NEW YORK STATE | Department of Health | Medicaid Redesign Team

Advocacy and Engagement

August 13th, 2015

Agenda

1) Team Introductions
2) Roles and Responsibilities
3) Introduction to Value Based Payments
4) Incentives Discussion

Team Introductions

Team Introductions

Co-chairs

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Now let us have our team members introduce themselves!

Roles and Responsibilities

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

We Differ from Other Subcommittees

- Some VBP subcommittees, such as Technical Design & Regulatory Impact, have specific, defined directives around implementation details that need to be addressed
- Our subcommittee is given less detail in the Roadmap, so we have a more flexible charge to raise the issues most important to Advocacy and Engagement
- Explicit recognition of the rights and role of the individual enrollee will be critical throughout the VBP development and implementation process. In addition, our subcommittee will make recommendations to design the appropriate patient incentives for VBP
- We will make decisions to determine the path we take

Meeting Focus

Meeting 1 and 2

- Intro to VBP
- Design effective culturally competent patient incentives
- Suggest guiding principles and requirements for future incentives

Meeting 3 and 4

- Determine Medicaid members' right to know
- Recommend best practice communication methods to Medicaid members

Meeting Schedule and Logistics

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	SPH 110A
Meeting 4	11/5/2015	10:30-2:00pm	SPH 110A

Introductions to Value Based Payments

NYS Medicaid in 2010: the crisis

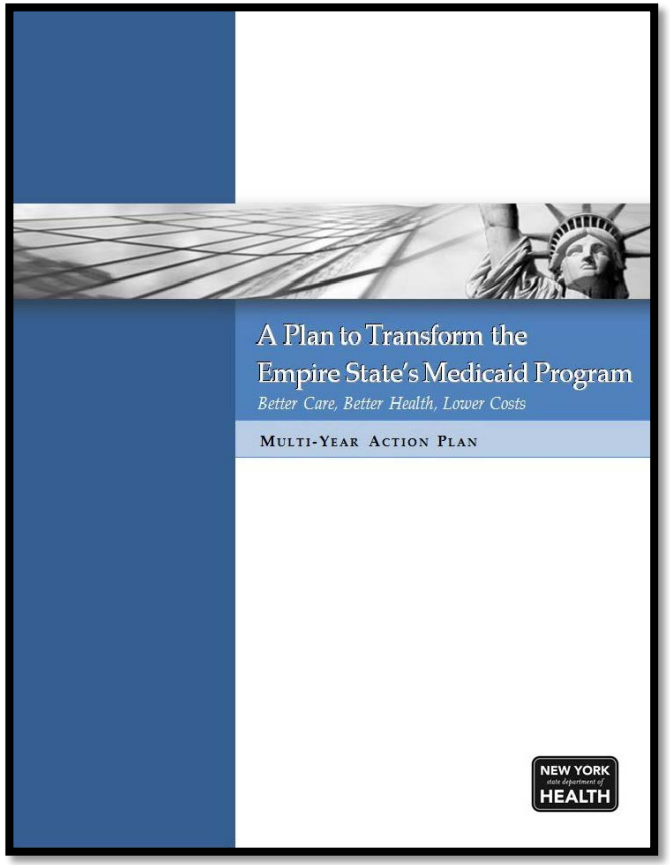
- Above 10% growth rate had become unsustainable, while quality outcomes were lagging
- Costs per recipient were double the national average
- NY ranked 50th in country for avoidable hospital use
- 21st for overall Health System Quality

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 Affordable Care Act (ACA) in NYS
  - The MRT developed a multi-year action plan. We are still implementing that plan today



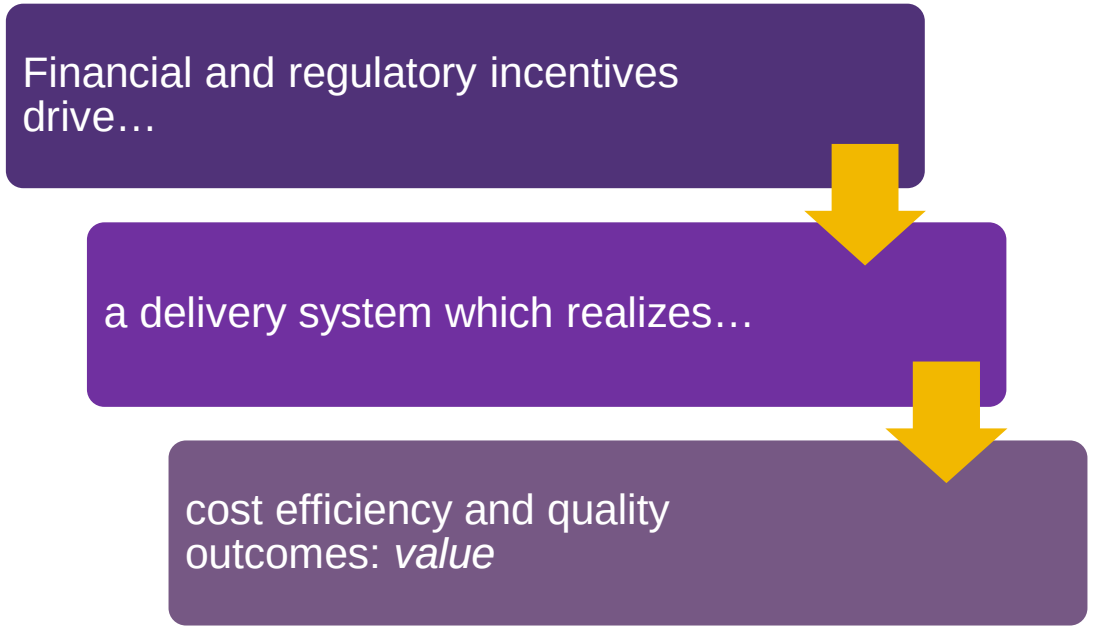
The 2014 MRT Waiver Amendment Continues to further New York State's Goals

- 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
  - Fee For Service (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

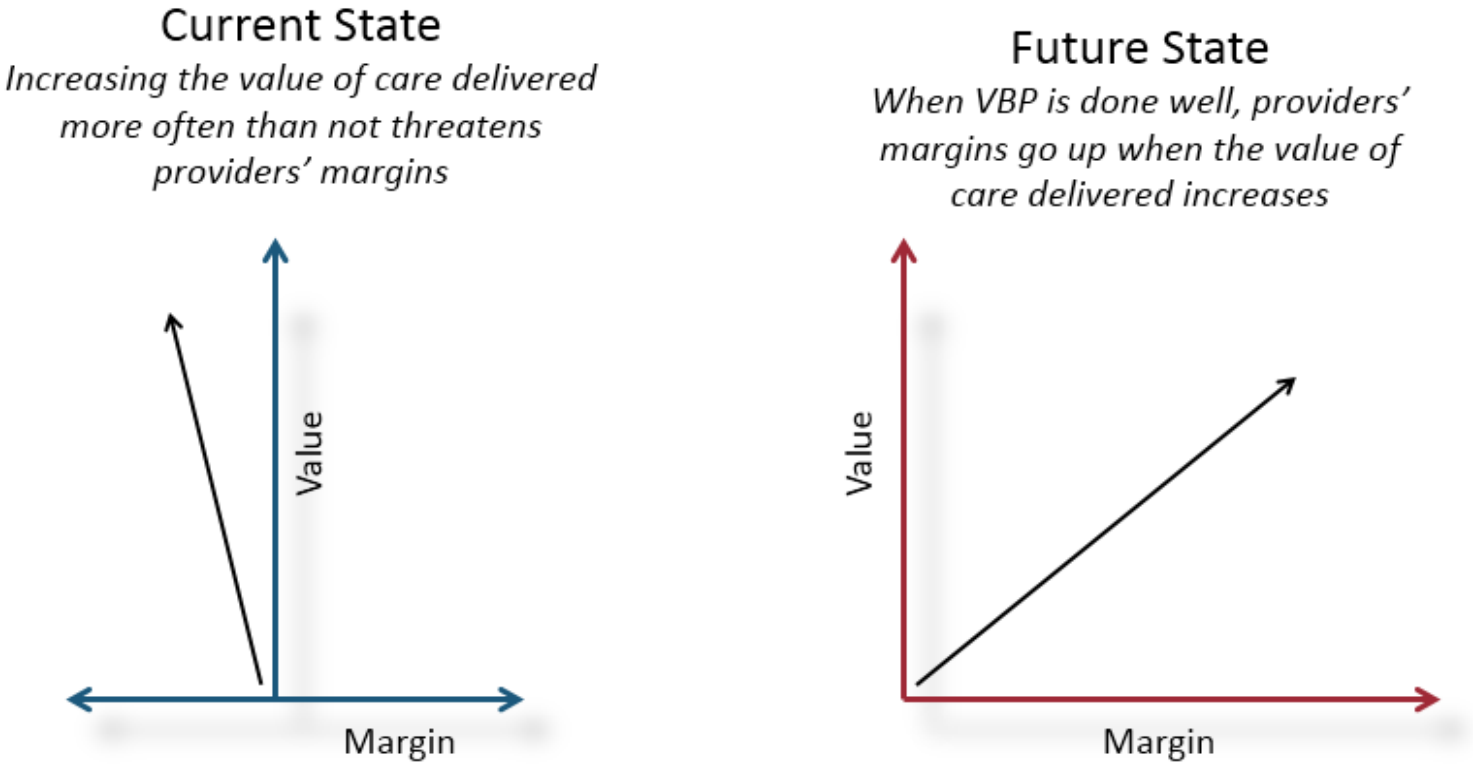


Payment Reform: Moving Towards Value Based Payments

- 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 Center for Medicare and Medicaid Services (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

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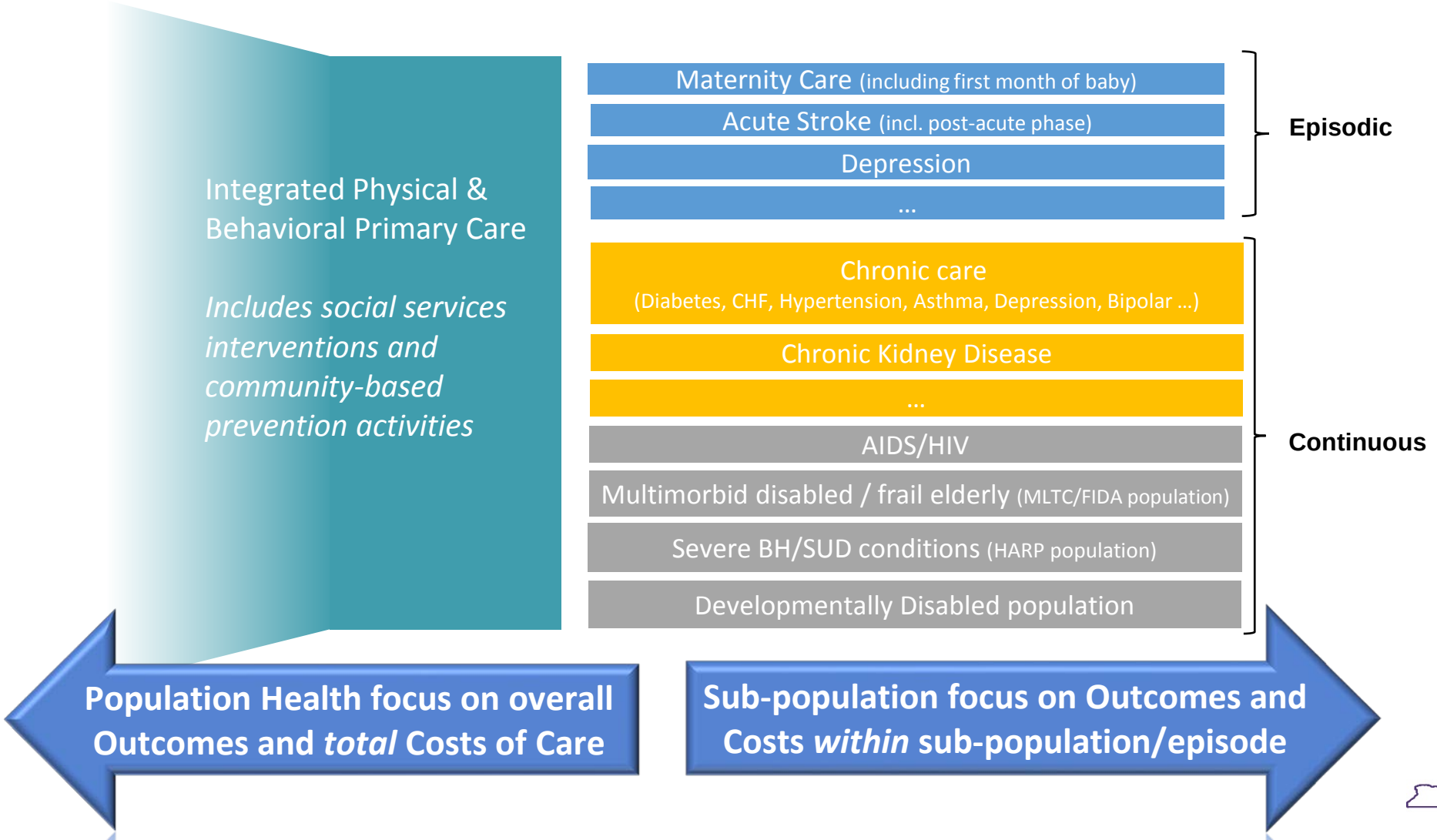
DSRIP Vision on How an Integrated Delivery System should Function

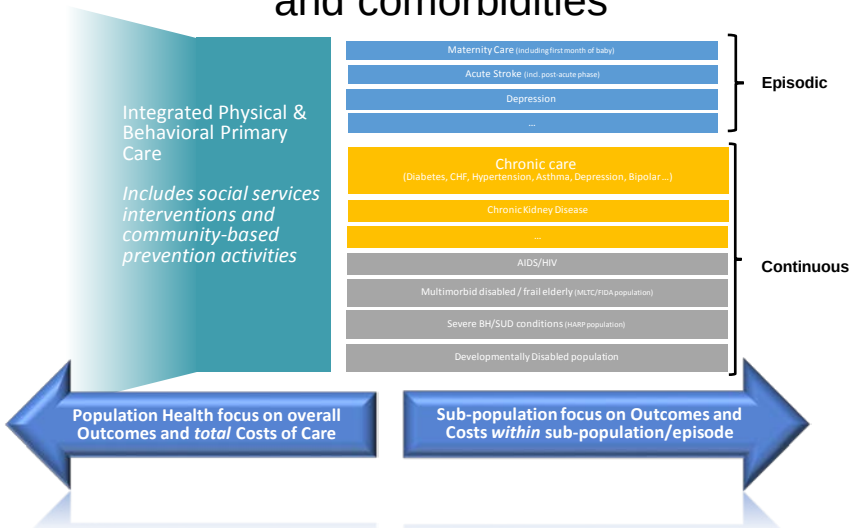


The Path towards Payment Reform: A Menu of Options

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) – Accountable Care Organization (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

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) ≥ 35% 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

Incentives

What are we Trying to Incentivize?

Patient Activation	Proper System Utilization	Preventive Care	Healthy Lifestyles	Disease Management	Other
• Enrollment • Finding PCP/ Specialist	• Decreasing unnecessary ED visits • Decreasing unnecessary hospitalization	• PCP wellness visits • Vaccinations • Regular behavioral health appointments • Prenatal care	• Smoking cessation • Weight management • Healthy eating • Exercise	• Utilizing intervention groups • Blood glucose monitoring • Medication compliance and adherence	…

Incentive Program Guiding Principles

Lessons Learned

Incentive Program Types
Monetary incentives in the form of debit cards
Lottery based monetary incentives
Transportation tokens
Coupons for food, diapers, toiletries, etc.
Backpacks with essential living gear for the homeless

The American College of Physicians suggest programs should be evidence based and promote positive health outcomes by increasing access for prevention and treatment of diseases. Incentives to promote behavior change should be designed to allocate health care resources fairly without discriminating against a class or category of people.

Over the last 10-15 years there has been an increased interest, in both the private and public sector, to offer incentive programs to promote healthier lifestyles and behaviors. Several studies have shown that financial incentives are effective for simple preventive care, such as well-child visits, immunizations or regular checkups, but there is still insufficient evidence to say if incentives are effective for promoting long-term behavior or lifestyle changes such as smoking cessation or weight management

Current and Past Incentive Programs

Program	Description	Who / What / Where	Status
Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD)	ACA mandated evidence-based prevention programs for chronic disease Medicaid enrollees who will receive incentives to encourage behavior change	10 states participating: CA, CT, HI, MN, MT, NV, NH, NY, TX, WS	Initiated Sept. 2011 and will be re-evaluated if program will extend beyond Jan. 2016
MIPCD in New York State	Program includes smoking, hypertension, diabetes management and diabetes onset prevention	Maximum incentive amount, in form of debit cards is $250 for participants in intervention group and $50 for control group participants	As Above

Current and Past Incentive Programs

Program	Description	Who / What / Where	Status
Wisconsin Individual Incentive Initiative	2 year grant to test whether offering financial incentives would encourage participants to adopt healthier behaviors	Required to address 1 of 4 key domains: Well-child visits, prenatal and post-partum care, childhood obesity or smoking cessation	April 2008 – September 2010. Found it not possible to assess impact on long-term health outcomes (due to short time-frames) but suggested incentives coupled with education can motivate to make small, positive changes

Current and Past Incentive Programs

Program	Description	Who / What / Where	Status
Florida Enhanced Benefits Account Program – The Enhanced Benefits Rewards Program	Credits earned by engagement of healthy behaviors such as well-child visits, preventive screenings, disease management programs, smoking cessation and weight management	Medicaid members earned credits for their healthy behaviors that could be used at participating pharmacy for items such as OTC medications, vitamins, dental and first aid products	Launched Sept 2006 and phased out May 2014. Faced many issues, including participants not being aware of the program and credits not redeemed. Little evidence program achieved the objectives
Idaho Prevention Health Assistance Program	Behavioral Health: Initially smoking cessation and weight management. Currently only weight management; Wellness Benefit for well-child checks and immunizations	Weight management enrollees receive up to $200 annually to help pay for program. Wellness enrollees earn points toward monthly premiums	January 2007 to present. The share of premium-paying children earning points increased from 40% in April 2007 to 73% in 2009

Current and Past Incentive Programs

Program	Description	Who / What / Where	Status/Outcome
New York DOH TB Directly Observed Therapy Program	365 patients in 6 inner city TB DOT programs over 3 years	Provide incentives to motivate patients, increase adherence to therapy. Incentives included snacks, food coupons and subway tokens, which were increased based on 3 month adherence to program	Final conclusion was increasing incentives is associated with improved adherence
Medication Adherence, University of Pennsylvania Anticoagulation Center	Program to study the relationship of incentives to motivate participants to take their warfarin as prescribed	Lottery system giving participants a chance to win cash each day they took the drug	Provided evidence of the feasibility/potential promise of financial incentive to improve medication adherence

Current and Past Incentive Programs

Program	Description	Who / What / Where	Status/Outcome
General Electric Employer-based Smoking Cessation Program	18 month program offering employees cash incentives to complete smoking programs and remain smoke-free for another 6 months	Employees offered $100 to complete smoking cessation program, $250 if quit smoking within 6 months, $400 if remained smoke-free for another 6 months after that	The incentive group outperformed the information-only group. Based on study, GE designed in incentive program for all employees in January 2010
Remote Monitoring for Diabetes Patients	Program to study the impact of lottery-based incentives on adherence to home-based wireless device monitoring	Daily lottery incentive worth an average of $1.40 per day	Lottery associated with significantly greater device usage than group who received no financial incentive

Current and Past Incentive Programs

Program	Description	Who / What / Where	Status/Outcome
Project Healthy Neighbors, Santa Barbara, CA	2-3 day event every November that offers homeless services such as flu and pneumonia vaccinations, TB tests, HIV test, etc.	Homeless Population. incentives are backpacks with sweatshirt, socks, rain ponchos, blanket, hat, gloves, first-aide kits. Also free pair of shoes	Started in 2005 and has grown exponentially every year

Next Steps

Subcommittee Co-chairs

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