

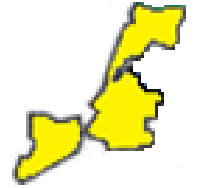


**Department
of Health**

Medicaid
Redesign Team

VBP Bootcamp Series

Session 3



NYC (excl. Queens)

Region 3: New York City (Bronx, Brooklyn, Manhattan, Staten Island)

September 2016

Welcome

Greg Allen
NYS DOH Director, Division of Program Development & Management
Office of Health Insurance Programs

Today's Agenda

Agenda Items		Time	Duration
Morning Session	Welcome	10:30 AM	15 mins
	Quality Measures Overview	10:45 AM	75 mins
	Performance and Target Budget: Reminder	12:00 AM	30 mins
Break	Lunch	12:30 PM	60 mins
Afternoon Session	Performance Data Overview	1:30 PM	75 mins
	Break	2:45 PM	15 mins
	VBP Dashboard Walkthrough	3:00 PM	75 mins
	Closing	4:15 PM	15 mins

What are VBP Bootcamps?

- This learning series will provide **foundational** knowledge about Value-Based Payment (VBP) structure and prepare you for VBP implementation
- Bootcamps will be held in 5 regions across NYS between June and October of 2016
 - Each Bootcamp will consist of 3 all-day sessions held approximately one month apart in a centralized location
 - You are highly encouraged to attend all 3 sessions
 - If unable to attend a session in your region, you may register for sessions in other regions. Also, webcast recordings are going to be available in the VBP Library
 - The content of sessions are applicable statewide
- We encourage networking during the sessions, so please bring appropriate staff to extract the most value out of these sessions. These will include: business and clinical leadership, contracting staff, finance staff, IT staff, etc.

VBP Bootcamp Regions

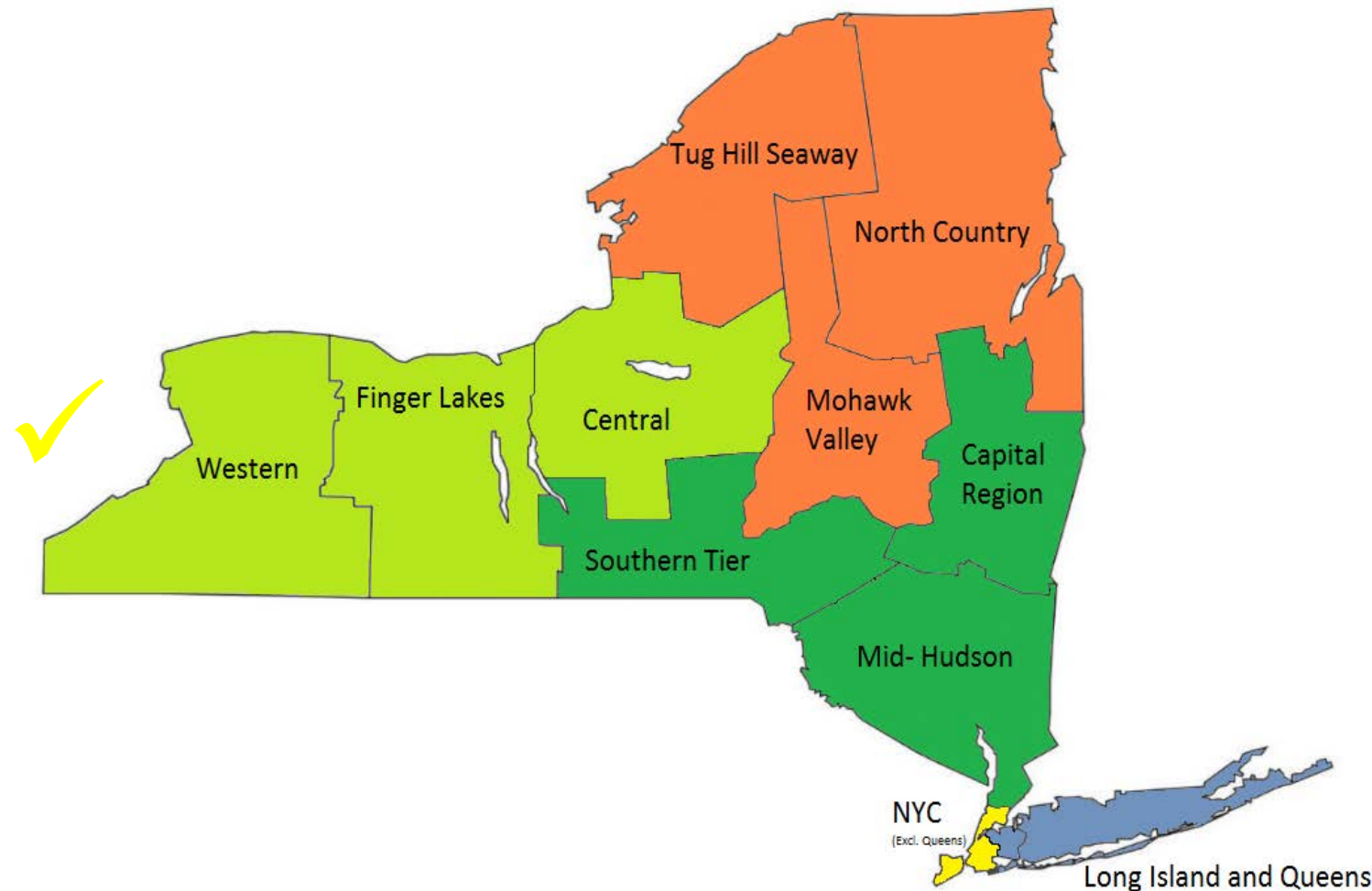
Region 1: Capital Region, Southern Tier, Mid-Hudson

Region 2: Mohawk Valley, North Country, Tug Hill Seaway


Region 3: New York City (excluding Queens)

Region 4: Central NY, Finger Lakes, Western NY

Region 5: Long Island and Queens



VBP Bootcamp Curriculum & Schedule

Session	Topics covered	Date & Time	Locations
Session 1	Introduction to VBP <ul style="list-style-type: none"> - VBP Design Overview - High Level Readiness Assessment Considerations 	Wednesday, July 20, 2016 9AM – 4PM	Bronx Community College
Session 2	Contracting & Risk Management <ul style="list-style-type: none"> - VBP Contracting - Target Budget Setting - Financial Risk Management 	Wednesday, August 17, 2016 9AM – 4PM	
 Session 3	Performance Measurement <ul style="list-style-type: none"> - Quality Measures - Understanding your performance: a data-driven approach - MAPP and the VBP Dashboards 	Monday, September 12, 2016 10.30AM – 4:30PM	

Explore the VBP Bootcamp Website

The Website will provide access to the following:

- Bootcamp Schedules
- Bootcamp Registration
- Session Materials
- VBP Resource Library

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_bootcamp/index.htm

DSRIP Program

- Home
- CMS Official Documents
- FAQs
- Medicaid Analytics Performance Portal (MAPP)
- Performance Data
- Performing Provider Systems (PPS)
- Value Based Payment Reform (VBP)
- Vital Access Provider Assurance Program
- Webinars & Presentations
- Archives

Contact

- Questions? Check-out the DSRIP FAQ
- Email: dsrip@health.ny.gov
- DSRIP LinkedIn Group

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DSRIP - VBP Bootcamps

About VBP Bootcamps

Description: The Value Based Payment (VBP) Regional Bootcamp learning series will be provided by the Department of Health to the plan and provider communities within the State to deliver necessary information about VBP and ensure a successful transition to its implementation. The series will be completed over the course of three all-day sessions in every region, approximately one per month. The State has been divided into five regions where each session will occur (please see map below).

Target Audience: These sessions will be directed towards all parties that will be implementing Medicaid payment reform. However, the content addressed will be most relevant to those who have little to no experience in executing value-based contracts.

Objectives: These Bootcamp sessions will aim to give an in-depth look at Value Based Contracting in New York State Medicaid. They will provide an overview of VBP arrangements, focusing on what it means to be a VBP contractor and how to make a VBP contract successful. The sessions will highlight the data and analytical capabilities that the State will make available, how Medicaid providers can move responsibly into accepting downside risk, what health plans are expected to do, and what the financial incentives in the VBP world will look like for both payers and providers. The Bootcamp sessions will also aim to facilitate networking between plans and providers.

Bootcamps Regions

To find information about your Bootcamp region, select your location from the map below.

Path: DSRIP Homepage → Value Based Payment Reform → VBP Bootcamps

Link: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_bootcamp/index.htm

Overview of Sessions 1 and 2

Session 1

- Overview of the Bootcamp series
- Introduction to VBP
- Types of VBP Arrangements
- VBP design standards
- Readiness assessment overview

Session 2

- VBP Contracting overview
 - Contracting entities
 - Types of contracts
 - Contracting considerations
 - Contract necessities vs. optional items
 - Contracting with CBOs
- Financial Risk Management
- Panel: Real life experience with VBP contracting

If you were unable to attend a session in your region, you may attend in another region or watch the recorded sessions found on the NYS DOH VBP Library:

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/index.htm

Session Logistics

Q&A:

- There will be multiple breaks throughout the day for Q&A
 - When asking a question in person, please wait to speak in the microphone
 - Please state your name and organization name (to help networking)

Quality Measures Overview

Quality Measures

This section will cover:



Starting Points

Clinical Advisory Groups (CAGs)

Role of Quality Measures in VBP

Current Status & What To Expect

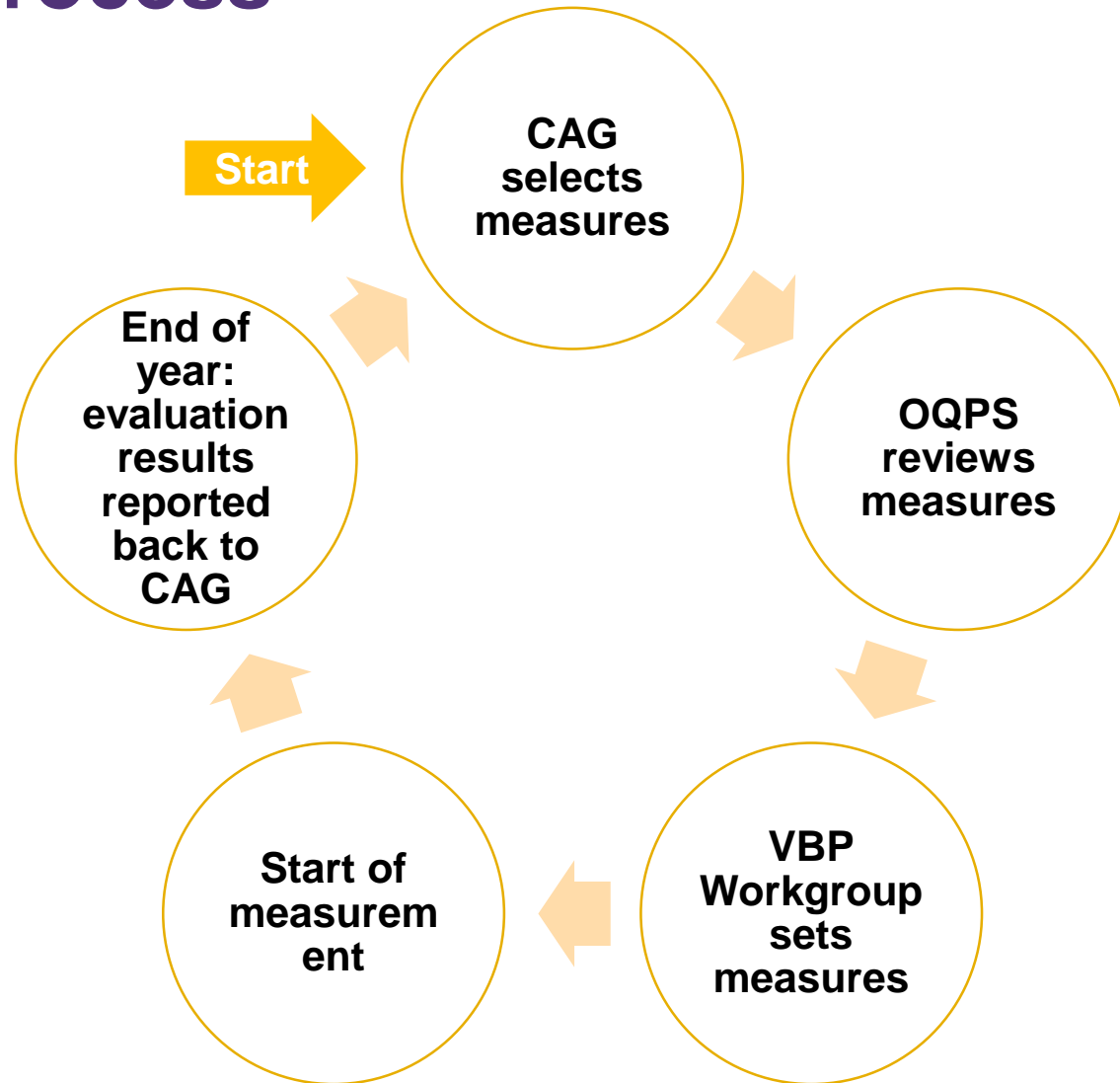
Timeline

Starting Points

Starting Points for Selection of Quality Measures

- Alignment with DSRIP (avoidable hospital use)
- Reduce 'drowning' in measures phenomenon: outcome measures have priority
- Measuring the quality of the total cycle of care of the VBP arrangement
- Relevance for patients and providers
- Alignment with Medicare: linking to point of care registration (EHR)
- Alignment with State Health Innovation Plan's Advanced Primary Care measure set
- Transparency of process, of measures, of outcomes

Selecting and Refining Quality Measures is an Ongoing Process



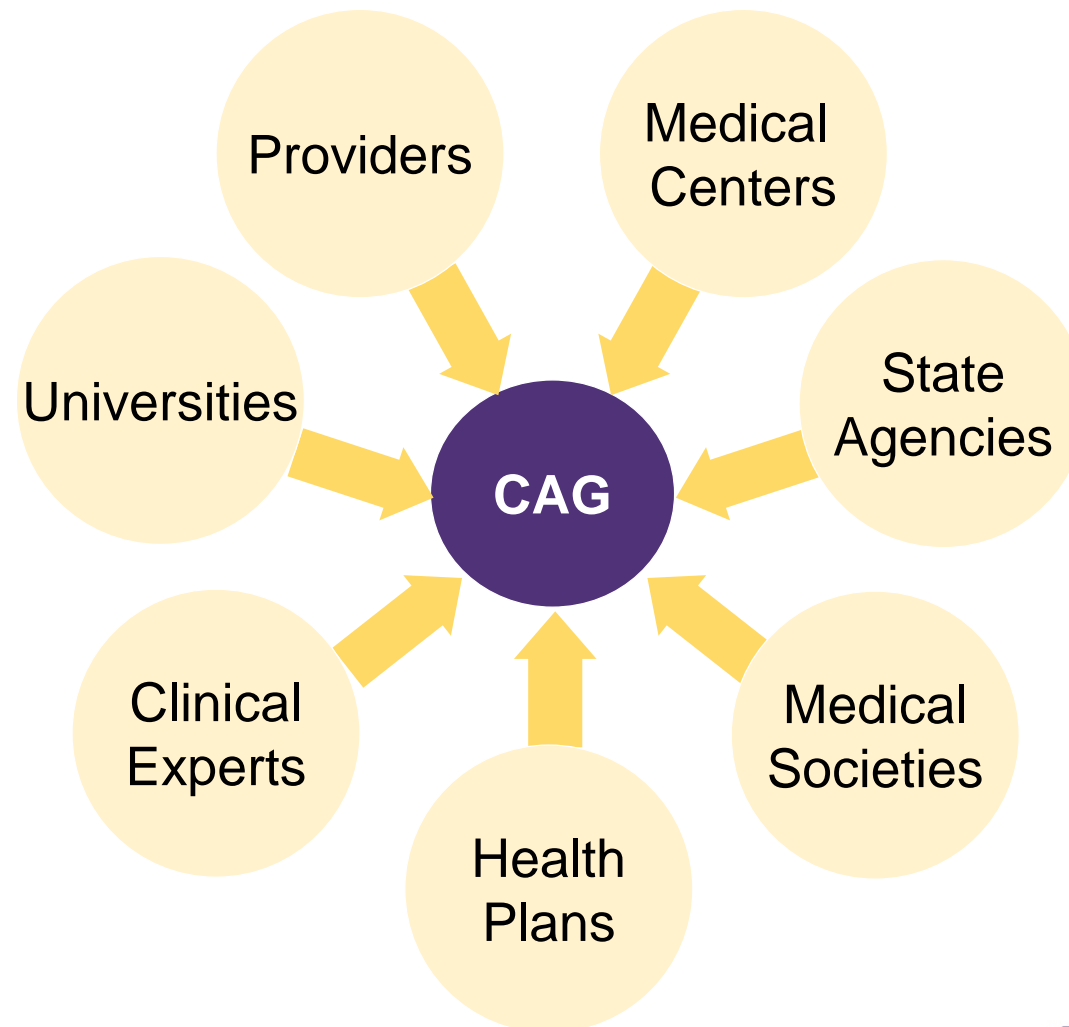
During the process:

- Lists gets refined and reduced to those measures that really matter (specific to VBP arrangement)
 - Key outcome measures
 - Measures that are key to DSRIP success
 - Nationally standardized key process measures
- Focus on outcomes will increase as outcome measures mature
- *Pilots are essential to test feasibility and relevance of measures*

Clinical Advisory Groups

Clinical Advisory Groups: Composition

Each CAG was comprised of leading experts and key stakeholders throughout NYS healthcare delivery system, spanning upstate and downstate regions. Their scope included **development of quality measures for all VBP arrangements.**



Clinical Advisory Groups: Status

CAG Name	Status
Maternity Care	Pending in the VBP Workgroup to be Finalized (Went through Public Comment Period)
Chronic Care: Heart Conditions & Diabetes	Draft Report Completed
Chronic Care: Pulmonary Conditions	Draft Report Completed
Behavioral Health (BH): HARP	HARP Draft Report Completed; reviewing quality measures with OMH and will reconvene the CAG in early October (Went through Public Comment Period)
BH: Substance Use Disorder, Trauma and Stressor, Depression and Anxiety	BH Chronic Episodes Draft Report Completed; will undergo public comment period in early October
HIV/AIDS	Pending in the VBP Workgroup to be Finalized (Went through Public Comment Period)
Managed Long Term Care (MLTC)	Draft Report Completed
Intellectually/Developmentally Disabled (I/DD)	Draft Report Completed
Children's Health CAG/Subcommittee	To Be Commenced This Month

CAG Reports with all quality measures as well as the definitions of the VBP arrangements will be posted in the VBP Resource Library.

Integrated Primary Care

- The Integrated Primary Care VBP arrangement consists of three components:
 - Prevention
 - Routine Sick Care
 - Chronic Care
- Input for the Chronic Conditions came from the CAGs
- Input for Prevention and Routine Sick Care came from the Advanced Primary Care workgroup (part of the Statewide Health Innovation Plan (SHIP)):
 - The output of the Chronic Care CAGs will be maximally aligned with the APC work as well
 - Given the specific nature of the Medicaid Population, there will be additional attention to Behavioral Health measures and Pediatric measures
- Strong focus on Prevention Measures and Potentially Avoidable Complications

Goal: right balance between feasibility and adequate attention to total scope of IPC VBP arrangement

Caveat: pending final decision by VBP Workgroup and the State

Total Care General Population

- There is no CAG for TCGP because between DSRIP and QARR this VBP arrangement was deemed to be adequately covered
- Because of the importance of population health and the strengthening of Primary Care the State is considering using the IPC measure set across the TCGP VBP arrangement as well
- However, the Behavioral Health and Pediatric CAGs will be there to address the needs of those groups

Goal: right balance between feasibility and adequate attention to total scope of TCGP VBP arrangement

Caveat: pending final decision by VBP Workgroup and the State

Clinical Advisory Groups: Objectives

CAG members convened to meet the following objectives:

Understand the State's visions for the Roadmap to Value Based Payment

Discuss and validate definitions of VBP arrangements

Review and Recommend quality measures for the VBP arrangement

Make additional recommendations to the State on:

- Data and other support required for providers to be successful
- Other implementation details related to each arrangement

Quality Measure Selection

The quality measure selection process began using the following sources:

- Relevant DSRIP Domain 2 and 3 measures
- NYS Quality Assurance Reporting Requirements (QARR)
- Relevant measures from CMS measure sets
- National Quality Forum (NQF) measures
- National Committee for Quality Assurance (NCQA)
- CAG-specific sets (e.g. NYS AIDS Institute measures for HIV/AIDS CAG)

Criteria for Selecting CAG Quality Measures



Criteria for Selecting CAG Quality Measures



- **Focused on key outcomes of integrated care process**
 - *I.e. outcome measures are preferred over process measures; outcomes of the total care process are preferred over outcomes of a single component of the care process (i.e. the quality of one type of professional's care).*
- **For process measures: crucial evidence-based steps in integrated care process that may not be reflected in the patient outcome measures**
- **Existing variability in performance and/or possibility for improvement**

Criteria for Selecting CAG Quality Measures



- **Measure is well established by reputable organization**
 - *By focusing on established measures (owned by e.g. NYS Office of Quality and Patient Safety (OQPS), endorsed by the National Quality Forum (NQF), HEDIS measures and/or measures owned by organizations such as the Joint Commission, the validity and reliability of measures can be assumed to be acceptable.*
- **Outcome measures are adequately risk-adjusted**
 - *Measures without adequate risk adjustment make it impossible to compare outcomes between providers.*

Criteria for Selecting CAG Quality Measures



- **As a starting point, claims-based measures are preferred over non-claims based measures (clinical data, surveys)**
- **When clinical data or surveys are required, existing sources must be available**
 - *I.e. the link between the Medicaid claims data and this clinical registry is already established.*
 - *The availability of the clinical data required for the measure (i.e. blood pressure, lab values) are deemed to be key for successful care delivery across organizational boundaries*
- **Preferably, data sources be patient-level data**
 - *This allows drill-down to patient level and/or adequate risk-adjustment.*
- **Data sources must be available without significant delay**

The Criteria Were Used to Categorize All Measures



CATEGORY 1

Approved quality measures that are felt to be both clinically relevant, reliable and valid, and feasible.



CATEGORY 2

Measures that are clinically relevant, valid and probably reliable, but where the feasibility could be problematic. These measures should be investigated during the 2016 or 2017 pilot.



CATEGORY 3

Measures that are insufficiently relevant, valid, reliable and/or feasible.

The following slides display current draft measures for Maternity and HIV/AIDS Arrangements as an example.

Maternity* – Category 1 Measures

The CAG recommended the following quality measures for use in the Maternity VBP Arrangement.

No.	Category 1 Measure	Reporting Source	State Recommended Category	P4R
1	Frequency of Ongoing Prenatal Care	State	1	No
2	Prenatal and Postpartum Care (PPC)	State	1	No
3	% of Vaginal Deliveries with Episiotomy	VBP Contractor	1	Yes
4	Vaginal Birth After Cesarean (VBAC) Delivery Rate	VBP Contractor	1	Yes
5	C-Section for Nulliparous Singleton Term Vertex (NSTV) (risk adjusted)	VBP Contractor	1	Yes
6	% of Early Elective Deliveries	VBP Contractor	1	Yes

*Measures are subject to VBP Workgroup review and approval.

Maternity* – Category 2 Measures

The CAG recommended the following quality measures for use in the Maternity VBP Arrangement.

No.	Category 2 Measure	Reporting Source	State Recommended Category	P4R
7	Antenatal Steroids	VBP Contractor	2	Yes
8	Antenatal Hydroxyl Progesterone	VBP Contractor	2	Yes
9	Experience of Mother With Pregnancy Care	VBP Contractor	2	Yes
10	Appropriate DVT Prophylaxis in Women Undergoing Cesarean	VBP Contractor	2	Yes
11	Intrapartum Antibiotic Prophylaxis for Group B Streptococcus (GBS)	VBP Contractor	2	Yes
12	Birth Trauma Rate – Injury to Neonate	State	1	No
13	Live Births Weighing Less than 2,500 Grams (risk adjusted)	VBP Contractor	1	Yes
14	% Preterm Births	VBP Contractor	1	Yes
15	Under 1500g Infant Not Delivered at Appropriate Level of Care	State	1	No
16	Postpartum Blood Pressure Monitoring	VBP Contractor	2	Yes
17	LARC Uptake	VBP Contractor	2	Yes
18	Neonatal Mortality Rate	VBP Contractor	3	N/A
19	Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Discharge	VBP Contractor	2	Yes
20	% of Babies Who Were Exclusively Fed with Breast Milk During Stay	VBP Contractor	1	Yes
21	Monitoring and Reporting of NICU Referral Rates	VBP Contractor	2	Yes

*Measures are subject to VBP Workgroup review and approval.

HIV/AIDS* – Category 1 Measures**

The CAG recommended the following quality measures for use in the HIV/AIDS VBP Arrangement.

No.	Category 1 Measure	Reporting Source	State Recommended Category	P4R
1	HIV Viral Load Suppression	VBP Contractor	1	Yes
2	Proportion of Patients with HIV/AIDS that have a Potentially Avoidable Complication during a Calendar Year	State	1	No
3	Sexually Transmitted Diseases: Screening for Chlamydia, Gonorrhea, and Syphilis	VBP Contractor	1	Yes
4	CD4 Cell Count or Percentage Performed	VBP Contractor	1	Yes
5	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	VBP Contractor	1	Yes
6	Substance Use Screening	VBP Contractor	1	Yes
7	HIV Medical Visit Frequency	State	1	No
8	Linkage to HIV Medical Care	VBP Contractor	1	Yes

*Measures are subject to VBP Workgroup review and approval.

** HIV/AIDS specific measures. Standard primary care measures may also apply.

HIV/AIDS* – Category 2 Measures**

The CAG recommended the following quality measures for use in the HIV/AIDS VBP Arrangement.

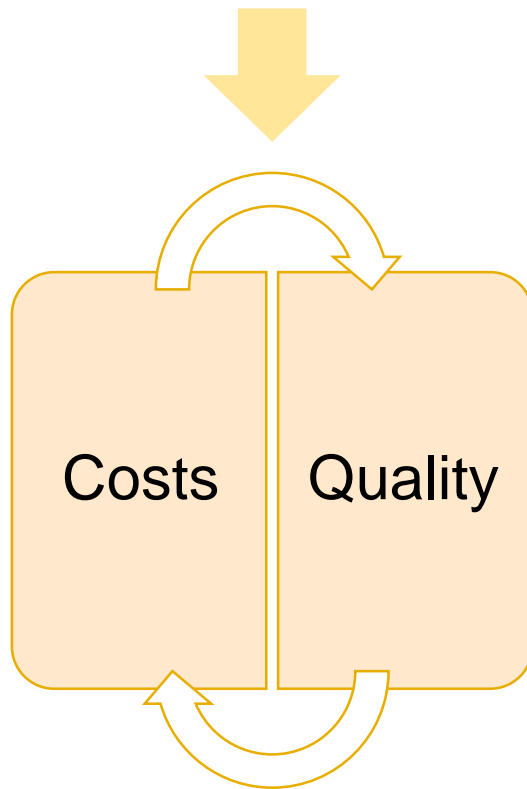
No.	Category 2 Measure	Reporting Source	State Recommended Category	P4R
9	Sexual History Taking: Anal, Oral, and Genital	VBP Contractor	1	Yes
10	Diabetes Screening	State	1	No
11	Hepatitis C Screening	VBP Contractor	2	Yes
12	Housing Status	VBP Contractor	2	Yes
13	Prescription of HIV Antiretroviral Therapy	VBP Contractor	2	Yes
14	Medical Case Management: Care Plan	VBP Contractor	2	Yes

*Measures are subject to VBP Workgroup review and approval.

** HIV/AIDS specific measures. Standard primary care measures may also apply.

Role of Quality Measures in VBP

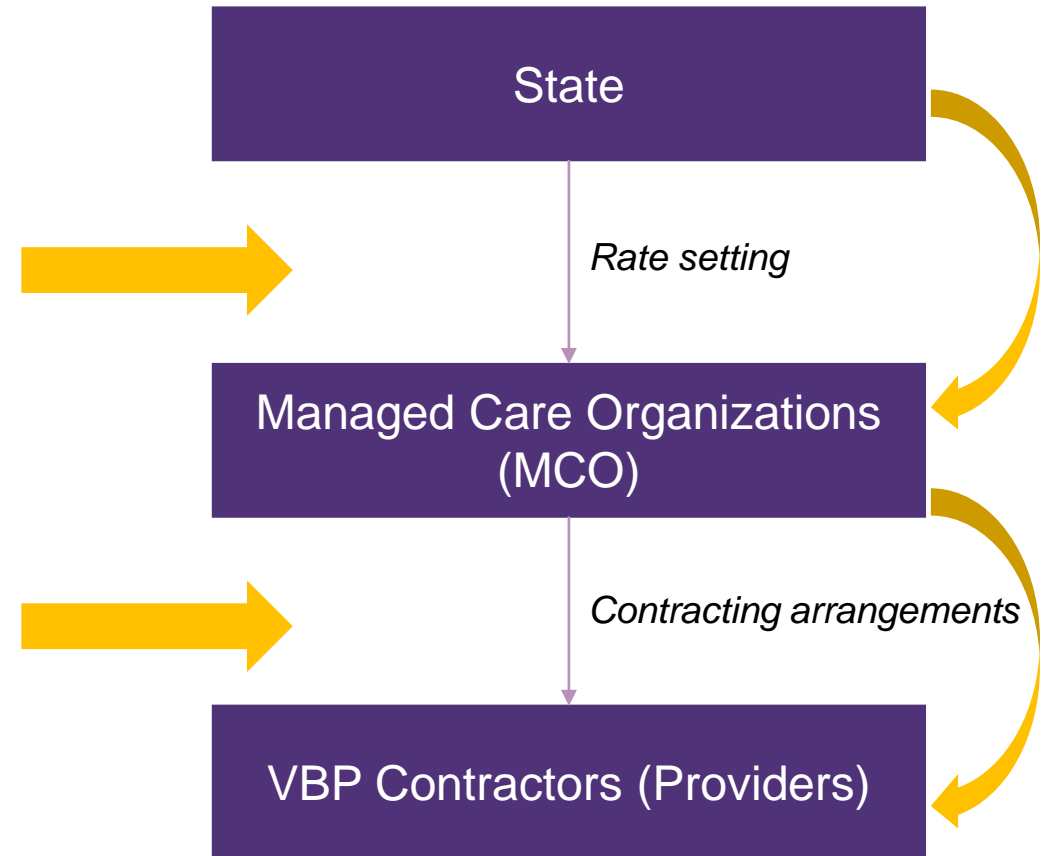
Value Based Payment



- Both from **member / patient** perspective
 - Not ‘cost of MRI or patient visit’ but of entire continuum of care (managed or not)
 - Not ‘quality of individual physician’ but of entire continuum of care
- For patients: what matters is outcomes
- Transparency of costs and outcomes to providers, payers, patients and the public is key for value based payment to succeed

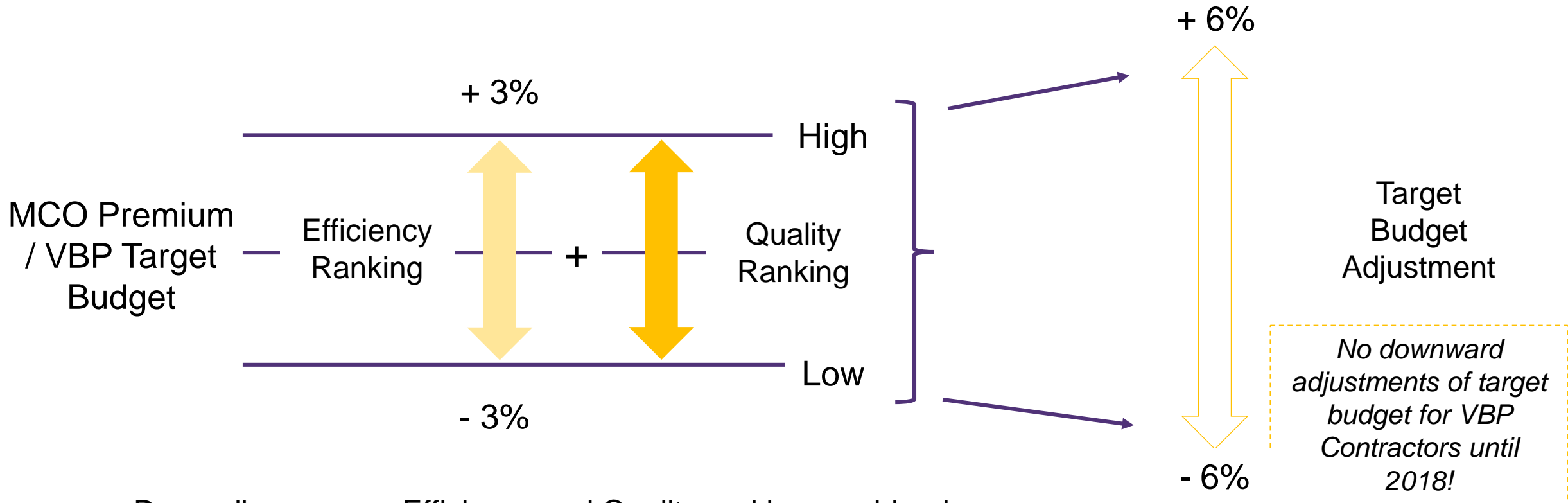
Role of Quality Measures in VBP Alignment

- Quality of **all** contracted care (whether VBP or not) is rewarded through up- and downwards adjustments of premiums received by MCO from the State *following the exact same guidelines as have been created by the VBP Subcommittees*
- According to the VBP Contracting Guidelines, *Current* Quality performance impacts the target budget set by the MCO for the VBP contractor
 - High/low quality = higher/lower target budget*
- Quality Performance *during contract year* determines percentages of savings / losses shared with VBP contractor



*See further for more explanation

Impact of Efficiency and Quality for MCOs and VBP Contractors Will Be Fully Aligned



Depending on your Efficiency and Quality ranking combined, target budgets will be adjusted accordingly.

Questions

Current Status & What To Expect

Quality Measure Refinement Process – Where We Are Now

CAGs

Clinical Advisory Groups compile measures as they are deemed Clinically Relevant, Valid, Feasible and Reliable.

DOH OHIP/OQPS

The Office of Quality and Patient Safety within DOH will continue to provide input and refine measures put together by the CAGs.

VBP Pilots

Lists of measures by VBP arrangement will be further refined if implementation calls for change (e.g. unfeasible measure, hard to collect, etc.)

VBP Workgroup

The VBP Workgroup together with the State will make decisions on any changes related to the quality measure sets.

Transitioning From Record Review For Key Measures To eMeasures: EHR Based Data Reporting

Several measures cannot be generated using claims data alone.

- Currently, these data are gathered for QARR and DSRIP through retrospective medical record review
 - Process is costly and (because of significant time delay) of limited relevance for providers
- Aligning with Medicare, the State will transition to a limited set of measures gathered at the point of care
 - Fully aligned with Medicare and other national standards
 - Already available in (most) EHRs
 - Directly aligned with DSRIP requirements on interoperability and data exchange
- These measures will all be Pay for Reporting, thus further supporting the building of an adequate IT infrastructure
- The ultimate goal is to move away from the manual chart reviews and fully utilize electronic extraction of EHR data through the RHIOs
- Testing the feasibility of the reporting of these data elements will be key to the Pilot.

Examples of currently used measures that are selected by the CAGs and/or APC requiring standardized clinical data items

VBP arrangement	Measure
IPC/TCGP	Blood pressure control (<140/90 mm Hg)
IPC/TCGP	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Maternity Care	Nulliparous Single Term Vertex C-section rate
Maternity Care	LARC uptake
HIV/AIDS	Viral Suppression Rate

Caveat: pending final decision by VBP Workgroup and the State

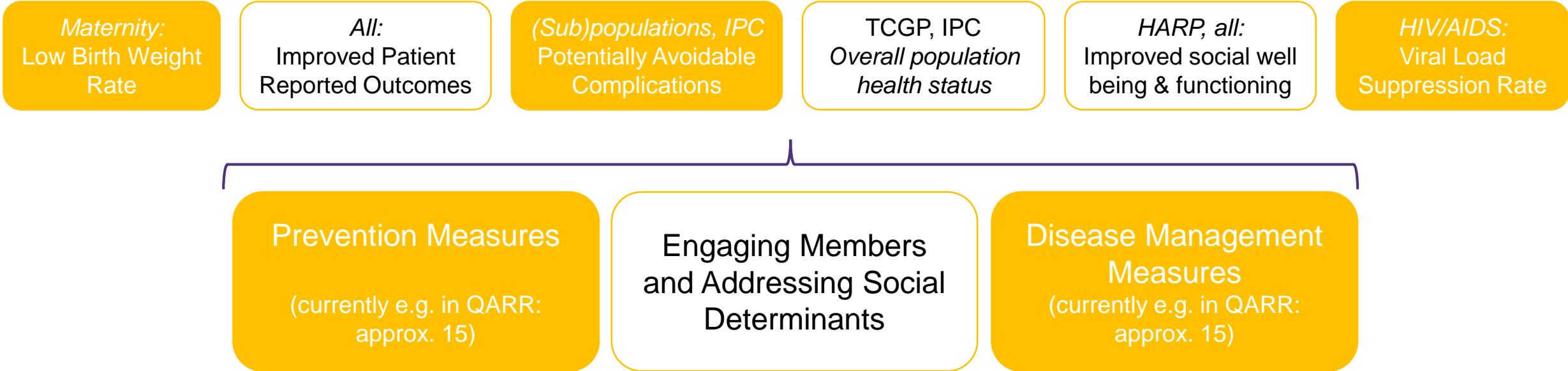
Focusing On Quality Measurement

In use or Available

Aspirational: recommended by CAG or Subcommittee but still in development

Most DSRIP, QARR and additional CAG measures are process measures that ‘roll up’ to a very limited set of key outcomes per VBP arrangement (1-3)

- Would grow to 3-5 if aspirational measures that would be taken into account



Distinction between Pay for Reporting measures and Pay for Value measures

VBP for Medicaid will have two types of Quality Measures:

Pay for Reporting (PFR)

- A more extensive set of measures that is predominantly process based and required for monitoring and process improvement (e.g. in diabetes care, reporting % of patients with Blood Pressure in control).

Pay for Value (PFV)

- A limited group of measures that is outcome based and fully aligned with DSRIP (e.g. in diabetes care, % avoidable hospitalizations and avoidable complications).

Caveat: pending final decision by VBP Workgroup and the State

Timeline

Timeline

- The measure sets and the reporting of eMeasures will be tested in the Pilots program and will become standard for VBP from 2017 onwards
- The target adjustments for the Pilots will be based on a combination of Pay for Reporting and Pay for Value
- In parallel, the Quality Incentive Program for MCOs will be adapted to fully align with VBP
- Initial release of VBP dashboards is preliminarily scheduled for Q1 of 2017; dashboard capabilities will increase with every quarter

Caveat: pending final decision by VBP Workgroup and the State

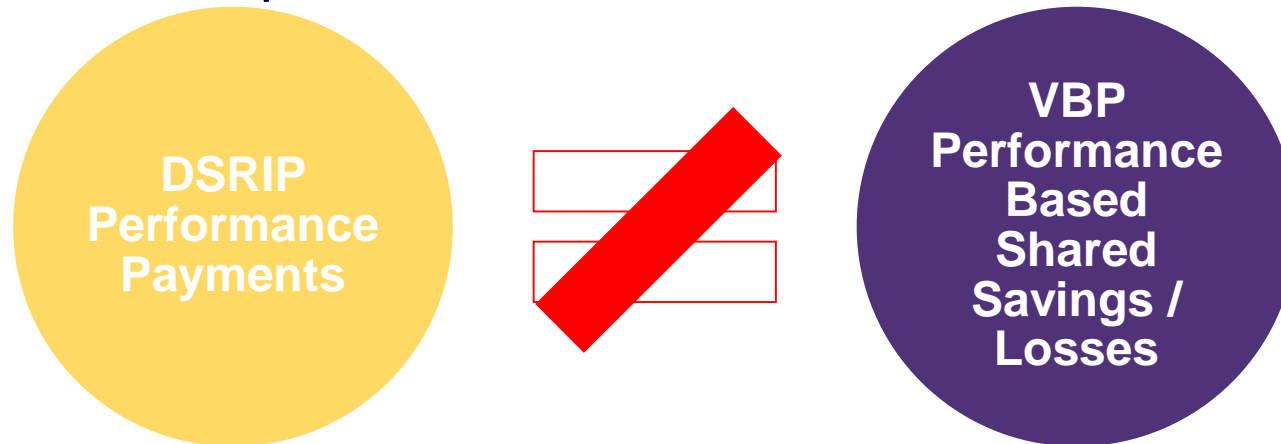
Questions

Performance and Target Budget: Reminder

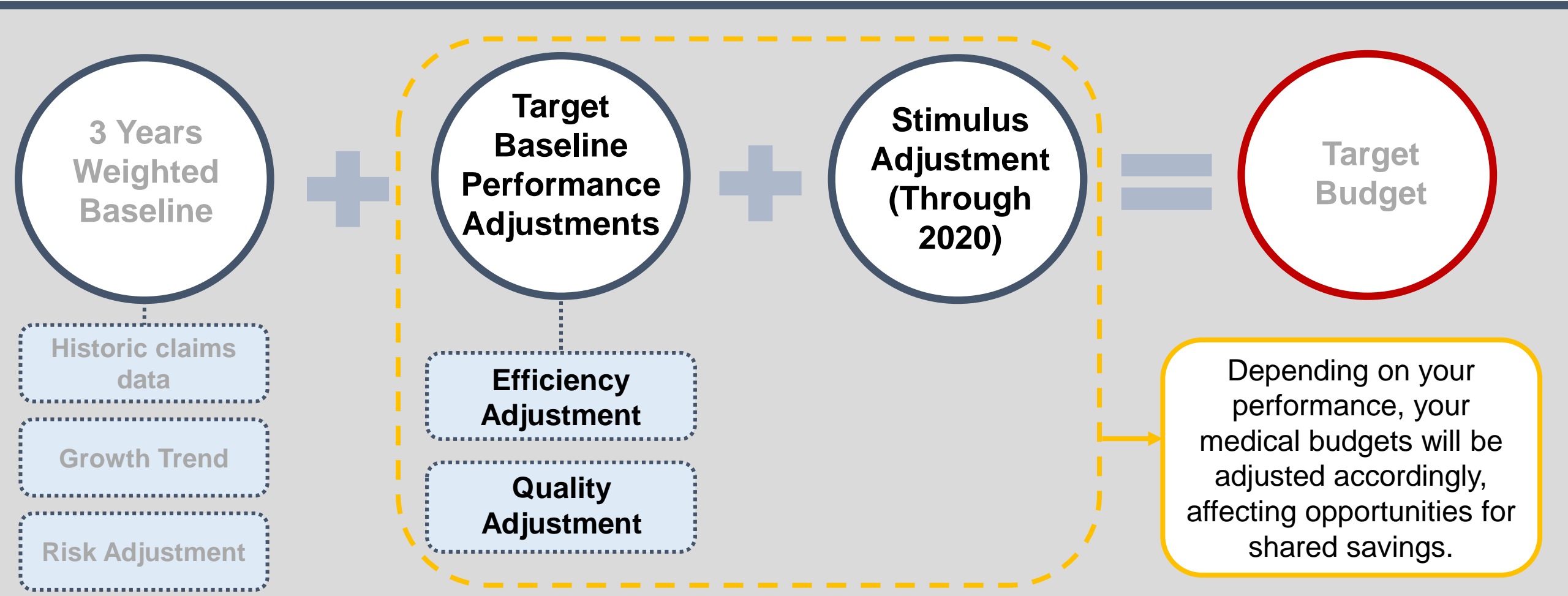
Performance in DSRIP and VBP: How Is It Different?

When participating in VBP, it is important to remember the following:

1. You can contract value-based arrangements while not participating in the DSRIP Program
2. There are payments made in the DSRIP program that depend on the implementation of projects selected and overall PPS achievement of the VBP Roadmap Goals
3. Savings resulted from contracting VBP arrangements are separate and distinct from the DSRIP payments. If you are participating in both, you may be receiving payments from both implementation efforts.

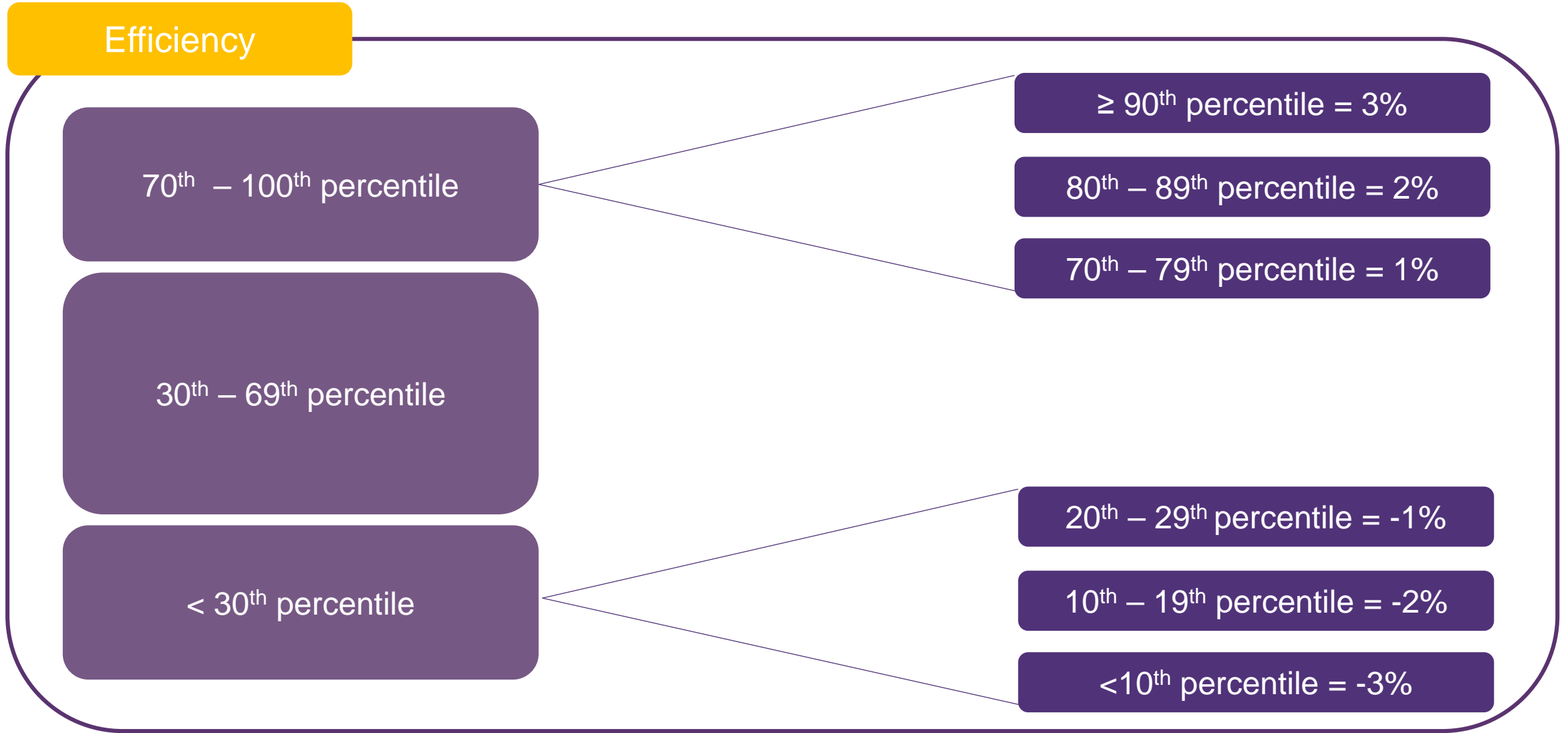


How Your Performance Affects Target Budget

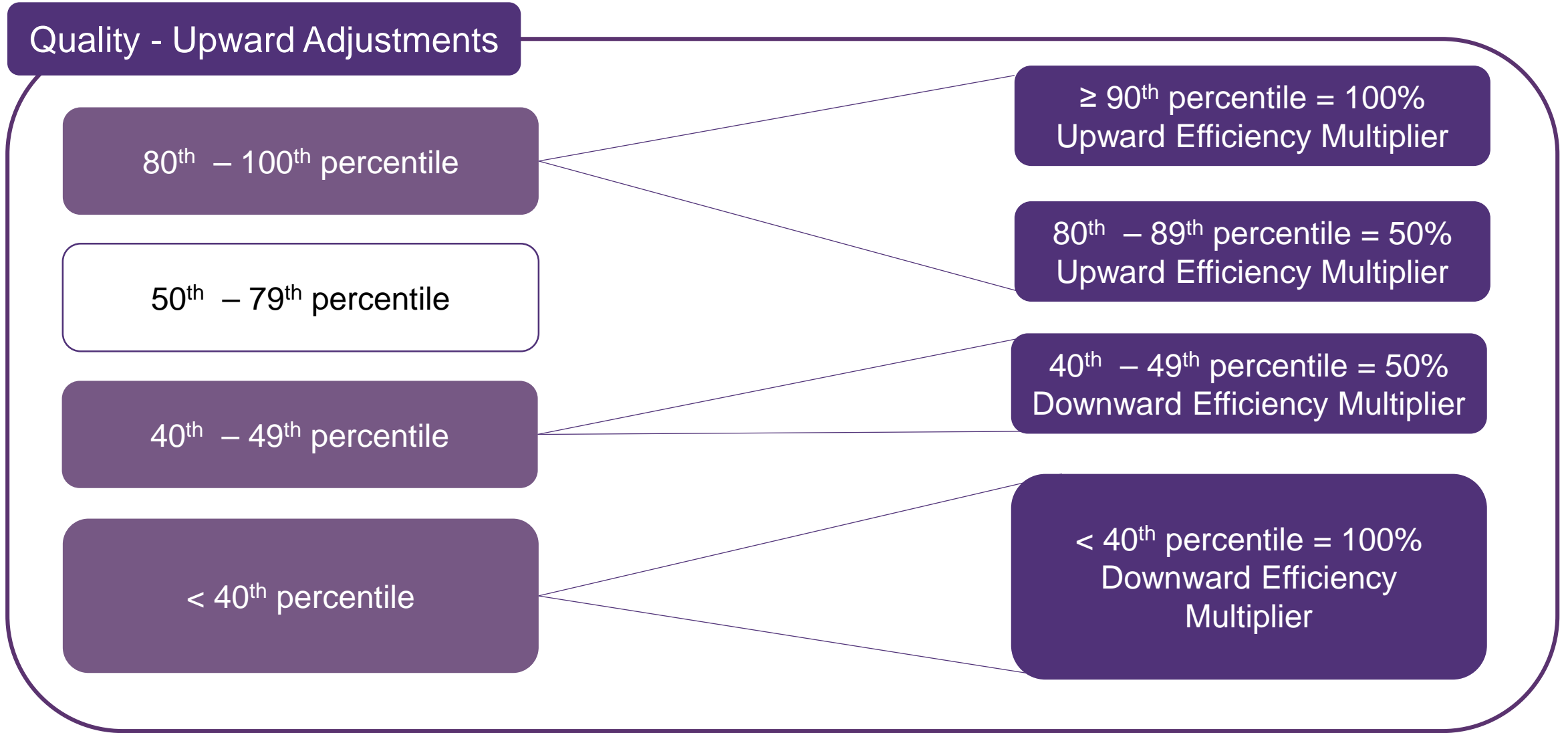


Note: The Target Budget Setting process outlined here is only a guideline. Plans and VBP Contractors are free to negotiate their own Target Budget Setting Methodology

VBP Contracts Performance Adjustments - Efficiency



VBP Contracts Performance Adjustments - Quality



VBP Contracts Performance Adjustments - Quality

Quality - Downward Adjustments

$\geq 80^{\text{th}}$ percentile

$\geq 80^{\text{th}}$ percentile = 50%
Upward Efficiency Multiplier

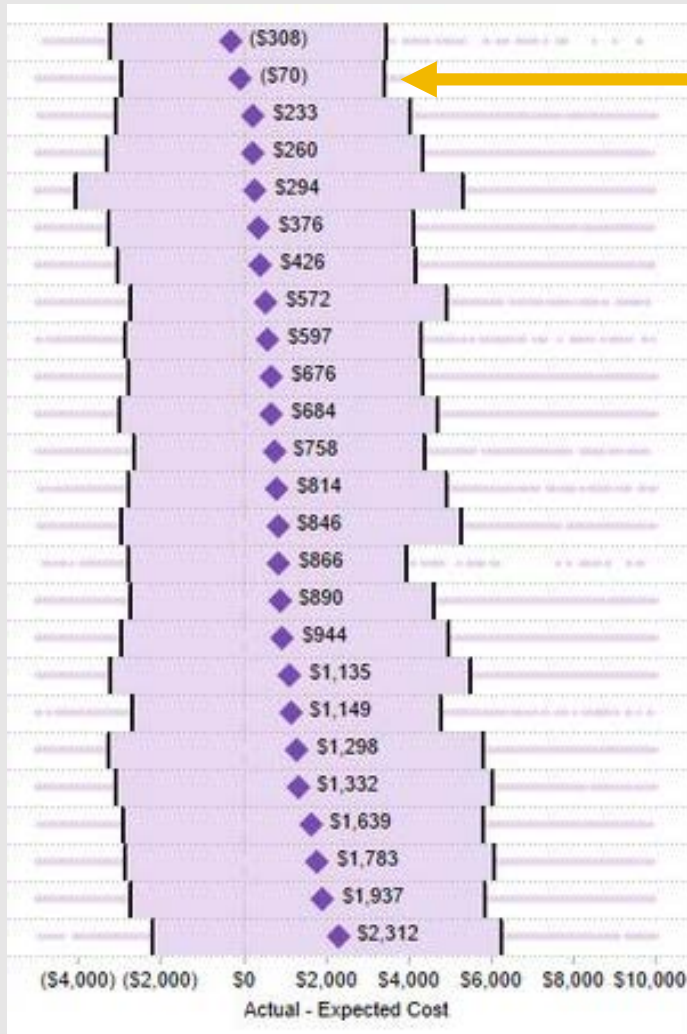
$30^{\text{th}} - 79^{\text{th}}$ percentile

$< 30^{\text{th}}$ percentile

$15^{\text{th}} - 29^{\text{th}}$ percentile = 50%
Downward Efficiency Multiplier

$< 15^{\text{th}}$ percentile = 100%
Downward Efficiency Multiplier

First Target Budget Adjustment: Efficiency Ranking

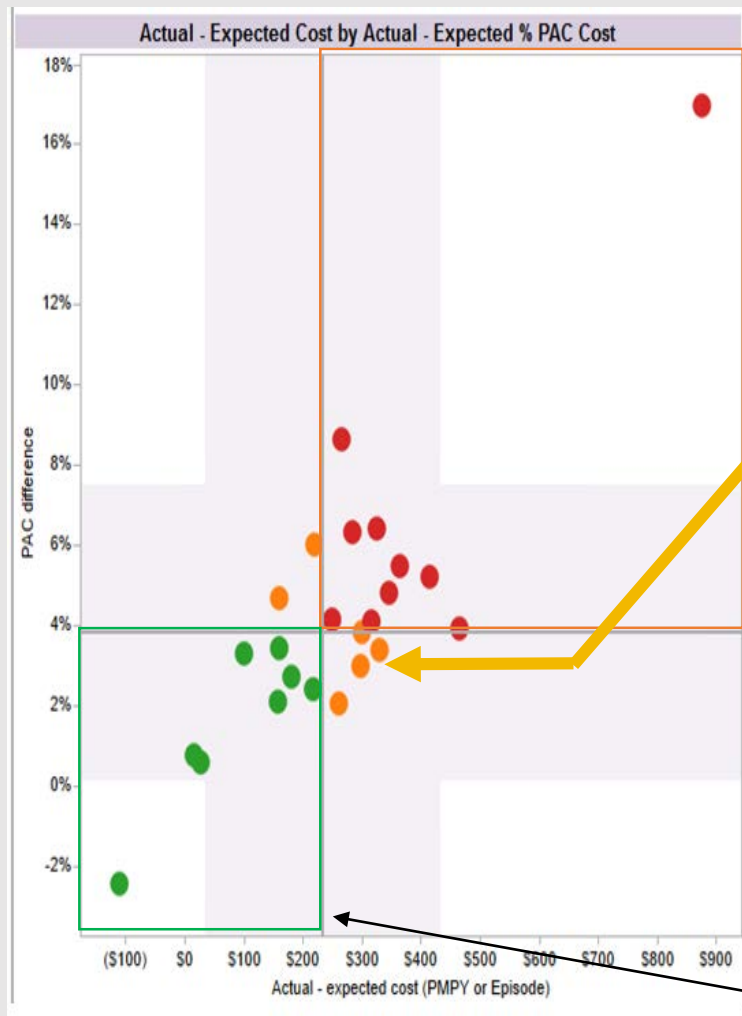


VBP Contractor in the example. Above the 90th Percentile in efficiency.

***Purpose:** An efficiency ranking is applied to the baseline to reward providers that exhibit lower historic costs to keep them in VBP arrangements while bringing higher cost providers closer to the State average.*

Example:
For this example, the VBP Contractor is in the 90th Percentile for Efficiency. Thus there is a 3% efficiency adjustment.

First Target Budget Adjustment: Quality Ranking



← Low performing

VBP Contractor in the example. Between the 70th and 80th percentile

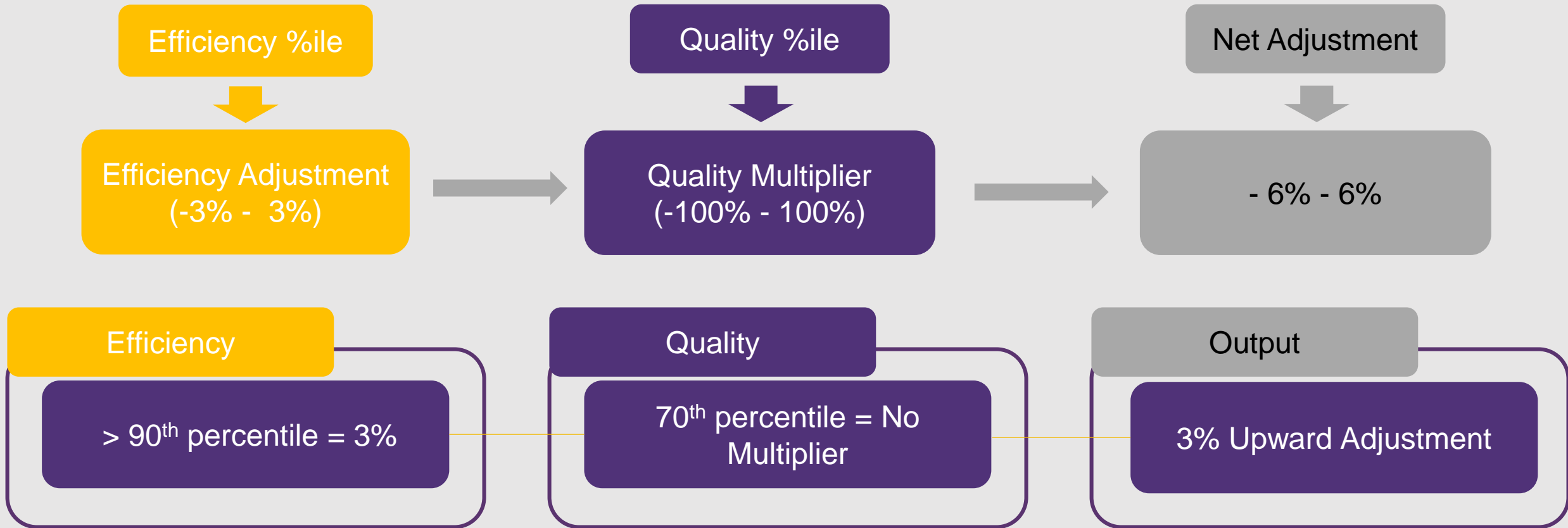
***Purpose:** The quality ranking rewards historically high-quality providers but also discourages providers from reducing costs to the point where there is a deterioration of care.*

Example:

For this example, assume the VBP Contractor is in the 70th Percentile for Quality. Thus there is no quality multiplier. Assuming that this example is for chronic care arrangement (IPC), the Y-axis 'PAC difference' is used as an overall outcome measure, which ties directly to the 'Pay for Value' approach.

High performing

Example Efficiency and Quality Calculation



VBP Contracts Performance Adjustments

	Rate Adjustments for Efficiency	Details	Adjustment
Upward Adjustment	Above 70 th Percentile for Efficiency and below 50 th Percentile for Quality	50% decrease in Upward Adjustment	0.5%
	Above 70 th Percentile for Efficiency and above 80 th Percentile for Quality	50% increase in Upward Adjustment	1.5%
	Above 70 th Percentile for Efficiency and above 90 th Percentile for Quality	100% increase in Upward Adjustment	2.0%
	Above 80 th Percentile for Efficiency and below 50 th Percentile for Quality	50% decrease in Upward Adjustment	1.0%
	Above 80 th Percentile for Efficiency and above 80 th Percentile for Quality	50% increase in Upward Adjustment	3.0%
	Above 80 th Percentile for Efficiency and above 90 th Percentile for Quality	100% increase in Upward Adjustment	4.0%
	Above 90 th Percentile for Efficiency and below 50 th Percentile for Quality	50% decrease in Upward Adjustment	1.5%
	Above 90 th Percentile for Efficiency and above 80 th Percentile for Quality	50% increase in Upward Adjustment	4.5%
	★ Above 90 th Percentile for Efficiency and above 90 th Percentile for Quality	100% increase in Upward Adjustment	6.0%
		Below 40 th Percentile for Quality	No adjustment regardless of Efficiency Ranking
Downward* Adjustment	Below 30 th Percentile for Efficiency and above 80 th Percentile for Quality	50% decrease in Downward Adjustment	-0.5%
	Below 30 th Percentile for Efficiency and below 30 th Percentile for Quality	50% increase in Downward Adjustment	-1.5%
	Below 30 th Percentile for Efficiency and below 15 th Percentile for Quality	100% increase in Downward Adjustment	-2.0%
	Below 20 th Percentile for Efficiency and above 80 th Percentile for Quality	50% decrease in Downward Adjustment	-1.0%
	Below 20 th Percentile for Efficiency and below 30 th Percentile for Quality	50% increase in Downward Adjustment	-3.0%
	Below 20 th Percentile for Efficiency and below 15 th Percentile for Quality	100% increase in Downward Adjustment	-4.0%
	Below 10 th Percentile for Efficiency and above 80 th Percentile for Quality	50% decrease in Downward Adjustment	-1.5%
	Below 10 th Percentile for Efficiency and below 30 th Percentile for Quality	50% increase in Downward Adjustment	-4.5%
	★ Below 10 th Percentile for Efficiency and below 15 th Percentile for Quality	100% increase in Downward Adjustment	-6.0%

★ Max Upward Adjustment = + 6.0% ★ Max Downward Adjustment = - 6.0%

Note: *At the start of 2018, in addition to Upwards Adjustments, VBP contractors' Efficiency and Quality may produce target budget decreases:

Second Target Budget Adjustment: Stimulus Adjustment

***Purpose:** To incentive providers to undertake more risk and engage in high levels of risk, the stimulus adjustment rewards providers in Level 2 or Level 3 arrangements by creating greater potential for generating shared savings.*

VBP Arrangement	Stimulus Adjustment Amount
Total Care for General Population	0.5%
Integrated Primary Care – Chronic Bundle	1.0%
Maternity Care	1.0%
Total Care for HARP Subpopulation	0.5%
Total Care for HIV/AIDs Subpopulation	0.5%

Formula:

Stimulus Adjustment Amount = Stimulus Adjustment Percent x 3 Year Weighted Baseline
Final Target Budget = 3 Year Weighted Baseline + Performance Adjustment + Stimulus Adjustment

- Stimulus adjustments are computed using arrangement specific contracts.
- The stimulus adjustment will be paid as an adjustment to the target budget in level 2+ contracts (conditional on the VBP Contractor being > 50th percentile in efficiency and quality) to incentivize movement into higher levels.
- The duration of adjustment is two years.

Questions

Lunch – 60 mins

Performance Measurement

This section will cover the following:



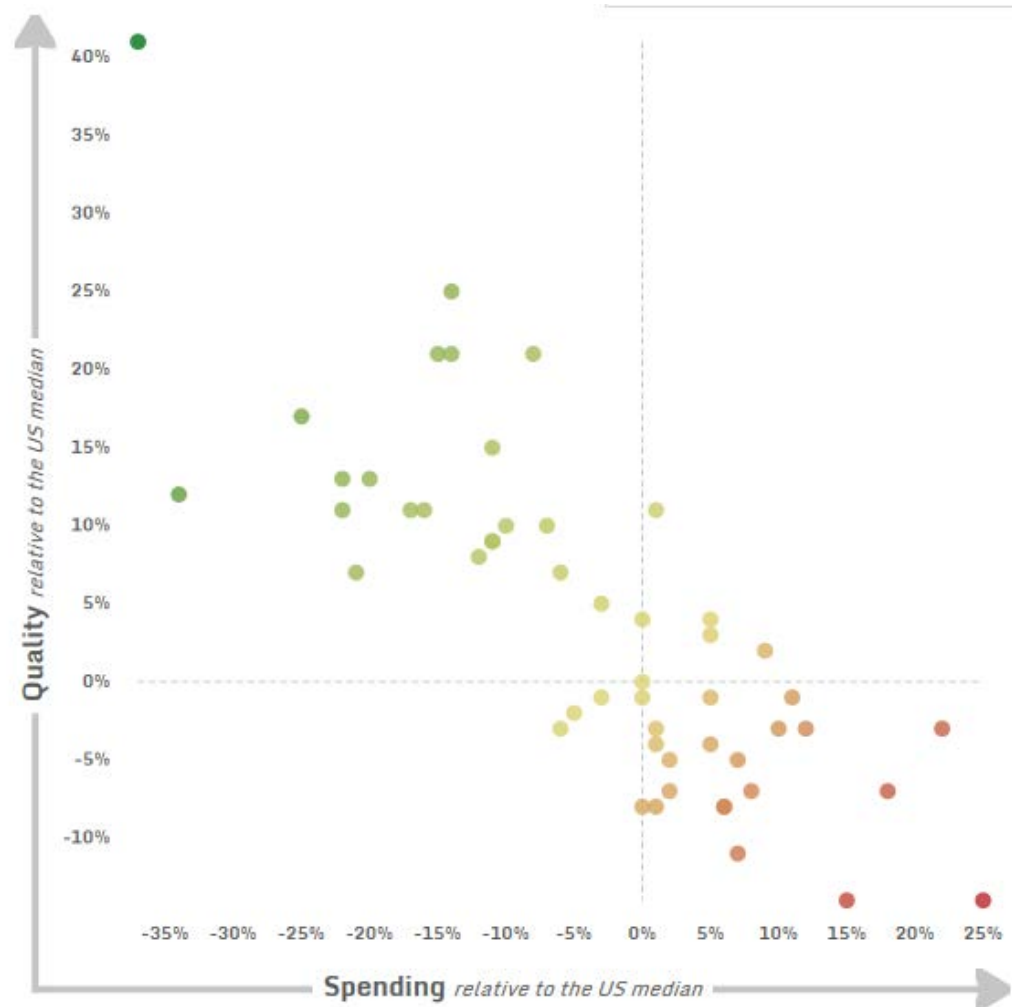
Performance Data Overview

VBP Dashboard Walkthrough: Medicaid Analytics Performance Portal

Performance Data Overview

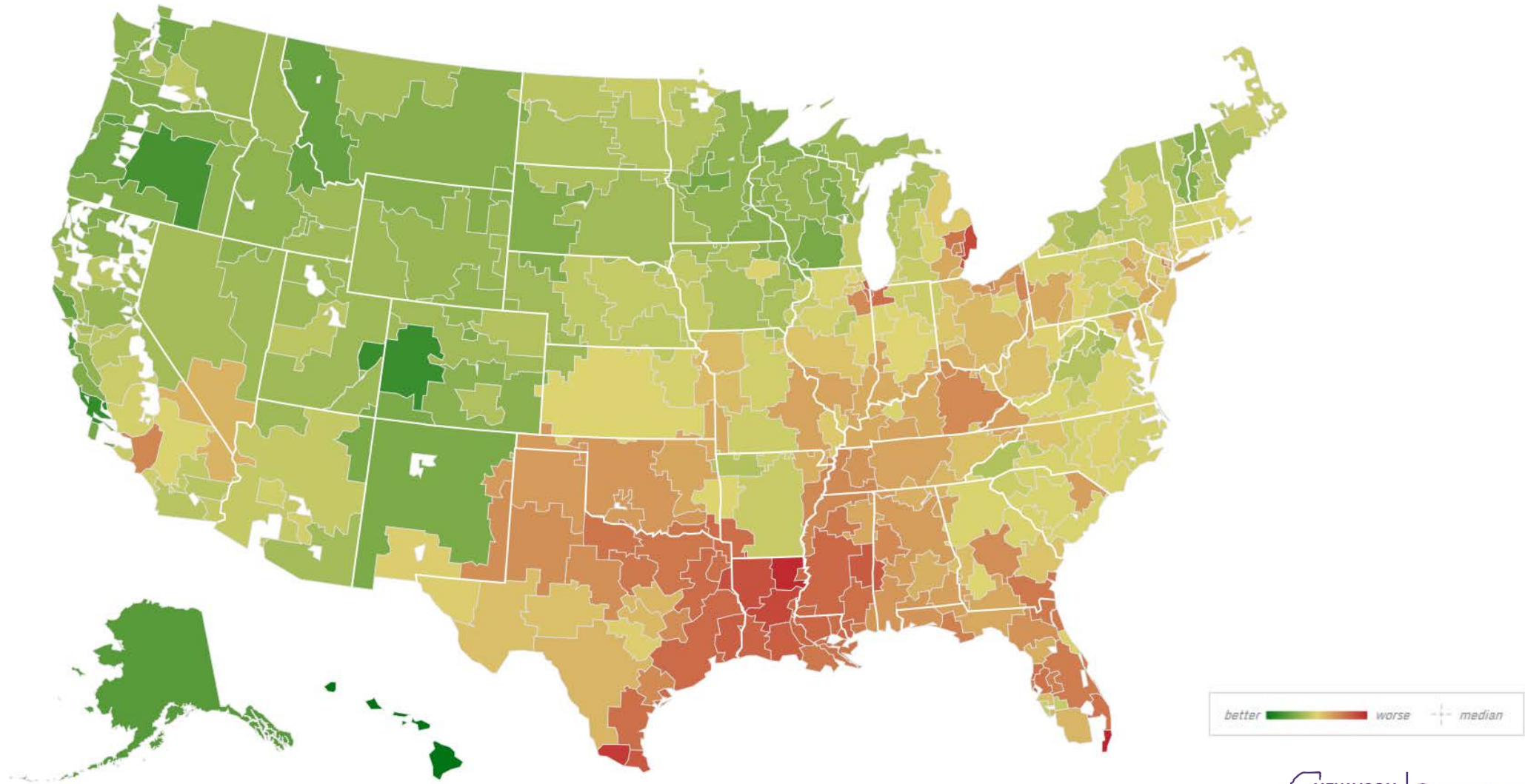
A Counter-intuitive Reality: Better Care is Usually Lower Cost

National Medicare data comparing performance between States



Source: Commonwealth Fund 'spending vs quality' interactive site. <http://www.commonwealthfund.org/interactives-and-data>

Value delivered: Total Medicare Spending & Quality



Source: Commonwealth Fund 'spending vs quality' interactive site; <http://www.commonwealthfund.org/interactives-and-data>

NYS Medicaid: Why Performance Data Matters

1

Transparency of overall quality and costs of VBP arrangements per VBP contractors and per MCO is key for success of VBP

- This is unprecedented in Medicaid NYS

2

Ranking of VBP contractor's and MCO's performance per VBP arrangement drives premium and target budget adjustments

3

Without insight in your own performance (MCO, VBP contractor), you cannot improve, build and manage your network & decide where you stronger and weaker points are

4

Without insight in the overall quality and costs of care, members can not choose for MCOs or VBP contractors

5

Without insight in the overall quality and costs of care, the State can not optimize the value of care for its Medicaid members

Measuring Efficiency

Metric:

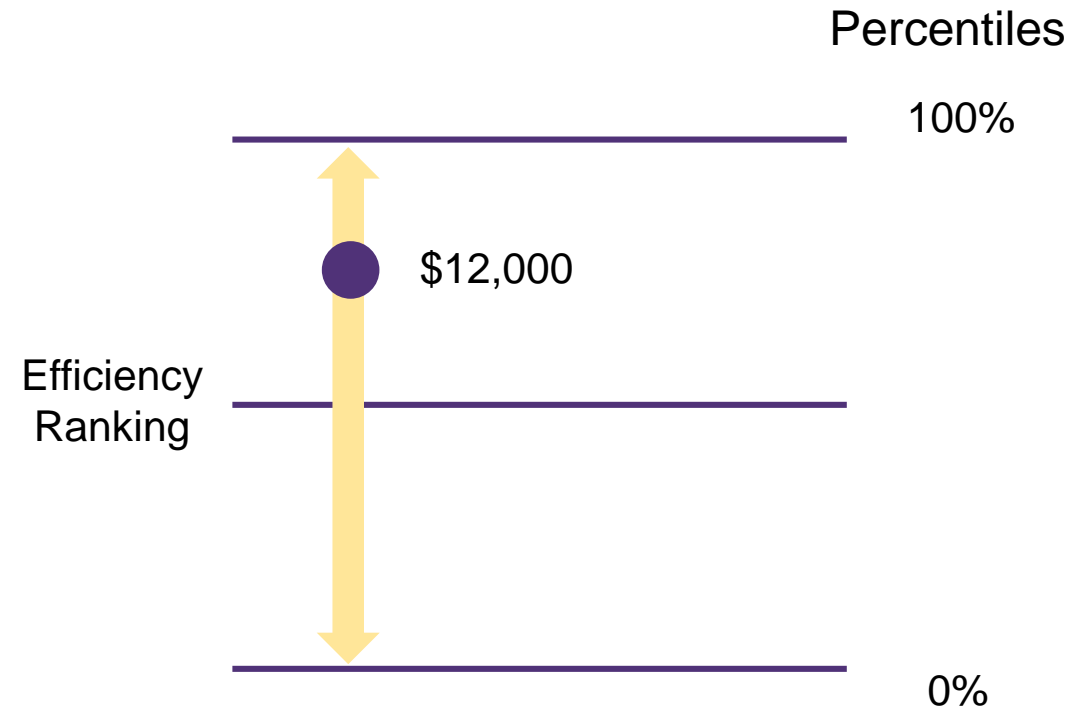
Average Total Cost per Episode (or per Member)

Detail:

- Across all members attributed to VBP contractors
- Across all MCOs' members eligible for VBP arrangement
- Risk Adjusted
- Calculated by HCI3 and 3M grouper
- Excluding differences in price

Example:

Average Total Cost for Maternity Episode = \$12,000



Examples are for illustration purposes only.

Measuring Quality

Metric:

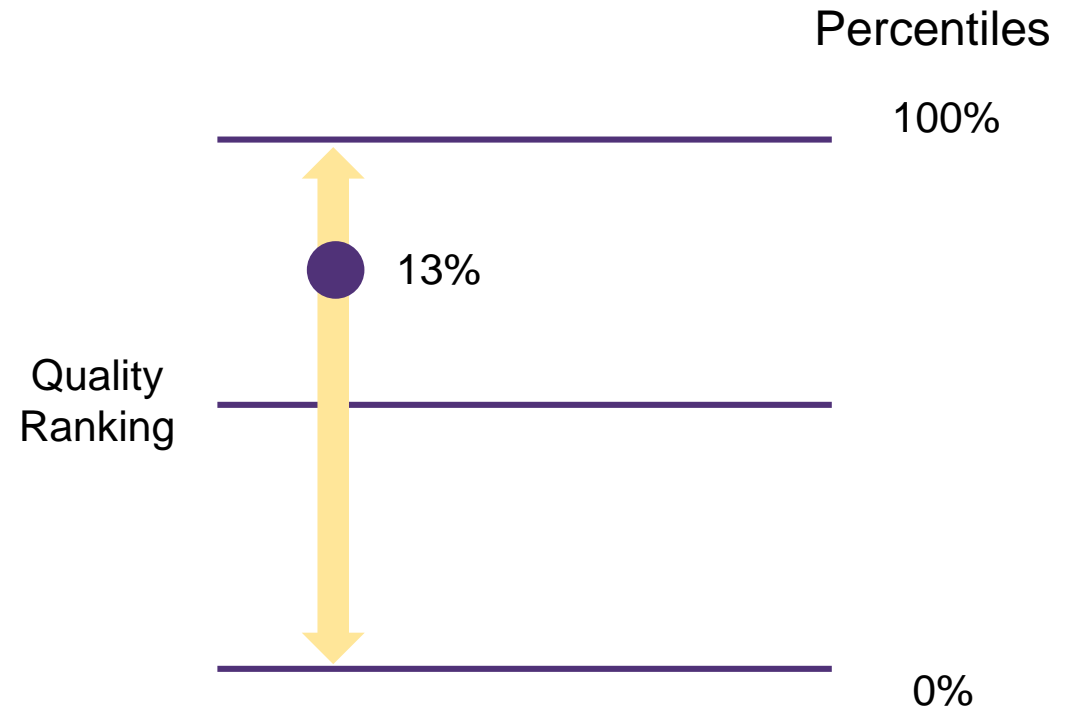
Average Outcome per Episode or per Member (P4V)

Detail:

- Across all members attributed to VBP contractors
- Across all MCO's members eligible for VBP arrangement
- Risk Adjusted

Example:

% of total costs associated with Potentially Avoidable Complications = 13% (smaller % is better)



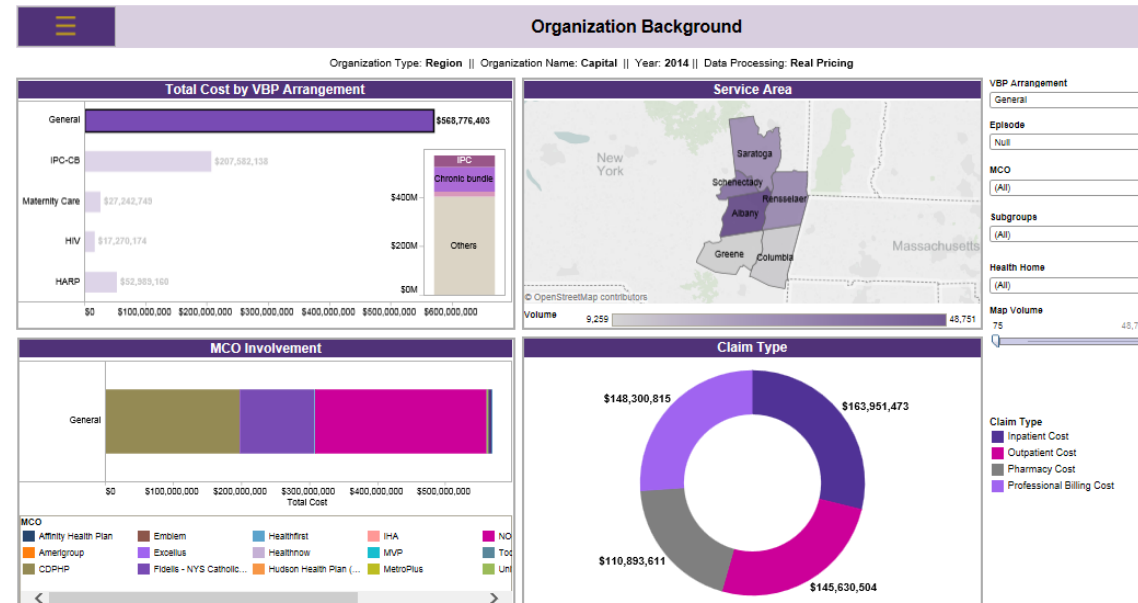
Examples are for illustration purposes only.

What are 'Performance Data'?

Area	Efficiency	Quality
Metric	Average Total Cost per Episode or per Member	Average Outcome per Episode or per Member (Pay for Value)
Scope	<ul style="list-style-type: none"> ▪ Across all members attributed to VBP contractors ▪ Across all MCOs' members eligible for VBP arrangement ▪ Risk Adjusted 	
Calculation	Calculated by HCI3 and 3M grouper Excluding differences in price	Based on claims and/or clinical data
Example	Total cost of a bundle	Percentage of total costs associated with Potentially Avoidable Complications (PACs)
		Pay for Reporting <ul style="list-style-type: none"> ▪ eMeasures ▪ Process measures (prevention, disease management)

VBP Dashboards

- The VBP Dashboards will become available through the **MAPP** (Medicaid Analytics Performance Portal) at the end of this calendar year
- Currently, Pilots are given access to these future dashboards through the Pilot Team
- As soon as possible (this Summer), PPSs, potential VBP contractors and MCOs will receive Performance Scorecard allowing validation, analysis of data quality and insight in key Efficiency and Quality performance



What Will Be In VBP Dashboard At The End Of This Year?

- Claims- and encounter based total cost measures and relevant drill-downs
- Potentially Avoidable Complications (dollars and counts) and relevant drill-downs
- VBP arrangement specific quality metrics (Low Birth Weight, C-section rate, under- and overuse)
 - Claims based
 - Not already available in Salient dashboard
- Medicaid only data (no duals)
- 2013 until now (take claims-delay into account)
- Updated every Quarter (some key attribution data updated Monthly)

Pricing	Details	Visible To*
Proxy	<ul style="list-style-type: none"> • A single price per service is set statewide • Costs that are strictly based on cost-weighted utilization • Allows for comparative analysis between regions or providers with systemic differences in price (e.g. different wage levels) • Effectively reflects utilization of services on a relative-cost basis 	Anyone who has access to the VBP Dashboards
Real	<ul style="list-style-type: none"> • Costs of care of delivery, removing add-on payments (medical education, HCRA payments) are removed from paid claims • Retains the significance of price levels when analyzing different regions/ providers 	VBP contractors in the network only

What Will Be In VBP Dashboard In The Future?

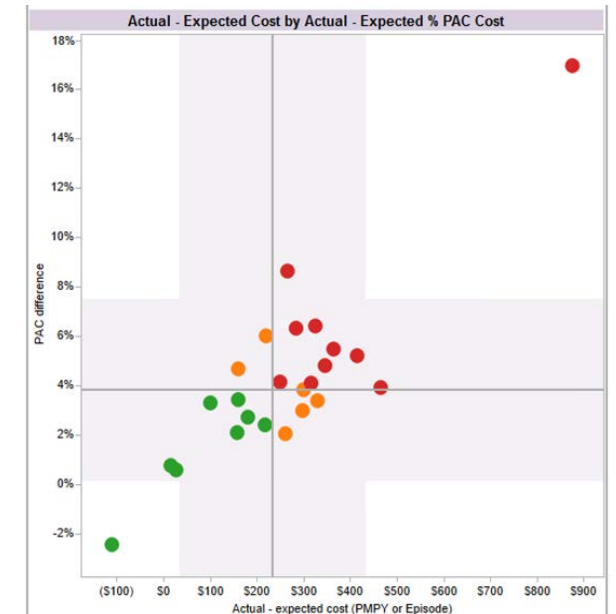
The following will be released later in 2017:

- Duals data (including Medicare data)
- Prioritized key eMeasures and registry-based data

Why Would the State Play a Role in Providing Data And Analytics to Providers, MCOs, Members and the Public?

Consistent with the VBP Roadmap, the State will provide this data for the following reasons:

- To ensure and make available 'one source of truth' in measuring value
- To create access to data sets only the State possesses (total Medicaid claims and encounters data)
- To allow access to advanced data and analytics for MCOs and providers that are either not yet ready or do not have resources to build their own capabilities
- To facilitate negotiations between VBP contractors and MCOs by providing a level playing field
- To create continuity of information and VBP arrangements for MCOs and VBP contractors
- To fulfill its obligation to monitor and manage the overall success of VBP and the value of the NYS Medicaid program
- To allow optimal choice for Medicaid members and inform the public



Investment in HIT and Data Analytics

The MAPP portal and the VBP Dashboards will empower you to be successful in VBP implementation.

If you are participating in the DSRIP Program*, you have more opportunities to improve your analytics capabilities:

1. VBP Contractors can work closely with their PPSs to leverage funds available for HIT
 - While PPSs cannot contract VBP arrangements unless they become legal entities (IPA/ACO), they may take on a role of a payment reform advocate & coordinator
2. VBP Contractors can utilize the analytical capabilities that the DSRIP Program has begun to provide to its participants

VBP Contractors should think about making additional investments in HIT to ensure the ability to make timely adjustments to their performance with a goal to improve outcomes and increase shared savings.

**Not everyone in VBP may be participating in the DSRIP program.*



Medicaid Analytics Performance Portal - MAPP

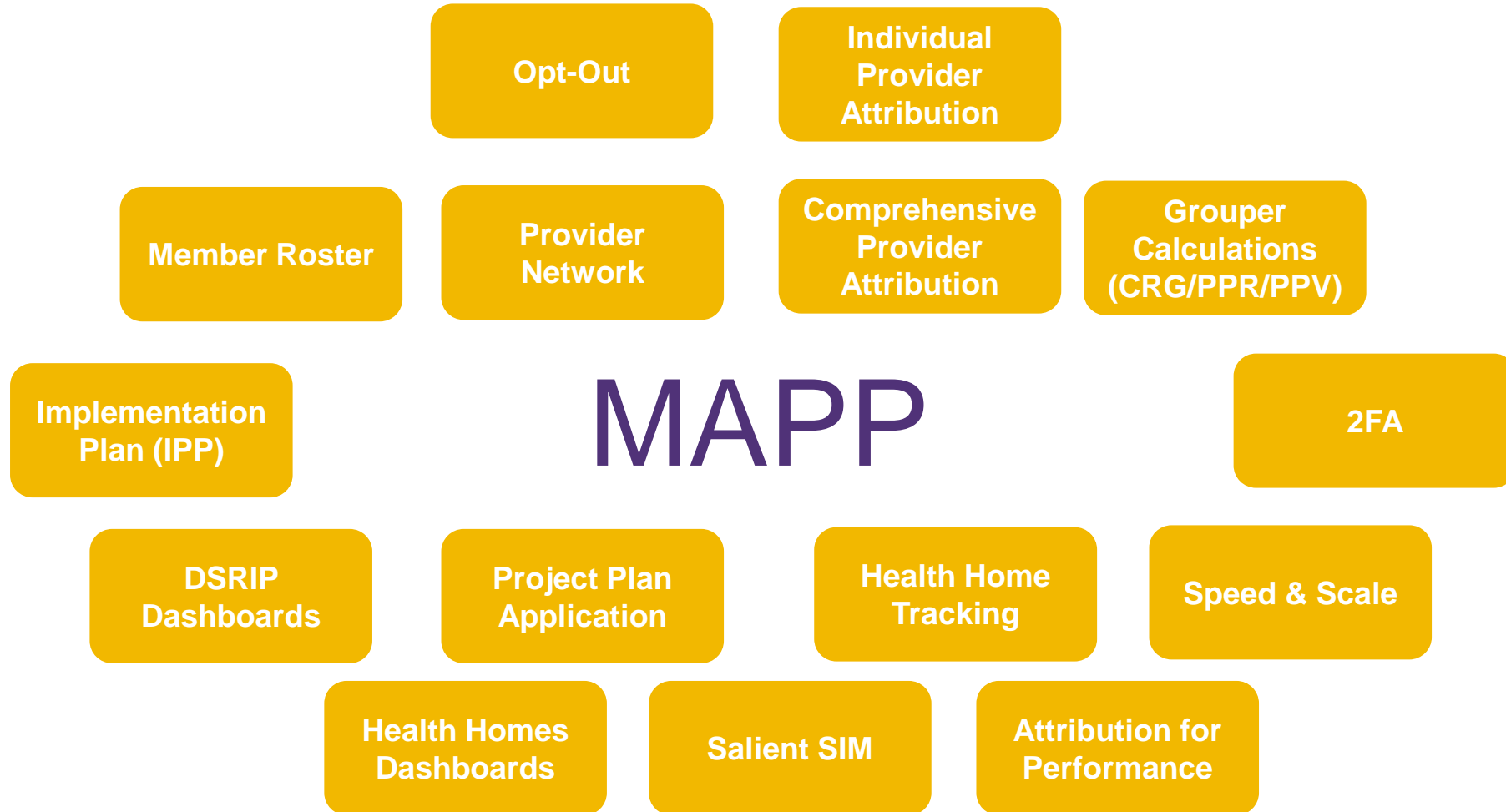
The MAPP is a performance management system that currently:

- Provides tools and program performance management technologies to Performing Provider Systems in their effort to develop and implement transformative projects through the Delivery System Reform Incentive Payment (DSRIP) Program
- Supports care management efforts for the State's Health Home (HH) program
- Next step: addition of Value Based Payment Dashboards

Link to the MAPP Web page:

http://www.health.ny.gov/health_care/medicaid/redesign/dsrp/medicaid_analytics_performance_portal.htm

Detailed MAPP Functionality



Next Steps

Access to the VBP Dashboards will be through the MAPP Portal based on access rights

Access will begin with MCO's, VBP Contractors, and the State

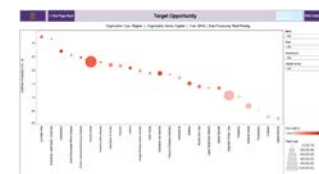
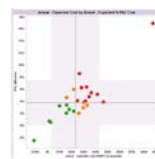
DSRIP Dashboards will be adapted so that VBP contractors and MCOs can drill down in more detailed performance on available process measures

Users of MAPP VBP Dashboard

- The Dashboard will be aimed at different groups of core users:
 - VBP contractors
 - Health Plans
 - PPSs (orientation only)
 - State
 - Broader Public (not yet in scope)
- MCOs and VBP contractors will have in-depth access to their own data and (for benchmarking purposes) to the quality & efficiency performance of their peers

Purpose of The VBP Dashboard: What Insights Will It Offer To Users?

Background	My Network and Attributed Members	Rankings	Looking for opportunities	Performance Monitoring	Predictive
<ul style="list-style-type: none"> Understanding the Data Set 	<ul style="list-style-type: none"> Knowing the population Insight in health status and key provider information prior to attribution (MCO/VBP contractor) 	<ul style="list-style-type: none"> How am I doing compared to others? Upward/downwards adjustments & potential target budget 	<ul style="list-style-type: none"> Understanding my (lack of) efficiency and how to improve it? Understanding my (lack of) quality performance and to improve it?* 	<ul style="list-style-type: none"> How am I trending during the contract period on quality and budget? 	<ul style="list-style-type: none"> Which members require special attention and interventions?



Core Users:

- VBP Contractors
- Health Plans
- State
- PPSs - orientation only
- Broader Public – TBD

*To avoid 'double work', the VBP dashboards currently do not include the quality measures included in the Salient tool. Interoperability will require the Salient tool to be able to have access to VBP attribution data and for MCOs to have access to the Salient tool. Key that Salient's workplan includes this.

Questions

VBP Dashboard Walkthrough: VBP as a Data Driven Approach

Steps Towards VBP

1. Understanding your populations, exploring opportunities, relative performance, bringing providers together

2. Discussions with MCO

3. Finalizing list of the attribution-driving providers

4. Creating the VBP contractor as a legal entity

5. MCO and VBP contractor reach VBP contract agreement

Entire process supported by data:
the level playing field



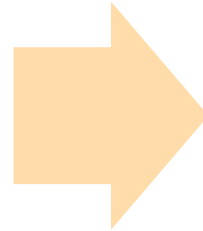
Understanding your Population

Looking at your Network and your Attribution



Viewing Network Specific Data

Potential VBP contractor
creates NPI list (the
'attribution-driving NPIs')



Data analysis shows
attribution volume, costs,
member profiles

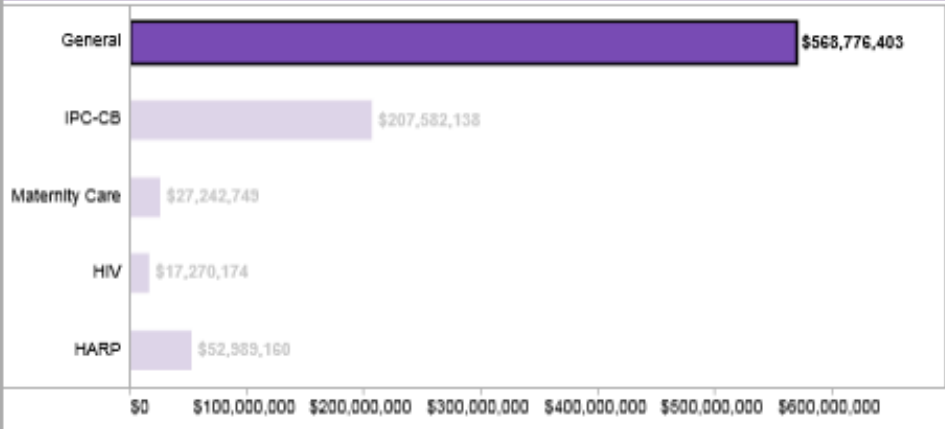


Total Dollars & Volume per County

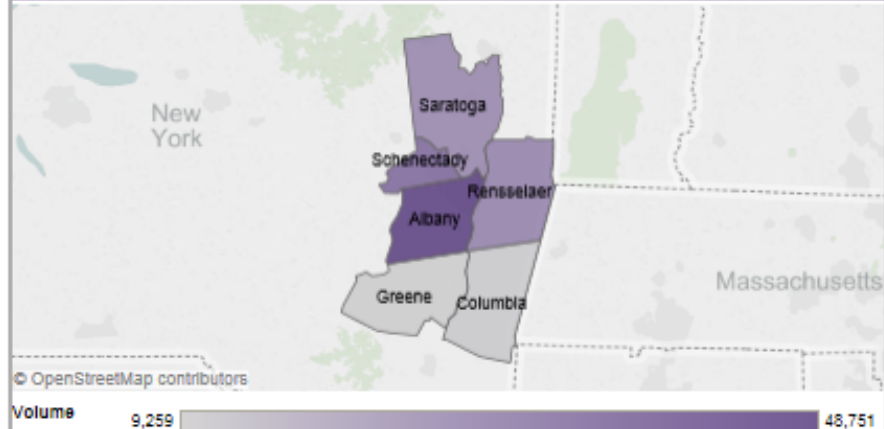
Organization Background

Organization Type: Region || Organization Name: Capital || Year: 2014 || Data Processing: Real Pricing

Total Cost by VBP Arrangement



Service Area



VBP Arrangement:

Episode:

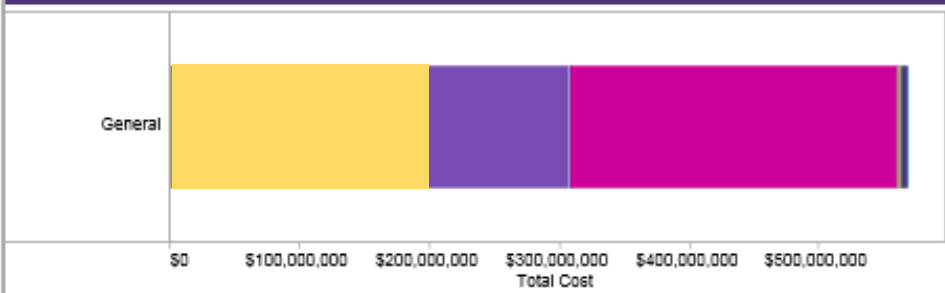
MCO:

Subgroups:

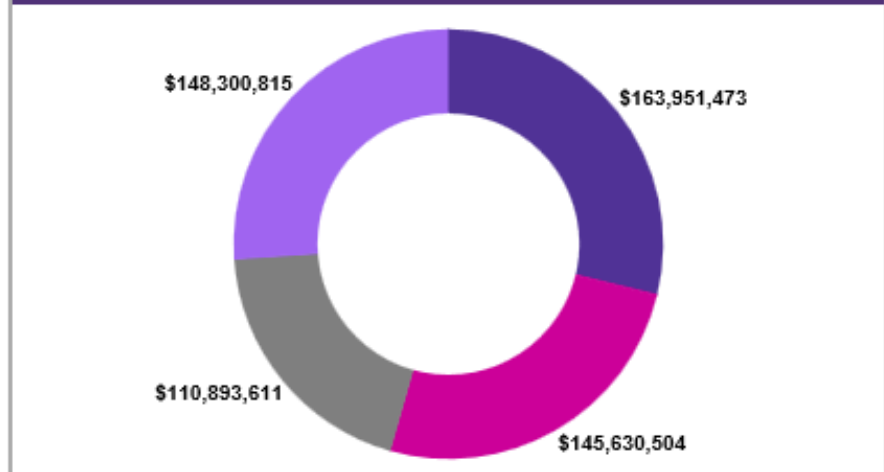
Health Home:

Map Volume: to

MCO Involvement



Claim Type



- Claim Type
- Inpatient Cost
 - Outpatient Cost
 - Pharmacy Cost
 - Professional Billing Cost

MCO Legend:

- Affinity Health Plan
- Amerigroup
- CDPHP
- Emblem
- Excellus
- Fidells - NYS Catholic...
- Healthfirst
- Healthnow
- Hudson Health Plan (...)
- IHA
- MVP
- MetroPlus
- NO
- Tod
- Unl

Disclaimer: Preliminary Data, work in progress; 2014, real-priced data



Co-morbidity

Organization Type: Region || Organization Name: Capital || Year: 2014 || Data Processing: Proxy Pricing

Episode / Member Count per County -> Zipcode

* Select a county below to activate graphs on the right side

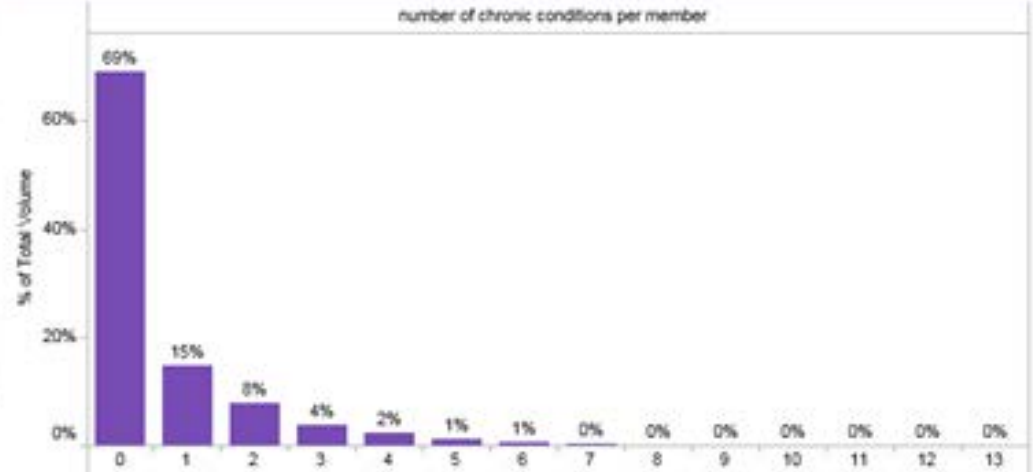


Selected County: Albany

Select a graph below to view

- Age & Gender distribution
- Care Utilization
- Prevalence (%) of Chronic Condition in the Selected Population or bundle
- Co-morbidity
- CRG distribution
- Risk score distribution

Co-morbidity: General



Comorbidity analysis was limited to the 14 conditions within the chronic bundle. The conditions were as follows: Arrhythmia-Heart Block, Asthma, Epigolar Disorder, Chronic Infection, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Depression & Anxiety, Diabetes, Gastro-Esophageal Reflux, ...

VBP Arrangement

Episode

MCO

Subgroups

Health Home

PCP

Map Volume
75 48,751



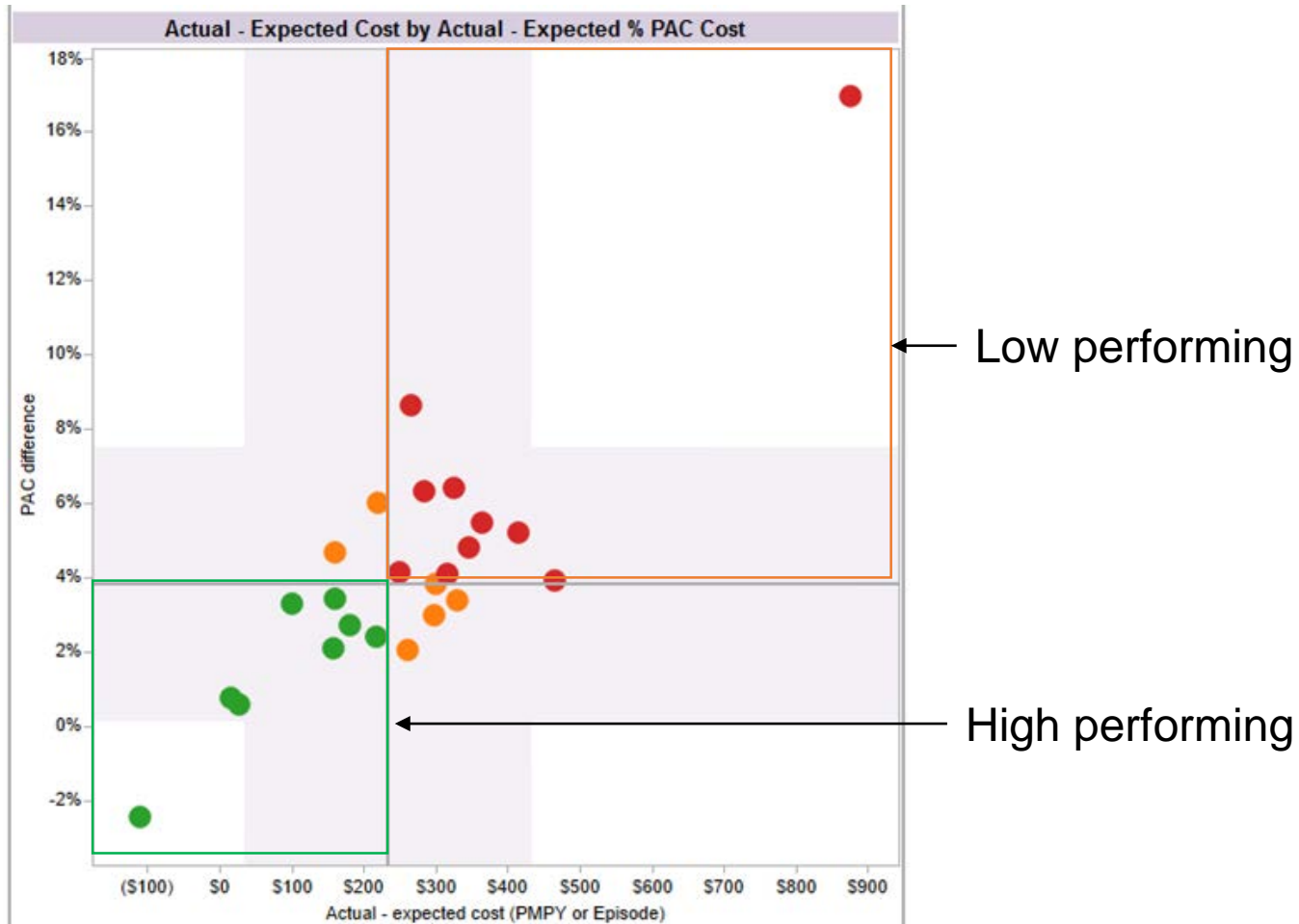
Exploring Performance and Opportunities

Can we increase efficiency while ensuring quality?

How can we find opportunities throughout the total cycle of care?

NYS Medicaid: similar situation

The Performance Comparison



Example VBP Contractors:

Horizontal Axis: ranking of risk-adjusted costs of Chronic Bundle

Vertical Axis: % of costs associated with Potentially Avoidable Complications

Where are you?

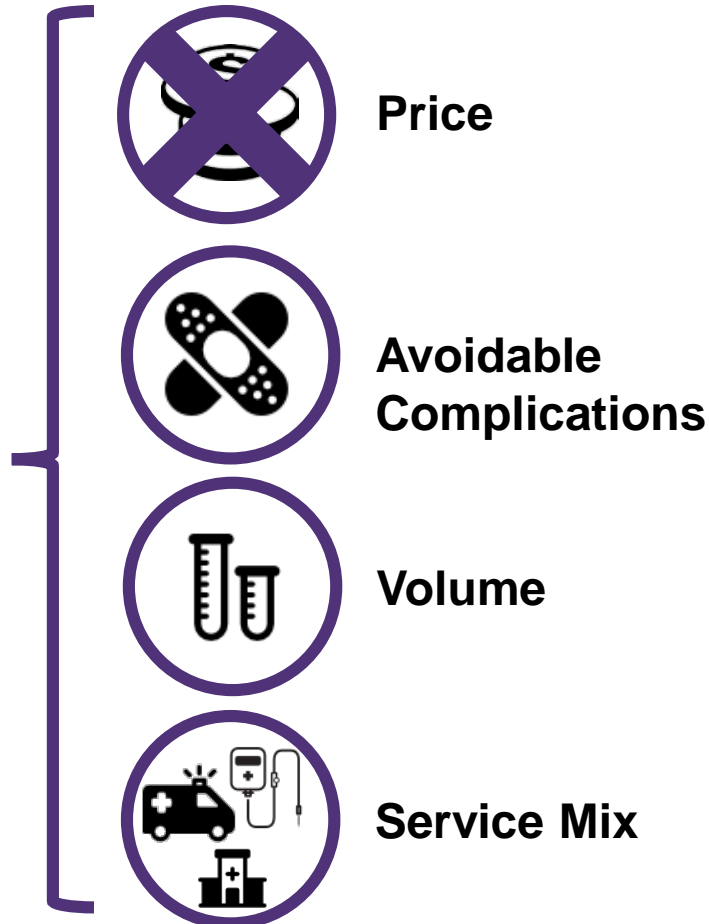
Disclaimer: Preliminary Data, work in progress; 2014, real-priced data

What Drives (In)Efficiency: Four Key Drivers

Costs of a VBP arrangement = total episode or PMPM costs from MCO/State perspective calculated from claims data



Cost Drivers



Price

The price of a service can vary based on providers' own costs (e.g. wages). For *ranking* purposes, price will be taken out of the equation ('proxy-priced'). For budget setting, negotiations & influencing opportunities for shared savings, *real priced* data remain key.

Avoidable Complications

Includes PPRs, PPVs, PQIs, PDIs and non-hospital based complications

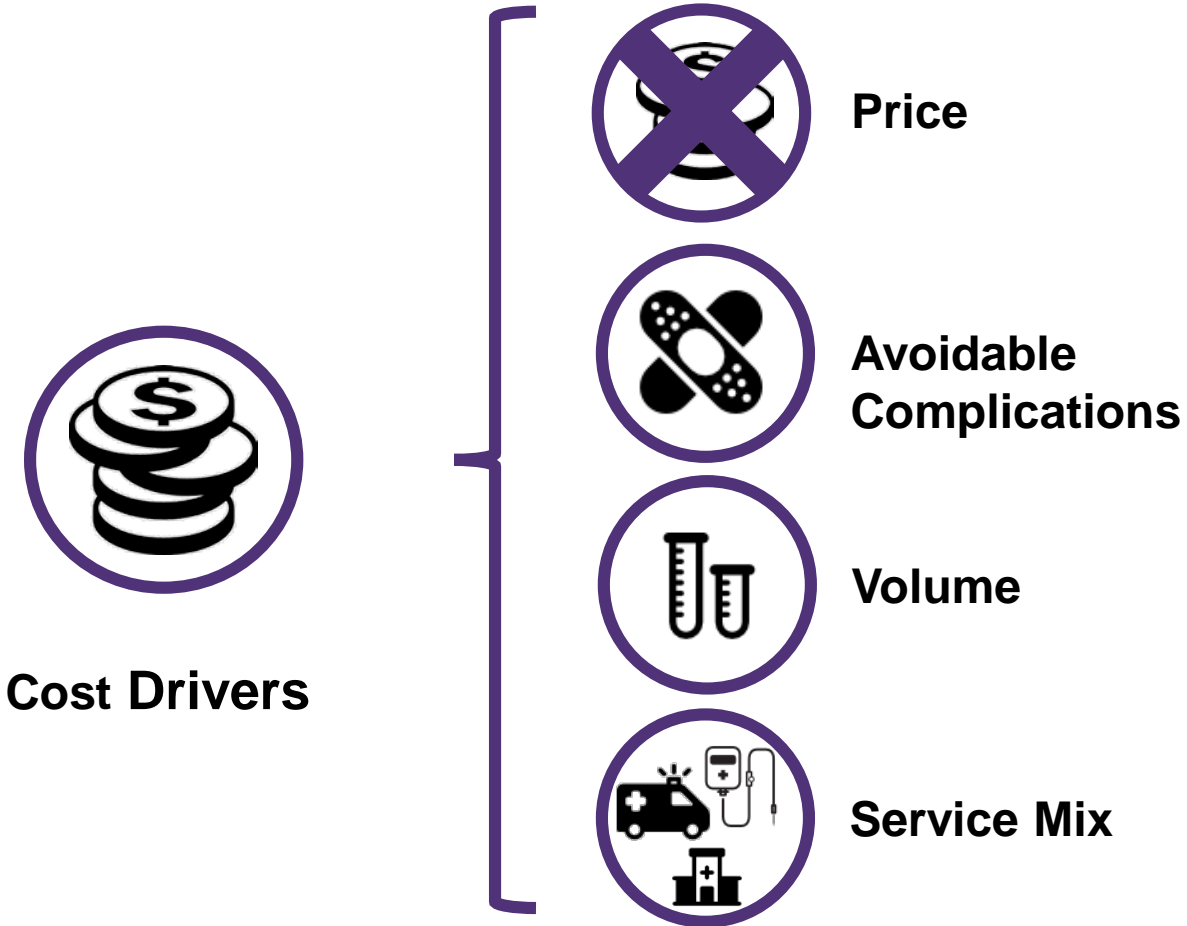
Volume

The volume of services rendered (e.g. # of office visits, admissions, expensive imaging)

Service Mix

The mix of services and intensity of care received during the episode (e.g. inpatient vs. outpatient vs. office-based point of care; generics vs. specialty drugs; choice of diagnostics).

What Drives (In)Efficiency: Four Key Drivers (Cont.)



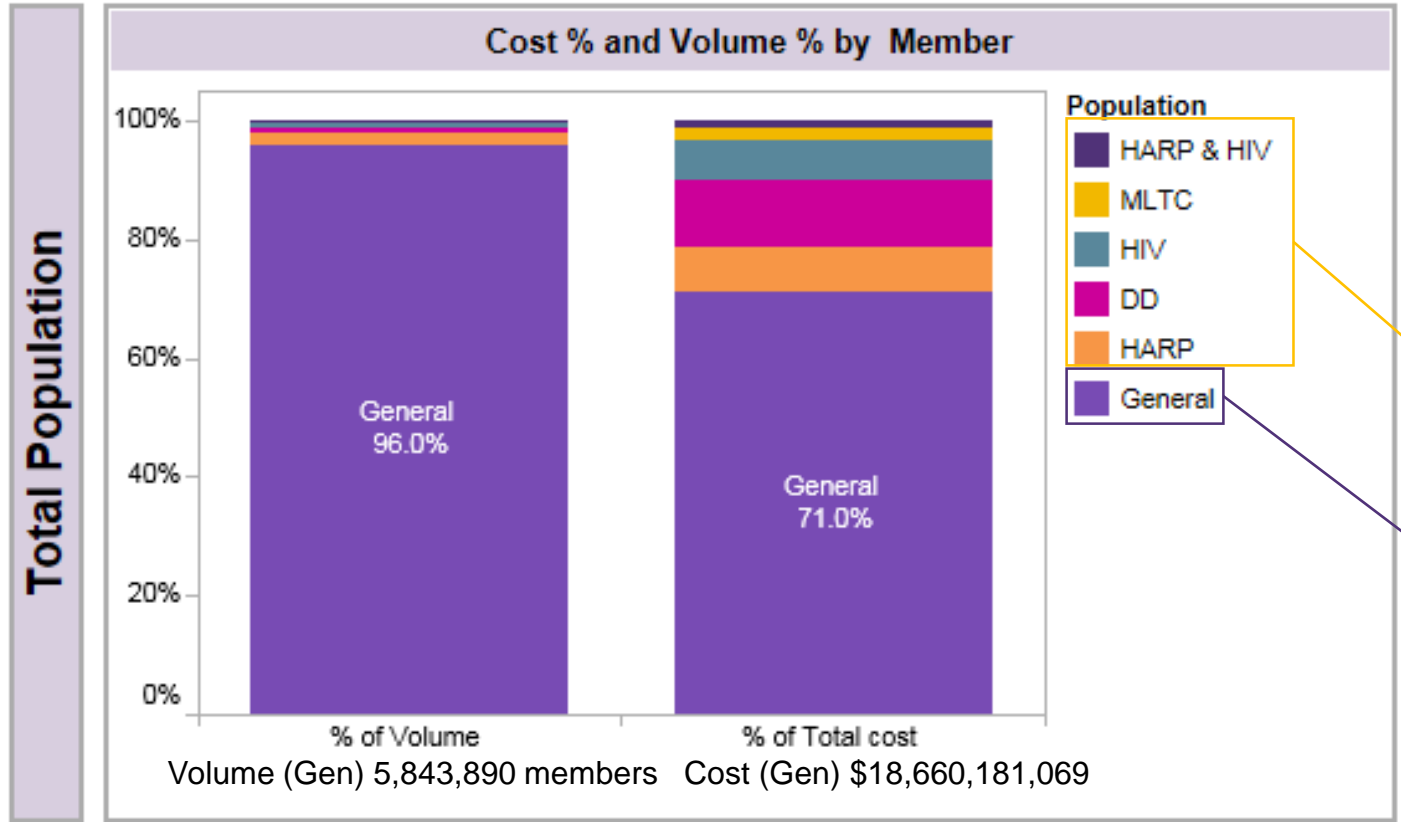
- Performance Overview allows for a first glance of where the opportunities may be the largest
- Drill-downs are possible in all these drivers
- Available paths for these drill downs:
 - The VBP arrangement itself (down into individual episodes and/or to individual CRGs)
 - Regional (counties to zipcodes)
 - Provider types to individual providers*



Member level table

* Further splits possible by MCO, by VBP contractor subgroup, Health Home, PCP

IPC as Part of TCGP



Members eligible for one of the subpopulations are *not* included in the IPC or the Maternity Bundle VBP arrangement

Subpopulations

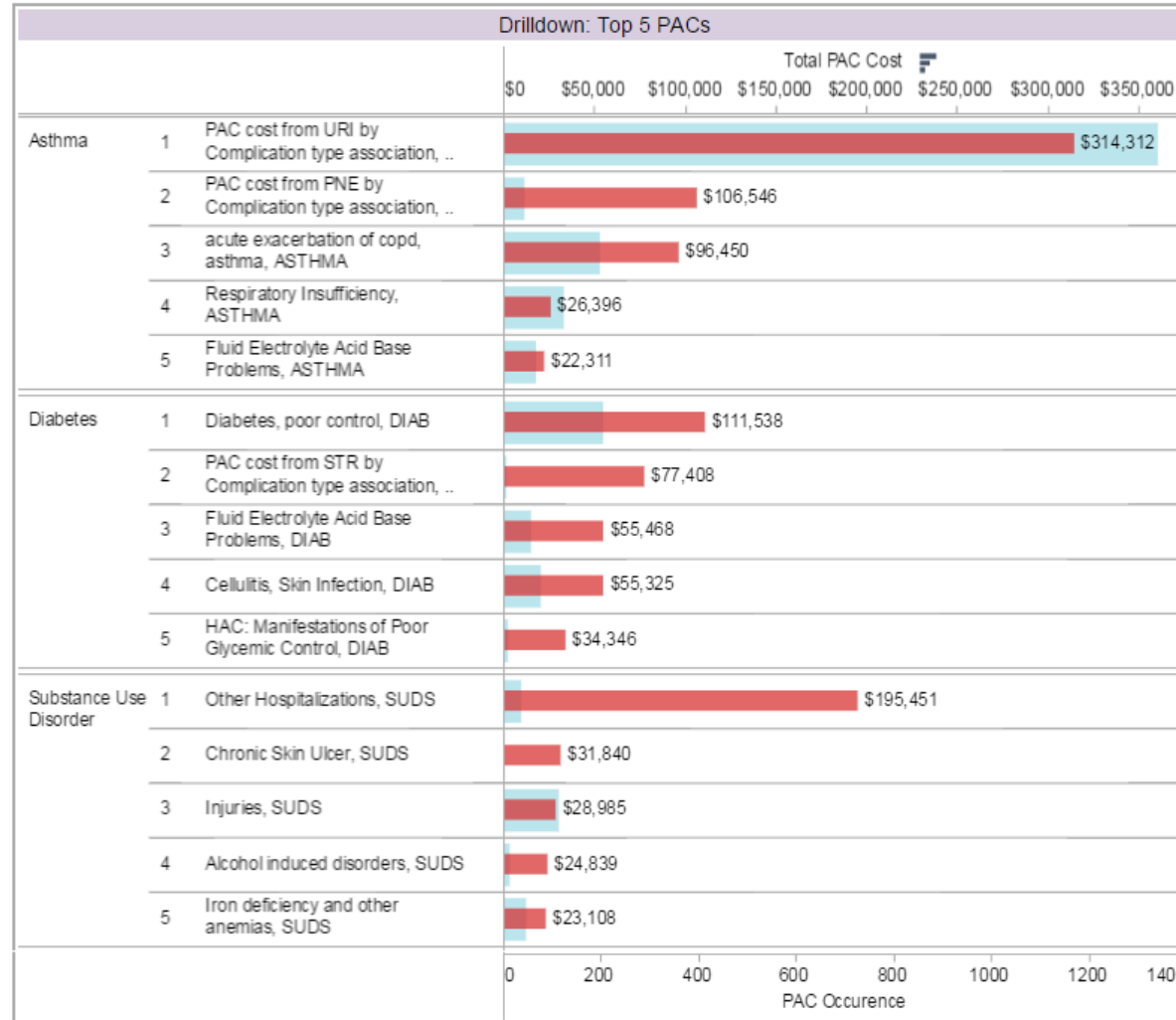
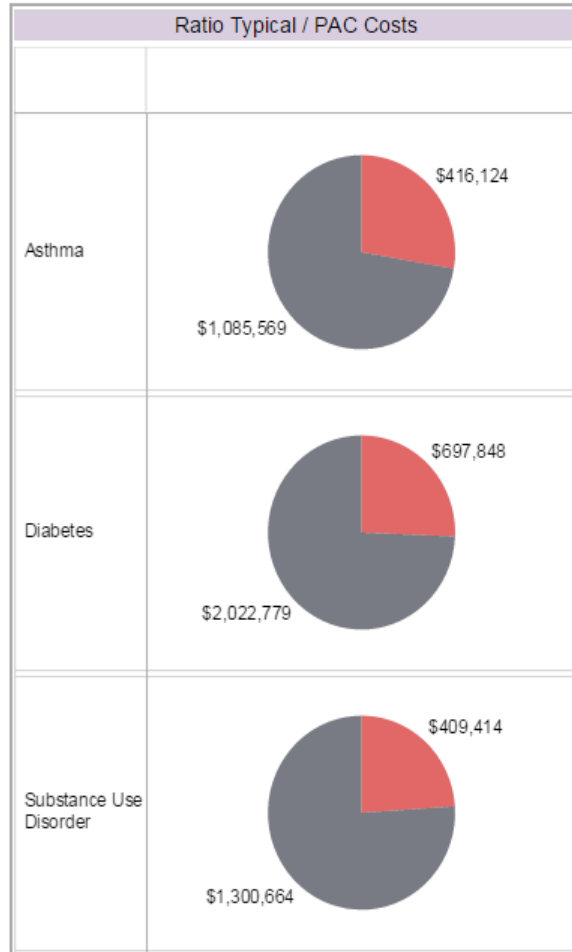
Total General Population

Disclaimer: Preliminary Data, work in progress; 2014, real-priced data

PACs: In Chronic Care, PACs Make Up 25% of the Total Cost of Care



Total Cost
 PAC Cost



PAC Occurrence
 Total PAC Cost

Costs Included:

- Fee-for-service and MCO payments (paid encounters);

Source: Fee-for-Service and Managed Care encounter records for Pulmonary Bundle Patients in CY2012-2013. Source: HCI3

Disclaimer: Preliminary Data, work in progress; 2014, real-priced data



Service Mix & Volume

Service Mix:

- Right care at the right place
- Optimal task-delegation between professionals
- Generics vs. specialty drugs

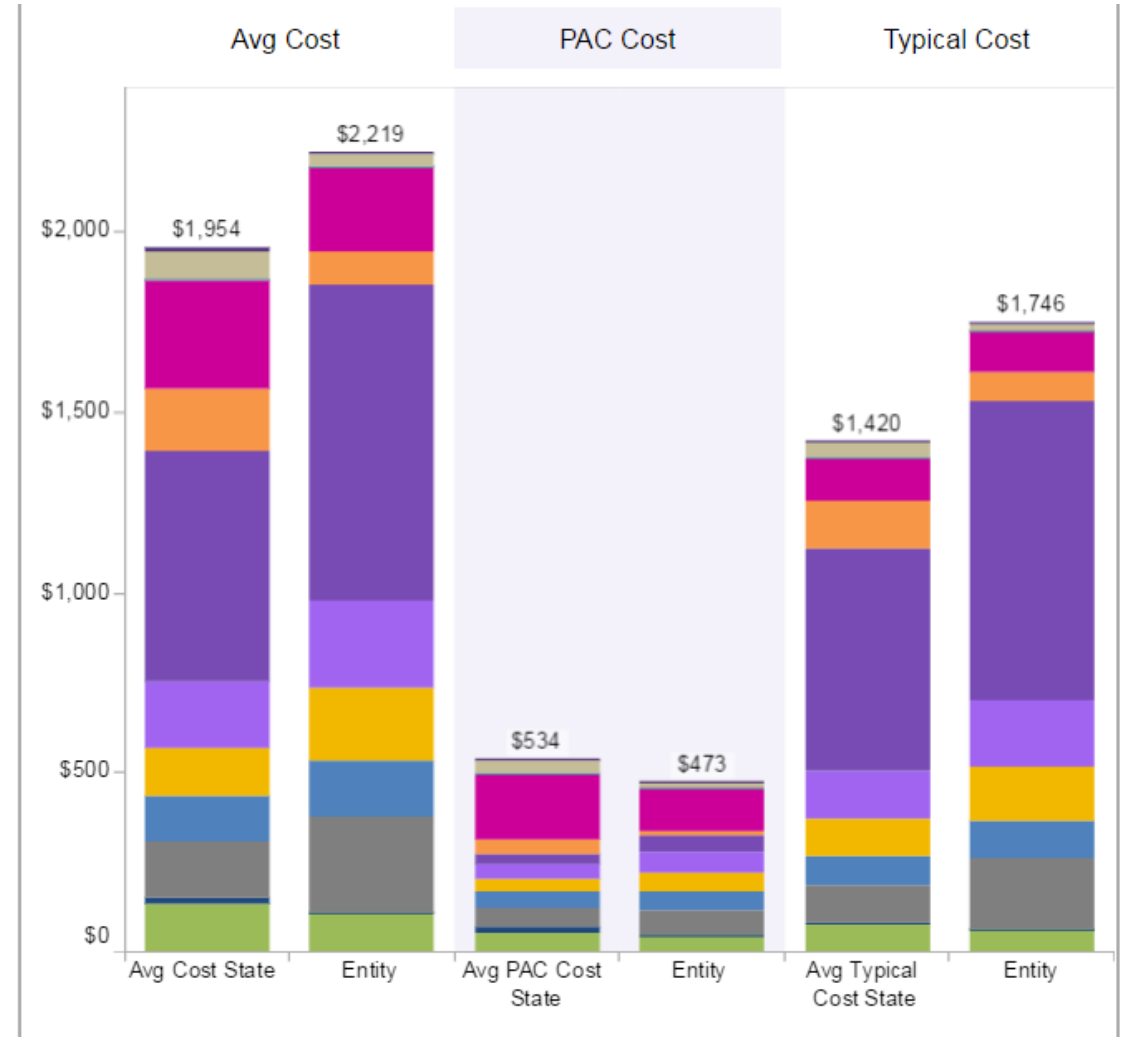
Volume:

- Length of Stay
- Number of ER visits
- Repeat Rx

Claim Provider Type

- Case Management/Health Home
- Clinic
- Hospice
- Practitioner - Non-Primary Care Provider (Non-PCP)
- Practitioner - Primary Care Provider (PCP)
- All Other
- Hospital
- Mental Health
- Pharmacy
- NOT AVAILABLE
- Nursing Home
- Substance Abuse

Disclaimer: Preliminary Data, work in progress; 2014, real-priced data



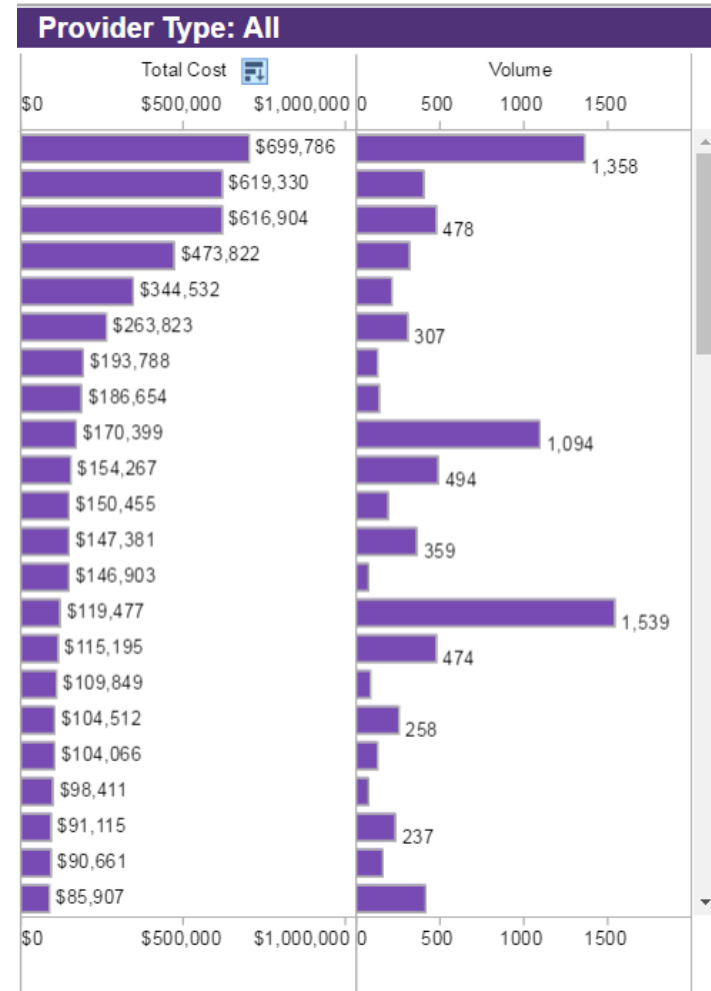
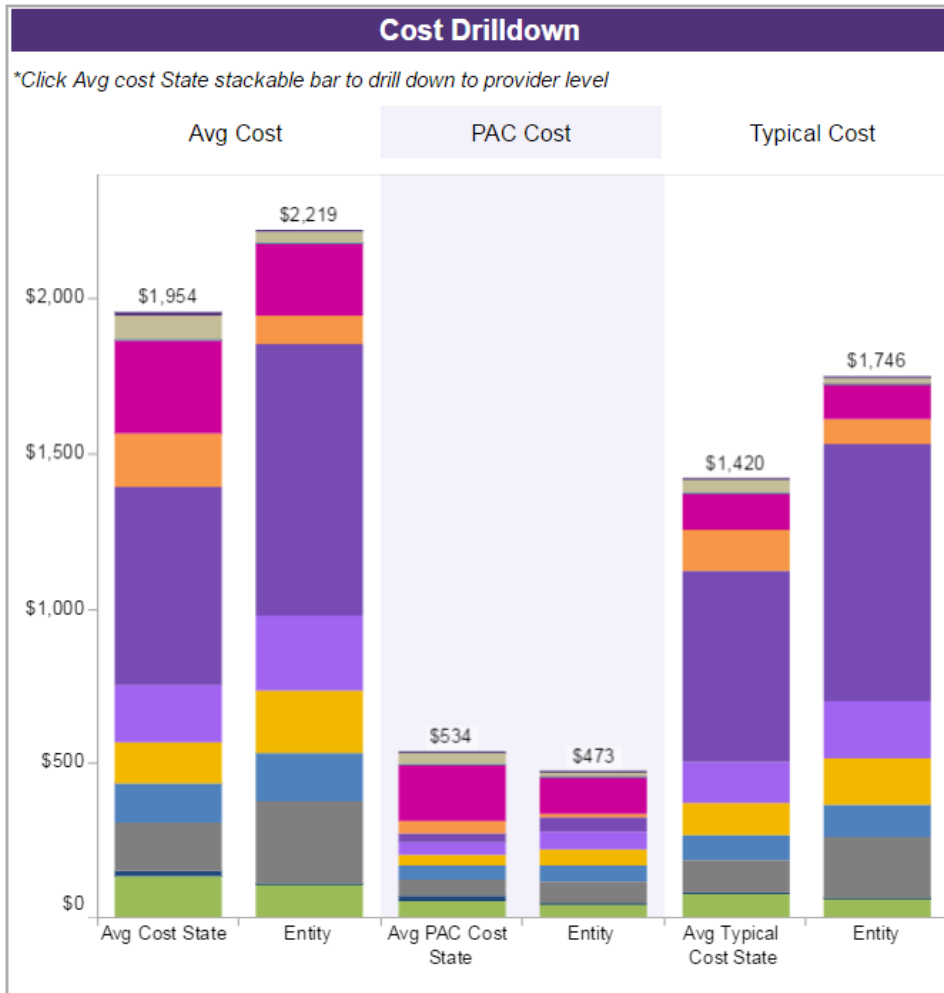


Creating the VBP Contractor

Where do our patients go?

What providers treat our patient across the total cycle of care?

Who Is Treating Our Patients?



Claim Provider Type

- Case Management/Health Home
- Hospital
- Practitioner - Non-Primary Care Provider (Non-PCP)
- NOT AVAILABLE
- Clinic
- Mental Health
- Practitioner - Primary Care Provider (PCP)
- Nursing Home
- Hospice
- Pharmacy
- All Other
- Substance Abuse

Disclaimer: Preliminary Data, work in progress; 2014, real-priced data

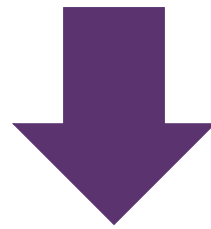
This Is Not All

E.g.:

- Quarterly score cards during VBP contract
 - Trending under / over budget?
 - Quality scores
- Basic Predictive Analytics

Questions

- Is Value Based Payment right for my organization?
- Which VBP arrangement should we choose ?
- Should we go at risk or not?
- Who should be our partners and how do we convince them to join?



Questions can only be answered by looking at **your** data ...
... and comparing them to others to learn where improvement is possible.

Questions

Recap & Closing

Recap & Closing

Session 1

- Overview of the Bootcamp series
- Introduction to VBP
- Types of VBP Arrangements
- VBP design standards
- Readiness assessment overview

Session 2

- VBP Contracting overview
 - Contracting entities
 - Types of contracts
 - Contracting considerations
 - Contract necessities vs. optional items
 - Contracting with CBOs
- Managing risk through the use of data and analytics tools
- Real life experience with VBP contracting (Panel)

Session 3

- Quality Measures
 - Role of Quality Measures in VBP
 - Starting Points
 - Clinical Advisory Groups
 - Current Status & What To Expect
 - Timeline
- Performance Data and VBP Dashboard (MAPP)

Important Information

Bootcamp Materials

VBP Resource Library:

- Path: DSRIP Homepage → Value Based Payment Reform → VBP Resource Library
- Link: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library

VBP Bootcamps Website:

- Path: DSRIP Homepage → Value Based Payment Reform → VBP Bootcamps
- Link: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_bootcamp

VBP Website:

- Path: DSRIP Homepage → Value Based Payment Reform
- Link: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform

VBP Bootcamps Contact Info

Website:

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_bootcamp

Twitter Account:

@NYSMedicaidVBP

Thank you