



**Department  
of Health**

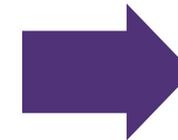
Medicaid  
Redesign Team

# **Advocacy and Engagement Subcommittee Meeting #4**

December 4, 2015

# Meeting Schedule, Logistics and Focus

Meeting #	Confirmed Date	Time	Location
Meeting 1	8/13/2015	10:30-2:00pm	SPH Auditorium
Meeting 2	9/10/2015	10:30-2:00pm	SPH 110A
Meeting 3	10/9/2015	10:30-2:00pm	HANYS
Meeting 4	12/4/2015	11:00-2:30pm	HANYS



## Meeting Focus

- Intro to VBP
  - Design effective culturally competent member incentives
  - Suggest guiding principles and requirements for future incentives
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- Discuss patient-reported outcomes
  - Determine Medicaid members right to know
  - Recommend best practice communication methods to Medicaid members

# Agenda

1. Review Incentive Recommendations Revisions
2. Review PRO Recommendations
3. Member Right to Know Recommendations:
  - What to Communicate
  - How and When to Communicate
4. Final Step



# 1. Incentive Recommendations Revisions

# Standard versus Guideline

Per option, the Subcommittee should recommend whether the State should set a **Statewide Standard** or a **Guideline** for the methodologies employed between MCOs and the providers. The State will consistently employ a standard in its own approaches regarding methodologies and data dissemination to both MCOs and providers. The Subcommittee should recommend whether MCOs and providers should adopt the same standard or are free to vary, using the State's methods more as a guideline.

- A **Standard** is required when it is crucial to the success of the NYS Medicaid Payment Reform Roadmap that all MCOs and Providers follow the same method.
- A **Guideline** is sufficient when it is useful for Providers and MCOs to have a starting point for the discussion, but MCOs and Providers may deviate without that harming the overall success of the Payment Reform Roadmap.

# Final Incentive Recommendations

The subcommittee revised four of the seven recommendations during the last meeting. The revised recommendations are highlighted in grey below and further outlined on the following slides:

No.	Recommendations	Revisions
1	Developing a Member Incentive Program	Yes
2	Guiding Principles for Member Incentive Programs	Yes
3	Creation of an Expert Group for Achieving Cultural Competence in Incentive Programs	Yes
4	Elimination of the \$125 Incentive Cap for Preventive Care	No
5	Implementation of Pilot Incentive Programs	No
6	Incentive Program Outcome Measurement	Yes
7	Development of a Library of Knowledge on Incentive Programs	No

# Recommendation 1: Developing a Patient Incentive Program

(Guideline for VBP level 1-2; Standard for VBP level 3)

**Recommendation:** The Subcommittee recommends all MCO and providers offer member incentives in the VBP environment.

**Comment from SC:** If a provider feels an incentive program is not appropriate they should have the option to apply for a waiver or “opt-out” of the program from the DOH.

**Revision made to description (in bold):**

**Providers will have the flexibility to experiment/test various incentive programs across different member populations and have the ability to request a waiver, from the Department of Health, to opt out of the incentive program if the program does not meet the expected outcomes.**

## Recommendation 2: Guiding Principles for Member Incentives

*(Guideline)*

**Recommendation:** The Subcommittee recommends that programs take into account a set of guiding principles in their design and implementation. The following guiding principles should be the building blocks of all member incentives: Culturally sensitive, Unbiased, Possess equity, Does not promote negative behavior, Provide reward in a reasonable timeframe from when it is earned, Communicate in a timely manner, Be relevant, Measurable.

### Comment from SC:

- Add a guiding principle to reflect members receiving information about incentive programs from providers
- Revise the title of two of the guiding principles
- Add language to the description of guiding principle (now revised to read): “communicate appropriately in a timely manner”

### Revisions made to (in bold):

*Guiding principles:*

- **Provide information about the program – Providers will provide detailed information to members concerning any incentive program they implement**
- Provide reward **as promised in a timely manner** from when it is earned
- Communicate **appropriately** in a timely manner

*Description of a guiding principle:*

Incorporate the most appropriate and farthest-reaching vehicle to communicate the incentive so as not to exclude members (e.g. lack of literacy and technology should be considered). **Appropriate messaging should capture high quality outcomes.**

## Recommendation 3: Creation of an Expert Group for Incentive Programs *(Guideline)*

**Recommendation:** The Subcommittee recommends that the State should convene a group of experts to create more detailed guidance (e.g. a “checklist”) for the development of incentive programs which follow the guiding principles in Recommendation #2.

### Comment from SC:

- Revise the title of the recommendation and recommendation to focus on cultural competency
- Add language to the description that the expert group will also include consumers

### Revisions made to (in bold):

*Title:* Creation of an Expert Group **for Achieving Cultural Competency in Incentive Programs**

*Recommendation:* The Subcommittee recommends that the State should convene a group of experts **and consumers** to create more detailed guidance (e.g. a “checklist”) for the development **of culturally competent incentive programs. The detailed guidance should track the guiding principles in Recommendation #2 with a particular focus on creating more specific suggestions for achieving cultural competency in program design.**

*Description:* Programs that support the member’s role in promoting positive health outcomes should be evidence-based and focus on increasing access to strategies for prevention and treatment of disease. In addition, programs need to incorporate respect for autonomy; consideration of variables influencing comprehension and learning; and understanding of cultural, religious and socioeconomic factors **(e.g. race, ethnicity, language, urban/rural, LGBT)**. The committee further states that incentives to promote behavior change should be designed to allocate health care resources fairly without discriminating against a class or category of people **and recommends consumers be involved in the expert group that the State convenes.**

## Recommendation 6: Incentive Program Outcome Measurement

*(Guideline)*

**Recommendation:** The Subcommittee recommends that the State should provide or contract a third party to evaluate outcomes of all incentive programs implemented for Medicaid.

### **Comment from SC:**

- The short description of the recommendation should not state “**all**” incentives
- Add language in the long description to include provider flexibility in reporting outcomes, and guidelines for the State’s analysis of data

### **Revisions made to (in bold):**

*Title:* The Subcommittee recommends that the State should provide or contract a third party to evaluate outcomes of incentive programs implemented for Medicaid

*Description:* Any well-thought out incentive program requires a close, unbiased attention to details, evaluation and measurement to ensure a program is a success for improving health outcomes. **Given the potential variations of incentive programs and the large number of members in a program, providers could be given some flexibility to identify a subset of relative outcomes to report on. When a third party is contracted to evaluate outcomes, the activities that include a behavioral health component will be overseen by a cross-agency group (e.g. representatives from OMH, OASAS and other NYS agencies).** The State should analyze the data **minimally on an annual basis** and identify best practices. The reports from the evaluation should be compiled and included in a public library of knowledge (see Recommendation #7).

## 2. Patient Reported Outcomes (PROs) Recommendations



# PRO Draft Recommendation 1: Providers Should Utilize PRO Measures in Their Practice (*Guideline*)

## Recommendation

Providers are encouraged to utilize PRO measures in order to assess members' well-being, feeling and functioning over time, engage patients in developing their treatment plans, and facilitate shared decision-making between patients and providers. Providers should have the flexibility to choose the mechanism they deem most appropriate for utilizing PRO measures, including introducing selected PRO measures in a brief independent survey or incorporating relevant PRO measure questions into existing assessment tools. Consideration should be given to gathering PRO measures during member visits. This will help providers understand how members are progressing, address any concerns real-time, and track their progress over time.

## Description

Incorporating the member's voice and perspective through PRO measures is a crucial element for clinical care, quality performance management and clinical research. PRO measures are by definition reports that come directly from a member regarding his or her health condition and treatment. Measures can be drawn from symptoms as well as functional status and health-related quality of life, allowing providers to gain a better understanding of less tangible symptoms, such as emotional health and/or fatigue. Some PRO measures are generic and appropriate for use in a wide range of conditions, while others focus on the specific symptoms and side effects of a given disease, condition or treatment.\*

\* Advances in the Use of Patient Reported Outcome Measures in Electronic Health Records

## PRO Draft Recommendation 2: Providers Should Incentivize Members to Complete PRO Measure Questionnaires (*Guideline*)

### Recommendation

PRO measures help to facilitate communications around quality of life issues and allows the member to feel supported and included in their care. Providers must receive responses from members in order for care to be improved. To increase survey rates, providers should consider incentivizing members to complete questionnaires.

### Description

It can be difficult to predict the level of survey participation, as response rates vary widely and a number of factors can impact the return rate. Studies show that offering respondents an incentive can greatly increase response rate.\* Providers choosing to utilize a separate questionnaire for PRO measures as opposed to incorporating them as part of their clinical assessment tool should consider giving incentives to members to encourage participation and completion of the questionnaire. All members who complete the questionnaire, regardless of where (e.g. home or in the provider's office) should be eligible for the incentive.

\*The Use and Effects of Incentives in Surveys, Survey Research Center, University of Michigan  
Please refer to the Advocacy and Engagement Subcommittee Draft Recommendations

# PRO Draft Recommendation 3: Implementation of Pilot PROs Program *(Guideline)*

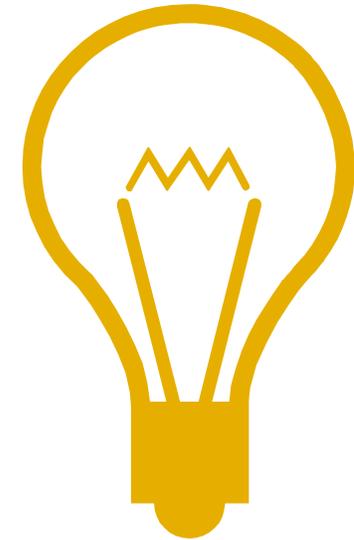
## Recommendation

The Subcommittee recommends that the VBP Pilot Programs, currently in development for early adopters, be considered as a vehicle for piloting the use of PRO measures in an assessment tool.

## Description

Early adopters of VBP will be piloting specific episodic and chronic care bundle(s) and may also consider piloting the use of PRO measures in their assessment tools to improve health outcomes. However, the design and implementation of PROs do not necessarily need to be limited to the bundle(s) chosen by the pilot or even to those participating in pilot programs altogether. In fact, all providers are encouraged to look for opportunities to incorporate PRO measures into their clinical practice, regardless of where they are in their path to VBP. By increasing patient engagement, PRO measures will be an effective tool for improving members' health outcomes and for provider self-improvement.

# 3. Medicaid Members' Right to Know



# New York State Department of Health VBP Video

[https://www.youtube.com/watch?v=94X7og\\_56XM&feature=youtu.be](https://www.youtube.com/watch?v=94X7og_56XM&feature=youtu.be)

## From the Roadmap:

**“Consumer rights to know the incentives that affect their care must be considered when developing strategies around what and when information related to VBP and DSRIP more broadly, will be communicated to members.”**

Do members need to know about VBP? If so, what do they need to know?

What is the best mechanism for communicating with members?

When should this information be communicated?



**Subcommittee Meeting #3 Consensus:** Yes, members should have a right to know about VBP. What members need to know is outlined on the following slides.

# Medicaid Member's Right To Know: Areas of Focus

The Subcommittee agreed that Medicaid members should be informed about the following four key areas:

## Patient-centered care

- Create a message that conveys the culture shift from volume to value and the new emphasis on patient-centered care
- Describe the plan for coordinating care and addressing patients' needs holistically through partnerships with community-based organizations

## Provider Decision-making

- Deliver information explaining that providers will share in both savings and costs
- Costs of treatment options should be transparent
- Members should be informed of their rights, including the rights to change providers, obtain second opinions, and obtain navigational assistance

## Clinical & Quality Data-sharing

- Explain the value for patients when providers share patients' health related information, and the need for patient consent
- Provide patients with access to provider performance on quality metrics relevant to patients' treatment plans

## Plan denials

- Inform members that they are not responsible for paying for services/ treatments when plans deny payment
- Inform members of their right to obtain advocacy assistance for service and/or coverage denials
- Explain state utilization monitoring and how to access this data

# Medicaid Member's Right To Know: Areas of Focus

In an effort to leverage Medicare ACO practices on what is communicated to members, research was conducted, as well as comments received from HCFANY, and the following themes emerged:

## Ensuring transparency and patient protection:

- Require a member to be informed of their rights and whether their provider is part of an ACO
- Create a description of the population to be served by the ACO
- Ensure notifications are standard and free from misleading information
- Initiate public reporting of how savings are shared
- Explain how the ACO will maintain patient autonomy and that there is no need to maintain prior authorization
- Prohibit ACOs from encouraging sick or high cost patients to seek care elsewhere
- Explanation of how the ACO will be patient-centered, including plans for partnering with community stakeholders, addressing the needs of the community, and their process for coordinating care

## Ensuring quality of care in ACOs:

- Require ACOs to maintain and report quality and safety standards
- Create notices in an appropriate reading level and multiple languages

**Is there anything the SC should incorporate into the Medicaid member right to know recommendations?**

# Medicaid Member's Right to Know Draft Recommendation:

## 1. Medicaid Members Have a Right to Know about VBP (*Guideline*)

### Recommendation

The State should effectively communicate information concerning VBP to Medicaid members and include how it impacts their care, their rights, and the providers they see.

### Description

The State should ensure that information concerning VBP is communicated effectively to Medicaid members. Communication about VBP should cover the impact on patient-centered care, payment structure changes influencing provider decision-making, data-sharing, and claim denials.

**The following slide lists the suggested information members should be aware of:**

# Medicaid Member's Right to Know Draft Recommendation:

## 1. Medicaid Members Have a Right to Know about VBP (*Guideline*)

### Description, cont'd

The following is a list we began at the last meeting regarding information members should be aware of:

- a. The current rights and protections in place for members will not change with the transition to VBP but an updated version of the NYS Patient Bill of Rights should be developed to reflect new players and areas of focus
- b. The difference between a Fee for Service payment model versus VBP and Pay for Performance models. This may include the benefits of rewarding value over volume, improving outcomes, and decreasing unnecessary services/tests, as well as potential risks when providers share in exposure for costs for more expensive treatments
- c. The plan for how providers will create a holistic approach to care. Providers will collaborate with Community Based Organizations and address Social Determinants of Health to best serve the member by effectively coordinating care with specialty providers and others in their care team
- d. The way in which providers will be rewarded when members' health outcomes improve
- e. The member always has the right to seek a second opinion. This includes the right of the member to seek assistance if they feel they are not receiving correct or sufficient tests and/or services, as well as information on how to seek a second opinion
- f. Information about claim denials and not being held responsible for tests and/or services denied payment
- g. Information around various incentive programs offered by their provider that will assist with improving overall health outcomes
- h. The benefits of data sharing while recognizing the member's right to confidentiality of their personal health information

## From the Roadmap:

***“Consumer rights to know the incentives that affect their care must be considered when developing strategies around what and when information related to VBP and DSRIP more broadly, will be communicated to members.”***



# What is the best mechanism for communicating with members and when should it be communicated?

What to Communicate	“How”	“When”
Patient-centered care		
Provider Decision-making		
Clinical & Quality Data-sharing		
Denials		

## Possible Methods “How”

- Websites
- MCO Handbook
- Mailed letters
- Videos
- Call Centers
- Patient Bill of Rights\*
- Other

## Possible Timing for “When”

- Prior to enrollment
- Upon enrollment
- Yearly
- When VBP changes occur within a members’ network
- When a member requests information
- Other

**Discussion:** Which of these methods, and others, should the Subcommittee recommend? Which are considered a “must have” versus “nice to have”?

\*A patient bill of rights currently lists patients rights (e.g. receive care in a safe environment) and patient responsibilities (e.g. provide complete and accurate information about yourself).

# 4. Final Step



## Final Step

The five Subcommittee's final recommendations will be consolidated into a Recommendations Report that will be submitted to the VBP Workgroup and incorporated in the roadmap.

**Thank you for all of your help and support!**

# Subcommittee Co-chairs

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