NEW YORK STATE | Department of Health | Medicaid Redesign Team

Managed Long-Term Care

Clinical Advisory Group Meeting 1

Meeting Date: 11/12

2015

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Tentative Meeting Schedule and Agenda

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A. Clinical Advisory Group Roles and Responsibilities
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Part II

A. Impressions of Data Available for Value-Based Contracting

Introductions

Tentative Meeting Schedule & Agenda

Depending on the number of issues addressed during each meeting, the meeting agenda for each CAG will likely consist of the following:

Meeting 1

- Clinical Advisory Group- Roles and Responsibilities
- Introduction to Value Based Payment
- Value Based Payment in Managed Long Term Care
- The Opportunities of Empowering Providers
- MLTC Subpopulation– Impressions of Data Available for Value Based Contracting

Meeting 2

- MLTC Population Definition Recap
- MLTC Population Outcome Measures - I

Meeting 3

- MLTC Population Outcome Measures - II

Part I

A. Clinical Advisory Group (CAG) Roles & Responsibilities

Roles and Responsibilities Overview

Clinical Advisory Group Composition

Comprehensive Stakeholder Engagement

- Comprehensive stakeholder engagement has been a key component to the development of the Value Based Payment Roadmap.
- We will continue engaging stakeholders as we develop and define opportunities for value based payment arrangements.

Composition of the CAG includes:

- Clinical experience and knowledge focused on the specific care or condition being discussed (MLTC)
- Industry knowledge and experience
- Geographic diversity
- Total care spectrum as it relates to the specific care or condition being discussed

CAG Objectives

- Understand the State's visions for the Roadmap to Value Based Payment
- Review clinical bundles/subpopulations that are relevant to NYS Medicaid
- Make recommendations to the State on:
  - outcome measures
  - data and other support required for providers to be successful
  - other implementation details related to each bundle/subpopulation

❖ *Definitions are standard, but financial arrangements between plans and providers around the bundles are not set by the State.*

❖ *We will discuss the specific characteristics of the MLTC population & the challenges of the Medicaid-Medicare divide later in the presentation*

Part I

B. Introduction to Value Based Payment

Brief background and context

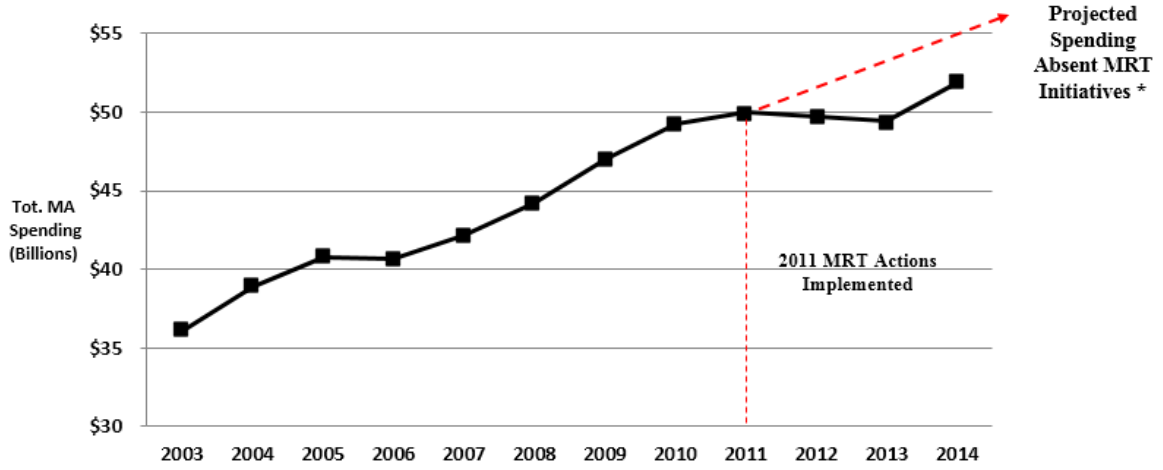
NYS Medicaid in 2010: the Crisis

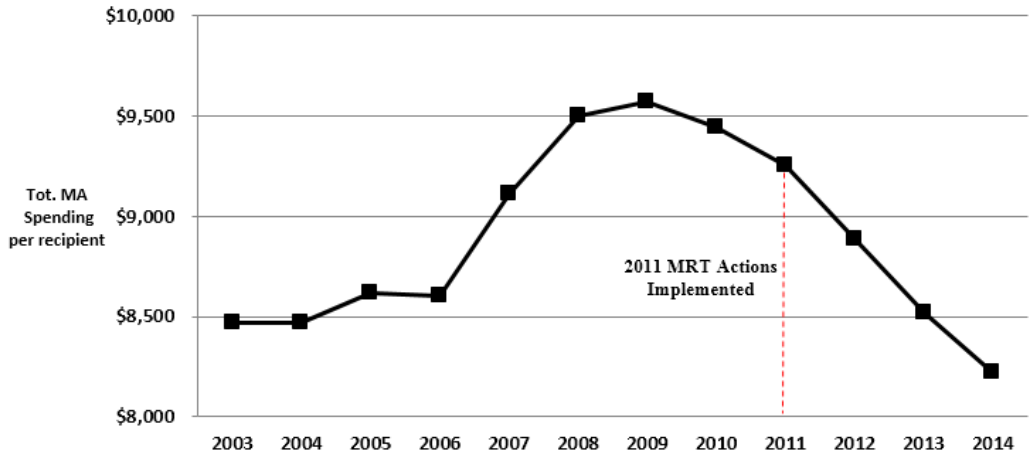
- > 10% growth rate had become unsustainable, while quality outcomes were lagging
  - Costs per recipient were double the national average
  - NY ranked 50th in country for avoidable hospital use
  - 21st for overall Health System Quality

2009 Commonwealth State Scorecard on Health System Performance

CARE MEASURE	*NATIONAL RANKING*
Avoidable Hospital Use and Cost	**50th**
✓ Percent home health patients with a hospital admission	49th
✓ Percent nursing home residents with a hospital admission	34th
✓ Hospital admissions for pediatric asthma	35th
✓ Medicare ambulatory sensitive condition admissions	40th
✓ Medicare hospital length of stay	50th

Medicaid Redesign Initiatives Have Successfully Brought Back Medicaid Spending per Member to below 2003 Levels





Since 2011, total Medicaid spending has stabilized *while number of members has grown > 12%*

Medicaid spending per-member has continued to decrease

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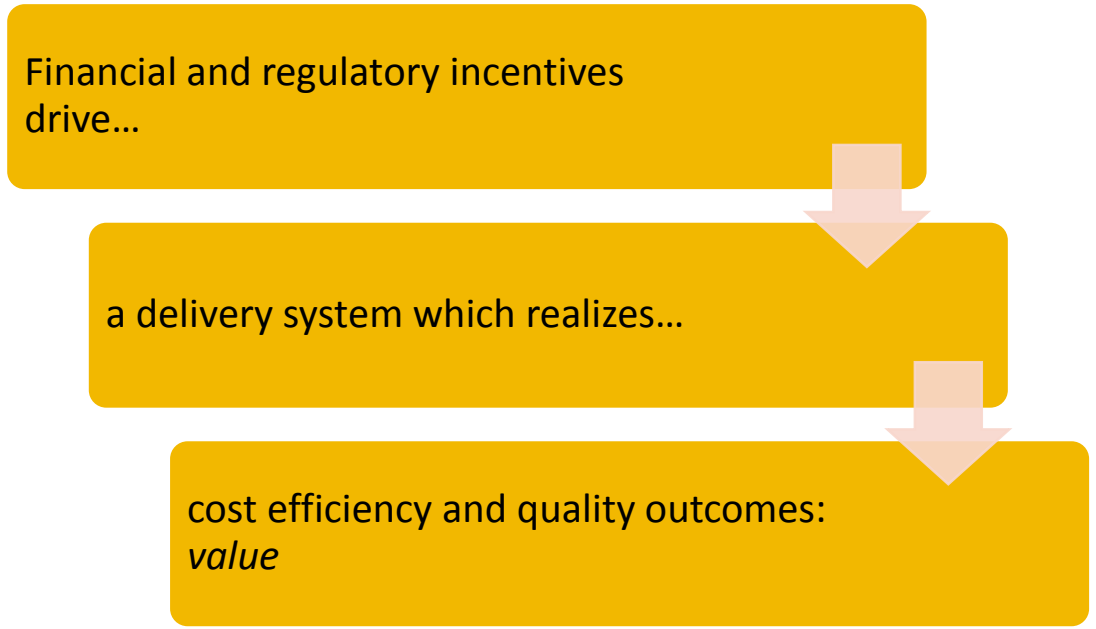
Delivery Reform and Payment Reform: Two Sides of the Same Coin

- A thorough transformation of the delivery system – DSRIP - can only become and remain successful when the payment system is transformed as well
- Many of NYS system's problems (fragmentation, high re-admission rates) are rooted in how the State pays for service
  - FFS pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
  - Current payment systems do not adequately incentivize prevention, coordination, or integration

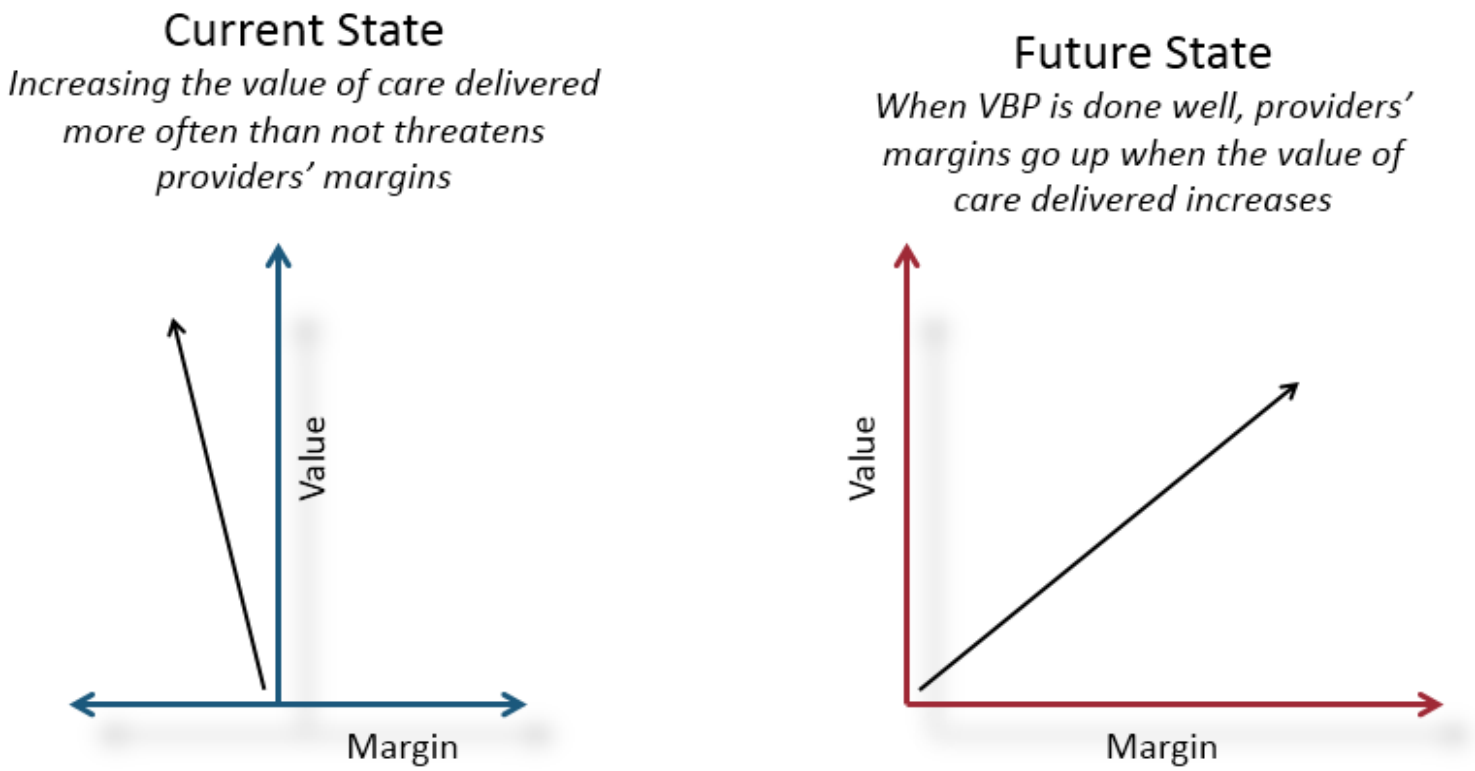


Payment Reform: Moving Towards Value Based Payments

- A Five-Year Roadmap outlining NYS' plan for Medicaid Payment Reform was required by the MRT Waiver
- By DSRIP Year 5 (2019), all Managed Care Organizations must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the *Special Terms and Conditions* of the waiver)
- Core Stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap

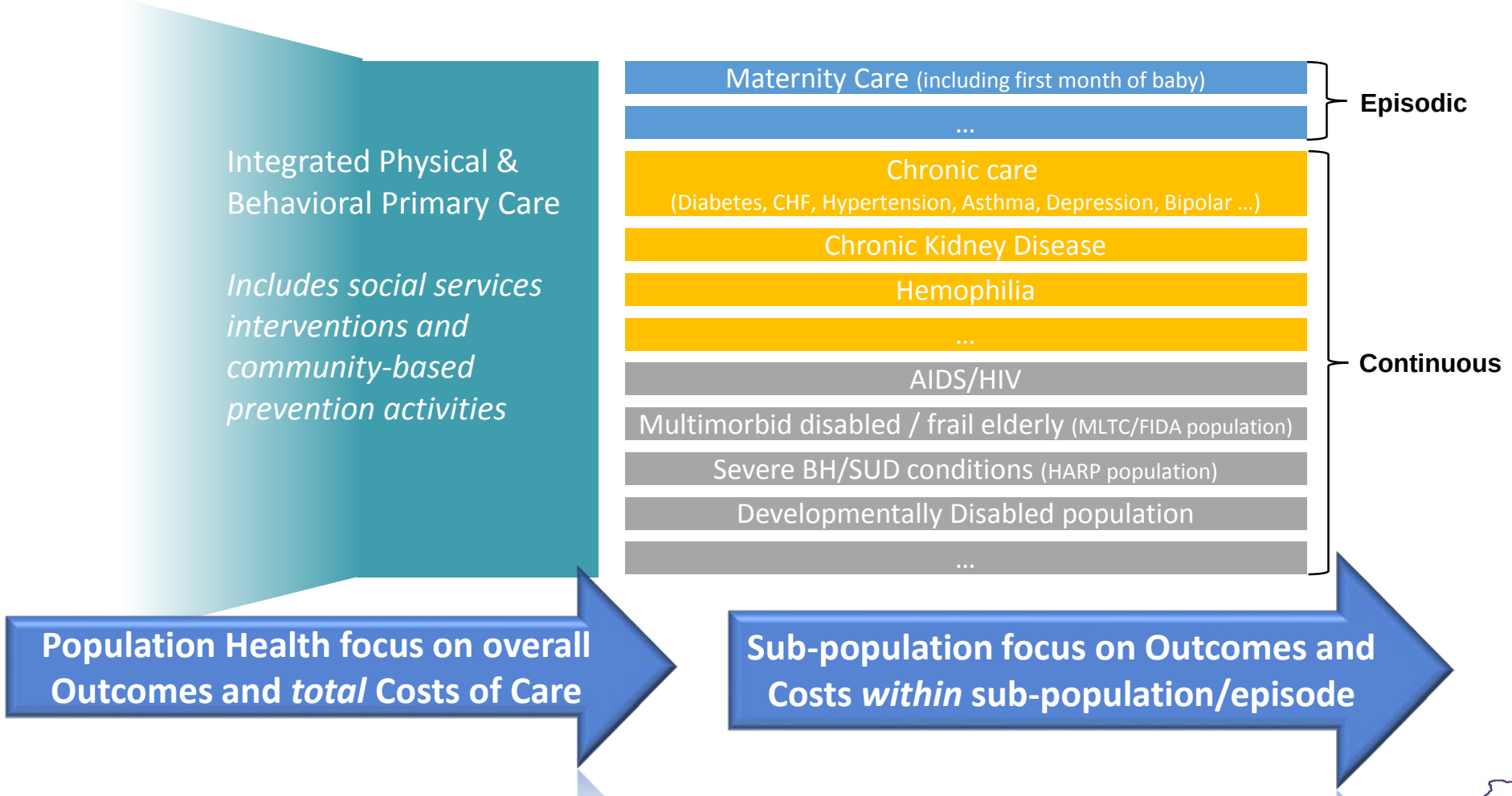
Learning from Earlier Attempts: VBP as the Path to a Stronger System

VBP arrangements are not intended primarily to save money for the State, but to *allow providers to increase their margins* ***by realizing value***



Goal – Reward Value not Volume

The VBP Roadmap starts from DSRIP Vision on How an Integrated Delivery System should Function

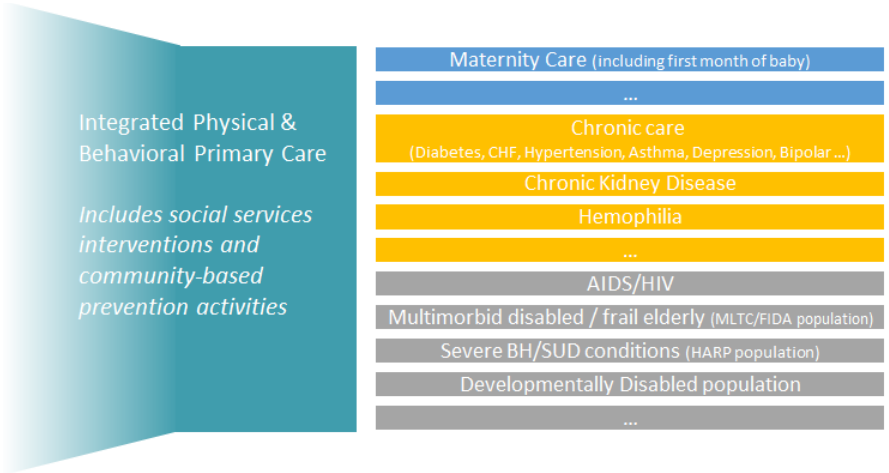


The Path Towards Payment Reform: A Menu of Options

There is not one path towards Value Based Payments. Rather, there will be a variety of options that MCOs and PPSs/providers can jointly choose from.

PPSs and MCOs can opt for different shared savings/risk arrangements (often building on already existing MCO/provider initiatives):

- For the total care for the total attributed population of the PPS (or part thereof) – ACO model
- Per integrated service for specific condition (acute or chronic bundle): maternity care; diabetes care
- For integrated Advanced Primary Care (APC)
- For the total care for a subpopulation: HIV/AIDS care; care for patients with severe behavioral health needs and comorbidities



MCOs and PPSs can make shared savings arrangements for the latter types of services between MCOs and groups of providers within the PPS rather than between MCO and PPS.

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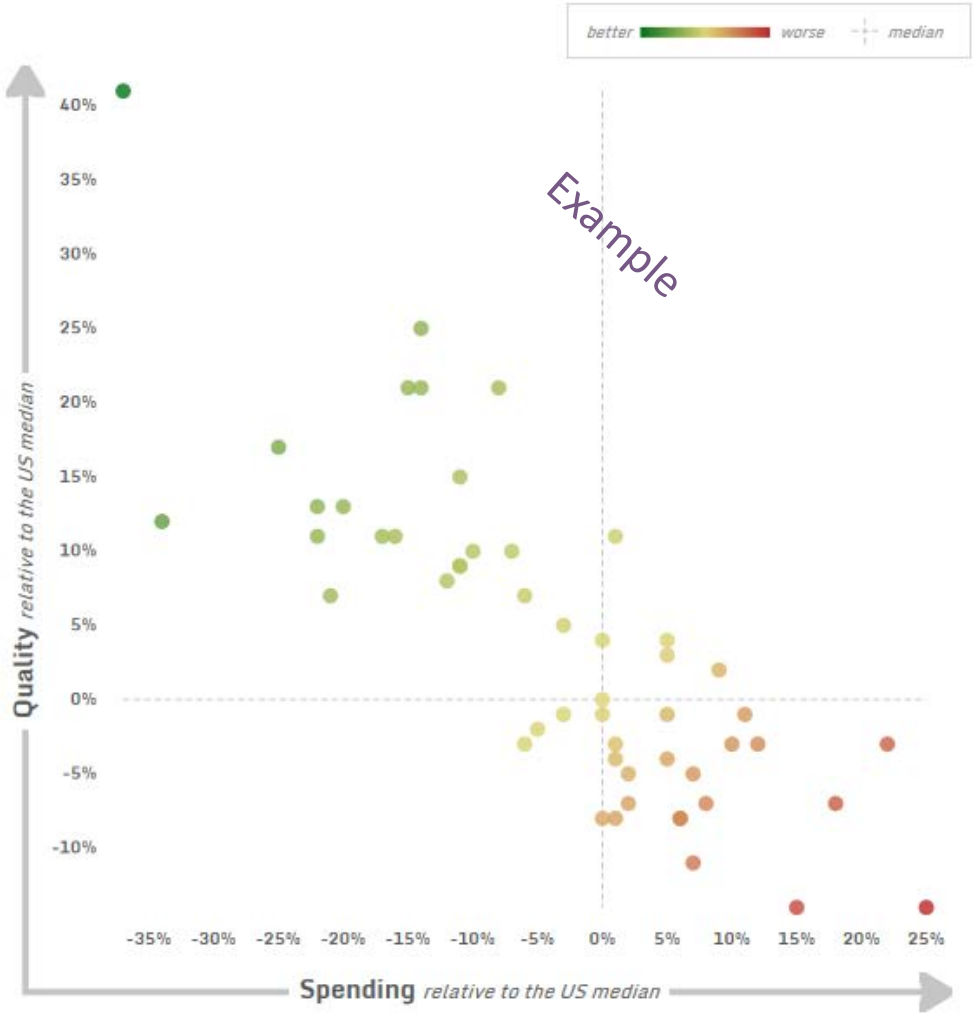
MCOs and PPSs can choose different levels of Value Based Payments

In addition to choosing *what integrated services* to focus on, the MCOs and PPSs can choose different levels of Value Based Payments:

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

- Goal of ≥80-90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- 35% of total managed care payments (full capitation plans only) tied to Level 2 or higher. For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans from this minimum target.

Value Information per VBP Arrangement
(using price-standardized data)



Providers and MCOs will receive

- Cost and Quality performance overviews per VBP arrangement (whether these arrangements are contracted or not)
- Including Target Budgets and actual costs (both cost-standardized, and, for their own members, real-priced)

Initially, PDF reports will be used, but providers and MCOs will get access to web-based analytical tools to dynamically interact with these data

- Including drill downs by geography and provider
- Including drill down possibilities to individual patients (for own members)

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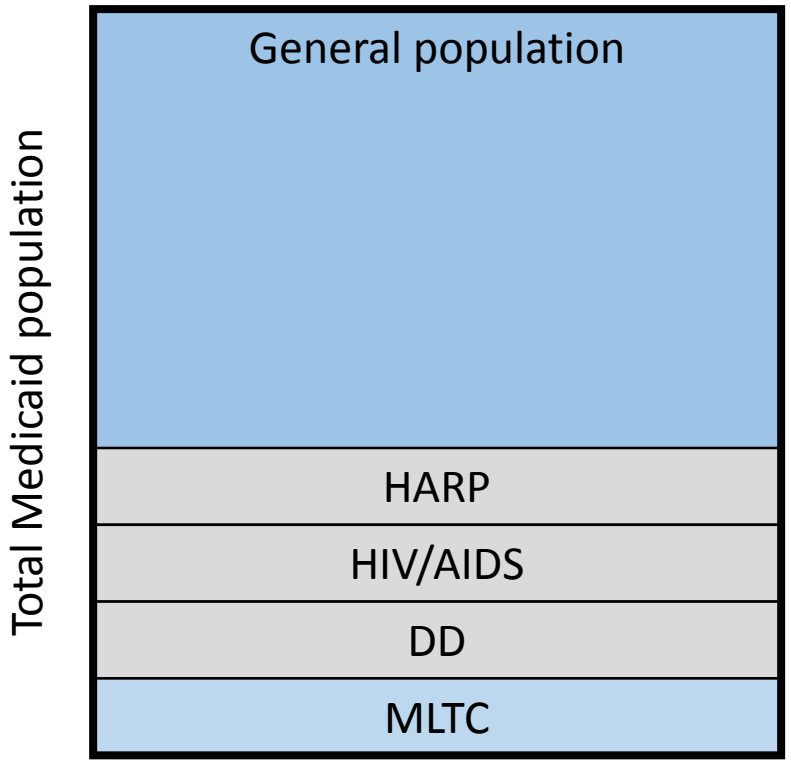
Part I

C. Value Based Payment in Managed Long Term Care

Understanding the target population

The total Medicaid population is divided in four subpopulations and the general population



- Four subpopulations are carved out of the total Medicaid population
- MLTC is one of those subpopulations
- Subpopulation arrangements are inclusive of *total* cost of care and outcomes are measured at the level of the whole subpopulation.
- When we speak of MLTC we include the Nursing Home care and costs currently being transitioned into the MLTC plans

MLTC delivers long-term services to the chronically ill or disabled and who wish to stay in their homes

MLTC services, like home care or adult day care, are provided through managed long-term care plans. All services that an enrolled member is entitled to can be received through the MLTC plan they have chosen.

Inclusion Criteria

Any individual who is enrolled in any one of three MLTC plan types, and where the payer for services is Medicaid, or where services are paid for by both Medicaid and Medicare:

- **MLTC Medicaid Plan** – Partially capitated services; covers certain Medicaid services only
- **Medicaid Advantage Plus** – Full capitated; provide all Medicare and Medicaid services in one plan, including primary, acute and long-term care
- **Program of All-Inclusive Care for the Elderly (PACE)** – Similar to Medicaid Advantage Plus – However, you must be over 55 years old to join PACE.

Exclusion Criteria:

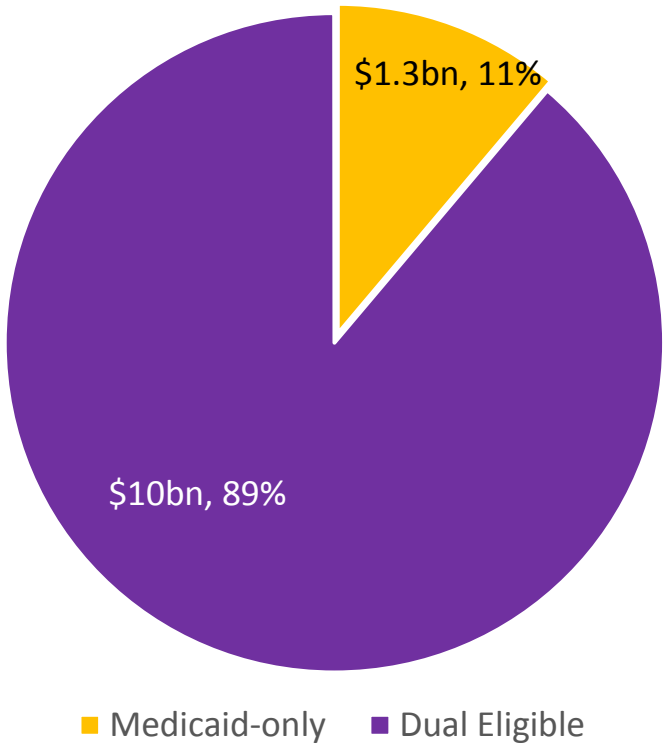
Individuals who cannot enroll in MLTC plans because they are:

- Under 18 years old
- Enrolled in a Community Alternative Systems Agency
- Enrolled in a Nursing Home Transition & Diversion waiver
- Enrolled in an Office of People with Developmental Disabilities (OPWDD) waiver
- Enrolled in a Long Term Home Health Care (Lombardi) program.
- MLTC beneficiaries who incur services which are paid for exclusively by Medicare without a Medicaid component

Special characteristics of MLTC CAG – I: Dual-Eligible members represent the majority of both Spend and Member Volume

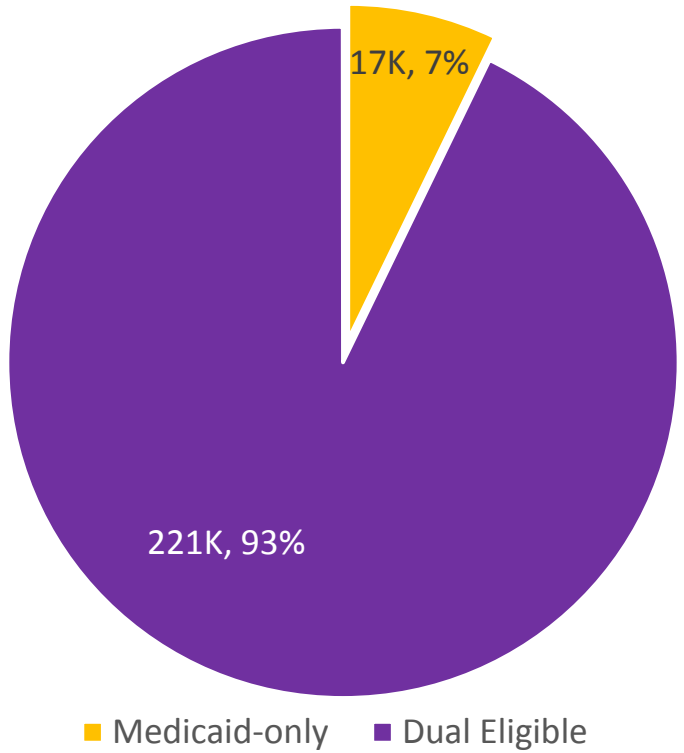
Medicaid-only MLTC Beneficiary Costs relative to Dual-Eligible MLTC Beneficiary Cost

Total Spend in 2014: $11.3bn



Medicaid-only MLTC Beneficiary Volume relative to Dual-Eligible MLTC Beneficiary Volume

Total Members in 2014: 238K



Costs Included:

- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.
- Caveat: Costs at $11.3bn are based on 2014 data and account for the planned future nursing home transition.

Source: 01/01/2014 – 12/31/2014 Medicaid claims (Salient Interactive Miner)

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Special characteristics of MLTC CAG - II

- We are in the midst of the transferring of nursing home care to MLTC
- Concurrently, State is considering expanding MLTC to include primary care services
- Key NYS goal is to reduce avoidable hospital use: admissions and ER visits.
  - Savings of those reductions may accrue to Medicare, not Medicaid…

- *NYS DOH wants to prioritize these goals even if that means investing in rewarding providers to achieve these goals*
- *In parallel, DOH is actively working with CMS on realizing Medicaid – Medicare alignment*

- *Opportunities to unlock value may also exist in Long-Term Care*

C. The Opportunities of Empowering Providers

VBP in MLTC – what could be possible

Opportunities in MLTC

- Would the specific nature of MLTC plans allow for > 50% shared savings even in Level 1 VBP arrangements?
  - Depending on the risk profile of the MLTC population

- Would the opportunity for significant shared savings for MLTC providers allow them to *improve margins while reducing hours and bed days?*

- What would be key outcome measures?
  - Client satisfaction surveys
  - An instrument to capture individual goals and preferences

Part II

A. MLTC– Impressions of data available for value-based contracting

Four Important Costs Drivers for the MLTC population are Price, Volume, PACs and Service Mix

Cost Drivers

Price

The price of a service can vary based on providers' own costs (e.g. wages).

Volume

The volume of services rendered (e.g. nursing home use).

PACs

Potentially avoidable complications (e.g. exacerbations).

Service Mix

The mix of services and intensity of care received during the episode (e.g. inpatient vs. outpatient point of care).

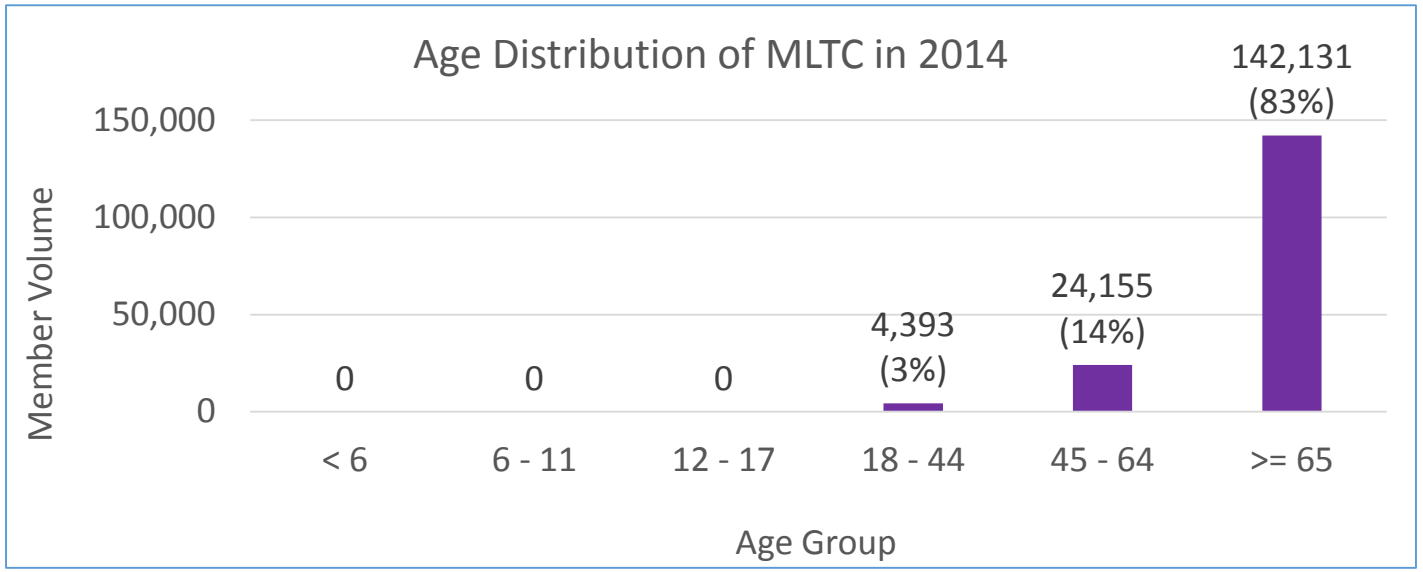
MLTC members account for $11.3 billion in Annual Medicaid Spend

Total Annual Cost of MLTC (to the State)
$11.3bn

Total annual cost to MLTC based on 2014 data and incorporates the State's expected transition of Nursing Home care into MLTC.

Annual Member Volume
238K Members

Average Cost per MLTC Member
($11.3bn / 238K members)
$47,606



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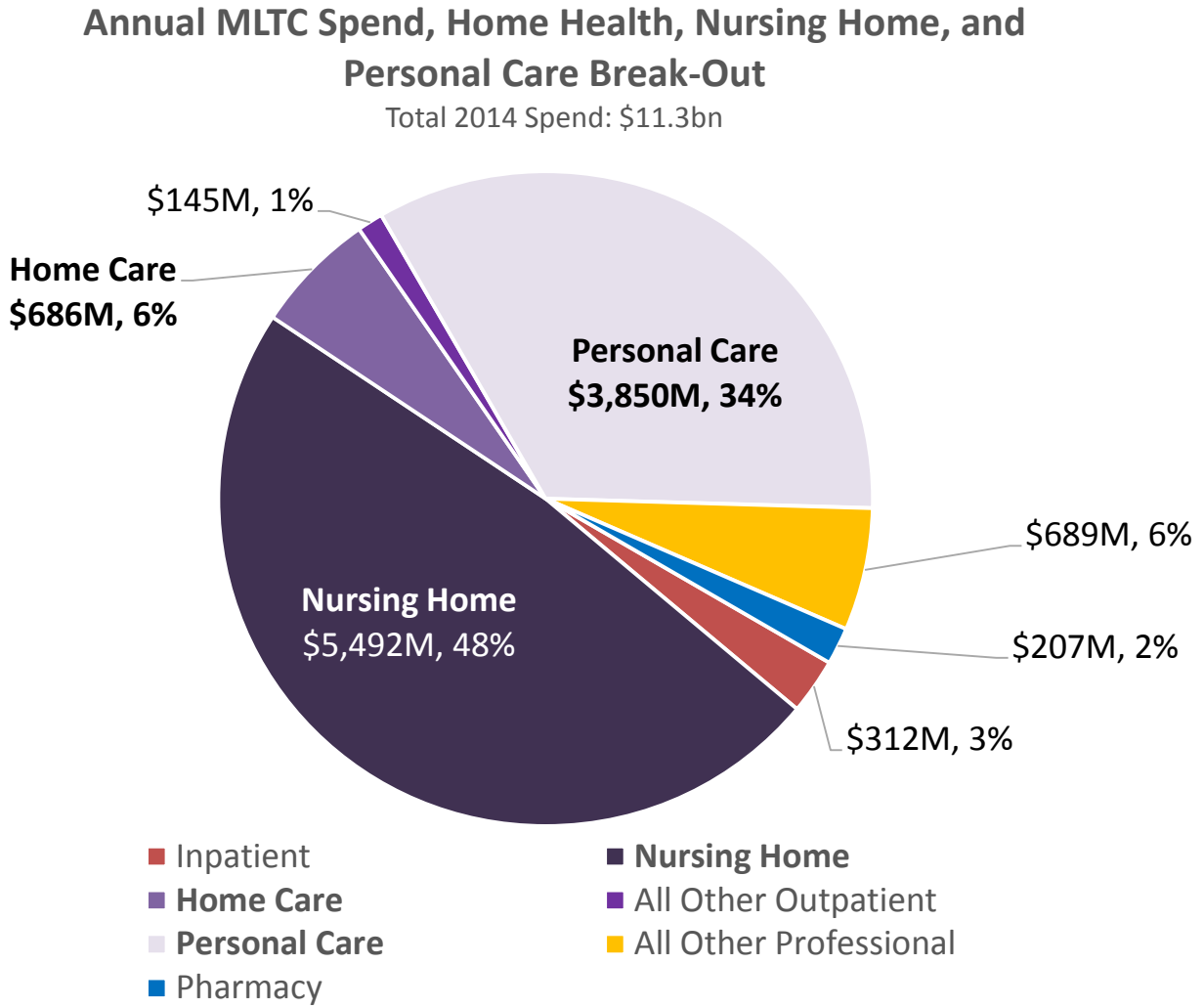
Nursing Homes and Personal Care represented 82% of MLTC costs in 2014



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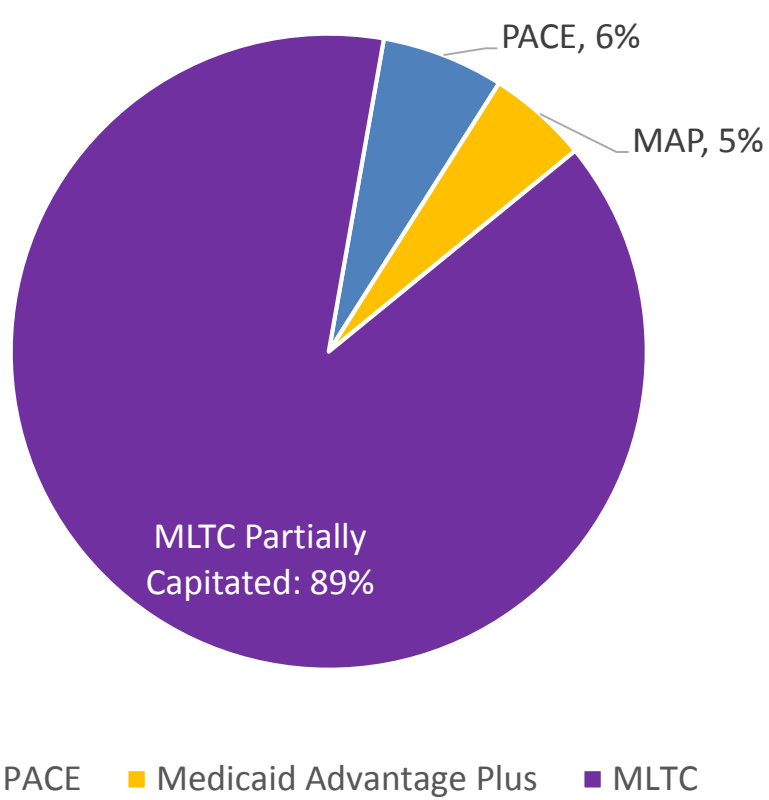
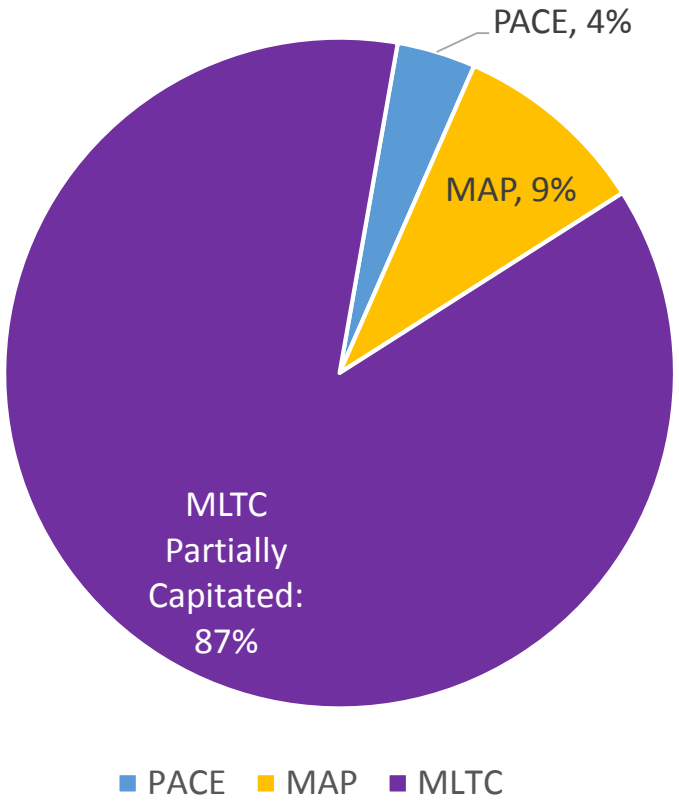
Partially-capitated MLTC plans are 89% of annual MCO MLTC spend

Total Annual MLTC Medicaid Costs by Plan Type
Total Spend in 2014: $11.3bn



Total Annual MLTC Members by Plan Type
Unique Members in 2014: 238K



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The 2nd CAG Meeting will be in early December in New York City

Meeting 2

- MLTC Population Definition Recap
- MLTC Population Outcome Measures - I