NEW YORK STATE | Department of Health | Medicaid Redesign Team

NYS Value Based Payments (VBP):

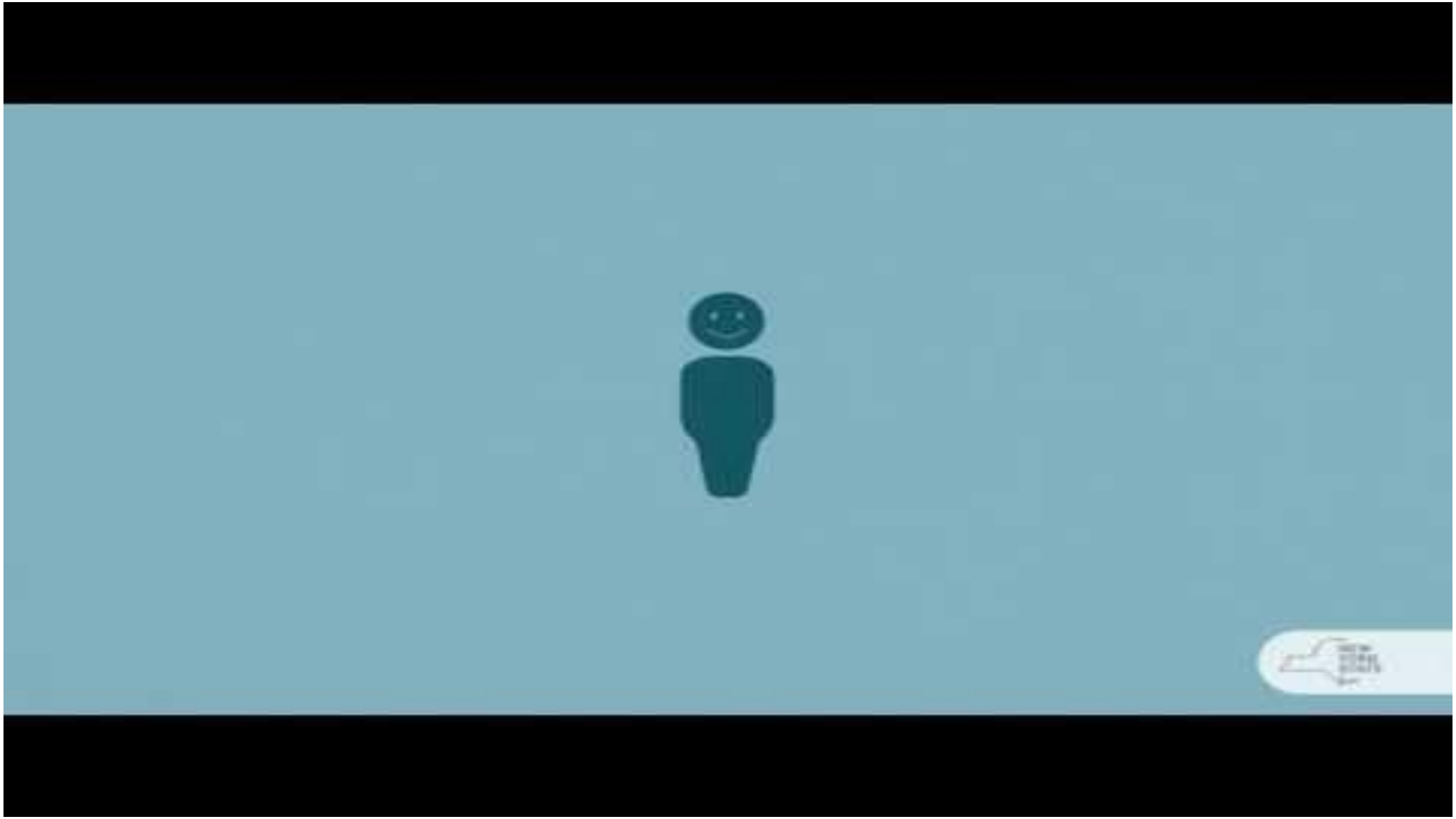
Provider Associations, Community Based Organizations, and Consumer Advocates Town Hall Meeting

Jason Helgerson
NYS Medicaid Director

December 16, 2016

Today's Agenda

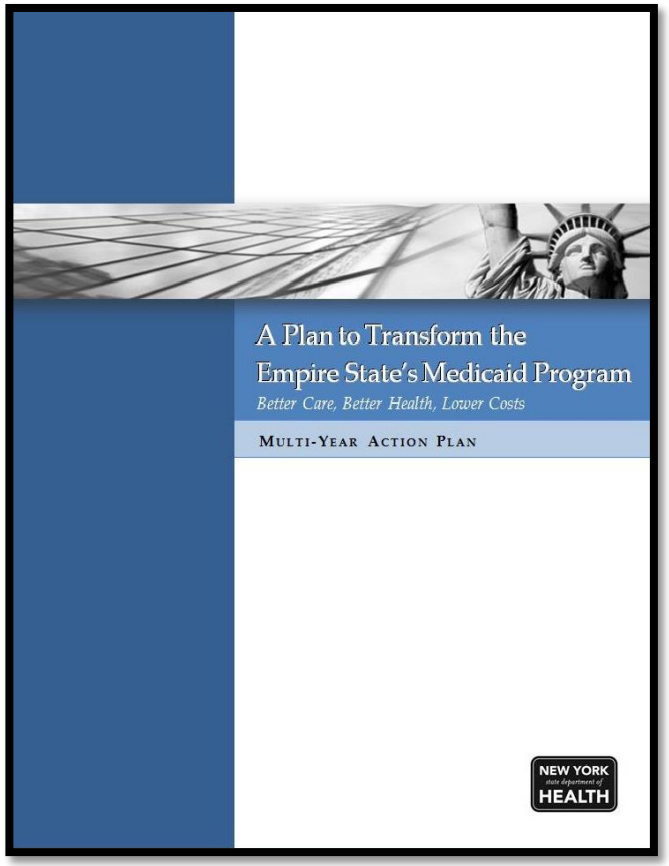
Agenda Items	Time	Duration
Welcome and overview of NYS Payment Reform	11:00	75 mins
Feedback Session and Q&A	12:15	75 mins



Overview of the NYS Payment Reform

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 Affordable Care Act in NYS
  - The MRT developed a multi-year action plan – we are still implementing that plan today



State of Quality - Medicaid

- New York has a well-established system to monitor quality of care for Medicaid managed care enrollees. Over time, measures have evolved from preventive care to measures of chronic care and outcomes.
- Since 2001, a managed care pay for performance program has been a driver of improved care and has focused on quality and patient satisfaction measures.
- The rates of Medicaid performance have:
  - Improved over time;
  - 96% of measures exceeded national benchmarks* based on 2013 data; and
  - Seen a reduction in the gap in performance between Medicaid and commercial managed care.
  - Now 34th in the country in avoidable hospital use end cost.

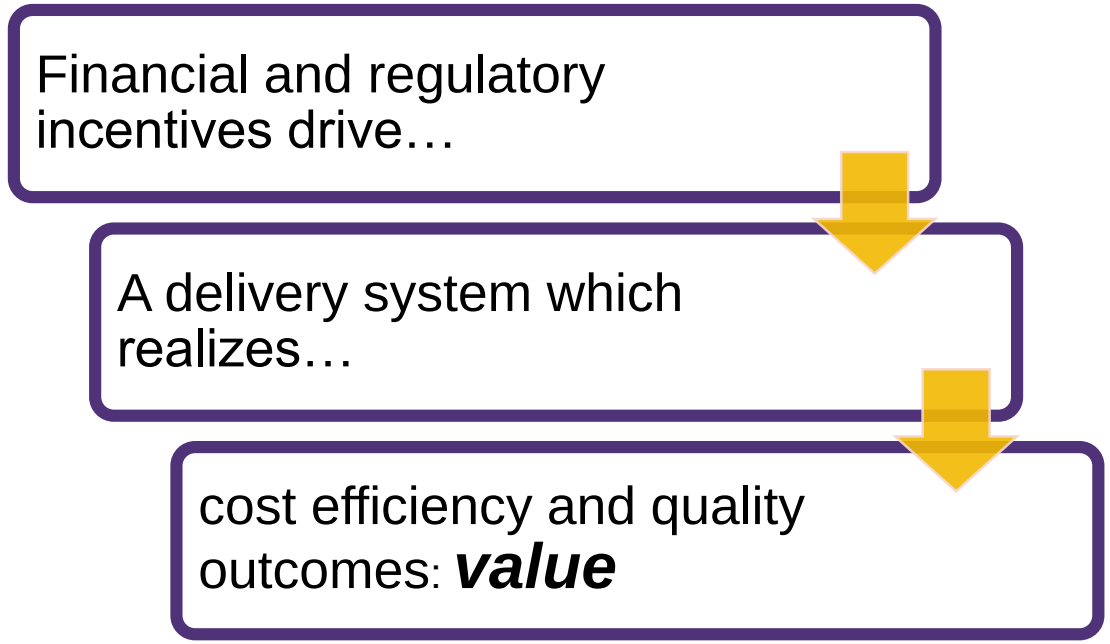
** National benchmarks are based on 2014 State of Healthcare Quality report from the National Committee for Quality Assurance (NCQA).*

The 2014 MRT Waiver Amendment Continues to further New York State's Goals

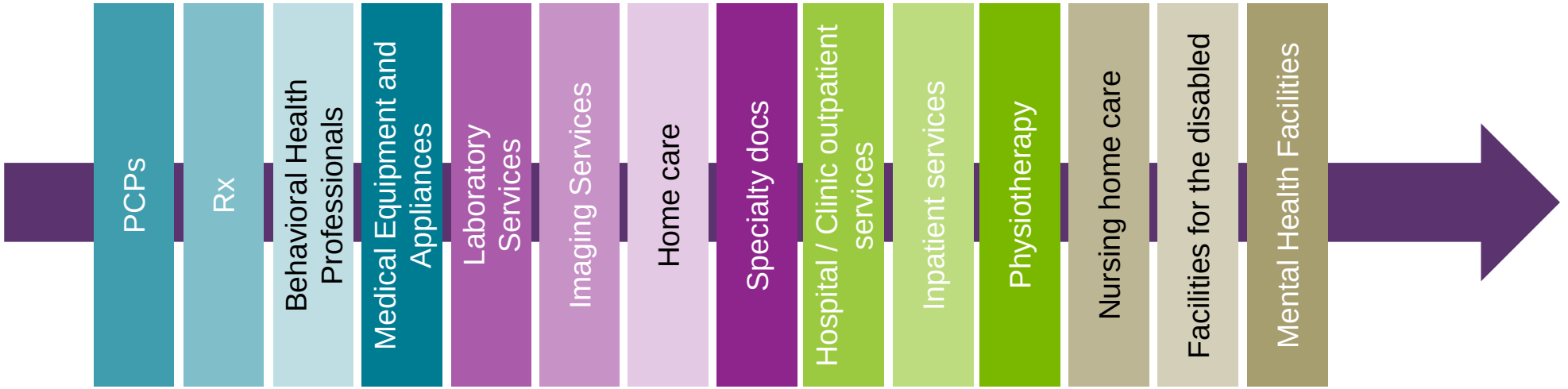
- Part of the MRT plan was to obtain an 1115 Waiver Amendment which would reinvest MRT generated federal savings back into New York's healthcare delivery system
- In April 2014, New York State and CMS finalized agreement on the MRT Waiver Amendment. In 2016, the waiver was renewed until **March 31, 2021.**
- Allows the State to reinvest $8 billion of $17.1 billion in Federal savings generated by MRT reforms
- $7 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 current delivery 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 re-admission is rewarded more than a successful transition to integrated home care
  - Current payment systems do not adequately incentivize prevention, coordination or integration
- The financial success of providers must be linked to providing value.



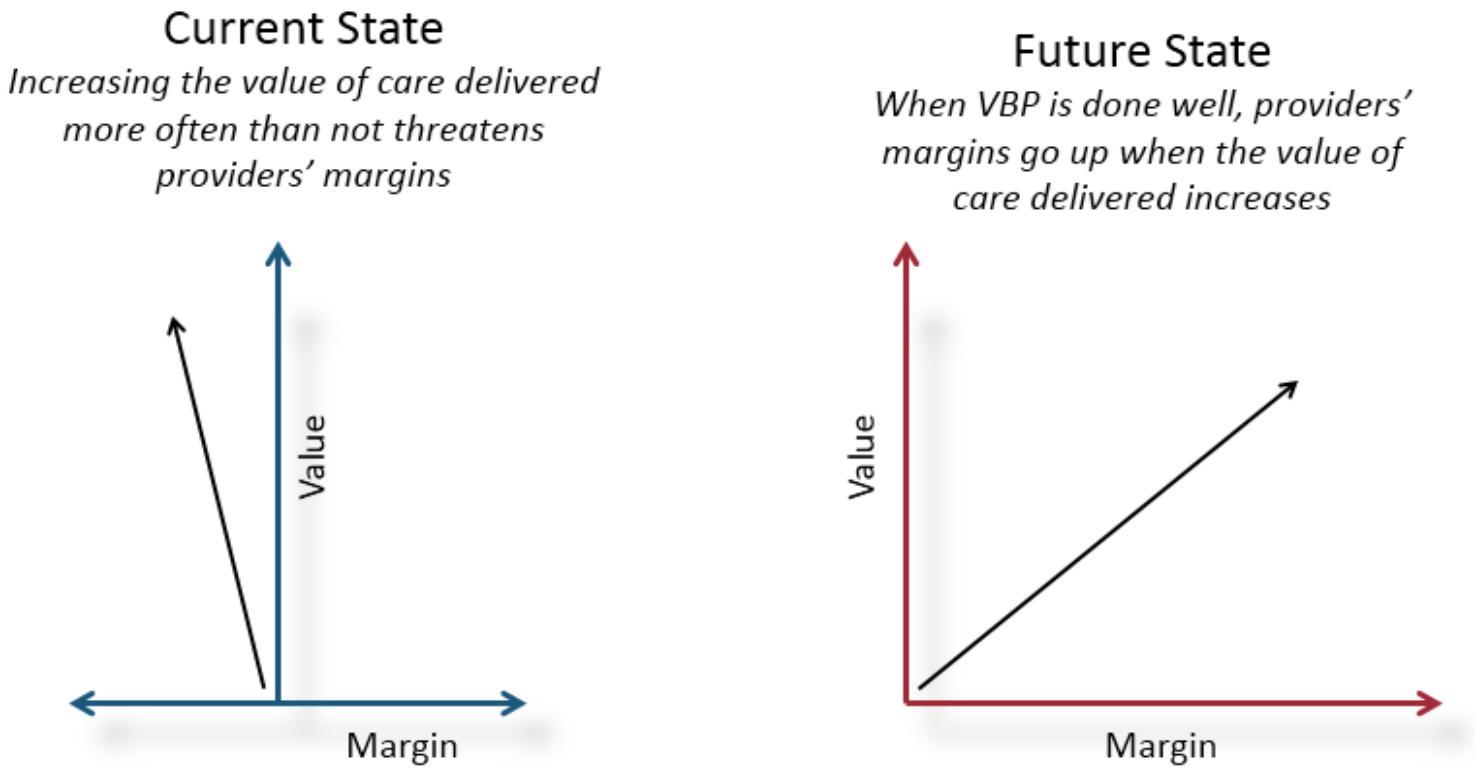
Old World: We Are Paying for Volume



- 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

New World: We Are Moving to Paying for Value

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



Goal – Pay for Value not Volume

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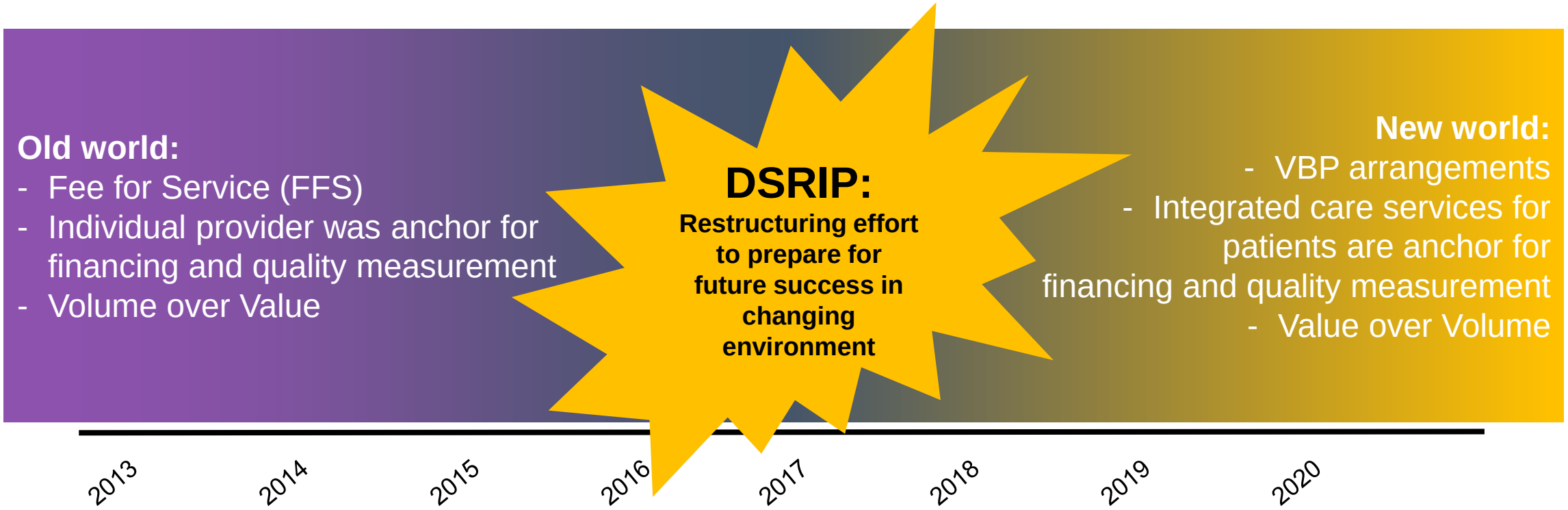
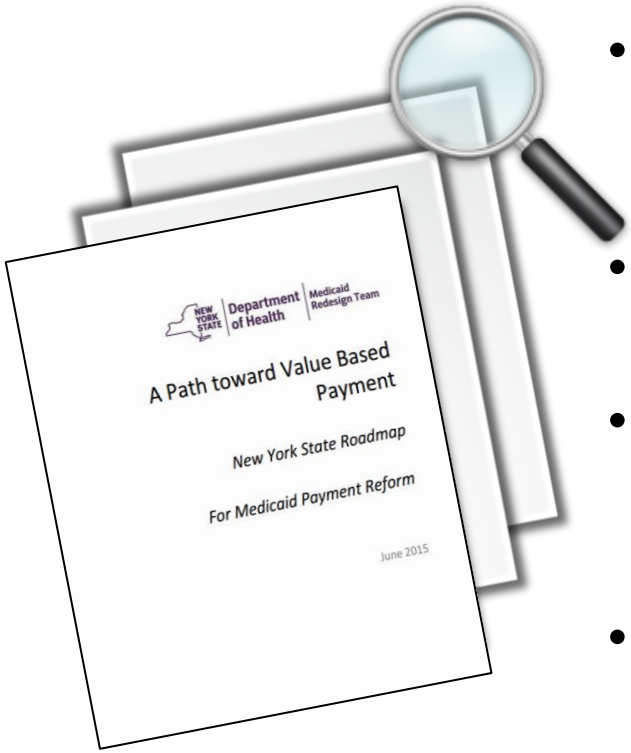
DSRIP and VBP Work Together



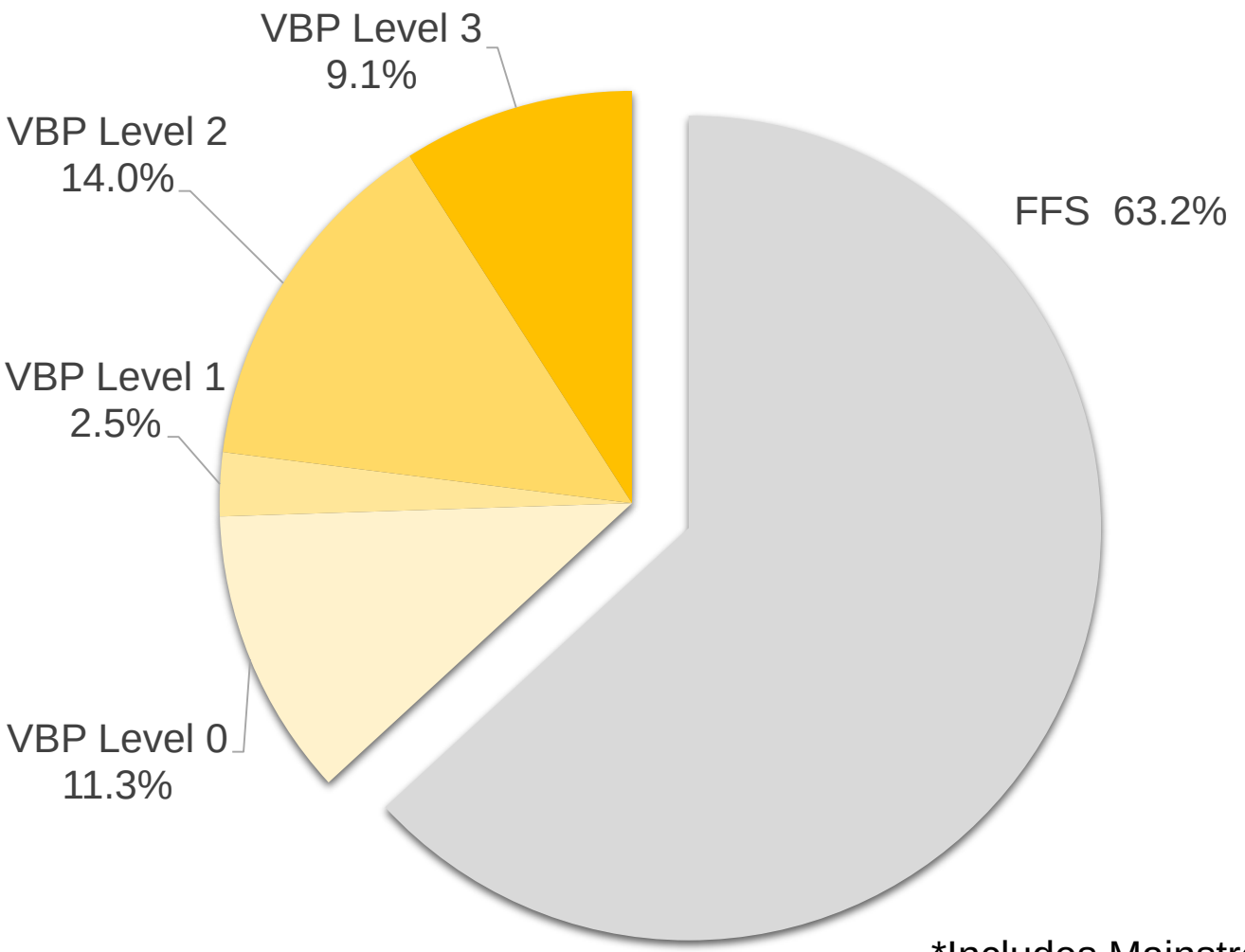
The Annual Update to the Roadmap



- To ensure the long term sustainability of the DSRIP investments in the waiver, the Terms and Conditions state that NYS must submit a multi-year roadmap for comprehensive payment reform.
- The Roadmap was developed with broad stakeholder input, the VBP Workgroup, and a public comment period
- As outlined in the original Roadmap, the State undertakes an annual update process every year to allow for best practices and updated policy.
- Each Roadmap update is made available for public comment for a period of 30 days.
- The Roadmap is revised based on public comments and was submitted to CMS for review and approval.

Today: >25% of Medicaid Spend is in VBP Level 1 or Higher

Per Survey, VBP Baseline of Levels 1 - 3 for CY 2014: **25.5%***



VBP Level	Spending or %
Total Spending	$ 22,741 M
FFS	$ 14,372 M 63.2%
VBP Level 0	$ 2,576 M 11.3%
VBP Level 0 Quality	$ 2,036 M 9%
VBP Level 0 No Quality	$ 539 M 2.4%
VBP Level 1	$ 567.5 M 2.5%
VBP Level 2	$ 3,172 M 14%
VBP Level 3	$ 2,062 M 9.1%

*Includes Mainstream, MLTC, MAP, and HIV SNP plans.

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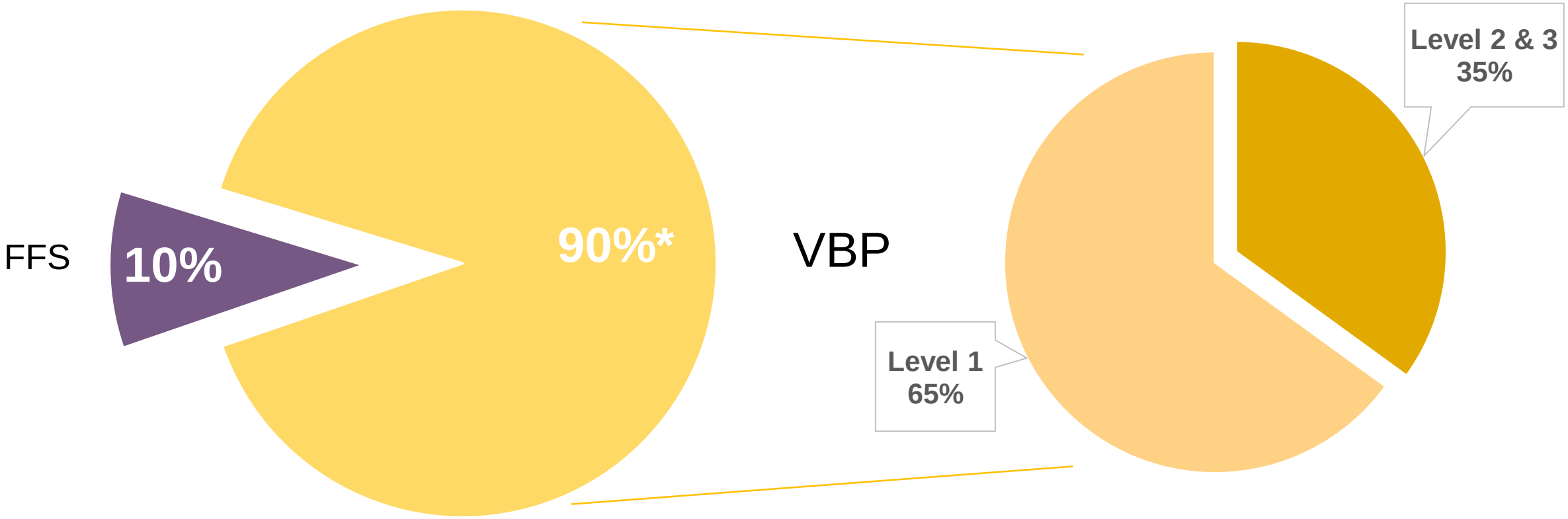
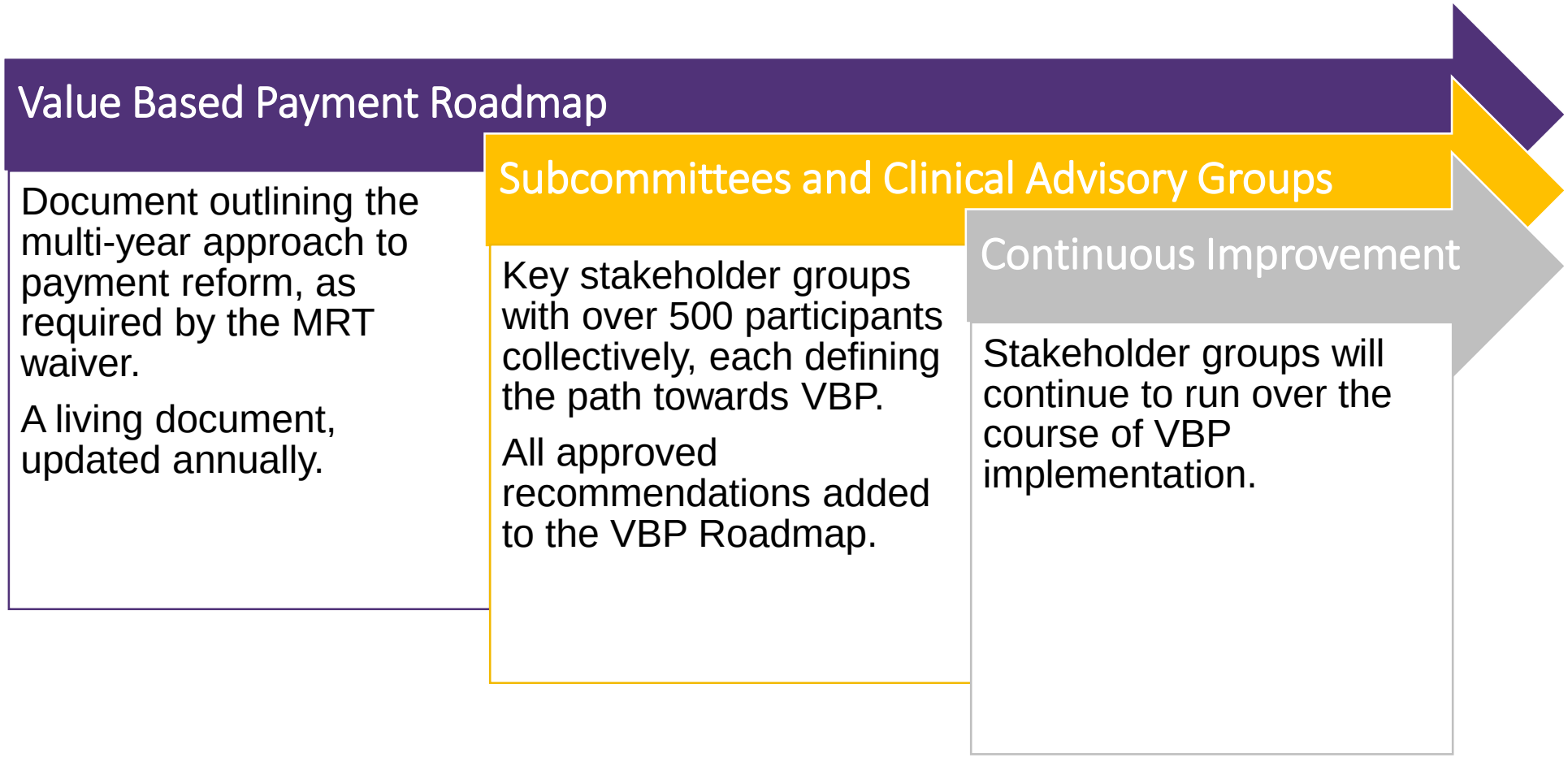
VBP Goals

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



*Minimum of 80%; includes MLTC and (depending on move to Managed Care) I/DD

Stakeholder Engagement is Key for Payment Reform



VBP Implementation Efforts

The State is providing additional financial incentives and support for early adoption of Value Based Payment as well as for execution of higher-risk contracts through:

VBP Pilot Program

- The goal of the Pilots is to help the State and its participating organizations learn how VBP transformation will work in practice as well as to incentivize early adoption of VBP. This is a voluntary 2-year program. DOH reserves the right to restrict enrollment to those pilots that it deems to be most relevant.

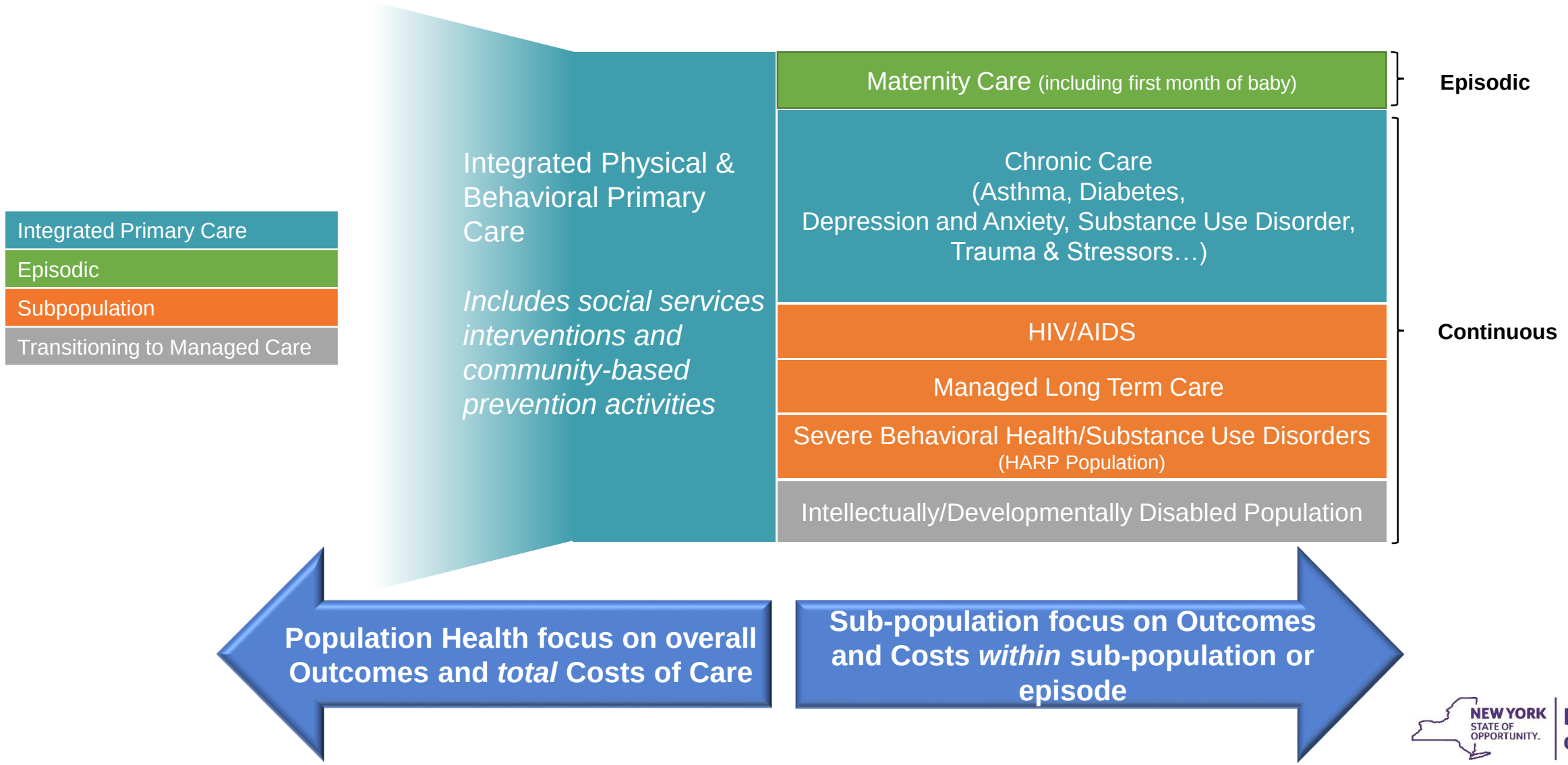
Ongoing Subcommittees

- As VBP is implemented, the State will continue to explore the need for the development of new subcommittees, like a Subcommittee on Children's Health, and reconvene existing groups as needed.

VBP Innovator Program

- The goal of the Innovator Program is to recognize providers that contract high risk Level 2 or Level 3 total cost of care for general and subpopulation arrangements by allowing up to 95% premium pass through.

How an Integrated Delivery System should Function



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There is a Menu of Options for VBP Arrangements

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.

VBP Arrangements can be at Different Levels of Risk

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.*

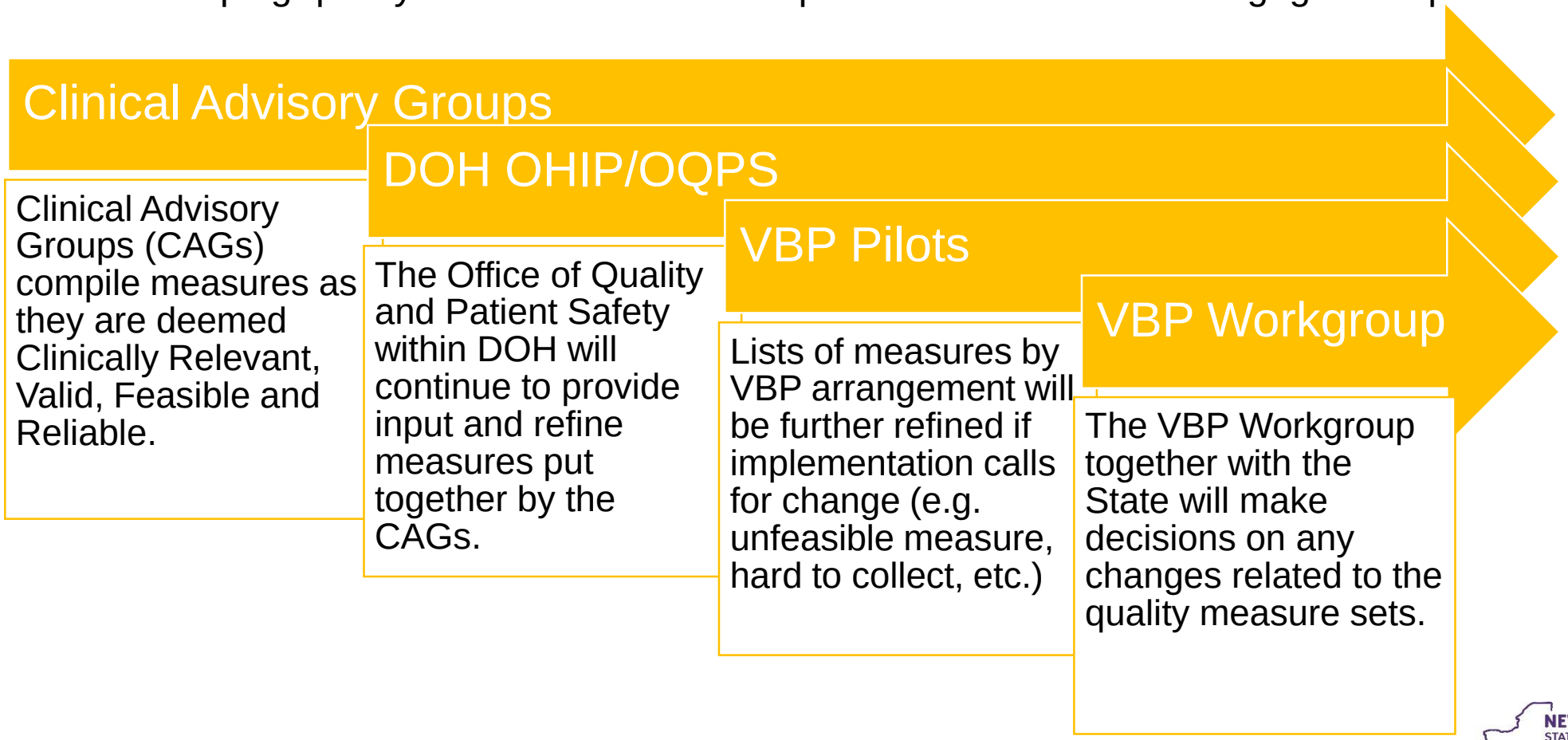
VBP Arrangement-Specific Quality Measures Enable Payment Reform

The State is designing quality measures for each VBP Arrangement that inhibit benefiting from providing 'low-cost' care, rather than *valuable* care; the design of the measures is guided by the following principles:

- Measuring the quality of the total cycle of care of the VBP arrangement
- Relevance for patients and providers
- Reduce 'drowning' in measures phenomenon: outcome measures have priority
- Alignment with DSRIP (avoidable hospital use)
- 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

Quality Measure Development Process Relies on Deep Knowledge of the Stakeholders

The State is developing quality measures via the comprehensive stakeholder engagement process.



There are Four Key Drivers that Cause (In)Efficiency

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

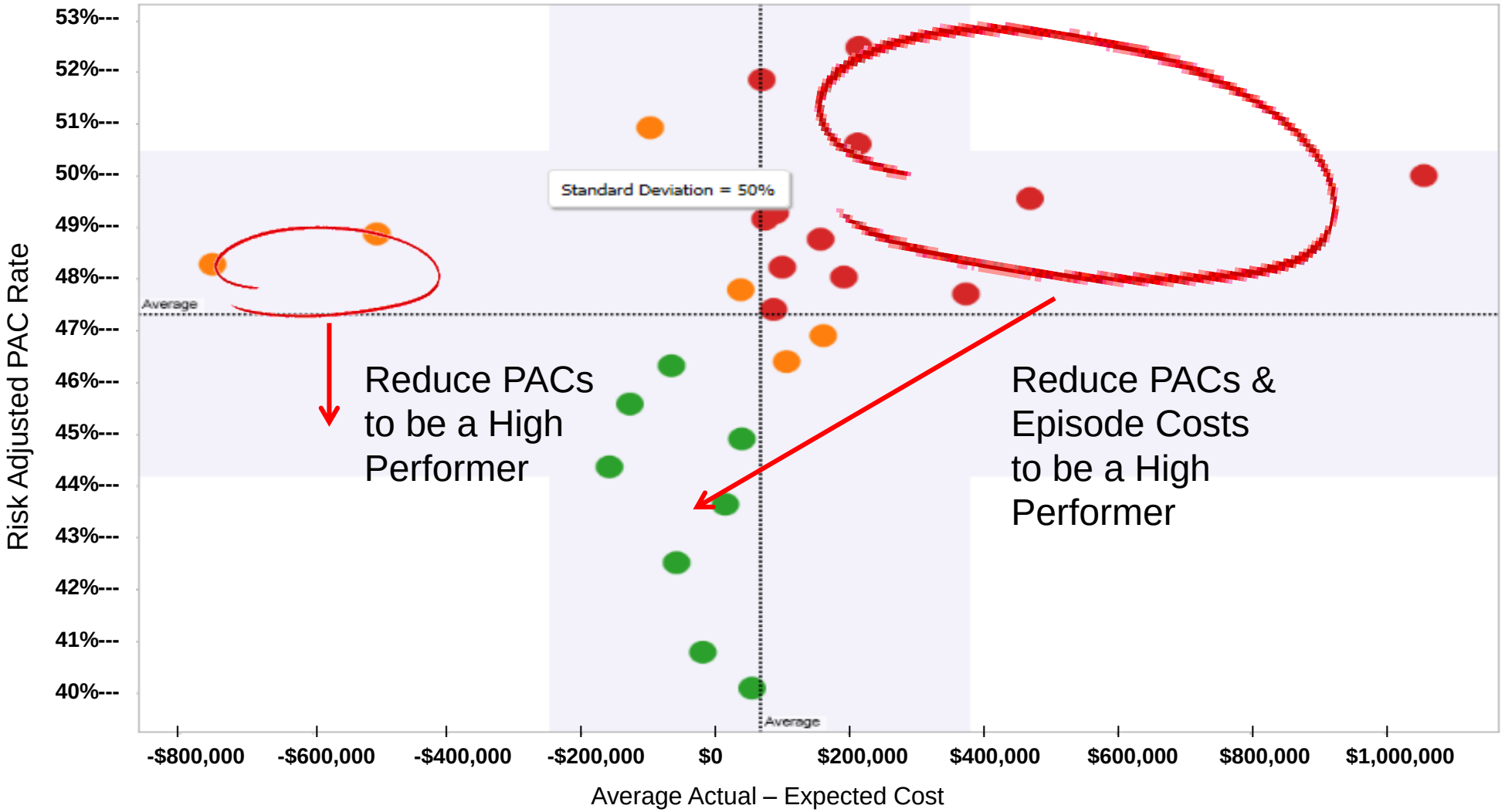
Volume

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).

There are Significant Opportunities to Increase Value



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Myths and Truths about Payment Reform

Myths

1. Everyone must eventually contract at Level 3
2. You can only reimburse innovative services if you are in a Level 3 contract
3. You are supposed to do more with less
4. VBP is about reducing the Medicaid Global Cap spend
5. Only PPSs can contract VBP arrangements
6. VBP is about reducing services offered to Medicaid members and limiting networks
7. All VBP policies within the Roadmap must be followed exactly as they are written

Truths

1. MCOs (and providers) will be penalized if the Roadmap goals are not achieved
2. The State will be providing analytical support to the VBP stakeholders
3. VBP provides flexibility in contracting - it is not a 'one size fits all'
4. The goal of VBP is to improve the quality of care and shift spending to keep members as healthy as possible and integrated in their community
5. VBP implementation is an iterative process - the State will keep learning as the process moves forward (pilots will play an important role in this learning)
6. VBP is focused on transparency around costs and outcomes

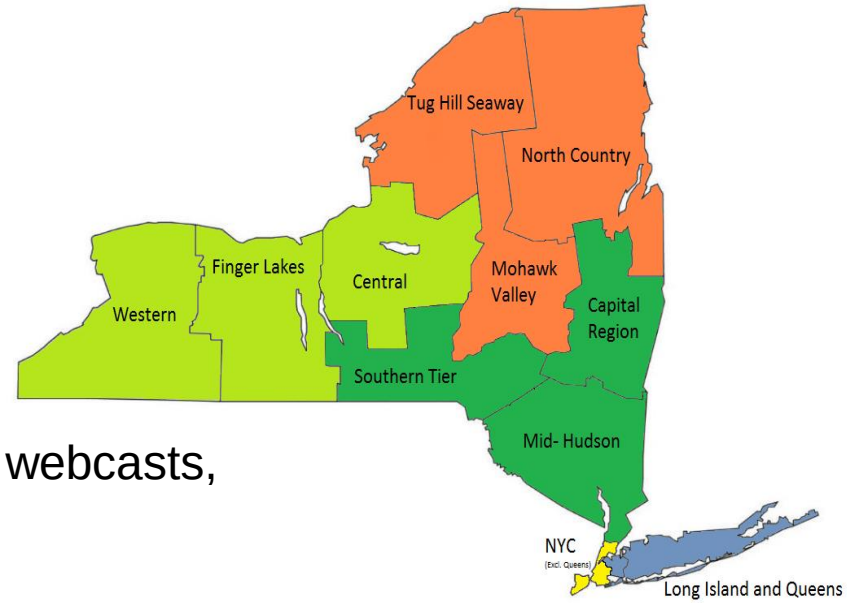
Overview of Proposed VBP Education & Outreach (VEO) Activities

VBP Education Efforts to Date

The **VBP Bootcamp** regional learning series offered to the NYS health plan and provider communities delivered necessary key information about Payment Reform and thus supported and encouraged VBP implementation.

The Bootcamp Series provided in 5 regions throughout the State from June through October of 2016 covered the following topics:

Session 1: Intro to VBP, Types of VBP Arrangements
Session 2: Contracting, Review Process, Target Budget and Risk Management
Session 3: Performance Measurement and VBP Dashboards



Additionally, DOH created a VBP website with a Library of resources dedicated specifically to VBP. It contains a large variety of educational materials and reports on VBP implementation efforts including Bootcamp webcasts, Webinars, Subcommittee & CAG reports, etc.

Path: DSRIP Homepage → Value Based Payment Reform → VBP Resource Library

VEO Strategy Planning is Underway

VEO Objective

To continue educating NYS Medicaid Stakeholders about Payment Reform in CY 2017, assisting them with timely access to important VBP implementation information through various communication channels, and positioning them for transition to VBP.

Feedback drives VEO Strategy for 2017

Pilots Feedback + Bootcamp Feedback + Town Hall Feedback + Other = **2017 VEO Strategy**

There are Preliminary VEO Activities Planned

Type of Communication		Description
	**VBP Subpopulation Learning Events**	In person meetings (recorded) that are centered around a specific population VBP discussion – HARP, DD, MLTC, etc.
	**VBP Contracting Templates**	Contract templates that help providers launch into VBP Level 1, at a minimum.
	**VBP Implementation Opportunities**	Launched pilots (plan and provider sides) as well as other VBP stakeholders convey their experiences and lessons learned during these knowledge-sharing meetings.
	**VBP "Now You Know" videos**	Five minute videos hosted by DOH clarifying policy questions or discussing innovative approaches to VBP implementation (e.g. addressing quality measures, SDH, etc.). Videos may include interviews or short Q&A sessions.
	**VBP Bulletin**	A VBP newsletter providing a summary of events over past period of time as well as a spotlight on upcoming VBP education and outreach releases and events.
	**VBP Mailbox Analysis**	A central point for VBP questions collection, monitored by the team for input to DOH on most pressing policy issues. It will also serve as a listserv.
	**VBP News Flash**	Quick facts and updates that are pushed out to the public 'real time' using social media (e.g. new roadmap draft posted, current status of reduction in avoidable hospitalizations, pilots launched, etc.).

Feedback Session and Q&A

Please Provide Your Feedback

1. Based on the VBP information shared by the Department up to date as well as your overall knowledge of Payment Reform in NYS, what would be helpful for you to know/learn in more detail? What is potentially hindering your transition to VBP?
2. What communication format do you find works the best (e.g. in person meetings, short videos, factsheets, etc.)?
3. What analytical support can the Department provide to further your VBP efforts?
4. Are there any specific tools that the Department can provide that you are in need of?
5. How can ***YOU*** help us in furthering VBP education in NYS? Please share any other feedback on the proposed Education and Outreach strategy.

Example Topics:

1. Flow of funds to downstream contractors: how does it work?
2. Why Potentially Avoidable Complications (PACs) are important?
3. Addressing Social Determinants of Health: where to start?
4. CBOs: Benefits of participating in VBP
5. Quality Measures for VBP Arrangements

Thank You

Additional suggestions can be sent to **DSRIP@health.ny.gov**
Please send your suggestion by no later than **December 23rd, 2016**.