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 Scrace, M.D.

November 17, 2015
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
UNM BBER Population Data, 1910
http://bber.unm.edu/visualizations/migrated/census/cenhist.htm

New Mexico Age-Sex Distribution, 1910

Source: BBER, UNM
UNM BBER Population Data, 1920
http://bber.unm.edu/visualizations/migrated/census/cenhist.htm

New Mexico Age-Sex Distribution, 1920

Source: BBER, UNM
UNM BBER Population Data, 1930

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

New Mexico Age-Sex Distribution, 1930

Source: BBER, UNM

AGE

85 and over
80 to 84
75 to 79
70 to 74
65 to 69
60 to 64
55 to 59
50 to 54
45 to 49
40 to 44
35 to 39
30 to 34
25 to 29
20 to 24
15 to 19
10 to 14
5 to 9
0 to 4

Male
Female
New Mexico Age-Sex Distribution, 1940

Source: BBER, UNM
New Mexico Age-Sex Distribution, 1950 (Baby Boomers: 0-4)

AGE

85 and over
80 to 84
75 to 79
70 to 74
65 to 69
60 to 64
55 to 59
50 to 54
45 to 49
40 to 44
35 to 39
30 to 34
25 to 29
20 to 24
15 to 19
10 to 14
5 to 9
0 to 4

Male
Female

Source: BBER, UNM
UNM BBER Population Data, 1960

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

New Mexico Age-Sex Distribution, 1960 (Baby Boomers: 0-14)

Source: BBER, UNM
UNM BBER Population Data, 1970

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

New Mexico Age-Sex Distribution, 1970 (Baby Boomers: 5-24)

Male

Female

Source: BBER, UNM
UNM BBER Population Data, 1980
http://bber.unm.edu/visualizations/migrated/census/cenhist.htm

New Mexico Age-Sex Distribution, 1980 (Baby Boomers: 15-

AGE

Source: BBER, UNM
New Mexico Age-Sex Distribution, 1990 (Baby Boomers: 25-44)

Source: BBER, UNM
New Mexico Age-Sex Distribution, 2000 (Baby Boomers: 35-54)

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
New Mexico Age-Sex Distribution, 2020 (Baby Boomers: 55-74)

Source: GPS, UNM
New Mexico Age-Sex Distribution, 2030 (Baby Boomers: 65-84)

Source: GPS, UNM
New Mexico Age-Sex Distribution, 2040 (Baby Boomers: 75-94)

Source: GPS, UNM
NM Population 1900 and 2030

New Mexico

AGE
85 and over
80 to 84
75 to 79
70 to 74
65 to 69
60 to 64
55 to 59
50 to 54
45 to 49
40 to 44
35 to 39
30 to 34
25 to 29
20 to 24
15 to 19
10 to 14
5 to 9
0 to 4

Male
Female

Source: BBER, UNM

Source: GPS, UNM
World, US and NM Population Data: 1900

Source: BBER, UNM

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: BBER, UNM

Figure 1-5. Population by Age and Sex: 1970
(for information on confidentiality protection, nonsampling error, and definitions, see

Age
85 and over
80 to 84
75 to 79
70 to 74
65 to 69
60 to 64
55 to 59
50 to 54
45 to 49
40 to 44
35 to 39
30 to 34
25 to 29
20 to 24
15 to 19
10 to 14
5 to 9
0 to 4

New Mexico


Source: BBER, UNM
World, US and NM Population Data: 2010

World 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: BBER, UNM

New Mexico

Source: BBER, UNM

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


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


http://ic.galegroup.com/cic/ovic/ReferenceDetailsPage/DocumentToolsPortletWindow?displayGroupName=Reference&jsid=39089e482c8c8d828db87529b5e6s3d&catid=13&documentId=GALE%7CEJ3011870101&u=tel_s_tsla&zid=a8b62b67a1e49125e7d00f3a9b66d last accessed 1/24/2016

<table>
<thead>
<tr>
<th>State</th>
<th>2000</th>
<th>2000 rank</th>
<th>2010</th>
<th>2010 rank</th>
<th>2030</th>
<th>2030 rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>12.4</td>
<td>(x)</td>
<td>13.0</td>
<td>(x)</td>
<td>19.7</td>
<td>(x)</td>
</tr>
<tr>
<td>Florida</td>
<td>17.6</td>
<td>1</td>
<td>17.8</td>
<td>2</td>
<td>27.1</td>
<td>1</td>
</tr>
<tr>
<td>Arizona</td>
<td>15.6</td>
<td>2</td>
<td>16.0</td>
<td>3</td>
<td>26.5</td>
<td>2</td>
</tr>
<tr>
<td>West Virginia</td>
<td>15.3</td>
<td>3</td>
<td>15.6</td>
<td>4</td>
<td>28.4</td>
<td>3</td>
</tr>
<tr>
<td>Louisiana</td>
<td>14.9</td>
<td>4</td>
<td>15.5</td>
<td>5</td>
<td>25.8</td>
<td>4</td>
</tr>
<tr>
<td>New Jersey</td>
<td>14.7</td>
<td>5</td>
<td>15.3</td>
<td>6</td>
<td>27.4</td>
<td>5</td>
</tr>
<tr>
<td>Montana</td>
<td>14.5</td>
<td>6</td>
<td>15.0</td>
<td>7</td>
<td>25.1</td>
<td>6</td>
</tr>
<tr>
<td>Nevada</td>
<td>14.1</td>
<td>7</td>
<td>14.9</td>
<td>8</td>
<td>24.8</td>
<td>7</td>
</tr>
<tr>
<td>Idaho</td>
<td>14.0</td>
<td>8</td>
<td>14.7</td>
<td>9</td>
<td>25.0</td>
<td>8</td>
</tr>
<tr>
<td>Maine</td>
<td>13.5</td>
<td>9</td>
<td>14.3</td>
<td>10</td>
<td>24.4</td>
<td>9</td>
</tr>
<tr>
<td>South Dakota</td>
<td>13.4</td>
<td>10</td>
<td>14.1</td>
<td>11</td>
<td>24.3</td>
<td>10</td>
</tr>
<tr>
<td>Arizona</td>
<td>13.2</td>
<td>11</td>
<td>13.9</td>
<td>12</td>
<td>23.5</td>
<td>11</td>
</tr>
<tr>
<td>Delaware</td>
<td>13.1</td>
<td>12</td>
<td>13.8</td>
<td>13</td>
<td>23.1</td>
<td>12</td>
</tr>
<tr>
<td>Missouri</td>
<td>13.0</td>
<td>13</td>
<td>13.7</td>
<td>14</td>
<td>22.8</td>
<td>13</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>12.9</td>
<td>14</td>
<td>13.6</td>
<td>15</td>
<td>22.5</td>
<td>14</td>
</tr>
<tr>
<td>New Mexico</td>
<td>12.7</td>
<td>15</td>
<td>13.5</td>
<td>16</td>
<td>22.1</td>
<td>15</td>
</tr>
<tr>
<td>North Dakota</td>
<td>12.6</td>
<td>16</td>
<td>13.3</td>
<td>17</td>
<td>21.7</td>
<td>16</td>
</tr>
<tr>
<td>South Dakota</td>
<td>12.4</td>
<td>17</td>
<td>13.2</td>
<td>18</td>
<td>21.3</td>
<td>17</td>
</tr>
<tr>
<td>Oregon</td>
<td>12.3</td>
<td>18</td>
<td>13.1</td>
<td>19</td>
<td>21.0</td>
<td>18</td>
</tr>
<tr>
<td>Maine</td>
<td>12.2</td>
<td>19</td>
<td>13.0</td>
<td>20</td>
<td>20.7</td>
<td>19</td>
</tr>
<tr>
<td>Mississippi</td>
<td>12.1</td>
<td>20</td>
<td>12.9</td>
<td>21</td>
<td>20.4</td>
<td>20</td>
</tr>
<tr>
<td>Iowa</td>
<td>12.0</td>
<td>21</td>
<td>12.8</td>
<td>22</td>
<td>20.1</td>
<td>21</td>
</tr>
<tr>
<td>Florida</td>
<td>11.9</td>
<td>22</td>
<td>12.7</td>
<td>23</td>
<td>19.8</td>
<td>22</td>
</tr>
<tr>
<td>Virginia</td>
<td>11.8</td>
<td>23</td>
<td>12.6</td>
<td>24</td>
<td>19.5</td>
<td>23</td>
</tr>
<tr>
<td>California</td>
<td>11.7</td>
<td>24</td>
<td>12.5</td>
<td>25</td>
<td>19.2</td>
<td>24</td>
</tr>
<tr>
<td>New Mexico</td>
<td>11.6</td>
<td>25</td>
<td>12.4</td>
<td>26</td>
<td>18.9</td>
<td>25</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>11.5</td>
<td>26</td>
<td>12.3</td>
<td>27</td>
<td>18.6</td>
<td>26</td>
</tr>
<tr>
<td>Illinois</td>
<td>11.4</td>
<td>27</td>
<td>12.2</td>
<td>28</td>
<td>18.3</td>
<td>27</td>
</tr>
<tr>
<td>Nevada</td>
<td>11.3</td>
<td>28</td>
<td>12.1</td>
<td>29</td>
<td>18.0</td>
<td>28</td>
</tr>
<tr>
<td>Mississippi</td>
<td>11.2</td>
<td>29</td>
<td>12.0</td>
<td>30</td>
<td>17.7</td>
<td>29</td>
</tr>
<tr>
<td>Utah</td>
<td>11.1</td>
<td>30</td>
<td>11.9</td>
<td>31</td>
<td>17.4</td>
<td>30</td>
</tr>
<tr>
<td>Colorado</td>
<td>11.0</td>
<td>31</td>
<td>11.8</td>
<td>32</td>
<td>17.1</td>
<td>31</td>
</tr>
<tr>
<td>Arizona</td>
<td>10.9</td>
<td>32</td>
<td>11.7</td>
<td>33</td>
<td>16.8</td>
<td>32</td>
</tr>
<tr>
<td>New Mexico</td>
<td>10.8</td>
<td>33</td>
<td>11.6</td>
<td>34</td>
<td>16.5</td>
<td>33</td>
</tr>
<tr>
<td>Nevada</td>
<td>10.7</td>
<td>34</td>
<td>11.5</td>
<td>35</td>
<td>16.2</td>
<td>34</td>
</tr>
<tr>
<td>Arizona</td>
<td>10.6</td>
<td>35</td>
<td>11.4</td>
<td>36</td>
<td>15.9</td>
<td>35</td>
</tr>
<tr>
<td>Oregon</td>
<td>10.5</td>
<td>36</td>
<td>11.3</td>
<td>37</td>
<td>15.6</td>
<td>36</td>
</tr>
<tr>
<td>New Mexico</td>
<td>10.4</td>
<td>37</td>
<td>11.2</td>
<td>38</td>
<td>15.3</td>
<td>37</td>
</tr>
<tr>
<td>New Mexico</td>
<td>10.3</td>
<td>38</td>
<td>11.1</td>
<td>39</td>
<td>15.0</td>
<td>38</td>
</tr>
</tbody>
</table>

**Legend:**
- **(x)**: Not available
- **(x)**: Not available

The table shows the projected population age 65 and over for various states in 2000, 2010, and 2030. New Mexico is highlighted, indicating a significant increase in its projected population age 65 and over by 2030.
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!”
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
CMS and Nursing Facility VBP

**SNF VBP** Important Dates and Timeline

- **Jan 2015 - Dec 2015**
  - Calendar Year (CY) 2015 Baseline time period
- **Oct 2016**
  - Confidential Feedback report with CY 2013 rates available in the QIES System
- **Feb 2017**
  - Confidential Feedback report with CY 2014 rates available in the QIES System
- **June 2017**
  - Confidential Feedback report with CY 2015 rates available in the QIES System
- **Aug 2017**
  - SNF VBP Program for FY 2019 finalized
- **Oct 2017**
  - SNF-RM rates posted publicly on Nursing Home Compare

**Jan 2017 - Dec 2017**
- Calendar Year (CY) 2017 Performance time period

**Oct 1, 2018**
- Medicare cuts go into effect
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

Traditional Medicaid and Other Programs

- NM General Fund
  - 27.74%
- Federal Government
  - 72.26%

$1:$2.60

2014 0%
2015 0%
2016 0%
2017 5%
2018 6%
2019 7%
2020 on 10%

Medicaid Expansion under the ACA

- NM General Fund
  - 2014 0%
  - 2015 0%
  - 2016 0%
  - 2017 5%
  - 2018 6%
  - 2019 7%
  - 2020 on 10%
- Federal Government
  - 2014 100%
  - 2015 100%
  - 2016 100%
  - 2017 95%
  - 2018 94%
  - 2019 93%
  - 2020 on 90%

$1:$19 -> $1:$9

2019 Medicaid Managed Care Organizations
  (BCBS, Presbyterian, Western Skies)

- New Mexico Hospitals
- NM Medical Groups
- Skilled and Long Term Care NFs
- Home Care
- Dentists
- DME Providers
- Many Others

1.4 M nursing facility bed days per year
and >90% LTC bed days
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.

Feedback-loop facilitates control of overall Medicaid.
Centennial Care Timeline

2014
- Centennial Care Initiated (1/1/2014)

2015
- Final Waiver Application, CMS Review and Approval (11/2017-12/2018)

2016
- Centennial Care 2.0 Stakeholder Input (10/2016-6/2017)
  - Subcommittee of the MAC
  - Tribal Consultation
  - Concept Paper
  - Public meetings
- Stakeholder Input (10/2016-6/2017)

2017
- Draft Waiver Application and Public Comment (9/2017-11/2017)
- Centennial Care 2.0 Contractors Named (1/2019)
- Centennial Care 2.0 Effective (1/1/2019)

2018
- Only 56 days from today!

2019
- Centennial Care 2.0 Effective (1/1/2019)
## 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) |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Level 1: 8%</td>
<td>Level 1: 10%</td>
<td>Level 1: 11%</td>
<td>Level 1: 12%</td>
</tr>
<tr>
<td></td>
<td>Level 2: 11%</td>
<td>Level 2: 13%</td>
<td>Level 2: 14%</td>
<td>Level 2: 15%</td>
</tr>
<tr>
<td></td>
<td>Level 3: 5%</td>
<td>Level 3: 7%</td>
<td>Level 3: 8%</td>
<td>Level 3: 9%</td>
</tr>
<tr>
<td><strong>Total: 24%</strong></td>
<td><strong>Total: 30%</strong></td>
<td><strong>Total: 33%</strong></td>
<td><strong>Total: 36%</strong></td>
<td></td>
</tr>
</tbody>
</table>

*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.

<table>
<thead>
<tr>
<th>Contract Period 1</th>
<th>Contract Period 2</th>
<th>Contract Period 3</th>
<th>Contract Period 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
<td>10%</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>• Traditional PH providers with at least 2 small providers.</td>
<td>• Traditional PH providers with at least 2 small providers.</td>
<td>• Traditional PH providers with at least 2 small providers.</td>
<td>• Traditional PH providers with at least 2 small providers.</td>
</tr>
<tr>
<td>• BH providers (whose primary services are BH).</td>
<td>• BH providers (whose primary services are BH).</td>
<td>• BH providers (whose primary services are BH).</td>
<td>• BH providers (whose primary services are BH).</td>
</tr>
<tr>
<td>• Long term care providers including nursing facilities.</td>
<td>• Long term care providers including nursing facilities.</td>
<td>• Long term care providers including nursing facilities.</td>
<td>• Long term care providers including nursing facilities.</td>
</tr>
<tr>
<td>All included provider requirements must exceed percentage achieved in prior year.</td>
<td>All included provider requirements must exceed percentage achieved in prior year.</td>
<td>All included provider requirements must exceed percentage achieved in prior year.</td>
<td>All included provider requirements must exceed percentage achieved in prior year.</td>
</tr>
</tbody>
</table>

### 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)

<table>
<thead>
<tr>
<th>Contract Period 1</th>
<th>Contract Period 2</th>
<th>Contract Period 3</th>
<th>Contract Period 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>11%</td>
<td>13%</td>
<td>14%</td>
<td>15%</td>
</tr>
<tr>
<td>• Traditional PH providers with at least 2 small providers.</td>
<td>• Traditional PH providers with at least 2 small providers.</td>
<td>• Traditional PH providers with at least 2 small providers.</td>
<td>• Traditional PH providers with at least 2 small providers.</td>
</tr>
<tr>
<td>• BH providers (whose primary services are BH).</td>
<td>• BH providers (whose primary services are BH).</td>
<td>• BH providers (whose primary services are BH).</td>
<td>• BH providers (whose primary services are BH).</td>
</tr>
<tr>
<td>• Actively build readiness for Long Term Care Providers (see definitions).</td>
<td>• Actively build readiness for Long Term Care Providers (see definitions).</td>
<td>• Long term care providers including nursing facilities.</td>
<td>• Long term care providers including nursing facilities over prior year.</td>
</tr>
<tr>
<td>• Actively build readiness for nursing facilities (see definitions).</td>
<td>• Actively build readiness for nursing facilities (see definitions).</td>
<td>• Actively build readiness for nursing facilities (see definitions).</td>
<td>• Actively build readiness for nursing facilities (see definitions).</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Contract Period 1</th>
<th>Contract Period 2</th>
<th>Contract Period 3</th>
<th>Contract Period 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>7%</td>
<td>8%</td>
<td>9%</td>
</tr>
<tr>
<td>- Traditional PH providers.</td>
<td>- Traditional PH providers.</td>
<td>- Traditional PH providers.</td>
<td>- 8% with traditional PH provider</td>
</tr>
<tr>
<td>- Implement a CONTRACTOR led BH provider level workgroup that works with BH providers to design full risk model (see definitions).</td>
<td>- Develop BH full-risk contracting model</td>
<td>- BH providers (whose primary services are BH).</td>
<td>- 2% with providers who are primarily BH.</td>
</tr>
<tr>
<td>- Actively build LTC and/or Nursing facility provider level workgroup to design full-risk model (see definitions).</td>
<td>- Implement a CONTRACTOR led BH provider level workgroup that works with BH providers to design full risk model (see definitions).</td>
<td>- Actively build LTC and/or nursing facility full-risk contracting model (see definitions).</td>
<td>- Long term care providers including nursing facilities over prior year.</td>
</tr>
</tbody>
</table>

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


<table>
<thead>
<tr>
<th>Points Allocation</th>
<th>Quality Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcers: Long Stay Measure</td>
<td>11.111</td>
</tr>
<tr>
<td>Physical Restraints: Long-Stay</td>
<td>11.111</td>
</tr>
<tr>
<td>Influenza Vaccination: Short Stay</td>
<td>5.55575</td>
</tr>
<tr>
<td>Pneumococcal Vaccination: Short Stay</td>
<td>5.55575</td>
</tr>
<tr>
<td>Urinary Tract Infection: Long Stay</td>
<td>11.111</td>
</tr>
<tr>
<td>Control of Bowel/Bladder: Long Stay</td>
<td>11.111</td>
</tr>
<tr>
<td>Self-Report Pain: Short Stay</td>
<td>5.55575</td>
</tr>
<tr>
<td>Self-Report Pain: Long-Stay</td>
<td>5.55575</td>
</tr>
<tr>
<td>Activities of Daily Living: Long-Stay</td>
<td>11.111</td>
</tr>
<tr>
<td>Staff Retention</td>
<td>11.111</td>
</tr>
<tr>
<td>30 Day All-Cause Readmission</td>
<td>11.111</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>
### 2013 Data: California Quality and Accountability Supplemental Payments (QASP)

Source: [http://www.dhcs.ca.gov/services/medica

<table>
<thead>
<tr>
<th>Payment Tier</th>
<th>Point Range</th>
<th>Previously Presented</th>
<th>Revised</th>
<th>Top Tier 1 1/2 Payout</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td># of SNFs</td>
<td>Payout per MCB</td>
<td>Total MCBs</td>
</tr>
<tr>
<td>Tier 0¹</td>
<td>0 - 49.9</td>
<td>346</td>
<td>$0.00</td>
<td>5,811,700</td>
</tr>
<tr>
<td>Tier 1</td>
<td>50 - 66.6</td>
<td>419</td>
<td>$4.28</td>
<td>4,381,696</td>
</tr>
<tr>
<td>Tier 2</td>
<td>66.7 - 100</td>
<td>211</td>
<td>$8.55</td>
<td>2,019,628</td>
</tr>
<tr>
<td>Tier 3</td>
<td></td>
<td>330</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Receiving Payment</td>
<td></td>
<td>30.14%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹Tier 0 includes facilities ineligible for QASP payment due to non-compliance with 3.2 NHPPD, AA/A citations, 0 MCB, 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 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 MCBs will not receive a payment.

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

Total Payout $36M
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](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

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

Accepted Manuscript

Improving Care of Patients After Hospital Discharge: A Novel Videoconferncial-based Team

Clinical Experience

ECHO-AGE: A Care Resident
Angela G. Catr M. Maria Morgan E. 

Impact of Restriction

ECHO-AGE

Grace Farris, MPH, MD, M.

Extension Transition Multidisciplinary Team

Amber B. Sirica, MC, L.P. Matti

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 interdisciplinatcy 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.


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 hospital 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.

Please cite this article in Video-Con 10.1016/j.vcc.2016.01.0001

This is a draft copyeditor's note for legal disclosure.

The American Journal of
Are you part of the ECHO?
Nursing Facility Quality Improvement and Hospitalization Avoidance (QIHA) Program in New Mexico
**Centennial Care and NF QIHA/VBP Timeline**

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Event</th>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centennial Care 2.0 Contractors Named</strong> (1/2019)</td>
<td></td>
<td>Crystal Hodges</td>
<td>Deputy Bureau Chief, LTSSB</td>
<td>HSD/MAD</td>
</tr>
<tr>
<td><strong>Centennial Care 2.0 Effective</strong> (1/1/2019)</td>
<td></td>
<td>Cynthia Olivas</td>
<td>Nurse Manager</td>
<td>ECHO Institute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>David Scrase</td>
<td>Medical Director</td>
<td>UNM GCOE Internal Med</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Elizabeth Clewett</td>
<td>Director of Replication</td>
<td>ECHO Institute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Erica Archuleta</td>
<td>Physical Health Unit Mgr, Centennial Care Contracts Bureau</td>
<td>HSD/MAD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Joseph Foxhood</td>
<td>Assistant Director, Uptown</td>
<td>Genesis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Karisa &quot;Risa&quot; Berry</td>
<td>Executive Director, San Juan Center in Farmington</td>
<td>Genesis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kevin Traylor</td>
<td>Executive Director, Uptown</td>
<td>Genesis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Marisa Marquez</td>
<td>Project ECHO NM Operations Student</td>
<td>ECHO Institute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Martha Carvour</td>
<td>University of New Mexico Health Sciences Center</td>
<td>ID Fellow</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pat Whitacre</td>
<td>Director of Quality and Clinical Services</td>
<td>NM Health Care Assn</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Remona Benally</td>
<td>Project Manager</td>
<td>HealthInsight New Mexico</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shannon Cupka</td>
<td>Project Manager</td>
<td>HealthInsight New Mexico</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Steven Littlehale</td>
<td>Chief Clinical Office and Executive VP</td>
<td>Point Right</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emilee Brodie</td>
<td>Program Specialist, Clinic Coordination</td>
<td>ECHO Institute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tallie Tolen</td>
<td>Bureau Chief, Long Term Services and Supports Bureau (LTSSB)</td>
<td>HSD/MAD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thomas Kim</td>
<td>Senior VP, Medical Affairs</td>
<td>Genesis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tracy Smith</td>
<td>Program Manager, Quality Improvement Initiatives</td>
<td>ECHO Institute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vanessa Rodriguez</td>
<td>Center Nurse Executive, Genesis Healthcare at Sandia Ridge</td>
<td>Genesis</td>
</tr>
</tbody>
</table>

**Q1 2018**

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

**QIHA**

- Meet with Medicaid
- Research NF VBP programs in other states

**VBP**

- Centennial Care 2.0
- Effective
- Contractors Named

**2018 2019**
Centennial Care and NF QIHA/VBP Timeline

- **Centennial Care 2.0 Contractors Named** (1/2019)
- **Centennial Care 2.0 Effective** (1/1/2019)

**Q1 2018**
- Meet with Medicaid to establish program parameters
- Meet with NMHCA
- Convene CAB
- Research NF VBP programs in other states

**Q2 2018**
- Build CAB and ECHO infrastructure
- Select 10 – 12 Pilot NFs
- Select four existing pilot quality metrics
- Convene MCO VBP group and develop infrastructure
Centennial Care and NF QIHA/VBP Timeline

Centennial Care 2.0 Contractors Named (1/1/2019)

Q1 2018
- Meet with Medicaid to establish program parameters
- Meet with NMHCA
- Convene CAB
- Research NF VBP programs in other states

2018
- Centennial Care 2.0 Effective (1/1/2019)

Q1 2018
- Meet with Medicaid to establish program parameters
- Meet with NMHCA
- Convene CAB
- Research NF VBP programs in other states

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SS Pneumonia Vac</td>
<td>NM</td>
<td>68.31593</td>
<td>64.43415</td>
<td>67.39485</td>
<td>68.34131</td>
<td>69.69712</td>
<td>13.41253</td>
<td>1</td>
</tr>
<tr>
<td>SS Influenza Vac</td>
<td>NM</td>
<td>72.47877</td>
<td>67.72366</td>
<td>66.71301</td>
<td>66.80579</td>
<td>70.52135</td>
<td>10.50172</td>
<td>2</td>
</tr>
<tr>
<td>LS Pneumonia Vac</td>
<td>NM</td>
<td>80.64335</td>
<td>79.14562</td>
<td>79.56349</td>
<td>82.89466</td>
<td>85.75912</td>
<td>8.385886</td>
<td>4</td>
</tr>
<tr>
<td>LS Influenza Vac</td>
<td>NM</td>
<td>86.27691</td>
<td>88.87254</td>
<td>87.17901</td>
<td>91.45866</td>
<td>92.61725</td>
<td>2.315015</td>
<td>7</td>
</tr>
<tr>
<td>LS Mobility Worse</td>
<td>NM</td>
<td>19.8982</td>
<td>21.41174</td>
<td>20.50572</td>
<td>20.50577</td>
<td>2.292328</td>
<td>2.92328</td>
<td>8</td>
</tr>
<tr>
<td>LS Outpatient ED Visits</td>
<td>NM</td>
<td>13.89574</td>
<td>13.37558</td>
<td>13.35203</td>
<td>1.494649</td>
<td>1.494649</td>
<td>1.494649</td>
<td>9</td>
</tr>
<tr>
<td>LS Catheter</td>
<td>NM</td>
<td>3.301297</td>
<td>2.943718</td>
<td>3.512884</td>
<td>3.313439</td>
<td>2.530768</td>
<td>0.665996</td>
<td>12</td>
</tr>
<tr>
<td>SS Antipsychotic</td>
<td>NM</td>
<td>2.904668</td>
<td>2.460702</td>
<td>2.490567</td>
<td>2.531788</td>
<td>2.314779</td>
<td>0.326286</td>
<td>13</td>
</tr>
<tr>
<td>SS PU</td>
<td>NM</td>
<td>0.992341</td>
<td>0.791212</td>
<td>1.503379</td>
<td>1.272956</td>
<td>1.008694</td>
<td>0.132106</td>
<td>14</td>
</tr>
<tr>
<td>LS Weight Loss</td>
<td>NM</td>
<td>7.161366</td>
<td>6.298023</td>
<td>7.234606</td>
<td>7.107744</td>
<td>7.179254</td>
<td>0.096303</td>
<td>15</td>
</tr>
<tr>
<td>LS Falls w Injury</td>
<td>NM</td>
<td>3.680669</td>
<td>3.858533</td>
<td>3.988173</td>
<td>4.239733</td>
<td>3.461082</td>
<td>0.087468</td>
<td>16</td>
</tr>
<tr>
<td>LS Restraints</td>
<td>NM</td>
<td>0.72376</td>
<td>0.583683</td>
<td>0.601877</td>
<td>0.511199</td>
<td>0.320772</td>
<td>-0.11002</td>
<td>17</td>
</tr>
<tr>
<td>LS Depression</td>
<td>NM</td>
<td>3.4918</td>
<td>3.007546</td>
<td>2.934389</td>
<td>3.838857</td>
<td>4.68194</td>
<td>-0.18908</td>
<td>18</td>
</tr>
<tr>
<td>LS UTI</td>
<td>NM</td>
<td>5.247255</td>
<td>4.651044</td>
<td>3.981836</td>
<td>3.072016</td>
<td>2.89301</td>
<td>-0.76767</td>
<td>19</td>
</tr>
<tr>
<td>SS Rehospitalization</td>
<td>NM</td>
<td>20.1547</td>
<td>20.26018</td>
<td>20.21202</td>
<td>20.21202</td>
<td>20.21202</td>
<td>0.087468</td>
<td>20</td>
</tr>
<tr>
<td>SS Successful Dis to Comm</td>
<td>NM</td>
<td>51.80244</td>
<td>59.73186</td>
<td>56.7146</td>
<td>56.7146</td>
<td>2.639491</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>SS Functional Improv</td>
<td>NM</td>
<td>61.28979</td>
<td>63.50563</td>
<td>63.87643</td>
<td>63.87643</td>
<td>63.87643</td>
<td>2.087468</td>
<td>22</td>
</tr>
</tbody>
</table>
Centennial Care and NF QIHA/VBP Timeline

- **2018**
  - **Centennial Care 2.0 Contractors Named** (1/2019)
  - **Centennial Care 2.0 Effective** (1/1/2019)

- **Q1 2018**
  - Meet with Medicaid to establish program parameters
  - Meet with NMHCA
  - Convene CAB
  - Research NF VBP programs in other states

- **Q2 2018**
  - Build CAB and ECHO infrastructure
  - Select 10 – 12 Pilot NFs
  - Select four existing pilot quality metrics
  - Convene MCO VBP group and develop infrastructure

---

### MCO VBP Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quinn Glenzinski</td>
<td>Blue Cross Blue Shield of New Mexico</td>
</tr>
<tr>
<td>Dr. Wei-Ann Bay</td>
<td>Blue Cross Blue Shield of New Mexico</td>
</tr>
<tr>
<td>Susan Dezavelle</td>
<td>Blue Cross Blue Shield of New Mexico</td>
</tr>
<tr>
<td>Holly Lawrence</td>
<td>Blue Cross Blue Shield of New Mexico</td>
</tr>
<tr>
<td>Eric Cibak</td>
<td>Blue Cross Blue Shield of New Mexico</td>
</tr>
<tr>
<td>Michael Archuleta</td>
<td>Blue Cross Blue Shield of New Mexico</td>
</tr>
<tr>
<td>Arlene Britt</td>
<td>Blue Cross Blue Shield of New Mexico</td>
</tr>
<tr>
<td>Mary Eden</td>
<td>Presbyterian Health Plan</td>
</tr>
<tr>
<td>Jordan Erp</td>
<td>Presbyterian Health Plan</td>
</tr>
<tr>
<td>Heather Ingram</td>
<td>Presbyterian Health Plan</td>
</tr>
<tr>
<td>Deb Revard</td>
<td>Presbyterian Health Plan</td>
</tr>
<tr>
<td>Nathan Cogburn</td>
<td>Western Sky Community Care</td>
</tr>
<tr>
<td>Dr. Latha Shankar</td>
<td>Western Sky Community Care</td>
</tr>
<tr>
<td>Messina Martinez</td>
<td>Western Sky Community Care</td>
</tr>
<tr>
<td>Rosanna Nelson</td>
<td>Western Sky Community Care</td>
</tr>
<tr>
<td>Marta Larson</td>
<td>Western Sky Community Care</td>
</tr>
<tr>
<td>Dr. David Scrase</td>
<td>HSD</td>
</tr>
<tr>
<td>Estevan Baca</td>
<td>HSD</td>
</tr>
<tr>
<td>Erica Archuleta</td>
<td>HSD</td>
</tr>
</tbody>
</table>
Centennial Care and NF QIHA/VBP Timeline

2018

Q1 2018
- Meet with Medicaid to establish program parameters
- Meet with NMHCA
- Convene CAB
- Research NF VBP programs in other states

Q2 2018
- Build CAB and ECHO infrastructure
- Select 10 – 12 Pilot NFs
- Select four existing pilot quality metrics
- Convene MCO VBP group and develop infrastructure

Q3 2018
- Site visits to 11 pilot NFs
- Begin Medicaid QIHA ECHO pilot with facility introductions
- Convene NMHCA VBP group
- Establish priorities for VBP

2019

Centennial Care 2.0
Contractors Named
(1/2019)

Centennial Care 2.0
Effective
(1/1/2019)
Centennial Care and NF QIHA/VBP Timeline

Q1 2018
• Meet with Medicaid to establish program parameters
• Meet with NMHCA
• Convene CAB
• Research NF VBP programs in other states

Q2 2018
• Build CAB and ECHO infrastructure
• Select 10 – 12 Pilot NFs
• Select four existing quality metrics for pilot
• Convene MCO VBP group and develop infrastructure

Q3 2018
• Site visits to 11 pilot NFs
• Begin Medicaid QIHA ECHO pilot with facility introductions
• Convene NMHCA VBP group
• Establish priorities for VBP

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
Centennial Care and NF QIHA/VBP Timeline

Q1 2018
• Meet with Medicaid to establish program parameters
• Meet with NMHCA
• Convene CAB
• Research NF VBP programs in other states

Q2 2018
• Build CAB and ECHO infrastructure
• Select 10 – 12 Pilot NFs
• Select four existing quality metrics for pilot
• Convene MCO VBP group and develop infrastructure

Q3 2018
• Site visits to 11 pilot NFs
• Begin Medicaid QIHA ECHO pilot with facility introductions
• Convene NMHCA VBP group
• Establish priorities for VBP
Centennial Care and NF QIHA/VBP Timeline

Centennial Care 2.0 Contractors Named (1/2019)

Centennial Care 2.0 Effective (1/1/2019)

Provider Advisory Group

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

Q2 2018

- Build CAB and ECHO infrastructure
- Select 10–12 Pilot NFs
- Select four existing pilot quality metrics
- Convene MCO VBP group and develop infrastructure

Q3 2018

- Site visits to 11 pilot NFs
- Begin Medicaid QIHA ECHO pilot with facility introductions
- Convene NMHCA VBP group
- Establish priorities for VBP
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

**Q1 2018**
- Meet with Medicaid to establish program parameters
- Meet with NMHCA
- Convene CAB
- Research NF VBP programs in other states

**Q2 2018**
- Build CAB and ECHO infrastructure
- Select 10 – 12 Pilot NFs
- Select four existing pilot quality metrics
- Convene MCO VBP group and develop infrastructure

**Q3 2018**
- Site visits to 11 pilot NFs
- Begin Medicaid QIHA ECHO pilot with facility introductions
- Convene NMHCA VBP group
- Establish priorities for VBP

**Q4 2018**
- Continue Medicaid QIHA ECHO pilot: case presentations, NF-prioritized curriculum
- Plan ECHO expansion
- Combine MCOs and NMHCA groups
- Design VBP program
- Create Data Mgr RFP
Centennial Care and NF QIHA/VBP Timeline

**Centennial Care 2.0 Contractors Named**
(1/2019)

**Centennial Care 2.0 Effective**
(1/1/2019)

---

**2018**
- **Q1 2018**
  - Meet with Medicaid to establish program parameters
  - Meet with NMHCA
  - Convene CAB
  - Research NF VBP programs in other states

**2019**

---

**Q4 2018**
- Continue Medicaid QIHA ECHO pilot: case presentations, NF-prioritized curriculum
- Plan ECHO expansion

---

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
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

<table>
<thead>
<tr>
<th>TIME</th>
<th>ITEM</th>
<th>LEADER</th>
<th>GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00–15</td>
<td>Welcome</td>
<td>Tracy Smith, BA</td>
<td>Set stage for meeting.</td>
</tr>
<tr>
<td>10:15-55</td>
<td>Case Discussion 1 – San Juan</td>
<td>Hub Team</td>
<td>Discuss a facility challenge as a community and possible recommendations for solutions or next steps.</td>
</tr>
<tr>
<td>10:55-11:25</td>
<td>Communication Strategies: SBAR Tool</td>
<td>Marissa Hotze, RN; David Scrase, MD</td>
<td>Discuss the importance of communication, review late night scenarios, and learn the SBAR tool.</td>
</tr>
<tr>
<td>11:25-55</td>
<td>Case Discussion 2 – Heights</td>
<td>Hub Team</td>
<td>Discuss a facility challenge as a community and possible recommendations for solutions or next steps.</td>
</tr>
<tr>
<td>11:50-55</td>
<td>Quality Tool: Run Chart Rules</td>
<td>Tracy Smith, BA</td>
<td>Develop shared understanding of quality tools.</td>
</tr>
<tr>
<td>11:55-12:00</td>
<td>Wrap up</td>
<td>Tracy Smith, BA</td>
<td>Share in chat: What went well? What could we improve on? How good of a job did our group do including everyone?</td>
</tr>
</tbody>
</table>
Centennial Care 2.0 Contractors Named (1/2019)

Centennial Care 2.0 Effective (1/1/2019)

2018

Q1 2018
- Meet with Medicaid to establish program parameters
- Meet with NMHCA
- Convene CAB
- Research NF VBP programs in other states

Q2 2018
- Build CAB and ECHO infrastructure
- Select 10 – 12 Pilot NFs
- Select four existing pilot quality metrics
- Convene MCO VBP group and develop infrastructure

Q3 2018
- Site visits to 11 pilot NFs
- Begin Medicaid QIHA ECHO pilot with facility introductions
- Convene NMHCA VBP group
- Establish priorities for VBP

Q4 2018
- Continue Medicaid QIHA ECHO pilot: case presentations, NF-prioritized curriculum
- Plan ECHO expansion
- Combine MCOs and NMHCA groups
- Design VBP program
- Create Data Mgr RFP
Centennial Care and NF QIHA/VBP Timeline

2018
- Centennial Care 2.0 Effective (1/1/2019)

2019
- Centennial Care 2.0 Contractors Named (1/2019)

Q1 2019
- Pilot continues through March
- Focus groups to evaluate pilot
- Finalize plan for expansion
- Complete data mgr RFP process
- Select data vendor
- Finalize VBP metrics

Q2 2019
- Outreach to additional NFs to enroll in QIHA
- Revise agendas and curriculum to reflect VBP metrics
- Finalize Data Mgr contract
- Create data use agreements

Q3 2019
- Revised structure, facilities, and curriculum implemented
- VBP program begins
- Data reporting begins

Q4 2019
- Planning for 2020 (TBD)
- Payout for 1st Q (July – September) of VBP
Conclusions: What we have learned so far…
Conclusions: What we have learned so far…

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