manatt

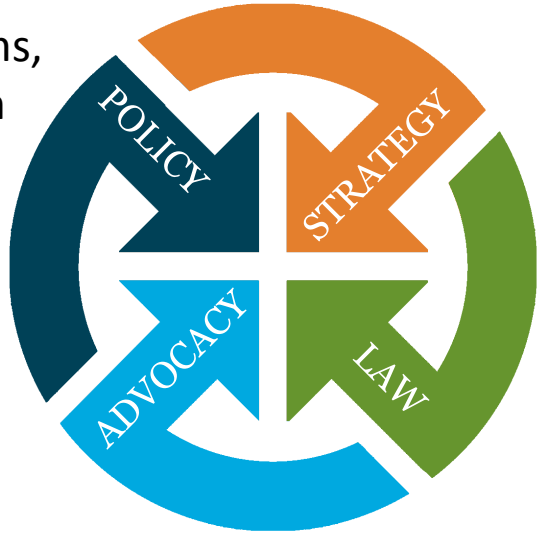
Reinventing Long-Term Care and Post-Acute Care:

Integrating into a New Healthcare System

Manatt Health Solutions (MHS)

Our mission is to be a practice whose multidisciplinary professionals, through excellence, deep substantive knowledge and teamwork, support clients seeking to transform America's health system by expanding coverage, increasing access and creating new ways of organizing, paying for and delivering care.

- Interdisciplinary team with over 60 professionals
- Provider strategy: academic medical centers, acute health systems, post-acute care providers, ACO/IDS formation , care coordination
- Payer strategy: provider-sponsored plans
- Health information exchange, health IT
- Medicaid program redesign and evaluation
- Mergers, acquisitions, joint ventures
- Corporate structure and governance
- Pharmaceutical strategy: health reform, pricing, Medicare reimbursement, regulation of research, approval, manufacturing and marketing of medicines

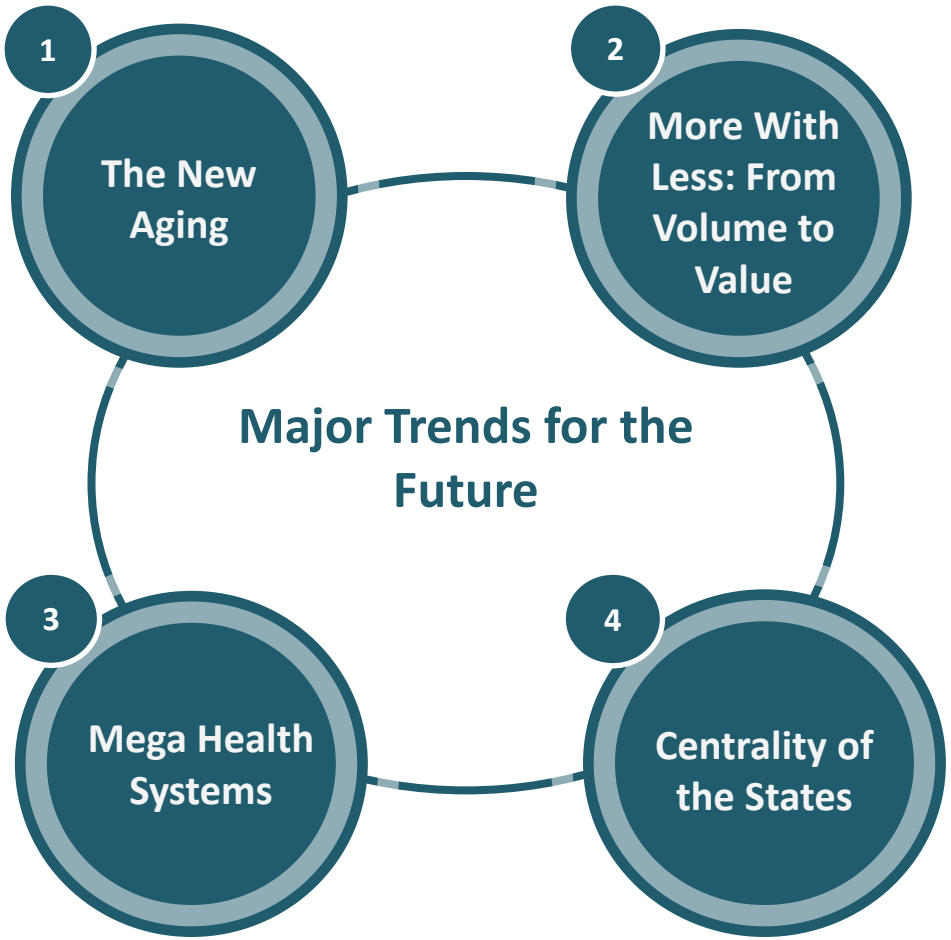


Today's Focus

Background

Define post-acute and long-term care and introduce their respective roles in the delivery system and the care continuum

Looking to the Future



Agenda

Background

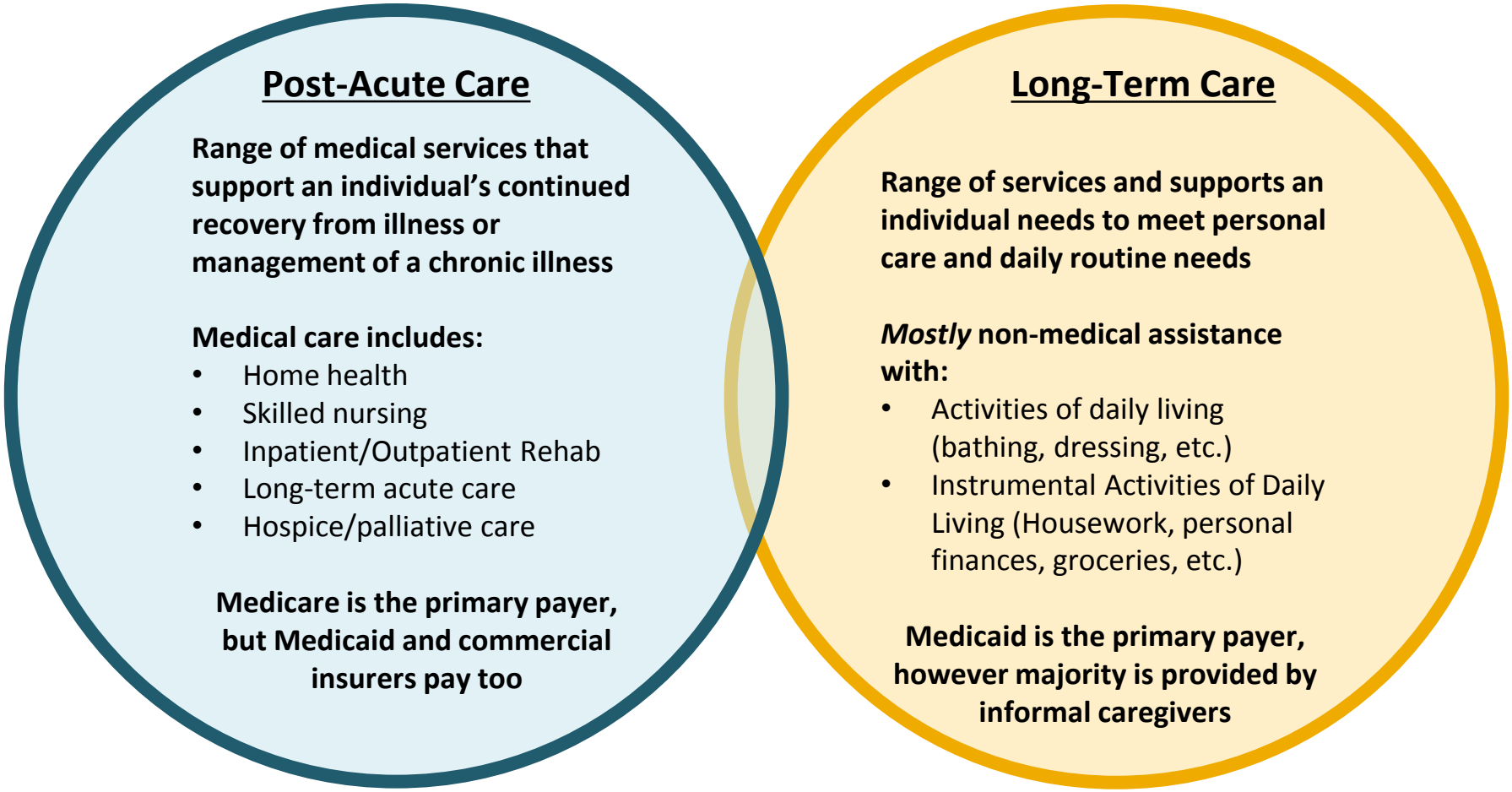
Trend #1: The New Aging

Trend #2: From Volume to Value

Trend #3: Mega Health Systems

Trend #4: Centrality of the States

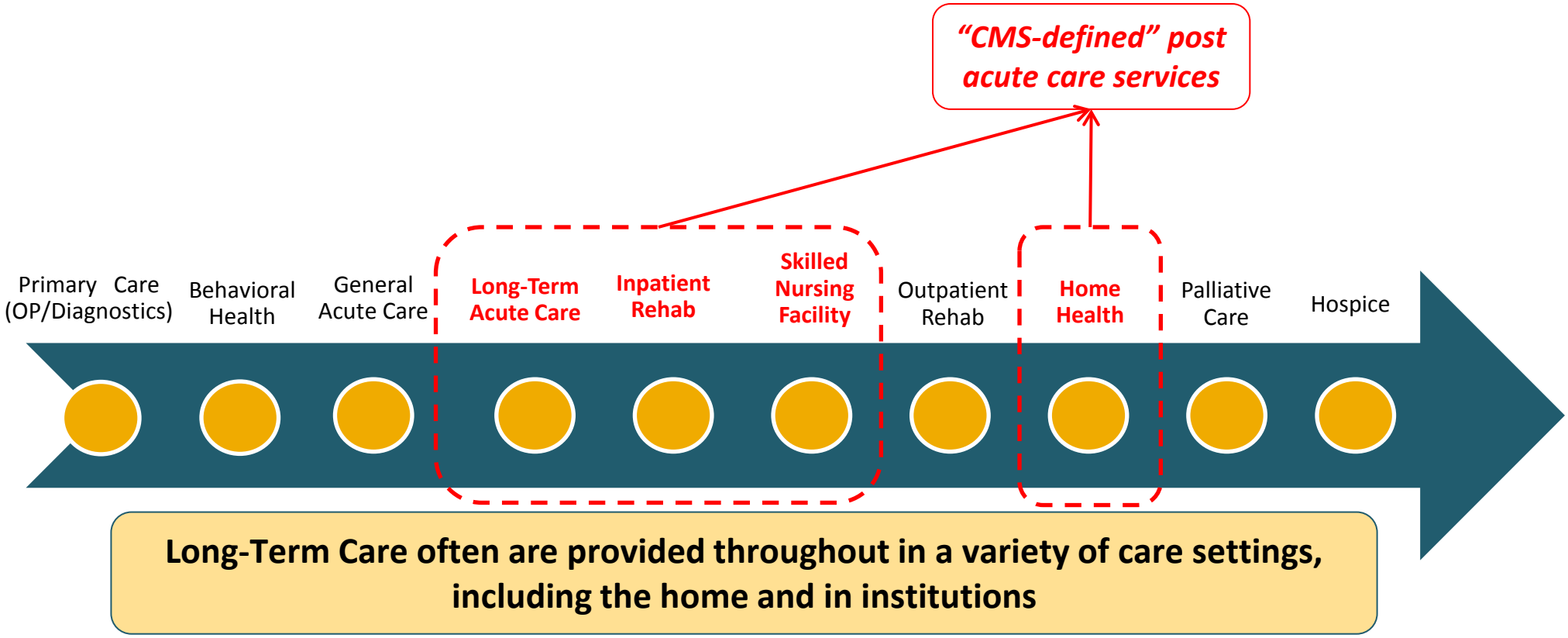
Defining Long-Term and Post-Acute Care



Often provided side-by-side either at home or in institutions

PAC is provided for discrete time periods with medical treatment as the main goal; Long-Term Care is provided on an ongoing basis focused on helping patients cope with disease in their daily lives

Post-Acute Care and Long-Term Care are Vital Parts of the Continuum



Long-Term Care often are provided throughout in a variety of care settings, including the home and in institutions

Post-Acute Care and Long-Term Care Differ from Other Elements of the Care Continuum

Patient Profiles	Higher rates of chronic conditions, often combined with co-morbidities, functional impairments and disabilities	
Use of Services	Often much longer use of intense and often costly services; dependence on non-medical services and ongoing monitoring of conditions	
Goals of Care	**Post-Acute Care** • Restore functional capabilities and ability to live independently following acute illness or development of chronic disease; • Palliative Care/Hospice: Provide physical and mental stability; reduce pain and suffering	**Long-Term Care** • Support for completing activities needed to live daily lives with minimal interruption/difficulty • No true "medical recovery" goals
Role of Family	Family and friends often play an enhanced role in patient care in the home and in different institutional settings	

Why Focus on Post-Acute and Long-Term Care?

- PAC and LTC providers play a critical role in **ensuring continuity of care** for individuals and **addressing complications** that can reduce hospital admissions, readmissions and ED use

- There is **significant opportunity** for quality improvement and cost-containment for these populations through improved care coordination and value-based purchasing

- **Managed care** for seniors and people with disabilities who use long-term care **is small, but steadily growing**
  - 389,000 people received **Medicaid LTC through managed care** in 2012, compared with 105,000 in 2004
  - 30% of Medicare beneficiaries are enrolled in **Medicare Advantage** in 2014, compared with 13% in 2004

- **Integrating the care continuum** requires a dedicated focus on PAC and LTC

Why the Focus?
Emerging Policy Issues Affecting LTC and PAC

Financing reform

Mandatory quality measurement and reporting

Mandatory access across certain populations

Need to ensure appropriate placement of patients in the right settings of care

Public reporting requirements for quality measures

Focus on reducing unnecessary variation in spending

Increased attention and scrutiny on provider compliance

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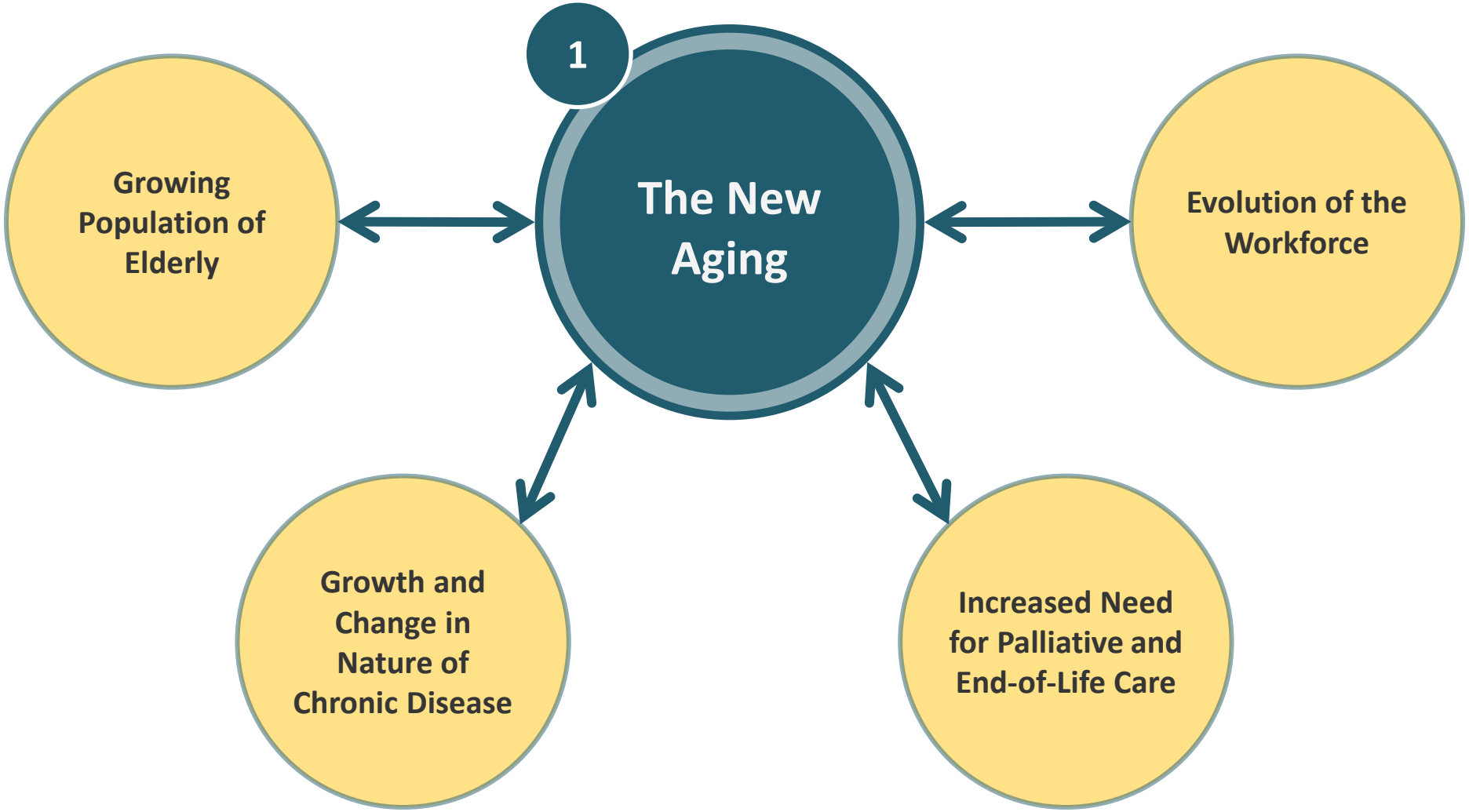
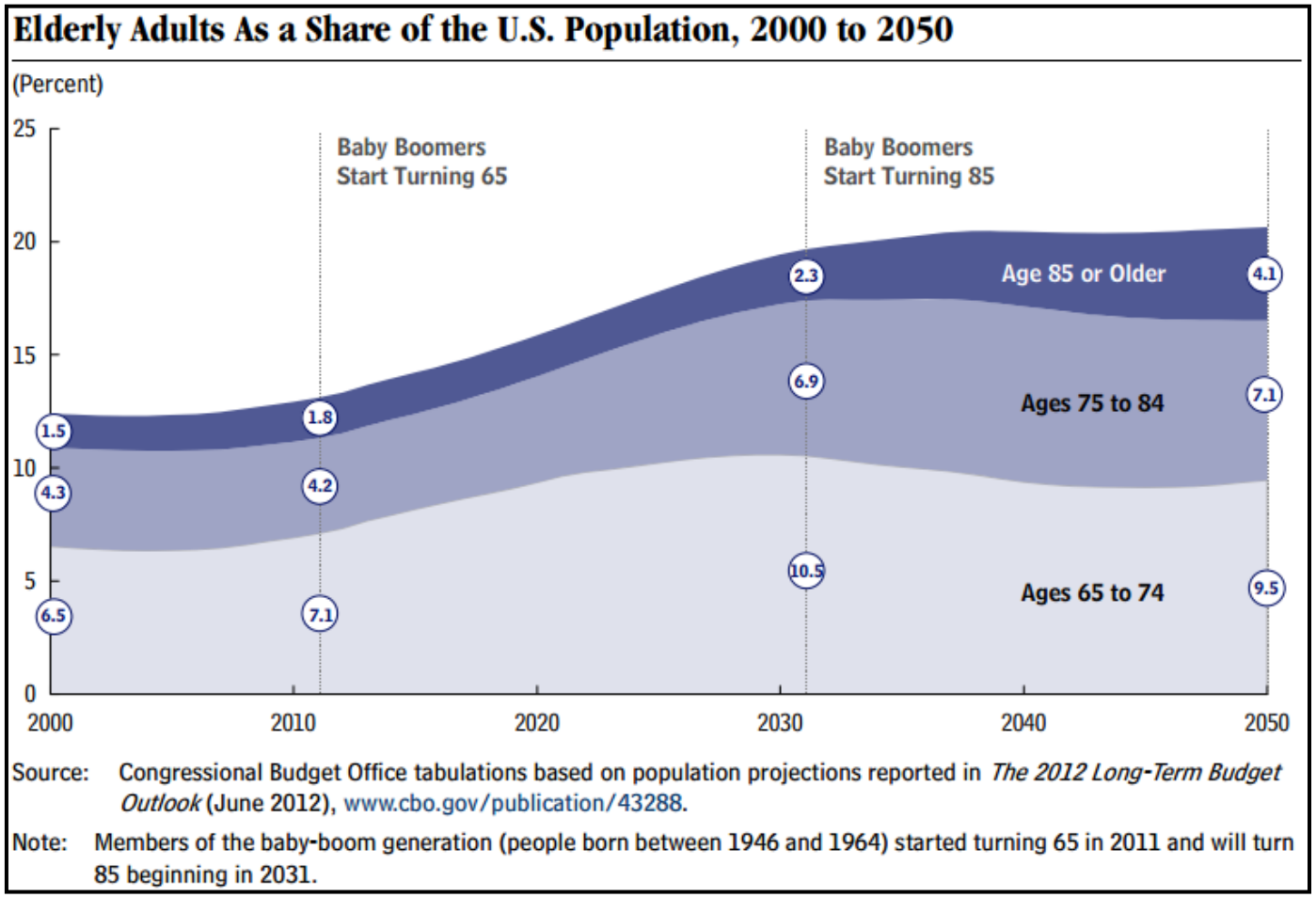
Trend #1: The New Aging



The Elderly Population in the U.S. is Growing



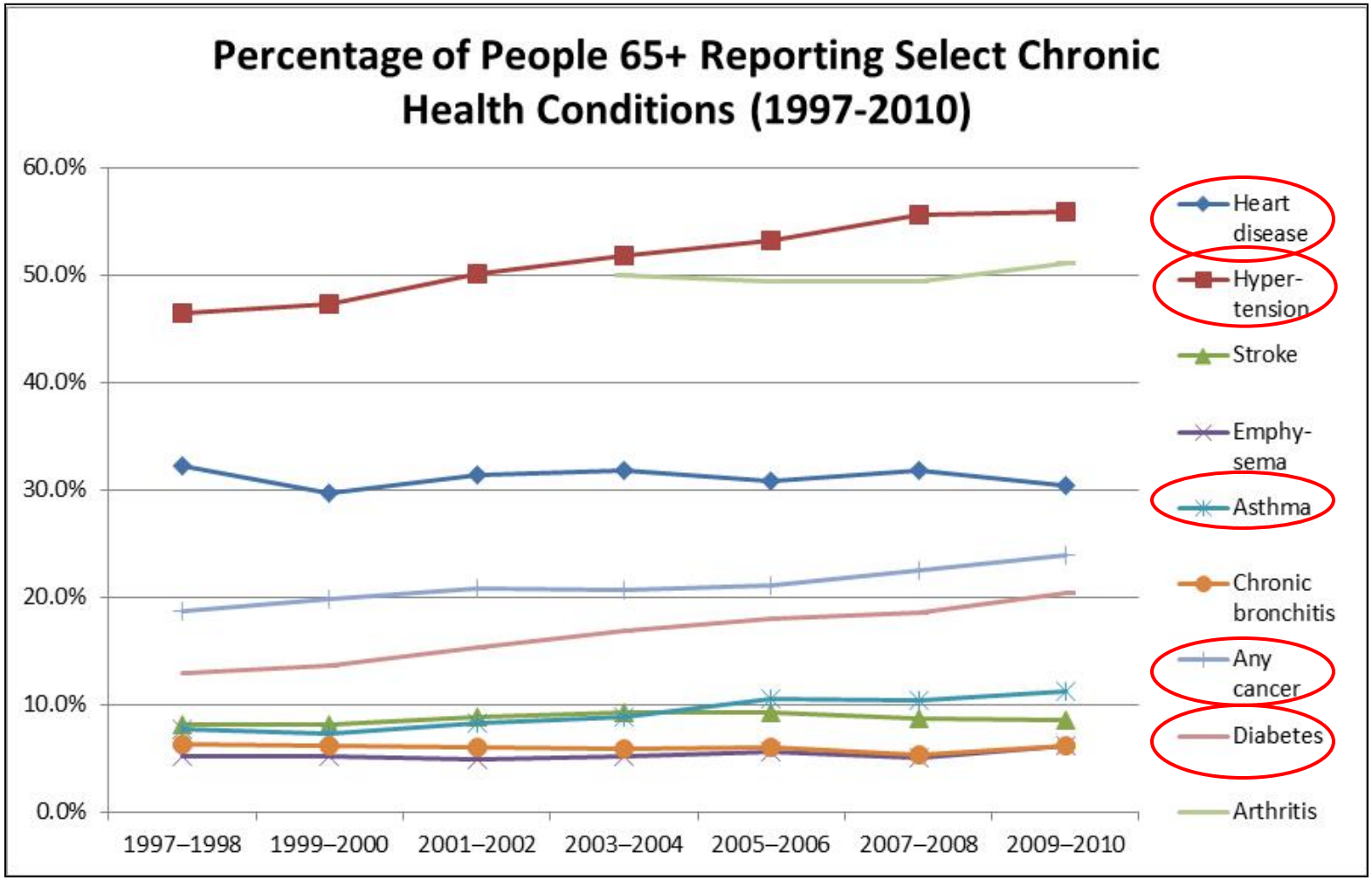
By 2050:

20% of total population will be 65+ (up from 12% in 2000, and 8% in 1950)

4% of the population will be 85+ (10 times its share in 1950)

Prevalence of Chronic Disease has Drastically Increased Over Time – And Will Continue

Advances in medical research, new medical treatments, and new technologies enable patients to live longer lives with chronic diseases



Data Source: Older Americans 2012: Key Indicators of Well-Being, Agingstats.gov

Growing Utilization of Palliative and End-of-Life Care Planning and Treatment

Attitudes are Changing

66%

The percentage of adults who have **written down or discussed wishes for end-of-life-care**

91.5%

The percentage of people 25+ who **would consider palliative care** for a loved one with a serious illness

91.5%

The percentage of people 25+ who believe **palliative care should be available at all hospitals** for patients with serious illnesses and their families

Hospital-Based Palliative Care has grown substantially

157%

The increase in **number of palliative care programs** in hospitals with 50+ beds - up from **658** in 2000 to **1,692** in 2011. The explosion of palliative care is driven by in-patient hospitals, rather than community based care.

Utilization & Spending are Steadily Rising

1.6 million

The **number of patients that received hospice care** in 2012. **84%** of those patients were **Medicare beneficiaries**.

$15b → $27b

Estimated **increase in Medicare hospice spending** from 2012 to 2020.

46%

The percentage of **Medicare decedents in 2012 who received hospice services**, indicating that there is **likely an unmet need**.

The Workforce is Under Pressure

The PAC and LTC systems face major workforce shortages for both direct service workers and informal caregivers

Formal Workforce

- Includes nurses, physical and occupational therapists as well as direct care workers such as home health aides and certified nursing assistants
- Direct care CNAs and HHAs have **significant job turnover**, with almost half of workers employed at more than one job in a 2-year period
- As demand for services increases over time, a projected shortage in the direct care workforce **will become more and more critical**

Informal Workforce

- Informal caregivers are often family members or friends
- **Over 75% of adults** with LTC needs depend on family or friends as their only source of care
- Providing care takes a **physical, emotional, and financial toll** on caregivers
- This workforce is declining with the decrease in family size, increase in women (who are the primary caregivers) in the workforce, and geographic dispersion of families

Trend #1: The New Aging

Key Points for Post-Acute and Long-Term Care Providers

Post-acute and long-term care need, utilization and spending will explode in the coming years due to the **growth in the elderly population** and **increased longevity** of those living with chronic and disabling conditions

The demographic changes will **increase pressure on providers** to develop **new delivery models, expertise and treatment methods** to help people manage chronic conditions that can last for the rest of their lives

The **care continuum must be integrated** - providers must collaborate across sites of care to effectively manage patients and account for overall costs

Individuals and their families increasingly are **embracing palliative care and hospice as alternatives** to intense treatment during and at the end of disease cycles, creating a premium for providers to design models of care that integrate these services

The **direct service and informal caregiver workforces are under tremendous strain**, requiring a deliberate strategy focused on workforce development and training.

Agenda

Background and Trends

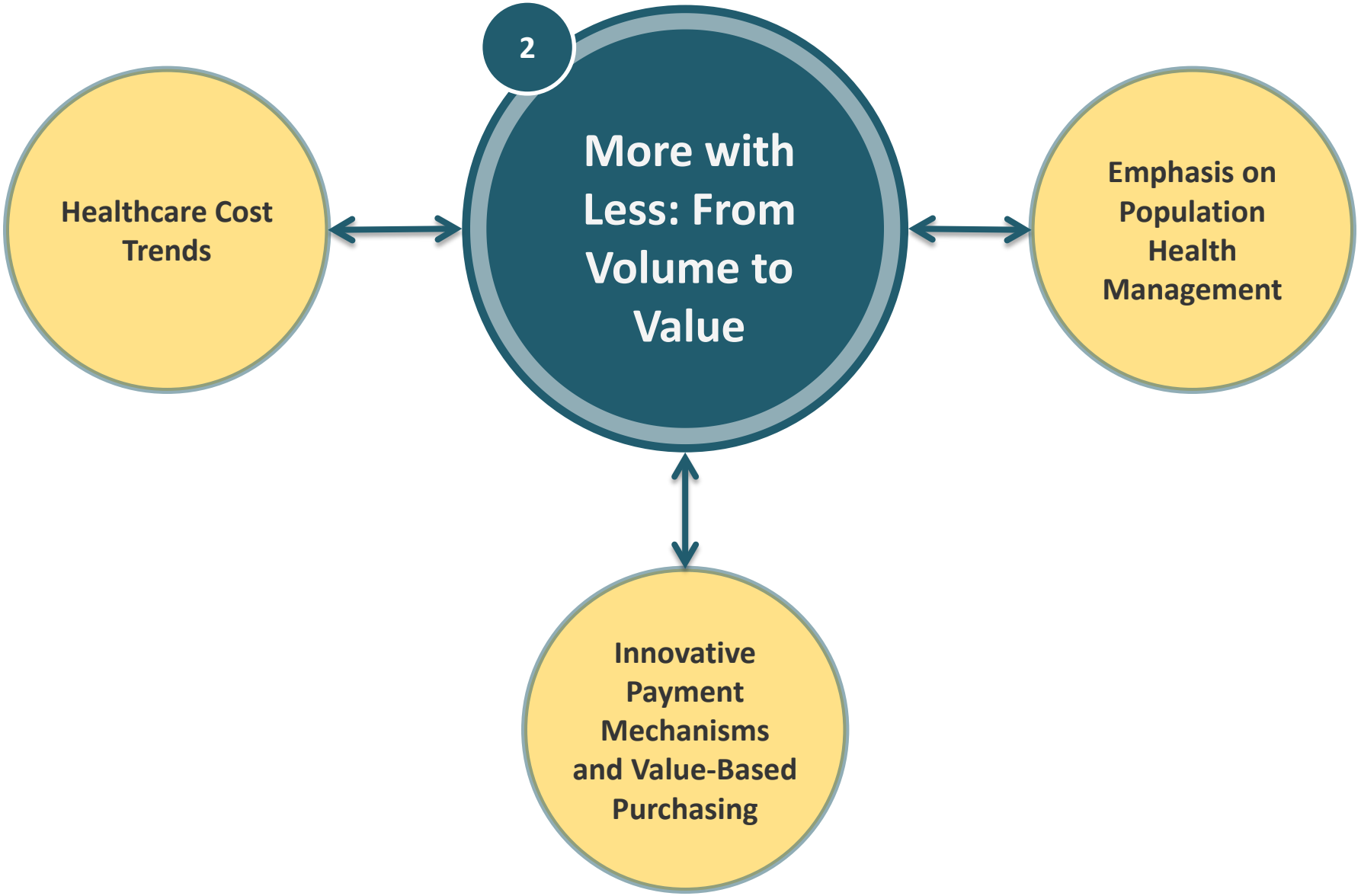
Trend #1: The New Aging

Trend #2: From Volume to Value

Trend #3: Mega Health Systems

Trend #4: Centrality of the States

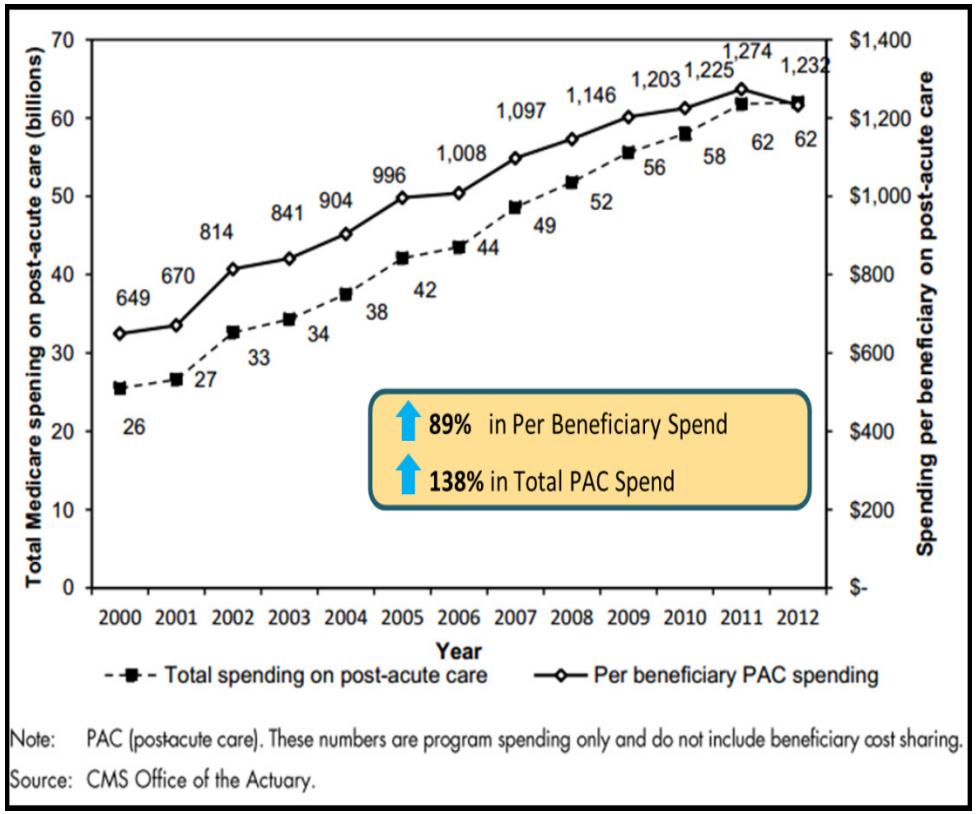
Trend #2: From Volume to Value



Overall Spending Trends and Significant Variation Increasing Focus on Post-Acute Providers

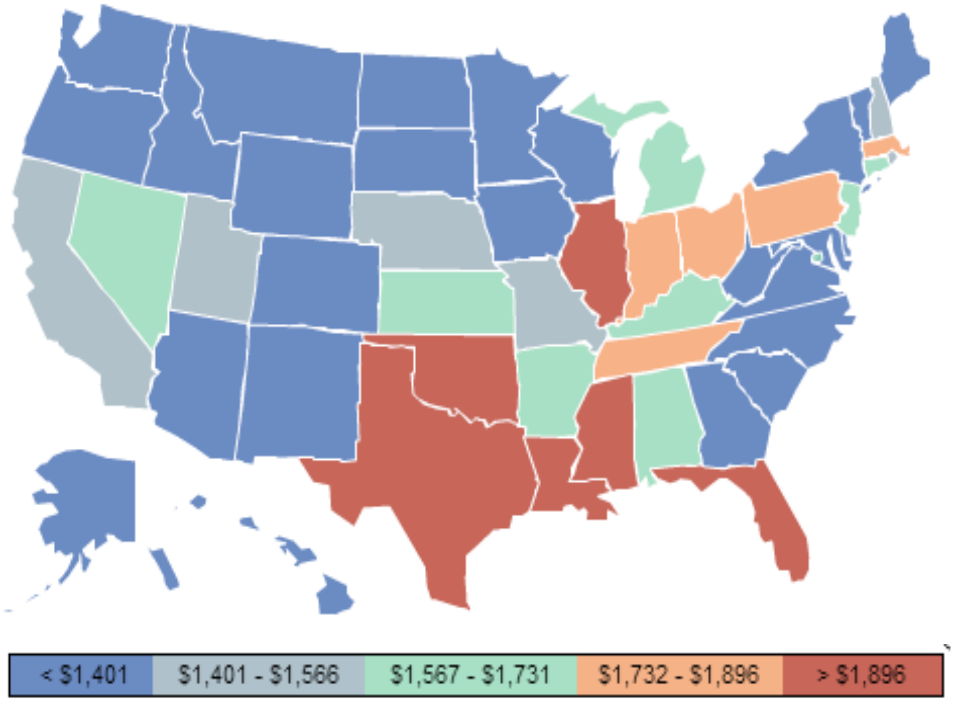
Year over year Medicare spending increases and significant variation in cost is driving increased attention to Medicare PAC reimbursement

Overall Medicare PAC Spend, 2000-2012



Note: PAC (postacute care). These numbers are program spending only and do not include beneficiary cost sharing.
Source: CMS Office of the Actuary.

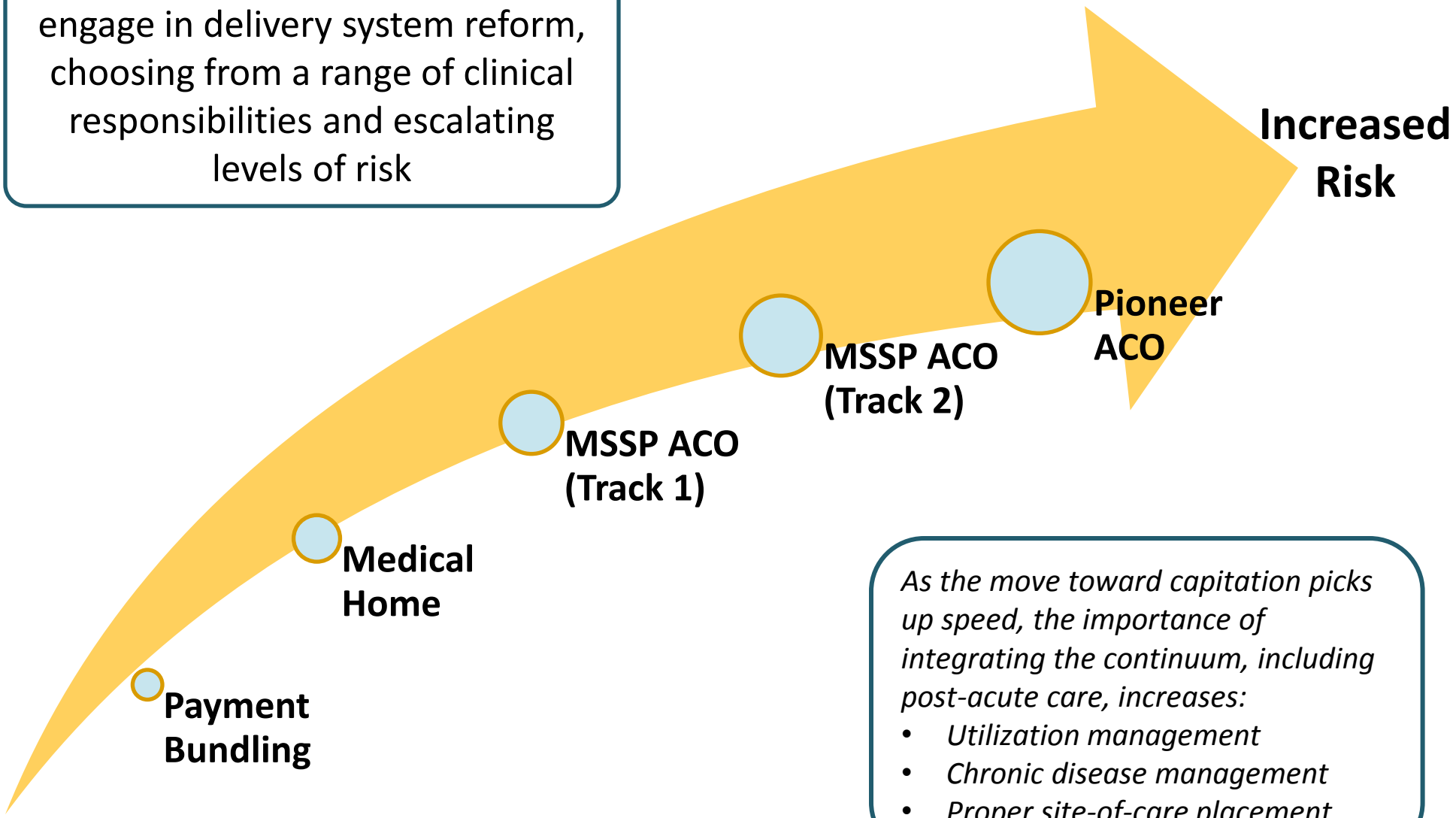
PAC Per Capita Costs, Medicare (2012)



Sources: CMS Office of the Actuary; MedPAC 2014 Report, CMS/Office of Information Products and Data Analytics

ACA Authorized New Medicare Payment Models

Enhanced options for providers to engage in delivery system reform, choosing from a range of clinical responsibilities and escalating levels of risk



As the move toward capitation picks up speed, the importance of integrating the continuum, including post-acute care, increases:

- *Utilization management*
- *Chronic disease management*
- *Proper site-of-care placement*

Looking Ahead: Key CMS Focus Areas Affecting Medicare Post-Acute Care Payment

Broadening readmission penalties *for acute care providers and extending penalties to post-acute sites of care*

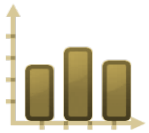
Site neutral payments *for comparable services in different post-acute settings for clinically similar patients*

Elimination of financial incentives *to provide excess services and* ***shrinking payment rates***

Center for Medicare & Medicaid INNOVATION

Piloting new payment programs *to encourage coordinated, efficient care in clinically appropriate care settings*

Use of common assessment instruments *to more clearly identify the optimal post-acute setting for each patient*



Adoption of common, consistent process *for measuring, collecting, and reporting quality, cost, and outcomes across settings*

CMS Is Testing New Reimbursement Models for Medicare PAC Services

Bundled Payments for Care Improvement (BPCI) initiative is testing the integration of acute and post-acute care in an effort to tightly coordinate and improve patient care and lower Medicare costs

Center for Medicare & Medicaid INNOVATION

Model 2 – Acute Care and Post-Acute Care

60 sites nationwide received bundled payments for retrospective acute and PAC episodes (10/1/13 or 1/1/14 start dates)

- Episode of care will include the inpatient stay in the acute care hospital and all related services during the episode, which will end either 30, 60, or 90 days after hospital discharge (participant chooses)
- Covers 48 different clinical condition episodes

Model 3 – Post-Acute Care Only

20 sites nationwide received bundled payments for retrospective PAC episodes (10/1/13 or 1/1/14 start dates)

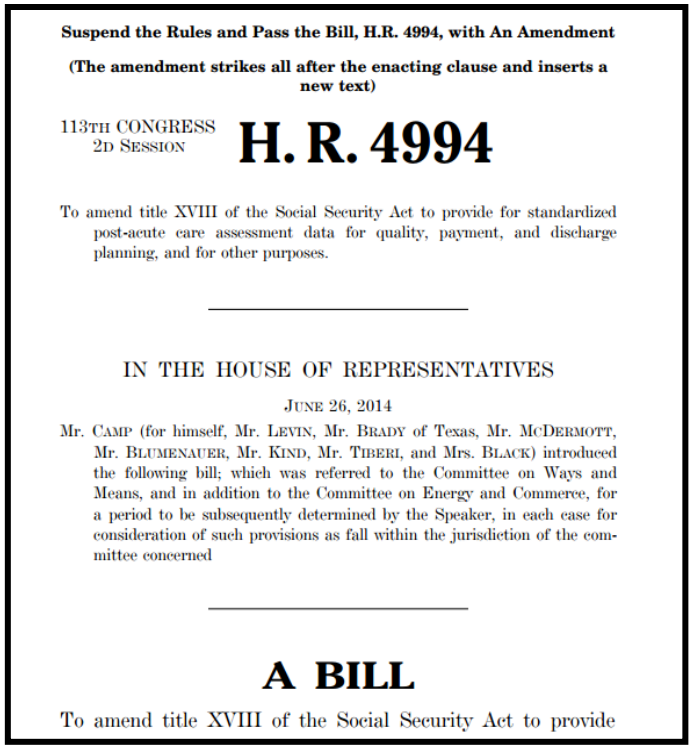
- Episode of care will begin within 30 days of discharge from an inpatient facility to a participating skilled-nursing facility, inpatient rehab facility, long-term care hospital or home health agency, and end either 30, 60 or 90 days after initiation of the episode
- Covers 48 different clinical condition episodes

Source: CMS Innovation Center

A New Emphasis on Measuring Patient Quality and PAC Provider Performance is Likely

There is a significant lack of comparable information across PAC settings, making it difficult to determine the effectiveness of each setting and making it even more difficult to advance PAC payment reforms

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014



Suspend the Rules and Pass the Bill, H.R. 4994, with An Amendment

(The amendment strikes all after the enacting clause and inserts a new text)

113TH CONGRESS
2D SESSION

H. R. 4994

To amend title XVIII of the Social Security Act to provide for standardized post-acute care assessment data for quality, payment, and discharge planning, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 26, 2014

Mr. CAMP (for himself, Mr. LEVIN, Mr. BRADY of Texas, Mr. MCDERMOTT, Mr. BLUMENAUER, Mr. KIND, Mr. TIBERI, and Mrs. BLACK) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to provide

- Introduced in June, passed by Congress on September 18th, signed by the President on October 6th
- Requires PAC providers to report:
  - ✓ Standardized patient assessment data;
  - ✓ Data on quality measures; and
  - ✓ Data on resources use and other measures
- Requires interoperability of data to coordinate care and improve Medicare beneficiary outcomes
- Modifies assessment tools
- Provides feedback to PAC providers on performance and make some data publically available
- Allows HHS to reduce market basket percentage for SNFs by 2% for failure to report data

New Care Management Models in the PAC Setting Are Easing Patient Transitions and Optimizing Care

Amedisys Chronic Care Management

- Program aims to decrease hospitalizations
- Programs focused on heart conditions, wound care, diabetes, rehab, orthopedic recovery, behavioral health, COPD, chronic kidney disease, and falls

Kindred Care Transitions

- Quality Improvement program designed to reduce readmissions and improve outcomes for patients with complex conditions. Also aims to increase patient engagement and provide greater continuity of care
- Proven track record of success with superior clinical outcomes, high patient satisfaction, and coordinated care across multiple settings
- Patient is assigned a Care Transitions Manager who visits the patient in the hospital and home and works with the patient to develop and achieve care goals.

IT Challenges Still Exist for PAC and LTC Providers – *But Change is on the Way*

Today

PAC and LTC providers were late in adopting EMR capabilities

- Not included in HITECH
- Requires significant capital which PAC/LTC providers struggle to develop
- Interoperability has historically been a major issue

Looking Ahead

PAC providers are beginning to adopt EMR technologies as technology

- Technology is improving with PAC-specific capability development
- Health systems are seeking tools to integrate with PAC EMRs to ease transitions and optimize patient care

IT tools including remote monitoring for home care, e-hospitalist and e-ICU programs, and other tele-health capabilities are increasing in prevalence in the PAC setting

- Reimbursement still remains an issue, however recent national attention to tele-health reimbursement is promising

Emerging PAC Technology Solutions to Optimize Care Transitions and Patient Management

NaviHealth

- Partners with risk-bearing healthcare organizations to lower PAC costs
- Aligns stakeholders through a severity adjusted data driven approach utilizing evidence-based PAC decision support technologies
- Uses analytics platform to focus on patients receiving the right amount of care in the most appropriate setting

SeniorBridge (owned by Humana)

- Provides a personalized plan of care to help the elderly stay at home and provides home care
- Care managers supervise and support the services in the home
- Provides services for basic custodial needs, medically complex cases, memory issues and behavioral management issues

Alegis (owned by Cigna)

- Multi-specialty medical health services organization focused on the medical home experience for homebound Medicare and Medicaid patients
- Through various care management programs, delivers specialized services including direct patient care for the chronically ill, transitional care from hospital to home, and comprehensive health assessment services for health plans.

Trend #2: From Volume to Value

Key Points for Post-Acute and Long-Term Care Providers

There is a push to **reduce payments** and pay for **bundles of services** across care sites

There is an increased focus on **quality reporting and clinical outcomes** as CMS and other payers look to minimize variation in spending and identify higher quality, lower cost PAC providers to include in narrowing networks

Providers are already **innovating to integrate care coordination and care management services** and will continue to do so at a more rapid pace as the industry evolves

New technologies are moving into the long-term care space more rapidly, helping providers manage patients in these care settings and connect to other providers on the continuum to optimize patient management

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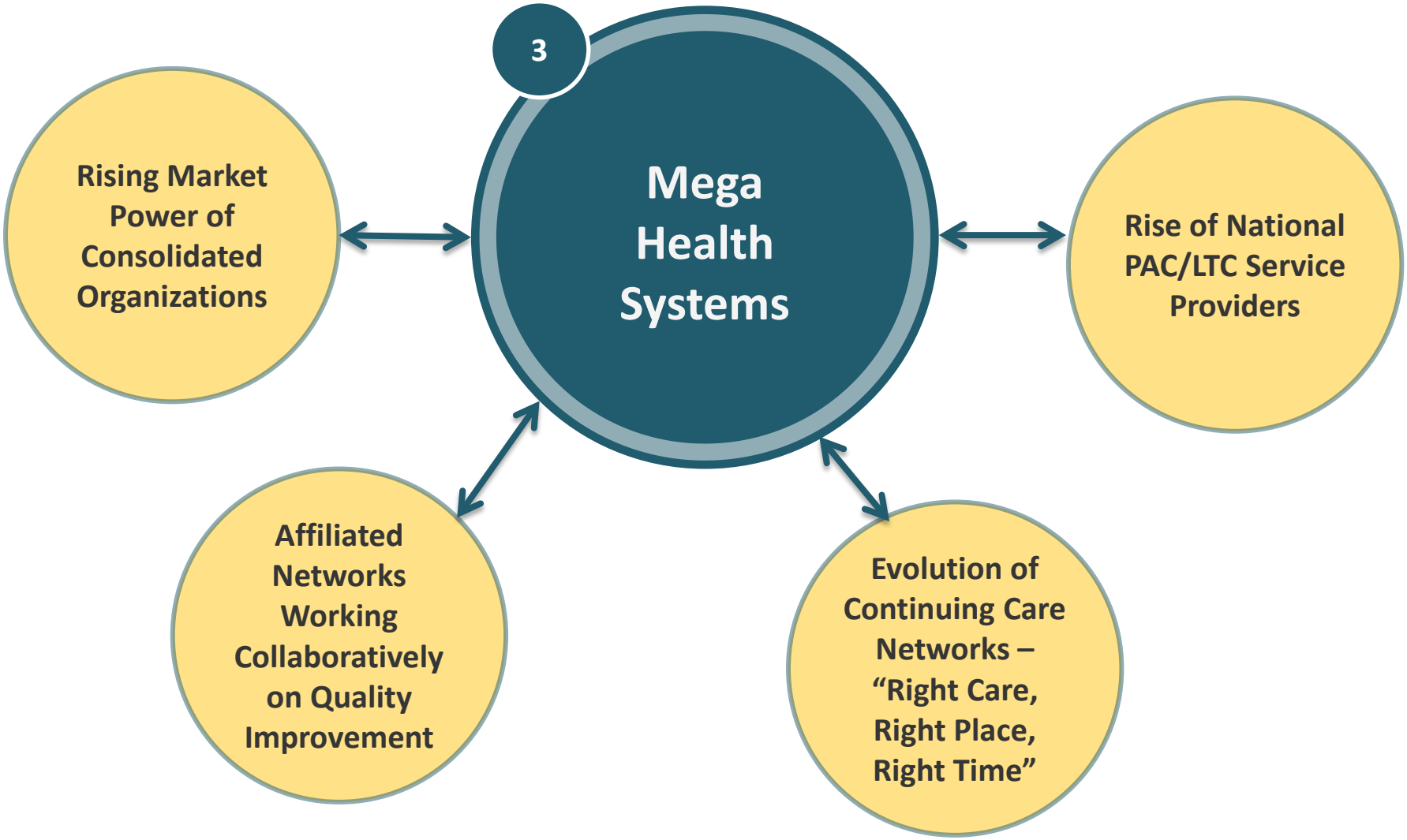
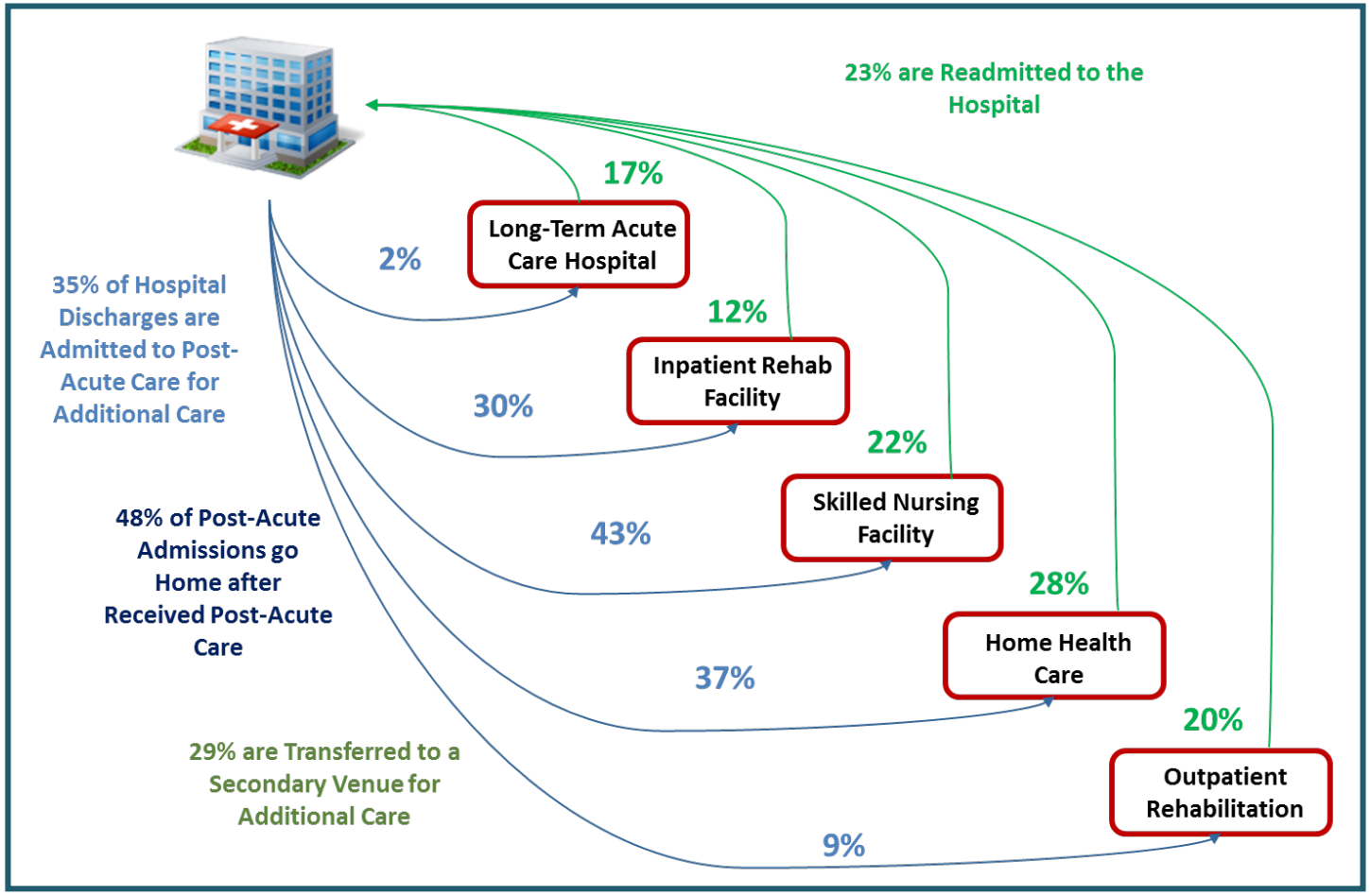


Episodes of Care Increasingly Include Utilization of Post-Acute Care Services

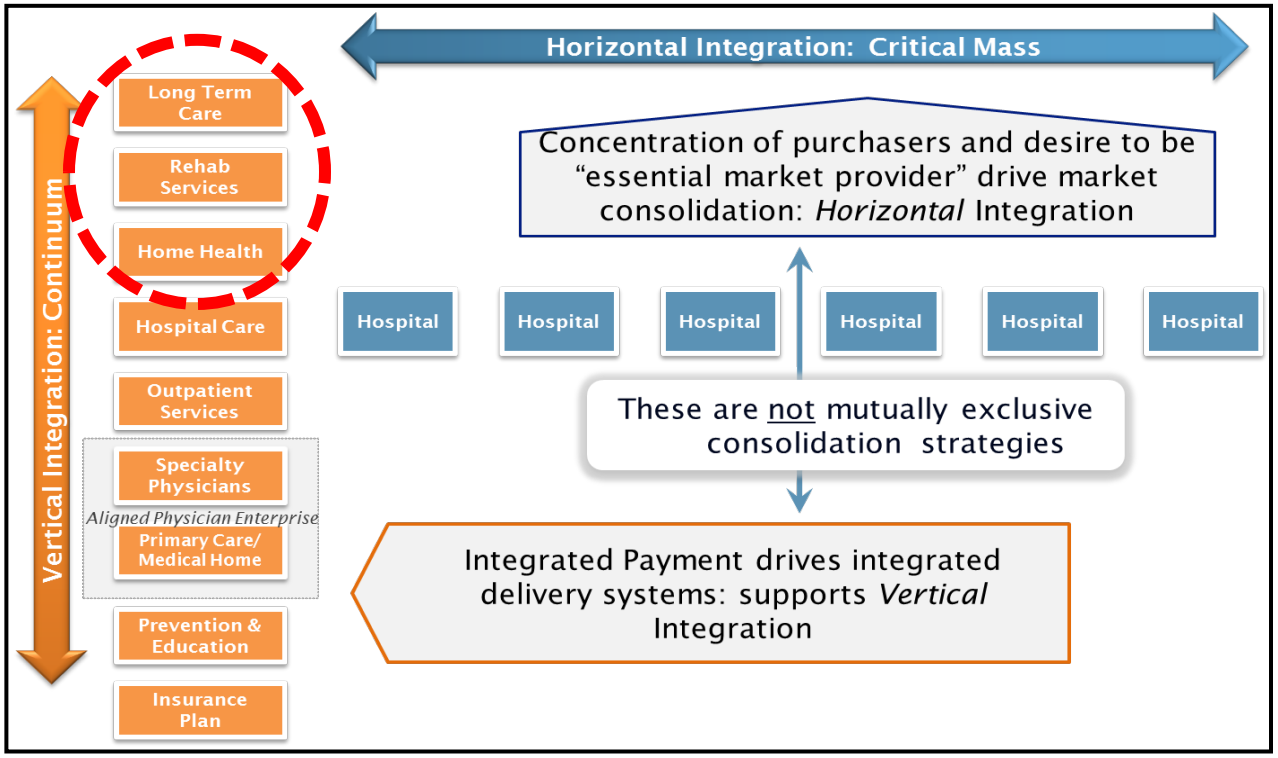
Over 1/3 of Medicare patients require some form of post-acute care after an inpatient stay. Many require multiple levels of care – a trend that is expected to hold or increase



Source: RTI/Cain Brothers Analysis, "Integrating Acute and Post-Acute Care", 2012

Formation of Integrated Delivery Systems in a "Race-to-Scale" for Health Systems

Health system consolidation continues to speed up, as systems seek to achieve scale and develop adequate services and coverage to meet the needs of populations



Source: Irving Levin Associates

Surges in consolidation are resulting in more integrated "super systems" that are blurring the lines between traditional insurers, hospital systems and provider networks. Systems are now turning attention to "population health management" and greater assumption of insurance risk.

Health Systems are Forming "Continuing Care Networks" of Preferred Post-Acute Care Providers

"Continuing Care Networks" are networks of aligned post-acute and sub-acute care partners that work collaboratively with hospitals and other providers to manage patients across the continuum in the right place, at the right time

Partners "Continuing Care"

- Unified subsidiary division of Partners Healthcare that encompasses two IRFs, two LTACHs, and three skilled facilities as well as the Partners Home Health division, and private duty nursing division
- Single board and management team oversees the PCC
- System wide strategic planning around post-acute care services and their integration into the complete continuum
- Strategies:
    1. Readmissions Reduction Program
    2. Embedded Clinician Program at PAC Sites
    3. Leveraging Population Health Tools for Post-Acute Care
    4. Creation of a Network of Additional Affiliated SNFs
    5. Care Integration

Advocate Health Care SNF Partnership Program

- "Two-tiered" set of relationships with 110 skilled facilities across their geographic region
- Tier 1 facilities have Advocate-deployed and employed advanced practice nurses and "SNFists" to oversee care plans for Advocate Patients
    - These visits are billed separately
- Tier 2 facilities also holds advanced training sessions and modules for SNF staff, as well as quarterly quality improvement and best practice review sessions
- Also working to connect SNF sites to Advocate's system-wide EMR to facilitate transitions

Mega-PAC Providers are Also On the Rise

Consolidation in the post-acute care market will likely continue given challenging economics and the need to develop scale in target markets

Recent Merger, Acquisition, and Joint Venture Activity in the Post Acute Care Space

Genesis HealthCare®

Skilled Healthcare

2014

- Merger that creates one of the largest ($5.5 billion) post-acute care providers in the country

Kindred Healthcare
Dedicated to Hope, Healing and Recovery

GENTIVA®

2014

- Merger that dramatically expands Kindred's home health and hospice business
- Creates the largest ($7.1 billion) integrated post-acute care provider in the country

Envision HEALTHCARE
PIONEERING THE DELIVERY OF CARE

ASCENSION HEALTH

2014

- Joint venture to offer home care, infusion, and hospice services in five key Ascension Health markets
- ON the heels of Ascension announcing the formation of a "Senior Care" business line to coordinate post-acute services development across its locations

Source: Manatt Health Analysis

Trend #3: Mega Health Systems

Key Points for Post-Acute and Long-Term Care Providers

System formation nationally is **creating larger and larger integrated delivery systems** that are seeking **to integrate more tightly with long-term care** providers through acquisition or through strategic partnerships

Emerging health systems are looking to **create networks of high-performing, collaborative long-term care providers** in continuing care networks, forcing long-term care providers to **establish formal relationships and demonstrate value**

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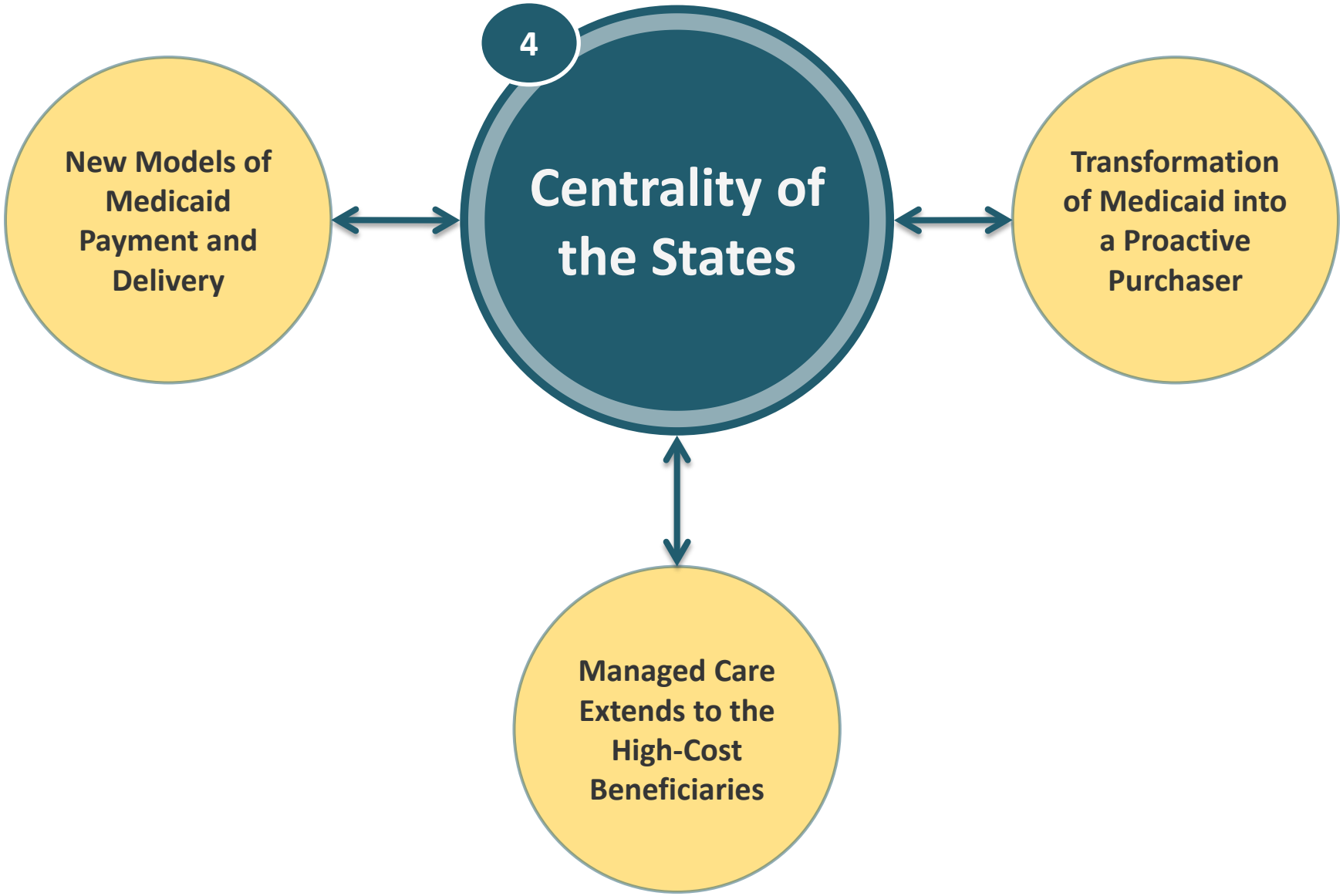


Medicaid is a Driver of Payment and Delivery System Reform

States are partnering with the Federal Government for seed funding to catalyze payment and delivery system reforms:

State Innovation Models (SIM)	Center for Medicare and Medicaid Innovation (CMMI)	1115 Waivers & Delivery System Reform Incentive Payments (DSRIP)	Coverage Expansion
CMS awarded over $300 million in SIM grants to States to support the development of multi-payer payment and delivery system transformation.	CMMI oversees $10 billion in transformation funding including $2 Billion in Health Care Innovation Awards (HCIA)	Reform funding that tie investments in provider-led delivery system reforms to improvements in quality, population health and cost containment.	Many states expanding Medicaid to ensure sustainability of delivery system and payment reforms. With expansion, Medicaid becomes single largest payer.

Many states are also seeking to advance multi-payer initiatives for long term, sustainable reform:

- Seven states testing models to align Medicaid and Commercial payers
- Nine states are participating in Dual Eligibles demonstration to align incentives for acute and long term care between Medicare and Medicaid.

Diverse Approaches to Medicaid Payment and Delivery Reform

Provider-Led Care Management

All beneficiaries will be assigned to a PCMH or a Health Home. Statewide, mandatory multi-payer episode of care bundled payment initiative

Regional provider networks partner with managed care plans to assume clinical and financial accountability for Medicaid populations

Managed Care Organization (MCOs) and ACOs

Three year provider-led Medicaid ACO demonstration program with shared savings. Geographically defined patient attribution. MCO participation voluntary

Medicaid MCOs are required to contract with and provide incentives to ACOs and PCMHs

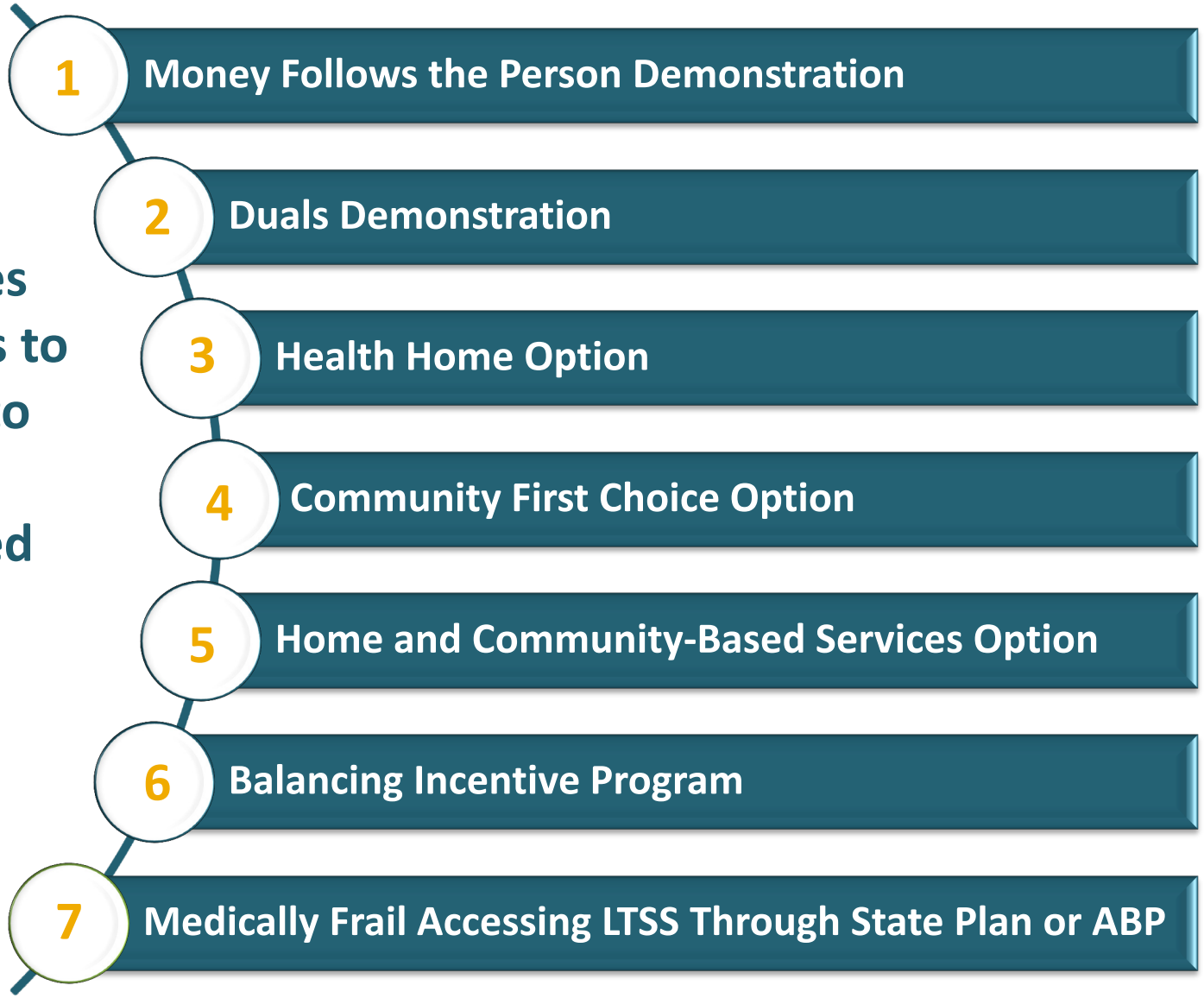
MCO Expansion

Statewide MCO expansion. Un-compensated care and delivery system reform incentive (DSRIP) funding tied to outcomes

"Managed Care for All" including ABD, dual eligible populations and long term care services and those with severe mental illness

ACA Expands Access to Community-Based LTSS

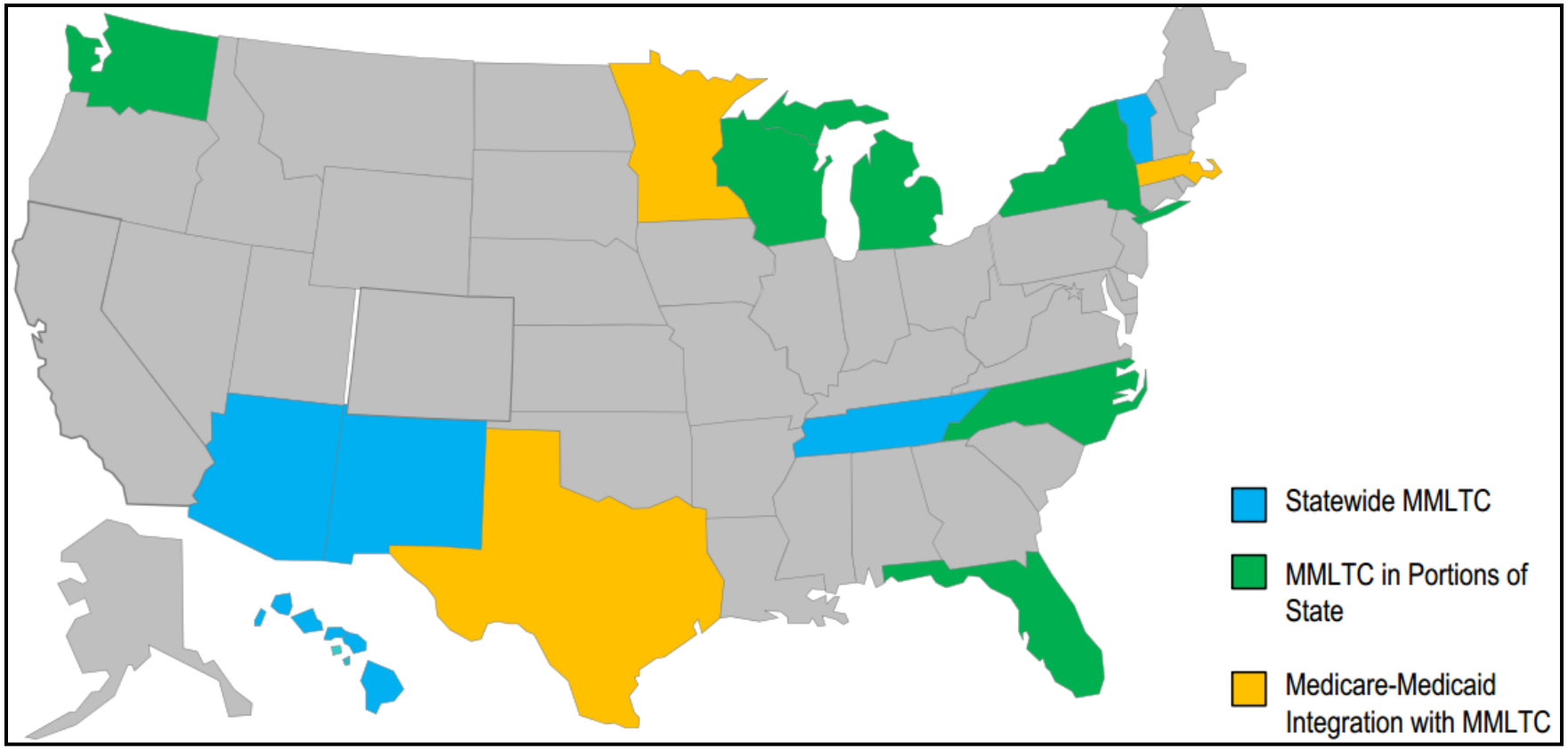
The ACA provides new opportunities to improve access to and delivery of community-based LTSS



Growth In Medicaid Managed Care Including Inclusion of Complex Long-Term Care Patients

Growth in Medicaid Managed Long-Term Care programs is expanding managed care coverage to more complex patient populations and will likely be a trend into the future

Current State of Medicaid Managed Long-Term Care Programs



Source: National Association of States United for Aging and Disabilities

Trend #4: Centrality of the States

Key Points for Post-Acute and Long-Term Care Providers

Medicaid programs are becoming **significant drivers** of **system transformation** in their states, often creating burning platforms for the **integration of long-term care** into the Medicaid benefit

Managed care will **continue to increase** in states, including managed care for long-term care services, forcing PAC/LTC providers to **demonstrate value to payers**

Emerging delivery models including **ACOs, PCMHs, and others** will increasingly impact how long-term care providers interact with Medicaid patients, encouraging them to become **part of networks** responsible for **overall cost and quality**

Conclusion

- The **increasing demand for services** is forcing providers to **better target patients** through differentiated interventions and new models of care. Providers need to focus on those with **multiple chronic conditions** and **better coordinate medical and supportive care**.

- There will be **considerable payment pressures** both in fee for service and managed care systems to **increase productivity and define and demonstrate value**. It will become necessary to be agile and adapt to different accountability and payment structures incorporating **broader clusters of services** and **increasing levels of risk**.

- The **consolidation and establishment of large systems** with horizontal and vertical integration will necessitate that **PAC and LTC providers integrate** into networks or become valued partners. These large systems find long-term care services difficult to provide and should not underestimate their importance to quality and clinical outcomes.

- **New competencies** like marketing, understanding costs, negotiating, and creating a culture and infrastructure for quality and clear accountability will be necessary.

- **Workforce capacity and technology**, both internal and external, **require extensive attention and investment** at a time when capital is scarce.

Questions?

Carol Raphael

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Education

- Harvard University, Kennedy School of Government, MPA
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About

Ms. Raphael is a nationally recognized expert in healthcare policy and in particular, post- acute, long term care and hospice and palliative care as well as care management models. She served as President and Chief Executive Officer of the Visiting Nurse Service of New York (VNSNY), the largest nonprofit home health agency in the United States from 1989 to 2011. Ms. Raphael expanded the organization's services and launched innovative models of care for complex populations with chronic illness and functional impairments.

Prior to joining VNSNY, Ms. Raphael held executive positions at Mt. Sinai Medical Center and in New York City government. In 2013, Ms. Raphael was appointed by President Obama to the Bipartisan Commission on Long Term Care. In 2012, Ms. Raphael was an Advanced Leadership Fellow at Harvard University. She is chair of the Long Term Quality Alliance and is a Board member of the New York eHealth Collaborative, a public-private partnership to advance the exchange of health information. Ms. Raphael is a member of the National Quality Forum Coordinating Committee where she chairs its Post Acute, Long Term Care and Hospice Workgroup. She served on numerous commissions including MedPAC , the New York State Hospital Review and Planning Council and several Institute of Medicine Committees.

She was a member of New York State Governor Cuomo's Medicaid Redesign Team. In 2012 and 2013, Ms. Raphael was involved in a Commonwealth Fund Project to spur the development of high-performing integrated health plans for dual eligibles.

She is Chair of the AARP Board and serves on the boards of Henry Schein, Inc., the Primary Care Development Corporation, Pace University and the Medicare Rights Center. She co-edited the book "Home Based Care for a New Century" and was a Visiting Fellow at the Kings Fund in the United Kingdom.

Stephanie Anthony

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Education

- Yale University School of Medicine, Department of Epidemiology and Public Health, M.P.H. with distinction, Health Policy and Administration, 1997
- St. John's University School of Law, J.D., 1994
- Boston College, B.A., English, 1991

About

Ms. Anthony has over 17 years of experience providing health policy and health law research, analysis and advisory services to public and private sector clients. Her areas of focus include state and national healthcare reform, Medicaid and Children's Health Insurance Program (CHIP), financing and waivers, long-term services and support, and coverage options for the uninsured.

Prior to joining Manatt, Ms. Anthony was a principal associate with the University of Massachusetts Medical School's (UMMS's) Center for Health Law and Economics. She also served as an instructor within its Department of Family Medicine and Community Health. While at UMMS, she led the team that supported Massachusetts Medicaid's design and implementation of the nation's first State Demonstration to Integrate Care for Dual Eligible Individuals.

Previously, Ms. Anthony was the Deputy Medicaid Director in the Massachusetts Executive Office of Health and Human Services, where she was in charge of relations with the federal Medicaid oversight agency. She also was integrally involved with the development and implementation of the Commonwealth's landmark healthcare reform law and oversaw CHIP and MassHealth 1115 Waiver.

Ms. Anthony also has worked as a director of federal and national policy management within the Office of Health and Human Services' Office of Medicaid; a senior policy analyst for the Economic and Social Research Institute; and a legal advisor and policy analyst for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Anthony Fiori

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Education

- Princeton University, Woodrow Wilson School of Public and International Affairs, M.P.A., 2003
- University of California, San Diego, B.A., 1998

About

Mr. Fiori has extensive expertise in Medicaid and Medicare managed care, healthcare financing and reimbursement, and health information technology. Mr. Fiori is recognized as an expert in health plan regulatory and financial issues.

Mr. Fiori has significant experience working with public health insurance programs and currently leads a coalition of non-profit Medicaid managed care plans in New York, representing ten plans before the State Health Department and other regulatory and legislative bodies on a myriad of health plan issues such as rate development, network adequacy, managed care expansion, health homes and quality measurement. He also advises the plans on the implementation of Medicaid Redesign in New York, including the expansion of Medicaid managed care to new populations and benefits.

Additionally, Mr. Fiori provides strategic counsel to key healthcare stakeholders on the implications of the Affordable Care Act and other payment reform initiatives. He recently provided an in-depth analysis of the Centers for Medicare & Medicaid Services, (CMS) Medicare Shared Savings Program and Financial Alignment Demonstration Program for the dually eligible. Mr. Fiori assists clients in navigating these complex initiatives and advises on the potential opportunities these programs bring to the healthcare marketplace.

Prior to joining Manatt, Mr. Fiori worked for the New York City Economic Development Corporation, served as a consultant to the Henry J. Kaiser Family Foundation, and was a policy advisor for the San Diego Regional Chamber of Commerce, where he led a campaign to educate community and business leaders on the importance of a comprehensive and affordable healthcare network.

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