BRIEF #4

# Utah LTSS Project

## HCBS Payment Models

**January 2025**

# Contents



***Prepared for:***
Utah Department of Health and Human Services (DHHS)

***Prepared by:***
Jami Petner-Arrey, Team Lead—Human Services Research Institute
Karen Westbrook, Team Member—Human Services Research Institute
John Agosta, Team Member—Human Services Research Institute
Colleen Kidney, Team Member—Human Services Research Institute

***About Human Services Research Institute***
Human Services Research Institute is a nonprofit, mission-driven organization, which works with government agencies and others to improve health and human services and systems, enhance the quality of data to guide policy, and engage stakeholders to effect meaningful systems change.

This study is sponsored by the Utah DHHS. All opinions expressed herein are solely those of the authors and do not reflect the position or policy of DHHS.

HSRI

# Introduction

The Utah Department of Health and Human Services (DHHS) strives to ensure all Utahns have fair and equitable opportunities to live safe and healthy lives. Through its Division of Integrated Healthcare (DIH), Division of Aging and Adult Services (DAAS), and Division of Services for People with Disabilities (DSPD), DHHS has established a comprehensive Long-Term Services and Supports (LTSS) system. In recent years DHHS and its divisions have engaged in multiple initiatives to improve services and supports.

DHHS contracted Human Services Research Institute (HSRI) to build on current initiatives to strengthen LTSS and make recommendations to DHHS on how to further these efforts. DHHS and our Steering Committee requested that we prioritize opportunities that focus on:

- *Inclusion—Support and honor people's choices for where they live and who they live with. Give people options for receiving community services and participating in competitive integrated employment.*
- *Service Quality—Ensure that people in Utah equitably receive the services that they need. Promote high quality services and highly qualified providers and direct support professionals.*
- *Person-Centered Support—Empower people to maintain control over their own life and services (self-direction) by offering holistic support.*
- *Effective Service System—Improve coordination between agencies, funding, and reimbursement of services to help more people.*

In this Research Brief (#4), we explore Home- and Community-Based Services (HCBS) payment models.

To inform our understanding of this topic, we (i) reviewed relevant Utah policy and program documents, DHHS and divisional websites, and relevant data (as applicable); (ii) conducted focus groups and informational interviews to learn from people receiving services, family members, providers, advocacy organizations, and field experts (as applicable), (iii) reviewed Utah's waivers and HCBS programs in other states; and (iv) researched a wide variety of literature.

Based on this research and as discussed in more detail in the sections that follow, we identified the following key opportunities for DHHS related to HCBS payment models:

- Strengthen vision for payment models
- Streamline and improve payment models
- Ensure adequacy and sustainability of existing payment models

Our initial research findings were presented to the Project Steering Committee, and the committee's feedback is incorporated in this research brief. The opportunities outlined in the brief are not final recommendations. These preliminary recommendations may change as we collect more information on this and other research topics and explore their feasibility. Some opportunities may not be possible for DHHS now or in the future. Our final recommendations will consider all research topics holistically, proposing the right plan for Utah. These will be outlined in our final report.

# Background

Nationally, LTSS is extremely expensive, and Medicaid is the primary payer (Chidambaram 2024). Due to these costs, about 700,000 people, mostly people with intellectual and developmental disabilities are waiting for services (Chidambaram 2024). Workforce shortages are severe, and nearly all states enhanced payments for HCBS direct support professionals (DSPs) recently in an effort to address these shortages (Chidambaram 2024). Yet, despite these investments, there is little data on the direct quality of services provided through HCBS. Many states, including Utah, are seeking to improve services through innovative payment models. DHHS, specifically, wants to explore potential changes to LTSS payment models to ensure that as many people as possible can be served with a robust workforce. The staff also want to ensure that services delivered are of the highest possible quality, all while balancing cost effectiveness. DHHS is interested in payment models for reimbursing providers, alternative payment methods, and value-based payment models, all with a focus of enhancing community supports.

## Utah Landscape

DHHS has nine current 1915(c) waivers administered by DAAS, DIH, and DSPD. HCBS payment models vary across different departments within Utah DHHS. They are complex and dependent on federal and programmatic requirements (e.g., for Medicaid and Older Americans Act funding). For example, DAAS funds and oversees services delivered by contracted providers through the Waiver for Individuals Age 65 or Older program and oversees services delivered by Area Agencies on Aging (AAA). DSPD funds and oversees services delivered by contracted service providers. DHHS also funds institutional supports such as the Utah State Developmental Center, nursing homes, and intermediate care facilities for individuals with intellectual disabilities. DHHS primarily funds HCBS through a fee-for-service model, wherein providers are paid a fixed rate for a unit of service that is typically time-based (e.g., hourly, daily).

Related to DSPD, a report prepared for the Social Services Subcommittee of the 2018 legislative session stated that a rate study had not been conducted for DSPD since the 1990s and that cost-of-living adjustments were not regularly applied, illuminating infrequent rate studies historically (Utah Office of the Legislative Fiscal Analyst 2017). Recently, however, Utah completed rate studies for DSPD in 2022 and for DAAS and DIH in 2023. DSPD is also engaged in a rate study. The 2023 rate study report issued to DIH and DAAS by Myers and Stauffer found that, of the 33 services reviewed, 20 were funded below cost.

Low rates may exacerbate staffing shortages. According to the Utah Commission on Aging, staffing shortages and increasing inflation has led to AAAs not being able to serve all with needs (Utah Commission on Aging 2023). The National Core Indicators State of the Workforce Survey shows that more than half the providers responding to DSPD reported having turned away or stopped accepting new service referrals in 2022 due to staffing issues with direct support professionals (DSPs). NCI shows that retention is difficult, with nearly half of the DSPs in Utah on payroll for less than a year, a much higher rate than the national average of 36.4%. In 2021, DSPD providers reported a 10.3% vacancy rate for full-time positions and a 14.2% vacancy rate for part-time positions.

Despite, or because of, Utah's reputation as being fiscally conservative (DAAS, 2019), DHHS may have missed opportunities to maximize federal reimbursement for services in several ways: (1) missing the period to capture a Medicaid match (Utah Office of the Legislative Fiscal Analyst 2017) and (2) not participating in high reimbursement programs such as Money Follows the Person.

# Research Findings

To inform our understanding, we reviewed research on payment models used across the country. We also synthesized information gathered through community engagement activities, focus groups, and key informant interviews with people in the state to identify issues associated with payment for services within Utah. Our analysis follows policy briefs that have already been completed on payment models, including the Budget Deep Dive into Disability Service Provider Rates prepared for the Social Services Appropriations Subcommittee (Utah Office of the Legislative Fiscal Analyst 2017), an HCBS rate study completed by Myers and Stauffer in 2023 for DIH, and a cost survey completed by Myers and Stauffer in 2022 for DSPD. We note that DSPD is currently engaged in a rate study and that the resulting recommendations may inform DHHS's future directions. Our findings on payment models are outlined below.

## Engagement Themes

We held community engagement meetings that included questions specific to payment models and value-based payments. Paying for services, however, has been a frequent theme of engagement since the beginning of this project. When asked what they would change about paying for services, one participant simply said, "More funding. More money." Another characterized the current state of funding as "serious under-funding," while another described the rates as "woefully inadequate." Other themes that surfaced included:

- Difficulty finding service providers, whether families are paying out of pocket or receiving waiver funding, sometimes leading to an inability to use allocated funds
- Lack of clarity over how individual funding can be used on supports and services
- Low DSP wages
- Rate increases not keeping pace with costs
- Need for tiered services funding to better address varying support needs
- Need for competitive rates, and rate parity for similar services
- Difficulty using the service billing codes
- Need for timely service authorizations and changes
- Need to streamline the billing process across programs
- Desire to simplify caregiver funding requirements
- Service specific concerns (e.g., losing money to provide transportation, Board Certified Behavior Analyst (BCBA) rate not being competitive, issues with rate worksheets for group settings)

When asked about value-based payments which tie payments to quality and outcomes of care, one participant commented, "I would like Utah to implement a sufficient payment approach. Rates are too low to start with," indicating the need to stabilize the system before engaging in any more innovative models. Respondents, however, noted that health and safety were among the top highest quality and outcome priorities for people receiving services.

# State Programs Research

Related to payment models, the Centers for Medicare & Medicaid Services (CMS) requires that states have rates consistent with efficiency, economy, and quality of care and be sufficient to enlist enough providers (§1902(a)(30)(A). States are also required to document rate setting methodologies within the 1915(c) waiver application, as well as cost neutrality (§1915(c)(2)(D) of the Social Security Act). This includes outcome based and supplemental payments. State Medicaid programs may also consider additional factors such as administrative simplicity, transparency, or budget predictability in their payment models. They should also consider alignment with policies such as strengthening the provider network and workforce. Finally, the newly passed Access Rule has requirements related to including minimum direct care staff compensation thresholds (with 80% of the rate required for wages and benefits) for HCBS home health aide, homemaker, and personal care services; transparency in the rate development process, particularly as it relates to the impact of rate changes on providers; stricter criteria for approving rate reductions; and stronger requirements related to payment adequacy (42 CFR 431, 438, 441, and 447).

## *Payment Models*

States use several different payment mechanisms through Medicaid to fund LTSS. States may choose to use Managed Long-Term Services and Supports (MLTSS), which feature capitated payments made to managed care entities, fee-for-service approaches similar to those used in Utah, or other alternative models (such as fee-for-service models that do not rely on traditional time units). In 2022 there were 13 states that employed an MLTSS approach for the majority of LTSS service recipients and 15 that used a blend of MLTSS and fee-for-service or an alternative model, with the remaining 23 using fee-for-service or alternative fee-for-service approaches (Advisory Ideas to Action in Healthcare & Aging 2022). These services are offered through a combination of 1115 and 1915 waiver authorities. 1115 waivers allow states to use experimental, pilot, or demonstration projects to flexibly improve their programs, often involving capitated payments or other incentive payments for quality. 1915(c) waivers offer less flexibility for funding services and often rely on fee-for-service models. For more detailed information on waiver types, see Brief 11: Medicaid Long-Term Services and Supports Programs Structure and Funding Options. Like Utah, most other states operate 1915(c) waiver programs. Most 1915(c) waivers are population-specific, with 47 states having 1915(c) waivers for people with intellectual or developmental disabilities and 42 states having waivers for people who are ages 65 and older or have physical disabilities (Burns 2023).

In this brief we describe the following payment models and provide state examples that may combine several different payment models.

| Fee-for-Service | Bundled Payments | Capitated Payments | Supplemental or Incentive Payments |
|---|---|---|---|
| • Payments that are fixed and may be based on a fee schedule | • Payments for a combined, or bundled, set of services | • Payments based on population, rather than specific services | • Payments to promote outcomes |

### *Fee-for-Service*

DHHS largely uses fee-for-service payments. These are broadly defined as fixed payments that may be based on a fee schedule (MACPAC 2015) or a worksheet. When programs use fee-for-service models, the fee schedule is known at the outset, and providers can determine their payment by multiplying the units of service by the fee listed on the fee schedule or determined through other methods. Billing units can vary in increments, including 15 minutes, hourly, daily, and monthly, depending on the service. Fee-for-service models are often informed by provider cost data and transparently outline cost assumptions; however, providers are paid for meeting the minimum requirements of the service rather than exceeding them. In many programs, these payments are determined by either actuary models or cost surveys distributed to service providers, along with published cost data. Rate models often include assumptions for:

- DSP wages and benefits
- DSP productivity to account for time spent on indirect tasks such as completing paperwork or attending training
- Service-specific costs such as real estate, vehicles, and program supplies
- Administration and overhead (Albaroudi 2023)

### *Bundled Payments*

Bundled payments allow providers to be paid for a bundle of services rather than for distinct services. Bundled payments can help shift focus from the discrete services that providers are delivering to allow for a more flexible provision of a range of services. For example, a bundled payment may be used to fund an initial therapy assessment, development of a therapy plan, and ongoing therapy services to allow providers flexibility in assessing and delivering services. While bundled payments allow flexibility, crucial data, which could have been included with discrete billing, may be lost. Bundled payments can be helpful for LTSS that is intended to be flexibly delivered or that encompasses a multitude of activities within the service period. Providers, however, may not actually be delivering all of the expected services during the payment period, either at their discretion or because the person does not need them. Bundled payments may limit people's choices, as they have to choose one provider for the range services offered.

### *Capitated Payments*

Capitated payments are population-based payments based on the number of people served over a period of time, rather than on the specific services they receive (Center for Healtchare Payment and Quality Reform ND). Capitated payments are frequently used in managed care models and administered through 1115 waivers. In a capitated arrangement, a managed care organization that oversees a provider network receives a capitated payment to pay for all the services delivered by the provider network. With capitated payments, the managed care organization is paid the capitated rate, regardless of the amount of services their provider network delivers. However, the organization may be at financial risk if more services are provided than are included in the capitated payment. An aim of capitated payments is to maximize quality by incentivizing managed care organizations to provide high quality care outlined in the managed care contract while spending efficiently.

### *Supplemental or Incentive Payments*

Finally, many state programs pursue supplemental or incentive payments to promote specific outcomes within service delivery (MACPAC 2015). For example, a state program may pay a supplemental payment for providers that deliver services in rural areas or for providers equipped to deliver services to people who are deaf or hard of hearing. These payments may also be part of a larger value-based payment strategy. The Tennessee example below shows how incentive payments operate within a broader value-based payment strategy.

## Tennessee

Tennessee operates TennCare under an 1115 waiver authority, so may have more flexibility to offer innovative payments than DHHS operating under a 1915 authority. Through TennCare, Tennessee is able to meet many of its stated aims for supporting people. Tennessee operates CHOICES for seniors and people with physical disabilities, and Employment and Community First (ECF) CHOICES for people with intellectual and developmental disabilities. Both CHOICES programs are intended to serve more people than previous programs, promote competitive employment, promote community integration, and improve quality. Payment models incentivize independence of people receiving services by paying for fading supports and for employment outcomes. Because TennCare uses an 1115 authority, it enables Tennessee to engage in preferred contracting that allows them to target specific providers who have demonstrated strong person-centered and employment practices (American Network of Community Options and Resources 2019). Tennessee provides resources to providers and incentivizes staff training (read more about these incentives below). Tennessee operates Health Link to enhance support coordination for members with behavioral health needs.

---

Quality … indicates that patients receive appropriate and timely care that is consistent with evidence-based guidelines and patient goals, and that results in optimal patient outcomes and patient experience. … Measure scores should also be meaningfully accessed, understood, and used by patients and consumers *(Health Care Payment Learning & Action Network 2017, 7)*.

---

## *Value-Based Payment Strategies*

Some states use value-based payments and strategies to pay more for higher-quality services. Value-based payments have been described as a means to achieve the "triple aim of healthier people, better care, and smarter spending" (Health Care Payment Learning & Action Network 2017, 14). Developing a strong value-based payment strategy takes a substantial amount of time and resources and requires significant buy-in from people receiving services, providers, advocacy groups, government officials, and others. Value-based payment models may require fundamental changes in the way that providers deliver care. They can be costly and administratively taxing, though may offer promise in the long-term (Health Care Payment Learning & Action Network 2017). Several states have been in the process of developing plans for value-based payment models for many years, some upwards of a decade. It can often pose a significant challenge for states to develop the data-collection capabilities to set benchmarks that can later be improved through value-based payments. Given these difficulties, many state programs choose to implement smaller-scale strategies to gain experience and make adjustments before larger-scale implementation. Value-based payments are

only those which focus on improving quality, and not just payment reforms, and they are only as good as the innovation they are intended to bring about (Health Care Payment Learning & Action Network 2017).

The nature of providing LTSS can cause challenges in planning and implementing a value-based payment strategy, particularly for certain populations. For example, people with intellectual and developmental disabilities are often the last to be enrolled in managed care value-based payment initiatives due to the high cost of care, limitations in data collection, and potentially intangible outcomes (Sharon Lewis 2018). Therefore, several important considerations are needed. First, the goals for acute care settings, where value-based payments are more often used, are different from those in LTSS (Sharon Lewis 2018). LTSS often must advance more intangible outcomes, such as community integration, independence, self-determination, and supporting families (American Network of Community Options and Resources 2019). Many current value-based payment initiatives for LTSS populations are relatively new, and most have not undergone comprehensive evaluation, so outcomes remain unclear (American Network of Community Options and Resources 2019).

Value-based initiatives should focus more heavily on improving services than on achieving cost savings (Sharon Lewis 2018). Initiatives should include feedback from providers and people receiving services (Centers for Medicare & Medicaid Services 2023) and should include a range of providers, including smaller providers, with different levels of experience and who serve people who have historically been unrepresented in existing value-based payment strategies such as specialists (Lisle 2024). Efforts to engage in value-based payments must be carefully planned and implemented to protect the continuity and stability of services, continue and expand service access, ease navigation, provide adequate funds, and achieve high outcomes (American Network of Community Options and Resources 2019).

While much attention is given to value-based payments in 1115 waivers (described briefly in the TennCare example above), value-based payment strategies are possible within a 1915(c) waiver. They are often developed with the same goals of encouraging coordination of care, improving service quality, and furthering program goals such as provider retention and highly trained DSPs (Centers for Medicare & Medicaid Services 2023). In a 1915(c) structure, outcome-based payments may be based on measurable criteria like providing specific provider reports, quality-related performance measures, or other criteria (Centers for Medicare & Medicaid Services 2023). Outcome-based payments can be directed at a single service and/or as an enhancement to the payment that the provider is already receiving for delivering a service (Centers for Medicare & Medicaid Services 2023). In some cases, these initiatives in fee-for-service models have been found to advance desired policy objectives (Advisory Ideas to Action in Healthcare & Aging 2022). As described below, California has developed a quality incentive program with its 1915(c) waiver.

States may also explore similar value-based payment strategies directed at other LTSS services such as nursing homes and ICFs (Grabowski 2023). Researchers, however, conclude that despite demonstrations, these efforts have not actually shown improvements in the quality of nursing home care to date (Grabowski 2023).

## California

California's Department of Developmental Services (DDS) is working on a quality incentive program in its 1915(c) waiver program for providers that focuses on issues such as workforce capacity, early

intervention, and employment for people with disabilities. We interviewed people who are knowledgeable and involved in the development of this model. To develop this strategy, DDS collaborated with a workgroup composed of people representing different roles within the service system. DDS tied this development to an existing rate study, withholding a portion of the rates earmarked as incentives for providers who meet certain thresholds.

DDS first elected to pay for reporting to establish baseline data; it is expected to pay for achieving outcomes within coming years. Currently the payments offered are one-time payments for reporting or meeting specific targets (e.g., a 5% increase in competitive integrated employment placements over the previous month).

In addition to this strategy, California's DDS is working to establish a DSP credential so that providers can receive a higher payment rate for highly trained DSPs (see more about credentialing below). Further, DDS also plans to offer supplemental funds for specific services that are delivered by DSPs who speak a language other than English to people receiving services who also speak that language (Burns & Associates, Inc. 2019), demonstrating a use of mixed payment models in order to achieve a range of goals.

### *Provider and Direct Support Professional Initiatives*

Managing a robust and accountable provider network is a key aim of HCBS systems. Providers come in all shapes and sizes, from large publicly traded multi-state corporations to independent providers hired directly by people receiving HCBS. National Core Indicators State of the Workforce Survey data show that Utah's Division of Services for People with Disabilities (DSPD) providers are more likely than providers nationally to serve fewer than 20 people and have a lower number of direct support professionals (DSPs) on payroll. Many providers struggle with staffing shortages that impact their ability to sufficiently deliver services. We describe this issue more extensively in Brief 1: Recruiting and Retaining High Quality Direct Support Professionals.

Though DSP wages assumed within rate models have increased over the past years, they vary significantly across the United States (Health Management Associates 2022). The assumed benefit packages for DSPs also vary significantly across states (Health Management Associates 2022). While improving wages are often rightfully described as a cornerstone to increasing DSP recruitment and retention, thus improving the stability of the provider network, increasing wage assumptions comes with a substantial cost, as Health Management Associates found when reviewing the provider impact of a potential $15-an-hour federal minimum wage (Health Management Associates 2021). Without investment, DSP expectations keep increasing, while wages remain low (Health Management Associates 2021). To bolster the retention of DSPs, state programs have explored payment models such as paying more for experienced DSPs, paying more for DSPs who can demonstrate specific competencies or skills, or paying more when DSPs support people with higher needs.

## Oregon

Oregon's Office of Developmental Disability Services (ODDS) employs a variety of strategies aimed at retaining the direct workforce. Oregon uses a functional needs assessment to outline "enhanced criteria." When directly hired personal support workers (PSWs) and homecare workers (HCWs) provide services to people who meet the enhanced criteria and the PSW completes the required training, the PSW receives a wage higher than the standard wage included in the collective bargaining agreement (CBA).

The Oregon Home Care Commission (OHCC) worked with Service Employees International Union to develop a ventilator-dependent quadriplegia certificate that pays HCWs an additional three dollars per hour for all hours worked caring for individuals with ventilator dependency and quadriplegia (VDQ) who need awake assistance 24 hours per day. For an HCW to receive the VDQ differential, they must be certified through the OHCC and an approved certified training program. These pay differentials also work together and can be stacked so the Enhanced and VDQ pay differentials can both be paid for the same services.

### Tennessee

Many states are implementing or considering a career ladder for DSPs to pay more for DSPs who have enhanced education. TennCare, described previously, uses the National Association of Direct Support Professionals (NADSP) three-tiered E-badge program to pay incentives to providers and DSPs:

- DSP 1: Credentials include training and experience, with non-negotiables in service delivery, such as the health and safety of the person and providing person-centered supports
- DSP 2: Credentials include training and experience with supporting people in their communities, supporting relationships, community navigation and networking, and supporting the person's choice
- DSP 3: Credentials include training and experience with supporting individualized values-based support, promoting rights, and advocating with and for the person

Tennessee participates in the E-badge Academy, in which all HCBS provider organizations in Tennessee (CHOICES, ECF CHOICES, 1915c, and Katie Beckett waiver providers) or DSPs can complete E-badges. When the provider or DSP completes the E-badge, they can receive bonuses. The program pays for training time and a bonus upon completion of training for both the DSP and the provider. The bonuses increase by level with DSP 1s receiving a $500 bonus ($250 for the provider) and DSP 3s receiving a $1500 bonus ($750 for providers). The program began in January 2024 with a goal of having 900 people complete E-badges. By mid-2024, 288 people had completed e-badges.

## *Individual Budgets and Service/Rate Tiers*

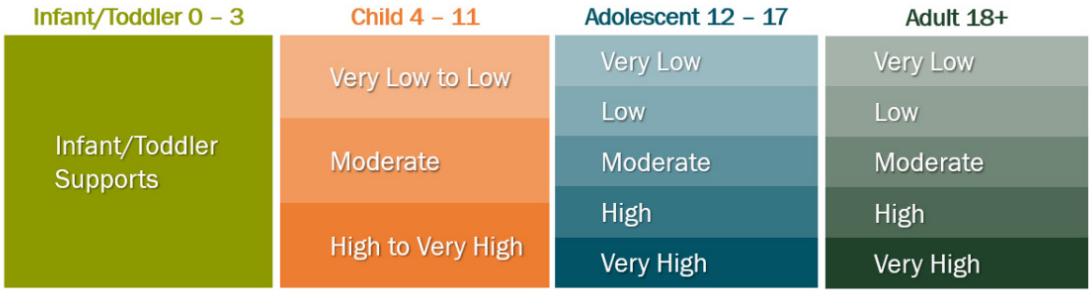
With the shortage of DSPs proving extremely challenging during and after the Covid 19 pandemic (Chidambaram 2024), states are increasingly moving toward expanding self-direction to allow people receiving services to have more authority over choosing their services, providers, and payment rates. To operationalize self-direction, many states use individual budgets that authorize a specific amount of funding for each person. This not only has the benefit of enhancing personal control over services, but also creates equity in the allowable costs for services for each person and helps to create a sustainable payment structure. In 38 states and D.C., people receiving services have some ability to define the rates they pay for self-directed services within an individual budget amount (Albaroudi 2023).

In a recent review of state waivers, we found 31 states were using assessments to create individual budgets for people receiving services (Petner-Arrey 2019). Assessments measure people's support needs for engaging in daily activities like eating, maintaining hygiene, or shopping. Those needs are then tied to costs and consider other factors such as where a person lives. States then derive a budget that the person can use to plan for services that recognize the person's strengths, while providing supports to help them achieve their overall goals.

States may use one of several methods for determining the budget, such as an algorithm that results in each person's having a unique budget, or more commonly, level-based budgets where the state uses the assessment to establish tiers or levels of support need (Petner-Arrey 2019). Some states combine individual budgets with rate tiers that pay higher rates for people with higher support needs. Regardless of the method chosen, assessment-based budgets should be developed with documented sound methods that are easily understood by community members, based on valid and reliable assessments and comprehensive and accurate data, and sustainable over time.

## Oregon

People receiving ODDS services are assessed using the Oregon Needs Assessment (ONA) to establish service tiers. The assessment and each persons' age are used to group people into one of 14 service groups, ranging from very low to very high needs, as shown below. Service groups are associated with a range of hours of support and payment categories or tiers, allowing for lower to higher payments to enable providers to better meet a range of needs.



# Opportunities for Change and Further Considerations

Based on this research and as discussed in more detail in the sections that follow, we have identified the following key opportunities for DHHS to consider regarding payment models, including: (i) strengthening its vision for payment model reform, (ii) streamlining and improving payment models, and (iii) ensuring adequacy and sustainability of existing payment structures. For our final report, we plan to work with the Steering Committee and DHHS to help select and prioritize opportunities for further exploration. Our recommendations may change as we collect more information on this and other research topics and explore their feasibility.

## Strengthen a Vision for Payment Models

Any large-scale efforts to alter the current payment models will require a considerable investment. State programs that have initiated an overhaul of their payment models may spend a decade or longer planning, financing, and implementing payment reform. Prior to engaging in such a significant undertaking, it is important that DHHS strengthen its vision for payment reform. In order to develop this vision, DHHS may work with a cross-department workgroup composed of representatives of different departments, provider organizations, support coordinators, and people receiving services to determine what type of payment reform will help DHHS achieve its stated aims. Currently, DSPD is engaged in a rate study which may help provide direction toward this vision, perhaps involving community members equipped to explore and decide on an appropriate payment model.

Some specific areas that DHHS may consider for payment model reform are bolstering self-direction through individual budgets and engaging in value-based payment strategies to improve the quality of services. DHHS may explore implementing individual budgets to support people in having greater authority over their services, while also gaining a better sense of the costs entailed for service delivery. DHHS may also examine whether any value-based payment initiatives may improve the quality of services delivered, including initiatives aimed at:

- Promoting individual and community, rather than congregate or facility-based care
- Incentivizing transition from more restrictive service settings (e.g., nursing homes, ICF-IIDs) to less restrictive settings
- Promoting independence through payment models directed at supporting outcomes in employment and independent living, especially for people newly entering DHHS services
- Paying for quality in services by focusing on key provider metrics that demonstrate how well providers are delivering services

Our forthcoming research, Brief #9: “Quality of Care in Long-Term Services and Supports,” will include opportunities that may also be considered for payment model reform. Should DHHS implement any value-based strategies, the department will need to have strong engagement, a

thorough review of enrollment and claims data, a realignment of goals and incentives, and a strong process for monitoring improvement (Centers for Medicare & Medicaid Services 2023).

### *Benefits of Opportunity*

Better defining a vision for a payment model can help DHHS align its aims with its funding strategy, maximizing the opportunity for system-wide improvements. It may also help the department determine a sustainable, long-term strategy for change. Working with a cross-agency group of people with varying roles and responsibilities within the system can help elevate the voices of people who may be most impacted by any forthcoming changes, also creating buy-in for any selected strategies, while supporting DHHS as it anticipates potentially negative impacts.

Should DHHS choose to implement individual budgets to better support people receiving services to self-direct their services, it will have the obvious benefit of supporting more choice, ensuring that support need and service costs are the best possible fit. Individual budgets can also help control and project costs. Lastly, focusing on value-based strategies may promote higher quality in services since, when done well, they directly tackle some of the most pressing issues plaguing HCBS (e.g., high turnover, inflexible service models).

### *Potential Barriers to Implementation*

Any effort to implement individual budgets or to improve the quality of services through value-based payments may require an initial investment in infrastructure, staffing, assessments, funding for individual budgets, or funding for incentive payments. These costs may be prohibitive to DHHS. Should DHHS pursue any value-based payment strategies, potential risks include rewarding the wrong measures, allowing providers to overlook quality in favor of meeting the measures selected, imbalance of meaningfulness and requirements of the chosen incentives, and a potential for unintended consequences or disparate outcomes for different populations (Grabowski 2023).

### *Impact on Utah LTSS Priorities and System*

DHHS has stated priorities to eliminate the all or nothing approach"—in which people can access all services once on the waiver—as well as equity in resources, including how much service people receive and the reimbursement for services.. Implementing individual budgets and improving self-direction can meet these specific priorities. Finally, since DHHS has limited funds available to support people as evidenced through the long waitlist for services, using individual budgets offers a predictable means of authorizing services so that DHHS can better grapple with the costs of delivering services.

DHHS has also articulated a need to explore payment models that offer financial flexibility, expand access with an emphasis on post-high transition and aging in place, promote value quality and cost effectiveness, and foster community-based supports. Value-based payment strategies could directly focus on these aims.

## Streamline and Improve Payment Models

As noted previously, we heard through engagement that providers may experience issues in receiving payment for services and that some existing systems are difficult to use. Providers described issues with using the billing codes and getting quick authorization of services or timely authorization of changes in services. Working to address these issues can help providers deliver

timely and needed services. In 2023, Provider Reimbursement Information System for Medicaid (PRISM) launched for DAAS and DIH, and providers delivering DAAS and DIH services have been using PRISM for billing. DSPD does not use PRISM and, instead, pending payments are validated and approved in USTEPS and paid in another system (CAPS). Streamlining the payment systems and processes can help enhance consistency across departments, improving the efficiency of payments and making it easier for providers to deliver services across populations.

DHHS has nine current 1915(c) waivers in place; the payment models differ from DAAS, DIH, and DSPD. When possible, DHHS should explore making these payment methodologies consistent across departments This might mean that DHHS takes the same approach to determining the rates and/or standardizing rates for similar services across different waivers.

### *Benefits of Opportunity*

A major benefit of streamlining payment systems and processes is that people receiving services have access to the timely services they need and the entire system runs more efficiently. A benefit of creating greater consistency across different departments is to allow for simultaneous development of the payment rates, rather than different rate structures and approaches for each department. Consistency in payment rates for similar services would benefit providers who deliver services across different departments and reduce competition within DHHS to help the department achieve a provider network fully capable of delivering services to people with diverse needs.

### *Potential Barriers to Implementation*

The primary barrier to implementation of streamlining rate structures is the cost and development needed to create more consistent structures. Each department has engaged in separate independent rate studies in recent years, all of which have taken different approaches to developing the rates. Moving to a more unified structure would require DHHS to align timelines for rates development, infrastructure for submitting claims, and, to some extent, provider expectations. The time, effort, and resources required may prove substantial.

### *Impact on Utah LTSS Priorities and Systems*

Reducing the burden on providers to navigate complex systems and processes can help them use their resources more appropriately for support provision. Making it easier for existing providers to deliver services to all people served by DHHS could also make better use of the existing provider network in filling service gaps.

## Ensure Adequacy and Sustainability of Existing Payment Structures

As many states are moving toward improving DSP wages, an opportunity for DHHS is to move toward funding higher DSP wages across departments and services. Should DHHS later want to invest in a DSP career ladder or other funding differentials, establishing a higher baseline wage will prove a beneficial first step. DHHS might also explore means to ensure a sufficient provider network. This may involve using supplemental payments to enable providers to deliver services in hard-to-serve rural areas, or to support people with significant or unique needs (e.g., deaf or hard of hearing).

To ensure the adequacy of existing payment structures, DHHS should collaborate with the existing provider network, including provider member organizations and any relevant DSP organizations. This

collaboration would not only involve collective routine review of the rate structure and rates but could also first focus on areas where there are gaps or severe inadequacies within the payment models. Finally, as DHHS moves to make any changes to update payment models, it will need to consider the Medicaid Access Rule obligations, including minimum DSP compensation thresholds for home health aide, homemaker, and personal care services; transparency in the rate development process, particularly as it relates to the impact of rate changes on providers; stricter criteria for approving rate reductions; and stronger requirements related to payment adequacy (42 CFR 431, 438, 441, and 447).

### *Benefits of Opportunity*

If payments are not adequate, the system cannot be sustainable. Having adequate payment structures in place ensures sustainability of DHHS's service systems. Working with people receiving services, providers, and other impacted parties can help resolve issues within the payment models themselves that lead to service gaps.

### *Potential Barriers to Implementation*

As mentioned previously in this report, changes to rates, such as increasing wages for DSPs, can be quite costly. Also diverting funds to improve the adequacy of the rates will necessarily mean that DHHS has less funds available for other needed objectives like reducing the waitlist for services.

### *Impact on Utah LTSS Priorities and System*

Utah has a strong history of promoting fiscal accountability and describes its programs as being fiscally conservative. Providing adequate payments for services can blend both aims of fiscal prudence and accountability of providers. Holding providers accountable for quality, helps DHHS move toward greater accountability and a greater return on its investment in HCBS providers.

## Further Considerations

As DHHS continues to spend down its American Recovery Plan Act (ARPA) funds, there are limitations in how the department will be able to alter its payment models. There are also two new federal rules that may significantly impact any efforts to reform DHHS's payment models. The first is the aforementioned Medicaid Access Rule, which has detailed requirements that will necessarily dictate future changes for specific services and payments, as well as stronger requirements for state programs in limiting negative fiscal impacts for providers. The second rule which may impact payment model reform is the Minimum Staffing Standards (Federal Register Doc. 2024-08273 of May 10, 2024, 89 FR 40876). While this rule does not directly impact HCBS, states that offer a large portion of services through institutional settings may see impacts to their HCBS settings as costs in institutions rise to meet staffing requirements.

This research shows that DHHS has numerous opportunities to explore changes to payment models that can better help the department meet its aims, from small-scale changes that can be implemented with minimal investment, to major funding changes that require a more-deliberate planning and implementation.

# References


Advisory Ideas to Action in Healthcare & Aging. 2022. *The Spectrum of State Models to Support Medicaid LTSS.* Report, ATI.

Albaroudi, Robert Nelb and Asmaa. 2023. "Medicaid Payment Policies to Support the Home and Community Based (HCBS) Workforce." MACPAC.

American Network of Community Options and Resources. 2019. *Advancing Value & Quality in Medicaid Service Delivery for Individuals with Intellectual & Developmental Disabilities.* Report, ANCO.

Burns & Associates, Inc. 2019. *DDS Vendor Rate Study and Rate Models.* Report, Burns and Associates, Inc.

Burns, A., Mohamed, M., and O'Malley Watts, M. 2023. *Payment Rates for Medicaid Home and Community-Based Services: States' Responses to Workforce Challenges.* Report, Kaiser Family Foundation.

Center for Healthcare Payment and Quality Reform. ND. *The Payment Reform Glossary: Definitions and Explanations of the Terminology Used to Describe Methods of Paying for Healthcare Services.* Report, Center for Healthcare Payment and Quality Reform.

Center for Medicare & Medicaid Services. 2023. "Outcome-Based Payments in a 1915(c) Home and Community-Based Services (HCBS) Fee-For-Service (FFS) System." CMS.

Centers for Medicare & Medicaid Services. 2021. *1915(c) Home and Community Based Services (HCBS) Waiver Financing and Payment Trends.* Presentation, Centers for Medicare & Medicaid Services.

Chidambaram, P. and Burns, A. 2024. *10 Things About Long-Term Services and Supports (LTSS).* Report, Kasier Family Foundation.

Division of Aging & Adult Services. 2019. *Utah State Plan Aging & Adult Services.* Plan, Utah Department of Health & Human Services.

Grabowski, D.C., Chen, A., & Saliba, D. 2023. "Paying for Nursing Home Quality: An Elusive but Important Goal." *Public Policy & Aging Report, 33(1)* S22-S27.

Health Care Payment Learning & Action Network. 2017. *Alternative Payment Model APM Framework.* Report, The MITRE Corporation.

Health Management Associates. 2021. *Estimating the Impact of an Increased Federal Minimum Wage on Direct Support Professionals' Wages and I/DD Service Providers' Costs.* Report, American Network of Community Options and Resources.

Health Management Associates. 2022. *Review of States' Approaches to Establishing Wage Assumptions for Direct Support Professionals When Setting I/DD Provider Rates.* Report, American Network of Community Options and Resources.

de Lisle, K., Bassano, A., Staheli, J., Morrison, S., & Mannon, M. 2024. *Analyzing the Expanded Landscape of Value-Based Entities.* Report, Health Management Associates.

MACPAC. 2015. *Chapter 7 A Framework for Evaluating Medicaid Provider Payment Policy.* Legislative Report, MACPAC.

Myers and Stauffer. 2023. *Utah Department of Health & Human Services Division of Integrated Healthcare Home and Community-Based Services (HCBS) Rate Study.* Report, Myers and Stauffer LC.

Myers and Stauffer. 2022. *Utah Department of Health Community Supports Waiver (CSW) Services Cost Survey Results—Prepared in Conjunction with the Utah Department of Health & Human Services.* Report, Myers and Stauffer.

Petner-Arrey, J., Kardell, Y., Kidney, C. 2019. *Making Self-Direction a Reality: Using Individual Budgets to Promote Choice, Control, and Equity.* Report, Human Services Research Institute.

Lewis, S., Patterson, R., and Alter, M. 2018. "Current Landcape: Managed Long-Term Supports and Services for People with Intellectual and Development Disabilities." Health Management Associates.

Utah Commission on Aging. 2023. "Alternatives Program." Utah Commission on Aging.

Utah Department of Health & Human Services. Services for People with Disabilities. 2023. Annual Report 2023, Utah Department of Health & Human Services.

Utah Office of the Legislative Fiscal Analyst. 2017. *Budget Deep-Dive into Disabiity Service Provider Rates: Issue Brief.* Legislative Report, Utah State Legislature.

# Appendix A: Plain Language Summary

## Brief 4: HCBS Payment Models

**Who is this brief for?**

This brief is for anyone interested in how DHHS pays for its services.

### What is this brief about?

There are different ways to pay for services; DHHS can change how it does so.

### What did researchers find out?

Changing the ways that DHHS pays for services can help make sure they work well. The department can (i) pay more for higher-quality services, (ii) make sure people can self-direct and use individual budgets, and (iii) pay more for staff who have training beyond the minimum. First, we recommend that DHHS makes sure that payments are enough today.

### What is most important to know?

Changing payment models is a major undertaking. Some changes take longer and cost more than others. Before making any changes, DHHS should determine what changes are best.

### Where can I learn more about this?

You can learn more about this research by reaching out to our Project Coordinator, Jasmine Hepburn, at jhepburn@hsri.org or by visiting the project webpage.