



**Department
of Health**

**Medicaid
Redesign Team**

VBP Bootcamp

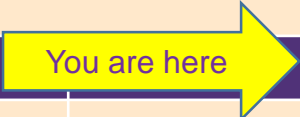
Social Determinants of Health (SDH) & Community Based Organizations (CBOs)

Class 2

January 9, 2018

Agenda

Area	Details	
Timing	Two 1-hour classes will be held.	
	Class 1	Class 2
Topics	<ul style="list-style-type: none"> • CBO & SDH Roadmap Requirements • Examples of SDH Interventions & Strategies • Provider Led Knowledge Sharing 	<ul style="list-style-type: none"> • Top 10 Things Providers & CBOs Should Know • CBO Contracting Methods • Reporting SDH Interventions and Tier 1 CBOs to the State • Existing Resources Available for CBOs
Speakers	<p>DOH</p> <ul style="list-style-type: none"> - Elizabeth Misa and Denard Cummings <p>External</p> <ul style="list-style-type: none"> - God's Love We Deliver 	<p>DOH</p> <ul style="list-style-type: none"> - Elizabeth Misa and Denard Cummings <p>External</p> <ul style="list-style-type: none"> - Green & Healthy Homes Initiative



Top 10 Things Providers & CBOs Should Know

Top 10 Things Providers/CBO Should Know

1. Addressing SDH does **NOT** require a CBO to enter into risk arrangements.
2. A **Tier One CBO** is defined as a **non-profit, non-Medicaid billing**, community based social and human service organization.
3. A CBO with **any Medicaid billing** component will **NOT** be considered a **Tier One CBO**.
4. A **Tier Two** and **Three CBO** may be contracted to address a social determinant of health, and will both have roles to play in VBP. In fact, Lead VBP Contractors & Payers are encouraged to include Tier Two and Three CBOs.
5. A CBO can be contracted to address a social determinant of health in **one** or **multiple VBP arrangements**.
6. Developing a **Value Proposition** is key! SDH Interventions should have measurable success and cost savings to **demonstrate ROI**.
7. CBOs may **contract with MCOs or VBP Contractors** to implement an SDH Intervention.
8. **A community needs assessment (CNA)** is critical to help inform the development of an intervention that is impactful to the members in your region.
9. Innovative **SDH interventions** can significantly **improve health** in populations & **reduce overall costs**.
10. Filling out the **SDH Intervention Template** is **REQUIRED** when submitting the **DOH 4255 certification form** and **VBP Contract**.

Review of CBO & SDH VBP Roadmap Standards

Quick Review of CBO and SDH Standards

- 1. All new and existing VBP Level 2 & 3 arrangements MUST include:**
 - a) At least one Social Determinant of Health Intervention
 - b) At least one Tier 1 Community Based Organization (starting January 2018)

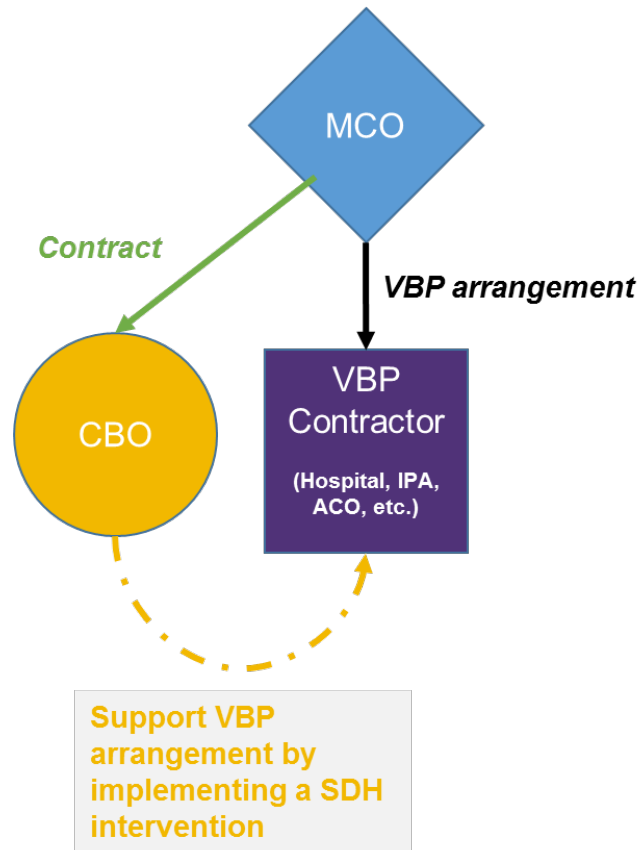
- 2. VBP Level 2 & 3 contracts without SDH and CBO requirements will not meet the definition of VBP.**

- 3. MCOs that do not meet the VBP goals outlined in the Roadmap will be subject to penalties.**

CBO Contracting Strategies

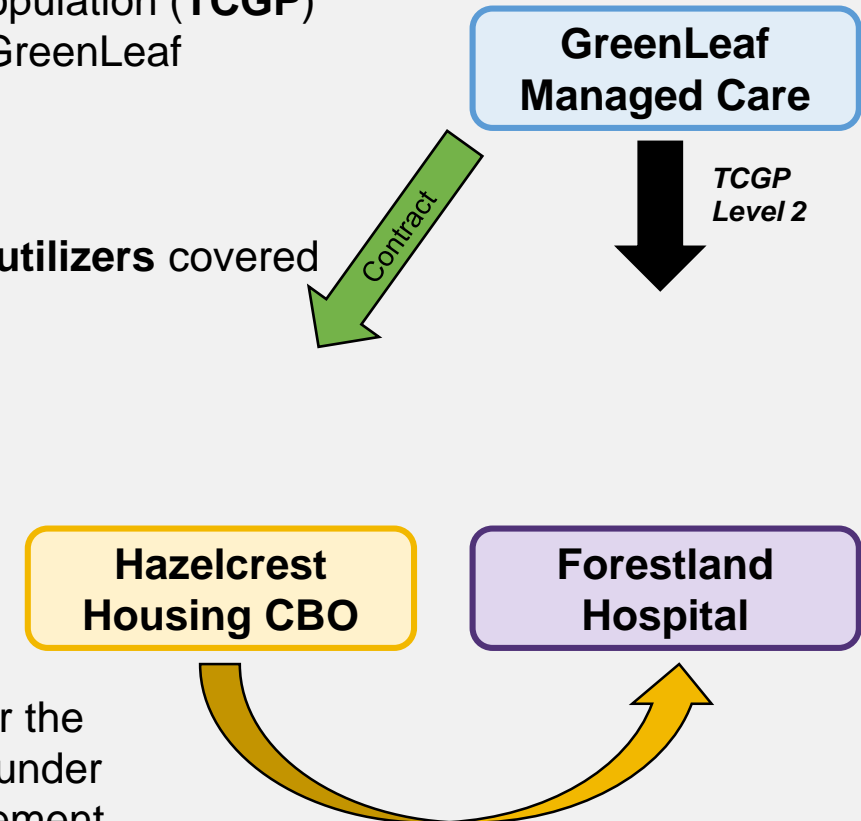
CBO Contracting Strategies – Scenario A

- CBOs may support VBP arrangements by:
 - A** contracting directly with an MCO to support a VBP arrangement



Hypothetical Example

- Forestland Hospital enters into a **Level 2 Total Care for General Population (TCGP) VBP arrangement** with GreenLeaf Managed Care
- Many of the **highest ED utilizers** covered under the arrangement have **lack of access to affordable housing**
- Greenleaf contracts with Hazelcrest Housing CBO to implement a **Housing Intervention** for the highest utilizers covered under Forestland's VBP arrangement

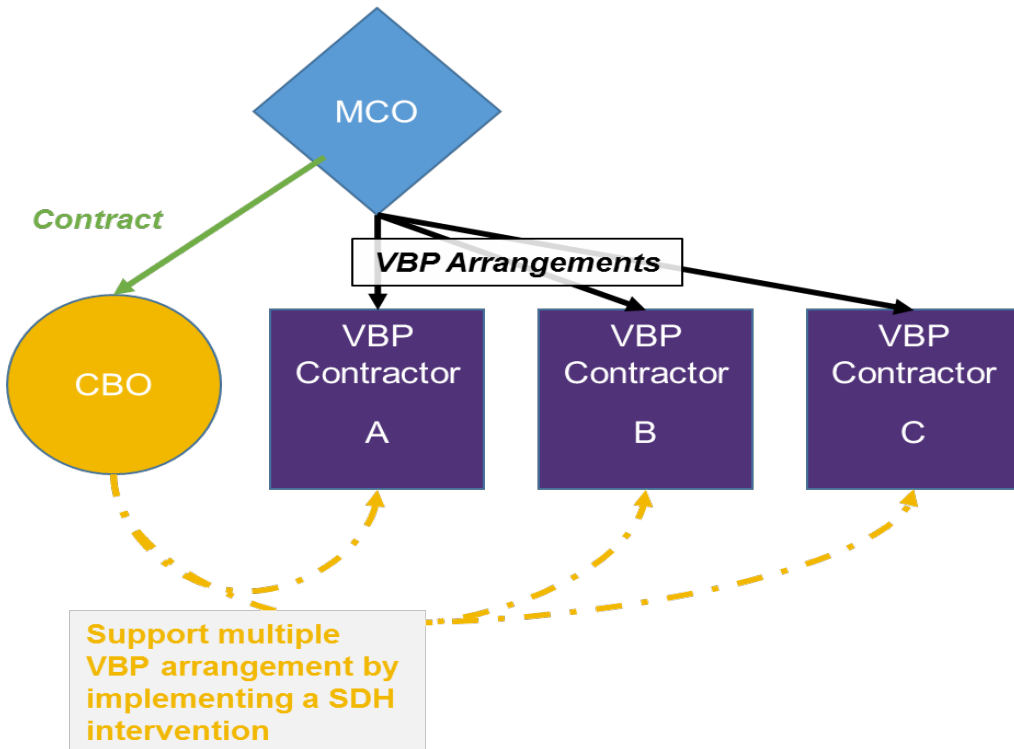


CBO Contracting Strategies – Scenario B

- CBOs may support VBP arrangements by:

A contracting directly with an MCO to support a VBP arrangement

B contracting directly with an MCO to support multiple VBP arrangements

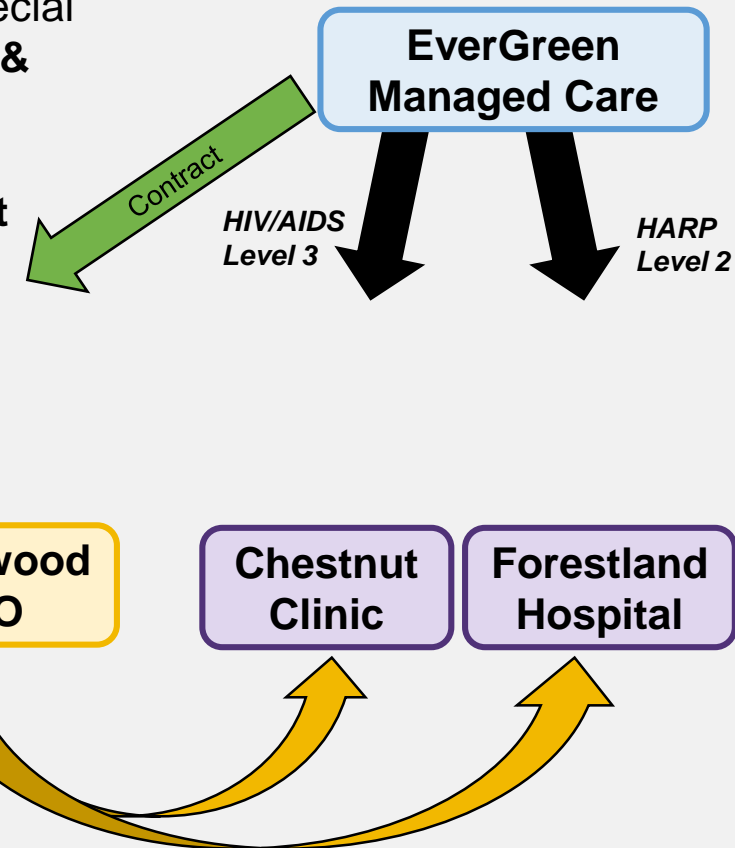


Hypothetical Example

- EverGreen contracts **multiple VBP arrangements** targeted at the Special Needs Subpopulations (**HIV/AIDs & HARP**)

- A **community needs assessment** has revealed that a large **challenge** facing the local Special Needs Subpopulation is **food insecurity**

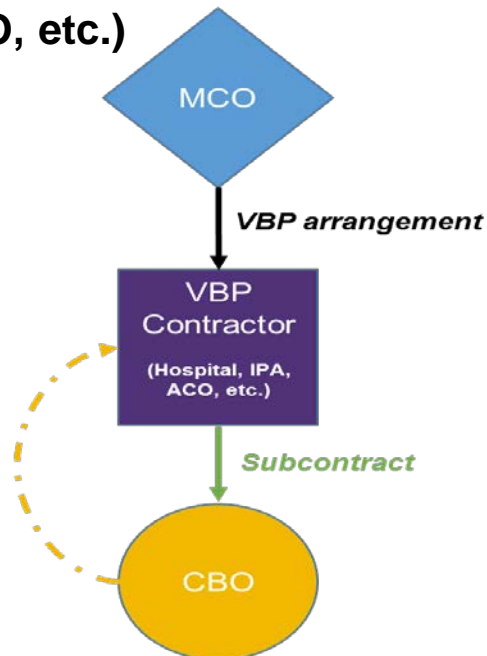
- EverGreen contracts with Applewood CBO to implement a **Nutrition Intervention** for the local Special Needs Subpopulation **served by the multiple VBP arrangements**



CBO Contracting Strategies – Scenario C

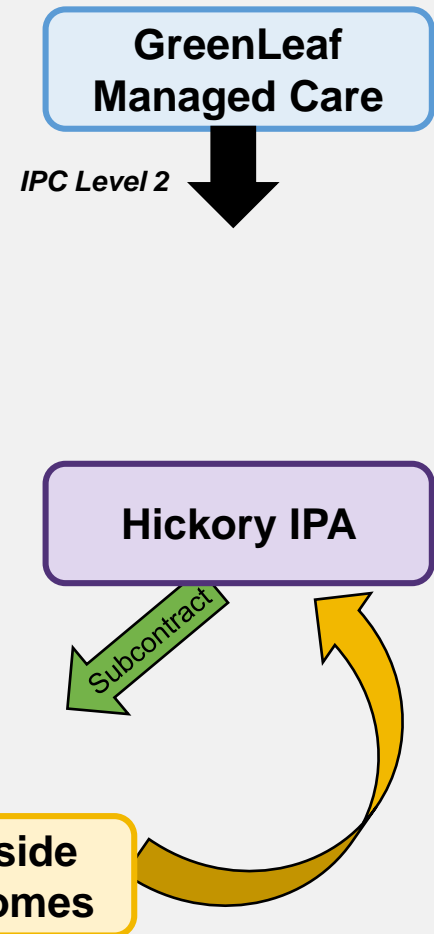
• **CBOs may support VBP arrangements by:**

- Ⓐ contracting directly with an MCO to support a VBP arrangement
- Ⓑ contracting directly with an MCO to support multiple VBP arrangements
- Ⓒ **subcontract with a VBP Contractor (Hospital, IPA, ACO, etc.)**



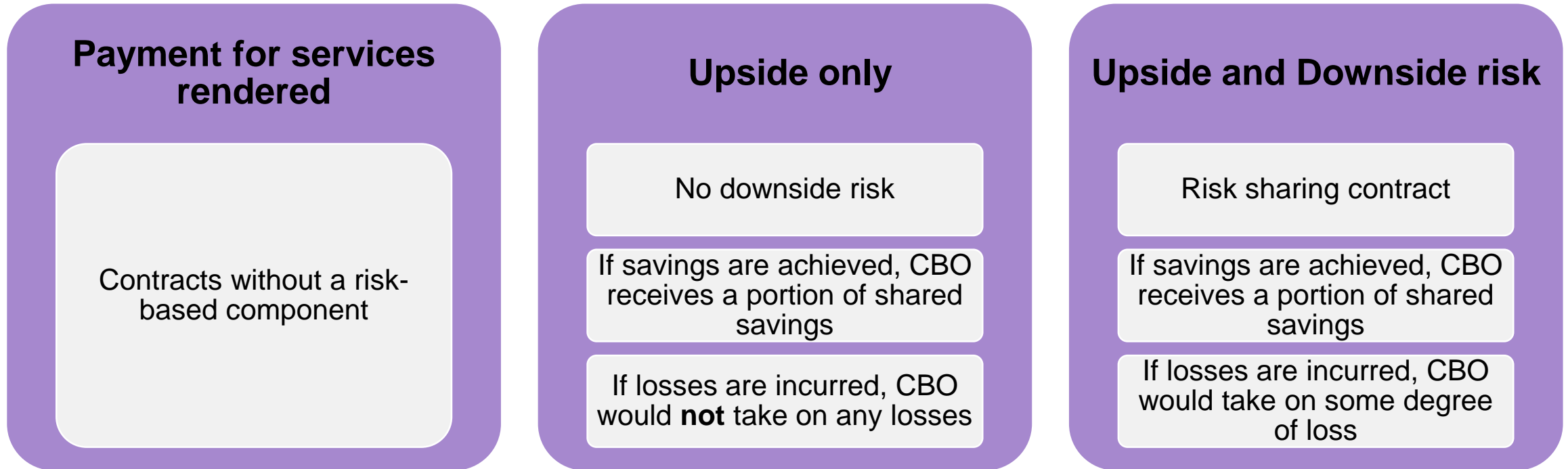
Hypothetical Example

- Hickory IPA enters into a **Level 2 Integrated Primary Care (IPC) VBP arrangement** with GreenLeaf Managed Care
- Hickory IPA is aware that **Asthma is a chronic care episode included in the IPC arrangement**, and is exploring innovative ways to prevent complications associated with asthmatics
- Mountainside Healthy Homes is a CBO that is known regionally for **home environment-based interventions**
- Hickory IPA subcontracts with Mountainside Healthy Homes to **implement home-based interventions targeted at improving air quality in the homes of asthmatics**



CBO Contracting Options

- CBO contracts are **not** required to include risk
- CBO contracts could be structured as:



- CBOs may be held to performance measure standards by the party they are contracting with (VBP Contractor or MCO) in order for contracting to continue

Role of Tier 2 & 3 CBOs in VBP

The Role of Tier 2 and 3 CBOs in VBP

Tier 2 and Tier 3 CBOs can and will play an important role in VBP!

The more the merrier

- While all Level 2 & 3 arrangements must include at minimum one Tier 1 CBO, a VBP Contractor can include more than one CBO (including Tier 2 & 3 CBOs) in an arrangement

Make a friend

- Tier 2 & 3 CBOs may partner with Tier 1 CBOs to help support the implementation of an SDH Intervention

VBP Contractors are incentivized to include multiple CBOs

- By addressing SDHs, CBOs (including Tier 2 and 3 CBOs) can have a large impact on the overall health of Medicaid members, which may result in more shared savings for a VBP Contractor

Align with a VBP arrangement

- Tier 2 and 3 CBOs may be the logical partners for specific types of arrangements if the services the CBO provides are aligned with the arrangement a lead VBP contractor is implementing

Cover a larger geographic area

- Tier 2 and 3 CBOs can cover regions/communities not already impacted by an SDH Intervention

Reporting SDH Interventions and Tier 1 CBOs to the State

MCO Contracting Requirements

Inclusion of at least one Tier 1 CBO

1. Contracts must be submitted by the MCO with a completed [DOH-4255 \(Contract Statement and Certification\)](#). This is required whether the CBO is contracted with the MCO or the VBP Contractor (Hospital, IPA, ACO, etc.)
2. In Section C of the DOH-4255, the CBO should be manually identified by the MCO in the area designated “Other” along with the SDH Intervention the CBO may be addressing
3. Submitted contracts must be in compliance with the April, 2017 Provider Contracting Guidelines
4. In instances where a CBO is contracted with a VBP Contractor (as opposed to an MCO) the MCO still must submit the agreement between the VBP Contractor and the CBO to the State.

Implement at least one Social Determinant of Health intervention

1. All contracts submitted for review **must** include the [SDH Intervention Template](#). Contracts that do not include the SDH Intervention Template will not be approved.
2. The SDH Intervention Template is *“a report explaining a measureable reason why the SDH was selected, and identifies metrics that will be used to track its success.”* (VBP Roadmap, p. 42)

Please see the [VBP Resource Library, SDH & CBO page](#) for more guidance

Existing Resources Available for CBOs

Existing Resources for CBOs

I. Community Based Organization (CBO) Planning Grants

1. Grants support CBOs with contracting and administrative resources
2. Grantees:
 - Arthur Ashe Institute for Urban Health (New York City)
 - The Health and Welfare Council of Long Island (Long Island/Mid-Hudson Region)

II. New York Performing Provider System (PPS) Innovation Fund Awards

Approximately half of the PPS are using “Innovation Funds” to support the efforts of CBOs and other partners to implement innovative approaches to achieve DSRIP and VBP performance goals.

III. Negotiating for Stimulus Adjustment Dollars

- Managed Care Organizations (MCOs) receive, in aggregate, \$85 million in guaranteed VBP stimulus funding for State Fiscal Years (SFYs) 2016-17 and 2017-18
- CBOs can negotiate with MCOs to receive a share of these dollars to facilitate investment in SDH Interventions

What CBOs Need to Know to Be Successful in VBP



Whiteboard video [link](#)

Lessons From the Field



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Green & Healthy Homes Initiative®

Value-Based Purchasing Bootcamp
Addressing Health Risk Factors

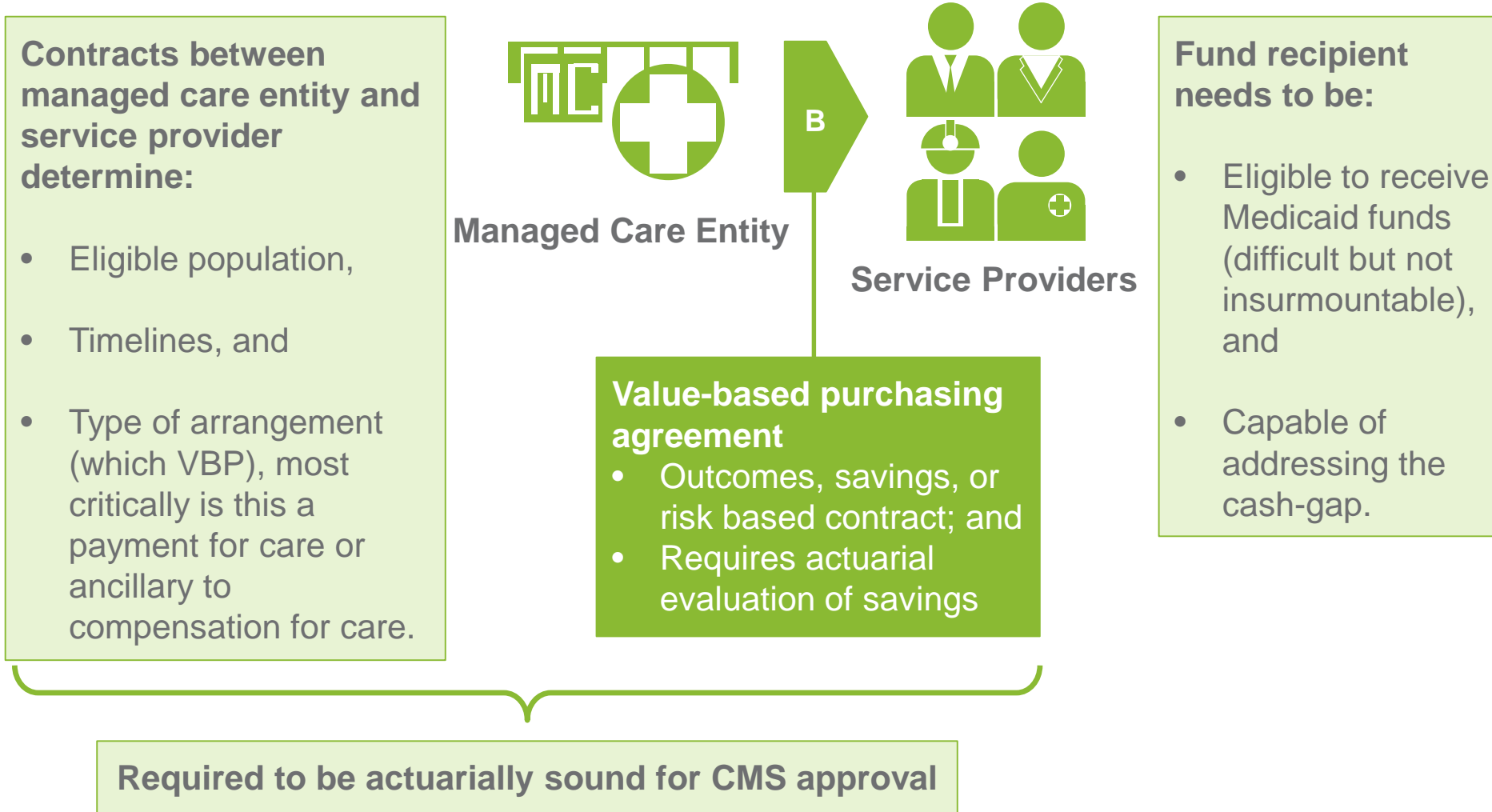
An Overview and Roadmap

January 9, 2017

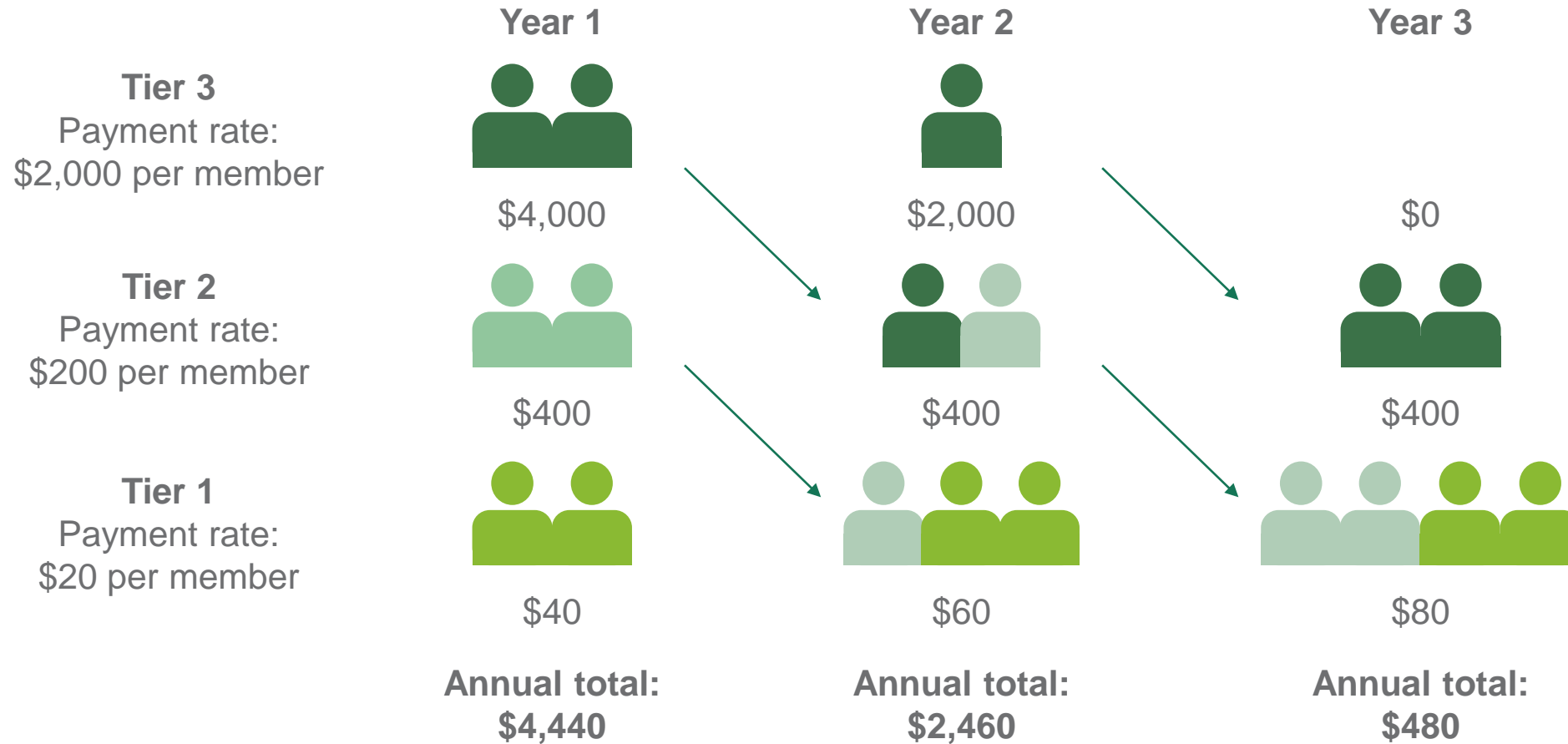
GHHI has 5 sites and two innovation projects in New York.



The value-based purchasing contract enables community-based service providers to receive Medicaid payments based on outcomes.



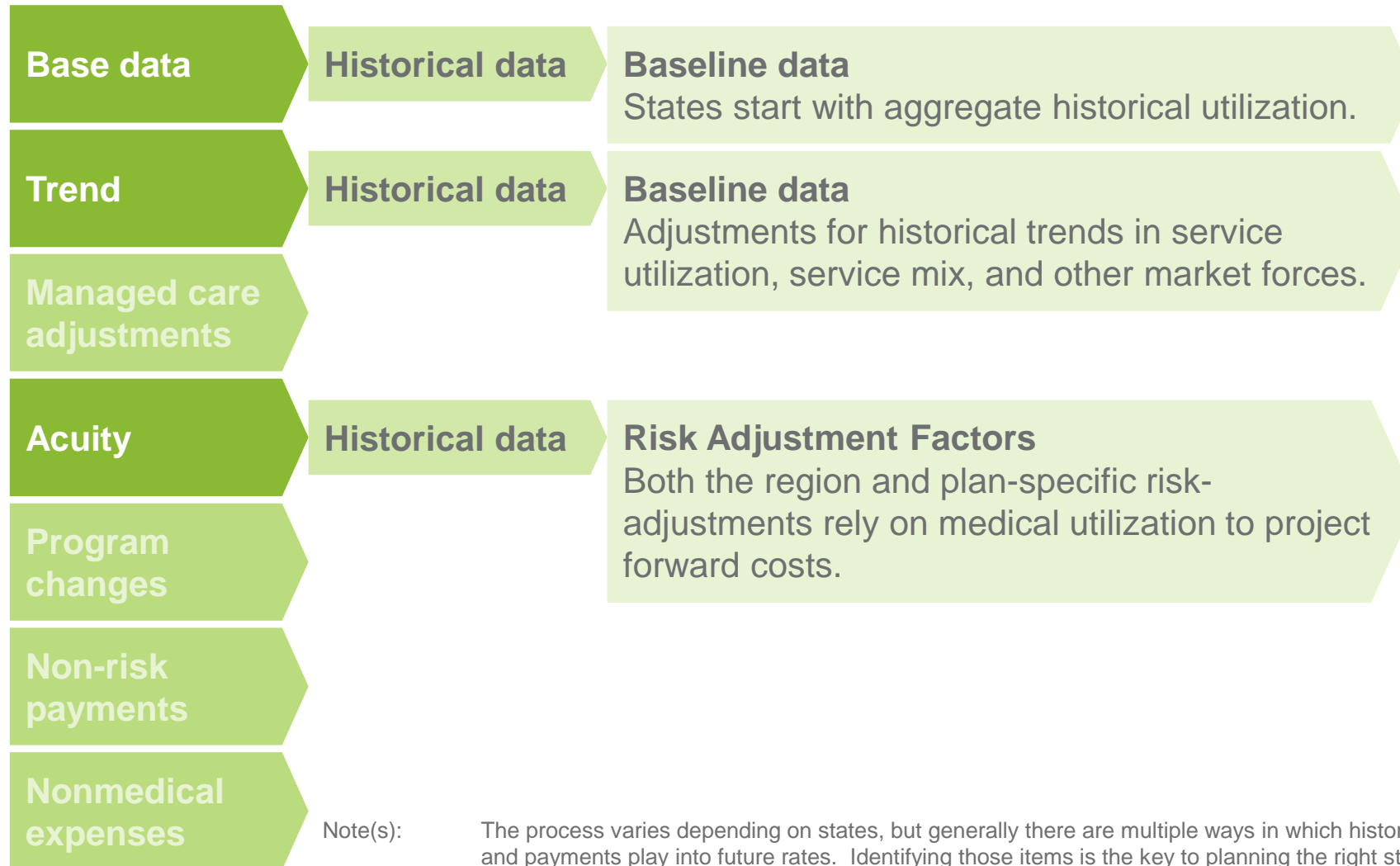
When providers reduce a managed care organization costs, the MCO receives less compensation and has to pay providers for the outcomes.



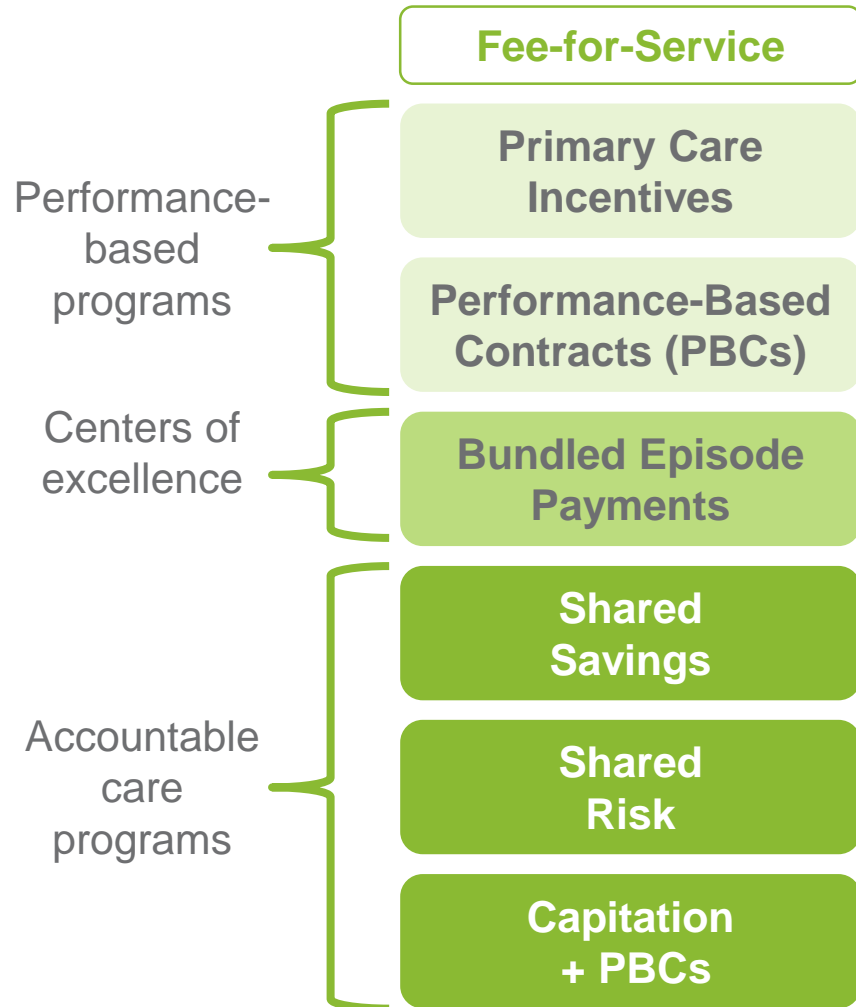
Key insight
Long-term investment value is captured by the State not Managed Care providers, so MCOs have little ability or incentive to invest in prevention.

Premium slide results from the capitation rate-setting process which uses historical data. (NYS Diagram adaptation)

Components of Capitation Rates



We typically recommend arrangements that tie the service provider payment to outcomes rather than volume of medical services delivered.



Outcomes-based payments included in your capitation are accountable care programs

- Start with the existing capitation rate;
- Add in performance contracts for:
 - Shared-savings,
 - Risk-sharing, or
 - Paying for quality outcomes.
- The result is an advanced value-based purchase that allows Medicaid to:
 - Secure federal matching funds,
 - Drive down the cost of care by investing in prevention, and
 - Use investment dollars to improve local communities.

Setting up the value-based purchase is relatively straight forward, if there is an existing service provider who can take the financial risk for success.



Development

Determine what programs you want to run, what the evidence base is and how to move forward.

Implementation

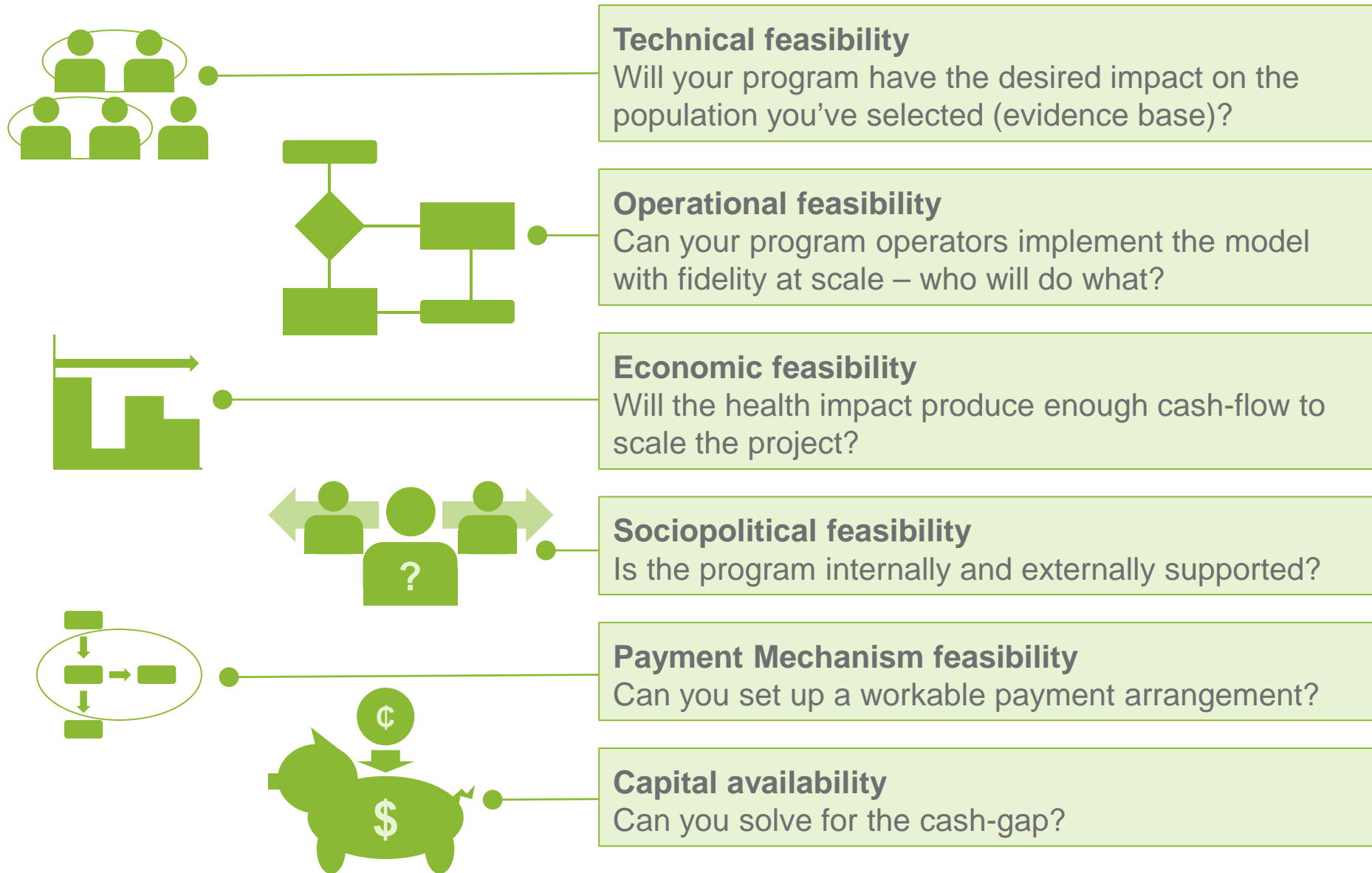
Build mechanisms for enrollment, service-delivery, evaluation, and payment.

- **Enrollment:** *Who is eligible for the program?*
- **Services:** *What will you be doing for them?*
- **Evaluation:** *How will you measure success?*

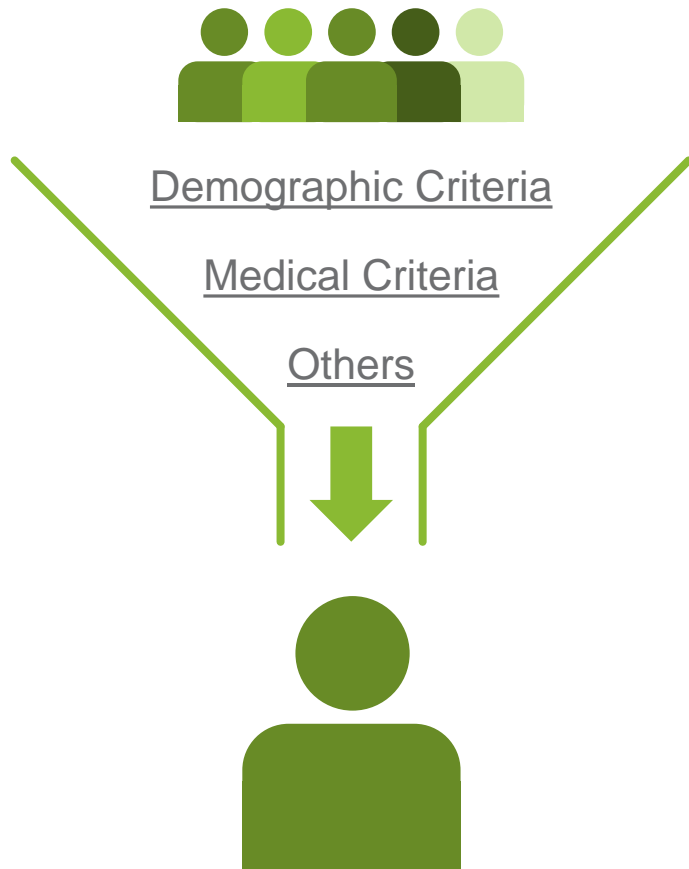
Payment

Determined by the terms of the value-based purchasing arrangement not standard service reimbursement.

Setting up a program means getting key elements right.



Determining who will be eligible for your program and how to enroll them will shape your project.



Target population size

You will be allowed and required to have the services available to anyone who meets your enrollment criteria under Medicaid rules.

Process elements

Your enrollment triggers may determine what the best way to enroll people into your program (ex. hospitalization, diagnosis, or social service)

Determining payment through evaluation

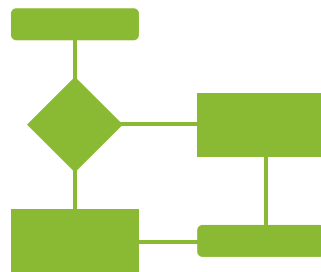
When determining the effectiveness of your program, you may need to apply similar criteria to your comparison group.

Determining what services to offer is a key issue because the service provider is accountable for the cost-benefit, not the insurer.



Necessary components

What are the key elements of the research intervention that made a difference?



Process flow

- Who will do what, when, and how?
- Is it the same for all enrollees?
- How will you manage the process and the associated data as it flows?

Key question: Which design options should you consider?

Are you trying to prove your intervention works in the first place? (Medicaid appropriate?)



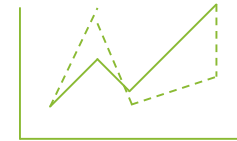
Randomized control trial

Are you trying to prove your intervention has broad impact?



Matched comparison

Are you trying to prove your intervention works at scale?



Comparative index

Are you trying to prove that the business model of providing interventions at scale is viable?



Historical index

Do you know that the business model is viable and your are trying to stand up a new program to deliver services?

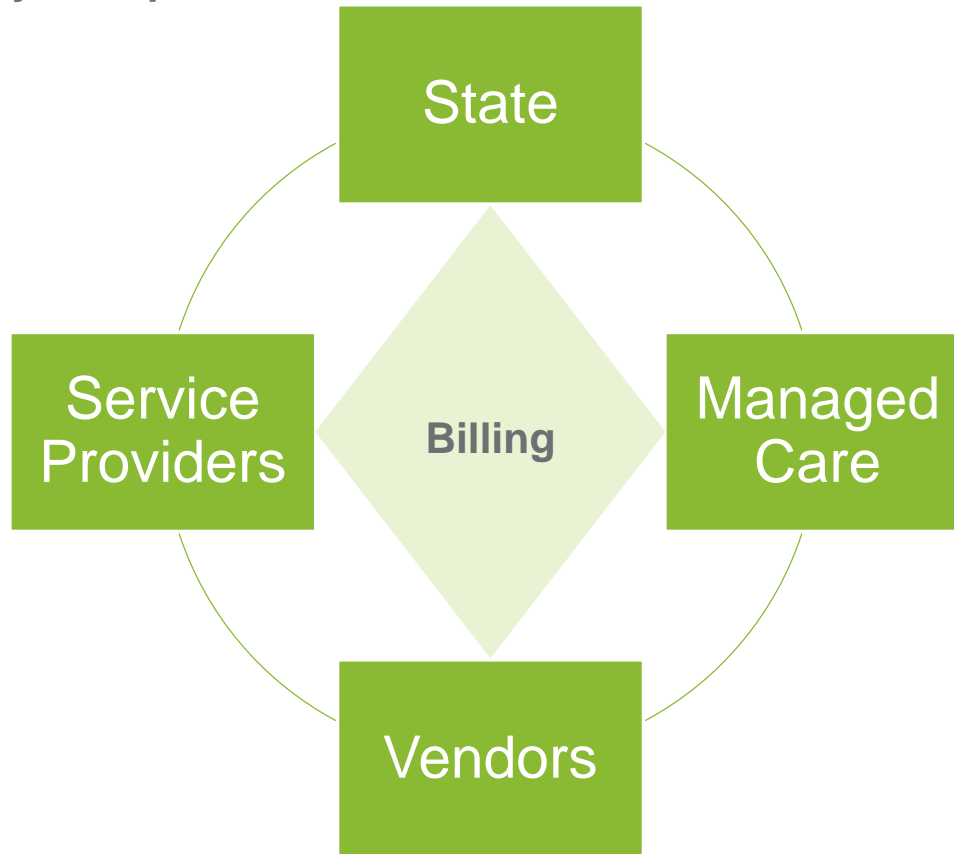


Target setting

What you're trying to accomplish makes a world of difference.

For inclusion, the data needs to be included in a system that is shared between providers, insurers, the state, and their rate-setting partners.

System partners



Existing systems

The existing billing infrastructure is the easiest and likely best choice ensuring value-based purchasing data:

- Existing system to work with,
- Transmitting secure data,
- Used for financial accountability, and
- Used for the same processes that need to include value-based purchasing data.

An example claim shows just how easy it would be to include program payments for the outcomes.

Claims example (select data-fields)

MemID	ClaimID	FromDate	ToDate	HCPCS	Modifier	Paid
1	120	1/1/2012	2012-12-31	VBP Enrollment	2017A.12-E	0
1	127	1/1/2012	2012-12-31	VBP Payment	2017A.12-P	926

Data availability

Once the claims are in the system, they can be used to implement value-based purchasing adjustments on the same level with traditional medical expenses.

Next steps

Contractual implementation is the key, your value-based purchasing strategy must treat the medical payments as a cost of care.



Green & Healthy Homes Initiative®

Example Project: GHHI Asthma Cohort

GHHI builds evidence-based programs that leverage existing community resources to address local problems, using feasibility studies as a vehicle.



Development

Conducting a feasibility study and capacity-building effort is an effective and comprehensive method.

Implementation

Build mechanisms for enrollment, service delivery, evaluation, and payment.

- **Enrollment:** *Medically-based enrollment criteria*
- **Services:** *Networks of local service providers*
- **Evaluation:** *Using more rigorous actuarial analysis than standard for Medicaid*

Payment

- Only after savings accrue is payment disbursed to the service provider.
- Solving for the cash-gap: Community Benefit Dollars, Pay for Success, and other innovations.

The health plan data records was used to analyze which members' improved health outcomes would generate returns from preventive services.

Enrollment Criteria

Health plan filters its member population for specific criteria.



Defining the target population in medical terms

The target population is defined as:

- Medicaid Managed Care Member,
- Hospitalized or seen in ED with asthma as any diagnosis code.

Stratification by subpopulations:

1. Hospitalized during timeframe,
2. Emergency department visit during timeframe, or
3. Both.

Asthma defined within diagnosis code family: 493

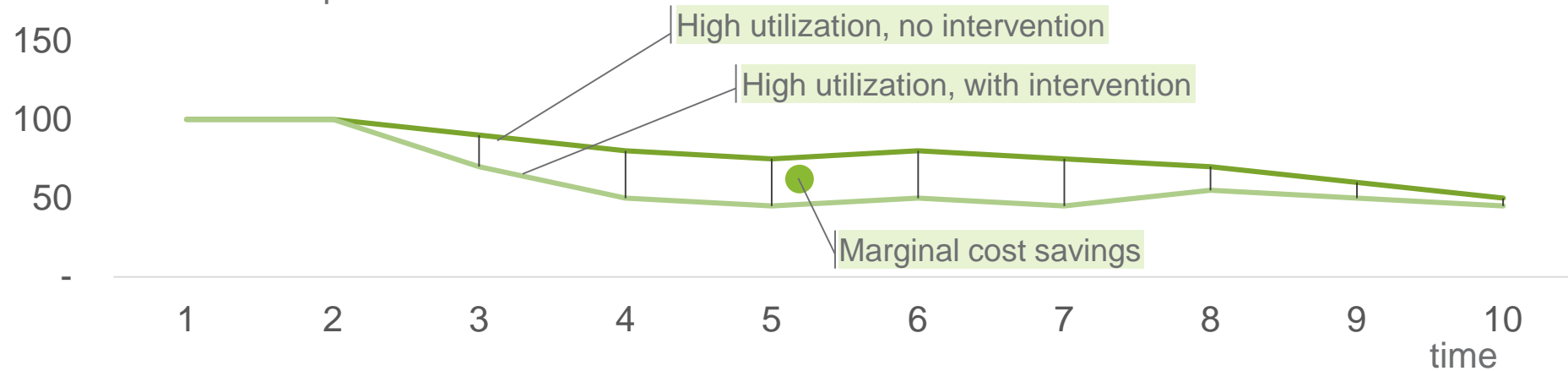
- 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92 – ICD9 codes only

Above listing is incomplete and representative of the type of work done.

The goal of the evaluation is to determine the marginal impact of adding comprehensive asthma intervention services.

Medical utilization

Value of services required over time



Without intervention group

Selected from the same enrollment criteria as the target population, ideally from broader data:

- Standard access to clinical services;
- Includes elements of ongoing community programs and provider group initiatives.

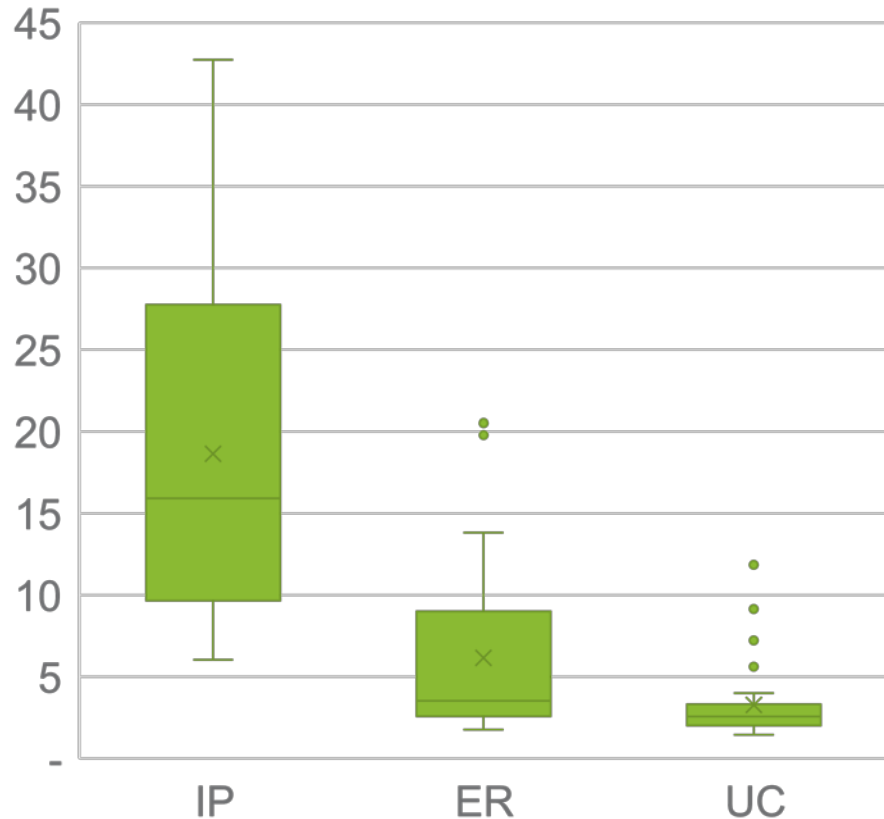
With intervention

This group is selected from the same enrollment criteria as the without intervention group:

- Same clinical services availability;
- Assessment of existing services they use; and
- Only provide new services not already getting.

Asthma patients are high-cost enrollees so preventing hospitalizations to save money is a win-win for all stakeholders.

Average Annual Cost to Medicaid Managed Care Company
\$, thousands



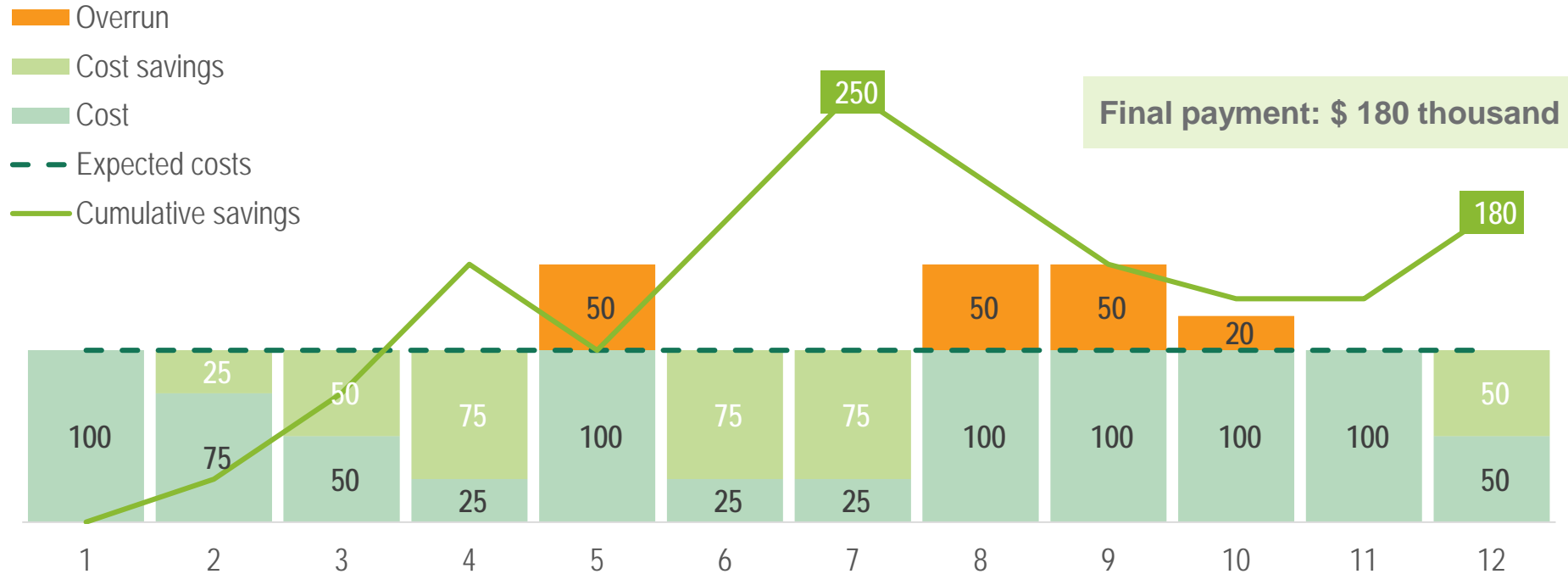
Asthma costs
Managed care companies are paying between \$7,500 and over \$43,000 per year for individual asthma patients who have been hospitalized for respiratory issues.

Savings opportunity
If the research findings hold, we can save 40 percent of costs through comprehensive intervention strategies.

How do we get the savings dollars from our programs back into the services?

We recommend use of shared savings or risk payments in most of our projects.

Outcomes based payments mechanism, 12 month period
\$ thousands



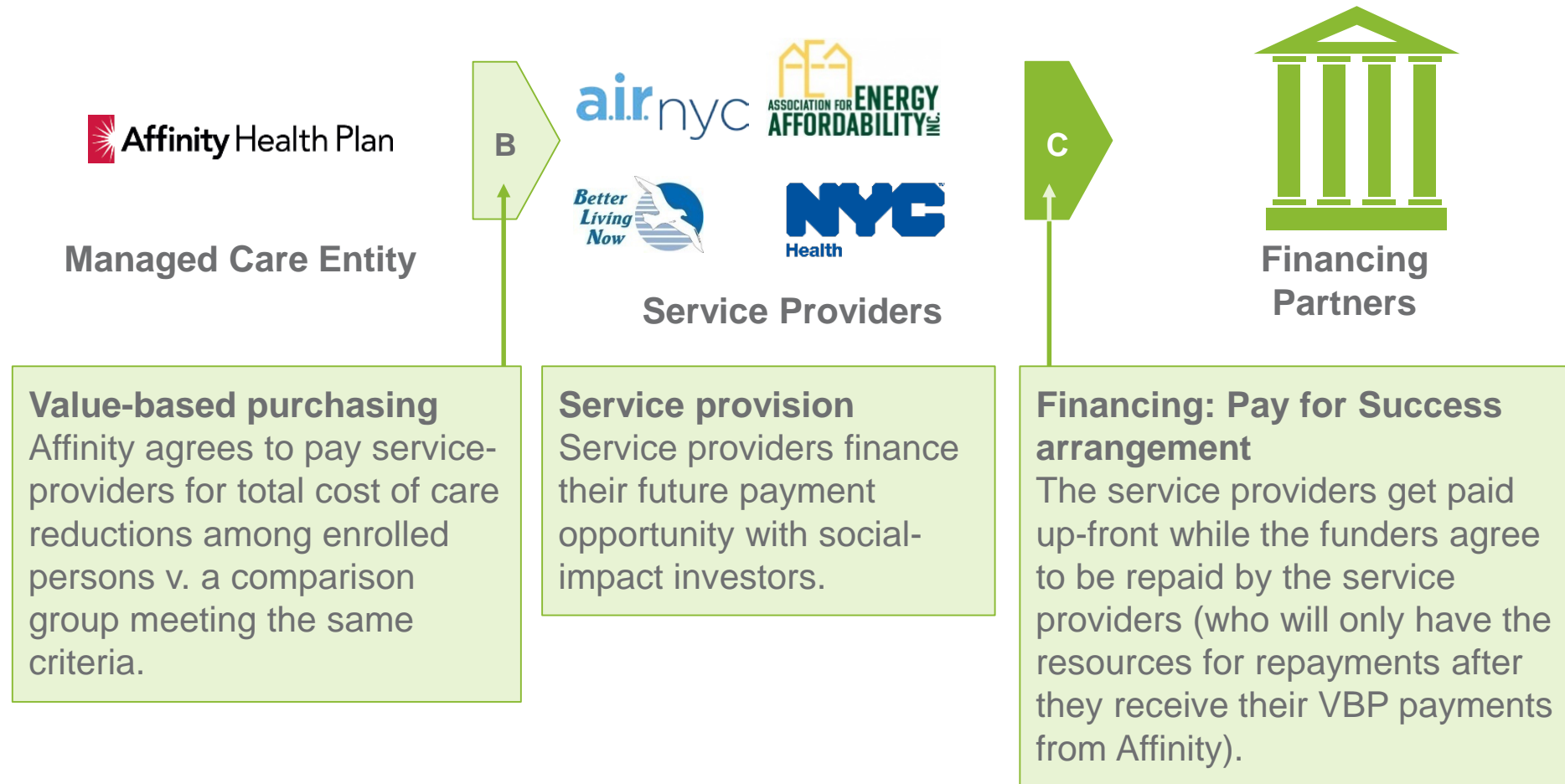
Key insight
Despite variability, outcomes-based payments allow repaying investments over their useful life up to the cost-savings value.

What does a contract arrangement look like?

Note(s): * Expectations could be based on historical projections or comparisons against a selected target population.

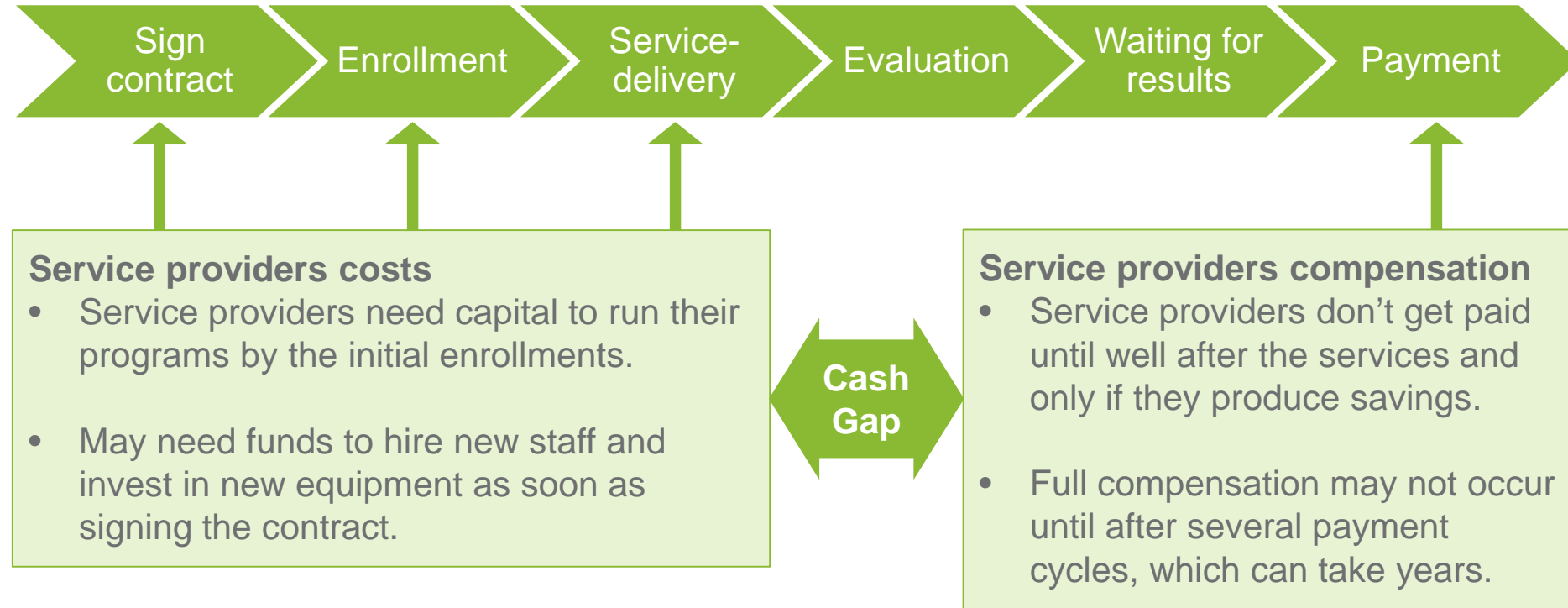
Source(s): GHHI analysis of publicly available information

At GHHI, we finance our projects with outside resources, usually a collective of philanthropic and investment interests call Pay for Success.



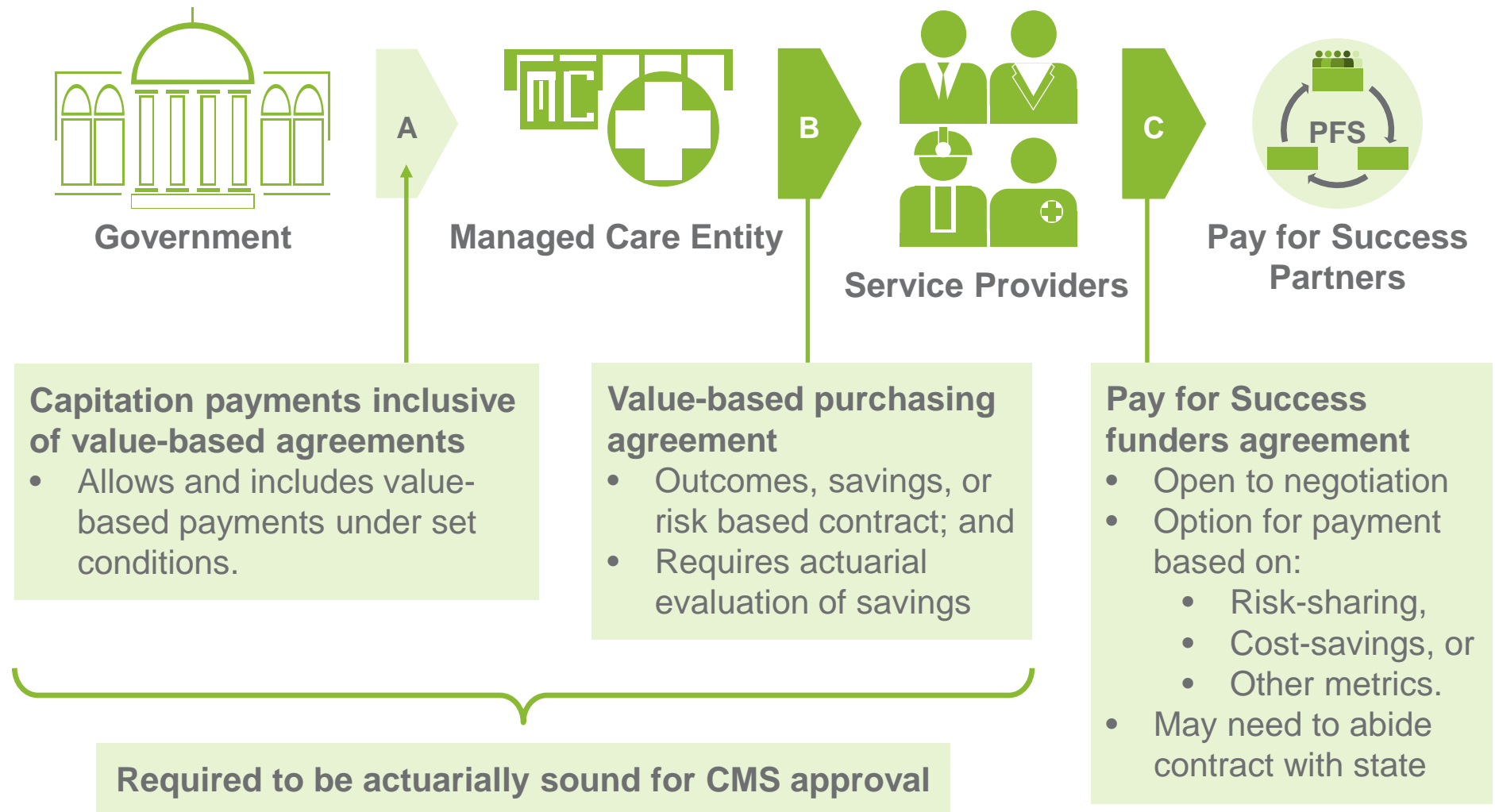
Specific arrangements are still in negotiation

Advanced value-based purchasing arrangements let service providers innovate with no risk to federal or state money but create a cash-gap.



How do you run a program without upfront funds?

Pay for Success can help create innovative funding arrangements for service providers that need funds.



Discussion

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Thank you!

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