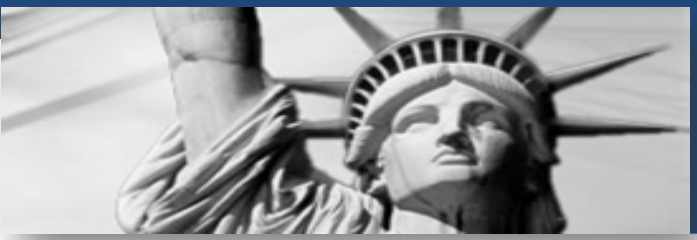


NEW YORK state department of HEALTH

Redesigning THE MEDICAID PROGRAM

New York Medicaid Redesign

Payment Reform & Quality Measurement Work Group

October 18th, 2011
New York State Department of Health
90 Church Street
Fourth Floor, Conference Room A/B
Manhattan, New York

Dan Sisto, Co-Chair
Dr. William Streck, Co-Chair

MRT Payment Reform & Quality Measurement Work Group Members

Co-Chair: Dan Sisto, President, Healthcare Association of NYS	Co-Chair: William Streck, MD, Chair, NY State Public Health and Health Planning Council
Rick Abrams, Executive VP, Medical Society of the State of NY	**Phyllis Lantos**, Executive VP & CFO, NY Presbyterian Hospital
Elizabeth Benjamin, VP of Health Initiatives, Community Service Society	**Art Levin**, Director, Center for Medical Consumers
Scott Cooper, MD, President & CEO, St. Barnabas in the Bronx	**Joseph McDonald**, President & CEO, Catholic Health Services of Western NY
Michael Cropp, MD, President & CEO, Independent Health	**Joe Quagliata**, President & CEO, South Nassau Communities Hospital
Joanne Cunningham, HCA, President, Home Care Association of NYS	**Steven M. Safyer, MD**, President & CEO, Montefiore Medical Center
Emma DeVito, President & CEO, Village Care of NY	**Susan Stuard**, Executive Director, Taconic Health Information Network and Community
Paloma Izquierdo-Hernandez, MS, MPH, President & CEO, Urban Health Plan	**James R. Tallon, Jr.**, President, United Hospital Fund
Sneha Jacob, MD, MS, Assistant Professor of Clinical Medicine, Columbia University & Assistant Medical Director, NY Presbyterian System Select Health	**Pat Wang**, President & CEO, Healthfirst
James Knickman, President & CEO, NYS Health Foundation	**Marlene Zurack**, Senior VP, Finance, NYC Health and Hospitals Corporation
Ronda Kotelchuck, Executive Director, Primary Care Development Corporation	

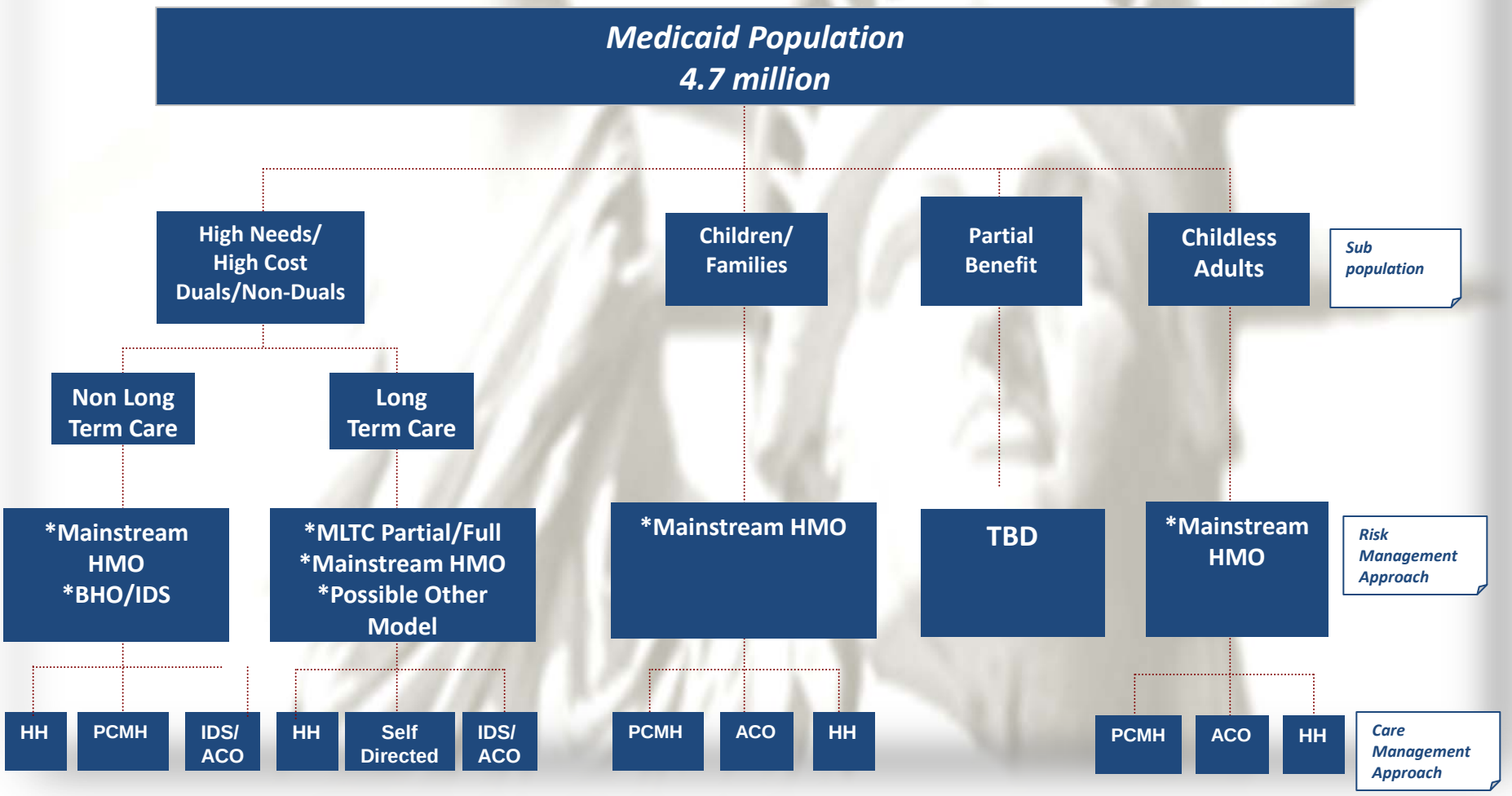
AGENDA

- Introductions
- Meeting Goals
- Putting the Puzzle Together
- Discussion & Adoption of Principles
- Discussion & Adoption of Recommendations
  - **Pursue partnership agreement with CMS to integrate Medicaid & Medicare service delivery and financing for the dual-eligible population.**
  - **Adopt a series of accepted performance measures across all sectors of health care (managed care, ACOs, BHOs, and Health Homes) aligning measures already being collected in New York in Medicaid managed care including managed long term care with federal requirements.**
  - **Develop general principles that can be applied towards revising the New York State DSH/Indigent Care program.**
  - **Create financing mechanisms that strengthen the financial viability of New York's essential community provider network.**

Fitting the Puzzle Pieces Together

Possible Initial Approach – Care Management
What Do You Think?

DRAFT



Care Management Tools and Transitions

MCO/ACO/BHO/SNP

- Organizes services for all and orchestrates system improvement including new care management models
- BHO transitions behavioral health services from managed FFS to risk based/performance based contracting
- SNPS could be utilized to design and organize care for special populations (e.g., behavioral health and high risk children)
- ACO/IDS could be utilized to further localize performance based contracting in some markets

PCMH/Care Co-location

- PCMH provides framework for evidence based practice improvement models for all
- Co-location of behavioral and physical health care service delivery where practical

Health Homes - High Need Patients

- Localizes accountability and reward for patients with higher risk profiles
- Further organizes care for patients with multiple chronic illness

Self Directed Care

- Member options for care setting, level & intensity
- Peer involvement in care management and delivery including outreach and engagement

Guiding Principles

General Guiding Principles

Innovative payment models should :

1. Be transparent and fair, increase access to high quality health care services in the appropriate setting and create opportunities for both payers & providers to share savings generated if agreed upon benchmarks are achieved.

2. Be scalable and flexible to allow all providers and communities (regardless of size) to participate, reinforce health system planning and preserve an efficient essential community provider network.

3. Allow for flexible multi-year phase in to recognize administrative complexities including systems requirements (i.e., IT).

4. Align payment policy with quality goals.

5. Reward improved performance as well as continued high performance.

6. Incorporate strong evaluation component & technical assistance to assure successful implementation.

General Guiding Principles

Quality measures should:

1. Be transparent and fair and be based on a standard of care or evidenced based science.
2. Be flexible enough to recognize advances in medicine that will improve patient care.
3. Include patient experience measurement.
4. Seek to align quality measurement across payers including Medicare and others.
5. Be appropriately risk-adjusted especially when used to compare providers or make incentive payments.
6. Align and incentivize providers across the continuum of care.
7. Promote patient participation and responsibility in health care decision-making.
8. Incorporate strong evaluation component & technical assistance to assure successful implementation.
9. Include a public reporting process on measures and outcomes.

Potential Recommendations

Potential Recommendation #1 (Payment Reform)

Pursue partnership agreement with CMS to integrate Medicaid & Medicare service delivery and financing for the dual-eligible population.

Goals:

- Achieve "*triple aim*" as defined by CMS: improve patient care experience; improve the health of populations; and reduce the per capita cost of health care.
- Create opportunities for providers/payors/patients to realize financial benefits and improved outcomes as system efficiencies are achieved and quality benchmarks attained.
- Promote improved patient outcomes.
- Secure investment of resources from CMS which are required to implement this recommendation. Such funds need to be flexible and could be used for continued funding of care management (Health Homes) beyond the two year incentive period; HIT; ACO or Medical Home development; shared savings initiatives; other innovative initiative development; and transition of all patients into care management with a focus on patient-centered/patient focused approaches.

Potential Recommendation #2 (Quality Measurement)

Adopt a series of accepted performance measures across all sectors of health care (managed care, ACOs, BHOs, health homes) aligning measures already being collected in New York in Medicaid managed care including managed long term care with federal requirements.

Goals:

- Need to utilize a core set of measures that are flexible to address the evolving delivery systems.
- Be based on a standard of care or evidence based science.
- Implement public reporting process on measures and outcomes.
- Reward providers for improved and continued high performance.

Potential Recommendation #3 (DSH)

Develop general principles that can be applied towards revising the New York State DSH/Indigent Care program.

These principles will be applied once CMS provides guidance for determining how state allocations of federal DHS funding will be reduced as part of federal reform.

Goals:

- Develop a new allocation methodology (consistent with CMS guidelines) to ensure that New York State does not take more than its share of the nationwide reduction.
- Fair & equitable approach to allocate funds across hospitals with a greater proportion of funds allocated to those hospitals that provide services to un/underinsured.
- Simplify allocation methodology and consolidate pools.

General Draft Principles for Revising New York State DSH/Indigent Care Program

1. It is critical for all New York State health interests to advocate against further cuts in federal funding for DSH and other programs for eligible consumers and providers.

2. New York State should make changes in its uncompensated care pool allocations consistent with CMS guidelines to preserve its share of available federal DSH funding.

3. Subject to federal guidelines, the components of need in valuing uncompensated care support should be primarily based on charity care and uncompensated care to low-income uninsured and underinsured patients, but not bad debt.

4. The current methodology has lost its progressivity. New York State needs to allocate funds across providers with a greater proportion of funds to those with higher need.

5. The State should include public hospital essential community provider funding under a waiver to mitigate shortfalls caused by reductions in federal dish funding.

Potential Recommendation #4 (Essential Community Provider Network)

Create financing mechanisms that strengthen the financial viability of New York's essential community provider network.

Goals:

- Ensure patient access to provider services that may be otherwise jeopardized by the provider's payer mix or geographic location.
- Focus should be on essential providers that are not financially viable, provide a disproportionate level of care to financially vulnerable populations, provide essential health care services and provide a high fraction of health services in their market area.
- Provide supplemental financial support to ensure the long-term viability of designated providers.
- Reinvest a portion of savings generated from reforms and downsizing within an impacted community to maintain that community's health care delivery system.
- Implement review process for designated providers for administrative/operational efficiencies, quality standards, provision of essential services, and potential for integration or collaboration with other entities.

Next Steps

Final Report

- Staff to prepare final draft report discussing process, principles and recommendations and distribute to workgroup members by October 28.
- Report to be distributed to full MRT membership and posted on MRT website on November 1.
- Comments and recommendations for changes submitted to co-chairs and workgroup leads by December 1.
- Final report recommendations to be voted on by full MRT at December 13th meeting.

Please visit our website:

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

Please feel free to submit any comments or inquiries to the following email address:

paymentreform@health.state.ny.us