New Mexico Medicaid:
Value Based Purchasing and Nursing Facilities

David Scrase, Tracy Smith, and Erica Archuleta

Medicaid Advisory Committee

November 5, 2018

Agenda

- Hepatitis C follow-up from MAC meeting on November 17, 2015
- Population changes in New Mexico (why is this topic so important?)
- Brief overview of value based purchasing (VBP) in the United States
- VPB in New Mexico Medicaid
- Nursing Facility-specific VBP in other states (Texas, California)
- Project ECHO
- **Nursing Facility Quality Improvement and Hospitalization Avoidance (QIHA) Program in New Mexico (2018 Pilot and 2019-2023 VBP Program)**
- Conclusions: what we have learned so far

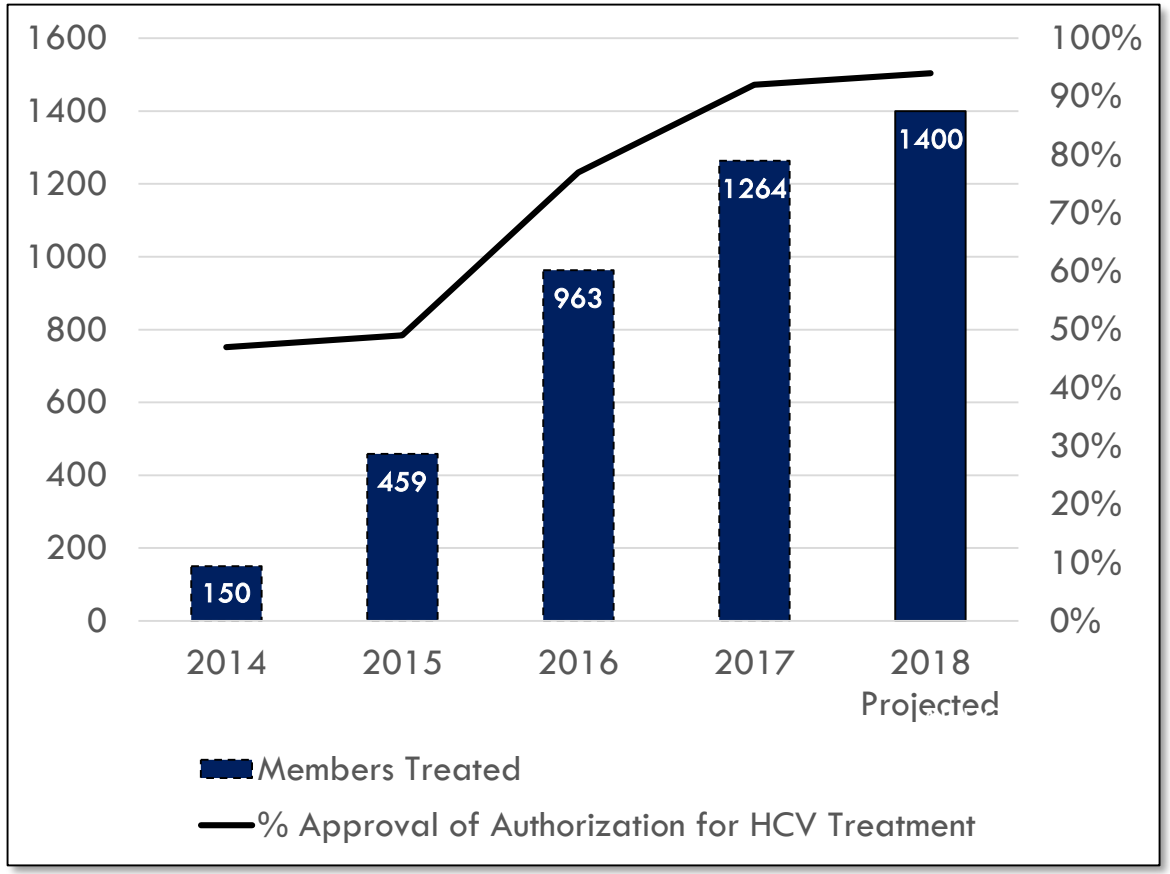
Follow-Up on Hepatitis C

Hepatitis C in the New Mexico Centennial Care Population: A Plan of Action

Nancy Smith-Leslie
David Scrase, M.D.

November 17, 2015

HUMAN SERVICES DEPARTMENT



HEALTH SCIENCES

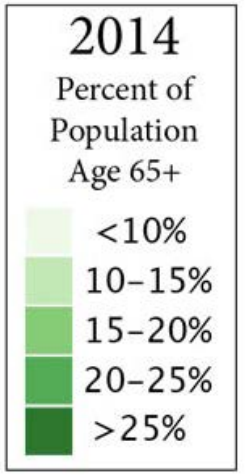
ECHO Institute Project ECHO

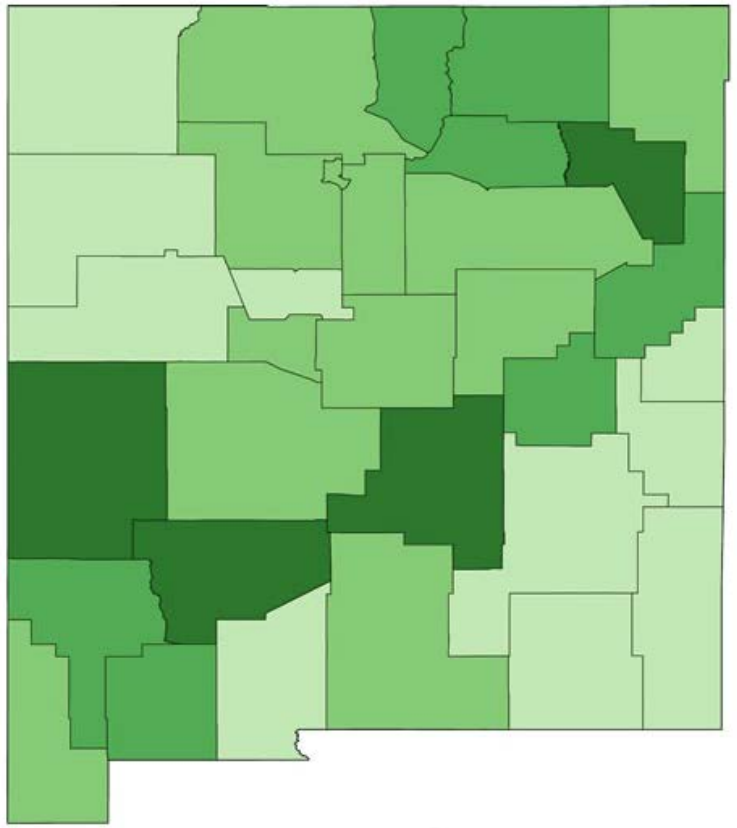
ENTENNIALCARE

Population Changes in New Mexico (why is this topic so important?)

New Mexico Population Data Sources

- UNM BBER Population Data: 1900-2010
- UNM Geospatial and Population Studies (GPS): 2020-2040, Robert Rhatigan
- West LA, Cole S, Goodkind D, He W. 65+ in the United States: 2010. US Bureau of Census. 2014.





UNM BBER Population Data, 1900

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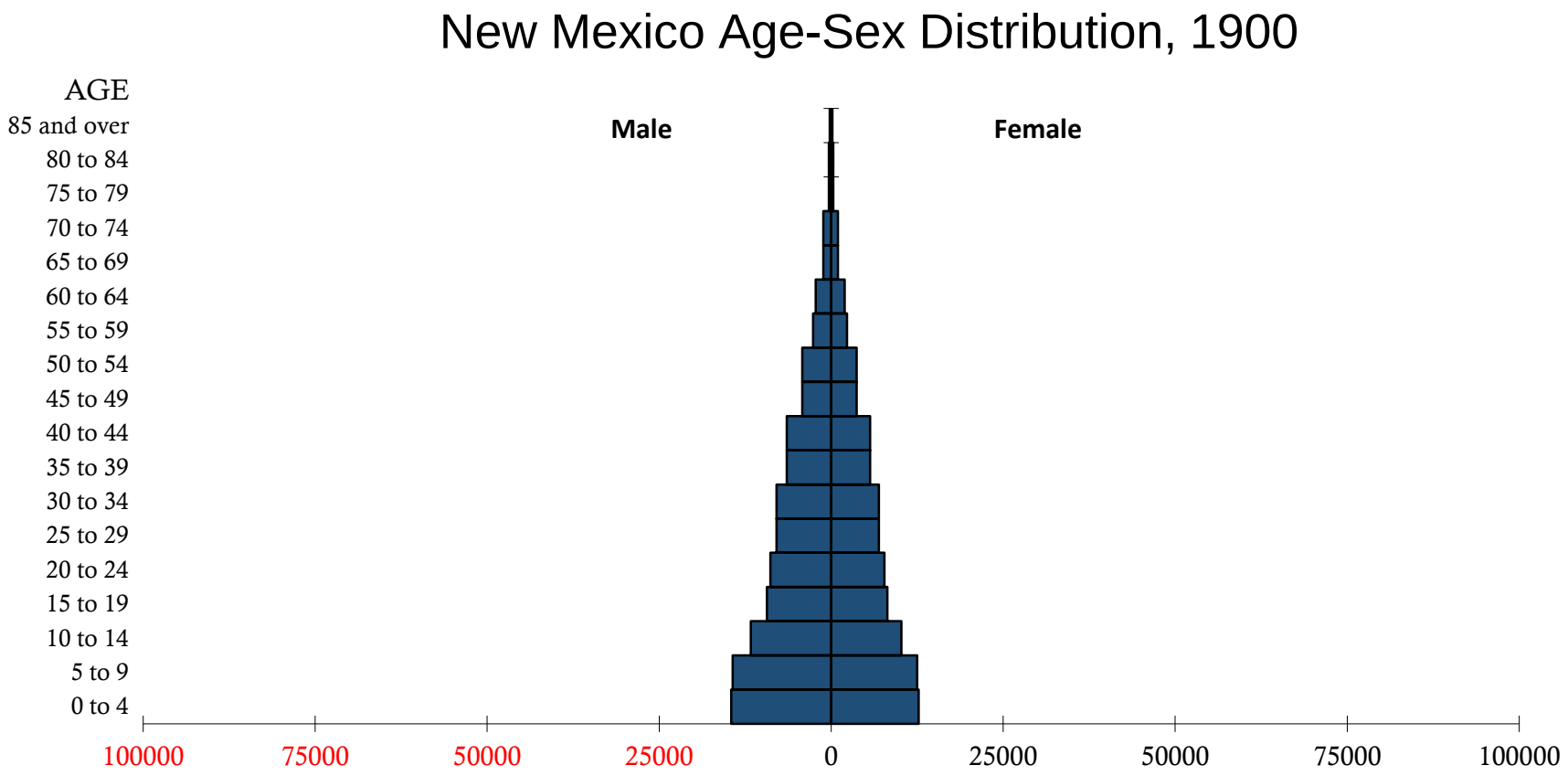

Source: BBER, UNM

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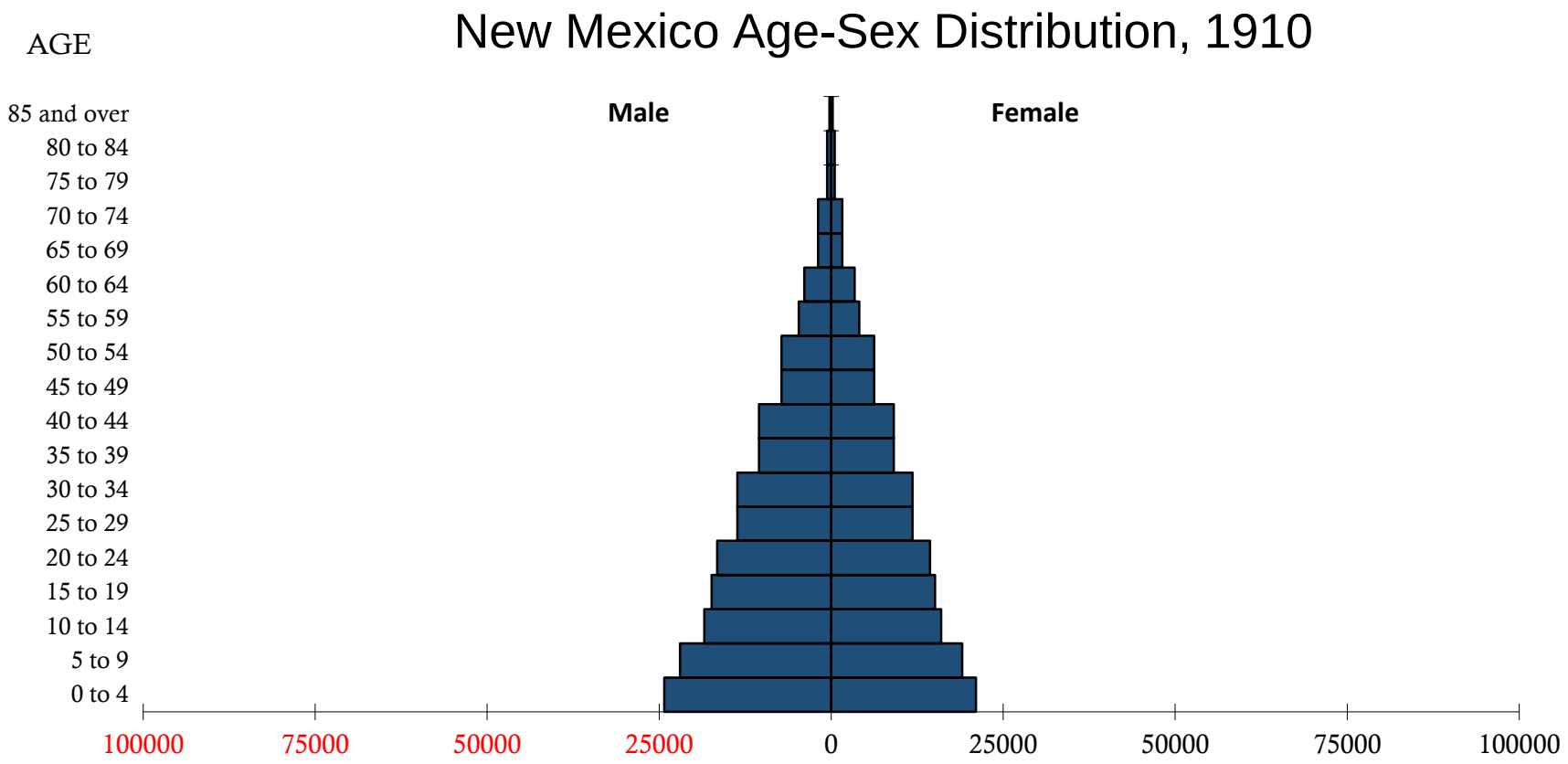

Source: BBER, UNM

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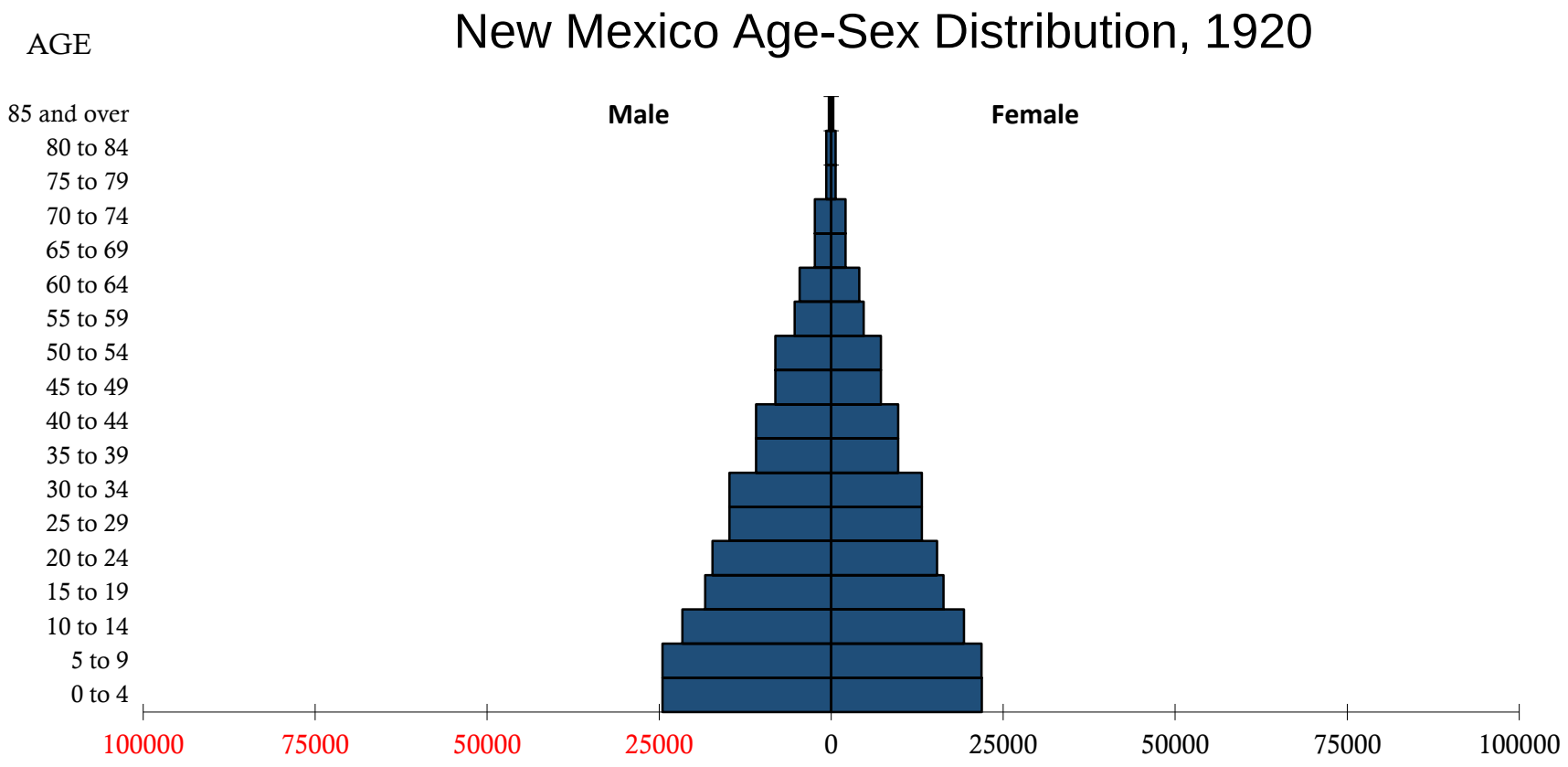

Source: BBER, UNM

UNM BBER Population Data, 1930

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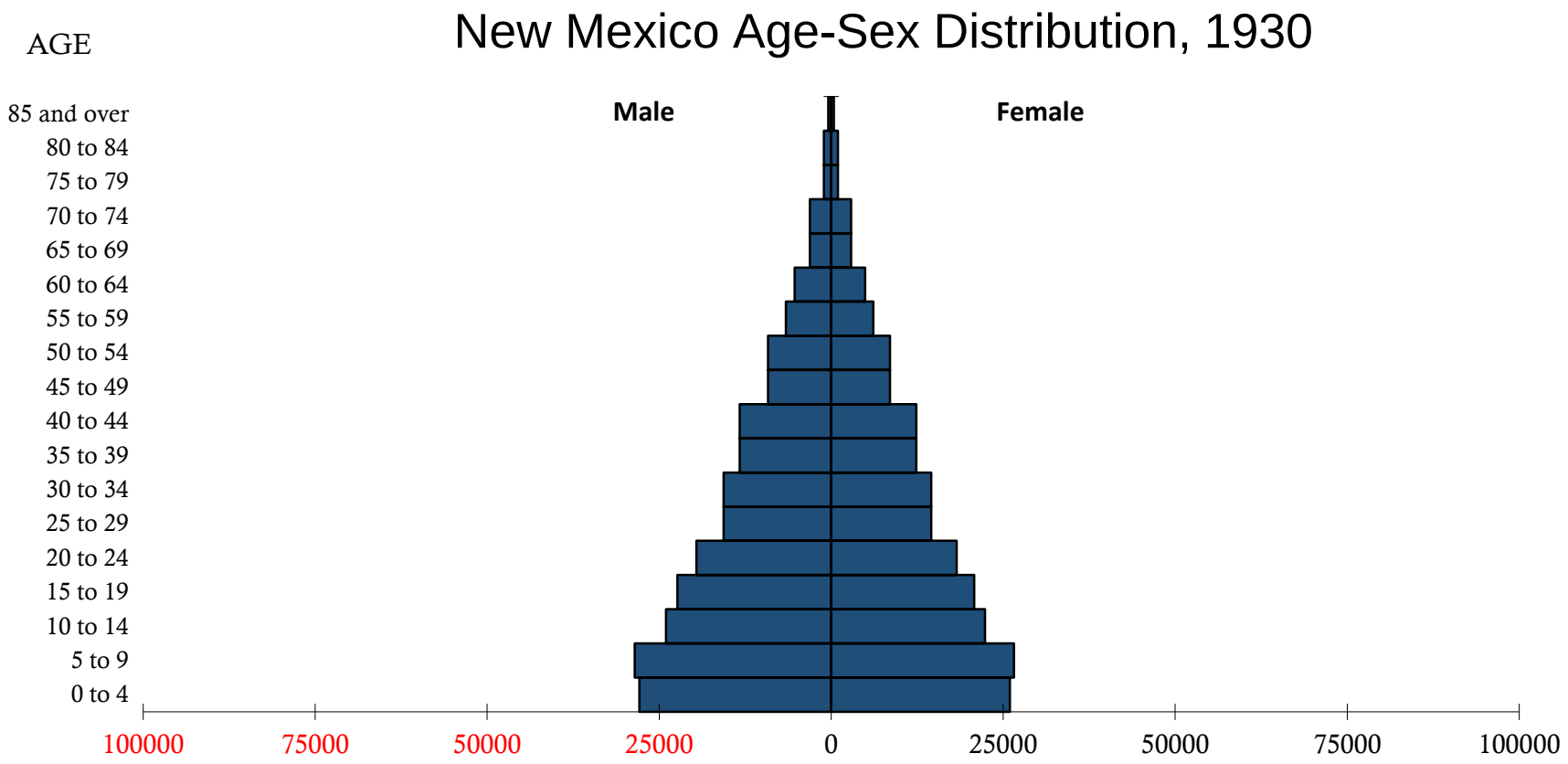

Source: BBER, UNM

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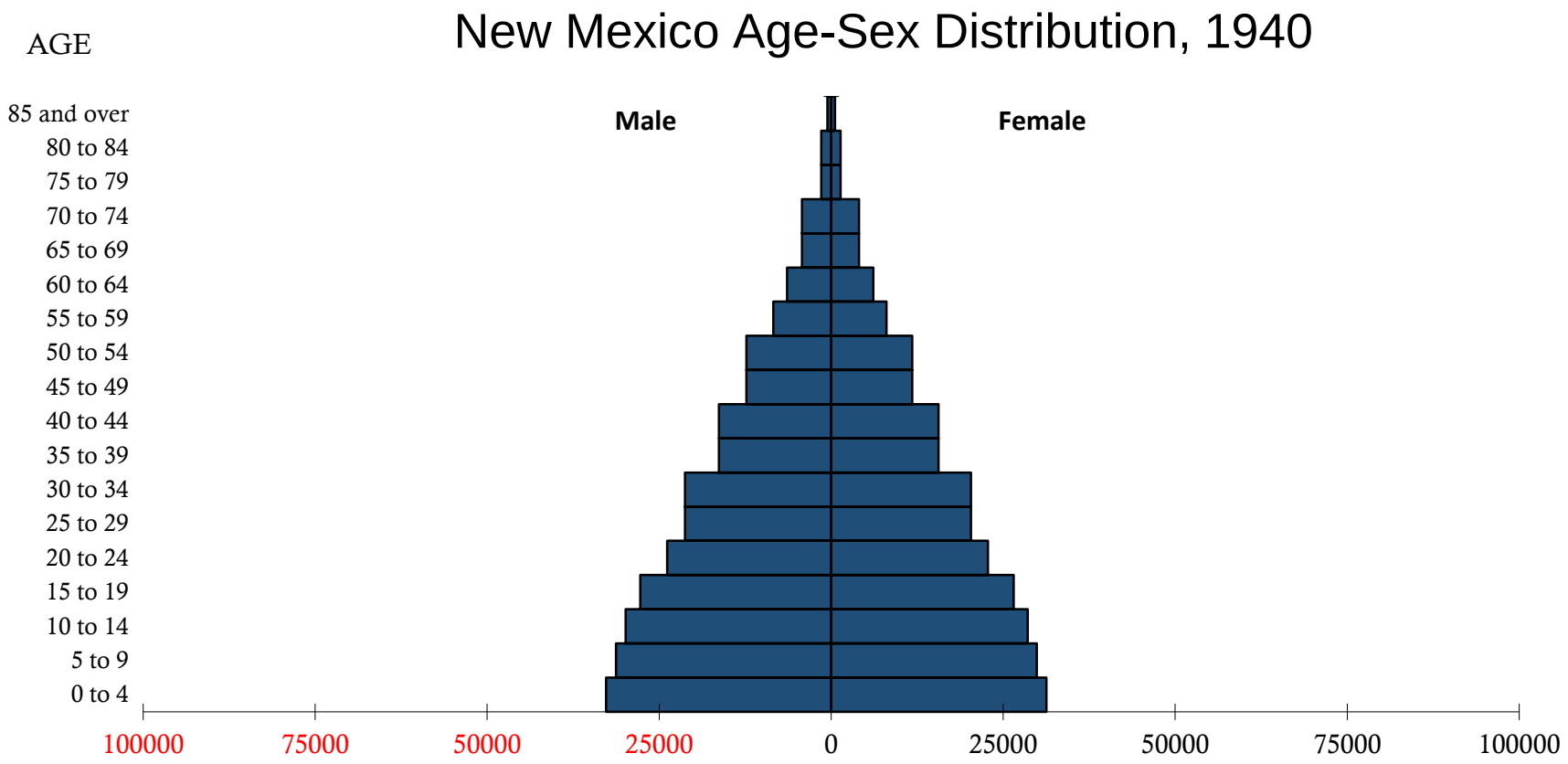

Source: BBER, UNM

UNM BBER Population Data, 1950

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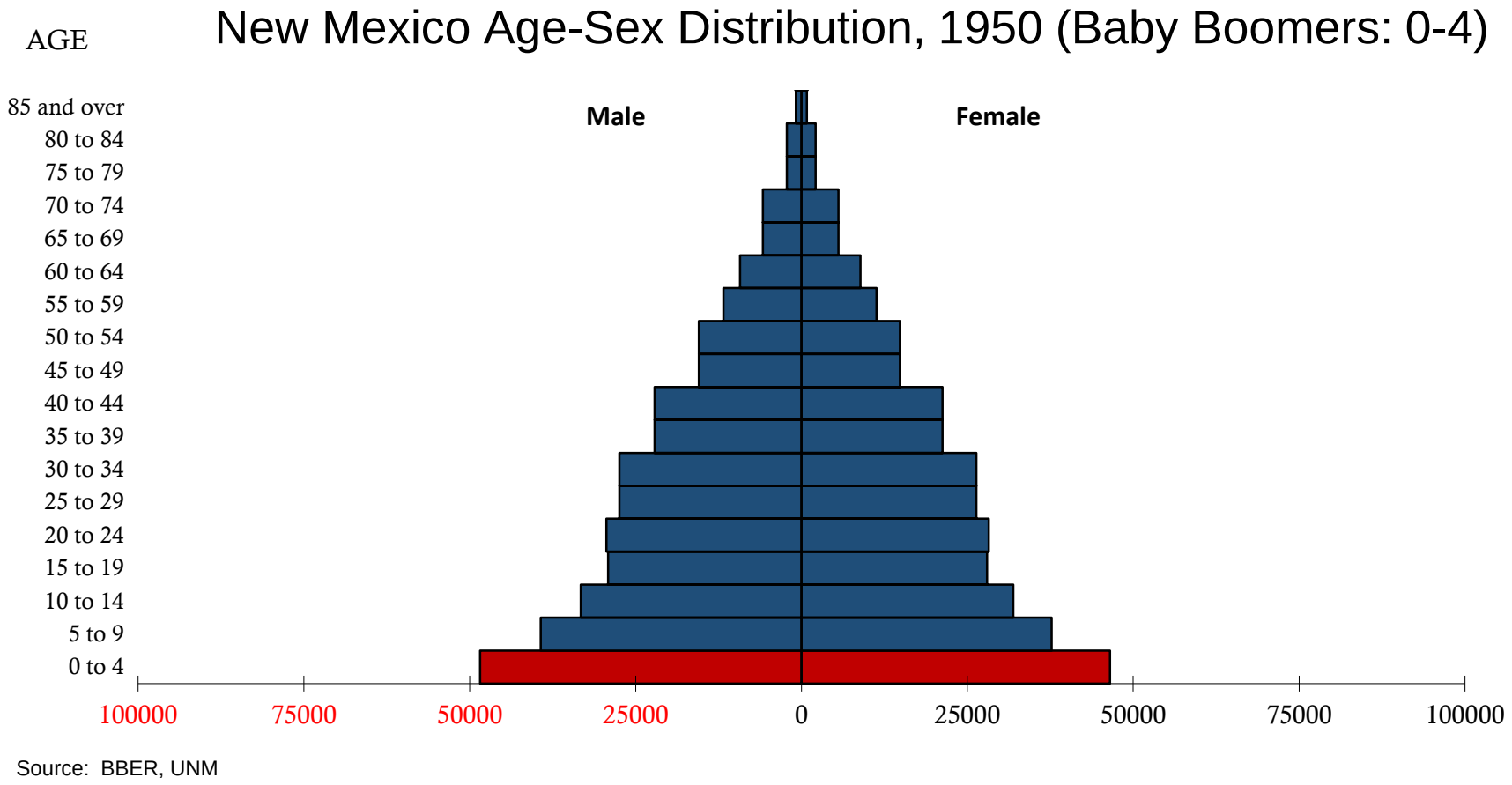

Source: BBER, UNM

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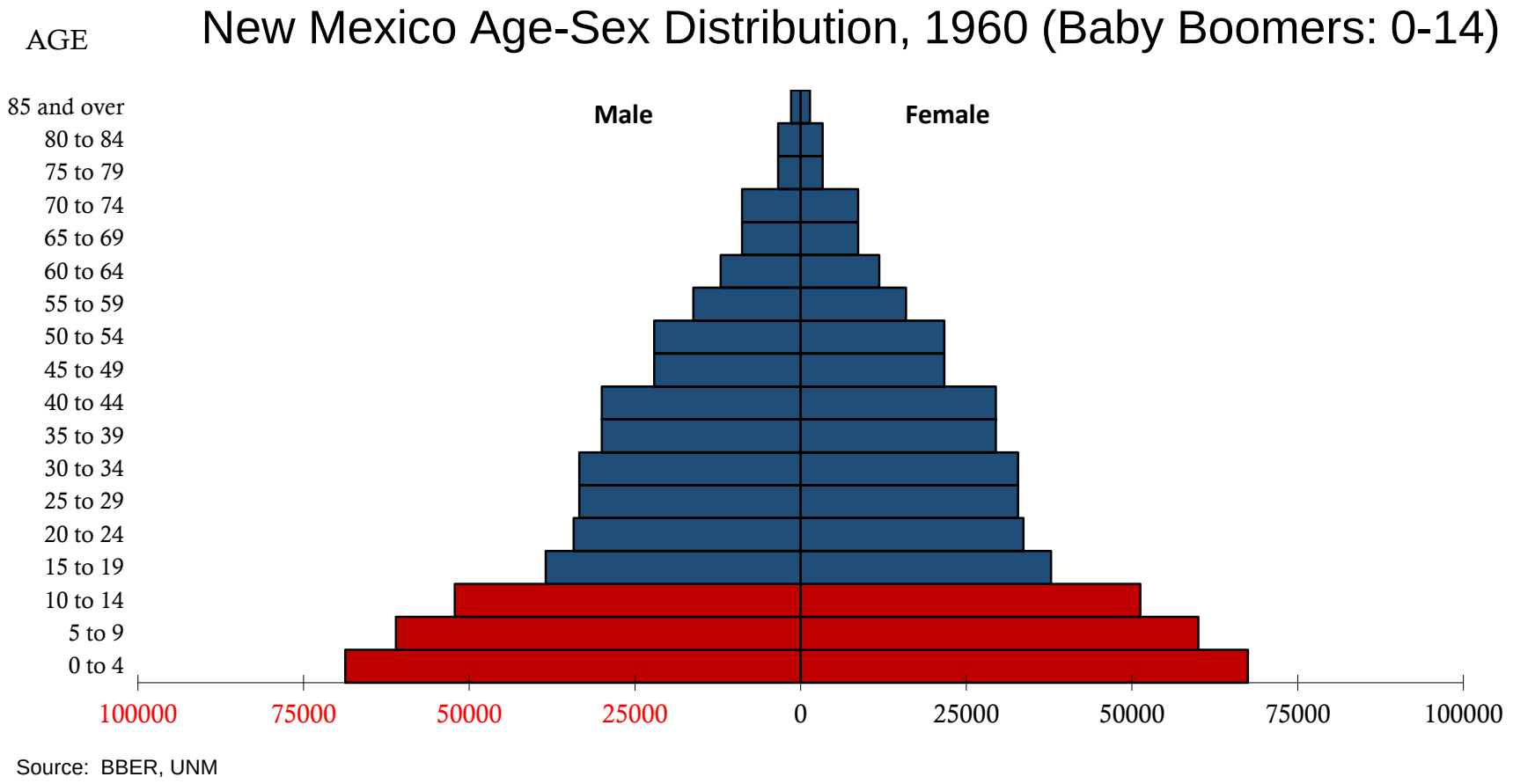

Source: BBER, UNM

UNM BBER Population Data, 1970

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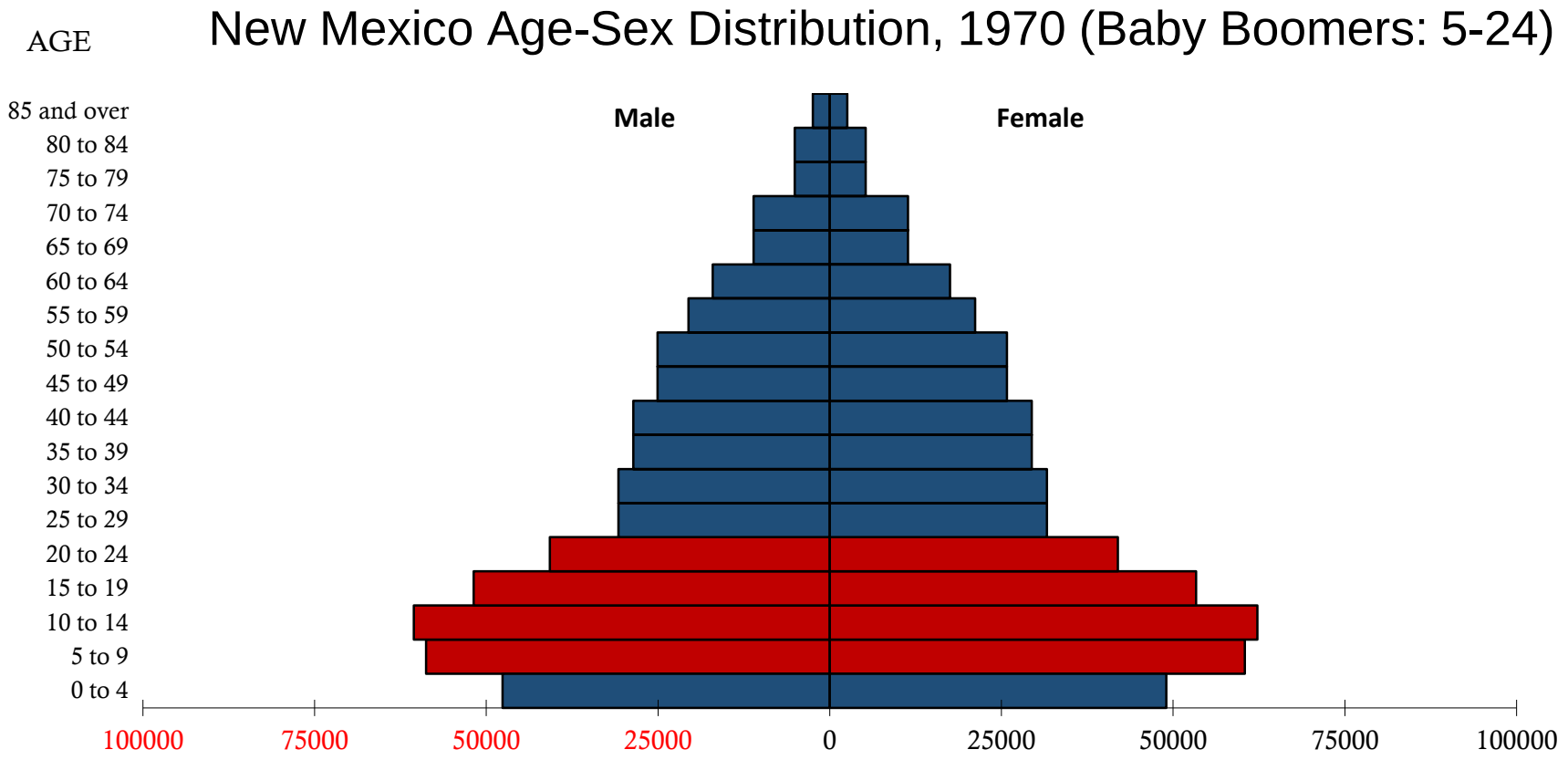

Source: BBER, UNM

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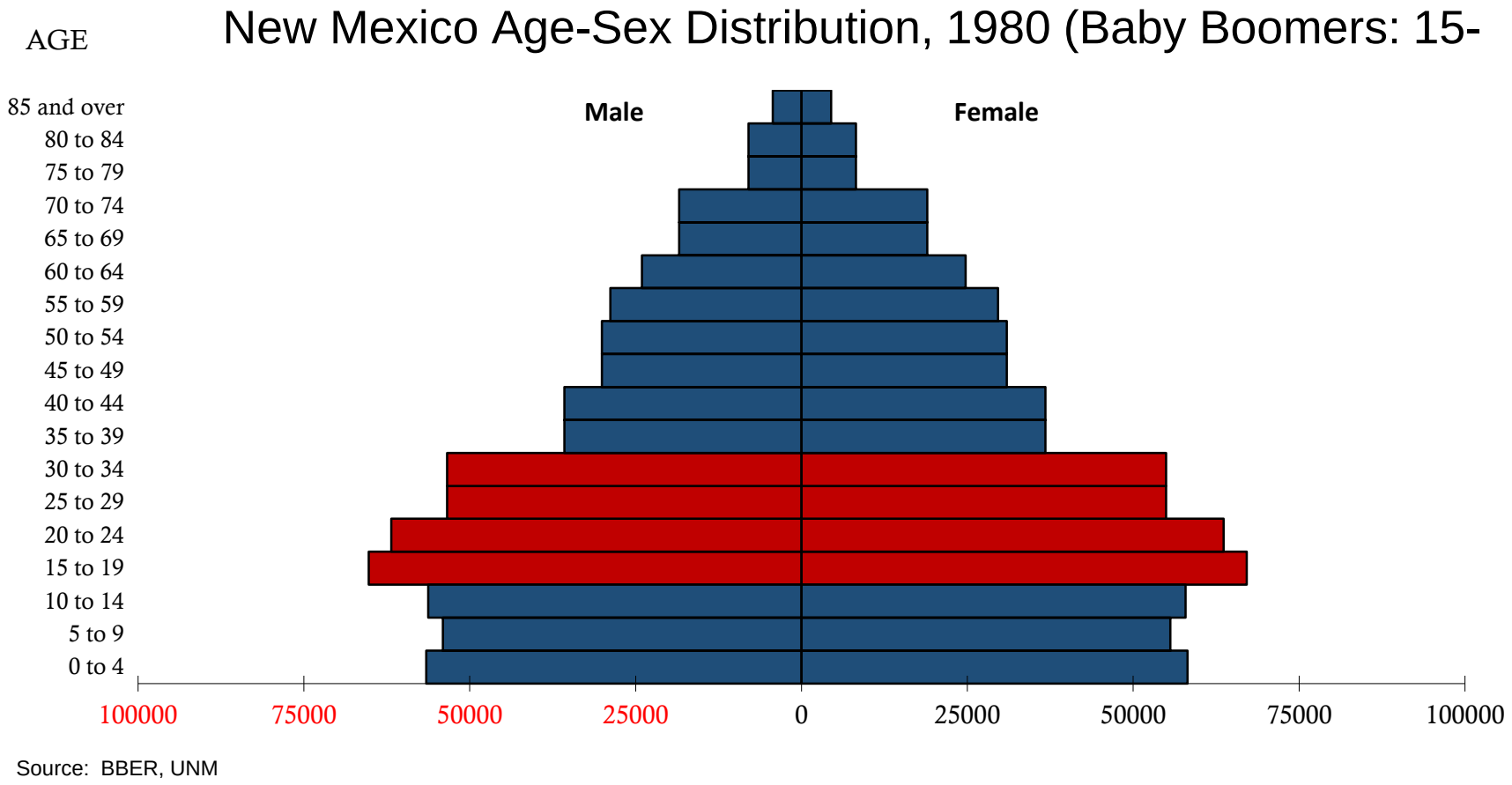

Source: BBER, UNM

UNM BBER Population Data, 1990

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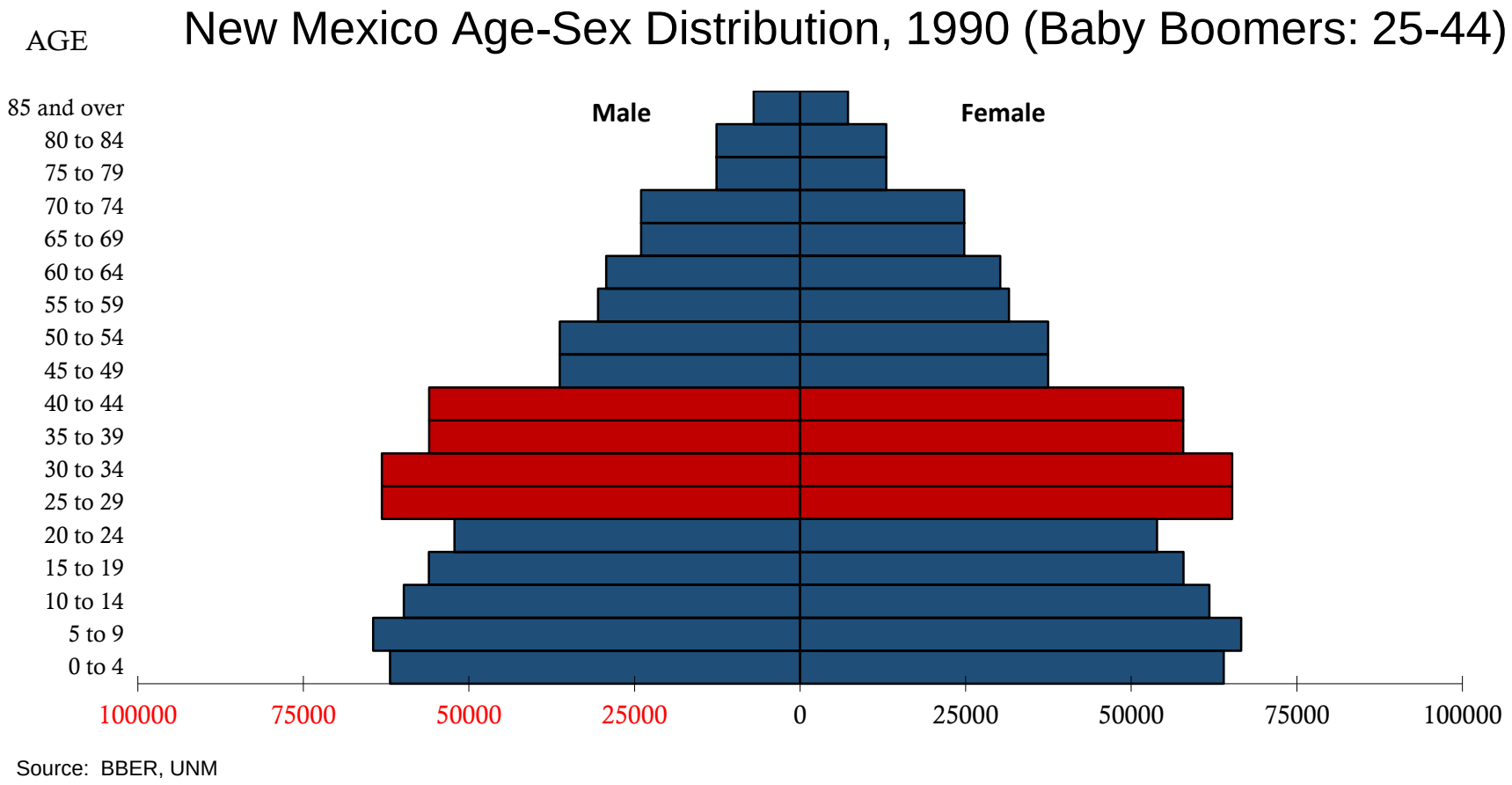

Source: BBER, UNM

UNM BBER Population Data, 2000

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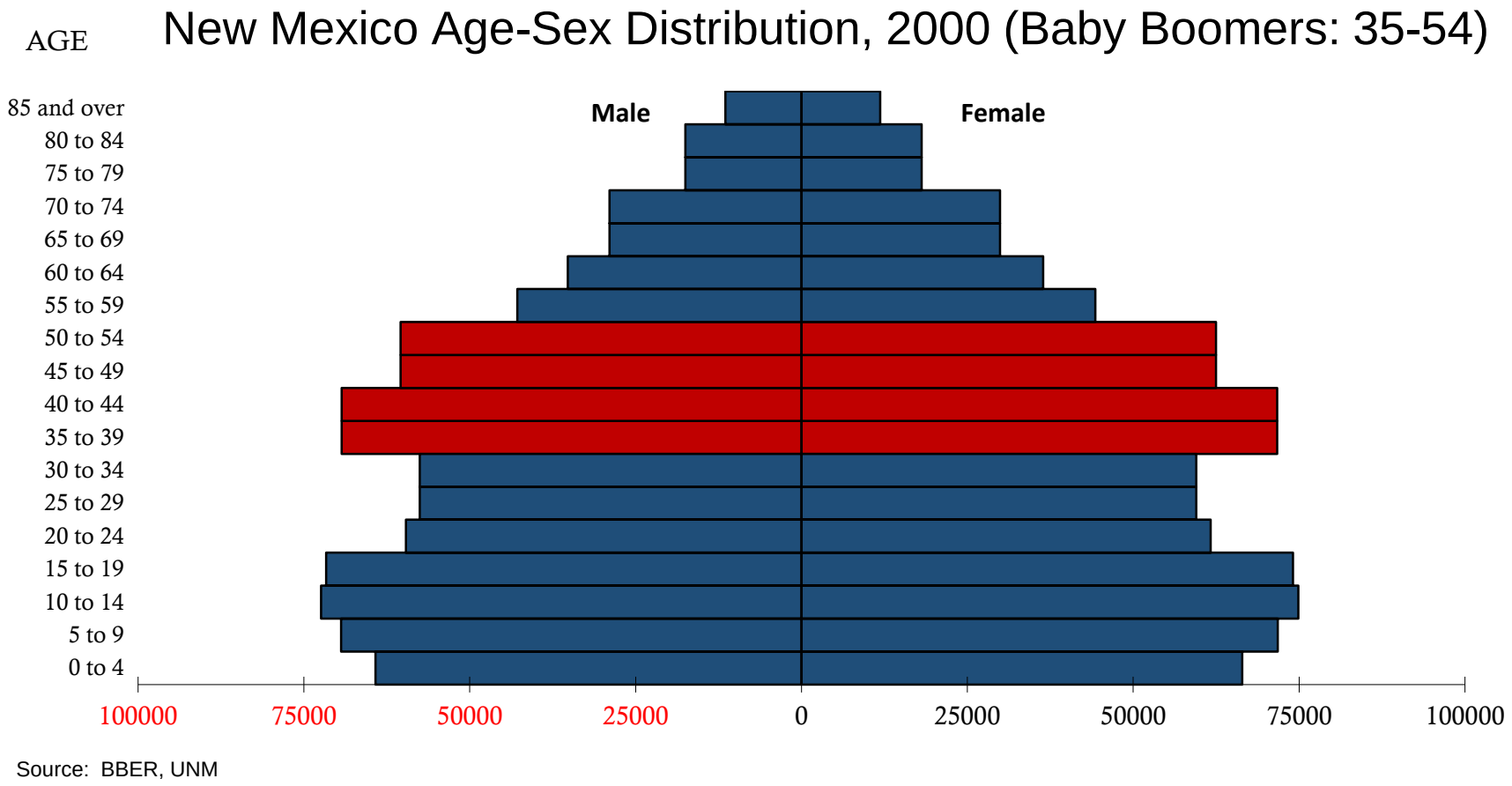
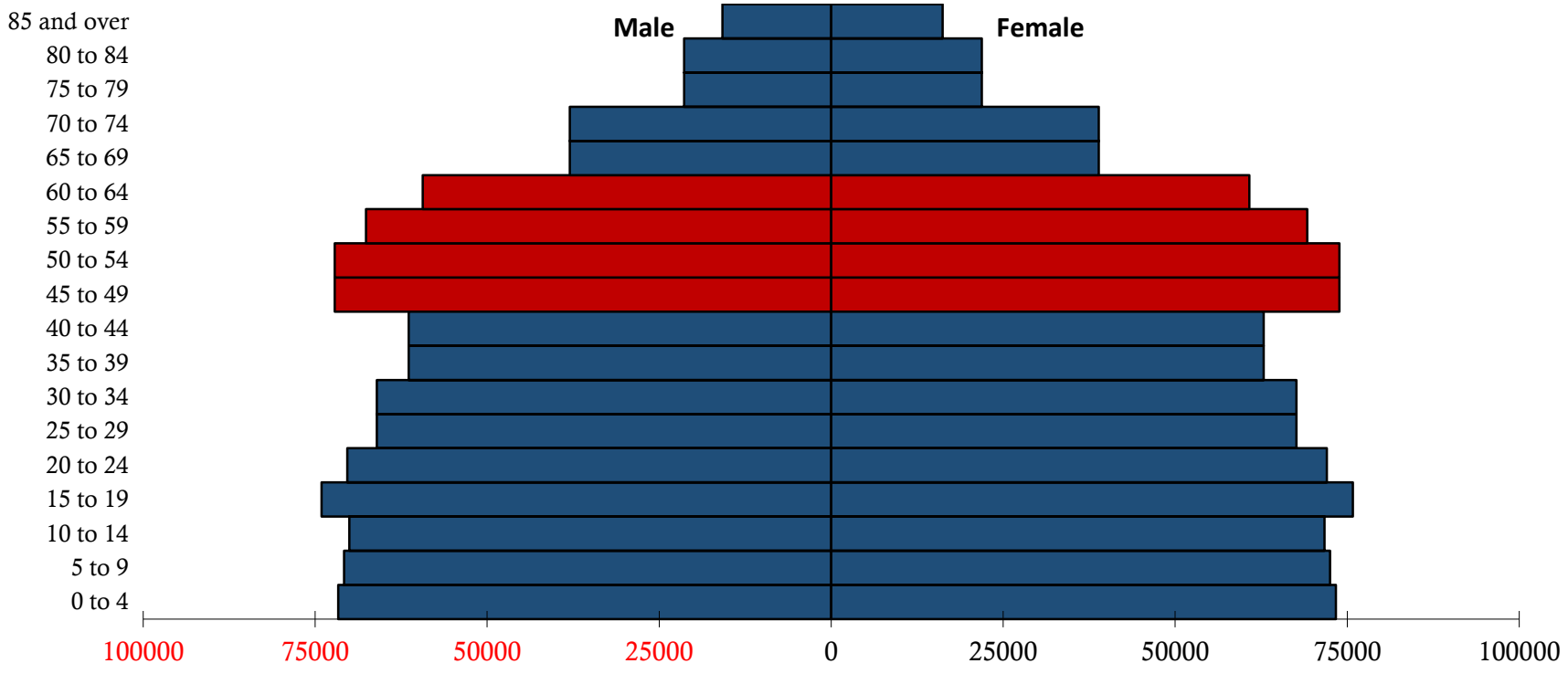


Source: BBER, UNM

UNM BBER Population Data, 2010

http://bber.unm.edu/visualizations/migrated/census/cenhist.htm

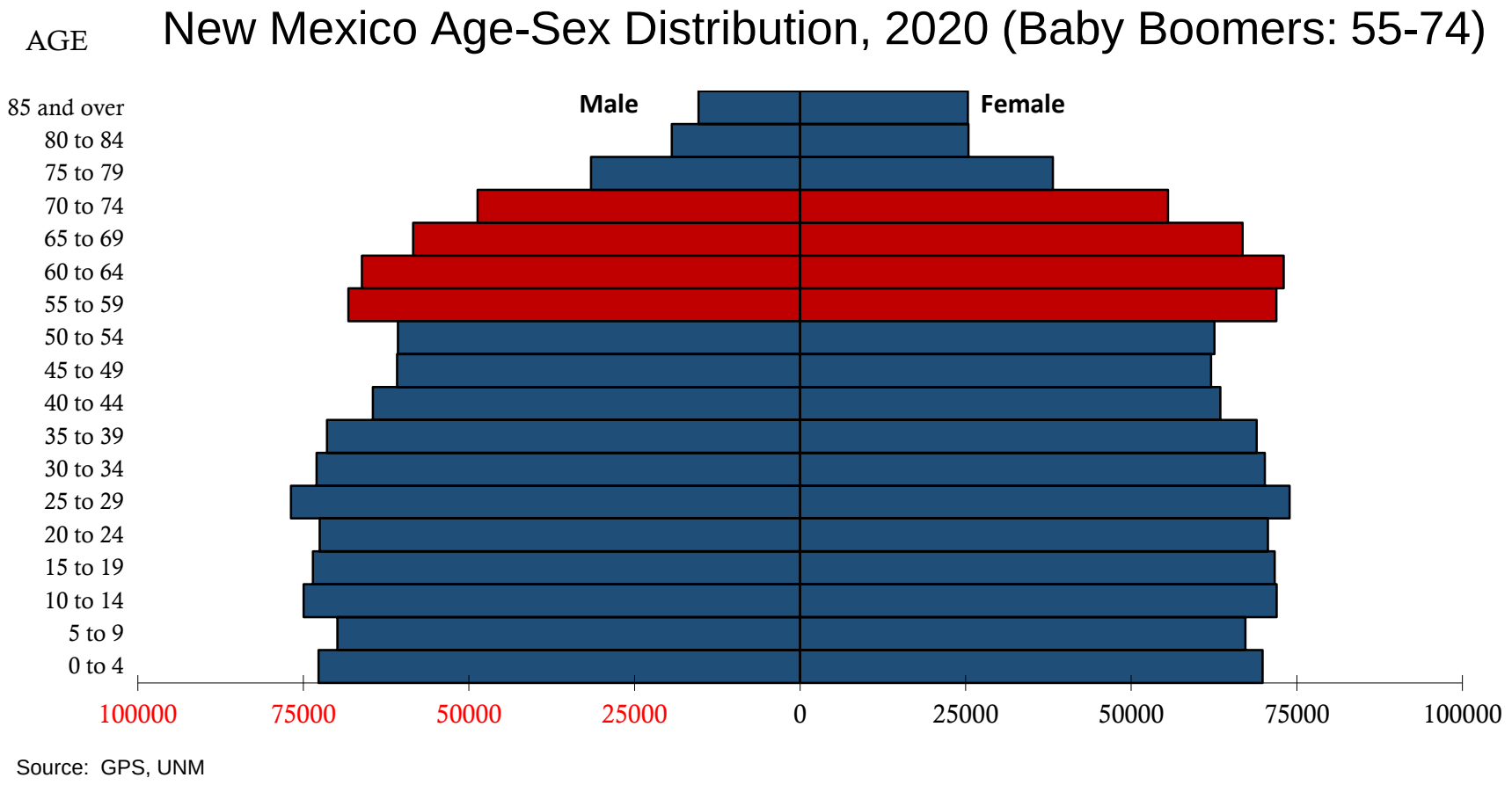
New Mexico Age-Sex Distribution, 2010 (Baby Boomers: 45-64)



Source: BBER, UNM

Robert Rhatigan, UNM Geospatial and Population Studies, Population Projections 2020

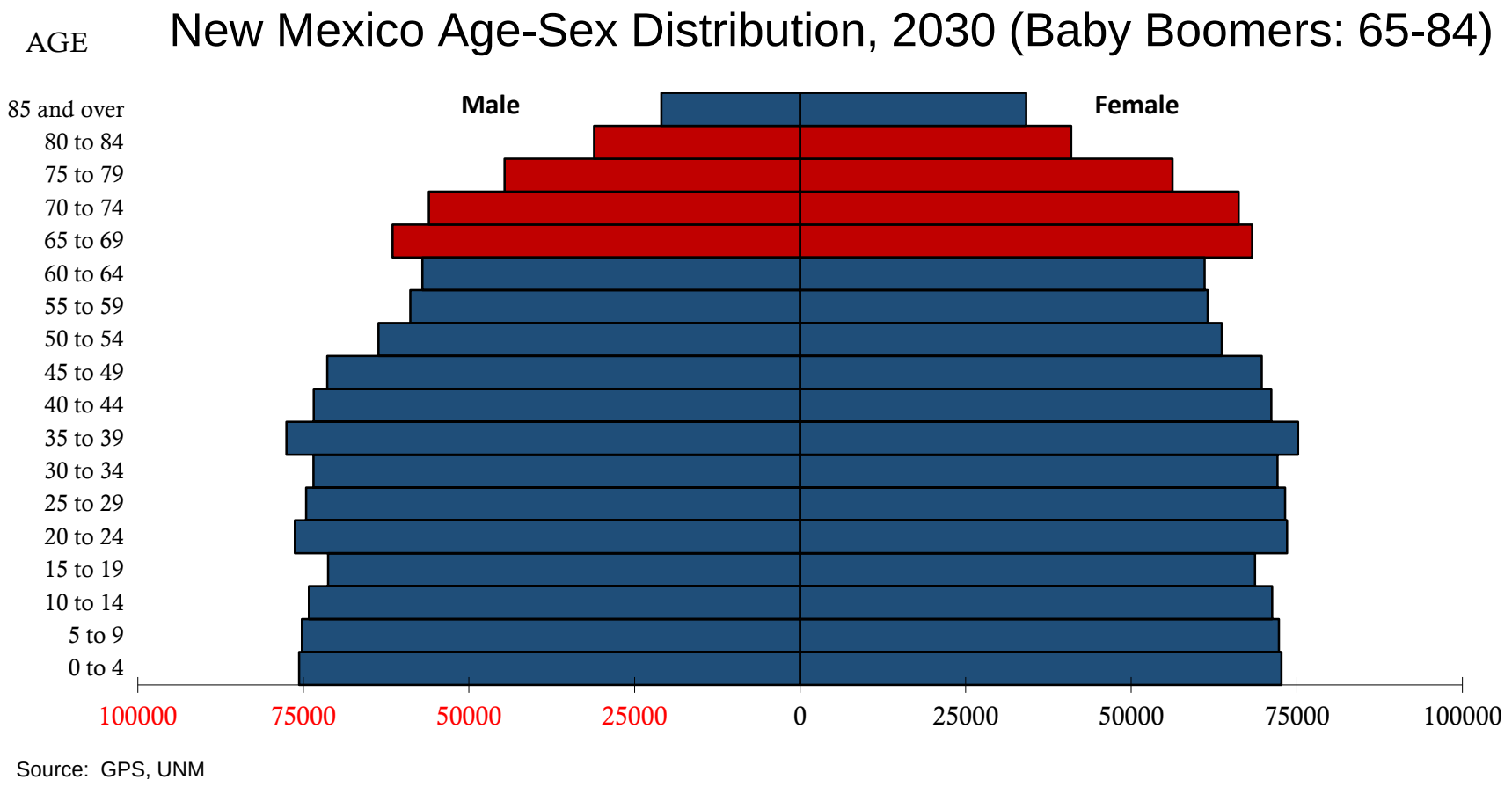
http://gps.unm.edu/data/Population%20Projections.html



Source: GPS, UNM

Robert Rhatigan, UNM Geospatial and Population Studies, Population Projections 2030

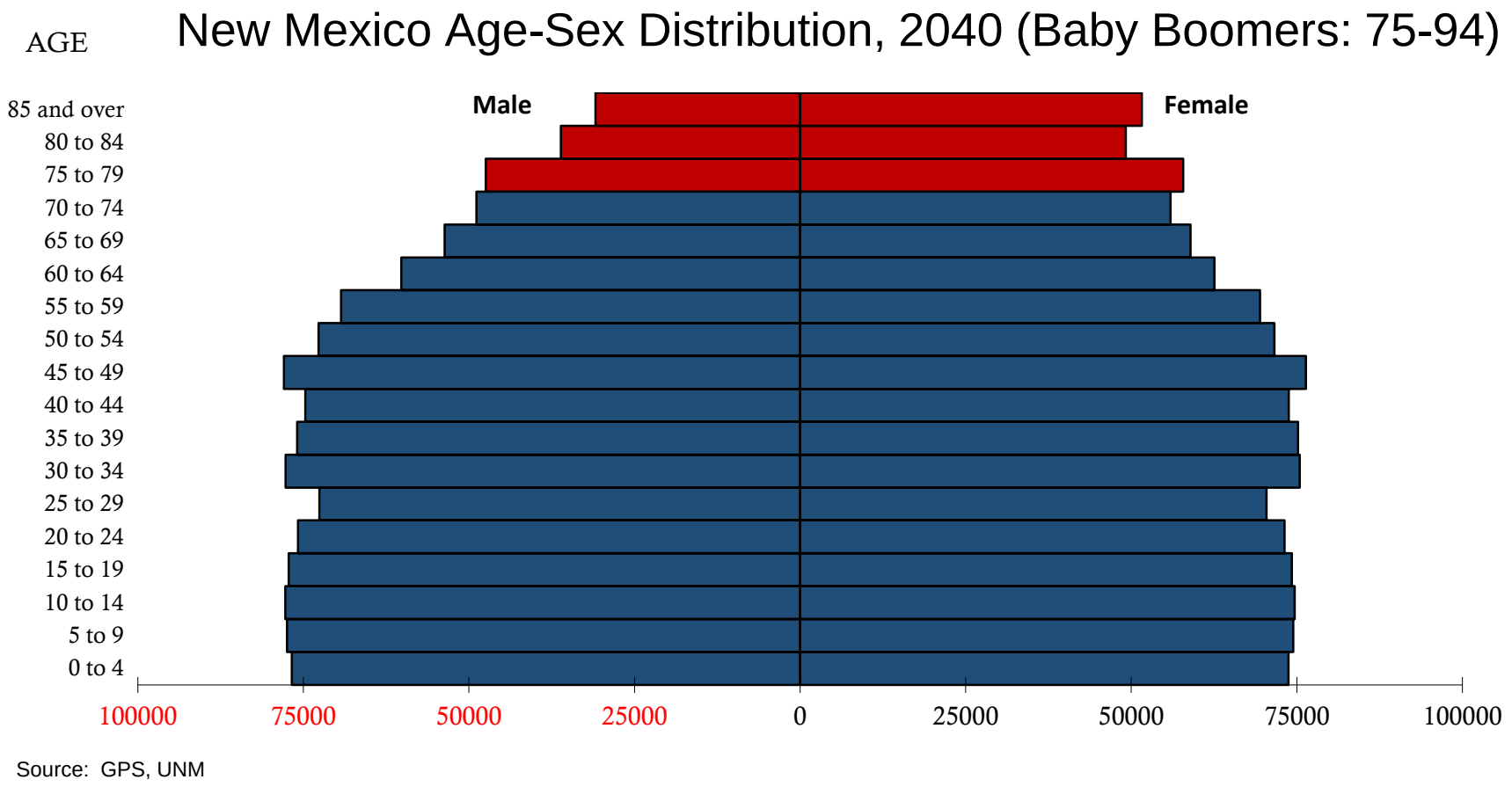
http://gps.unm.edu/data/Population%20Projections.html



Source: GPS, UNM

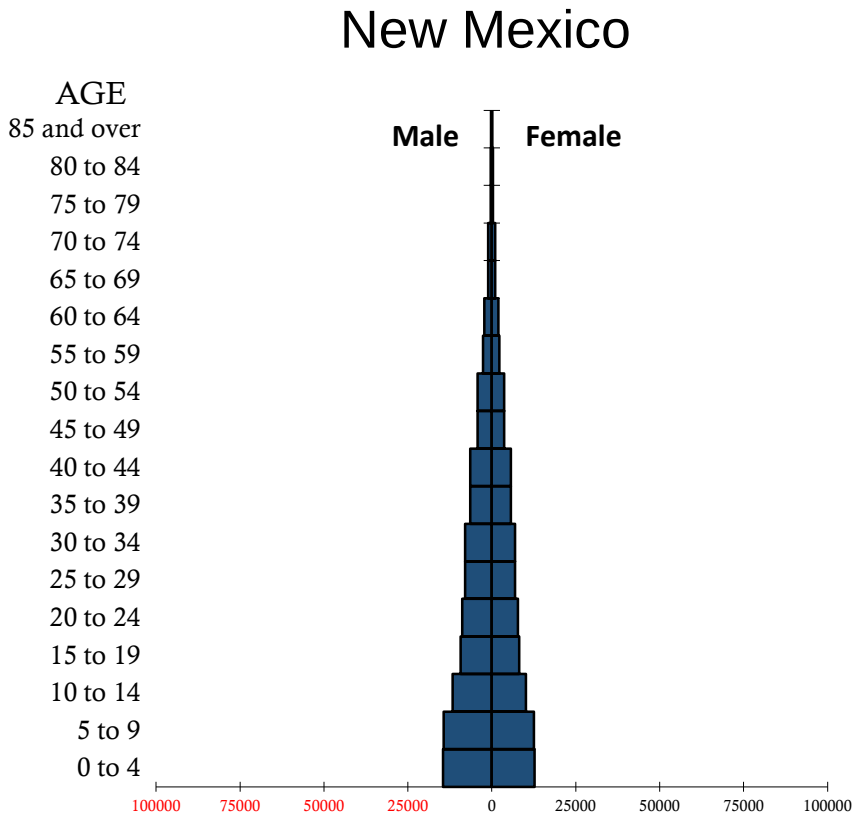
Robert Rhatigan, UNM Geospatial and Population Studies, Population Projections 2040

http://gps.unm.edu/data/Population%20Projections.html

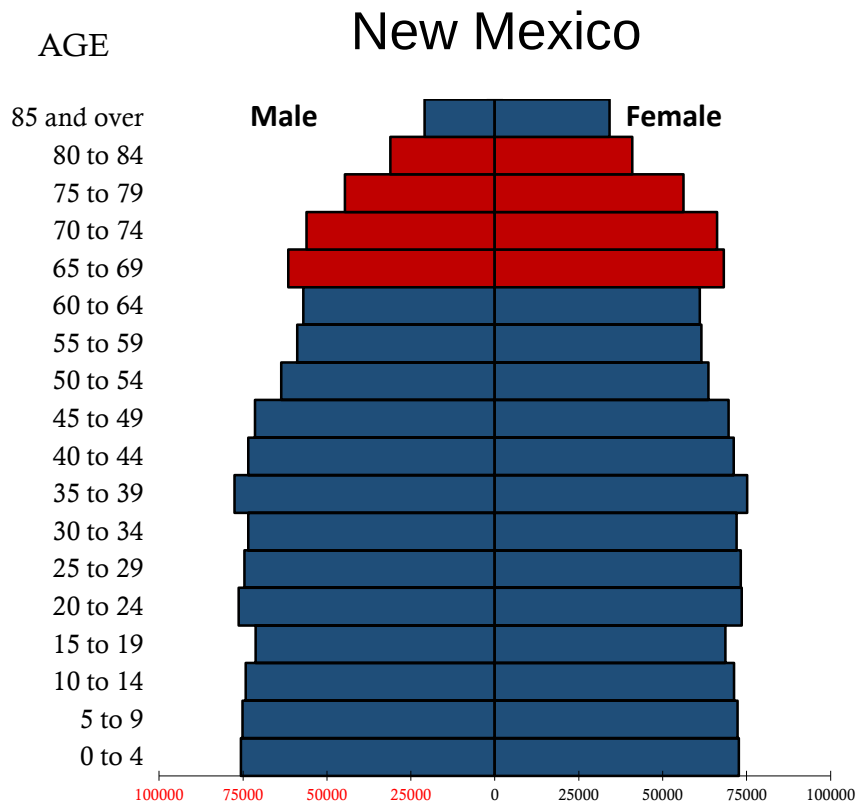


Source: GPS, UNM

NM Population 1900 and 2030



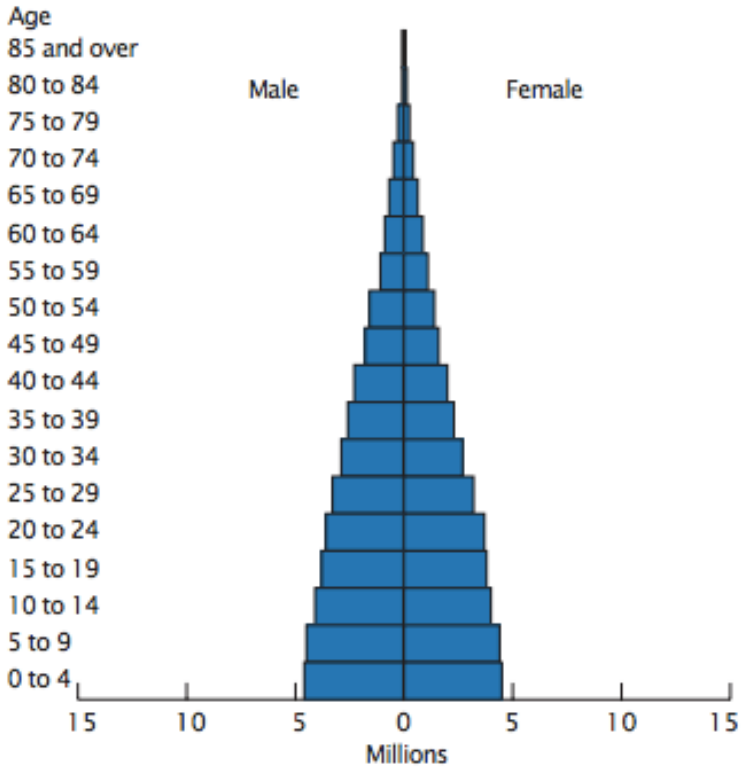
Source: BBER, UNM



Source: GPS, UNM

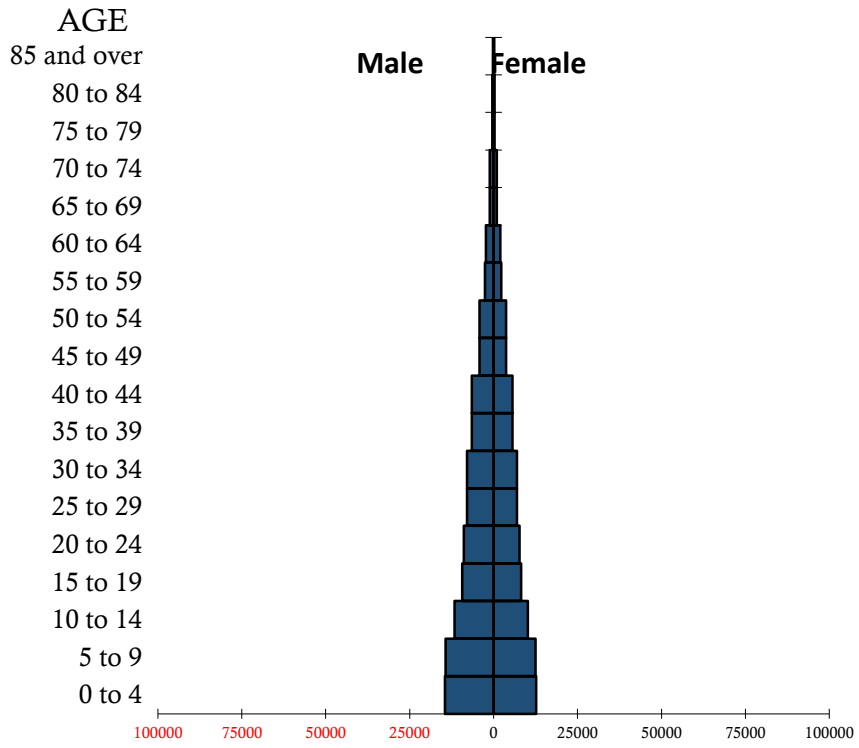
World, US and NM Population Data:1900

Figure 1-5.
Population by Age and Sex: 1900
(For information on confidentiality protection, nonsampling error, and definitions, see *www.census.gov/prod/cen2010/doc/sf1.pdf)*



Source: U.S. Bureau of the Census, 1983; 1900 Census.

New Mexico



Source: BBER, UNM

World, US and NM Population Data: 1970

WORLD ▾

1970

Population: 3,682,487,691

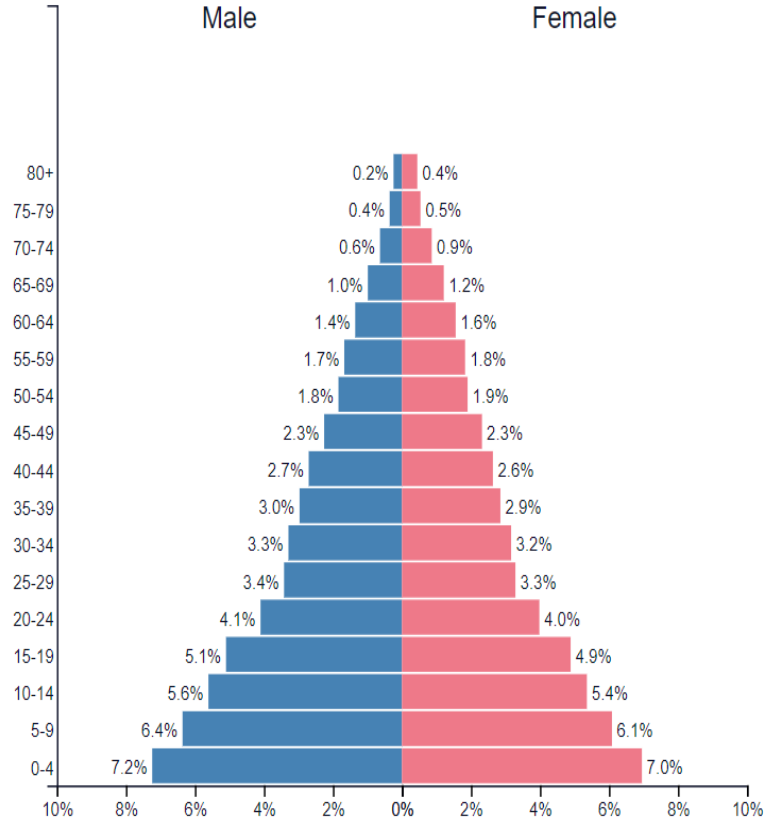
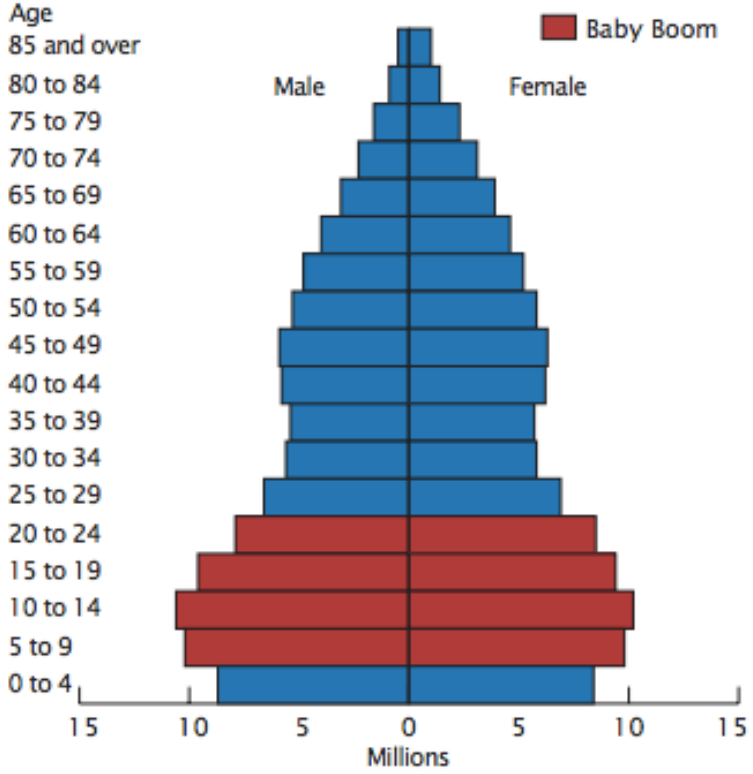
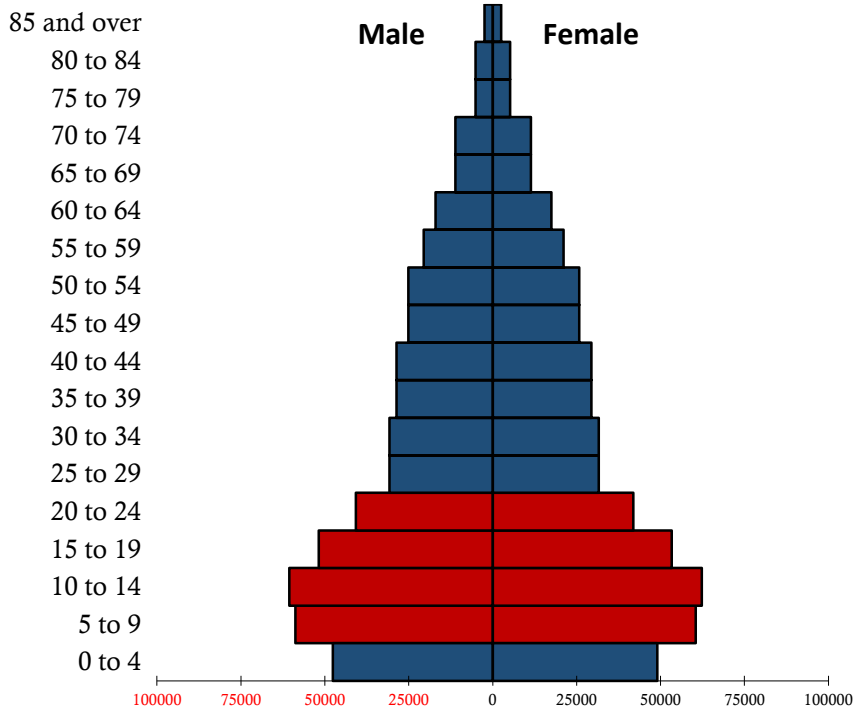


Figure 1-6.
Population by Age and Sex: 1970
(For information on confidentiality protection, nonsampling error, and definitions, see *www.census.gov/prod/cen2010/doc/sf1.pdf)*



Source: U.S. Bureau of the Census, 1983; 1970 Census.

New Mexico



Source: BBER, UNM

World, US and NM Population Data: 2010

WORLD ▾

2010

Population: 6,929,725,043

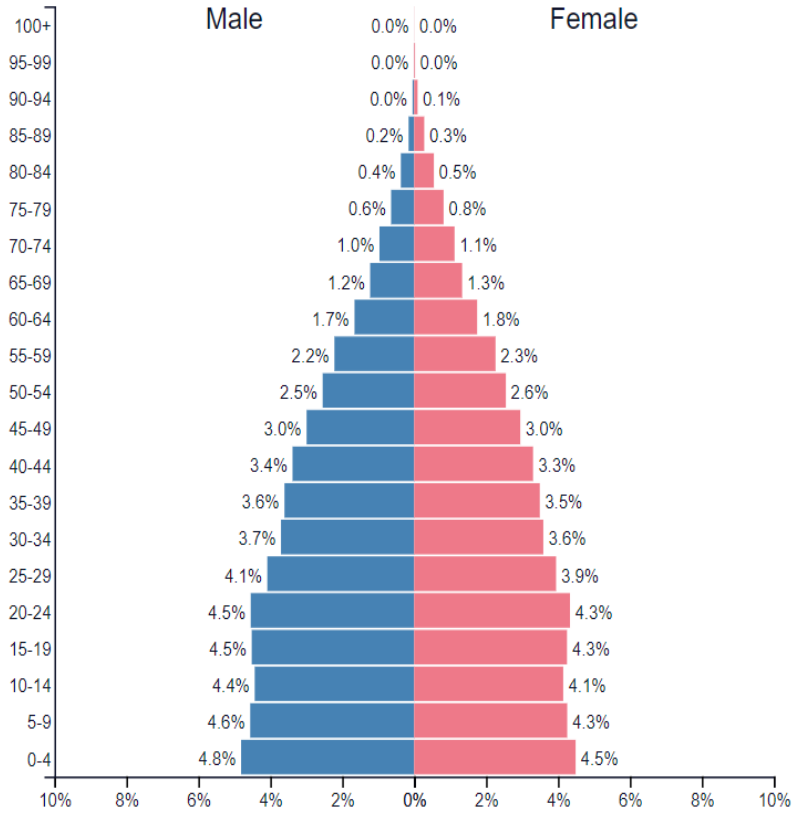
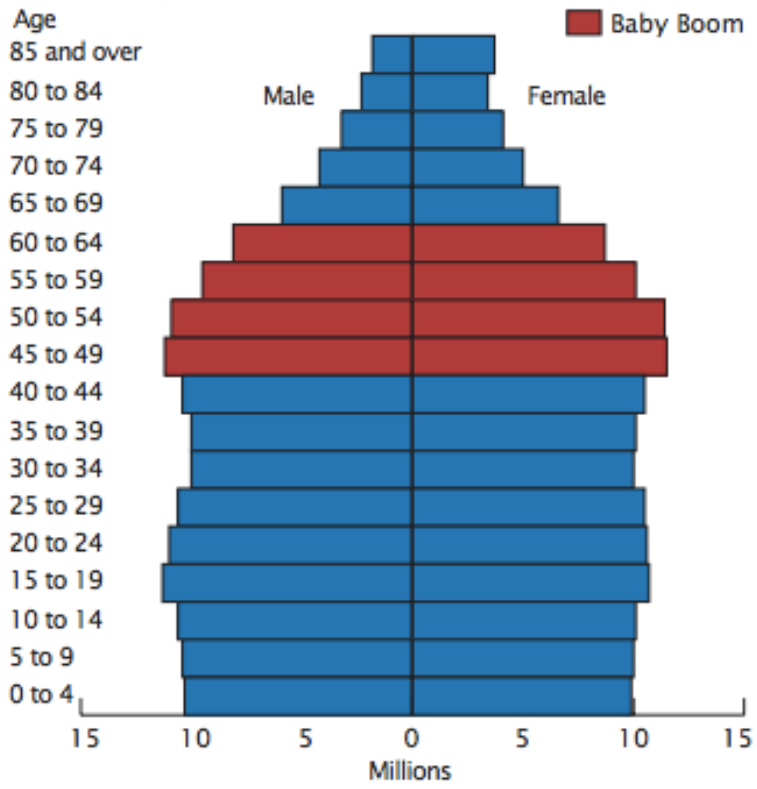
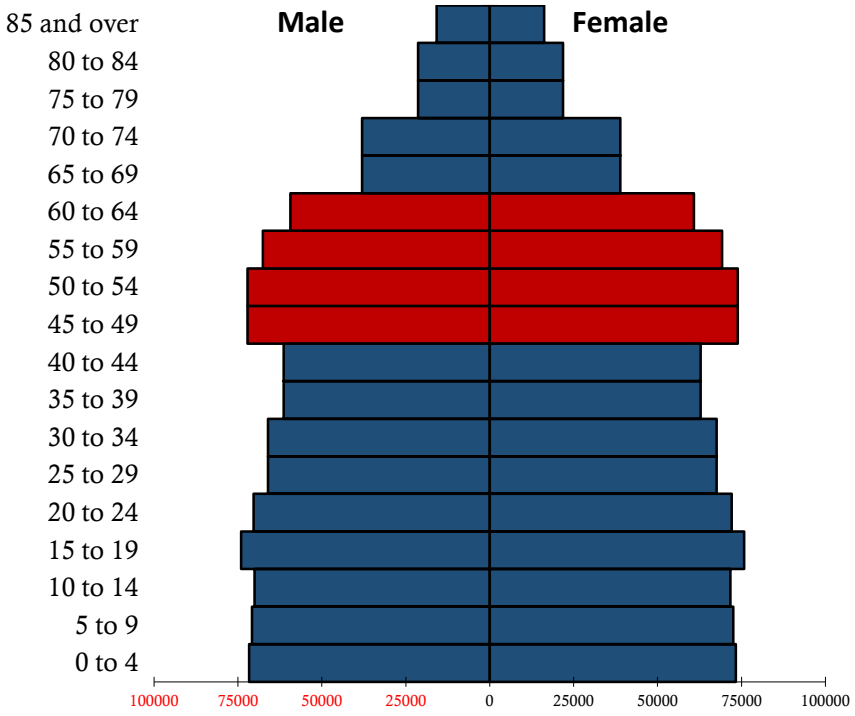


Figure 1-7.
Population by Age and Sex: 2010
(For information on confidentiality protection, nonsampling error, and definitions, see *www.census.gov/prod/cen2010/doc/sf1.pdf*)



Source: U.S. Census Bureau, 2011; 2010 Census.

New Mexico



Source: BBER, UNM

World, US and NM Population Projections: 2030

WORLD ▾

2030

Population: 8,500,766,052

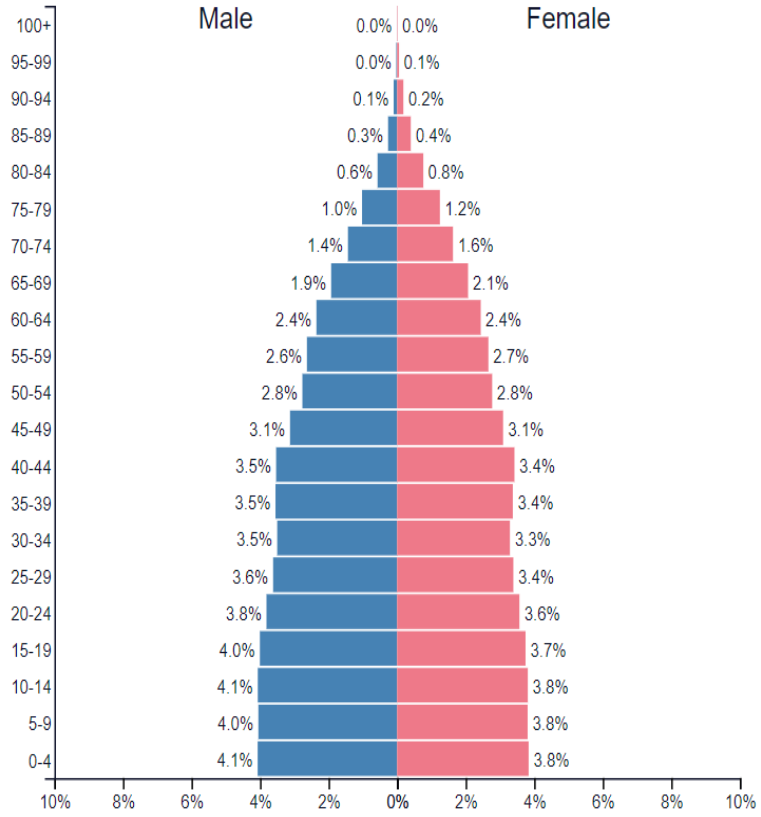
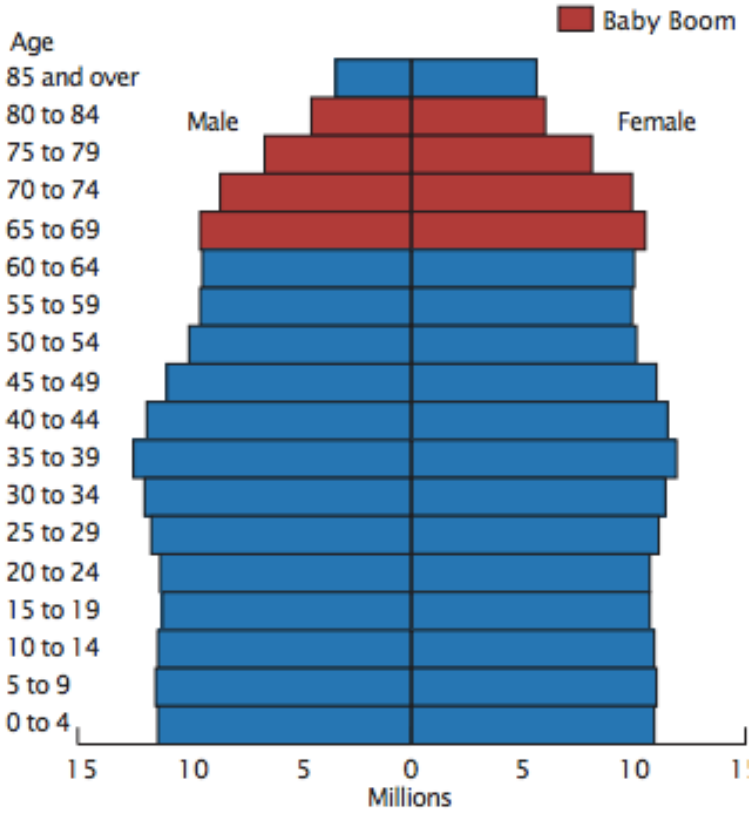
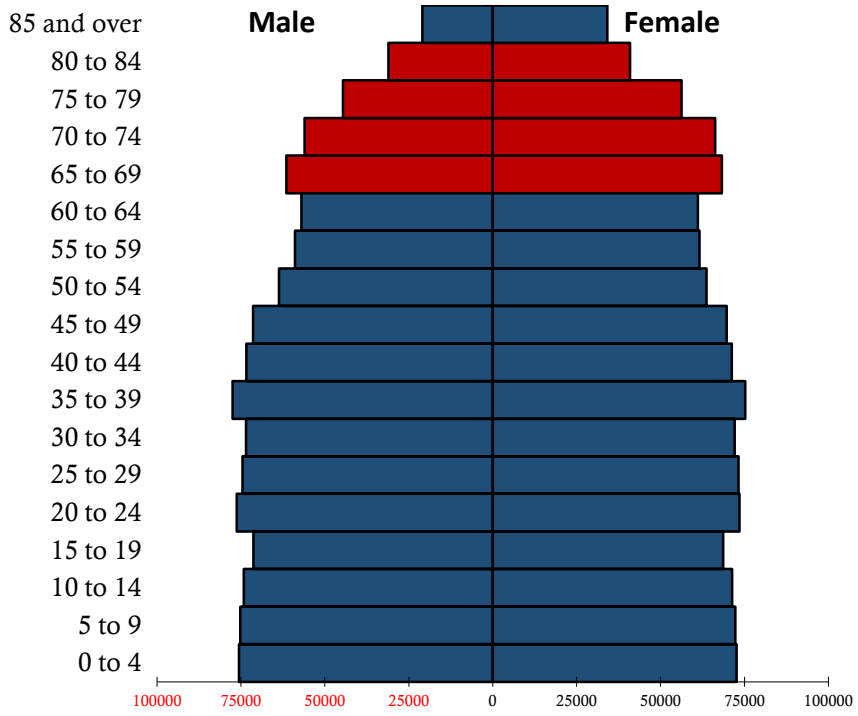


Figure 1-8.
Population by Age and Sex: 2030



Source: U.S. Census Bureau, 2012a; *2012 National Population Projections*, Middle series.

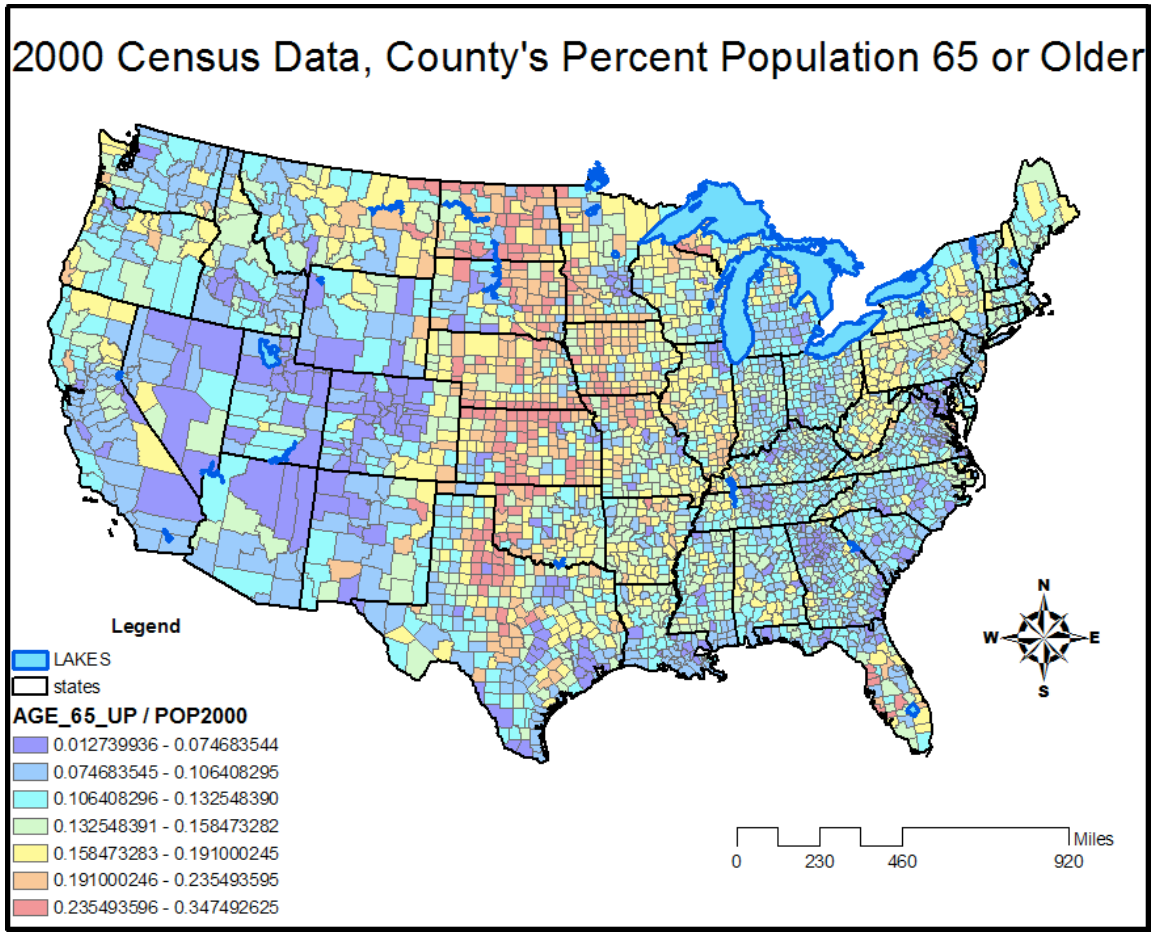
New Mexico



Source: GPS, UNM

In 2000, New Mexico ranked 39th among states in the percent of population ≥ 65. **Where do you think we will rank in 2030?**

- **4th**
- 14th
- 24th
- 34th
- 44th



Ranking of States by projected population age 65 and over: 2000, 2010, and 2030

"Older Americans—A Diverse and Growing Population." *Growing Old in America*. Barbara Wexler. 2008.
http://ic.galegroup.com/ic/ovic/ReferenceDetailsPage/DocumentToolsPortletWindow? displayGroupName=Reference&jsid=39089e482c48b82edbb8752954d5c460&action=2&catId=&documentId=GALE%7CEJ3011870101&u=tel_s_tsla&zid=a8b62bf67a1e49125e7d00fb3ad9b66d last accessed 1/24/2016

2000 state	2000 percent	2000 rank	2010 state	2010 percent	2010 rank	2030 state	2030 percent	2030 rank
United States	12.4	(x)	United States	13.0	(x)	United States	19.7	(x)
Florida	17.6	1	Florida	17.8	1	Florida	27.1	1
Pennsylvania	15.6	2	West Virginia	16.0	2	Maine	26.5	2
West Virginia	15.3	3	Maine	15.6	3	[illegible]	[illegible]	[illegible]
Iowa	14.9	4	Pennsylvania	15.5	4	New Mexico	26.4	4
North Dakota	14.7	5	North Dakota	15.3	5	[illegible]	[illegible]	[illegible]
Rhode Island	14.5	6	Montana	15.0	6	North Dakota	25.1	6
Maine	14.4	7	Iowa	14.9	7	West Virginia	24.8	7
South Dakota	14.3	8	South Dakota	14.6	8	Vermont	24.4	8
Arkansas	14.0	9	Connecticut	14.4	9	Delaware	23.5	9
Connecticut	13.8	10	Arkansas	14.3	10	South Dakota	23.1	10
Nebraska	13.6	11	Vermont	14.3	11	Pennsylvania	22.6	11
Massachusetts	13.5	12	Hawaii	14.3	12	Iowa	22.4	12
Missouri	13.5	13	Delaware	14.1	13	Hawaii	22.3	13
Montana	13.4	14	Alabama	14.1	14	Arizona	22.1	14
Ohio	13.3	15	[illegible]	[illegible]	[illegible]	South Carolina	22.0	15
Hawaii	13.3	16	New Mexico	14.1	16	Connecticut	21.5	16
Kansas	13.3	17	[illegible]	[illegible]	[illegible]	New Hampshire	21.4	17
New Jersey	13.2	18	Arizona	13.9	18	Rhode Island	21.4	18
Oklahoma	13.2	19	Missouri	13.9	19	Wisconsin	21.3	19
Wisconsin	13.1	20	Oklahoma	13.8	20	Alabama	21.3	20
Alabama	13.0	21	Nebraska	13.8	21	Massachusetts	20.9	21
Arizona	13.0	22	Ohio	13.7	22	Nebraska	20.6	22
Delaware	13.0	23	Massachusetts	13.7	23	Mississippi	20.5	23
New York	12.9	24	New Jersey	13.7	24	Ohio	20.4	24
Oregon	12.8	25	New York	13.6	25	Arkansas	20.3	25
Vermont	12.7	26	South Carolina	13.6	26	Missouri	20.2	26
Kentucky	12.5	27	Wisconsin	13.5	27	Kansas	20.2	27
Indiana	12.4	28	Kansas	13.4	28	New York	20.1	28
Tennessee	12.4	29	Tennessee	13.3	29	New Jersey	20.0	29
Michigan	12.3	30	Kentucky	13.1	30	Kentucky	19.8	30
District of Columbia	12.2	31	Oregon	13.0	31	Louisiana	19.7	31
South Carolina	12.1	32	Michigan	12.8	32	Michigan	19.5	32
Minnesota	12.1	33	Mississippi	12.8	33	Oklahoma	19.4	33
Illinois	12.1	34	Indiana	12.7	34	Tennessee	19.2	34
Mississippi	12.1	35	Louisiana	12.6	35	Minnesota	18.9	35
North Carolina	12.0	36	New Hampshire	12.6	36	Virginia	18.8	36
New Hampshire	12.0	37	North Carolina	12.4	37	Nevada	18.6	37
[illegible]	[illegible]	[illegible]	Virginia	12.4	38	Idaho	18.3	38
New Mexico	11.7	39	Illinois	12.4	39	Oregon	18.2	39
Louisiana	11.6	40	Minnesota	12.4	40	Washington	18.1	40
Maryland	11.3	41	Nevada	12.3	41	Indiana	18.1	41
Idaho	11.3	42	Washington	12.2	42	Illinois	18.0	42
Washington	11.2	43	Maryland	12.2	43	California	17.8	43
Virginia	11.2	44	Idaho	12.0	44	North Carolina	17.8	44
Nevada	11.0	45	California	11.5	45	Maryland	17.6	45
California	10.6	46	District of Columbia	11.5	46	Colorado	16.5	46
Texas	9.9	47	Colorado	10.7	47	Georgia	15.9	47
Colorado	9.7	48	Texas	10.5	48	Texas	15.6	48
Georgia	9.6	49	Georgia	10.2	49	Alaska	14.7	49
Utah	8.5	50	Utah	9.0	50	District of Columbia	13.4	50
Alaska	5.7	51	Alaska	8.1	51	Utah	13.2	51

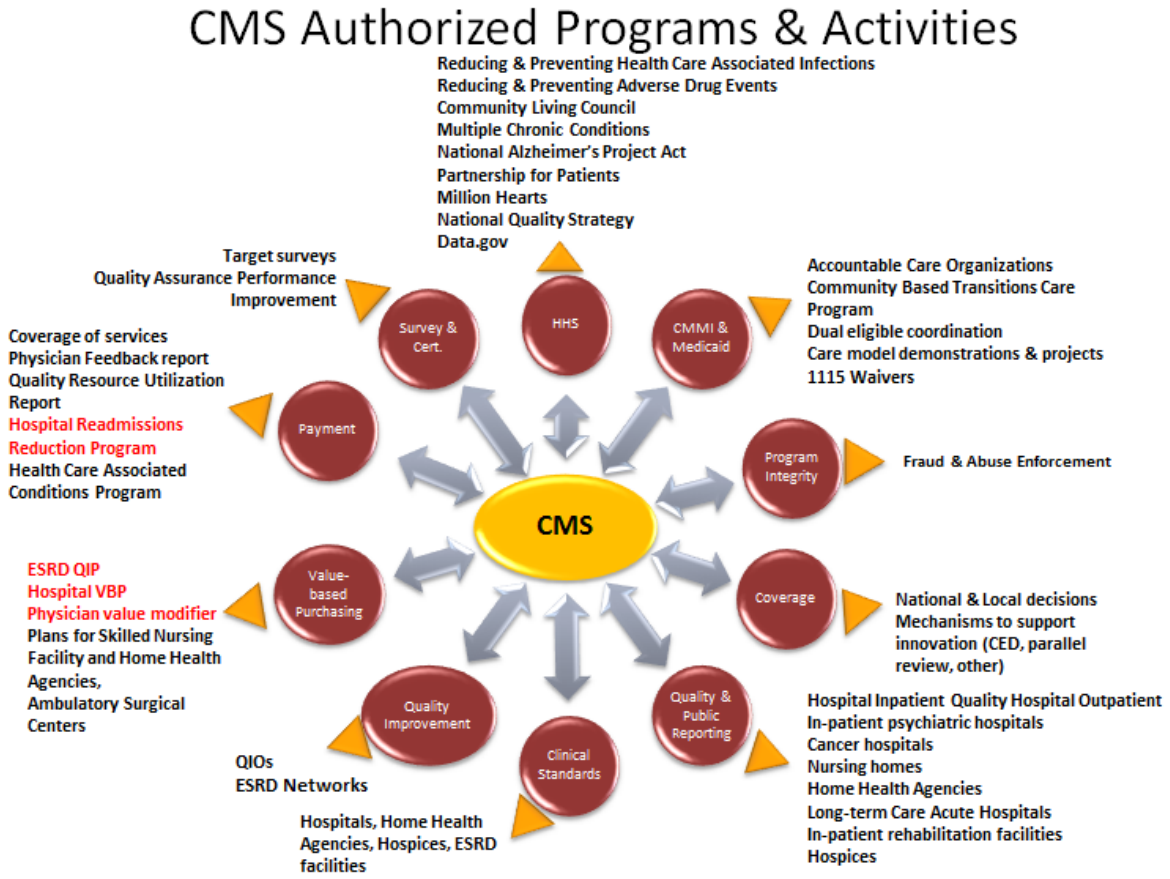
Important Differences in Health Services Use Rates in Older Population Demographics

- Use rates for all adult healthcare services are higher for those > 64
  - Use rates for ages **65-84** are 2.0 to 3.5 times use rates of those <65 (weighted average ~ **3x**)
  - Use rates for ages **85 and above** are 3.5 to 11.5 times use rates of those <65 (weighted average ~ **6x**)
- The aggregate impact of population growth and use rates will require NM to expand virtually all categories of healthcare services, by **30 to 45 percent,** between 2010 and the year 2030
- Nursing home use in NM could **double**

Brief Overview of Value Based Purchasing (VBP) in the United States

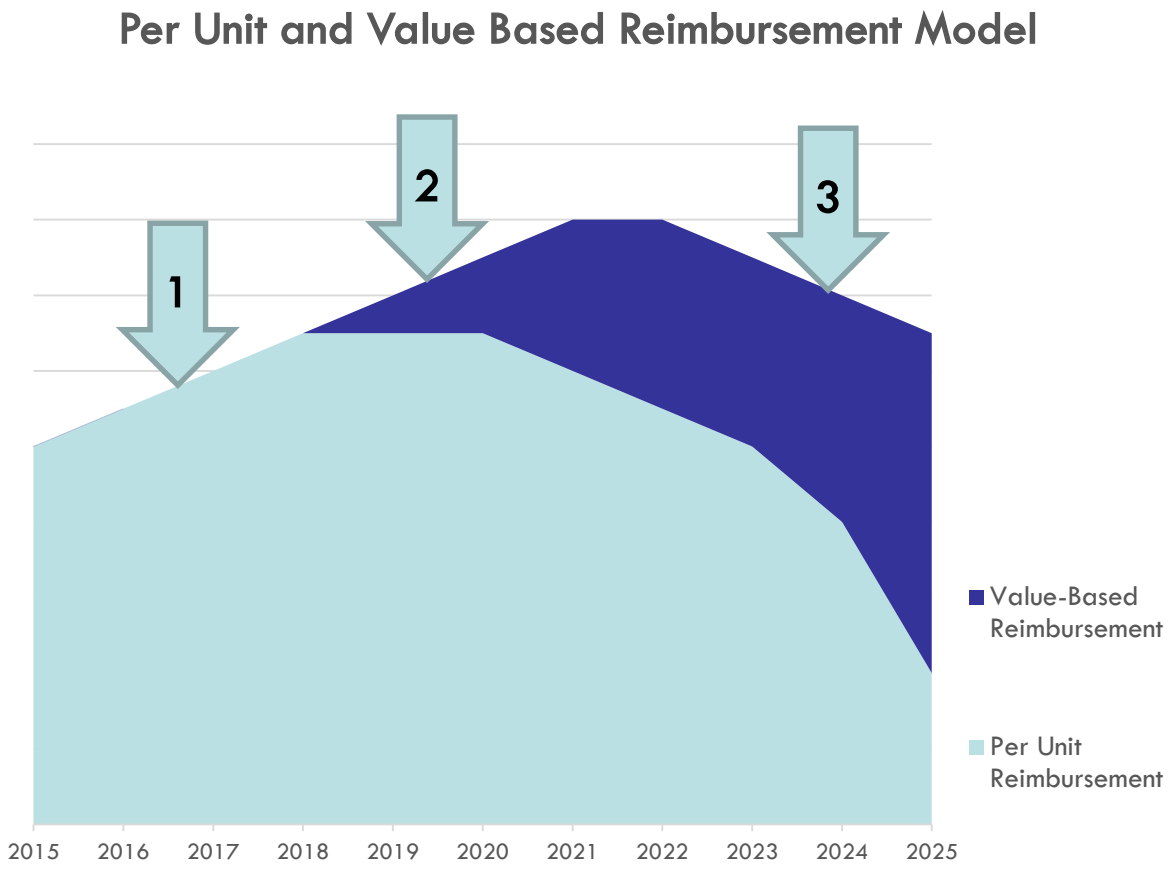
History

- In 1983, the federal government implemented DRGs, the first VBP program, which:
  - Stopped paying per diem rates
  - Started paying a fixed fee for hospitalizations by diagnosis
- CMS has been a consistent leader in program development since then



What does “Value” Mean?

- What you get divided by what you pay for (Quality / Cost)
- Fee for Service payments reward providers for doing more, not necessarily for doing “better”
- Payers are now moving to payment systems to reward quality of care and outcomes

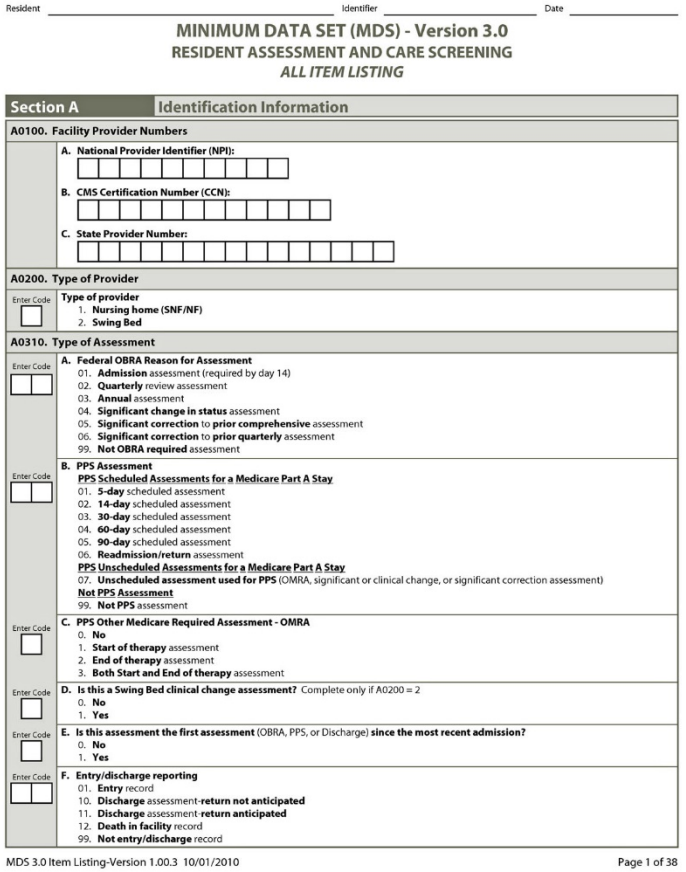


Why Implement VBP Programs in Nursing Facilities?

- Robust data (MDS) and established reporting system
- Changing CMS incentives
- Manageable number of providers

Why Implement VBP Programs in Nursing Facilities?

- The Minimum Data Set (**MDS**) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes
- Established and refined mid-1990s
- This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems
- "No new measures!"



Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
ALL ITEM LISTING

Section A Identification Information

A0100. Facility Provider Numbers

A. **National Provider Identifier (NPI):**
B. **CMS Certification Number (CCN):**
C. **State Provider Number:**

A0200. Type of Provider

Enter Code
Type of provider
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

A0310. Type of Assessment

Enter Code
A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code
B. PPS Assessment
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **Not PPS** assessment

Enter Code
C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code
D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2
0. **No**
1. **Yes**

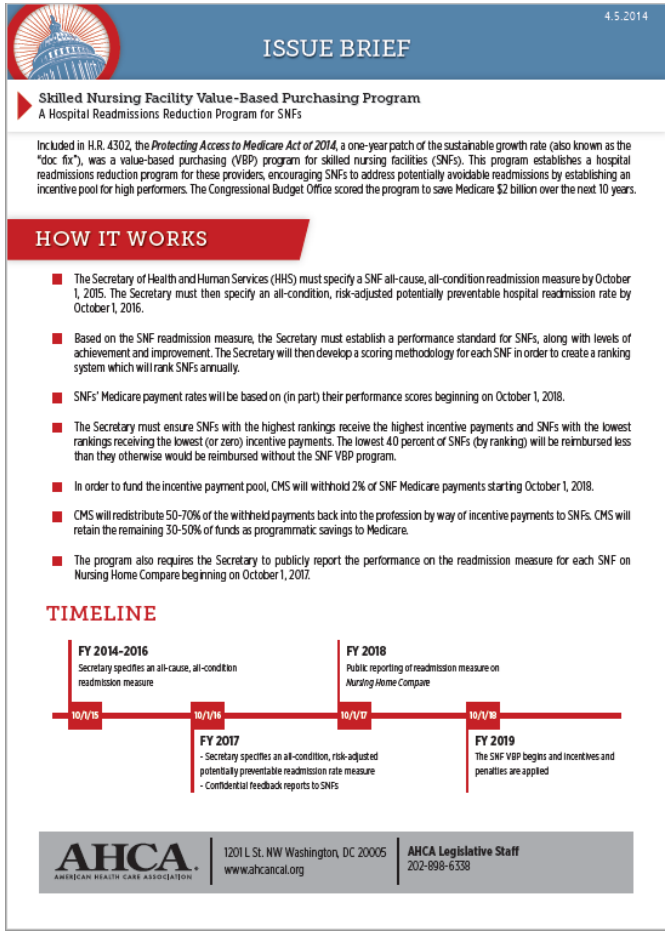
Enter Code
E. Is this assessment the first assessment (OBRA, PPS, or Discharge) **since the most recent admission?**
0. **No**
1. **Yes**

Enter Code
F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

MDS 3.0 Item Listing-Version 1.00.3 10/01/2010 Page 1 of 38

Skilled Nursing Facility Value Based Purchasing Program: 4.5.2014
A Hospital Readmissions Reduction Program for SNFs

- H.R. 4302, the *Protecting Access to Medicare Act of 2014* legislates a value-based purchasing (VBP) program for skilled nursing facilities (SNFs)
- Establishes a hospital readmissions reduction program for these providers, encouraging SNFs to address potentially avoidable readmissions by establishing an incentive pool for high performers
- The Congressional Budget Office scored the program to save Medicare $2 billion over the next 10 years



4.5.2014

ISSUE BRIEF

Skilled Nursing Facility Value-Based Purchasing Program
A Hospital Readmissions Reduction Program for SNFs

Included in H.R. 4302, the *Protecting Access to Medicare Act of 2014*, a one-year patch of the sustainable growth rate (also known as the "doc fix"), was a value-based purchasing (VBP) program for skilled nursing facilities (SNFs). This program establishes a hospital readmissions reduction program for these providers, encouraging SNFs to address potentially avoidable readmissions by establishing an incentive pool for high performers. The Congressional Budget Office scored the program to save Medicare $2 billion over the next 10 years.

HOW IT WORKS

- The Secretary of Health and Human Services (HHS) must specify a SNF all-cause, all-condition readmission measure by October 1, 2015. The Secretary must then specify an all-condition, risk-adjusted potentially preventable hospital readmission rate by October 1, 2016.
- Based on the SNF readmission measure, the Secretary must establish a performance standard for SNFs, along with levels of achievement and improvement. The Secretary will then develop a scoring methodology for each SNF in order to create a ranking system which will rank SNFs annually.
- SNFs' Medicare payment rates will be based on (in part) their performance scores beginning on October 1, 2018.
- The Secretary must ensure SNFs with the highest rankings receive the highest incentive payments and SNFs with the lowest rankings receiving the lowest (or zero) incentive payments. The lowest 40 percent of SNFs (by ranking) will be reimbursed less than they otherwise would be reimbursed without the SNF VBP program.
- In order to fund the incentive payment pool, CMS will withhold 2% of SNF Medicare payments starting October 1, 2018.
- CMS will redistribute 50-70% of the withheld payments back into the profession by way of incentive payments to SNFs. CMS will retain the remaining 30-50% of funds as programmatic savings to Medicare.
- The program also requires the Secretary to publicly report the performance on the readmission measure for each SNF on Nursing Home Compare beginning on October 1, 2017.

TIMELINE

FY 2014-2016
Secretary specifies an all-cause, all-condition readmission measure
10/1/15

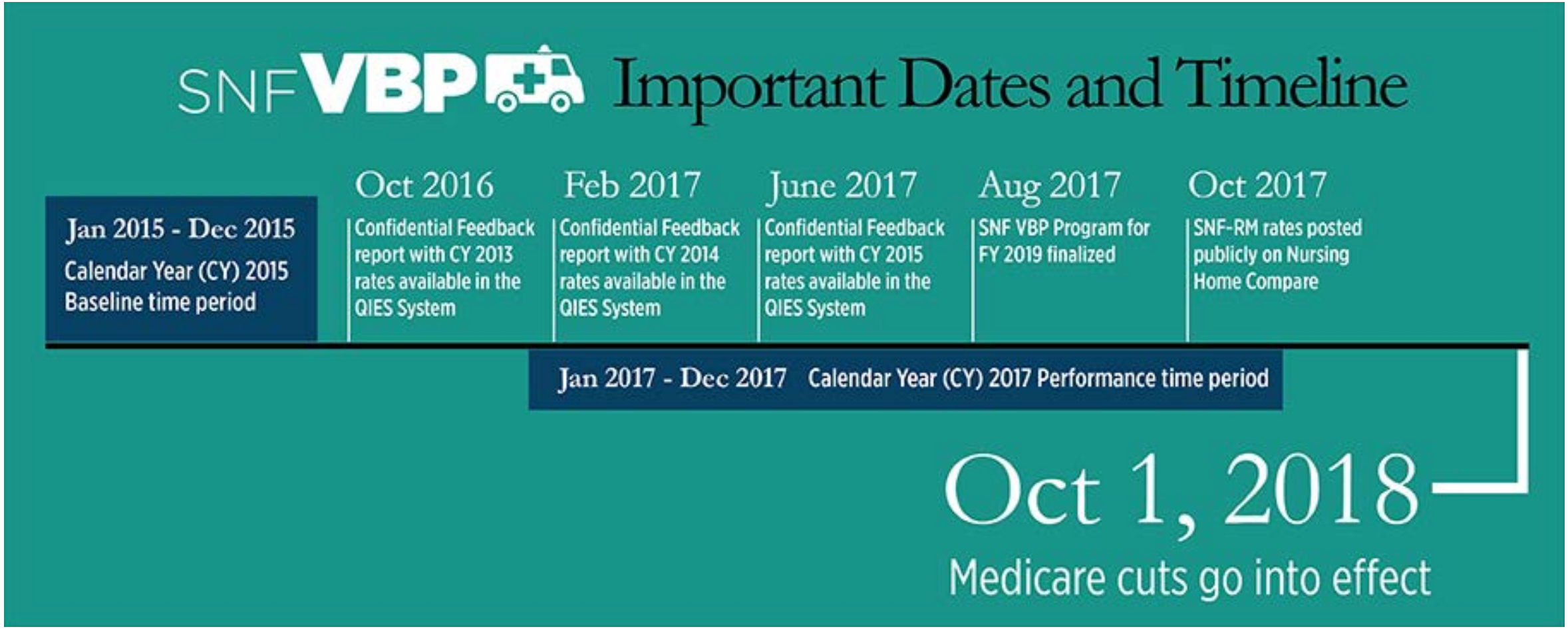
FY 2017
- Secretary specifies an all-condition, risk-adjusted potentially preventable readmission rate measure
- Confidential feedback reports to SNFs
10/1/16

FY 2018
Public reporting of readmission measure on *Nursing Home Compare*
10/1/17

FY 2019
The SNF VBP begins and incentives and penalties are applied
10/1/18

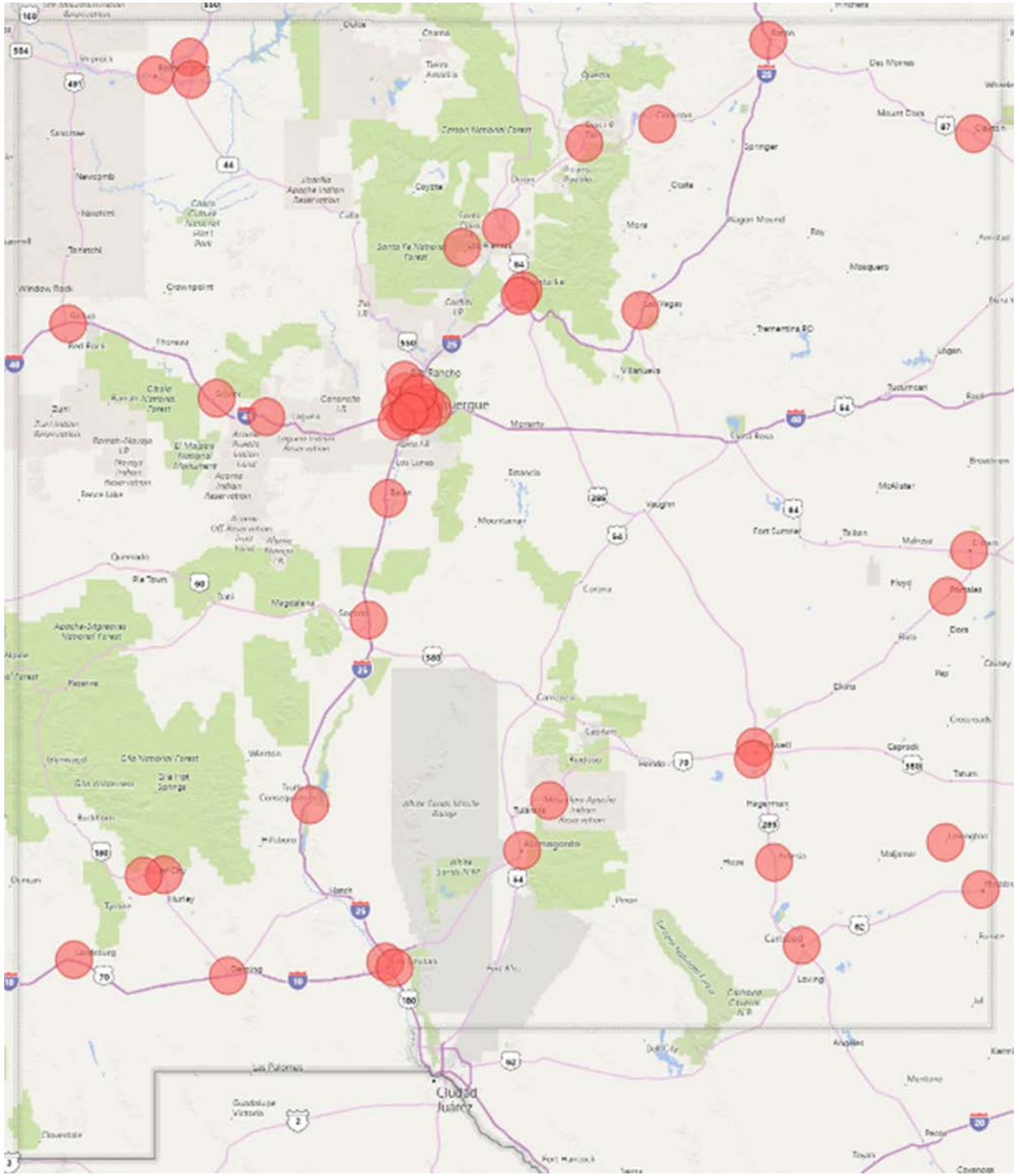
AHCA AMERICAN HEALTH CARE ASSOCIATION | 1201 L St. NW Washington, DC 20005 www.ahcancal.org | AHCA Legislative Staff 202-898-6338

CMS and Nursing Facility VBP



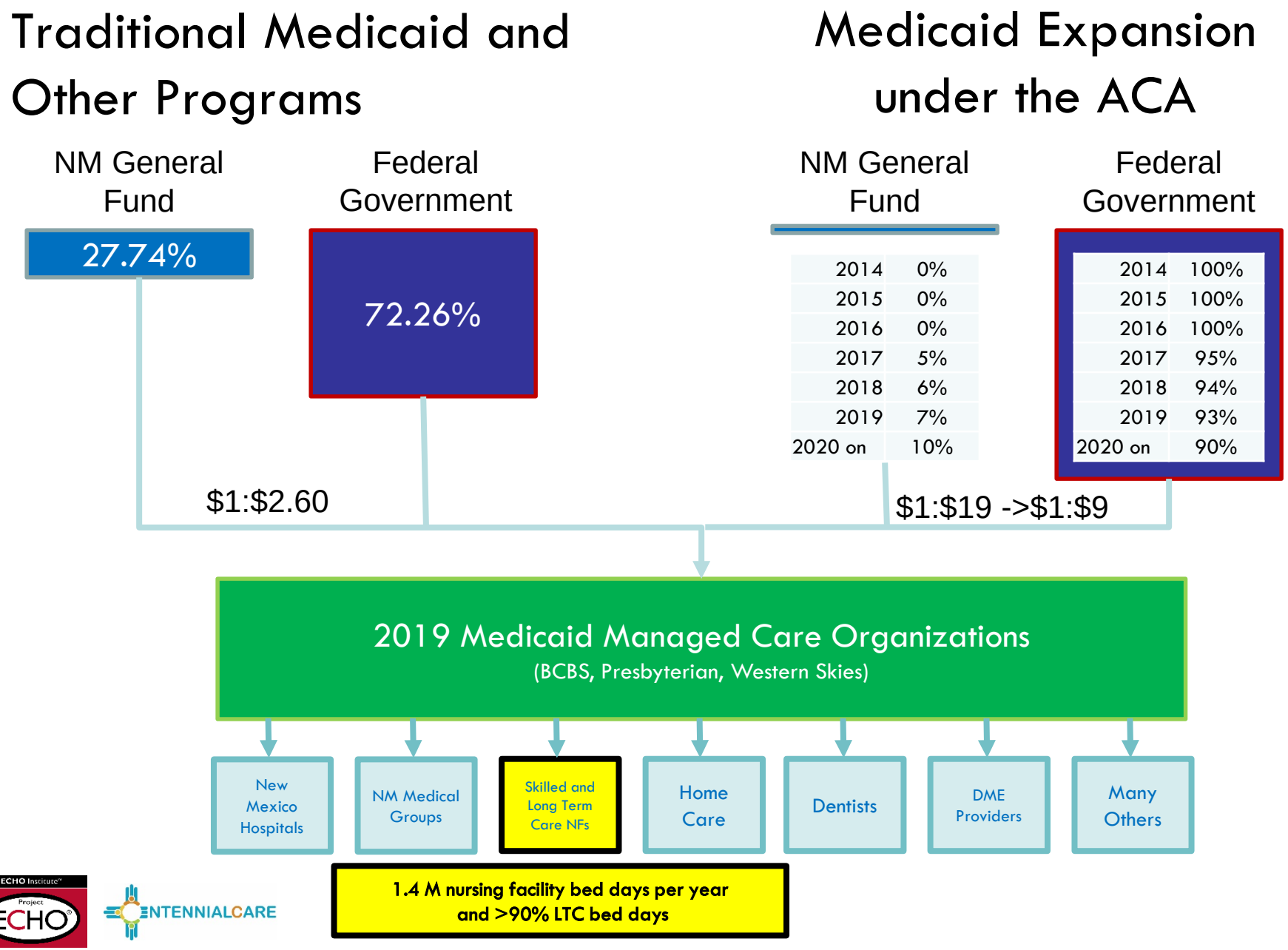
Key NM Medicaid Nursing Facility Facts

- Medicaid pays for about 1.4 M NF days per year
- Medicaid is the primary payer for >90% of Long Term Care facility days
- There are only 76 licensed NFs in New Mexico (compared to > 1000 in California and Texas)



VBP in New Mexico Medicaid

Oversimplified View of Health Care Financing through Centennial Care



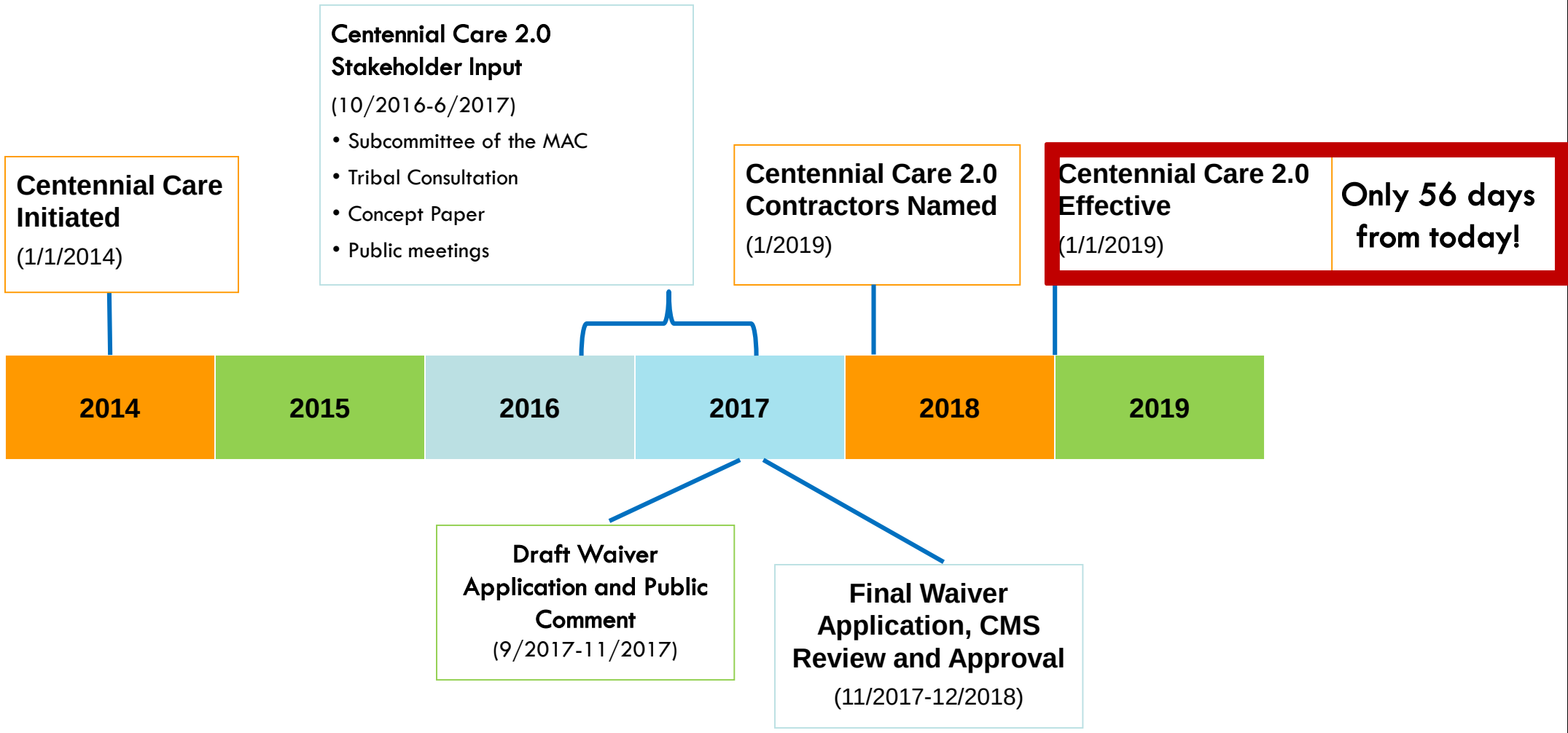
How VBP “Works”

Pay MCOs for value delivered to their total membership per VBP arrangement (whether contracted or not)

MCOs will drive providers to improve their value to increase their premium and their returns. VBP arrangements and insight in the potential performance of providers vs their target budgets will be actionable entry point for MCOs

Members receive better quality care at lower overall cost for the State, allowing further re-investment of Medicaid dollars in delivery system

Centennial Care Timeline



VBP Requirements in CC 2.0 RFP

Aggregate VBP Targets			
Contract Period 1 (Jan 1 – Dec 31, 2019)	**Contract Period 2** (Jan 1 – Dec 31, 2020)	**Contract Period 3** (Jan 1 – Dec 31, 2021)	**Contract Period 4** (Jan 1 – Dec 31, 2022)
• Level 1: 8% • Level 2: 11% • Level 3: 5% • **Total: 24%**	• Level 1: 10% • Level 2: 13% • Level 3: 7% • **Total: 30%**	• Level 1: 11% • Level 2: 14% • Level 3: 8% • **Total: 33%**	• Level 1: 12% • Level 2: 15% • Level 3: 9% • **Total: 36%**
		HSD reserves the right to modify the percentage in Year 3 increasing 5% from Contract Period 2.	***HSD reserves the right to modify the percentage in Year 4 increasing 5% from Contract Period 3.***
Modifications will be conveyed to the CONTRACTOR at least 60 days prior to the beginning of contract period three.			

VBP Level 1 – Minimum Requirements			
Level 1: Fee schedule based with bonus or incentives and/or withhold payable only when outcome/quality scores meet agreed-upon targets.			
Contract Period 1	**Contract Period 2**	**Contract Period 3**	**Contract Period 4**
8%	**10%**	**11%**	**12%**
• Traditional PH providers with at least 2 small providers. • BH providers (whose primary services are BH).	• Traditional PH providers with at least 2 small providers. • BH providers (whose primary services are BH).	• Traditional PH providers with at least 2 small providers. • BH providers (whose primary services are BH).	• Traditional PH providers with at least 2 small providers. • BH providers (whose primary services are BH).
• Long term care providers including nursing facilities.	• Long term care providers including nursing facilities.	• Long term care providers including nursing facilities.	• Long term care providers including nursing facilities.
	All included provider requirements must exceed percentage achevied in prior year.	***All included provider requirements must exceed percentage achevied in prior year.***	***All included provider requirements must exceed percentage achevied in prior year.***
Additional Requirements: 1. Must include a mix of physical health, behavioral health, long term care and nursing facility providers.			
VBP Level 1 Definitions: 1. Traditional PH providers are providers whose primary services are not behavioral health, long term care or nursing facilities. Traditional PH providers include FQHC, hospitals etc… 2. **Small provider** is defined as practices with 1,000 or less assigned/attributed members or as determined by HSD prior to the start of the contract period.			

VBP Level 2 – Minimum Requirements			
Level 2: Fee schedule based, upside-only shared savings-- available when outcome/ quality scores meet agreed-upon targets (may include downside risk)			
Contract Period 1	**Contract Period 2**	**Contract Period 3**	**Contract Period 4**
11%	**13%**	**14%**	**15%**
• Traditional PH providers with at least 2 small providers. • BH providers (whose primary services are BH). • Actively build readiness for Long Term Care Providers (see definitions). • Actively build readiness for nursing facilities (see definitions).	• Traditional PH providers with at least 2 small providers. • BH providers (whose primary services are BH). • Actively build readiness for Long Term Care Providers (see definitions). • Actively build readiness for nursing facilities (see definitions).	• Traditional PH providers with at least 2 small providers • BH providers (whose primary services are BH) • Long term care providers including nursing facilities.	• Traditional PH providers with at least 2 small providers. • BH providers (whose primary services are BH) • Long term care providers including nursing facilities over prior year.
	All included provider requirements must exceed the percentage of payments achieved in prior year.	***All included provider requirements must exceed the percentage of payments achieved in prior year.***	***All included provider requirements must exceed the percentage of payments achieved in prior year.***
Additional Requirements: 1. Must include two or more bundled payments for episodes of care. 2. At least 5% of the overall total Contract Year Percentages in Levels 2 and/or Level 3 VBP contracting must be with **high volume hospitals** and require **avoidable readmission reduction targets** of at least 5% of the hospital's CY 2017 or MY 2016 baseline as outlined in definitions below.			

VBP Level 3 – Minimum Requirements			
Level 3: Fee schedule based or capitation with risk sharing (at least 5% for upside and downside risk); and/or global or capitated payments with full risk.			
Contract Period 1	**Contract Period 2**	**Contract Period 3**	**Contract Period 4**
5%	**7%**	**8%**	**9%**
• Traditional PH providers. • Implement a CONTRACTOR led BH provider level workgroup that works with BH providers to design full risk model (see definitions).	• Traditional PH providers. • Develop BH full-risk contracting model • Implement a CONTRACTOR led LTC and/or Nursing facility provider level workgroup to design full-risk model (see definitions).	• Traditional PH providers. • BH providers (whose primary services are BH). • Actively build LTC and/or nursing facility full-risk contracting model (see definitions).	• 8% with traditional PH provider • 2% with providers who are primarily BH. • Long term care providers including nursing facilities over prior year.
	All included provider requirements must exceed the percentage of payments achieved in prior year.	***All included provider requirements must exceed the percentage of payments achieved in prior year.***	***All included provider requirements must exceed the percentage of payments achieved in prior year.***

Additional Requirements:

1. Global or capitated payments with full risk. Arrangements with full risk for Covered Services shall include Full Delegation of Care Coordination as detailed in bullet 2 below. Full Delegation of Care Coordination within Level 3 VBP arrangements as outlined in definitions below.
2. At least 5% of the overall total Contract Year Percentages in Levels 2 and/or Level 3 VBP contracting must be with **high volume hospitals** and require **avoidable readmission reduction targets** of at least 5% of the hospital's CY 2017 or MY 2016 baseline as outlined in definitions below.

Nursing Facility-Specific VBP Programs in Other States (California, Texas)

Example #1: California

2016-17 Point Allocation by Quality Measure

https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/CDPH2017QrtlyBenchmarksFNL508.pdf

Points Allocation	Quality Measure
Pressure Ulcers: Long Stay Measure	11.111
Physical Restraints: Long-Stay	11.111
Influenza Vaccination: Short Stay	*5.55575*
Pneumococcal Vaccination: Short Stay	*5.55575*
Urinary Tract Infection: Long Stay	11.111
Control of Bowel/Bladder: Long Stay	11.111
Self-Report Pain: Short Stay	*5.55575*
Self-Report Pain: Long-Stay	*5.55575*
Activities of Daily Living: Long-Stay	11.111
Staff Retention	11.111
30 Day All-Cause Readmission	11.111
Total	**100**

2013 Data: California Quality and Accountability Supplemental Payments (QASP)

Source:http://www.dhcs.ca.gov/services/medi-cal/Documents/AB1629%20QASP/QASP%20Scoring_%20Side%20by%20Side%207.11.2013.pdf

Quality and Accountability Supplemental Payment Scoring										
		Previously Presented					Revised			
		Top Tier Double Payout					Top Tier 1 1/2 Payout			
Payment Tier	Point Range	# of SNFs	Payout per MCBD	Total MCBDs per Tier	Total Payout per Tier	Ave Payout per SNF	Payout per MCBD	Total MCBDs per Tier	Total Payout per Tier	Ave Payout per SNF
Tier 0[1]		346	$0.00	5,811,700	$0	$0	$0.00	5,811,700	$0	$0
Tier 1	0 – 49.9	419	$0.00	10,280,958	$0	$0	$0.00	10,280,958	$0	$0
Tier 2	50 – 66.6	211	$4.28	4,381,696	$18,753,659	$88,880	$4.86	4,381,696	$21,295,043	$100,924
Tier 3	66.7-100	119	$8.55	2,019,628	$17,267,819	$145,108	$7.29	2,019,628	$14,723,088	$123,723
Total Receiving Payment		330 30.14%				$109,156				$109,146

[1]Tier 0 includes facilities ineligible for QASP payment due to non-compliance with 3.2 NHPPD, AA/A citations, 0 MCBD, or missing MDS data.

Quality Measure Scoring:

For each MDS Measure that a facility reached the mean (benchmark), the facility received half the possible points.

If a facility reached the 75 percentile, the facility received the full points for that MDS measure.

All facilities were included in calculating the benchmark and 75 percentile.

No points were awarded for meeting the 3.2 NHPPD requirement, however facilities that did not meet the NHPPD will not receive payment.

Payment:

Facilities with AA/A citations, Any days of non-compliance with the 3.2 NHPPD requirement, or facilities with no MCBDs will not receive a payment.

For purposes of this estimate, the 58 facilities with missing MDS measure data were removed.

Total Payout $36M

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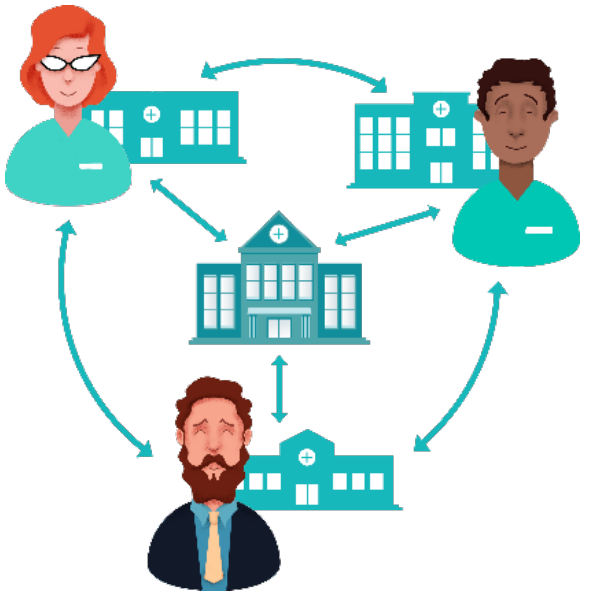
Example #2: Texas QIPP Program

- The **Quality Incentive Payment Program (QIPP)** encourages nursing facilities to improve the quality and innovation of their services, using the Centers for Medicare & Medicaid (CMS) 5-star rating system as its measure of success for the following 4 quality measures:
  - High-risk long-stay residents with pressure ulcers
  - Percent of residents who received an antipsychotic medication (long-stay)
  - Residents experiencing one or more falls with major injury
  - Residents who were physically restrained
- Credit given for both meeting targets and also for improvement
- Payout of $20 per Medicaid resident per day in initial phase of program

Source: https://hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program-nursing-homes



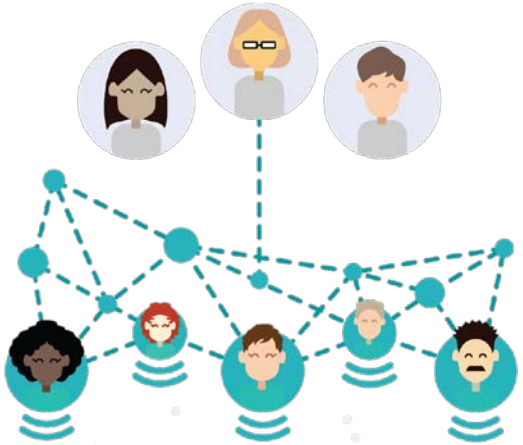
Project ECHO
(Extension for Community Health Outcomes)

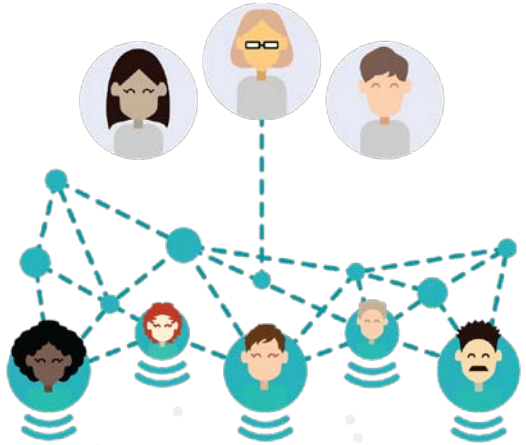
Est. 2003

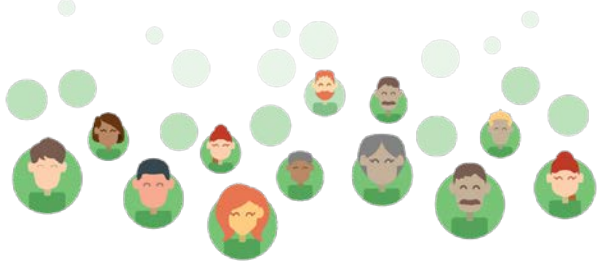
Mission: To democratize knowledge and get best practice care to underserved people all over the world.

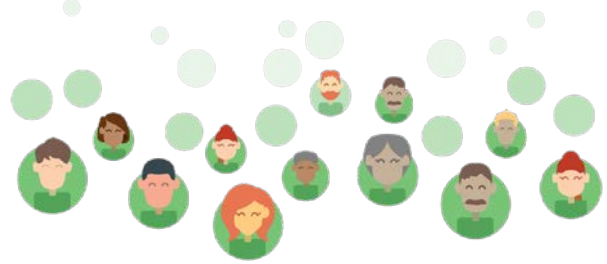
Supported by New Mexico Department of Health, Agency for Health Research and Quality, New Mexico Legislature, Robert Wood Johnson Foundation, GE Foundation, Helmsley Trust, Bristol Myers Squibb Foundation, Merck Foundation, and New Mexico Medicaid.

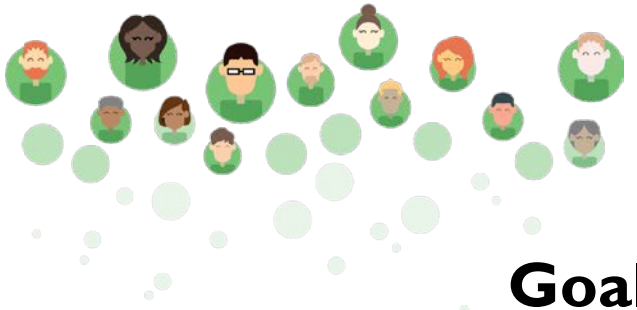
Moving Knowledge Instead of Patients

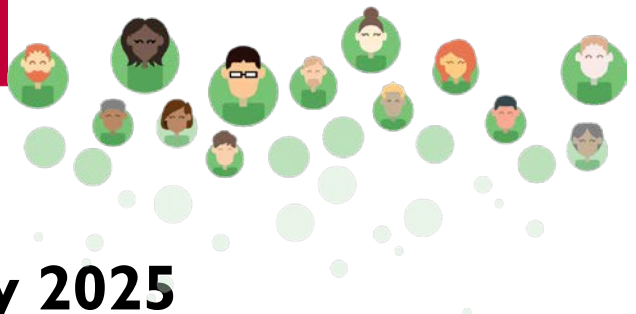












Project ECHO®

Goal to improve the lives of 1 billion people by 2025

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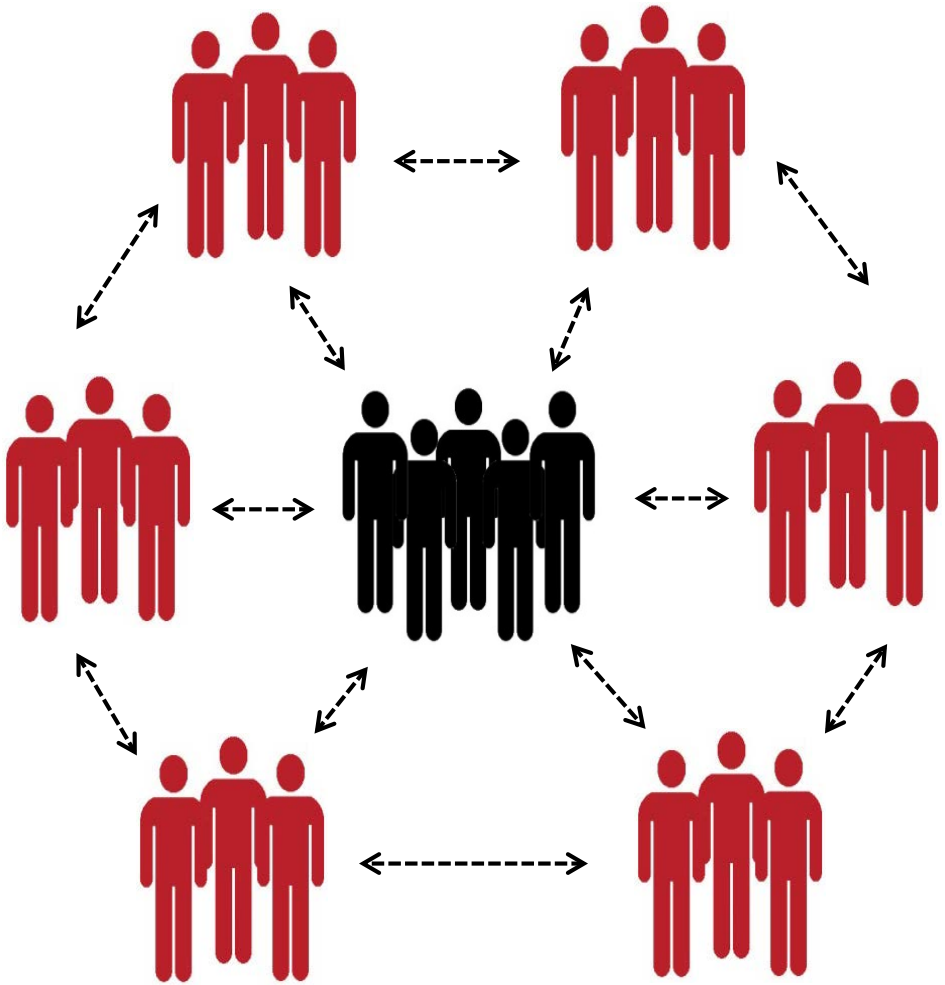
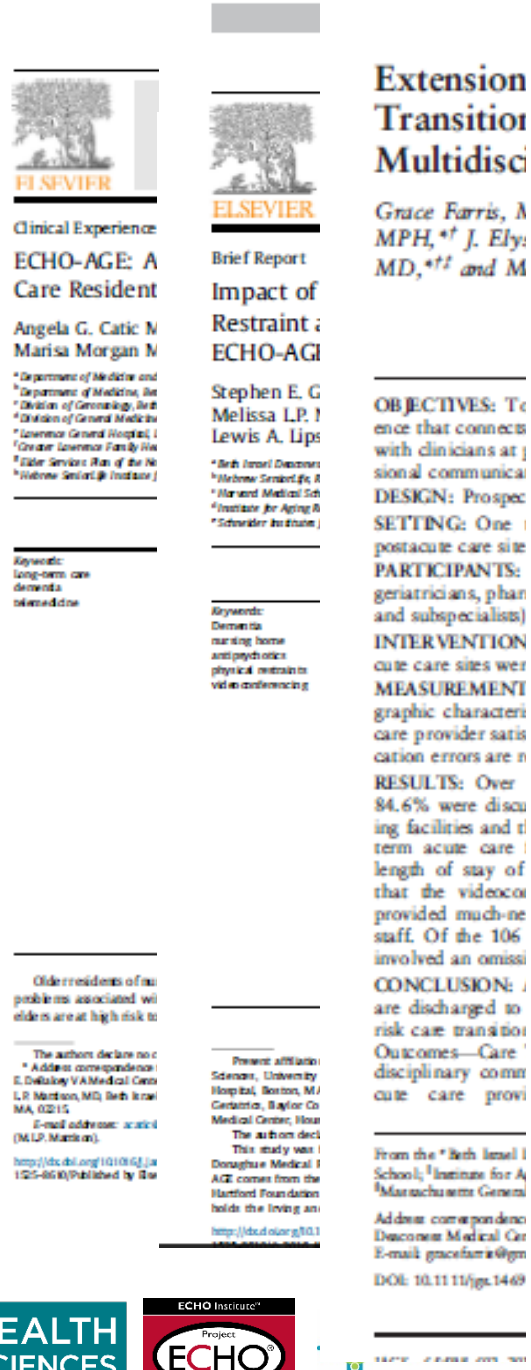
http://echo.unm.edu

The ECHO Model™

- Use Technology to leverage scarce resources
- Share “best practices” to reduce disparities
- Case-based learning to master complexity
- Web-based database to monitor outcomes



Arora S, et al: Acad Med. 2007 Feb;82(2):154-60.



Extension
Transitio
Multidisc

Grace Farris, M
MPH,*† J. Ely
MD,*†‡ and M

OBJECTIVES: To
ence that connects
with clinicians at
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DESIGN: Prospec
SETTING: One
postacute care site
PARTICIPANTS:
geriatricians, phar
and subspecialists)
INTERVENTION
cute care sites wer
MEASUREMENT
graphic characteri
care provider satis
cation errors are
RESULTS: Over
84.6% were discu
ing facilities and
term acute care
length of stay of
that the videoco
provided much-ne
staff. Of the 106
involved an omissi
CONCLUSION:
are discharged to
risk care transitio
Outcomes—Care
disciplinary comm
cute care provi

From the *Beth Israel
School; †Institute for A
‡Massachusetts Genera

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DOI: 10.1111/jgs.1469

Clinical Experience

ECHO-AGE: A
Care Resident

Angela G. Catic M
Marisa Morgan M

Brief Report

Impact of
Restraint
ECHO-AGE

Stephen E. G
Melissa L.P.
Lewis A. Lips

Keywords:
long-term care
dementia
telemedicine

Keywords:
Dementia
nursing home
antipsychotics
physical restraints
videoconferencing

Older residents of nu
problems associated wi
elders are at high risk to

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E-mail address:
(M.L.P. Mattison).

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Hospital, Boston, MA
Geriatrics, Baylor Co
Medical Center, Hou
The authors decl
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PURPOSE: Within 30 days of hospital discharge to a skilled nursing facility, older adults are at high risk for death, re-hospitalization and high-cost healthcare. The purpose of this study was to examine whether a novel videoconference program called Extension for Community Health Outcomes-Care Transitions (ECHO-CT) that connects an interdisciplinary hospital-based team with clinicians at skilled nursing facilities, reduces patient mortality, hospital readmission, skilled nursing facility length of stay and 30-day health care costs.

METHODS: A prospective cohort study comparing cost and health care utilization outcomes between ECHO-CT facilities and matched comparisons from January 2014-December 2014.

RESULTS: 30-day readmission rates were significantly lower in the intervention group (OR 0.57; 95% CI 0.34 – 0.96; p-value 0.04) as was the 30-day total healthcare cost ($2,602.19 lower; 95% CI -$4,133.90- -$1,070.48; p-value <.001) and the average length of stay at the skilled nursing facility (-5.52 days; 95% CI -9.61- -1.43; p=0.001). The 30-day mortality rate was not significantly lower in the intervention group (OR 0.38; 95% CI 0.11-1.24; p=0.11).

CONCLUSION: Patients discharged to skilled nursing facilities participating in the ECHO-CT program had shorter lengths of stay, lower 30-day rehospitalization rates, and lower 30-day health care costs compared to those in matched skilled nursing facilities delivering usual care. ECHO-CT may improve patient transitions to post-acute care at lower overall cost.

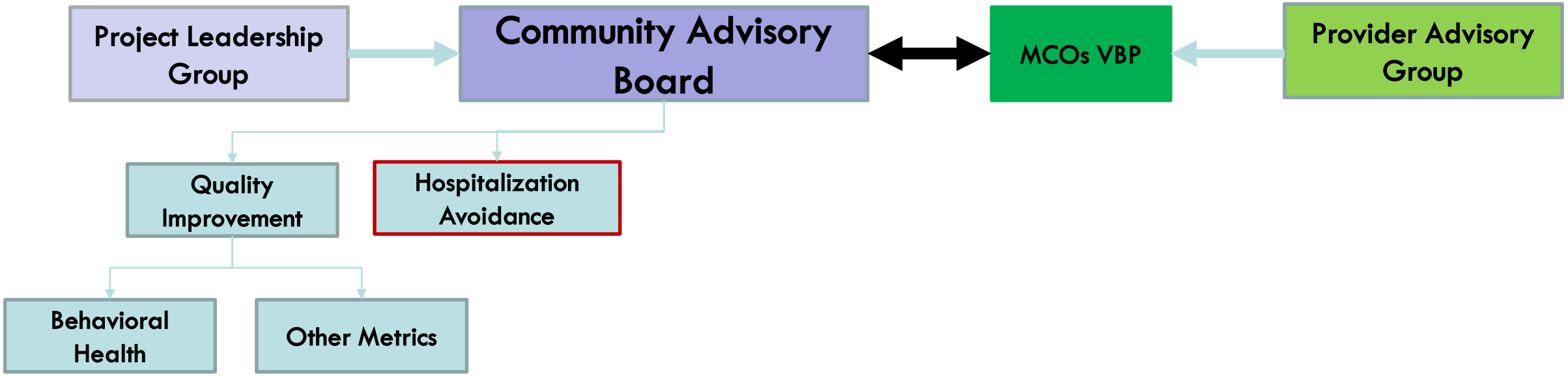
HEALTH SCIENCES

ECHO Institute™ Project ECHO®

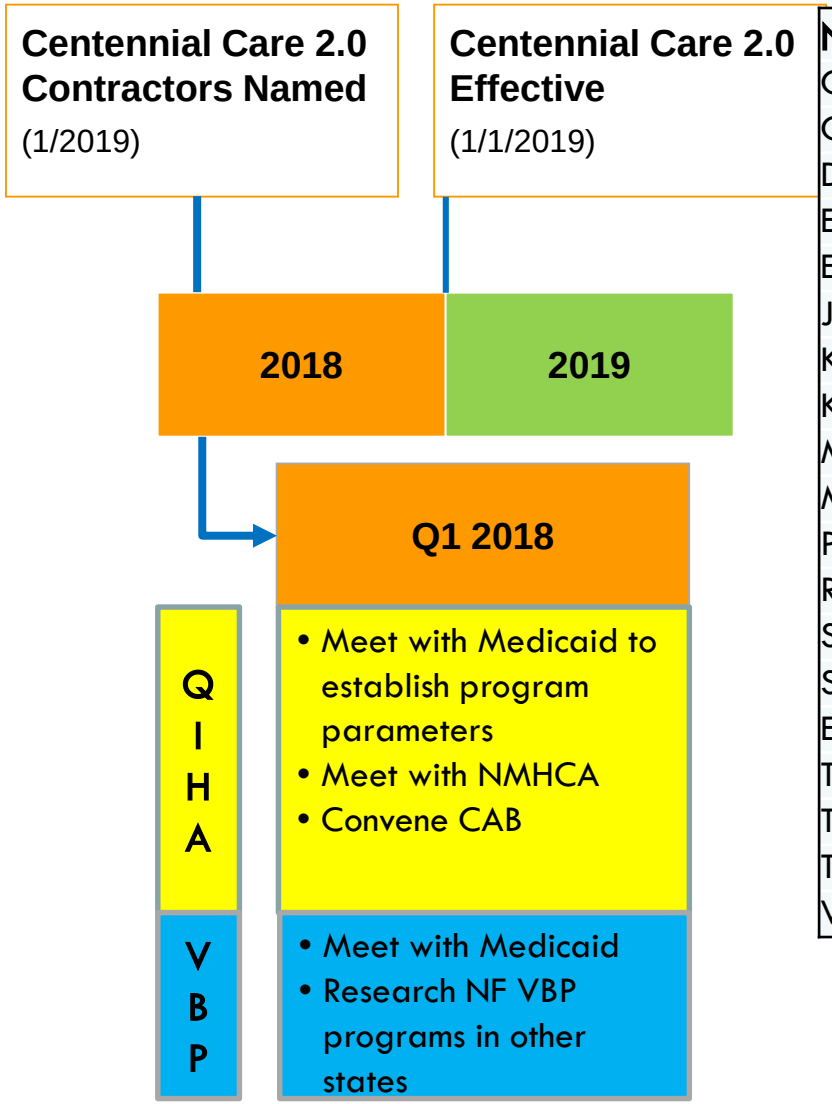
Are you part of the ECHO?

Nursing Facility Quality Improvement and Hospitalization Avoidance (QIHA) Program in New Mexico

The Structure



Centennial Care and NF QIHA/VBP Timeline



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Kevin Traylor	Executive Director, Uptown	Genesis
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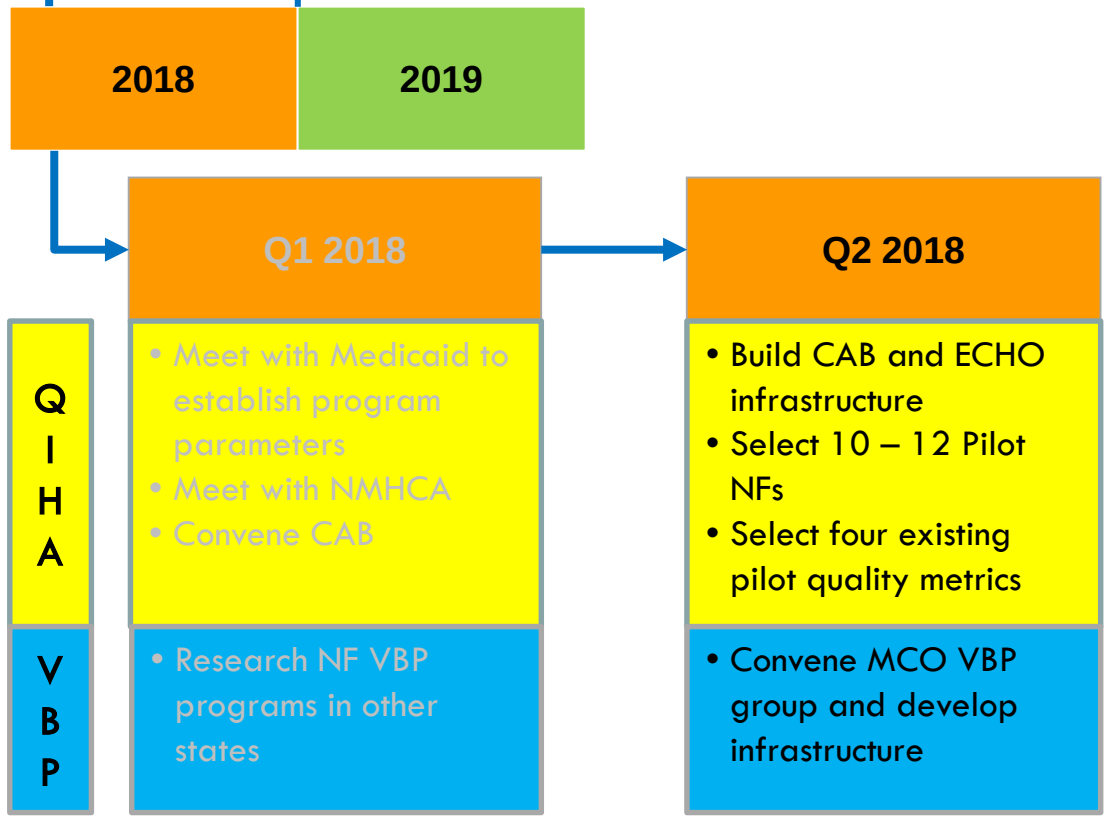
Thomas Kim	Senior VP, Medical Affairs	Genesis
Tracy Smith	Program Manager, Quality Improvement Initiatives	ECHO Institute
Vanessa Rodriguez	Center Nurse Executive, Genesis Healthcare at Sandia Ridge	Genesis

Centennial Care and NF QIHA/VBP Timeline

Centennial Care 2.0 Contractors Named
(1/2019)

Centennial Care 2.0 Effective
(1/1/2019)



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CENTENNIALCARE

Centennial Care and NF QIHA/VBP Timeline

Centennial Care 2.0 Contractors Named
(1/2019)

Centennial Care 2.0 Effective
(1/1/201)

2018

2

Q1 2018

Q I H A

- Meet with Medic
- establish progra parameters
- Meet with NMH
- Convene CAB

V B P

- Research NF VB programs in othe states

Quality Measure	Group	2013	2014	2015	2016	2017	Gap	Rank
SS Pneumonia Vac	NM	68.31593	64.43415	67.39485	68.34131	69.69712	13.41253	1
SS Influenza Vac	NM	72.47877	67.72346	66.71301	66.80579	70.52135	10.50172	2
SS Pain	NM	23.26298	23.05328	24.09461	23.99083	22.69283	9.028904	3
LS Pneumonia Vac	NM	80.64335	79.14562	79.56349	82.89466	85.75912	8.385886	4
LS Pain	NM	9.452523	8.633543	11.44037	11.35775	9.733362	4.161743	5
LS ADL	NM	19.11791	19.22245	18.44584	19.54841	18.54308	3.566242	6
LS Influenza Vac	NM	86.27691	88.87254	87.17901	91.45866	92.61725	2.315015	7
LS Mobility Worse	NM			19.8982	21.41174	20.50577	2.292328	8
SS Outpatient ED Visits	NM			13.89574	13.37558	13.35203	1.494649	9
LS PU	NM	6.347849	6.174637	6.079916	6.209895	6.727337	1.124526	10
LS Antipsychotic	NM	19.1337	17.23704	16.45566	17.15094	16.70944	1.026828	11
LS Catheter	NM	3.301297	2.943718	3.512884	3.313439	2.530768	0.665996	12
SS Antipsychotic	NM	2.904668	2.460702	2.490567	2.531788	2.314779	0.326286	13
SS PU	NM	0.992341	0.791212	1.503379	1.272956	1.008694	0.132106	14
LS Weight Loss	NM	7.161366	6.298023	7.234606	7.107744	7.179254	0.096303	15
LS Falls w Injury	NM	3.680669	3.858533	3.988173	4.239733	3.461082	0.087468	16
LS Restraints	NM	0.72376	0.583683	0.601877	0.511199	0.320772	-0.11002	17
LS Depression	NM	3.4918	3.007546	2.934389	3.838857	4.68194	-0.18908	18
LS UTI	NM	5.247255	4.651044	3.981836	3.072016	2.89301	-0.76767	19
SS Rehospitalization	NM			20.1547	20.26018	20.21202	-0.88745	20
SS Successful Dis to Comm	NM			51.80244	59.73186	59.67146	-2.63949	21
SS Functional Impr	NM			61.28979	63.50563	63.87649	-3.59513	22

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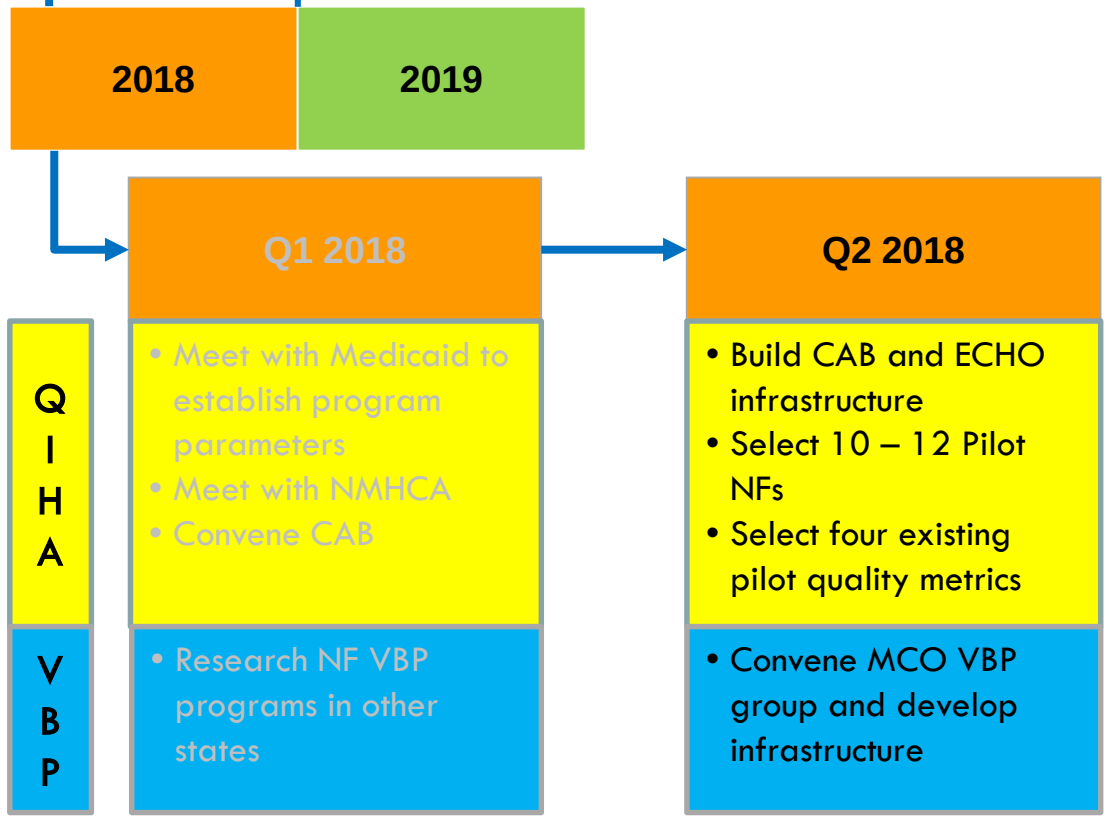

MCO VBP Group

Name	Organization
Quinn Glenzinski	Blue Cross Blue Shield of New Mexico
Dr. Wei-Ann Bay	Blue Cross Blue Shield of New Mexico
Susan Dezavelle	Blue Cross Blue Shield of New Mexico
Holly Lawrence	Blue Cross Blue Shield of New Mexico
Eric Cibak	Blue Cross Blue Shield of New Mexico
Michael Archuleta	Blue Cross Blue Shield of New Mexico
Arlene Britt	Blue Cross Blue Shield of New Mexico
Mary Eden	Presbyterian Health Plan
Jordan Erp	Presbyterian Health Plan
Heather Ingram	Presbyterian Health Plan
Deb Revard	Presbyterian Health Plan
Nathan Cogburn	Western Sky Community Care
Dr. Latha Shankar	Western Sky Community Care
Messina Martinez	Western Sky Community Care
Rosanna Nelson	Western Sky Community Care
Marta Larson	Western Sky Community Care
Dr. David Scrase	HSD
Estevan Baca	HSD
Erica Archuleta	HSD

Centennial Care and NF QIHA/VBP Timeline

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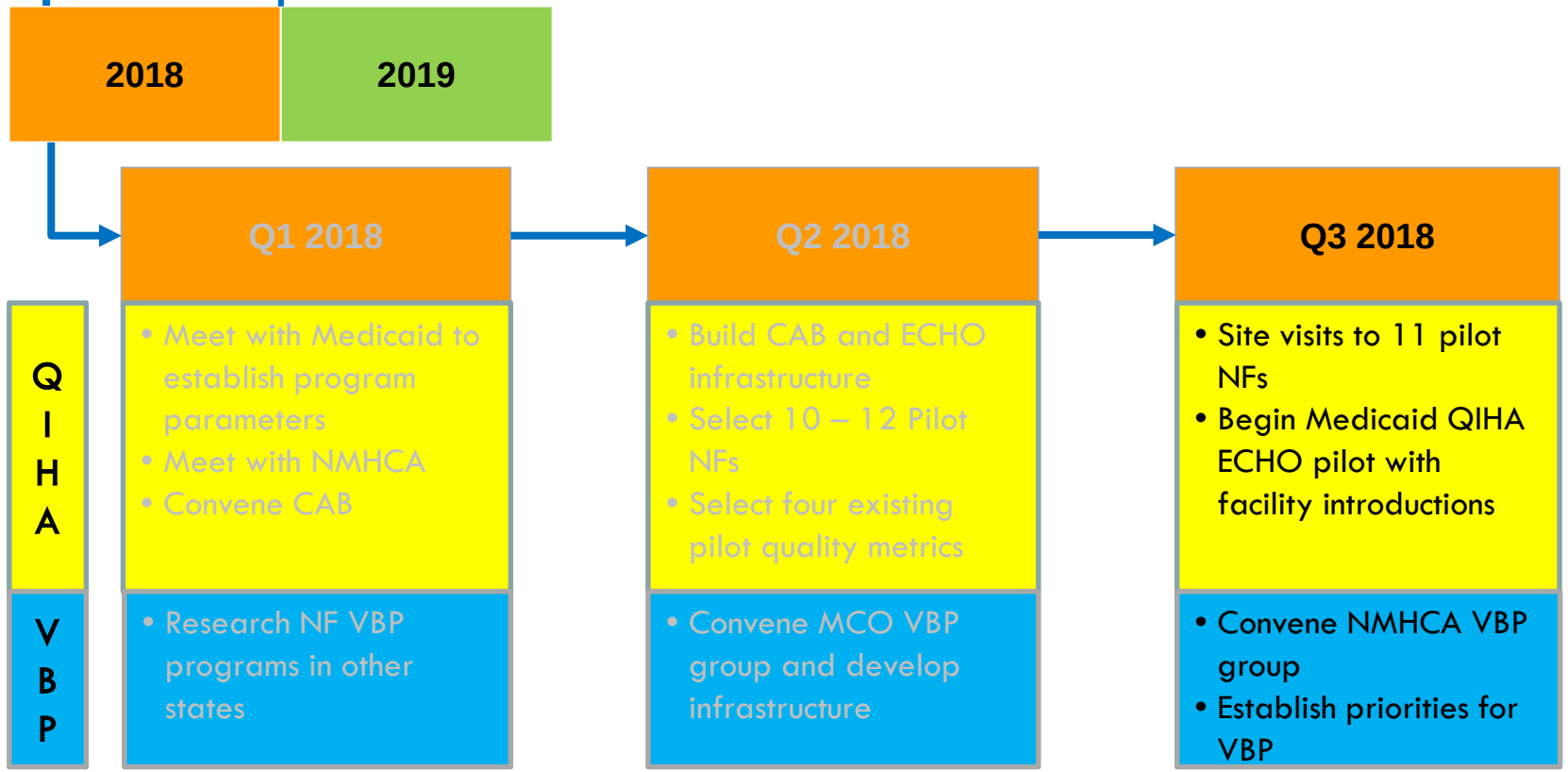

Centennial Care and NF QIHA/VBP Timeline

NAME OF FACILITY	LOCATION OF FACILITY
Rio Rancho Center	4210 Sabana Grande SE, Rio Rancho
Las Palomas Center	8100 Palomas NE, ABQ, 87109
The Rehabilitation of ABQ	5900 Forest Hills Dr. NE, ABQ, 87109
Albuquerque Hts. Healthcare	103 Hospital Loop NE, ABQ, 87109
Ladera Center	5901 Ouray Road NW, ABQ, 87120
Skies Healthcare	9150 McMahon NW, ABQ, 87114
Uptown Rehabilitation Center	7900 Constitution Ave. NE, ABQ, 87110
Sandia Ridge Center	2216 Lester Dr. NE, ABQ 87112
Canyon Transitional Rehab	10101 Lagrima de Oro NE, ABQ, 87111
Genesis Bear Canyon	5123 Juan Tabo Blvd NE, ABQ, 87111
San Juan Center	806 West Maple Street Farmington, 87401

Q3 2018

- Site visits to 11 pilot NFs
- Begin Medicaid QIHA ECHO pilot with facility introductions

- Convene NMHCA VBP group
- Establish priorities for VBP

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Centennial Care and NF QIHA/VBP Timeline

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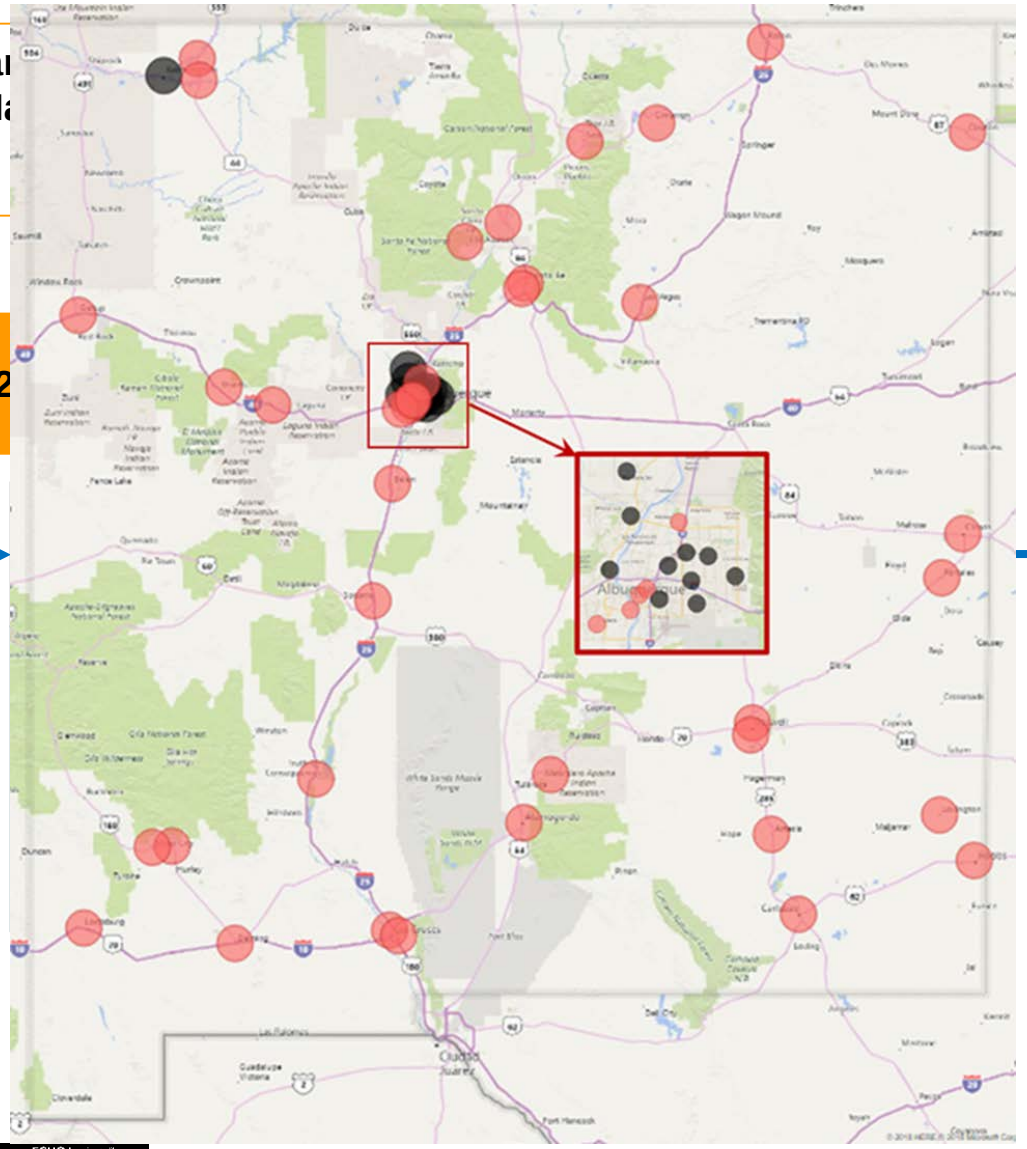

Q I H A

V B P

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Centennial Care and NF QIHA/VBP Timeline

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Centennial Care 2.0 Effective
(1/1/2019)

Provider Advisory Group

Name	Organization
Jason Espinoza	New Mexico Health Care Association
Kelley Whitaker	Fundamental
Pat Whitacre	New Mexico Health Care Association
Lashuan Bethea	Genesis HealthCare
Lori Greer-Harris	Genesis HealthCare
Jerry Cahill	Genesis HealthCare
Rayna Fagus	Eduro Healthcare
Brian Falkler	Fundamental
Sara Farmer	Genesis HealthCare
Terry Harman	Genesis HealthCare
Michael Jacobs	Fundamental
Jody Knox	Lakeview Christian Home
Pete Looker	South Valley Care Center
Cynthia Myers	Genesis HealthCare
Heidi Trimble	Fundamental
Lillian Werntz	Genesis HealthCare
Horace Winchester	OnPointe
Irene Torres	Genesis HealthCare
Fran Chapman	Fundamental

2

QIHA

VBP

Q3 2018

- Site visits to 11 pilot NFs
- Begin Medicaid QIHA ECHO pilot with facility introductions

- Convene NMHCA VBP group
- Establish priorities for VBP

HEALTH SCIENCES ECHO CENTENNIALCARE

MCO Basic Principles that Should Drive a NM NF VBP Program (9.14.18)

- "One stop shopping" - a single program
- KPIs metrics must be standardized (national data)
- Leverage best practices in other states
- Co-branding
- Provider ownership/buy-in, contribute to design of program
- Provider centric (stratified by level of providers)
- All providers have the opportunity to "win", and there are early wins
- Supports other goals (e.g., community reintegration)
- Based on Medicaid members/data
- Financial component has to be significant enough to be an incentive
- Rewards for both meeting targets and improvement
- Actuarially sound
- Sustainable over the long run
- Quarterly or semi-annual payments
- Some metric for resident satisfaction
- Consider special situations (e.g., behavioral health facilities)
- Figure out DSNIP
- Transparent feedback to providers
- Performance scorecard
- Payouts based on aggregate membership
- Patient centered care (continuity)
- Include all stakeholders in this process
- Care is coordinated and integrated to address both PH and BH and Social Determinates of Health (SDoH)
- Financial drivers are aligned with the population's need
- Have data management strategy
- Quality measures should be understandable, valid/reliable, achievable, fair, and worth the effort

Common Principles for both MCOs and Provider Advisory Group

- **Evidence based benchmarks (tied to clinical outcomes and evidence)**
- **Rewards for both improvement (with defined tiers) and reaching targets**
- **All providers have the opportunity to "win", and there are early wins**
- **Payouts based on Medicaid bed days (volume in each facility)**
- **Quarterly or semi-annual payments**
- **Specialty facility special considerations (e.g., behavioral health and wound care facilities)**
- **Transparent feedback to providers**

Provider Advisory Guiding Principles (10.19.18)

- Rewards for both improvement (with defined tiers) and reaching targets
- Evidence based benchmarks (tied to clinical outcomes and evidence)
- Prospective and fair method for setting (and resetting) targets over time
- Specialty facility special considerations (psych and wound care facilities)
- More frequent payouts (e.g., every 3 months)
- Consideration in metric selection regarding time frames (e.g., fall with injury may continue for 270 days)
- Possible for everyone to "win"
- Opportunity to address behavioral and opioid patient population (will discuss how later)
- Tiered system to provide extra reward for challenging patients but need to be sure training and ability to provide care is in place
- Defined conditions of participation (TBD)
- Need to address the DOH-related regulatory issues related to taking on BH patients
- Voluntary
- Transparent data – clearly published
- Need to evaluate retroactive changes in membership
- Payouts based on Medicaid bed days (volume in each facility)

Centennial Care and NF QIHA/VBP Timeline

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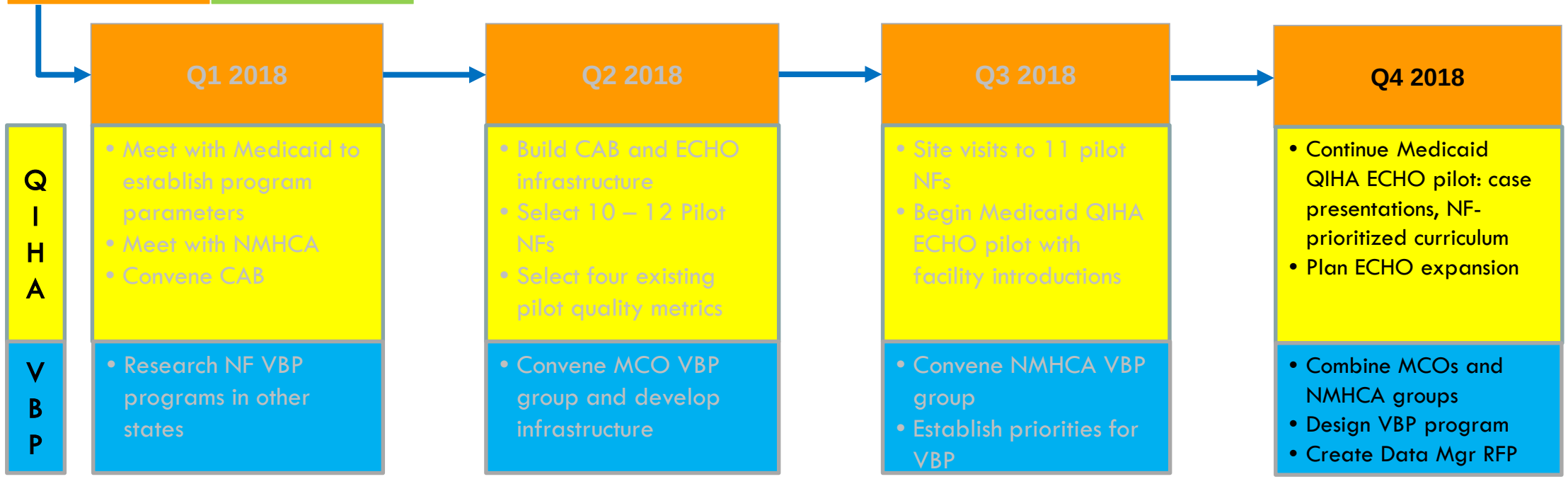

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2018 | **2019**

Q1 2018

QIHA
- Meet with Medicaid to establish program parameters
- Meet with NMHCA
- Convene CAB

VBP
- Research NF VBP programs in other states

List of topics for prioritization for Oct-Dec:

- Medication reconciliation
- Protocol development – first 24 hours
- Adjunctive medication treatments for pain
- Substance use disorder (opioids)
- Coping and pain
- Risk assessment tools
- Communication strategies
- Discharge data sets – what is out there?
- Infection control 101
- UTIs and protocol for ordering UAs

Q4 2018

QIHA
- Continue Medicaid QIHA ECHO pilot: case presentations, NF-prioritized curriculum
- Plan ECHO expansion

VBP
- Combine MCOs and NMHCA groups
- Design VBP program
- Create Data Mgr RFP

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Medicaid QIHA ECHO Session: October 26

Standard Agenda:

- Welcome & Updates
- "Case" Discussion
  - Facility presents challenge
  - Structured facilitated discussion
    - Clarifying questions – community, faculty
    - Recommendations – community, faculty
- Brief Lecture (~10-15 minutes)
- "Case" Discussion
- Quality Tool
- Wrap Up

TIME	ITEM	LEADER	GOAL
10:00–15	Welcome	Tracy Smith, BA	Set stage for meeting.
10:15-55	Case Discussion 1 – San Juan	Hub Team	Discuss a facility challenge as a community and possible recommendations for solutions or next steps.
10:55-11:25	Communication Strategies: SBAR Tool	Marissa Hotze, RN; David Scrase, MD	Discuss the importance of communication, review late night scenarios, and learn the SBAR tool.
11:25-55	Case Discussion 2 – Heights	Hub Team	Discuss a facility challenge as a community and possible recommendations for solutions or next steps.
11:50-55	Quality Tool: Run Chart Rules	Tracy Smith, BA	Develop shared understanding of quality tools.
11:55-12:00	Wrap up	Tracy Smith, BA	Share in chat: What went well? What could we improve on? How good of a job did our group do including everyone?


Recording...
Speaker View
Exit Full Screen
MQHIA ECHO
Project ECHO IT
Gail Wilder
Tracy Smith
Cynthia Olivas
hodgesc
Paul Reid
Nakiesha Lee
Derek Wheeler
Jeremy Averella
Remona Benally
Unmute
Vanessa Rodriguez
Erica Archuleta
Norm
Katarzyna Wilam...
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Patricia Whitacre
Marisa - ECHO...
Karisa Berry
Skies Healthcare
Estevan Baca
Amy Burkart
Shannon Cupka
Karen Jenkins
Marissa Hotze
David Scrase (UN...
Unmute
Start Video
Invite
Manage Participants
26
Share
Chat
Pause/Stop Recording
Breakout Rooms
End Meeting

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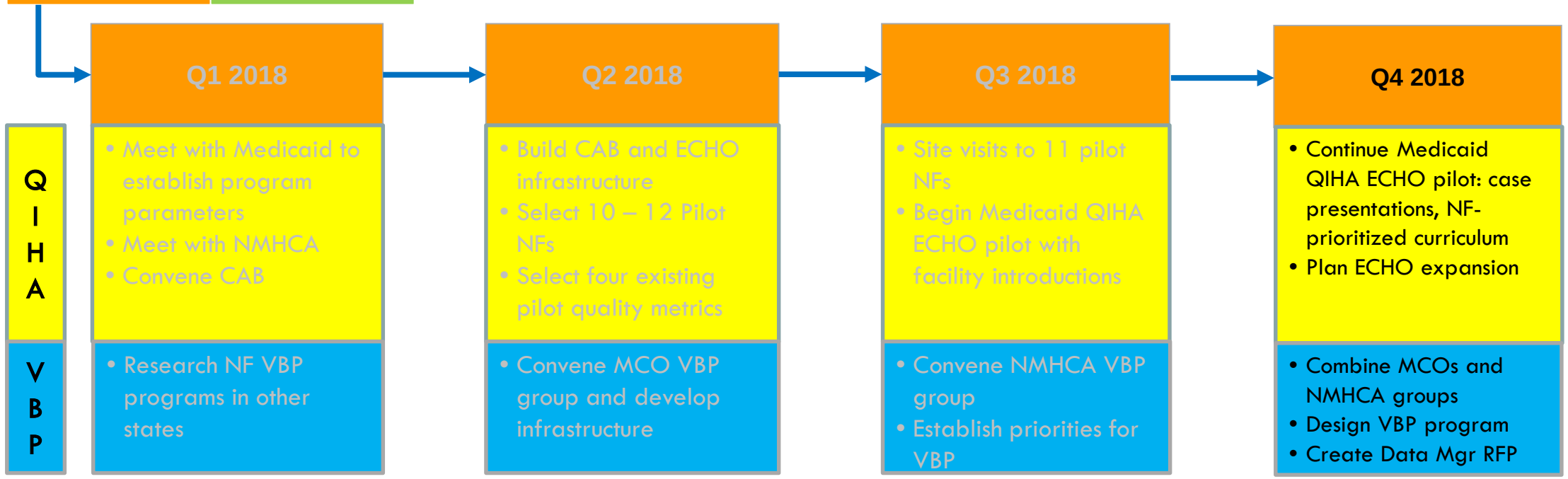

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2018 | **2019**

	Q1 2019	Q2 2019	Q3 2019	Q4 2019
QIHA	• Pilot continues through March • Focus groups to evaluate pilot • Finalize plan for expansion	• Outreach to additional NFs to enroll in QIHA • Revise agendas and curriculum to reflect VBP metrics	• Revised structure, facilities, and curriculum implemented	• Planning for 2020 (TBD)
VBP	• Complete data mgr RFP process • Select data vendor • Finalize VBP metrics	• Finalize Data Mgr contract • Create data use agreements	• VBP program begins • Data reporting begins	• Payout for 1st Q (july – September) of VBP

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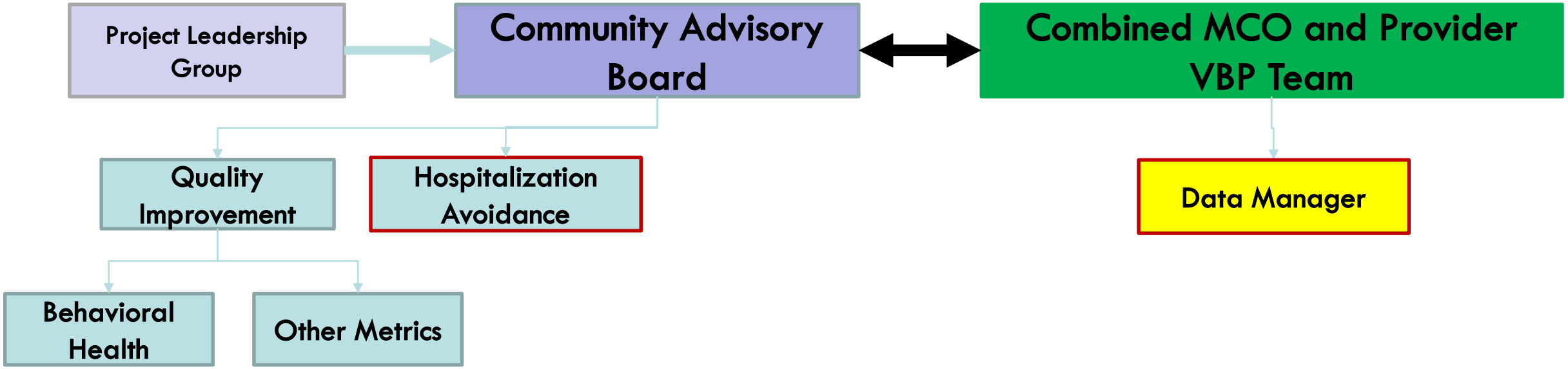
The Structure, Revised



Conclusions: What we have learned so far…

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1. Focus of QIHA and VBP will become **long term care** residents and metrics
2. The concept of a statewide program resonates with the values of NF participants and the business plans of MCOs
3. This is *much* more popular than we expected in terms of QIHA participation by NFs
4. This is *much* more popular than we expected in terms of VBP involvement of both MCOs and NFs
5. A successful VBP program *requires* co-development by *all* parties – efforts have stalled or failed in other states without this
6. This combined program is unique in that we are providing not only financial incentives to improve quality but developing a *unique* statewide learning community to accelerate improvement; this can become a model for other states, and other countries

Questions and Comments