to choose any measure that is meaningful to them. Three programs (NF PIPP, ICSP and HCBS PIPP) also allow providers to propose the amount of money they would like to receive if they meet program requirements.

Minnesota's existing VBP programs use a provider-led approach to do the following:

- Accommodate variation among providers
- Create widespread buy-in among providers
- Avoid unintended consequences
- Develop in-program variation.

Most of the DHS program managers with whom the study team spoke identified the flexible approach as a strength. Providers can buy in to the project, start small and grow their participation over time. One program manager explained, "We run into the problem that when we prescribe things, it doesn't make sense for providers and what they do and the people they support. That can build inequity in their services or create services that don't make sense for their populations as an unintended consequence."

Theme 3: In most of Minnesota's programs, DHS selects or negotiates with providers to establish programs with meaningful goals, measures and payments.

Through the application or negotiation process, DHS shapes the provider-submitted proposals so they are achievable and align with DHS' goals for QI. The way in which DHS does so varies by program:

- In HCBS PIPP, DHS awards money to projects based on proposals that appear to best achieve their specified objectives
- In IHP, DHS provides data to providers that focus on certain themes (e.g., mental health issues among the formerly incarcerated) and encourages QI efforts to focus on these topics
- When ICSP first started, DHS worked closely with the MCOs that were required to implement VBP programs to help them select program topics and measures
- In NF PIPP, providers select measures from a pre-established menu, and DHS negotiates payment targets with each facility, up to a maximum amount.

DHS helps shape VBP models by doing the following:

- Setting application criteria
- Selecting qualified proposals
- Using data to steer project selection
- Negotiating topics and payment targets

Theme 4: Minnesota's provider-led approach resulted in programs that (1) contain a wide variety of VBP projects that target different objectives, services or populations, (2) measure progress differently and (3) reward providers through varying mechanisms and amounts.

Within each program, the breadth of QI efforts that providers are involved in is wide. For example, HCBS PIPP funded eight projects on person-centered services, seven on health promotion, five on community options and engagement, three on employment, two on housing, one on culturally competent services and one on caregiver support. Participating providers included home health care services, employment services, in-home supports, assisted living and residential services.

Provider-led VBP creates in-program diversity in the following areas:

- Topics
- Measures
- Benchmarks
- Payment amounts.

The HCBS QI add-on rate increase involved similar types of providers. The projects sought to improve people's ability to perform everyday activities, increase person centeredness, improve health, increase independence and use people's feedback to improve services, among other things.

IHP funded only one project focused on HCBS that involved behavioral health providers, a home health provider and a primary care provider who are paid risk-adjusted, population-based payments to support care coordination related services and infrastructure. IHP also implements an equity initiative to provide medication therapy management to adults with intellectual and developmental disabilities.

HCBS-related projects in ICSP include one project to increase the use of interpreters for people who use HCBS waivers.

Theme 5: Measures of HCBS quality in Minnesota's previous VBP programs have been process-oriented and homegrown.

Across Minnesota's six programs, the topics and usefulness of measures that relate to HCBS have varied extensively.

Providers in the HCBS PIPP and QI add-on projects overwhelmingly selected process measures, many of which were "homegrown" (i.e., not specified in a national measure set). DHS staff reported that these types of measures catered to the specific needs of providers. However, measure reliability and validity has been poor. Process measures are also limited in their ability to measure the impact of a program on the people it serves.

HCBS process measures have the following features:

- Oriented to processes, not outcomes
- Constructed by providers
- Not part of a national, standard set
- Challenged by reliability and validity concerns.

DHS acknowledges that calculating new measures, particularly those that are more outcome-oriented, would require new data collection from providers. Further, any additional data that providers collect and report themselves for the purposes of receiving enhanced payment could carry a conflict of interest and the potential for manipulation. In Washington and Wisconsin, measures are also structure- and process-oriented.

Programs not exclusively focused on HCBS providers have limited measures of HCBS. In the Minnesota ICSP and IHP programs, there are no agreed-upon HCBS measures on the lists from which providers select. Measures used for the PIPP and QIIP programs are exclusively focused on nursing facilities, even though program objectives for PIPP include rebalancing—a goal that requires the participation of HCBS providers.

Theme 6: Federal funds have facilitated VBP models inside and outside Minnesota.

Federal funds through the Innovation Accelerator Program, State Innovation Model (SIM) initiative or Delivery System Reform Incentive Payment Program (DSRIP) facilitated development and implementation of many VBP models inside and outside Minnesota. Tennessee's QuILTSS and Minnesota's IHP used time-limited SIM grant funding. The IHP program manager suggested that SIM funding was important in the beginning of the program because it supported a wide range of activities, including implementation support for providers. The models in Washington and Wisconsin were state-initiated, though both states received technical assistance through the IAP program.

Federal grant and Medicaid matching funds can help launch and sustain programs.

- Federal matching funds require transparent terms of payment.

Though the NF PIPP and QIIP programs in Minnesota were developed before SIM and IAP funding were available, officials secured federal financial participation (i.e., Medicaid matching funds) as well as collections from private pay facility residents to support the programs. These funds provide an important source of ongoing support.

Two of Minnesota's VBP programs (HCBS PIPP and the HCBS QI add-on) launched and operated on state funds alone, which presented some challenges. The legislation authorizing these two programs required DHS to include all providers and service types and to pilot test different measures, including those in the HCBS Report Card that was developed in 2014 and 2015.[9] A drawback to including all providers was that DHS could not identify standardized measures to use across the many HCBS providers and services. The basis for these payments was not transparent to all stakeholders, so DHS could not secure federal funding to support them.

[9] The Minnesota Legislature defined HCBS providers broadly in Minn. Stat. §256B.438.

Theme 7: One-time funding provided useful momentum, but continued funding is required for programs to sustain QI efforts over the long term.

Four of Minnesota's programs (NF PIPP, QIIP, ICSP and IHP) have secured ongoing state and federal funding to support QI over many years. In contrast, the HCBS PIPP and HCBS QI add-on programs received one-time state funding and were unable to continue after funds expired.

Though program managers reported that these two HCBS VBP programs provided useful momentum for some providers, sustaining QI projects was a challenge for many. One-time funding was helpful for projects that invested in staff training or technology, but projects that required ongoing funds (e.g., to support new staff) were more difficult to sustain. One-time funding was particularly difficult for disability service providers to use because many of them relied on Medicaid funds for most of their revenue and could not turn to other sources of funding for sustainability. Providers also reported that the short duration of the projects were a challenge because launching their project took more time than anticipated (Davila et al. 2016).

Short-term, one-time funding has pros and cons:

- Pro: Can help launch projects that require staff training or technology
- Con: Is insufficient for projects that require permanent staff
- Con: Is particularly difficult for disability service providers to manage in the long term.

Theme 8: Minnesota has provided extensive implementation support for each VBP program.

Across the six Minnesota programs, DHS provided a range of implementation support activities, including:

- Hosting in-person learning opportunities for providers
- Providing one-on-one technical assistance to identify, measure and transform practices to facilitate QI
- Connecting providers to peers also working on QI
- Providing access to data and help to review implications of VBP for providers.

Even for long-standing programs such as NF PIPP and QIIP, implementation support remains a key aspect of the program and has not diminished over time. For the ICSP program, DHS has phased out of its role of reviewing and providing technical assistance to MCOs on QI projects. According to the ICSP program manager, letting MCOs fully own the project has been a sign of success for the program because "you set up it and it runs itself." One downside this same manager identified, however, is that DHS no longer has a comprehensive understanding of all the ICSP projects going on because they are completely managed by the MCOs.

Providers need help implementing VBP because:

- Existing programs have used a range of supports
- Implementation requires dedicated funding and/or staff
- Access to QI coaching and data encourages provider participation in VBP

The level of implementation support provided in Minnesota's six programs requires dedicated funds above and beyond what is paid to providers. Such funds support full-time state staff, outside consultants for training and conference expenses. For example, the NF PIPP and QIIP programs employ one full-time quality nurse who leads the annual boot camp, helps providers write applications and provides QI coaching. The legislation authorizing the HCBS PIPP and HCBS QI add-on included money to hire dedicated staff and contract with experts (e.g., staff from the Institute for Community Integration) to provide training on QI topics and techniques for providers new to the practice.

All Minnesota program managers interviewed for this study reported that implementation support was critical to making the programs work. Several also reported that the additional support for providers was a major draw for participation. The IHP program in particular reported its providers were very interested in the data they received through their participation in the program.

Other state's models, like Washington's program, included significant implementation support as well, such as support staff and completion criteria for workforce training for home care aides (SEIU 775 Benefits Group n.d.). Massachusetts is investing in health care workforce development and training, technical assistance to providers, and infrastructure funding to ensure the success of HIT (Massachusetts Executive Office of Health & Human Services 2016). New York invested in a series of regional boot camps for MLTC VBP stakeholders, in addition to webinars, learning series, tailored technical assistance, in-person stakeholder meetings and a VBP resource library (CHCS 2018). Washington provides support staff and completion criteria for workforce training for home care aides (SEIU 775 Benefits Group n.d).

Theme 9: All of Minnesota's programs experienced strong provider participation, but HCBS provider participation was strongest in HCBS-focused programs.

Though all of Minnesota's programs are voluntary for providers, many choose to participate. Among HCBS providers, however, participation rates are stronger in HCBS-focused programs than programs focused on medical or nursing facility care. For example, interest in HCBS PIPP exceeded the amount of money available to support providers. DHS received 64 proposals but was only able to award funding to 27 of them. Participation in the HCBS QI add-on was also high. Of about 5,000 providers who participated in both years, all but eight providers submitted the required documentation and were allowed to keep the additional funds. (However, DHS put considerable resources into eliciting the required materials from providers, even past the advertised deadline.)

In the IHP and ICSP programs, which welcome but do not explicitly focus on HCBS providers, participation from HCBS providers is low. Neither program includes explicit measures of HCBS, which may discourage HCBS providers from participating. In IHP, low HCBS provider participation may also stem from challenges in incorporating HCBS providers into a total-cost-of-care model, as described earlier. IHP also does not enforce shared savings with any HCBS providers that participate, though DHS has contemplated whether that would be helpful.

HCBS providers have demonstrated interest in VBP:

- Strongest participation is in HCBS-focused programs
- Non-participating providers may be either high or low performing

Despite low participation, one program manager reported that HCBS providers were "continually coming to us because they want to be a part of the share in savings and rewarded for what they are doing, but they don't know how to crack into the system." Examples of HCBS providers included in ICSP projects are limited but include a project related to translation services for people who use HCBS and another related to care coordination. One DHS program manager felt that even a little involvement from HCBS providers was better than none. In her words, "quality improvement happens one provider at a time."

4. Guiding principles for designing a new VBP methodology for HCBS waivers that serve people with disabilities

Based on discussions with program managers inside and outside Minnesota, the study team identified the following guiding principles for any VBP program for HCBS providers. These principles informed the proposed methodology in this report.

Principle 1: Align any new VBP program for HCBS providers with existing QI efforts.

HCBS providers in Minnesota may currently or previously been involved in QI through other VBP and grant programs sponsored by the state. As one program manager explained, "We hear pretty consistently that it doesn't work well for providers to feel they are pulled in a million different directions." For this reason, DHS should align any new VBP program it designs in two ways:

- **Consider a VBP model that allows providers to propose or select QI topics and measures that are meaningful to them and the people they serve.** This provider-led approach has been used in all of Minnesota's existing VBP programs. Continuing it in a new program will help providers identify the best next steps in QI based on their own previous efforts. DHS should especially consider approaches in which providers select from a pre-identified menu of measures, benchmarks and payment models. Models that do not limit the measures and the terms of payment that providers can propose (e.g., HCBS PIPP program) will not qualify for federal matching funds, which will limit the reach and sustainability of the program.
- **Use established HCBS measures that can be calculated by using data providers already collect.** In the HCBS PIPP and QI Add-On Rate Increase programs—Minnesota's two VBP efforts most directly targeted to HCBS providers—most of the quality measures providers used were structure and process measures. Though many experts prefer using outcome measures in VBP strategies, DHS should consider including existing structure and process measures in the VBP model for HCBS providers because they may be easier to calculate with existing data and may be more valuable for HCBS providers. Such measures should also be statistically valid because providers may be more willing to take on risk if the measures are standardized, clear and directly apply to their work.

Principle 2: Use an incremental approach to VBP for HCBS providers that increases in complexity for certain providers over time.

Many program managers recommended DHS "start small" and view VBP as an incremental process that increases in complexity for providers who want to continue to improve on quality over time. DHS can apply this incremental approach through one or both of the following options:

- **Involve most or all providers early on and expand the model's complexity over time.** In the early stages, DHS would allow most or all HCBS providers to use simple VBP models, such as payments for infrastructure or pay for reporting (P4R) based on a limited number of measures. Over time, DHS would gradually encourage or require providers to

be paid for performance outcomes or for taking on more risk so they can earn greater rewards.

- **Involve a limited set of provider types early on and expand the model to additional providers over time.** DHS would include certain provider types in the initial program rather than including all providers at once. DHS could consider picking one or two topics (e.g., employment or housing), build a model for those services and expand to additional service types over time. Employment providers are strong candidates for this approach because DHS already operates the Employment Dashboard. Stakeholders have expressed interest in seeing these data at the provider level so they can compare similar providers on progress toward the same goals.

Principle 3: Adjust payments to providers so they reflect differences in the complexity of services and populations.

HCBS providers offer an array of services that vary in intensity based on the needs of the population served. Providers who serve more complex populations may require more resources to do so. As such, they may desire greater compensation for their work. Adjusting quality scores and payments to providers to reflect the relative risk of the population served is one way to promote equity across providers. However, risk adjustment will require continual updating and maintenance, which will require resources and capacity from DHS.

Principle 4: Dedicate resources and/or DHS staff to support implementation and provide technical assistance to providers.

Program managers suggested implementation support was critical to the success of any VBP program, especially for providers new to quality measurement. Regardless of its form (e.g., one-on-one support to providers, group learning sessions or conferences), implementation support should do the following:

- **Provide clear, timely information to providers.** Especially for provider-led VBP models, DHS should clearly describe the amount of payment available to providers and the conditions on which payments will be made. Providers should know early on what can and cannot be funded. Although it is tempting to develop broad, inclusive programs that encourage creativity, it is important to not exclude providers because the funding rules were not clear early on and the projects they designed could not be funded.
- **View the relationship with providers as a partnership.** DHS should work closely with providers, particularly in the early stages, to help them identify their goals and work with them to meet those goals. DHS should also help providers refine their ideas into realistic proposals to help maximize participation.

- **Help connect providers working on similar QI topics.** DHS should facilitate peer-to-peer or mentor-like relationships among providers. This will allow providers to build on each other's successes.

Principle 5: Document evidence of the value of VBP and the change it produces.

Demonstrating the value of investment is critical to the long-term sustainability of any program. For this reason, several program managers emphasized the importance of documenting the results of VBP for the Minnesota Legislature and DHS officials. The HCBS PIPP program managers also suggested that the program did not receive additional funding past its first year because providers did not generate evidence within the timeframe necessary for state legislators to act on the funding request. Therefore, as DHS designs the program, DHS should plan to document early and continued results of VBP to ensure it can collect the necessary data in a timeframe useful to stakeholders.

Table B.1. Six Minnesota VBP programs that serve or served people with disabilities [a]

Model summary	NF PIPP	QIIP	ICSP	IHP	HCBS PIPP	HCBS QI Add-On Rate Increase
Delivery system	FFS	FFS	MMC	FFS and MMC	FFS and MMC	FFS and MMC
Services targeted	Nursing facility care	Nursing facility care	Primary, acute, long-term care and mental health care covered through MSHO, MSC+ and SNBC [12]	All Medicaid services, medical and non-medical [14]	HCBS covered through at least one waiver or the Alternative Care Program, ICFs/DD, state plan-funded home care services [16, 17]	HCBS (same as providers in HCBS PIPP) [19]
Calendar year(s) of operation	2007–present [1]	2015–present [1]	2013–present	2012–present	2014	Passed in 2013, implemented in 2014 and 2015 [19]
Model type [b]	Varies by provider; ranges from FFS P4P (category 2C) to APMs with shared savings and downside risk (category 3B)	FFS P4P (category 2C)	Varies by project; ranges from FFS P4P (category 2C) to APMs with shared savings (category 3A)	Track 1: APMs with shared savings (category 3A) Track 2: APMs with shared savings and downside risk (category 3B)	P4R (category 2B)	Foundational payments for QI planning (category 2A)

Model summary	NF PIPP	QIIP	ICSP	IHP	HCBS PIPP	HCBS QI Add-On Rate Increase
Provider participation	Voluntary with a competitive application process To date, 80% of facilities have had at least one PIPP project. [4, 5]	Voluntary and available for any interested provider [2]	Voluntary for providers, but each MCO must have at least four ICSPs (only two required for MCOs that serve one county) Providers may participate in more than one ICSP and may contract with more than one MCO. [12, 21]	Voluntary; all track 1 (upside gains only) applicants are accepted and a competitive application process is required for track 2 (shared savings and losses) [14]	Voluntary with a competitive application process; 27 of 64 proposed projects received awards [18, 19]	Voluntary, but DHS recouped the 1% add-on dedicated to QI from providers that did not submit a QI plan [19]
Duration of commitment	One or two years (varies by project) [2, 4]	One year	Varies by project	Three years, with one-year performance cycles [14]	12 to 15 months; last payment by June 30, 2015 [16]	One year [19]

Model summary	NF PIPP	QIIP	ICSP	IHP	HCBS PIPP	HCBS QI Add-On Rate Increase
Model details						
Objectives	1. Improve the quality of care and quality of life of nursing home residents in a measurable way 2. Deliver high-quality care more efficiently 3. Rebalance long-term care and make more efficient and effective use of resources [4]	1. Recognize QI efforts 2. Ensure all Medicaid-certified nursing facilities in the state have the opportunity to receive financial rewards for improving nursing home resident's quality of care or quality of life [6, 7]	Improve health care access, coordination and outcomes through payment reform by establishing partnerships between MCOs and primary, acute, long-term care and mental health providers [2]	Reduce the total cost of care for Medicaid patients while maintaining or improving quality of care Core principles emphasize coordination of care across providers and the promotion of innovation and sustainability, among other things. [14]	1. Improve the quality of life of people who use HCBS in a meaningful way 2. Improve the quality of services in a measurable way 3. Deliver high-quality services more efficiently while using the savings to enhance services [17, 18]	1. Improve the quality of life of people who use HCBS in a meaningful way 2. Improve the quality of services in a measurable way 3. Deliver high-quality services more efficiently while using the savings to enhance services [19]

Model summary	NF PIPP	QIIP	ICSP	IHP	HCBS PIPP	HCBS QI Add-On Rate Increase
Number of measures and selection process	Providers negotiate with DHS to work on one or more measures [4]	Providers choose one measure [7]	MCOs select from a menu of measures to include in ICSPs and resulting subcontracts, or they propose alternatives [10, 21]	IHPs negotiate measures with DHS [14]	Providers propose measures [18]	Providers propose measures [19]

Model summary	NF PIPP	QIIP	ICSP	IHP	HCBS PIPP	HCBS QI Add-On Rate Increase
Measure sources	1. Minnesota Nursing Home Report Card quality measures (including long- and short-term stay resident and family survey domains, MDS-based clinical and transition indicators, staffing data submitted to DHS) 2. Other validated measures at the provider's discretion, subject to DHS approval [4]	Minnesota Nursing Home Report Card measures in the quality of care or quality of life domains [2, 3]	Ambulatory care sensitive conditions admission rates and measures related to care plans (n = 4), high-risk medications (n = 2), hospitalizations (n = 8), medication management (n = 4), outpatient care (n = 2) and preventative screening (n = 11) [11]	1. Quality measures from the MDS Statewide Quality Reporting and Measurement System, the Adult and Child Medicaid Core Measures Sets, and the HEDIS 2. Health information technology measures from the EHR Incentive Program 3. Pilot measures not included in domains 1 and 2 4. Qualifying alternatives. [14]	Providers proposed their own measures based on existing data, customer satisfaction surveys, complaints, interviews, compliance data and other sources. [18]	Providers proposed their own measures that supported the program goals. [19]

Model summary	NF PIPP	QIIP	ICSP	IHP	HCBS PIPP	HCBS QI Add-On Rate Increase
Who calculates performance scores?	DHS [4]	DHS [6]	MCOs, which then submit descriptive reports of performance and progress to DHS each year [12, 13]	DHS [14]	Providers [18]	Providers

Model summary	NF PIPP	QIIP	ICSP	IHP	HCBS PIPP	HCBS QI Add-On Rate Increase
Benchmark or target to release payment	DHS negotiates targets with each facility, establishing a portion of incentive payments at risk if the facility does not achieve its performance targets. There is a 5% cap on how much providers can request for their projects, with a negotiable amount at risk if they do not meet their outcome goals by a project's end. [3]	To earn the maximum payment, facilities must improve their performance one standard deviation over their own baseline or reach the statewide 25th or 75th percentile, whichever represents more improvement. [6]	Benchmarks or targets vary by MCO [2]	Payment is based on performance score, which consists of care quality (70%), health IT (20%) and pilot measures (10%). Points are awarded based on achievement relative to the statewide distribution or improvement between performance years—whichever is greater. [14]	Benchmarks or targets vary by provider	To keep the increased payment, providers had to develop QI projects that addressed one of the three specified goals of the program. [19]

Model summary	NF PIPP	QIIP	ICSP	IHP	HCBS PIPP	HCBS QI Add-On Rate Increase
Amount of provider payment	Amount varies by provider, but no more than 5% of the operating payment rate (e.g., a facility with a high-risk PIPP that meets its performance targets could receive and keep an increase of $10 per day) Facilities can participate in QIIP and PIPP and receive rewards from each program. [2, 4]	Amount varies based on performance; maximum incentive payment is $3.50 per resident per day; no penalty if providers do not improve Facilities can participate in QIIP and PIPP and receive rewards from each program. [2, 6]	Amount varies by MCO[2]	Track 1 IHPs can earn a quarterly payment based on the size of the attributed population. Track 2 IHPs share in 50% of savings or losses above or below 2% of the actual total cost of care, relative to the total cost target. [14]	Amount varies by provider DHS made awards to as many top-scoring proposals as it could with the available funds.	Most HCBS providers received a 1% add-on rate increase. [19]

Model summary	NF PIPP	QIIP	ICSP	IHP	HCBS PIPP	HCBS QI Add-On Rate Increase
Mechanism for payment	One-time add-on to the per diem rate during the project period (one or two years), with recoupments possible following the project [2]	One-time add-on to the per diem rate (i.e., the resident rate) for the following year [6]	Varies by MCO (generally PMPM or quality bonuses, less commonly shared savings) [2]	Risk-adjusted, population-based payment each quarter [14]	One-time award [16]	One-time award [19]
Funding source and amount	State Medicaid funds (up to $6.5 million annually), federal matching funds and collections from private-pay residents of facilities participating in PIPP and QIIP [c]	Same funding source as PIPP ($9.2 million in state Medicaid funds in 2019) [2, 7]	VBP payments funded from existing capitation amounts, which cannot exceed 105% of total capitation payments, per 42 CFR 438.6(b)(2) [2]	2013 SIM testing grant ($45 million over four and a half years) [15]	$3.5 million in state funds [20]	$80 million [23]

Implementation support	1. Formal mentorship, in which successful facilities earn a payment to help other facilities that are new to the program 2. Annual DHS-hosted PIPP boot camp, a multisite workshop that guides facilities and helps them learn from each other as they develop their QI projects [3, 5]	Annual DHS-hosted boot camp, a multisite workshop that guides facilities and helps them learn from each other as they develop their QI projects [2]	Clinical work group coordinated by DHS that helps MCOs continue developing ICSP quality metrics and reporting for ICSP models. [13]	1. Quarterly data users group meetings with DHS 2. Annual IHP learning day 3. Other learning activities related to health care delivery and payment reform DHS also shares patient-level data with providers to help with population health activities. [14]	Requirements of participation included: 1. Participating in the Age & Disabilities Odyssey Conference 2. Sharing lessons learned and best practices with other selected providers 3. Providing six-month project status reports 4. Submitting data to help DHS better understand the financial implications of a specified strategy	DHS paired providers with each other for informal mentoring, sponsored person-centered trainings and created a series of webinar trainings based on topics identified by grantees. These webinars and a growing list of best practice ideas and QI resources were available at www.HCBSimprovement.info (site is no longer active). [19]

Model summary	NF PIPP	QIIP	ICSP	IHP	HCBS PIPP	HCBS QI Add-On Rate Increase
					5. Providing evidence of progress in achieving the goals of the project DHS also provided technical assistance to providers and brought in external speakers to discuss QI. [17]	

AHRQ = Agency for Healthcare Research and Quality; APM = alternative payment model; CFR = Code of Federal Regulations; DHS = Department of Human Services; EHR = electronic health record; FFS = fee-for-service; HCBS = home and community-based services; HCPLAN = Health Care Payment Learning & Action Network; HEDIS = Healthcare Effectiveness Data and Information Set; ICF/DD = intermediate care facility for persons with developmental disabilities; ICSP = Integrated Care System Partnerships; IHP = Integrated Health Partnerships; MCO = managed care organization; MDH = Minnesota Department of Health; MDS = Minimum Data Set; MMC = Medicaid managed care; MSHO = Minnesota Senior Health Options; MSC+ = Minnesota Senior Care Plus; NF = nursing facility; P4P = pay-for-performance; PIPP = performance-based incentive payment program; PMPM = per member per month; SIM = State Innovation Models; SNBC = Special Needs BasicCare; QI = quality improvement; QIIP = quality improvement incentive program; VBP = value-based payment.

[a] The program list excludes the Assisted Living PIPP program, which is under development.

[b] The model type is based on the 2017 HCPLAN APM Framework, available at HCPLAN APM Framework (PDF).

[c] With a few exceptions, Minnesota's rate equalization law sets private pay daily rates equal to the Medicaid daily rate. Therefore, a PIPP or QIIP add-on to a facility's Medicaid rate results in an equal add-on to a facility's private pay rate. [2, 3]

References for Table B.1:

1. Held, Robert. "Minnesota Value-Based Purchasing." Presentation at the Long-Term Care Value-Based Purchasing Invitational Meeting. Atlanta, GA, March 11, 2015.

2. Libersky, Jenna, Julie Stone, Leah Smith, James Verdier, and Debra Lipson. "Value-Based Payment in Nursing Facilities: Options and Lessons for States and Managed Care Plans." Integrated Resource Center. November 2017. Accessed March 27, 2020. Value-Based Payment in Nursing Facilities: Options and Lessons for States and Managed Care Plans (PDF).

3. Lewis, Teresa. "Minnesota Nursing Facility Value-Based Reimbursement System." Personal communication to the Minnesota Department of Human Services, January 11, 2017.

4. Minnesota Department of Human Services. "Nursing Facility Performance-Based Incentive Payment Program (PIPP) Request for Proposals." Minnesota Department of Human Services. February 2019. Accessed March 27, 2020. Nursing Facility Performance-Based Incentive Payment Program (PIPP) Request for Proposals (.doc).

5. Cooke, Valerie, Sue Kvendru, Teresa Lewis, and Gretchen Ulbee. Personal communication to the Minnesota Department of Human Services, January 11, 2017.

6. Lewis, Teresa. "Minnesota Nursing Facility Value-Based Reimbursement System." Personal communication to the Minnesota Department of Human Services, January 11, 2017.

7. Boyd, Sue. "DHS Posts Resources, Announces Deadline for QIIP Projects." Leading Age Minnesota News. April 30, 2019. Accessed March 27, 2020. DHS Posts Resources, Announces Deadline for QIIP Projects.

8. Lewis, Teresa. "Minnesota Nursing Facility Value-Based Reimbursement System." Personal communication to Minnesota Department of Human Services, January 11, 2017.

9. Cooke, Valerie. "Nursing Facility Rate Payment Overview." Accessed March 27, 2020. Nursing Facility Rate Payment Overview (PDF).

10. Cooke, Valerie, Sue Kvendru, Teresa Lewis, and Gretchen Ulbee. Personal communication to the Minnesota Department of Human Services, January 11, 2017.

11. Minnesota Department of Human Services. *Potential and Active Measures for SNBC Enrollees in Integrated/Coordinated Medicare Medicaid ICSP Subcontract Arrangements*. St. Paul, MN: Minnesota Department of Human Services, December 2015.

12. Minnesota Department of Human Services. "Special Needs Basic Care Model Contract." Minnesota Department of Human Services. January 1, 2020. Accessed March 27, 2020. Special Needs BasicCare (SNBC) for People with Disabilities.

13. Coll, J. "Integrated Care System Partnership's Overview: 2015." Minnesota Department of Human Services. January 4, 2016. Accessed March 27, 2020. Integrated Care System Partnership's Overview: 2015 (PDF).

14. Minnesota Department of Human Services, Health Care Administration. "Request for Proposals for a Qualified Grantee to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnerships (IHP) Demonstration." Minnesota Department of Human Services. June 11, 2018. Accessed March 27, 2020. Request for Proposals for a Grantee to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through Track 1 of the Integrated Health Partnerships (IHP) Demonstration (PDF).

15. Minnesota Accountable Health Model. "Minnesota Accountable Health Model – State Innovation Model Grant." Minnesota Department of Human Services. March 13, 2018. Accessed March 27, 2020. Minnesota Accountable Health Model – State Innovation Model Grant.

16. Minnesota Board on Aging. "Status Check: Service Quality and Standards." Minnesota Board on Aging. August 8, 2017. Accessed March 27, 2020. https://mn.gov/dhs/assets/service-quality-status-check_tcm1053-308393.pdf.

17. Minnesota Department of Human Services. "Home and Community-Based Services Performance-Based Incentive Payment Program (HCBS PIPP)." November 12, 2013. Accessed March 27, 2020. Home and Community-Based Services Performance-Based Incentive Payment Program (HCBS PIPP) (.doc).

18. Thorson, Sarah, Valerie Cooke, and Miriam DeVaney. "DIY QI: Home and Community-Based Services Performance-Based Incentive Payment Program (HCBS PIPP)." Minnesota Department of Human Services. Accessed March 27, 2020. DIY QI: Home and Community-Based Services Performance-Based Incentive Payment Program (HCBS PIPP) (PDF).

19. Minnesota Department of Human Services, Disability Services Division. “2017 Biennial Report on Long-Term Services and Supports for People with Disabilities.” Minnesota Department of Human Services. January 2017. Accessed March 27, 2020. 2017 Biennial Report on Long-Term Services and Supports for People with Disabilities (PDF).

20. Benson, Kari, and Sarah Thorson. “A First PIPP into the Home and Community-Based Services Performance-Based Incentive Payment Program (HCBS PIPP).” Minnesota Department of Human Services. Accessed March 27, 2020. A First PIPP into the Home and Community-Based Services Performance-Based Incentive Payment Program (HCBS PIPP) (PDF).

21. Minnesota Department of Human Services. “Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services.” January 2, 2020. Accessed March 27, 2020. Minnesota Senior Health Options (MSHO).

22. Cowan, Janene, and Miriam DeVaney. Personal communication to the Minnesota Department of Human Services, February 26, 2020.

23. Leading Age Minnesota. “2014 Legislative Report.” Leading Age Minnesota. Accessed March 27, 2020. 2014 Legislative Report, HCBS Programs Rate Increase section.

Table B.2. VBP programs that serve or served people with disabilities in three states

Model Characteristics	Tennessee	Washington	Wisconsin
Model description	The QuILTSS VBP initiative (included in the ECF CHOICES managed care program) pays providers that report offering pre-employment and employment services to people with I/DD. [1, 2]	The state established a "meaningful day activities" add-on rate ($30 per day) for adult family homes that provide individualized, self-directed day activities for people who receive services. [8, 9] The state also implemented a raise for home care aides who complete a 70-hour, classroom- and web-based training on person-centered care. [10, 11]	The state withholds and returns up to 0.5% of an MCO's capitation rate based on performance on member satisfaction surveys and in terms of competitive, integrated employment. The state also offers up to 0.3% of an MCO's capitation rate as an incentive for meeting the performance benchmarks for member satisfaction and competitive, integrated employment. [13, 14]
Model type	Pay for reporting (Category 2b) [2-5]	Pay for reporting (Category 2b) [9, 11]	P4P (Category 2c) [13, 14]
Applicability to Minnesota	HCBS providers are included in a P4R model for employment services. [1,2]	The state implemented two programs for HCBS providers: 1. $30 per day add-on rate for HCBS providers that offer meaningful day activities to people who receive services [8, 9] 2. Raise for HCBS providers that engage in workforce training [10, 11]	The state instituted a P4P component for MCOs, with payment based on member satisfaction surveys and metrics of competitive, integrated employment .[13, 14]
Provider types	HCBS providers and vocational rehabilitation agencies [1, 2]	HCBS providers (adult family homes and home care aides) [8-10]	HCBS providers [13, 14]
Delivery system	MMC and FFS	FFS	MMC
Highlights of approach	1. Formal agreements between MCOs and HCBS providers, and between MCOs and vocational rehabilitation agencies [1, 2] 2. Mandated written reports to earn payment, with payments to	1. Formal agreements between providers of adult family homes and the state to offer meaningful day activities, [8, 9] and the service employees union and the state to train home care aides [12]	1. Formal agreements between the state and MCO [13] 2. Mandated quality measure reporting in which the state collects member satisfaction survey data (access to services, participation in care planning, satisfaction

Model Characteristics	Tennessee	Washington	Wisconsin
	vocational rehabilitation agencies partially based on people's successful placement in competitive, integrated employment [2-5]	2. Mandated written reports that describe individualized plans and provide activities logs [8, 9]	with care plan and team, satisfaction with services) and notifies MCOs of their performance 3. MCO self-reports of their competitive integrated employment results, which are then validated by the state [13, 14] 4. Public reporting on P4P measures through report cards. [14]
Implementation support	Website, support staff, workforce development and tailored support to help people complete self-referral forms [6, 7]	Website, support staff and completion criteria for workforce training [9]	Not publicly available

Notes: ACO = accountable care organization; CAG = clinical advisory group; CP = community partners; DSRIP = Delivery System Reform Incentive Payment Program; ECF CHOICES = Employment and Community First CHOICES, Tennessee's managed care program for individuals with intellectual and developmental disabilities; FFS = fee-for-service; HCBS = home and community-based services; HCPLAN = Health Care Payment & Learning Action Network; HEDIS = Healthcare Effectiveness Data and Information Set; I/DD = intellectual/developmental disabilities; LTSS = long-term services and supports; MA = Massachusetts; MCO = managed care organization; MLTC = managed long-term care; MMC = Medicaid managed care; NY = New York; PCP = primary care provider; P4P = pay-for-performance; QuILTSS = Tennessee's LTSS program; SIM = State Innovation Model; TA = technical assistance; VBP = value-based payment; VSNY CHOICE = Visiting Nurse Service of New York CHOICE health plans.

References for Table B.2:

1. RTI International. "State Innovation Models, Round 2: Model Test Annual Report." Research Triangle Park, NC: RTI International, June 22, 2018. Accessed March 5, 2020. State Innovation Models, Round 2: Model Test Annual Report (PDF).

2. Tennessee Department of Human Services, Division of Rehabilitation Services, Vocational Rehabilitation Program and the Tennessee Division of Health Care Finance and Administration, Bureau of TennCare, Division of Long-Term Services and Supports. "Memorandum of Understanding." Tennessee Department of Human Services. March 2017. Available at Memorandum of Understanding (PDF).

3. BlueCare Tennessee and Amerigroup. "ECF Choices Implementation Provider Training." BlueCare Tennessee. February 2016. Accessed March 5, 2020. ECF Choices Implementation Provider Training (PDF).

4. BlueCare Tennessee. “Employment and Community First CHOICES.” BlueCare Tennessee. Accessed March 5, 2020. Employment and Community First CHOICES (PDF).

5. Amerigroup. “Employment and Community First CHOICES (ECF CHOICES) Provider Orientation.” Amerigroup. October 2018. Accessed March 5, 2020. Employment and Community First CHOICES (ECF CHOICES) Provider Orientation (PDF).

6. TennCare. “Advancing Value-Based Payment Models in Medicaid MLTSS: Opportunities for Community-Based Care.” Center for Health Care Strategies, Inc. September 18, 2018. Advancing Value-Based Payment Models in Medicaid MLTSS: Opportunities for Community-Based Care (PDF).

7. TennCare. “Signing Up for the Program.” TennCare. Accessed March 19, 2020. Signing up for the program.

8. Washington State Department of Social and Health Services, Aging and Long-Term Support Administration. “HCS Management Bulletin: H19-035—Policy & Procedure.” Washington State Department of Social and Health Services. July 1, 2019. Accessed March 19, 2020. HCS Management Bulletin: H19-035—Policy & Procedure (.doc).

9. Washington State Department of Social and Health Services. “Developmental Disabilities Administration, Adult Family Homes—Meaningful Day Policy Brief.” Washington State Department of Social and Health Services. Accessed March 19, 2020. Developmental Disabilities Administration, Adult Family Homes—Meaningful Day Policy Brief (PDF).

10. Washington State Department of Social and Health Services. “Advanced Home Care Aide Specialist Pilot Project.” Washington State Department of Social and Health Services. Accessed March 19, 2020. Available at Advanced Home Care Aide Specialist Pilot Project (AHCAS).

11. SEIU 775 Benefits Group. “Advanced Home Care Aide Specialist.” SEIU 775 Benefits Group. Accessed March 19, 2020. Advanced Home Care Aide Specialist.

12. Washington State Health Care Authority. “Apple Health Managed Care.” Washington State Health Care Authority. Accessed March 19, 2020. Apple Health Managed Care.

13. Wisconsin Department of Health Services. “Medicaid Managed Care Quality Strategy.” Wisconsin Department of Health Services. June 2018. Accessed March 19, 2020. Medicaid Managed Care Quality Strategy (PDF).

14. Wisconsin Department of Health Services. “[Program] Contract between Wisconsin Department of Health Services Division of Medicaid Services and [Name of MCO].” Wisconsin Department of Health Services. 2020. Accessed March 19, 2020. “[Program] Contract between Wisconsin Department of Health Services Division of Medicaid Services and [Name of MCO] (PDF).

Appendix C: Characteristics of people enrolled in HCBS waivers and providers

In July 2020, the study team analyzed claims data for home and community-based services (HCBS) in Minnesota to profile characteristics of people enrolled in HCBS waivers and providers. This appendix summarizes the team's methods and findings.

Methods

The study team's analysis explored characteristics of people enrolled in HCBS waivers and providers and service use trends by using waiver claims data and definitions of service types supplied to Mathematica by DHS. The team stratified results by Minnesota's economic development regions, waiver type, year and service type.

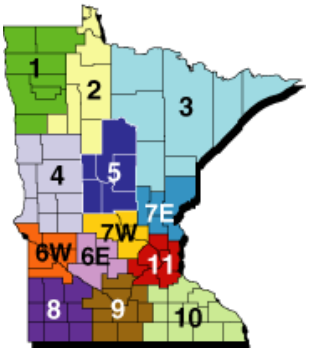
Years of analysis

The team analyzed claims data from calendar years 2016–2019. The analyses primarily used data from 2018, which was the most recent year for which there were complete claims data at the time of the analysis. Though some 2019 claims data were available, they appeared to be missing some data due to typical runout issues (which occurs when claims are not processed or finalized until several months into the next calendar year). However, a few of the analyses included results from 2016 through 2019 to display or calculate values across years.

Geographic distribution

To analyze the geographic distribution of people enrolled in HCBS waivers, the team assigned people to Minnesota economic development regions based on their county of financial responsibility, not their county of residence. See Figure C.1 for a map of counties and economic development regions.

Figure C.1. Economic development regions



Source: Minnesota Department of Employment and Economic Development. DEED economic development regions

Assignment to waivers

People may switch waivers during the year or be enrolled in multiple waivers. However, it is not possible to use claims data to identify people who are enrolled more than one waiver or who switch waivers. To facilitate the analyses, the team assumed people did not change waivers during the year and did not un-enroll and then re-enroll in the same year. Then, the team assigned each person to the waiver listed in their last claim of the year.

Provider categories

The team assigned HCBS providers to mutually exclusive provider type categories, based on classifications and their associated procedure codes from definitions provided by DHS. Provider categories included:

- Consumer directed community supports (CDCS)
- Day and employment services
- Personal supports
- Personal care assistance (PCA)
- Residential services
- Respite
- Other services.

Providers that offered day and employment services and other services were grouped together as day and employment providers. Providers that did not fall neatly into one category were assigned to the category for which they received the most waiver payments during the year.

Findings

A. Demographics of people enrolled in waivers

In 2018, Minnesota provided HCBS to nearly 53,000 people with disabilities through four section 1915(c) waivers. Together, these four waivers provide a wide variety of services, including:

- CDCS
- Day and employment services, such as day training and habilitation, adult day services and supported employment
- Personal supports, such as adult companion services, in-home family supports, independent living skills training and homemaker services
- PCA services, including state plan PCA
- Residential services, such as corporate and family foster care, corporate and family supported living and customized living
- Respite
- Other services not included in the previous categories, including environmental accessibility adaptations and specialized equipment and supplies.

People enrolled in the four HCBS waivers are diverse in their demographic characteristics. These patterns influenced the VBP methodology proposed in this report. Based on analyses of fiscal year (FY) 2017 and 2018 data (the most recent available data at the time of this study), the study team found the following:

- The waivers serve people in both residential and non-residential settings. Most people (53% of adults and 96% of children in FY 2017) receive services in nonresidential settings, though the proportion in each setting varies by waiver (Table C.1). In addition, different types of providers are likely to be associated with each setting.
- The waivers serve a population that is diverse in age and level of functional need (Table C.1). As of FY 2017, most people (76%) were adults. Among adults, most had low to moderate levels of need for support with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The levels of need for these people are assessed as low (26.8%), level 1 (13.5%) or level 2 (24.6%), according to a scale developed by the Human Services Research Institute (Taylor et al. 2018).[10] Because the intensity of services varies by age, functional need and other factors, DHS must ensure differences in populations served are appropriately accounted for in measures included in a VBP strategy (e.g., through stratification or risk adjustment).
- People enrolled in waivers are geographically dispersed across the state. In 2018, the largest proportion of all people enrolled in waivers (46%) lived in the Twin Cities (Table C.2). The second greatest concentration of people enrolled in waivers was in the northwest (region 1).

[10] The framework developed by Taylor and coauthors (2018) identifies both numerical and categorical support ranges. Numerical support levels are sorted from 1 to 4, representing people with relatively low support needs to higher support needs, informed primarily by their need for supports in ADLs and IADLs. Two categorical levels—L, or low to moderate general support need with high health and/or high psychosocial support needs, and H, or high to extensive general support need with high health and/or high psychosocial support needs—are assigned to people with a range of support needs in ADLs and IADLs who also have particular medical or psychosocial (i.e., behavioral) health needs. These two ranges are separate because these needs often change the type, amount or duration of support people need, so they are more appropriately served through inclusion in categorical ranges. An additional support range, E, for extraordinary health or psychosocial needs, is reserved for people with needs greater than what is reflected in other ranges.

- Once enrolled, the vast majority of people remain enrolled in the same waiver, though people enrolled in the Brain Injury (BI) and Developmental Disabilities (DD) waivers are most likely to stay enrolled from one year to the next (Table C.3).

Table C.1. Demographics of people enrolled in HCBS waivers

Demographics	Total [a]	BI	CAC	CADI	DD
Total enrollment, FY 2017 [b] (*N*)	**47,317**	**1,295**	**516**	**26,783**	**18,511**
Estimated age of enrollees, 2018 [c] (*N*)	27,808	890	389	17,359	9,170
Children, age 0–6 (%)	1.6	0.2	15.9	1.3	1.7
Children, age 7–17 (%)	9.0	2.5	34.2	7.8	10.9
Adults, age 18–21 (%)	5.3	1.5	9.3	3.8	8.2
Adults, age 22–34 (%)	20.1	18.3	22.6	15.1	29.6
Adults, age 35–49 (%)	19.9	27.2	9.8	18.2	22.9
Adults, age 50–64 (%)	36.0	41.9	5.9	45.5	18.9
Adults, age 65 or older (%)	8.1	8.4	2.3	8.4	7.9
Estimated support needs for adult enrollees, 2018 [c] (*N*)	24,857	866	194	15,781	8,016
Level 1 (%)	13.5	9.1	0.0	14.8	11.8
Level 2 (%)	24.6	16.3	0.5	23.2	28.7
Level 3 (%)	11.3	6.1	1.5	10.5	13.7
Level 4 (%)	3.7	2.9	1.5	3.2	4.9
Low needs (%)	26.8	36.4	3.1	30.3	19.4
High needs (%)	15.1	21.2	38.1	13.4	17.3
Extraordinary needs (%)	5.0	8.0	55.2	4.6	4.2
Place of residence, FY 2017 [d] (*N*)	32,614	988	338	16,375	14,823
Adult enrollees (*N*)	29,985	964	171	15,138	13,622
Corporate foster care/supported living (%)	37.6	48.2	18.1	18.6	58.2
Family foster care/supported living (%)	2.7	2.5	4.1	2.7	2.7
Customized living/other residential (%)	7.0	12.6	0.0	13.0	0.0
Non-residential (%)	52.7	36.7	77.8	65.7	39.1
Child enrollees (*N*)	2,629	24	167	1,237	1,201
Corporate foster care/supported living (%)	3.4	0.0	1.8	3.2	4.0
Family foster care/supported living (%)	1.2	0.0	0.0	1.7	0.9
Customized living/other residential (%)	0.0	0.0	0.0	0.0	0.0
Non-residential (%)	95.4	100.0	98.2	95.1	95.1

Source: Mathematica analysis of data presented in Taylor and coauthors (2018).

BI = Brain Injury Waiver; CAC = Community Alternative Care Waiver; CADI = Community Access for Disability Inclusion Waiver; DD = Developmental Disabilities Waiver; HCBS = home and community-based services.

[a] Waiver-specific counts of people on the waiver and percentages using CDCS included only people enrolled in one waiver. However, 212 people were enrolled in more than one waiver, and 70 people were enrolled in more than one waiver and used CDCS. These individuals were included in the totals.

[b] Analysis by Taylor and coauthors (2018) of FY 2017 claims data.

[c] Analysis by Taylor and coauthors (2018) of MnCHOICES data as of January 2018. The total number of people on each waiver eligible for analysis differed by category. Support ranges were first sorted from 1 to 4, representing people with relatively low support needs to people with higher support needs, informed primarily by their need for supports in activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Three categorical levels (L, low to moderate general support need with high health and/or high psychosocial support needs; H, high to extensive general support need with high health and/or high psychosocial support needs; and E, extraordinary health and/or psychosocial needs) were assigned to people with a range of support needs in ADLs and IADLs who also had particular medical or psychosocial (behavioral) health needs.

[d] Burns and Associates Inc. (2018) analyzed expenditure data for people who used waiver services in FY 2017. "Corporate Foster Care/Supported Living" corresponded to paid group-home type settings (labeled Corporate Foster Care on the BI, CAC, and CADI waivers and Supported Living on the DD waiver). "Family foster care/supported living" corresponded to foster care settings in which a person lived with an unrelated family who help to care for them (labeled family foster care on the BI, CAC, and CADI waivers and supported living on the DD waiver). "Nonresidential" corresponded to people who lived at home with family or in an independent residence.

Table C.2. Counts of all people enrolled in waivers, by waiver and region, 2018

Economic development regions	Any waiver	BI	CAC	CADI	DD
Any region	**52,761**	**1,050**	**620**	**30,591**	**20,499**
1	7,229	151	59	4,490	2,529
2	645	11	11	383	240
3	1,349	38	9	649	653
4	2,789	37	46	1,731	975
5	1,429	15	21	818	575
6E	1,183	28	15	648	492
6W	526	8	4	246	268
7E	1,363	15	30	796	522
7W	2,601	20	38	1,434	1,109
8	1,725	18	27	877	803
9	2,746	57	65	1,469	1,155
10	4,918	59	60	2,718	2,081
11	24,125	591	234	14,216	9,084

Tribal nation	131	2	1	116	11

Source: Mathematica analysis of Minnesota HCBS waiver claims, 2018.

BI = Brain Injury Waiver; CAC = Community Alternative Care Waiver; CADI = Community Access for Disability Inclusion Waiver; DD = Developmental Disabilities Waiver; HCBS = home and community-based services.

Note: People were assigned to the waiver listed in their last claim of the year.

Table C.3. Percentage of people enrolled in the same waiver as the previous year

Waiver	2016–2017	2017–2018	2018–2019
Any waiver	**86.1**	**86.9**	**88.0**
BI	96.2	93.8	96.4
CAC	83.9	87.6	88.5
CADI	82.0	83.3	84.6
DD	91.5	91.9	92.6

Source: Mathematica analysis of Minnesota HCBS waiver claims, 2016 to 2019.

BI = Brain Injury Waiver; CAC = Community Alternative Care Waiver; CADI = Community Access for Disability Inclusion Waiver; DD = Developmental Disabilities Waiver; HCBS = home and community-based services.

Note: People were assigned to the waiver listed in their last claim of the year.

B. Service use among people enrolled in waivers

The four HCBS disability waivers cover a wide variety of services. Using HCBS claims data from 2018, the study team found the following:

- Some service types were used more than others. Across people enrolled in one of the four waivers, day and employment services were the most common set of services used in 2018 (24%), followed by residential services (23%) and in-home supports/personal assistance (20%) (Table C.4).
- Overall, people typically used only one provider for all services within a given category, with the exception of the "other" services category, for which most people used two providers (Table C.5). During 2018, most people used three to four total HCBS providers across all of the HCBS they received.

Table C.4. Number of waiver enrollees using each service, FY 2017

Enrollees	Any waiver [a]	BI	CAC	CADI	DD
Total adults and children	**65,905**	**2,345**	**797**	**33,713**	**29,050**
Adults	**61,945**	**2,302**	**466**	**31,829**	**27,348**
CDCS	1,976	45	47	590	1,294
Day and employment services	14,654	492	3	3,962	10,197
In-home habitation/personal assistance (other than PCA)	12,149	294	25	8,093	3,737
Medical/professional services	2,638	297	85	1,905	351
PCA	5,206	96	64	4,317	729
Residential services	14,128	610	37	5,182	8,299
Respite	1,759	21	2	204	1,532
Children	**3,960**	**43**	**331**	**1,884**	**1,702**
CDCS	1,766	15	117	815	819
In-home habitation/personal assistance (other than PCA)	397	5	5	158	229
Medical/professional services	152	5	47	74	26
PCA	427	5	24	237	161
Residential services	116	N/A	3	60	53
Respite	355	2	3	151	199

Source: Mathematica analysis of FY 2017 waiver data from Burns and Associates Inc. (2018).

BI = Brain Injury Waiver; CAC = Community Alternative Care Waiver; CADI = Community Access for Disability Inclusion Waiver; CDCS = consumer directed community supports; DD = Developmental Disabilities Waiver; PCA = personal care assistance.

[a] The total column sums counts across the four waivers. It is possible people were enrolled in more than one waiver and, therefore, would be counted more than once.

Table C.5. Average maximum number of providers used by people enrolled in waivers, by provider type and waiver, 2018

Provider type	All waivers	BI	CAC	CADI	DD
Total	**3.7 (20)**	**4.0 (14)**	**3.7 (14)**	**4.0 (20)**	**3.2 (10)**
Residential	**2.4 (14)**	2.6 (9)	2.5 (14)	2.6 (11)	1.9 (9)
Personal supports	**1.3 (7)**	1.4 (4)	1.1 (3)	1.4 (7)	1.2 (5)

PCA	**1.2 (6)**	1.2 (4)	1.3 (4)	1.2 (6)	1.1 (3)
Day and employment	**1.1 (5)**	1.3 (4)	1.0 (1)	1.1 (5)	1.1 (4)
Respite	**1.0 (3)**	1.1 (2)	1.0 (2)	1.0 (3)	1.0 (3)
CDCS	**1.2 (3)**	1.2 (2)	1.2 (3)	1.2 (3)	1.2 (3)
Other	**1.1 (3)**	1.1 (2)	1.0 (1)	1.1 (3)	1.0 (2)

Source: Mathematica analysis of Minnesota HCBS waiver claims, 2018.

BI = Brain Injury Waiver; CAC = Community Alternative Care Waiver; CADI = Community Access for Disability Inclusion Waiver; DD = Developmental Disabilities Waiver; HCBS = home and community-based services.

Note: People were assigned to the waiver listed in their last claim of the year.

C. Waiver providers

In 2018, more than 4,700 providers delivered services to people enrolled in HCBS waivers. Using claims data from 2016 to 2019, the study team found the following:

- Each year, from 2016 to 2019, the number of providers serving people enrolled in waivers grew for all waiver types (Table C.6). Among this group, the largest portion served people enrolled in the CADI Waiver exclusively (41%) or in addition to people who are enrolled in other waivers. The next largest portion (11%) served only people enrolled in the DD Waiver.
- In 2018, nearly half of all providers serving people enrolled in waivers (47%) were residential services providers (Table C.7). Nearly 90% of all providers offer services to people who use the CADI Waiver. There were only 20 CDCS providers in Minnesota.

Table C.6. Number of unique providers who billed at least one waiver claim, 2016–2019

Waiver(s)	2016	2017	2018	2019	Total	Four-year average
Any waiver	**4,199**	**4,414**	**4,773**	**5,129**	**18,515**	**100%**
CADI	1,709	1,810	1,949	2,110	7,578	41%
CADI and DD	814	890	1,024	1,145	3,873	21%
DD	509	487	506	550	2,052	11%
BI, CADI and DD	403	416	446	470	1,735	9%
BI and CADI	318	304	312	299	1,233	7%
All others	446	507	536	555	2,044	11%

Source: Mathematica analysis of Minnesota HCBS waiver claims, 2016 to 2019.

BI = Brain Injury Waiver; CAC = Community Alternative Care Waiver; CADI = Community Access for Disability Inclusion Waiver; DD = Developmental Disabilities Waiver; HCBS = home and community-based services.

Table C.7. Number of unique providers, by provider type and waiver served, 2018

Provider type	All	BI	CAC	CADI	DD
Total	**4,779**	**1,020**	**503**	**4,164**	**2,330**
Residential	**3,169**	594	322	2,721	1,279
Personal supports	**349**	112	32	316	222
PCA	**595**	102	109	583	329
Day and employment	**466**	160	11	404	349
Respite	**149**	23	9	91	118
CDCS	**20**	14	18	19	20
Other	**30**	15	2	30	13

Source: Mathematica analysis of Minnesota HCBS waiver claims, 2018.

BI = Brain Injury Waiver; CAC = Community Alternative Care Waiver; CADI = Community Access for Disability Inclusion Waiver; DD = Developmental Disabilities Waiver; HCBS = home and community-based services.

Note: Each row represents people seen by providers in a given service category, not the type of service offered to those people. The same provider can offer services to people from different waivers. Each person was assigned to only one waiver.

D. Waiver spending

In 2018, DHS spent nearly $2.9 billion on HCBS waiver services. Over half of all waiver spending (52%, or $1.5 billion) was for services provided to people enrolled in the DD Waiver, while only 6% (almost $166 million) was for services provided to people enrolled in the BI and CAC waivers (Table C.8). Nearly 60% percent of spending across all waivers was for residential services (close to $1.7 billion).

Per-person waiver spending in 2018 also differed by waiver and provider type (Table C.9). While per-person spending was much higher for CAC than for other waivers (mostly due to expenditures on residential and medical and professional providers), per-person spending for the CADI Waiver was consistently low across provider types. Per-person spending was highest for residential providers.

Table C.8. Total spending, by provider type and waiver, 2018

Provider category	All waivers ($)	BI ($)	CAC ($)	CADI ($)	DD ($)
All provider types	**2,881,407,550**	**74,013,198**	**91,643,069**	**1,185,804,698**	**1,501,629,760**
Residential	**1,880,557,449**	58,602,138	49,518,454	761,332,274	986,620,399
Personal supports	**191,896,387**	4,193,533	2,635,341	91,403,507	93,024,748
PCA	**252,734,413**	4,117,994	12,871,702	196,292,835	39,107,162
Day and employment	**270,741,581**	4,666,560	46,791	53,281,788	211,717,435
Respite	**15,623,924**	600,223	1,685,438	10,002,745	3,309,090
CDCS	**267,266,823**	1,787,373	24,876,391	71,254,200	167,571,303
Other	**2,586,973**	45,376	8,951	2,237,349	279,623

Source: Mathematica analysis of Minnesota HCBS waiver claims, 2018.

BI = Brain Injury Waiver; CAC = Community Alternative Care Waiver; CADI = Community Access for Disability Inclusion Waiver; DD = Developmental Disabilities Waiver; HCBS = home and community-based services.

Note: Each row represents people seen by providers in a given service category, not the type of service offered to those people. The same provider can offer services to people from different waivers. Each person was assigned to only one waiver.

Table C.9. Per-person spending, by provider type and waiver, 2018

Provider category	All waivers	BI ($)	CAC ($)	CADI ($)	DD ($)
Total	**54,612**	**70,489**	**147,811**	**38,763**	**73,254**
Residential	**36,009**	55,971	81,045	25,068	48,855
Personal supports	**12,356**	10,921	43,922	7,991	25,500
PCA	**22,738**	27,638	58,243	21,488	24,290
Day and employment	**13,769**	10,324	1,376	7,408	17,665
Respite	**5,271**	13,959	51,074	4,042	8,012
CDCS	**36,205**	30,817	79,477	27,311	38,067
Other	**1,634**	1,163	1,119	1,577	2,390

Source: Mathematica analysis of Minnesota HCBS waiver claims, 2018.

BI = Brain Injury Waiver; CAC = Community Alternative Care Waiver; CADI = Community Access for Disability Inclusion waiver; DD = Developmental Disabilities Waiver; HCBS = home and community-based services.

Note: Each row represents people seen by providers in a given service category, not the type of service offered to those people. The same provider can offer services to people from different waivers. Each person was assigned to only one waiver.

Implications for VBP

This study's findings on the characteristics of people enrolled in HCBS waivers and providers informed the services on which DHS should focus in the initial approach to VBP. The study team considered several potential approaches, including:

1. Affecting as many people enrolled in waivers as possible by targeting provider types/services most frequently used
2. Affecting as many services as possible by targeting the most common provider types/services with the largest volume
3. Affecting the provider/service types that are most costly
4. Focusing on CDCS
5. Improving quality among providers in greater Minnesota or counties and tribal nations with below-average waiver spending
6. Pushing the bounds of quality by targeting providers that are experienced in QI
7. Raising minimum standards on quality by targeting providers who are not experienced with QI.

Feedback from the stakeholder surveys suggested DHS should focus on the first two approaches, and DHS expressed an interest in focusing on the third. These preferences resulted in the recommendation to focus on VBP that aims to improve quality in residential and employment services.

Appendix D: Survey of stakeholder perspectives on VBP for HCBS

Purpose of the surveys

To inform the proposed approach for value-based payment (VBP) in home and community-based services (HCBS), the study team gathered feedback from two key stakeholder groups:

- HCBS providers and lead agencies (i.e., counties and tribal nations)
- People who receive HCBS services, their families and advocates.

The team originally planned to convene these stakeholders at in-person events during spring 2020. However, due to COVID-19, the team instead gathered input through two web-based surveys. The team surveyed providers and lead agencies in October 2020 and people who use HCBS, their families and advocates in February 2021.

The surveys gauged stakeholder preferences on six components of VBP design:

1. Goals and objectives of VBP in HCBS
2. Performance and outcome measures for each goal
3. Benchmarks that providers must meet to receive payment
4. Mechanisms for paying providers who achieve quality goals
5. Potential payment amounts for providers who achieve quality goals
6. Prior experience with QI and implementation considerations for a new VBP program.

The survey of providers and lead agencies (survey 1) informed all six components. The survey of people who use HCBS, their families and advocates (survey 2) informed the first and sixth components.

Methodology

To develop the content for the surveys, the study team drafted key questions to inform VBP design, drawing on background information gathered in the study and discussions between the Mathematica and DHS stakeholders. The team pre-tested questions in each survey and revised them based on this feedback. The pre-test group for survey 1 was DHS staff who have worked

on previous surveys for providers. The pre-test group for survey 2 was providers who participated in survey 1 and volunteered to pre-test survey 2.

DHS sent the survey to potential respondents through existing electronic mailing lists. Survey 1 was open Oct. 19–Oct. 30, 2020. Survey 2 was open Jan. 28–Feb. 18, 2021.

The team used a fully accessible, web-based platform (Survey Monkey) to collect data. Survey 1 was conducted in English. Survey 2 was conducted in seven languages: English, Hmong, Karen, Russian, Somali, Spanish and Vietnamese.

There are some limitations to the survey methodology and its results, which may mean the information collected in these surveys does not fully reflect the views and preferences of all stakeholders. First, both surveys used convenience samples and were offered only online. Previous studies have documented that people with disabilities access the internet less often than the general population (Fox 2011). People with disabilities who complete surveys online also differ in age, education, gender, race and ethnicity from those who complete surveys via other modes (Feldman et al. 2020). Second, relatively few people who use HCBS (n = 44) responded to survey 2. Most respondents to survey 2 were advocates or families. It is unknown how well their responses represent the views of people who use HCBS.

Results from survey 1 of HCBS providers and lead agencies

A. Respondent characteristics

Overall, 219 people responded to survey 1. This included 142 respondents from provider organizations (65%) and 77 respondents from lead agencies (35%). Among provider organizations and lead agencies, the top three most common services provided were employment services (n = 51 or 23%), corporate foster care/supported living services[11] (n = 47 or 21%) and day training and habilitation (n = 37 or 17%). (See Figure D.1, located at the end of Appendix D).

Most respondents (n = 43 or 20%) came from large organizations serving 200 people or more per month. There were at least some respondents from each size category: 18 providers served up to 9 people per month, 11 providers served 10–19 people per month, 18 providers served

[11] In 2021, supported living services in corporate or family foster care homes were reconfigured as community residential services and family residential services.

20–49 people per month, 24 providers served 50–99 people per month and 16 providers served 100–199 people per month.

Respondents from both provider organizations and lead agencies were geographically distributed across the state. For example, 76 of the 142 provider organizations (54%) and 34 of the 77 lead agencies (44%) were from the Twin Cities metro region. The other portion of each group was from greater Minnesota (see Table D.1).

Table D.1. Provider organizations and lead agencies serving regions in Minnesota

Economic development region	Provider organizations serving region (N = 142)		Lead agencies serving region (N = 77)	
	Count	Percentage	Count	Percentage
1: Northwest	13	9%	0	0%
2: Headwaters	19	13%	2	3%
3: Arrowhead	38	27%	6	8%
4: West Central	25	18%	7	9%
5: North Central	19	13%	4	5%
6E: Southwest Central	16	11%	3	4%
6W: Upper Minnesota Valley	12	8%	1	1%
7E: East Central	22	15%	2	3%
7W: Central	35	25%	7	9%
8: Southwest	14	10%	1	1%
9: South Central	25	18%	6	8%
10: Southeast	25	18%	3	4%
11: 7 County Twin Cities	76	54%	34	44%

Source: Survey 1, Question 4, "What regions do you serve? Select all that apply."

Note: Responses were limited to those who responded that they were affiliated with lead agencies in question 1. Regions served were not mutually exclusive.

B. Findings related to VBP methodology

1. Objectives

There are many types of HCBS offered by a variety of providers to people with diverse needs. For this reason, the study team sought stakeholder feedback on how to focus the first round of VBP on certain services or providers. When asked to identify their top three strategies for targeting services and providers in the first round of VBP, most respondents voted for the following strategies:

- The provider types and services used by the most people (68 votes, or 53%)
- Services used the most, regardless of how many people used them (56 votes, or 44%).

Respondents provided their opinions on which services DHS should prioritize in the first round of the VBP effort. Outside of "other services," the most popular responses were:

- Corporate foster care/supported living (61 votes, or 28%)
- Employment services (47 votes, or 21%)
- Customized living (45 votes, or 21%)
- Personal care assistance (PCA) (43 votes, or 20%)

For more information about these results, see Figure D.2 at the end of Appendix D.

2. Measures

When the study team asked respondents to rank 11 domains of quality improvement (QI), the three highest-ranked domains were:

- Service delivery and effectiveness (i.e., the level to which services are provided in a manner consistent with the person's needs, goals and preferences)
- Person-centered planning and coordination (i.e., an approach to assessment and coordination of services and supports focused on the person's needs, goals, preferences and values)
- Choice and control (i.e., the level to which people who use HCBS, on their own or with support, make life choices, choose their services and supports and control how they receive them).

For other areas of QI, see Figure D.3 at the end of Appendix D.

Providers and lead agencies that participate in VBP may need to modify or expand their reporting of data, such as enrollment records and service claims, assessment and case management records, surveys of people who receive services and their families and/or reports of critical incidents or adverse events. Most respondents (n = 61, or 49%) reported they were open to submitting new data to DHS for VBP. Twenty-nine percent of respondents were open to having DHS modify the data their organization already reports but did not want to submit new data. Eighteen percent of respondents said they did not want to modify current data or add new data and suggested that DHS should calculate the performance of the organization using data it already collects. Four percent selected another response or said they were unsure.

3. Benchmarks

VBP models compare provider performance on measures against pre-established standards (i.e., benchmarks) for each measure. Most respondents (n = 56, or 46%) preferred measuring individual improvement goals set by each provider. Others preferred using statistically derived benchmarks based on relative provider performance (29%) or absolute benchmarks determined by DHS and stakeholder groups (25%). Using free-text fields, respondents also suggested using different options for different measures or provider types and emphasized the need to adjust for risk with any measurement approach.

4. Payment model

Most respondents preferred payments based on their organization's performance. Forty-nine respondents (48%) ranked this option as their first choice. Payment for QI and submitting data also received a sizable share of votes; 46 respondents (45%) ranked one of these two options as their first choice.

5. Payment amount

Many respondents submitted unusable data to questions about how much they would like to be paid for VBP, which made analysis difficult. Among providers that submitted usable data, the average share of total Medicaid revenue for VBP they requested was 5–25% (data not shown). Larger providers serving 200 people or more per month requested less payment (5% of total Medicaid revenue) than smaller providers serving up to 9 people per month (22% of total Medicaid revenue).

6. Implementation

Most provider organizations already had experience implementing QI for the waiver services they provide (n = 119, or 84%; Figure D.5 at the end of Appendix D).

Provider organizations of all sizes reported experience with QI. However, in each size category, a small number of respondents (1–3) reported no experience with QI (7% in organizations serving 200 or more people and 27% in organizations serving 10 to 19 people). Provider organizations and lead agencies reporting experience with QI served all regions of the state. In the Twin Cities metro region, 69 of the 119 provider organizations (58%) and 35 of the 57 lead agencies (61%) had experience in VBP. In greater Minnesota, 75 of the 119 provider organizations (63%) and 41 of the 57 lead agencies (72%) had experience in VBP.

Among provider organizations and lead agencies that described previous experience with QI, the top five topics included:

1. Measurement (n = 81)
2. Person-centeredness (n = 75)
3. Delivery of care (n = 50)
4. Community engagement (n = 18)
5. Employment services (n = 13).

Most respondents (n = 103, or 47%) indicated an interest in QI but did not have or were unsure about having staff and funds to participate at this time (Figure D.6 at the end of Appendix D).

Provider organizations and lead agencies identified the greatest barriers to participating in future QI work to be staff capacity and funding (Figure D.7 at the end of Appendix D).

Results from Survey 2 of people who use HCBS, their families, and advocates

A. Respondent characteristics

Survey 2 received 658 total responses:

- 44 people who use HCBS
- 159 family members of people who use HCBS
- 443 advocates (Figure D.8 at the end of Appendix D).

Most respondents reported using (or supporting someone who uses) Developmental Disabilities (DD) or Community Access for Disability Inclusion (CADI) waivers (n = 459, or 70% and n = 438, or 67%, respectively). Of other respondents, 213 (32%) used the Brain Injury (BI) Waiver, 176 (27%) used other waivers (including the Elderly Waiver [EW]) and 114 (17%) used the Community Alternative Care (CAC) Waiver.

Among respondents, the top four services they or the people they supported used were:

- PCA (n = 290, or 46%)
- Foster care/supported living services (n = 279, or 45%)
- Independent living skills training (n = 275, or 44%)
- Employment services (n = 273, or 44%).

B. Findings related to VBP methodology

Most respondents reported satisfaction with the services they (or the people they supported) used. Respondents most liked that their HCBS services helped them:

- Live a better life (n = 416, or 75%)
- Meet their needs and goals (n = 229, or 41%)
- Manage their health (n = 222, or 40%)
- Work with staff who treated them with respect (n = 221, or 40%) (Figure D.9 at the end of Appendix D).

Most respondents somewhat agreed or strongly agreed that their backgrounds, customs and language preferences were respected when receiving services. For example, 93% of respondents (n = 470) felt their providers and staff respected their customs (Figure D.10 at the end of Appendix D). In contrast, only 75% of respondents (n = 382) reported their providers and staff came from a similar background to them.

The survey also asked respondents what they disliked about their services. The top three reasons respondents disliked their HCBS services were:

- Staff changed too often (n = 245, or 47%)
- Case managers changed too often (n = 168, or 33%)
- Staff did not show up when supposed to (n = 100, or 19%) (Figure D.11 at the end of Appendix D).

When asked for the top three services that should receive more funding, respondents voted for:

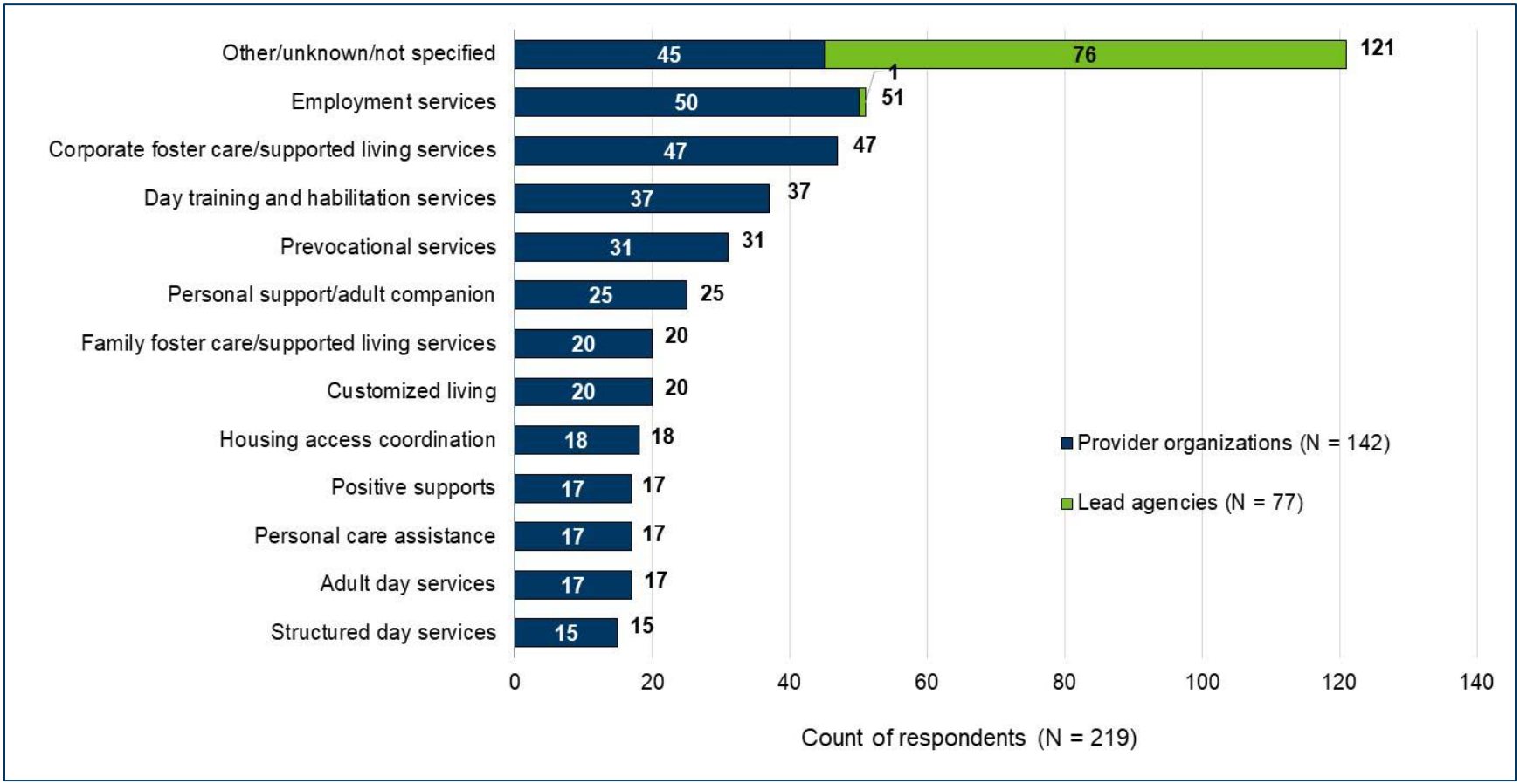
- PCA (n = 158, or 30%)
- Independent living skills training (n = 144, or 28%)
- In-home family supports (n = 138, or 27%) (Figure D.12 at the end of Appendix D).

The three services that received the fewest votes for more funding were:

- Night supervision (n = 21, or 4%)
- Structured day services (n = 30, or 6%)
- Prevocational services (n = 36, or 7%).

In free-text fields, 324 respondents also described other services that should receive funding or be improved in some other way. Their suggestions included raising wages and reducing turnover among direct support staff and expanding housing and transportation options, among others.

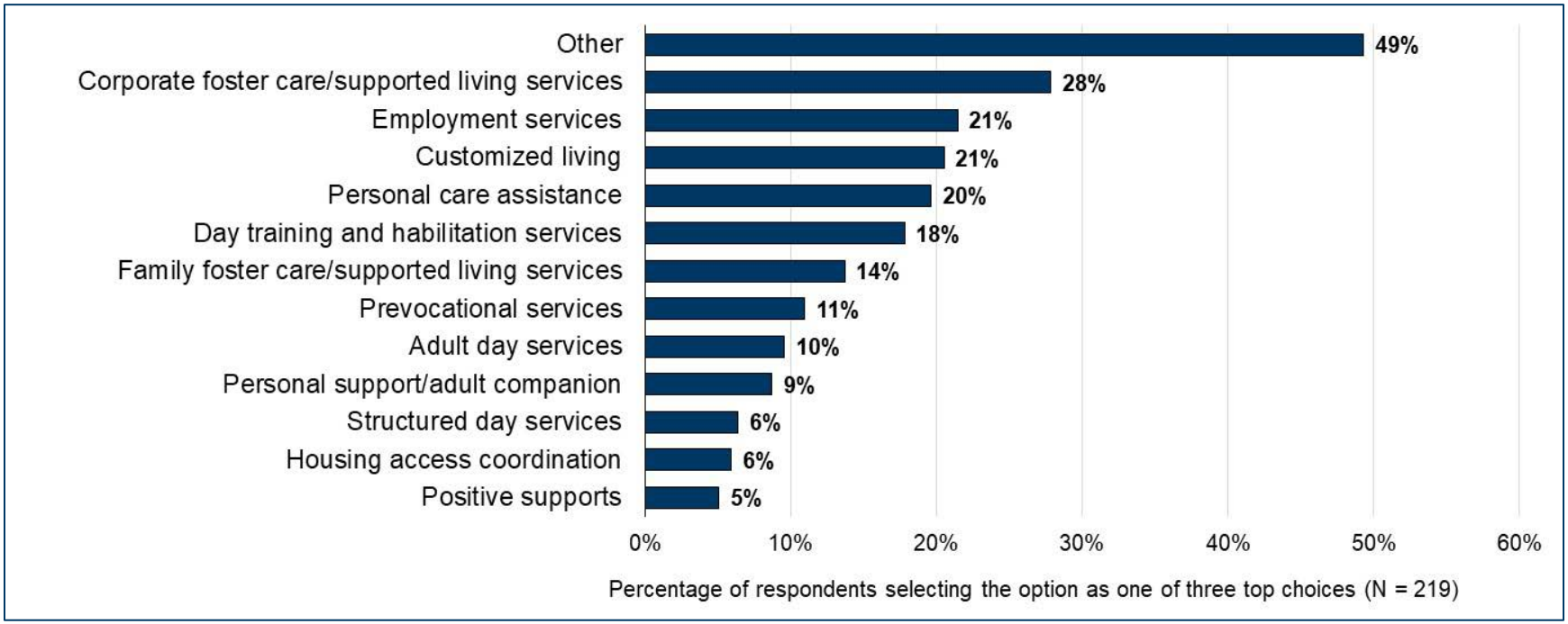
Figure D.1. Services provided, by respondent type



Source: Survey 1, Question 2, "What types of services does your organization provide? Select all that apply."

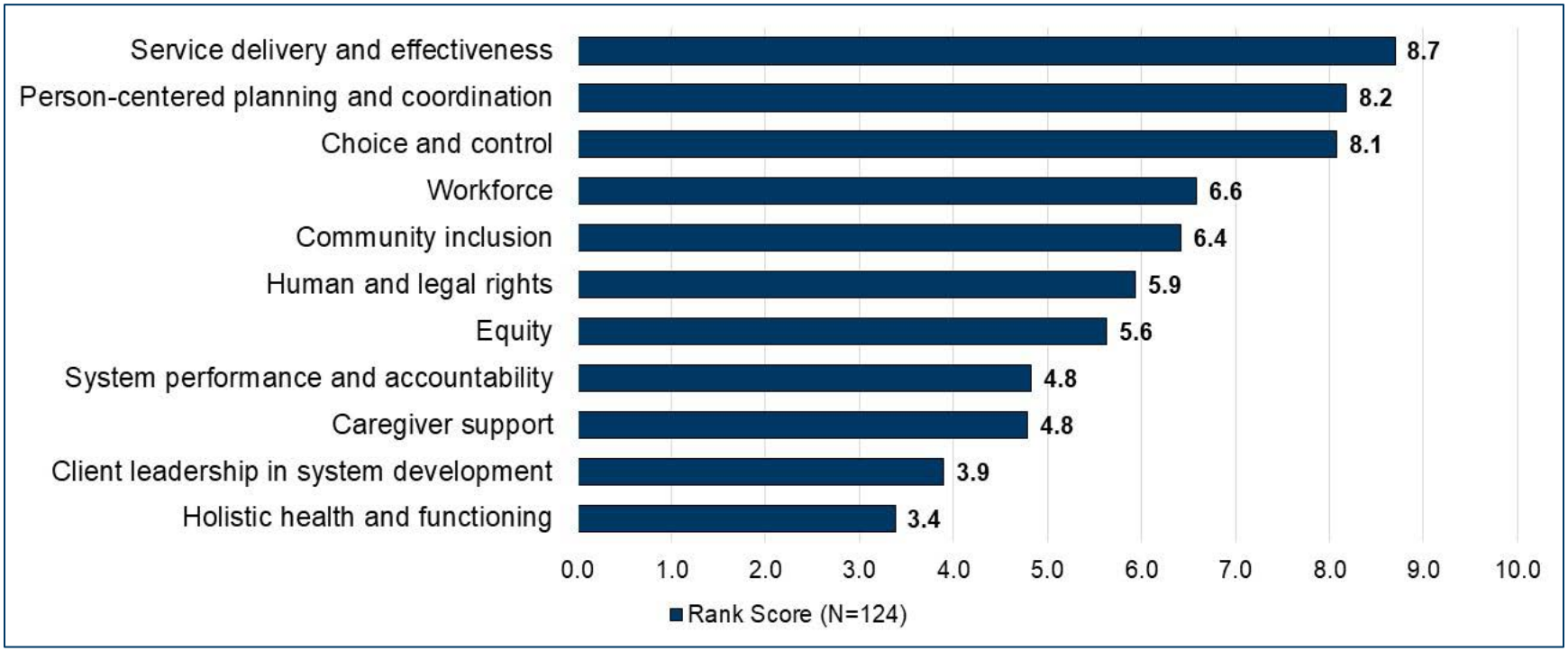
Note: Responses were limited to those who responded to question 1 about their affiliations with provider organizations or lead agencies. Service categories were not mutually exclusive.

Figure D.2. Services to prioritize for VBP



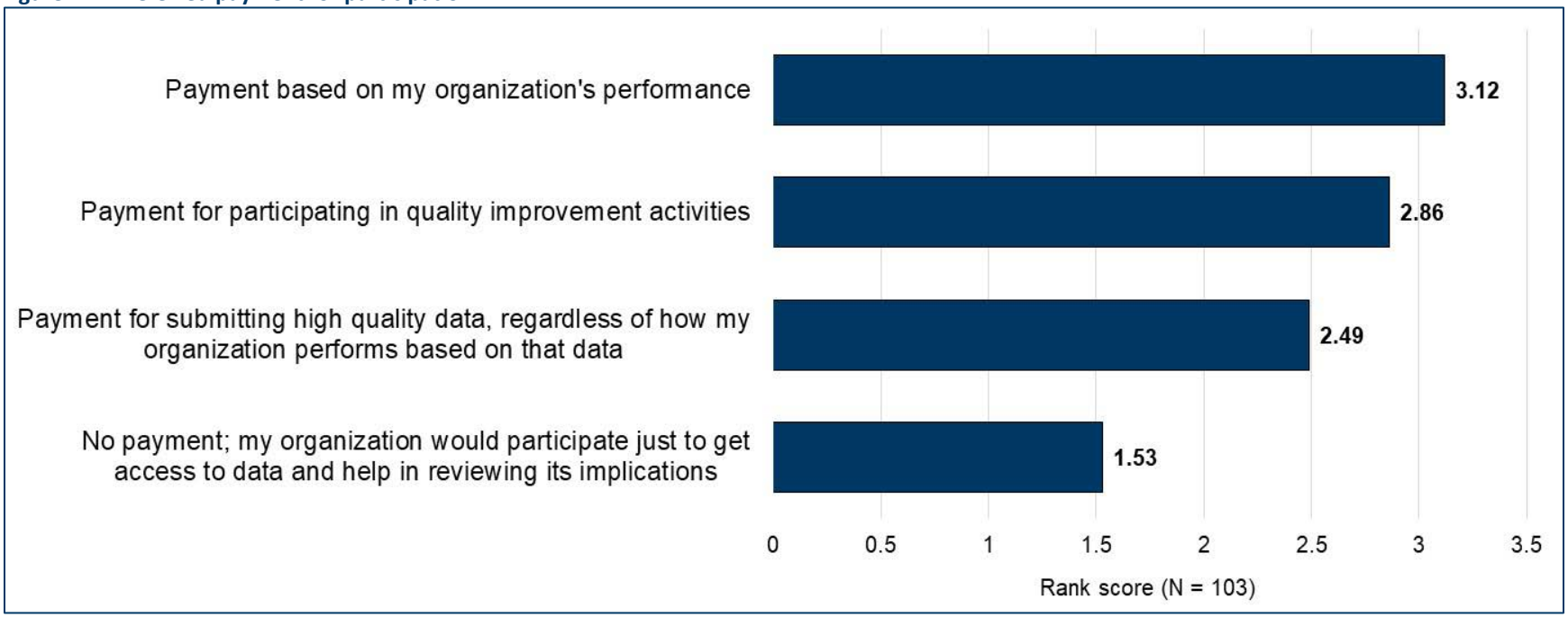
Source: Survey 1, Question 10, "Which services should the Minnesota Department of Human Services (DHS) include in the initial value-based payment (VBP) effort? Select three."

Figure D.3. Relative importance of HCBS quality domains



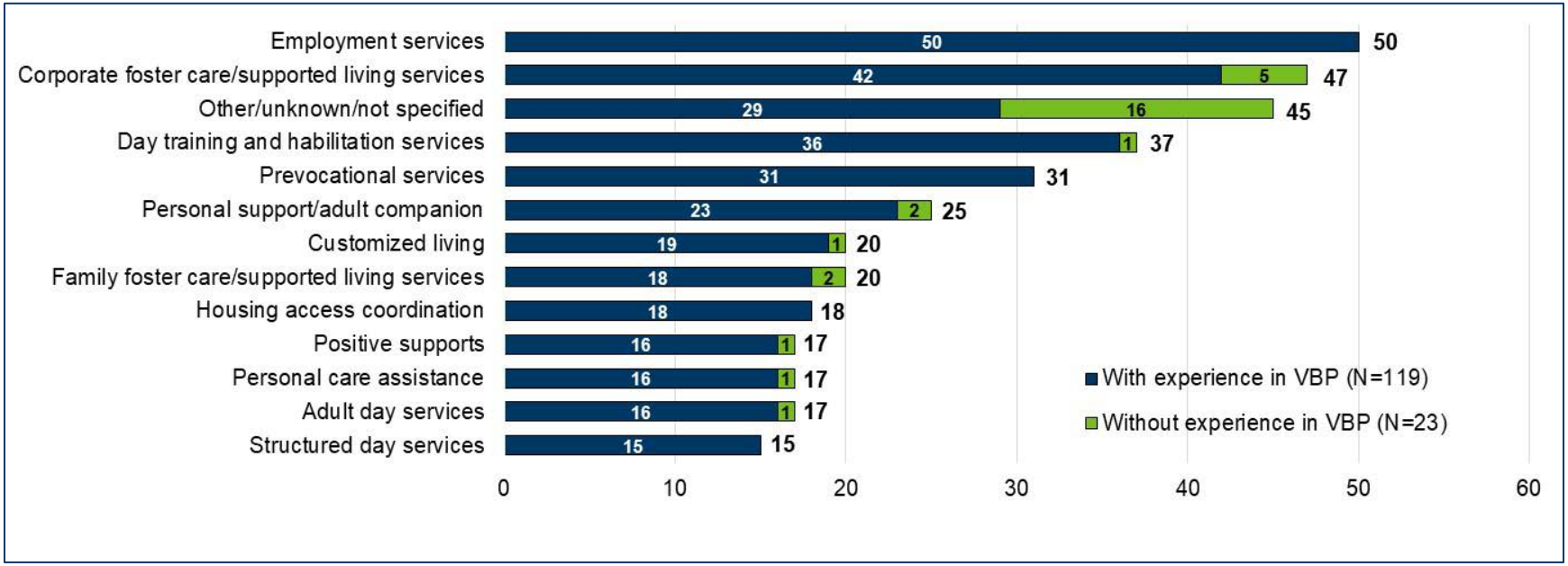
Source: Survey 1, Question 11, "The study team has identified 11 areas in which the Minnesota Department of Human Services (DHS) could assess the quality of home and community-based services (HCBS). Please rank the areas below in order from most to least important. Assign '1' to the most important area of quality and '11' to the least important."

Figure D.4. Preferred payment for participation in VBP



Source: Survey 1, Question 15, "Please rank what factor would most motivate your organization to participate in VBP. Assign '1' to the objective that would most motivate you and '5' to the objective that would least motivate you."

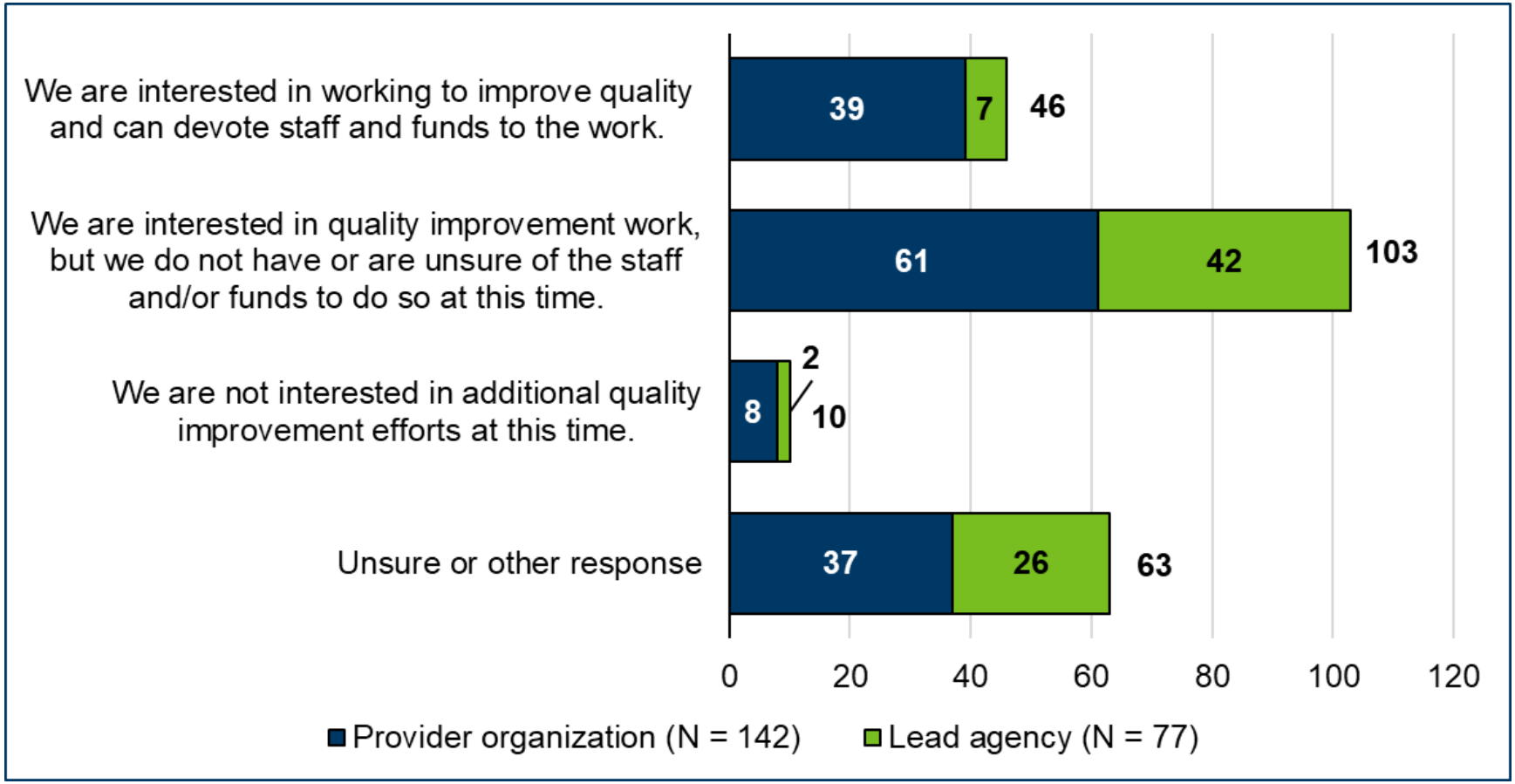
Figure D.5. Experience with QI among provider organizations, by service type



Source: Survey 1, Question 5, "Has your organization worked to improve the quality of the waiver services it provides since January 2018?" Please see Appendix A for the full list of questions and response options.

Note: Service categories were not mutually exclusive. "Experience with QI" means respondents indicated that they had worked to improve the quality of the waiver services they provide since January 2018. Responses were limited to those who identified themselves as providers in question 1 and indicated the types of services they provide in question 2.

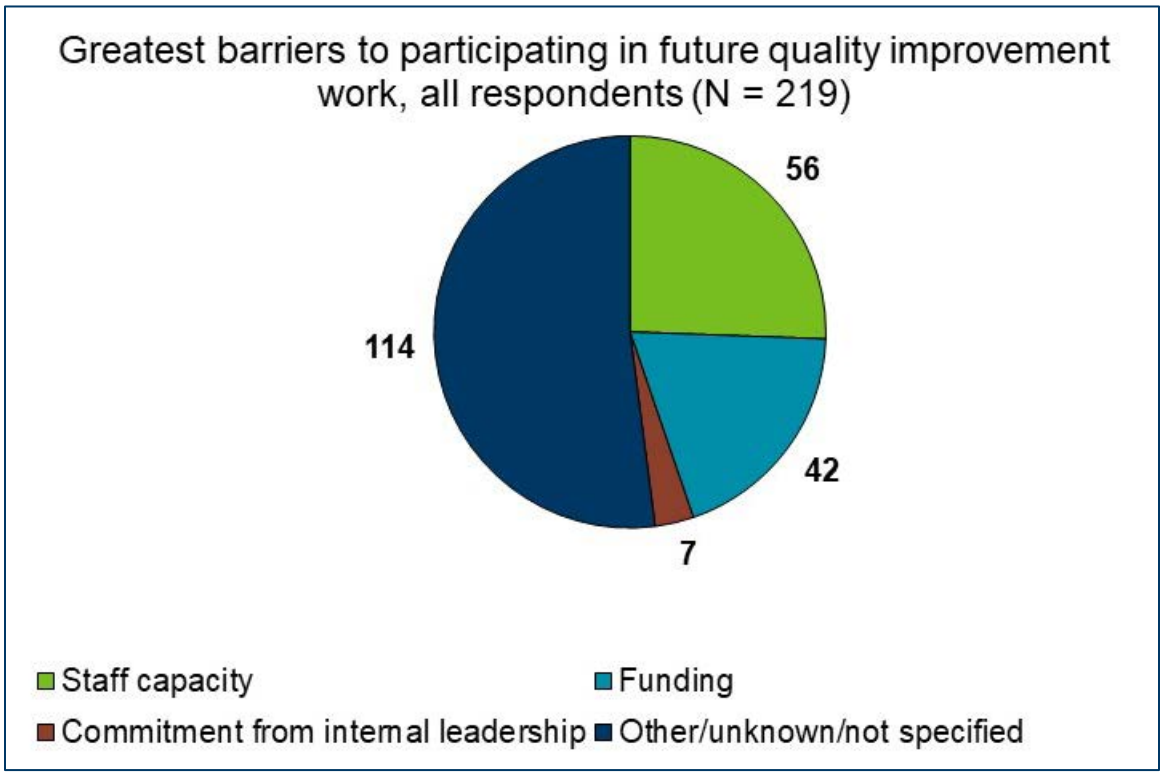
Figure D.6. Interest in and capacity for future QI work



Source: Survey 1, Question 7, "Please select the statement that best reflects your organization's capacity for and interest in quality improvement work. This question is required."

Note: Categories were mutually exclusive.

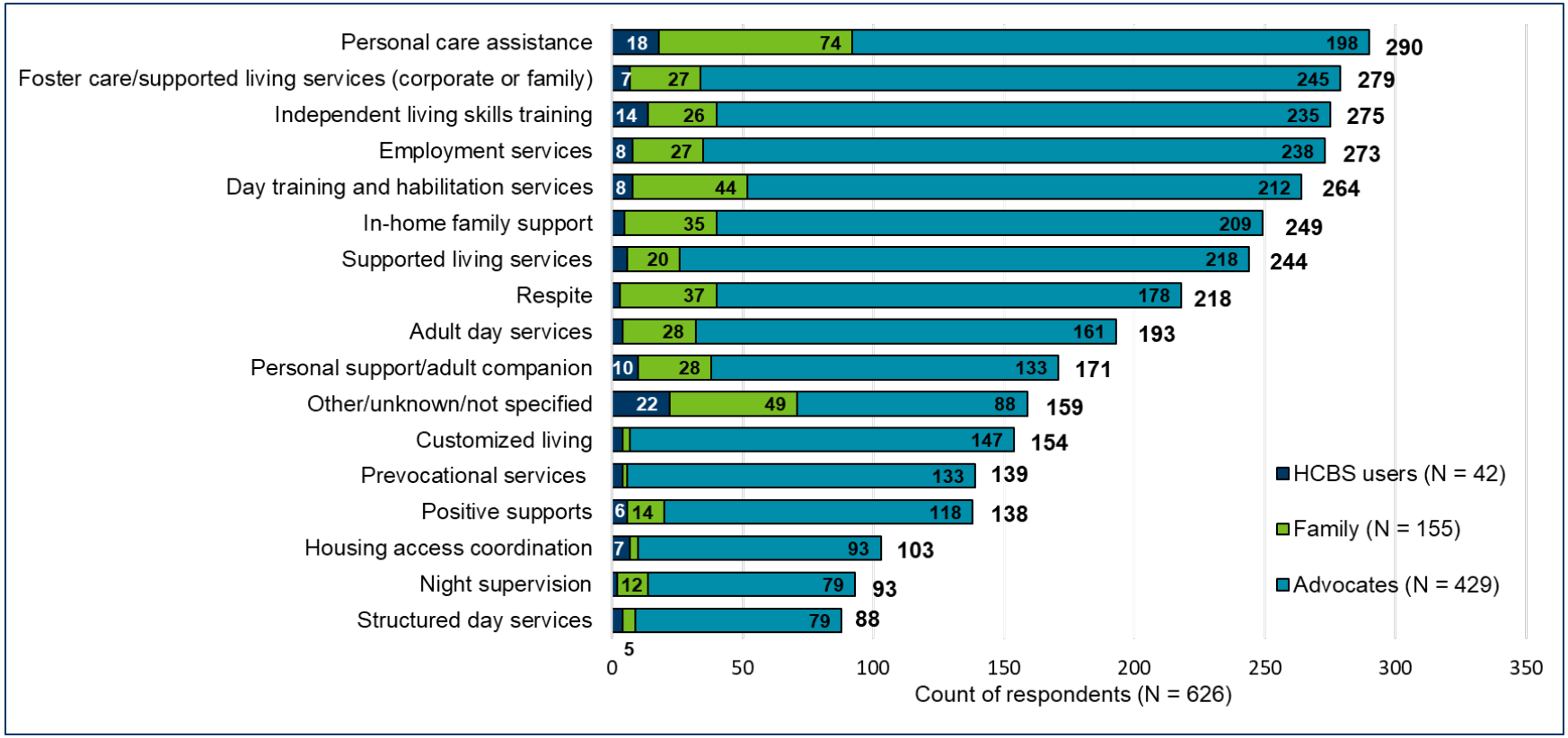
Figure D.7. Greatest barriers to participating in QI work



Source: Survey 1, Question 8, "What is your biggest barrier to participating in QI work? This question is required."

Note: Categories were mutually exclusive.

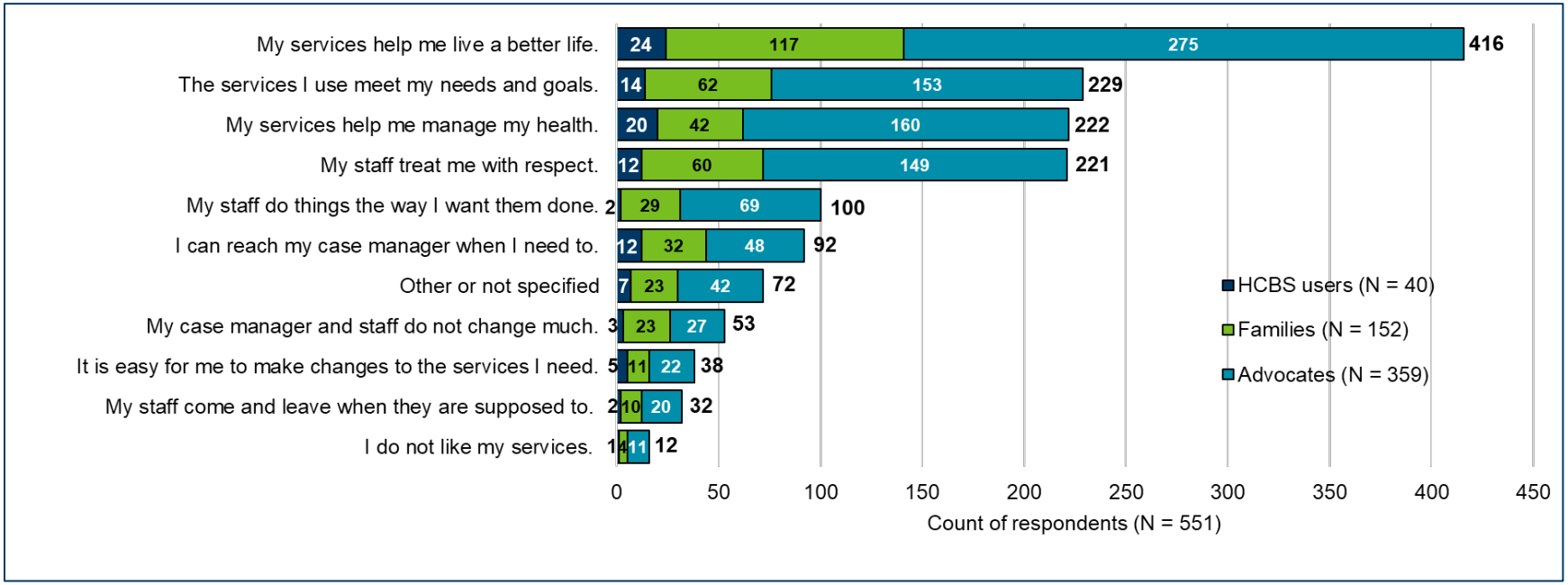
Figure D.8. Services used, by respondent type



Source: Survey 2, Question 3, "Which waiver services have you or the people you support used in the last 12 months? Select all that apply."

Note: Responses were limited to those who responded to question 1 about their relationship to HCBS. Services were not mutually exclusive. Responses to question 3 were not required, so the number of responses varied by question.

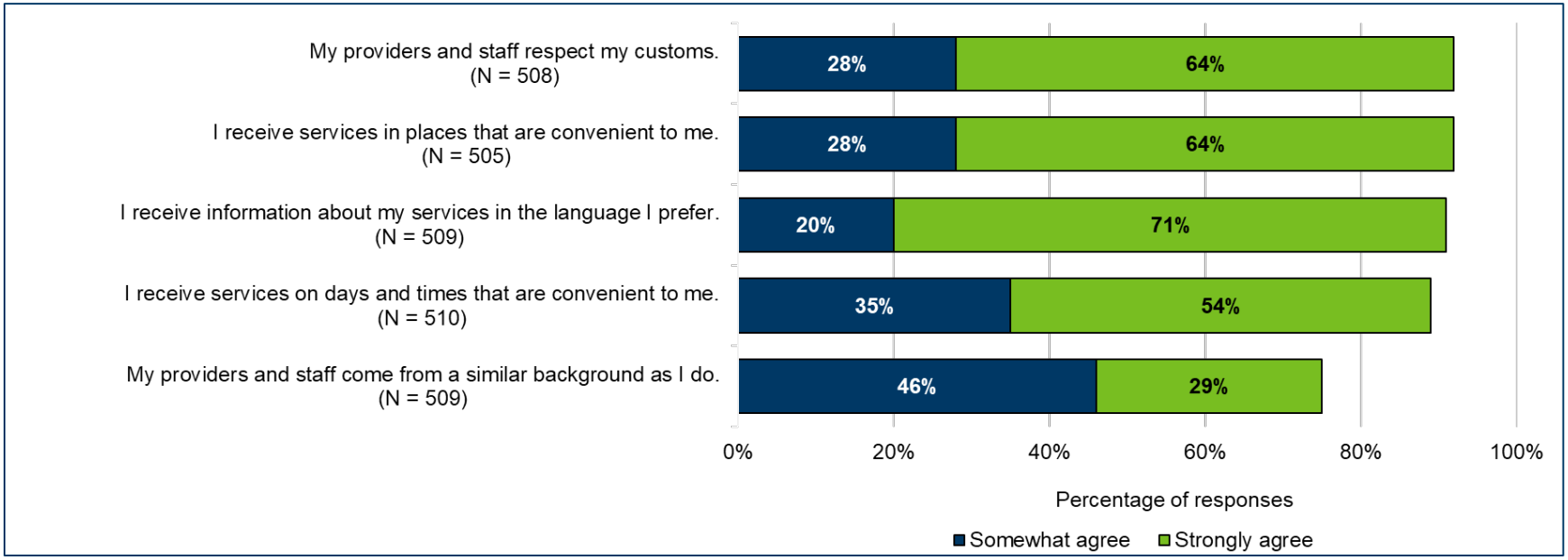
Figure D.9. What respondents like most about their services



Source: Survey 2, Question 5, "What do you like most about the services you use? Select your top 3 options."

Note: Responses were limited to those who responded to question 1 about their relationship to HCBS. Services were not mutually exclusive.

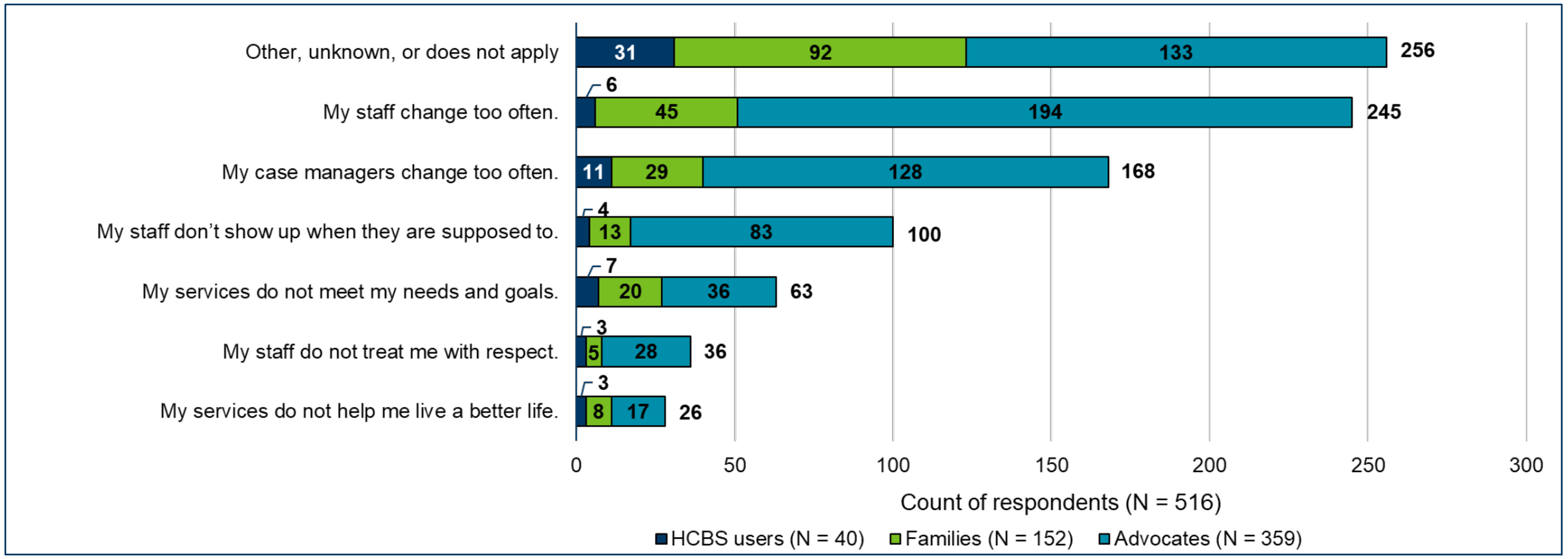
Figure D.10. Respondent backgrounds are respected



Source: Survey 2, Question 7, "Please select how much you agree with the following statements."

Note: "Background" refers to race, ethnicity, cultural identity, religion, place of living and other factors.

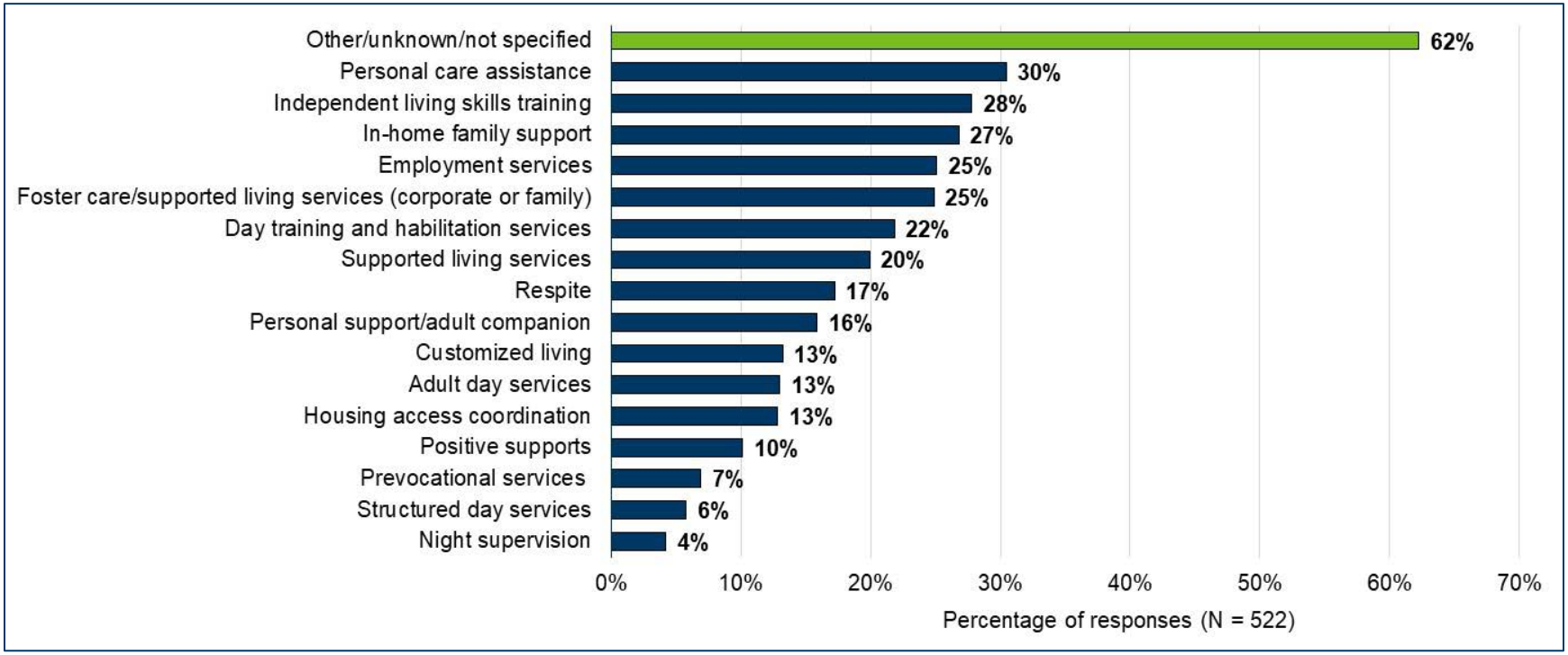
Figure D.11. What respondents dislike about services



Source: Survey 2, Question 6, "What do you dislike about the services you use? Select all that apply."

Note: Responses were limited to those who responded to question 1 about their relationship to HCBS. The response options were not mutually exclusive.

Figure D.12. Services that should receive more funding



Source: Survey 2, Question 8, "Which waiver services or supports do you think should be given more funding? Select up to three options."

Note: The response options were not mutually exclusive. Percentages do not sum to 100%.

Appendix E: DHS initiatives influencing the proposed VBP methods

To improve HCBS for people with disabilities, DHS has recently implemented several initiatives that change the assessment process, services offered and provider payment (Minnesota DHS Disability Services Division 2019). These changes affect the landscape for HCBS as well as the objectives, design and implementation process for value-based payment (VBP). The following sections provide information about these initiatives.

MnCHOICES

The MnCHOICES assessment system used for people enrolled in HCBS waivers—especially the Long-Term Services and Supports (LTSS) Improvement Tool—is a strong candidate data source for VBP. However, DHS has been phasing in the system gradually, and conversations with DHS staff in March 2021 suggest that only 70% of assessments used the MnCHOICES system. The remaining 30% used the legacy system.

Before settling on VBP measure topics and specifications that use LTSS Improvement Tool data, DHS will need to assess the quality of the data in the system and develop measure specifications that recognize the two assessment systems currently in use. Alternately, it could propose a timeline for implementation that aligns with the full implementation of MnCHOICES.

Disability Waiver Rate System (DWRS)

Since 2014, DHS has gradually transitioned providers to a statewide rate methodology based on individual service need, called the DWRS. Many providers have experienced or will experience rate changes in the move to the DWRS. DWRS was fully implemented in January 2021.

The implementation timeline proposed in this study allows for full implementation of DWRS. However, as DHS finalizes the VBP payment methodology and payment amounts, it should consider changes in base payments for certain providers.

Waiver Reimagine

DHS is beginning to reconfigure its home and community-based services (HCBS) disability waivers through the Waiver Reimagine project. The implementation timeline proposed in this study suggests implementing VBP alongside these other planned waiver changes (i.e., no earlier than 2023).

Changes to service types

Aside from Waiver Reimagine, DHS is changing several service types available through existing waivers in response to the federal HCBS setting rule and other state-based initiatives. Examples include modified housing services and new employment services. As DHS finalizes the VBP payment methodology, it will need to account for the services available during the first year VBP will be offered.

Innovation Grants

DHS has provided Innovation Grants to organizations that serve people with autism and disabilities to spur improvement in outcomes. The grants do not require providers to document improved performance or outcomes. In discussing potential VBP methodologies, DHS advised that there was no inherent conflict between previous grants and future VBP payments, so providers who have received such grants should be eligible for VBP. The recommendations of this study reflect DHS' request.

Person-centered models of care

Since fiscal year (FY) 2018, DHS has supported training activities to assist providers in their move to person-centered models of care. As DHS finalizes an implementation plan for VBP, it should consider how VBP methodologies that incentivize person-centeredness recognize or capitalize on the extensive supports already available to providers.

Summary of disability-related initiatives

Table E.1. Summary of disability-related initiatives and their relationship to VBP in HCBS waivers

Initiative	Description
Case management redesign initiative	To assess the potential impact of changes to current payment structures, DHS is developing models for a potential universal base rate for the cost of providing case management services and comparing models to current payment structures and rates.
Disability Innovation Grants program	Launched in 2016, Disability Innovation Grants provide large ($50,000), small ($2,000–$50,000) and microgrants ($500) to people and organizations that are working to promote new ideas to achieve positive outcomes for people with disabilities. DHS distributed grants totaling more than $3.6 million in 2017.

Initiative	Description
DWRS	Since 2014, DHS has gradually transitioned providers to a statewide rate methodology based on individual service need, called the DWRS. The established rate formulas (i.e., frameworks) are based on the statewide average costs required to provide HCBS through the disability waivers. During the transition (i.e., banding) period, DHS has limited rate changes for providers that provided services and people who received them in in 2013. DHS fully implemented of framework rates in 2021.
Enhanced personal care assistance (PCA) reimbursement rate	To offset the increasing challenges in finding skilled workers, DHS began a 5% rate or budget enhancement for certain PCA services and Consumer Support Grants on July 1, 2018. PCA Choice agencies and financial management services providers must pass on the enhanced rate/budget percentage to the specific worker who completed the trainings in the form of wages or benefits.
Federal HCBS Rule	DHS has been modifying service definitions to comply with the HCBS service settings rule. Full compliance is expected by March 2022.
Innovation and autism respite grants	In 2016, DHS made grants to large and small organizations, as well as to individuals, to develop in-home respite activities to build informal supports and capacity in marginalized communities, and to test new ideas. The grants provided funding and technical assistance to encourage community businesses to become more autism- and sensory-friendly. The grants also supported counties and one tribal nation in the state to build their own autism-support capacity by developing curricula and training.
MnCHOICES	Over the past five years, DHS has developed and rolled out MnCHOICES, a new assessment and support planning process for long-term services and supports. As of 2017 (the most recent year of available data), 47% of the 126,555 people enrolled in a waiver used MnCHOICES. The remaining 53% used the legacy assessment. Conversations with DHS staff in March 2021 suggest that use of MnCHOICES has increased to 70%. While DHS continues phasing in MnCHOICES, it is also planning updates as part of the MnCHOICES revision.
Move to person-centeredness	Minnesota is moving toward person-centered practices in all areas of service delivery. In FY 2018, DHS trained and supported thousands of practitioners through numerous activities, including a peer learning community, online training modules and in-person trainings. DHS also created the Person-Centered, Informed Choice and Transition Protocol as a guide for lead agencies to implement person-centered practices.
New and modified housing services	Beginning July 2020, the housing access coordination waiver service was replaced by two new state plan services: transition and stabilization.

Initiative	Description
New employment services	In July 2018, DHS launched three new employment services through the HCBS disability waivers. The first separates community-based employment from day training and habilitation (DT&H) and prevocational services. The second replaces employment supports with employment development and support services. The third adds employment exploration to provide people with disabilities experiences that help them make an informed choice about competitive, integrated employment.
Waiver Reimagine	DHS is planning to consolidate the four HCBS disability waivers into two—an Individual Support waiver and Residential Support waiver. DHS anticipates it will make a common set of services available across the two proposed waivers, except for limitations based on living setting (e.g., some services will only be available on the residential support waiver). People will receive a funding amount to pay for HCBS based on their MnCHOICES assessment. DHS will manage the budget allocations through an individual budget model (as opposed to the two current budget methodologies) that assigns a support range to each person. The proposed timeline envisions full implementation by 2024.

Source (unless otherwise noted): Minnesota DHS Disability Services Division (2019).