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ISSUE BRIEF

Value-Based Payment and the Home Care Workforce: What New York Can Teach Other States

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While value-based payment originated in acute care, it is gaining momentum across the broader health care system, including in long-term services and supports (LTSS). However, there is limited evidence about how best to incorporate the direct care workforce into value-based payment models in LTSS, especially in the home care sector. To help fill this gap, PHI conducted a case study of value-based payment in home care in New York, interviewing stakeholders from home care agencies, Medicaid managed long-term care (MLTC) plans, and the New York State Department of Health, as well as national experts. Our research shows that value-based payment holds promise for the future of the home care workforce in New York, and other states can learn from New York's experience of implementing this model.

EXECUTIVE SUMMARY

Value-based payment is designed to reward health care providers for the *quality* of the services they provide, rather than the *volume* of those services (as with the traditional fee-for-service model). While value-based payment originated in acute care, it is gaining momentum across the broader health care system, including in long-term services and supports (LTSS).¹

Given their central role in care delivery, direct care workers (home care workers and nursing assistants) are essential to the success of any value-based payment initiative in LTSS. However, there is limited evidence about how best to incorporate the direct care workforce into value-based payment models in LTSS, especially in the home care sector.

To help fill this gap, PHI conducted a case study of value-based payment in home care in New York, a state with a large Medicaid-funded home care program and an established roadmap for implementing value-based payment across Medicaid. In the study, we interviewed stakeholders from home care agencies, Medicaid managed long-term care (MLTC) plans, and the New York State Department of Health. We also consulted with national experts on this topic and reviewed the literature to identify challenges and opportunities in implementing value-based payment in home care.

The experts we interviewed for this case study spoke vividly about the promise of value-based payment for New York's home care system, but also identified pressing challenges that have arisen in the early stages of implementation. They voiced concerns about the structure and timeliness of performance payments, the accuracy of quality measurement in home care, and the financial uncertainty that value-based payment has engendered, among other challenges. They also underscored the vital importance of both data-related and care-related communication, at every level, for realizing the potential of value-based payment in home care. Finally, they reported that value-based payment is already elevating the role of home care workers, despite systemic challenges including the workforce shortage, reduced service authorization, and funding limitations.

Our research shows that value-based payment holds promise for the future of the home care workforce in New York, and other states can learn from New York's experience of implementing this model. When designing a value-based payment program in home care, we recommend that states, MLTC plans, and home care agencies:

- Create a strategic plan for value-based payment;
- Build value-based payment capacity;
- Ensure shared rewards;
- Set data- and care-related communication requirements;
- Incorporate workforce quality measures;
- Compile and share best practices; and
- Address broader workforce challenges.

BACKGROUND

Value-Based Payment and the Direct Care Workforce

Value-based payment arrangements are designed to reward health care providers for the *value* rather than solely the *volume* of their services. In this context, value is generally defined as a higher quality of services at a lower cost. Although value-based payment emerged in acute care,² where it is more common, this model is now also gaining traction in long-term services and supports (LTSS).³

The direct care workforce plays a key role in achieving value in LTSS. Home health aides, personal care aides, and nursing assistants provide the majority of paid care to LTSS consumers and, in turn, greatly influence consumers' health outcomes and quality of life. For example, a home care worker might prevent an avoidable hospitalization by observing and reporting a suspected urinary tract infection, thus helping to meet two value-based payment goals: reducing costs and improving care outcomes. Therefore, value-based payment presents a new impetus to invest in and elevate the role of direct care workers in LTSS. However, there is limited evidence about how to best incorporate the direct care workforce into value-based payment models in LTSS, especially in home care.

New York State leads many other states in introducing value-based payment across Medicaid programs, including in Medicaid-funded home care.⁴ We conducted this study to learn from the state's early experiences with implementing a value-based payment approach in home care—and specifically with incorporating the home care workforce in this model.



New York's Value-Based Payment Roadmap

In 2015, the New York State Department of Health released a strategic plan for implementing value-based payment across Medicaid programs: *A Path toward Value Based Payment: New York State Roadmap For Medicaid Payment Reform*.⁵ Because the majority of New York's Medicaid payments are administered through Medicaid managed care plans, the value-based payment roadmap focuses on managed care (rather than fee-for-service arrangements between the New York State Department of Health and providers). The roadmap's overarching goal is to convert 80 to 90 percent of Medicaid managed care payments to providers into value-based payment arrangements by April 1, 2020.

The roadmap outlines three levels of value-based payment arrangements and establishes requirements for each of these levels across Medicaid programs. The value-based payment levels and

requirements for home care payments made through Medicaid managed long-term care (MLTC) plans include⁶:

- **Level 1 arrangements**, which provide a payment bonus to home care agencies who meet or exceed specific quality thresholds. The only mandatory quality measure for Level 1 arrangements is potentially avoidable hospitalizations (see sidebar), but MLTC plans may choose additional measures. All MLTC plans were required by the New York State Department of Health to implement Level 1 arrangements with home care agencies by December 31, 2017.⁷
- **Level 2 arrangements**, which provide a payment bonus or penalty to home care agencies depending on their quality performance. In addition to potentially avoidable hospitalizations, MLTC plans must also choose at least one additional quality measure from a list of optional quality measures provided by the New York State Department of Health.⁸ MLTC plans and agencies may also identify their own supplementary measures from outside of the list.⁹ Five percent of MLTC plan expenditures in home care were required to be at Level 2 by April 1, 2019, and 15 percent will be required by April 1, 2020.¹⁰
- **Level 3 arrangements**, which are broadly defined in the value-based payment roadmap as *capitated payments* (a fixed payment per patient) or *bundled payments* (based on the full cost of a single episode of care). Level 3 requirements have not yet been specified for home care payments made through MLTC plans.

Parallel to its value-based payment efforts, the New York State Department of Health has also established the Managed Long Term Care Workforce Investment Program, which provides funding to approved workforce training organizations (called Workforce Investment Organizations, or WIOs).¹¹ The goal of this program is to “support the critical long term health care workforce infrastructure through retraining, redeployment, and enhancing skillsets,” which includes addressing their value-based payment-related training needs.¹²

Methods

To learn about New York’s implementation of value-based payment in home care, we conducted 12 interviews with stakeholders from: licensed home care services agencies (LHCSAs; hereafter

POTENTIALLY AVOIDABLE HOSPITALIZATIONS: THE PRIMARY QUALITY MEASURE FOR MLTC PLANS IN NEW YORK

A *potentially avoidable hospitalization* is defined by the New York State Department of Health as “an inpatient hospitalization that might have been avoided if proper outpatient care was received in a timely manner.” In New York’s value-based payment model, a hospitalization is considered “potentially avoidable” when a consumer is admitted to the hospital with one of these primary diagnoses:

1. Anemia
2. Congestive heart failure
3. Electrolyte imbalance
4. Respiratory infection
5. Sepsis
6. Urinary tract infection

Since MLTC plans and home care agencies are not always notified when a patient is hospitalized (given that acute care is typically covered by Medicare rather than Medicaid), the New York State Department of Health calculates and shares each agency’s performance with MLTC plans.

Source: NYSDOH. 2017. “Managed Long Term Care Clinical Advisory Group.” https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/docs/2017-oct_mltc_cag_rpt_vbp_recommend.pdf Consumer Directed Personal Assistance Program.

referred to as “home care agencies”) and MLTC plans from different regions of New York; the New York State Department of Health; and national organizations with expertise on value-based payment.

Stakeholders were identified through existing organizational contacts and through snowball sampling, whereby respondents were asked to suggest other potential respondents. The interviews were guided by a set of semi-structured questions that were adapted according to each stakeholder’s role and area of expertise. Completed in-person or by telephone between March and May 2019, the interviews were recorded, summarized in written notes, and thematically analyzed.

We supplemented the interview data with evidence from the literature on value-based payment models in LTSS, focusing primarily on reports from research or policy organizations.

Key Findings

Respondents offered valuable insight on the process of implementing value-based payment in home care in New York, as well as discussing its impact on the home care workforce. We begin by presenting overall findings on value-based payment implementation, then draw out the importance of communication before focusing on implications for the home care workforce.

Implementation Opportunities and Challenges

In their interviews, home care agency and MLTC plan respondents confirmed that New York is in the early stages of implementing value-based payment in home care, with the majority of value-based payment arrangements at Level 1. While a few Level 2 arrangements are in place, they involve a small number of larger home care agencies that can manage the risk of a payment penalty. Respondents also reported considerable variation in value-based payment implementation across regions, with more progress in the New York City area than in the rest of the state.

Nonetheless, respondents indicated that value-based payment holds promise for improving the quality of home care services in the state. Home care agency respondents expressed hope that value-based payment will bring attention to the value of home care services within the broader health care system—and the value of home care workers, specifically. MLTC plan respondents noted that value-based payment facilitates alignment between financial and care goals for both plans and home care agencies, which encourages partnership in pursuing quality improvement. MLTC plan respondents also claimed that, by requiring agencies to participate in value-based payment, the New York State Department of Health has encouraged their buy-in and strengthened the implementation process.

Respondents also cited the WIOs—which are designed to prepare New York’s workforce, especially direct care workers, to meet the needs of an evolving LTSS system—as important facilitators of success in value-based payment in home care. Although not all MLTC plans and home care agencies have chosen to send workers to WIO-based trainings, our respondents maintained that this program has played an essential role in educating workers on value-based payment and on topics that relate to value-based payment goals. Without WIOs, they suggested, it would be difficult for



home care agencies to fund the training that is necessary to prepare the workforce for value-based payment.

However, stakeholders also raised several implementation challenges that must be resolved to realize the benefits of value-based payment in home care, described below.

Shared rewards

Respondents from the New York State Department of Health identified a fundamental challenge to the success of value-based payment in home care: home care stakeholders may not necessarily share the financial rewards of achieving value-based payment goals. Most MLTC plan enrollees in New York are dually eligible, meaning that they are covered by both Medicare and Medicaid. Medicare covers their acute and primary care costs, while Medicaid covers LTSS. Outside of integrated care models, savings that result from investing in home care will likely accrue to Medicare, rather than to MLTC plans and home care agencies. Establishing avoidable hospitalizations as the primary quality measure for value-based payment in home care is currently the main strategy for aligning MLTC goals with New York's overall value-based payment goals, but the New York State Department of Health respondents noted that the department is exploring other ways to ensure that home care payers and providers reap the benefits of value-based payment.

Innovation versus uncertainty

New York's value-based payment roadmap is designed to foster innovation by allowing MLTC plans and home care agencies considerable leeway in designing and implementing their own payment arrangements within the baseline parameters described above. MLTC plan respondents indicated that this flexibility is useful because, given the diversity among home care agencies and client populations, there is no "one size fits all" strategy for quality improvement.

However, this flexibility also engenders some uncertainty. Both MLTC plan and home care agency respondents reported that they are still determining how to position themselves in a value-based payment setting and how to leverage the home care workforce in their value-based payment arrangements. Notably, home care agencies told us that they are finding it difficult to make financial projections because of the variable and evolving nature of their value-based payment contracts with different MLTC plans.

Performance payments

Respondents also raised concerns about the timeliness of value-based payment rewards. Although the New York State Department of Health allocated \$50 million in value-based payment "performance adjustment funds" to MLTC plans for calendar year 2018, this funding will not be distributed to plans until 2020-21.¹³ While MLTC plans have the option of distributing financial rewards to home care agencies prior to receiving their performance adjustment funds from the state, respondents indicated that few have chosen to do so. This substantial delay in payment creates challenges for home care agencies, who are limited—largely by low Medicaid reimbursement rates—in their abilities to invest in strategies for achieving value-based payment goals. In contrast, if an agency received its value-based payment reward shortly after the end of the first year of implementation, it could invest that revenue in technology updates, workforce supports, or other changes to improve future outcomes. Both MLTC plan and home care agency respondents note that smaller home care agencies are struggling more with this challenge.

Quality measurement

As noted above, New York’s value-based payment roadmap mandates “potentially avoidable hospitalizations” as the primary quality metric in home care. Although the New York State Department of Health has provided a menu of additional quality measures for MLTC plans and home care agencies to consider,¹⁴ respondents reported that these measures fall short of fully capturing an important component of quality in LTSS: quality of life. In turn, reliance on the current slate of measures, which predominantly relate to medical care and outcomes, risks undervaluing important non-medical interventions and outcomes in home care, such as social and community engagement. Additionally, the New York State Department of Health’s list of quality measures includes only three measures that pertain to the home care workforce (see sidebar)—and respondents suggested that few MLTC plans appear to have incorporated these limited measures into their value-based payment arrangements.

Ensuring that quality is comprehensively captured by value-based payment arrangements in home care—including with regards to the quality of home care jobs and the stability of the home care workforce—appears to be an ongoing implementation challenge in New York.

The Importance of Communication

Our interview respondents emphasized the centrality of communication to the success of value-based payment in home care, as good communication allows MLTC plans and home care agencies to identify when a health intervention is needed and determine how care processes can be improved. MLTC plans and agencies discussed both data-related and care-related communication as areas for innovation and improvement.

Data-related communication

Respondents indicated that the timely reporting of aggregate data—such as a home care agency’s potentially avoidable hospitalizations rate—is essential for agencies to implement quality improvement initiatives and thereby increase their capacity to meet value-based payment goals. More than one home care agency respondent cited the same MLTC plan that models “best practices” in data-related communication: creating an online dashboard to communicate with home care agencies, sharing data with agencies monthly, holding regular performance reviews, and providing examples of successful interventions to help agencies improve their performance. By contrast, home care agency respondents shared that some MLTC plans rarely or belatedly provide data relevant to value-based payment.

WORKFORCE QUALITY MEASURES

The New York State Department of Health provides three home care workforce measures on its menu of quality measures, all of which derive from a consumer satisfaction survey:

- Percentage of members who rated the quality of home health aide or personal care aide services within the last 6 months as “good” or “excellent”
- Percentage of members who responded that they were “usually” or “always” involved in making decisions about their plan of care*
- Percentage of members who reported that within the last six months the home health aide or personal care aide services were always or usually on time

*This is considered a workforce measure because home care workers play a key role in facilitating consumers’ involvement in care plan implementation.
Source: NYSDOH. 2018. “Managed Long Term Care Partial Subpopulation.” https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/quality_measures/2019/docs/mltc_sub_qms.pdf

Limited funding, a weak technology infrastructure, and insufficient technical expertise were all identified as significant barriers to consistent information-exchange between home care agencies and MLTC plans. MLTC plans and agencies both highlighted that data collection and reporting systems are evolving and hold promise for improving communication in the future.

Care-related communication

For the purposes of this brief, care-related communication describes the timely exchange of information about individual consumers between home care workers and clinical staff, as well as between home care agencies and MLTC plans. The primary goal of this form of communication is to promptly identify and appropriately address consumers' needs. Home care agency respondents indicated that they are exploring different tools to improve care-related communication with workers. For example, some agencies are using the INTERACT STOP and WATCH tool¹⁵ to prompt workers to share specific types of information with clinical staff, such as whether the client is disoriented or experiencing high pain levels.

However, care-related communication between home care agencies and MLTC plans was identified as a persistent challenge. One home care agency respondent shared a story in which a client developed bed sores because the agency was not able to get in touch with the client's MLTC plan about obtaining a hospital bed for three months. Another agency reported that one of their MLTC plans requires telephonic communication, which imposes a time burden on staff and is more difficult to track—highlighting the need for more efficient communication strategies. Home care agency respondents suggested that without well-structured, reciprocal communication pathways from the point of care to MLTC plans, they will continue to struggle to improve care quality and meet value-based payment goals.

Elevating the Home Care Workforce

Interview respondents affirmed that home care workers play a pivotal role in monitoring clients' health status and helping reduce their risk of hospitalization, the primary value-based payment goal for home care. In this way, they suggested, value-based payment is bringing new attention to the role and contribution of home care workers. As an example, respondents suggested that the inclusion of quality measures derived from consumer satisfaction surveys in value-based payment arrangements (see page 6) has underscored the importance of home care workers' interpersonal and problem-solving skills, since these skills help drive higher survey ratings.

MLTC plan and home care agency respondents also identified new opportunities to elevate the role of the home care worker through value-based payment. For example, value-based payment offers a financial rationale for developing advanced home care roles, such as a senior aide role that focuses on improving consumers' transitions between care settings and thereby preventing unnecessary rehospitalizations. As well as helping achieve value-based payment goals, these advanced roles also provide a much-needed career advancement opportunity for home care workers.¹⁶

However, respondents identified at least three systemic barriers to realizing the full value of home care workers within value-based payment arrangements, as discussed below.

Workforce supply and stability

A stable, well-prepared workforce is paramount to achieving value-based payment goals. One MLTC respondent reported that their data show that enrollees with consistent, long-term home care workers are less likely to visit the emergency room or be hospitalized than those without such care continuity. However, persistently low compensation and poor job quality for home care workers have contributed to a recruitment and retention crisis in home care.¹⁷ MLTC plan and home care agency respondents from outside New York City reported that a shortage of home care workers is causing some home care agencies to turn away new clients—putting those potential clients at risk of adverse outcomes, such as avoidable hospitalizations and nursing home placement. Further, MLTC plans mentioned that some home care agencies have been unable to take advantage of WIO training programs because they cannot find additional workers to replace those who are in training—which compromises the preparedness of their workforce to support value-based payment goals.



However, some MLTC plans and home care agencies were hopeful that, by creating a sense of “ownership of outcomes” among home care workers and bringing new attention to the importance of workers’ contributions, value-based payment might help strengthen the appeal of home care jobs and therefore improve workforce supply and stability.

Service authorization

Home care agency respondents reported that, since the rollout of mandatory managed care for LTSS consumers began in New York State in 2012, there has been a trend toward authorizing a lower number of home care service hours per consumer. Agencies suggested that this trend represents another systemic challenge to maximizing the role of the home care worker to meet value-based payment goals because workers do not have enough hours to spend with clients, build relationships, and provide the services and supports they need.

Funding

Insufficient funding was identified as a major challenge to strengthening the workforce through value-based payment (and implementing value-based payment in general). Home care agency respondents conveyed that they have experienced considerable financial pressure in recent years, as they have struggled to cover mandatory labor costs without sufficient reimbursement rate increases. Also noting the delay in value-based payment performance payments and their uncertainty about the size of rewards, they suggested that they are woefully limited in their capacity to invest in efforts to reposition themselves and their workforces for value-based payment. Some respondents expressed concern that the funding will not fully cover the costs of implementing value-based payment, which will hinder their ability to invest in workers by, for example, creating advanced roles or increasing compensation.

Additionally, while the WIOs were highlighted as providing much-needed training opportunities for home care workers, respondents were concerned about whether workforce training will be sustained after funding for New York’s Workforce Investment Program ends in March 2020.¹⁸

Finally, respondents expressed concern about the lack of requirements for home care workers to share in value-based payment performance rewards. Although both types of respondents expressed a desire for home care workers to directly financially benefit from their contributions to achieving value-based payment goals, MLTC plan respondents suggested that it is the responsibility of home care agencies to decide how to distribute their value-based payment rewards. Home care agencies were uncertain about whether they will be able to share value-based payment rewards with workers, however, since they do not precisely know how much funding they will receive or the timing.

RECOMMENDATIONS FOR OTHER STATES

The findings from this case study can help other states in developing and implementing value-based payment in home care. Although these recommendations are primarily aimed at state policymakers (since state-level standards and guidelines determine how value-based payment is structured and implemented), we have also included considerations for MLTC plans and home care agencies.

- **Create a strategic plan for value-based payment.** The implementation of value-based payment in home care throughout New York has been guided by the New York State Department of Health’s value-based payment roadmap.¹⁹ Other states interested in establishing value-based payment approaches in home care should create a strategic plan that incorporates extensive stakeholder input and can be regularly updated (similar to New York). MLTC plans and home care agencies can devise their own plans for implementing value-based payment within the parameters of the state plan.
- **Build value-based payment capacity.** States should support MLTC plans and home care agencies in building the necessary infrastructure for implementing value-based payment. Infrastructure needs include a well-trained workforce—as supported in New York through the WIOs—and technology systems for data collection and communication, as two primary examples. MLTC plans and home care agencies should work closely with each other and the state to build this infrastructure in the most effective manner.
- **Ensure shared rewards.** When introducing value-based payment in home care, states should ensure that home care agencies receive the financial benefits of their efforts. This means structuring value-based payment models to guarantee that the cost savings derived through the reduced utilization of acute care (which is generally covered by Medicare for LTSS consumers) are shared appropriately with Medicaid MLTC plans and home care agencies. MLTC plans and home care agencies should also commit to distributing a portion of value-based payment rewards to the workforce, through additional compensation, training, or other supports.
- **Set data- and care-related communication requirements.** New York respondents emphasized that communication is critical to implementing value-based payment. States should respond by establishing minimum requirements for data-related and care-related communication, such as what types of information must be shared and how frequently. Additionally, MLTC plans and home care agencies can work together to strengthen their communication practices, ideally with funding and technical assistance from the state.

- **Incorporate workforce quality measures.** The New York State Department of Health includes three workforce measures, derived from consumer satisfaction surveys, on its menu of quality measures for value-based payment in home care (see page 6). While these measures are a starting point, states should institute additional workforce-related quality measures that reflect the centrality of home care workers in value-based payment, such as measures related to retention, turnover, training, compensation, and more. Regardless of state requirements, managed care plans and home care agencies should include workforce-related quality measures in their value-based payment arrangements.
- **Compile and share best practices.** Home care agency and MLTC plan respondents in this research reported uncertainty about how to implement value-based payment in home care. In response, states should compile and disseminate best practices in value-based payment, including practices related to designing workforce innovations, identifying quality metrics, collecting and reporting data, and more.
- **Address broader workforce challenges.** MLTC plans and home care agencies identified the workforce shortage and high turnover rates as two significant impediments to implementing value-based payment in New York’s home care system. States can enact a variety of parallel policy reforms to boost recruitment and retention in this workforce, including: convening a home care workgroup; increasing compensation for home care workers; establishing new employment supports that incentivize workers to enter and remain in the home care field; and creating career development opportunities for home care workers; among others. MLTC plans and home care agencies can also collaborate in addressing workforce challenges, including by identifying and funding training opportunities, piloting advanced roles, and sharing value-based payment rewards with workers.

CONCLUSION

The aim of this case study was to learn from various stakeholders in New York about the introduction of value-based payment in home care, with a focus on identifying opportunities to elevate the role of home care workers. The stakeholder interviews made clear that New York—a national leader among states in this area—is in the early stages of implementation, and grappling with questions of funding and sustainability, quality measurement, communication, and other issues. Nonetheless, our findings suggest that, if these issues are properly identified and resolved (in New York and in other states considering value-based payment), then value-based payment holds promise for strengthening the home care workforce and improving care quality.

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PHI works to transform eldercare and disability services. We foster dignity, respect, and independence for all who receive care, and all who provide it. As the nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care.

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- Implement best practices through hands-on coaching, training, and consulting, to help long-term care providers deliver high-quality care;
- Support policymakers and advocates in crafting evidence-based policies to advance quality care

For more information, visit PHI at www.PHInational.org and 60Caregiverissues.org.

NOTES

¹Chee, Tingyin T, Andrew Ryan, Jason Wasfy, and William Borden. 2016. “Current State of Value-Based Purchasing Programs.” *Circulation* 133(22): 2197-2205. doi:10.1161/CIRCULATIONAHA.115.010268

²Chee et al., 2016.

³In a 2015 survey of state Medicaid programs, many states identified LTSS VBP as the “next frontier” for improving Medicaid value. Bailit Health & the National Association of Medicaid Directors. 2015. “The Role of State Medicaid Programs in Improving the Value of the Health Care System.” http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf; Herman Soper, Michelle, Debra Lipson, Maria Dominiak, and James Lloyd. 2018. *Achieving Value in Medicaid Home- and Community-Based Care: Considerations for Managed Long-Term Services and Supports Programs*. Hamilton, New Jersey: Center for Health Care Strategies. https://www.chcs.org/media/Achieving-Value-in-Medicaid-Home-and-Community-Based-Care_091818.pdf

⁴Other states that have introduced VBP in LTSS include but are not limited to Minnesota, Tennessee, Texas, and Virginia. Change Healthcare. 2019. *Value-Based Care in America: State-by-State*. <https://inspire.changehealthcare.com/stateVBRstudy>.

⁵New York State Department of Health (NYSDOH). 2015. *A Path toward Value Based Payment: New York State Roadmap For Medicaid Payment Reform*. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf.

⁶Note that New York’s value-based payment roadmap sets requirements for MLTC plans’ contracts with home care agencies but does not yet include the Consumer Directed Personal Assistance Program. Given the decentralized nature and distinct goals of consumer-directed programs, policymakers in New York (and elsewhere) have yet to determine the best way to incorporate value-based payment arrangements into these programs.

⁷NYSDOH. 2017a. “Value Based Payment for Managed Long Term Care Plans.”

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/docs/2017-07-12_mltc_lev1_contracting.pdf

⁸NYSDOH. 2017b. “Managed Long Term Care Clinical Advisory Group.”

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/docs/2017-oct_mltc_cag_rpt_vbp_recommend.pdf.

⁹NYSDOH. 2018a. “Value Based Payment For Partially Capitated Plans.”

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2018-06_vbp_for_pcp_faqs.htm

¹⁰NYSDOH. 2018b. “Value Based Payment for Managed Long Term Care (MLTC) Plans.”

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2018/2018-jul_mltc_lev2_contracting.htm

¹¹NYSDOH. 2018c. “Managed Long Term Care Workforce Investment Program.” Updated April 2018.

https://www.health.ny.gov/health_care/medicaid/redesign/2017/mltc_invest.htm

¹²Ibid.

¹³NYSDOH, 2018a.

¹⁴NYSDOH, 2017b.

¹⁵Ouslander, Joseph, Alice Bonner, Laurie Herndon, and Jill Shutes. 2014. “The Interventions to Reduce Acute Care Transfers (INTERACT) Quality Improvement Program: An Overview for Medical Directors and Primary Care Clinicians in Long Term Care.” *Journal of the American Medical Directors Association*. 15(3): 162-170. doi: 10.1016/j.jamda.2013.12.005.

¹⁶For example, the Care Connections Senior Aide project established a senior home health aide role and was associated with a range of positive outcomes, including an 8 percent drop in emergency department visits. PHI. 2018. “A Career Development Project That Improved Clinical Outcomes.” https://phinational.org/impact_story/career-development-project-improved-clinical-outcomes/.

¹⁷New York State Assembly. 2017. “2-22-17 Public Hearing on the Home Care Workforce.”

https://nystateassembly.granicus.com/MediaPlayer.php?view_id=8&clip_id=4114_

¹⁸NYSDOH, 2018c.

¹⁹NYSDOH, 2015.