NEW YORK STATE | Department of Health | Medicaid Redesign Team

Value Based Payment:

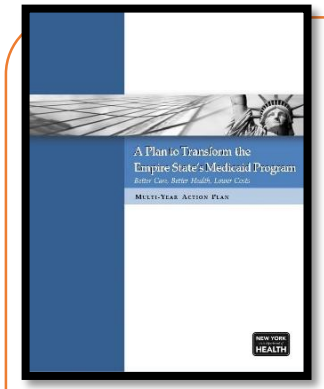
Work in (Rapid) Progress

VBP Learning Event BPHC

Mercy College, Bronx, NYC

October 27, 2016

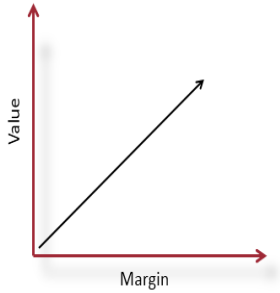
Recap: New York State Medicaid Transformation



2011: Governor Cuomo created the Medicaid Redesign Team (MRT) which developed a series of recommendations to lower immediate spending and propose future reforms

2014: As part of the MRT plan NYS obtained a 1115 Waiver which would reinvest MRT generated federal savings back into redesigning New York's health care delivery system known as **DSRIP**

NEW YORK STATE DSRIP



2015: As part of DSRIP, NYS undertakes an ambitious payment reform plan working towards 80% value based payments by the end of the waiver period

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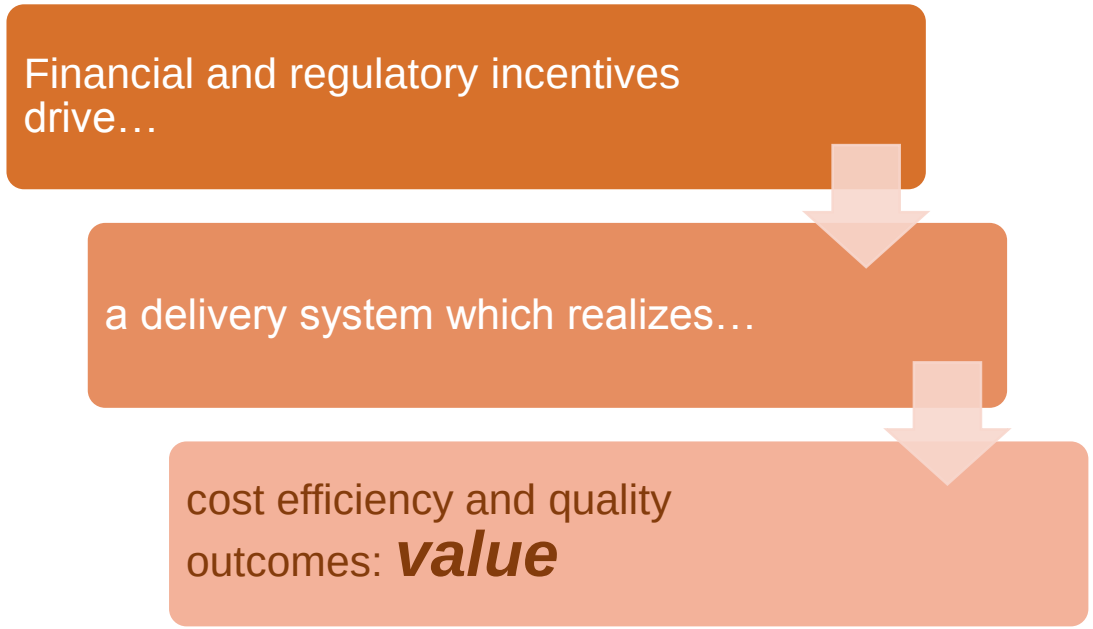
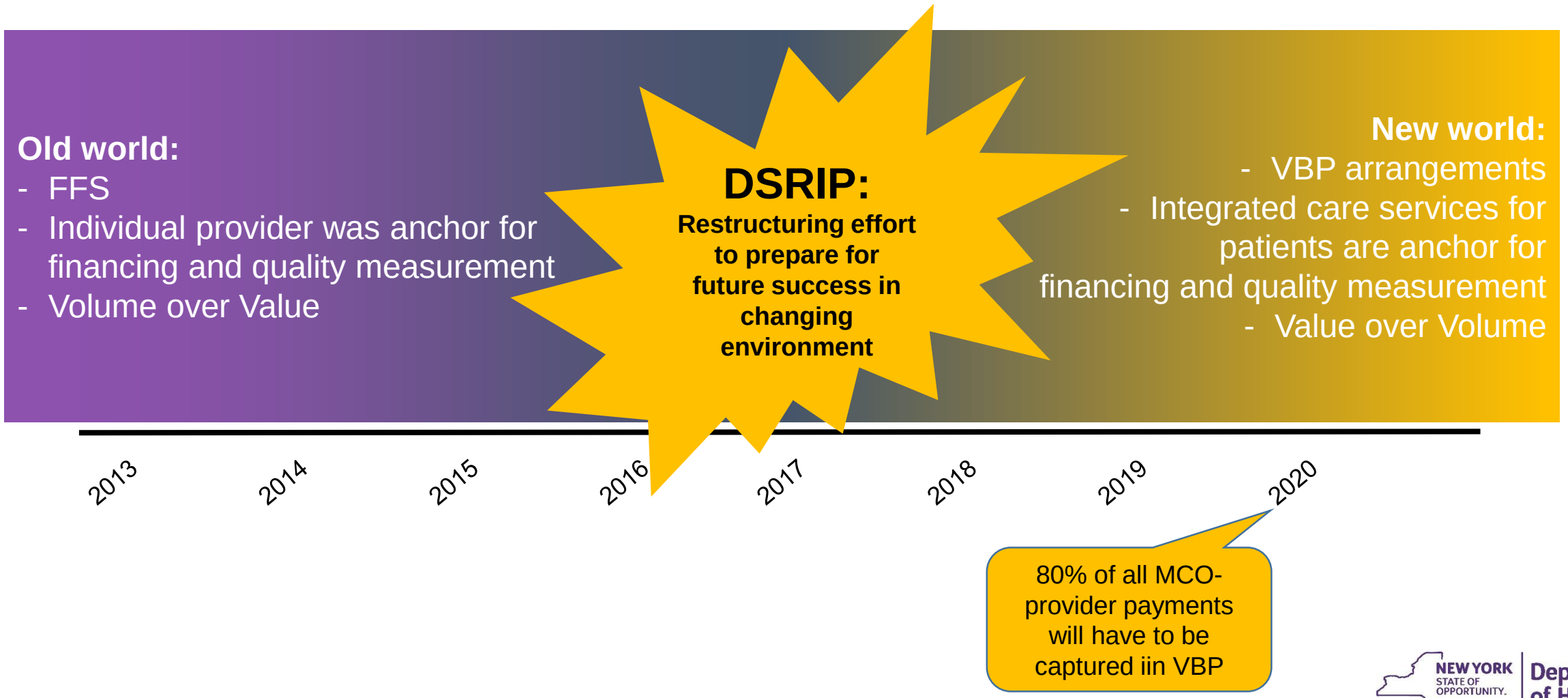
Delivery Reform and Payment Reform: Two Sides of the Same Coin

- 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
  - 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



How DSRIP and VBP Work Together



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The Menu of Options

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.

Types of care:

- For Integrated Primary Care (IPC)
- Per integrated service for specific condition: Maternity Care bundle
- Total Care for General Population (TCGP)
- Total Care for Special Needs Population (HIV/AIDS, HARP, MLTC)

Risk level

- Upside only (Level 1)
- At risk (up- and down side) (Level 2, 3)

Vision Behind This Approach

- Flexibility for Providers and MCOs
- Local circumstances differ:
  - Provider readiness
  - Demographics & geography
- Health care is very heterogeneous

Financial and regulatory incentives drive…

a delivery system which realizes…

cost efficiency and quality outcomes: *value*

Healthy people	Population health: prevention, screening, health education, monitoring
People with acute conditions	Rapid, effective, efficient and patient-centered diagnosis, treatment, rehabilitation and follow-up
People with chronic conditions	Patient-directed, continuous, effective, efficient disease management, incl. secondary prevention and focus on life style & social determinants
People with multiple conditions	Patient-directed, continuous, quality of life focused care coordination

- Different types of *outcomes* that are relevant
- Different role for the *beneficiary/patient*
- Different *models of care*
- Different *organizational forms*
- Different *payment models*

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Total Care for General Population (TCGP):

- In this arrangement the VBP Contractor assumes responsibility for the care of the entire attributed population.
  - All mainstream managed care covered services included
  - Excluding HIV/AIDS, HARP and MLTC eligible members
  - Members attributed to this arrangement through MCO-assigned PCP

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

Why TCGP Can Be Attractive – and what is the risk?

- Maximum impact for health systems focusing on both population health and streamlining specialty and inpatient care across the different types of care
  - Reduce inefficiencies and potentially avoidable complications throughout the entire spectrum of care
- The larger the budget, the more opportunity for shared savings
- Larger budgets and control across the spectrum of care implies more opportunities to (re-) invest and restructure the delivery system

But:

- *Larger budget implies larger risk when moving to Level 2 or higher*

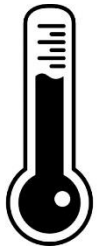
The Alternative for Physician Led Practices: Integrated Primary Care VBP Arrangement

IPC-Chronic Bundle =

Preventive Care

+

Routine Sick Care



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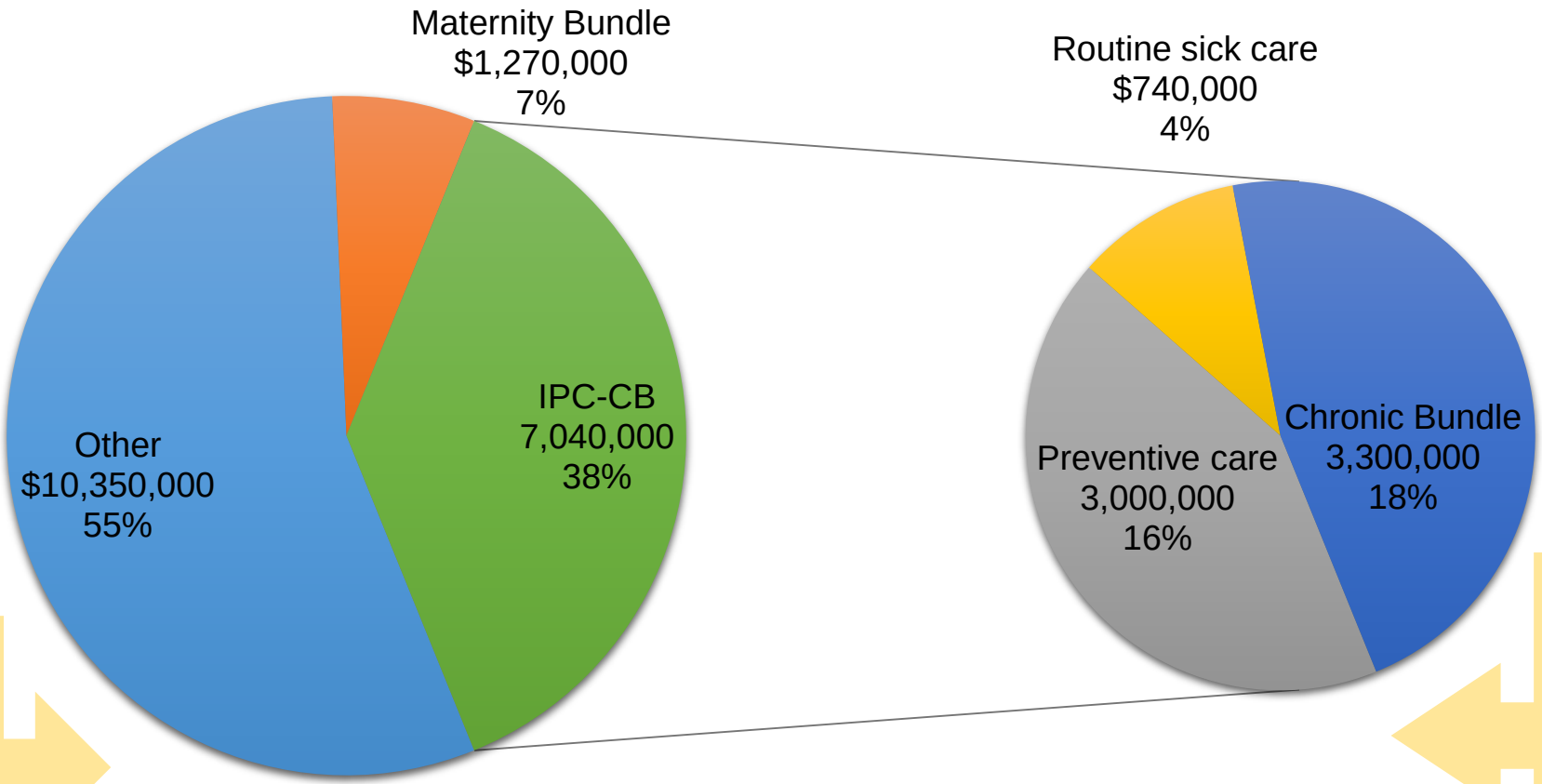
Chronic Care

Why the Integrated Primary Care Bundle Can Be Attractive



Rather than being 'at risk' for total downstream costs…

… VBP contractor is at risk for that component that s/he most controls, and where the potential savings are high.

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

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VBP is for everyone

- Going at risk (Level 2) requires ability to coordinate across practices, manage performance (costs/outcomes), financial capabilities
- *But moving into Level 1 only requires the desire to learn and have the possibility to receive shared savings.*

Key to success:

- Willingness to learn
- Understanding that all payers (Medicare, Medicaid, commercial) are moving into the same direction
- Optimally use available State resources, including available data on performance, direct support, learning opportunities

Thank you

Program Performance Overview

Organization Type: **PPS** || Organization Name: **SBH Health System** || Year: **2014**

This tab provides detailed information on the organizations performance (in terms of spend and quality) at the population/bundle/episode level, allowing for identification of areas of improvement.

▼ If difference < -10%
■ If -10% <= difference <= 10%
▲ If difference > 10%

	Spend (1)				Quality	
	General (Real Pricing)		Spend (PMPY or episode) (Real Pricing)	Spend (PMPY or episode) (Proxy Pricing)	% PAC spend (PMPY or episode) (Proxy Pricing)	
	Number of members or episodes (2)	Total Spend	Spend	(Actual / Expected) - 1	Total % PAC Spend	(Actual / Expected) - 1
IPC (3)	203375 M	$290,385,178	$1,428			
Preventive Care (4)	176726 M	$55,004,073	$311	■ 8.1%		
Routine Sick Care	101379 M	$36,859,346	$364	■ 5.0%		
Chronic Bundle	80837 M	$198,521,759	$2,456	■ -3.0%		
Total Care General Population	253774 M	$1,056,223,059	$5,237	■ 4.4%		
Total Care HIV/AIDS	4533 M	$179,102,818	$42,299			
Total Care HARP	8084 M	$191,052,568	$24,597			

Drilldown: Chronic Bundle

Arrhythmia / Heart Block / Condn ..	2847 E	$4,915,467	$1,727	■ -8.9%	57.5%	▲ 13.5%
Asthma	30661 E	$28,748,656	$938	■ -1.2%	40.3%	▲ 16.8%
Bipolar Disorder	2765 E	$12,236,879	$4,426	▼ -14.0%	15.1%	▼ -32.9%
Chronic Obstructive Pulmonary Di..	2593 E	$3,323,387	$1,282	▼ -21.3%	40.3%	■ -6.8%
Coronary Artery Disease	2521 E	$5,606,318	$2,224	■ 0.9%	48.8%	▲ 15.2%
Depression & Anxiety	15531 E	$14,210,922	$915	■ -7.6%	12.4%	■ 9.1%
Diabetes	11409 E	$40,463,322	$3,547	■ -1.9%	29.6%	▲ 12.3%
Gastro-Esophageal Reflux Disease	10323 E	$5,069,971	$491	■ 9.6%	20.0%	▲ 16.5%
Heart Failure	1705 E	$7,294,511	$4,278	■ -9.5%	46.7%	■ -7.4%
Hypertension	22794 E	$21,965,956	$964	■ 5.3%	35.0%	■ 4.6%
Low Back Pain	18450 E	$11,776,418	$638	▲ 11.9%	35.0%	▲ 19.4%
Osteoarthritis	4983 E	$13,490,328	$2,707	■ 4.8%	16.4%	■ -0.6%
Substance Use Disorder	8845 E	$26,045,601	$2,945	▼ -10.3%	24.8%	▼ -33.0%
Trauma & Stressors Disorders	6221 E	$3,374,024	$542	▼ -19.4%	9.2%	■ -7.3%

Organization Type
PPS

Organization Name
SBH Health System

MCO
(All)

Subgroups
(All)

Health Home
(All)

Year
2014

Volume
4,175 — 253,774

1. The Actual Spend and Actual - Expected Spend is computed per member per year (PMPY) for populations and per episode for bundles.
2. E: Episode || M: Member. We show the number of episodes for episode type VBP arrangements and for individual episode rolled into bundles because any given member can have multiple episodes (and pregnancies) in any given year. On the other hand, we show a member count for population type VBP arrangements. For IPC-CB, Routine Sick Care, and Chronic bundle, we show number of unique members even though those were built by episode as VBP contract will be made at a member-bundle level. The member count removes double counting if one member has multiple episodes in a bundle.
3. IPC is combined Integrated Primary Care and Chronic bundle. It is broken into Preventative Care, Routine Sick Care, and the Chronic bundle. Routine Sick Care includes: Sick Care, Allergic Rhinitis/Chronic Sinusitis, Upper Respiratory Infection, and Tonsillectomy.
4. Icons were grayed out for Preventive Care bundle due to ambiguity on performance decision. For example, high preventive care spend could reduce overall healthcare spend and have a positive impact on member health.