Medicaid Nursing Facility Reimbursement Quality and Value Based Purchasing Stakeholder Meeting #1

Indiana Family and Social Services Administration

June 10, 2021

Why Reform Indiana's LTSS System?

Choice: Hoosiers want to age at home

- 75% of people over 50 prefer to age in their own home – but only 45% of Hoosiers who qualify for Medicaid are aging at home*
- The risk of contracting COVID and impact of potential isolation drives an even increased desire to avoid institutional settings

Cost: Developing long-term sustainability

- Indiana has about 2% of the U.S. population, but over 3% of nursing facilities
- LTSS members are 4% of Medicaid enrollment, yet 28% of spend - only ~ 19% of LTSS spend goes to home and community-based services (HCBS)
- For next ten years, population projections show 28% increase in Hoosiers age 65+ and 45% increase in Hoosiers age 75+

Quality: Hoosiers deserve the best care

- AARP's LTSS Scorecard ranked Indiana 44th in the nation
- LTSS is uncoordinated and lacks cultural competency
- Payment for LTSS services is poorly linked to quality measures and not linked to outcomes

From 2010 to 2030 the proportion of Hoosiers over 65 will grow from 13% to 20%. Indiana's disjointed system must be reformed to meet growing demand and to ensure Choice, drive Quality and manage Cost.

Indiana's Path to Long-term Services and Supports Reform

Our Objective

1) 75% of new LTSS members will live and receive services in a home and community-based setting
2) 50% of LTSS spend will be on home- and community-based services

Key Results (KR*) to Reform LTSS

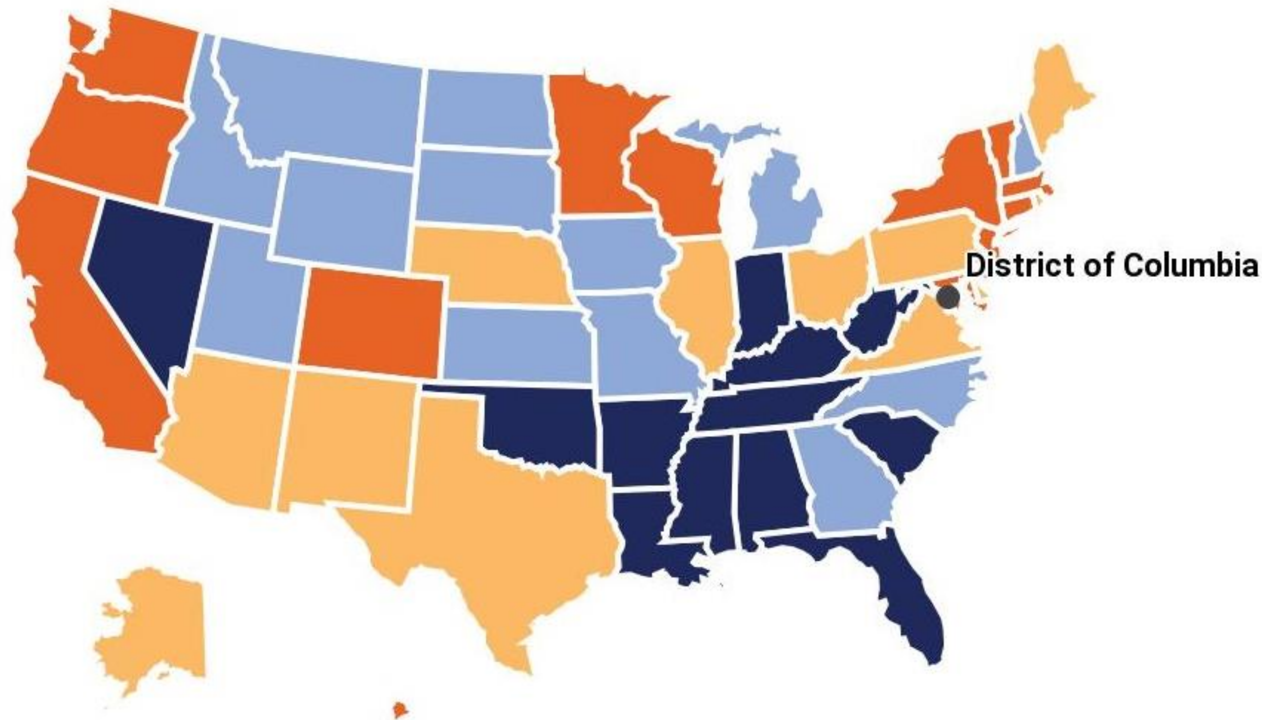
1. Ensure Hoosiers have access to home- and community-based services within 72 hours
2. Move LTSS into a managed model
3. Link provider payments to member outcomes (value-based purchasing)
4. Create an integrated LTSS data system linking individuals, providers, facilities, and the state

Agenda

- Project Background
- Alignment to mLTSS and other Provider Value Based Purchasing (VBP) Programs
- Overview of Indiana’s Current VBP Program
- Best Practices in VBP: Key VBP Frameworks and Requirements
- Stakeholder Feedback
- Next Steps

Project Background

Current Indiana Performance: 2020 AARP Scorecard Report

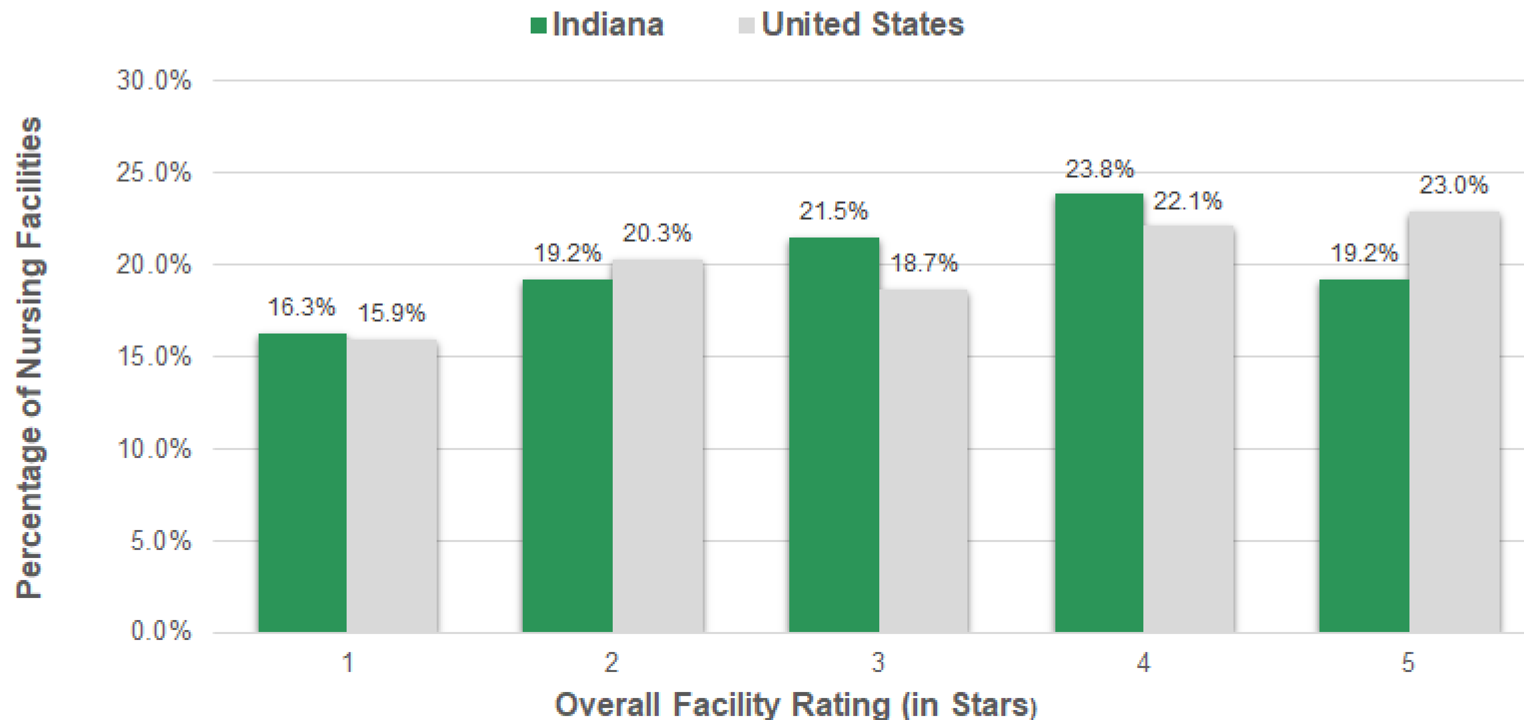


LTSS System Performance

- Overall Indiana ranks in the bottom quartile at 44th nationally
- Ranking in Key Performance Areas:
  - Affordability & Access: 41
  - Choice of Setting & Provider: 48
  - Quality of Life & Quality of Care: 19
  - Support for Family Caregivers: 51
  - Effective Transitions: 25

Source: https://www.longtermscorecard.org/2020-scorecard/state-rankings

Current Indiana Performance: April 2021 Medicare Five-Star Ratings



- The average Medicare Five-Star nursing facility rating in Indiana is 3.10
- The national average Medicare Five-Star rating is 3.16
- Indiana ranks 35th nationally in average nursing facility quality

Source: https://data.cms.gov/provider-data/dataset/4pq5-n9py

FSSA Reimbursement Goals

To develop Nursing Facility (NF) rate setting methods that comply with Centers for Medicare and Medicaid Services (CMS) rules and achieve the following:

- **Alignment** - Bring continuity and alignment across the rate methodologies, providing a consistent framework and supporting payment rates that advance FSSA goals.
- **Sustainability** - Facilitate adequate participant access to quality services, as required by CMS. Cost effective, provide for long-term workforce growth and provider stability, and affordable by the State. Reduce administrative burden. Ensure predictability.
- **Promote Person-Centeredness and Value-Based Purchasing** - Striving to align provider and participant incentives to achieve access to person-centered services, encourage services that drive healthy outcomes and participant satisfaction.
- **Reduce Disparities** – Analyze and quantify disparities in access, quality, site of care, and person-centeredness, then build payment structures to level the playing field.

These goals will be translated into evaluation criteria, to be used for evaluating the current system relative to potential options. Criteria will be established through the stakeholder process.

Benefits to Stakeholders

- All stakeholders
  - New VBP payment methodologies will reflect input from all types of stakeholders including providers, advocates, participants and their families, and others.
  - VBP payment will be developed using a transparent process, so all stakeholders can understand how the payments are calculated, distributed, and financed
- Individuals and their circle of support
  - May see higher quality and more choice
  - New methodologies will be designed to support access to services and promote staff retention
- Provider stakeholders
  - Payment methods will promote payment equity and predictability
  - VBP payments will be based on a sound methodology that recognizes the resource requirements while tying payment to quality and outcomes
  - New methodologies will seek opportunities to maintain the objectives of the base claim payment methodology

Introduction to the Milliman Team

- Christine Mytelka, Milliman
- Ben Mori, Milliman
- Jim Pettersson, Milliman
- Anne Jacobs, Milliman
- Jessica Bertolo, Milliman
- Brad Armstrong, Milliman

Alignment of Nursing Facility VBP to mLTSS and Other Provider VBP and Quality Programs

Potential for Many VBP Programs – How to Align?

Fee-for-Service

FSSA

Quality Goals/VBP
(embedded in NF per diem rate)

NFs

mLTSS

FSSA

Quality Goals/VBP
(capitation withhold, incentive, etc.)

MCEs

Quality Goals/VBP
(embedded in state-directed NF fee schedule, supplemental payment, etc.)

Quality Goals/VBP
(APMs 2-4)

Medical/Rx Providers

HCBS Providers

NFs

Fee-for-Service

FSSA

Quality Goals/VBP
(embedded in NF per diem rate)

Quality Goals/VBP
(embedded in supplemental payment)

NFs

VBP – Part of Larger Quality Strategy

VBP is just one of many “levers” that can drive behavior changes that lead to desired program outcomes.

Each Program Goal

- Outreach and Education
- Feedback and Public Reporting
- Value Based Purchasing
- Administrative Streamlining
- Other

Where We Pay for NF Quality Today

Base Rate	• Allowed profit add-on payment to three rate components (except as may be limited by application of overall rate ceiling): Direct Care, Indirect Care, and Capital
Supplemental Payments	• Payments not currently linked to quality
Quality Add-On (i.e., VBP Program)	• Based on the NF's total quality score using the latest published CMS data • Maximum amount is $18.45 per patient day (2021)

Where should we pay for quality in the future?

Overview of Indiana’s Current VBP Program

Quality Rate Add-On Methodology

Nursing Facility Total Quality Score	Nursing Facility Quality Rate Add-On
0 - 23	$0
24 - 79	$18.45 – ((80 – Nursing Facility Total Quality Score) x 0.323684)
80 – 100	$18.45

Source: http://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_4/4.19d_i-44.pdf

Quality Rate Add-On Performance Measures

Performance measures to which VBP payments are linked:

Quality Score Component	Maximum Quality Points Awarded (effective 7/1/2019)	Maximum Quality Points Awarded (effective 7/1/2020)
1. Nursing Home Health Survey Score	55	25
2. Long-Stay Quality Measures	30	60
3. NF Staff Retention Rate	10	10
4. Advance Care Planning	5	5
Total Maximum	**100**	**100**

Previous measures tied to the Quality Add-On from 2013-2019 include:

- Report Card Scores (75 pts)
- Normalized weighted average nursing hours per resident day (10 pts)
- RN/LPN & CNA retention & turnover rates (9 pts)
- Administrator & Director of Nursing turnover rates (6 pts)

Source: http://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_4/4.19d_i-44.pdf

Quality Rate Add-On Performance Measures: Nursing Home Health Survey

- Score is “total weighted health survey score developed and published by CMS”
- Facilities without a survey score as of June 30 are awarded statewide average score

Nursing Home Health Survey Scores	Quality Points Awarded
0 – 21	25
22 - 77	Proportional quality points awarded as follows: 25 – [(nursing home health survey score – 21) x 0.4385965)]
78 and above	0

Source: http://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_4/4.19d_i-44.pdf

Quality Rate Add-On Performance Measures: Long-Stay Quality Measures

- Percentage of long-stay residents whose need for help with daily activities has increased
- Percentage of high risk long-stay residents with pressure ulcers
- Percentage of long-stay-residents with catheter inserted and left in their bladder
- Percentage of long-stay residents with urinary tract infection
- Percentage of long-stay residents who were physically restrained*
- Percentage of long-stay residents experiencing one or more falls with major injury
- Percentage of long-stay residents who received an antipsychotic medication
- Percentage of long-stay residents whose ability to move independently worsened
- *Percentage of long-stay residents who self-report moderate to severe pain***

Based on CMS published quality measures

Long-Stay Quality Scores	Quality Points Awarded
0 – 540	0
541 - 699	Proportional quality points awarded as follows: 60 – [(700 – facility long-stay quality score) x 0.375)]
700 and above	60

*Notes: * indicates measure was removed from CMS 5-Star Rating System; ** indicates measure is no longer being calculated and reported by CMS so is no longer used for IN NF VBP*
Source: http://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_4/4.19d_i-44.pdf

Quality Rate Add-On Performance Measures: Nursing Facility Retention Rate

Based on data from current Schedule X reporting and calculated as follows:

$$\textbf{NF Staff Retention Rate} = \frac{\text{Total Employees at the Beginning of the Calendar Year that are Still Employed at the End of the Calendar Year}}{\text{Total Employees at the Beginning of the Calendar Year}}$$

Nursing Facility Retention Rates	Quality Points Awarded
Less than or equal to 53%	0
Greater than 53% and less than 72%	Proportional quality points awarded as follows: 10 – [(72% – nursing facility's retention rate) x 52.6316)]
Equal to or greater than 72%	10

Source: http://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_4/4.19d_i-44.pdf

Quality Rate Add-On Performance Measures: Advance Care Planning

Awarded if nursing facility employs staff who have completed an advance care planning training program approved by OMPP in accordance with criteria (effective July 1, 2021 and thereafter)

- Minimum of 1 employee must complete a level one advance care planning training program (for previous calendar year); or
- Employee(s) must be employed by the nursing facility following training completion for a minimum of six months

Advance Care Planning	Quality Points Awarded
Do not meet criteria	0
Meet criteria	5
New operations if minimum of 1 employee completed advance care planning training within 6 months of Medicaid certification	5

Source: http://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_4/4.19d_i-44.pdf , http://provider.indianamedicaid.com/ihcp/Bulletins/BT202023.pdf

Timing of Quality Add-On

2018												2019												2020												2021
J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J

SFY 2019 | SFY 2020 | SFY 2021 Rate Period

Survey: Most recently published nursing home health survey score as of 6/30/2020
(possible survey publication date of 4/1/2019-6/30/2020)

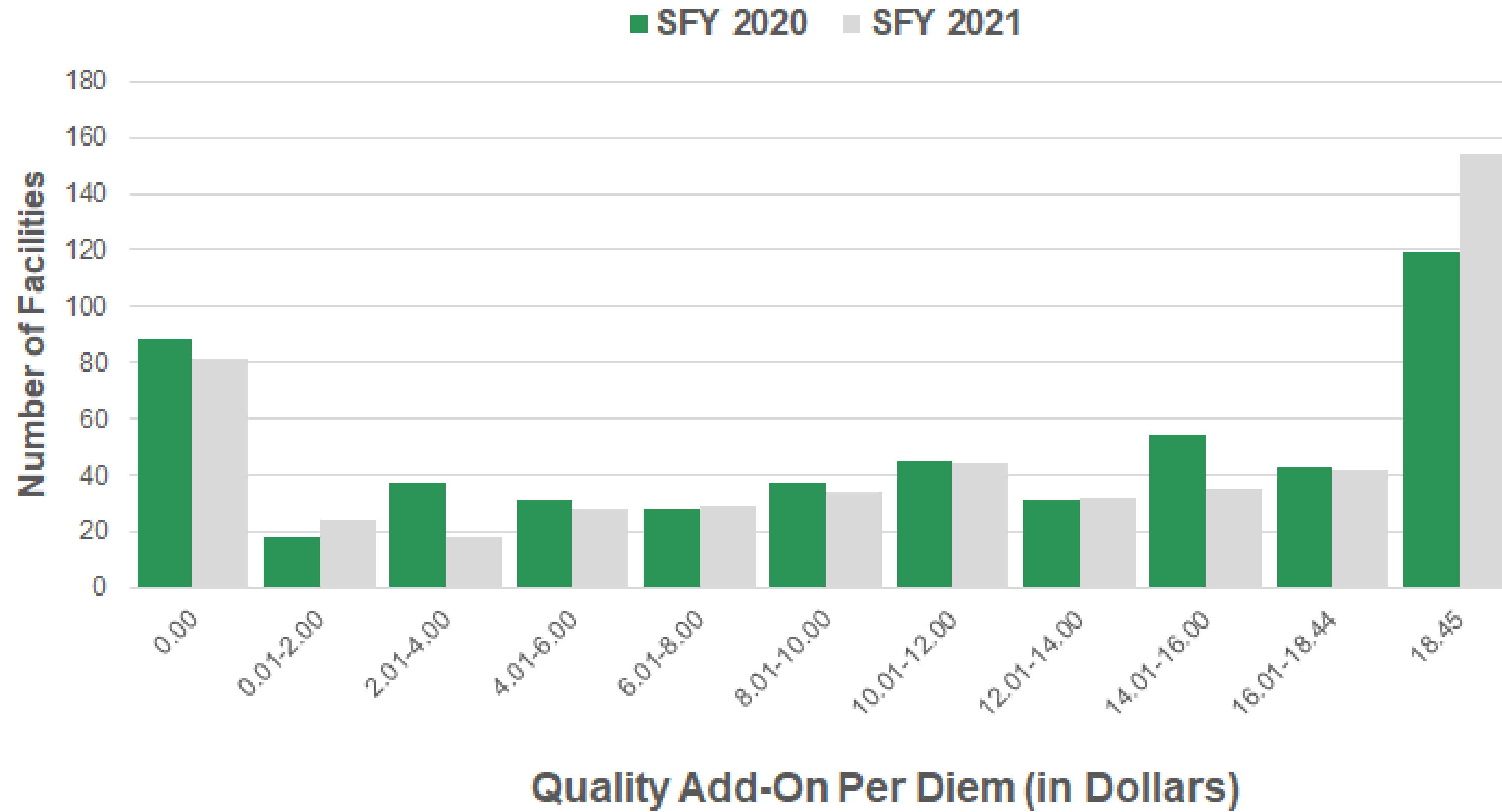
Long-Stay: Most recently published 4 quarter average nursing home compare long-stay quality measures of the previous calendar year
(1/1/2019-12/31/2019)

Retention: Most recently completed calendar year Schedule X
(1/1/2019-12/31/2019)

Advanced Care Planning: for previous calendar year
(1/1/2019-12/31/2019)

SFY 2021
7/1/2020 – 6/30 /2021
Quality Add-On

Quality Add-On Per Diems by State Fiscal Year



Historical Nursing Facility Performance

Mean Quality Score by Rate Effective Date

Mean Quality Score

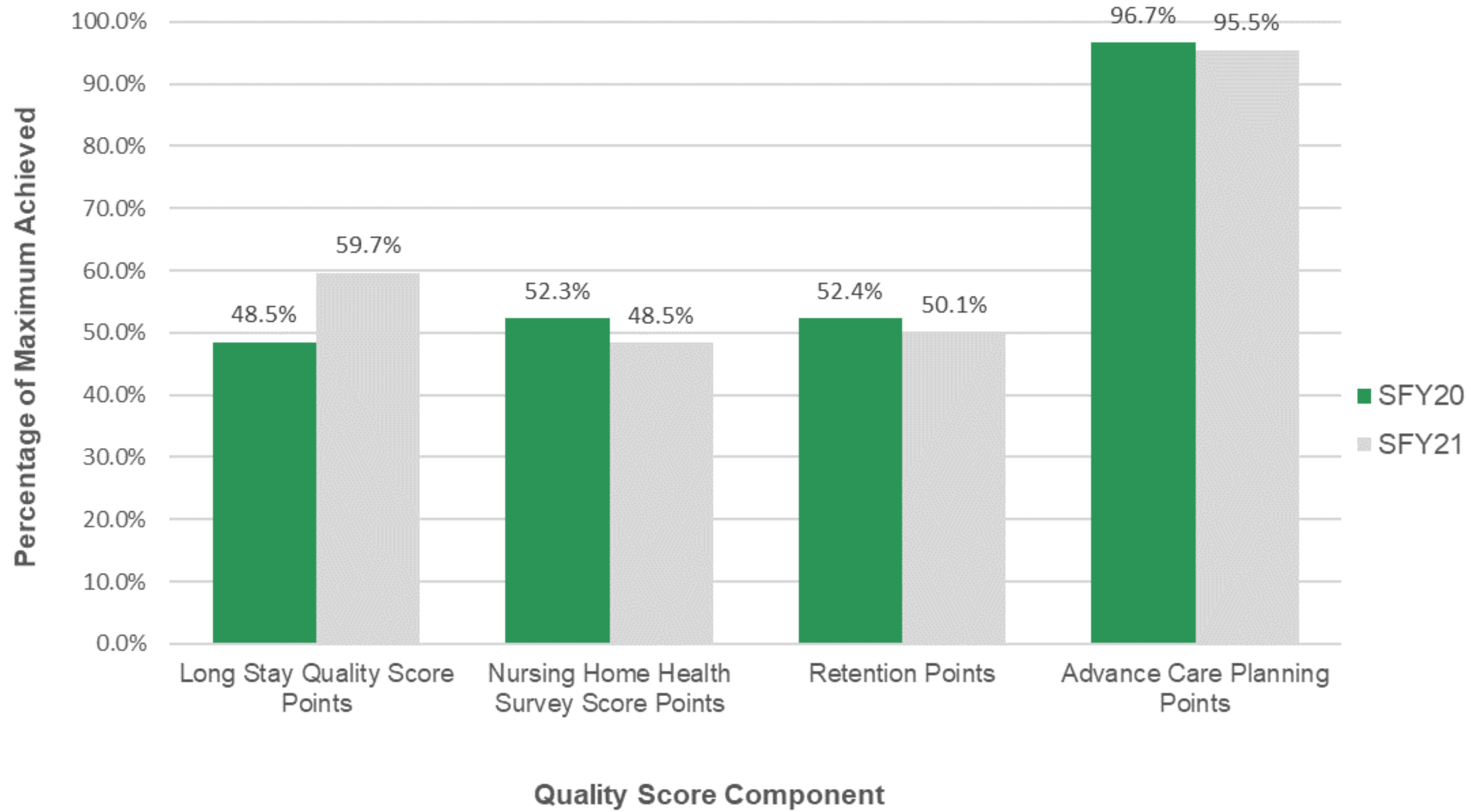
64.00
62.00
60.00
58.00
56.00
54.00
52.00
50.00
48.00

2016 2017 2018 2019 2020 2021

Rate Effective Date (State Fiscal Year)

New Scoring Methodology Takes Effect

Quality Score Achievement by Component



Historical Nursing Facility Performance

QUALITY PAYMENT AS A PORTION OF AGGREGATE LTSS MEDICAID ALLOWED PAYMENT (IN MILLIONS)

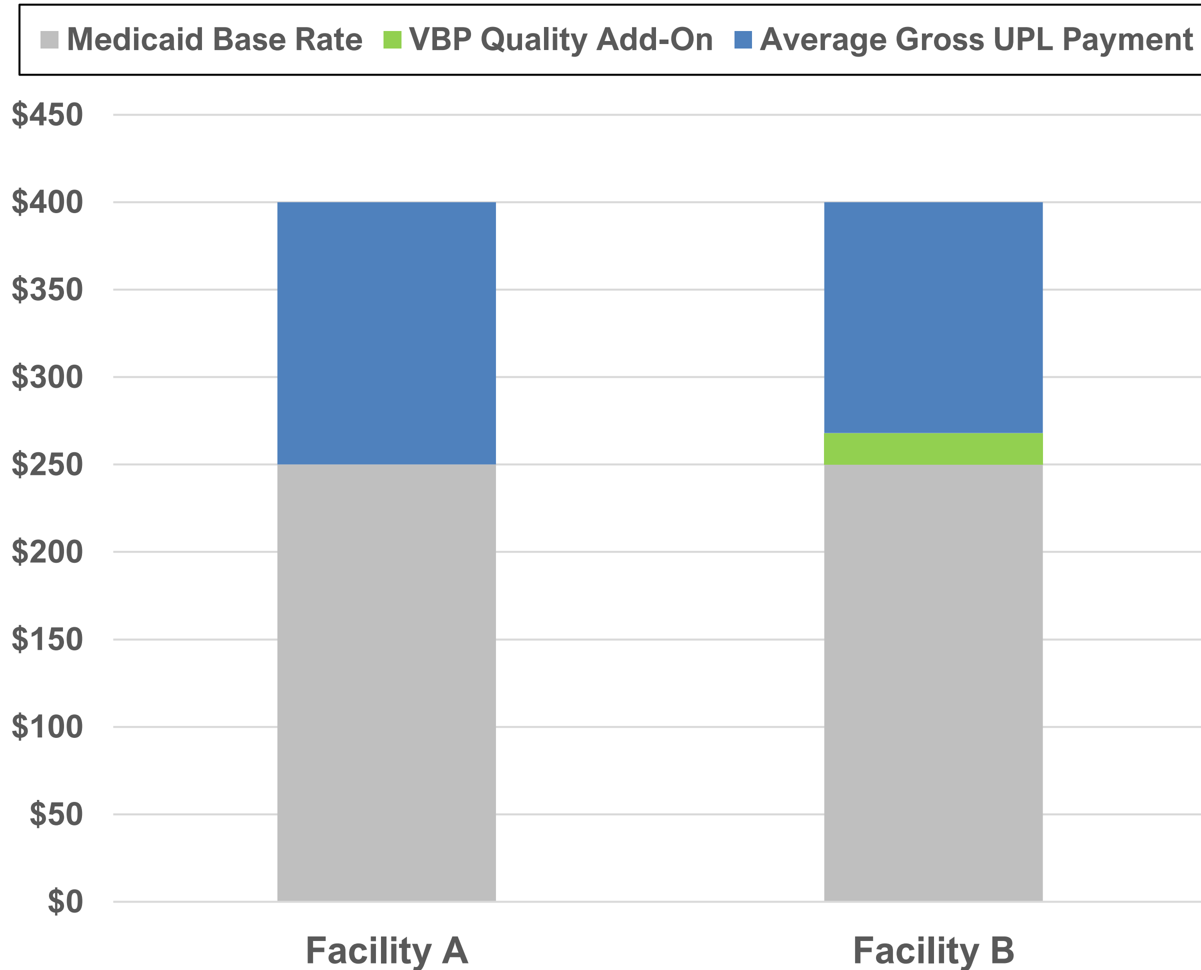
SFY	CURRENT QUALITY PAYMENTS[1]	MAXIMUM QUALITY PAYMENTS[1]	CURRENT TOTAL ALLOWED[2]	POTENTIAL MAXIMUM TOTAL ALLOWED
2019	$ 80.7	$ 125.5	$ 1,859.0	$ 1,903.8
2020	$ 87.6	$ 160.6	$ 1,957.3	$ 2,030.3

IMPACT OF MAXIMUM QUALITY SCORE ACHIEVEMENT ON MEDICAID LTSS RATES (BEFORE ADD-ON)

	PERCENTAGE OF RATE ALLOCATED TO QUALITY ADD-ON		
SFY	USING CURRENT QUALITY RATINGS	IF MAXIMUM QUALITY RATING ACHIEVED	MAXIMUM INCREASE TO TOTAL RATE DUE TO INCREASED QUALITY SCORES
2019	4.5%	7.1%	2.5%
2020	4.7%	8.6%	3.9%

Notes:
1. Aggregate quality payments were calculated using the applicable facility-level per diems, multiplied by the estimated number of Medicaid days for each facility, as reported in the EDW as of June 3, 2021.
2. The Current Total Allowed reflects total allowed charges for nursing facilities, inclusive of current quality add-on payments and exclusive of supplemental payments, as reported in the EDW as of June 3, 2021.
3. The maximum quality add-on per diem increased from $14.30 in SFY 2019 to $18.45 in SFY 2020.

UPL Payment – Per Diem Example



- The Medicare target under the UPL payment methodology potentially neutralizes differences in Medicaid base payments (such as quality add-ons/VBP)
- For example:
  - Facility A and Facility B have identical case mix, but FSSA pays Facility A $0 quality add-on/VBP and Facility B the maximum quality add-on
  - FSSA makes a smaller UPL payment for Facility B in order to pay up to Medicare

Highlights from Stakeholder Feedback Regarding Quality Measures (from February 2021 VBP Meeting)

- Additional Measures to Consider
  - Quality of life
  - Consumer satisfaction
  - Measures aligned with rebalancing such as:
    - MDS referrals
    - Low acuity NF residents
- Other Considerations
  - Availability of measures across LTSS settings
  - Consistency of measures and VBP programs across MCEs and other payers
  - Risk adjustment (e.g., not done for some long stay measures)
  - Equity lens (e.g., geography, demographics)
  - Survey citations sometimes not useful

Key Questions

- How does the current VBP program incentivize or change behavior?
  - Is the dollar amount meaningful? How has it changed behavior?
  - Do you have timely information on your current performance? How do you track performance?
  - Are there measures that should be changed or replaced?
- What quality measures can be used to better address the FSSA goals of rebalancing, equity and resident outcomes?
  - How can quality incentives reflect participant choice/rebalancing rather than nursing facility-only measures?
  - How can we acknowledge facilities located in underserved areas or facilities with higher case mix or higher barriers to success? (e.g., SDOHs, geography, demographics, etc.)
- What rate components should reflect quality?
- How frequently should VBP measures and methodology be changed?
  - How much advance notice of upcoming change is needed?
  - Should changes be considered for the next rate year?
- What should be the timing for making payouts?

Best Practices in VBP:
Key VBP Frameworks and Requirements

HCP-LAN Framework

Emphasis on Quality/Value

Scope of Risk Transfer

CATEGORY 1 FEE-FOR-SERVICE – NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE-FOR-SERVICE – LINK TO QUALITY & VALUE	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION-BASED PAYMENT
	A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for health information technology investments)	**A** APMs with Shared Savings (e.g., shared savings with upside risk only)	**A** Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	**B** APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	**B** Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
	C Pay-for-Performance (e.g., bonuses for quality performance)		**C** Integrated Finance & Delivery Systems (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	**4N** Capitated Payments NOT Linked to Quality

Figure 1: The Updated APM Framework

- **HCP-LAN is widely adopted** across all major payer segments
- APMs focus on **payment for quality and value** vs. volume
- HCP-LAN **promotes best practices** for APM design, implementation, and measurement
- Many **resources** to help payers and provider organizations optimize APMs

Federal VBP Requirements Under Managed Care

- In managed care, special payment provisions in contracts like withhold and incentive arrangements must meet regulatory requirements
- If a state wishes to implement a value-based purchasing model for provider reimbursement within managed care, a 438.6(c) preprint is required
  - In its application, the state must explain how it expects to advance goals in its quality strategy and have an evaluation plan
- CMS encourages uses of VBP (2020 State Medicaid Director Letter)

Source: https://www.law.cornell.edu/cfr/text/42/438.6

Best Practices in Medicaid VBP

- VBP is part of a broader quality strategy designed to improve targeted outcomes
- Dollar impact is sufficient to motivate provider investment in operational and workflow changes needed to positively impact outcomes
- Timing of payments is closely linked to performance
- Incentives are aligned across payers, where feasible (i.e., multi-payer participation)
- Evolves over time (e.g., measures, payment methods)
- Creates a pathway to sustainability

Additional Considerations

- What percentage of total NF payments should be linked to quality and should that change over time?
- How and when should payments be made, for example:
  - As a rate add-on (i.e., as part of the per diem rate) or as a separate lump-sum payment
- What type of risk sharing arrangements will be used?
  - Do we continue with upside-only risk (i.e., Pay for Performance)?
  - Are NFs ready for upside-downside risk arrangements?
- To what extent should MCEs be encouraged or required to share incentive payments with network providers?

Stakeholder Feedback

Invitation to Provide Input

- Provide further input via email
- What is and is not working in NF service delivery today?
- What new quality measures should be considered?
- Which if any current quality measures should be changed or removed?
- How can NF VBP be better aligned with overarching mLTSS goals?
- What states should we consider researching and why?
- What data analyses should we consider performing to understand current performance?
- What should be the timing of VBP program changes?
- How can we be sure that the perspectives of all stakeholders/participants are considered?

Next Steps

Nursing Facility Reimbursement – Project Timelines

CY 2021										CY 2022					
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun

Review of current program and research alternatives

Finalize Rates, Methods, and Simulation Results

- Select and Evaluate Alternatives
- Conceptual Design, with Refinements
- Simulate Rates and Payments

State and CMS approval process

Stakeholder engagement will occur throughout the process

Next Steps

- Please send input on suggested research and analysis
- Next meetings
  - *Preliminary results of research and analysis: July*
  - *Follow-up analysis, evaluation of options, and first conceptual design: September*
- Meeting topics and agendas to be developed and sent five business days in advance of the Workgroup meetings
- New workgroup members may email backhome.Indiana@fssa.in.gov to be added to the mailing list for this workstream

Caveats and Limitations

The services provided for this project were performed under the contract between Milliman and FSSA approved May 14, 2010, and last amended December 4, 2020.

The information contained in this presentation has been prepared solely for the business use of FSSA, related Divisions, and their advisors for a provider stakeholder workgroup meeting presentation on April 29, 2021. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in health care modeling that will allow appropriate use of the data presented.

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Guidelines issued by the Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Christine Mytelka is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses in this report.

The work for this project is still on-going. FSSA has not made any final decisions. FSSA policy decisions, which have yet to be determined, will be subject to state legislative and federal approval.

Appendices

NF Reimbursement Evaluation Criteria

Potential Evaluation Criteria

Rate setting methods may be evaluated against the following potential objectives, or *evaluation criteria*, which will be modified and updated as part of the stakeholder process:

1. **Access** - Promote beneficiary access to care, from a range of providers, in consideration of socioeconomic or geographic barriers to care.
2. **Quality** – Promote the delivery of high quality care for all individuals. Build infrastructure and payment supports that enhance and sustain quality and person-centered planning.
3. **Efficiency** - Promote provider economy, efficiency, and good stewardship of federal and local funds that support the program.
4. **Payment equity** – Provide for payments that are equitable and rational. Recognize reasonable and measurable differences in intensity or cost of services. Provide for wages commensurate with skills and experience across all settings.
5. **Alignment** – Provide for alignment and consistency with other programs.

NF Reimbursement Evaluation Criteria

Potential Evaluation Criteria (continued)

6. **Transparency** – Promote understanding of exactly what service or value is being purchased, and how related payments are determined. Facilitate oversight of fund flow.
7. **Reduce disparities**– Analyze and quantify disparities in access, quality, site of care, and person-centeredness, then build payment structures to level the playing field.
8. **Simplicity**– Reduce cost and administrative burden of current system, while maintaining only the complexity necessary to advance payment equity, quality, and other goals.
9. **Predictability**– Promote a clear understanding of the payment structure and how future updates will occur is a fundamental support for long-term planning and workforce development.
10. **Forward Compatibility** – Rate setting Method must be compatible with transition to managed care environment.

Best Practices in VBP

Key VBP Frameworks and Requirements

- VBP has been widely adopted in many sectors
- Existing frameworks will serve as a resource, including:
  - Health Care Payment Learning and Action Network (HCP LAN)
  - CMS guidance and requirements
  - Guidance provided by thought leaders and other agencies
- Medicaid VBP programs used in other states can also serve as examples

HCP-LAN Framework Overview

Background

- Designed to drive alignment in payment approaches across both private and public sectors of the healthcare system
- Mission: To accelerate the health care system's transition to alternative payment models (APMs) by combining the innovation, power, and reach of the private and public sectors.

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%

8 Guiding Principles

- Changing providers' financial incentives is not sufficient.
- Reformed payment mechanisms will only be as successful as the delivery system capabilities and innovations they support.
- Goal: to transition health care payments from FFS to APMs.
- Value-based incentives should ideally reach care teams who deliver care.
- Payment models that do not take quality into account are not considered APMs in the APM Framework.
- Value-based incentives should motivate providers to invest in and adopt new approaches to care delivery, without subjecting providers to financial and clinical risk they cannot manage.
- APMs will be classified according to the dominant form of payment if 1+ is used.
- Centers of excellence, accountable care organizations, and patient-centered medical homes are examples.

Best Practice Guidance

- Integrated Care Resource Center, Lessons Learned for NF VBP Structure:
  - Align measures with those reported by CMS's Nursing Home Compare Five-Star Rating System
  - Standardize data collection methods or instruments
  - Approach quality measures as a work in progress and adjust over time
  - Adjust the size of payments to make participation worthwhile
- Center for Health Care Strategies, VBP in MLTSS Checklist:
  - Assess available support from state policy environment—*are other reforms underway? Is there a long-term plan?*
  - Select the right measures—*what are appropriate improvement targets?*
  - Select payment models that create the right financial incentives for improved value—*what level of reward and risk is appropriate?*
  - Address operational issues faced by plans and providers—*how do states help providers prepare for and engage in VBP?*

Sources:
https://www.integratedcareresourcecenter.com/pdfs/ICRC_VBP_in_Nursing_Facilities_November_2017.pdf
http://www.advancingstates.org/sites/nasuad/files/MLTSS-VBP-checklist-121018.pdf

Federal VBP Guidance

- CMS's encourages use of VBP; published State Medicaid Director letter in 2020 discussing pathways toward adoption of VBP models in Medicaid
- CMS Key Considerations
  - Level/Scope of financial risk
  - Use of Benchmarking
  - Payment Operations
- How States can facilitate the shift
  - Multi-payer participation
  - Assessment of delivery system readiness
  - Robust HIT
  - Stakeholder engagement
  - Quality measure selection
  - Ensure pathway to sustainability

Source: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf

Value-Based Purchasing Balancing

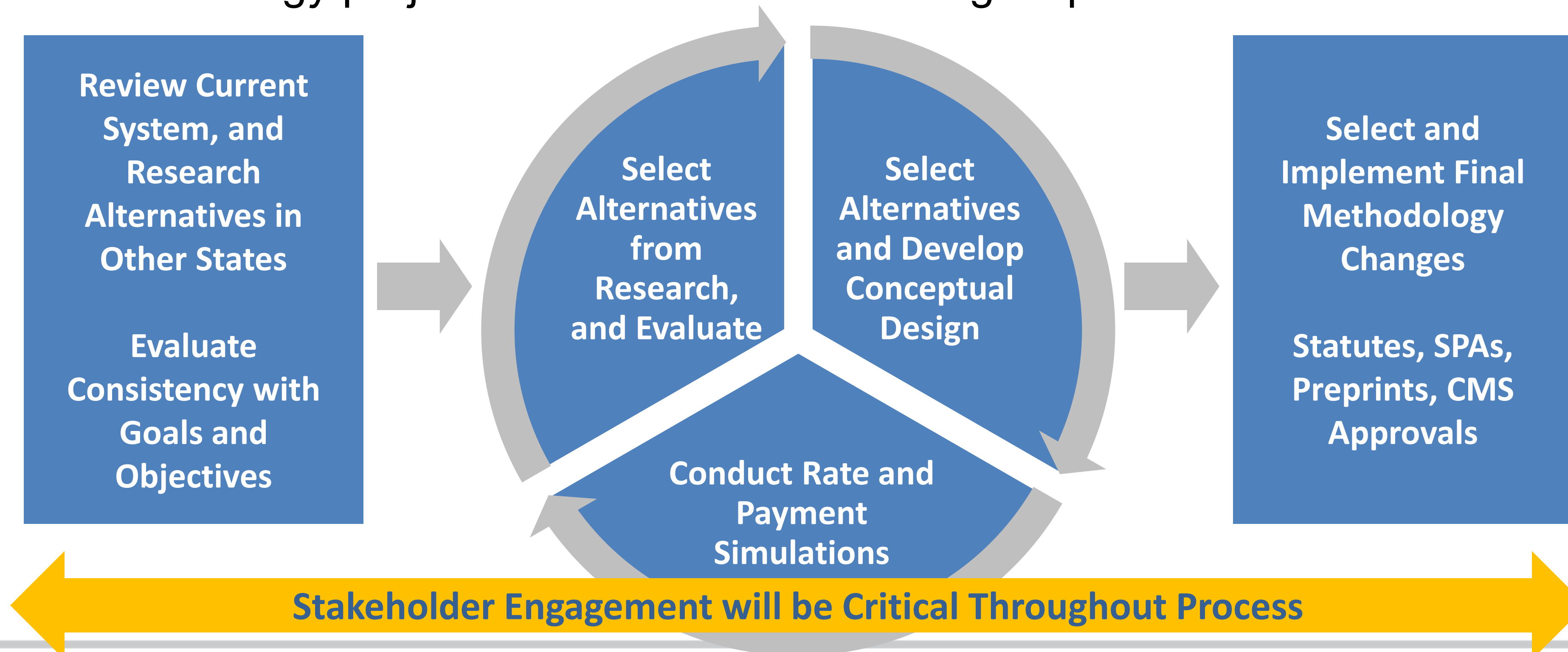
Range of Value-Based Purchasing Consideration

Full Directed Fee Schedule Increase	Mix of Directed Fee Schedule and Quality Payment Pool	Full Quality Payment Pool
• Full directed fee schedule increases without quality pool • Potential transitional period retaining select existing supplemental payments • May require quality portion beginning in years 2-3	• Majority of payment pool dedicated to directed fee schedule increases • Smaller quality pool with pay-for-performance requirements where providers can "earn back" full increases (or other payment targets)	• Full quality payment pool without directed fee schedule • Quality metrics could include mix of baseline qualifications and higher thresholds

Project Approach

Overall Project Approach

- FSSA has engaged Milliman to perform research and analysis to evaluate the current methodology relative to alternatives, offer options for consideration, then assist with redesign
- Rate methodology projects will involve the following steps:



Stakeholder Engagement

Stakeholder Process

- Balanced input from the full range of stakeholders is critical to this process.
- FSSA wants to hear from a variety of stakeholders, including providers and associations, direct service providers, participants and their informal supports, families, advocacy groups, and other key state and federal government stakeholders.
- Stakeholder engagement will include multiple modes of communication, such as:
  - In-person meetings (when it becomes practical)
  - Webinars and virtual meetings
  - Project website, FAQs, and email address
- In addition, per federal requirements, prior to any rate method or rate changes there will be an official 30-day public comment period, followed by 30 days for FSSA to review and respond to public comment. CMS then has a 90 day approval process (which may be extended).