Department of Health | Medicaid Redesign Team

VBP 101

General VBP Concepts and Overview

October 18, 2016

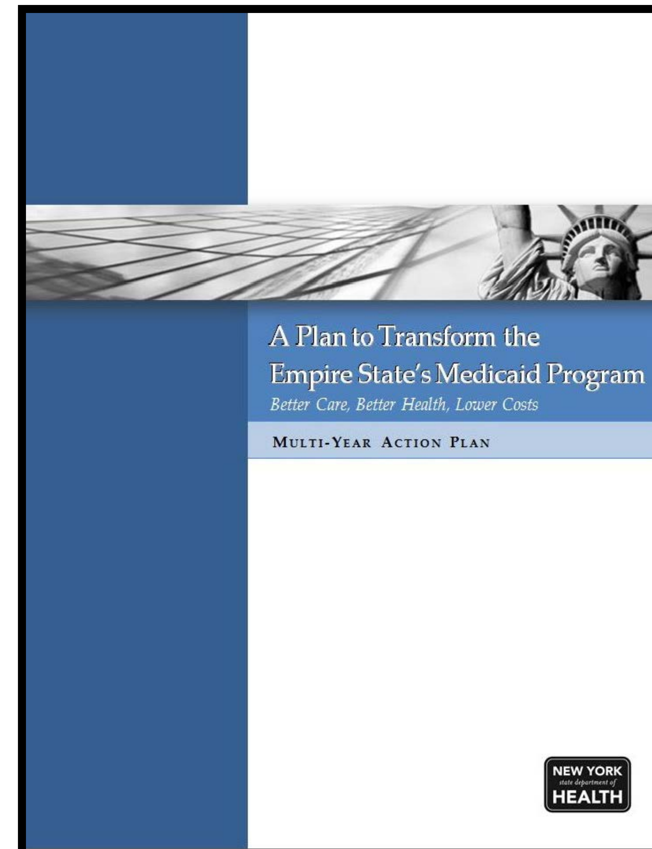
Agenda

I. Value Based Payment (VBP) Reform: The Basics
II. Overview of VBP Levels and Arrangements
III. Driving Efficiency and Quality
IV. The Role of Quality Measures in VBP
V. Clinical Advisory Groups
VI. Ongoing Implementation

I. Value Based Payment (VBP) Reform: The Basics

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 furthers New York State's Reform 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 the Waiver Amendment
  - Allows the State to reinvest $8 billion of $17.1 billion in Federal savings generated by MRT reforms
  - $7.3 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
  - Fee-for-Service (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

Financial and regulatory incentives drive…

a delivery system which realizes…

cost efficiency and quality outcomes: ***value***

The Old World: Fee for Service; Each in its Own Silo

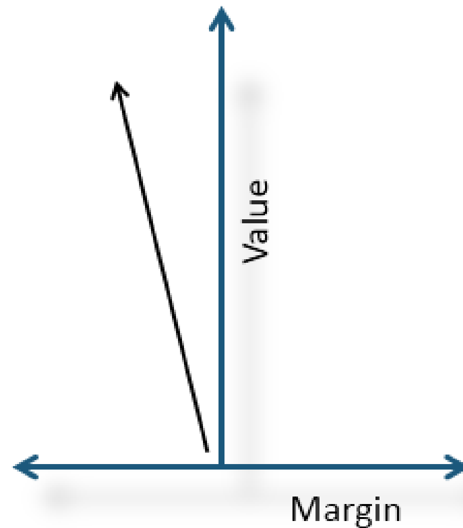
- There is no incentive for coordination or integration *across* the continuum of care
- Much Value is destroyed along the way:
  - Quality of patient care & patient experience
  - Avoidable costs due to lack of coordination, rework, including avoidable hospital use
  - Avoidable complications, *also* leading to avoidable hospital use

Moving to a New World

VBP arrangements are not intended primarily to save money for the State, but to *allow providers to increase their margins* ***by realizing value***

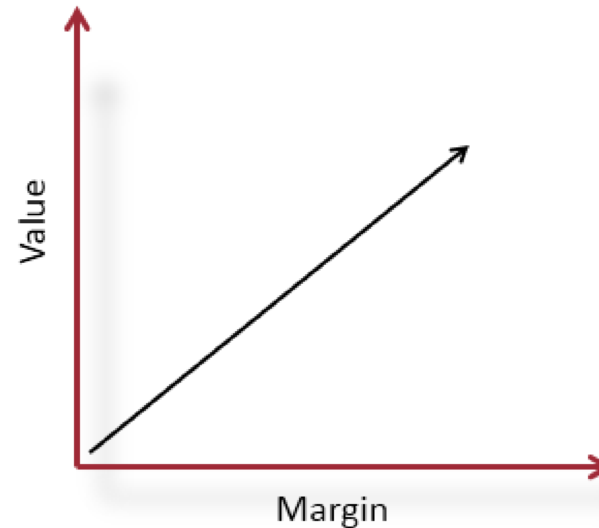
Current State

Increasing the value of care delivered more often than not threatens providers' margins



Future State

When VBP is done well, providers' margins go up when the value of care delivered increases

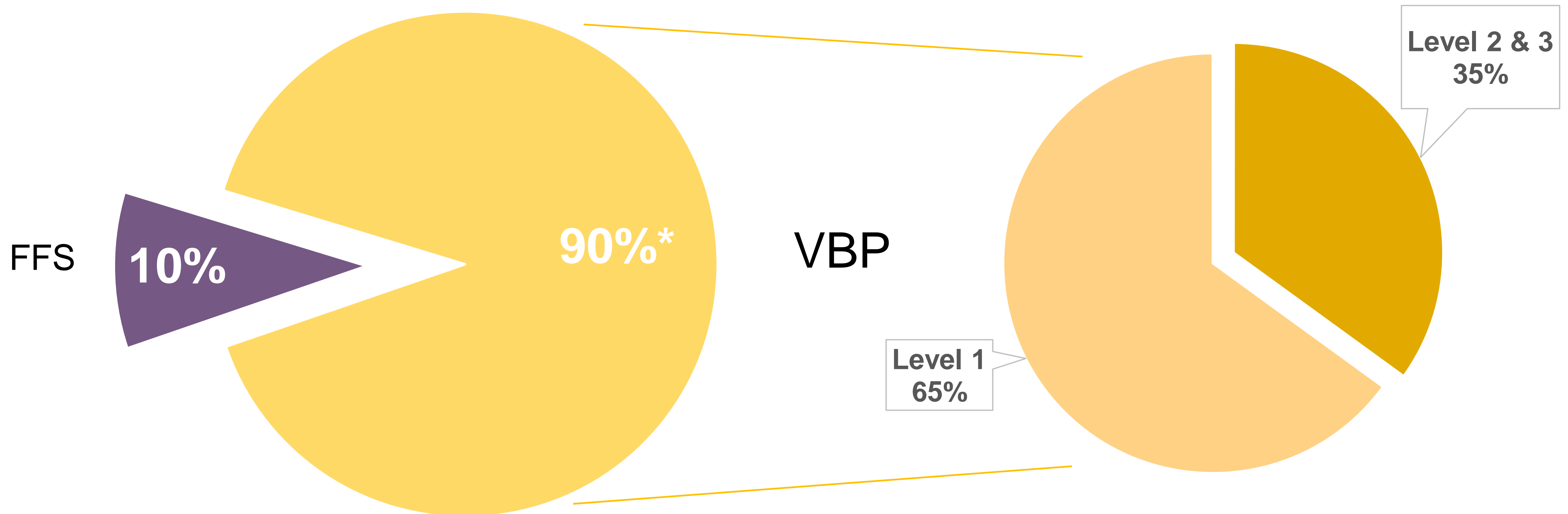


Goal – Pay for Value not Volume

Payment Reform: Moving Toward VBP

- 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

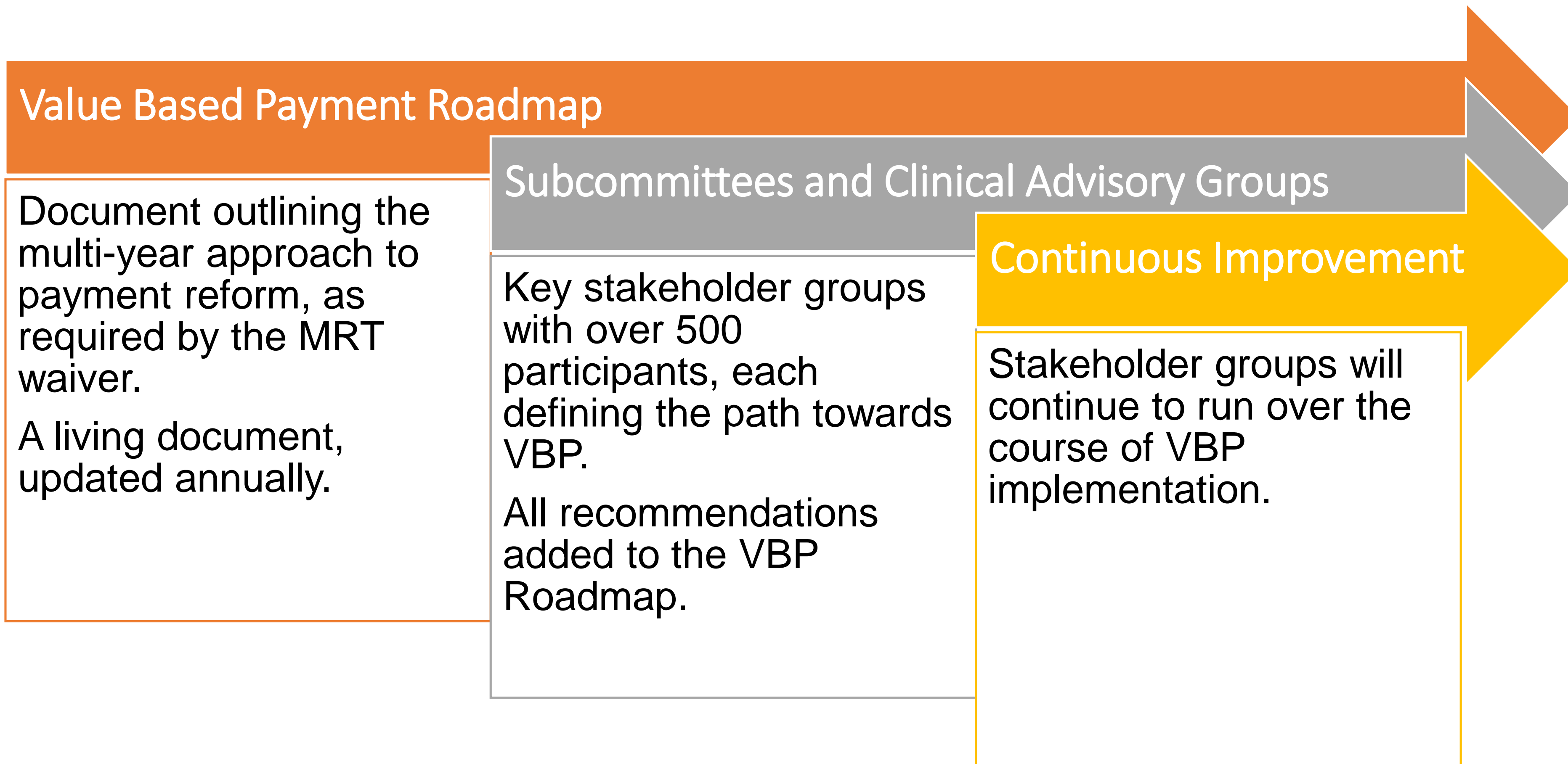
By April 2020, 80-90%* of Medicaid Managed Care Spend (Plan to Provider Payments) Will Be in VBP Level 1 or Higher



*Minimum of 80%; includes Managed Long-Term Care (MLTC) and (depending on move to Managed Care) Intellectually/Developmentally Disabled population

NEW YORK STATE OF OPPORTUNITY. Department of Health

Stakeholder Engagement: Creating the Path to VBP



How DSRIP and VBP Work Together

Old world:
- Fee for Service (FFS)
- Individual provider was anchor for financing and quality measurement
- Volume over Value

DSRIP:
Restructuring effort to prepare for future success in changing environment

New world:
- VBP arrangements
- Integrated care services for patients are anchor for financing and quality measurement
- Value over Volume

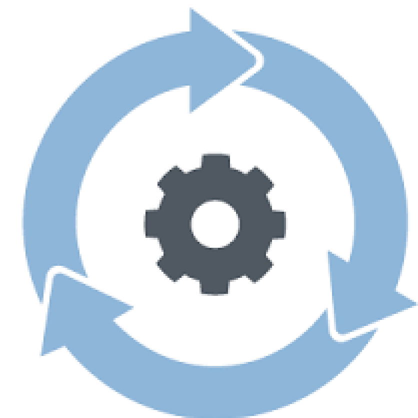
2013 2014 2015 2016 2017 2018 2019 2020

II. Overview of VBP Levels and Arrangements

The Menu of Options in Practice

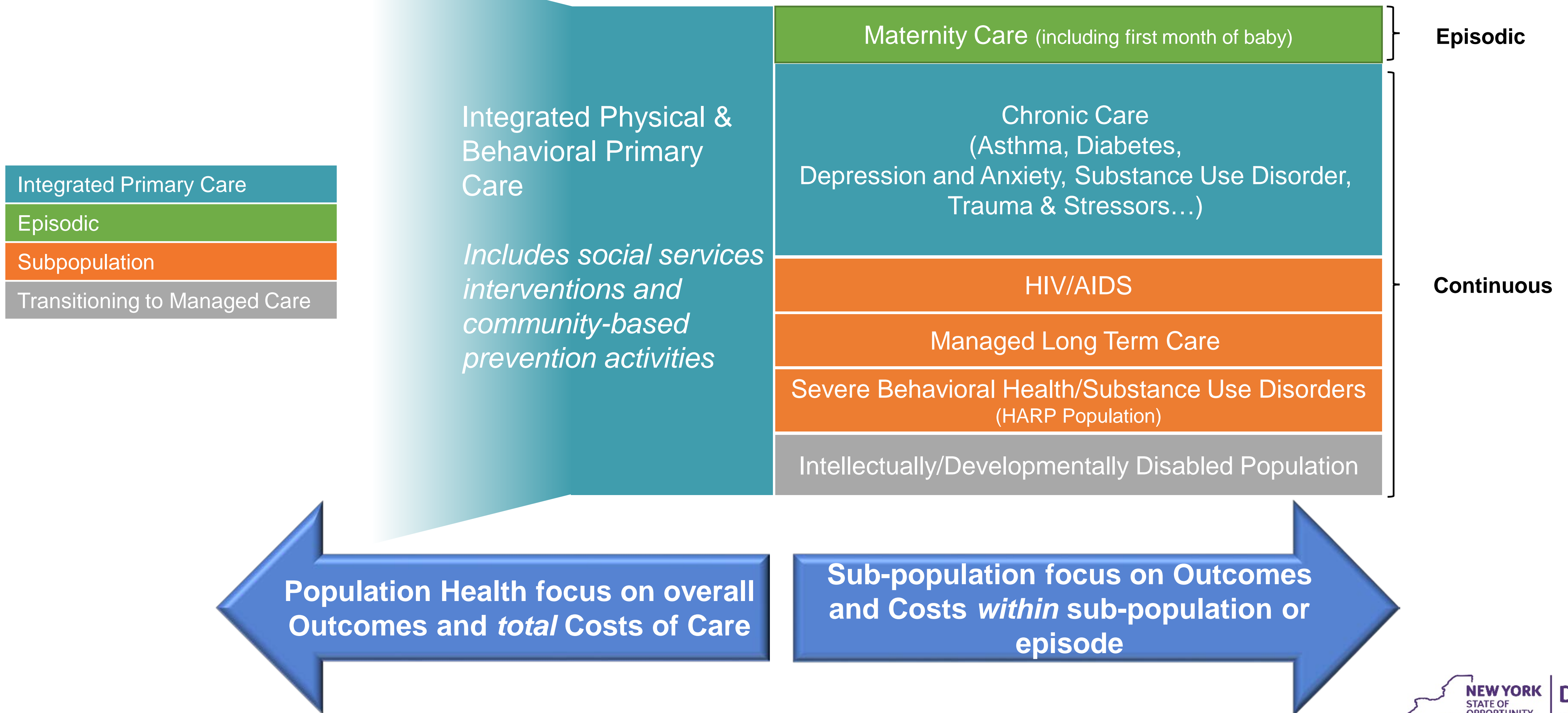
There is not a single path towards Value Based Payments. Rather, there are a variety of options that MCOs and providers can jointly choose from.

- Total Care for General Population (TCGP)
- Total Care for Special Needs Population
- Per integrated service for specific condition: Maternity Care bundle
- For Integrated Primary Care (IPC): includes Chronic Care bundle



These VBP arrangements are limited to Medicaid-only members. Duals will be integrated in the VBP arrangements from 2017 on.

How an Integrated Delivery System should Function



Different Types of VBP Arrangements

Types	Total Care for General Population (TCGP)	Integrated Primary Care (IPC)	Care Bundles	Special Need Populations
Definition	Party(ies) contracted with the MCO assumes responsibility for the total care of its attributed population	Patient Centered Medical Home or Advanced Primary Care, includes: • Care management • Practice transformation • Savings from downstream costs • Chronic Bundle (includes 14 chronic conditions related to physical and behavioral health related)	Episodes in which all costs related to the episode across the care continuum are measured • Maternity Bundle	Total Care for the Total Subpopulation • HIV/AIDS • Managed Long-Term Care (MLTC) • Health and Recovery Plans (HARP)
Contracting Parties	IPA/ACO, Large Health Systems, Federally Qualified Health Centers (FQHCs), and Physician Groups	IPA/ACO, Large Health Systems, Federally Qualified Health Centers (FQHCs), and Physician Groups	IPA/ACO, Federally Qualified Health Centers (FQHCs), Physician Groups and Hospitals	IPA/ACO, Federally Qualified Health Centers (FQHCs), and Physician Groups

MCOs and Contractors can Choose Different Levels of Value Based Payments

In addition to choosing which integrated services to focus on, the MCOs and contractors can choose different levels of Value Based Payments:

Level 0 VBP*	**Level 1 VBP**	**Level 2 VBP**	**Level 3 VBP** (feasible after experience with Level 2; requires mature contractors)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/IPC, 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)
FFS Payments	FFS Payments	FFS Payments	Prospective total budget payments
No Risk Sharing	↑ Upside Risk Only	↑↓ Upside & Downside Risk	↑↓ Upside & Downside Risk

**Level 0 is not considered to be a sufficient move away from traditional fee-for-service incentives to be counted as value based payment in the terms of the NYS VBP Roadmap.*

Bundles of Care

A bundled payment is a single payment to providers for all services related to a single condition.

Bundles of Care: Maternity Care Example

Maternity-related obstetrician fees

Delivery facility fee

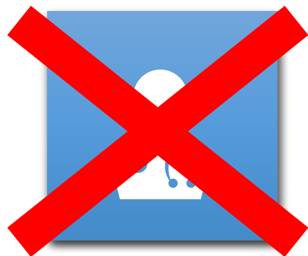
Inpatient stay post-delivery

Maternity-related medication

Echo

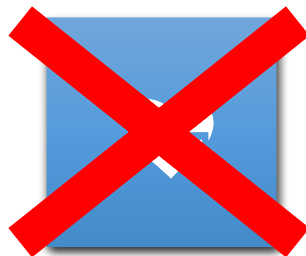
ER visit for abdominal pain during pregnancy

Sum of group services
(based on encounter data)

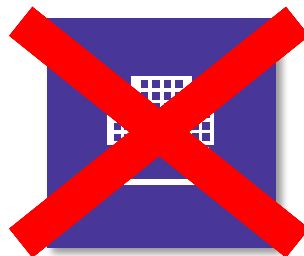


Routine wellness visit

Antibiotics for throat infection



COPD care

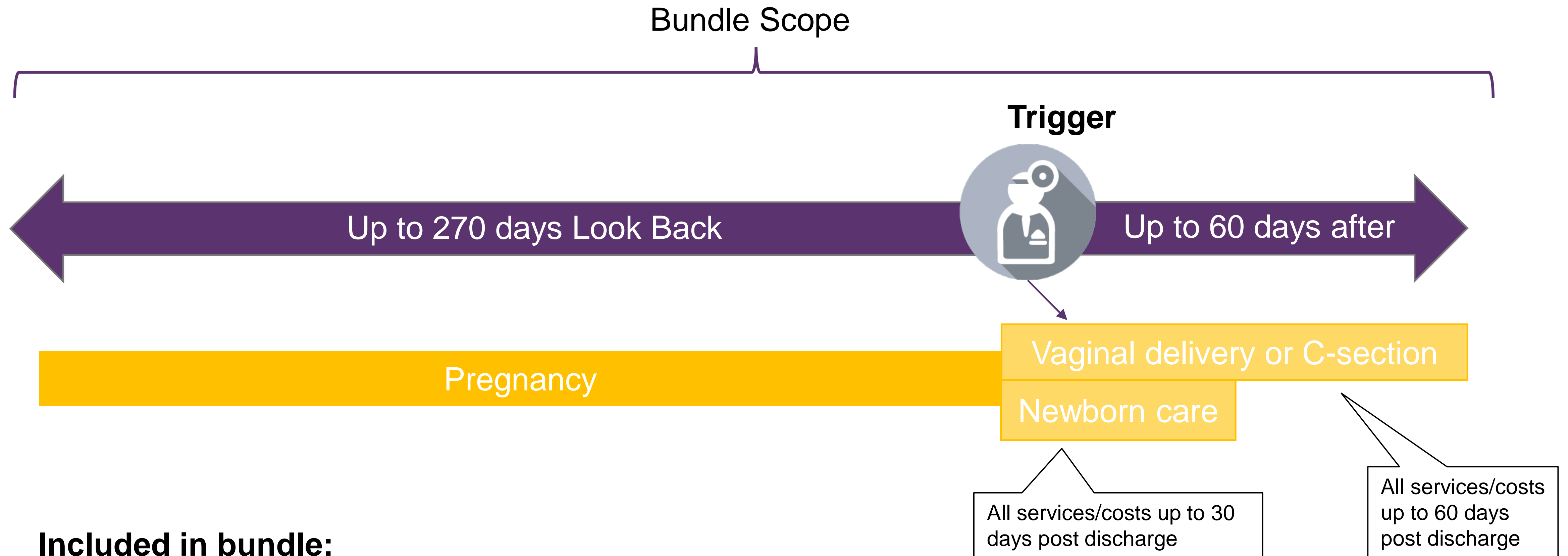


Readmission after appendectomy

Diabetes care

- Included when pregnancy related
- Not included when diabetes pre-dates pregnancy

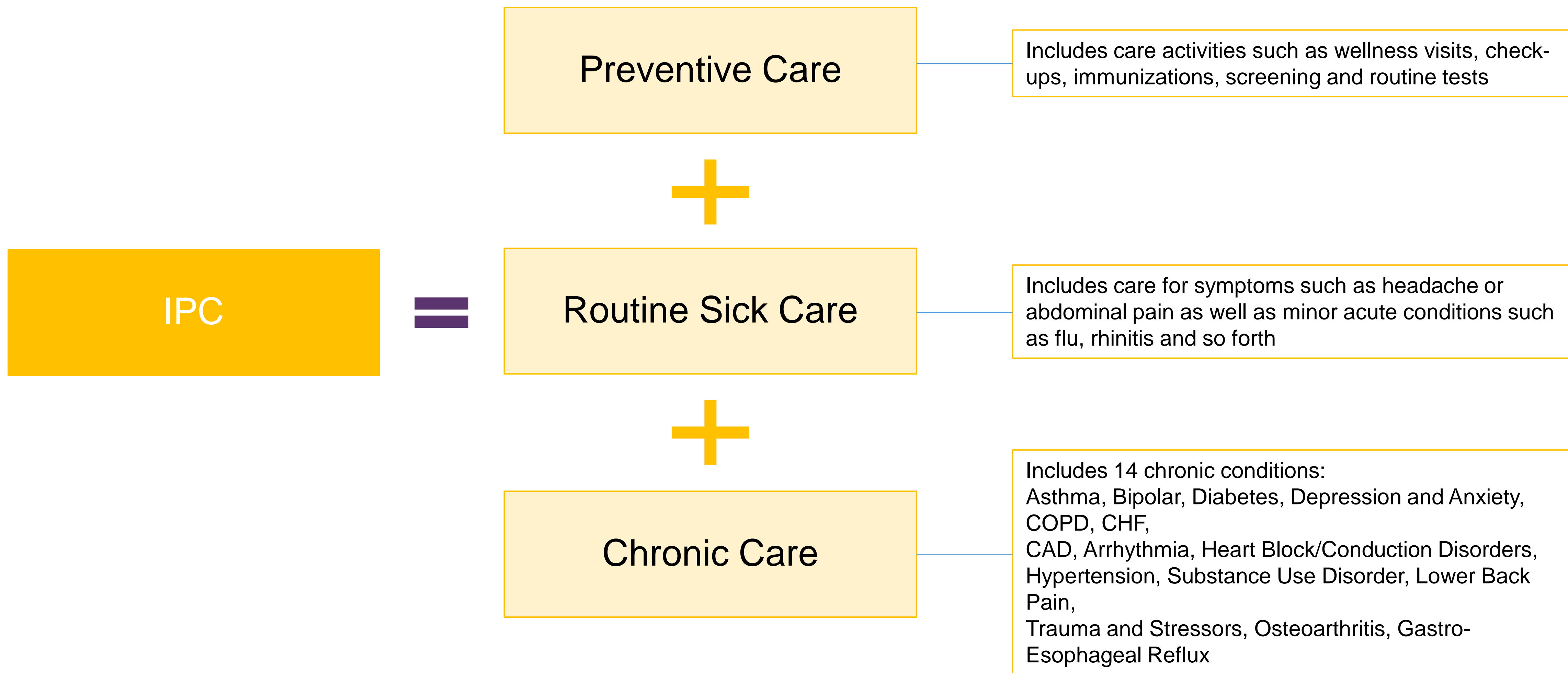
Maternity Bundle



Included in bundle:

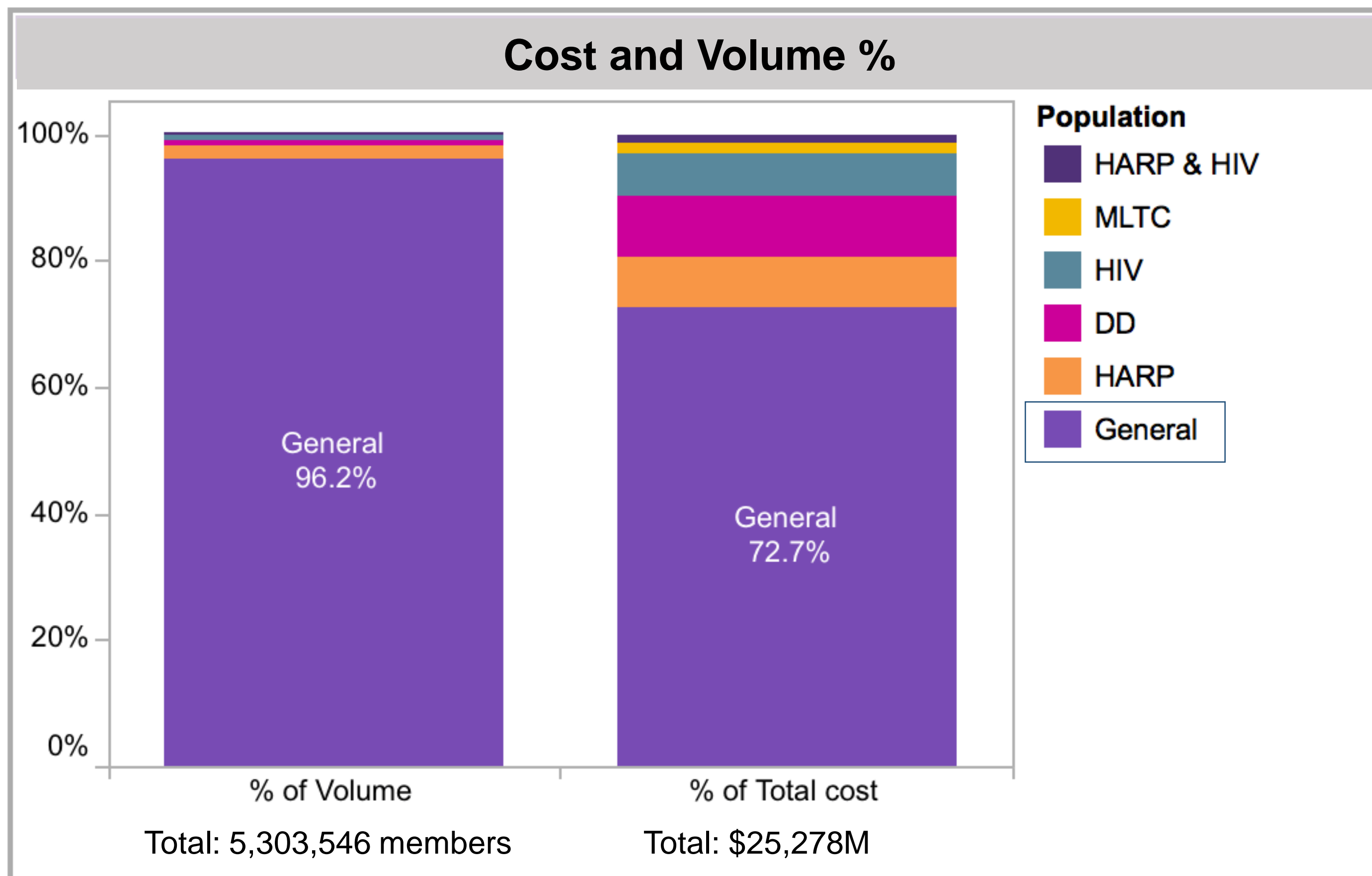
- Both low risk and high risk pregnancies with severity markers
- **For the mother**: all related services for delivery including post discharge period (60 days post discharge) and entire prenatal care period (270 days prior to delivery)
- **For the infant**: initial delivery stay and all services/costs up to 30 days post discharge

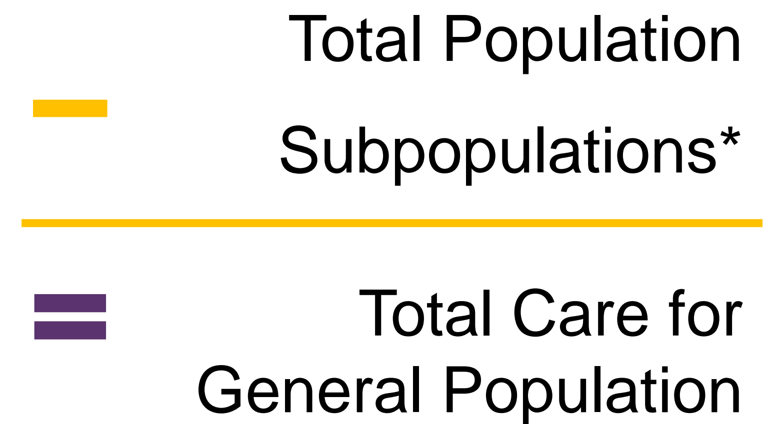
Integrated Primary Care



Note: Patients that are attributed to subpopulations are excluded.

Total Care for General Population (TCGP) Definition





In this arrangement the VBP Contractor assumes responsibility for the care of the entire attributed population. Members attributed to this arrangement cannot be covered by a different arrangement.

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

**Note: VBP Contractors and MCOs are free to add one or more subpopulations to their TCGP contracts.*

NEW YORK STATE OF OPPORTUNITY. Department of Health

Why Total Care for Subpopulations Can Be Attractive

- Dedicated focus on these subpopulations can get lost in larger Total Care for Total Population models (such as Medicare ACOs)
- Dedicated incentive to reduce the significant inefficiencies and potentially avoidable complications within these subpopulations creates maximum positive impact for these subpopulations
- The significant budgets of these subpopulations and the significant potential for shared savings become available for these groups of dedicated providers
- Rather than relying on separate and often small grants to improve housing and other social determinants of health, a large budget is now available to (re-)invest and restructure the delivery system and invest in Community Based Organizations & the social determinants of health
    - For these subpopulations (HARP, HIV/AIDS, MLTC, DD), these social determinants are especially important

Scope of Care within TCGP and Subpopulation Arrangements

1. TCGP and Subpopulation agreements include comprehensive care for their respective populations, so members that are already in these arrangements cannot simultaneously receive care as part of the IPC or Maternity bundles
2. Vice versa, members included in IPC or Maternity arrangements are excluded from TCGP or Subpopulation agreements

A contract can include both the general population and one or more sub-populations for a contract approaching the total population.

Similarly, VBP contractors can combine non-overlapping elements of different agreements, often at different Levels: e.g., IPC and the 'remainder' of TCGP.

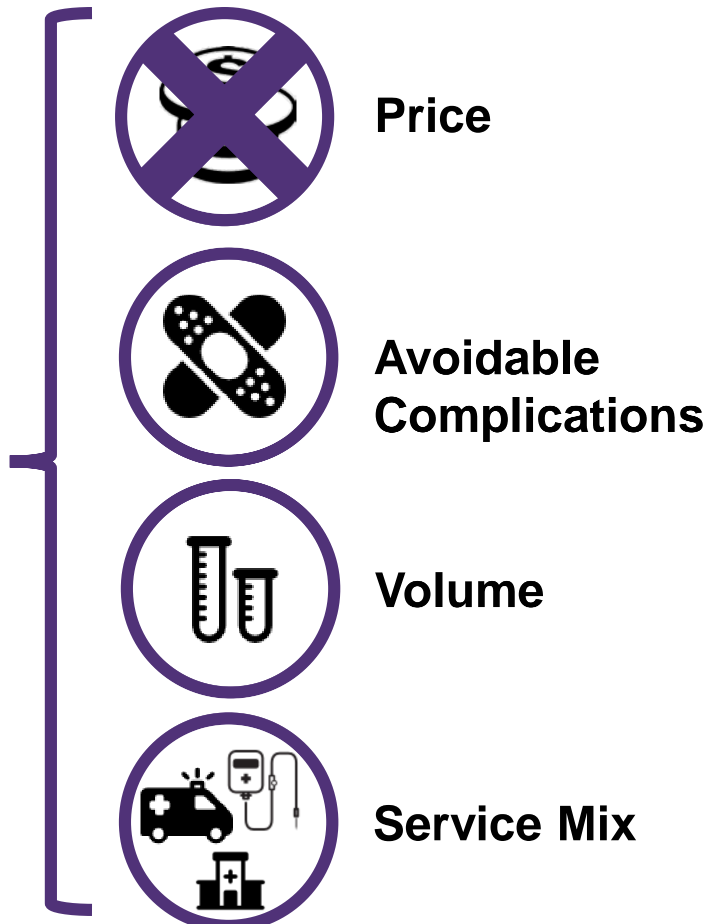
This is relevant when the VBP contractor wants to go at risk for IPC but not for TCGP.

III. Driving Efficiency & Quality

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

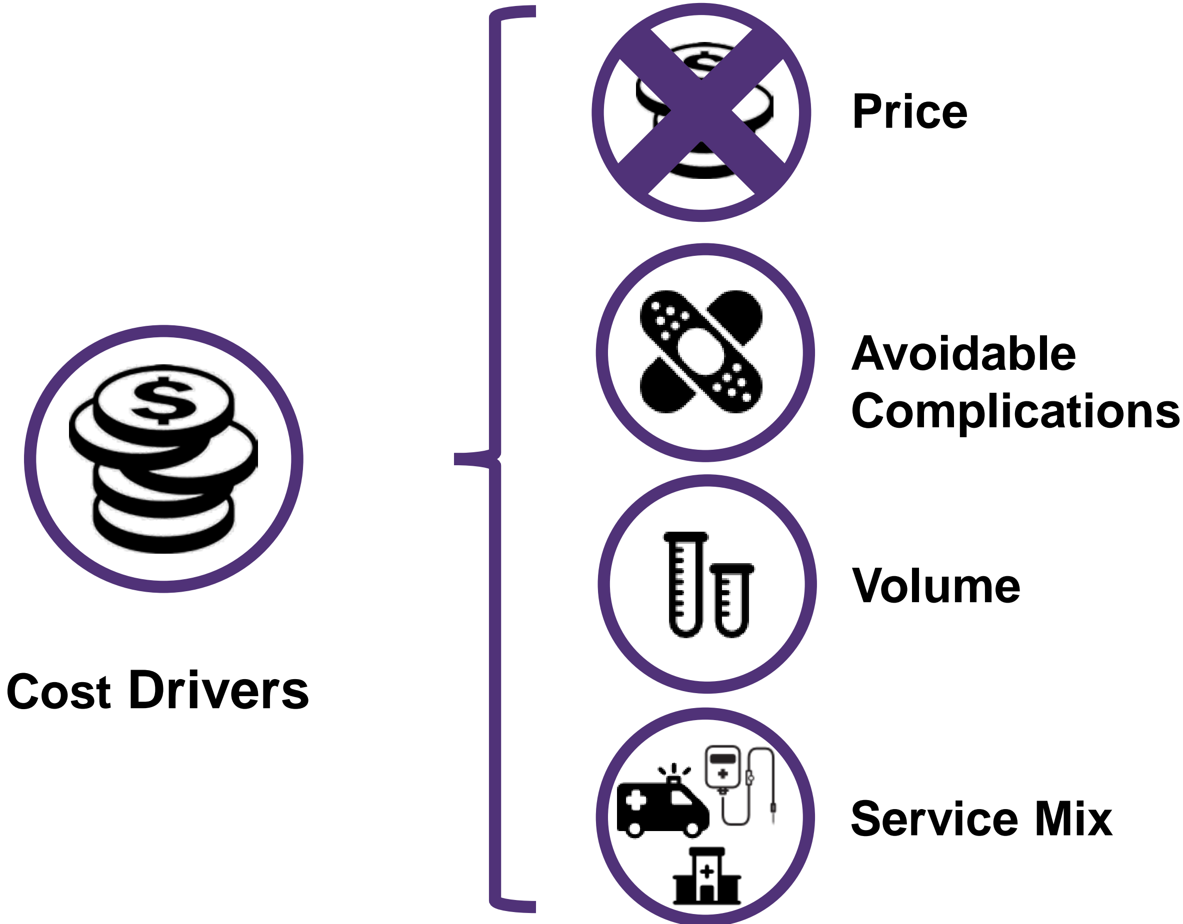
Volume

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

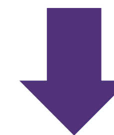
Service Mix

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.)



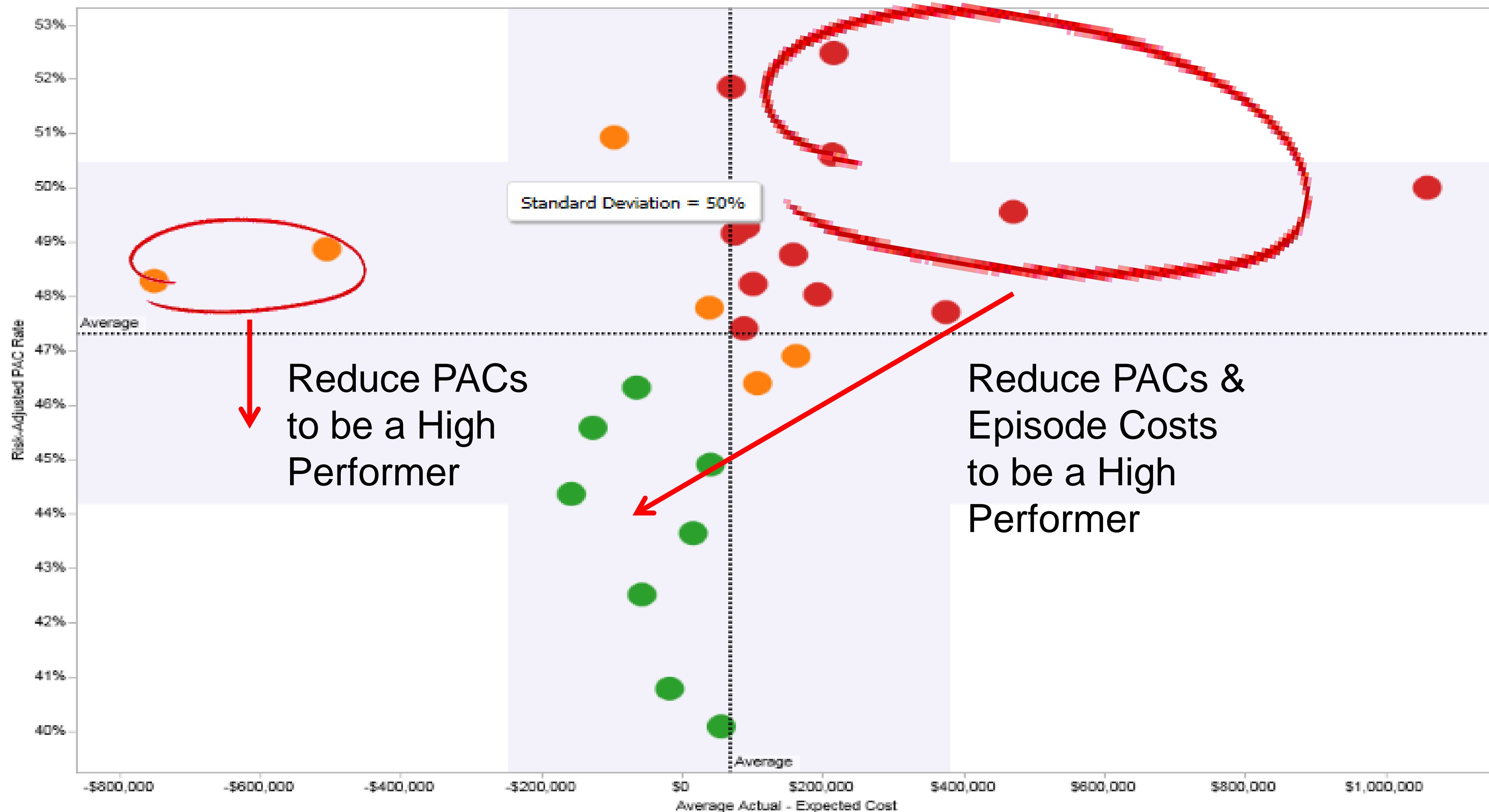
- Performance Overview allows for a first glance of where the opportunities may be the largest
- Drill-downs are possible in all these drivers
- Available paths for these drill downs:
  - The VBP arrangement itself (down into individual episodes and/or to individual CRGs
  - Regional (counties to zipcodes)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



Member level table

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

There are Significant Opportunities to Increase Value



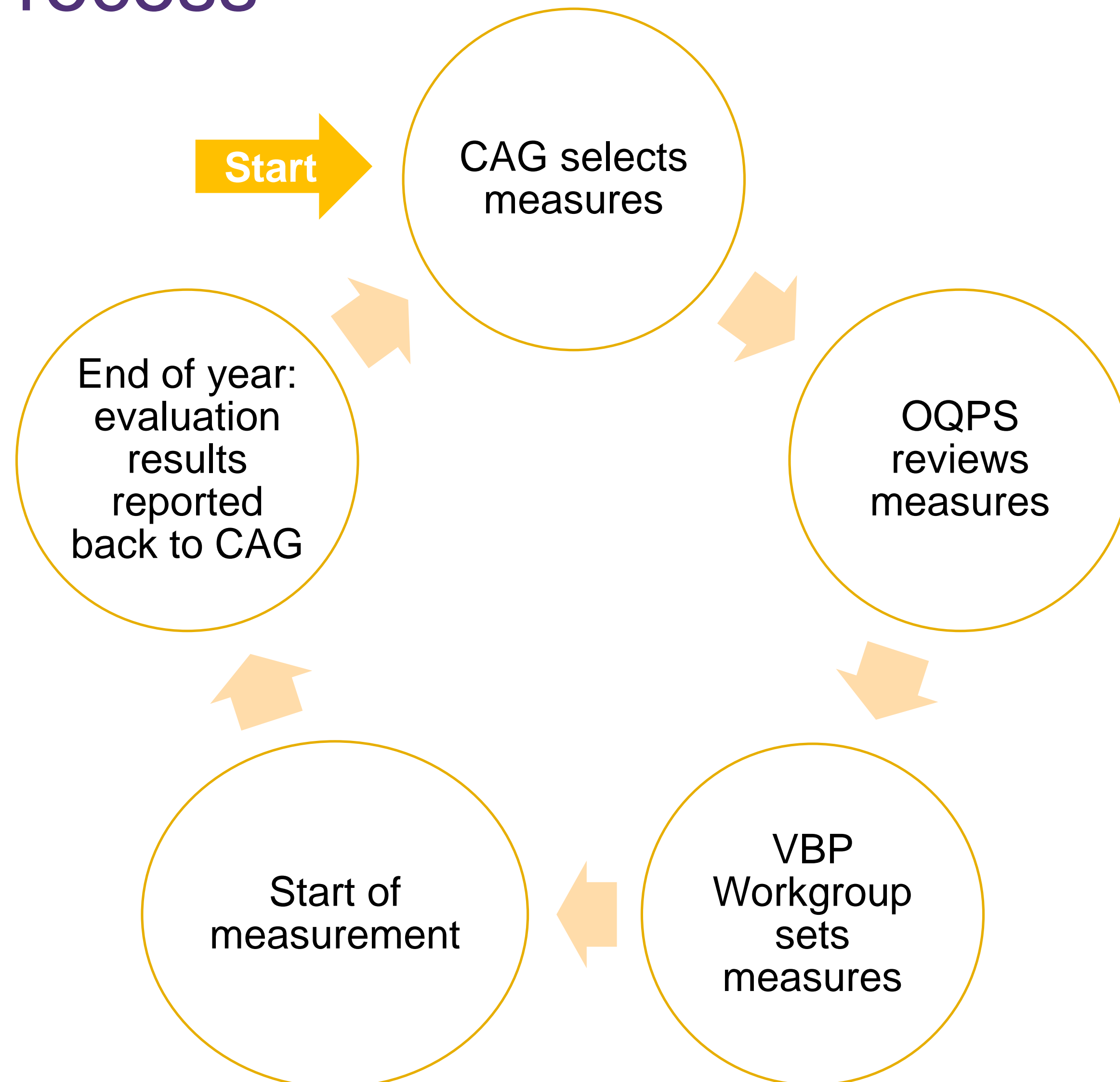
NEW YORK STATE OF OPPORTUNITY. Department of Health

IV. The Role of Quality Measures in VBP

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 Heath Innovation Plan’s Advanced Primary Care measure set
- Transparency of process, of measures, of outcomes

Selecting and Refining Quality Measures is an Ongoing Process



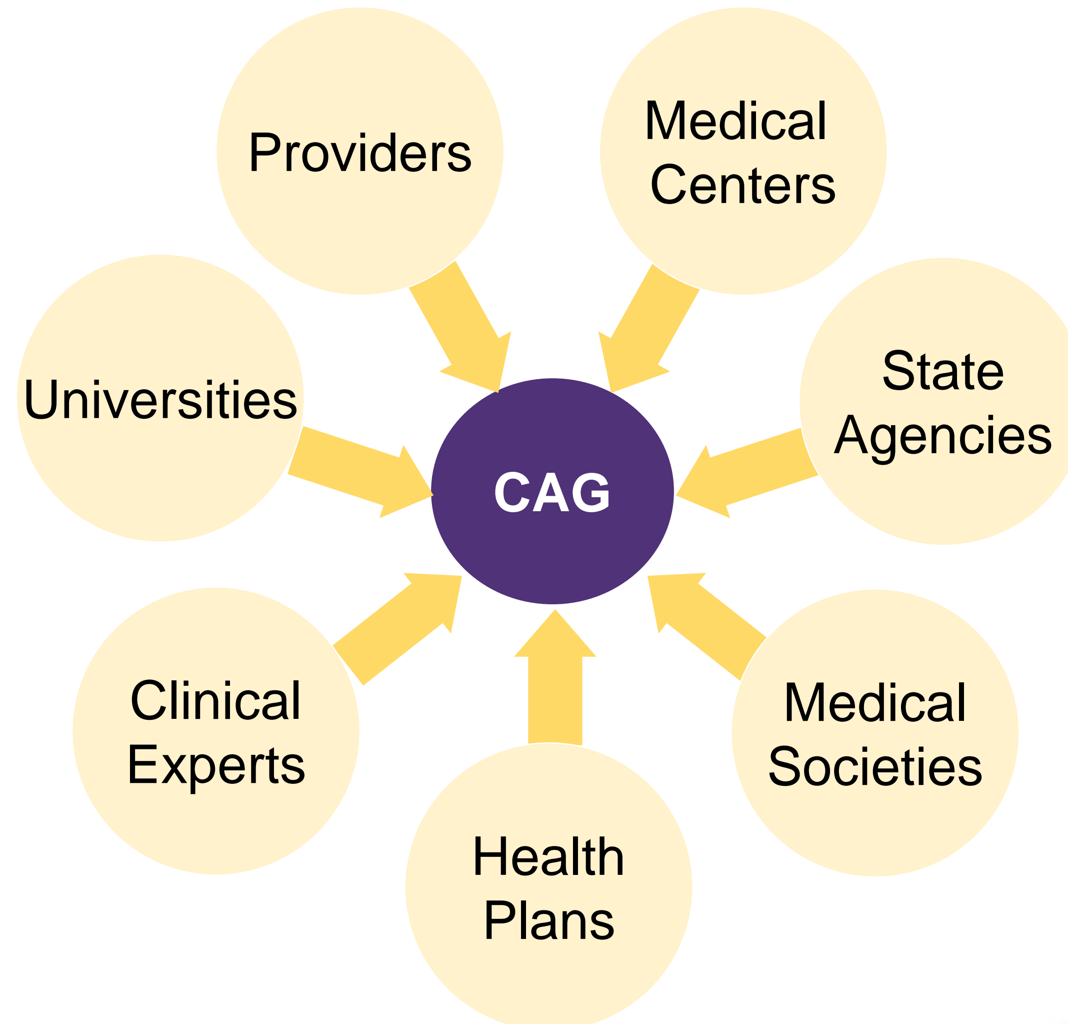
During the process:

- 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*

V. Clinical Advisory Groups

Clinical Advisory Groups: Composition

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



Clinical Advisory Group Objectives

CAG members convene 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

Criteria for Selecting CAG Quality Measures

Quality Measure Selection

The quality measure selection process begins 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

- **Focus 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**

VI. Ongoing Implementation

VBP Implementation Timeline

Questions?