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ISSUE BRIEF

Value-Based Payment in New York: Assessing Progress on Integrating the Home Care Workforce

BY ALLISON COOK

Value-based payment initiatives seek to improve health care quality while reducing unnecessary costs by compensating health care providers for the value rather than volume of services. In home care, the success of value-based payment relies on the integration of home care workers into the care team. Building on findings from our 2019 case study, PHI interviewed home care agencies and Workforce Investment Organizations (WIOs) in New York City to further examine the progress and opportunities associated with Medicaid value-based payment in home care, as well as the impact of COVID-19 and state budget changes. Our research found significant progress in leveraging the home care workforce to achieve value-based payment goals, but an array of opportunities for improvement remain. Further, the research shows that while COVID-19 and state budget changes curtailed value-based payment initiatives, they did not completely halt them.

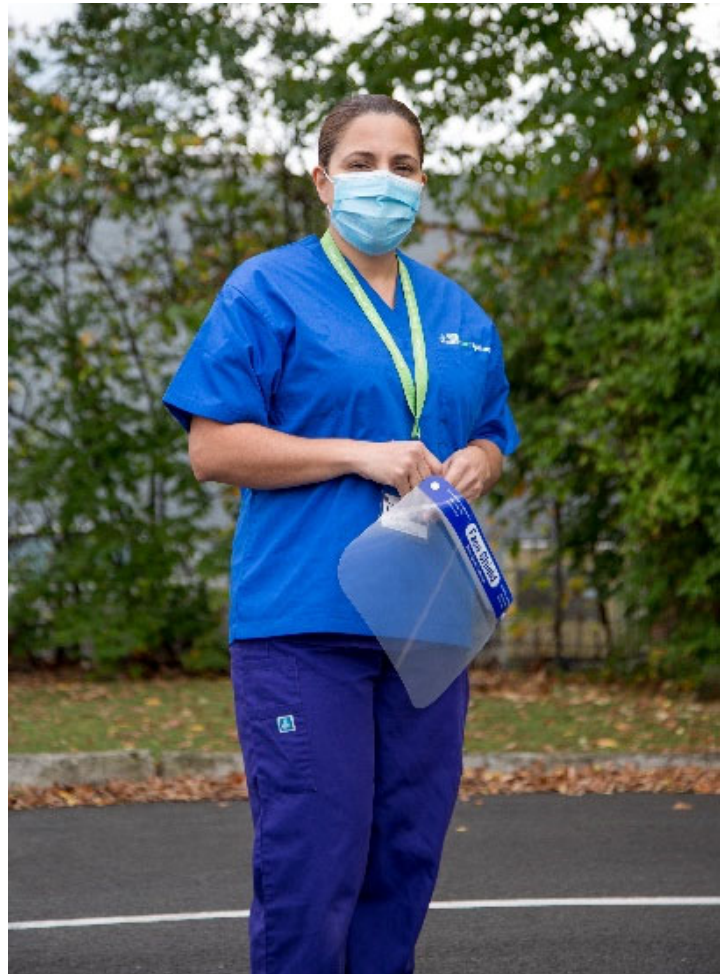
EXECUTIVE SUMMARY

Value-based payment is predicated on the concept that health care providers should be rewarded for the *value* rather than the *volume* of services they provide. Given their essential role in determining quality of care for their clients, home care workers must be integrated into value-based initiatives—with adequate preparation and support—for these initiatives to be successful.

In 2019, PHI conducted a case study of value-based payment in home care across New York, a state that has paved the way on this payment innovation in home care. Building on the findings from the that case study, PHI interviewed seven home care agencies and four Workforce Investment Organization (WIO) training experts in New York City to further delve into the progress and opportunities associated with value-based payment in home care. Additionally, PHI assessed the impact of the COVID-19 crisis and recent, state-level budget changes on value-based payment and the home care workforce.

Our new research found that, despite the impact of COVID-19 and recent changes to the state budget, value-based payment initiatives remain in place, though there is significant uncertainty about what they will look like in the future. The home care agencies and WIOs we interviewed agreed on the value of home care workers in realizing value-based payment goals and shared significant progress across the four opportunity areas identified in the 2019 case study, which were: training, data, care-related communication, and evolving worker roles. For example, interviewees described making progress toward training all staff on value-based payment topics, creating new data collection systems, improving communication between aides and home care agencies, and leveraging home care workers' new knowledge and skills. At the same time, interviewees noted that opportunities remain in each of these areas, including with regard to incentivizing collaboration on training interventions, better measuring home care quality, funding the implementation of new communication systems, and facilitating the establishment of advanced roles.

Based on these findings, this report concludes that successful value-based payment in home care relies on home care workers being fully integrated in the care team, sustainable funding, adequate planning time, and collaboration among a variety of stakeholders. State leaders and other stakeholders—in New York and throughout the country—should draw from these findings when structuring and implementing value-based payment in home care.



BACKGROUND

Federal and state health insurance programs have increasingly adopted value-based payment initiatives that shift the focus from service volume to value. This new approach originated in acute care and has gradually worked its way into long-term services and supports, including home care.¹

Value-based payment initiatives are rooted in the importance of delivering quality care. In the home care sector, home care workers are essential to this goal because they provide a majority of the paid hands-on care that clients receive.² Therefore, the skills and contributions of home care workers must be formally integrated into value-based initiatives.

Because of New York State's leadership role in implementing value-based payment in home care, PHI published a case study in 2019 examining the impact of the rollout of value-based payment requirements in Medicaid-funded home care services on the home care workforce.³ This study builds on the 2019 findings by further exploring how home care workers are being leveraged in value-based payment, as well as investigating the impact of COVID-19 and new state budget realities on home care overall. This study differs from the first study in three key ways: (1) it includes the perspective of Workforce Investment Organizations (WIOs), in addition to home care agencies, because of the value-based payment training support they provide to home care agencies; (2) it focuses on New York City, given the greater progress in this region identified by the 2019 study compared to other areas of New York State; and (3) it examines how COVID-19 and recent budget changes have impacted value-based payment initiatives.

Home Care Value-Based Payment Requirements in New York State

As of December 31, 2017, all Medicaid-funded licensed home care services agencies are required to include value-based payment initiatives in all of their Managed Long Term Care (MLTC) contracts.⁴ By April 2020, at least 15 percent of MLTC expenditures were required to hold a higher level of risk (known as Level 2 contracts, see box), though enforcement has been delayed because of COVID-19.⁵

In these initiatives, the primary quality measure is “potentially avoidable hospitalizations,” defined by the New York State Department of Health as when a person is hospitalized with a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection.⁶

LEVELS OF VALUE-BASED PAYMENT CONTRACTS IN NEW YORK STATE

The New York State Department of Health has established three levels of value-based payment contracts, with different levels of financial risk:

Level 1: Home care agencies receive a payment bonus for meeting or exceeding quality goals. The only required measure is “potentially avoidable hospitalizations,” but plans can choose additional measures.

Level 2: Home care agencies receive a payment bonus or penalty, depending on their performance on quality goals. Arrangements must include at least one quality measure in addition to potentially avoidable hospitalizations.

Level 3: This arrangement is broadly defined as a fixed or bundled payment but has not yet been specified for home care.

Source: New York State Department of Health. 2019. “A Path toward Value Based Payment: Annual Update, September 2019: Year 5.” https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2020/docs/2019-09_final_vbp_roadmap.pdf.

COVID-19 and the New York State Budget

Throughout New York State, COVID-19 has caused widespread economic challenges and forced home care agencies to focus primarily on emergency management rather than quality improvement. State budget challenges have worsened as this pandemic has strained state resources, leading to a range of budget changes that have deeply impacted the home care field, including value-based payment initiatives. Before the pandemic hit New York, the state was already beginning to identify \$2.5 billion in cuts and cost-saving measures to the Medicaid program⁷—and this imperative was exacerbated by COVID-19’s economic impact. Consequently, the state budget that runs from April 2020 through March 2021 includes three substantial changes that directly and indirectly impact value-based payment in home care:⁸

- **Elimination of \$42.5 million in value-based payment stimulus funding** – While the requirements for value-based payment contracts remain intact, the stimulus funding that was intended to help fund quality bonuses was eliminated.
- **Reduction in patient assessment requirements from twice to once per year** – The patient assessment is how most value-based payment data is collected. These assessments will now occur annually unless there is a change in patient condition.
- **Decrease in payments to all Medicaid providers, including MLTC plans**, by 1.5 percent (in addition to a one percent across-the-board cut implemented at the beginning of 2020)⁹ – Each MLTC plan can choose how much of this cut to pass on to home care agencies through reduced payments.

New York State’s Long Term Care Workforce Investment Program

Approved in 2014 as part of New York State’s 1115 Medicaid waiver, the Long Term Care Workforce Investment Program (referred to as the Workforce Investment Program) “makes available up to \$245 million through March 2021 for initiatives to retrain, recruit and retain health care workers in the long-term care sector.”¹⁰ Through an application process, the state designated Workforce Investment Organizations (WIOs) in every region of the state, including New York City. For each of the three program years (from April 2018 through March 2021), the state has distributed funding to participating MLTC plans, which have then distributed the funding to WIOs in their regions.

WIOs offer an array of training programs that support entry-level, specialty, and advanced roles in home care. While the funding is not exclusively for this purpose, the state strongly encouraged WIOs to offer training interventions that align with the quality goals of value-based payment.¹¹ Funding for this program expires at the end of March 2021, and there is no clear plan for the state to continue providing workforce training funding to WIOs beyond this period.

METHODOLOGY

In designing this case study, PHI considered the following key findings from our 2019 study:

1. Providers in New York City had made more progress in implementing value-based initiatives than providers in other areas of the state;
2. Four major areas of opportunity identified by interviewees were training, data, care-related communication, and evolving worker roles;
3. MLTC plans had largely focused on the higher-level structuring of value-based payment initiatives, while home care agencies, due to their on-the-ground provision of services, were particularly concerned about how to best leverage the contributions of home care workers; and
4. WIOs provided training interventions that greatly supported home care agencies in implementing value-based payment initiatives.



Building on those findings, in this case study PHI interviewed home care agencies and WIOs in New York City to assess the progress they have made in leveraging home care workers in value-based payment initiatives and identify future opportunities to strengthen this work. We also examined the profound impact of COVID-19 and recent state budget changes on value-based payment initiatives and the home care workforce.

Qualitative interviews were conducted with seven licensed home care services agencies and four WIOs throughout New York City via telephone or video conferencing in October 2020. (One home care agency was interviewed in April 2020, with email follow-up in November 2020.) These interviews examined four areas: training, data, care-related communication, and evolving worker roles. Key findings and themes were distilled from these interviews and categorized as either a sign of “progress” or an “opportunity” for improvement.

FINDINGS

Training

This category includes training programs related to value-based payment that are offered to any level of staff. It includes entry-level, specialty, and advanced role training, among others.

Progress

- **Training has been provided on a variety of value-based payment topics** – The value-based payment trainings described by interviewees—much of which has been provided by WIOs—fall into three main areas: (1) an overview of value-based payment; (2) quality measure-related topics (such as falls prevention); and (3) skills-building topics (such as communication). Some but not all trainings also address racial or gender equity, often framed as cultural competence. Interviewees noted that refresher courses to reinforce and build upon new knowledge and skills are also important, but such trainings have been paused due to COVID-19.
- **All levels of staff have been provided with training** – WIO and home care agency interviewees reported training all levels of staff—including home care workers, nurses, trainers, administrative staff, and others—with the understanding that effective value-based payment interventions require across-the-board understanding and buy-in.
- **COVID-19 has shifted how training is provided** – Interviewees stated that, after pausing their training efforts at the onset of the pandemic, they resumed training in new ways, including through smaller in-person classes, remote classes, or a combination thereof. Although making it safer to resume training, these changes have created new challenges. Remote training is still largely instructor-led in real time, which has required trainers to develop new curricula and skills and required both trainers and trainees to utilize new technology. Further, the pause in trainings and smaller class sizes have reduced the number of workers trained in recent months.

Opportunity

- **Enable WIOs to better support in-service training** – Most home care agency interviewees described training home care workers on value-based payment topics primarily through in-service programs. Agencies also reported a backlog of in-service trainings caused by COVID-19, identifying a clear opportunity for WIOs to fill a gap and support value-based training. However, interviewees noted that full coverage of the cost of in-services would better enable them to take advantage of this opportunity. (It has just recently been clarified that WIOs are authorized to provide in-services, but costs for trainers and trainees' wages are not covered for these programs.¹²)
- **Incentivize training collaboration** – Interviewees noted that collaboration among key stakeholders—MLTCs, home care agencies, and WIOs—has been rare, but asserted that such collaboration, if well-incentivized, would yield better-designed and more targeted interventions.
- **Incorporate planning time** – Interviewees shared that planning time would allow them to better identify and build successful interventions. For example, WIOs reported that the lack of a planning stage in the Workforce Investment Program prevented them from implementing more substantial interventions until the second or third year, which COVID-19 then interrupted.
- **Integrate training and other funding opportunities** – Some interviewees shared that funding for interventions that pair training with other supports would better achieve value-based goals. For example, training on effective communication may be more successful when paired with a new communication system (such as an app or telephonic system).

Data

This category includes the aggregate data used to support value-based payment goals, determine bonus or penalty payments, and identify and inform interventions.

Progress

- **Data infrastructure has improved** – Home care agency interviewees reported significant progress in building the infrastructure that allows them to better utilize data to meet value-based payment goals. Examples include systems that aggregate data from care-related communication systems or from nurse assessments of clients to identify trends. Other interviewees mentioned that certain MLTC plans have created helpful data “dashboards” where agencies can view their care quality data.
- **Home care agencies have implemented their own data collection processes** – Home care agency interviewees reported implementing their own data collection processes to track their performance on value-based payment metrics. Even if they are collecting the same data collected by MLTC plans, the ability to more readily access that data enables agencies to employ data-driven strategies to improve their performance on key quality measures *before* incurring penalties. Interviewees emphasized that agency-collected data has become even more important due to the budgetary change that will reduce client assessments (which are used to collect value-based payment data) from twice to once per year.
- **Data is informing interventions** – With the improved abilities to access and analyze data, both home care agency and WIO interviewees reported using this data to determine where interventions are needed and how they should be structured. For example, one interviewee reported seeing an uptick in client falls, which compelled them to implement a new falls prevention training.

Opportunity

- **Measure all aspects of home care quality** – While some interviewees expressed confidence in existing quality measures, others identified a need to better capture data in two areas: quality of life for clients and outcomes for workers (such as retention).
- **Support technology implementation through funding, systems improvements, and technical assistance** – Some home care agency interviewees reported undergoing involved processes to identify, implement, and adjust new technologies. Most emphasized that their technology use was limited by a lack of funding. Additionally, one interviewee commented that state-funded technical assistance would help agencies more efficiently determine and implement the technology that best meets their needs. Another home care agency shared that client data accessed through the regional health care information organization (RHIO)¹³ helps them address care transition issues in a timely way, but noted that many other home care agencies do not use the RHIO—which suggests a specific opportunity for enhancing access to this digital resource.
- **Collect better data on the impact of training** – WIO interviewees shared that their training data derives mainly from pre- and post-training knowledge tests. They reported having limited or no access to data on trainee outcomes (such as retention) and client care outcomes, both of which would more accurately measure the effectiveness of training interventions. Notably, interviewees raised two confounding factors for measuring the impact of training: (1) the pandemic has complicated outcomes data, obscuring the impact of training; and (2) the implementation of simultaneous changes—for example, providing a training on effective communication while rolling out a new communication system—makes it difficult to isolate direct results of training.

Care-Related Communication

Care-related communication refers to communication among various members of the interdisciplinary care team about a client's health status and needs.

Progress

- **Care-related communication between the agency and home care worker has improved** – Home care agency interviewees noted that care-related communication with their workers has improved through new communication systems and additional training. Two helpful training topics noted by home care agency interviewees (and offered by WIOs) include: effective communication and identifying changes in client condition. Several interviewees also described using telephonic or app-based systems to ask workers about care topics related to value-based payment measures at the end of each shift. In some cases, this communication has been paired with the electronic visit verification systems that are used by workers to clock in and out.¹⁴
- **Infrastructure has been built to address care needs** – Most home care agency interviewees described building new internal infrastructure to address care-related needs identified by home care workers. Many interviewees noted that they have dedicated office and clinical staff to monitor communication and address issues that arise. They also noted that they have created new internal systems to ensure that “red flags” are addressed immediately and that other needs are addressed in a timely manner. Some interviewees stated that they also follow up with home care workers to make sure they know how their concerns had been addressed.
- **Communication between home care agencies and MLTC plans has improved for Level 2 contracts** – While there is still room for improvement, interviewees with Level 2 contracts (i.e., value-based payment contracts with the potential for a payment bonus or penalty) shared that care-related communication with those MLTC plans has improved. Examples of communication improvements include regular case management meetings for clients with complex needs and the ability to consistently communicate with MLTC case managers.

Opportunity

- **Ensure consistent care-related communication between home care agencies and MLTC plans** – Interviewees reported a lack of consistency in care-related communication between agencies and MLTC plans. Most interviewees found that their Level 1 contracts (i.e., value-based payment contracts with the potential for a payment bonus) were not supported by regular communication with the relevant MLTC plans, with negative implications for care quality.
- **Offer technical assistance on care-related communication** – Home care agency interviewees reported having spent significant funds and staff time to research and build care-related communication systems. Some interviewees expressed that they would benefit from technical assistance in a range of areas, including: using technology to facilitate communication between home care workers and agencies; supporting workers in using the technology to identify when a client care intervention may be needed; and building the best infrastructure to triage and address identified care needs.
- **Fund technology implementation** – Almost all home care agency interviewees found it challenging to implement new technologies to facilitate care-related communication without dedicated funding, especially given the combined financial impact of COVID-19 and state budget cuts.

Evolving Worker Roles

This category covers new responsibilities for existing occupations and the creation of new roles within home care, particularly among home care workers.

Progress

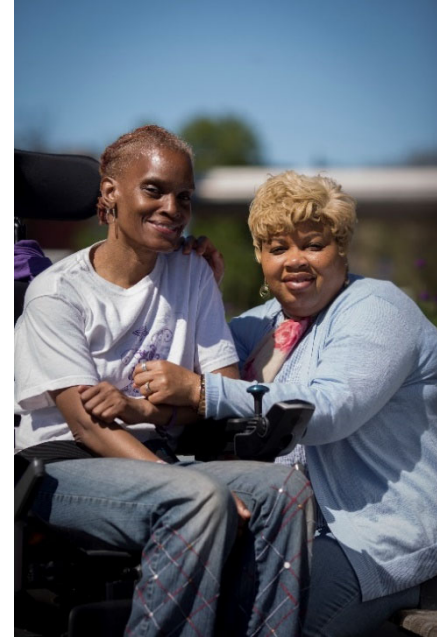
- **The role of the home care worker is evolving** – Both WIO and home care agency interviewees reported that greater skills and knowledge are required among home care workers to meet value-based payment goals. For example, as described by one interviewee, for a home care worker to report changes in status for a client with chronic obstructive pulmonary disease (COPD)—thus helping the agency support this client and meet value-based payment goals—the worker needs a greater understanding of COPD, the skills to observe, record, and report on the client’s condition, and greater integration into the care team. In some cases, interviewees reported that they have made communication a required competency for the home care job, resulting in clearer expectations and accountability for home care workers.
- **Home care workers are more valued** – Interviewees shared anecdotes about workers feeling more recognized and valued for their important role in client care and their integration into the care team. However, agencies have little data on how evolving roles have impacted worker retention—the measurement of which has been further complicated by the pandemic’s multi-layered impact on staffing.
- **New office and clinical roles have been established** – Most home care agency interviewees have established new roles for office and clinical staff to support value-based payment goals, even if they have not yet implemented new roles for home care workers. The new roles reported by interviewees are primarily designed to support the collection, analysis, and/or utilization of data (such as data managers) or respond to client care needs identified by home care workers (such as care coordinators).

Opportunity

- **Create and expand advanced roles for home care workers** – Interviewees expressed an interest in creating advanced roles for home care workers that help meet value-based payment goals, but noted the need for additional funding (especially to cover increased wages) and dedicated time for planning and implementation. Although some interviewees *have* developed new advanced roles, they shared that they have been unable to implement as many of those roles as hoped due to funding constraints. Interviewees also stated that COVID-19 halted the limited progress on advanced roles for home care workers because of home care agencies’ need to focus limited staff time and finances on addressing the pandemic.
- **Reward home care workers for their role in value-based payment outcomes** – Some interviewees identified an unrealized opportunity to align care goals while also improving compensation by financially rewarding workers for their role in achieving value-based payment goals. They noted that they had been exploring ways to share value-based payment bonuses with workers, but COVID-19 and budget cuts have prevented forward movement on this idea.
- **Provide other supports that increase retention** – Since it takes a significant amount of time to build the additional skills and knowledge that home care workers increasingly require, some interviewees highlighted the importance of improving worker retention in order to meet value-based goals. These interviewees noted that providing additional employment supports—especially increased wages—would improve job quality and thus retention and care outcomes.

CONCLUSION

COVID-19 and recent budget changes have curtailed, although not entirely halted, value-based payment initiatives throughout New York City—and there is uncertainty about how value-based payment requirements will change in the upcoming year. Despite these challenges, New York City home care agencies, supported by WIOs, have made considerable progress in leveraging the home care workforce to realize value-based payment goals since the establishment of value-based payment contracting requirements. But significant areas of opportunity for future improvement remain. The implications delineated below are drawn from this case study and meant to guide stakeholders in New York and other states in maximizing home care workers' role in value-based payment initiatives.



- **Home care workers are essential to realizing value-based payment goals.** Since home care workers provide the majority of the paid hands-on care to home care clients, they are best positioned to understand their clients' needs and recognize changes in their conditions. This centrality to clients means that these workers help maximize quality of care for their clients, helping achieve value-based payment goals.
- **Planning time and sustainable funding are necessary to spur progress on the implementation of value-based payment initiatives.** Transforming the home care system through value-based payment requires considerable investments of time and long-term funding—to enable home care agencies and others to design, implement, and evaluate new strategies for achieving value-based payment goals. Sufficient funding to cover value-based payment bonuses is also critically needed to incentivize and facilitate such quality improvement efforts.
- **All types of collaboration are vital for achieving value-based payment goals.** Through collaboration, stakeholders are able to break down silos and work together to better provide quality care. The most effective training interventions, for example, involve close collaboration between training providers (e.g., WIOs), payers (e.g., MLTC plans), and home care agencies. Care team integration, which facilitates collaboration between home care workers and the rest of the interdisciplinary team, is also vitally important.

With robust investment in and integration of home care workers, value-based payment initiatives can create an environment that better values workers and leverages their skills and knowledge. This report highlights the progress that has been made in New York City—despite the challenges associated with COVID-19 and the state budget—since New York State implemented value-based payment requirements, as well as the opportunities that remain. Drawing on these findings, stakeholders in New York and other states can strengthen efforts to achieve home care quality improvements through effective investments in home care worker job quality.

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