Department of Health | Medicaid Redesign Team

Introduction to VBP, Episode Development and Quality Measures

Clinical Advisory Group Introduction Webinar

Meeting Date: 10/14

Source: Fee-for-Service and Managed Care encounter records for non-dual Medicaid members in CY2012-2013. Source: HCI3

2015

Content

Introductions & Meeting Schedule

Part I

A. Clinical Advisory Group Roles and Responsibilities
B. Introduction to Value Based Payment
C. Contracting Chronic Care: the Different Options
D. HCI3 - Understanding the HCI3 Grouper and Development of Care Episodes

Part II

A. Introduction to Quality Measures.

Introductions

Meeting Schedule & Agenda

Meeting 1
- Introduction to Value Based Payment
- Clinical Advisory Group- Roles and Responsibilities
- Understanding the Approach: HCI3 Overview
- Chronic Heart Episodes – Definition
- Chronic Heart Episodes – Impressions Available Data

Meeting 2
- Chronic Heart Episodes Definition Recap
- Chronic Heart Episodes Quality Measures

Webinar
- Introduction to Value Based Payment
- Clinical Advisory Group – Roles and Responsibilities
- Understanding the Approach: HCI3 Overview
- Introduction to Quality Measures

Meeting October 20th
- Short Review and Questions from Previous CAG Meeting
- Diabetes Episode Definition
- Diabetes Quality Measures
- Closing this Series of CAG Sessions and Next Steps

Part I

A. Clinical Advisory Group (CAG) Roles & Responsibilities

Roles and Responsibilities Overview

Clinical Advisory Group Composition

Comprehensive Stakeholder Engagement

- Comprehensive stakeholder engagement has been a key component to the development of the Value Based Payment Roadmap
- We will continue engaging stakeholders as we develop and define opportunities for value based payment arrangements

Composition of the CAG includes:

- Clinical experience and knowledge focused on the specific care or condition being discussed (diabetes)
- Industry knowledge and experience
- Geographic diversity
- Total care spectrum as it relates to the specific care or condition being discussed

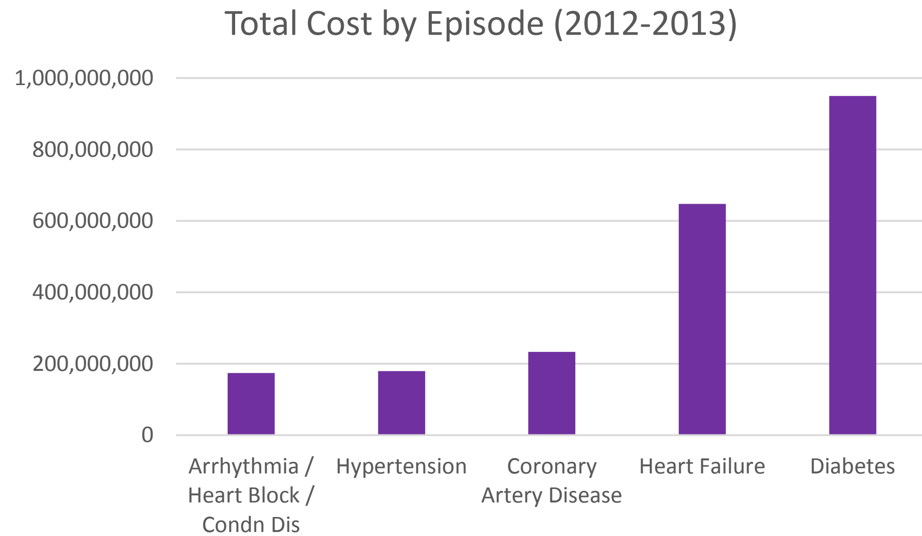
CAG Objectives

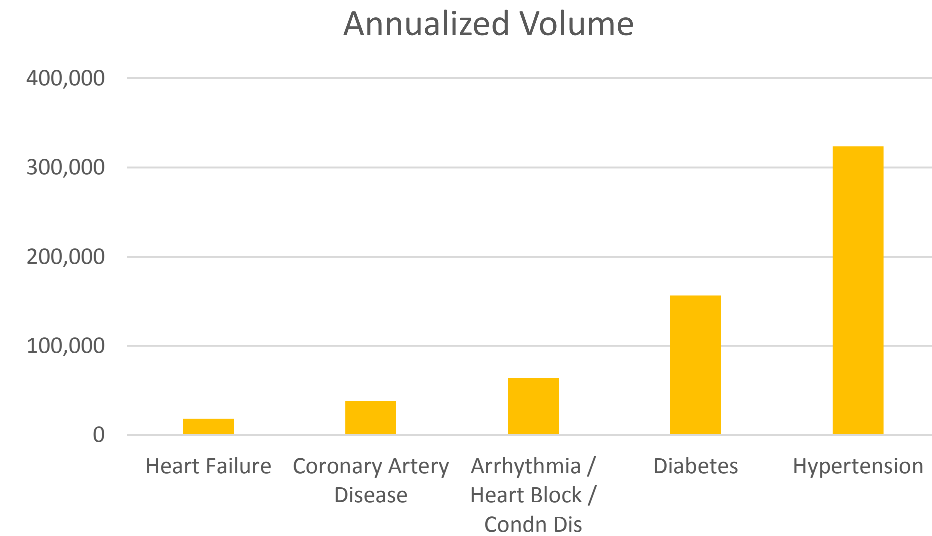
- Understand the State's visions for the Roadmap to Value Based Payment
- Understand the HCI3 grouper and underlying logic of the bundles
- Review clinical bundles that are relevant to NYS Medicaid
- Make recommendations to the State on:
  - outcome measures
  - data and other support required for providers to be successful
  - other implementation details related to each bundle

❖ *The CAGs will be working with national standard bundles and are not asked to tailor definitions at this point, but focus on outcome measures and NYS implementation details. Working experience with bundles can lead to new insights and definition enhancements as with any reimbursement methodology.*

❖ *Definitions are standard, but financial arrangements between plans and providers around the bundles are not set by the State.*

Annualized Volume and Total Costs by Episode





Costs Included:

- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

Source: 01/01/2012 – 12/31/2013 Medicaid claims for non-dual Medicaid members.

Part I

B. Introduction to Value Based Payment

Brief background and context

NYS Medicaid in 2010: the Crisis

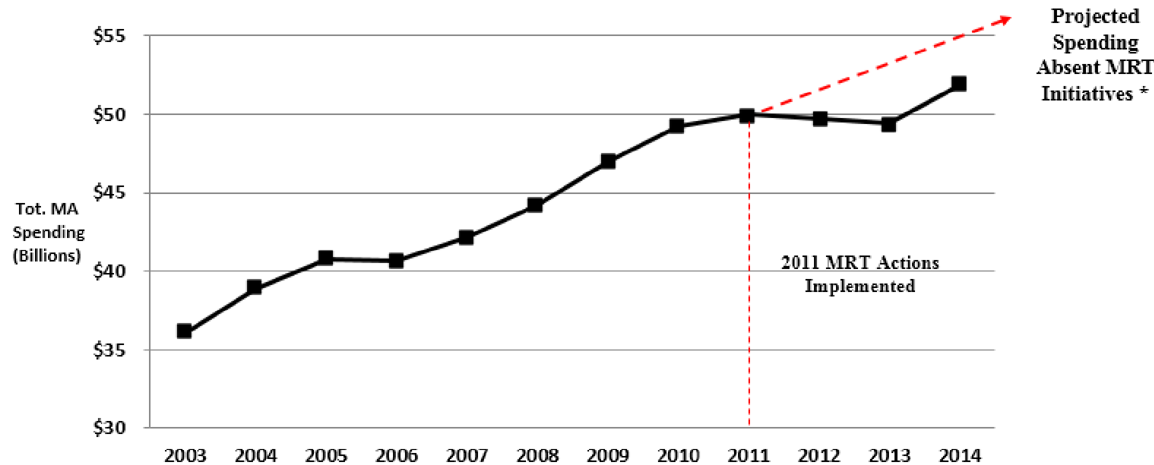
> 10% growth rate had become unsustainable, while quality outcomes were lagging

- Costs per recipient were double the national average
- NY ranked 50th in country for avoidable hospital use
- 21st for overall Health System Quality

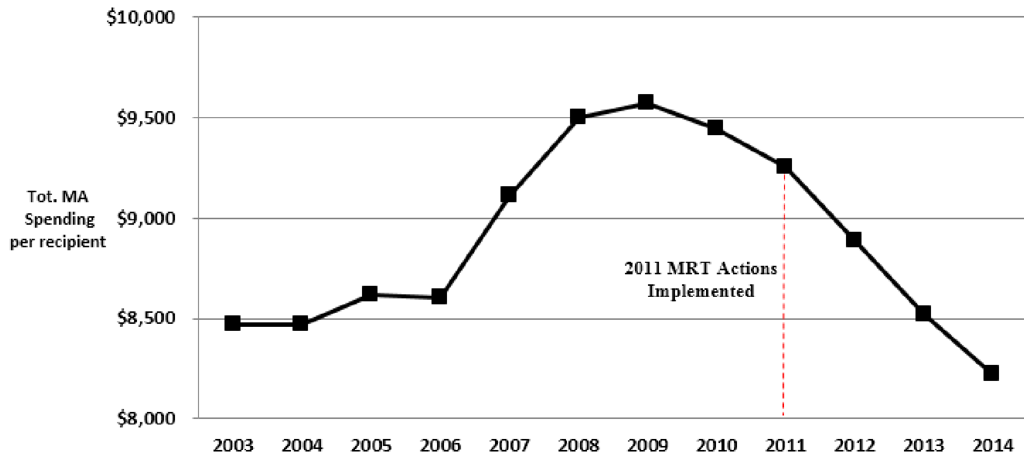
2009 Commonwealth State Scorecard on Health System Performance

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 patients receiving recommended heart attack care	33rd
✓ Medicare ambulatory sensitive condition admissions	40th
✓ Medicare hospital length of stay	50th

Medicaid Redesign Initiatives Have Successfully Brought Back Medicaid Spending per Beneficiary to below 2003 Levels



Since 2011, total Medicaid spending has stabilized *while number of beneficiaries has grown > 12%*



Medicaid spending per-beneficiary has continued to decrease

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

- A thorough transformation of the delivery system – DSRIP - 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 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

Financial and regulatory incentives drive…

a delivery system which realizes…

cost efficiency and quality outcomes: *value*

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Payment Reform: Moving Towards Value Based Payments

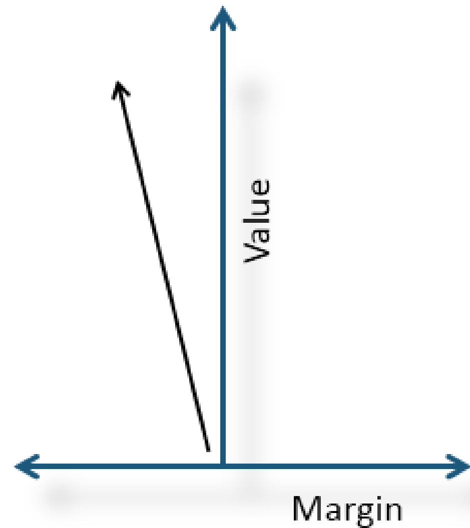
- A Five-Year Roadmap outlining NYS' plan for Medicaid Payment Reform was required by the MRT Waiver
- By DSRIP Year 5 (2019), all Managed Care Organizations must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the *Special Terms and Conditions* of the waiver)
- Core Stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap

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***

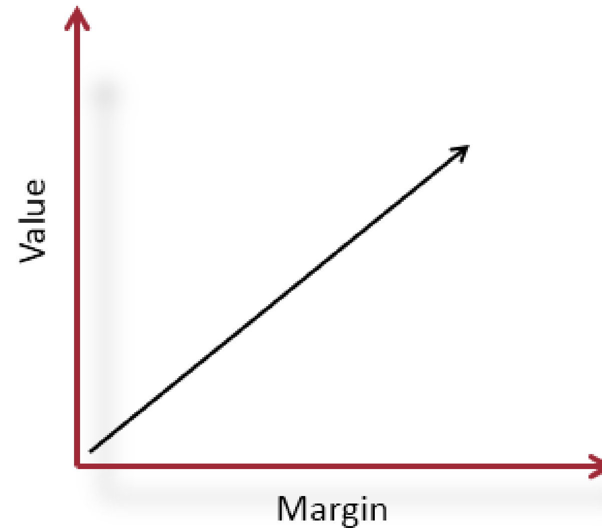
Current State

Increasing the value of care delivered more often than not threatens providers' margins



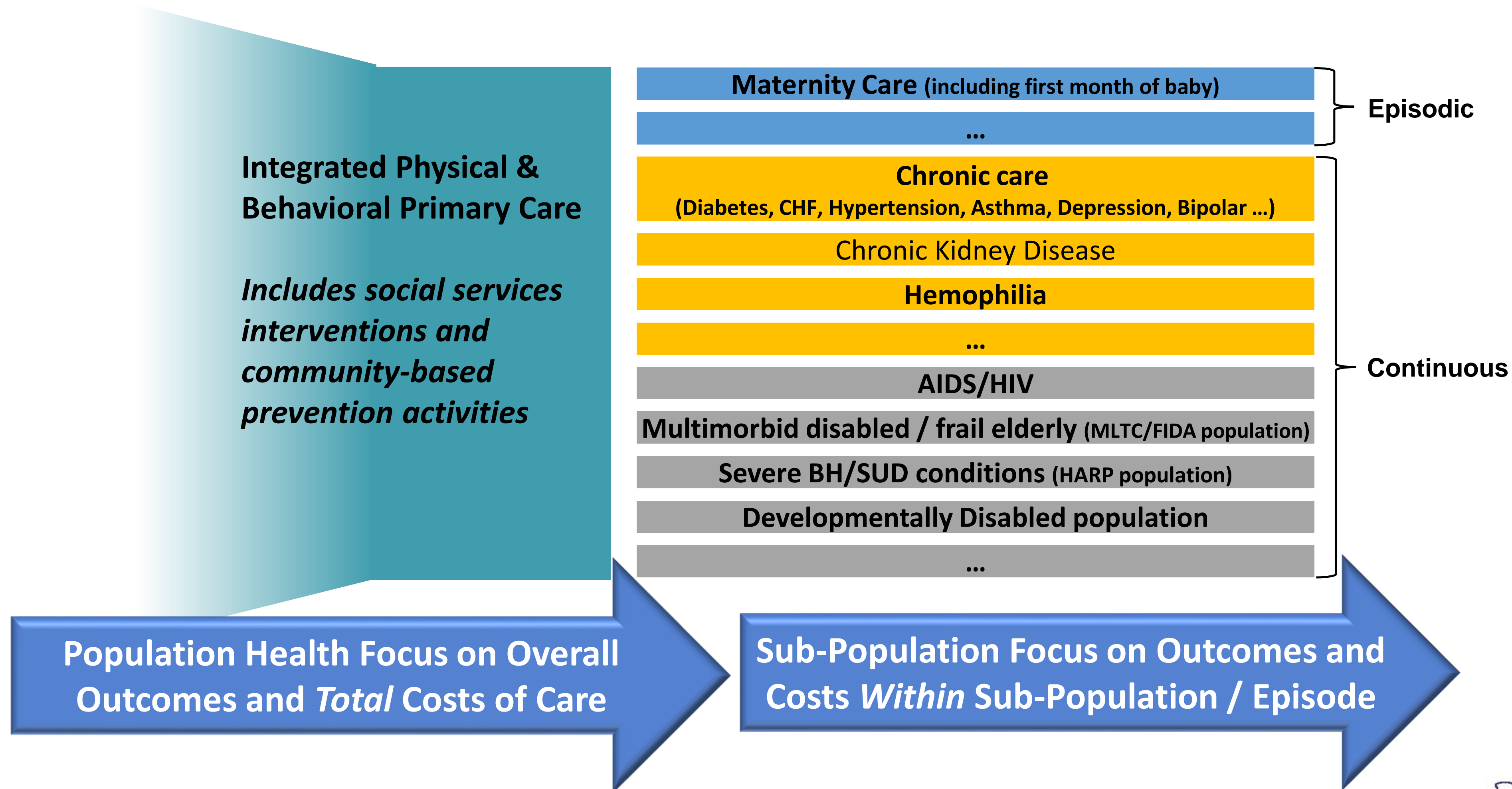
Future State

When VBP is done well, providers' margins go up when the value of care delivered increases



Goal – Reward Value not Volume

The VBP Roadmap Starts from DSRIP Vision on How an Integrated Delivery System Should Function

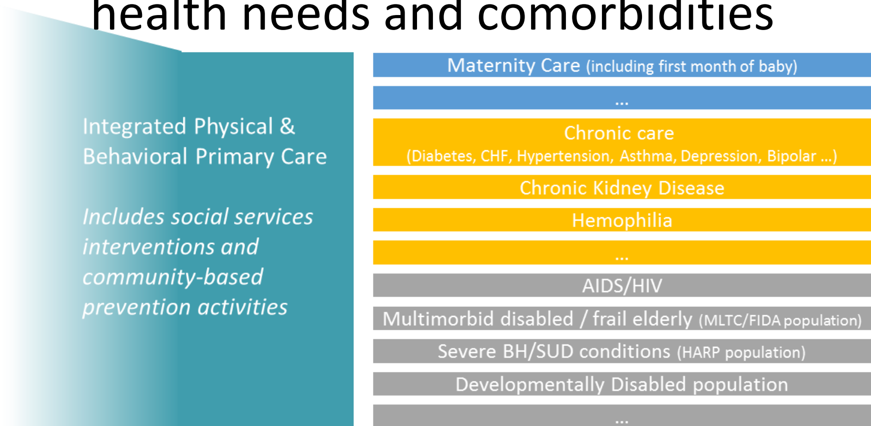


The Path Towards Payment Reform: A Menu of Options

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) – ACO model
- Per integrated service for specific condition (acute or chronic bundle): for example 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 can 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.

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
- 35% of total managed care payments (full capitation plans only) tied to Level 2 or higher. For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans from this minimum target.

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Value Information per VBP Arrangement
(Using Price-Standardized Data)

Providers and MCOs will receive

- Cost and Quality performance overviews per VBP arrangement (whether these arrangements are contracted or not)
- Including Target Budgets and actual costs (both cost-standardized, and, for their own beneficiaries, real-priced)

Initially, PDF reports will be used, but providers and MCOs will get access to web-based analytical tools to dynamically interact with these data

- Including drill downs by geography and provider
- Including drill down possibilities to individual patients (for own beneficiaries)

Part I

C. Contracting Chronic Care: the Different Options

The Context: Strong Push to Strengthen Primary Care in NYS

- Strengthening Primary Care has long been a central piece of DOH policy
- DSRIP includes significant focus on Integrated Behavioral and Physical Care within the Primary Care context
- New York State Health Innovation Plan centers on the concept of Advanced Primary Care

The Context: Advanced Primary Care in NYS

The APC model will go beyond new structures and capabilities to specify and measure processes and outcomes associated with more integrated care, including prevention, effective management of chronic disease, integration with behavioral health, and coordination among the full range of providers working together to meet consumer needs. [...T]his is essential in moving away from a reactive health care system that patients largely have to navigate on their own, to a truly proactive system, in which patients are helped to actively manage and improve their health.

New York State Health Innovation Plan

APC Model

- Closely aligned to DSRIP milestones

APC Stages of Transformation

Tier	Pre-APC	Standard APC	Premium APC
Description	● Largely reactive approach to patient encounters of care	● Capabilities in place to more proactively manage a population of patients	● Processes in place to clinically integrate primary, behavoiral, acute, post-acute care[1]
Capabilities Required to Enter Tier	● Limited pre-requisites ● Willingness to exchange targeted clinical data	● Certified EHR ● Full medical home capabilities aligned with NCQA level 1-3, or equivalent	● Certified EHR, Meaningful Use Stage 1-3[3], HIE interoperability ● Enhanced capabilities, aligned with expanded NCQA Level 3[2], or equivalent
Validation	None	● Required to maintain care coordination fees >12 months ● To couple with practice transformation support	
Care Coordination Skills	Limited or none	● Care planning for 5-15% highest-risk patients ● Track and follow up on ADT, other scalable data streams ● Facilitate referrals to high-value providers	● Plus, functional care agreements in medical neighborhood ● Plus, community facing care coordination
Payment Model Mix	● FFS + P4P ● Potential EHR support	● Shared savings or capitation ● Care coordination fees ● Transformation support	● Shared savings or capitation
Metrics and Reporting	● Standard statewide scorecard of core measures ● Consolidated reporting across payers, leveraging APD, portal		

[1] Vision, LTC, home aids, rehabilitative & daycare are excluded from all advanced primary care models
[2] Establishes, additional must pass NCQA requirements, that are not already mandatory in existing NCQA
[3] Once available

Vision on Chronic Care contracting in NYS VBP

Type of Population / Condition	Population / Condition	Type of Contracting
For specific subpopulations: intensive and interdependent chronic care needs, best coordinated by specialized provider	• HIV/AIDS • HARP • MLTC	Total Care for Subpopulation (capitation); i.e., a condition-specific ACO model
For more common chronic conditions: integrated approach is part and parcel of APC vision	• Asthma • COPD • Chronic Depression • Bipolar Disorder • Substance Use Disorder • **Coronary Artery Disease** • **Hypertension** • **CHF** • **Arrhythmia / Heart Block** • **Diabetes**	The default is that the individual chronic bundles are contracted together by integrated care providers (guideline)

Contracting Options

Default is that these are contracted together…

… but not all bundles need to be included…

… and some bundles may be contracted by other providers

Integrated Physical & Behavioral Primary Care

Includes social services interventions and community-based prevention activities

Maternity Care (including first month of baby)

…

Chronic care (Diabetes, CHF, Hypertension, Asthma, Depression, Bipolar …)

Chronic Kidney Disease

Substance Use Disorder

…

AIDS/HIV

Multimorbid disabled / frail elderly (MLTC/FIDA population)

Severe BH/SUD conditions (HARP population)

Developmentally Disabled population

…

Finally, a Total Care for the Total Population (ACO) model includes the care included in these chronic care bundles

Part I

D. HCI3 Understanding the Grouper & Development of Care Episodes

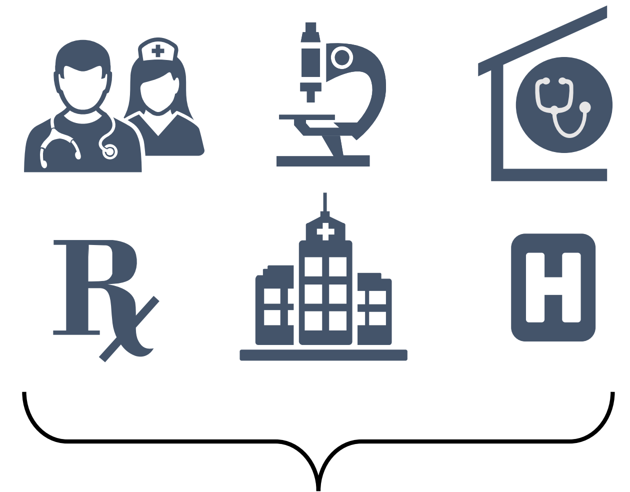
Why HCI3?

- One of two nationally used Bundled Payment Programs, also known as “Prometheus Payment”
- Specifically built for use in value based payment
- Not-for-profit and independent
- Open source
- Clinically validated
- National Standard which evolves based on new guidelines as well as lessons learned

Evidence Informed Case Rates (ECRs)

Evidence Informed Case Rates (ECRs) are the HCI3 episode definitions

- ECRs are patient centered, time-limited, episodes of treatment
- Include all covered services related to the specific condition
  - E.g.: surgery, procedures, management, ancillary, lab, pharmacy services
- Distinguish between "typical" services from "potentially avoidable" complications
- Are based on clinical logic. Clinically vetted and developed based on evidence-informed practice guidelines or expert opinions



All patient services related to a single condition

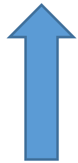
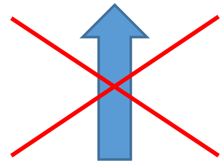
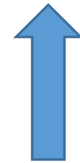
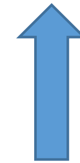
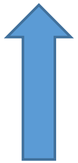
Sum of services (based on encounter data the State receives from MCOs).

Source: HCI3 Presentation: http://216.70.89.98/onlinecourses/Module201prt1.htm

Clinical Logic

The Diabetes Episode

Diabetes (DIAB)

Initial doctor visit, during which a diagnosis of DIAB is given.

Doctor visit for a broken bone (e.g. a sports injury) unrelated to the DIAB

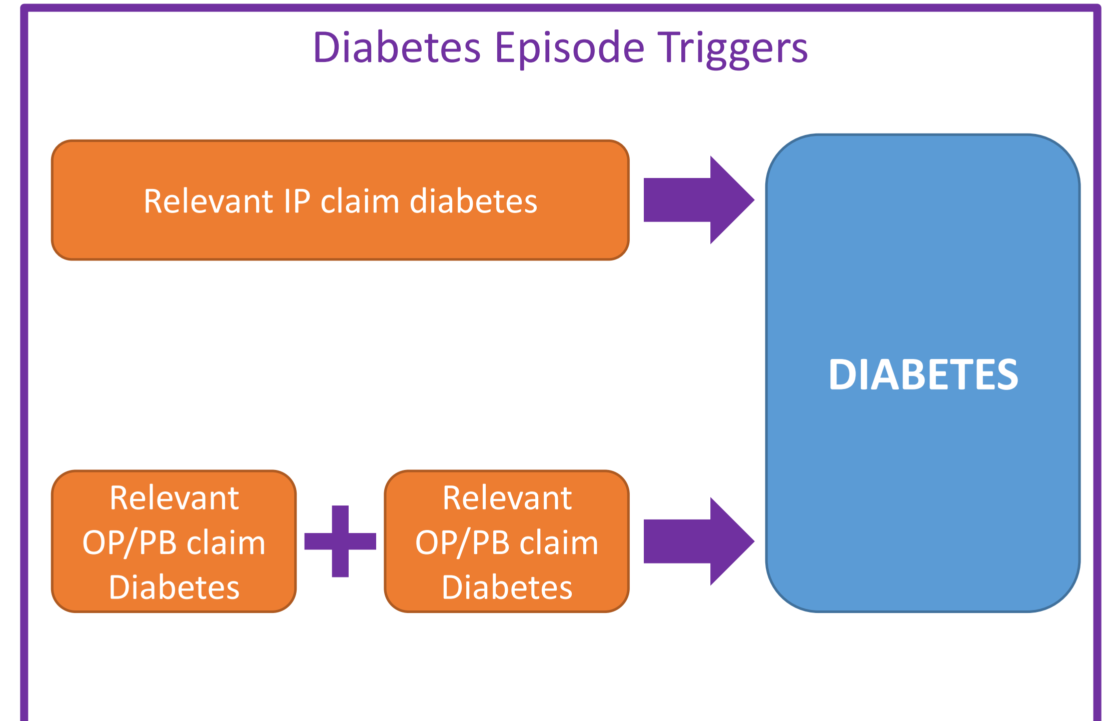
ER Visits and inpatient admissions related to DIAB episode

Prescription medicine to treat DIAB.

Readmission following inpatient treatment for DIAB.

Episode Component: Triggers

- A trigger signals the opening of an episode, e.g.:
  - Inpatient Facility Claim
  - Outpatient Facility Claim
  - Professional Claim
- More than one trigger can be used for an episode
  - Often a confirming claim is used to reduce false positives
- Trigger codes are unique to each episode—no overlaps



Episode Components : PACs

- Costs are separated by "typical" care from costs associated with Potentially Avoidable Complications (PACs)
- PACs for chronic conditions and some acute conditions have been endorsed by the NQF as comprehensive outcome measures[1]
- Expected costs of PACs are built in as an incentive towards shared savings
- Only events that are generally considered to be (partially) avoidable by the caregivers that manage and co-manage the patient are labeled as 'PACs'
- Can stem from poor coordination, failure to implement evidence-based practices or medical error
- Examples: ambulatory-care sensitive admissions, hospital acquired conditions and inpatient-based patient safety features

Example Diabetes PACs

Cellulitis	Diabetes, Poor Control
Sepsis	Urinary Tract Infection

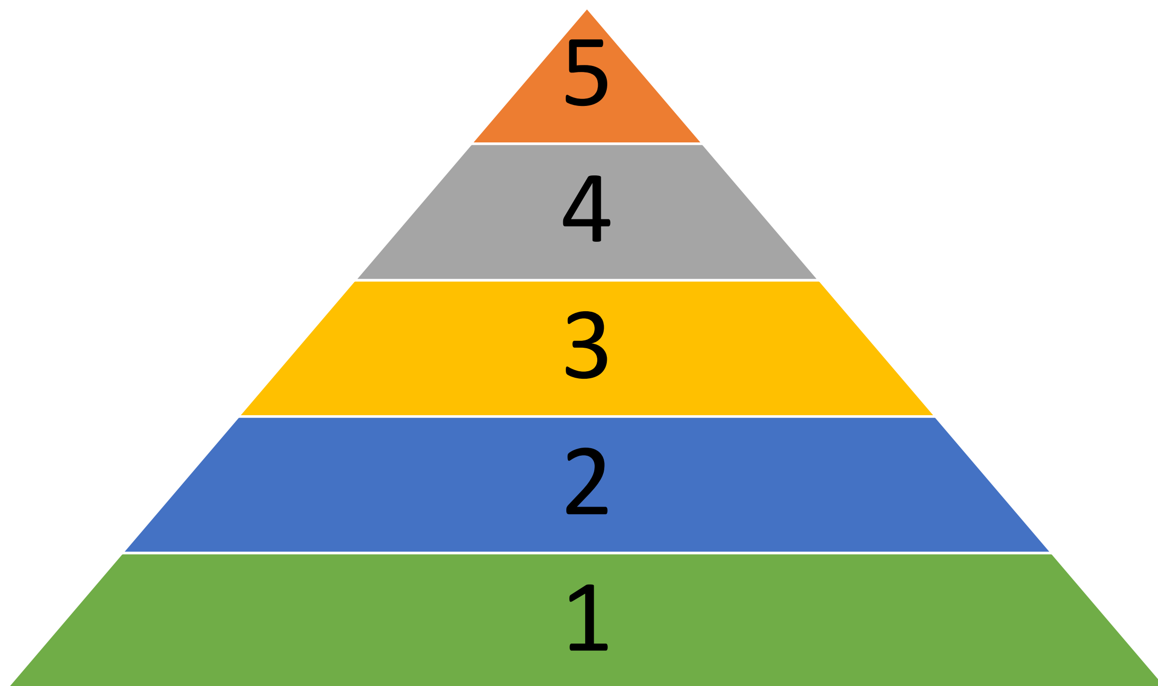
Alignment with NQF

Many PAC measures are based on established National Quality Forum (NQF) measures. Four unique PAC measures have been endorsed by the NQF with 7 more submitted this year

1 http://www.hci3.org/content/hci3s-measures-improve-quality-and-outcome-care-patients-endorsed-nqf

Episode Components - Leveling

The grouper uses the concept of leveling (1-5), in which individual associated episodes may get grouped together into a "bundles" as you move higher in the levels.

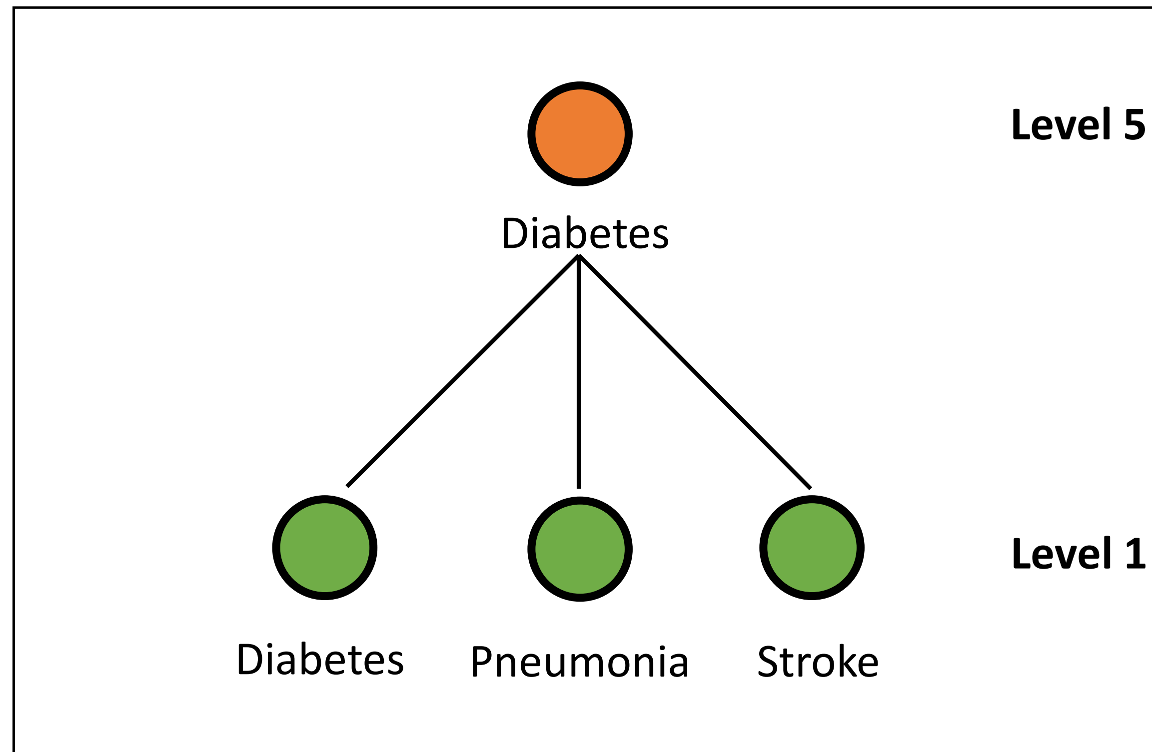


As you move higher up in levels, associated episodes get grouped together into a bundle. In our example, acute myocardial infarction, pneumonia and stroke roll up under Diabetes Episode

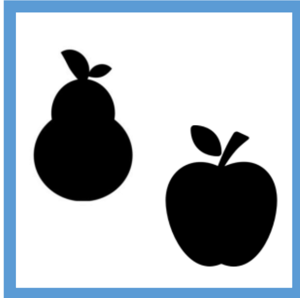
In Level 1, claims are grouped into defined episodes. For example pneumonia, acute myocardial infarction and stroke, exist as separate episodes at level 1.

Leveling for Diabetes Conditions

- At level 1 both pneumonia and upper respiratory are separate episodes
- At level 5 those episode become PACs for the diabetes episode

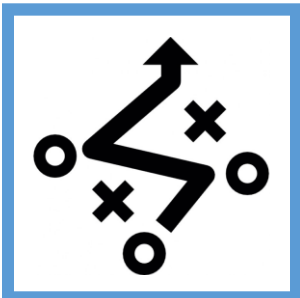


Risk Adjustment for Episodes



Make “apples-to-apples” comparisons between providers by accounting for differences in their patient populations

Takes the patient factors (co-morbidity, severity of condition at outset, etc.) out of the equation



Separate risk adjustment models are created for ‘typical’ services and for ‘potentially avoidable complications’

More information can be found at http://www.hci3.org/sites/default/files/files/Reliability%20of%20Prometheus%20Measures_0.pdf

Inclusion and Identification of Risk Factors

Risk Factors

- Patient demographics – Age, gender, etc.
- Risk factors - Co-morbidities
- Subtypes - Markers of clinical severity within an episode

Patient related risk factors

Episode related risk factors

Identification Risk Factors

- Risk factors come from historic claims (prior to start of an episode) and same list is applied across all episode types
- Subtypes identified from claims at start of the episode and specific to episode type

Inclusion and Identification of Risk Factors

Risk Factors

- Patient demographics – Age, gender, etc.
- Risk factors - Co-morbidities
- Subtypes - Markers of clinical severity wit

Examples of DIAB SubTypes

Diabetes mellitus with neurologic manifestations, diabetes mellitus with ophthalmic manifestations, Diabetes Mellitus with Peripheral Circulatory Disorders, diabetes mellitus with renal manifestations, Diabetes, other manifestation, Diabetic cataract,
Endo - Diabetes - secondary, Endo - DM Type I, Heart Failure, Cardiomegaly, hyperlipidemia, Morbid Obesity, Obesity, Severe Protein Calorie Malnutrition, Sleep Apnea

Identification Risk Factors

- Risk factors come from historic claims (prio applied across all episode types
- Subtypes identified from claims at start of the episode and specific to episode type

Part II

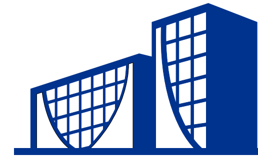
Introduction to Quality Measures

And their role in Value-Based Payments

How Are the Quality Measures Going to be Used?

NY State / MCO relationship

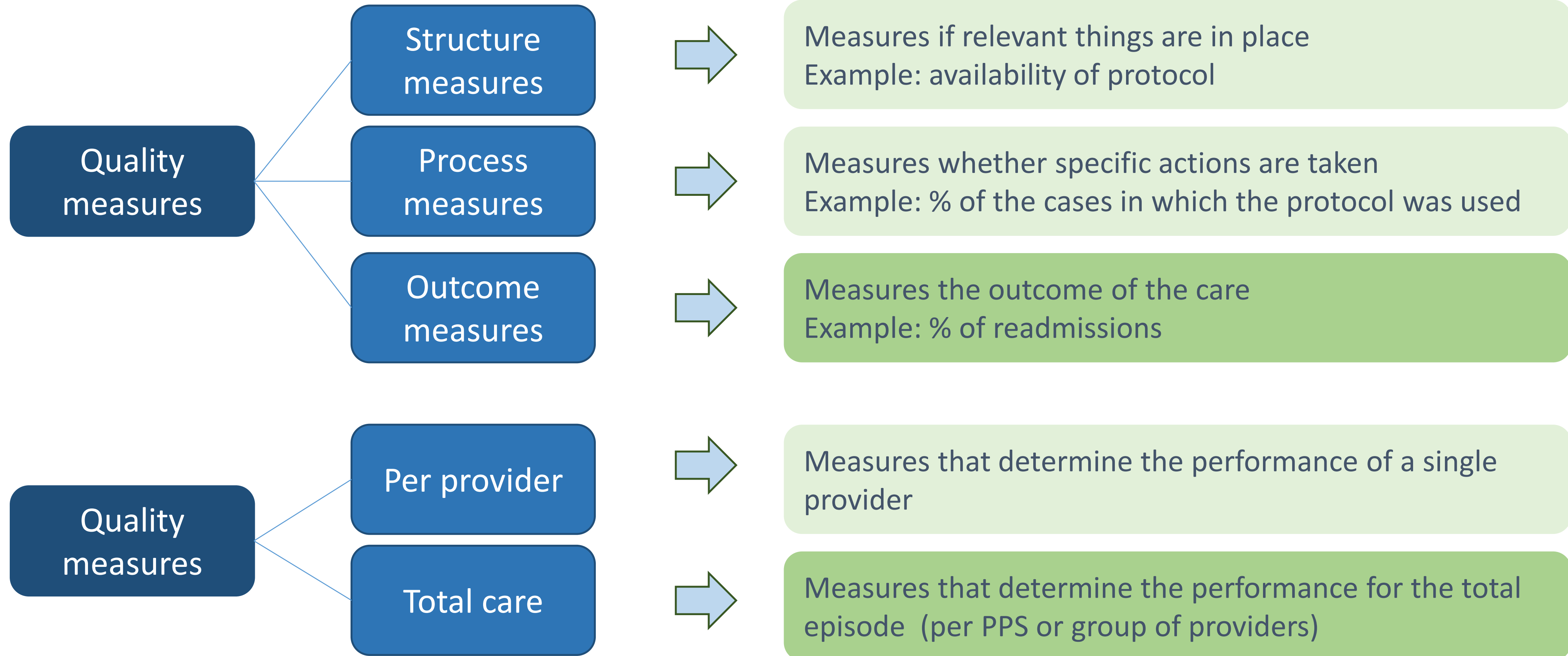
- MCO's will be held accountable for the quality measures, and will get upward or downward adjustments based on the value of the care their network.
- The State will make the outcomes of the recommended measures transparent to all stakeholders. The quality measures set by the CAG and accepted by the State will be mandatory for the VBP arrangement involved.



MCO / Provider relationship

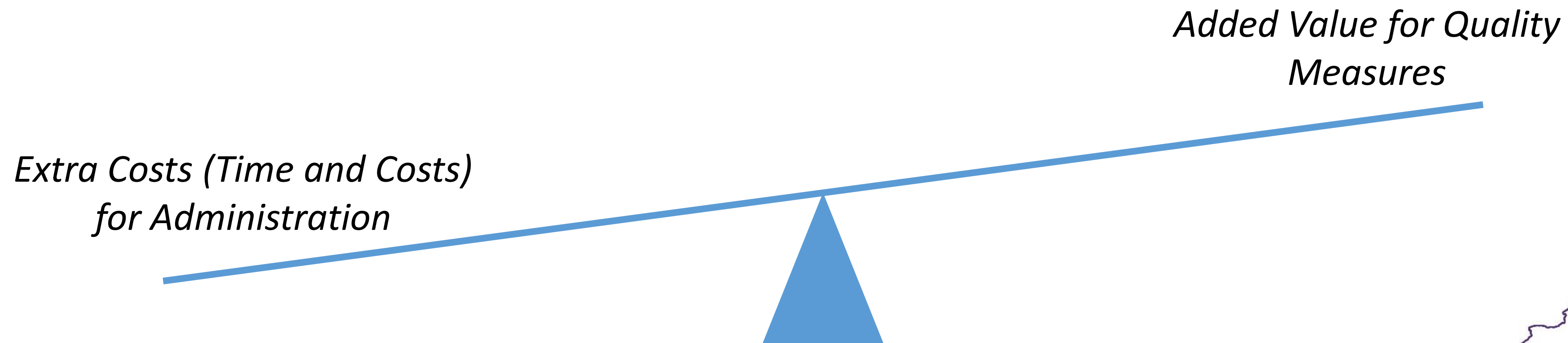
- How the providers and MCO's translate the quality measures into financial consequences, and which measure(s) they want to focus on primarily, is left to these stakeholders.
- Improvement of quality measures could affect payment in different ways:
  - A higher or lower score leading to a higher or lower percentage of savings respectively available for the providers
  - A higher or lower score leading to a higher or lower negotiated rate respectively

To Assess Value, a Small Key Set of Quality Measures is Needed. Focus Should Be on the *Performance* of the Overall Episode.



The Effort of Collecting Additional Data for Quality Measurement Must Be Weighed Against the Added Value

- For care for patients with diabetes, most widely used quality measures can be derived from claims data.
- Other data sources for quality measures including patient surveys, medical records and assessments. Incorporating this data will require standardized collection efforts and can be costly, unless currently existing clinical registries or available data collection mechanisms are used. Identification of key measures is important.
  - *The extra costs (in time and money) of collecting the additional data has to be weighed against the added value that the measure brings.*



Suggested Process for Fine Tuning Quality Measures

Pilot 2016 &
Data Analyses

Evaluation of Quality Measures

Pilot 2016. In 2016 a pilot project will be started on the Chronic Bundle, which encompasses the chronic heart episodes as well as the diabetes episodes, with use of quality measures.

Data Analyses. 2016 will be used to do additional data analyses (if necessary) within pilot sites:

- Explore addition of clinical data elements

Evaluation Quality Measures. At the end of the pilot period the projects will be evaluated and quality measures for the chronic bundle can be refined.

The CAG will be re-assembled yearly during the first years to discuss results of quality measures and suggestions for improvement. First-year review will result in recommended modifications for the quality measures set.

Process to Quality Measures Selection

The CAG will discuss relevant quality measures from different sources.

- DSRIP measures
- HEDIS / QARR
- CMS Medicaid Core Set
- NQF endorsed measures

In the October 20th meeting we will provide a framework for prioritization of the quality measures. Measures will be selected based on three selection criteria:

- Clinical relevance
- Reliability and validation
- Feasibility

CAG Meeting: October 20, 2015 in NYC (2 PM – 5 PM)

- Short Review and Questions from Previous CAG Meeting
- Diabetes Episode Definition
- Diabetes Quality Measures
- Closing this Series of CAG Sessions and Next Steps