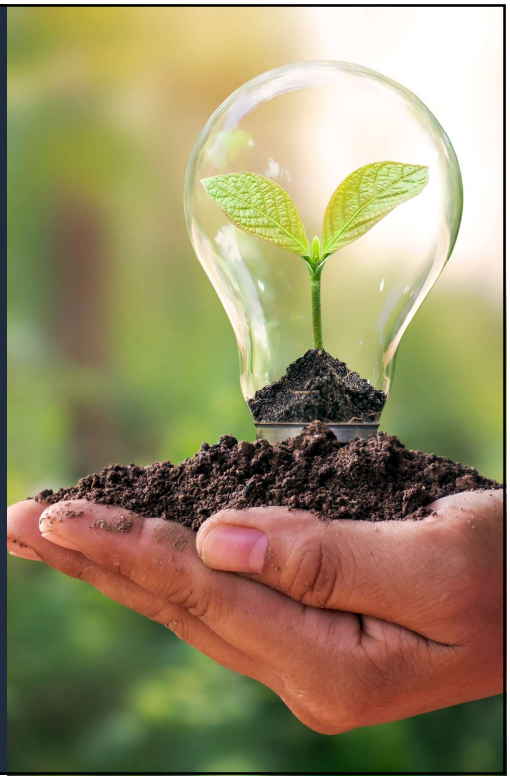
Lyle Health Advisors & Spiritus

Value Based Care Are You Ready?



Prepared for Kentucky Association of Health Care Facilities
By Jill Lyle Sumner & Mark Hunt

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Content

VALUE BASED CARE MODEL BASICS
Model review

VALUE BASED CARE IN KENTUCKY
Models operating close to home

THE CASE FOR VALUE BASED CARE PARTICIPATION
Proactive vs reactive approaches

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Thank you

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Model Basics

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VALUE BASED CARE

- **Performance-based reimbursement models**, where providers are rewarded for **achieving specific health outcomes**, Ex. hospital readmissions or improving chronic disease management
- **Centered on individual care**, with providers paid based on the outcomes and quality of care they deliver to each patient.
- Focuses on improving individual patient outcomes and **incentivizing** providers to deliver **high-quality care while reducing unnecessary services**.

POPULATION HEALTH MANAGEMENT

- **Population level**, aiming to improve **overall health outcomes across a group** by **managing the health of that population as a whole**
- **Proactive, focusing on prevention**, early intervention, and **managing health risks across a broader community** or patient cohort.
- **Improving the health** of a population (group of people) by **managing health risks, preventing illness, and addressing social determinants of health**.

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Medicare Advantage

Institutional Special Needs Plans

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Models	Medicare Advantage
Types	Traditional MAPD Special Needs Plans: DSNP, CSNP, ISNP/IESNP
Reimbursement model	Capitation FFS FFS & Value based bonus
Care Model	Enhanced primary care with nurse practitioner and/or RN coordinator

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Institutional Special Needs Plans (ISNP)

Three types

- Facility Insitutional SNP (FISNP)
- Institutional Equivalent SNP (IESNP)
- Combination

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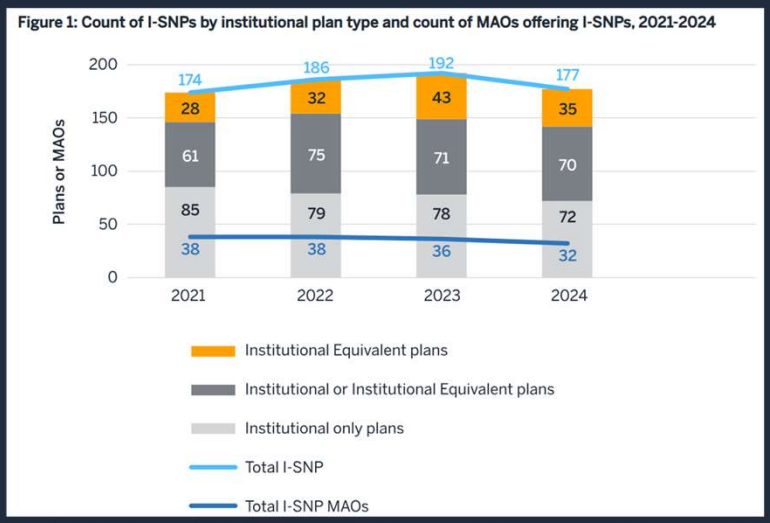

https://www.milliman.com/en/insight/institutional-special-needs-plans-2024-market-landscape-future

- Decline in total number of plans
- Largest decline in IE-SNP
- Fewer organizations
- Plan consolidation

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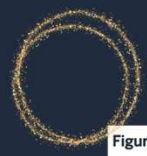

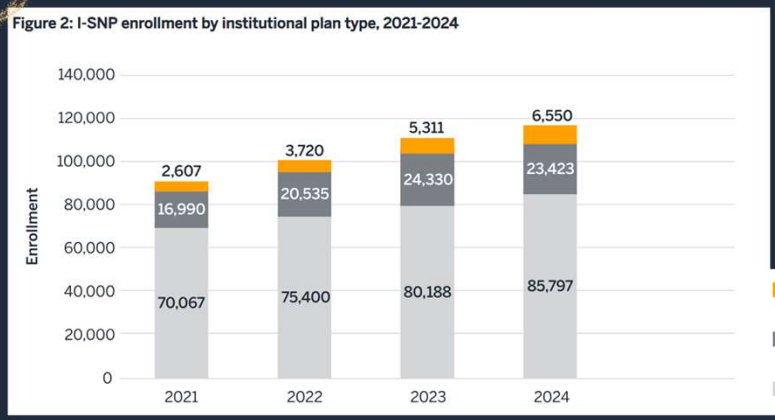

- Increase in enrollment
- Growth more rapid in rural than urban areas

https://www.milliman.com/en/insight/institutional-special-needs-plans-2024-market-landscape-future

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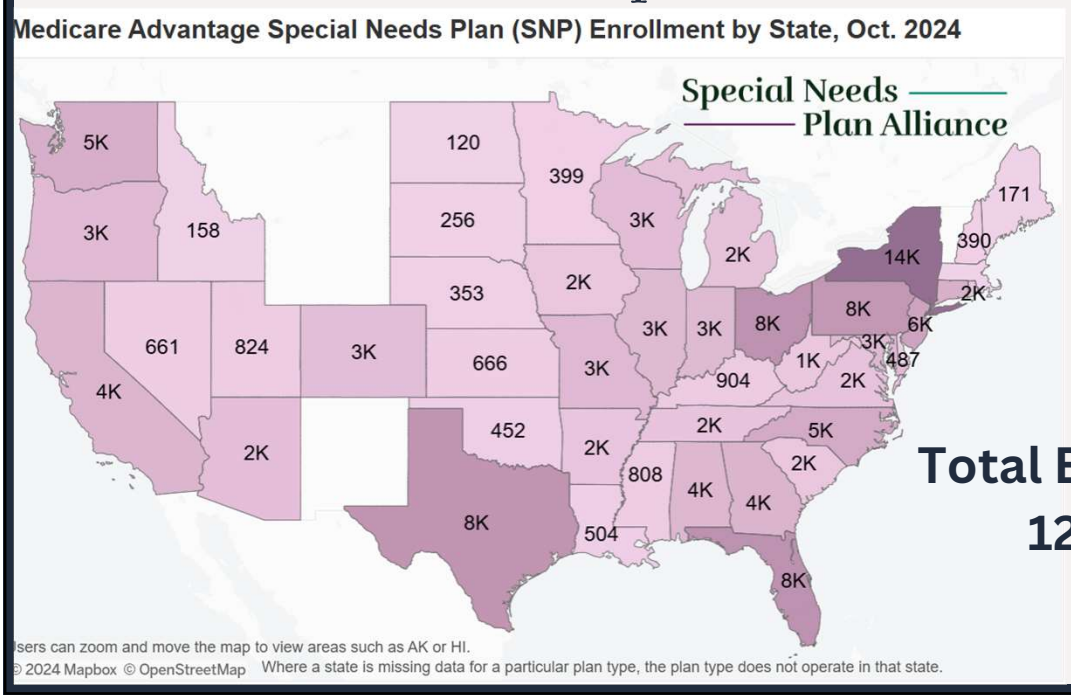
Institutional Special Needs Plans



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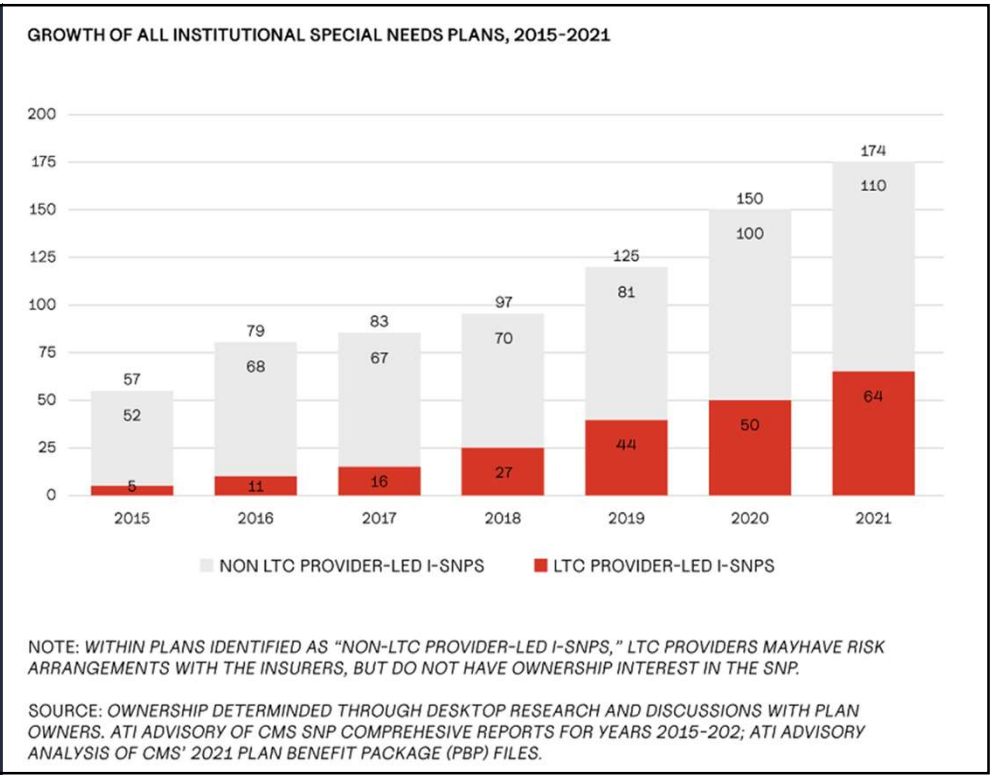
LTC Provider Owned ISNP Growth



NOTE: *WITHIN PLANS IDENTIFIED AS "NON-LTC PROVIDER-LED I-SNPS," LTC PROVIDERS MAYHAVE RISK ARRANGEMENTS WITH THE INSURERS, BUT DO NOT HAVE OWNERSHIP INTEREST IN THE SNP.*

SOURCE: *OWNERSHIP DETERMINDED THROUGH DESKTOP RESEARCH AND DISCUSSIONS WITH PLAN OWNERS. ATI ADVISORY OF CMS SNP COMPREHESIVE REPORTS FOR YEARS 2015-202; ATI ADVISORY ANALYSIS OF CMS' 2021 PLAN BENEFIT PACKAGE (PBP) FILES.*

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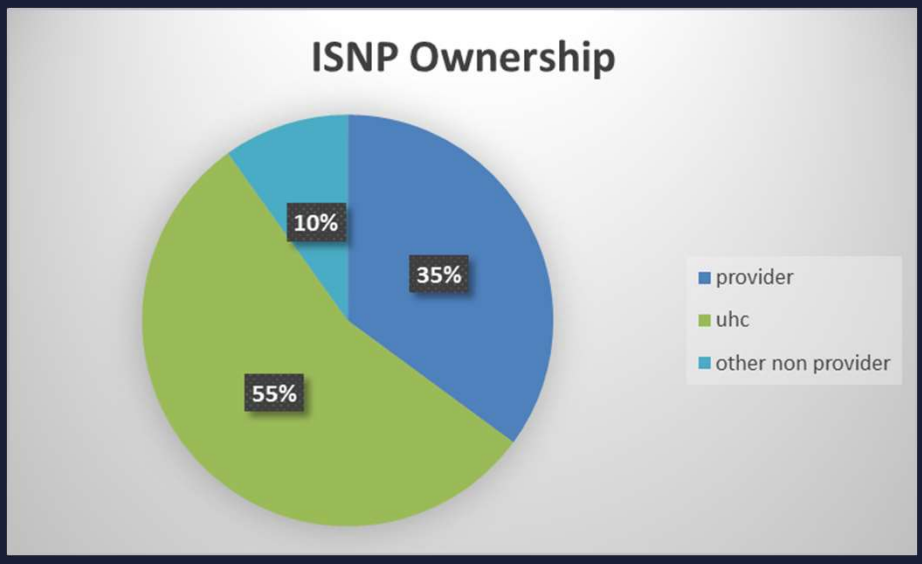
Provider Owned ISNP



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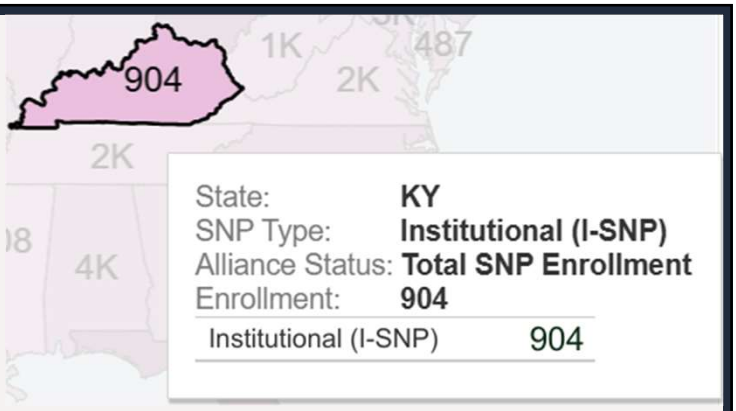
Kentucky

- 904 enrollees
- 4 plans
- 2 organizations



United Healthcare

159 enrollees

Signature Advantage

BrightSpring Health Services

1012 enrollees

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Successes

Better outcomes for long stay nursing facility residents

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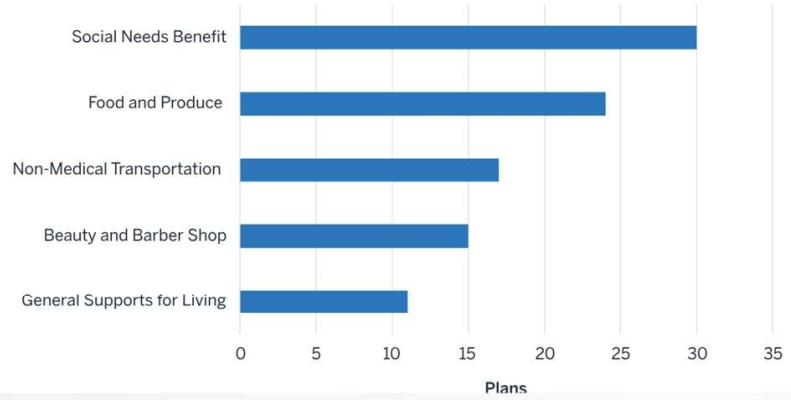
Figure 6: Count of 2024 I-SNPs with most common SSBCI offerings



50% of members in regional ISNPs have access to SSBCI as compared to 2% of members in national plans.

Custom SSBCI offerings include beauty and barber shop, non-Medicare covered restorative nursing, pet assistance, travel care assistance, nonfood grocery and memory activity box.

Source: Institutional special needs plans: 2024 market landscape and future considerations, Yeh, Mary; Yen, Ivan; 08 February 2024; https://www.milliman.com/en/insight/institutional-special-needs-plans-2024-market-landscape-future#9

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Successes

Evidence based, peer reviewed study documenting improved outcomes for SNF/NF population.

Managed Care for Long-Stay Nursing Home Residents: An Evaluation of Institutional Special Needs Plans

Brian E. McGarry, PT, PhD; and David C. Grabowski, PhD

Am J Manag Care. 2019;25(9):400-405

RESULTS: In comparison with FFS institutionalized Medicare beneficiaries, I-SNP members had 51% lower ED use, 38% fewer hospitalizations, and 45% fewer readmissions, whereas their SNF use was 112% higher.

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Managed Care for Long-Stay Nursing Home Residents: An Evaluation of Institutional Special Needs Plans

Brian E. McGarry, PT, PhD; and David C. Grabowski, PhD

TABLE 3. Differences in Utilization Across I-SNP and FFS Medicare Beneficiaries[a]

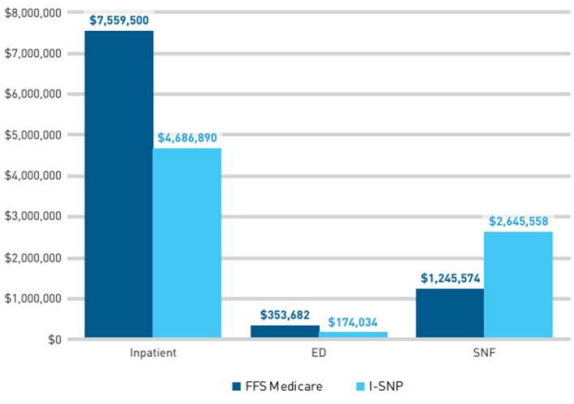
	Unadjusted Differences		Adjusted for Demographics	
Utilization Measure	I-SNP	FFS	I-SNP	FFS
Inpatient stays per 1000 residents	288	524	310	500
30-day readmissions per 1000 inpatient stays	167	334	175	318
ED visits per 1000 residents	218	452	217	441
SNF stays per 1000 residents	481	253	514	242

ED indicates emergency department; FFS, fee-for-service; I-SNP, Institutional Special Needs Plan; SNF, skilled nursing facility.

[a]All differences are statistically significant at the 5% level or better (adjusted and unadjusted). Demographic adjusters include age, gender, and state of residence.

Source: Authors' calculations based on UnitedHealthcare data of I-SNP enrollees and the Medicare 5% sample of FFS beneficiaries.

FIGURE. Actual Medicare Expenditures per 1000 Long-term Nursing Home Residents in FFS Medicare Versus Projected Expenditures Based on Utilization of I-SNP Beneficiaries



ED indicates emergency department; FFS, fee-for-service; I-SNP, Institutional Special Needs Plan; SNF, skilled nursing facility.

Source: Authors' calculations based on UnitedHealthcare data of I-SNP enrollees and the Medicare 5% sample of FFS beneficiaries.

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Shared Savings for Nursing Homes — The Potential Role of Institutional Special-Needs Plans

Amanda C. Chen, M.S., Scott Sarran, M.D., M.B.A., and David C. Grabowski, Ph.D.

N ENGL J MED 391;9 NEJM.ORG SEPTEMBER 5, 2024

There are roughly 1 million long-stay residents in nursing homes in the United States, many of whom are frail, have complex medical conditions, and have cognitive and functional impairment. Long-stay residents are disproportionately likely to be members of marginalized racial groups and low-income people covered by Medicaid, and they are at high risk for receiving low-quality care and having adverse outcomes, including preventable hospitalizations, inappropriate medication use, and low satisfaction with care. Such outcomes have prompted discussions about how to create a value-based payment system that could promote better quality of care in nursing homes.

We believe I-SNPs warrant further investigation as a value-based model for financing care provided to nursing home residents. The financial risk taken on by these plans creates incentives for on-the-ground investments in clinical care. A key component of the I-SNP model is the on-site presence of a clinician, such as a nurse practitioner (NP),

Leading researchers recommend looking to ISNP model to promote better quality of care in nursing homes.

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Current Challenges

Long term care staffing shortages

Health systems not willing to contract with Medicare Advantage plans or, specifically, small plans.

Growth of other value-based care models targeting the long-term nursing home resident population (MSSP, ACO REACH)

State efforts to align Medicare and Medicare benefits under one plan

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Integration Needs for Long Term Care Residents

- Medicare and Medicaid benefits coordinated by staff
- Majority of Medicaid capitation payment is pass through room and board payment
- Low volume of members by any one health plan other than ISNP
- Need for enhanced primary care and long-term care integration
- Dedicated NP, enhanced primary care model viable when significant membership in one facility

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Opportunity for Aligned ISNP

States may contract with ISNPs to coordinate Medicaid benefits and assume risk

Opportunity to partner with state Medicaid agency, share data, assume risk

Increased opportunity for alignment when integrated with nursing facility provider

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Accountable Care Organizations

Medicare Shared Savings Program

ACO REACH

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Models	Accountable Care Organization
Types	Medicare Shared Savings Program (MSSP) ACO REACH -basic & high needs
Reimbursement model	FFS Shared savings after reconciliation Value based
Care Model	light - physician vbp medium - remote monitoring high - replace physician group and add NPs

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ACOs

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

- permanent program
- hospital/physician holds CMS contract
- static benchmark
- Annual application period
- 3 day hospital stay waiver does not apply to nursing facility residents

ACO REACH

- demonstration program
- Providers other than hospitals and physicians may hold contract with CMS
- Fewer available, application period has passed
- High Needs designed to take into consideration higher acuity

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Current Challenges

Physicians aligned with one ACO and SNF aligned with another

Rapid growth in organizations with little experience

Organizations growing faster than they can handle to secure PE funding

Unclear about costs, shared savings – SNF not knowing to dig deeper

Program incompatibility with SNF populations

Potential to drive CMS concerns

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Discussion

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Strategic Participation

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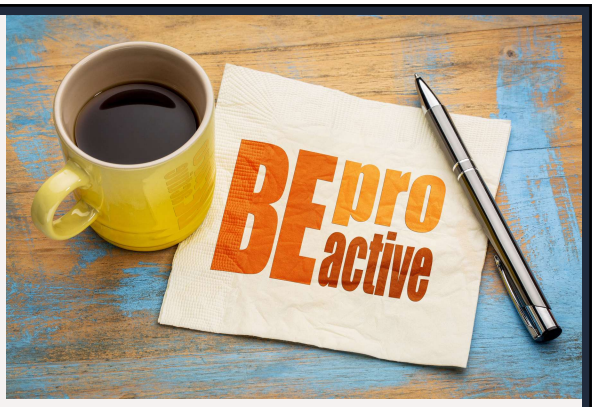
Change the Narrative

Proactive vs Reactive



Proactive

- Education on models
- Identifying your population
- Identifying your strengths and weaknesses
- Identifying your decision criteria
- Identifying all potential partners
- Positioning - look for provider partners or solo participation
- Request proposals
- Compare proposals across standard key elements and metrics
- Compare to Decision Criteria
- Interview potential partners, site visits for finalists

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Models	Medicare Advantage	Accountable Care Organization
Types	Traditional MAPD Special Needs Plans: DSNP, CSNP, ISNP/IESNP	Medicare Shared Savings Program (MSSP) ACO REACH -basic & high needs
Reimbursement model	Capitation FFS FFS & Value based bonus	FFS Shared savings after reconciliation Value based
Care Model	Enhanced primary care with nurse practitioner and/or RN coordinator	light - physician vbp medium - remote monitoring high - replace physician group and add NPs

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Start with your population

SKILLED NURSING FACILITY	ASSITED LIVING	COMMUNITY BASED	MEMORY CARE
ISNP	IESNP	MAPD	CSNP - Dementia
MSSP	CSNP	CSNP	ISNP
REACH ACO - high needs	MSSP	MSSP	IESNP
	REACH ACO - high needs	REACH ACO	MSSP
		REACH	ACO REACH - high needs
		Care Management	

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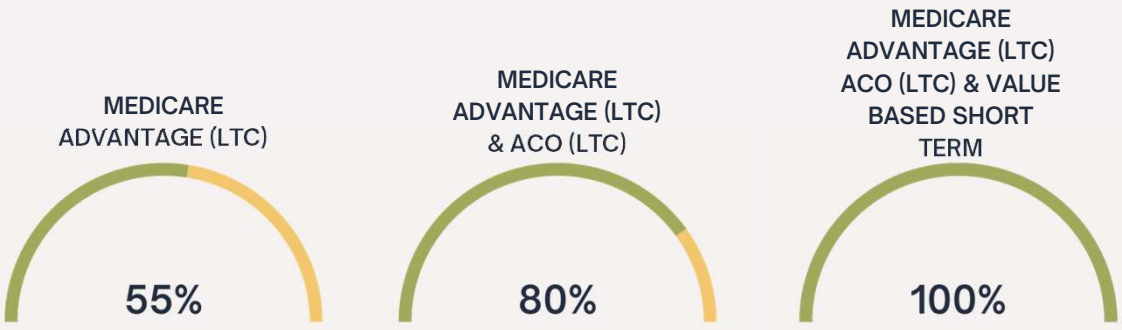
Value Based Care Coverage

Moving to 100%



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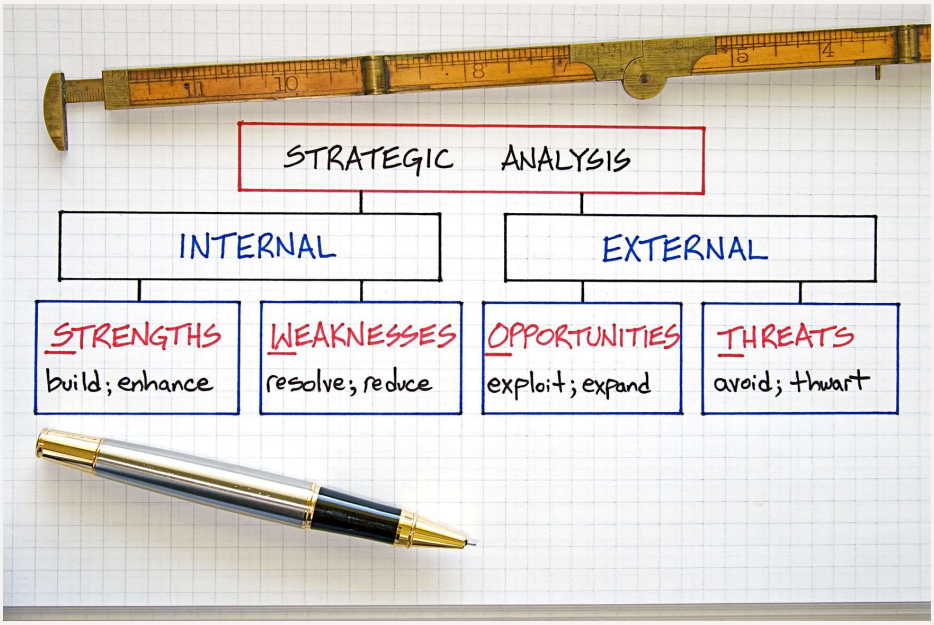

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Decision Criteria

VBC PARTICIPATION

- What is your organizational strategy (long term commitment to ownership/operation or short term profitability and divestiture)
- Need to improve financial stability?
- Have clinical staffing challenges?
- Need competitive edge?
- Want to take higher acuity patients or is population acuity already increasing in acuity
- Access to quality physicians that are both proactive and responsive?
- Already have ability to treat in place but 3 day hospital waiver is an impediment
- Issues with DSNPs and MLTSS

CHOICE OF PARTNER

- Alignment with your organizational strategy
- How does partner clinical model align or complement what you have
- Experience delivering shared savings or no results to date
- Data on clinical outcomes, ability to manage MLR
- Interest in ownership or participation
- UM process
- Ability to provide input - processes, benefits
- Willingness to be transparent/flexible

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Partner vs Solo

Considerations:

- size of your organization
- market share individually or as group
- goals - option for state for MLTSS?

American Senior Communities

CarDon & Associates Inc. Family-first Senior Living Communities

BRICKYARD Healthcare

TRILOGY HEALTH SERVICES, LLC

Miller's Health Systems, Inc.

TLC Management

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Identify Potential Partners

ISNP	ACO	Both
Provider Partners	BrigntSpring (MSSP)	Provider Partners
American Health Plans	LTC ACO (MSSP)	Curana/Align Senior Care
Align Senior Care (Curana)	Sound Physicians (MSSP)	BrightSpring/Signature
Longevity/Humana/Aetna	Curana (MSSP/ACO REACH)	
United Healthcare	Eventus (MSSP)	
Signature/BrightSpring	Provider Partners (ACO REACH)	

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Critical Components

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Organizational Structure

- How is the organization financed?
- Who is the controlling entity?
- Who are the leadership?
- How close/removed will you be from leadership/control?
- Who owns contract with CMS,
- Who owns network contracts?

Model of Care

- How does clinical model integrate into your operations?
- Who employs staff?
- Is care management entity formed?
- What flexibility is there in determining processes such as UM and care management?

Financial Model

- What are the revenue streams?
- What are the capitation amounts, percentage of shared savings, quality metrics
- What is the equity offering, start up costs

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	Partner A	Partner B
Organizational Structure		
Clinical Model		
Financial Model		
Transparency		
Opportunity for Input		

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Decision Criteria

SERVICE TO THE COMMUNITY

Must be of value to greater community

SUSTAINABILITY

Places providers in position to grow and flourish

TRANSPARENT PARTNER

Partner that shares information and provides education

CLINICAL EXCELLENCE

Drives clinical outcomes

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