NEW YORK STATE | Department of Health | Medicaid Redesign Team

VBP Introduction

Brief background and context

July 1, 2015

NYS Medicaid in 2010: The Crisis

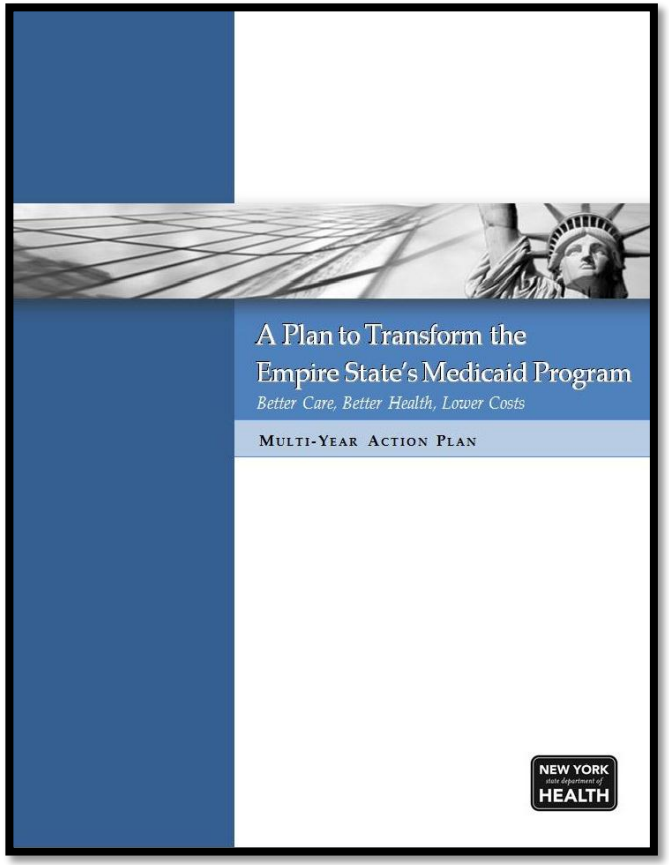
- > 10% growth rate had become unsustainable, while quality outcomes were lagging
  - Costs per recipient were double the national average
  - NY ranked 50th in country for avoidable hospital use
  - 21st for overall Health System Quality

2009 Commonwealth State Scorecard on Health System Performance

CARE MEASURE	*NATIONAL RANKING*
Avoidable Hospital Use and Cost	**50th**
✓ Percent home health patients with a hospital admission	49th
✓ Percent nursing home residents with a hospital admission	34th
✓ Hospital admissions for pediatric asthma	35th
✓ Medicare ambulatory sensitive condition admissions	40th
✓ Medicare hospital length of stay	50th

Creation of Medicaid Redesign Team – A Major Step Forward

- In 2011, Governor Cuomo created the *Medicaid Redesign Team (MRT)*.
  - Made up of 27 stakeholders representing every sector of healthcare delivery system
  - Developed a series of recommendations to lower immediate spending and propose reforms
  - Closely tied to implementation of ACA in NYS
  - The MRT developed a multi-year action plan. We are still implementing that plan today



The 2014 MRT Waiver Amendment Continues to further New York State's Goals

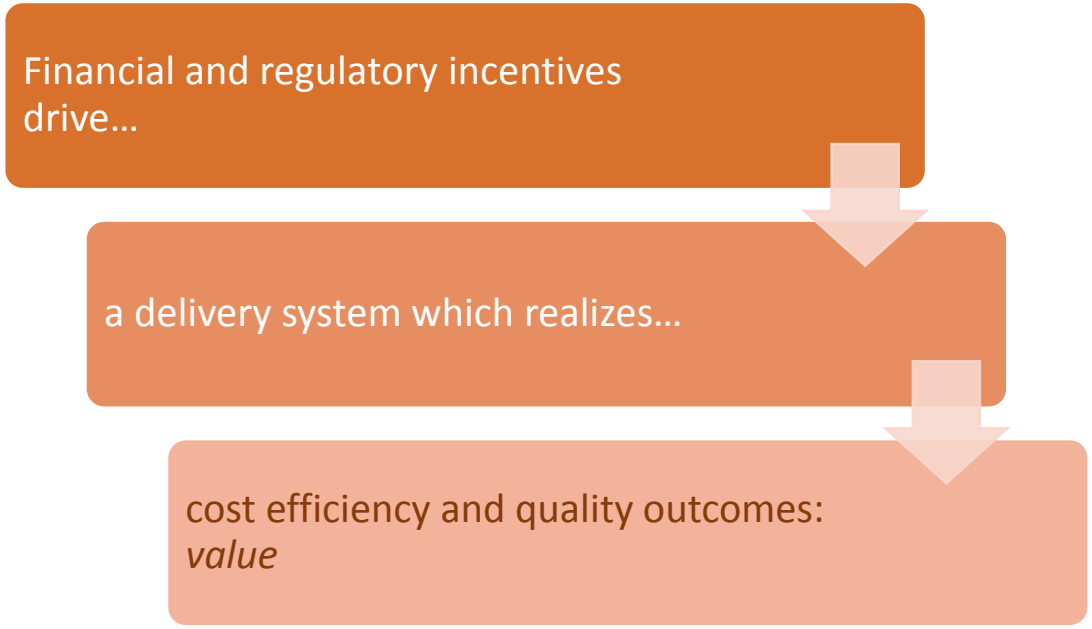
- Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York's health care delivery system
- In April 2014, New York State and CMS finalized agreement Waiver Amendment
  - Allows the State to reinvest $8 billion of $17.1 billion in Federal savings generated by MRT reforms
  - $6.4 billion is designated for **Delivery System Reform Incentive Payment Program** (DSRIP)
- The waiver will:
  - Transform the State's Health Care System
  - Bend the Medicaid Cost Curve
  - Assure Access to Quality Care for all Medicaid Members
  - Create a financial sustainable Safety Net infrastructure

Delivery Reform and Payment Reform: Two Sides of the Same Coin

- A thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well

- Many of NYS system's problems (fragmentation, high re-admission rates) are rooted in how the State pays for services

  - FFS pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
  - Current payment systems do not adequately incentivize prevention, coordination, or integration

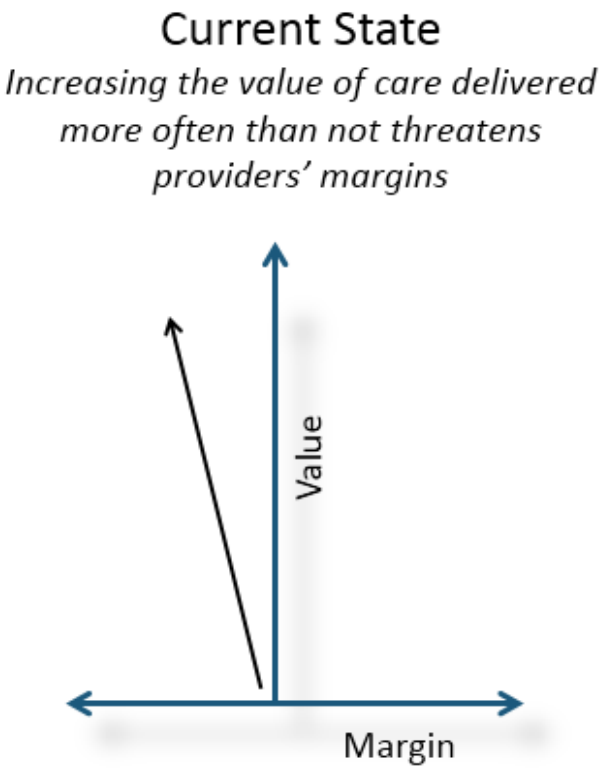


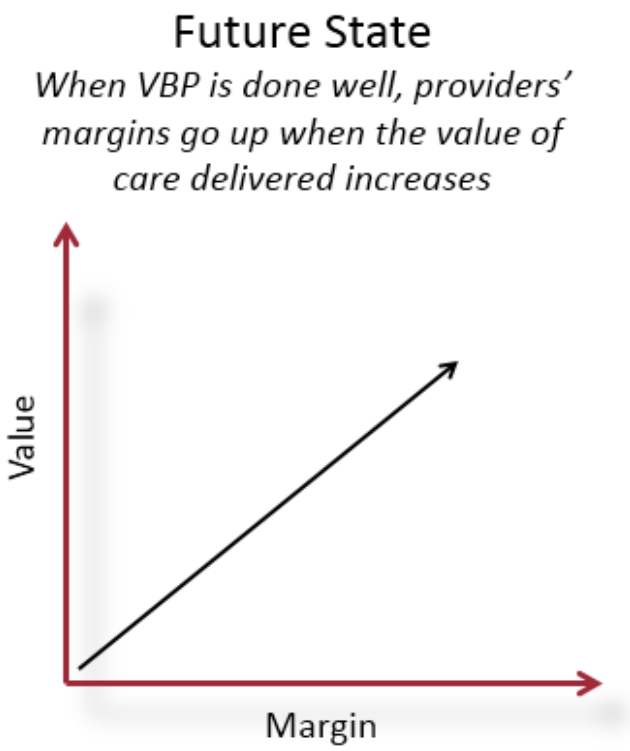
Payment Reform: Moving Towards Value Based Payments

- A Five-Year Roadmap outlining NYS' plan for Medicaid Payment Reform was required by the MRT Waiver
- By DSRIP Year 5 (2019), all Managed Care Organizations must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the *Special Terms and Conditions* of the waiver)
- The State and CMS have thus committed itself to the Roadmap
- Core Stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap
- If Roadmap goals are *not* met, overall DSRIP dollars from CMS to NYS will be significantly reduced

Learning from Earlier Attempts: VBP as the Path to a Stronger System

VBP arrangements are not intended primarily to save money for the State, but to *allow providers to increase their margins* ***by realizing value***





Goal – Pay for Value not Volume

The VBP Roadmap starts from DSRIP Vision on How an Integrated Delivery System should Function

Integrated Physical & Behavioral Primary Care

Includes social services interventions and community-based prevention activities

Episodic

- Maternity Care (including first month of baby)
- Acute Stroke (incl. post-acute phase)
- Depression
- …

Continuous

- Chronic care (Diabetes, CHF, Hypertension, Asthma, Depression, Bipolar …)
- Chronic Kidney Disease
- …
- AIDS/HIV
- Multimorbid disabled / frail elderly (MLTC/FIDA population)
- Severe BH/SUD conditions (HARP population)
- Developmentally Disabled population

Population Health focus on overall Outcomes and *total* Costs of Care

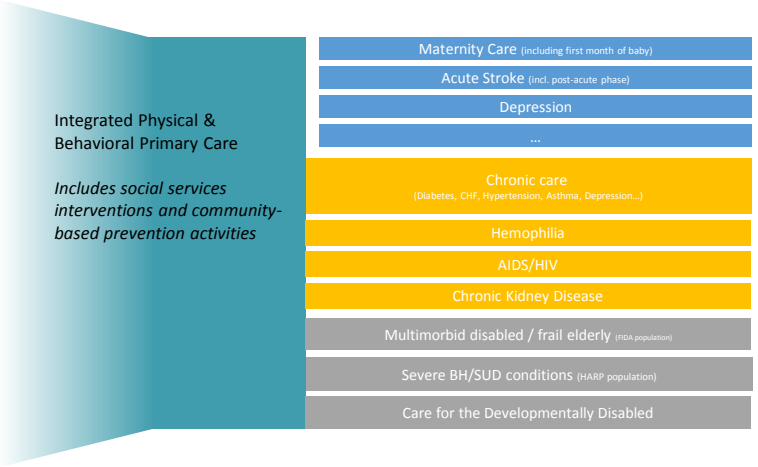
Sub-population focus on Outcomes and Costs *within* sub-population/episode

The Path towards Payment Reform: A Menu of Options

There is not one path towards Value Based Payments. Rather, there will be a variety of options that MCOs and PPSs/providers can jointly choose from.

PPSs and MCOs can opt for different shared savings/risk arrangements (often building on already existing MCO/provider initiatives):

- For the total care for the total attributed population of the PPS (or part thereof) – ACO model
- Per integrated service for specific condition (acute or chronic bundle): maternity care; diabetes care
- For integrated Advanced Primary Care (APC)
- For the total care for a subpopulation: HIV/AIDS care; care for patients with severe behavioral health needs and comorbidities



MCOs and PPSs may choose to make shared savings arrangements for the latter types of services between MCOs and groups of providers within the PPS rather than between MCO and PPS

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MCOs and PPSs can choose different levels of Value Based Payments

In addition to choosing *what integrated services* to focus on, the MCOs and PPSs can choose different levels of Value Based Payments:

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

- Goal of ≥80-90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- Aim of 25% of total costs captured in VBPs in Level 2 VBPs or higher

Key Defining Factors our the New York VBP Approach

1. Addressing all of the Medicaid program in a holistic, all-encompassing approach rather than a pilot or piecemeal plan
2. Leveraging the Managed Care Organizations (MCO) to deliver the payment reforms
3. Addressing the need to change provider business models through positive financial incentives
4. Allowing for maximum flexibility in the implementation for stakeholders while maintaining a robust, standardized framework
5. Maximum focus on transparency of costs and outcomes of care

Outcome and cost information (fully aligned with DSRIP) to be provided to Providers / MCOs for all types of care services discussed

Integrated Physical & Behavioral Primary Care

For the healthy, patients with mild conditions; for patients requiring coordination between more specialized care services

Total Cost for APC Services (PMPM)

Outcomes (PPVs, PPRs, PQIs, PDIs, *Total Downstream Cost*)

Maternity care (incl. first 30 days of neonatal care)

Depression – 6 months episode

…

Total Episode Cost

Outcomes (Potentially Avoidable Complications (PACs), healthy baby & healthy mom)

Chronic care

Drill down

Diabetes

Asthma

Hypertension

CHF

COPD

Total Cost for Bundle for 1 yr of care

Including potentially shared savings

Outcomes (PACs, Diabetes-specific PQIs, HbA1c/LDL-c values)

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Flexible, Yet Robust Approach

- State involvement focuses on standardization of VBP principles across payers & providers to reduce administrative complexity:
  - Standardizing definitions of bundles and subpopulations, including outcomes
  - Guidelines for shared savings/risk percentages and stop-loss
  - No rate setting, but providing benchmark data (including possible shared savings)

- Allowing flexibility:
  - Menu of options
  - MCO and providers can make own adaptations, as long as criteria for ‘Level 1’ or higher are met

- No haircut when entering VBP arrangements. To the contrary, the more dollars are captured in higher level VBP arrangements, the higher the PMPM value MCOs will receive from the State

VBP Transformation Overall Goals

Goal of VBP reform within the NYS Medicaid system:

To improve population and individual health outcomes by creating a system of sustainable delivery of integrated through care coordination and rewarding of high value care delivery.

By end of 5-year DSRIP plan, the State aims to have…

1. 80-90% of total MCO-PPS/provider payments (in terms of total dollars) as value based payments.

2. 25% of total managed care payments tied to VBP arrangements at Level 2 or higher in order to optimize the incentives and allow providers to maximize their shared savings.

VBP Subcommittees

How are the SCs relevant to VBP?

- VBP **subcommittees will play a crucial role** in terms of figuring out the VBP implementation details
- Each subcommittee will be comprised of stakeholders who have direct interest in, or knowledge of, the specific topics related to each respective subcommittee
- Each subcommittee will have co-chairs designated from the VBP Work Group. They will manage the SC work towards the development of a final Subcommittee Recommendation Report

Technical Design Tentative Agenda

Workgroup I (Financial/Methodological)
1
1. What methodology should be adopted for benchmarking? (P. 20 of the Roadmap) 2. What methodology should be utilized for the patient attribution as it relates to IPC, TCTP, chronic bundles and subpopulations? (P. 21)
2
1. When considering shared savings, what should the risk percentages be? Also, how should shared savings be split? (P.14 and 10) 2. In Level 2, what should be the practical approach to retrieving overpayment by plan to provider?
3
1. How should the Stop Loss mechanism be designed? (P. 18) 2. What should be the approach and risk adjustment methodology to establishing the 'remainder' of TCC when bundles/IPC is subcontracted? (P. 11, 20) 3. Incentivizing the MCOs to contract VBP arrangements and High Value providers (P. 33)
4
1. Should the lowest number of beneficiaries be established to contract for VBP? (P. 23) 2. How should the risk reserve pool work and how should it be funded and accessed?

Key Questions for all Topics

- Should the State set a *Standard* (or should an issue be left to MCOs and providers)?
  - If yes, the topic merits scrutiny and detailed discussion
  - If no, is it useful to have a *Guideline* to aid in the negotiations between MCOs and providers?
    - If yes, the topic merits adequate discussion
    - If no, the topic does not require additional discussion

- If a topic has relevance for how the State will provide cost and outcome information (including potentially shared savings) to MCOs and providers, a *Guideline* will be required to inform the way this data is calculated and reported

Technical Design Meeting Schedule

Meeting	Date	Time	Location
Meeting 1	7/01/15	2:00 pm	Albany
Meeting 2	7/23/15	2:00 pm	Albany
Meeting 3	8/17/15	11:00 am	Albany
Meeting 4	TBD		
Meeting 5	TBD		
Meeting 6	TBD		

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