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## Using Pay-For-Performance Payment Methodology Framework For Medicaid Reimbursement Rate In State Government

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# Walden University

College of Health Sciences and Public Policy

This is to certify that the doctoral study by

Motunrayo S. Dindi

has been found to be complete and satisfactory in all respects,  
and that any and all revisions required by  
the review committee have been made.

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Walden University  
2024

Abstract

Using Pay-For-Performance Payment Methodology Framework For Medicaid

Reimbursement Rate In State Government

by

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MPA, American Public University, 2013

BS, University of Maryland, University College, 2007

Professional Administrative Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Public Administration

Walden University

November 2024

## Abstract

Medicaid Home Community Based Services (HCBS) program reimbursement rate policy plays a critical role in the rate determination and influences the type of care services received by program recipients. This qualitative case study evaluated the impact of the reimbursement rate policy on the quality of care received by Medicaid HCBS program beneficiaries. The practice-focused question for this study was from the Office of Rates and Reimbursements management perspective as to how the state can implement an effective alternative reimbursement rate policy to achieve value-based care services that would result in better healthcare outcomes. To achieve the desired result, thematic and narrative analyses were used to analyze collected data, including all literature reviews and archived documents. Semi structured interview data and all reviewed pieces of the literature showed that the pay-for-performance reimbursement model could impact the health outcomes of program recipients. By implementing the pay-for-performance reimbursement model, the client organization leaders' policy on reimbursement rate may inspire the care providers to implement new innovative care services that will improve the health outcomes of the program recipients. The findings of the study showed that the pay-for-performance reimbursement model is the best alternative value-based payment model for improving the health outcomes of the program beneficiaries. This study will promote positive social change as the less privileged Medicaid HCBS recipients will have access to high-quality care services that will improve their health outcomes.

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## Dedication

This study is dedicated to Almighty God, who gave me the desire, courage, and determination to pursue and complete the program. It is also dedicated to my deceased parents, Alhaji Sauban Dindi and Alhaja Aliat Dindi, for their unconditional love and encouragement since my childhood to always shoot for the moon and be a voice for the voiceless. Your inspiration and guidance contributed immensely to this highest educational goal. I believe you are feeling proud of me in heaven. You both inspired me greatly during your lifetime to become who I am today; I will forever be grateful for your love, care, and guidance.

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## Section 1: Introduction

### **Introduction**

Medicaid Home Community Based Services (HCBS) reimbursement rate policy plays a critical role in the quality of healthcare received by the program beneficiaries from the healthcare providers. Most Medicaid HCBS beneficiaries find it difficult to get quality care to manage and improve their health conditions, nor are they satisfied with their healthcare services. Meanwhile, the value-based alternative payment reimbursement rates can assist the client organization's leadership in achieving whole-care benefits for the program beneficiaries and motivate healthcare providers to pay more attention to their healthcare services.

This qualitative case study evaluated the quality-of-care services given to one of the United States government's Medicaid Home Community Based Services (HCBS) program beneficiaries to achieve the best alternative reimbursement model to provide high-quality care services and motivate Medicaid HCBS healthcare providers. The client organization discovered that its Medicaid HCBS program beneficiaries found it difficult to get high-quality healthcare services to manage and improve their health conditions nor satisfied with the care services received from the care providers. Meanwhile, the cost of funding the HCBS program continues to increase with fewer quality care services.

### **Organization Background and Problem Statement**

The client organization state government has a Medicaid agency whose mission is to improve its resident's health outcomes through access to comprehensive, cost-effective, and quality healthcare services. This agency is a medium-sized state

government of about two thousand employees (DHCF, 2022). This state administers health insurance programs for the state immigrant children, the state Child Health Insurance Program popularly known as CHIP, and Medicaid programs. The client organization for this study is a sub-organization under the Medicaid agency, known as the Office of Rates and Reimbursements. This office is responsible for setting and implementing Medicaid Home Community Based Services (HCBS) program reimbursement rate policies.

The office is also tasked with ensuring the integrity and reliability of the provider's cost reports and data for Medicaid HCBS program reimbursable rates. The client organization State recently switched from the federal framework of the Fee for Service (FFS) payment model that fails to provide quality healthcare services, despite its historically high price tag (DHCF, 2022). Under the FFS, the cost variations for Medicaid beneficiaries' healthcare procedures and tests increased with the overutilization of services that do not address the care needs of the program beneficiaries. Therefore, as Medicaid HCBS healthcare providers spent more to care for the program beneficiaries, their health outcomes were not improved (CHCS, 2021). In the fiscal year (FY) 2021, the federal MCO/HCBS program accounted for 52% of the \$728 billion total spending of the Medicaid program (McDonough & Adashi, 2022). At the same time, the client organization Medicaid HCBS program spending in FY2021 was \$4 billion compared to \$2.6 billion in FY2019 (DHCF, 2022). Meanwhile, the state's client organization Medicaid HCBS plan, most physician services, physician-administered drugs, durable medical equipment (DME), and laboratory services are reimbursed at 80% of the

Medicaid rates as established by the Federal Centers for Medicare and Medicaid Services (CMS), except for certain primary care physicians who have qualified for an enhanced rate and certain DME items and other chemotherapy-related physician-administered drugs, and are paid at 100% of the Medicare rate.

As the Medicaid HCBS program spending continues to rise with low quality of care services, and the program leaderships are striving for a better care outcome for the program beneficiaries, it became necessary to access a value-based alternative payment model that would increase the quality of healthcare services with reasonable spending. In 2018, the Kaiser Family Foundation (KFF) recommended three quality measures initiatives; some of which are pay-for-performance/performance bonus, capitation withhold, and auto-assignment algorithm on performance measures. However, in 2019, the KFF discovered from the 19th Annual Budget Survey of Medicaid Officials in 50 states and DC conducted by the National Association of Medicaid Directors in collaboration with Health Management Associates (HMA) that the majority of states did not include nor reported quality care initiatives in their healthcare contracts (KFF, 2019).

Similarly, Gifford et al. (2018) analyzed some of the federal government improvement initiatives that could strengthen the quality-of-care services in the Medicaid program and what should be the key focus areas in FY2018 and FY2019. One of the key focus areas was the alternative payment models that would focus on social determinants of health and care coordination between program beneficiaries and care providers. Another key focus area was the program expansions and enhancements that would increase reimbursement rates and expand community-based efforts to address health

issues (Gifford et al., 2018). An increased reimbursement rate would facilitate care coordination between program beneficiaries and care providers.

Based on these initiatives, it was suggested that the client organization leadership could evaluate some of these alternative payment models to see how they could improve Medicaid HCBS healthcare services with reasonable spending. The public administrative issue addressed in this study was how the client organization could implement a value-based reimbursement rate that would allow Medicaid Home Community Based Service (HCBS) program beneficiaries to receive high-quality care services with reasonable spending and a reimbursement rate policy that would motivate HCBS care providers to deliver high quality of healthcare services. Based on research findings, an alternative value-based payment methodology through a pay-for-performance model could be an effective policy decision for setting Medicaid HCBS program reimbursement rates. The value-based care payment methodology is based on accountability, efficiency, and quality of care services through the pay-for-performance framework.

This study evaluated and analyzed alternative payment methodologies that showed prominent features of healthcare needs that will impact the quality of care received by the HCBS program beneficiaries. The pay-for-performance payment methodology tied Medicaid HCBS reimbursement rate to quality care, best practices, and program beneficiaries' satisfaction, resulting in healthcare services that provide complete care.

## **Purpose**

The practice focus questions that guided this study were from the Office of Rates and Reimbursement management perspective: how can the state implement an effective alternative payment model for Medicaid Home Community Based Service (HCBS) reimbursement rate policy to achieve value-based care services? This study recommendation provided an alternative value-based reimbursement rate policy that would result in high-quality healthcare services, smart program spending, and retention of program care providers. While this qualitative study analyzed the client organization's Medicaid HCBS program reimbursement rates policy, it also evaluated the alternative value-based payment methodologies. It recommended effective alternative value-based payment that would result in better healthcare outcomes for the program beneficiaries, and also motivate client organization Medicaid HCBS healthcare providers to deliver quality healthcare services.

The federal legislation Affordable Care Act (ACA) is one of the genuinely sustainable eras of value-based reimbursement policy that placed greater financial risk sharing on the healthcare providers through entwined cost and quality (Boudreaux & Vetter, 2016). However, the increasing concept of corporate social responsibility is another factor healthcare providers must emulate to provide complete care for the program beneficiaries (Montgomery, 2022). However, the leadership policy on setting reasonable reimbursement rates is crucial in how healthcare providers motivate and provide quality care services. For instance, some medical scholars have believed holistic engagement is critical in managing modifiable factors in healthcare services. The holistic

engagement allows collaborative efforts between the care providers and program beneficiaries to engage in care participation, teaching health conditions and options in the way the program beneficiaries would understand (CHCS, 2022). Such an engagement strategy would allow the healthcare providers to develop a better relationship that would address the healthcare needs of the program beneficiaries. While the client organization's focus is based on the improvement in overall healthcare outcomes of the program beneficiaries with good program spending, they must address all the unmet basic resource needs, such as financial motivation through a generous reimbursement rate policy that contributes to the decline in the quality of the program beneficiaries care outcome.

### **Summary of Data Sources and Analysis**

This study's sources of evidence were based on archived documents and semi-structured interviews with the client organization leader, who narrated the organization's perceptions of the reimbursement rate policy and analyzed its impact on the alternative value-based reimbursement model of pay-for-performance and quality of healthcare services. In addition, the client organization leader's responses to the interview questions supported the recommendation idea regarding policy and funding. These resources provided the evidence needed to support the recommendation.

This qualitative case study was built upon previous research on reimbursement rate policy and program beneficiaries' health outcomes, and it identified and explained areas for improvement. This study also determined the barriers and challenges impeding the client organization from embarking on a policy that would advance the value-based reimbursement rate policy.

### **Archival and Website Data**

I received information and data from the client organization's website. I accessed archived data from the following websites: the Kaiser Family Foundation (KFF), the Centers for Medicare and Medicaid Services (CMS), the Urban Institute, and the Robert Wood Foundation, in addition to personal phone interviews with the client organization senior leader that was involved in the policy-making of Medicaid Home Community Based Services (HCBS) reimbursement rate setting. Below is the list of independent organizations that I assessed and retrieved archived data on policy, survey, and research findings.

#### **Federal Funded Research and Development (FFRDC).**

FFRDC is the first federal research center sponsored by The Centers for Medicare & Medicaid Services (CMS) to strengthen the nation's healthcare system. CMS Alliance to Modernize Healthcare (CAMH) is the convener of the Health Care Payment Learning & Action Network (HCPLAN) through the Department of Health and Human Services (HHS) and other government entities to access unbiased research, advice, guidance, and analysis to solve complex business, policy, technology and operational challenges in health mission areas. The FFRDC objectively analyzes long-term health system problems, addresses complex technical questions, and generates creative and cost-effective solutions in strategic areas such as quality of care, new payment models, and business transformation.

**Kaiser Family Foundation (KFF)**

KFF is an independent health policy research, polling, and journalism source. It is an information organization that creates and disseminates information about health policy and program results. The KFF's mission is to serve as a nonpartisan source of information for policymakers, the media, the health policy community, and the public. It has four major program areas: KFF Policy, KFF Polling, KFF Health News, and KFF Social Impact Media, which conducts specialized public health information campaigns. KFF findings are based on facts and data without affiliation to any political party or external interest. It is an information organization that creates and disseminates information about health policy.

**Medicaid and CHIP Payment and Access Commission (MACPAC)**

MACPAC is another nonpartisan legislative branch agency that provides policy and data analysis and recommends to Congress, the US Department of Health and Human Services Secretary, and the states on various issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). MACPAC is an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. MACPAC's authorizing statute also requires the Commission to submit reports to Congress annually by March 15 and June 15. In carrying out its work, the Commission holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

## **The Center for Health Care Strategies (CHCS)**

CHCS is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS brings together state and federal agencies, health plans, providers, and community-based organizations to advance models of organizing, financing, and delivering health care services. CHCS is dedicated to strengthening the US health care system to ensure better, more equitable outcomes for citizens, especially Medicaid recipients.

The CHCS website features the organization's publications, such as reports, working papers, toolkits, and briefs. Its online resource center provides relevant, operationally-oriented information for purchasers of publicly financed health care, managed care organizations, consumer groups, and other essential healthcare stakeholders. Finally, the Walden University Library was used to access databases to locate peer-reviewed research on *alternative payment methods, value-based purchasing, pay-for-performance, Medicaid reimbursement rates, quality of care, and patient satisfaction.*

### **Definitions**

The following terms are defined and explained to ensure an appropriate understanding of the study's acronym and that readers understand the study's context.

*Medicaid Program:* Medicaid health insurance is a federal and state-funded program that provides free or low-cost health coverage to approved low-income people, families, children, pregnant women, and people with disabilities (CMS, 2020). Medicaid

program's policy benefits vary from state to state because each state determines who is eligible for the program benefits.

*Medicaid Program Reimbursement Rate:* The Medicaid reimbursement rate is the rate at which healthcare providers are reimbursed for services they provided and reported under the Medicaid program contract. The Medicaid reimbursement rate mechanism varies from state to state because each state determines the policy that guides the methodology of their state reimbursement rate.

*Medicaid Managed Care Organization (MCO):* Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality, while managed care organization provides the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and home community-based services (HCBS) that accepts a set per member per month with a capitation payment.

*Home Community-Based Services (HCBS):* Medicaid HCBS is a special program that provides long-term care services to Medicaid-eligible individuals who live in the community and avoid institutionalization. The HCBS program empowers the state government to implement a long-term continuum of care for low-income elderly and people with disabilities. The continuum of care includes personal care, respite care, and other types of home and community-based services. Mellor et al. (2023) discovered that HCBS expenditures in 2019 were \$183 billion, 43% of the long-term care spending and 33% of the overall Medicaid spending (Mellor et al., 2023). The improvements in health plan performance, healthcare quality, and outcomes are the key objectives of Medicaid

HCBS (CMS, 2020). The Medicaid HCBS program beneficiaries will be treated as whole persons under the pay-for-performance alternative payment model.

*Alternative Payment Model (APM):* An alternative payment model (APM) is a payment approach that gives added incentive payments to promote high-quality and cost-efficient healthcare. (CMS, 2021) The alternative payment model represents payment of third parties between the program beneficiaries and care providers for the receipt and delivery of highly integrated healthcare services. The alternative payment model provides a significant opportunity to improve the quality and outcomes of patient care, which would lower the program's care funding.

*Value-Based Purchasing (VBP):* Value-based purchasing is an approach to ensure the quality and value of health care services a person receives and to improve health care providers' performance. This form of payment holds healthcare providers accountable for both the cost and quality of care they provide (CMS, 2021). VBP is a strategy to reduce inappropriate care and identify and reward the best-performing healthcare providers because the patients would receive whole personal care between mind and body; it allows for effective collaboration between patient and provider on the right kind of care and the right amount of care. It allows patients to make informed good decisions through ongoing communications between the patient and care providers (McDonough & Adachi, 2022).

*Pay-for-Performance (P4P) Model:* The pay-for-performance model is a form of value-based purchasing that offers financial incentives to healthcare providers to meet certain performance criteria and measures. Medicaid state program reimburses healthcare providers based on administrative claims, defined quality measures, or a cost-of-care

summary (CHCS, 2022). In some cases, program beneficiaries' satisfaction data are used to measure the access and communication effectiveness of the care providers, and those who meet the target may receive pay-for-performance incentives. At the same time, those who do not may be entitled to just a basic reimbursement method.

### **Significance**

The Medicaid HCBS program is a state government-run program that ensures healthcare access to underprivileged elderly citizens and people with physical disabilities. According to the Kaiser Family Foundation (2023), more than two-thirds, about 72% of all Medicaid beneficiaries, received their care through comprehensive HCBS, which makes it the dominant delivery system for Medicaid enrollees. The significance of this study in the field of public administration was that the client organization's Medicaid Home Community Based Services (HCBS) program is one of the public health insurance options for low-income elderly people and people with physical disabilities; however, one of the factors affecting the program beneficiaries' access to timely and high-quality care service was attributed to the program reimbursement rate policy. Medicaid HCBS program care providers give low priority and low-quality services to the program beneficiaries due to a lack of financial incentives that could empower them to provide innovative care services that could improve beneficiaries' health. Because Medicaid HCBS program beneficiaries are low-income citizens, they cannot afford high-cost private health insurance and are therefore subjected to low-quality care services that do not add value to their overall health despite numerous consultations with the care

providers, thereby resulting in unnecessary care services that increase compensation rather than improving health.

This study recommended an alternative value-based reimbursement model that will help program beneficiaries access high-quality care services similar to private healthcare insurance. The pay-for-performance alternative value-based reimbursement model will improve program beneficiaries' health and discourage overutilization of healthcare services that will not address care needs. It will promote social change by ensuring high-quality care services to less privileged community members and improving their overall health outcomes.

### **Summary**

In this section, I provided an overview of the background of the client organization and the administrative needs of the study. The purpose of the study and an approach to organize and collect data through research questions were discussed. Some definitions of the key concepts of the research topic, including citations, were discussed, and the significance of the study as it relates to positive social change was also discussed. Finally, I highlighted and discussed some of the study's terminology with their definition to ensure an appropriate understanding of the terms.

In Section 2, I outline the conceptual framework and relevant literature review that formed the basis of the research. The study's literature search strategy on how to get vital information is discussed. Also, I provided a detailed analysis of the study's literature reviews with some previous survey results and research findings.

## Section 2: Conceptual Framework and Relevant Literature

### **Introduction**

This qualitative study evaluated the impact of client organization reimbursement rate policy on the quality-of-care services received by the Home Community Based Services (HCBS) program beneficiaries. It recommended a value-based reimbursement model that would improve health outcomes. The general purpose of the study was to examine, conceptualize, and evaluate alternative value-based payment methodologies and recommend effective reimbursement policies that would result in better healthcare outcomes and smart program spending and motivate care providers to deliver quality healthcare services. The study analyzed how Medicaid reimbursement rates impacted the quality of care received by the Home Community Based Services (HCBS) program beneficiaries. I used the research question of how the state can implement an effective alternative payment model policy for Medicaid HCBS reimbursement rates to achieve value-based care services from the Office of Rates and Reimbursements management perspective.

### **Literature Search Strategy**

To ensure relevant findings and accurate information on the study, I used Walden University Library databases such as Academic Search, Abstracts of Reviews, Library Search, ProQuest Central, Public Administration Abstracts, and PubMed to locate and access peer-reviewed research using the key search terms on *alternative payment methods, value-based purchasing, pay-for-performance, Medicaid reimbursement rates, quality of care, and patient satisfaction*. I also accessed some of the independent research

organizations' journals, published articles, and research findings, such as American Medical Associations (AMA), Federal Funded Research and Development (FFRDC), Kaiser Family Foundation (KFF), Medicaid and CHIP Payment and Access Commissions (MACPAC), and the Center for Health Care Strategies (CHCS).

Considering the dynamic development of the study, I reviewed articles such as journals and research findings publication from 2018 to date. However, some research findings, which were older than 5 years, identified vital information relevant to the study. In addition, I reviewed various relevant government websites, including Medicaid.gov, which publishes all enacted laws on the Medicaid program. While searching for articles and journals related to the study, I focused on the use of OR/NOT/AND commands to ensure precision in retrieving desired information. Using wildcards, truncation, limiters, and specific phrase searches helped me find peer-reviewed articles utilized in the literature reviews.

### **Conceptual Framework**

The conceptual framework supporting this study includes the client organization's policy decision on Medicaid HCBS reimbursement rate, value-based purchasing method, alternative payment model of pay-for-performance, quality healthcare services, Medicaid HCBS program spending, and program beneficiaries' healthcare. The source of the conceptual framework was the experiences of the HCBS program beneficiaries and its impact on their overall health. This qualitative case study design aimed to recommend a value-based alternative payment methodology policy for setting Medicaid HCBS reimbursement rates that would result in high-quality care that will improve the health of

the program beneficiaries. The combination of the client organization leadership policy on reimbursement rate setting and perceived quality of care services provided the basis for the pay-for-performance reimbursement rate model, an alternative value-based payment methodology for setting Medicaid HCBS reimbursement rates for healthcare providers. This model was seen as a powerful tool to improve the health of Medicaid HCBS program beneficiaries with reasonable spending compared to other private insurance healthcare services, which helped develop study recommendations to answer the study's objective.

In addition, the peer-reviewed journal articles made up most of the literature reviewed; their contributions provided a base for the historical background and development process involved in client organization leadership policy decisions on the HCBS program reimbursement rate and its impact on the overall health of the program beneficiaries. They also helped analyze some issues associated with the continuous downgrade of healthcare services, which resulted in the pay-for-performance payment model.

Pay for pay-for-performance model has been used by businesses and organizations to improve quality and efficiency. Implementing a pay-for-performance alternative payment method in HCBS programs would improve the quality-of-care services and health outcomes. The pay-for-performance payment model in the federal Medicaid HCBS program arose from the concerns of legislators and program beneficiaries due to wrong-incentivized services that continue to drive the Medicaid HCBS program's cost higher and with no improvements to the program's beneficiaries'

health (George, 2019). The pay-for-performance payment model is considered an alternative way to change adverse incentive payments, which pay more for volume and complexity.

Using the research question of how the client organization leadership can achieve value-based care services from the Office of Rates and Reimbursements management perspective, this qualitative professional administrative project aimed to evaluate the impact of the HCBS reimbursement rate policy decision on the quality of care received by the program beneficiaries.

### **Literature Review for the Study**

A systematic literature review was applied in this study. They are selections of peer-reviewed articles and journals on the study's topic between 2018 and 2024 from different databases, including research findings on reimbursement rate policy, alternative payment model, and the quality of healthcare services based on reimbursement rate policy. DeCherrie et al. (2021) found that an alternative payment model was needed to extend the benefits of the Medicaid program to its beneficiaries as their research showed a positive impact the new payment model has on the quality and improvement of patient benefits. Their study discovered a decrease in illness complications when the innovative payment model is applied with patient satisfaction compared to an increase in illness complications when the traditional payment model is applied (DeCherrie et al., 2021), which means that the leadership reimbursement rate strategies have negatively impacted the program beneficiaries.

On reimbursement rate policy and methodology research, Walker et al. (2021) acknowledged that healthcare billing and reimbursement policy was a complex issue that contributed to ever-increasing program costs with no positive impact on program beneficiaries; they found that as the healthcare providers are trying to maximize costs to the fullest, healthcare insurers and policymakers are actively examining all negative impact it would have on program beneficiaries and continue to signal their preference for protections through healthcare policy that would give the beneficiaries better information and more choices. Walker et al. (2021) call for healthcare policymakers to adopt innovative reimbursement methods that would align the quality-of-care services provided with a reimbursement payment model.

Similarly, Aghajani et al. (2021) analyzed that the pay-for-performance payment model aligned healthcare delivery services to a quality service focusing on patient health outcomes. They acknowledged that the government's old fee-for-service payment model has led to poor and improper quality of healthcare outcomes. However, using the pay-for-performance reimbursement model has shown improvement in the quality of healthcare service delivery, which ultimately led to greater efficiency because it promoted responsiveness between care providers and patients (Aghajani et al., 2021). This showed that it is time for the state government to focus on the healthcare policy that will improve the overall health of the citizens instead of just providing access to healthcare services.

Robert et al. (2019) recommended that for the government to reduce overall healthcare costs, especially healthcare costs in Medicare and Medicaid programs, they must reduce the prices paid for healthcare services and utilization of such services, and

the government must shift to more cost-effective care providers that are willing to increase beneficiary engagements and at the same time willing to reduce the cost associated with waste, fraud, and abuse (Robert et al., 2019) because this will help control cost and improve health.

However, Forest (2022) described the challenges of implementing a value-based healthcare reimbursement model. As the goal of the alternative payment model is to tie reimbursement payments to care service outcomes, there has been limited progress because of a fragmented system “where some healthcare providers are treating healthcare as an economic good in a market justice system and some are treating it as a social good in a social justice system” (Forest, 2022). Most care providers in traditional systems did not have system features that are necessary for various value-based payment model requirements, such as standards to measure and report on the quality of health, profitability measures of treatment types to understand how to evaluate the model, and operating functions across multiple payer processes, while the systems make it difficult to capture data that will compute new performance measurement for value-based payment model.

Similarly, Fanburg et al. (2019) found that healthcare industry profitability is driven by the large billing codes and other requirements that are limited on the type of technology that the providers may use; unfortunately, the electronic government development, accounting practices, and guideline do not limit one to addressing only the technical issue but on an essential financial management reform that led to organizational changes and a new managerial approach (Fanburg et al., 2019). This could result in the

economic and political life of social communities through quality public service delivery and customer satisfaction because when quality service is delivered, customer satisfaction will improve, and citizens' trust in government will increase.

Additionally, McDonough and Adachi (2022) analyzed the lengthier delay in the US congressional approval process resulting from a bureaucratic implementation and evaluation process. They cited an example of the Affordable Care Act (ACA) that took longer to implement. They believed that to successfully align the value-based reimbursement model with caring service outcomes, healthcare providers and government officials must make the value-based purchasing method universal, simple, and affordable (McDonough & Adachi, 2022). The simplicity of the process requirements and performance measurement are the fundamental metrics for the value-based purchasing evaluation.

Meanwhile, Hackmann (2019) investigated the quality effects of policies that increase regulated reimbursement rates or local care competition. He discovered an 8.7% quality improvement when there was a 10% increase in reimbursement rates in care services (Hackmann, 2019). He also discovered that low Medicaid reimbursement rates play an important role in the quality-of-care services. He noted that moderate increases in Medicaid reimbursement rates led to a significant increase in the quality-of-care services, even though there was an increase in competition, which had a small positive effect on the quality of care. He discovered that the skilled nurse-to-resident ratio has a direct quality of care measure, meaning that there is a positive relationship between skilled care providers and quality of care outcomes, including improvements in health outcomes and

reduction in patient complaints, as evidenced in the Kaizer Family Foundation survey (KFF, 2021)

However, some research shows that paying for performance through value-based purchasing to improve care quality has become a costly distraction in healthcare services. Meanwhile, McDonough and Adachi (2022) described that various metrics to measure outcome performance had become care providers' major focus as they are mostly concerned about reputational damage and loss of revenue rather than focusing on the care improvement of the patient. They noted that their focus became so narrow that they would modify patient care to meet the performance metric (McDonough & Adachi, 2022), which ultimately alters the appearance of quality compared with true quality service outcomes.

In conclusion, Jan et al. (2020) described large numbers of specifics for pay-for-performance schemes that can be formed from various combinations of elements that are crucial for the successful implementation of alternative payment models, such as clinical outcomes, process quality, patient safety, access to and availability of care, service quality, patient experience or satisfaction, cost efficiency, cost-effectiveness, adherence to evidence-based medical practice, productivity, administrative efficiency, and compliance, adoption of information technology, reporting of performance indicators, and participation in performance-enhancement activities (Jan et al., 2020). Similarly, Khan et al. (2020) found that as the government continues developing schemes for healthcare quality improvement, there is a need for relevant and context-sensitive evidence (Khan et al., 2020) to support policy interventions that would minimize

significant ambiguity over the design of pay-for-performance schemes to derive efficiency and tolerability. They noted that policymakers need to understand various socioeconomic contexts to assess stakeholders' needs, values, perceptions, and experiences when implementing this model. Finally, the performance scheme should consider skilled care providers with competing high-priority values, meaning that they should be in an “influencer role” rather than being “responsive agents” (Khan et al., 2020) because understanding this value would ensure higher acceptance and successful implementation.

### **Summary**

Based on the study’s literature reviews, there was evidence of a practice gap between reimbursement rate policy and quality healthcare services; therefore, this study filled the gap through the evaluation of policy decisions that motivate the care providers to provide high-quality care services that would result in better health outcome for the program beneficiaries. This section also explored some peer-reviewed articles and organizations' research findings to understand the effect of reimbursement rate policy on the overall health of the Medicaid HCBS program beneficiaries. The literature reviews highlighted the crucial role of some previous survey results and research findings on the study and helped in developing an approach for the data collection process and analysis in section three.

### Section 3: Data Collection Process and Analysis

#### **Introduction**

The public administrative issue addressed in this study was how the client organization could implement a value-based reimbursement rate that would allow Medicaid Home Community Based Service (HCBS) program beneficiaries to receive high-quality care services with reasonable spending, and a reimbursement rate policy that would motivate HCBS care providers to deliver high quality of healthcare services.

Through the data collection and analysis, I examined and developed a thorough understanding of the potential barriers to a value-based alternative reimbursement rate policy that could improve the overall health of the program beneficiaries. I evaluated alternative value-based payment methodologies and recommended effective alternative value-based payment that would result in better healthcare outcomes for HCBS program beneficiaries.

In this section, I discussed the study's data collection and analysis processes, including an explanation of how the pay-for-performance value-based reimbursement model recommendation addressed the research question through data collection and thematic and narrative data analysis. Furthermore, my role, including the relationship with the client organization, is addressed. The trustworthiness and ethical procedures were addressed, and some of the independent organization's data on policy, survey, and research findings were explained.

### **Practice-Focused Research Question and Research Design**

The following practice-focused question guided this study: from the Office of Rates and Reimbursement management perspective, how can the state implement an effective alternative payment model policy for Medicaid Home Community Based Services (HCBS) reimbursement rates to achieve value-based care services?

In this qualitative study, I gathered data through semi-structured phone interviews with one of the client organization's senior leaders who make policy decisions regarding setting the state's Medicaid HCBS reimbursement rates. I also analyzed publicly available research data of the client organization before recommending the pay-for-performance alternative value-based payment model that will improve the quality-of-care services of the program beneficiaries. To achieve this qualitative study's results, I investigated and evaluated the understanding of the client organization's leadership policy on reimbursement rate setting and presented the analysis of the alternative value-based payment model that will allow them to leverage available policy, financing, and operational tools for setting up Medicaid HCBS reimbursement rates.

### **Roles of the Researcher and Client Organization**

Through data collection and analysis, I investigated and recommended the best alternative payment model that will improve the overall health outcome of the client organization's Medicaid HCBS program beneficiaries and, at the same time, motivate the program care providers. I am in the public administration program, which allows the examination and analysis of the issues affecting the public and provides the best available solutions. I was also involved in data collection and analysis and presented the study

results to the client organization leaders. I did not have any personal or professional relationship with the client organization's leadership, nor know anyone benefitting from the client organization's Medicaid HCBS program.

The motivation to conduct this study came from the news media outlets and independent survey organizations on the unsatisfactory state of the program beneficiaries coupled with the exorbitant funding of the program, all of which were ongoing concerns about the low quality of care services and ever-increasing program costs. I am a government employee in the accounting reporting division with access to know the exorbitant price at which federal and state governments fund the Medicaid HCBS program and the level of care services resulting from it. No bias was encountered throughout this study because I have no affiliation with the client organization and program beneficiaries.

The role of the client organization in this study was the granting of a semi structured interview with one of their leaders to share the perspective of their policy decision in reimbursement rate setting, in addition to publicly available client organization data in the independent organizations' websites and government websites. The basic goal of the client organization is to make the best policy decision on Medicaid HCBS program reimbursement rates that will ensure program beneficiaries receive high-quality care services with reasonable spending.

### **Methodology**

In this qualitative case study, I created several interview questions that were approved by the committee chairperson and second member committee on the current

policy of setting Medicaid HCBS reimbursement rate, such as challenges and pain points of the program beneficiaries as it relates to the policy decision of the client organization, the impact of reimbursement rate policy on the program beneficiaries and engagement with a healthcare provider.

Each interview question was outlined, I listed all the different topics that emerged from the responses, and developed four themes that identified the alternative payment methodology for an effective Medicaid reimbursement rate. Below are the interview questions.

- How would you describe the quality-of-care Medicaid HCBS program beneficiaries receive compared to private insurance?
- What factor(s) would you say contributed to your organization's policy of setting a Medicaid HCBS reimbursement rate?
- In your opinion, does current eligibility and reimbursement rate works fairly, if yes, how, if not why not?
- What influences your policy when setting up Medicaid HCBS reimbursement rate?
- How do you determine reasonable compensation for Medicaid HCBS reimbursement rate?
- Explain your organization's strategies to motivate Medicaid HCBS program care providers. How do you motivate healthcare providers?

I got the information and data from the client organization's website and archived data from the following websites: the Kaiser Family Foundation (KFF), the Centers for

Medicare and Medicaid Services (CMS), the Urban Institute, and the Robert Wood Foundation, in addition to personal phone interviews with the client organization senior leaders that were involved in policy making of Medicaid reimbursement rate setting. Below is the list of independent organizations whose archives and data on policy, survey, and research findings were reviewed.

**Federal Funded Research and Development Center (FFRDC).**

FFRDC is the first federal research center sponsored by The Centers for Medicare & Medicaid Services (CMS) to strengthen the nation's healthcare system. CMS Alliance to Modernize Healthcare (CAMH) is the convener of the Health Care Payment Learning & Action Network (HCPLAN) through the Department of Health and Human Services (HHS) and other government entities to access unbiased research, advice, guidance, and analysis to solve complex business, policy, technology and operational challenges in health mission areas. The FFRDC objectively analyzes long-term health system problems, addresses complex technical questions, and generates creative and cost-effective solutions in strategic areas such as quality of care, new payment models, and business transformation.

**Kaiser Family Foundation (KFF)**

KFF is an independent health policy research, polling, and journalism source. It is an information organization that creates and disseminates information about health policy and program results. The KFF's mission is to serve as a nonpartisan source of information for policymakers, the media, the health policy community, and the public. It has four major program areas: KFF Policy; KFF Polling; KFF Health News, and KFF Social

Impact Media, which conducts specialized public health information campaigns. KFF findings are based on facts and data without affiliation to any political party or external interest. It is an information organization that creates and disseminates information about health policy.

### **Medicaid and CHIP Payment and Access Commission (MACPAC)**

MACPAC is another nonpartisan legislative branch agency that provides policy and data analysis and recommends to Congress, the US Department of Health and Human Services Secretary, and the states on various issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). MACPAC is an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability.

MACPAC's authorizing statute also requires the Commission to submit reports to Congress annually by March 15 and June 15. In carrying out its work, the Commission holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

### **The Center for Health Care Strategies (CHCS)**

CHCS is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS brings together state and federal agencies, health plans, providers, and community-based organizations to advance models of organizing, financing, and delivering health care services. CHCS is dedicated to

strengthening the US health care system to ensure better, more equitable outcomes for citizens, especially Medicaid recipients.

The CHCS website features the organization's publications, such as reports, working papers, toolkits, and briefs. Its online resource center provides relevant, operationally-oriented information for purchasers of publicly financed health care, managed care organizations, consumer groups, and other important healthcare stakeholders.

### **Strategy for Data Analysis**

Data were collected through phone interviews with the client organization's senior leader who makes decision policies in setting the State's Medicaid HCBS reimbursement rates and used thematic and narrative analysis to analyze both the publicly available research data and interview data of the client organization. Data analysis was based on documents, archived data, and semistructured interviews of senior officials of the client organization. I conducted data analysis on a clean file to eliminate biases that could affect the quality of the study. During interviews, I used a recorder to record the interview and took notes of the interviewee's body language and facial expression when answering follow-up questions. All interviews and information collected are treated as classified information and were properly secured in a file cabinet that only student researcher can access. I promptly transcribed the raw audio data of the interviewee into Microsoft Word and saved it securely on the laptop that only I had the password to unlock.

I compared interviewees' responses to each question and took note of similarities, and differences between previous research findings and interview responses. I also

compiled a masterwork file containing the interviews and notes taken from the archived data and reviewed them multiple times which helped in gaining a deeper understanding of the administrative issue. Finally, I stored these data files on a computer with a stronger password to protect the confidentiality of the study.

### **Issues of Trustworthiness**

I took all necessary measures to protect the integrity of the collected data. I maintained the trustworthiness of this study by promptly transcribing the collected data and kept securely on a file to protect the data integrity which focused on credibility, transferability, dependability, and confirmability (Burkholder et al., 2016). My primary role was to conduct this qualitative case study professionally for all components involved. I encouraged credibility by obtaining informed consent from the participant and ensured that interviewees had enough time to respond to the interview questions. To achieve dependability, I ensured that the research process was reasonable, distinguishable, and detailed.

In addition, I promoted transparency by sharing the outcomes of the study with the client organization leader. To achieve confirmability, I met with the client organization leaders and presented the study in a walkthrough meeting where all pertinent pieces of information were shared including the study's recommendation, the presentation was logical and easy to follow for both I and the client organization because the qualitative study is subjective and could result in possible biases affecting outcomes (Sebele-Mpofu, 2020) of the study.

### **Ethical Procedures**

I followed the American Psychological Association (APA) code of ethics, especially the five principles of ethics code; beneficence and non-maleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity (APA Code of Ethic, 2017) when conducting the study. Before the interview date, I sent the interview request letter and consent forms to the interviewees; these are forms prepared and used for the research study from Walden University IRB. In addition, letters of invitation and consent forms were given in advance to the interviewee. Before the start of the interview, I reminded the interviewee that the study participation was voluntary and they could withdraw participation at any time. Also, I informed them that the study participation had no financial incentive and promised to protect the client organization's name and the participant's identifiable information that could jeopardize the integrity of the interview responses. I started the interview with the participant's informed consent to proceed with the interview, followed by a brief introduction of the study and what it seeks to accomplish. I then notified the interviewee of the ability to discontinue the interview at any time during the interview or if no longer interested in continuing with the study. I utilized a personal laptop to gather and record data collected for the study. The laptop is password-protected, and I am the only person with access to it.

### **Summary**

This qualitative case study evaluated and analyzed client organization reimbursement rate policy that could improve its Medicaid Home Community Based Services (HCBS) program beneficiaries' health outcomes. This section explained the

study's practice-focused research question and research design. I addressed the research question through archived data and narrative analysis of the client organization's responses to research questions. The role of the researcher and client organization were addressed, and the analysis and findings from the qualitative study informed the research on a policy recommendation that would improve the client organization's program beneficiaries.

This qualitative study methodology and strategy for data analysis were explained. The methodology outlined and identified data sources to address the practice-focused research question, because the study built on the emerging concepts of exploring alternative value-based reimbursement rates policy of the Medicaid HCBS program. I addressed the issue of trustworthiness and ethical procedures and explained some steps to mitigate these issues.

In Section 4, I address the study's results and recommendations, including data collection and analysis, the findings, and deliverables.

## Section 4: Results and Recommendations

### **Introduction**

This qualitative professional administrative study evaluated and analyzed alternative value-based payment methodologies that would improve the health outcomes of the beneficiaries of the Medicaid Home Community-Based Services (HCBS) program. This study identified a promising alternative value-based payment and highlighted some challenges that could impede the successful implementation of the policy. This study's findings also highlight one value-based structure of reimbursement rate policy that would result in high-quality care services and improve the health outcome of the program beneficiaries. The study data was collected through phone interviews and prior research findings on Medicaid Home Community Based Services (HCBS) reimbursement rate policy. Data analysis was done through narrative and thematic analysis. I identified a promising strategy for alternative reimbursement rate initiatives that would tie the Medicaid HCBS reimbursement rate to quality care and best practices and satisfy program beneficiaries, resulting in healthcare services that would provide complete care.

In this section, I will present findings from the data collected through the phone interview. All data collected were thoroughly reviewed and analyzed, and I noted differences and similarities between research questions, interview responses, and archived research data on the subject. The analysis made it possible to identify the best value-based alternative payment methodology for the client organization. This section addresses the study's results and recommendations, starting with the data collection, data

analysis, findings, deliverables, and recommendations, as well as evidence of the study's trustworthiness, strengths, and limitations.

### **Data Collection**

Only one participant was interviewed for this case study. This participant is one of the directors at the client organization agency, has worked there for over 25 years, and became a director 10 years ago. This client organization participant had varied experiences throughout the agency, had served different roles, and was directly involved in the agency reimbursement rate decision-making.

The data collection was done through a phone interview. The interview was conducted on Friday, May 31, 2024; it started at 2 pm and lasted 1 hour and 6 minutes. I reminded the client organization participant of the purpose of the study, provided a brief explanation of the ethics of the study as noted by the IRB office, and the importance of the study towards creating positive social change if implemented in the future. I sought permission from the client organization participant to record the interview, and the participant approved the recording. I used a small recorder to record the entire interview period and used a Walden University student account for Microsoft Office 365 for the transcription of the voice recording into a Microsoft Word document. After I finished transcribing the audio recording, I immediately locked the tape recorder in a file cabinet so that I was the only one with the cabinet key. I also saved the transcribed Word document on a secured laptop, and I am the only one with its password to unlock the laptop.

### **Data Analysis**

I used a tape recorder to collect data and Microsoft Word to transcribe the interview audio recording into Word document data. After multiple reviews of the transcribed data, the I used narrative analysis and thematic analysis to analyze the data. I used narrative analysis for the transcribed data and thematic analysis for the literature reviews and independent research findings. I employed codes later transformed into code categories and synthesized them into themes. Finally, I applied the themes from both analyses to the study's research question, which was used to provide feedback to the client organization leadership.

### **Findings**

I had sufficient information from the data findings evaluation to reach a proposed recommendation to the client organization leadership. The interview participant is one of the agency's leaders who makes policy decisions on the agency's reimbursement rate. The collected data were evaluated to identify relevant information addressing the research question of how the state can implement an effective alternative payment model policy for Medicaid Home Community Bases Services (HCBS) reimbursement rates to achieve value-based care services. Based on data analysis, four themes emerged from the thematic and narrative analysis process:

- No quality standard measurements
- Healthcare providers' mindset on services
- Shortage of healthcare providers
- Healthcare providers' quest for more money

## **Themes**

### ***No Quality Standard Measurements***

Based on federal government regulations and several nuances in Medicaid regulation structures, coupled with the complexity of multiple components calculation of cost that is based on several services provided, there are no formal quality standard measurements to assess the health outcome of the Medicaid Home Community-Based Services (HCBS) program recipients from the voluminous care services they are receiving. The client organization efforts are focused on applicants' eligibility, enrollments, and easy access to healthcare services (DHCF, 2024). There are no formal quality standards to measure healthcare providers' services against the Medicaid program recipient's health outcome.

This finding highlights a critical gap in how client organization leaders made policy decisions when setting reimbursement rates, even when the office changed from the prior federal rule of fee-for-service payment to a value-based payment methodology. It is known that quality measurement is one of the powerful tools to identify and monitor disparities in care services. However, a more standardized approach is required to ensure the process works correctly. On a federal level, as more states are now shifting from fee-for-service payment to value-based payment, they could directly incentivize equity by passing financial incentives to not just performances on aggregate measures but also to link payment data to patient-reported outcomes (Navathe et al., 2022), doing so will eliminate healthcare services disparities between private health insurance and government-assisted health insurance. However, any intervention to assess quality care

services must be thoroughly reviewed so that it will not result in unexpected and unintended outcomes. Any quality standards measurement must consider both positive and negative broader sets of quality measures (Maratt et al., 2019).

While there is so much to celebrate regarding the increase in public healthcare access compared to some years back, one KFF survey showed that seven in ten people acknowledged that the majority of US citizens have access to healthcare services either through private insurance or public insurance, and the coverage is excellent or good. Meanwhile, it will take additional efforts to sustain and augment the positive changes we have seen so far, especially in the Medicaid Home Community Based Services (HCBS); there is much work ahead to ensure the program beneficiaries do not only have access to healthcare but receive high quality of care services.

**Healthcare Providers Mindset on Services.** In response to one of the research questions, the client organization participant noted the consistent pattern of billing by the care providers, usually with the cost report used for paying the healthcare providers. As there is no limitation on the number of services provided, there was a pattern of continuous increase in the number of services provided every year, which translates to more money billed for reimbursement by the healthcare providers. According to the client organization participant, the obstacle of the care needed makes it challenging to control the number of services they should provide.

The client organization cannot limit the number of times the program recipients can receive care services. This analogy corresponds to one of the literature reviews that due to the complexity of healthcare needs, it is impossible to determine when a patient

would require care services (urgent and non-urgent); they are at the mercy of the healthcare providers who have the power to direct their care needs, and take advantage of the unknown recommends unnecessary care that will increase the number of their services for more money.

In addition, the client organization participant explained that, under cost-based reimbursement, healthcare providers are given some blank checks when providing care services. After all, they are entitled to be reimbursed for all costs, which means that they have the motivation to incur costs because there is a guarantee that they will get paid, enabling them to provide unnecessary services to bill higher costs because to them "more services lead to higher costs and high revenues" (DHCF, 2024). Meanwhile, the concept of value-based payment is that the healthcare provider should be accountable for both quality of care and costs.

This is a widespread issue in all United States Medicaid programs and one of the reasons for the enactment of the Affordable Care Act (ACA); to mitigate this issue, ACA established the Center for Medicare and Medicaid Innovation (CMMI) team who plans, reviews, and hastens the transition of fee for service payment models to value-based payment model. One of the strategic objectives of the office is to align priorities and policies across the Center for Medicare and Medicaid Services (CMS) by engaging "payers, purchasers, providers, states and beneficiaries to improve quality, achieve equitable outcome and reduce health care costs" (McDonough & Adashi, 2022). Changing how healthcare providers receive payment for services provided under the

value-based payment should improve the quality of healthcare services received by Medicaid HCBS program recipients.

***Shortage of Healthcare Providers for Medicaid HCBS Program***

Based on the narrative analysis of the interview data and response to one of the research questions, one of the issues impeding the effective reimbursement rate policy is the shortage of healthcare providers in the state. The issue has become the law of demand and supply. In the state of the client organization, demand for healthcare providers is higher than supply. As the agency worked to implement a reasonable incentive to encourage healthcare providers, the shortage of care providers derails it because they have become essentials. Shortage of care providers is a universal issue in the country because multiple surveys on the national level reveal that the country is experiencing a serious shortage of healthcare providers. As loud as this issue has been in the country, some congressmen and women have sponsored a bill to address the issue.

According to the client organization's 2023 Health Professional Shortage Area (HPSA) report, there was a 28% shortage increase in a year; for instance, the healthcare provider shortages increased from eight (8) in 2021 to twenty-one (21) in 2022 (DC Health, 2023). Because there is no decrease in the program eligibility and enrollment, it allows the healthcare providers to be more competitive, which could adversely affect the value-based payment methodology. Out of all health insurance program categories within the client organization state, the most significant shortage of healthcare providers was found in the Medicaid program.

Due to the widespread healthcare shortages across the country, some state leaders, including senators, are implementing a series of incentives to motivate healthcare providers already in the state and attract those outside the state to lessen the shortage. For instance, some senators sponsored a bill in Congress to address this issue by capping the reimbursement rates of healthcare providers to an acceptable level, especially for the Medicaid program, noting that they are skilled professionals delivering high-quality, in-home care. Still, the reimbursement rates need to catch up with the actual cost of their services. It is a fact that state residents rely on the care providers' expertise and services to improve their health and maintain a good standard of living. Senator Weinberg noted that reimbursing more money to the care providers will allow them to increase pay to the hard-working professionals caring for patients and suggested that a registered professional nurse (RN) should not receive less than \$60 per hour, and \$48 per hour for a licensed practical nurse (State News Service, 2021). The resolution of this issue continues to evolve in each state because each state is empowered to administer reimbursement rate policy that fits their state program needs.

### ***Healthcare Providers' Quest for More Money***

The universal shortage of healthcare providers increases the healthcare providers' quest to ask for more money. According to the client organization participant, no incentive is enough for the healthcare providers; "they always want more money" (DHCF, 2024). Since the value-based care strategy involves all parties: state, care providers, and program recipients, the client organization always has ongoing discussions with all parties, individually and collectively, to discuss and address health improvement,

process enhancement, and measures to ensure program spending is aligning well with the program cost and with the recipient's health outcome. However, the client organization discovered that incentives are only suitable for healthcare providers; they always ask for more money even when they fail to address any care service discrepancies.

The state criteria for setting reimbursement rates are based on providers' cost report, which follows federal guidelines, state policy, and inflation, resulting in more services provided and more money billed. The client organization participant expressed a concern that having a stricter policy on reimbursement rate might hurt the program recipients' health because a "value-based care strategy to get high-quality care services does not necessarily equate to a positive relationship between program recipients and the care providers" (DHCF, 2024). It was further explained that the Medicaid HCBS program is a long-term assistance program, coupled with the intricacy of caring services needed, it is important not to jeopardize the relationship that already exists between the recipients and the healthcare providers, any stricter policy on reimbursement rate will impact the care services rendered. However, there was a unanimous decision to compromise by ensuring that healthcare providers are meeting the basic standards of providing care; more so, there is a mutual understanding that the health outcome of the program recipients will be one of the standards policies for setting reimbursement rates in the future. (DHCF, 2024).

The study's findings reveal that much work lies ahead for the client organization to successfully implement the best alternative value-based payment methodology that would not only address access to healthcare services but also a strategy that would

measure the quality of services that can tie to the health outcome of the program recipients. Nevertheless, the study findings reveal that the pay-for-performance (P4P) methodology is the best alternative payment model that will correct the mindset of healthcare providers on more services, more money, and their quest to always negotiate for more money. P4P reimbursement methodology will ensure that the providers understand how to care for the program recipients and improve their overall health because their professional services are tied to it.

### **Implications**

The implications of this qualitative case study offer another state agency with similar functions an opportunity to use value-based alternative payment recommendations. As the Medicaid HCBS program recipients continue to grow, receiving high-quality care that will improve their health becomes more critical. Research continues to support the importance of effective performance standards that measure healthcare performance to successfully implement alternative payment reimbursement rates that would translate to high-quality care services. As a result of this study, I concluded that the pay-for-performance alternative payment model would effectively achieve better health outcomes for Medicaid HCBS program recipients.

### **Recommendations**

The research question that guided this study was from the Office of Rates and Reimbursement management perspective: how can the state implement an effective alternative payment model for Medicaid Home Community Based Service (HCBS) reimbursement rate policy to achieve value-based care services? I discovered multiple

ways the client organization could achieve this goal, but the most effective alternative value-based payment methodology was the pay-for-performance (P4P) model. The P4P model is a form of value-based purchasing that offers financial incentives to healthcare providers when they meet certain performance criteria and measures, which, in this case, is the overall health outcome of the Medicaid HCBS program recipients. The P4P value-based alternative reimbursement methodology will improve client organization Medicaid HCBS program beneficiaries' health and discourage overutilization of healthcare services that do not address healthcare needs. The P4P will promote social change by ensuring that all residents, regardless of their type of health insurance, have access to high-quality healthcare services that will improve their health.

### **Evidence of Trustworthiness**

I ensured the study was completed diligently following Walden University IRB guidelines. All efforts are made to ensure data integrity and trustworthiness, such as credibility, transferability, dependability, and confirmability.

### **Credibility**

Before the interview began, I obtained the participant's consent to be interviewed and recorded. I used the case study interview guide to safeguard data collection and analysis. The interview participant answered all research questions approved by the committee chairperson and second-member committee without reservation. At the same time, I maintained the key major points of the participant responses with no alteration.

**Transferability**

This qualitative study's transferability is limited in nature, unlike quantitative study. The data collected is not subject to any other interpretation beyond the study's scope. However, due to the universal nature of the Medicaid program, the study's findings and recommendations can be implemented in another state Medicaid HCBS program.

**Dependability**

I guided the collected data to maintain its integrity. The interview tape recorder was securely locked immediately. It was transcribed into a Word document. I then reviewed transcribed data multiple times before reaching the emerged themes. These multiple reviews ensure that the data integrity was secured throughout the analysis while there was no misrepresentation of collected data, resulting in data reliability. Dependability is a critical criterion for qualitative research and is of the utmost importance (Burkholder et al., 2016).

**Confirmability**

I had no existing bias towards the study before and after collecting the data, while transcribing the data, during multiple reviews of the transcription for themes, and after identifying the themes. I had no bias towards the study because none of the family members nor friends are Medicaid HCBS program recipients. The study was done specifically to address concerns of the client organization. I ensured proper note-taking and identification of crucial information from the participant regardless of the pre-

knowledge of the topic, which was not influenced by interview questions; the study committee chairperson and second member committee vetted all the interview questions.

### **Strengths and Limitations of the Study**

I found several strengths in the study. One of the biggest strengths of this study is the direct information from the experienced client organization participants who provided rich data based on experience, which corroborated with prior research findings on the subject. Another strength is the wealth of information that enhances a complete understanding of the research issue and an effective method to analyze and answer the research questions. This wealth of information enhances a full understanding of the research issue and an effective method to analyze and answer the research question.

Additionally, the number of emerging themes helped me inform the recommendation of a pay-for-performance alternative payment model that is crucial in achieving high-quality care. Because this is case study research, the limitation of the study is the limited number of study participants, which is only one person, and the study is limited in scope. This study was appropriate for a case study because I was able to generate rich and in-depth information from the actual policy decision-makers on the program. The participant shared a thorough understanding of the program policy that was valuable in exploring the complex phenomena of the study as to why the office was trying to implement the best alternative value-based reimbursement model. This study is a qualitative case study that only requires a small pool of participants; also, the study is limited in scope because the study is specifically for the client organization, which is a

small organization within the state. However, another state agency with a similar program can benefit from the emerging themes when applied to their program.

### **Summary**

In this section, I discussed the findings of the study by grouping them into four themes: no standard quality measurement of care services, healthcare providers' mindset on more services for more money, shortage of healthcare providers for Medicaid HCBS recipients, and healthcare providers' quest for more money. Furthermore, the findings identified the pay-for-performance value-based alternative payment method as a powerful tool for measuring healthcare providers' performance to achieve high-quality care. The study's findings also reveal that much work lies ahead for the client organization to successfully implement the best alternative value-based payment methodology that would address not only access to high-quality care services but also a strategy that would measure the quality of services that can be tied to the health outcome of the program recipients. I concluded the section with a recommendation on how the client organization can use the P4P reimbursement rate model to achieve high-quality healthcare services for Medicaid HCBS program recipients. I also presented the strengths and limitations of the study.

## Section 5: Dissemination Plan and Conclusion

### **Dissemination Plan**

This qualitative study was conducted to help the client organization implement the best value-based alternative payment methodology to improve health outcomes for the Medicaid Home Community Based Services (HCBS) program beneficiaries. Based on data analysis and findings, I recommended a P4P policy for setting the Medicaid HCBS program reimbursement rate. I have identified the client organization leaders who will accept the recommendation and are willing to implement the study's recommendation; I plan to present this study in the form of a memorandum and one-on-one oral presentation to the organization leaders. The memorandum will summarize the purpose of the study, research question, methodological approach, significant findings, and recommendations.

For effective dissemination, I will meet with the client organization leaders, present the memorandum as a walkthrough meeting, and email the memorandum to the participants after the meeting. There is a belief that one-on-one communications will allow the client organization leaders to hear directly from me and provide immediate answers to questions regarding the study on how the organization can implement value-based alternative reimbursement rate methodology for the Medicaid HCBS program.

### **Conclusions**

In this qualitative case study, I evaluated and analyzed the client organization Medicaid Home Community Based Services (HCBS) reimbursement policy for setting up an effective alternative reimbursement rate policy. The primary question of this study

was from the Office of Rates and Reimbursement management perspective: How can the state implement an effective alternative payment model policy for Medicaid HCBS reimbursement rates to achieve value-based care services?

The findings of the study showed that because there was no formal standard to measure quality of healthcare services provided to Medicaid HCBS program recipients, evidence shows that there was low quality of healthcare services and did not improve the health outcome of the program recipients, this study found that the effective alternative payment methodology that would address this issue is to implement pay-for-performance P4P payment methodology, which has been proved to be a powerful tool to measure the healthcare provider's performance, thereby improving the healthcare outcome of the Medicaid HCBS recipients. It is worth noting that future research is needed on this subject. Future researchers should focus attention on the healthcare providers' quest for more money (Theme 4) challenges that deal with the unmotivated healthcare providers to provide high-quality care "because value-based care strategy to get better care out of the providers does not necessarily equate to a positive relationship between you and the provider" (DHCF, 2024).

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## Appendix A: Data Collection Instrument

### Data Collection Instrument

Below questions serves as data collection instrument for my study. These questions have been reviewed and approved by Dr. Victoria Landu, one of the Walden University program coordinators. They were found to be appropriate and sufficient for the study. Please review and approve.

Interview Questions:

- How would you describe the quality-of-care Medicaid HCBS program beneficiaries receive compared to private insurance?
- What factor(s) would you say contributed to your organization's policy of setting a Medicaid HCBS reimbursement rate?
- In your opinion, does current eligibility and reimbursement rate works fairly, if yes, how, if not why not?
- What influences your policy when setting up Medicaid HCBS reimbursement rate?
- How do you determine reasonable compensation for Medicaid HCBS reimbursement rate?
- Explain your organization's strategies to motivate Medicaid HCBS program care providers. How do you motivate healthcare providers?

I thank you in advance for your feedback.

Dr. Singh's Approval or Comment: \_\_Approved via 3/3/2024 email\_\_\_\_\_

Dr. Escobedo's Approval or Comment: \_\_Approved via 3/15/2024 email\_\_\_\_\_