NEW YORK STATE | Department of Health | Medicaid Redesign Team

CNYCC PPS-Wide Annual Meeting 2018

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November 2018

I. **What are we doing?**
II. Where are we going?
III. How will we get there?
IV. Questions

Health Care Quality, Health Care Spending, and Social/SDH Spending

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

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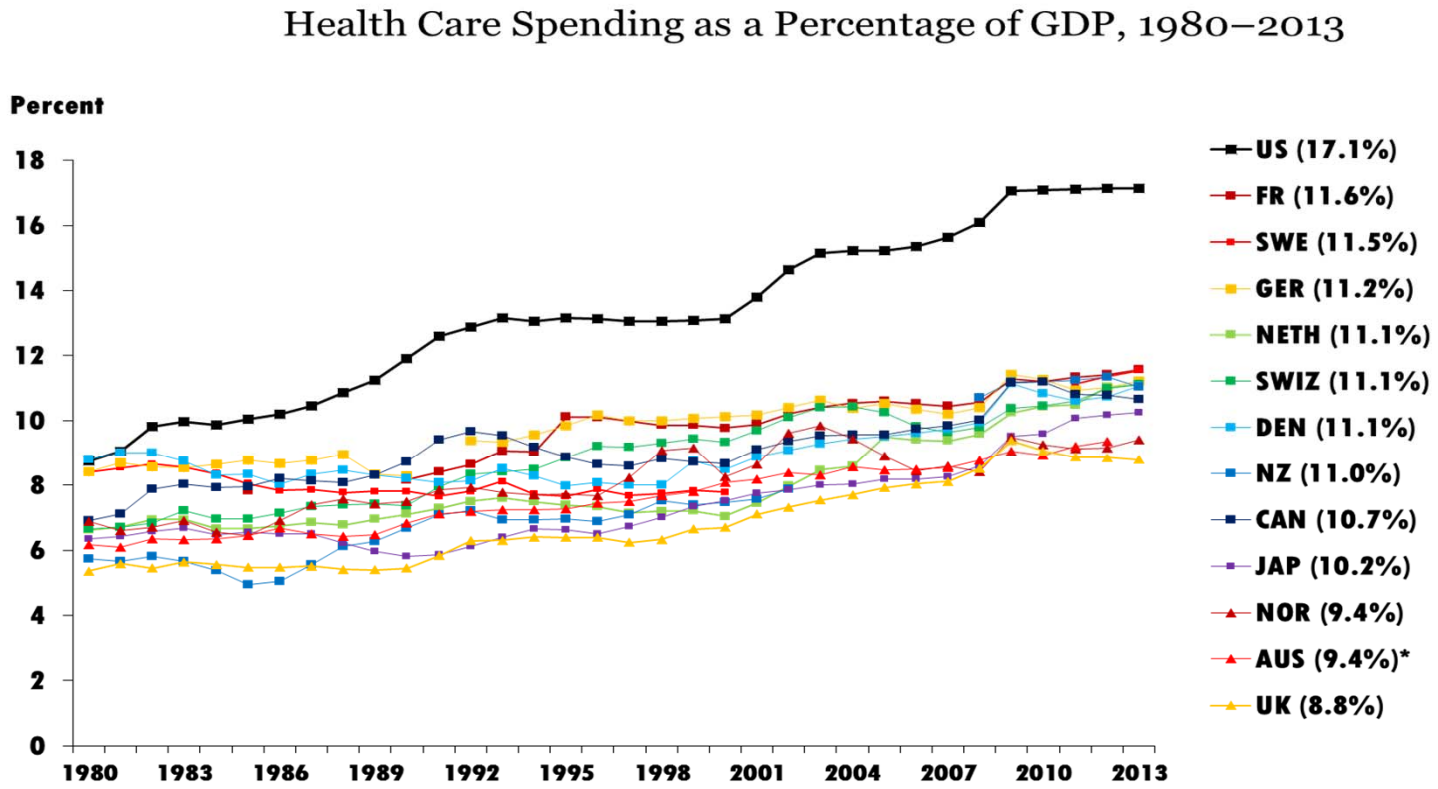
Health Care Spending in US & Other Countries



* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

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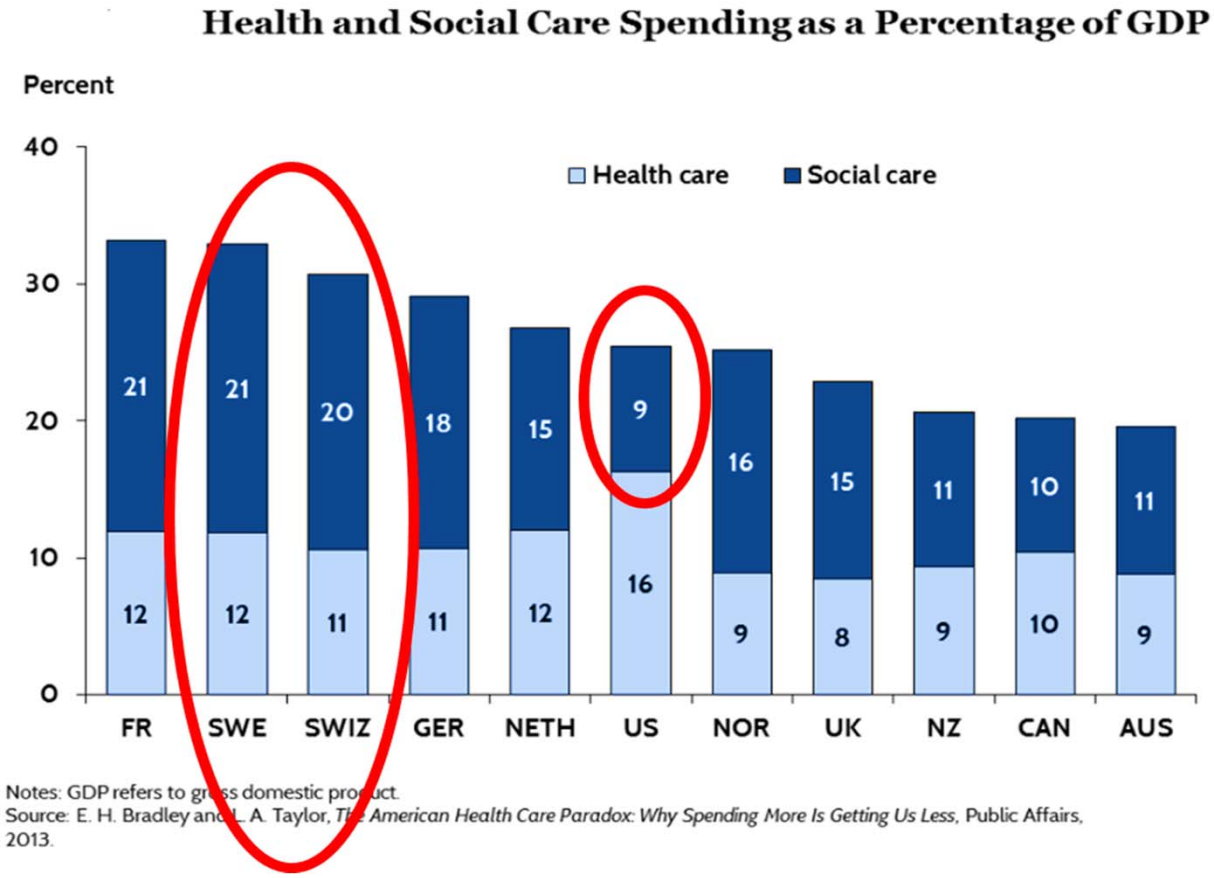
Health Care and Social/SDH Spending



Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

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PREVENTION AGENDA

Priority Areas::

- Prevent chronic diseases
- Promote a healthy and safe environment
- Promote healthy women, infants, and children
- Promote mental health and prevent substance abuse
- Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases, and healthcare-associated infections

STATE HEALTH INNOVATION PLAN (SHIP)

Pillars and Enablers:

- Improve access to care for all New Yorkers
- Integrate care to address patient needs seamlessly
- Make the cost and quality of care transparent
- Pay for healthcare value, not volume
- Promote population health
- Develop workforce strategy
- Maximize health information technology

ALIGNMENT:
VBP

MEDICAID DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

Key Themes:

- Integrate delivery – create Performing Provider Systems
- Performance-based payments
- Statewide performance matters
- Regulatory relief and capital funding
- Long-term transformation & health system sustainability
- Promote population health

POPULATION HEALTH IMPROVEMENT PROGRAM (PHIP)

PHIP Regional Contractors:

- Identify, share, disseminate, and help implement best practices and strategies to promote population health
- Support and advance the Prevention Agenda
- Support and advance the SHIP
- Serve as resources to DSRIP Performing Provider Systems upon request

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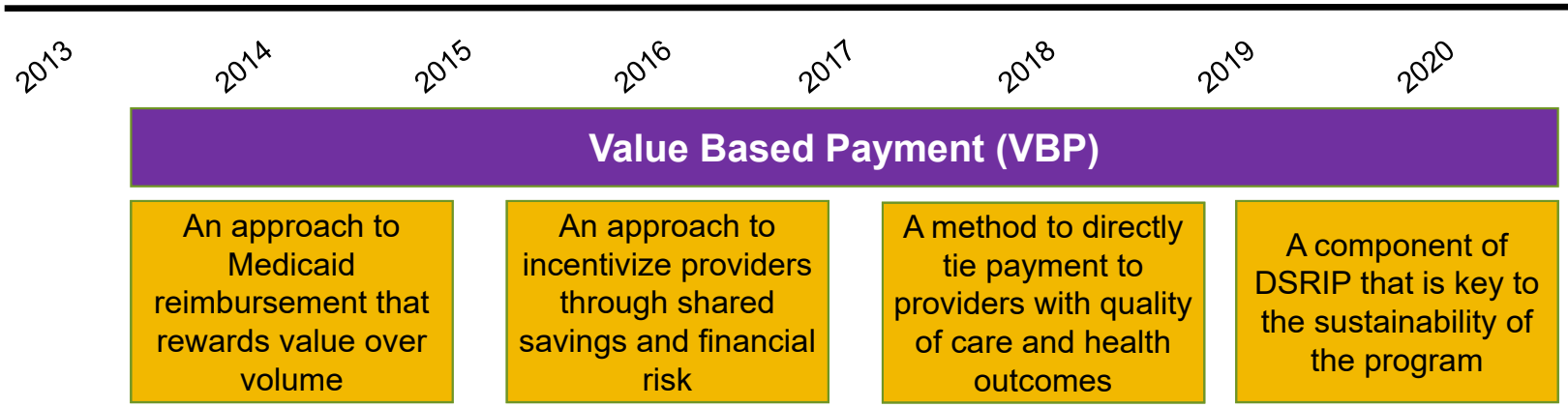
Better care, less cost– transforming today for a VBP tomorrow

Old world:
- 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



Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYSDOH DSRIP Website. Published June 2015.

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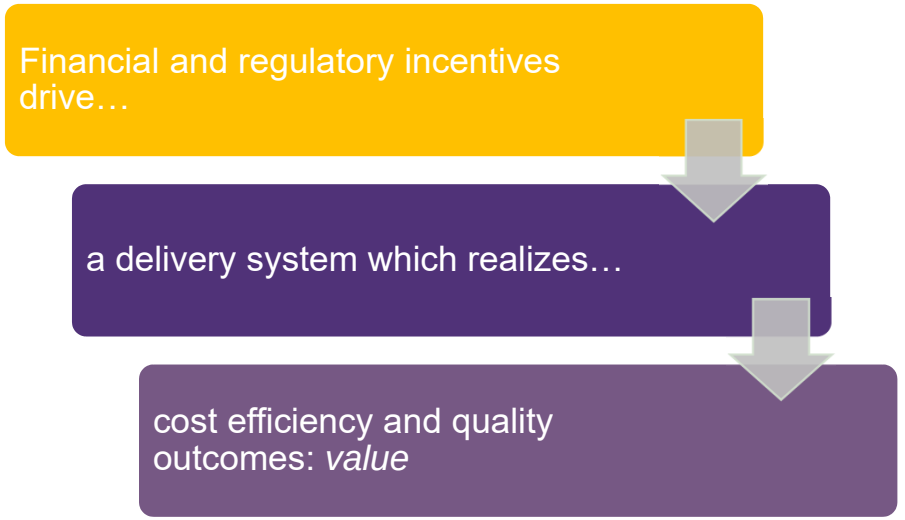
Delivery Reform and Payment Reform: Two Sides of the Same Coin

- 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



VBP Transformation: Overall Goals and Timeline

Goal: To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.

New York State (NYS) Payment Reform

Towards 80-90% of Value Based Payments to Providers

Today

2017	2018	2019	2020
April 2017	***April 2018***	***April 2019***	***April 2020***
Performing Provider Systems (PPS) requested to submit growth plan outlining path to 80-90% VBP ☑	≥ 10% of total Managed Care Organization (MCO) expenditure in Level 1 VBP or above ☑	≥ 50% of total MCO expenditure in Level 1 VBP or above. ≥ 15% of total payments contracted in Level 2 or higher *	80-90% of total MCO expenditure in Level 1 VBP or above ≥ 35% of total payments contracted in Level 2 or higher *

* For goals relating to VBP level 2 and higher, calculation excludes partial capitation plans such as MLTC from this minimum target.

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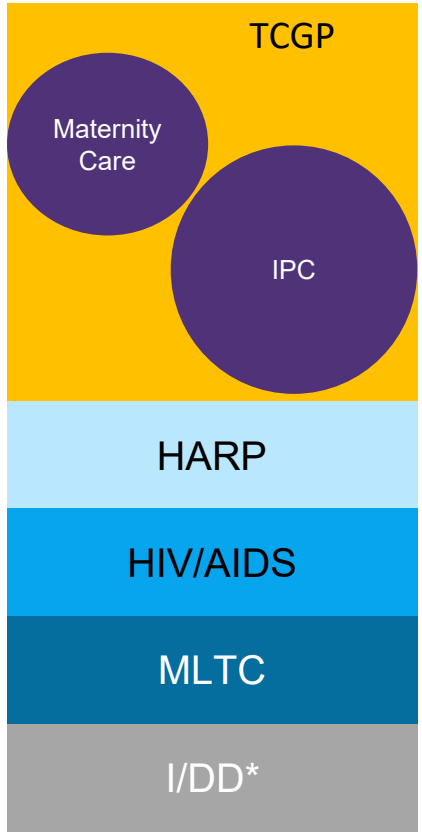
VBP Arrangements

Arrangement Types

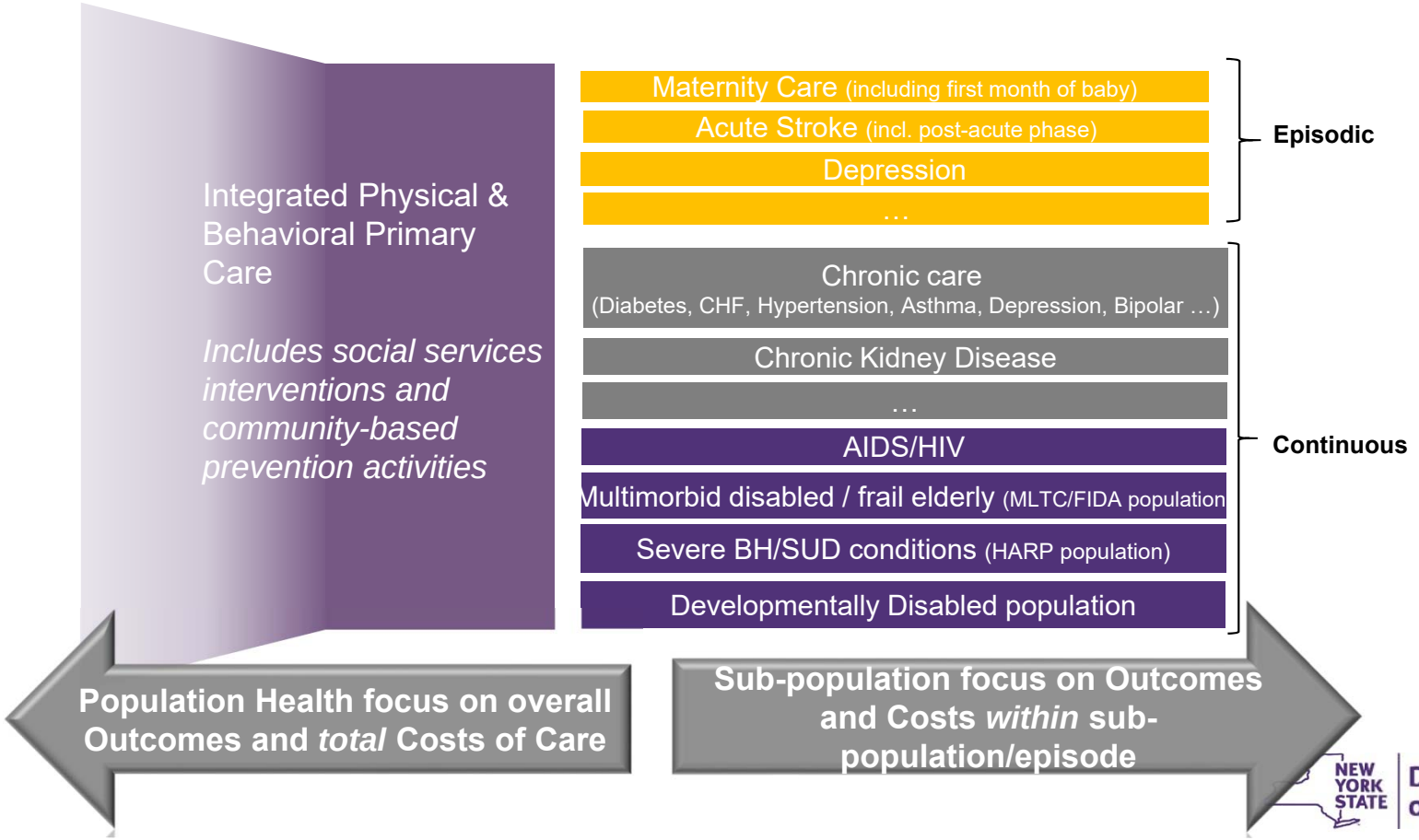
- **Total Care for the General Population (TCGP):** All costs and outcomes for care, excluding MLTC, HARP, HIV/AIDS, and I/DD* subpopulations.
- Episodic Care
  - **Integrated Primary Care (IPC):** All costs and outcomes associated with primary care, sick care, and a set of chronic conditions selected due to high volume and/or costs
  - **Maternity Care:** Episodes associated with pregnancies, including delivery and first month of life of newborn and up to 60 days post-discharge for mother
- Total Care for Special Needs Subpopulations: Costs and outcomes of total care for all members within a subpopulation exclusive of TCGP
  - **HARP:** For those with Serious Mental Illness or Substance Use Disorders
  - **HIV/AIDS**
  - **Managed Long Term Care (MLTC)**
  - **I/DD***



VBP Contractors can contract TCGP as well as Subpopulations as appropriate; nothing mandates that the Roadmap-defined arrangement types must be handled in standalone contracts.

*Total Care for the I/DD Subpopulation will be available as an arrangement when the population is moved to managed care.
Acronyms: MLTC = Managed Long Term Care; HARP = Health and Recovery Plans; I/DD = Intellectually/Developmentally Disabled

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



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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)

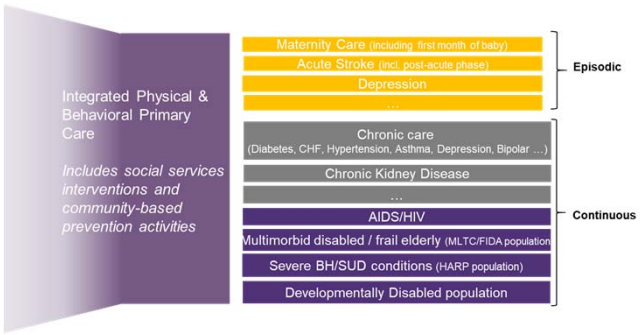
- Goal of ≥80-90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- Aim of ≥ 35% of total costs captured in VBPs in Level 2 VBPs or higher

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 patients 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

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How will VBP impact practice staff on the front line?

- More pressure for front staff to ensure patients are showing up for appointments, and following up with “no shows”
- Clinicians will need to complete fields on the Electronic Health Records to accurately measure quality
- Referrals to downstream providers (e.g. care managers) to be tracked in practice site workflow
- New emphasis on engaging and collaborating with CBOs to embed Social Determinants of Health in practice site workflow
- Consider staff impact on VBP participation/goals when looking at salary and performance evaluation

For VBP Success:

Yesterday's Performance Payments fuel Tomorrow's Shared Savings

INNOVATE: Think patient needs over billable services

Partner across the Care Delivery Spectrum

Build from DSRIP Infrastructure

Do what you do best: Provide the highest quality care for those who need it most, each and every day

I. What are we doing?

II. Where are we going?

III. How will we get there?

IV. Questions

New Horizons of Healthcare Delivery

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New Horizons of Healthcare Delivery

Whole-Person Care

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What is whole-person care?

Mental Health
SUD Treatment
Emergency Medicine
Specialty Care
Radiology
Laboratory and Diagnostics
Long Term Care
Maternity Care
Physical Therapy
Pharmacy
Inpatient Hospital
Primary Care

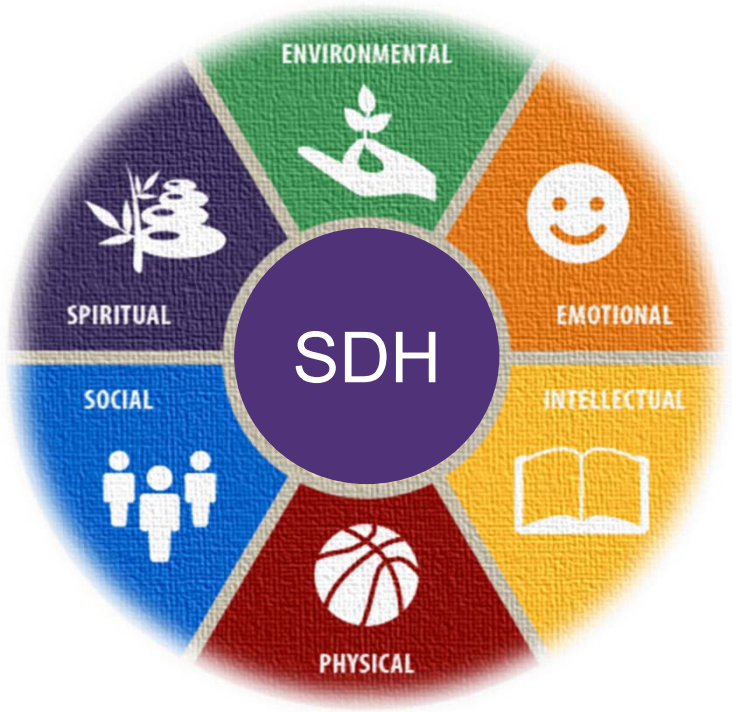
Integrating and Collaborating Medical Care Around the Patient

Addressing their Social Determinants of Health

Social determinants of health *are defined as the* ***conditions in which people are born, grow, live, work and age****. These circumstances are* ***shaped by*** *the* ***distribution of money, power and resources at global, national and local levels****.*

Experts estimate that ***medical care accounts for only 10% of overall health****, with social, environmental, and behavioral factors accounting for the rest.* ***Lack of*** *upstream* ***investment in social determinants of health*** *probably* ***contributes to exorbitant*** *downstream* ***spending on medical care*** *in the US.*

– The New England Journal of Medicine (NEJM)



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The Trinity of Wholesomeness

wholesome
adjective
whole·some | \ ˈhōl-səm \
Definition of *Wholesome*
1: promoting health or well-being of mind or spirit
2: promoting health of body

Rogers: Be Kind to People
Irwin: Be Kind to the Environment
Ross: Be Kind to Yourself

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"**Whole-person care** can be **defined** as the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources."

~California's 1115 Waiver: An Opportunity to Move from Coverage to Whole-Person Care

I. What are we doing?

II. Where are we going?

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IV. Questions

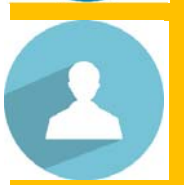
Neighborhood & Environment

Social, Family, & Community

Education

Economic Stability

Access to Health & Healthcare



Pillars of Self and Patient Activation

Collaborative, Integrated Care

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Behavioral Health Crisis Stabilization:

AccessCNY was awarded CNYCC with funding under the Behavioral Health Crisis Stabilization request for proposal.

1. Developed Berkana House – a Crisis Respite Program
2. Uses peer support services to assist the patient to engage and connect to services.

Access CNY
PARTNERS IN PERSON-CENTERED SERVICES

The Berkana Institute
whatever the problem, community is the answer

Evidence Based & Cost Effective

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Leveraging Community Partnerships:

AccessCNY works in collaboration with Liberty Resources Mobile Crisis team. There are informal partnerships with Helio Health, Hutchings Out patient Clinics.

1. -Development of Wellness Recovery Action Plans (WRAP)
2. -Facilitate a smooth exit to guests and connect them to supporting services provided by AccessCNY mental health programs or other com munity organizations

LIBERTY RESOURCES
Improving Lives, Building Futures

Helio Health
Where hope meets healing

The Berkana Institute
whatever the problem, community is the answer

Evidence Based & Cost Effective

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Medicaid Accelerated eXchange (MAX)

Innovation & Transformation of Care:

- Rome Memorial created a team that included staff, executive leadership and community partners to identify high utilizers.
- Delved into needs of higher utilizers from patient perspective, and psychosocial needs and how to connect them with appropriate resources.

Nascentia Health
TOMORROW'S HEALTHCARE TODAY

ROME MEMORIAL HOSPITAL
An Affiliate of St. Joseph's Health

RCIL
RESOURCE CENTER FOR INDEPENDENT LIVING

Care Management Services
Where Care Comes Together

Impacting the most vulnerable in big ways

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Medicaid Accelerated eXchange (MAX)

Starting at Home; Creating Changes That Will Last:

- The Rome Hospital began by working with their IT department to id entify high utilizers and creating daily care team huddles to brainstorm and problem solve; leading to the identification of gaps in care and staff engagement.
- The MAX Series project also provided the opportunity to assign care team leads to build trust with high utilizers and address unmet needs as well as acting as the liaison for warm hand-offs to community partners.

Medicaid Accelerated eXchange (MAX)

Building on the successes from the MAX Series to improve processes and expand the approach:

- Over the first 90 days of MAX implementation, Rome Hospital accomplished:
  - Reduced Admissions for high utilizers by 83 encounters
  - Approximately 687 patient days,
  - A 56% reduction in admissions
  - 73% reduction in patient days for high utilizers.

Medicaid Accelerated eXchange (MAX)

Strengthened relationships with providers & community partners better coordinate care, improve patients' quality of life:

- the collaboration of the MAX team identifies and removes barriers to services by:
  - Coordinating meetings with family members and critical providers when and where it mattered to the patient.
  - Advocating on the patient's behalf based on what is important to the patient and their needs.
  - Warm hand-offs with community partners.

Measures to Celebrate

Measures to Applaud

Measures to Rally Behind

Potentially Preventable Emergency Room Visits ±

± A lower rate is desirable

MY0 MY1 MY2 MY3 PPS Result

= MY3 result met the AIT

Improving

Not Improving

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Potentially Preventable Readmissions ±

± A lower rate is desirable

MY0 MY1 MY2 MY3 PPS Result

= MY3 result met the AIT

Improving

Not Improving

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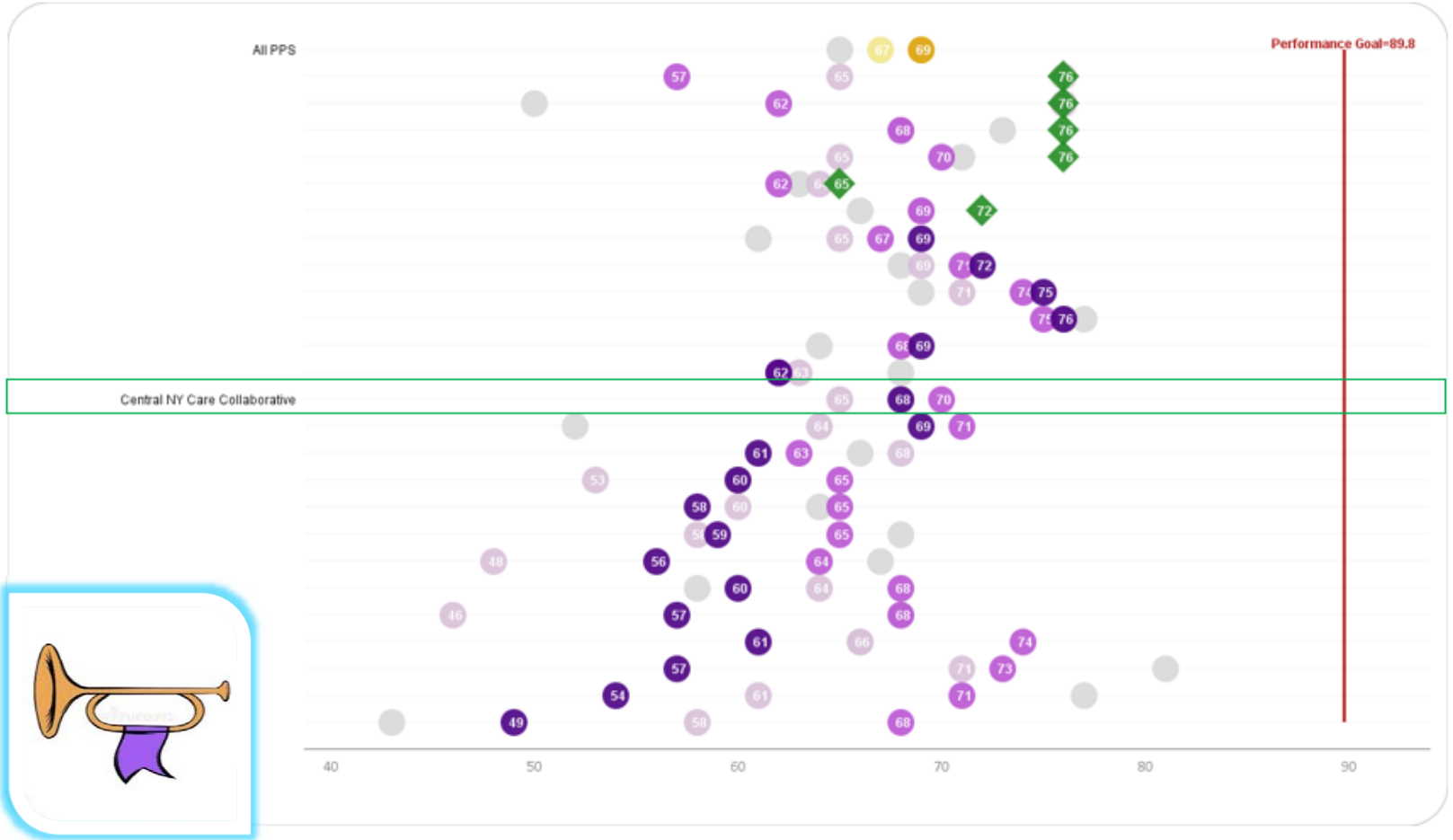
Diabetes Monitoring for People with Diabetes and Schizophrenia ^

^ Rates may not be stable due to small numbers (< 30) in denominator



MY1 MY2 MY3 PPS Result

= MY3 result met the AIT

Improving

Not Improving

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Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)

MY1 MY2 MY3 PPS Result

= MY3 result met the AIT

Improving

Not Improving

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Initiation of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)

MY1 MY2 MY3 PPS Result

= MY3 result met the AIT

Improving

Not Improving

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Potentially Preventable Emergency Room Visits (BH Population) ±

± A lower rate is desirable

MY0 MY1 MY2 MY3 PPS Result

= MY3 result met the AIT

Improving

Not Improving

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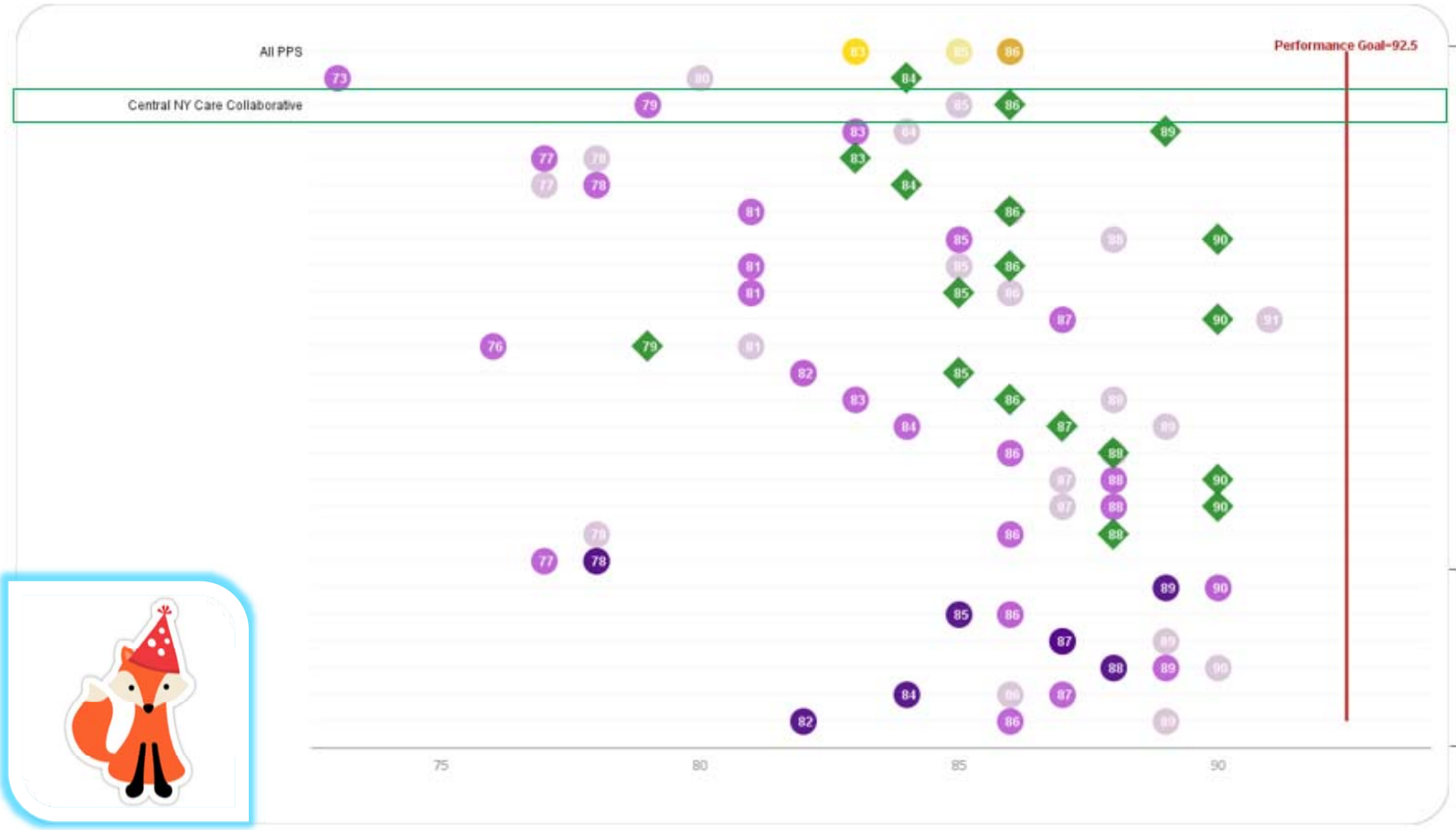
Getting Timely Appointments, Care and Information



MY1 MY2 MY3 PPS Result

= MY3 result met the AIT

Improving

Not Improving

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I. What are we doing?

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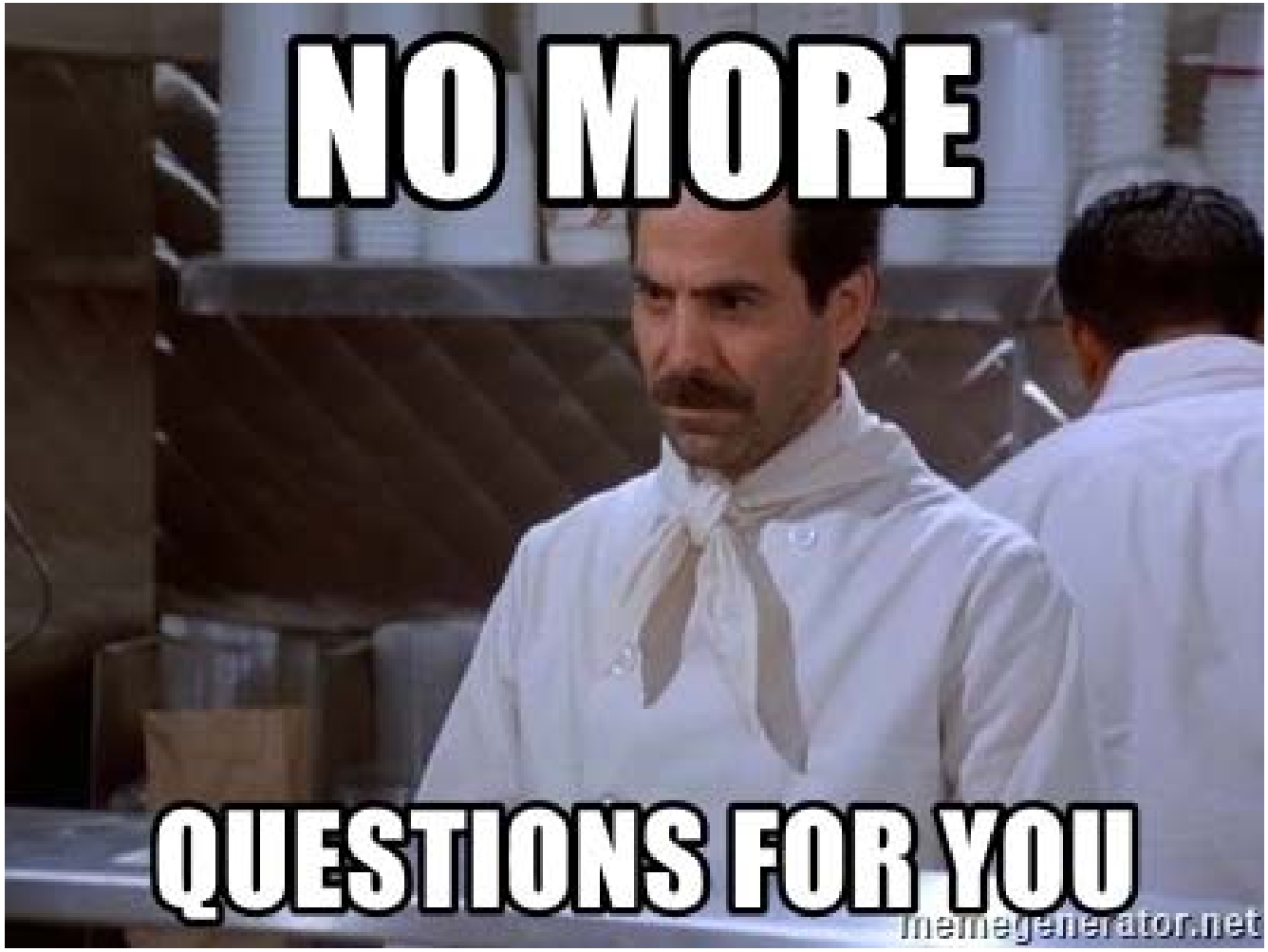
YOUR QUESTIONS
GIVE THEM TO ME NOW
memegenerator.net


NO MORE
QUESTIONS FOR YOU
memegenerator.net

For more information

VBP Roadmap

- In depth roadmap of VBP implementation under Medicaid Payment Reform. Full descriptions of the key points addressed in the VBP University.
- https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/docs/2016-06_vbp_roadmap_final.pdf

VBP University

- Four semesters of content broken into several short (5 mins or less) videos and fact sheets providing an overview of VBP implementation.
- https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_u/index.htm

VBP Bootcamps

- The VBP Bootcamp regional learning series was provided by the Department of Health to plan and provider communities throughout the State to fill payment reform knowledge gaps and ensure successful transition to VBP implementation.
- Recordings: https://www.totalwebcasting.com/view/?id=nysdohvbp
- Materials: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_bootcamp/2017_sessions.htm

Additional information available at:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

DSRIP e-mail:
dsrip@health.ny.gov