NEW YORK STATE | Department of Health | Medicaid Redesign Team

Speakers

Peggy Chan, New York State Department of Health, DSRIP

Cheryl Lulias, Medical Home Network

Alexandro Damiron and **Mary Ellen Connington, RN, MA FNYAM,** Advocate Community Partners PPS

Edina Vukic and **Victoria Fancher,** Affinity Health PPS

New York State

A Path Toward Value Based Payment

Value Based Payments: Levels and Targets

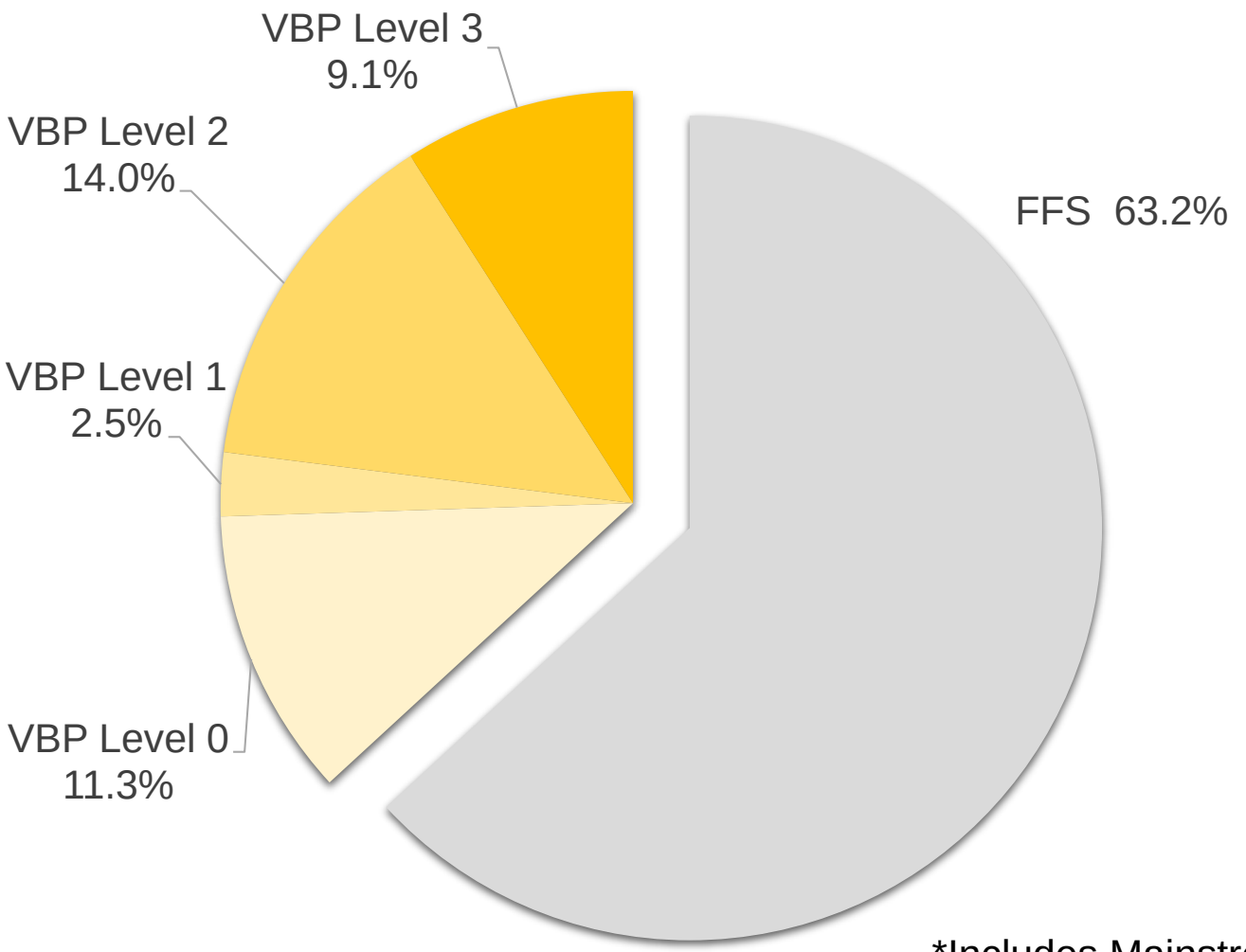
In addition to choosing what integrated services to focus on, Managed Care Organizations (MCOs) and PPSs can choose different levels of Value Based Payments:

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)
No Risk Sharing	↑ Upside Risk Only	↑↓ Upside & Downside Risk	↑↓ Upside & Downside Risk

- 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

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 Transformation: Overall Goals and Timeline

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

2016	2017	2018	2019	2020
DSRIP Goals	***April 2017***	***April 2018***	***April 2019***	***April 2020***
	PPS requested to submit growth plan outlining path to 90% VBP	**≥ 10% of total 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**

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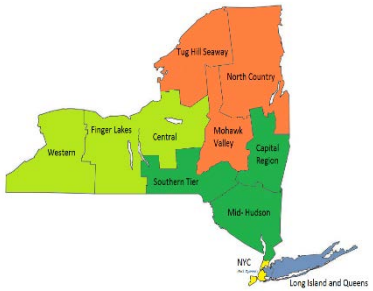
VBP Bootcamps: Current Status



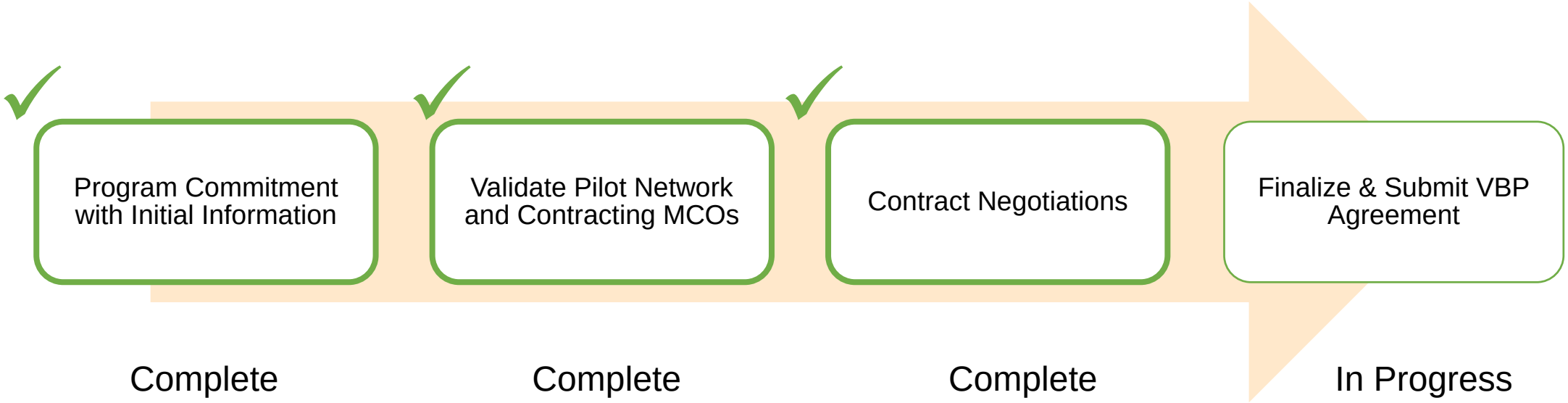
- VBP Bootcamps are a learning series that provides **foundational** knowledge about VBP design with a goal to prepare MCOs and providers for VBP implementation.
- Bootcamps are being held in 5 regions across NYS between June and October of 2016; each region is offered 3 different sessions.
- As of Wednesday September 14th, DOH has delivered a total of 10 out of 15 Bootcamps.

Region 1	Region 2	Region 3	Region 4	Region 5
Capital Region, Southern Tier, Mid-Hudson	Mohawk Valley, North Country, Tug Hill Seaway	New York City (excluding Queens)	Central NY, Finger Lakes, Western NY	Long Island and Queens
✓ Complete	✓ Complete	✓ Complete	In progress	Starting soon

VBP Pilot Program: Milestones and Timeline

One of the primary goals of the Pilot Program is to support the adoption of the VBP arrangements across the State, and to support other providers and payers with lessons learned and guidance from the Pilots.

To ensure that the goals of the Pilots will be met, the State has set the following milestones:



Program Commitment with Initial Information	Validate Pilot Network and Contracting MCOs	Contract Negotiations	Finalize & Submit VBP Agreement
Complete July 29, 2016 (For pilots currently in process)	Complete Aug. 26, 2016	Complete Sept.16, 2016	In Progress Level 1: Oct. 31, 2016 Level 2: Nov. 30, 2016

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PPS VBP Progress Reporting

In development and more to come!!

Thank you

Peggy Chan – Peggy.Chan@health.ny.gov

MEDICAL HOME NETWORK

Building Partnerships for Better Health

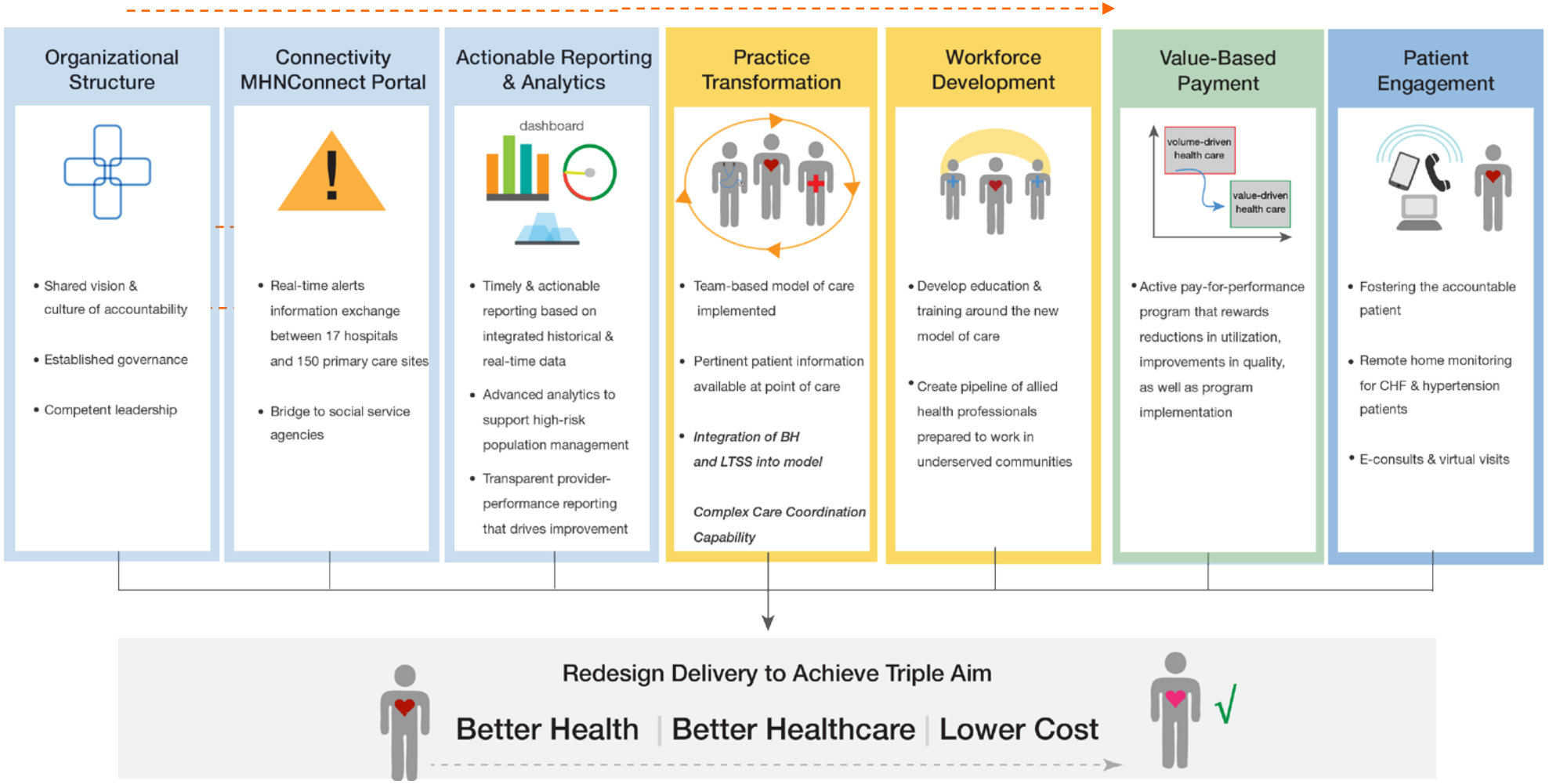
Journey Toward Value-Based Payment Arrangements

September 20, 2016

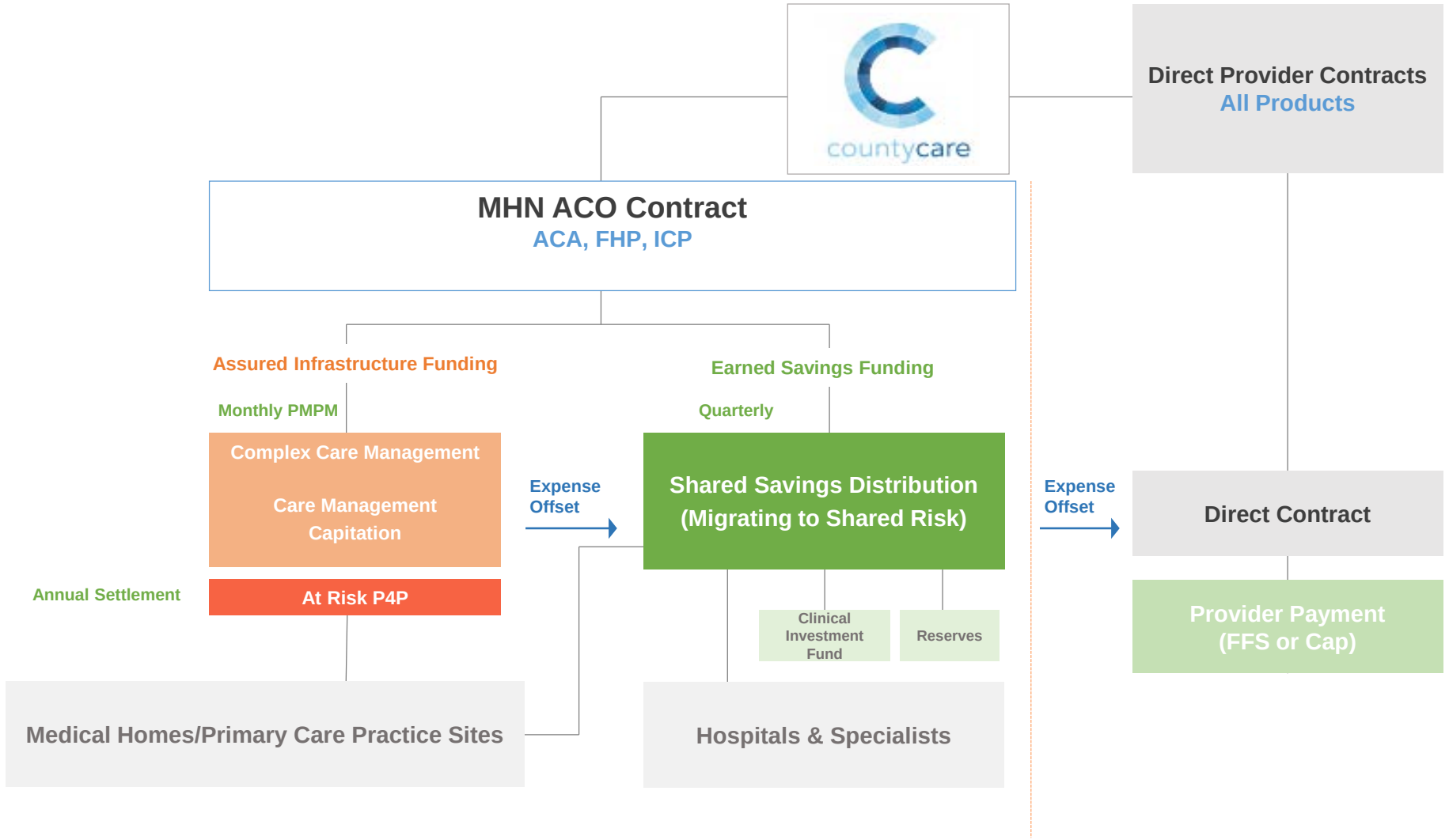
Cheryl Lulias clulias@mhnchicago.org

Medical Home Network *Building Blocks for Delivery System Transformation*

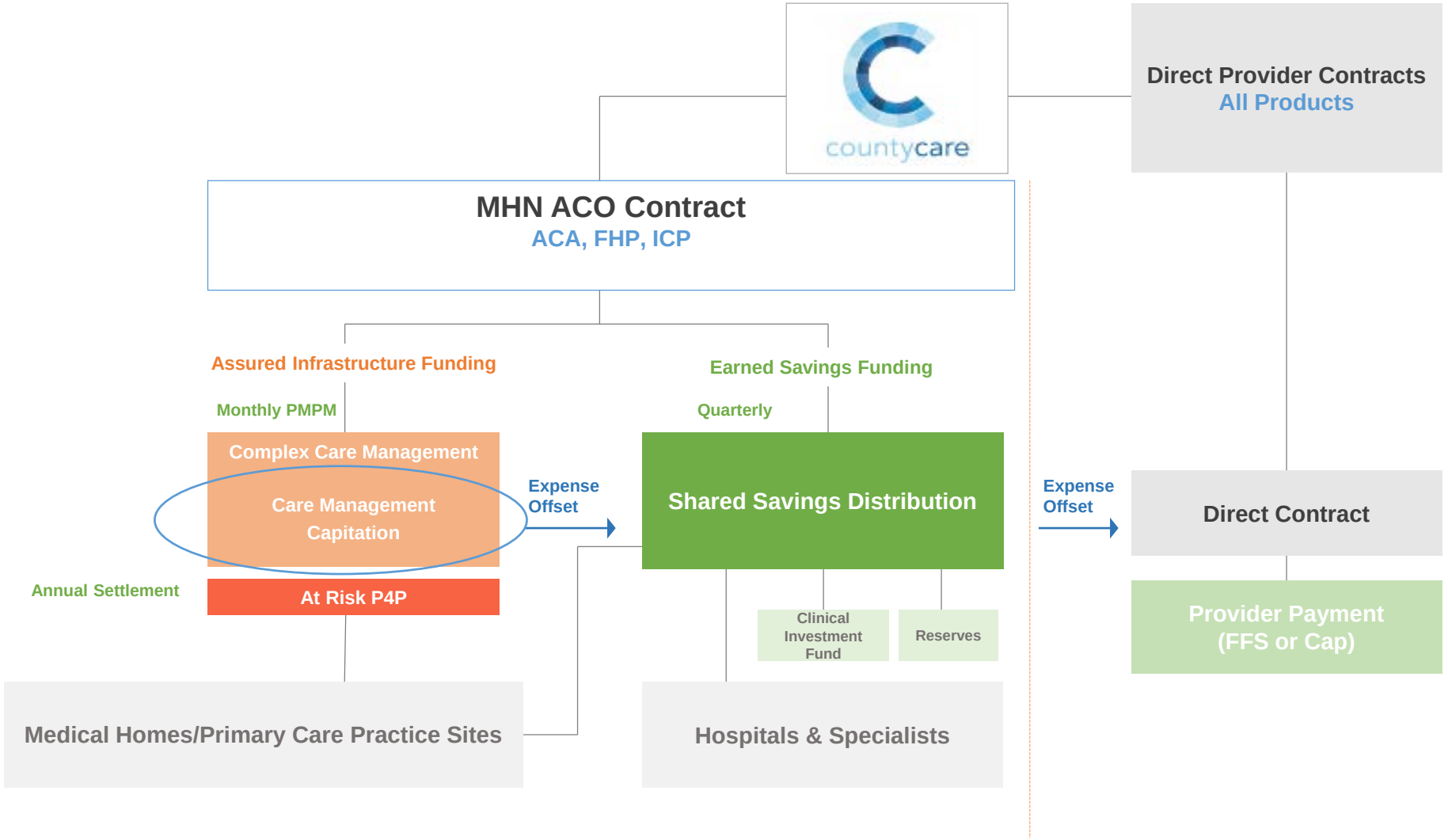
Medical Home Network's Path



Medical Home Network *Value Based Contracting Construct*



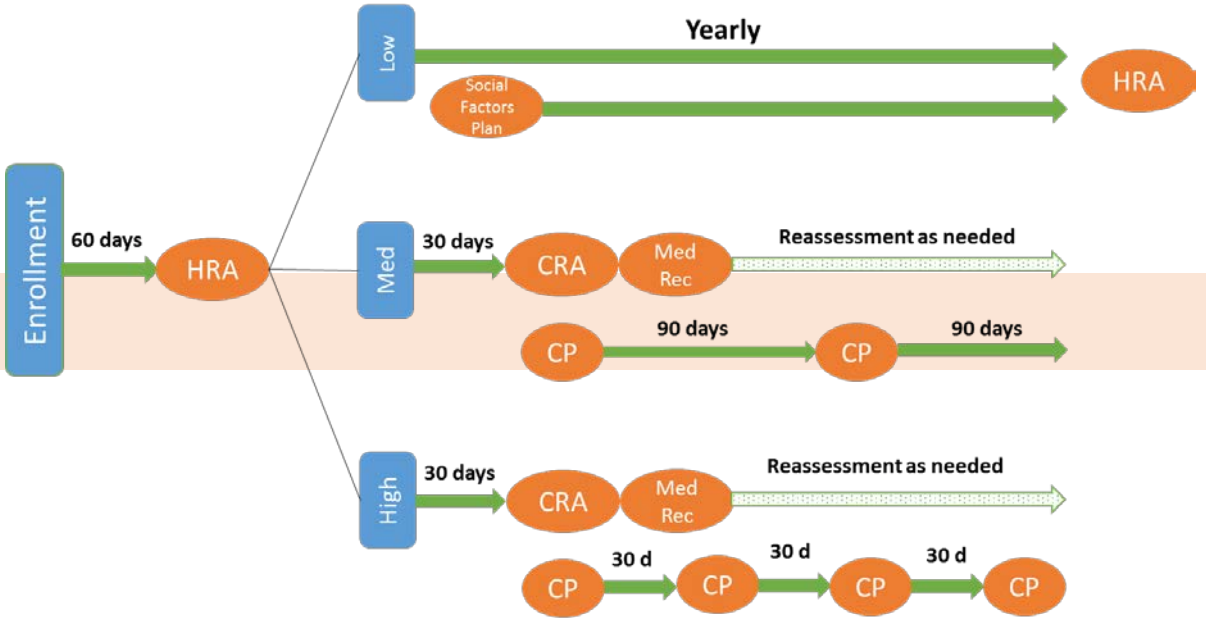
Value Based Contracting Construct *Assured Infrastructure Funding*



Care Management Value Based Payment *Tasks to Impact Total Cost of Care*

Complex Care Management

Care Management Capitation

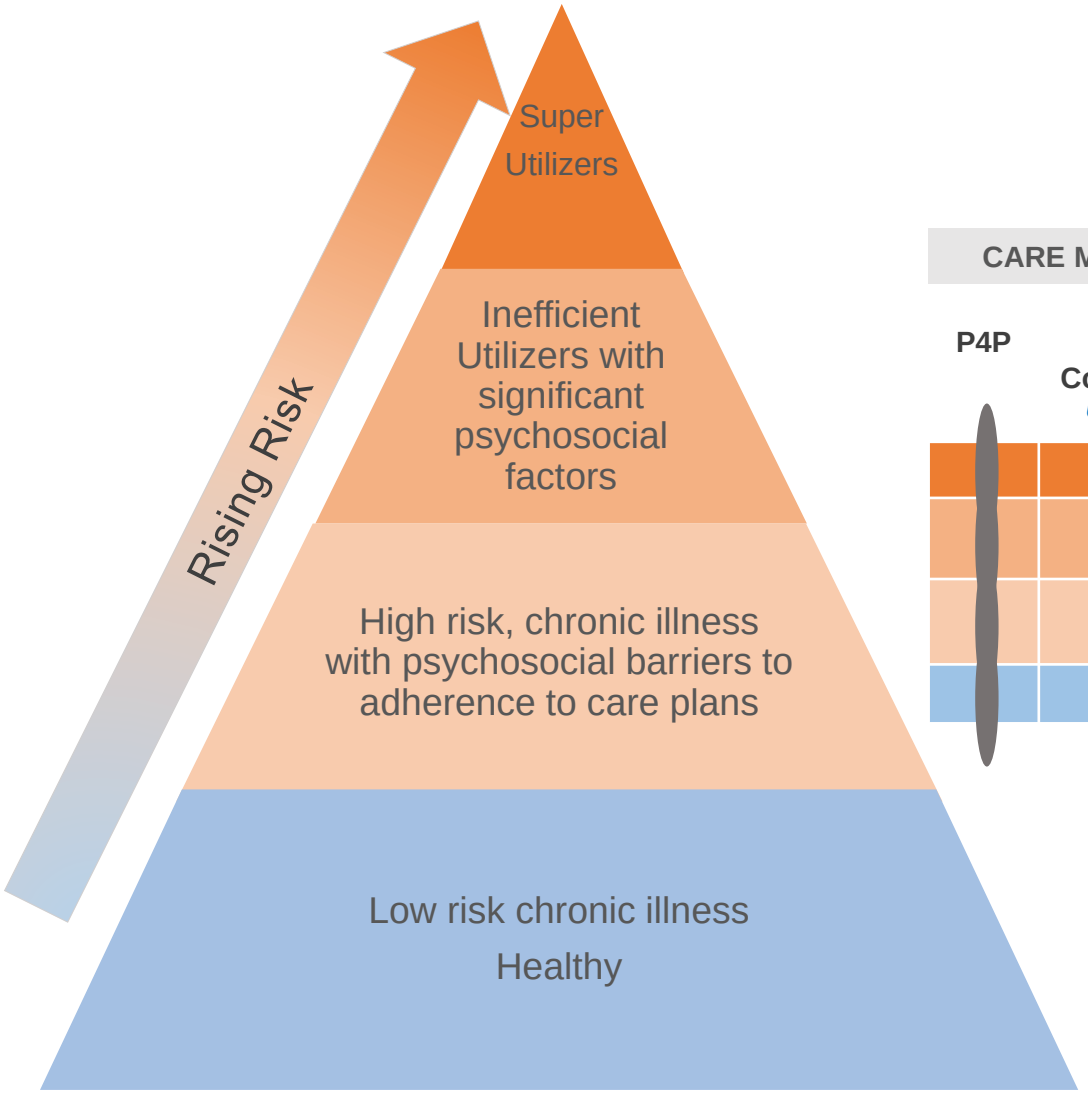


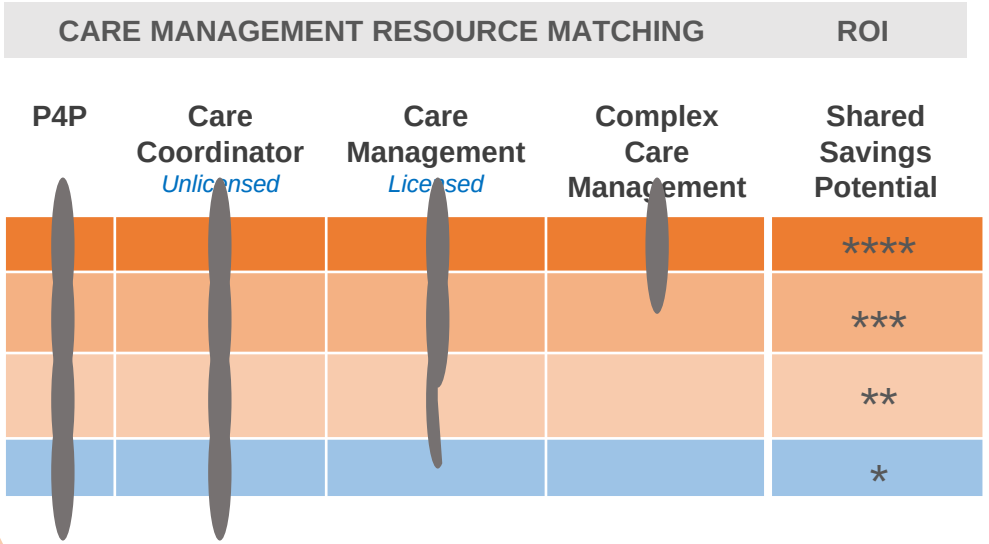
At Risk P4P

Engagement: HRA Completion = >70%

Quality: + 5 HEDIS Measures

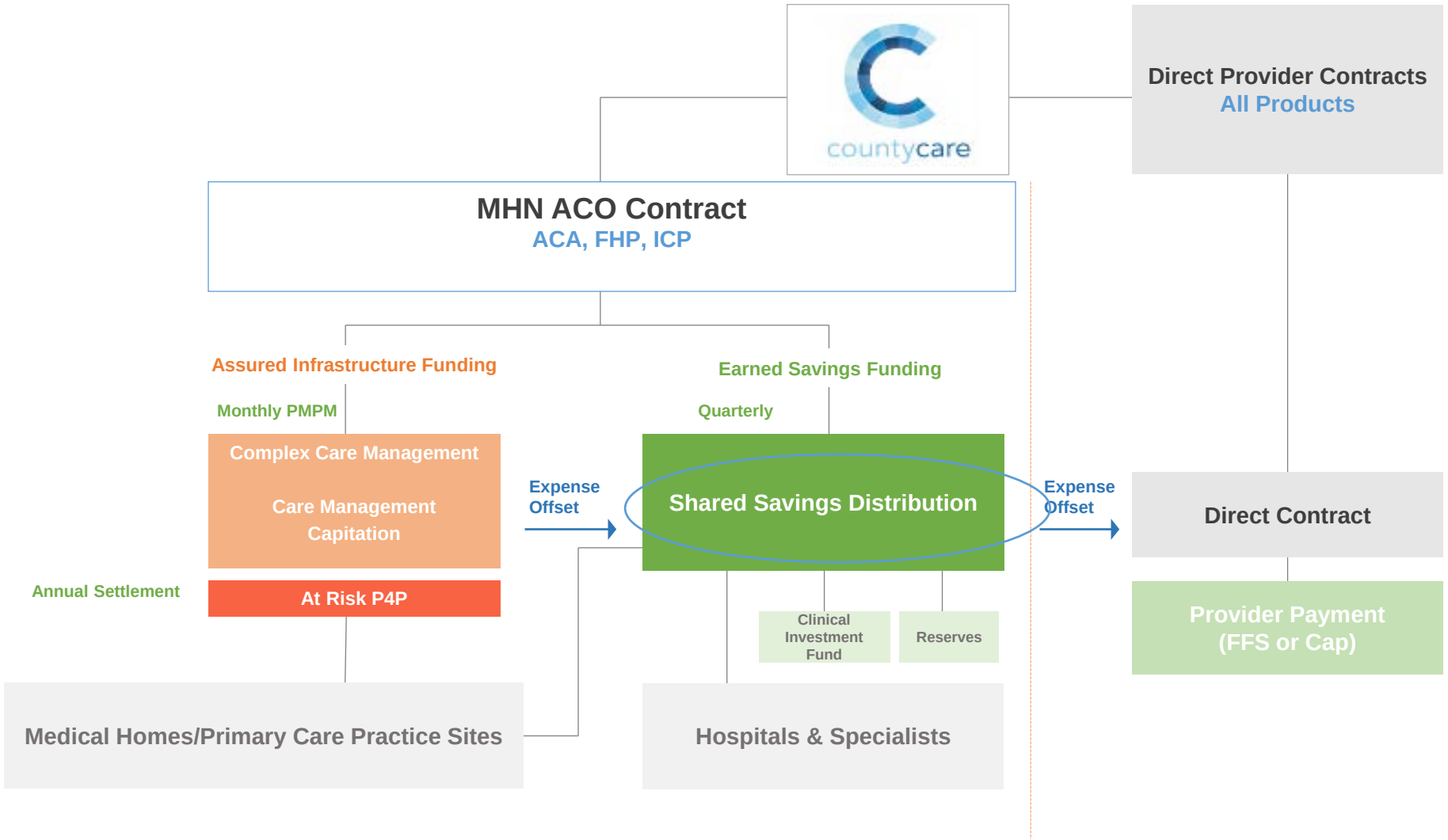
MHN Model of Care *Effective Care Management Drives Total Cost of Care ROI*



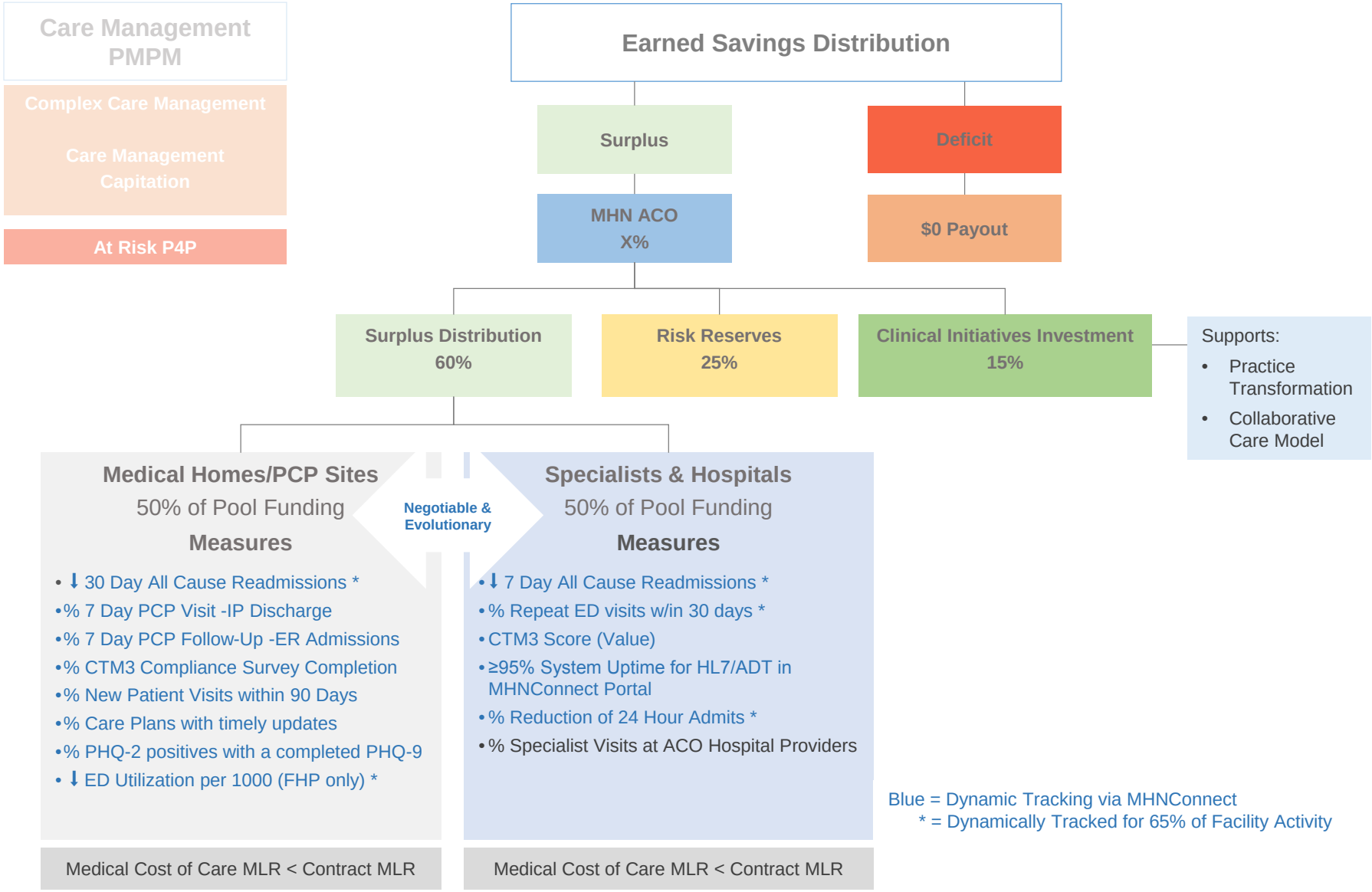


*The Advisory Board Company, "Successful population health managers prevent the escalation of rising-risk patients"
**Denver Health Health Affairs, 34, no.8 (2015):1312-1319

Value Based Contracting Construct *Earned Savings Funding*



Earned Shared Savings Funding *Enabling Collaborative Delivery Redesign*



Earned Shared Savings Distribution & Calculation *Increasing Reward for Outcomes*

Years 1 & 2

TARGET

50%

Provider Attainment Pool

ACTUAL

35%

Residual Unattained Funds

50%

Cost of Care Surplus Pool

65%

Year 3

TARGET & ACTUAL

65%

Provider Attainment Pool

35%

Cost of Care Surplus Pool

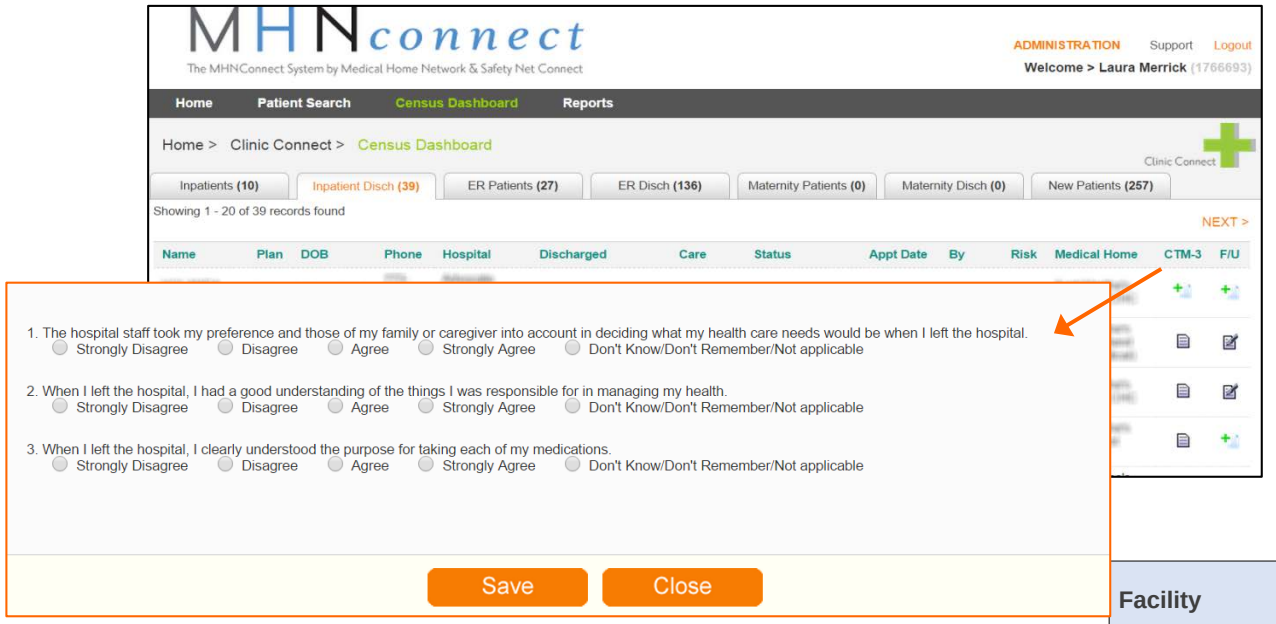
Calculations & Weights

Scoring

0x	Failed Goal
1x	Reached Goal
2x	EXCEEDED Goal

Domain	Total Domain Measures	Measurement Weighting
Process	7	5-10%
Outcomes	6	5-10%
Realtime Connectivity/Exchange	1	5%
Cost of Care	2	35%

Driving Critical Workflows via Shared Savings Measures *Transitions of Care*



MHN's process drives performance monitoring.

1) Hospital discharges patient and provides instruction on health management and medication.
2) Clinic calls patient within 48 hrs. and schedules a timely follow up appointment post-ED or IP hospital visit.
3) Clinic completes CTM-3 to identify and address patient questions about their follow up care.
4) MHNConnect captures CTM-3 score, allowing us to evaluate hospital care transition practices.

Facility	Discharges with completed CTM3	Average CTM3 Score
Hospital A	393	77.16
Hospital B	67	74.92
Hospital C	82	71.12
Hospital D	91	70.79
Hospital E	82	69.17
Hospital F	99	72.45
Hospital G	404	79.82
All Portal Facilities	**1,218**	**73.63**

Earned Shared Savings *Timely Performance Reporting*

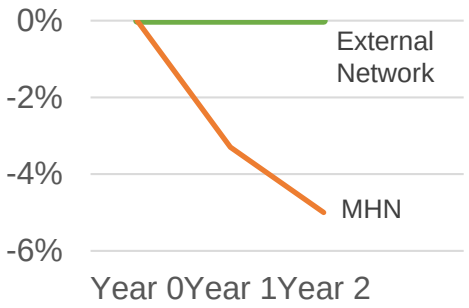
MHN ACO Shared Savings Audit - Sample Medical Home
PY3 Q1 (July 2016 - September 2016)

	Reduce 30 Day Admissions	CTM3 Compliance	IP Timely Follow-Up	ER Timely Follow-Up Rate	New Member Visit within 90 Days	ED Utilization/1000	%PHQ 2 Positives with Completed PHQ 9	% Care Plans with Timely Updates	Medical Cost of Care	Total
	Initiatives									
Total Eligible Opportunities	681	435	789	1,120	4,788		316	584		
Missed Opportunities	54	132	630	870	2,562		50	102		
Clinic Result	-28.2%	69.7%	20.2%	22.3%	46.5%		84.2%	82.5%	91.2%	
Goal	-23.0%	75.0%	35.0%	50.0%	25.0%		75.0%	50.0%	85.0%	
Unearned Shared Savings	$ -	$163,503	$ 151,307	$60,196	$ -		$ -	$ -	$289,782	$ 664,787
Award	1x	0x	0x	0x	2x		1x	1x	0x	

Medicaid Results *MHN's Impact on Cost, Outcomes & Engagement*

Total Cost of Care – State Medicaid Pilot

The difference in cost of care for MHN versus other Medicaid patients in IL is 3.5% in Year 1 and 5% in Year 2



5% LOWER COST
(risk adjusted)

Difference is MHN risk adjusted cohort vs Non-MHN risk adjusted cohort percent change in cost of care
Source: Findings of the MHN HFS Care Coordination Pilot for the Illinois Health Connect population

Patient Engagement - ACO

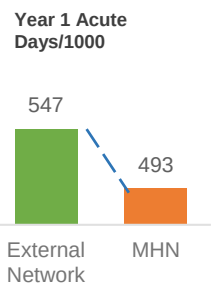
MHN's engagement efforts reach over 2½ times as many patients as other IL Medicaid providers/plans.

MHN ACO:
79% COMPLETE

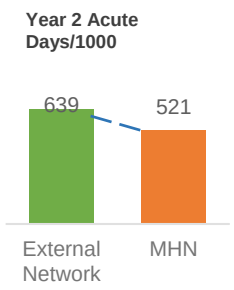
Period: July 1, 2014 – May 19, 2015

ACA Utilization - ACO

Inpatient Days/1000

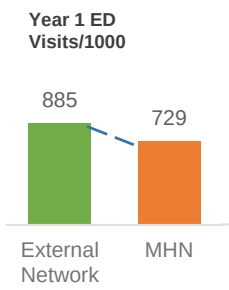


YEAR 1 Jul14–Jun15
10% BETTER OUTCOME

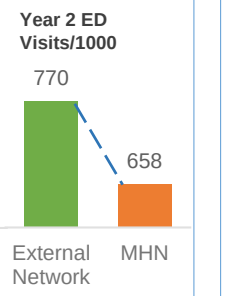


YEAR 2 Jul15– Mar16
18% BETTER OUTCOME

ED Visits/1000



YEAR 1 Jul14–Jun15
18% BETTER OUTCOME



YEAR 2 Jul15–Mar16
15% BETTER OUTCOME

Total Cost of Care - ACO

Contract Year 1

$17.7m

SAVINGS

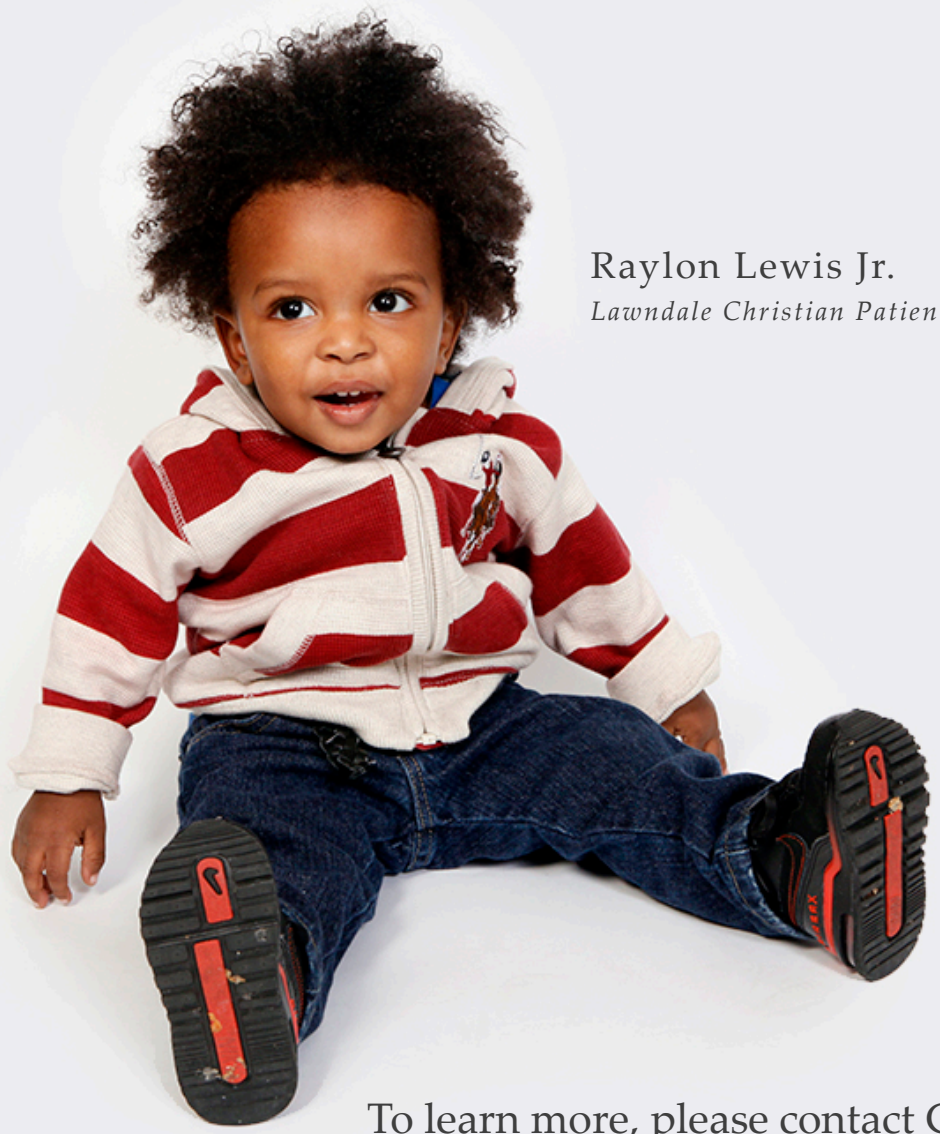
+12.1% variance from target

Contract Year 2 Q1

$6.6m

SAVINGS

+18% variance from target



Raylon Lewis Jr.
Lawndale Christian Patient

Thank you.

Questions?

To learn more, please contact Cheryl Lulias at clulias@mhnchicago.org

Journey toward Value-Based Payment Arrangements

Alexandro Damiron, ACP
Mary Ellen Connington, RN, MA FNYAM, ACP
Edina Vukic, Affinity

September 20, 2016

ADVOCATE COMMUNITY PROVIDERS

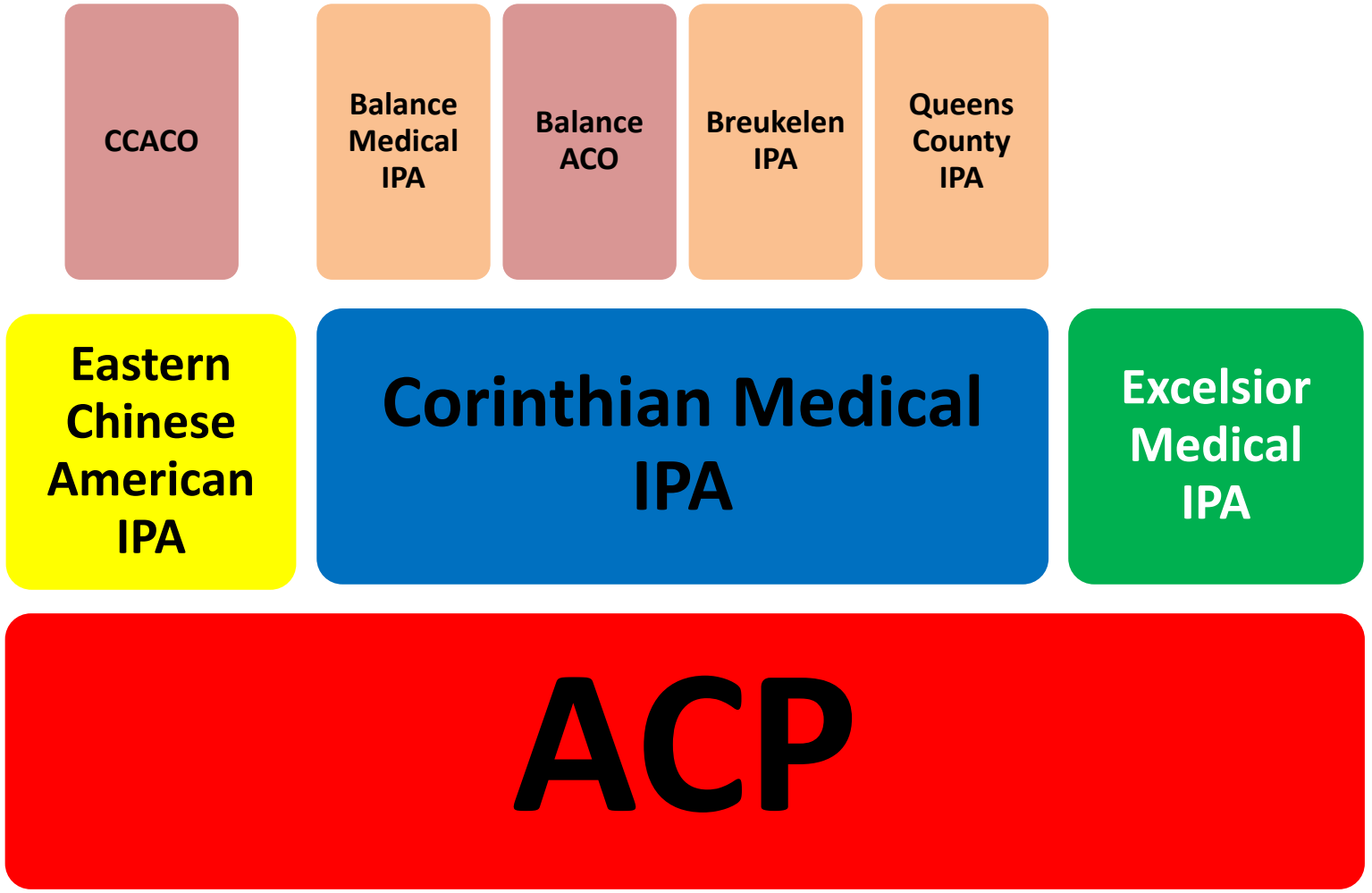
Agenda

- Alexandro Damiron, Chief of Staff and VP Operations, ACP
  - About ACP.
- Mary Ellen Connington, RN MA COO, ACP
  - Creating the foundation for VBP.
- Edina Vukic, Executive Director Primary Care; VP Sales & Community Engagement, Affinity and Victoria Fancher, Director, Primary Care Operations, Affinity
  - What a payor seeks in a VBP Partner.

ADVOCATE COMMUNITY PROVIDERS

About ACP

ADVOCATE COMMUNITY PROVIDERS



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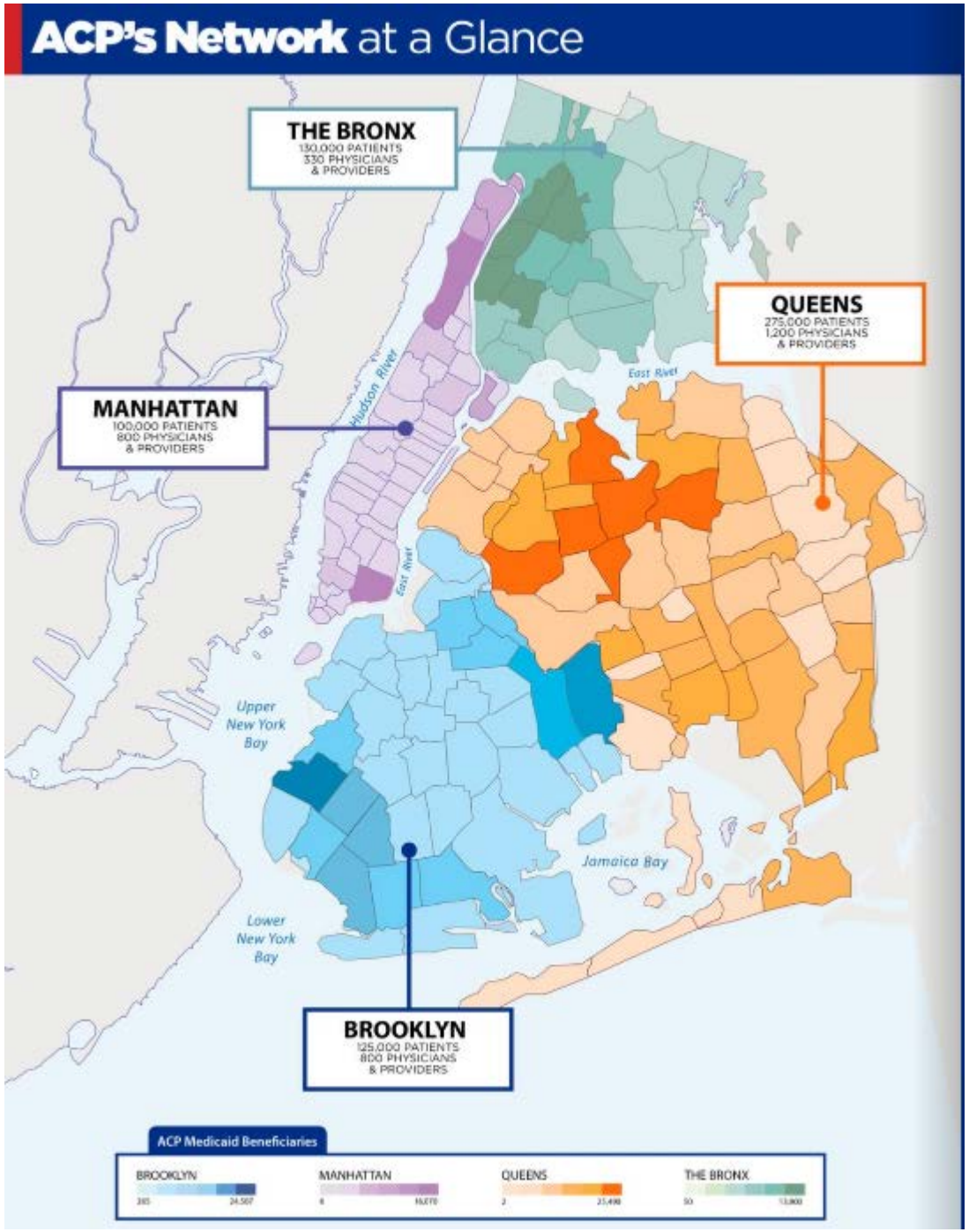


- More than 1,200 Primary Care Physicians
- Strong community-based network
- DSRIP attribution shows 664,000 patients
- Four boroughs:
  - Manhattan
  - The Bronx
  - Queens
  - Brooklyn

Our IPA's

- More than 15 years serving the community doctors
- Vast experience with Risk and share saving contract
- Serving approximate 1.1 million life in NYC
- Cultural Competent

Creating the foundation for VBP

ADVOCATE COMMUNITY PROVIDERS


WE ARE DIFFERENT.
1
2
3
ACP

A Matter of Survival

- For the community based Primary Care Provider (PCP), current payment arrangements (e.g. primary care capitation) make it difficult to sustain a model of enhanced primary care.
- Many community based PCP's face an existential crisis.
  - Many practices are like small business.
  - 1 month cash on hand.
  - Expect to provide free care on a regular basis.
  - Lack resources to function at Advanced Primary Care levels.
  - Lack size and scale to negotiate with payors or manage risk.

ADVOCATE COMMUNITY PROVIDERS

ACP is Excited About VBP!

1. Opportunity to re-engage the Primary Care infrastructure and rebuild relationships with independent community based PCP's. Create nimbleness in the delivery system to deal with public health issues.
2. Opportunity to create the ***size and scale*** of primary care to manage risk arrangements and **transform** the current Medicaid delivery system.
3. Centering risk and reward around the community based primary care physician – closest to the patient.
4. Opportunity to improve care quality and the beneficiary experience.

ADVOCATE COMMUNITY PROVIDERS

Critical Success Factors

- Vision: Imagine the transformed entity.
- Mindset:
  - Health Plans share goals of ↑ efficiency; ↓ cost; ↑increased quality and ↑ patient experience.
  - Align with health plans on shared goals: Acuity, QARR, PPV/A/R, Access, DM.
  - Pick health plan partners for success.
- Language: Become fluent in the vernacular of managed care.
- Robust technology systems to store/report on large data sets. Share data with partners. Unleash data from EMR's and RHIO.
- Tools to model and manage risk arrangements.
  - Actuarial support
  - CRG metrics
  - Historical patterns of utilization.
  - Know your population: CC/HL, demographics, chronic conditions, etc.
  - CM/DM/UM; Community Health Workers; CBO collaboration.
- Communicate and collaborate.

ADVOCATE COMMUNITY PROVIDERS

Driving PCP Engagement

- Affiliating IPA's under DSRIP created sufficient**size and scale** to:
  - Participate in the DSRIP Program bringing resources and guidance needed to transform primary care.
  - Develop an infrastructure (MSO) to support enhanced primary care capacity, e.g. Data and Analytics, RHIO connectivity, EMR functionality, support to attain PCMH Level 3, learn/implement correct coding initiatives, learn/achieve quality scores, etc.
  - Leverage negotiations with Payers to secure VPB contracts.
  - Increase the scope of services (e.g. BH/PC)
  - Expand access to primary care.

ADVOCATE COMMUNITY PROVIDERS

Signs of Engaged (Transformed) Primary Care Systems

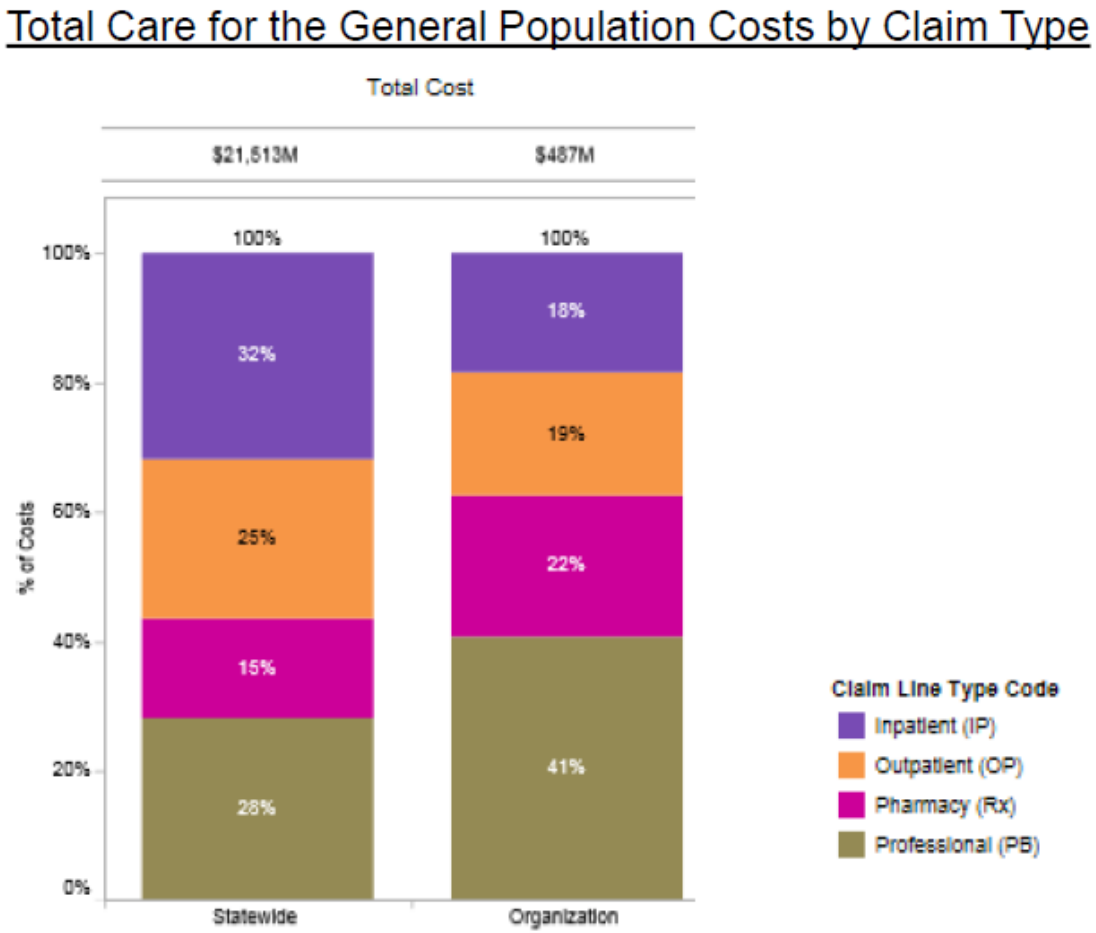
ACP Strives for:

- Decreasing levels of PPV, PPA and PPR's demonstrating improved care coordination.
- Increasing quality metrics demonstrating improved clinical outcomes. P-4-P.
- Improved beneficiary experience with care.
- Improved coding to accurately reflect acuity.
- Successful VBP that centers risk/reward around community primary care providers to sustain the engaged model.
- Stabilized community PCP's.

ADVOCATE COMMUNITY PROVIDERS

Total Care for the General Population

Cost Breakdown by Claim Type.



Profile of Engaged Primary Care:

- Professional Costs
- Pharmacy Costs

- Outpatient
- Inpatient (half)

ADVOCATE COMMUNITY PROVIDERS

What Payors Seek in VBP Partner

ADVOCATE COMMUNITY PROVIDERS

Affinity Health Plan

Primary Care Strategy

Strategic Alliances with community health providers to *change* how primary care is delivered

Edina Vukic
Executive Director, Primary Care and Vice President, Sales & Community Engagement

Victoria Fancher
Director, Primary Care Operations

Guiding principles of Affinity's primary care strategy

Respect, consideration, superior service and support are at the heart of the Guiding Principles that govern the Strategic Alliance.

Guiding Principles

These principles commit our alliance to:

- Enriched and cost efficient patient and Member experience and care, continuously improved outcomes, and sustained use of actionable, intelligent data, analysis, and alerts, that is exchanged throughout the continuum of care
- Appropriate levels of accountability for cost, utilization and quality management, for both Affinity and its partners, encouraged through a range of value-based reimbursement and care coordination delegation opportunities
- Collaborations with other health care and community based entities that support this strategic alliance, and demonstrate commitment and understanding of underserved communities and their challenges
- Development and execution of effective and sustainable opportunities for mutual patient and member growth
- Active and varied engagements that promote, build and empower primary care providers and their practices; engagements may include education, training, outreach and investment

Goals and objectives of Affinity's primary care strategy

Goals and objectives of strategy (in alignment with DSRIP):

- Strive to reduce avoidable hospital use
- Align incentives with primary care strategic partners
- Achieve improved clinical, quality, and financial outcomes
- Offer beneficiaries who elect to enroll in Affinity Health Plan access to one of New York's broadest networks of high quality primary care physicians and services

Affinity's partnership with community health providers works towards a **shared commitment & mission** to improving primary care

What Affinity brings

- Dedicated account manager
- Dedicated customer service support team
- Data analytics tools to identify avoidable ER visits, admissions, and re-admissions
- Cost benchmarking data to compare to other community providers
- Daily alerts for inpatient admissions to improve transition of care outreach
- Enhanced reporting and analytics
- Care management coordination and regular 'clinical rounds' on high risk/high cost patients
- Joint community outreach campaigns targeting specific health needs and quality gaps

What PCPs bring

- Network of providers and staff with ability to significantly influence member health outcomes
- Cost-efficient and high quality care delivery
- Touchpoints with members to improve impact of community-based outreach and engagement programs
- Commitment to serve underserved communities and an understanding of community-specific challenges
- Care management resources and community health workers to impact high risk patients
- Additional membership growth opportunities through joint partnership strategies

Collaborative offerings support common mission and goals:

- Risk contracts with performance incentives and bonus opportunities provide shared savings opportunities
- Clinical program development and improvement promotes mission to serve high-quality care to members
- Enhanced member outreach and engagement program development ensures community-based focus and supports joint goal to improve patient-centered care

Executing a successful partnership and shared savings or risk arrangement requires a number of **planning considerations**

- Staff allocations and available resources to complete work required
- Technical resources to collaborate on data sharing and analytics components
- Competing priorities and initiatives
- System compatibility and training needs required to understand and respond to reports and analysis
- Current care management or patient outreach/engagement programs in place
- Community-based mission alignment

Some examples of plan/provider collaboration to support VBP and shared savings arrangements

- Non-user outreach campaign
- Diabetic eye exam targeted health campaigns
- Asthma home health assessment outreach
- Mobile medical unit to target at-risk populations with access to care issues
- ER diversion programs
- Transition of care follow-up post-discharge
- Analysis and review of incoming data feeds (i.e. claims) to ensure data completeness and accuracy
- Smoking cessation program development and member engagement for specific communities (i.e. Chinese)

MEDICAL HOME NETWORK

Building Partnerships for Better Health

Journey Toward Value-Based Payment Arrangements

September 20, 2016

Cheryl Lulias clulias@mhnchicago.org

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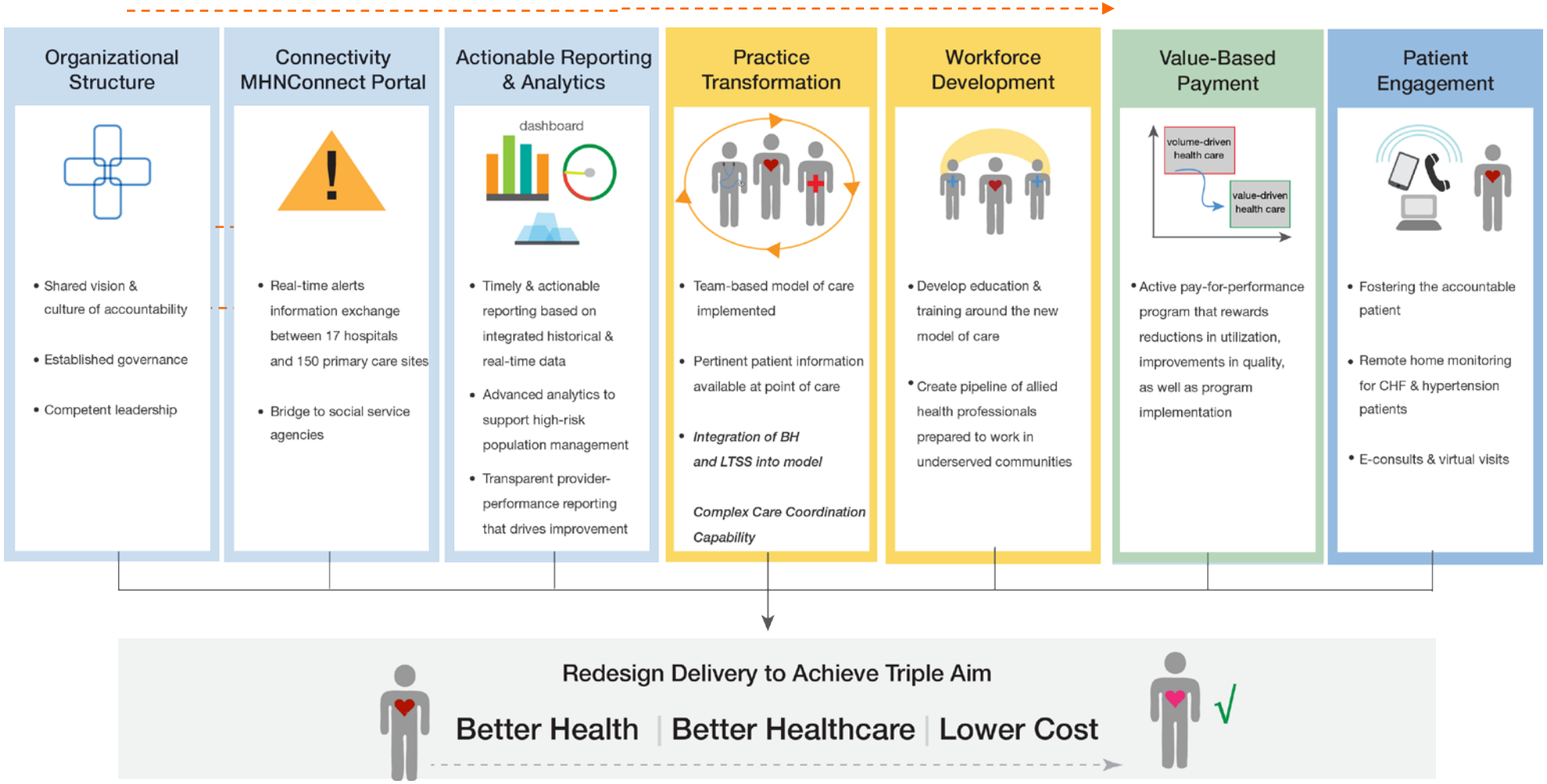

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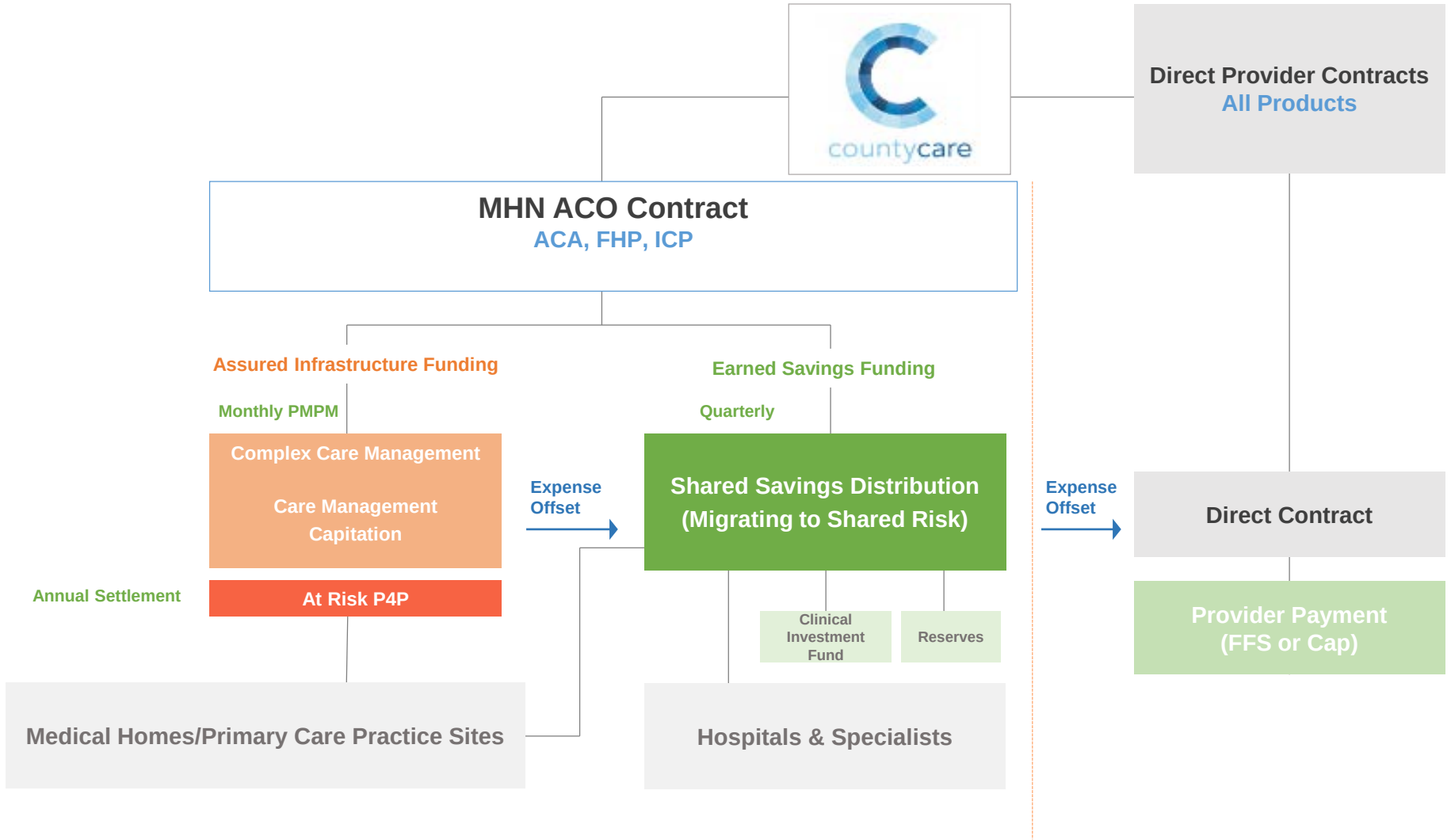

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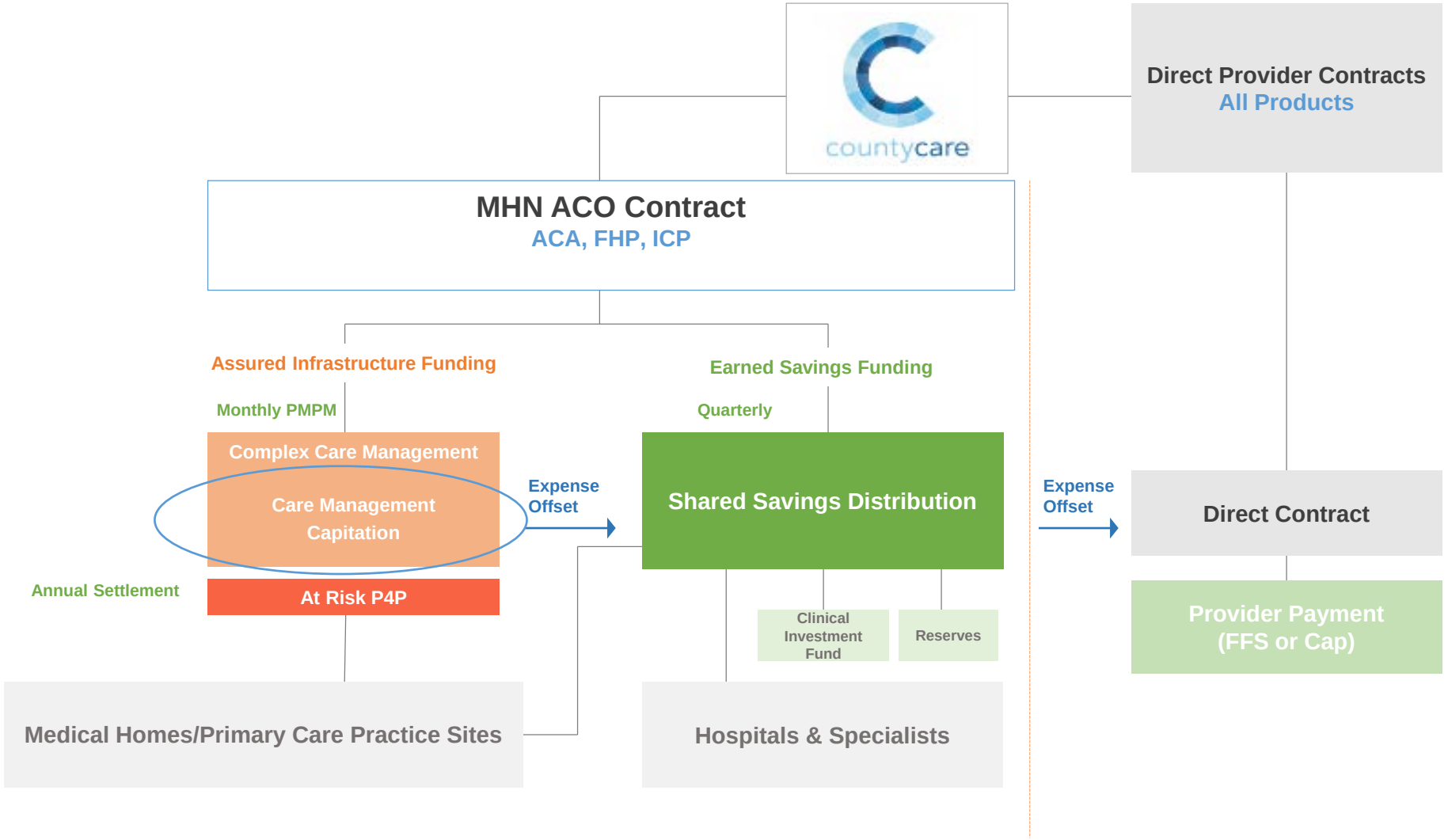

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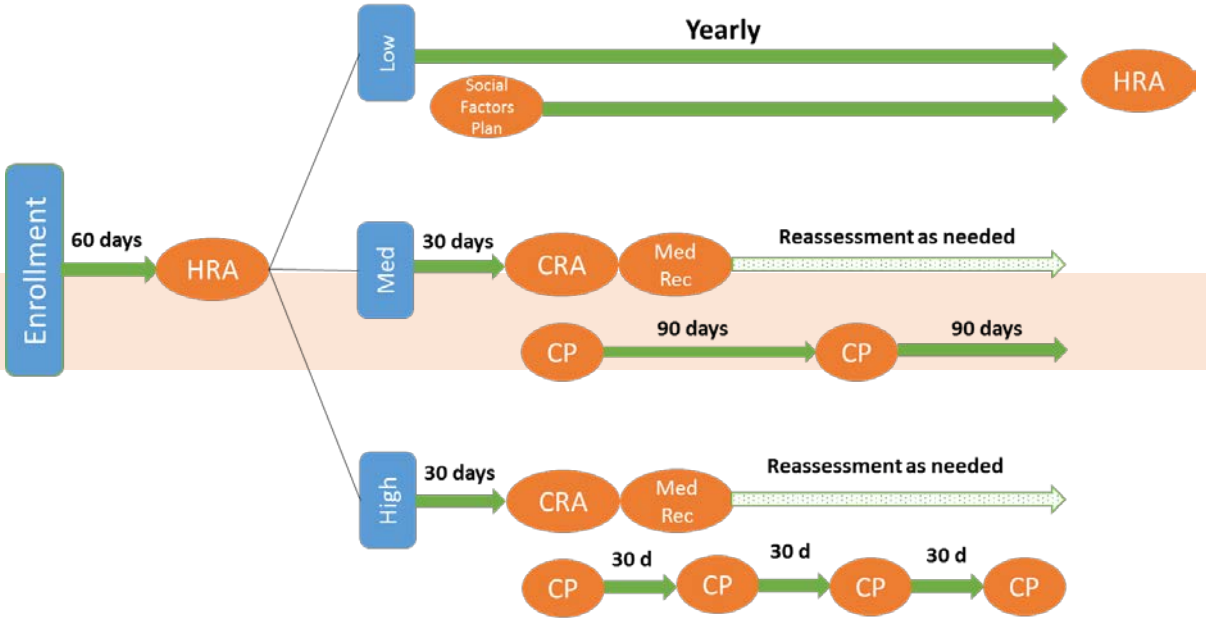

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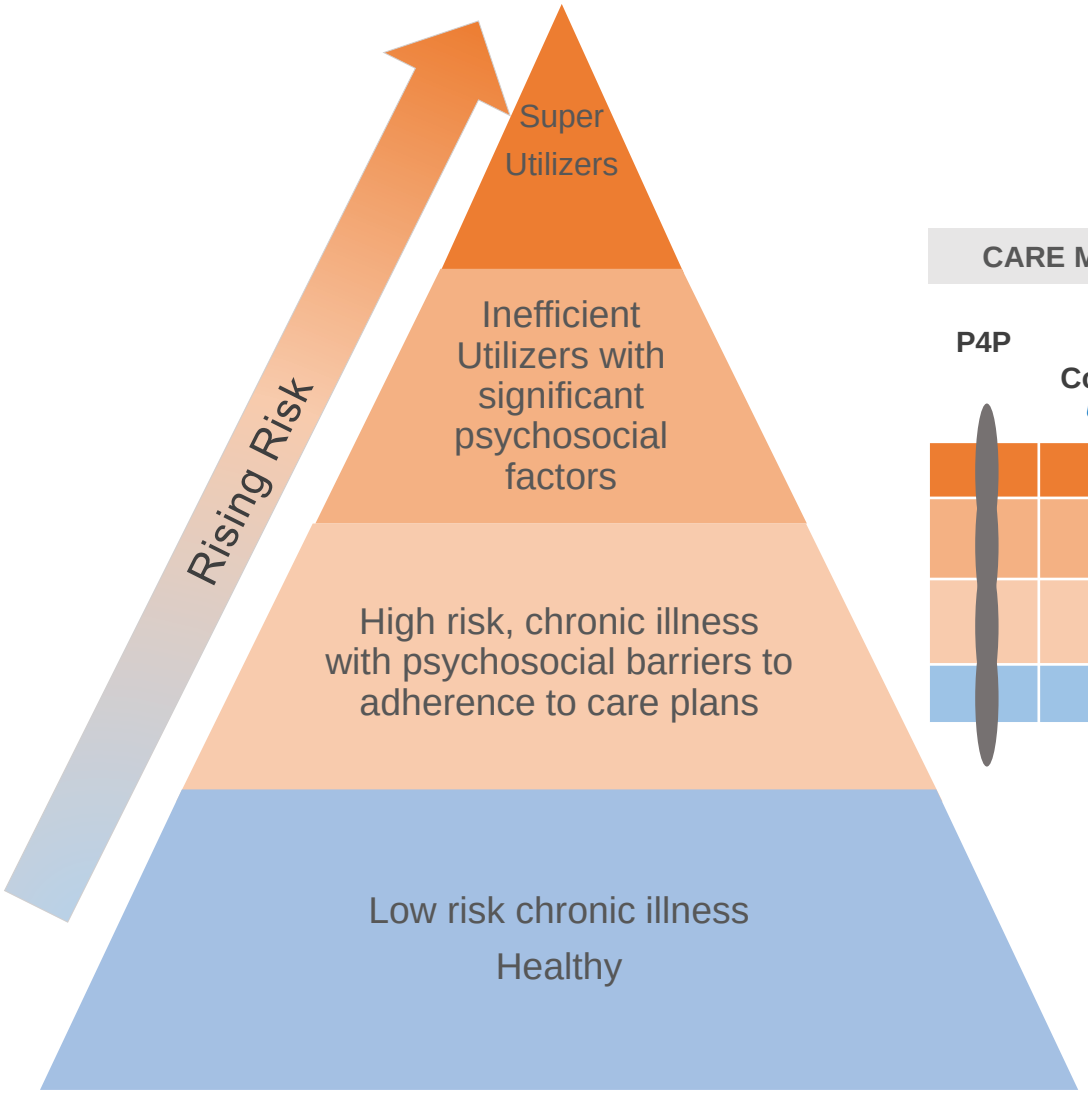
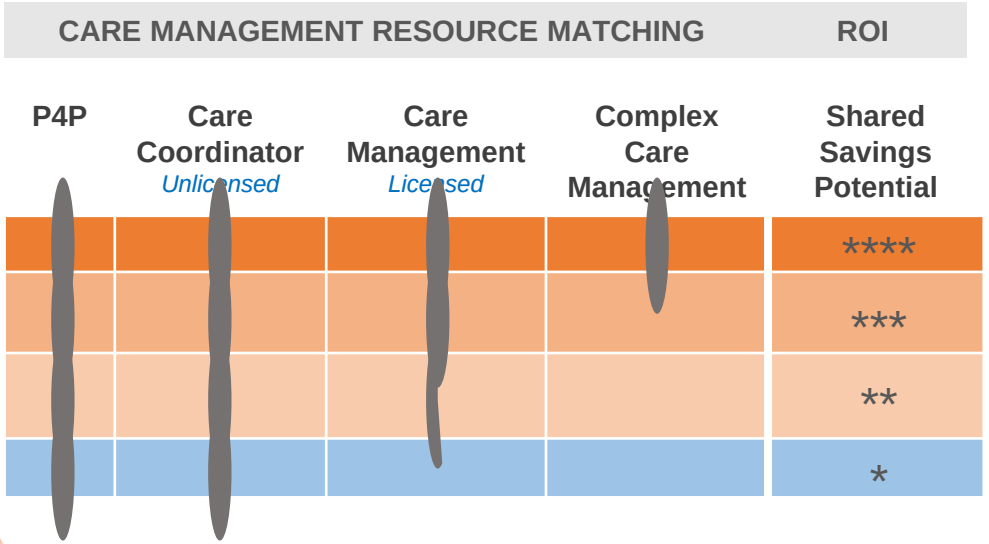
Quality: + 5 HEDIS Measures

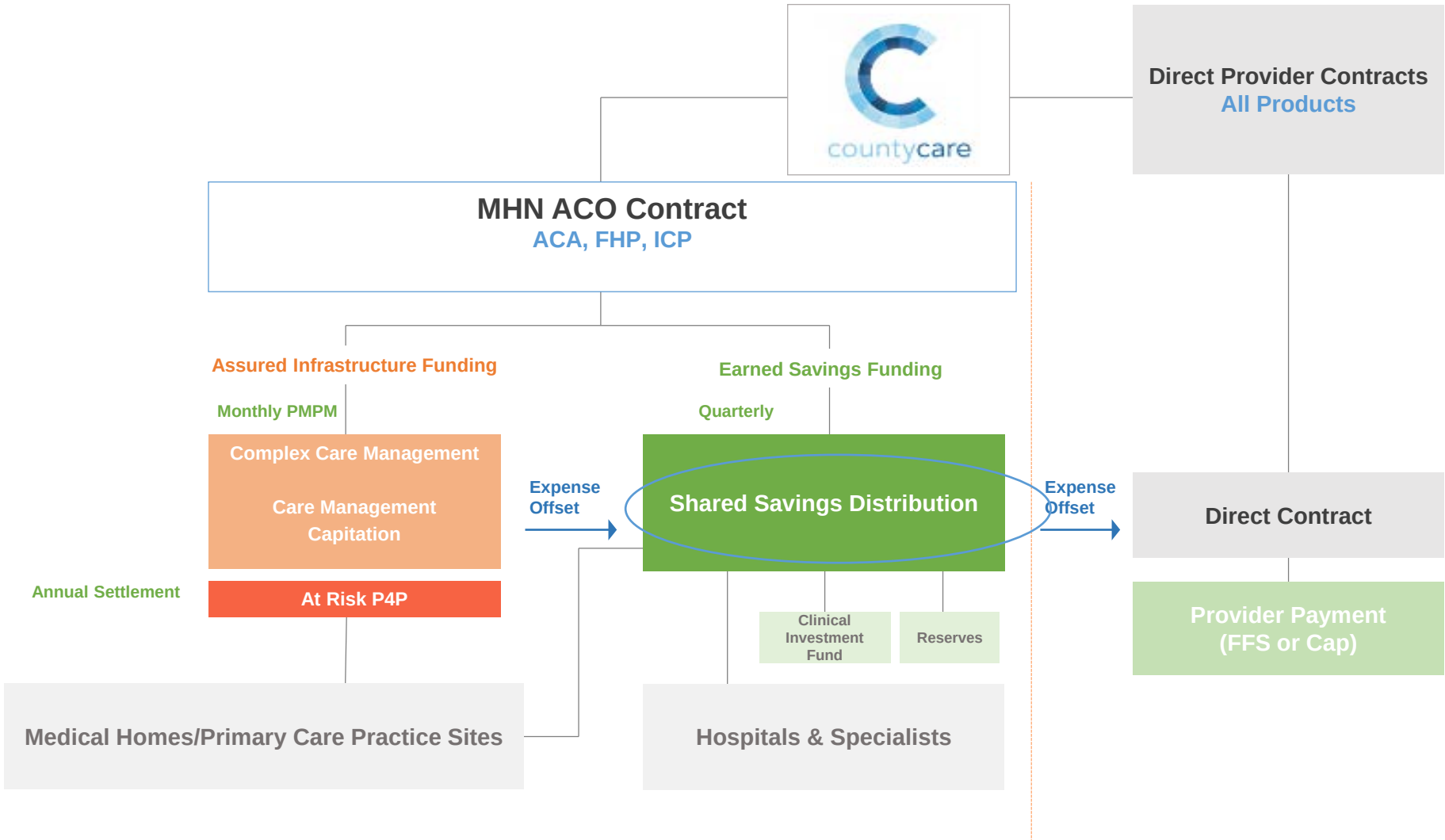
MHN Model of Care *Effective Care Management Drives Total Cost of Care ROI*



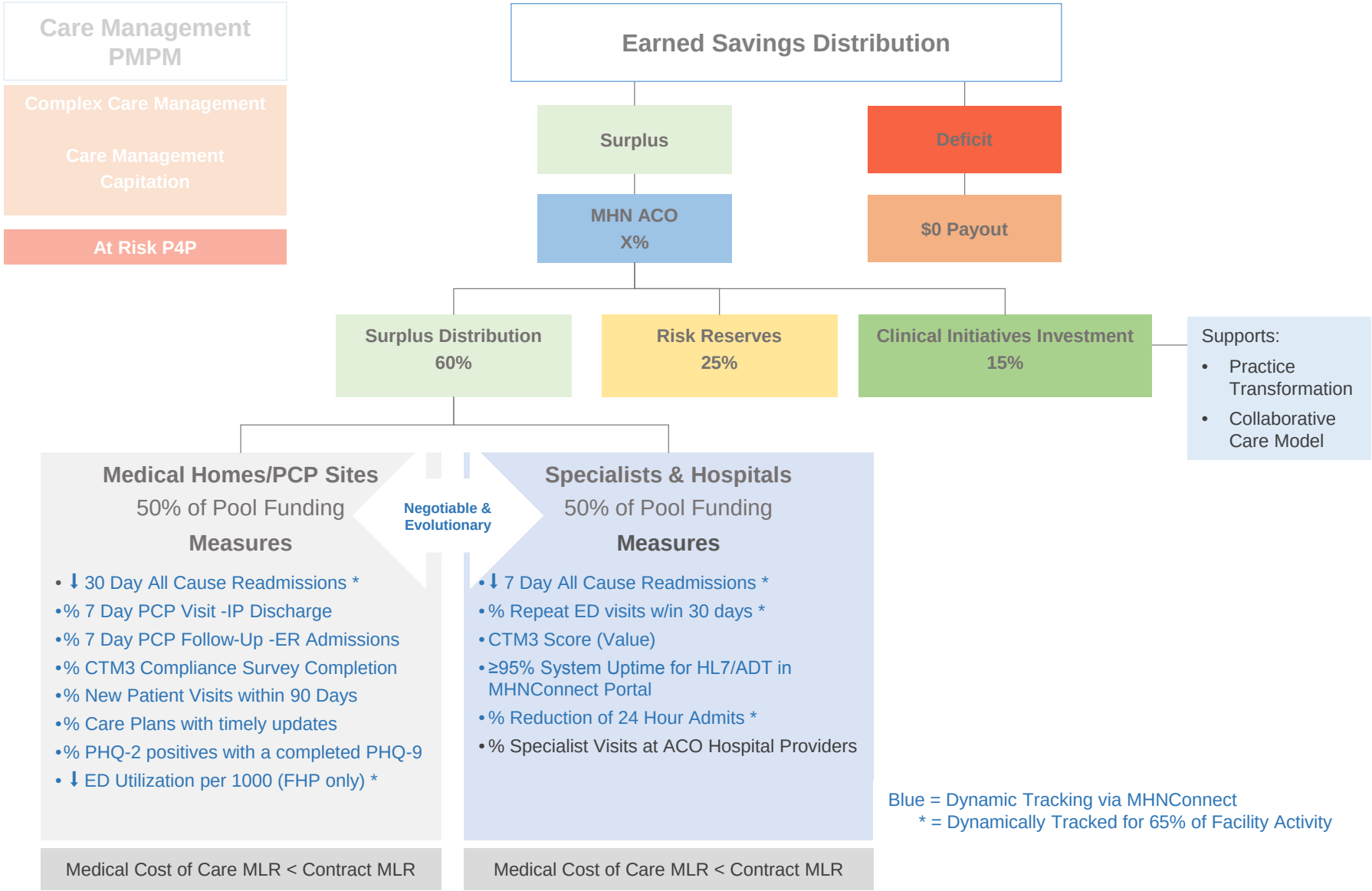


*The Advisory Board Company, "Successful population health managers prevent the escalation of rising-risk patients"
**Denver Health Health Affairs, 34, no.8 (2015):1312-1319

Value Based Contracting Construct *Earned Savings Funding*



Earned Shared Savings Funding *Enabling Collaborative Delivery Redesign*



Earned Shared Savings Distribution & Calculation *Increasing Reward for Outcomes*

Years 1 & 2

TARGET

50% — Provider Attainment Pool

Residual Unattained Funds

50% — Cost of Care Surplus Pool

ACTUAL

35% — Provider Attainment Pool

65% — Cost of Care Surplus Pool

Year 3

TARGET & ACTUAL

65% — Provider Attainment Pool

35% — Cost of Care Surplus Pool

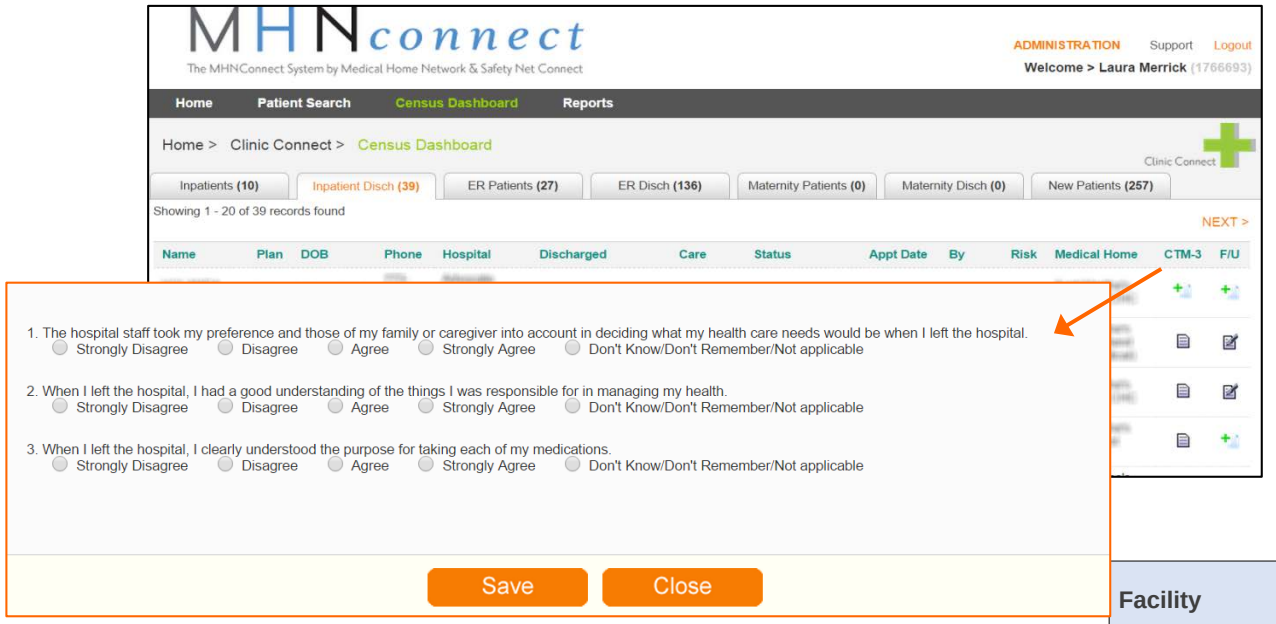
Calculations & Weights

Scoring

0x	Failed Goal
1x	Reached Goal
2x	EXCEEDED Goal

Domain	Total Domain Measures	Measurement Weighting
Process	7	5-10%
Outcomes	6	5-10%
Realtime Connectivity/Exchange	1	5%
Cost of Care	2	35%

Driving Critical Workflows via Shared Savings Measures *Transitions of Care*



MHN's process drives performance monitoring.

1) Hospital discharges patient and provides instruction on health management and medication.
2) Clinic calls patient within 48 hrs. and schedules a timely follow up appointment post-ED or IP hospital visit.
3) Clinic completes CTM-3 to identify and address patient questions about their follow up care.
4) MHNConnect captures CTM-3 score, allowing us to evaluate hospital care transition practices.

Facility	Discharges with completed CTM3	Average CTM3 Score
Hospital A	393	77.16
Hospital B	67	74.92
Hospital C	82	71.12
Hospital D	91	70.79
Hospital E	82	69.17
Hospital F	99	72.45
Hospital G	404	79.82
All Portal Facilities	**1,218**	**73.63**

Earned Shared Savings *Timely Performance Reporting*

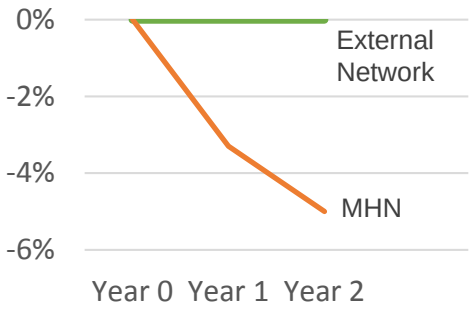
MHN ACO Shared Savings Audit - Sample Medical Home
PY3 Q1 (July 2016 - September 2016)

	Reduce 30 Day Admissions	CTM3 Compliance	IP Timely Follow-Up	ER Timely Follow-Up Rate	New Member Visit within 90 Days	ED Utilization/1000	%PHQ 2 Positives with Completed PHQ 9	% Care Plans with Timely Updates	Medical Cost of Care	Total
	Initiatives									
Total Eligible Opportunities	681	435	789	1,120	4,788		316	584		
Missed Opportunities	54	132	630	870	2,562		50	102		
Clinic Result	-28.2%	69.7%	20.2%	22.3%	46.5%		84.2%	82.5%	91.2%	
Goal	-23.0%	75.0%	35.0%	50.0%	25.0%		75.0%	50.0%	85.0%	
Unearned Shared Savings	$ -	$163,503	$ 151,307	$60,196	$ -		$ -	$ -	$289,782	$ 664,787
Award	1x	0x	0x	0x	2x		1x	1x	0x	

Medicaid Results *MHN's Impact on Cost, Outcomes & Engagement*

Total Cost of Care – State Medicaid Pilot

The difference in cost of care for MHN versus other Medicaid patients in IL is 3.5% in Year 1 and 5% in Year 2



5% LOWER COST
(risk adjusted)

Difference is MHN risk adjusted cohort vs Non-MHN risk adjusted cohort percent change in cost of care
Source: Findings of the MHN HFS Care Coordination Pilot for the Illinois Health Connect population

Patient Engagement - ACO

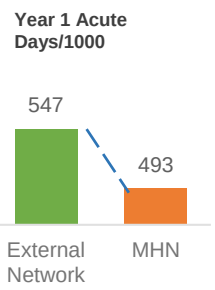
MHN's engagement efforts reach over 2½ times as many patients as other IL Medicaid providers/plans.

MHN ACO:
79% COMPLETE

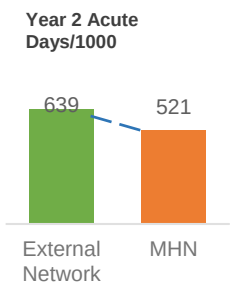
Period: July 1, 2014 – May 19, 2015

ACA Utilization - ACO

Inpatient Days/1000

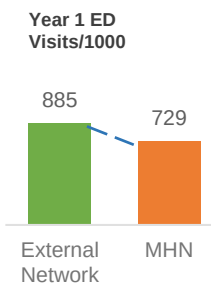


YEAR 1 Jul14–Jun15
10% BETTER OUTCOME

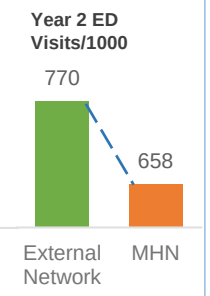


YEAR 2 Jul15– Mar16
18% BETTER OUTCOME

ED Visits/1000



YEAR 1 Jul14–Jun15
18% BETTER OUTCOME



YEAR 2 Jul15–Mar16
15% BETTER OUTCOME

Total Cost of Care - ACO

Contract Year 1

$17.7m

SAVINGS

+12.1% variance from target

Contract Year 2 Q1

$6.6m

SAVINGS

+18% variance from target

Raylon Lewis Jr.
Lawndale Christian Patient

Thank you.

Questions?

To learn more, please contact Cheryl Lulias at clulias@mhnchicago.org

NEW YORK STATE | Department of Health | Medicaid Redesign Team

Q&A and Discussion