

New York State Health Innovation Plan



Goal Delivering the Triple Aim – Better health, better care, lower costs

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| <p>Pillars</p> | <p>1 Improve access to care for all New Yorkers, without disparity</p> <p>Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way</p> | <p>2 Integrate care to address patient needs seamlessly</p> <p>Integration of primary care, behavioral health, acute and postacute care; and supportive care for those that require it</p> | <p>3 Make the cost and quality of care transparent to empower decision making</p> <p>Information to enable consumers and providers to make better decisions at enrollment and at the point of care</p> | <p>4 Pay for healthcare value, not volume</p> <p>Rewards for providers who achieve high standards for quality and consumer experience while controlling costs</p> | <p>5 Promote population health</p> <p>Improved screening and prevention through closer linkages between primary care, public health, and community-based supports</p> | | | | | | | | | |
| <p>Enablers</p> | <table border="1"> <tr> <td data-bbox="291 779 875 911"> <p>Workforce strategy</p> </td> <td data-bbox="875 779 1054 911"> <p>A</p> </td> <td data-bbox="1054 779 1744 911"> <p>Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities</p> </td> </tr> <tr> <td data-bbox="291 911 875 1042"> <p>Health information technology</p> </td> <td data-bbox="875 911 1054 1042"> <p>B</p> </td> <td data-bbox="1054 911 1744 1042"> <p>Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation</p> </td> </tr> <tr> <td data-bbox="291 1042 875 1185"> <p>Performance measurement & evaluation</p> </td> <td data-bbox="875 1042 1054 1185"> <p>C</p> </td> <td data-bbox="1054 1042 1744 1185"> <p>Standard approach to measuring the Plan's impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation</p> </td> </tr> </table> | | | | | <p>Workforce strategy</p> | <p>A</p> | <p>Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities</p> | <p>Health information technology</p> | <p>B</p> | <p>Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation</p> | <p>Performance measurement & evaluation</p> | <p>C</p> | <p>Standard approach to measuring the Plan's impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation</p> |
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SHIP Objectives and Goals

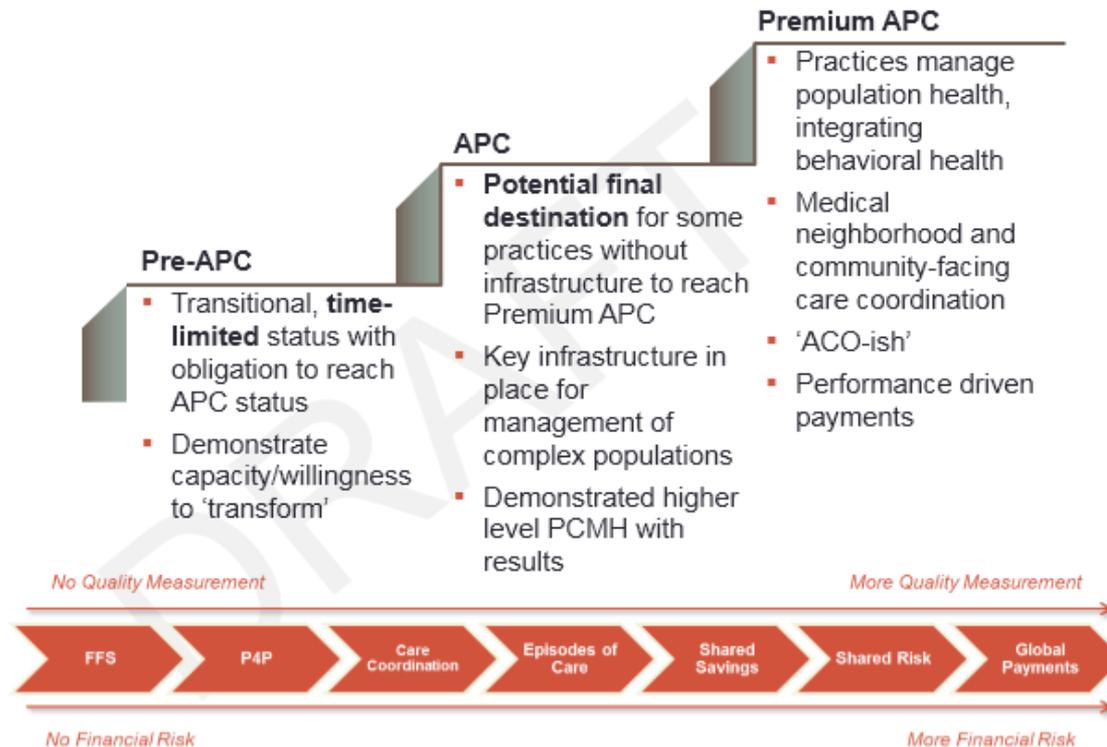
Three Core Objectives within 5 Years:

1. 80% of the state's population will receive primary care within an APC setting, with a systematic focus on population health and integrated behavioral health care;
2. 80% of the care will be paid for under a value-based financial arrangement; and,
3. Consumers will be more engaged in, and able to make more informed choices about their own care, supported by increased cost and quality transparency.

Goals:

1. Achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement within five years;
2. Achieve high standards for quality and consumer experience;
3. Promote efficient use of health care resources by shifting care to most appropriate settings, reducing avoidable hospital admissions and readmissions, and ensuring a clear link between cost and quality.

Heart of the SHIP: “Advanced Primary Care (APC)”



A critical goal of design and implementation is for multi-payer alignment on this multi-tiered model coupled with value based payment that supports transformation, care management AND team-based care.

Advanced Primary Care Principles*

- Health care cost containment (and therefore affordability) cannot be achieved without delivery system transformation across multiple aligned payers.
- Delivery system transformation is predicated upon access to high-quality primary care and supporting services.
- High-quality primary care is more likely to occur in a formally recognized, patient-centered medical home setting.
- The nurturing of primary care transformation can only be successful in a uniformly applied, multi-payer model (involving many different health care payers) coupled with collaborative learning and team-based care.

*<http://healthaffairs.org/blog/2014/09/04/new-report-from-the-milbank-memorial-fund-aligning-payers-and-practices-to-transform-primary-care/> accessed May 5, 2015.

APC and Population Health

Potential Practice Expectations Related to Population Health:

- Identify patients due for preventive or chronic care management services and communicate reminders.
- Evaluate health disparities in access/outcome as part of QI plan.
- Offer or refer patients to structured health education programs such as group classes, peer support, and self-management programs.
- Measure and report one (or several) prevention agenda (PA) goals.
- Identify patients due for preventive or chronic care management services, communicate reminders and ensure provision of appropriate follow-up care
- Maintain a list of community-based services that are relevant to the practice's high-risk population and establish referral and feedback mechanisms for linking patients with these services.

Delivery System Reform and Payment Reform – Necessary and Complementary

1. The goal of setting **APC standards** is to develop consensus about core elements of high quality primary care desired by patients and valued by providers and payers.
2. The goal of **payment reform** in the context of setting APC standards: Develop a payment model that supports and promotes proven interventions leading to high quality cost effective care
3. How do we develop this payment model?

VALUE BASED PAYMENT

What is Value Based Care?

- Pay for Performance (may be transitional)
- Care Coordination and Care Management Payments
- Episode of Care Payments
- Shared Savings
- Shared Risk
- Global Payments



Source: DFS Report (<http://www.dfs.ny.gov/reportpub/payment-reform-report.pdf>)

The Building Blocks of Successful Payment Reform

1. **Flexibility** - to enable providers to deliver care in a way that they believe will achieve high quality or outcomes in the most efficient way and to adjust care delivery to the unique needs of individual patients
2. **Accountability for Spending** - a mechanism for controlling utilization and spending
3. **Accountability for Quality** - a mechanism for assuring adequate quality and outcomes
4. **Adequacy of Payment** - adjusting payment to reflect real differences in patients' needs

Health Plans and Providers are Already Engaged in Payment Reform

DFS Survey (published July 2014) found:

- **Variability.** All major insurers had value-based payment (VBP) programs. But they are independent with inconsistent progress.
- **Few Providers Impacted.** Just 15% of participating providers were in VBP.
- **Few Consumers Impacted.** Just 12% of insurers' members were in VBP.
- **Most VBP Programs Still Pay on FFS Basis.** Most insurers' VBP (80%) make value-based or care coordination payments *in addition to* FFS payments.
- **Pay-for-Performance (P4P) Predominates.** Almost half of VBP are “Pay-for-Performance” models.
- **Some Evidence of Savings, But Most Yet to Be Measured.**
- **Primary Care Focused.** Most of VBP models involve primary care. Specialists, hospitals, non-physician services and emergency room (ER) to a lesser degree. Lab and radiology services the least.

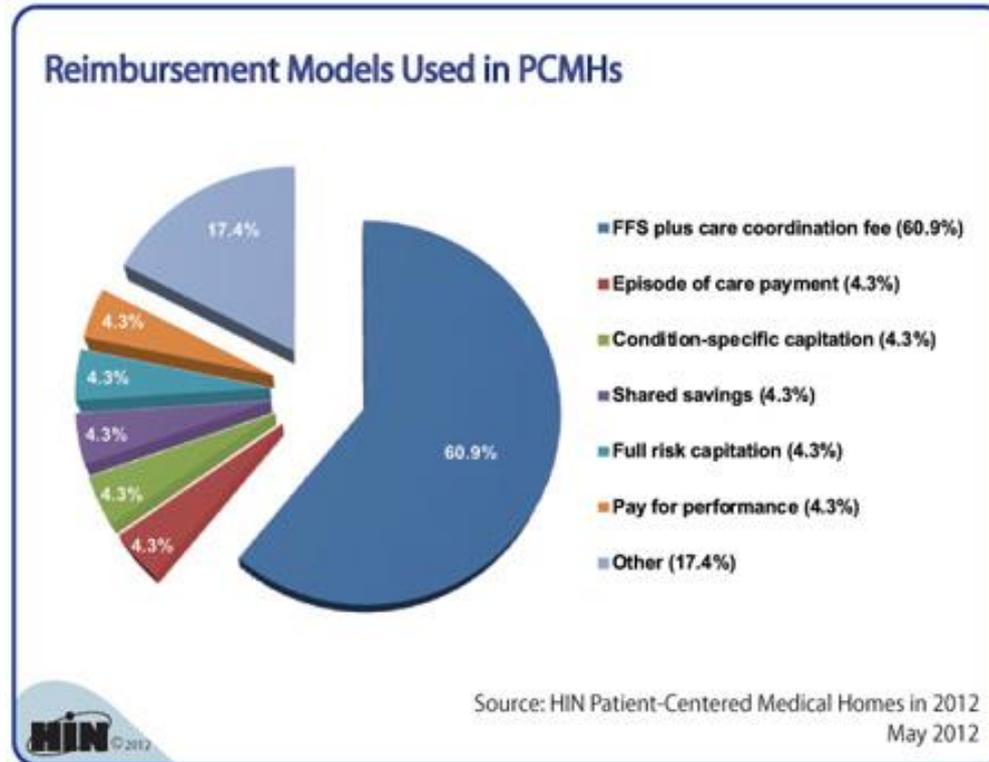
NYS State Innovation Model: Advanced Primary Care Supported by Value-Based Payment Model(s)

NY proposes, under the SHIP, to evolve payment for Advanced Primary Care from strictly FFS to value-based reimbursement to ensure consistency of incentive across providers and payers.

NY's plan for shifting towards value-based payment includes:

- Developing a flexible framework for APC payment that reflects start-up and longer-term costs, and providers' varying ability/interest in assuming risk, and;
- Pursuing value-based payment broadly, embracing a range of approaches to connect payment to process and outcome measures, for all payers

Reimbursement Models used in PCMHs



V-BID

- As part of the SIM grant, the State requested funding to engage the V-BID Center to better understand the potential of this model and discuss possible application to NYS employee health coverage.
- What is V-BID?
 - Decrease cost-sharing for high-value services – e.g., disease management, smoking cessation, generic medications
 - Increase cost-sharing for low-value services – e.g., certain back surgeries.

V-BID - Multiple Options for Implementation

- Encourage insurers to market VBID plans to consumers with specific conditions, such as diabetes and asthma.
 - Effectively targeting consumers with specific chronic conditions and providing appropriate incentives could be less costly for plans than it would be to offer the same benefit to all enrollees regardless of condition.
- Highlight and promote plans incorporating VBID elements when consumers search for a health plan
- Promote plans that couple consumer incentives with innovative payment models (e.g., patient-centered medical homes) that reward value over volume
- Recognize VBID designs in plan quality ratings.
- For Self-Insured, develop statewide criteria and/or “star” ratings that could be adopted and used to promote VBID plans

V-BID Next Steps

- Webinar to provide detail on VBID experiences in other States
- Exploration of ongoing and new opportunities throughout NYS.
- Development of tools, templates and technical assistance for plans, providers and consumers.