August 14, 2015

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

RE: COMMENTS ON MEDICARE AND MEDICAID VALUE-BASED PAYMENT ALIGNMENT

Dear Mr. Helgerson:

On behalf of LeadingAge New York, I am writing to share our preliminary comments on the draft paper, *Value-Based Payment Reform in New York State: A Proposal to Align Medicare's and NYS Medicaid's Reforms ("the paper")*. LeadingAge NY represents almost 500 not-for-profit and public providers of long term and post-acute care (LTPAC) and housing services to elderly individuals and people with disabilities 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) and Fully Integrated Duals Advantage (FIDA) plans and Programs of All-Inclusive Care for the Elderly (PACE).

Our comments are preliminary in nature; we may supplement them prior to August 31, 2015 based on an upcoming meeting of the LeadingAge NY Task Force on Alternative Payment Arrangements, which is comprised of provider and plan members of the Association.

I. Overall Comments

We agree with the paper's stated goals of reducing fragmentation, increasing consistency in payment models, and recognizing Medicare savings within the Roadmap's Value-Based Payment (VBP) models. However, as discussed in more detail below, the paper appears to accelerate the shift of Medicare payments into Alternative Payment Models (APMs), focusing on the benefits of this rapid and wide-ranging VBP adoption, without acknowledging and addressing its risks. The paper's proposals would drive more than 80 percent of the total operating revenues of LTPAC providers into VBP arrangements within the next four years.[1] Unlike hospitals and physician practices, LTPAC providers rely almost entirely on Medicare and Medicaid funding. They will not have the ability to cushion the transition to VBP with commercial revenue. Yet, the proposed VBP models that will determine their viability are

[1] See, e.g., New York's Nursing Homes, Shifting Roles and New Challenges," United Hospital Fund, 2013 at 23, available at http://www.uhfnyc.org/publications/880922 (84 percent of net patient revenue received by nursing homes is derived from Medicaid and Medicare).

13 British American Blvd. | Suite 2 | Latham, NY 12110
P 518.867.8383 | F 518.867.8384 | LeadingAgeNewYork.org

just beginning to be evaluated. According to a Rand study commissioned by the U.S. Department of Health and Human Services:

> "ACOs and bundled payment programs that embed clinical quality measures have only recently emerged and are just now being tested and evaluated. There is currently very limited evidence regarding the impact of these programs and whether they can be successfully implemented."[2]

We are further concerned that the providers most dramatically affected by these proposals – LTPAC and other providers that rely heavily on governmental payers – are likely to lack the infrastructure necessary to manage risk and succeed under APMs. LTPAC and behavioral health providers, for example, have been excluded from Electronic Health Record (EHR) incentive payments and often lack the Health Information Technology (HIT) capacity needed to exchange clinical information and to support robust data collection and analytics.

In addition, although the paper strives to reduce administrative complexity by seeking to include Medicaid beneficiaries in Medicare APMs and vice versa, we are concerned that this may only add to administrative challenges. Under these scenarios, the attribution of a beneficiary to a model would not be determined by the payer (i.e., Medicare or Medicaid) for the covered services. Conceivably, each patient/resident could be eligible for several different models, and providers would need complex systems to identify the applicable payment model for each patient/resident and his/her condition, service or procedure.

Finally, the paper proposes new models of integrating care for dual eligibles – a special needs Accountable Care Organization (ACO), Medicare Advantage Plans with "wraparound functionality," and the Montefiore *Patients First* Demonstration – without acknowledging existing models and the roles that they may play in achieving the State's payment reform and Triple Aim goals. The special needs ACO sounds like a PACE program. Similarly, provider-sponsored FIDA plans are risk-bearing entities integrated with provider networks. Both PACE and FIDA plans bear risk for a comprehensive array of Medicare and Medicaid services for their members and should be leveraged as key components of the State's efforts.

II. Recognizing Medicare Savings

In our previous comments on the New York State (NYS) VBP Roadmap, we expressed support for alignment of Medicaid and Medicare VBP policies, particularly in relation to LTPAC services provided to dually eligible beneficiaries. To the degree that achieving "value" involves reductions in health care spending, most of the value-creation opportunity in LTPAC services lies not with managing Medicaid-funded long-term care services, but with reducing avoidable utilization of the Medicare-covered services for dually eligible beneficiaries. We remain concerned that the proposals set forth in the paper do not create a clear path for recognizing Medicare savings achieved by LTPAC providers.

---

[2] Damberg, C. et al., "Measuring Success in Health Care Value-Based Payment Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions," Rand, 2014, available at www.rand.org/pubs/research_reports/RR306.html.

The dually-eligible beneficiaries served by our members have complex medical conditions and functional limitations. Aggressive management of long-term care services is often inappropriate for these vulnerable beneficiaries. 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 (FFS) rates have eliminated most opportunities for unit cost savings. Thus, the most significant source of savings in the total cost of care for these beneficiaries is likely to be reductions in avoidable hospitalizations—savings which accrue to Medicare.

If LTPAC providers cannot benefit from the Medicare savings they help to generate, the fragmented system we experience today will likely continue to exist and value-based care transformation will not achieve sufficient scale in the LTPAC sector. Without proper mechanisms in place to recognize Medicare savings, LTPAC providers would bear risk from a predominant payer (i.e., Medicaid) without the opportunity to benefit from a reduction in the overall cost of care.

Although the draft paper speaks to "virtually pooling" Medicare and Medicaid dollars, it does not clearly address how this will be achieved. The paper proposes that beneficiaries under one program be covered by the payment models of another program, yet it appears that the two payment streams will remain separate, except perhaps in the case of the Montefiore demonstration.

Recommendations: The goal of aligning NYS Medicaid VBP with Medicare's efforts is conceptually worthwhile for the reasons cited in the paper (i.e., reduced fragmentation, helping providers and MCOs achieve scale in VBP, and increasing quality). However, the discussion on fragmentation in the paper should be augmented to acknowledge explicitly that Medicare-covered services are, as a practical matter, the primary area of opportunity for LTPAC providers to actually increase value.

The Centers for Medicare & Medicaid Services (CMS) and NYS should work together to implement effective mechanisms to ensure that LTPAC providers that drive Medicare savings receive a share of those savings or other appropriate incentive payments through their Medicaid VBP models. If the State pursues "virtual pooling," the discussion should be expanded to clarify that providers of Medicaid-funded services would receive a portion of the Medicare savings they generate through their Medicaid payment arrangements. For example, a LTPAC network contracting with an MLTC under a risk model would receive a share of any reductions in the overall cost of Medicare and Medicaid services delivered to its patients/residents, even though its contract with the MLTC covers only the delivery of Medicaid services. In addition, any Medicaid rate of payment that incorporates one or more pay for performance elements (e.g., reducing avoidable hospital use, improving quality scores, etc.) should count in its entirety towards the 80-90 percent VBP Level 1 goal and result in enhanced Medicaid payments. These steps are critical to achieving the scale needed to realize value-based care transformation among LTPAC providers.

III. Readiness of LTPAC Providers for Accelerated Penetration of VBP

We are most concerned about the readiness of LTPAC providers and MCOs to move more than 80 percent of their patient care revenues to VBP arrangements in the short-run. There has been no

meaningful sharing of data for benchmarking purposes; provider and plan billing, data and analytics infrastructure, and HIT systems are simply not ready for wide scale adoption of VBP arrangements; and the structure, process and culture of care delivery need to be transformed. LTPAC providers were left out of federal HITECH funding and have been under-represented in NYS grant awards for EHR adoption and for building health information exchange capacity. Consequently, important elements of the infrastructure needed for success in a value-based arena are still lacking for LTPAC providers.

By including Medicare beneficiaries in the State's VBP arrangements, the proposal would tend to accelerate the movement of Medicare revenues to higher levels of VBP in a shorter timeframe and heighten the effects of VBP on LTPAC providers. As a result of this proposal, the vast majority of LTPAC provider revenues will be paid through VBP models within the next few years. Many of these models are just beginning to be tested, and their effects on outcomes and the financial stability of providers are unknown. Ironically, this proposal would most profoundly impact those providers that are most financially vulnerable and least prepared from an infrastructure perspective for a rapid foray into VBP, namely LTPAC and other providers that depend on Medicare and Medicaid for the overwhelming majority of their funding.

Recommendation: LTPAC providers need financial support for the development of the infrastructure (particularly interoperable EHRs, health information exchange capacity, data and analytics capabilities, reconfigured billing systems) and operational knowledge needed to transition from being primarily funded by two payers (i.e., Medicare and Medicaid FFS) to receiving VBP from multiple MCOs through various arrangements, including direct contracting and multi-provider agreements.

IV. Models for Dual Eligibles with Long Term Care Needs

For the MLTC population, the paper (page 5) suggests that a condition-specific/disease-specific ACO may provide the structure for the payment model. While this is an interesting concept, to the best of our knowledge this model is largely untested, particularly for the population and constellation of services covered by MLTC plans. In addition, a condition-specific ACO, overlaid on top of an MLTC plan, would create another layer of overhead which must be reimbursed and may present some challenges when applied to a multimorbid population already under managed care.

The paper pays scant attention to FIDA and PACE, even though both seek to achieve Medicaid and Medicare alignment. The text box on page 8 discusses the NYS dual eligible population and the FIDA program, and refers to improving the quality and efficiency of care for this population in a complementary way. We recognize that FIDA plans are in their infancy, and their scale may inhibit VBP adoption initially. However, the State and federal governments should examine and address barriers to enrollment in both programs and elaborate on the roles these programs can play in VBP efforts.

While the paper includes little discussion on the FIDA or PACE programs, the proposal to permit Montefiore to be the first fully-integrated Medicare/Medicaid ACO is reminiscent of a PACE program or provider-sponsored FIDA plan. We suggest that rather than building new models of integrated care, the State may want to focus on expanding those already in operation. Once again, this underscores

the importance of joint NYS-CMS efforts to address enrollment and other operational barriers facing these existing programs.

Similarly, the paper proposes to align MCOs and Medicare Advantage (MA) plans (page 13) which, while conceptually appealing, raises several questions. We presume that the term "MCOs" would include MLTC plans. However, since MLTC and MA plans cover significantly different benefits, it will be difficult to align the VBP arrangements, rules and outcomes between the two. We question whether the goal should be to align the VBP arrangements between these two types of plans; or rather, to give both types of plans and their network providers a stake in the outcomes and overall spending associated with their members.

Toward that end, the paper refers to creating "'wrap around' functionality" under which MA plans would manage all Medicaid and Medicare expenditures for their members. According to the paper, this would require contracting with 'special needs' ACOs focused on the MLTC subpopulation (text box page 14). Assuming wrap around functionality refers to the Medicaid benefits covered by MLTC plans, how does this differ from a FIDA plan? From a PACE program? Why is contracting with a special needs ACO necessary to the model?

Recommendation: Rather than creating new models, the State should leverage existing infrastructure first. We do not see a compelling need to create yet another model aimed at aligning these benefits.

V. Specific Comments

Our more specific comments on the draft alignment paper follow:

- On page 1, the paper states: "Providers' incentives to transition to value based payment arrangements will be greatly increased with approx. 50% of total provider payments moving towards value based payments in unison." While this may be true system-wide, as noted above, Medicare and Medicaid payments comprise a far greater portion of LTPAC providers' patient care revenues (i.e., on the order of over 80 percent), and these payment models are largely untested. They may have the potential to provide significant rewards, but also pose substantial risks, particularly when nearly all of a provider's revenue stream is tied to them.

- On page 2, the paper claims: "Financially weak safety-net providers in NYS will be greatly supported by the ability to be rewarded for delivering value consistently across Medicaid and Medicare." It is important to recognize that financially weak, safety-net providers are also less likely to have the infrastructure necessary to succeed and funding for the reserves necessary to take on risk. They also typically lack the technology and other resources necessary to optimize performance on the quality measures that determine eligibility for incentive payments. Finally, these providers are typically more dependent on government financing programs (i.e., Medicare and Medicaid) than other providers. As a result of these features, they will be placed at greater risk of financial collapse, if they do not achieve savings or quality goals. Ironically, the alignment proposal could expose them to greater financial risk than other providers.

- Page 3 of the paper indicates that, in the absence of VBP, increasing the value of care delivered negatively impacts the financial sustainability of providers, and that the NYS Roadmap would reward value with potentially higher margins. 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 or community integration) for dually eligible persons in long-term care settings could reasonably be expected to increase the costs of certain Medicaid-covered services over time. This may reduce or eliminate the ability of LTPAC providers to generate savings and may even expose them to financial penalties. Under the current system, Medicare's FFS reimbursements offset losses that LTPAC providers sustain under Medicaid. Depending on how Medicare savings are calculated and apportioned to LTPAC providers under the Roadmap, and what effect APMs such as bundling will have on payments to these providers, higher margins may not result.

- The paper's discussion of "allowing" Medicaid beneficiaries into CMMI Innovation models (p. 10) is a good start, but does not go far enough. For instance, today there is no opportunity for additional LTPAC providers to become Model 3 (post-acute initiated) bundlers under the Bundled Payments for Care Improvement (BPCI) initiative because that program is currently closed to new entrants. If NYS and CMS could facilitate voluntary participation of LTPAC providers serving duals into a Model 3 style BPCI program with upside-only risk (with some of the modifications recently announced in the Comprehensive Care for Joint Replacement Model), this could create a viable opportunity for SNFs and home health agencies to enter into VBP. In order to encourage voluntary uptake, the State would have to be clear that all of the payments (Medicare and Medicaid) would automatically be regarded as meeting Level 1 (or as appropriate Level 2) VBP goals, resulting in enhanced Medicaid payments.

- Enrollment of Medicare FFS beneficiaries in NYS VBP arrangements will not necessarily result in reduced complexity for providers, as suggested on page 8. We assume that the Medicare APMs would continue to operate for Medicare FFS beneficiaries. As a result, services provided to Medicare FFS beneficiaries would be dispersed among Medicare APMs and Medicaid VPB models. This may add to, rather than reduce, administrative complexity and risk. Instead of applying Medicare models to Medicare services and Medicaid models to Medicaid services, providers will have to track the model that each beneficiary and each service is attributed to on an individual basis. Medicaid payments will be made through MCOs and may vary in structure and amount by MCO, whereas some Medicare FFS payments will be made either by Medicare, with shared savings/losses calculated and processed by DOH or directly by Medicare through Medicare APMs.

- With respect to the proposal to include Medicare FFS duals in NYS VBP models (page 12), we presume that Medicare would contract with a group of providers for all of the ambulatory and acute care on a value basis, and the Medicaid MLTC would pay providers for the long-term care services on a value basis. The State proposes to calculate and administer baseline data, shared savings, potential shared losses and risk adjustment models, at the total cost of care per APM, including both Medicaid and Medicare components.

How would savings/losses be calculated and allocated when crossover payments are occurring (e.g., Medicaid paying Medicare cost sharing amounts)? If the State is calculating shared savings/losses on a total cost of care basis, what would the role of the MLTC be in value-based contracting? Would the MLTC receive a share of savings/losses? What role, if any, would the MLTC play in overseeing/facilitating transitions of care? It is also not clear how savings/losses would be divided among the providers. Would LTPAC providers receive a share in the savings derived from hospitalizations they helped to avert? Or is this savings intended for hospitals to compensate them for lost revenue? Some examples of the types of arrangements the State is envisioning and their financial impact should be included in the paper.

- This proposal excludes dual eligibles with developmental disabilities, a population that has not yet transitioned to Medicaid managed care. Will the proposal also exclude other populations that have not yet transitioned (e.g., pediatric patients, TBI and NHTD waivers, etc.) and/or are excluded from Medicaid managed care (e.g., hospice-covered, etc.)?

In conclusion, we continue to believe that it is vitally important to create a *platform* for integrated, value-based care, particularly for dually eligible beneficiaries. 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. 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.

Through its Task Force on Alternative Payment Arrangements, LeadingAge NY will continue to provide substantive feedback on the alignment paper, as well as through the VBP subcommittees and clinical advisory groups. 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

cc: John Ulberg
Mark Kissinger
Vallencia Lloyd
Marc Berg
Meghan Gleason