Health Care For All New York

Health System Transformation

ACOs, Bundled Payments, FIDA/MLTC,
& DSRIP

Health Care For All New York
www.hcfany.org

MEDICARE RIGHTS CENTER
Getting Medicare right

Medicare Rights Center

- The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through:
  - Counseling and advocacy
  - Educational programs
  - Public policy initiatives

This training will cover

- Accountable Care Organization (ACO) basics
  - The Medicare Shared Savings Program (MSSP) ACO
- Managed Long-Term Care (MLTC)
- Fully Integrated Duals Advantage (FIDA)
- Bundled Payments
- Delivery System Reform Incentive Payment (DSRIP) Program

What is health system transformation?

- Health system transformation (HST) reforms the current structure of health care in the U.S. to achieve the goals of the triple aim:
  - Patient-centered care
  - High quality, low cost care
  - Healthier communities
- While there are several different models/programs tackling HST, they all employ similar methodologies to achieve the triple aim
  - Care coordination and shared decision-making
  - Value-based payment and quality measure reporting
  - Focus on population health and social determinants of health

Where is HST happening?

- Health system reform takes place at both the state and federal levels
  - Federal models: ACOs and Bundled Payments
  - State models: DSRIP, FIDA/MLTC
- Several new models target Medicare beneficiaries, Medicaid beneficiaries, and dual-eligibles

ACO basics

What is an ACO?

- A group of doctors, hospitals, and/or other health care providers that work together to provide coordinated care
- ACOs aim to improve the quality of patient care while lowering the costs incurred by the health system
  - This is achieved by making providers financially accountable for the health of the beneficiaries they serve
    - ACOs receive incentives for providing better care to beneficiaries at a lower cost
    - An ACO may have to take on a greater share of financial losses when costs are not lowered

Coordinated care

- The key way that ACOs are expected to save money is by coordinating patient care
- Providers share information and decide treatment plans with input from the patient
  - All providers working with a beneficiary communicate with one another, discuss issues they've treated, and build consensus around next steps
  - Medicare also shares additional patient health information/records with providers (though patient can ask that Medicare not share such information)
  - Beneficiaries should experience a reduction in repetitive care, for instance duplicated tests and having to fill out the same form multiple times

Who can receive care from a Medicare ACO?

- Anyone with Medicare
  - ACOs are not a health insurance plan (i.e. not a Medicare Advantage Plan, HMO, or Medigap)
  - ACOs are networks of health care providers that work together with the aim of giving patients better care at a lower cost
- Those with Medicare Advantage Plans cannot be assigned to an ACO, but can still see ACO doctors if those doctors are also in their plan's MA network
- An individual can only be aligned with/assigned to one ACO
- Even when in an ACO, patients can receive care from providers that are not part of the ACO

Current Medicare ACO models

- Medicare Shared Savings Program (MSSP)
  - Currently, majority of ACOs are MSSPs
- Pioneer ACO model
- Comprehensive ESRD Care (CEC) ACO
- Next Generation ACO model

The Medicare Shared Savings Program (MSSP)

Medicare Shared Savings Program (MSSP)

- Federal model established by the Affordable Care Act (ACA)
- MSSP ACOs are meant to facilitate cooperation among Medicare providers to increase the quality and decrease the cost of patient care
  - Reward providers who are able to lower health care costs while providing their patients with better care
  - Participation is voluntary for both providers and beneficiaries

Which providers can participate?

- ACOs may consist of:
  - ACO professionals* in group practice arrangements
  - Networks of individual practices
  - Partners or joint ventures between hospitals and ACO professionals
  - Hospitals employing ACO professionals
  - Other Medicare providers and suppliers as determined by the Health & Human Services (HHS) Secretary
- An ACO must serve at least 5,000 Original Medicare beneficiaries and participate in the program for three years

What are shared savings?

- The Centers for Medicare & Medicaid Services (CMS) has incentivized ACO participation by introducing shared savings models
- CMS sets a benchmark for how much it should cost providers to care for their patients
  - If a participating ACO's costs fall below the benchmark (with positive health outcomes), they have created savings
  - Savings are shared between CMS and providers, meaning that providers have a financial reason to reduce the overall cost of health care while continuing to deliver quality care

Shared losses

- ACOs also have the option of sharing in the losses with CMS
  - If total costs are above the benchmark, ACO is responsible for taking on a share of losses
  - Also called two-sided model
- ACOs that elect to share in the losses are eligible for a greater portion of shared savings
  - Taking on higher risks for greater rewards

Quality performance scoring

- Before an ACO can share in any savings, it must meet the quality performance standard
- Graded on the quality of patient care
- 33 measures that ACOs must report on
- ACO patients also weigh in through satisfaction surveys

Quality measures

- Measures broken into four categories:
  1. Patient/caregiver experience
  2. Care coordination/patient safety
  3. At-risk population
  4. Preventive care (i.e. screenings)
- Data reported through claim and administrative data, clinical measure data, and patient experience of care surveys

Patient experience surveys

- Beneficiaries who receive care through an ACO can share following information via surveys:
  - Getting timely care, appointments, and information
  - How well their providers communicate
  - Rating of their provider
  - Access to specialists
  - Quality of health promotion and education
  - Shared decision-making
  - Their health status following care
  - Availability of additional health care resources through ACO

The patient experience

- ACOs aim to avoid unnecessary duplication of care to reduce costs, meaning beneficiaries may find the following changes in their medical experience:
  - All providers will know what medical services they've received in an ACO
  - Fewer repeated medical tests
  - Fewer forms to fill out (only fill out forms once)
- Beneficiaries may be asked to fill out surveys
- Providers will involve the beneficiary in making care decisions
  - Shared decision-making
  - Individualized care plans

Shared decision-making

- Means ACO professionals must take into account a beneficiary's:
  - Unique needs
  - Preferences
  - Values
  - Priorities
- ACOs required to promote beneficiary engagement in numerous ways, including shared decision-making
- Each ACO may have different process for engaging beneficiaries in shared decision-making

Individualized care plans

- Developed by a beneficiary and ACO professionals
- Specific to beneficiary's needs
  - Meant to improve health care outcomes, especially for high-risk patients and those with multiple chronic conditions
  - Beneficiary should be at the center of the process
- ACO applicants must submit descriptions of their individualized care program to CMS
  - Includes criteria for creating plan
  - Beneficiaries may have varying experiences with individualized care plans because each ACO may have a different process for developing plans

Differences between MSSP and Pioneer models

- The Pioneer ACO model includes a few notable differences from MSSPs:
  - Pioneer ACOs must be responsible for at least 15,000 beneficiaries (5,000 in rural areas)
  - Pioneer ACOs are allowed to take on higher levels of risk for larger portions of any created savings
  - Certain Pioneer ACOs may elect or have elected to use a population-based payment model
  - Pioneer ACOs are testing a voluntary beneficiary alignment process*
- Patients retain the same rights, no matter the ACO model

FIDA & MLTC

MLTC and FIDA: What's the difference?

MLTC

- Only covers Medicaid long term care, dental, vision, hearing, and podiatric services, along with physical, occupational and speech therapy outside the home
- Does not affect Medicare coverage
- Is **mandatory, including for nursing home residents**

FIDA

- Covers all health care services and items, including prescription drugs
- Provides both Medicare and Medicaid benefits
- Is **optional**

Four MLTC eligibility criteria

To be eligible for mandatory MLTC, a beneficiary must	
1) Be dually eligible	Have both Medicare and Medicaid
2) Be at least 21 years old	Beneficiaries under 21 may enroll if they are 18 or older and need certain types of care. Enrollment for 18-21 year olds is not mandatory
3) Receive 120+ days of community-based long term care	Long term care = Ongoing care one needs to help perform everyday activities. Can include care in the community or in a facility. Examples include but are not limited to: • Home health care • Nursing home care • Medical adult day health care
4) Live in New York state	MLTC is now mandatory in all NYS counties

Beneficiaries must meet **all four** eligibility criteria to qualify for mandatory MLTC in NY

MLTC coverage

- Home care
  - Help with Activities of Daily Living (ADL)
  - Skilled nursing
  - Physical, occupational, speech therapy
- Adult day health care
  - Medical only, or Medical and Social together
- Home-delivered meals, congregate meals
- Medical equipment, eyeglasses, hearing aids, home modifications
- Non-emergency medical transportation
- Podiatry, audiology, dentistry, and optometry
- Physical, occupational, and speech therapy
- Nursing home care

Four FIDA eligibility criteria

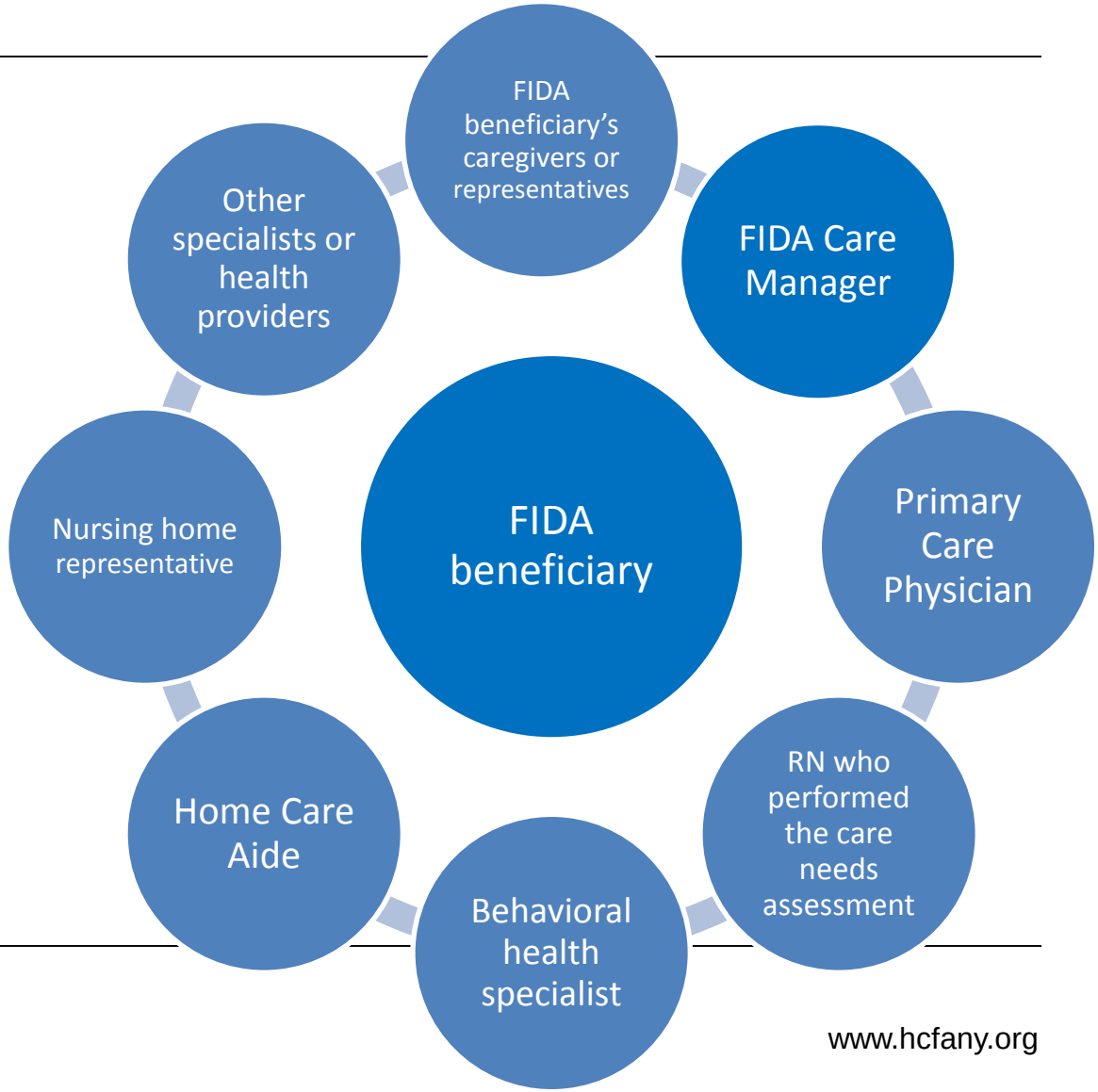
To be eligible for FIDA, a beneficiary must meet all of the following:	
1) Be dually eligible	Have both Medicare and Medicaid
2) Be at least 21 years old	
3) Receives 120+ days of community-based long term care	Long term care = Ongoing care needed to help perform everyday activities. Can include care in the community or in a facility. Examples include but are not limited to: • Home health care • Nursing homes • Medical adult day health care
4) Live in a county in New York State where FIDA has been rolled out	Downstate counties: New York City and Nassau

FIDA coverage

- FIDA plans cover all services a dual eligible beneficiary is entitled to including:
  - Medicare coverage
  - Medicaid coverage
  - Long term care coverage
  - Drug coverage
- There are no costs for covered benefits from in-network providers
  - Balance billing is illegal
- FIDA beneficiaries must stay within a network of doctors and hospitals
- This rule applies to all Medicare and Medicaid services except:
  - Beneficiaries already in nursing homes can stay in their current nursing homes regardless of plan networks
  - Beneficiaries receiving behavioral health services can keep current behavioral health providers for 2 years after they join a FIDA plan if their treatment began before they transitioned into FIDA

Interdisciplinary Team (IDT)

- Ensures the integration and coordination of beneficiary's health care through the Person-Centered Service Plan and ongoing support
  - IDT must authorize most care services
- IDT must contain care manager and beneficiary at minimum



Person-Centered Service Plan

- "A written description in the care management record of participant-specific health care goals to be achieved and the amount, duration, and scope of the covered services" (FIDA Memorandum of Understanding)
  - Developed by IDT and the plan if the member requires services outside of the scope of practice of the IDT members
  - Must be completed within 30 days of a care needs assessment or reassessment
  - Beneficiary preferences must be included
  - The FIDA plan must monitor and address any gaps in care in the Person-Centered Service Plan

Differences between ACOs & FIDA

- The FIDA demonstration is a capitated model
  - Meaning the state, CMS, and the health plan enter a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care
- In ACOs, the providers contract with CMS
  - ACOs are still fee-for-service from the beneficiary perspective
- ACOs do not have “closed” networks, FIDA enrollees must see in-network providers
- FIDA plans align Medicare and Medicaid benefits for beneficiaries who need long term care while ACOs are networks of physicians coordinating Medicare benefits
- Participants in capitated model demonstrations are ineligible for assignment to an ACO

Bundled Payments

What are bundled payments?

- Reimbursing health care providers based on the expected costs for a clinically-defined “episode of care”
- Episodes of care include all the care received by a patient from their initial hospitalization to recovery
  - An episode of care includes re-hospitalizations and post-acute care, so long as they are related to the patient’s initial diagnosis
  - Providers receive a lump sum for all the care a patient will receive, estimating
- Typically, bundles include all Part A & B related items and services related to the episode of care

Example demonstrations

- Bundled Payments for Care Improvement (BCPI)
  - Four separate models (BCPI 1-4)
  - These models involve episodes of care from inpatient stay to post-acute care services
  - Actual costs are compared to a target price determined by CMS*
- Comprehensive Care for Joint Replacement (CJR)
  - Two separate bundles for hip and knee replacements
  - Episode begins at admission and lasts until 90 days after discharge
  - At the end of the year, total expenditures are compared to a target determined by CMS**

End result

- Bundled payments take common and expensive procedures and stops rewarding physicians for quantity of care
- Physicians are incentivized to:
  - Coordinate care efforts, from inpatient to post-acute
  - Lower costs (by minimizing care duplication)
  - Prevent re-hospitalization
  - Provide higher quality care

DSRIP

What is DSRIP?

- Delivery System Reform Incentive Payment (DSRIP) program
  - Expand and transform primary care, as well as bring value-based payment (VBP) to New York State
  - Overhaul of Medicaid by the Medicaid Redesign Team (MRT)
  - Reduce avoidable hospital use
- DSRIP is a five year program
  - Post-DSRIP, health systems and networks developed using DSRIP funding must be self-sustaining
  - State program targeting Medicaid beneficiaries

Value-based payment

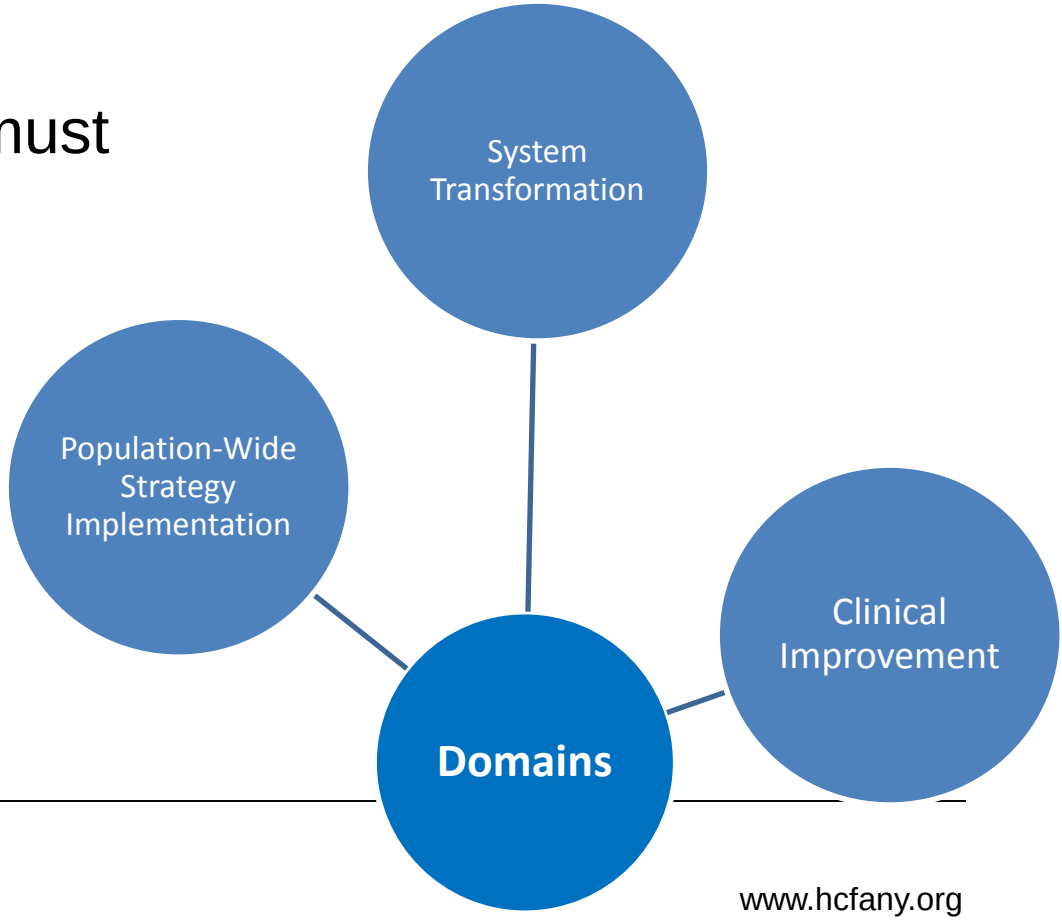
- VBP arrangements are those that reward the quality, rather than the volume, of services
- VBP can include arrangements such as:
  - FFS with provider risk-sharing
    - Upside-only (i.e. shared savings), or
    - Upside and downside (i.e. shared savings & losses)
  - Prospective capitation
  - Bundled payments

Performing Provider System (PPS)

- A PPS is a entity composed of providers and other partners that collaborate to deliver a DSRIP project
- A PPS can include the following:
  - Hospitals
  - Skilled nursing facilities
  - Behavior health providers
  - Home care agencies
  - Community-based organizations
  - Other key stakeholders
- Together, a PPS delivers coordinated care, is responsible for care management, and assumes responsibility for the total care of its attributed population

DSRIP projects

- DSRIP projects are divided into three categories, called domains
  - DSRIP participants must select 5-11 projects (certain projects are required)



Post-DSRIP

- The end goals of DSRIP are that:
  - PPS's give rise to integrated clinical networks
  - 80-90% of all provider reimbursements are VBP
  - The avoidable hospitalization rate is reduced by 25%

Recap

- HST models use different methods, but they all tackle the triple aim:
  - Patient-centered care
  - High quality, low cost care
  - Healthier communities