NEW YORK STATE | Department of Health | Medicaid Redesign Team

Behavioral Health
(HARP, Depression, Bipolar Disorder)

Clinical Advisory Group

Meeting Date: 8/12

August 2015

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A. HARP population – Introduction
B. Introduction to Outcome Measures

Tentative Meeting Schedule & Agenda

Depending on the number of issues address during each meeting, the meeting agenda for each CAG meeting will consist of the following:

Meeting 1

- Clinical Advisory Group- Roles and Responsibilities
- Introduction to Value Based Payment
- HARP population definition and analysis
- Introduction to outcome measures

Meeting 2

- HARP subpopulation Outcome Measures
- Bundles - understanding the Approach
- Depression Bundle
- Bipolar disorder

Meeting 3

- Depression and Bipolar Disorder Outcome Measures
- Wrap-up of open questions
- If necessary a fourth meeting could be scheduled

Part I

A. Clinical Advisory Group (CAG) Roles & Responsibilities

Roles and Responsibilities Overview

CAG Composition – 'C' Stands for Clinical

- Specific clinical experience and understanding of the condition under discussion
- Industry knowledge and experience
- Geographic diversity
- Total spectrum of care for condition under discussion

** Continues the comprehensive stakeholder engagement begun with the development of New York's Roadmap to Value-Based Payment and the Medicaid Redesign Team*

CAG Objectives

- Understand the Value Based Payment Roadmap
- Understand the HCI3 grouper (Prometheus) and the underlying logic of the bundles
- Understand the specific subpopulation (HARP) and bundles (depression and bipolar)
- Make recommendations on:
  - outcome measures
  - data and other support needed for providers to be successful
  - other implementation considerations

❖ *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 and populations are not set by the State.*

Behavioral health covers a number of topics, which we will cover in different sessions

- HARP Population (Today)
- Depression (2nd session)
- Bipolar disorder (2nd session)
- Substance use disorder (Separate CAG series)
- Schizophrenia / ADHD bundles will be created for analytical purposes only (Not in CAG series)

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 admissions for pediatric asthma	35th
✓ Medicare ambulatory sensitive condition admissions	40th
✓ Medicare hospital length of stay	50th

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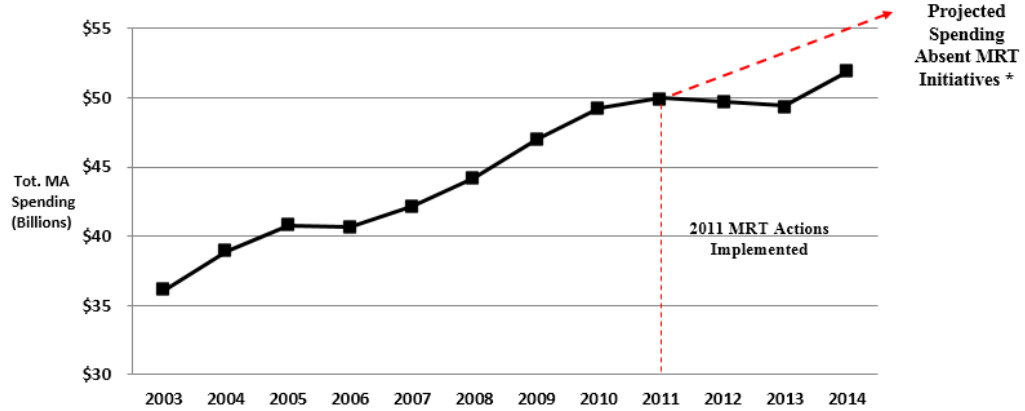
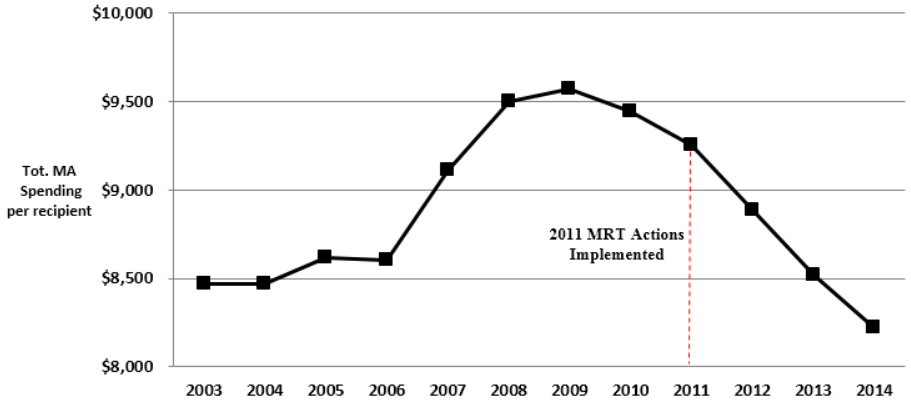
Medicaid Redesign Initiatives Have Successfully Brought Back Medicaid Spending per Beneficiary to below 2003 Levels





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

Medicaid spending per-beneficiary has continued to decrease

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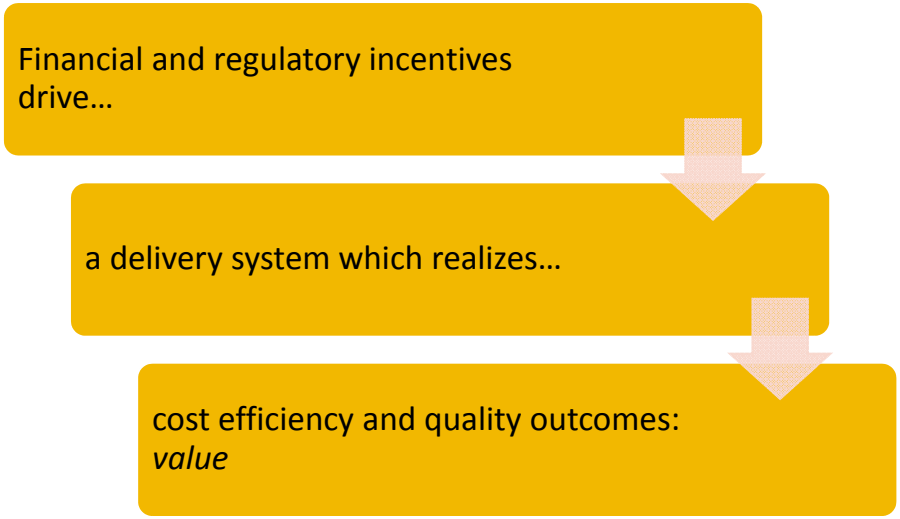
Delivery Reform and Payment Reform: Two Sides of the Same Coin

- 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 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

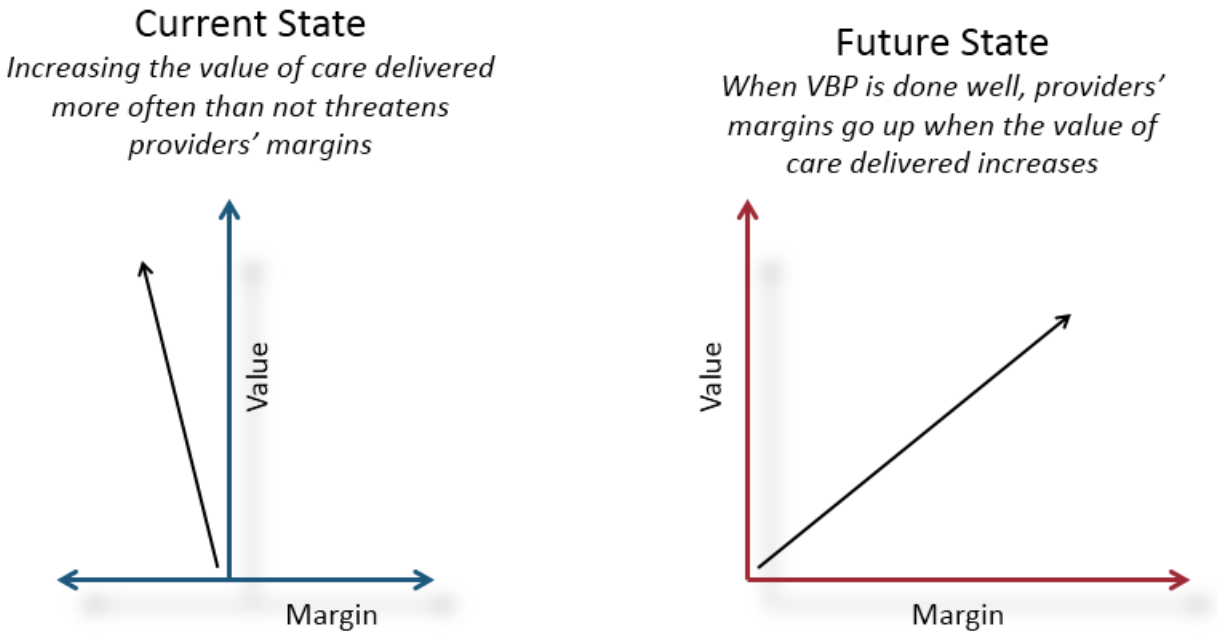


Payment Reform: Moving Towards Value Based Payments

- 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)
- 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***



Goal – Reward Value not Volume

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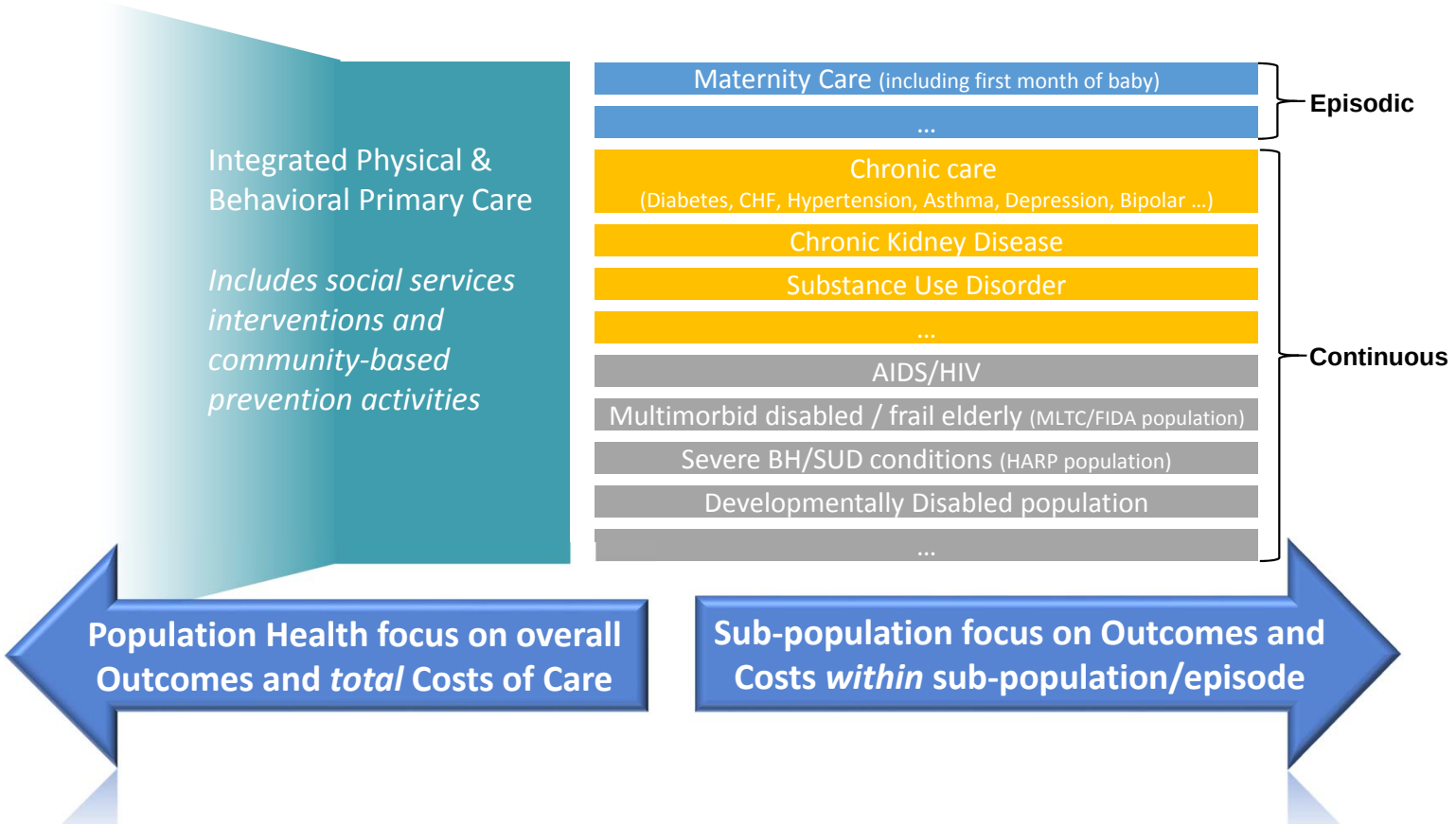
The VBP Roadmap starts from DSRIP Vision on How an Integrated Delivery System should Function

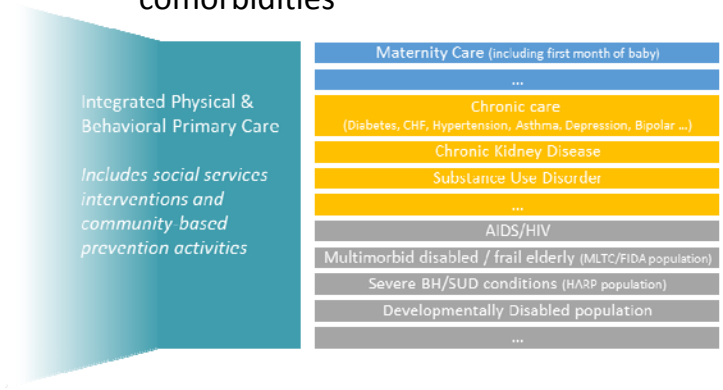


The Path Towards Payment Reform: A Menu of Options

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): 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
- 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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Part II

A. HARP Population

Introduction

HARP is a distinctly qualified, specialized, and integrated managed care product for adults meeting the serious mental illness (SMI) and substance use disorders (SUD) targeting criteria and risk factors

Inclusion Criteria:

The HARP population is a list of beneficiaries maintained by the New York State Office of Mental Health (OMH). Individuals are eligible for HARP designation if they are an adult Medicaid beneficiary 21 years or older who are eligible for mainstream managed care organizations and meet one of the following criteria:

1. Have target criteria or risk factors as defined by the OMH (*see* https://www.omh.ny.gov/omhweb/bho/final-rfq.pdf regarding the full list of criteria and risk factors); or
2. Be identified by an individual's case review or completion of a HARP eligibility screen.

Common Diagnoses:

- Bipolar Disorder
- Depression
- Schizophrenia
- Substance Use

HARP Population Characteristics (looking retrospectively)

177k beneficiaries

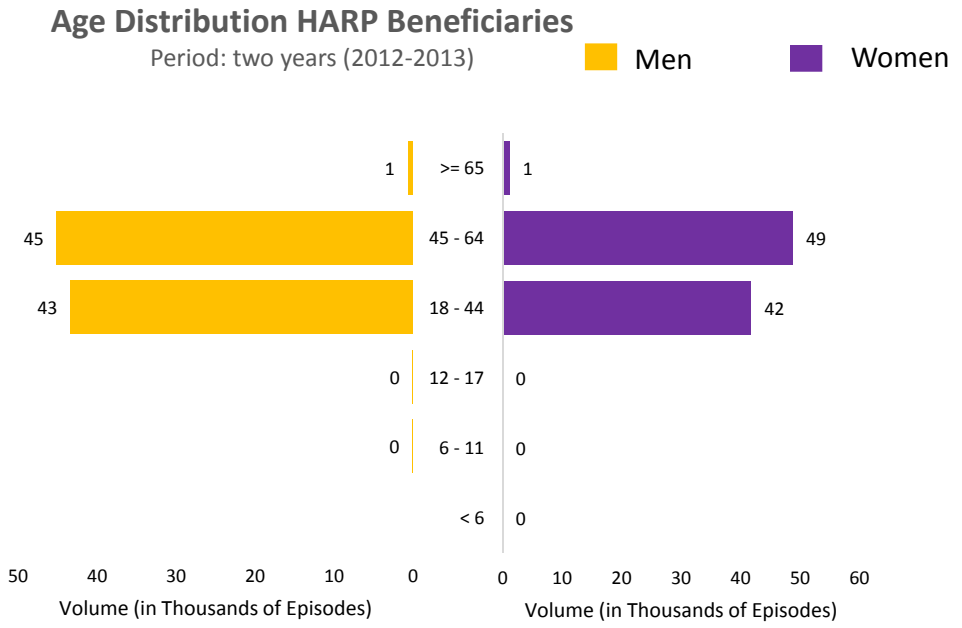
Total Volume HARP Beneficiaries in two Years (2012-2013)

$6.2 billion

Total Costs HARP Beneficiaries in two Years (2012-2013)

$ 35,000

Average Costs per HARP Beneficiary for two years



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. Dual population not included. 100k beneficiaries have been excluded due to data quality issues

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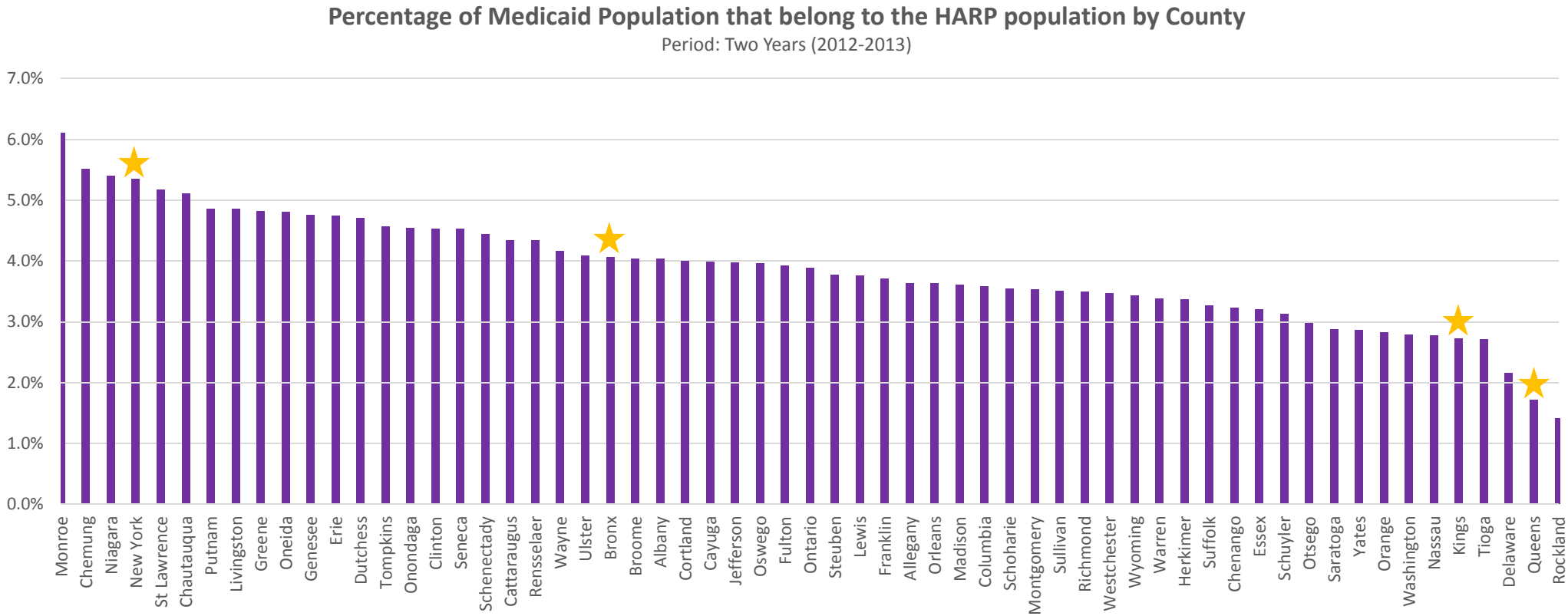
The percentage of Medicaid beneficiaries that is part of the HARP population varies between <2% and >6% per county



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★ Counties with largest HARP populations (absolute numbers)

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The HARP population suffers from illnesses that are often ineffectively treated and can have severe consequences

The HARP population often receives low quality treatment

- More than 20% of those discharged from general hospital psychiatric units are readmitted within 30 days. A majority of these readmissions are at different hospitals.
- There is little coordination between inpatient care and outpatient aftercare, often resulting in these readmissions.
- Only about 20% of adults with mental health disorders are seen by mental health specialists.

As a result, much of the HARP population face poor outcomes

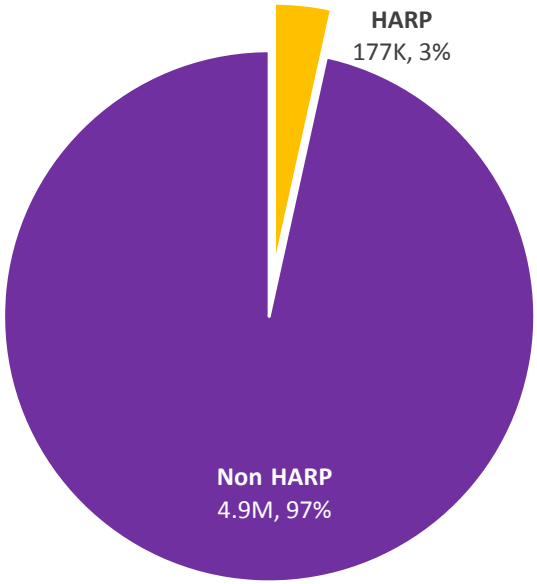
- A significant percentage of single, homeless individuals suffer from serious mental illnesses or substance abuse disorders.
- Approximately 42% of individuals in a New York City jail have a substance use disorder and 33% have a serious mental illness. Of those with a mental illness diagnosis, 50% have a co-occurring substance abuse disorder.
- The unemployment rate for people with serious mental illnesses is 85%.
- People who suffer from serious mental illnesses **have a life expectancy that is about 25 years less** than the general population, typically due to poorly managed chronic conditions.

Source: The New York State Office of Mental Health website: https://www.omh.ny.gov/omhweb/bho/final-rfq.pdf

The HARP population makes up 3% of the Medicaid beneficiaries, and 14% of the 2012-2013 Medicaid spend

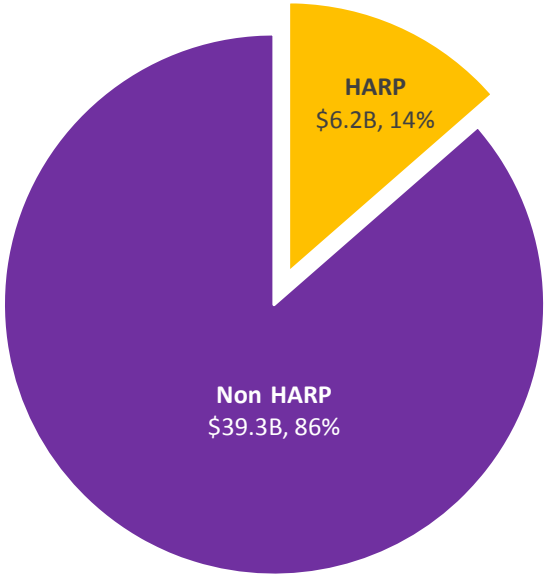
Medicaid Population Breakdown by Volume

Total Medicaid Beneficiaries: 5.1M in two years (2012-2013)



Medicaid Population Breakdown by Cost

Total Medicaid Spending: $45.5B in two years (2012-2013)



Costs Included:

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Source: 01/01/2012 – 12/31/2013 Medicaid claims. Dual population not included. 100k beneficiaries have been excluded due to data quality issues

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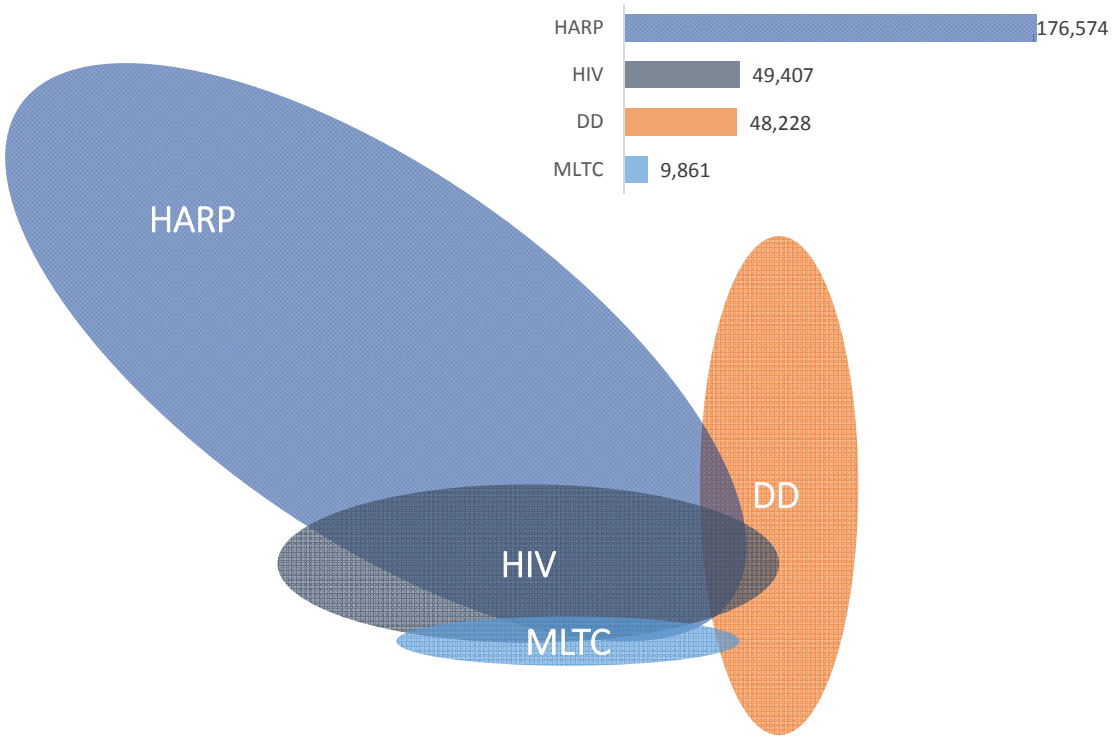
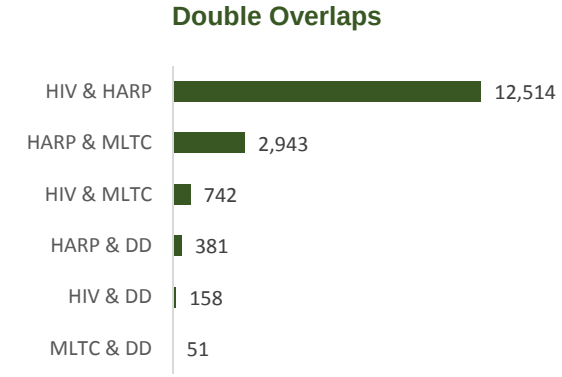
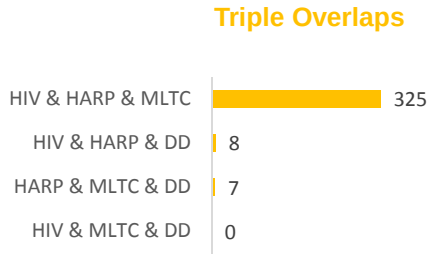
Many of those in the HARP population are also in the HIV, Managed Long-Term Care (MLTC), or Developmental Disability (DD) populations







Source: Based on OHIP data extract for 2012-2013 calendar years. Extract does not include duals. HIV populations is based on the list provided by HIV/AIDS Institute

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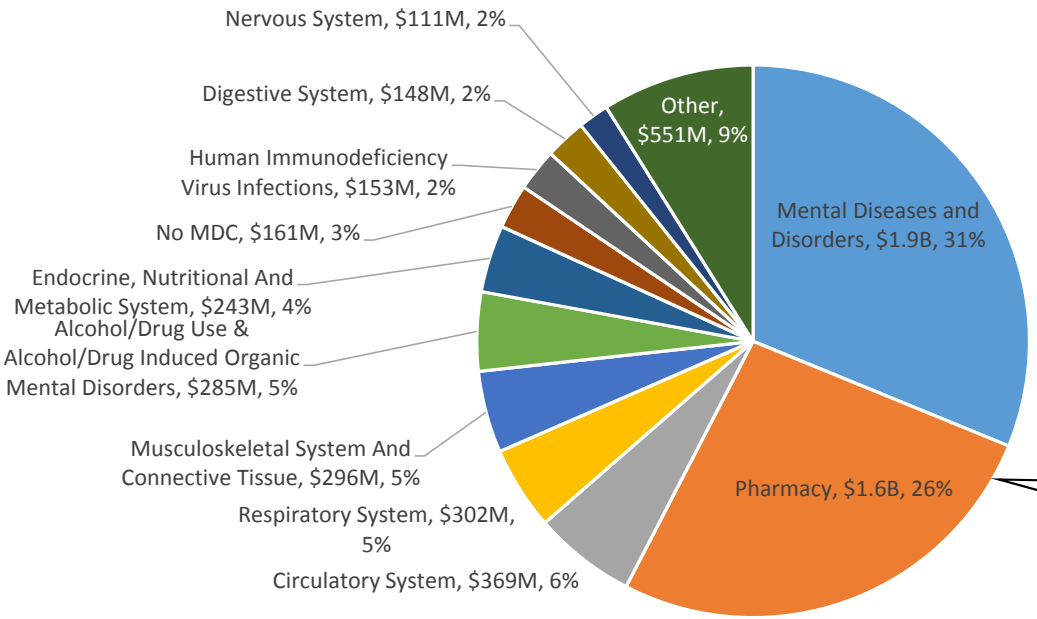
Only 31 percent of spending on HARP Beneficiaries is for mental diseases and disorders, meaning a holistic approach to treatment may be warranted

Total Cost of HARP Beneficiaries divided by Diagnostic Groups (MDC's)

Total costs: $6.2B in two Years (2012-2013)



Pharmacy costs are not attached to MDC categories

Costs Included:

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Source: 01/01/2012 – 12/31/2013 Medicaid claims. Dual population not included. 100k beneficiaries have been excluded due to data quality issues

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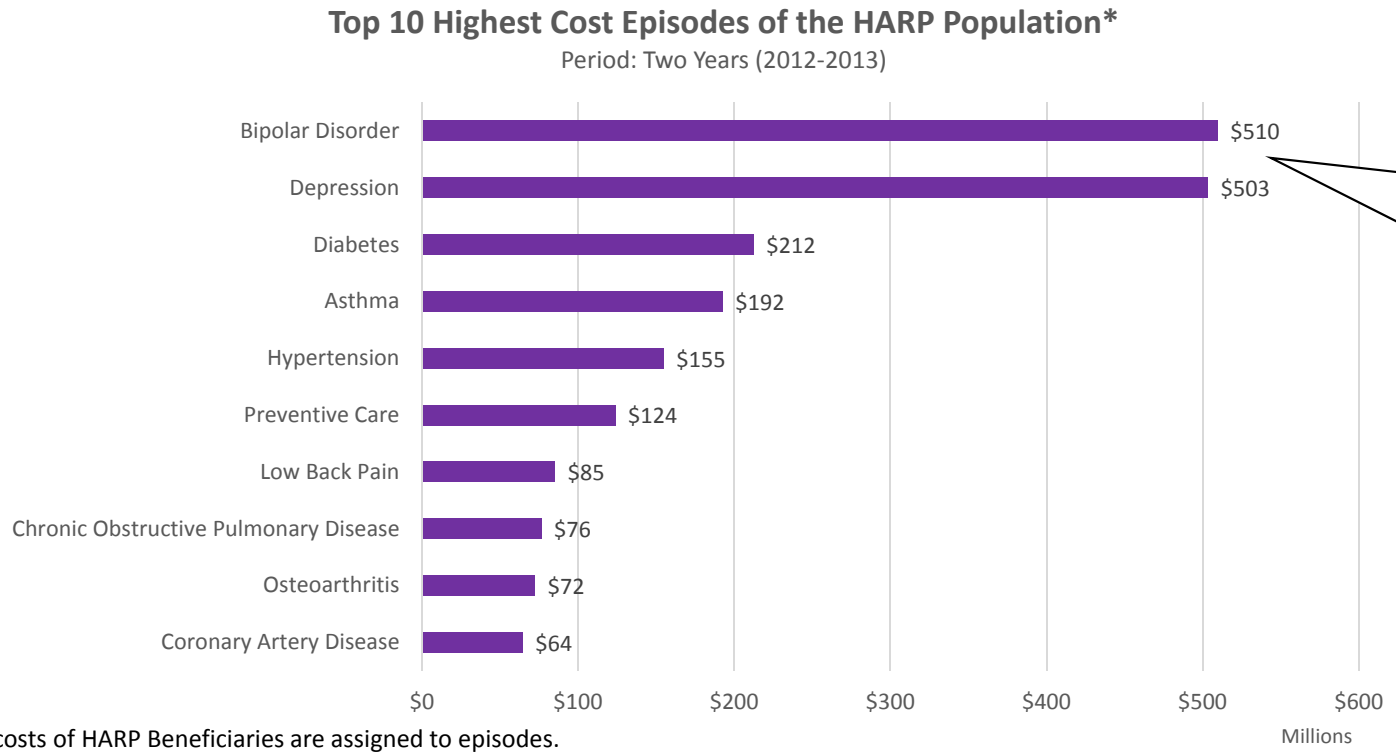
Using the current version of the HCI3 grouper, bipolar disorder and depression are the two highest cost episodes for the HARP Population



The bipolar disorder and depression episodes make up a large portion of HARP spending. We will be covering them in more detail in the next behavioral health CAG session.

NOTE: *44% of the total costs of HARP Beneficiaries are assigned to episodes.

Costs Included:

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Source: 01/01/2012 – 12/31/2013 Medicaid claims. Dual population not included. 100k beneficiaries have been excluded due to data quality issues

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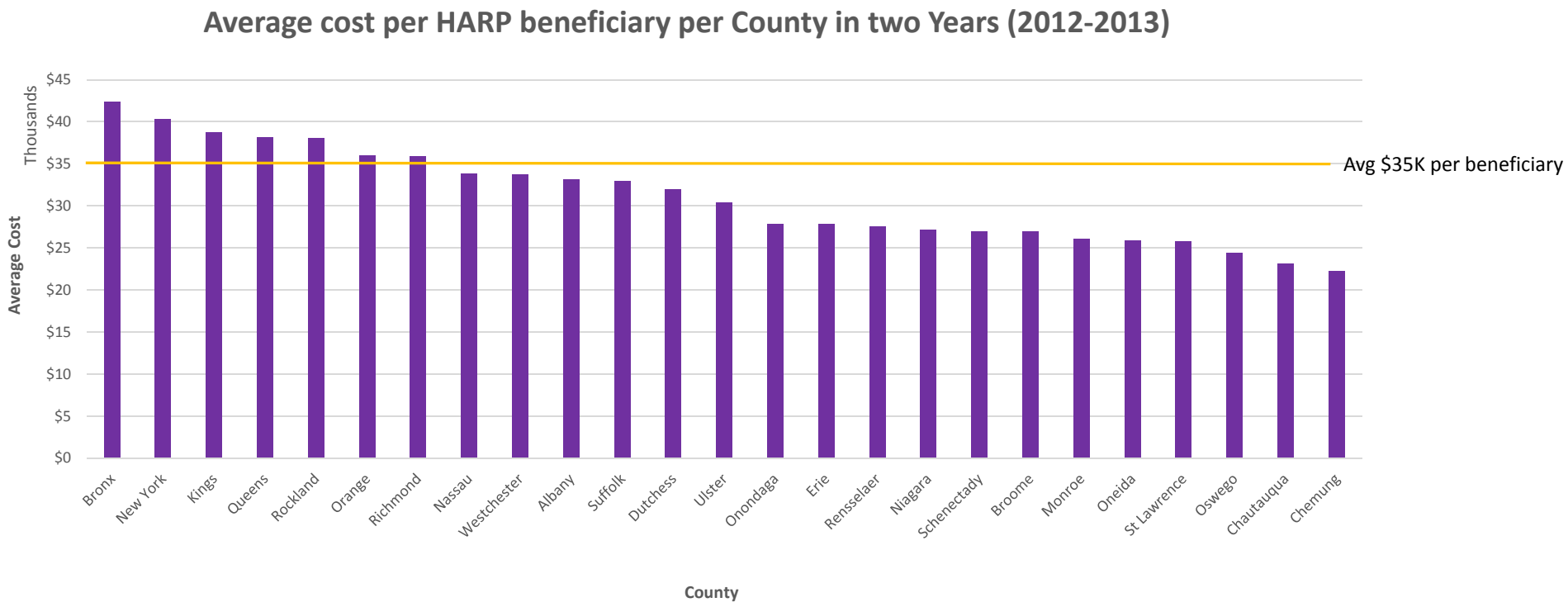
Average Medicaid cost per HARP beneficiary varies between $22K and $42K per county (minimum of 1,000 beneficiaries)



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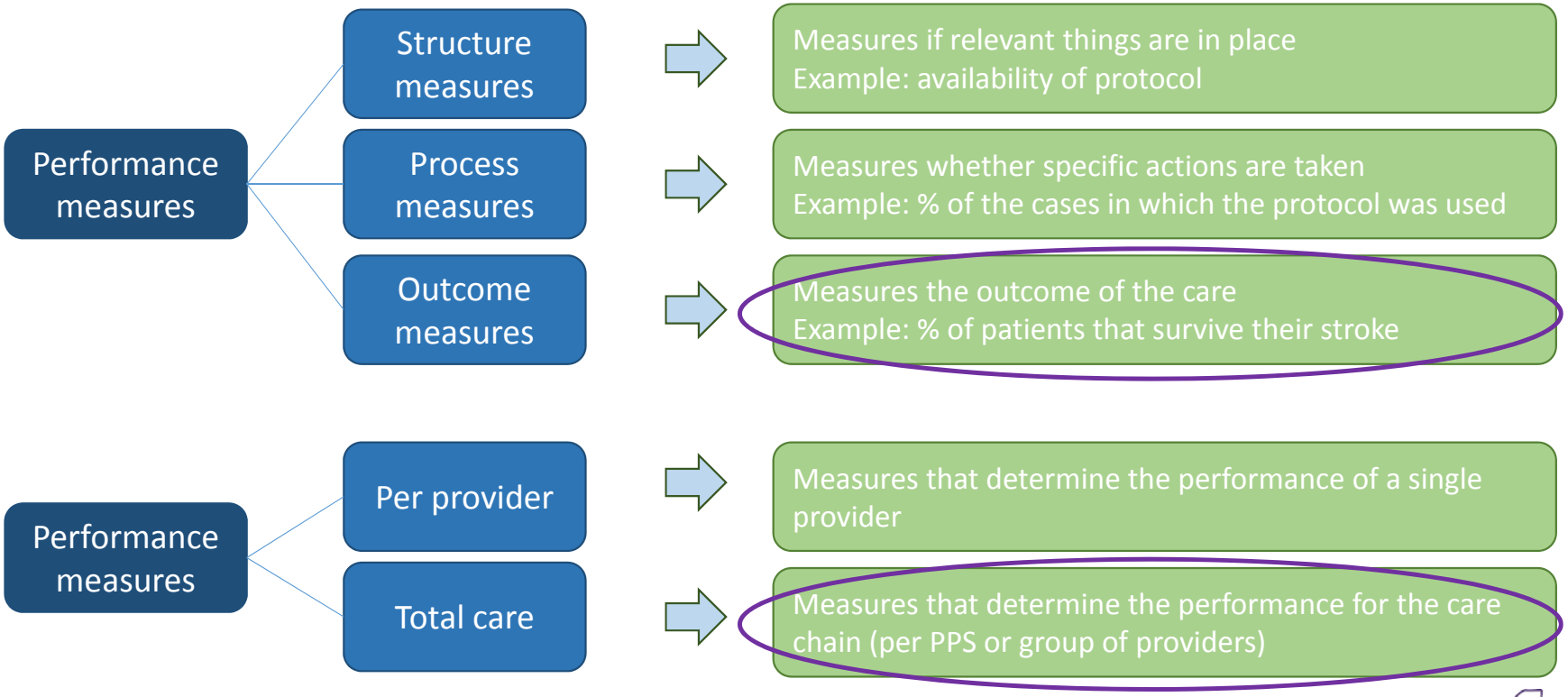
B. Introduction to Outcome Measures

To assess value and cost a small key set of performance measures is needed. Focus should be on outcome measures for total care.



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Outcome measures for the HARP population

- Many quality measures available
- Discussion: which outcome measures should be taken into account?

Examples of outcome measures and proxies of outcome measures[1]		
Mental Health inpatient care readmissions <30 days after discharge	Admission to lower level care within 14 days of discharge from inpatient rehab or detox treatment	SUD pharmacotherapy for alcohol and opioid dependence
Use of medication	Daily functioning	Substance use
Treatment of physical health conditions	Quality of life	Patient satisfaction

Before next meeting: can you all think about what relevant outcome measures for the HARP population should be taken into account? Which of those measures are already available?

1. https://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-3-27_final_mrt_update.pdf

Outcome measures for the HARP population – already in place

Year One Performance Measures

- Existing HEDIS/QARR measures for physical and behavioral health for HARP and MCO product lines
- Development of a limited number of new behavioral health measures
  - New measures can be derived from claims and encounter data
  - Measures include MH outpatient engagement, MH and SUD readmission, linkages to ambulatory care for SUD, and medicated assisted treatment for SUD. Specifics are under development.
- BHO Phase One measures will continue to be run administratively
- Measures are also being proposed for HARPs that are based on data collected from HCBS eligibility assessments. These measures are related to social outcomes – employment, housing, criminal justice, social connectedness, etc

1. https://www.omh.ny.gov/omhweb/bho/applicants-conference.pdf

Outcome measures for the HARP population – already in place

Year One Performance Measures

- Member Satisfaction – all are existing QARR measures
  - Based on CAHPS survey
  - A recovery focused survey for HARP members is also being developed. Measures derived from this survey may be created in the future

1. https://www.omh.ny.gov/omhweb/bho/applicants-conference.pdf