IPA - New Strategy for LTC Providers

"By 2020, the American health insurance industry will be extinct. Insurance companies will be replaced by accountable care organizations — groups of doctors, hospitals and other health care providers who come together to provide the full range of medical care for patients“

Ezekiel Emanuel, New York Times, Jan. 30, 2012

<u>Insurance Industry Response:</u> ***“To paraphrase Mark Twain, the death of the health insurance industry has been greatly exaggerated. Plans simply have to develop new business models. …. ”***

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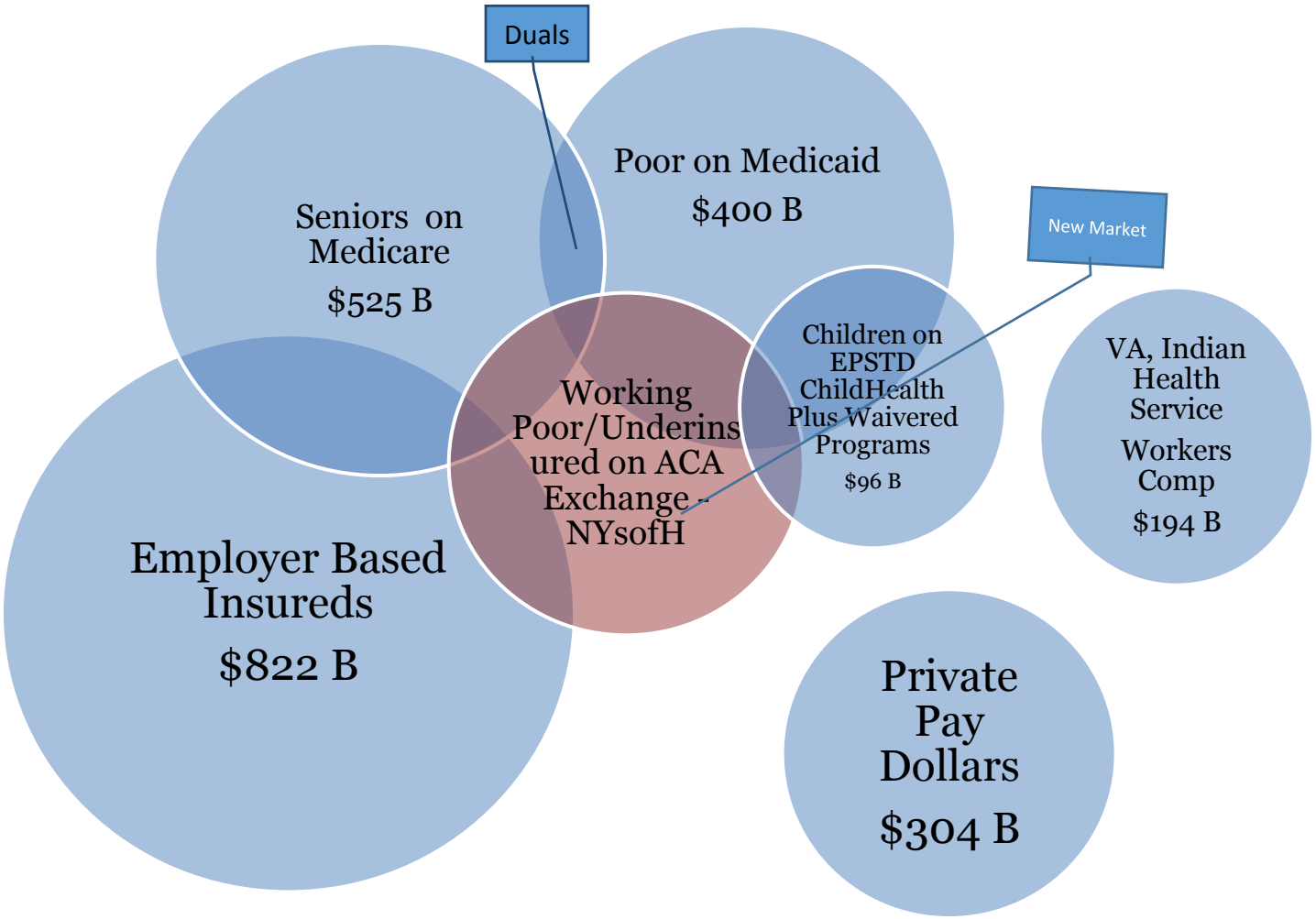
Disruption for MCOs and Providers…

"What we're talking about is the end of insurance companies in their current form," says Charles Kennedy, CEO of Aetna Accountable Care Solutions. "The suite of activities that insurers have is built for a business model that's changing.

"In the new ACO model, there will no longer be a relationship based on negotiations over rates. It will be a relationship based on data, care management, and analytics," he explains. "We will still pay claims and do sales and marketing. But the core premise of health plans, which is contracting with providers at discounted rates, is dying. When people say health insurance companies will go away, that's what they mean."

Managed Care Magazine – April, 2012

Multi-Payor Market - $2.5 Trillion (2010)



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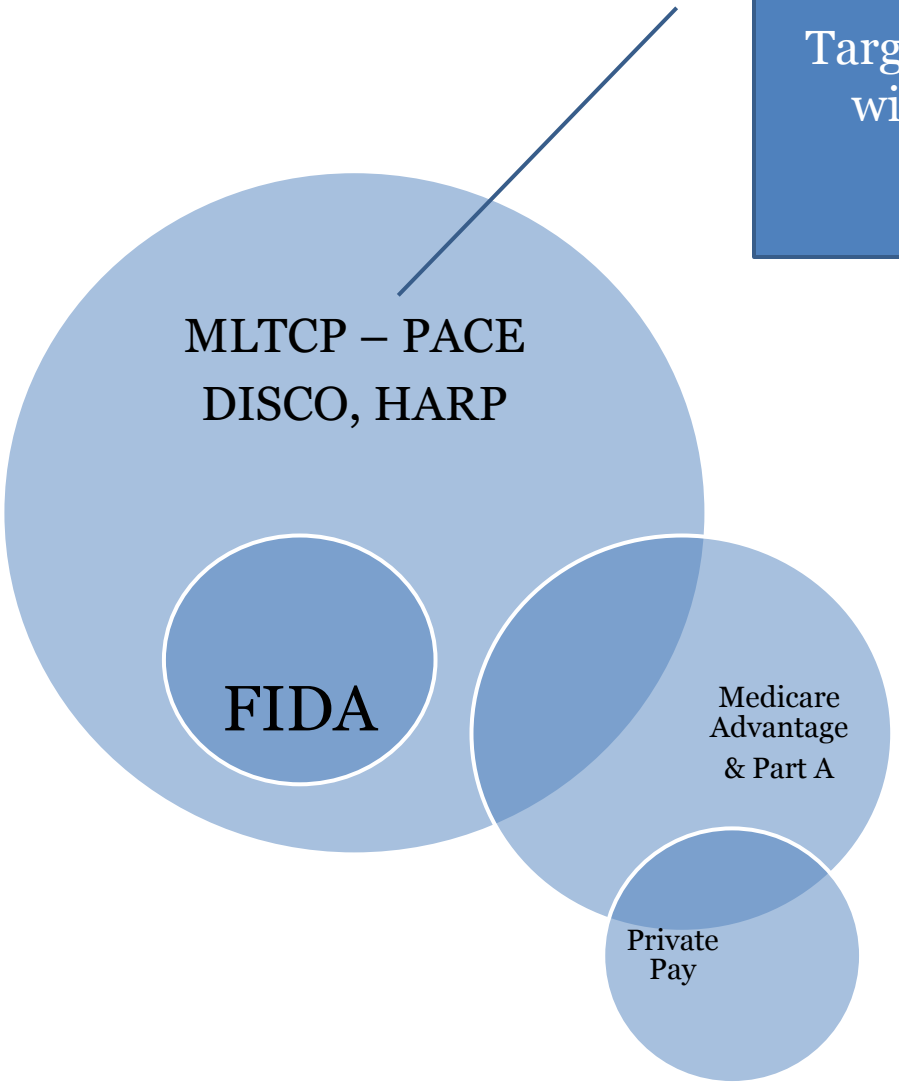
Future World of Managed Care Coverage – Tackling a segmented payor market.



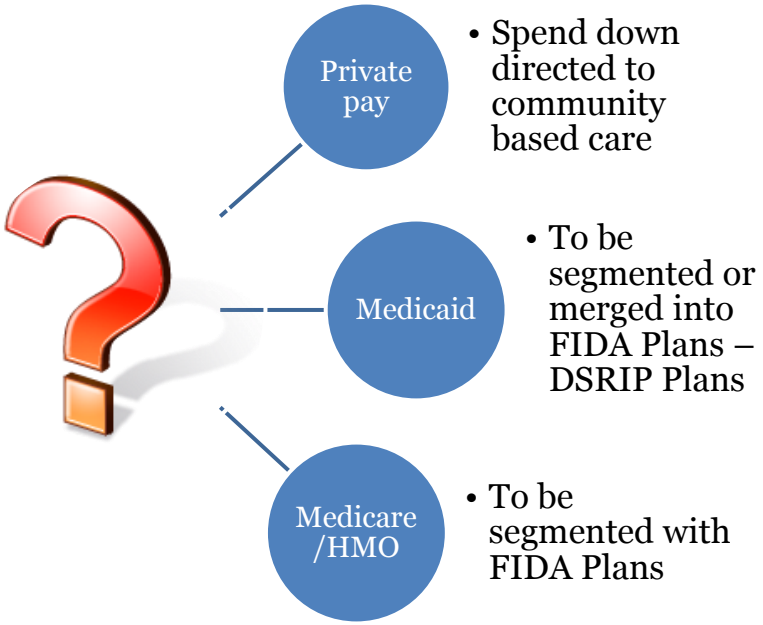
Target – DSRIP could connect the dots with a more comprehensive MCO market.

5 year journey to integrate coverage and align up hospital, physician and ancillary payor markets for the State's Medicaid population.

Medicaid Deficits Increase making Current Payment System Unsustainable

Traditional Payment Mix is now going through Price De-Regulation

		Private	Medicaid	Medicare/HMO
Revenue		16.9%	64.1%	19.0%
Days of Care		14.3%	75.1%	10.6%
Disparity		2.6%	-11.0%	8.4%



Unknown Future:

Transition to Managed Care – Utilization Controls; CFEEC – UAS-NY

DSRIP Incentive Payments

Bundled/Capitated Payments

Efficiencies/P4P

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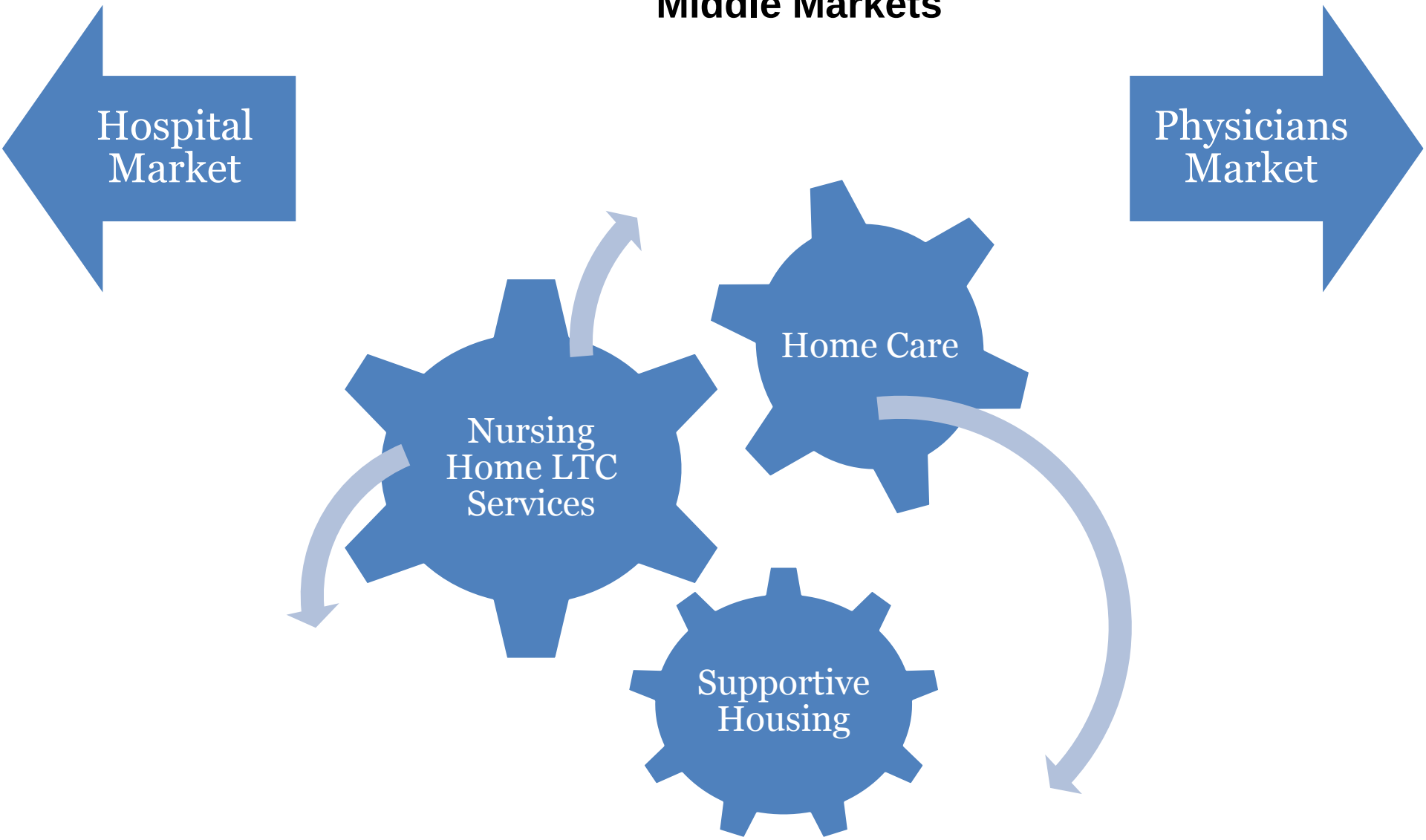
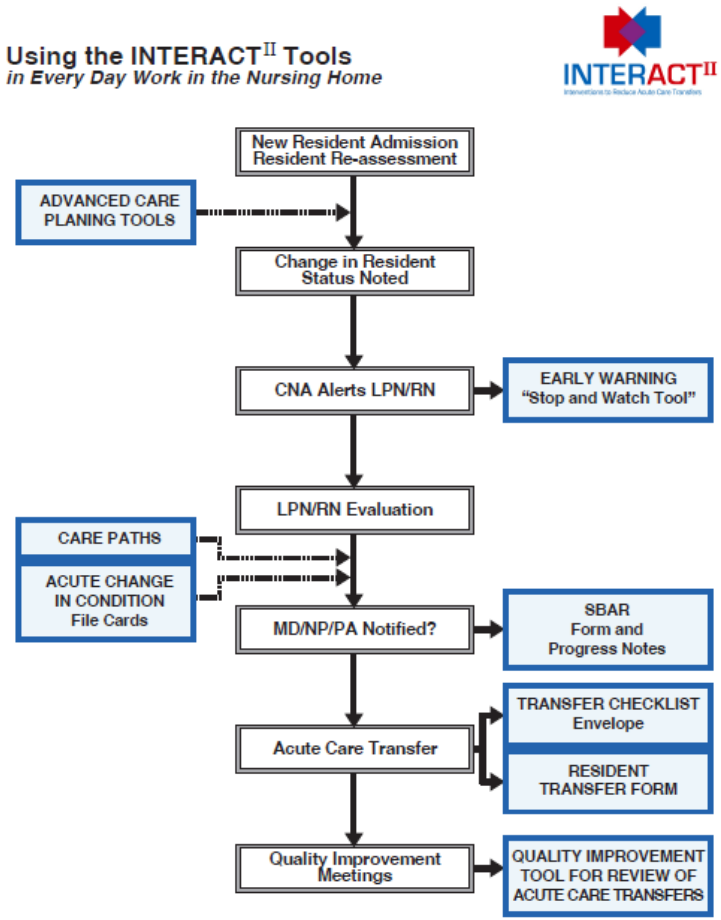
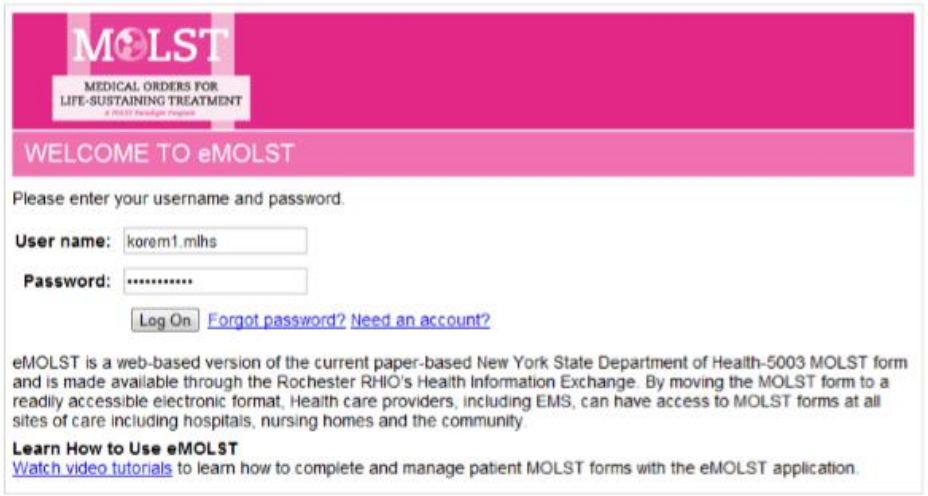
Current Care Patterns -
Assessment of Regional LTC Integration for Middle Markets



Level of Collaboration and Complexity of Care Coordination will require legal structures which provide the flexibility and fluidity of capital to survive - IPA model may provide solution.





http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center/emolst

Source – CMS & Administration on Aging:

http://www.aoa.gov/aging_statistics/docs/AoA_ACA_Slides_032712.pdf

Current Structure in Many Cases:

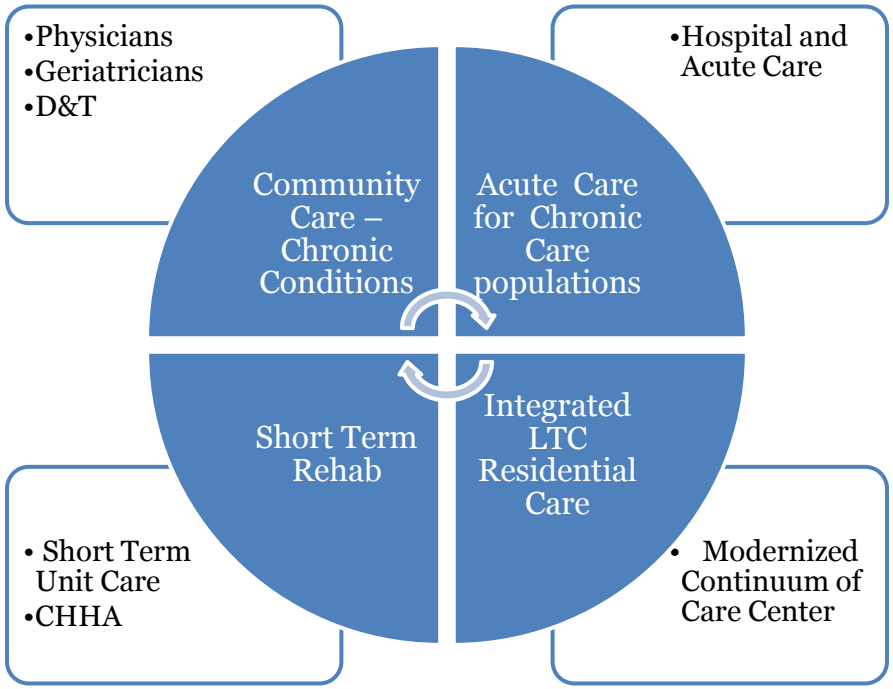
Hospital & Acute Care

- Community Discharges - Status of rehospitalization prevention efforts .
- SNF Discharges without integrated follow up.
- Readmission penalty 1-3 % for 2015.

Nursing Homes

- No formal Affiliation
- Reliance on Community Standing
- Just beginning to develop Electronic Health Records

Goals of MRT and CMS Policy: Integrated Delivery Systems



Quality	Clinical	IPA
PMPM	Capitation	IPA
RHIO	HIT	IPA

Q: What is an IPA?
A: A creature of regulations

10 NYCRR 98-1.5(b)(6)(vii) *(a)* the certificate of incorporation or articles of organization of the IPA, which shall include "Independent Practice Association" or "IPA" within the IPA name, **contains powers and purposes permitting the arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between the IPA and one or more MCOs** which have been granted a certificate of authority pursuant to the provisions of article 44 of the Public Health Law of the State of New York, as amended;

State ACOs – Proposed Regulations

Modifications to IPA Regulations

- Subdivision (w) of section 98-1.2 of Part 98 is amended to read as follows:
- (w) *Independent Practice Association* or *IPA* means a corporation, limited liability company, or professional services limited liability company, other than a corporation or limited liability company established pursuant to articles 28, 36, 40, 44 or 47 of the Public Health Law, which contracts directly with providers of medical or medically related services or another IPA in order that it may then contract with one or more MCOs and/or workers' compensation preferred provider organizations to make the services of such providers available to the enrollees of an MCO and/or to injured workers participating in a workers' compensation preferred provider arrangement. An IPA may also be considered a provider within the meaning of section 4403(1)(c) of the Public Health law, but only for the purpose of and to the extent it shares risk with an MCO and/or the IPA's contracting providers, and shall be considered a provider for the purposes of paragraphs (1) and (2) of subdivision (a) of Section 98-1.21 of this Subpart. An IPA may be certified as an Accountable Care Organization pursuant to Article 29-E of the Public Health Law and Part 1003 of this title, and upon obtaining a certificate of authority may contract with third party health care payers defined in section 1003.2(x) of this title. To the extent allowed under New York's Partnership Plan section 1115(a) Medicaid Demonstration extension, as amended April 14, 2014, an IPA may participate in a Performing Provider System ("PPS") established as part of a Delivery System Reform Incentive Payment ("DSRIP") Program project.
- New subclauses (f) and (g) are added to clause (vii) of paragraph (6) of subdivision (b) of section 98-1.5 of Part 98 to read as follows:

  (f) An IPA, in addition to the powers and purposes allowed under this Part, may seek certification as an Accountable Care Organization ("ACO") pursuant to article 29-E of the Public Health Law and Part 1003 of this Title. An IPA certified as an ACO shall comply with all the requirements of Part 1003, including but not limited to the requirements of section 1003.6(e) and (g). Upon receiving such certification, an IPA acting as an ACO may contract with the entities listed in section 1003.2(x) of this title.
  (*g*) An IPA, in addition to the powers and purposes allowed under this Part, may include any and all necessary powers and purposes as authorized, allowed, or required under an approved Delivery System Reform Incentive Payment ("DSRIP") Program project pursuant to New York's Partnership Plan section 1115(a) Medicaid Demonstration extension, as amended April 14, 2014.

Q: Are all IPAs alike?
A: No, IPAs Take Various Forms -

- ***Captive IPAs*** - Some Plans and MLTCs consider forming IPAs to delegate certain functions
  - Single Point Contracting
  - Payment Administration
  - UR, Appeals, etc.

- ***Association of Providers in same Field*** - These are separate entities formed among similarly-situated organizations – historically involved physicians.
  - Separate Board appointed by participating members
  - Requires capital from some or all participating members
  - Contract negotiations are managed directly by the IPA Board and/or individuals designated by the Board
  - Single signature can make a regional network of organizations MLTC network participants without individual negotiations

- ***Hospital/System IPAs*** – These are dominated by a hospital or system and include ancillary providers/physicians and agencies

Q: Why would nursing homes form an IPA?
A: As a means of reducing costs and retaining market share under Medicaid Price De-Regulation.

- Smaller providers, linking with larger providers, or grouping together might consider forming a regional network within a geographical market which is suitable and practical to achieve common goals – pooling of resources such as IT and evidence based practice protocols.

- The primary goals in IPA participation may be to achieve a strategic position that:
  - Makes you too big to ignore by the MLTCs and Plans
  - Makes you too big to exclude from MLTC provider networks
  - Provides members with negotiating leverage and attractive one-stop shopping for Plans
  - Meets the State and Federal Goals on Triple Aim Programs, ACO and MRT.

- Each organization may determine whether to contract individually or in collaboration with an IPA – non-exclusivity is preferred from a risk vantage point.

Q: What else can an IPA do?
A: Focus on Clinical Integration to Ensure Successful Payor Plan Payments & Contract Administration

Goals for Collaboration:

- Coordinated fee for service contracting for LTC services - MLTCP and FIDA consumers
- Development of Bundled Payment or capitated payment – management of health care risk.
- Clinical Integration and practice protocols in collaboration with IDT at MCO level and related payor network participants – Care Coordination
- Smooth enrollment and assessment
- Quality Performance Benchmarks
- Customer Satisfaction

Functions:

- Development of uniform clinical protocols designed to comply with payor and DSRIP expectations
- Receivables Management
- Network and Linkage Development.
- Accreditation
- Development of Information Network
- Common IT interfaces
- Enrollment and Eligibility Systems
- Contract Administration Services
- Grievance and Appeals Management

Q: What is the downside?

A: It depends…

- Mandatory reserve requirements in risk-sharing arrangements
- Costs to form / administer the IPA
  - Formation document requires approval of Department of Health, Department of Financial Services, and State Education Department
  - Department of Health requires specific language per regulation
- Contracting advantages are not guaranteed and even if achieved, may not offset cost of formation / administration
- Sole purpose cannot be to negotiate better rates
  - Anti-trust issues
- Requires critical mass of participants to be viable and selective criteria.
- Demands an investment of time by leadership and key management
- Must assure Antitrust Compliance at State and Federal Levels

IPA - Risk Assessment - Antitrust

Clinton Attempted Reforms 1993-1997: Antitrust Safety Zones Now Revived under the ACA

Federal Laws:

Sherman Antitrust Act – 1890 – Cartels/Price Fixing/Boycotts
Clayton Act - 1914 - Mergers in Restraint of Trade
Robinson – Patman Act – 1936 – Producer Price Manipulation

NYS – Donnelly Act - 1899

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IPA Members – Risk Awareness…

DNESDAY, NOVEMBER 24, 1976

Lefkowitz Is Investigating Whether Nursing Homes Violated Antitrust Laws

Attorney General Louis J. Lefkowitz said yesterday that his office would investigate whether nursing-home owners in New York State were conducting a boycott of the Medicaid program in violation of the state's antitrust laws.

Such a boycott had been proposed and later rescinded by the trade association of New York City nursing-home owners.

Mr. Lefkowitz said he had been in-

- "***Messenger Model***" IPAs must strictly assure that group discussions do not allow for sharing of data, sharing of pricing and generally prohibit group contracting – model is not clinically or financially integrated.
- ***Clinically Integrated Network*** IPAs fall within the Clinton Safety Zones where there is true clinical or financial integration.

Assessment of Litigation

Potential competitors: The courts have restricted claims by those left outside of a network requiring that competing providers who are not IPA Participants prove "adverse impact on price, quality, or output of medical services offered to consumers in the relevant market." (Capital Imaging v. Mohawk Valley Medical Association, 996 F.2d 537 (2nd Cir. 1993).)

Health Plans: In other more recent cases, health plans have brought suit due to a loss of network capabilities,

Work Force Members: Those in the labor work force have brought suit on the basis that combinations have the effect of lowering wage rates. Major hospitals in Capital District settled a suit brought by RNs and LPNs prior to 2013 alleging that the sharing of nurse salaries resulted in salary freeze.

Consumers: In California, a case was recently dismissed in a potential class action suit against a dominant hospital and physician system where it was alleged that the IPA's agreements with health plans significantly limited access and increased prices. (Sidibe v. Sutter Health (N.D.Cal Civ. 12-04854 (2014).) The case is being appealed but it is informative on how collaborations and systems may be targeted in litigation when they do not follow appropriate FTC guidance.

Assessment of Litigation

Spurned Members/Participants in the IPA: Participants in an IPA are subject to being disciplined and terminated from participation if they do not follow IPA rules. (Sykes v. Health Network Solutions, 13 CVS 2595 (NC Superior Court, Forsyth County 2013).) The chiropractor here brought suit after he was placed on "probation" and ultimately terminated from the IPA because he allegedly could not decrease his average cost per patient. He sought an injunction but the court denied the stay based on defenses raised by the IPA. proper structuring of the collaboration may be used to avoid law suits of this nature is a case in which the court denied a preliminary injunction sought by a chiropractor when it was shown that the IPA in question had relied upon the FTC safe zones

*** The court noted that this IPA relied upon compliance with the U.S. Dep't of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, Statement 8: Enforcement Physician Network Joint Ventures § B(1) (revised August 1996). Importantly, the court rejected any form or injunctive relief because collaborative IPA agreements which fall within the FTC guidelines would not be considered illegal *per se*. In sum, if the IPA agreements with payors are properly constructed and achieve the goals sought by the State and Federal government -- known as the triple aim of better care, better care outcomes and lower cost, the structure is viable

Assessment of Litigation

FTC or NYS Attorney General: Both the FTC and the State Attorney General may receive complaints alleging antitrust violations. Each has separate authority to review and investigate. Compliance with regard to FTC oversight will hinge on assessment of an IPA's clinical integration as per the Safety Zones noted above and as applied by the FTC in advisory opinions. In this regard, the FTC will apply a **"rule of reason".** Under this analysis, where an IPO **exceeds 30% provider market share** the FTC and DOJ will apply heightened antitrust scrutiny.

The last advisory opinion issued by the FTC applied clinical integration standards in approving a proposed physician-hospital organization as sufficiently clinically integrated based on its commitment to further the goals of the Affordable Care Act through accountable care. (Norman PHO Advisory Opinion, Op. FTC 19 (Feb. 13, 2013).)

https://www.ftc.gov/news-events/press-releases/2013/02/ftc-staff-advises-oklahoma-physician-hospital-organization-it

FTC Antitrust Safe Zone
Clinically Integrated Networks

a. Indicia of Clinical Integration

- Commentators and industry experts describe various techniques and programs for achieving clinical integration. Commentators primarily focus on four indicia of clinical integration: **(1) the use of common information technology to ensure exchange of all relevant patient data; (2) the development and adoption of clinical protocols; (3) care review based on the implementation of protocols; and (4) mechanisms to ensure adherence to protocols.**

b. Are Joint Negotiations on Price Reasonably Necessary to Achieve Clinical Integration?

- clinically integrated IPAs "can offer payers a single, comprehensive, and integrated network" and should therefore "be priced in the aggregate, not through individual contracts with physicians."
- Commentators similarly asserted that joint pricing is necessary to ensure the active and ongoing participation of an entire group's members. These commentators also contend that joint negotiations are necessary to help physician members recover the substantial time and financial commitments that are necessary to implement a clinical integration program. Finally, they argue that joint negotiations are necessary to prevent physician members from free-riding on the contributions of their colleagues.
- **The extent to which joint contracting is reasonably necessary to achieve efficient clinical integration will vary, depending on the facts and circumstances**

From: "Improving Health Care: A Dose of Competition"

http://www.justice.gov/atr/public/health_care/204694/chapter2.htm#4b3

NYS - "COPA" Procedures:

NEW YORK STATE

Services News Government

Department of Health
Information for a Healthy New York

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You are Here: Home Page > Redesigning New York's Medicaid Program > Certificate of Public Advantage (COPA)

Certificate of Public Advantage (COPA)

Public Health Law (PHL) Article 29-F sets forth the State's policy of encouraging appropriate collaborative arrangements among health care providers who might otherwise be competitors. The statute requires the New York State Department of Health (Department) to establish a regulatory structure allowing it to engage in appropriate state supervision as necessary to promote state action immunity under state and federal antitrust laws. The regulations establish a process for providers to apply for a Certificate of Public Advantage (COPA) for their collaborative arrangements such as mergers and clinical integration agreements. The Department will consult with the Office of the Attorney General and, if appropriate, the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services and/or the Office for People With Developmental Disabilities, and will consult with and receive a recommendation from the Public Health and Health Planning Council before granting a COPA.

COPA Regulations

Pursuant to Article 29-F, the Department has issued regulations establishing a process for the issuance of a Certificate of Public Advantage. The regulations, effective December 17, 2014, can be found here:

- COPA Regulations (PDF)

It should be noted that although such regulations were initially proposed as a new Subpart 83-1 of Title

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- Employment Opportunities
- Forms
- Community, Family & Minority Health
- Health Care Professionals & Patient Safety
- Hospitals, Nursing Homes & Other Health Care Facilities
- Diseases & Conditions
- Health & Safety in the Home, Workplace & Outdoors

FTC Warns DOH on DSRIP-COPA

"COPAs are likely to lead to increased health care costs and decreased access to health care services for New York consumers."

UNITED STATES OF AMERICA
Federal Trade Commission
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics

April 22, 2015

Center for Health Care Policy and Resource Development
Office of Primary Care and Health Systems Management
New York State Department of Health
Corning Tower - Room 1815
Empire State Plaza
Albany, New York 12237

Re: Certificate of Public Advantage Applications Filed Pursuant to New York Public Health Law, 10 NYCRR, Subpart 83-1

Dear Sir or Madam:

The staffs of the Federal Trade Commission's ("FTC" or "Commission") Office of Policy Planning, Bureau of Competition, and Bureau of Economics[1] respectfully submit this public comment regarding the potential competitive impact of the Certificate of Public Advantage ("COPA") applications submitted by three newly formed performing provider systems ("PPSs") under the Delivery System Reform Incentive Program ("DSRIP") – Adirondack Health Institute Performing Provider System,[2]

- “FTC staff is concerned that combining the DSRIP program with the COPA regulations will encourage health care providers to share competitively sensitive information and engage in joint negotiations with payers in ways that will not yield efficiencies or benefit consumers.”

- “Typically, antitrust exemptions create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers”

Best Practice – “Must Haves”

True Clinical Integration.

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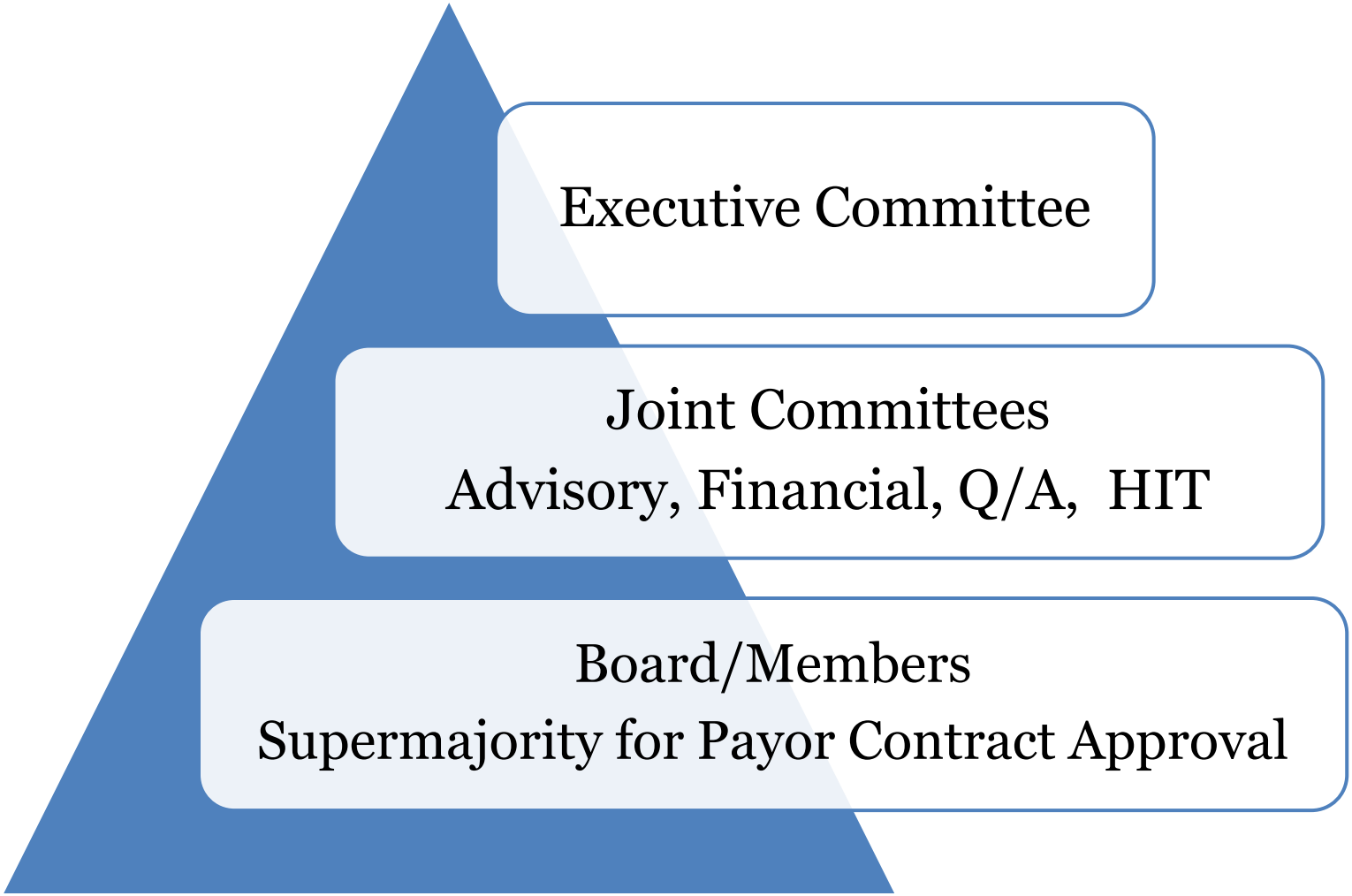
IPAs or ACOs in LTC Clinically Integrated Network – The "Must Haves" (For Success/Compliance)

1. Must Explore benefits of Clinical Integration; cost efficiencies and uniform FIDA/MLTCP/DSRIP contracting. Must assure clinical integration aligns up with public policy benefits to community/consumers.
2. Must have a Joint Committee Structure. (See below.)
3. Must have some leadership integration composed of leadership from within each organization - CEO/CFO/COO and Board membership
4. Governance in "independent" entity may be structured with participant organizations either using a non-profit corporate model or a Limited Liability Company model.
5. Ultimate IPA could be used to negotiate contracts with payors; conduct U/R; receive and disburse claims payments; arrange for bundled payment models; develop HIT systems, etc.
6. Non-exclusivity – Members may enter into separate payor agreements and use alternate means of MCO contracting.
7. Antitrust Compliance Training must be provided to members and staff.

Must Have: Governance, Operations & Contracting



Must Have - Assessment of Market Area – LTC Market Share is Untested and Undefined

- Associations commented to the FTC in 2011 regarding ACO guidelines under Safety Zones: "the Proposed Statement provides examples for how an ACO's PSA shares would be calculated for physician groups, hospitals, and ambulatory surgery centers, but does not provide an example for how an ACO's PSA shares would be calculated for a SNF or other post-acute care facility.

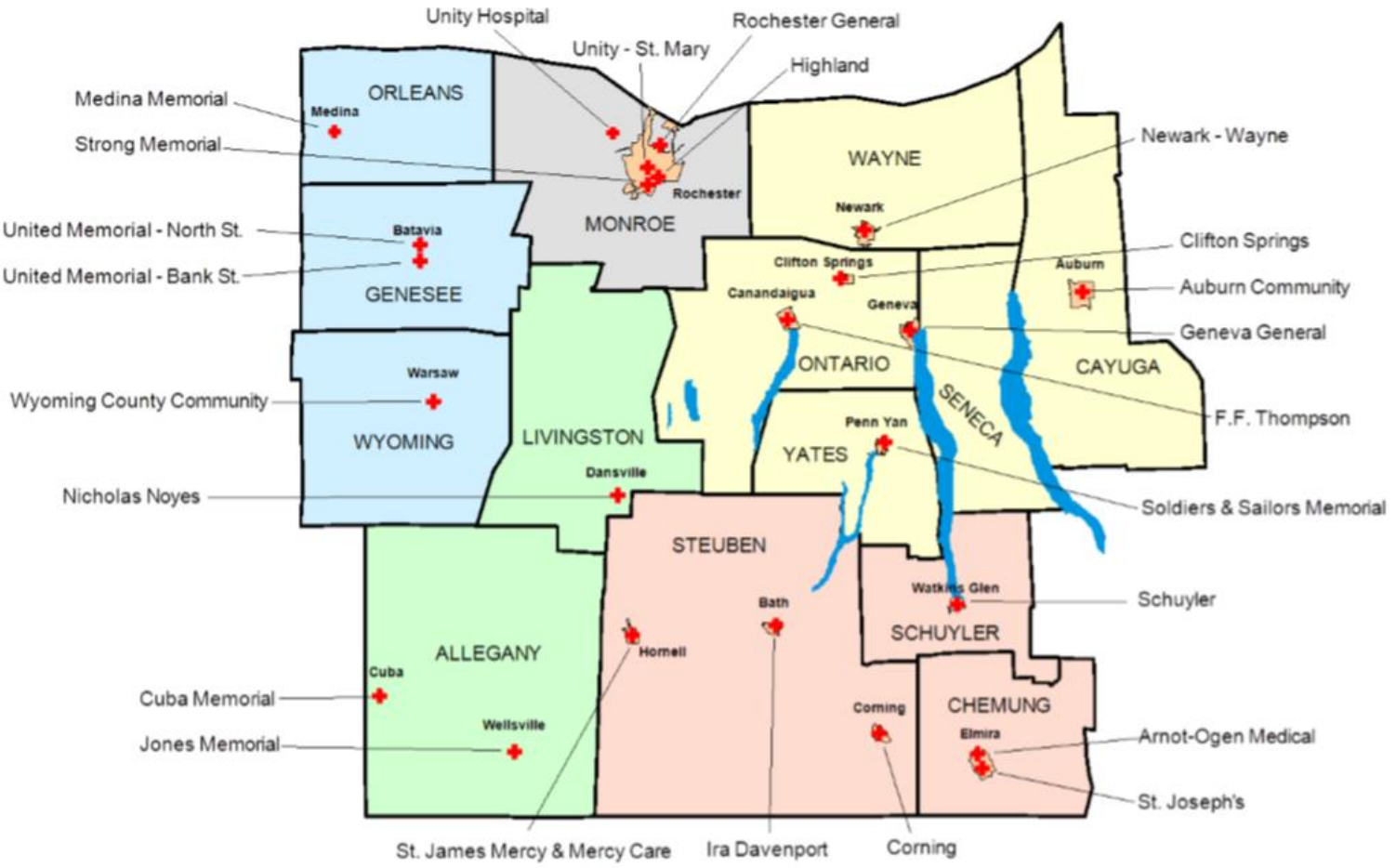
- Because it is expected that many ACOs will involve SNFs and other post-acute care facilities in some capacity, whether as an ACO participant, ACO provider, an advisory board member, or community stakeholder, additional antitrust guidance would provide much needed direction to ACOs.

- FTC uses concept of "Primary Service Area" PSA to assess market manipulation or dominance and "common services". Unclear whether this would be defined by resident capacity, rehabilitation services or other factors in LTC residential field. Guidance:

- https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care/accountable-care-organizations/primary-service-area-questions-and-answers

Primary Service Areas – Market Analysis

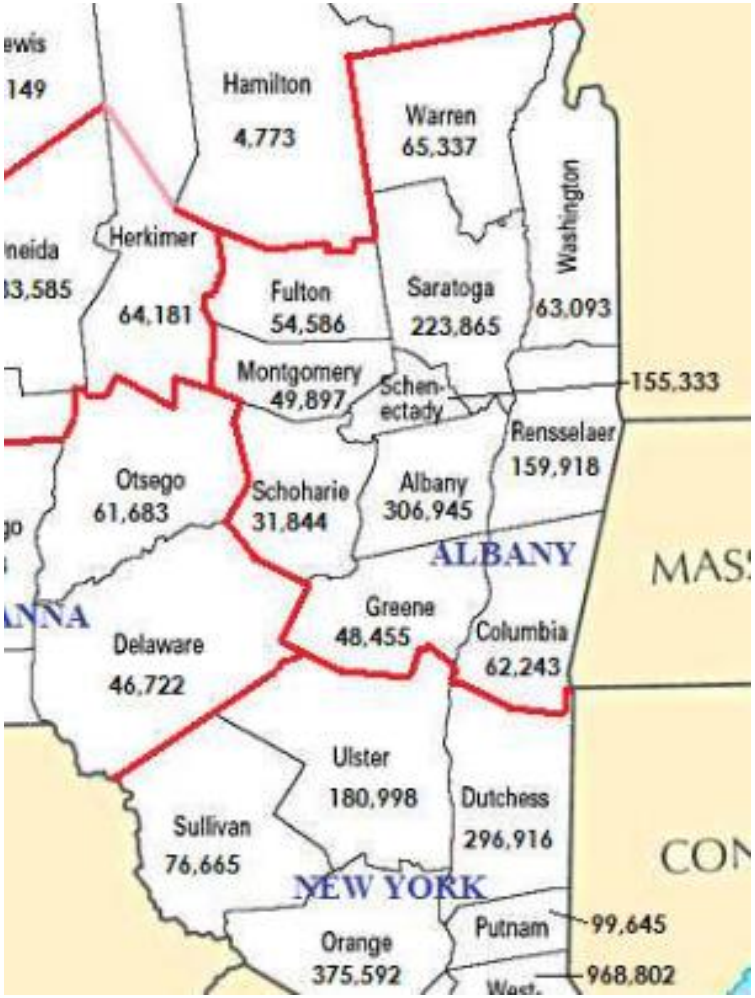
http://www.flhsa.org/community-needs-assessment-for-finger-lakes-performing-provider-system-dsrip-application



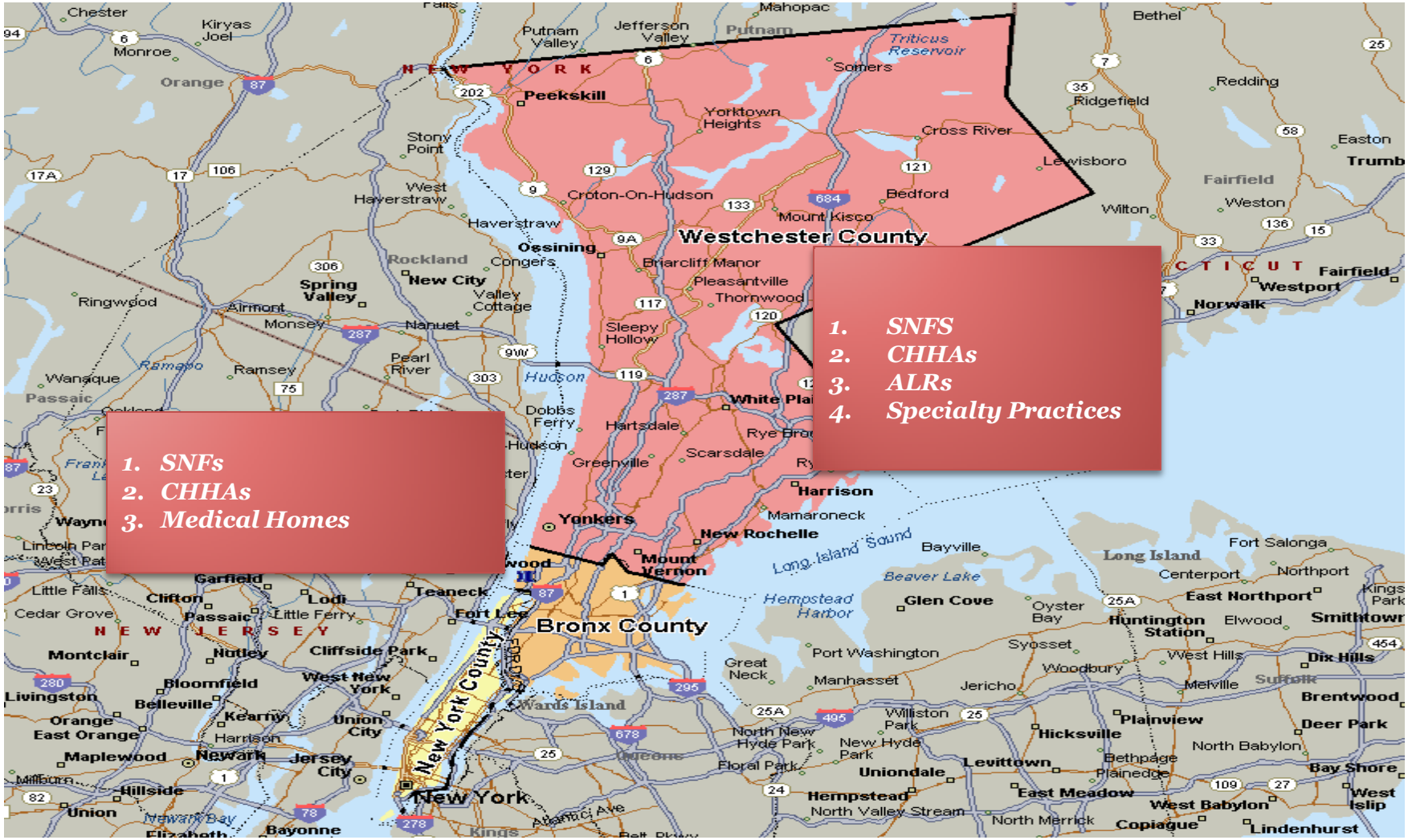
Map 2 – FLPPS Acute Care Facilities

Sample Market Area:

	Total Beds	Total DSRIP Attribution	Beds	DSRIP Attribution	Facility	
Washington	528	853	200	270		
Saratoga	905	760	300	450		
Renslr	1243	1612	350	480		
Albany	1829	2943	80	130		
			200	250		
			300	390		
Schenectady	976	1035	250	350		
Dutchess	1926	2711	100	150		
Totals	7407	9914	1889	2426	26%	24%



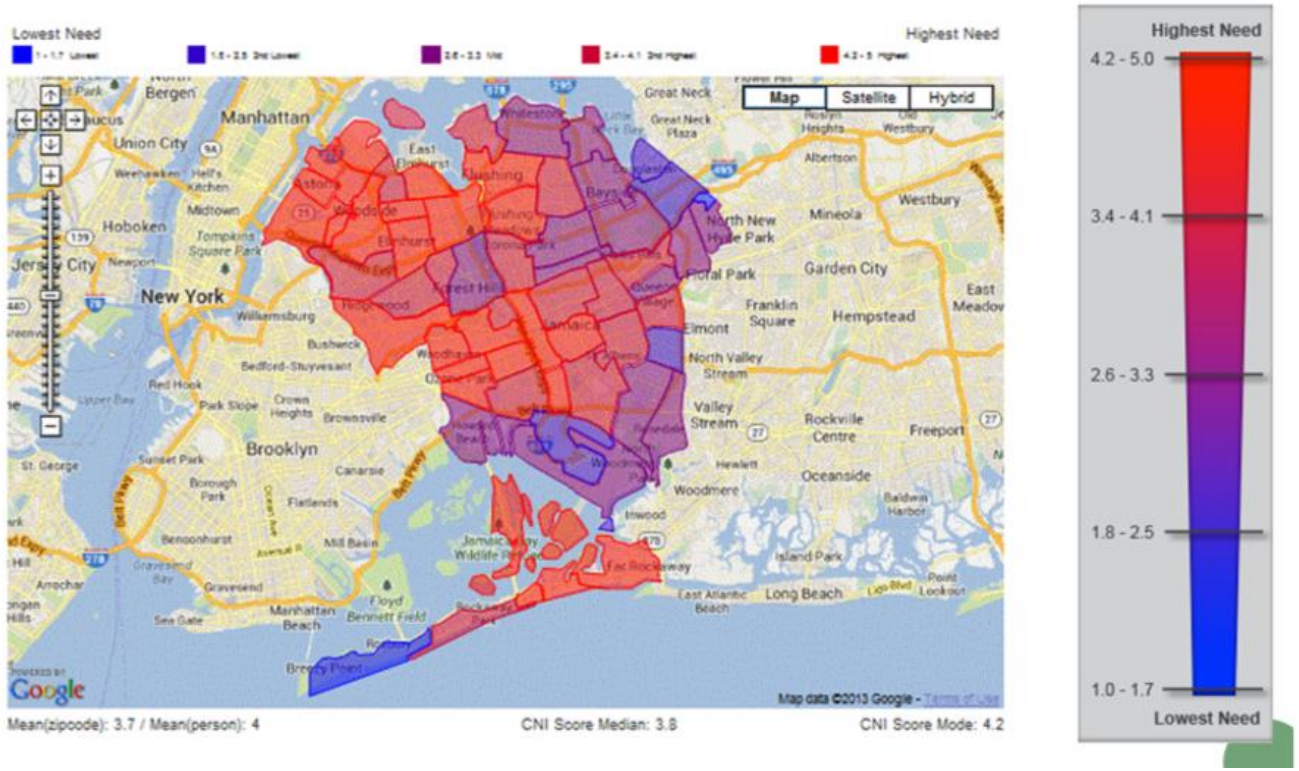
Sample Market Area:



Aligning up with Hospital Markets:

The New York Hospital Medical Center of Queens Community Health Needs Assessment And Implementation Strategy/Community Service Plan 2013-2017

Community Need Index[14]
Queens County
2013



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Aligning up with Hospital and PPS Service Agenda

live birth. Variance from New York City and New York State was less than 1% for adult smoking and pre-term births.

New York Hospital Queens Selected Prevention Agenda Priorities[16]
Queens County Performance by Indicator
2012

			Comparison		% Variance	
NYS Prevention Agenda Priority	**Prevention Priority Indicator**	**Queens**	**NYC**	**NYS**	**NYC**	**NYS**
Prevent Chronic Disease	Obese Adults	20.6	21.3	23.2		
	Obese Children	21.1	21.7	17.6		-19.9%
	Adult Smokers	14.6	14.5	16.8	-0.7%	
	Colorectal Screening	NA	68.3	66.3		
	Asthma ED Visits	76.4	127.0	83.7		
	Asthma ED Visits - Age 0-4	262.2	334.6	221.4		-18.4%
	Heart Attack Hospitalizations	14.4	14.7	15.5		
	Diabetes Hospitalizations 6-17	2.5	3.6	3.2		
	Diabetes Hospitalizations 18+	4.5	6.7	5.6		
Promote Healthy Women, Infants, and Children	Preterm Birth	12.1	12.7	12.0		-0.8%
	In-Hospital Breastfeeding	27.5	32.4	42.5	17.8%	54.5%
	Maternal Mortality	32.5	29.2	23.3	-10.2%	-28.3%
	Well-Child Visits (Govt Insured Pts)	73.2	70.8	69.9		
	Third Grade Children Tooth Decay	NA	NA	24.0		
	Adolescent Pregnancy	35.4	47.5	31.1		-12.1%
	Unintended Pregnancy Live Births	26.4	24.6	26.7	-6.8%	
	Live Birth <24 mos of previous birth	13.6	14.8	18.0		

The eight remaining indicators in which Queens County performed below New York City and/or New York State included:

- Obese Children
- Adult Smokers
- Asthma ED visits – Age 0-4
- Pre-term Births
- In-hospital exclusive breastfeeding

Risks of Status Quo

"A ship is always safe at shore, but that is NOT what it was built for" -- Albert Einstein

Risks of Not Making a Decision & The Risk of Not Assessing Strategic Options

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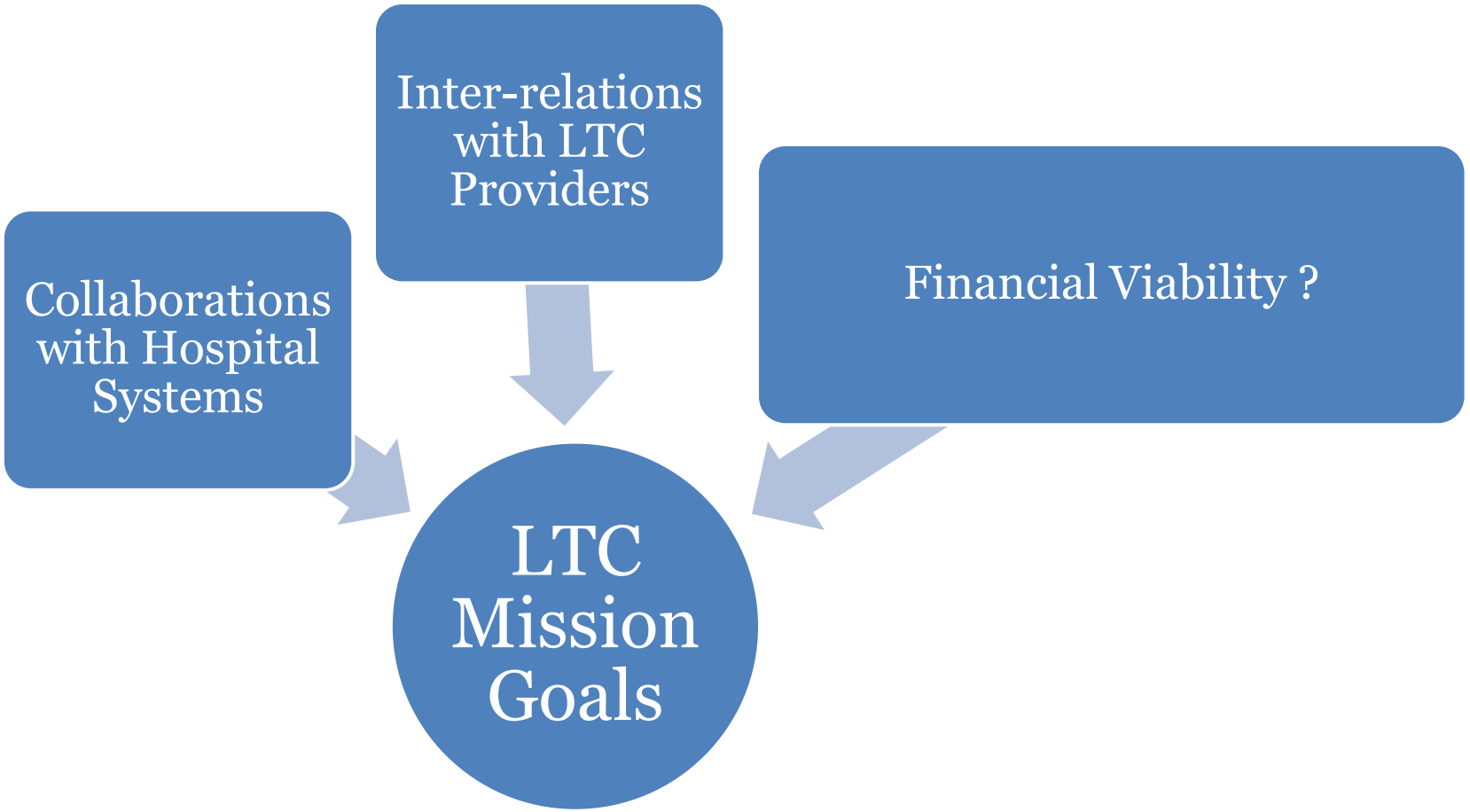
Avoiding Risk of Status Quo

https://www.jewishvirtuallibrary.org/jsource/ww2/navypearl.html

"When the Japanese attacked Pearl Harbor, two surface ship task forces of the Pacific Fleet were carrying out assigned missions at sea, and two such task forces were at their main base following extensive operations at sea. Discounting small craft, eighty-six ships of the Pacific Fleet were moored at Pearl Harbor. Included in this force were eight battleships, seven cruisers, twenty-eight destroyers and five submarines. No United States aircraft carriers were present."

Options - Strategic Assessment



Evaluation – Meeting Community Goals and Mission? Sustainability?

Gap Analysis Collaborations

- Collaborations which drive revenues
- Collaborations which centralize resources
- Shared Services
- Cost assessment
- Margins

Clinical Affiliations

- Provides integration
- Provides access to Health Information Systems
- Provides forum for strategic planning
- Provides Community Planning and Q/A

Alliances

- Affiliations
- Integrated Delivery Systems
- ACOs, IPAs

Facilities will be Forced into Price De-Regulation

Referral Patterns will be (are being) Disrupted

IPA and Centralized Resources May Provide Strength Needed to Navigate and Steer through program after program implemented by State and Federal Agencies.

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Future of LTC in NYS

- The future of LTC will require integrated delivery systems which consist of collaborations between primary community care, chronic care physicians, acute care interventions and needed residential health care.
- Payment for LTC will reward those integrated systems which manage the care needs of the populations they serve with efficiency, economies of scale and high quality of care.
- The legal structure and contractual relationships needed in the redesigned world of LTC will be a critical element for successful outcomes.

DSRIP/MCO Strategies

- **Network and Linkage Development.**
  - Hospital Affiliations
  - RHIO/EMR Interfaces
  - Network Credentialing
- **Coordination of admissions and discharge policies and legal documentation.**
  - Admission Agreement – MCO/HMO Addenda – Short Term Agreements
  - Discharge Planning – Custodial Care (LTC conversion)
- **Payment – Receivables Management Integration**
  - Notices required by MLTCP/FIDA/DSRIP Consents
  - Guardianship, POA FHCDA.
  - Q/A P4P DSRIP Measures.

Example: FIDA Demonstration MOU: A natural fit for Clinically Integrated IPAs:

- Key objectives of the initiative are to improve the Participant experience in accessing care, deliver person-centered care, promote independence in the community, improve quality, eliminate cost shifting between Medicare and Medicaid, and ***achieve cost savings for the State and Federal government through improvements in care and coordination. CMS and the State expect this model of integrated care and financing to, among other things, improve quality of care and reduce health disparities, meet both health and functional needs, and improve transitions among care settings.*** Meeting Participant needs, including the ability to self-direct care, be involved in one's care, and live independently in the community, are central goals of this initiative.***.
- The initiative ***will test the effect of an integrated care and payment model on serving both community and institutional populations. In order to accomplish these objectives, comprehensive contract requirements will specify access, quality, network, financial solvency, and oversight standards. Contract management will focus on performance measurement and continuous quality improvement. ***** This will be further specified in a Three-way Contract to be executed among the FIDA Plans, the State, and CMS.

Example: DSRIP Standards for SNFs:

Project Domain	**System Transformation Projects (Domain 2)** **B.** *Implementation of Care Coordination and Transitional Care Programs*
Project ID	2.b.v
Project Title	Care transitions intervention for skilled nursing facility (SNF) residents

Objective

Utilizing a similar model as 2.b.iv, this will provide a supported transition period after a hospitalization to ensure discharge directions are understood and implemented for skilled nursing home patients at high risk of readmission, particularly those with cardiac, renal, diabetes, respiratory and/or psychiatric disorders.

Rationale and Relationship to Other Projects

Nursing home patients with recent hospital discharges are at risk of early re-hospitalizations even though they are in a controlled medical environment. This is often due to inadequate care coordination between the SNF staff and the hospital staff. For example, discharge summaries may not be complete nor include minor facts that can become significant in the SNF environment. Additionally, information about treated precursors to pressure ulcers or increased risk for healthcare associated infections may not be fully transferred, preventing what should be continuous surveillance measures.
Additional resources for these projects can be found at www.caretransitions.org and http://innovation.cms.gov/initiatives/CCTP/.

Project Index Score

41

Core Components

Systems undertaking this project will be required to complete the following components to meet the two main objectives of this project, 1) SNF staff access to hospital patient record and hospital staff prior to patient discharge and 2) timely care record transition to SNF and receiving practitioner:

- The community assessment will be utilized to identify the key causes of SNF readmissions at the partner hospitals, including diagnoses, identifiable social concerns, and medical issues such as lack of engagement with a primary care physician, medication access and medication reconciliation.
- These hospitals will partner with associated SNFs to develop a standardized protocol to assist with resolution of the identified issues. This may include development of a standard medical record transfer form to follow the patient during any care site transfer.
- The PPS will engage with the Medicaid Managed Care and Managed Long Term Care or FIDA Plans associated with their identified population to develop transition of care protocols that will ensure coordination of care will be supported, covered services including DME will be readily available and that there is a payment strategy for the transition of care services.
- Transition of care protocols will include as early as possible notification of planned discharges and the ability of the SNF staff to visit the patient and staff in the hospital to develop the transition of care services. SNF staff will be allowed access to review the hospital medical record. Additionally, SNF staff will be able to discuss patient care issues with the staff caring for the patient prior to discharge and additional access to staff post-discharge/re-admission to the SNF.
- Protocols will include standardized care record transitions to the SNF staff and medical personnel.
- Hospitals and SNFs will be expected to have shared EHR system capability and RHIO HIE access for

- Economies of scale will be essential to proper implementation of DSRIP, MLTCP and FIDA Contract Requirements.
- Micro-Systems such as IPA or ACO models which seek to establish uniformity of compliance will reduce costs and enhance quality.

DSRIP Project - 2.a.i "Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management"

Project Objective: Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management.

Project Description: This project will require an organizational structure with committed leadership, clear governance and communication channels, **a clinically integrated provider network,** and **financial levers to incentivize and sustain interventions to holistically address the health of the attributed population and reduce avoidable hospital activity.** For this project, avoidable hospital activity is defined as potentially preventable admissions and readmissions (PPAs and PPRs) that can be addressed with the right community-based services and interventions. **This project will incorporate medical, behavioral health, post-acute, long term care, social service organizations and payers to transform the current service delivery system – from one that is institutionally-based to one that is community-based.** This project will create an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of services. If successful, this **project will eliminate fragmentation and evolve provider compensation and performance management systems to reward providers demonstrating improved patient outcomes.**

DSRIP Project - 2.b.iv "Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions"

"Project Objective: To provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission, particularly patients with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.

Project Description: A significant cause of avoidable readmissions is non-compliance with discharge regiments. Non-compliance is a result of many factors including health literacy, language issues, and lack of engagement with the community health care system. Many of these can be addressed by a transition case manager or other qualified team member working one-on-one with the patient to identify the relevant factors and find solutions. The following components to meet the three main objectives of this project, 1) pre-discharge patient education, 2) care record transition to receiving practitioner, and 3) community-based support for the patient for a 30-day transition period post-hospitalization.

Additional resources for these projects can be found at www.caretransitions.org and http://innovation.cms.gov/initiatives/CCTP/"

Example: Resources for LTC Delivery

Development of Potentially Avoidable Readmission and Functional Outcome SNF Quality Measures

3/14/2014 ▪ Document Type: Contractor Reports ▪

by the SNF population. MedPAC began reporting potentially avoidable rehospitalization rates in 2004. Since

Chapter 7: Post-acute care providers: Steps toward broad payment reforms (March 2014 report)

3/14/2014 ▪ Document Type: Report Chapter ▪ Download Full Report

be evaluated. For example, risk-adjusted rates of rehospitalization are a good gauge of the care furnished, , two risk-adjusted outcomes (rehospitalization rates and changes in mobility) did not differ significantly across SNFs, IRFs, and HHAs. LTCHs had lower rehospitalization rates, reflecting

Chapter 8: Skilled nursing facility services (March 2014 report)

3/14/2014 ▪ Document Type: Report Chapter ▪ Download Full Report

relatively stable between 2011 and 2012. Rehospitalization and community discharge rates show small, of rehospitalization for SNF patients with any of five potentially avoidable conditions and the rate, the rehospitalization measure to better reflect potentially avoidable readmissions. In the past, the measure, avoidable rehospitalization rates (while the beneficiary was still a SNF patient) declined between 2011, of community discharge and potentially avoidable rehospitalization Measure 2011 2012 Discharged

Chapter 9: Home health care services (March 2014 report)

3/14/2014 ▪ Document Type: Report Chapter ▪ Download Full Report

22% Note: MSS (medical social services). Sample includes freestanding agencies with complete data for three consecutive years (2008–2010). A home health agency is classifed as relatively effcient if it is in the lowest third in cost per episode or rehospitalization and is not in the highest third of either measure for three consecutive years. Quality is measured using a risk-adjusted measure of hospitalization, and cost is measured using risk-adjusted cost per episode. Sample includes freesta

MEDPAC Medicare Payment Advisory Commission

MEDPAC Findings - 2014

TABLE 8: Average Facility Outcome Measure Rates During SNF Stay and 30 Days Post SNF Discharge

Outcome Measure	Rate	
During SNF Stay[1]	FY 2011	FY 2012
Community Discharge		
Observed	33.4%	34.9%
Risk Adjusted	28.8%	30.6%
Potentially Avoidable Readmission		
Observed	12.5%	11.7%
Risk Adjusted	12.5%	11.7%
30-Day Post SNF Discharge Potentially Avoidable Readmission[2]		
Observed	6.0%	5.9%
Risk Adjusted	5.9%	5.8%
Combined During and 30-Day Post SNF Discharge Potentially Avoidable Readmission[1]		
Observed	17.0%	16.2%
Risk Adjusted	15.6%	14.9%

[1] Includes SNFs with 25 or more SNF stays excluding deaths during the SNF stay (Fiscal Year 2011 N=12,944, Fiscal Year 2012 N=12,911).
[2] Includes SNFs with 20 or more SNF stays excluding deaths during the SNF stay, 30 days post SNF discharge stay, and readmissions during the SNF stay (Fiscal Year 2011 N=12,549, Fiscal Year 2012 N=12,615).

http://www.medpac.gov/documents/contractor-reports/mar14_snfqualitymeasures_contractor.pdf?sfvrsn=0

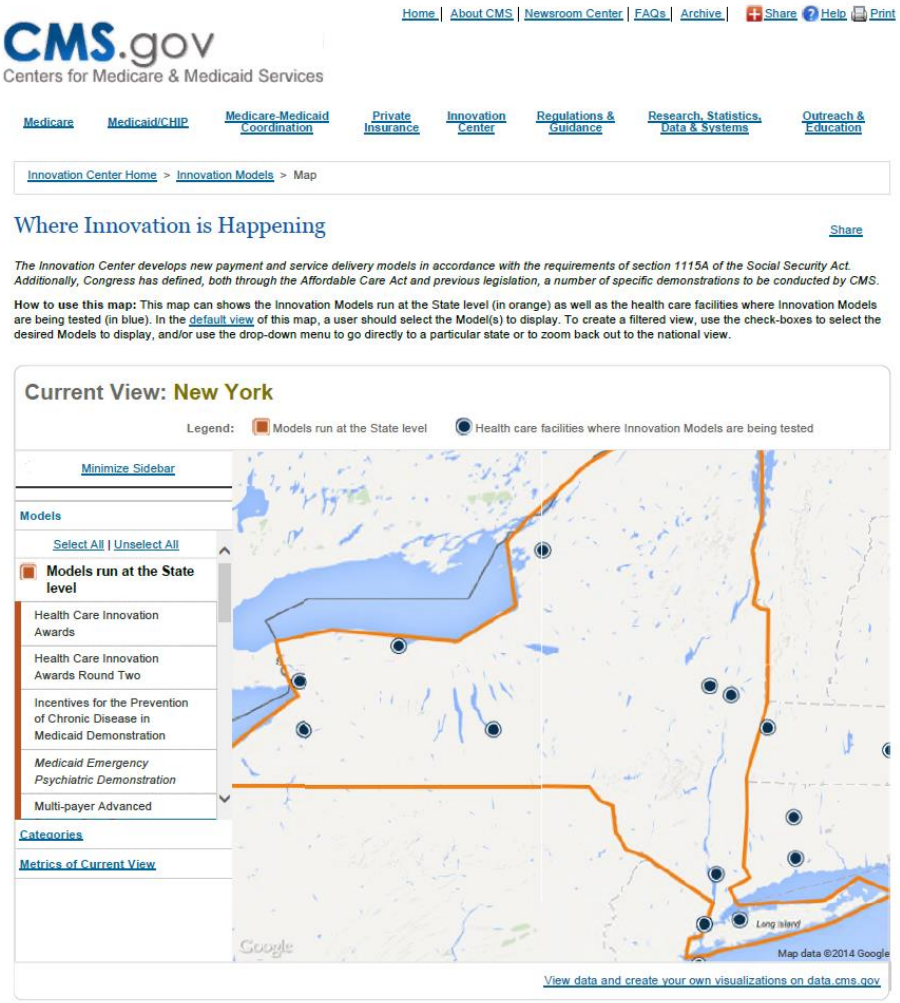
Level of Collaboration and Complexity of Care Coordination is easier to manage in acute care/primary care markets – CMS projects are numerous in this field.

CMS Innovations Center – provides much of the research and results on care transitions.

Innovations outside of the LTC settings are depicted.

http://innovation.cms.gov/initiatives/map/index.html#state=NY&model=community-based-care-transitions-program+independence-at-home-demonstration

Collaboration and Complexity of Care Coordination in LTC world is still experimental as shown by how few projects are in place in two focus areas of DSRIP transitions project:



Community Based Care Transitions Program sites

Independence at Home sites (only two)

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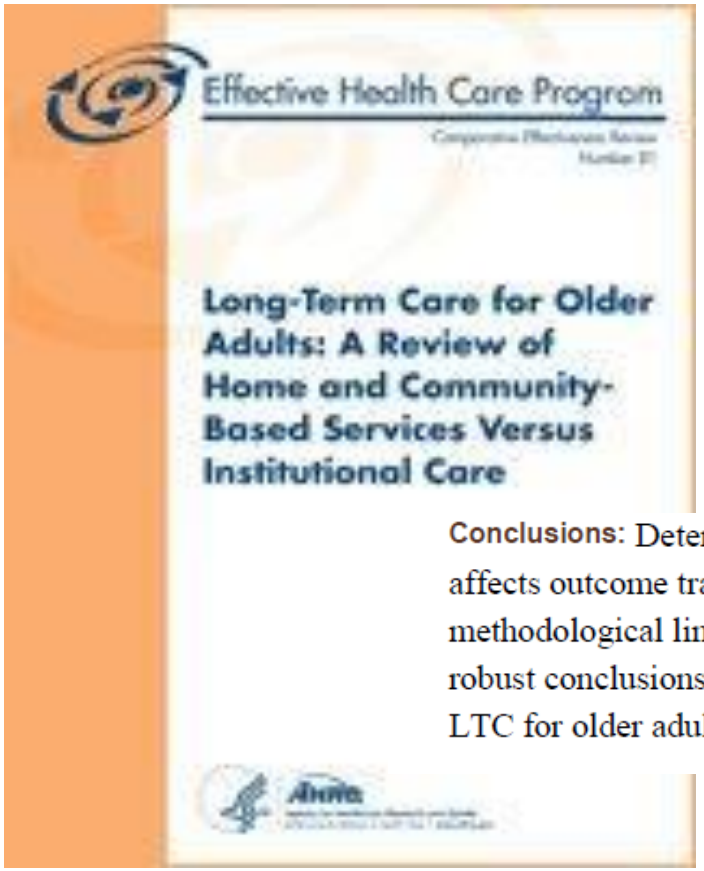
DSRIP seeks to convert evidenced based research into practice - in LTC evidence on better care in transitions is still unresolved.



Long-Term Care for Older Adults

A Review of Home and Community-Based Services Versus Institutional Care

Comparative Effectiveness Reviews, No. 81

http://www.ncbi.nlm.nih.gov/books/NBK114863/

Conclusions: Determining whether and how the delivery of LTC through HCBS versus NHs affects outcome trajectories of older adults is difficult due to scant evidence and the methodological limitations of studies reviewed. More and better research is needed to draw robust conclusions about how the setting of care delivery influences the outcomes and costs of LTC for older adults.

Pooled Resources

Managing the Managed Care Contract
Legal Ammunition
Revenue Cycle Management

Mark Mainello, Esq.

Heads up Receivables Management Team at Bond's LTC Practice

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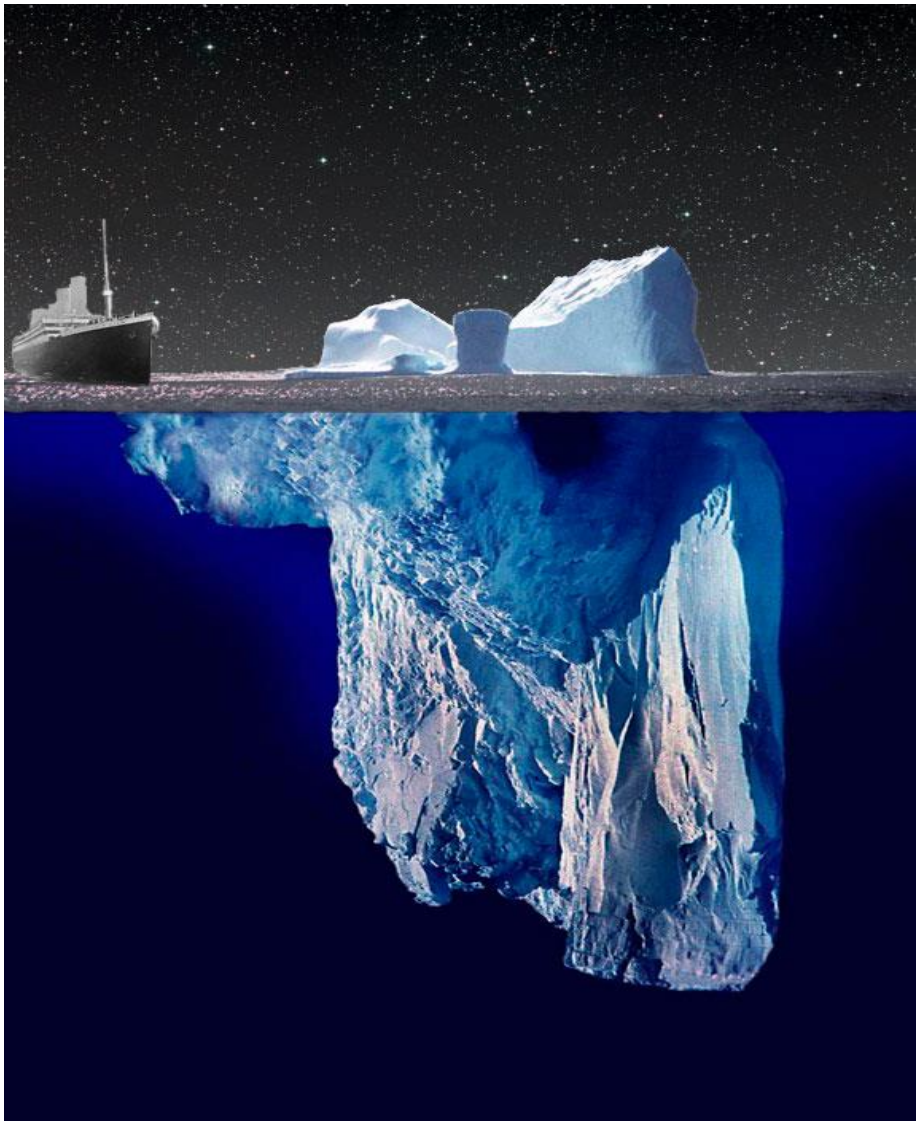
Setting a course, avoiding risk …

Screening to lower the risk of unknown dangers



Inter-Departmental Coordination – Crucial to Success - Intake

A. **Admission agreement**
B. **Private pay/Financial Status**
C. **POA and Designated Representatives.**
D. **Third party insurance/payors**
E. **Coverage issues – Short Term/LTC**
F. **NAMI Coordination/Changes**

Knowledge = Power

A. **Financial Screen - Questionnaire**
B. **PRI/Admitting Screens**
C. **Managed Care – Coverage Cards – Calls to MLTCP – Rosters Available.**
D. **UAS-NY – Document Need for Future Appeals MCO Grievance.**
E. **MLTCP – Quick links to existing Plan requirements under contracts – establish MCO Data Center.**

Take-Away Items – Lowering the risk for the Worst Case Admission:

- Knowledge of an Applicant's Payor Source crucial upon admission – contact and prior approval request should be made ASAP
- Approval of services is Gold Standard toward ensuring prompt and sustained payment
- Uniform Assessment System (UAS-NY) is essential for conversion to Medicaid + Enrollment – MDS should document need.
- Information and Communications Flow may need to be re-designed for DSRIP and MLTCP

Fresh and Refresh Data Center:

http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm

Information for All Providers – Managed Care Information

Prepaid Capitation Plans (PCP)

Key:

Plan Type Abbreviation	description	Model contract link
Partial LTC	Long Term Care: Partial Capitation	http://www.health.state.ny.us/health_care/managed_care/mltc/pdf/mltc_contract.pdf
LTC Pace	Long Term Care: PACE	http://www.health.state.ny.us/health_care/managed_care/mltc/pdf/pace_model_contract.pdf
MA Adv Plus	Medicaid/Medicare Advantage Plus	http://www.health.state.ny.us/health_care/managed_care/mltc/pdf/map_model_contract.pdf
FHP	Family Health Plus	http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
SNP	Special Needs Plan	http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
Mainstream	Medical Assistance	http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
MA Advantage	Medicaid/Medicare Advantage	http://www.health.state.ny.us/health_care/managed_care/docs/medicaid_advantage_model_contract.pdf

Plan Code	Plan ID #	PCP Provider Name	Telephone Number	Plan Type
82	00477156	Affinity Health Plan, Inc.	(800) 553-8247	Mainstream
92	00894519	Metroplus Health Plan, Inc.	(800) 597-3380	Mainstream
AC	03114514	Catholic MLTC - ArchCare Senior Life	(646) 289-7722	LTC Pace
AH	03458546	Aetna Better Health	(855) 456-9126	Partial LTC
AL	03560441	AlphaCare	(212) 466-6000	Partial LTC
AM	03598258	Amida Care Home Life Plus	(646) 545-2580	Partial LTC
AP	03466800	Archcare-Catholic Managed LTCS MLTC	(855) 467-9351	Partial LTC
AV	03560432	Ahava Revival Choice	(718) 819-3876	Partial LTC
C2	01249265	HealthNow NY, Inc. (Community Blue)	(716) 887-6900	Mainstream
C7	01234037	CenterLight HealthCare	(718) 515-8600 (877) 226-8500	LTC Pace
CG	01183013	Capital District Physician's Health Plan	(518) 641-3500 (800) 926-7626	Mainstream
CH	03072740	Catholic Health Life PACE	(716) 819-5433	LTC Pace
CP	03506989	Centers Plan for Healthy Living	(718) 215-7000	Partial LTC
E7	01674982	Senior Care Connection	(518) 382-3290	LTC Pace
EC	03549135	Extended MLTC	(855) 299-6492	Partial LTC
ED	03253707	Elderplan, Inc dba Homefirst	(718) 921-7979	Partial LTC
EH	03234044	Elderserve	(800) 370-3600	Partial LTC
GD	01788325	Fidelis Care at Home	(888) 343-3547	Partial LTC
GN	01827572	Guildnet	(212) 769-6200	Partial LTC
H1	02104369	Senior Health Partners, Inc.	(800) 633-9717	Partial LTC
HC	03522947	Hamaspik Choice	(855) 552-4642	Partial LTC
HT,98,99,02	00313979	HIP of Greater NY	(646) 447-5000	Mainstream

New York State Department of Health
Division of Managed Care and Program Evaluation
County Directory of Managed Care Plans

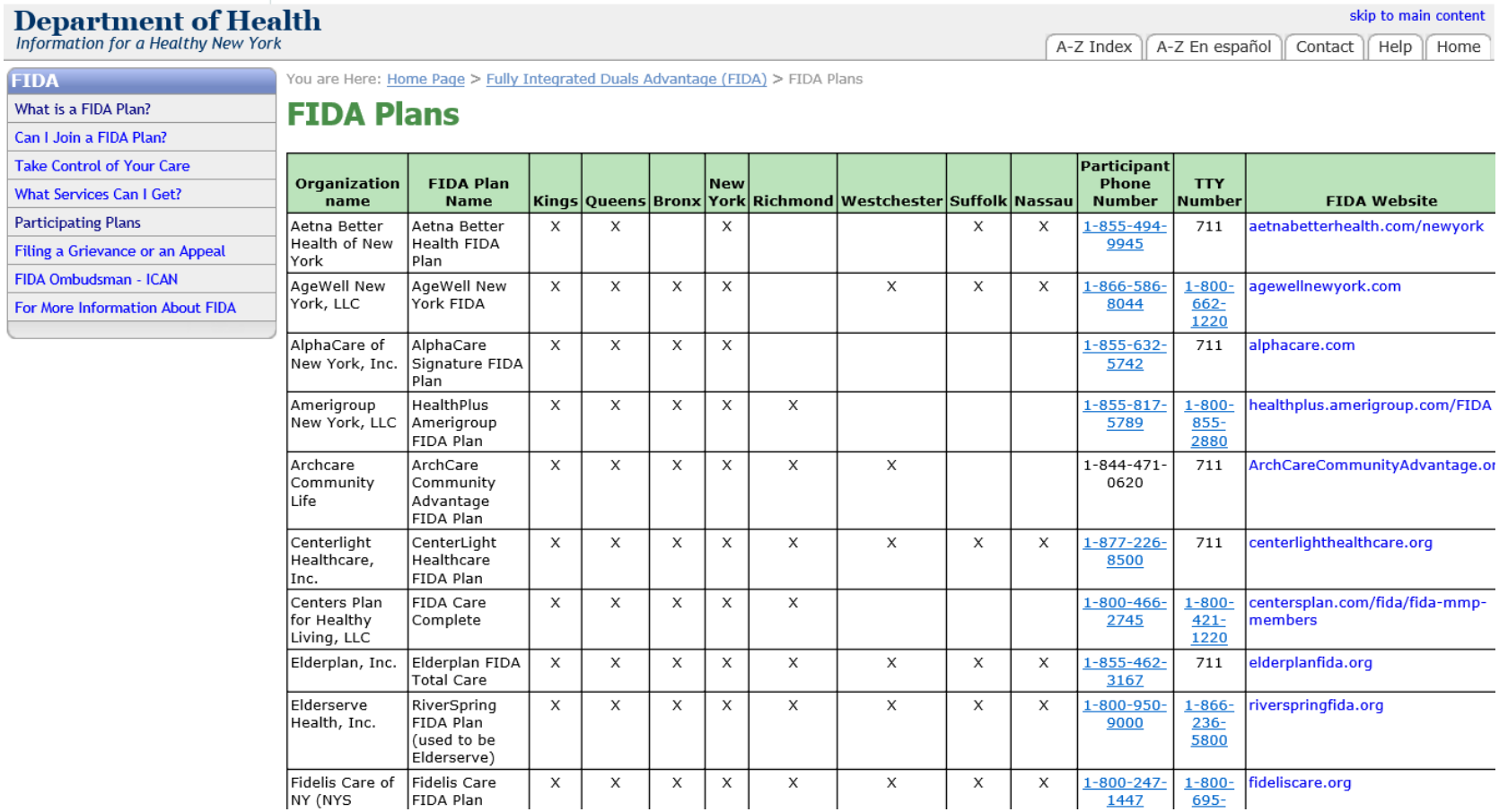
Tuesday, March 03, 2015

County: Queens

Plans	Participating Programs			
	Comm	Mcaid	CHP	FHP
1. Aetna Health Inc.	YES	***	***	***
2. Affinity Health Plan, Inc.	***	YES	YES	YES
3. AMERIGROUP New York,LLC	***	YES	YES	YES
4. Amida Care, Inc. (HIV/SNP)	***	YES	***	***
5. Atlantis Health Plan, Inc.	YES	***	***	***
6. Empire HealthChoice HMO, Inc.	YES	***	YES	***
7. Health Insurance Plan of Greater New York	YES	YES	YES	YES
8. Health Net of New York, Inc.	YES	***	***	***
9. HealthFirst PHSP, Inc.	***	YES	YES	YES
10. Managed Health, Inc.	YES	***	***	***
11. MetroPlus Health Plan, Inc.	YES	YES	YES	YES
12. MetroPlus Health Plan, Inc. Special Needs Plan (HIV/SNP)	***	YES	***	***
13. Neighborhood Health Providers, Inc.	***	YES	YES	YES
14. New York State Catholic Health Plan, Inc.	***	YES	YES	YES
15. OHP PHSP, Inc.	***	***	YES	***
16. Oxford Health Plans (NY), Inc.	YES	***	***	***
17. The New York-Presbyterian Community Health Plan, Inc.	***	YES	***	YES
18. UnitedHealthcare of New York, Inc.	***	YES	YES	YES
19. VNS Choice SNP (HIV/SNP)	***	YES	***	***
20. WellCare of New York, Inc.	***	YES	YES	YES

MCO Data Center – Quick Links

http://www.health.ny.gov/health_care/medicaid/redesign/fida/plans.htm



Department of Health
Information for a Healthy New York

skip to main content

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FIDA

- What is a FIDA Plan?
- Can I Join a FIDA Plan?
- Take Control of Your Care
- What Services Can I Get?
- Participating Plans
- Filing a Grievance or an Appeal
- FIDA Ombudsman - ICAN
- For More Information About FIDA

You are Here: Home Page > Fully Integrated Duals Advantage (FIDA) > FIDA Plans

FIDA Plans

Organization name	FIDA Plan Name	Kings	Queens	Bronx	New York	Richmond	Westchester	Suffolk	Nassau	Participant Phone Number	TTY Number	FIDA Website
Aetna Better Health of New York	Aetna Better Health FIDA Plan	X	X		X			X	X	1-855-494-9945	711	aetnabetterhealth.com/newyork
AgeWell New York, LLC	AgeWell New York FIDA	X	X	X	X		X	X	X	1-866-586-8044	1-800-662-1220	agewellnewyork.com
AlphaCare of New York, Inc.	AlphaCare Signature FIDA Plan	X	X	X	X					1-855-632-5742	711	alphacare.com
Amerigroup New York, LLC	HealthPlus Amerigroup FIDA Plan	X	X	X	X	X				1-855-817-5789	1-800-855-2880	healthplus.amerigroup.com/FIDA
Archcare Community Life	ArchCare Community Advantage FIDA Plan	X	X	X	X	X	X			1-844-471-0620	711	ArchCareCommunityAdvantage.or
Centerlight Healthcare, Inc.	CenterLight Healthcare FIDA Plan	X	X	X	X	X	X	X	X	1-877-226-8500	711	centerlighthealthcare.org
Centers Plan for Healthy Living, LLC	FIDA Care Complete	X	X	X	X	X				1-800-466-2745	1-800-421-1220	centersplan.com/fida/fida-mmp-members
Elderplan, Inc.	Elderplan FIDA Total Care	X	X	X	X	X	X	X	X	1-855-462-3167	711	elderplanfida.org
Elderserve Health, Inc.	RiverSpring FIDA Plan (used to be Elderserve)	X	X	X	X	X	X	X	X	1-800-950-9000	1-866-236-5800	riverspringfida.org
Fidelis Care of NY (NYS	Fidelis Care FIDA Plan	X	X	X	X	X	X	X	X	1-800-247-1447	1-800-695-	fideliscare.org

Upload Lists and Contract Standards & Manuals

SAMPLE CONTRACT MCO LISTING:

- Aetna
- Fidelis
- GuildNet
- Senior Health Partners
- HealthPlus

Links to Approval & Billing Standards

- Aetna
- http://www.aetnabetterhealth.com/ny/providers/manual/claims

http://www.aetnabetterhealth.com/ny/providers/manual/

aetna℠

AETNA BETTER HEALTH®
Managed Long Term Care
Provider Manual

www.aetnabetterhealth.com
Contact our Provider Relations Department at 1-855-456-9126

For the New York Managed Long Term Care (MLTC) program, Aetna Better Health in New York serves the following counties:

▪ Nassau County	▪ Queens
▪ Suffolk County	▪ New York
▪ Kings	

Aetna Better Health will process service authorization requests and issue written member and provider notifications within state-mandated timeframes or notify via telephonically, as follows:

Decision	Decision/notification timeframe	Notification to	Notification method
Expedited Prior Authorization	3 business days from request for service	Member	Telephonic and Written
		Provider if indicated	Electronic and Written
Standard Prior Authorization	Within 3 business days of receipt of necessary information, but no more than 14 days of receipt of request for services	Member	Telephonic and Written
		Provider if indicated	Electronic and Written
Standard Concurrent Review	Within 1 business day of receipt of necessary information, but no more than 14 days of receipt of request for services	Member	Telephonic and Written
		Provider if indicated	Electronic and Written
Expedited Concurrent Review	Within 1 business day of receipt of necessary information, but no more than 3 business days of	Member	Telephonic and Written

06/04/2012 18
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	receipt of request for services	Provider if indicated	Electronic and Written
Post-service	30 calendar days from receipt of the request.	Member	Oral and Written
		Provider if indicated	Electronic and Written
Termination, Suspension, or Reduction of Service Authorization	At least 10 Calendar Days before the date of the action.	Member	Oral and Written
		Provider if indicated	Electronic and Written

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