NEW YORK STATE | Department of Health | Medicaid Redesign Team

Technical Design II Subcommittee

Meeting #1

July 20, 2015

Agenda

Today's Agenda includes the following:

Agenda Item	Time
Welcome & Introductions	2:00
Subcommittee Role	2:05
Introduction to VBP	2.15
Agenda Items for Discussion: 1. How to continue to incentivize preventive activities within VBP? (What activities/services should remain FFS and will be considered VBP?) 2. How will the technical assistance be provided to those providers that run into performance challenges in VBP arrangements?	3.30

Subcommittee Role

How are the SCs relevant to VBP?

- VBP **subcommittees will play a crucial role** in creating recommendations about important implementation details from the VBP Roadmap
- 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

Key Questions for all Topics

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.

Technical Design II Tentative Agenda

Workgroup II (Quality/Support/ Design)	
Discussion	**Introduction to**
Meeting 1	
VBP Introduction	1. How to continue to incentivize preventive activities within VBP? (What activities/services should remain FFS and will be considered VBP?) 2. How will the technical assistance be provided to those providers that run into performance challenges in VBP arrangements?
Meeting 2	
Topics from previous meeting – Deep Dive	1. Should certain services or providers be excluded from VBP? 2. What should be the criteria and policies for the VBP Innovator Program?
Meeting 3	
Topics from previous meeting – Deep Dive	1. Should a special status be created for financially challenged providers? 2. What will be included in the planned assessment of the progress made in the VBP participation and market dynamics?
Meeting 4	
Topics from previous meeting – Deep Dive	1. What should be the Quality and Outcome measures in the TCTP arrangement? 2. How should the workforce measures (generic level) be defined? 3. What will be the best way to align MCO measures with VBP measures?
Meeting 5	
Topics from previous meeting – Deep Dive	1. TBD

Technical Design II Meeting Schedule

Meeting	Date	Time	Location
Meeting 1	7/20/15	2:00 pm	Albany
Meeting 2	8/17/15	2:30 pm	Albany
Meeting 3	9/29/15	1:00 pm	NYC
Meeting 4	10/22/15	1:00 pm	NYC
Meeting 5	11/18/15	1:00 pm	Albany

NEW YORK STATE | Department of Health | Medicaid Redesign Team

VBP Introduction

Brief background and context

NYS Medicaid in 2010: The Crisis

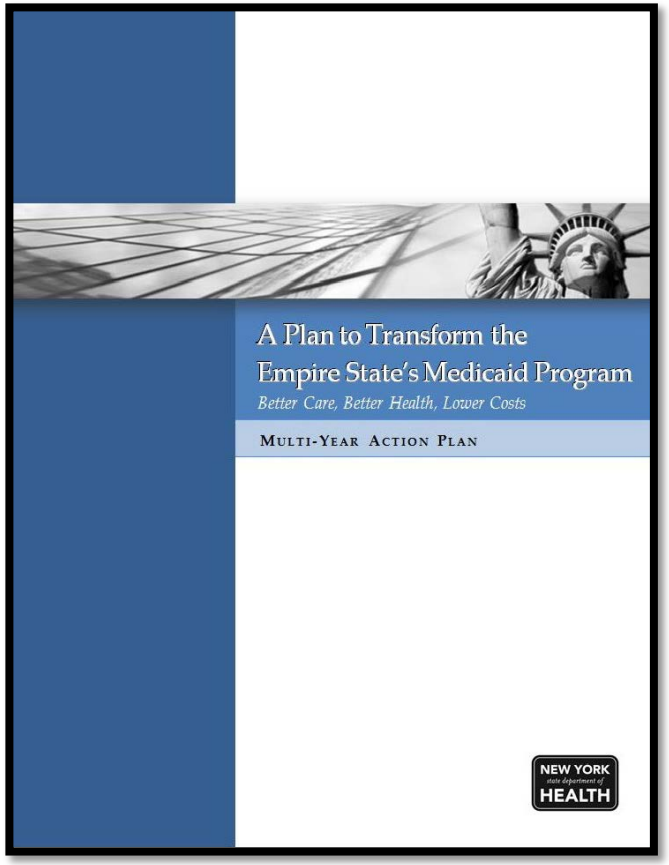
- > 10% growth rate had become unsustainable, while quality outcomes were lagging
  - Costs per recipient were double the national average
  - NY ranked 50th in country for avoidable hospital use
  - 21st for overall Health System Quality

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

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 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

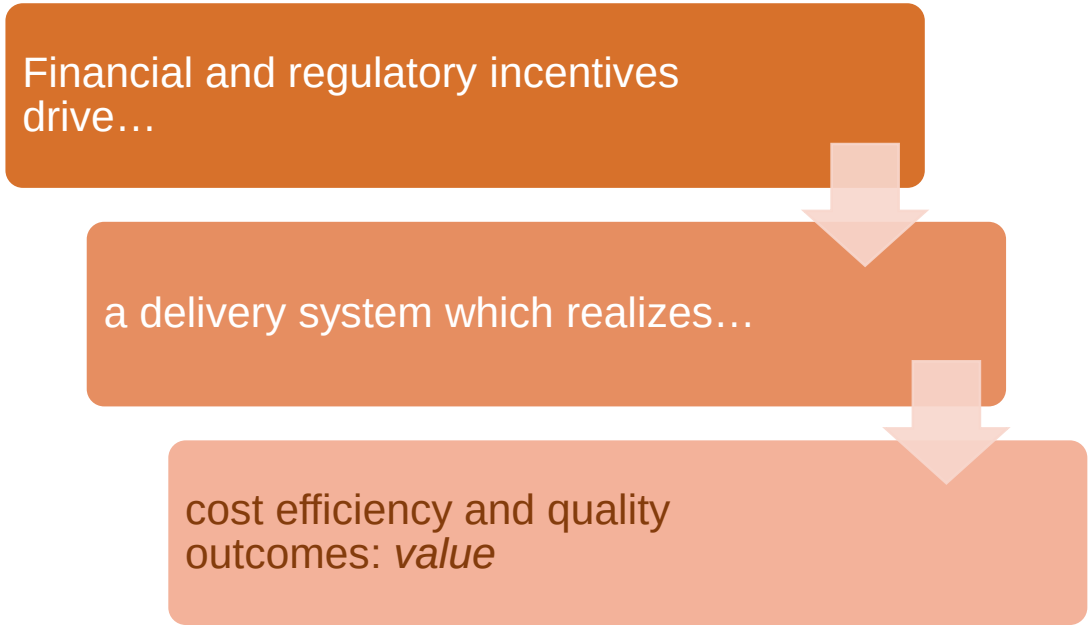
- Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York's health care delivery system
- In April 2014, New York State and CMS finalized agreement Waiver Amendment
  - Allows the State to reinvest $8 billion of $17.1 billion in Federal savings 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

    - 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

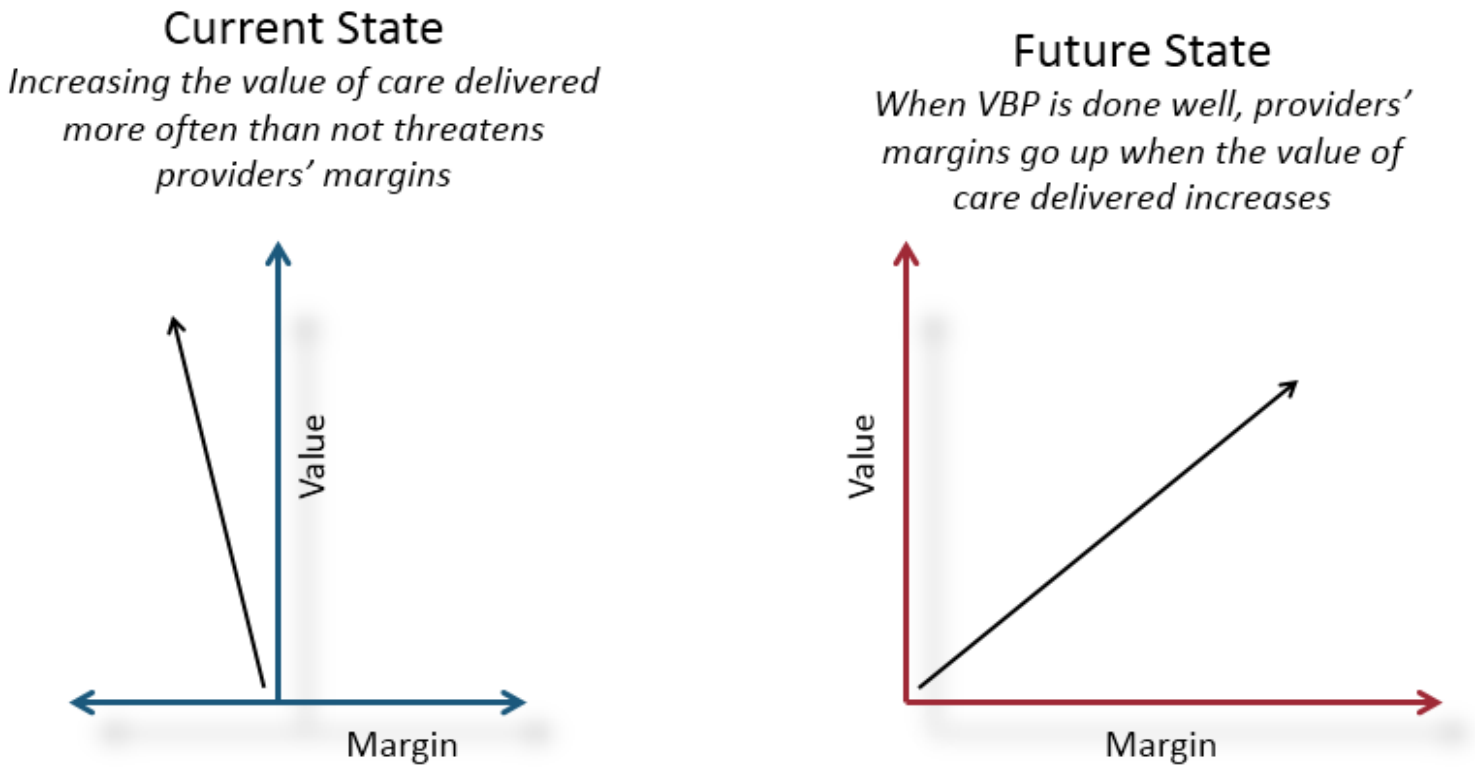


Payment Reform: Moving Toward Value Based Payments

- 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 CMS are committed 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

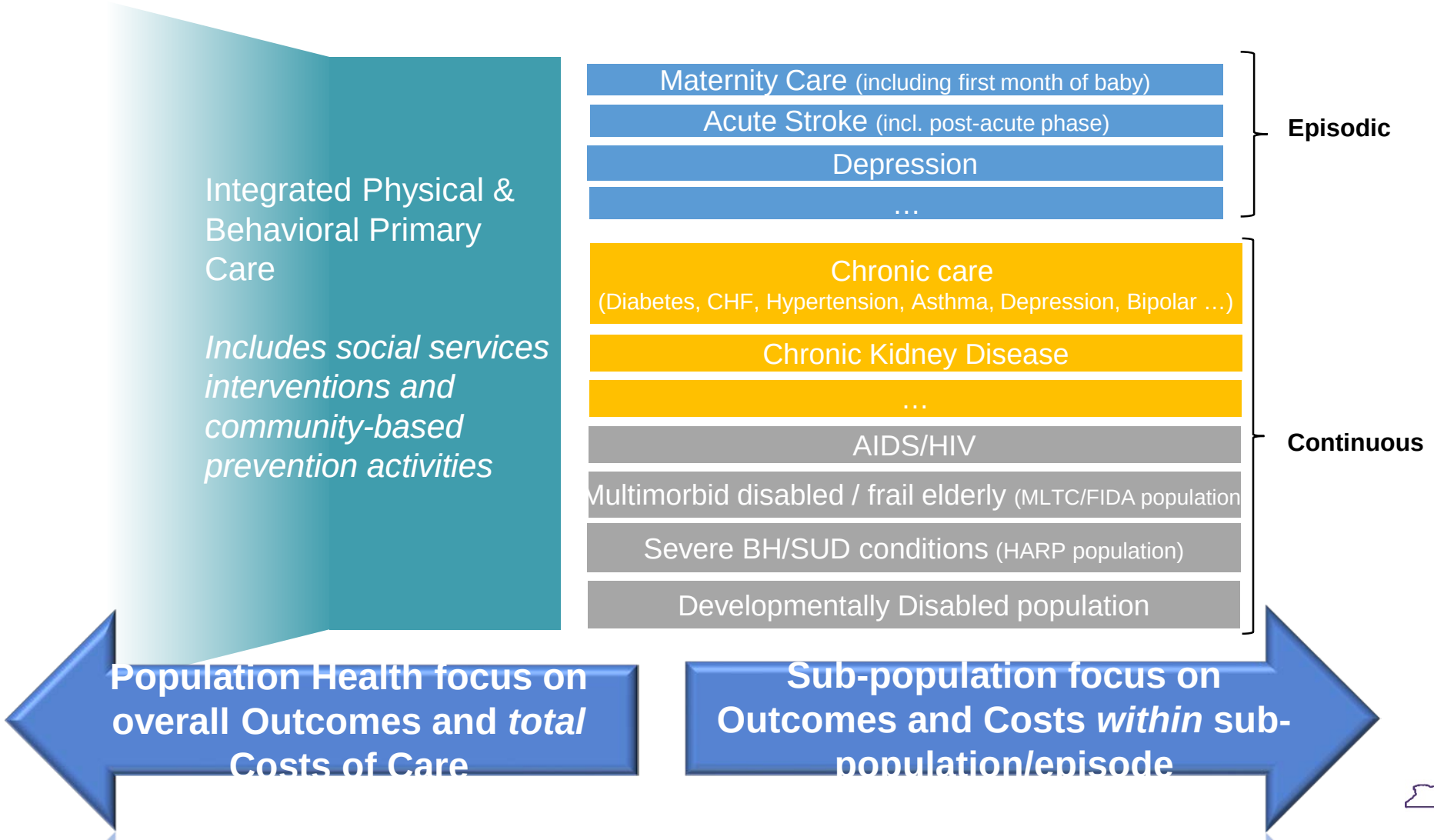
Learning from Earlier Attempts: VBP as the Path to a Stronger System

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

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



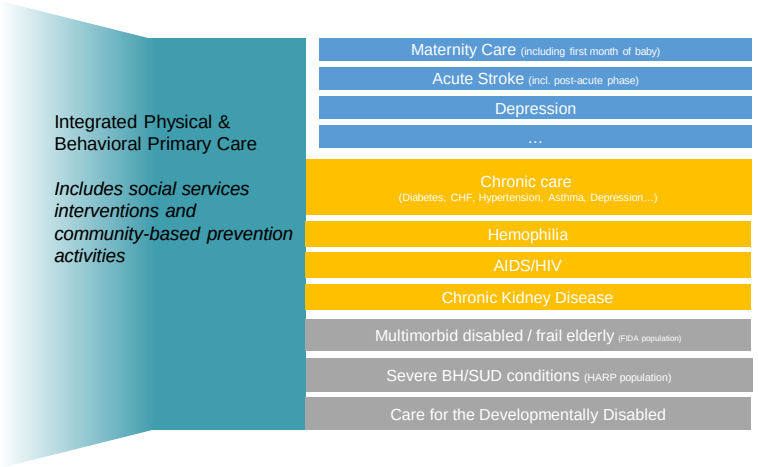
NEW YORK STATE OF OPPORTUNITY. Department of Health

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 members 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

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 of 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 payment reforms
3. Addressing the need to change provider business models through positive financial incentives
4. Allowing maximum flexibility in the implementation 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 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 sustainable system through integrated care coordination and rewarding 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. 25% 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.

NEW YORK STATE | Department of Health | Medicaid Redesign Team

How to continue to incentive preventative and other positive activities within VBP?

What activities/services should remain FFS and be considered VBP?

Remember: Key Questions for all Topics

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.

Identify activities/services that should remain FFS and be considered VBP

Fee-for-Service incentivizes volume. For those care services where high volumes are desirable, Fee-for-Service may be considered VBP when aligned with Quality Measurement.

What is Preventive Care

The Center for Disease Control and Prevention defines preventive care as care that, “Includes health services like screenings, check-ups, and patient counseling that are used to prevent illnesses, disease, and other health problems, or to detect illness at an early stage when treatment is likely to work best.”[1]

[1] Center for Disease Control and Prevention. *CDC Prevention Checklist.* Retrieved from http://www.cdc.gov/prevention/ on July 8, 2015.

Affordable Care Act – Preventive Care

Preventive
es as per 45 CFR 1

The ACA contains a provision that specifically addresses preventative health coverage for certain services for which cost sharing requirements shall not be imposed. The inclusion of these provision highlights the fact that preventive care is an critical component of a truly comprehensive continuum of care. [1]

1. “Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; For the complete list of services please refer to Table 1 in the embedded document.

2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; For the complete list of services please refer to Table 2 in the embedded document.

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; For the complete list of services please refer to Tables 3.1 through 3.3 in the embedded document.

4. With respect to women, evidence-informed preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration”; For the complete list of services please refer to Table 1 in the embedded document.

[1]45 CFR 147.130

Quality Measures

Key Points:

1. For preventive services, Quality Measures usually measure *whether* the preventive services have been provided where indicated.

2. Several current DSRIP and HEDIS measures already target this topic.

3. With the HCI3 grouper, it is possible to broaden the focus on preventive services and their appropriate use.

4. Are there instances where a more outcome-focused approach (i.e., measuring the events that are to be prevented) is to be preferred?

Other Options?

Key Question:

Are there other approaches to consider to incentivize this type of value-adding services?

How will technical assistance be provided to those providers that run into performance challenges in VBP arrangements?

Technical assistance to providers

The Roadmap suggests that technical support be provided to providers in VBP arrangements that are encountering performance challenges.

Key Questions:

- Does the Subcommittee feel this should be the State's responsibility to provide such assistance?
  - If yes, what should technical assistance include?
- Does the Subcommittee feel this assistance should be provided by the MCOs?

Contact Us

Co-Chair
Lynn Richmond
LRichmon@montefiore.org

Co-Chair
Denise Gonick
DGonick@mvphealthcare.com

Zamira Akchurina
KPMG Lead
ZAkchurina@kpmg.com