Department of Health | Medicaid Redesign Team

Technical Design I Subcommittee

Meeting # 4

October 21, 2015

Welcome Back

Today’s Agenda includes the following:

Agenda Item	Time
Welcome	11:00
Introduction to: 1. Overview of Contracting Total Care for the Total Population in Combination with other VBP Arrangements	11:05
Break (15 minutes)	12:15
2. Criteria for Hospitals to Receive 50% of Shared Savings in IPC Contracting	12:30

Total Care for Total Population, Subpopulations & Bundles

How does combining VBP Arrangements work in practice?

For Discussion in Technical Design Subcommittee I, NYS Value Based Payment Workgroup

Medicaid from a VBP perspective

Care for Medicaid members will be covered by the payment structures detailed below

Total Care for Total Population – Includes members who are not part of other bundles or subpopulations, and members with costs partially covered by other bundles and subpopulations

Maternity Care (incl. first month of newborn)

Preventive Care & Routine Sick Care

Chronic Bundle

Advanced Primary Care

AIDS/HIV population

Populations with intense dependency on Long Term Care (MLTC)

Severe BH/SUD conditions (HARP population)

Developmentally Disabled population

Estimated Medicaid costs from a VBP perspective[1]

Chronic Bundle	# of episodes/Y: ~1.57M Total cost/Y: ~ $2.8B
AIDS/HIV population	# of members: 50K Total cost/Y: $1.7B
Populations with intense dependency on Long Term Care (MLTC)[2]	# of members: 238K Total cost/Y: $11.3B
Severe BH/SUD conditions (HARP population)	# of members: 177K Total cost/Y: $3.2B
Developmentally Disabled population	# of members: 48K Total cost/Y: $3B

1.The cost overview excludes Duals, with the exception of MLTC, which includes duals and their Medicaid costs. Only MCO Medicaid is included; all traditional Medicaid (Medicaid FFS) is either assumed to be rolled into Managed Care or excluded

2. Includes Duals but only Medicaid's cost

Detailed Review: Chronic Bundle Costs[1,2]

of episodes/Y: ~1.57M
Total cost/Y: ~ $2.8B

Individual Bundles	Annualized Volume	Annualized Total Split Cost	Per Episode Annualized Split Costs
Diabetes	187,157	$689,635,258	$3,685
COPD	67,490	$140,099,818	$2,076
Asthma	326,723	$392,381,979	$1,201
Hypertension	388,868	$411,940,626	$1,059
Coronary Artery Disease	47,412	$112,763,492	$2,378
Low Back Pain	248,740	$226,051,218	$909
Osteoarthritis	66,696	$166,727,787	$2,500
Chronic Heart Failure	23,410	$115,692,893	$4,942
Arrhythmia / Heart Block	75,549	$112,226,629	$1,485
Chronic Depression	224,648	$368,351,584	$1,640
Bipolar Disorder	61,586	$357,733,919	$5,809
Substance Abuse	*Under development*		
Gastro-Esophageal Reflux Disease	162,627	$112,754,760	$693

1. Source: HCI3 grouper version 5.3 - episodes shown at level 5
2. For a specific chronic condition, every 'episode' is one individual with the condition (equivalent to counting members in a population). However, any individual with a chronic condition can (and indeed often has) more than one condition – hence multiple episodes

Costs outside of Maternity care, Preventative care, and Chronic Bundles in TCTP: Unassigned Costs

Total Care for Total Population

- Maternity Care
- Preventive and Routine Sick Care
- Chronic Bundles
- AIDS/HIV population
- Managed Long Term Care (MLTC population)
- Severe BH/SUD conditions (HARP population)
- Developmentally Disabled population

The highest cost diagnosis in unassigned costs within TCTP:

- N/A
- Developmental Disorders
- Schizophrenia
- Epilepsy/Convulsions
- Attention-deficit, conduct, and disruptive behavior disorders
- Trauma
- Acquired disabilities
- Cancer

Contracting options: combinations of individual VBP arrangements

In the below VBP arrangement combination, the **Total Expected Costs for TCTP *Remainder*** is the difference between the Total Expected Cost of Total Population [excluding subpopulations but including HIV/AIDS patients] and the Total Expected cost of Maternity Bundle

Total Care for Total Population	**$5000**
Maternity Care	$100
AIDS/HIV population	$250
Populations with intense dependency on Long Term Care (MLTC)	
Severe BH/SUD conditions (HARP population)	
Developmentally Disabled population	

VBP Arrangement	Expected	Actual
TCTP	$5000	$4,900
Maternity	$100	$80
AIDS/HIV	$300	$310
Total	**$4,600**	**$4,510**

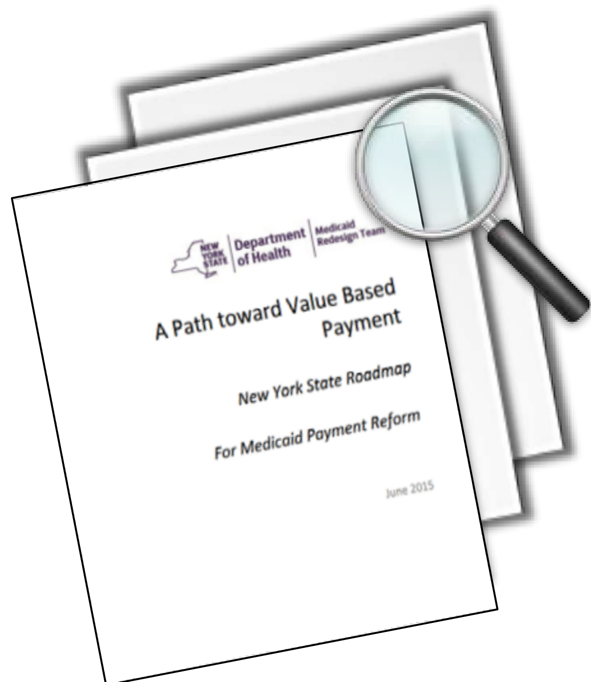
Note: The figures listed in the above example are fictional and only to illustrate an example of combining VBP arrangements.

Break – 15 mins

Criteria for Hospitals to Receive 50% of Shared Savings in Integrated Primary Care (IPC) Contracting

For Discussion in Technical Design Subcommittee I, NYS Value Based Payment Workgroup

Roadmap Language on Collaboration with Hospitals in the IPC Model



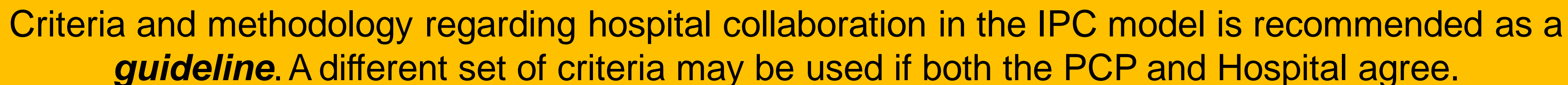
…To maximize shared savings in this model, PCMHs/APC's are encouraged to collaborate with hospitals and other providers on activities such as outreach, care management, and post-discharge care. Because shared savings will derive in large part from avoided hospital use, ***earned savings should be shared evenly between PCMHs/APCs and associated hospitals, provided that the hospitals work cooperatively with PCMHs/APCs to better manage their patient populations****. This would include establishing effective strategies for notifying PCMHs/ACPs on a timely basis about patient admissions and ED visits and collaborating on care transitions by sharing discharge summaries with medication information.*

Page 9-10 of NYS VBP Roadmap

Remember: Key Questions for all Topics

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.



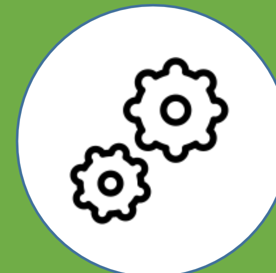
Criteria and methodology regarding hospital collaboration in the IPC model is recommended as a ***guideline***. A different set of criteria may be used if both the PCP and Hospital agree.

Four Criteria for Collaboration

1 Health Information Technology

2 Innovation and Care Redesign

3 Efficiency



4 Quality and Engagement

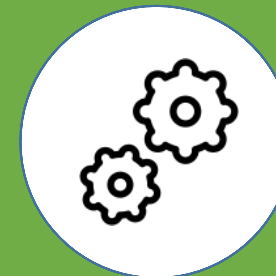
Potential Points for Inclusion in HIT Criteria

1. Attest to **Meaningful Use** Stage 2
2. Exchange clinical data with PCP through **Regional Health Information Organization** (RHIO)
3. Provide **direct data feeds** to PCPs for emergency room utilization, admissions, and discharges (including behavior health and substance abuse)
4. Facilitate **Shared Treatment Plans** post discharge and for factors affecting the population health of the community (such as: BHS/substance abuse treatment and patients with frequent ER use for non-emergent conditions)

Potential Points for Inclusion in Innovation and Care Redesign Criteria

1. Enter into MOU, or an equivalent agreement, with PCPs for **joint accountability of the care** they deliver
2. **Standardization of care plan** based on evidenced-based guidelines and practices to eliminate variation in the organization for a given service area such as high cost imaging, emergency room care, oncology treatment, diagnostic testing, etc.
3. Enhance **care transitions to post-acute settings** such as Skilled Nursing Facilities and Home to reduce readmission rates and potential complications
4. Implementation of **Palliative Care** and collaboration with Hospice

Potential Points for Inclusion in Efficiency Criteria



1. Collaborate with PCP on **analyzing cost drivers** and development and implementation of new workflows/processes to improve efficiency
2. Set and achieve goals in improved efficiency in reducing avoidable admissions, re-admissions, and emergency room utilization

Potential Points for Inclusion in Quality and Engagement Criteria

1. Achieve/maintain full accreditation from a recognized body such as Joint Commission, HFNP, DNV
2. Conduct annual patient satisfaction survey and incorporation of results/recommendations as part of plan in collaboration with PCPs
3. Collaborate with PCPs on DSRIP IPC Domain 2 and 3 metrics quality indicators affecting population health

Additional Considerations for IPC Criteria

Discussion Questions:

Should the savings split be graduated based on the number of criteria met? For example, if two out of four criteria are met then the hospital retains half of the savings split.

How will shared losses be split?

What is the timing for these criteria to be met?

Final Meeting

When: November 18th at 1:00 PM

Location: Albany

Agenda:

1. Finalize Meeting #4 Agenda Items
   - Overview of Contracting Total Care for the Total Population in Combination with other VBP Arrangements
   - Criteria for Hospitals to Receive 50% of Shared Savings in IPC Contracting
2. Close

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