March 30, 2015

Jason Helgerson
New York State Medicaid Director
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

RE: COMMENTS ON THIRD DRAFT OF VBP ROADMAP

Dear Mr. Helgerson:

On behalf of LeadingAge New York, I am writing to share our comments on the Third Draft version of the Value-Based Payment (VBP) Roadmap for the Delivery System Reform Incentive Payment (DSRIP) program. LeadingAge NY represents over 500 not-for-profit and public providers of long term and post-acute care (LTPAC) and housing services to elderly and disabled individuals of all ages. Our membership includes skilled nursing facilities (SNFs), home care agencies, hospices, assisted living, adult day services, other community-based programs, housing and retirement communities, as well as provider-sponsored managed long term care (MLTC) plans.

Our comments reflect the deliberations of the LeadingAge NY Task Force on Alternative Payment Arrangements, which is comprised of provider and plan members of the Association.

I. Overall Comments

General Support for VBP. The provider and managed care plan members of LeadingAge NY support the philosophy behind New York's Roadmap for Value-based Payment. We believe that policies which help to prevent or delay the progression of chronic illness and acute exacerbations thereof are integral to creating successful value-based care, as well as to the overall success of the DSRIP and Fully Integrated Duals Advantage (FIDA) programs.

Support for Recent Revisions to the Roadmap. We also support the intent of recent edits to the Roadmap to incorporate greater flexibility into the VBP framework, including: (1) revision of the 90 percent VBP target for DSRIP Year 5 to a more flexible range of 80-90 percent; (2) explicit awareness of the need to enable different categories of providers to proceed at different rates towards the VBP targets; (3) the commitment to treat the Roadmap as a "living document" that will be periodically revisited and modified; and (4) enabling "off-menu" options for providers and plans to develop alternative VBP arrangements that are consistent with VBP policy aims.

Integrated Medicare-Medicaid Approach is Necessary for LTPAC VBP. Most of the Medicaid beneficiaries for whom LeadingAge NY members provide care are also eligible for Medicare and have

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disabilities and/or multiple chronic conditions. To the extent that "value" is defined as reductions in health care spending, we believe and the research suggests that most of the opportunity for value-creation lies with managing and coordinating the ***Medicare-covered*** services for dually eligible recipients who are chronically ill and/or require long term and post-acute care services.[1] While some savings may be available from transitioning or diverting beneficiaries from SNFs to home and community-based services (HCBS) settings, we believe these savings will be relatively small given the significant costs of providing HCBS to medically-complex beneficiaries with functional limitations. Furthermore, years of cuts to fee-for-service rates have eliminated most opportunities for unit cost savings.

As such, we believe that it is vitally important that New York's Medicaid policies – including VBP – recognize these realities and help to create a *platform* for integrated, value-based care for dually eligible persons. In this regard, ensuring alignment between Medicaid and Medicare VBP definitions, policies and timeframes is particularly important. This alignment should include the development of consensus-based quality measures and parameters around risk and shared savings appropriate to LTPAC settings.

Significant Concerns about Readiness for VBP. Although there is potential to enhance the value of services to frail elderly and disabled beneficiaries, we are concerned about the readiness of LTPAC providers and managed care organizations (MCOs) to move to VBP in the short-run. There has been no meaningful sharing of data for benchmarking purposes; provider and plan billing and health information technology (HIT) systems are simply not ready; and perhaps most importantly, the structure, process and culture of care delivery need to be changed.

Available evidence from initiatives such as Pioneer Accountable Care Organizations (ACOs) and Financial Alignment Demonstrations in other states shows that efforts to develop infrastructure and effectuate culture change take time in order to be effective and sustainable. In addition, LTPAC providers were left out of federal HITECH funding and under-represented in NYS grant awards for electronic health record (EHR) adoption and health information exchange (HIE) development. Consequently, important parts of the infrastructure needed for success in a value-based arena still need to be built for LTPAC providers.

II. LTPAC Value and Shared Savings

A. Issues:

Defining value and shared savings/shared risk opportunities for the chronic care population creates certain challenges:

- **Defining "Value" in the Long Term Care (LTC) Context -** While the term "value" is not expressly defined in the Roadmap, the implication is that increased value will lead to Medicaid financial savings. On the contrary, improving quality of care (through better chronic care management) for

[1] See, e.g., "Care for Dual Eligibles," *Health Affairs*, June 13, 2011: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=70

dually eligible persons in LTC settings could reasonably be expected to *increase* the costs of certain Medicaid-covered services over time, but will actually lower the *total* costs of care when that patient's Medicare-covered costs are included.

With this in mind, LeadingAge NY is concerned about the ability of SNFs and HCBS providers to effectuate *savings* for Medicaid-covered services to their long-term, custodial care residents/patients and thus qualify for Level 1 (and beyond) VBPs as they are currently defined. If these providers are unable to qualify for Level 1 (and beyond) VBPs, they will not receive the resources needed for the infrastructure development and workforce training essential to succeed in a value-based environment. LTPAC providers are prepared to demonstrate "value" through improvements in quality and the patient's/resident's experience of care.

- **Difficulty Demonstrating Medicaid Savings** - As noted above, we believe that much of the obtainable savings for dually eligible persons are for services typically covered by Medicare. Medicaid-only beneficiaries, for whom the Medicaid program is responsible for acute care costs, make up a relatively small proportion of the Medicaid LTC beneficiaries who will be enrolled in managed care plans, providing little opportunity for providers serving these populations to succeed in earning incentive payments under Level 1. For example, less than 4 percent of all Medicaid patient days reported by nursing homes are attributable to Medicaid-only beneficiaries for whom providers could meaningfully impact acute care costs. MLTC plan enrollments are comprised almost exclusively of dually eligible beneficiaries.

- **Unit Cost Reductions Are Not a Likely Source of Savings** - SNFs are currently paid an all-inclusive rate pursuant to a pricing structure that has been in effect for 30 years. Certified home health agencies are paid episodic rates for a bundle of services, and other HCBS providers are paid under various other rate methodologies. With no inflationary adjustments having been made to Medicaid rates in the last seven years, and given other recurring rate cuts, unit cost savings for these services have long ago been effectuated.

- **Unique VBP Challenges for FIDA and MLTC Covered Services** - Under FIDA, Interdisciplinary Teams are responsible for developing and overseeing enrollees' care plans for the full range of Medicaid and Medicare services. MLTC plans are required to develop and oversee care plans for all Medicaid-covered LTPAC services, care manage all services regardless of payer and coordinate with physicians and non-covered providers. Under DSRIP, Performing Provider Systems (PPSs) are undertaking projects that will necessitate care planning and coordination of acute, primary, LTPAC and other services. These overlapping structures are likely to create conflicting incentives and potentially limit providers' and plans' ability to effectuate shared savings and qualify for Level 1 VBP.

B. <u>Recommendations:</u>

Following are recommendations aimed at addressing these concerns:

- **Redefine the VBP Levels** - Create alternative definitions of Level 1 and above VBP standards, or re-designate the current NYS Level 0 as Level 1 (consistent with the Medicare VBP categories) so that

SNFs and HCBS providers are not disadvantaged when additional payments are made to MCOs and PPSs to support VBP. The alternative definitions should be designed to ensure access to additional funding for providers and plans as a result of the *actual achievement* of Medicare savings for a patient or group of patients. This too would promote greater alignment with Medicare's VBP approach.

- **Consider Pay for Performance (P4P)** – For purposes of the redefinition of Level 1 (and beyond) VBP suggested above, Medicaid payments for managed care enrollees residing in SNFs would be subject to a P4P payment structure similar in design and scope to the Nursing Home Quality Pool (NHQP). For this purpose, the NHQP would be funded with new money (instead of reductions to the base) in order to support new investment in clinical process transformation, workforce and HIT. In addition, the NHQP program would be modified to ensure that: (1) scoring metrics are better aligned with managed care and DSRIP measures; (2) payment incentives are more meaningful and clearly set out in advance of the performance measurement period; and (3) updates to the payments are made much more timely. Similar P4P structures could be also developed for other LTPAC services.

- **Consider Other Value-Enhancing Models** – In addition to the various types of managed care for dually eligible enrollees offered in New York (e.g., FIDA, Programs of All-Inclusive Care for the Elderly and Medicaid Advantage Plus), there are other care models that could leverage synergies between Medicaid and Medicare and take advantage of existing infrastructure including: (1) SNFs that offer enhanced primary care through staff practitioners; (2) arrangements between SNFs and Medicare Advantage Institutional Special Needs Plans; (3) hospice and palliative care programs offered in LTC facilities and patients' homes; and (4) end stage renal disease services offered in the SNF setting.

- **Institute Exclusion Criteria When Appropriate** – As part of the periodic Roadmap review process, determinations should be made as to whether specific service categories lend themselves to the VBP levels agreed to between CMS and the State. If not, the service category should be excluded from the calculations of VBP goal attainment. If there is a delay in developing the necessary components (e.g., standardized quality metrics, billing codes, etc.) for a VBP structure for a particular service line, the timeframes for VBP goal attainment should automatically be modified.

- **Need for Separate MLTC/FIDA Workgroup** – Given the unique challenges noted above, the total expenditures associated with LTPAC services and the high degree of potential fragmentation posed by multiple PPSs in certain markets, there should be a separate VBP workgroup formed to specifically address the MLTC/FIDA population in the Roadmap implementation process.

III. Infrastructure Needs of Providers and Plans

A. Issues:

Achievement of scale is necessary for the success of VBP and is made significantly more challenging by the multiplicity of payer and provider arrangements in New York and by the unique circumstances

facing smaller and rural providers. Significant infrastructure development will be required in the following areas as part of a strategy to promote widespread adoption of VBP:

- **Development Assistance** - LTPAC providers need assistance in developing the infrastructure (particularly interoperable EHRs and HIE capacity, data and analytics capabilities, reconfigured billing systems) and operational knowledge in order to transition from being primarily funded by two payers (Medicare and Medicaid fee-for-service) to receiving VBP from multiple MCOs through various arrangements including direct contracting and multi-provider agreements (including PPSs).

- **Standardization Where Necessary** - For both providers and plans, this major transition will require standardization of certain areas (e.g., bill coding, performance metrics, etc.), training, funding and deployment of interoperable EHR and HIE infrastructure, robust data and analytics tools and the expertise to deploy them effectively, and availability of Medicaid claims and administrative data for analysis and benchmarking.

- **Integration of Data into an All-Payer Database** - For reasons noted above, the integration of Medicare and Medicaid claims data, along with administrative data sets containing clinical information (e.g., the Minimum Data Set, Outcome and Assessment Information Set and Uniform Assessment System – NY), will be vitally important to developing comprehensive quality and cost strategies. To date, efforts at data integration across payers and types of data sets are well behind schedule and need to be stepped up if VBPs are going to be successful.

B. Recommendations:

Following are recommendations aimed at addressing these concerns:

- **Readiness Checklist** - The State's Roadmap should include a VBP readiness checklist that can be used by providers and plans in their implementation of VBP. The readiness checklist should address areas such as: (1) capacity for real-time collection and sharing of clinical, cost and outcome data; (2) interoperable EHR and HIE capacity; and (3) enhanced staff skill levels.

- **Interoperable EHRs and HIE** - A master plan for interoperability of EHR and HIE capacity across service settings must be developed, and the associated funding should account for the fact that LTPAC providers were ineligible for federal HITECH funding and significantly under-represented in State HIT grant awards.

- **Explicit Funding Scenarios** - Plans to pass funds on to providers to help with costs associated with infrastructure should be made explicit in the Roadmap and account for the fact that not every LTPAC provider is involved in a PPS and few have a seat at the governance table of the PPSs under DSRIP. Our concerns along these lines particularly include rural LTPAC providers that may only have access to a single PPS and may also have difficulty achieving sufficient scale under VBP. The Roadmap should explicitly state how the infrastructure needs of smaller and rural providers and/or those involved with only a single PPS will be met, and how the standards for VBP will be modified in order maintain the viability of the service safety net.

- **Master Plan for Data** - Consistent with the State Health Innovation Plan, there should also be a State master plan for data accumulation, analytics and dissemination. This plan should address in detail the development of an all-payer claims database that is accessible to PPSs, as well as to non-DSRIP providers and MLTC/FIDA plans to facilitate VBP arrangements that are not going through a DSRIP PPS. The plan needs to include a strategy to integrate commonly collected administrative data sets and must be integrated with federal plans under the IMPACT Act (see below).

- **Interim Checkpoints and Automatic Adjustment of Goals** - The Roadmap should contain interim checkpoints that assess progress toward pre-determined milestones for the development of necessary infrastructure, and automatically recalibrate the overall goals for achieving certain percentages of Level 1-3 VBPs.

IV. Alignment with Medicare

A. Issues:

Alignment of NY's VBP Roadmap with Medicare's plans is vitally important to LeadingAge NY members because, as noted above, Medicare-covered services are the likely source of much of the value-creation. If Medicaid standards are similar, but different, from Medicare, then significant duplication of efforts and inability to reconcile variances could result.

Here are just two examples of important Medicare initiatives that will impact LTPAC providers' VBP efforts:

- **Improving Medicare Post-acute Care Transformation (IMPACT) Act of 2014** – This law mandates that the federal government develop a common core of patient assessment items as well as quality and resource use measures across LTPAC settings. This information will be used to facilitate VBP in the Medicare program, among other things.

- **Medicare SNF Readmissions Reduction Incentives** – Included in the Protecting Access to Medicare Act of 2014, this law mandates that the Medicare program consider and implement incentive payments based on measures of readmission rates, using either an attainment or improvement standard.

B. Recommendations:

Following are recommendations aimed at promoting greater alignment with Medicare:

- **Align VBP Definitions and Timeline** - An important gesture to demonstrate New York's commitment to alignment between Medicare and Medicaid -- from both a philosophical and practical standpoint -- would be for the State to align its definitions of VBP categories (Levels 0-3) and associated timelines with the federal government's VBP categories and timelines (see attached table).

- **Make Alignment with Medicare Explicit** - The VBP Roadmap should make the intended alignment with Medicare more explicit and should include a specific review of all applicable federal VBP initiatives that are intended to be implemented during the next five years. Specifically, New York's patient assessment and quality measure strategy for LTPAC should not be duplicative of or at variance with the IMPACT Act.

V. Alignment of FIDA VBP Timeline with the State's Roadmap

A. Issue:

- **Readiness for VBP in FIDA -** LeadingAge NY members that operate FIDA plans are concerned about requirements for plans to implement VBP prior to the development of databases and infrastructure to support large scale VBP. We note that for Medicare initiatives such as ACOs and Bundled Payments for Care Improvement, Medicare supports such entities with ready access to claims and benchmarking data, affording participants the ability to design and effectuate VBP arrangements in a more informed manner.

B. Recommendation:

- **Align FIDA VBP Timeline and Goals** - Given these concerns about readiness and data availability, we recommend that the timeframes and other aspects of the transition to VBP under FIDA be aligned with the corresponding elements of the State's VBP Roadmap for DSRIP.

VI. Alignment of MLTC/FIDA with VBP Innovator Program

The VBP Innovator Program, which we understand is aimed at allowing providers to progress to higher levels of VBP payments in exchange for multi-year commitments and a high percentage of capitation (i.e., 95%) from the plans, is designed to accelerate VBP in scenarios where there are a high percentage of patients at risk.

A. Issue:

- **Program Eligibility** - Since MLTC and FIDA plans are at risk for 100 percent of payments and many of these plans are provider-sponsored, we request clarification on whether those plans will be eligible entities for VBP Innovator Program funds. Similarly, LTPAC providers could only ever qualify for such funds if they virtually replicated an MLTC or a FIDA plan.

B. Recommendation:

- **Clarify Eligibility of LTPAC Providers for VBP Innovator Program** - The Roadmap should clarify the eligibility of MLTC and FIDA plans for VBP Innovator Program and outline a scenario whereby a LTPAC provider that is primarily contracting with such plans could qualify for this program.

VII. Alignment with Audit Policies

A. Issue:

- **Potential for Misalignment** - Historically, audit policies lag behind policy developments and payment innovation. In the case of VBP, new arrangements between providers and plans will be developed and policies utilized in fee-for-service arrangements such as prior authorization and utilization review will be revisited. It is vitally important that audit policies do not have an unintended chilling effect on development of creative new ways to improve care and lower costs.

B. Recommendation:

- **OMIG Roadmap Review** - The Office of Medicaid Inspector General should be asked to review the Roadmap, provide formal comments and provide proactive policy guidance to providers and plans.

- **Clarify Gainsharing** - Applicable laws and regulations on gainsharing should be reviewed and, either changes made or safe harbors created, in order to ensure that practices consistent with the objectives of VBP are not unintentionally discouraged.

Through its Task Force on Alternative Payment Arrangements, LeadingAge NY will continue to provide substantive feedback on VBP approaches for the LTPAC population in the coming weeks. Thank you for your consideration of our concerns and recommendations. If you have any questions, please do not hesitate to contact us at (518) 867-8383.

Sincerely,

Daniel J. Heim
Executive Vice President

Attachment

cc: Marc Berg

Comparison of CMS and NYS Plans for Value-Based Payment Roll-Out[2]

CMS	NYS
Payment Taxonomy	
• **Category 1**—FFS with ***no*** link of payment to quality. Not "value-based"	N/A
• **Category 2**— FFS with a link of payment to quality (e.g., hospital value-based purchasing, readmission penalties)	• **Level 0** – FFS with bonus or withhold based on quality.
• **Category 3**—alternative payment models built on fee-for-service architecture - includes models with shared savings only or with 2-sided risk (e.g., bundled payment initiative or ACOs)	• **Level 1 –** FFS, FFS bundle, or FFS based on subpopulation capitation with shared savings only when outcome scores are sufficient
• **Category 3**—alternative payment models built on fee-for-service architecture - includes models with shared savings only or with 2-sided risk (e.g., bundled payment initiative or ACOs)	• **Level 2** – FFS, FFS bundle, or FFS based on subpopulation capitation with 2-sided risk based on outcome scores.
• **Category 4**—population-based payment (Pioneer ACOs)	• **Level 3** – Capitation (global, primary care, prospective bundle, or subpopulation) with outcome-based component.
Timeline*	
• **Categories 2-4 (includes equivalent of NYS Levels 0-3):** 85% *of FFS* by 2016 90% *of FFS* by 2018 • **Categories 3 and 4 (includes equivalent of NYS Levels 1-3):** 30% *of FFS* by 12/2016 50% *of FFS* by 12/2018	• **Levels 1-3 (includes equivalent of CMS Categories 3 and 4) :** *80-90% of managed care payments to providers are VBP by end of 2019 (DY5).* • **Levels 2 and 3 (includes equivalent of CMS Category 3 with 2-sided risk and Category 4):** *70% "of total costs" are VBP by end of 2019 (DY5).*

* The CMS timeline applies only to fee-for-service payments (not Medicare Advantage plan payments), whereas the NYS timeline applies to managed care payments.

[2]Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume," CMS, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html (accessed 3/18/15); "VBP Roadmap – Third Draft," NYS Dept. of Health, March 2015.