NEW YORK STATE | Department of Health | Medicaid Redesign Team

Advocacy and Engagement Subcommittee

Meeting #3

October 9, 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	11/5/2015	10:30-2:00pm	SPH 110A

Meeting Focus

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

- Patient-reported outcomes
- Determine Medicaid members right to know
- Recommend best practice communication methods to Medicaid members

Agenda

1. Review Member Incentive Recommendations
2. Finalize Patient Reported Outcomes (PROs)
3. Discuss Medicaid Members' Right to Know
4. Review Topics for Next Meeting

Member Incentive Recommendations

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.

Incentivizing Members to Utilize High-Value Providers – A Deeper Dive

Upon review of Federal and State regulations and laws, there is no legally sound way to incentivize a patient to use a particular provider.

Recommendations

1. Developing a Patient Incentive Program (Guideline for VBP level 1-2; Standard for VBP level 3)

- The Subcommittee recommends all MCO and providers offer member incentives in the VBP environment. Depending on the VBP agreement level, a MCO and provider will be held to this recommendation as a *Guideline* or *Standard*

Recommendations

2. Guiding Principles for Member Incentives

(Guideline)

- 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 patient incentives:
  - Culturally sensitive
  - Unbiased
  - Possess equity
  - Does not promote negative behavior
  - Provide reward in a reasonable timeframe from when it is earned
  - Communicated in a timely manner
  - Be relevant
  - Measurability

Recommendations

3. Creation of an Expert Group on Incentive Programs (Guideline)

- 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 culturally sensitive incentives that are aligned with the guiding principles in Recommendation #2

4. Elimination of the $125 Incentive Cap for Preventive Care (Standard)

- The Subcommittee recommends that the State eliminates the $125 incentive cap for preventive care services in the current New York State Medicaid managed care contract

Recommendations

5. Implementation of Pilot Incentive Programs (Guideline)	• The Subcommittee recommends that the established VBP Pilot Programs, currently in development for early adopters, be considered as a vehicle for piloting incentive programs
6. Incentive Program Outcome Measurement (Guideline)	• The Subcommittee recommends that the State should provide or contract a third party to measure outcomes of all incentive programs implemented for Medicaid

Recommendations

7. Development of a Library of Knowledge on Incentive Programs
(Guideline)

- The Subcommittee recommends that the State develop a library of knowledge where all providers, payors and members will have access to information on current incentive programs, as well as past programs and their efficacy

Patient Reported Outcomes (PROs)

Why would PROs be relevant for A&E?

During the last meeting, the Subcommittee discussed whether to recommend the use of PROs within the NYS Medicaid program. To recap:

- **PROs addresses *member engagement* in that PROs allow members to be central in the (e)valuation of their care, including:**
  - Decision-making about treatment options
  - Evaluation of outcomes
- **PROs addresses *advocacy for patients* in that PROs incentivizes providers to become oriented towards member goals in addition to their own provider goals**
  - Utilizing PRO information could provide an opportunity to discuss alternative treatments and more holistic or global care plans for members
  - Including the member's view of treatment in outcome reporting helps prioritize patient experience for providers

Benefits and Challenges with PROs

Benefits

- **Members** – Results can lead to better informed decisions for treatment and selection of providers
- **Purchasers** – Reporting can help to identify which providers deliver care that members find most beneficial
- **Providers** – Increases member engagement with care and creates a powerful instrument for constant self-improvement

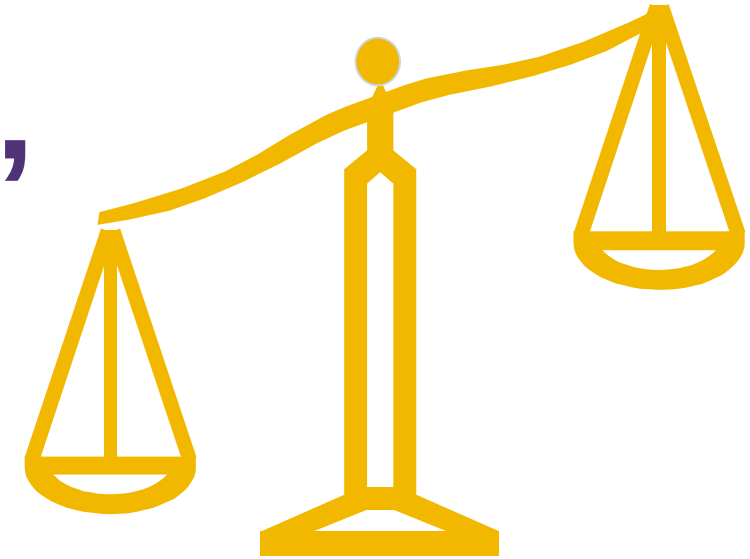
Potential Challenges

- Cost of implementation and design
- Increased burden for members
- Resistance from professionals / providers given the amount of other surveys they are already managing
- Lack of infrastructure to collect information on a population level
- Ability to standardize information received and provide meaningful information to members and providers
- Accuracy of information can be skewed due to individual perceptions (e.g. state of mind of the participant)

Questions for Discussion

- Would the Subcommittee like to recommend the use of PROs in the context of value-based payments?
- If so, how could PROs be implemented? Consider:
  - Guideline vs. standard
  - Level of VBP arrangement
  - Other?

Medicaid Members' Right to Know



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? (Meeting 4)

How and when should this information be communicated? (Meeting 4)

Medicaid Member's Right To Know: Areas of Focus

Categories to consider when Medicaid members are transitioning to VBP:

- Patient-centered care
- Payment structure changes impacting provider decision-making
- Data-sharing
- Claim denials

Patient Centered Care

Impact of Moving towards VBP:

- Coordination & integration of care
- Collaboration & team management
- Emphasis on primary care providers
- Members are connected and active participants in health outcomes
- Involvement of family, friends, and community
- Information, communication and education
- Transition/continuity of care

Moving to VBP: What This Should Look Like for Medicaid Members

- A holistic and collaborative relationship between members and providers for greater health value outcomes
- Greater focus on preventing or controlling different diseases and medical ailments rather than treating them after they occur
- Provider's outcomes of care will be available to members and they will have the opportunity to use that information to select provider(s) that fit them best

Payment Structure Changes Impacting Provider Decision-Making

Current state of Medicaid: Fee for Service (FFS)

Positives

- Provider can advocate for member treatment (denials/not supported by MCO)
- Minimal incentives for providers to ration care

Negatives

- Provider paid for each medical service or treatment
- Member may undergo unnecessary tests or treatment
- Provider incentivized to keep member returning

Transformation to VBP

Future State: Value Based Payments

Positives

- Provider is incentivized to provide quality care/value over volume
- Provider is paid set amount for each member attributed to them (level dependent)
- Positive outcomes = $avings

Negatives*

- Care rationing ~ member may not receive necessary tests or treatment
- Providers may not advocate for higher cost evidence based treatments for members

*Technical Design I Subcommittee is scoped with designing mitigation strategies to care rationing through the creation of outcome measures to show the success of a provider's care

How VBP Providers Decision Making Impacts Members (By Level)

Level 0

- No Change

Level 1

- Risk sharing could incentivize provider to attempt less expensive services rather than latest evidence based service
- Care rationing* (low concern)

Level 2

- Risk sharing could incentivize provider to attempt less expensive services rather than latest evidence based service
- Care rationing* (higher concern than Level 1)
- Providers will be accountable for outcomes

Level 3

- Capitation could incentivize provider to attempt less expensive services
- Care rationing* (higher concern than other levels)
- Providers will be accountable for outcomes

*Technical Design I Subcommittee is scoped with designing mitigation strategies to care rationing through the creation of outcome measures to show the success of a provider's care

Data-Sharing

In the future state of VBP, data-sharing is a critical component to the success of developing integrated delivery systems.

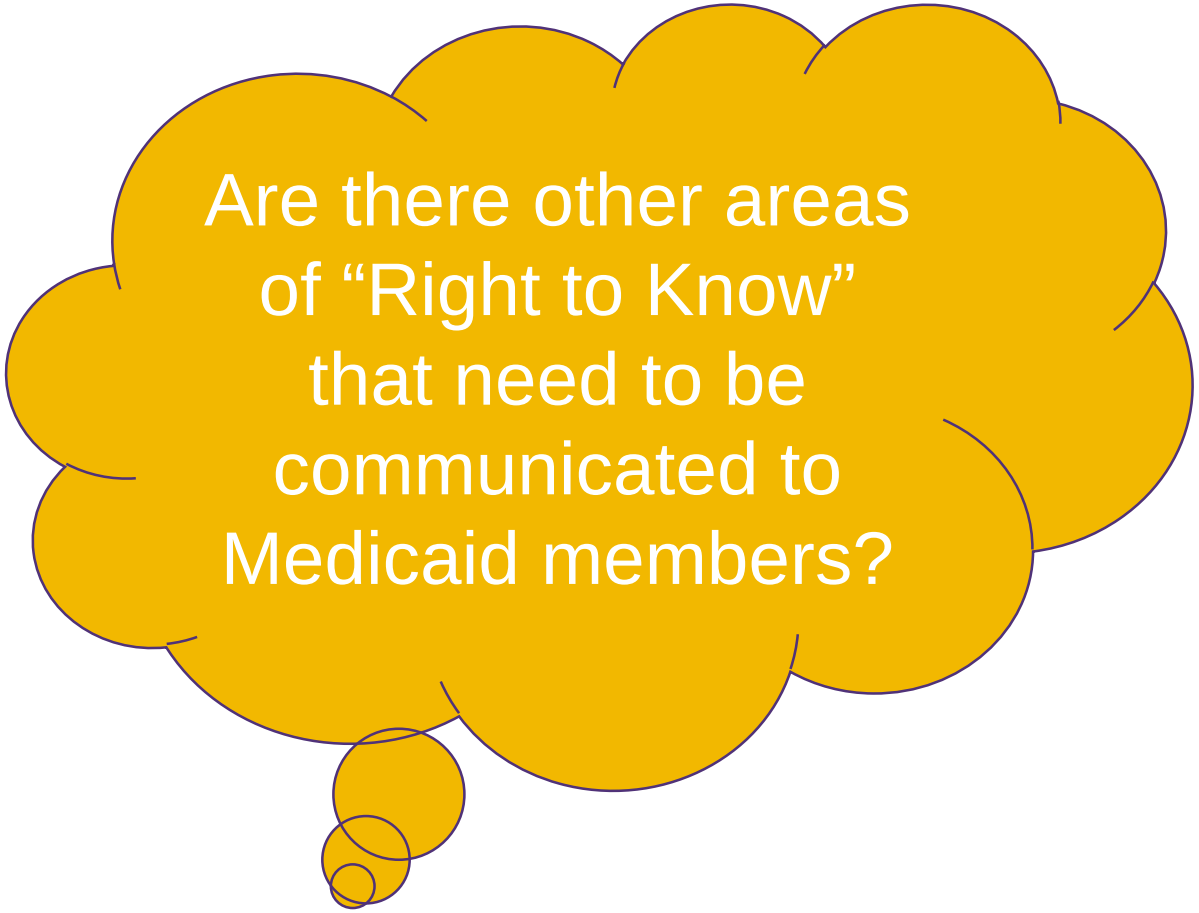
From a member's perspective, education may include:

- Benefits of sharing medical information between providers
- Member rights related to their personal health information
- Other?

Claim Denials

- In the future state of VBP, all providers, except those in Level 3, may be less incentivized to assist the member with claim and preapproval denials
- By law, denial of Medicaid claims impacts provider reimbursement, but not the member
- Providers cannot request reimbursement directly from the member but it is often attempted by both providers and collection agencies since members are not always aware of their rights
- Preapproval for treatments and/or specialists can be denied
  - Laws exist to mitigate providers and plans from improper care rationing
  - Several advocacy organizations exist to provide assistance when denials occur

Brainstorming Discussion



Reminder: Meeting Schedule

The next meeting will take place on November 5, 2015 from 10:30 to 2 PM at SPH 110A.

Please be prepared to discuss the following topics:

- Review “Right to Know” recommendations
- What are the best mechanisms for communicating with Medicaid members?
- How and when should the information be communicated?

Subcommittee Co-chairs

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Appendix

How VBP Affects Providers Care Plan Decision Making

Options	Level 0	Level 1	Level 2	Level 3
All care for total populations	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced when outcome scores are high)	Global capitation (with outcome-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMOM subsidy) with upside only shared savings based on total cost of care (savings available when outcome scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced when outcome scores are high)	PMPM capitated payment for Primary Care Services (with outcome-based component)
Acute and Chronic Bundles	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundles of care (savings available when outcome scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced when outcome scores are high)	Prospective bundle payment (with outcome-based component)
Total care for subpopulations	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (savings available when outcome scores are sufficient)	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced when outcome scores are high)	PMPM capitated payments for total care for subpopulation (with outcome-based component)