Medicaid Payment Reform at Scale: The New York State Roadmap

ASTHO Technical Assistance Call
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New York State Medicaid
Overview

• Background and Brief History

• Delivery System Reform and Payment Reform: two sides of the same coin

• NYS Medicaid Payment Reform – brief overview
New York State Medicaid

• Approximately 6 million individuals in New York State are Medicaid beneficiaries (ranking 2\textsuperscript{nd} in the nation, after CA)

• Current Medicaid spend in New York is approximately $59 billion annually (also 2\textsuperscript{nd} in nation)
NYS Medicaid in 2010: the crisis

• > 10% growth rate had become unsustainable, while quality outcomes were lagging

• Costs per recipient were double the national average
• NY ranks 50th in country for avoidable hospital use
• 21st for overall Health System Quality

• Attempts to address situation had failed due to divisive political culture around Medicaid and lack of clear strategy

2009 Commonwealth State Scorecard on Health System Performance

<table>
<thead>
<tr>
<th>CARE MEASURE</th>
<th>NATIONAL RANKING</th>
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<tbody>
<tr>
<td>Avoidable Hospital Use and Cost</td>
<td>50th</td>
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<td>✔ Percent home health patients with a hospital admission</td>
<td>49th</td>
</tr>
<tr>
<td>✔ Percent nursing home residents with a hospital admission</td>
<td>34th</td>
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<tr>
<td>✔ Hospital admissions for pediatric asthma</td>
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<tr>
<td>✔ Medicare ambulatory sensitive condition admissions</td>
<td>35th</td>
</tr>
<tr>
<td>✔ Medicare hospital length of stay</td>
<td>40th</td>
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<td></td>
<td>50th</td>
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Creation of Medicaid Redesign Team – A Major Step Forward

• In 2011, Governor Cuomo created the Medicaid Redesign Team (MRT).
  • Made up of 27 stakeholders representing every sector of healthcare delivery system
  • Developed a series of recommendations to lower immediate spending and propose reforms
  • Closely tied to implementation of ACA in NYS
  • The MRT developed a multi-year action plan – we are still implementing that plan today
Key Components of MRT Reforms

• **Global Spending Cap**
  • Introduced fiscal discipline, transparency and accountability
  • Limit total Medicaid spending growth to 10 yr average rate for the long-term medical component of the Consumer Price Index (currently estimated at 3.8 percent).

• **Care Management for All**
  • NYS Medicaid was still largely FFS; moving Medicaid beneficiaries to managed care helped contain cost growth and introduced core principles of care management

• **Patient Centered Medical Homes and Health Homes**
  • Stimulating PCMH development and invest in care coordination for high-risk and high-cost patients through the NYS Health Homes Program

• **Targeting the Social Determinants of Health**
  • Address issues such as housing and health disparities through innovative strategies (e.g. supportive housing.)
Medicaid Redesign Initiatives Have Successfully Brought Back Medicaid Spending per Beneficiary to below 2003 Levels

Since 2011, total Medicaid spending has stabilized while number of beneficiaries has grown > 12%

Medicaid spending per-beneficiary has continued to decrease
The 2014 MRT Waiver Amendment Continues to further New York State’s Goals

- Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York’s health care delivery system.

- In April 2014, New York State and CMS finalized agreement Waiver Amendment.
  - Allows the State to reinvest $8 billion of $17.1 billion in Federal savings generated by MRT reforms.
  - $6.4 billion is designated for Delivery System Reform Incentive Payment Program (DSRIP).

- The waiver will:
  - Transform the State’s Health Care System.
  - Bend the Medicaid Cost Curve.
  - Assure Access to Quality Care for all Medicaid Members.
  - Create a financial sustainable Safety Net infrastructure.
The DSRIP Challenge – Transforming the Delivery System

• Largest effort to transform the NYS Medicaid Healthcare Delivery System to date
  • From fragmented and overly focused on inpatient care towards integrated and community focused
  • From a re-active, provider-focused system to a pro-active, patient-focused system
  • Allow providers to invest in changing their business models

<table>
<thead>
<tr>
<th>Patient-Centered</th>
<th>• Improving patient care &amp; experience through a more efficient, patient-centered and coordinated system.</th>
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<tbody>
<tr>
<td>Transparent</td>
<td>• Decision making process takes place in the public eye and that processes are clear and aligned across providers.</td>
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<tr>
<td>Collaborative</td>
<td>• Collaborative process reflects the needs of the communities and inputs of stakeholders.</td>
</tr>
<tr>
<td>Accountable</td>
<td>• Providers are held to common performance standards and timelines; funding is directly tied to reaching program goals.</td>
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<tr>
<td>Value Driven</td>
<td>• Focus on increasing value to patients, community, payers and other stakeholders.</td>
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</table>
Over 5 Years, 25 Performing Provider Systems (PPS) Will Receive Funding to Drive Change

- A PPS is composed of regionally collaborating providers who will implement DSRIP projects over a 5-year period and beyond
- Each PPS must include providers to form an entire continuum of care
  - Hospitals
  - PCPs, Health Homes
  - Skilled Nursing Facilities (SNF)
  - Clinics & FQHCs
  - Behavioral Health Providers
  - Home Care Agencies
  - Community Based Organizations
- Statewide goal:
  - 25% of avoidable hospital use ((re-) admissions and ER visits)
  - No more providers needing financial state-aid to survive

RESPONSIBILITIES MUST INCLUDE:

- Community health care needs assessment based on multi-stakeholder input and objective data
- Implementing a DSRIP Project Plan based upon the needs assessment in alignment with DSRIP strategies
- Meeting and Reporting on DSRIP Project Plan process and outcome milestones
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
  - 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

Financial and regulatory incentives drive...

a delivery system which realizes...

cost efficiency and quality outcomes: value
NYS Medicaid Payment Reform: A Brief Overview
Payment Reform: Moving Towards Value Based Payments

• By DSRIP Year 5 (2019), all Managed Care Organizations must employ non-fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the Special Terms and Conditions of the waiver)

• A Five-Year Roadmap outlining how NYS aims to achieve this goal was required by the MRT Waiver early May

• The State and CMS are committed to the Roadmap

• Core Stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap

• If Roadmap goals are not met, overall DSRIP dollars from CMS to NYS will be significantly reduced
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
The VBP Roadmap starts from DSRIP Vision on How an Integrated Delivery System should Function

Integrated Physical & Behavioral Primary Care
Includes social services interventions and community-based prevention activities

Population Health focus on overall Outcomes and total Costs of Care

Sub-population focus on Outcomes and Costs within sub-population/episode

Episodic
- Maternity Care (including first month of baby)
- Acute Stroke (incl. post-acute phase)
- Depression
- Chronic care (Diabetes, CHF, Hypertension, Asthma, Depression, Bipolar ...)
- Chronic Kidney Disease
- AIDS/HIV
- Multimorbid disabled / frail elderly (MLTC/FIDA population)
- Severe BH/SUD conditions (HARP population)
- Developmentally Disabled population

Continuous
The Path towards Payment Reform: A Menu of Options

There is not one path towards Value Based Payments. Rather, there will be a variety of options that MCOs and PPSs/providers can jointly choose from.

PPSs and MCOs can opt for different shared savings/risk arrangements (often building on already existing MCO/provider initiatives):

• For the total care for the total attributed population of the PPS (or part thereof) – ACO model
• Per integrated service for specific condition (acute or chronic bundle): maternity care; diabetes care
• For integrated Advanced Primary Care (APC)
• For the total care for a subpopulation: HIV/AIDS care; care for patients with severe behavioral health needs and comorbidities

MCOs and PPSs may choose to make shared savings arrangements for the latter types of services between MCOs and groups of providers within the PPS rather than between MCO and PPS
MCOs and PPSs can choose different levels of Value Based Payments

In addition to choosing *what integrated services* to focus on, the MCOs and PPSs can choose different levels of Value Based Payments:

<table>
<thead>
<tr>
<th>Level 0 VBP</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient)</td>
<td>Prospective capitation PMPM or Bundle (with outcome-based component)</td>
</tr>
</tbody>
</table>

- 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 ≥ 50% of total costs captured in VBPs in Level 2 VBPs or higher

**More details: afternoon session**
Outcome and cost information (fully aligned with DSRIP) to be provided to Providers / MCOs for all types of care services discussed.

Integrated Physical & Behavioral Primary Care

For the healthy, patients with mild conditions; for patients requiring coordination between more specialized care services.

Chronic care

Drill down

- Diabetes
- Asthma
- Hypertension
- CHF
- COPD

Maternity care (incl. first 30 days of neonatal care)

Depression – 6 months episode
...

Outcomes (Potentially Avoidable Complications (PACs), healthy baby & healthy mom)

Total Episode Cost

Total Cost for APC Services (PMPM)

Outcomes (PPVs, PPRs, PQIs, PDIs, Total Downstream Cost)

Bundle for 1 yr of care

- Diabetes
- Asthma
- Hypertension
- CHF
- COPD

Outcomes (PACs, Diabetes-specific PQIs, HbA1c/LDL-c values)
Example: variation in total cost vs potentially avoidable admissions & complications (perinatal care)
Value-Based Insurance Design

- 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)

Outcomes of Care

Risk-adjusted Cost of Episode / PMPM

‘Shared savings’ awarded per patient (up to yearly maximum)

No awards
DOH will provide PPS Performance Information through the MAPP Portal

- Provide a central location for PPS’s to actively monitor progress and target areas for improvement
- Several ‘views’ available within the Performance Dashboards*:
  - Accountability view: customized summary of PPS DSRIP performance on all DSRIP indicators across the Domains
  - Improvement view: more recent and more actionable indication of progress (proxies for Performance Metrics)
  - Value Based view**: total cost of care for all care for total population; subpopulations; per care bundle (risk-adjusted, using both 3M and HCI3/ECR grouping technology)
  - Attribution view: provide point-in-time and historical analysis of the PPS’s attributed population including population size, demographic information, and points of care
  - Network view: details on the characteristics of the providers in the PPS network.
- Features*:
  - Ability to track gap-to-goal for DSRIP metrics
  - Drill down using various filters (Population, Provider, geography filters, etc.)
  - Geo-heat maps
  - Drillable to the level of patient lists (where appropriate)

* Phased approach. Phase 1 go live Q4 2015
** Phase 2
State Solution Performance Dashboards ➔ ...to Member detail
Questions?
Additional information available at:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

DSRIP e-mail:
dsrip@health.ny.gov