Value-Based Payment: What’s in Store for New York Long-Term & Post-Acute Care Providers

Defining Terminology

Medicare APM Market Dynamics

NY's VBP Roadmap: MLTC Policy

How to Survive and Thrive
Value-based payments (VBP) refers to a broad set of performance-based payment strategies that link financial incentives to providers’ performance on a set of defined measures.

Medicare refers to VBP as alternative payment models (APMs).

Defining Shared Savings: Target Budget, Attribution & Value Modifiers

- Target budgets for VBP arrangements are created by measuring key metrics of attributed patients in base period.
- Target budgets are risk adjusted to account for differences in case load, further adjusted by value modifiers to account for variation in initial performance levels and trended for inflation.
- During the performance period, quality measures and costs are compared to target metrics and, depending on the arrangement, savings will be shared or payments due.
Defining Episode Payment Models: Retrospective, Two-sided Risk

- **Episode Trigger**
- **Target Price**
- **Episode Spending (less exclusions)**
- **Gain**
- **Loss**

Reconciliation of target prices to spending occurs after episode is over.

Medicare APM Market Dynamics

Despite What You May Have Heard, Value-Based Payments Are Not Going Away Any Time Soon
As predicted, repealing and replacing the Affordable Care Act (ACA) has been difficult; to date, it has focused on two main things:

1. Reform of individual health insurance market, including repeal of individual mandate
2. Changes to Medicaid financing: *Per capita allotment or block grants*

Large-scale Medicare changes have NOT been in the discussions

**“Nobody knew health care could be so complicated.”** President Trump, February 2017

Even if this were to pass Congress and get signed, implementation would take years

Meanwhile...

- Federal budget deficits will persist
- Readmission penalties, the IMPACT Act, and other value-based payment initiatives will go on
- MACRA (physician payment) will need Advanced APMs to work properly
Physician Payment Rule (MACRA): Important Driver of Advanced APMs

Physicians will qualify for 5% lump sum bonus (2019) if a significant percentage of Part B revenues come from Advanced APMs.

Rewards or penalizes physicians by up to +/- 9% depending on their Merit-based Incentive Payment System (MIPS).

Starting in 2021, other payors will be included in Advanced APM calculation.

Either way, the intent is to drive physicians to value-based behavior.

Advanced APMs require:

- Explicit linkage of potential gains to quality performance
- Use of certified EHR technology
- Payment model must have meaningful downside risk

Intent is to drive behavior-changing downside risk, while requiring attention to quality and technology adoption.
### Current and Future Advanced APMs

<table>
<thead>
<tr>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Comprehensive Primary Care Plus</td>
<td>• Comprehensive Joint Replacement (CJR) Track 1</td>
</tr>
<tr>
<td>• ESRD Model</td>
<td>• Episode Payment Models (now may be off the table)</td>
</tr>
<tr>
<td>• Next Generation ACO</td>
<td>• MSSP ACO Track 1+</td>
</tr>
<tr>
<td>• Oncology Model</td>
<td>• Advanced BPCI</td>
</tr>
<tr>
<td>• Medicare Shared Savings Program (MSSP) Tracks 2 &amp; 3</td>
<td></td>
</tr>
</tbody>
</table>

**Bottom line:** more Advanced APMs are necessary so that MACRA goals can be met

### Medicare ACOs Are Growing in NY: Most Are Still in Upside-Only Risk

- ACOs are incentivized to manage cost and quality for population of at least 5,000 Medicare FFS lives attributed to the ACO based on physician visits
- 42 Medicare ACOs in New York
  - 31 Medicare Shared Savings Programs
    - (2 in Track 3: Trinity Health & Catholic Medical Partners)
  - 1 Next Generation ACO (Bronx Accountable)

As ACOs move to two-sided risk, they will be looking for effective partners to manage episodes of care
Interacting with Medicare ACOs: Key Questions & Lessons Learned

- How long have they been in operation?
  - Have they generated savings yet?
  - What are their quality metrics?
- Patient attribution/alignment can drive ACO behavior
  - Retrospective (MSSP) or prospective (Next Gen) attribution/alignment
  - Importance of preventing leakage
- Governance of ACO—hospital or physician driven?
- Mentality on taking and sharing risk
  - Which risk track is the ACO in?
  - Opportunities for gainsharing
  - Use of three-day SNF waiver?

Bundled Payments for Care Improvement: "BPCI Classic"

Established as 3-year, voluntary demonstration program by Center for Medicare & Medicaid Innovation (CMMI)

- "Clinical episodes" are selected from 1 of 48 possible diagnostic families triggered by anchor hospitalization
- Episodes are 30, 60, or 90 days in length
- **Base period** target price (less 2%–3% discount) is compared to **performance period** expenditures on apples-to-apples basis
Bundled Payments for Care Improvement: Important Role for Post-Acute

- 1,305 organizations in 2017
- 214 organizations in 2013

NY:
- 27 Model 2
- 10 Model 3

Episode Initiators by Provider Type:
- 622 SNFs
- 341 Hospitals
- 252 Physician groups
- 81 HHAs
- 9 IRFs

Source: CMS BPCI Website, January 3, 2017

CMS Has Conducted Two Formal Evaluations of BPCI

- Evaluation primarily focuses on 2013 to 2014 time period, before large growth in BPCI occurred
- Analysis compared utilization of BPCI participants to a comparison cohort; also looked at qualitative data
- Key findings:
  - Utilization went down in both the analysis & comparison groups; utilization shifted from institutional to community-based PAC
  - Ortho Model 2 bundles were $900 lower than comparison group
  - Model 2 bundlers had challenges motivating small-volume post-acute providers

Model 2 Bundlers Look to Post-Acute Partnerships

Successful acute care/PAC relationship depends on:
- Communication and shared goals
- Coordinated discharge planning
- PAC provider buy-in
- PAC partner’s willingness to collaborate and change behaviors

“Knowing the majority of our bundle episode cost and variations do occur within the PAC setting, any redesign success really demands key stakeholder involvement not only from those of us on the acute-care side but certainly from our PAC partners.”

“I think the [PAC providers] have a pretty good understanding that changes are coming down the road, and like us, you either jump on the train early and help to define it, or you can continue the status quo.”

Three-Day Stay Waiver for SNF Coverage in BPCI Was Low Initially

Concerns exist regarding:
- Waiver increasing SNF utilization when HHA would have met needs
- Issues around waiver implementation
- Potential financial liability for providers and beneficiaries

Sources: Lewin Group, CMS BPCI Year 2 Evaluation & Monitoring Report, August 2016
**Care Redesign in Bundling**

<table>
<thead>
<tr>
<th></th>
<th>Model 2</th>
<th>Model 3-SNF</th>
<th>Model 3-HHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Pathways</td>
<td>95%</td>
<td>77%</td>
<td>94%</td>
</tr>
<tr>
<td>Enhanced Care</td>
<td>92%</td>
<td>61%</td>
<td>92%</td>
</tr>
<tr>
<td>Delivery</td>
<td></td>
<td>13%</td>
<td>94%</td>
</tr>
<tr>
<td>Patient</td>
<td>94%</td>
<td>61%</td>
<td>94%</td>
</tr>
<tr>
<td>Activation,</td>
<td></td>
<td>18%</td>
<td>13%</td>
</tr>
<tr>
<td>Engagement,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Coordination</td>
<td></td>
<td>64%</td>
<td></td>
</tr>
</tbody>
</table>

"I think the pathway is the biggest thing that helped us standardize [the use of high-cost medication] and reduce costs."

"I think [BPCI] is the biggest opportunity that’s come along in American health care in at least 20 years for meaningful care redesign."

"I think that [the hospitals, nursing homes, and home care entities] are all talking the same language and communicating that same information across the care continuum. The navigators are reinforcing that and collaborating with the primary care physicians to hopefully decrease the readmission rate."

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**Mandatory Bundling Program: Comprehensive Care for Joint Replacement (CJR)**

**Five-Year Program Went Live April 1, 2016**

**Mandatory Program**
- Mandatory demonstration, requiring participation from all inpatient PPS hospitals in 67 metropolitan regions

**Hospitals Bear Financial Risk**
- Hospitals must bear risk for hospital care and 90 days post-discharge for all related costs to joint replacement (MS-DRGs 469 & 470)

**Shared Savings Directly Tied to Quality Measures**
- To qualify for realized savings, hospitals must meet specified quality measure performance targets

Source: https://innovation.cms.gov/initiatives/cjr
Emerging Issue of Overlapping APMs: Very Important to Know Who Owns the Risk

• Comprehensive Joint Replacement & Bundled Payments for Care Improvement
  – BPCI episodes would take precedence over mandatory joint replacement episodes

• Accountable Care Organizations
  – ACOs would have been eligible to become EPM collaborators
  – Beneficiaries in prospective attribution models, such as Next Generation ACO, would be excluded from the EPMs; otherwise, bundler takes precedence

Mandatory Episode Payment Models (EPMs): Proposed Rule to Cancel New Models

• Original rule would have implemented 3 new mandatory EPMs: CABG, AMI, and surgical hip/femur fracture treatment (SHFFT) as well as Cardiac Incentive Rehab program
  – Two cardiac bundles (AMI & CABG) would have been tested in 98 randomly selected regions
  – Hip fracture episodes would have been tested in current 67 CJR regions

• August 17, 2017, proposed rule would cancel the 3 new mandatory EPMs and Cardiac Incentive Program and make CJR optional in 33 of the 67 regions
  – New York City: Mandatory CJR
  – Buffalo: Voluntary CJR (one time opt-in for hospitals)
Why Cancelling Mandatory Bundling May Actually Increase Value-Based Transformation

• **Mandatory Episode Payment Models:**
  – Had phase-in to two-sided risk, which slows transformation rate
  – Only occurs in specific regions
  – Would have only occurred for carefully selected diagnostic categories

• **By contrast, voluntary bundling is likely to be:**
  – Dealing with highly motivated participants
  – Addressing a broad range of diagnostic categories
  – Having a more immediate transition to two-sided risk
  – Allowing direct risk taking to occur with multiple provider types in addition to hospitals (e.g., physician groups, post-acute care)

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**CMS Has Repeatedly Expressed Intent for “BPCI Advanced”**

> “...building on the BPCI initiative, the Innovation Center **intends to implement a new voluntary bundled payment model for CY 2018** where the model(s) would be designed to meet the criteria to be an Advanced APM.”  

(August 2, 2016)

> “Building on the BPCI initiative, the Innovation Center **expects to develop new voluntary bundled payment model(s) during CY 2018** that would be designed to meet the criteria to be an Advanced APM.”

(August 17, 2017)

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Proposed cancellation of mandatory EPMs does not necessarily mean BPCI Advanced will not happen; in fact, it increases the likelihood
BPCI Advanced:
Details Beginning to Emerge

• Models 1 and 4 of BPCI not likely to be continued
• Looking to build off existing BPCI risk-bearing architecture
  – Likely to continue to use Convener and Episode Initiators structure
• Tweaks under consideration by CMS Innovation Center:
  – Allowing new participants
  – Longer performance periods
  – Target price calculation
  – Ensuring that the new model qualifies as Advanced APM

Stay Tuned...

Why Engage in Voluntary Bundling?

- Learn by doing; force culture change
- Understand markets through data
- Improve quality through care redesign
- Earn positive margins
- Master skills for gainsharing in other arenas
Managed Care for Medicare Is Growing:
Setting Value-Based Payment Goals as Well

- Medicare Advantage penetration has increased by more than **30% nationally in the last 6 years**
  - Medicare Advantage now covers close to one-third of enrollees
  - 5 states average greater than 40% Medicare Advantage penetration
- Medicare Advantage plans also establishing goals for **value-based payment**, and CMS is working with plans on multi-payor initiatives to align fee-for-service and managed care value-based payment goals
Medicare FFS Payments to Hospitals: Readmission Penalties and MSPB

- Hospitals face reimbursement penalties based on 30-day readmission rates for 6 diagnostic categories
  - Acute myocardial infarction (AMI); heart failure (HF); pneumonia (PN); COPD; elective total hips and knees; and CABG
  - Up to 3% penalties apply to all Medicare FFS discharges based on three-year average
- In 2015, hospitals became subject to new adjustment based on Medicare Spending Per Beneficiary (MSPB) as part of Hospital Value-Based Purchasing (VBP) program

SNF VBP Also Focuses on Readmissions: Performance Period Underway

- Starting October 1, 2018, SNF PPS Part A rates adjusted based on performance on 30-day all-cause readmission measure
- Measure would be risk-adjusted and calculated using full year of data
  - Achievement threshold 20%*
  - Benchmark threshold 16%*
- Funded by 2% withhold, with higher of improvement or achievement score determining degree of withheld funds to be returned to SNFs
  - 60% of the dollars withheld will be returned to SNFs in the aggregate
  - 40% of SNFs required to have a net lower rate
- Data to be made available to SNFs on CASPAR system

* Rounded thresholds
Bottom Line for Medicare Alternative Payment Models...

- Value-based payment will continue to expand
- MACRA will drive Advanced APMs
- Other payors are climbing on board
- Scale and value-based know-how are critical

NY’s Value-Based Roadmap
Ambitious Overall VBP Goals Still in Play
More Modest MLTC VBP Goals for 2017 Clarified
Goals and Timeline for NYS VBP Roadmap

New York State Payment Reform

<table>
<thead>
<tr>
<th>Deliver System Reform Incentive Payment (DSRIP) Program Goals</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source: MLTC Clinical Advisory Group Meeting, June 2017</td>
<td></td>
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</tr>
</tbody>
</table>

Four NYS Roadmap VBP Models for Total Cost of Care

<table>
<thead>
<tr>
<th>VBP Arrangement</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Care for General Population</td>
<td>All Medicaid covered services for all members eligible for mainstream managed care and not eligible for one of the subpopulations (excluding duals)</td>
</tr>
<tr>
<td>Total Care for HIV/AIDS Subpopulation</td>
<td>All Medicaid covered services for all members eligible for HIV/AIDS SNP (excluding duals)</td>
</tr>
<tr>
<td>Total Care for HARP Subpopulation</td>
<td>All Medicaid covered services for all members eligible for HARP (excluding duals)</td>
</tr>
<tr>
<td>Total Care for MLTC Subpopulation</td>
<td>All Medicaid covered services for all members eligible for MLTC (including Medicaid component of duals)</td>
</tr>
</tbody>
</table>
### Levels of VBP for Mainstream Medicaid

<table>
<thead>
<tr>
<th>Level 0 VBP</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP *</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/IPC, FFS may be complemented with PMPM subsidy)</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient)</td>
<td>Prospective capitation PMPM or Bundle (with outcome-based component)</td>
</tr>
<tr>
<td>FFS payments</td>
<td>FFS payments</td>
<td>Upside risk only</td>
<td>Upside &amp; downside risk</td>
</tr>
<tr>
<td>No risk sharing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Feasible after experience with Level 2; requires mature contractor

Source: Final approved NYS VBP Roadmap, April 17, 2017

### Initial VBP Pilots Announced in May 2017

<table>
<thead>
<tr>
<th>Arrangement</th>
<th>Provider</th>
<th>MCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>HARP</td>
<td>Maimonides Medical Center</td>
<td>Healthfirst PHSP, Inc.</td>
</tr>
<tr>
<td></td>
<td>Mount Sinai Health Partners</td>
<td></td>
</tr>
<tr>
<td>Integrated Primary Care</td>
<td>Community Health IPA</td>
<td>Affinity Health Plan</td>
</tr>
<tr>
<td></td>
<td>Hudson Headwaters Health Network</td>
<td>New York State Catholic HP</td>
</tr>
<tr>
<td>Total Care for General Population</td>
<td>Greater Buffalo United ACO</td>
<td>YourCare Health Plan</td>
</tr>
<tr>
<td></td>
<td>Somos Your Health IPA</td>
<td>Affinity Health Plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HealthPlus HP, LLC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>New York State Catholic HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Healthfirst PHSP, Inc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>United Healthcare of NY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>WellCare of New York</td>
</tr>
<tr>
<td>School Readiness</td>
<td>St. Joseph's Hospital Health Center</td>
<td>New York State Catholic HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TotalCare/Molina Healthcare of NY</td>
</tr>
<tr>
<td></td>
<td>Albany County Pediatric Providers</td>
<td>Capital District PHP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MVP Health Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>New York State Catholic HP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UnitedHealthcare of NY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>WellCare of New York</td>
</tr>
</tbody>
</table>

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**MLTC Clinical Advisory Group Report**

- MLTC population can, but does not have to, be divided into 2 subpopulations: **home care** and **nursing home**
- Reducing potentially avoidable hospital use remains a priority for NYS, even prior to intended Medicare alignment
- Concerns expressed about readiness of MLTC for VBP
- Potential quality measures for VBP identified and categorized

**VBP Quality Measure Selection Process**

> "The Category 1 quality measures recommended by each CAG and accepted by the State are to be reported by the VBP contractors. The measures are also intended to be used to determine the amount of shared savings that VBP contractors are eligible for."

1 New York State Department of Health, Medicaid Redesign Team, A Path toward Value Based Payment: Annual Update, June 2016: Year 2, New York State Roadmap for Medicaid Payment Reform, June 2016, p. 34. Available at [link]
Categories of Quality Measures Defined

CATEGORY 1
Approved quality measures that are clinically relevant, reliable and valid, and feasible.

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.

Annual Measure Set Review Process

1. NYSDOH Communicates to MCO & VBP Contractors
2. Final VBP Workgroup Approval
3. Data Collection & Reporting
4. NYSDOH Technical Review
5. Review Measure Results
6. Annual Cycle Review
7. Assess Changes to Measures, Retirement or Replacement
8. CAG Annual Meeting

Source: MLTC CAG, June 9, 2017
For MLTC Providers: Pay-for-Performance Will Be Regarded as Level 1 VBP

• Every MLTC plan is to convert provider contracts to Level 1 pay-for-performance (P4P) contracts by December 31, 2017, using the State-recommended MLTC VBP Category 1 quality measures

• All Level 1 VBP contracts must include the potentially avoidable hospitalizations (PAH) measure

• Other Category 1 VBP measures are drawn from MLTC quality incentive program

• MLTC plans & VBP contractors may engage in Level 2 or 3 VBP

Category 1 MLTC VBP Measures:
Ten Possible Options

<table>
<thead>
<tr>
<th>Category 1 MLTC VBP Measure</th>
<th>Source</th>
<th>State Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Percentage of members who did not have an emergency room visit in the last 90 days*</td>
<td>UAS-NY</td>
<td>92%</td>
</tr>
<tr>
<td>2. Percentage of members who did not have falls resulting in medical intervention in the last 90 days*</td>
<td>UAS-NY</td>
<td>94%</td>
</tr>
<tr>
<td>3. Percentage of members who did not experience uncontrolled pain*</td>
<td>UAS-NY</td>
<td>85%</td>
</tr>
<tr>
<td>4. Percentage of members who were not lonely and not distressed*</td>
<td>UAS-NY</td>
<td>90%</td>
</tr>
<tr>
<td>5. Percentage of members who received an influenza vaccination in the last year*</td>
<td>UAS-NY</td>
<td>77%</td>
</tr>
<tr>
<td>6. Percentage of members who remained stable or demonstrated improvement in pain intensity*</td>
<td>UAS-NY</td>
<td>86%</td>
</tr>
<tr>
<td>7. Percentage of members who remained stable or demonstrated improvement in Nursing Facility Level of Care (NFLOC) score*</td>
<td>UAS-NY</td>
<td>83%</td>
</tr>
<tr>
<td>8. Percentage of members who remained stable or demonstrated improvement in urinary continence*</td>
<td>UAS-NY</td>
<td>74%</td>
</tr>
<tr>
<td>9. Percentage of members who remained stable or demonstrated improvement in shortness of breath*</td>
<td>UAS-NY</td>
<td>36%</td>
</tr>
<tr>
<td>10. Potentially Avoidable Hospitalizations (PAH) for primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection*</td>
<td>NYS/SPARCS</td>
<td>4.03%</td>
</tr>
</tbody>
</table>
Potentially Avoidable Hospitalization (PAH) Measure Details

- PAH measure defined by primary diagnosis from SPARCS all-payer databases
  - Anemia
  - Congestive heart failure
  - Electrolyte imbalance
  - Respiratory infection
  - Sepsis
  - Urinary tract infection

- PAH measure calculated by NYS from SPARCS all-payer hospital file
  - DOH will calculate PAH for all plan-provider combinations
  - Plans will submit attribution files by September 8, 2017
  - Assigns members to a provider organization (CHHA, LHCSA, SNF)

- Baseline (2016) attribution, one row per member
- State will run PAH measure based on attribution file and report 2016 results to plan by mid-October

Moving Beyond P4P for MLTC VBP: Likely Would be 2019 At the Earliest

<table>
<thead>
<tr>
<th>Component</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope of Services</td>
<td>For Partially Capitated MLTCs - All Medicaid covered services for attributed members</td>
<td>For Fully Medicare Integrated Product Lines – All covered services for attributed members</td>
<td></td>
</tr>
<tr>
<td>Attribution</td>
<td>To the most appropriate VBP Contractor (responsible for/encompassing total costs) – Home Care Agency, Nursing Home, PCP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Measures</td>
<td>Reporting of all MLTC Category 1 measures</td>
<td>Pilots to test Category 2 measures and provide meaningful feedback</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contracts to include Target Budget, Shared Savings / Losses, SDH and CBO requirements similar to Mainstream VBP?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Guidelines

Standards
Longer Term Vision for MLTC VBP: Evolving from P4P to Shared Risk

Details Under Discussion

<table>
<thead>
<tr>
<th>Component</th>
<th>MLTC VBP Level 1</th>
<th>MLTC VBP Level 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope of Services</td>
<td>MLTC plans can make performance payments to any</td>
<td>Per VBP Roadmap MLTC VBP Arrangements are a</td>
</tr>
<tr>
<td></td>
<td>provider within their network.</td>
<td>Subpopulation Arrangement to include the total cost</td>
</tr>
<tr>
<td>Attribution</td>
<td>Attribution files needed for quality measure use</td>
<td>of care including all covered services for a member.</td>
</tr>
<tr>
<td></td>
<td>but not for setting of target budget or shared</td>
<td>A VBP Contractor takes responsibility for the cost</td>
</tr>
<tr>
<td></td>
<td>savings.</td>
<td>and quality of an attributed member’s total care.</td>
</tr>
<tr>
<td>Quality Measures</td>
<td>Category I quality measures must be reported.</td>
<td>Attribution guideline is home care or nursing home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>provider. Contracts should specify an attribution</td>
</tr>
<tr>
<td></td>
<td></td>
<td>methodology but it can differ from guideline.</td>
</tr>
<tr>
<td>Target Budget</td>
<td></td>
<td>Contract must commit to reporting on all Category I</td>
</tr>
<tr>
<td></td>
<td></td>
<td>quality measures and Category 2 quality measures if</td>
</tr>
<tr>
<td>Shared Savings / Losses</td>
<td></td>
<td>required.</td>
</tr>
<tr>
<td></td>
<td>Target budgets, shared savings/losses, and risk</td>
<td>Contract should specify that a target budget will</td>
</tr>
<tr>
<td>Risk Level</td>
<td>levels are not considered in MLTC VBP Level 1.</td>
<td>be used and give a methodology.</td>
</tr>
</tbody>
</table>

Guidelines

Standards

Source: MLTC CAG Meeting, August 17, 2017

VBP for MLTC Population: Opportunities and Challenges

Opportunities

• 17% of the community-dwelling elderly Medicare population is hospitalized annually

• If hospitalized, 5%–25% will be placed into long-term nursing facility care within 6 months (depending on risk)

• According to 2016 MLTC Annual Report, about 17% of MLTC members’ Nursing Facility Level of Care Score increases between assessments, driving ADL needs

Challenges

• Independent provider associations (IPAs) are not prevalent yet for MLTC providers

• Managing downstream risk of long-term nursing facility placement of community-based MLTC members can be daunting

• Medicare receives the lion’s share of benefit from Medicaid-funded VBP reform (but Medicaid does benefit from lower ADL needs and NF use)


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Observations About Where We Are Going with MLTC VBP

• 2017 MLTC VBP contracting with providers likely to be modest due to timing constraints, 2018 represents better opportunity; plan on evolving beyond P4P by 2019

• Providers will want P4P contracts to align with MLTC plan needs; look at 2016 MLTC Annual Report for guidance and talk to the plans to understand their needs

• Mechanisms to reward providers that are already high performing need to be developed (improvement vs. attainment)

• IPAs for MLTC providers will need to continue to evolve

• Ongoing enrollment of custodial nursing home patients into MLTC will represent a challenge for VBP, especially without Medicare Alignment

Case Study 1: Other States Beginning to Set VBP Goals for Managed LTSS

| Arizona | • MCOs in Arizona Long Term Care System (ALTCS) and D-SNP ALTCS plans required to have minimum of 15% of their total payments to providers in VBP arrangements  
• VBP threshold increased to 35% in 2017  
• State withholds 1% of capitation to ALTCS plans that can be earned back for performance against 5 measures; however, plans that have not met VBP contract requirements not eligible to earn back any portion of withhold |
| --- | --- |
| Kansas | • MCOs required to increase number of PEAK (Promoting Excellent Alternatives in Kansas Nursing Homes) facilities in their contracted networks  
• MCOs also accountable for increasing integration across physical, mental health and substance use disorder, long-term care, and HCBS waiver services  
• MCOs can earn back part or all of 5% capitation payment withheld for meeting defined quality targets for physical, behavioral health, and long-term care |
| Texas | • MCOs, including Texas “STAR+PLUS” plans for seniors & individuals with disabilities, must submit to state proposals that encourage VBP arrangements with providers; proposals must include quality incentive payments to providers  
• Review of health plans’ 2016 VBP contracting proposals found at least 3 plans considering performance-based incentive payments for NFs in form of additional PRPM payment; in general, NFs evaluated against national (e.g., CMS MDS) and state quality measures  
• 4% of capitation payment for Texas MCOs, including Texas STAR+PLUS plans for seniors & individuals with disabilities, at risk based on performance against specified quality measures |
Case Study 2: Arizona Long Term Care System (ALTCS)

- Arizona directed ALTCS plans & D-SNPs to have minimum of 25% of their total payments to providers in VBP models for 2016 and 35% in 2017
- State provides guidance on what qualifies as VBP model, but allows flexibility
- Plans must meet VBP target to access 1% of capitation rate the State withholds; plans earn back withhold for performance on 5 measures:
  - ED utilization
  - Readmissions within 30 days of discharge
  - HbA1c testing
  - LDL-C screening
  - Flu shots for adults 18 years and older

Case Study 3: Shared Savings for Care Management

- **Essentia Health**, an integrated delivery system, and **Blue Cross and Blue Shield of Minnesota**, a MN Senior Health Options (MSHO) plan, entered into a shared savings agreement to improve care coordination for seniors
- The organizations saw opportunities for cost savings from improved care coordination, care transitions, and management of chronic diseases, which would contribute to a reduction in hospital admissions and emergency room visits
- Amount of savings which Essentia is eligible to receive is determined by performance on 2 HEDIS measures:
  - Plan all-cause readmissions
  - Use of high-risk medications in the elderly

Source: State Strategies for VBP for Medicaid Populations with Complex Care Needs, August 2016
Looking to the Future: How to Survive and Thrive

Position for Preferred Networks
Create Effective Care Redesign
Achieve Scale
Learn to Take Risk

Preferred Networks Continuing to Form: Especially in Markets with Excess Capacity

- Hospitals participating in bundling, ACOs, and other VBP, along with managed care plans, will continue to seek to utilize preferred or narrow networks
- Preferred provider selection process often includes:
  - Five-star quality rating
  - Readmission rate
  - Medical director
  - Stability of management team
  - Depth and breadth of clinical capabilities
  - Patient satisfaction
Effective Care Redesign Is Essential

Care Redesign Strategies

- Transitions management: acute, post-acute, and community
- Coordination with primary and specialty care
- Readmissions prevention
- Risk stratification
- Patient activation, teaching, and self-care
- Medication reconciliation
- Telehealth

Effective Care Redesign Is Essential

Gain and Risk Sharing

Data Sharing Supports All Activities and Exchanges


Importance of Achieving Scale in VBP: Do The Math!

Suppose there are 5 plans contracting with 10 providers for care representing, in total, 10% of each plan’s spend...

Plan #1 = 20%
Plan #2 = 20%
Plan #3 = 20%
Plan #4 = 20%
Plan #5 = 20%

In this example, each provider represents only 0.2% of the plan’s spending

Math can be similar in urban versus rural environments
One Possible Answer to Scale Challenge:
Independent Provider Associations (IPAs)

- Multiple LTPAC Providers
- Managed Care Contracting
- Gain-sharer or Risk Taker in Bundling or ACOs

NY VBP Roadmap Envisions:
New Contracting Relationships Among Providers

VBP contractor is entity that contracts the VBP arrangement with the MCO; this can be:

- Accountable care organization (ACO)
- Independent provider association (IPA)
- Individual provider (either assuming all responsibility and upside/downside risk or subcontracting with other providers)
- Individual providers brought together by an MCO to create a VBP arrangement through individual contracts with these providers

Source: VBP Bootcamp Series, Sessions 1-3, NYSDOH, 2016
Examples of LTPAC IPAs

Cincinnati-based clinical integration model focused on value-based payments:

- Medicare Model 3 bundled payment convener
- Negotiating performance-based reimbursement with Medicare Advantage and MyOhio duals plans

**LeadingChoice will:**
- Negotiate managed care contracts;
- Develop clinical protocols;
- Educate participants;
- Assist with billing and credentialing

- IPA recently formed by LeadingAge Wisconsin members
- Initially focused on Medicare Advantage contracts and member education

Successfully Managing Risk Under APMs

- Understand variation within clinical categories
- Achieve sufficient scale
- Implement lean, but effective, care redesign
- Deploy user-friendly benchmarks and feedback loops
- Motivate partners with data and/or gainsharing

Next Steps

- Consider participating in Advanced BPCI
- Understand who in your market is bearing downside risk
- Systematically reach out with your (quality & cost) value proposition
Final Thoughts on VBP: Learning to Take Risk

• Don’t assume VBP is going away
• Understand risk-based payors’ incentives in your market, particularly those that face downside risk
• Force your organization to learn how to take risk
  – Consider next round of voluntary bundling
• Achieve scale in VBP
  – But if in group or IPA, make sure incentives are properly aligned and metrics risk-adjusted

Thank You!
Any Additional Questions?
### Health Dimensions Group: What We Do

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### Brian Ellsworth, MA  
**Director, Payment Transformation**

- Over 30 years of experience in Medicare & Medicaid policy, payment, and care delivery transformation, with an emphasis on care integration for the chronically ill
- Background includes provider, payor, and governmental policymaking roles, as well as experience in multiple states and at the federal level
  - Provider roles: American Hospital Association, CT Association for Home Care & Hospice (CEO), and LeadingAge NY
  - Payor roles: NY Medicaid and Optum (UnitedHealth Group)
- Consulting clients include over 75 providers taking risk under Medicare’s Bundled Payments for Care Improvement (BPCI) initiative; advise providers and plans on value-based payment strategic positioning and transformation
- Respected thought leader and frequent presenter; served on numerous policy and technical advisory groups
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