NEW YORK STATE | Department of Health | Medicaid Redesign Team

Value Based Purchasing in New York State:

Next Steps for the NYS Medicaid VBP Roadmap

August, 2015

Overview

- Brief overview of the Medicaid Payment Reform Roadmap
- Value-Based Payment (VBP) arrangements: the different options
- Role of the PPS and the MCO

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Brief overview of the Medicaid Payment Reform Roadmap

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The DSRIP Challenge – Transforming the Delivery System

- DSRIP is a major effort to collectively and thoroughly transform the NYS Medicaid Healthcare Delivery System
  - From fragmented and overly focused on inpatient care towards integrated and community, outpatient focused
  - From a re-active, provider-focused system to a pro-active, community- and patient-focused system
  - Reducing avoidable admissions and strengthening the financial viability of the safety net

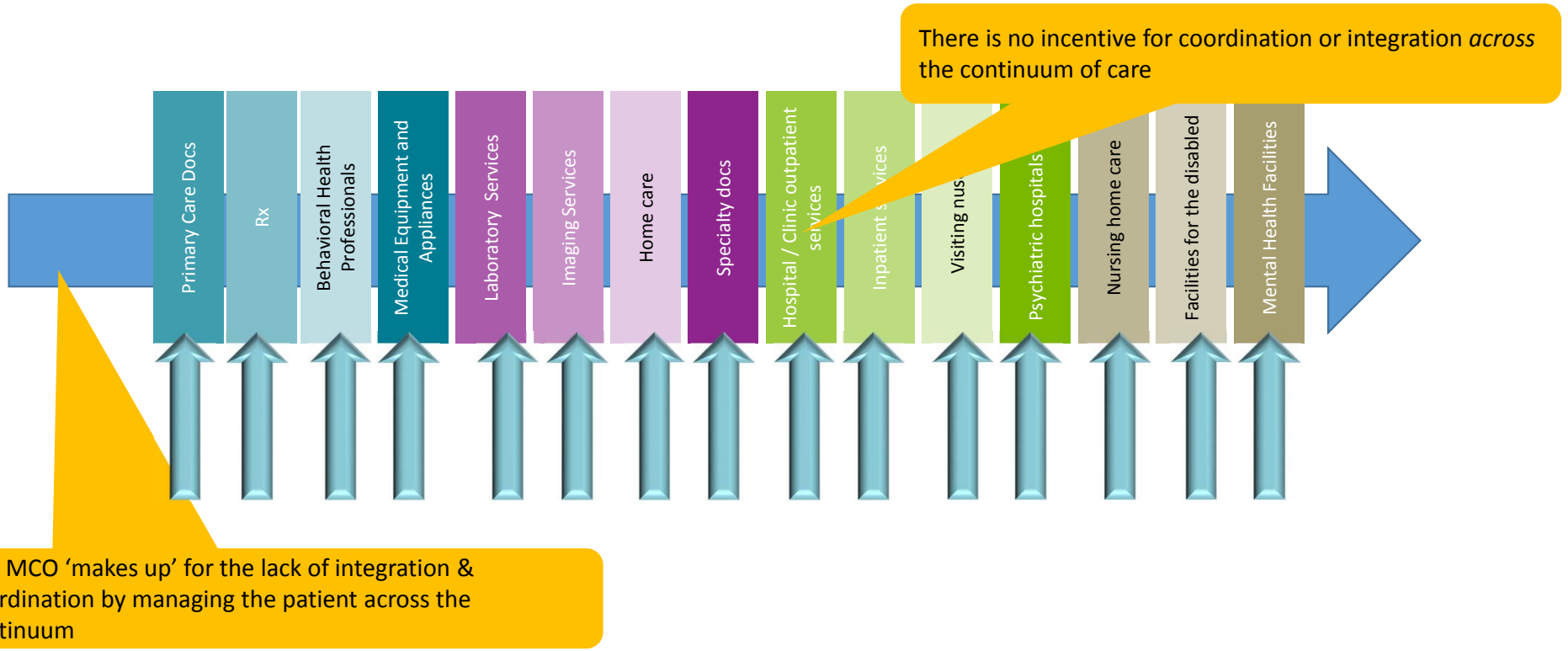
- Building upon the success of the MRT, the goal is to collectively create a future-proof, high-quality and financially sustainable care delivery system

The DSRIP Challenge – Transforming the Payment System

- A thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well

- Many of our system's problems (fragmentation, high (re)admission rates, poor primary care infrastructure, lack of behavioral and physical health integration) are rooted in how we pay for services
  - Paying providers Fee For Service incentivizes volume over value, pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
  - Our current payment system does not adequately incentivize prevention, coordination or integration

In FFS world (and sometimes still in early VBP steps), every individual provider has its own MCO contract and funding….



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The DSRIP Challenge – Transforming the Payment System

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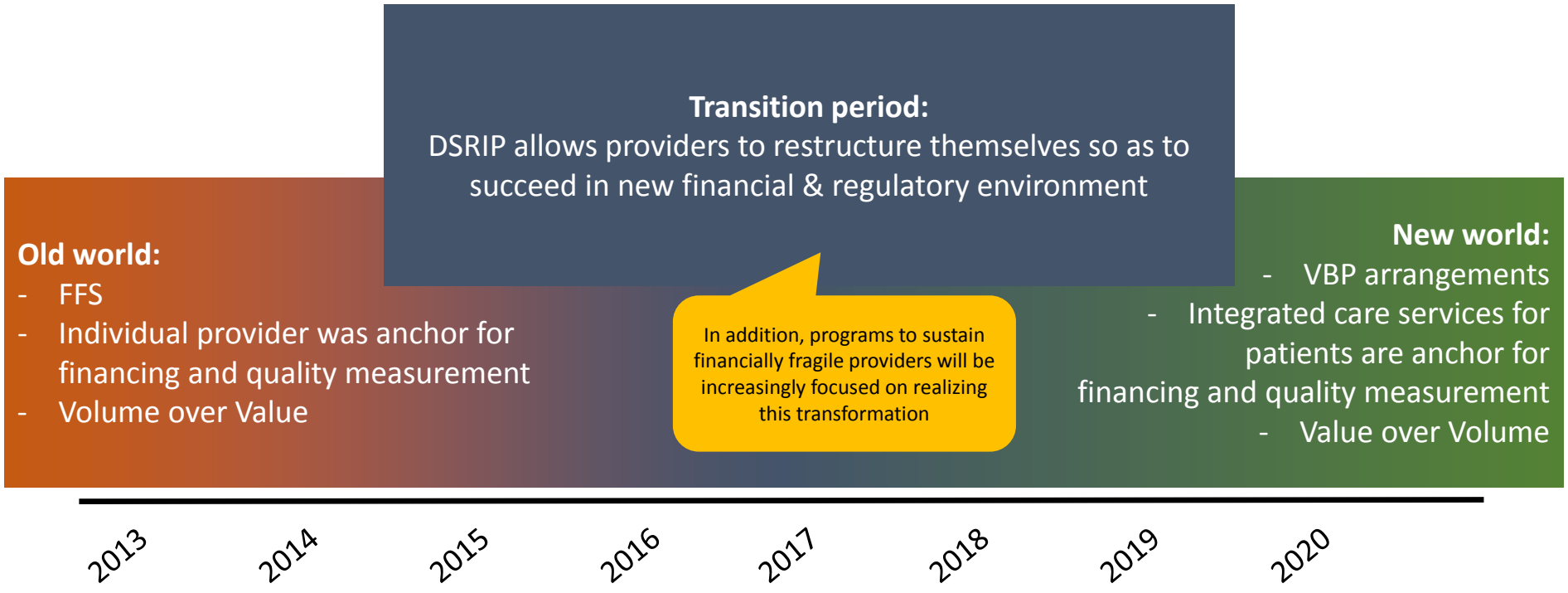
The DSRIP Challenge – Transforming the Payment System



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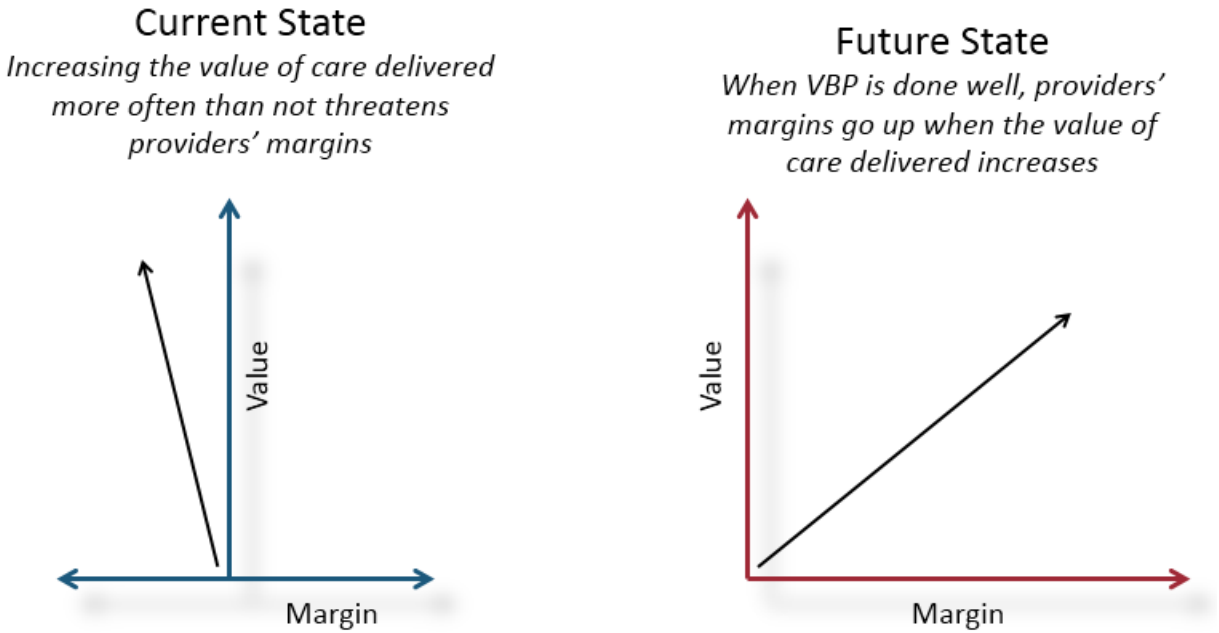
A new business model

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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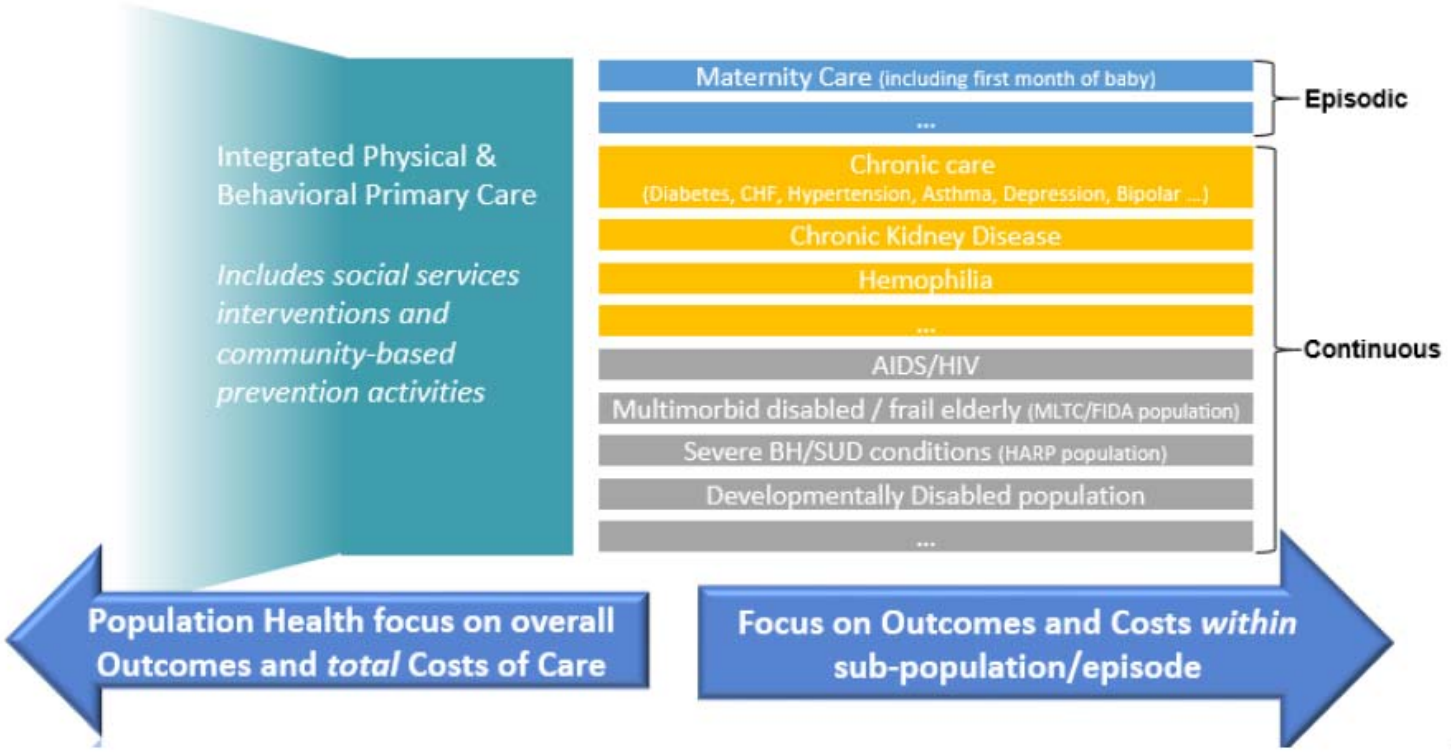
How should an integrated delivery system function – DSRIP Vision



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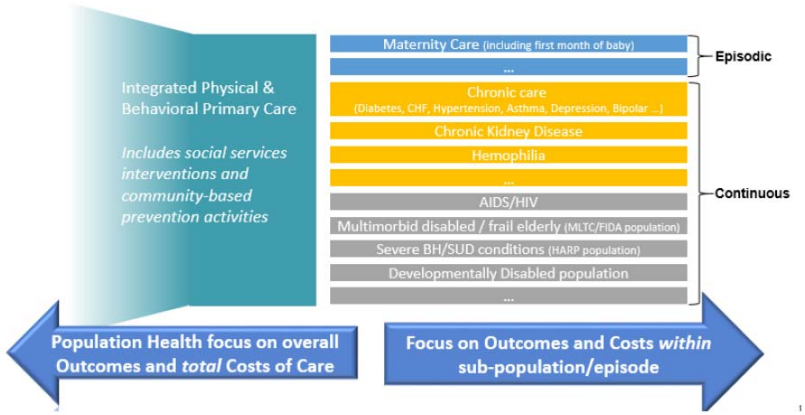
The Path towards Payment Reform

- There will not be one path towards 90% Value Based Payments. Rather, there will be a variety of options that MCOs and PPSs/providers can jointly choose from
- PPSs/providers and MCOs will be stimulated to discuss opportunities for shared savings arrangements (often building on already existing MCO/provider initiatives):
  - For the total care for the total attributed population of the PPS (or a hub or other entity)
  - Per integrated service for specific condition (bundle): maternity care; diabetes care
  - For integrated PCMH/APC
  - For the total care for a subpopulation: HIV/AIDS care; care for HARP population



MCOs and providers may choose to make VBP arrangements between MCOs and groups of providers within the PPS rather than between MCO and PPS

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The Path towards Payment Reform

- In addition In addition to choosing what integrated services to focus on, the MCOs and PPSs/providers 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)

- Guiding principles:
  - ≥80-90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
  - 35% of total costs of fully capitated plans captured in VBPs should be in Level 2 VBPs or higher

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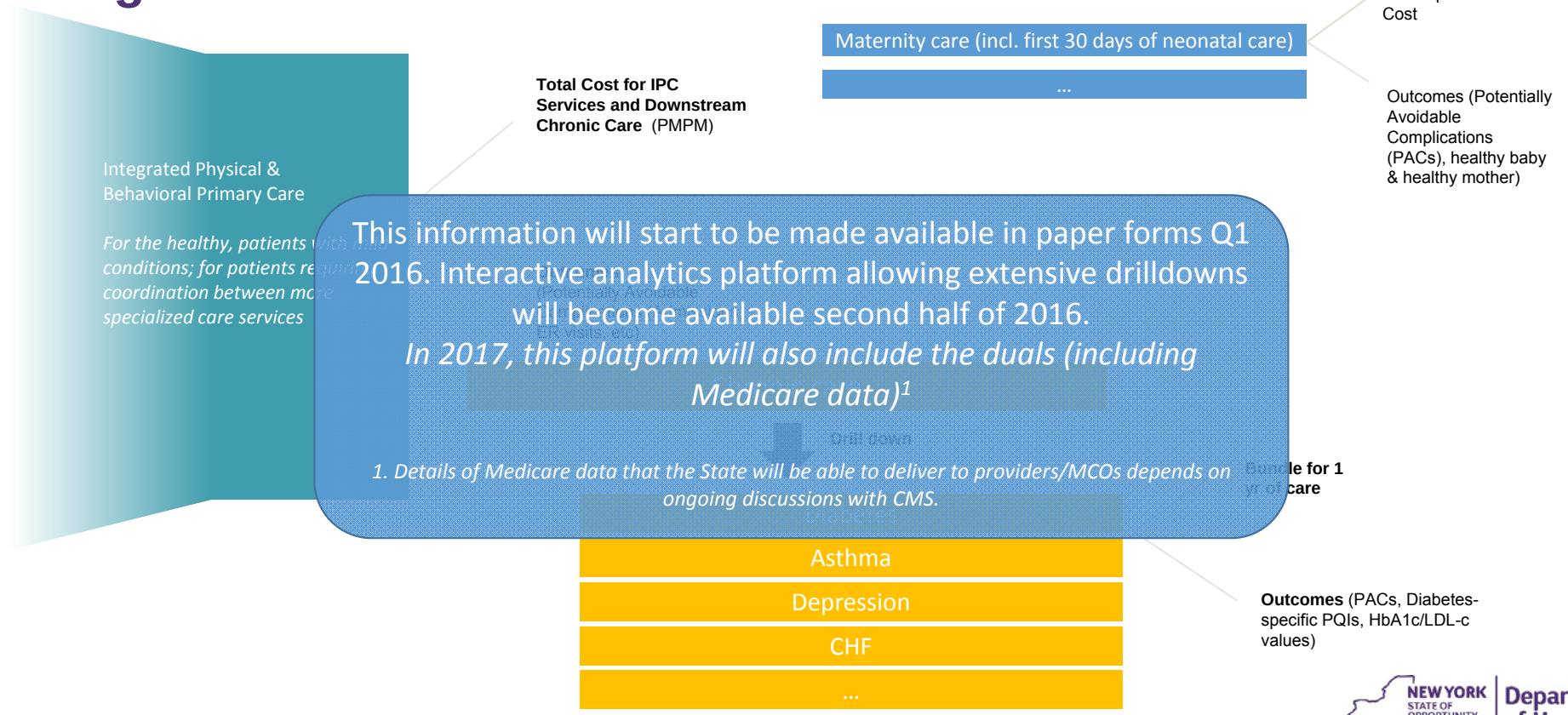
Outcome and cost information (fully aligned with DSRIP) will be provided to Providers / MCOs for all types of VBP arrangements discussed



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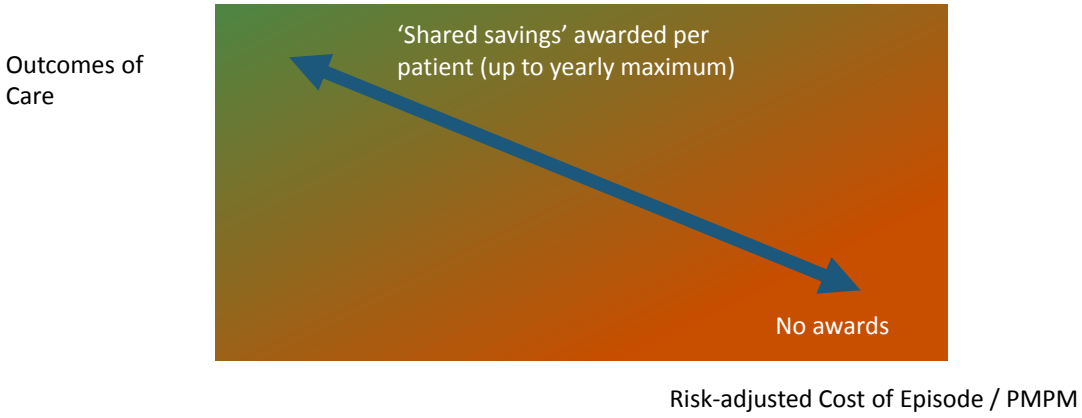
Incentives for Beneficiaries

- Beneficiary incentives are an important part of successful payment reform
  - Focus not on negative incentives (co-pays etc) but on positive incentives
  - Embed the most powerful innovative Value Based Insurance Design mechanisms as prerequisite in benefit packages
  - Focus both on wellness & health lifestyle improvement…
  - **… and on stimulating the right choices for high value providers** (introducing 'inclusive shared savings' in which the beneficiary shares as well)



Value-Based Payment (VBP) arrangements: the different options

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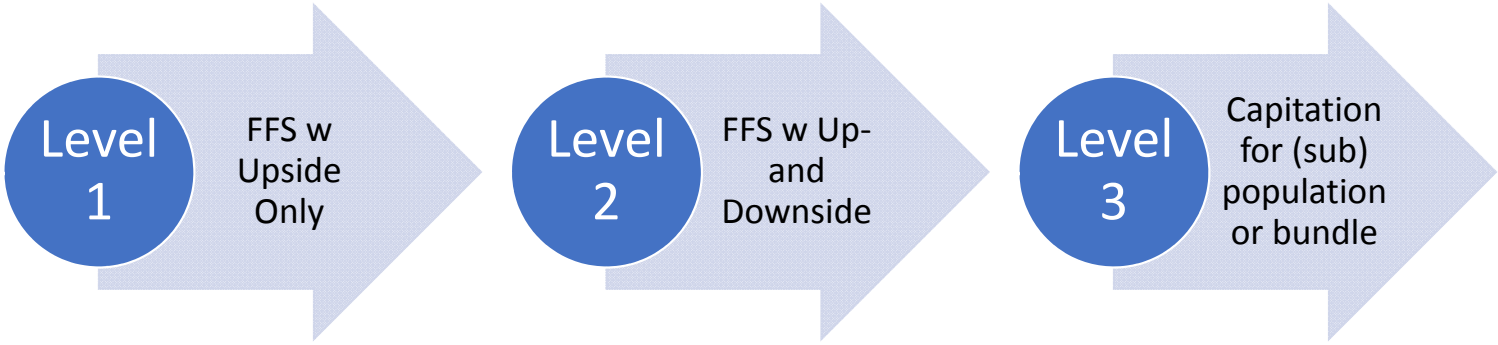
Different options – Same Principles



- **Total Care for Total Population**
- Advanced Primary Care
- Bundles
  - Acute Bundles
  - Chronic Bundles
- Total Care for Subpopulation

ACO like model; population health focus at PPS, Hub or other (integrated!) level

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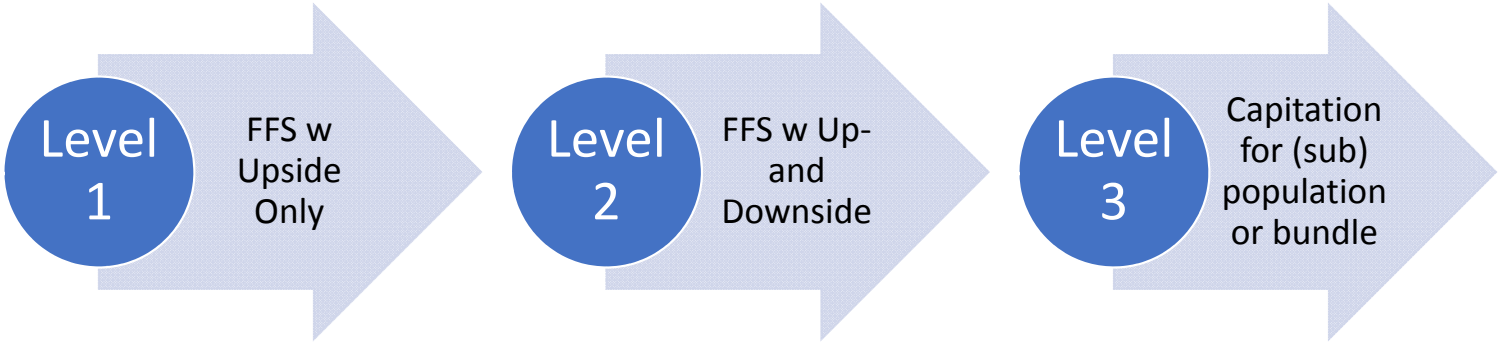
Different options – Same Principles



- Total Care for Total Population
- **Advanced Primary Care**
- Bundles
  - Acute Bundles
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- Total Care for Subpopulation

Building on NYS tradition of strengthening Primary Care and APC model further developed in Statewide Health Innovation Plan

APC contract includes focus on downstream costs including reducing the volume of downstream bundles. *Shared savings can be significant*

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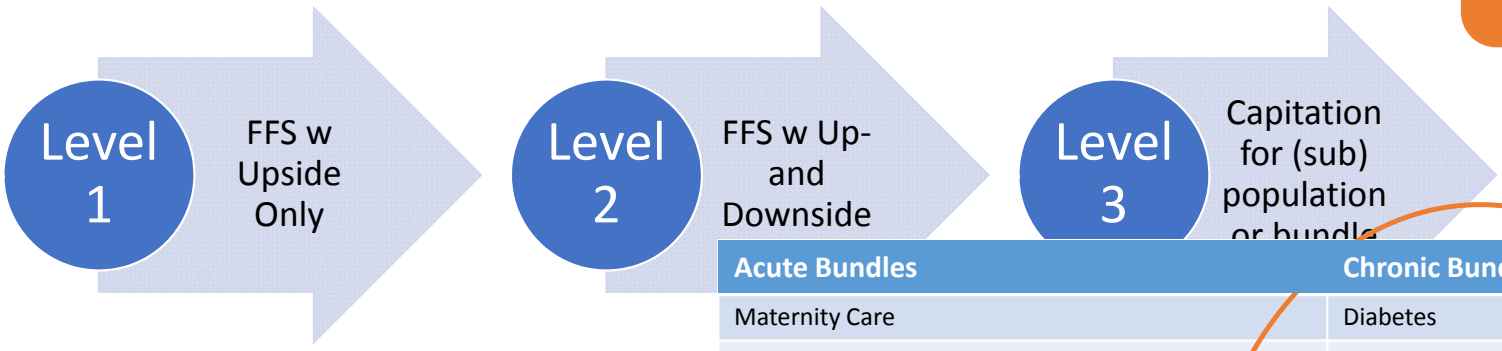
Different options – Same Principles



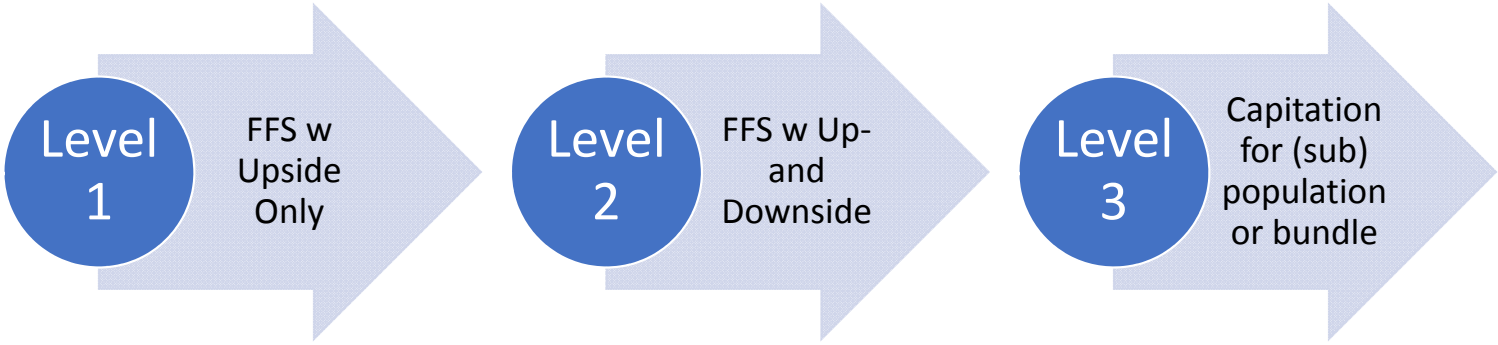
Typically not contracted separately, but as one 'Chronic Bundle'; typically contracted with IPC

- Total Care for Total Population
- Advanced Primary
- **Bundles**
  - Acute Bundles
  - Chronic Bundles
- Total Care for Subpopulation

Newest Prometheus Grouper

Acute Bundles	Chronic Bundles
Maternity Care	Diabetes
Hepatitis C (TBD)	COPD
	Asthma
	Chronic Depression
	Substance Abuse
Specialty Chronic Bundles	Bipolar Disorder
Chronic Kidney Disease (TBD)	Hypertension
	Coronary Artery Disease
	CHF
	Arrhythmia / Heart Block
	Gastro-Esophageal Reflux Disease
	Low Back Pain
	Osteoarthritis

Different options – Same Principles



- Total Care for Total Population
- Advanced Primary Care
- Bundles
  - Acute Bundles
  - Chronic Bundles
- **Total Care for Subpopulation**

Subpopulations
HIV-AIDS
HARP
MLTC/FIDA
Developmentally Disabled Population (TBD)

As the first model, but focused on a specific special needs subpopulation (condition specific ACO)

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There are many combinations possible – for example

- Total Care for Total Population (VBP Level 1 or higher)
- Total Care for Total Population (Level 2), with carve-out for e.g. two Episodic Bundles (Level 2)
- PCMH/APC and some episodic / subpopulation care separately contracted with IPC, PPS or Hub (Level 2); remaining care Level 1 VBP Total Care Total Population
- PCHM/APC and episodic / subpopulation care all separately contracted with PPSs or Hub (various levels)

Role of the PPS and of the MCO

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Roadmap Timeline – DSRIP Implementation Plan

2015	• Finalizing implementation details of VBP Roadmap
2016	• First large scale pilots start • Every MCO-PPS combination will submit a growth plan outlining their path towards 90% value-based payments (does NOT have to include PPS level contracting)
2017	• Every MCO-PPS combination will have at least one Level 1 VBP arrangement in place for IPC care and one other care bundle or subpopulation; or a total care for the total population arrangement (does NOT have to include PPS level contracting)
2018	• At least 50% of State's MCO payments to providers will be contracted through at least Level 1 VBPs
2019	• At least 80-90% contracted through Level 1 VBPs • At least 35% (of full capitation MCOs) contracted through Level 2 or higher

Statewide DSRIP payments are dependent on achieving these goals

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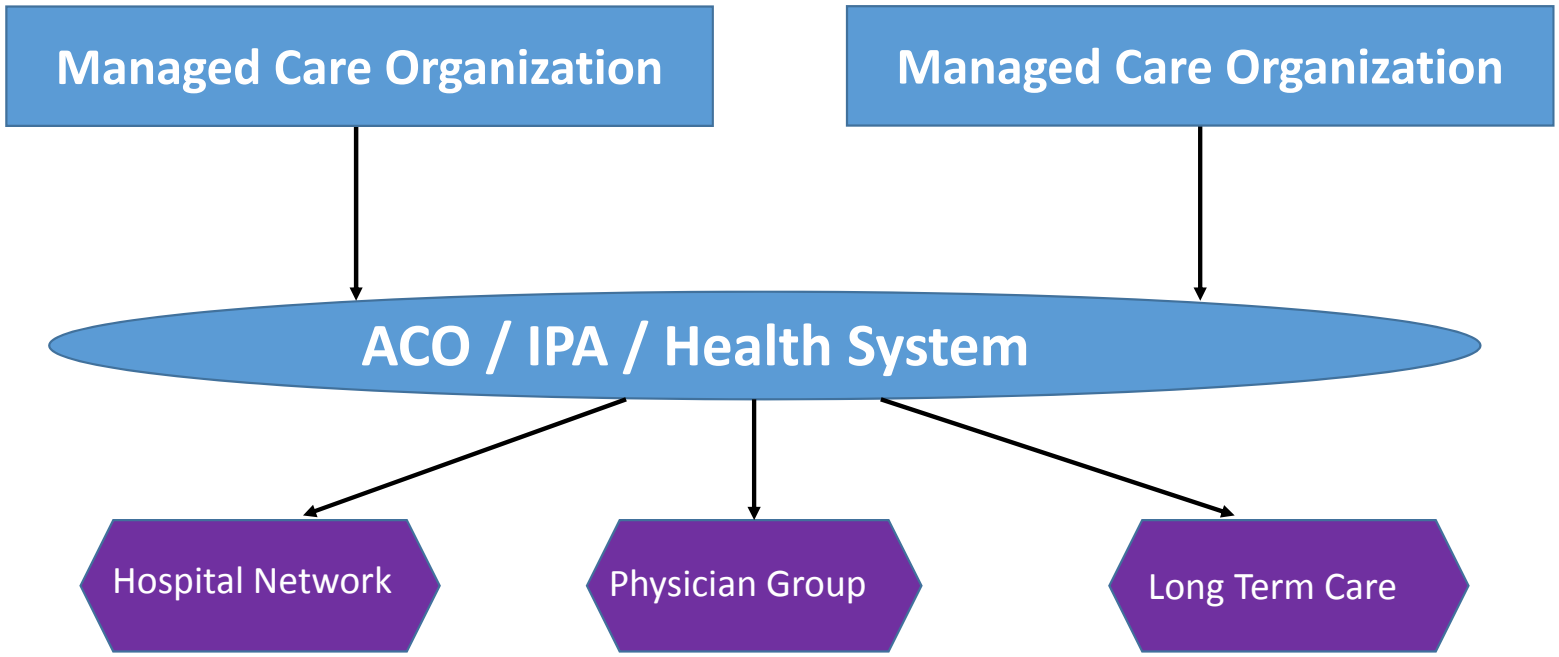
The VBP Contractor

- VBP contracts will be created between MCOs and a 'VBP Contractor':
  - Medicaid ACO
  - IPA
  - Individual provider



Example

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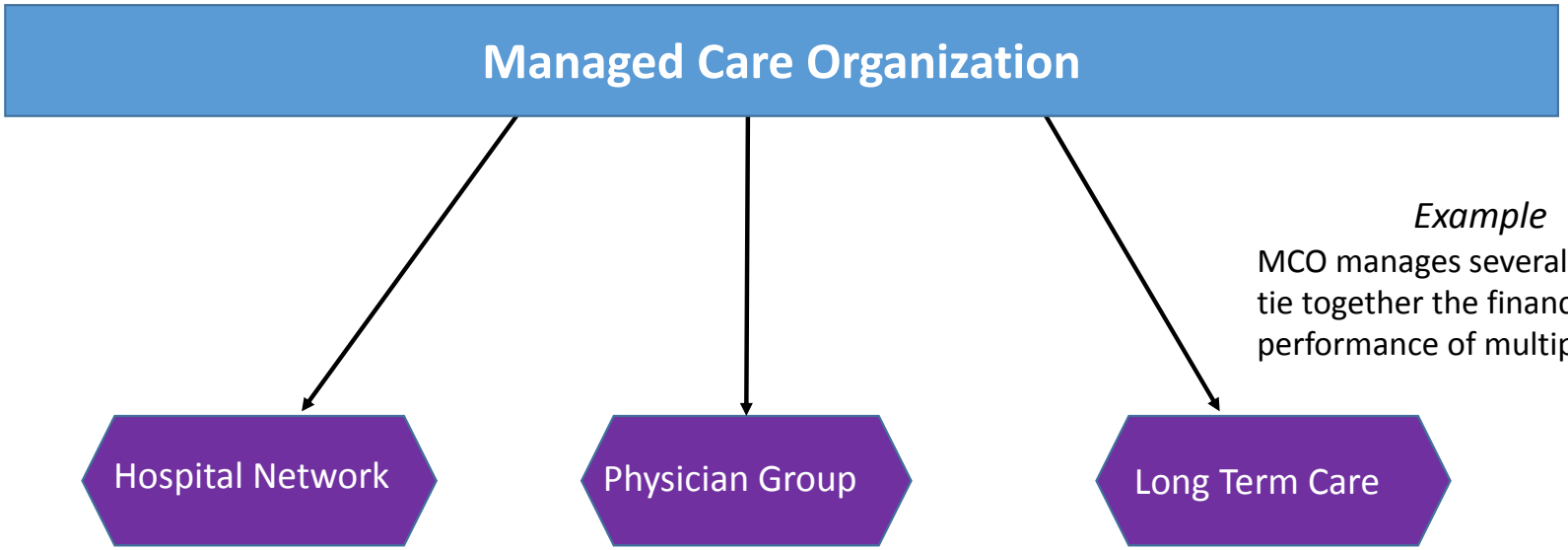
The VBP Contractor

- VBP contracts will be created between MCOs and a 'VBP Contractor':
  - Medicaid ACO / IPA / Individual Provider
  - Individual providers brought together by MCO (less feasible for Level 2; impossible for level 3)



Example

MCO manages several contracts that tie together the financial and quality performance of multiple providers

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Role of PPS

- VBP contracts will be created between MCOs and a 'VBP Contractor':

  - Medicaid ACO
  - IPA
  - Individual provider(s)

Can be at the PPS level, but that is no obligation
- Hubs
- Other meaningful provider-clusters within (or between) PPSs

Within DSRIP framework, PPS does have responsibility to initiate steps towards VBP between providers and MCOs

PPS remains responsible for safeguarding population-health infrastructure build with DSRIP dollars

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Role of MCO

- VBP contractors *and* MCOs will be rewarded for high-value care (efficient and high quality) …
- … and payments will gradually be adjusted downwards when care remains inefficient and/or low quality

- *MCO will be incentivized to increase value of care delivered by:*
  - *Itself more aggressively contracting VBP arrangements*
  - *Channeling patients to high value providers*
  - *Ultimately, adjusting payments downwards for persistently poor performers*

None of this will be a mechanic process: providers may need additional support to improve, or be in a special position due to geography or patient selection

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