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Leading Age NY CFO Council

Managed Care Update

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Today's Agenda

- Market Update
- What's going on?
  - Federal
  - State
- Why VBP
- MLTC VBP Assessment Measures
- Implementing MLTC VBP
- Bonuses & Payments
- Managed Care Impact
- Next Steps

Market Update - MLTC

Plan	Nov. '17 Census	Share
Aetna Better Health	4,897	3%
Agewell New York	8,868	5%
AlphaCare	14,215	9%
Archcare Community Life	3,124	2%
Centers Plan For Healthy Living	24,383	15%
Elderplan	12,234	7%
ElderServe	11,390	7%
Extended MLTC	3,320	2%
Fidelis Care At Home	10,645	6%
GuildNet	9,027	5%
HealthPlus	4,760	3%
Independence Care Systems	6,602	4%
Integra	7,949	5%
MetroPlus	1,715	1%
Montefiore HMO	1,447	1%
Senior Health Partners Inc	14,419	9%
United Healthcare	2,454	1%
Village Care	9,105	5%
VNS Choice	11,511	7%
Wellcare	4,933	3%
Grand Total	**166,998**	

*Merged with Centers Plan
**Merged with Centers Plan
***Merged with AlphaCare

Integrated Plans are Growing

MAP		
Plan	**Nov. '17 Census**	**Share**
Elderplan	1310	15%
GuildNet	562	6%
HealthFirst	5138	58%
HealthPlus	2	0%
NYS Catholic Health Plan	45	1%
Senior Whole Health	104	1%
Village Care	132	1%
VNS Choice Plus	1580	18%
Grand Total	**8873**	

FIDA		
Plan	**Nov. '17 Census**	**Share**
Aetna Better Health	48	1%
Agewell New York	183	4%
Elderplan FIDA Total Care	379	8%
FIDA Care Complete	25	1%
Fidelis Care	303	7%
GuildNet Gold Plus	606	14%
HealthFirst Absolute Care	971	22%
ICS Community Care Plus	105	2%
MetroPlus	189	4%
North Shore-LIJ FIDA LiveWell	38	1%
River Spring	14	0%
SWH Whole Health	138	3%
Village Care Max Full Advantage	18	0%
VNSNY Choice FIDA Complete	1451	32%
Grand Total	**4468**	

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Federal Reforms

IMPACT Act

- *Improving Medicare Post-Acute Care Transformation Act of 2014* or IMPACT Act of 2014 (H.R. 4994) is a bill that is intended to change and improve Medicare's post-acute care (PAC) services and how they are reported
- Drivers for the IMPACT Act:
  - Absence of interoperable data standards
  - Escalating costs associated with PAC
  - $74 Billion or 14.8% of Medicare spending
- Goals of the IMPACT Act
  - Improve discharge planning;
  - Facilitate coordinated care across PAC settings, improves outcomes and overall quality comparisons;
  - ***Provides a data foundation to develop a future payment systems to PAC providers;***
  - Framework to reduce, by 2%, the update to the market basket percentage for skilled nursing facilities which do not report assessment and quality data

IMPACT Act:
Quality Reporting Program (QRP)

- The SNF QRP is a mandatory reporting program
  - Quality Measure Domains- 5
  - Resource Use Element Domains- 1
  - Additional measures being rolled out annually
- Data reporting began October 2016
- Requirements avoid 2% reduction off market basket update for calendar year CMS payment updates includes measures/data required by IMPACT

Alternative Payment Models

- CMS, through the Innovation Office, has put forth an aggressive agenda of varying models of alternative payment models for Medicare
- Three models that have direct impact on SNFs include:
  - Bundled Payments for Care Improvement (BPCI) Initiative
  - Comprehensive Care for Joint Replacements (CJR)
  - SNF Value Based Purchasing Program (SNF VBP)

Skilled Nursing Facility (Medicare) Value Based Purchasing

- SNFVBP will pay participating skilled nursing facilities for their services based on the quality of care, not simply quantity of the services provided in a given performance period to people **with Medicare**
- Starting October 2018 for FY 2019, CMS will adjust Medicare payments to providers based on how well they manage hospital readmissions based on performance in this calendar year (CY) 2017 compared to CY 2015.
- Some SNFs will see a payment reduction upwards of two percent for all of their Part A Medicare payments for an entire fiscal year.
  - SNFs can partially earn back based on SNF VBP Measure score
    - Earn back is between 50 – 70 % of total amount of reductions
    - Rank SNFs based on their performance from low to high; lowest ranked 40% will receive less than in FFS

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html

Bundled Payments for Care Improvement (BPCI) Initiative

- BPCI initiative is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care
- Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care
- This program provides financial incentive for a risk bearing entity to improve coordination of care, at a lower cost to Medicare, across health settings and providers, including hospitals, nursing facilities and home care agencies
- BPCI is set to expire Summer 2018 and be replaced with the Advanced BPCI

Source: https://innovation.cms.gov/initiatives/bundled-payments/

Comprehensive Care for Joint Replacements

- Beginning in April 2016, CMS began a mandatory bundled payment program for Medicare hip/knee replacement in 67 metropolitan areas, with 789 hospital participants that covers inpatient stay and all care for 90 days after discharge
- The acute care hospital will be held accountable for spending during the episode of care
- Hospitals can earn performance-based payments by managing costs and meeting quality metrics
  - Gain access to data and educational resources to better understand patients' PAC needs
  - Participants may apply for a waiver (beginning in 2017) of the 3-day prior hospital stay requirement; however, participating hospitals must identify nursing facilities in advance that have a high quality rating (3 or more stars)
- Expansion of CJR was postponed by former HHS Secretary Tom Price

Source: https://innovation.cms.gov/initiatives/CJR

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State Reforms

What is NYS DOH Up To?

- MRT → DSRIP → VBP
- Achieving Financial Growth Control
- Mandatory Managed Care
- SNF Transition to Managed Care

Delivery System Reform Incentive Payment

- DSRIP is the main conduit NYS is using to implement Medicaid reforms laid out by the MRT Waiver Amendment
- The purpose of DSRIP is to fundamentally restructure the Medicaid health care delivery system
  - ***Primary goal of reducing avoidable hospital use by 25% over 5 years***
- Upwards of $6.4 billion dollars have been made available as payouts to providers based upon achieving pre-determined outcomes and transformation measures
  - DSRIP funds are based on performance linked to achievement of project milestones and paid out directly to providers
- Promotes community-level collaborations and focuses on system reform

DSRIP & SNFs

- Direct impact of DSRIP initiatives have yet to be experienced by SNFs
- System-wide focus on a net 25% reduction in avoidable hospital use
- SNFs should expect to experience either one of two possible outcomes:
  - Option one- a corresponding decrease in short-term admissions, as driven by a drop off in net hospitalizations for the provider's region
  - Option two- a potential increase in referrals and direct admissions, bypassing a hospitalization, as alternative treatment sites in support of the effort to reduce avoidable hospitalizations

Value Based Payment (VBP)
Medicaid Payment Reform

- Aligns payment incentives with population health management
- Rewards value over volume
- Reinvests in the delivery system
- Improves margins for providers who deliver high-value services and
- Decreases overall Medicaid dollars spent on administrative services
- By waiver Year 5, all MCOs must employ non-fee-for-service payment systems that reward value over volume for at least 80% of their provider payments

Source: NYS DOH VBP Roadmap, June '15

Key Features of VBP

- **Level -** the degree to which the provider or group of providers party to the VBP contract is exposed to risk
- **VBP Contractor -** Provider or Group of Providers entering a VBP contract with a Managed Care Plan
- **Attribution -** VBP Contractor responsible for the cost and quality of the care for a group of assigned members
- **Target Budget or Prospective Global Payment -** method for benchmarking episodic, bundled or total cost of care for VBP Contractors in a VBP contract

Scale and Size Considerations

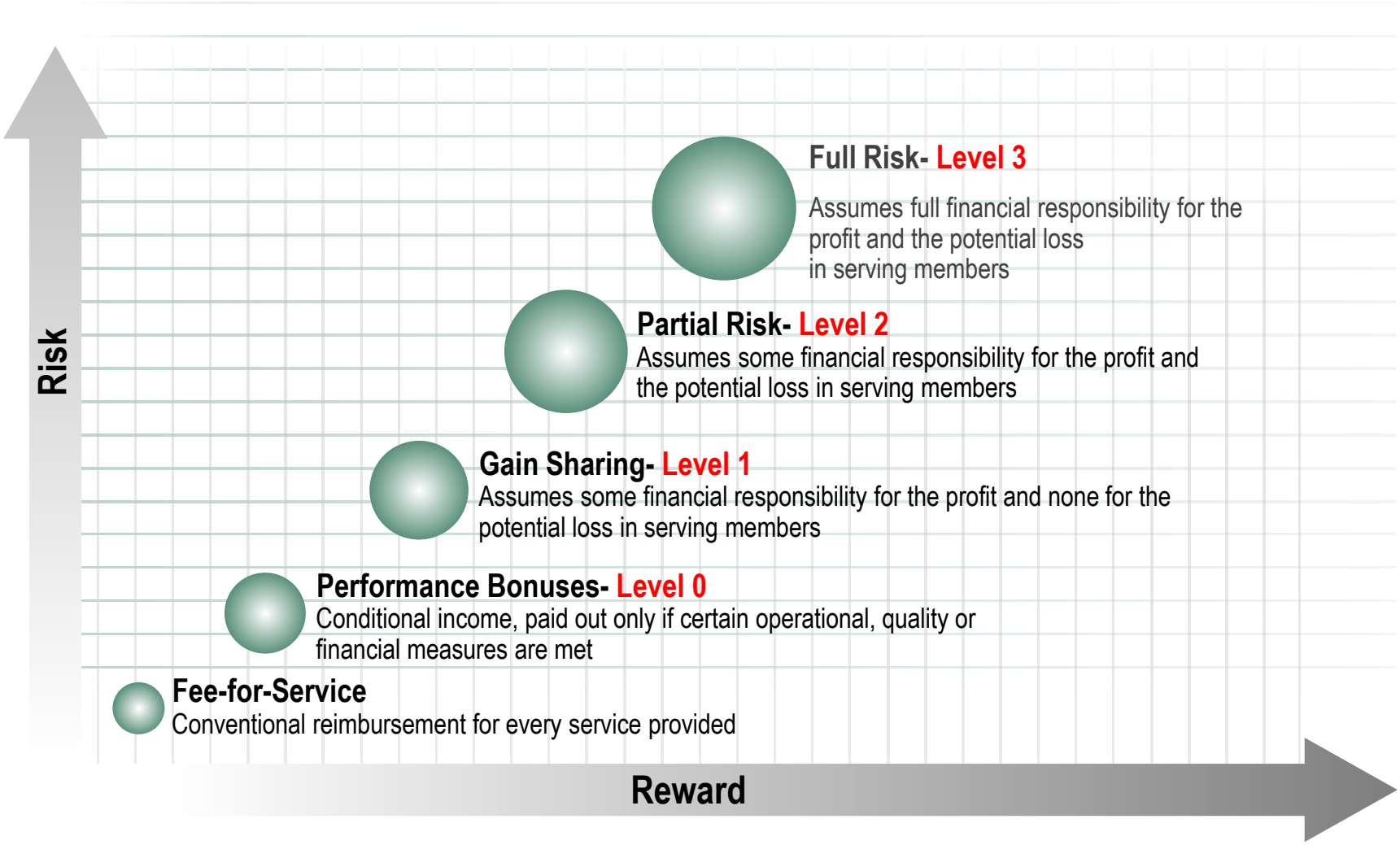
- The size of the attributed population matters
  - Larger sample sizes provider a better understanding of cost trends and population behaviors
- Small-population sizes should avoid risk-based VBP contracts

VBP Arrangements

The VBP Roadmap outlines different types of VBP arrangements to be included for Measurement Year (MY) 2017

- Total Care for the General Population (TCGP) Arrangement: Includes all costs and outcomes for care, excluding certain subpopulations (specified below).
- Total Care for Special Needs Subpopulation Arrangements: Includes costs and outcomes of total care for all members within a subpopulation exclusive of TCGP
  - Health and Recovery Plans (HARP): For those with Serious Mental Illness or Substance Use Disorders
  - HIV/AIDS
  - **Managed Long Term Care (MLTC)**
- Episodic Care Arrangements:
  - Integrated Primary Care (IPC): Includes all costs and outcomes associated with primary care, sick care, and a set of chronic conditions selected due to high volume and/or costs.
  - Maternity Care: Includes episodes associated with a pregnancy, including prenatal care, delivery and postpartum care through 60 days post-discharge for the mother, and care provided to the newborn from birth through the first month post-discharge.

Payment Model Concepts



Levels of Value-Based Payments

VBP Levels for MMC & MLTC			
Level 0 VBP	**Level 1 VBP**	**Level 2 VBP**	**Level 3 VBP**
Bonus and or withhold for quality scores	Upside-only shared savings when quality scores are sufficient	Risk sharing (upside available when quality scores are sufficient)	Prospective capitation PMPM (with quality-based component)
Payment not tied to budget	FFS Retrospective Reconciliation	FFS Retrospective Reconciliation	Prospective total budget payments
Limited	⇧Upside Only	⇧Upside & ⇩ Downside Risk	⇧Upside & ⇩ Downside Risk

- Level 0 is the equivalent of Level 1 for MLTC
- Goal of ≥80%90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of Demonstration Year 5
- 35% of total managed care payments (full capitation plans only) tied to Level 2 or higher for Level 2 (risk-bearing VBP arrangements)

Contracting Relationship Dynamics:
State — Plan — VBP Contractor Relationships

Examples of VBP Contractors

- *Independent Practice Associations (IPA)*
- *Accountable Care Organizations (ACO)*
- *Large Individual Providers*

- Quality of **all** contracted care (whether VBP or not) is rewarded through up and downward adjustments of premiums received by MCOs from the state
- MCOs and VBP Contractors select quality measures to include in their VBP Contracts.
  - These are selected from the measure sets recommended for VBP by can include other measure at the preference of the contracting parties
- Quality Performance *during contract year* determines percentages of savings/losses shared with VBP Contractors

Goals of the Quality Measure Selection

- Focused on outcomes of care, not process
  - Difference between the desired end result of high quality care and an interim step that captures activities undertaken by healthcare providers
    - Example –member maintains independent care skills versus member screened for depression
- Relate to person-centered care
  - Centered on the individual, not the systemic goals of the healthcare system
    - Example-member chooses/controls aspects of life plan versus nursing home diversion rate
- Captures key aspects of care continuum
  - Measure gaps that are identified as significant are addressed even if aspirational (for future)
    - Example –behavioral health intervention effectiveness measures
- Not too voluminous in number
  - Avoids measure "wash out" where providers are unable to focus on key desired outcomes and some measures work against others

Quality Measure Categories

Category 1

- Clinically relevant, reliable and valid and feasible; including **Pay for Performance (P4P)** and **Pay for Reporting (P4R)**
  - P4P measures are intended to be used in the determination of shared savings amounts for which VBP contractors are eligible; measures can be included in both the determination of the target budget and in the calculation of shared savings for VBP Contractors
  - P4R measures intended to be used by the MLCT plan to incentive VBP contractors to report data on the quality of care delivered to members under a VBP contract; incentive payments for reporting will be based on the timeliness, accuracy and completeness of data submitted

Quality Measure Categories

Category 2

- Measures that are clinically relevant, valid and probably reliable, but where the feasibility could be problematic; these measures require further investigation before being fully implemented

Category 3

- Measures that are insufficiently relevant, valid, reliable and/or feasible

Category 1 Measures

Measure	Measure Source	Classification
Percentage of members who did not have an emergency room visit in the last 90 days*	UAS-NY	P4P
Percentage of members who did not have falls resulting in medical intervention in the last 90 days*	UAS-NY	P4P
Percentage of members who received an influenza vaccination in the last year	UAS-NY	P4P
Percentage of members who remained stable or demonstrated improvement in pain intensity*	UAS-NY	P4P
Percentage of members who remained stable or demonstrated improvement in Nursing Facility Level of Care (NFLOC) score	UAS-NY	P4P
Percentage of members who remained stable or demonstrated improvement in urinary continence*	UAS-NY	P4P

Category 1 Measures

Measure	Measure Source	Classification
Percentage of members who remained stable or demonstrated improvement in shortness of breath*	UAS-NY	P4P
Percentage of members who did not experience uncontrolled pain*	UAS-NY	P4P
Percentage of members who were not lonely and not distressed*	UAS-NY	P4P
Potentially Avoidable Hospitalizations (PAH) for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection*	UAS-NY	P4P
Potentially Avoidable Hospitalizations (PAH) for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection‡	MDS 3.0§/New York State with linkage to SPARCS data	P4P

* Included in the NYS DOH MLTC Quality Incentive measure set
+ UAS – NY denotes the Uniform Assessment System for New York for MLTC members
‡ Included in the NYS DOH Nursing Home Quality Initiative measure set
^ SPARCS denotes the Statewide Planning and Research Cooperative System
§ MDS 3.0 denotes the Centers for Medicare and Medicaid Services Minimum Data Set for nursing home members

Category 2 Measures

Measure	Measure Source	Classification
Percent of long stay high risk residents with pressure ulcers‡	MDS 3.0/CMS	P4P
Percent of long stay residents who received the pneumococcal vaccine‡	MDS 3.0/CMS	P4P
Percent of long stay residents who received the seasonal influenza vaccine‡	MDS 3.0/CMS	P4P
Percent of long stay residents experiencing one or more falls with major injury‡	MDS 3.0/CMS	P4P
Percent of long stay residents who lose too much weight‡	MDS 3.0/CMS	P4P
Percent of long stay residents with a urinary tract infection‡	MDS 3.0/CMS	P4P
Care for Older Adults – Medication Review	NCQA	P4R
Use of High–Risk Medications in the Elderly	NCQA	P4R
Percent of long stay low risk residents who lose control of their bowel or bladder‡	MDS 3.0/CMS	P4P

Category 2 Measures

Measure	Measure Source	Classification
Percent of long stay residents whose need for help with daily activities has increased‡	MDS 3.0/CMS	P4P
Percentage of members who rated the quality of home health aide or personal care aide services within the last 6 months as good or excellent*	MLTC Survey	P4R
Percentage of members who responded that they were usually or always involved in making decisions about their plan of care*	MLTC Survey	P4R
Percentage of members who reported that within the last 6 months the home health aide or personal care aide services were always or usually on time*	MLTC Survey	P4R
Percent of long stay residents who have depressive symptoms‡	MDS 3.0	P4P
Percent of long stay residents with dementia who received an antipsychotic medication‡	MDS 3.0	P4P
Percent of long stay residents who self– report moderate to severe pain‡	MDS 3.0	P4P

‡ Included in the NYS DOH Nursing Home Quality Initiative measure set
+ MDS 3.0 denotes the Centers for Medicare and Medicaid Services Minimum Data Set for nursing home members
§ NCQA denotes the National Committee for Quality Assurance
* Included in the NYS DOH MLTC Quality Incentive measure set

MLTC and VBP

- Level 1 for MLTC will be a Pay For Performance (P4P) program
  - MLTC Level 1 is Level 0 in the VBP Roadmap
  - Plans must convert provider contracts to Level 1 by ***December 31, 2017***
  - **Plans are doing this by issuing binding non-signature required amendments-retrospective for 2017**

- A key feature of MLTC Level 1 VBP is potentially avoidable hospital use
  - Contracts should include the potentially avoidable hospitalizations measure
  - P4P VBP measures are drawn from the MLTC Quality Incentive

- MLTC Plans and Providers can engage in Level 2 or 3 VBP agreements

Implementing MLTC VBP

- Most MLTC Plan VBP contracts will focus on “PAH” or Potentially Avoidable Hospitalizations:
  - Means the measure in use as a performance measure in the MLTC incentive, as calculated by NYSDOH. PAH is in inpatient hospitalization that might have been avoided if proper outpatient care was received in a timely manner. Six conditions are covered by the PA measure: (1) anemia, (2) congestive heart failure, (3) electrolyte imbalance, (4) respiratory infection, (5) sepsis, & (6) urinary tract infection
- There are no reporting requirements for measures; NYS will calculate the measure result for MY 2017
- The State is requesting insurers to submit a Patient Attribution file, which will be used to create aggregated quality results by VBP contractor; DOH will calculate all reportable Category 1 quality measure results for the arrangements

MLTC VBP Attribution Methodology

- Attribution are the lives a VBP contractor has assigned to a specific MLTC plan
  - A provider must have **30 or more** attributed MLTC lives in single plan to participate in an individual MLTC Level 1 VBP contract
  - If a provider has **less than 30** lives per plan, providers will participate in the MLTC plan's aggregated contracted provider VBP program

MLTC VBP Payment Methodology

- MLTC Plan will compare each measure, such as PAH, as calculated by DOH, against the baseline PAH measures for contracted providers
- If provider's measurement criteria meets the measurement threshold, Plan will pay the provider a bonus as identified in your specific contract
- The baselines for the PAH measure was calculated by DOH using provider performance data from July through December 2016; baseline provider performance was provided to MLTC plans in October 2017
  - Each measurement that is compared against the baseline PAH measure becomes the baseline for the next measurement year
- **When a provider has less than 30 attributed lives, its members and PAH baseline will be pooled with all other SNFs that are contracted with the MLTC and also have less than 30 attributed lives; the plan will use the combined average PAH baseline for the assessment measure**

Bonus Payments

- 2017 Bonus Pool (for all MLTC plans) is estimated to be $10M and $50M in 2018
- Funds will likely be allocated to MLTC plans proportionally based on membership
- Bonus payments can either be specified in your VBP amendments or indicate a payment rate at a later date; e.g.
  - $100 per MLTC member per year

Develop Your Managed Care Strategy

1. What's your value proposition?
2. Review your current Managed Care contracts
3. Identify who do you want to partner with
4. How many contracts do you want to sign?
5. Are you equipped to take risk?

Contracting Strategies

- Specify payment terms
  - Identify all elements of rates that should be expressly articulated
  - Take nothing for granted
- Develop acceptable payment options
  - What, if any, alternative reimbursement models work?
- Develop payment for quality outcomes
- Research how quality measures are used today with MCOs

Managed Care Plan Relations

- Plans maintain "Provider Relations" departments
- Providers need to identify a point person to manage their Plan relationships
- Participation with a Plan's provider network is increasingly competitive

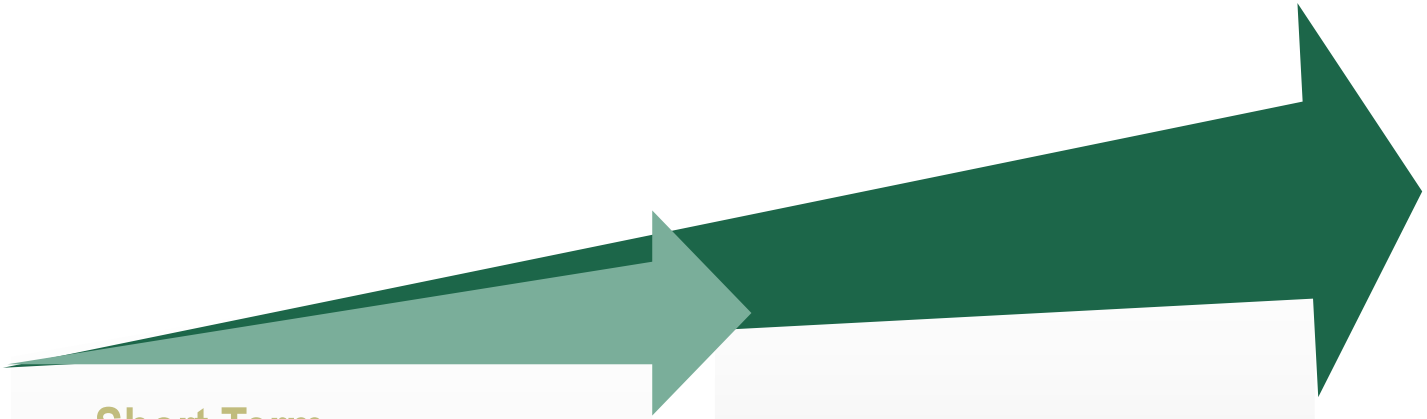
General Operating Concerns

- Federal and State payment reforms have begun
- Quality ratings at the State and Federal level have begun to impact referrals and revenue
- Data is key to performance and documentation, including alignment between Federal and State requirements
- Managed Care Organizations are increasingly cognizant of quality/performance ratings of their provider network
- Increasing pressure to decrease length of stay, while increasing the general medical acuity of patients served

Managed Care Operational Issues

- Growing Accounts Receivables
- Decreasing lengths of stay
- Downward pressure on rates and authorized levels of care
- Increasingly competitive network participation
- Rates and reimbursement nuances

Practical Implications for SNFs



Short Term

- Cash Flow
- Growing Accounts Receivables
- Growing Bad Debt
- Seek-out Operational Efficiencies

Long Term

- Efficient Operators
- Rate Uncertainty
- Capital Funding Questions
- Construction
- Margins

Key Takeaways

1. VBP obligation is on the plan to contract with you
2. Know your current clinical performance & areas of opportunity
3. Outcome & Quality driven payments

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