GET READY FOR VALUE-BASED PAYMENT

Adult Day Health Care Annual Conference
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Presentation Agenda

• Context
• New incentives and priorities under VBP
• VBP in Medicare and Medicaid
  – Possible opportunities for ADHC
• Strategic imperatives
High Rates of Chronic Disease Among Medicare Beneficiaries

Source: CMS, Public Use File, State-County All Beneficiaries Table, 2013.

LTC Spending Growth Across All Payers

LTSS spending growing at higher rate nationwide, primarily due to HCBS growth.

Eiken, Truven Health Analytics for CMS, Apr. 2016.
Medicare PAC Spending Grows/Varies

- Medicare spending on post-acute care has more than doubled since 2000; per capita spending has grown by 90%. (MedPac testimony before House WAM, June 2013)
- IOM concluded that spending on post-acute care around the country accounts for 73% of the regional variation in Medicare spending.

The Triple Aim

- Better Health
- Better Care
- Lower Costs
Triple Aim

Population Health Management

Value-Based Payment

Consumer Engagement

Collaborations along Health and Social Services Continuum

Performance Measurement and Management

Information Technology (including EHR, Data/Analytics and HIE)

NYS Medicaid Redesign

Care Management for All
- Managed Care
- Health Homes, PCMH

Delivery System Reform
- DSRIP PPSs

Payment Reform
- Value-Based Payment
Statewide Medicaid Managed Long Term Care Enrollment

Source: NYSDOH 2/9/17 Policy and Planning Meeting; based on enrollment reports from 9/2016 – 1/2017

Medicare Advantage Plan Penetration

• 37% of Medicare beneficiaries in NYS were enrolled in Medicare Advantage plans in 2015, up 5% from the previous year.
  – 44% in Queens
  – 56% in the Bronx
  – 57% in Erie County
  – 64% in Monroe County

• 31% of Medicare beneficiaries nationwide were enrolled in 2015.

VALUE-BASED PAYMENT: NEW INCENTIVES AND PRIORITIES

From “Heads in Beds” to “Feet on the Ground”
Achieve Value by Reducing Waste and Improving Quality

- Missed Prevention Opportunities
- Inflated Prices
- Unnecessary Services
- Excess Admin
- Poor Transitions
- Poor Medication Management

Aligning Incentives

<table>
<thead>
<tr>
<th>Yesterday’s Incentives</th>
<th>Tomorrow’s Incentives</th>
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<tr>
<td>Payers</td>
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<tr>
<td>Control utilization</td>
<td>Reduce demand through prevention</td>
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<td>Emphasize lower cost settings and services</td>
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<td>Reduce rates</td>
<td>Restructure rates to reward lower costs and higher quality</td>
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<td>Providers</td>
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<td>Increase admissions, NH days</td>
<td>Reduce demand through prevention</td>
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<tr>
<td>Increase services</td>
<td>Emphasize lower cost settings and services</td>
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<tr>
<td>Increase rates per day or episode</td>
<td>Provide high quality at lower overall cost to earn bonuses and share in savings</td>
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Keys to Success in New Policy Environment

• Scale
  – To increase the number of people served
  – To invest in IT infrastructure, data and analytics
  – To distribute fixed costs
  – To mitigate risk

• Efficiency
  – Clinical: Lowest appropriate level of care
  – Operational: Business processes
  – Financial: Contract, claims submission/payment management

• Clinical integration and excellence
• Strong referral/collaborative relationships
MEDICARE VBP AND ALTERNATIVE PAYMENT ARRANGEMENTS

Medicare’s Value-Based Payment Plan

SNF Value-Based Purchasing Program:
- Oct. 1, 2016 - CMS to provide reports to SNFs on readmissions.
- Oct. 1, 2018 - VBP applies to SNF services.
Medicare VBP Initiatives Demand LTPAC Involvement

- Hospital VBP
  - Medicare Spending Per Beneficiary (MSPB) Measure
  - Readmissions Reduction Program
- SNF VBP
  - Readmissions reduction measure
  - Medicare Spending Per Beneficiary quality measure
- Bundled Payments
  - BPCI
  - CJR
  - Cardiac - coming soon
- Shared Savings Program/Accountable Care Organizations
  - Shared savings is based on total per capita Medicare Part A and B spending, including post-acute care.

Medicare Accountable Care Organizations

- 20% of Medicare FFS Beneficiaries in NYS are attributed to 27 ACOs
Quality Reporting Program (QRP)

Four new measures from 2017 SNF PPS Rule:

- **Discharge to Community:** Assesses successful discharge to the community from a SNF setting – no unplanned re-hospitalizations and no death in the 31 days following discharge from the SNF. (2018)
- **Medicare Spending per Beneficiary:** Holds SNF providers accountable for Medicare payments within an “episode of care” (episode), which includes the period during which a patient is directly under the SNF’s care and a defined period after the end of the SNF treatment, which may be reflective of and influenced by the services furnished by the SNF. (2018)
- **Potentially Preventable Readmission:** Assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries in the 30 days post-SNF discharge. (2018)
- **Drug Regimen Review:** Assesses whether PAC providers were responsive to potential or actual clinically significant medication issue(s) when such issues were identified. (2020)

Possible Medicare Opportunities for ADHCs

- Ability to reduce readmissions and MSPB by substituting for SNF days creates value.
- Absence of Medicare FFS coverage creates barrier, but some possibilities are worth exploring:
  - Supplemental Benefit Medicare Advantage
    - D-SNPs
    - FIDA, MAP
  - Bundled Payment Arrangements
    - Post-acute care coordination for Duals?
    - Rehab for Duals?
- Consult with your attorney
NYS MEDICAID’S VBP ROADMAP

NYS Delivery System Reform Incentive Payment (DSRIP) Program

• Medicaid Waiver Incentive Payments: $6.42 billion over 5-6 years
• Goals:
  – 25% reduction in avoidable hospitalizations over 5 Years
  – Create integrated systems of care that transform health care delivery
  – Shift Medicaid reimbursement away from fee-for-service to value-based payment and lead the way for other payers
  – Improve population health
  – Improve the financial stability of the health care safety net
• Performing Provider Systems (PPSs):
  – Network of providers organized by a Lead Applicant
  – Comprised of safety net and non-safety net providers
  – Collaborating on projects to achieve metrics and milestones and earn incentive payments
By 2019, all MCOs must employ non-fee-for-service payment systems that reward value over volume for 80-90% of their provider payments.

Examples of VBP for a frail elderly population:
- MLTC Level 1: FFS with a pay-for-performance element tied to avoidable hospital use and other quality metrics
- MMC Level 1: FFS with upside-only shared savings (shared savings available only when outcome scores sufficient)
- Level 2: FFS with 2-sided risk sharing (upside available when outcome scores sufficient; downside reduced when outcome scores high)
- Level 3: PMPM capitated payment for total care for subpopulation (with outcome-based component)

* The State has agreed to count these types of arrangements between MLTC plans and providers as Level 1.

DOH survey results show that only 6% of MLTC payments are made via VBP arrangements. Most Level 2 arrangements were in MAP (duals) plans.
Hypothetical P4P Example

- MLTC pays contracted providers a share of its quality incentive pool award for achieving rates of potentially avoidable hospitalizations below statewide average and attaining specified levels of performance on quality measures.
- Potentially Avoidable Hospitalizations for MLTCs: Primary diagnosis of respiratory infection, urinary tract infection, congestive heart failure, anemia, sepsis, or electrolyte imbalance.

Completely Hypothetical Bundle Example

![Graph showing potential savings and losses for members with different service mixes.](chart.png)
Medicaid VBP Presents Challenges for LTPAC Providers

• Potential opportunities for LTPAC providers to share in savings BUT
• The people we serve are dual eligible; and
• Most of the savings available would be derived from reductions in avoidable hospital use and would accrue to Medicare; and
• When we reduce hospital use, personal care hours, nursing home days, and ADHC visits increase, driving Medicaid spending growth.

Medicare and Medicaid: Inconsistent Incentives
Possible Medicaid VBP Roles for ADHCs

- Interventions to reduce avoidable hospital use
  - In collaboration with personal care and home health
- Nursing home diversion/transition services
  - Prevent conversions from post-acute to long-term.
  - Work with discharge planners and coordinate post-discharge services, home safety assessments, modifications.
  - Reduce rates of nursing home use by prolonging independence in community.

STRATEGIC IMPERATIVES
New Models Demand New Metrics/Strategies

Today
- # of Registrants and Days
- Survey performance
- Professional standards
- Case mix
- Cost per registrant
- EHR adoption

Tomorrow
- # of Covered Lives
- Avoidable hospitalizations, outcome measures
- Evidence-based practices, clinical efficiencies, utilization management
- Population health, predictive analytics
- Total cost of care in comparison with benchmark
- Bi-directional health information exchange

New Challenges

New models of care and payment demand scale and an organized continuum of care to support:

- Care coordination and clinical integration
- Capital (for investments in IT, telehealth, updated physical plants, non-institutional services)
- Population management, value-based payment and managed care strategies
- Administrative efficiencies – shared infrastructure
- Cost savings to counteract reduced revenues
- Large patient population to spread risk
Succeeding in the New Environment

• Be open to new collaborations
  – Consider service diversification or affiliations to create a continuum of services and consolidate back-office services.
  – Networks are attractive partners to hospitals, ACOs and plans and may have more bargaining power.

• Invest in IT
  – To collect, analyze and report on financial and quality indicators
  – To support delivery of high-quality care and clinical integration
  – To engage in health information exchange with other providers

Succeeding in the New Environment

• Monitor and benchmark performance on key indicators
  – Hospitalization/readmission rates
  – Quality/outcome measures
  – Consumer satisfaction
  – Unit cost of services

• Review managed care readiness within/ across depts.
  – Especially operations related to claims submission.

• Evaluate readiness and tolerance for risk/shared savings arrangements
  – Shared savings arrangements with managed care plans and provider networks
  – Assuming partial risk from a managed care plan
  – Joint venturing to share risk
Questions or Reactions?

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