Redesign Medicaid in New York State

DSRIP and the Path towards Value Based Payments

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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

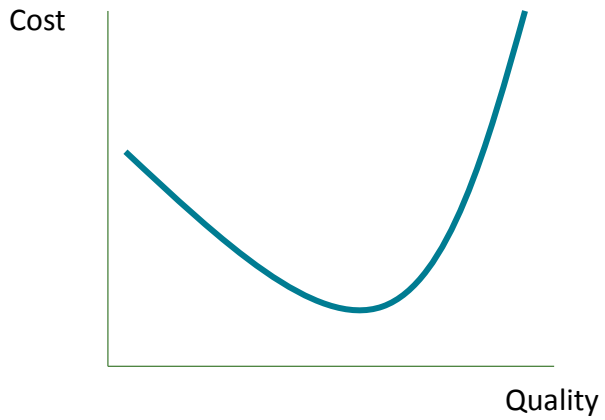
The DSRIP Challenge – Transforming the Delivery System

DSRIP aims to improve core population and patient outcomes:

- Reducing potentially avoidable (re)admissions
- Reducing potentially avoidable ER visits
- Reducing other potentially avoidable complications (diabetes complications, patients at-risk for becoming multi-morbid, crisis stabilization)
- Improving Patient experience (CAHPS)

In a fascinating reversal of common sense economics, improving health care quality more often than not makes the delivery of health care less rather than more expensive – even in Medicaid

This will allow NYS to remain under the Global Cap, without curtailing eligibility, while continuing to invest in innovation and improving outcomes



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

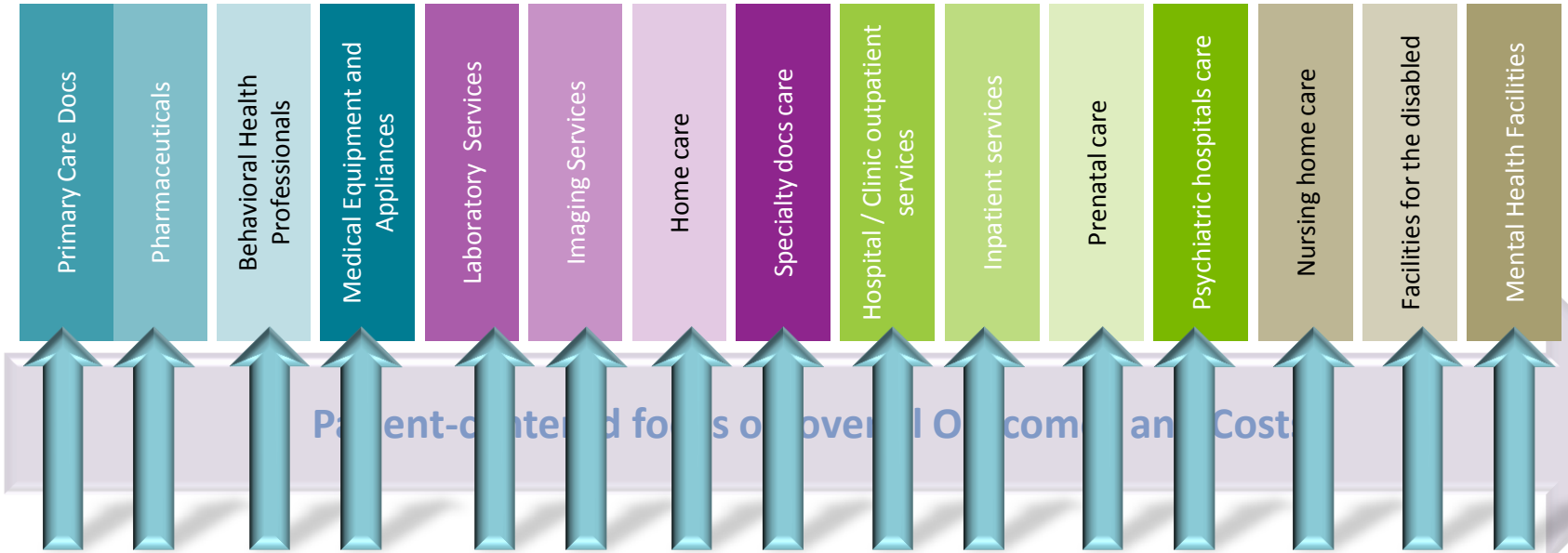
Many of our system's problems (fragmentation, high (re)admission rates, poor primary care infrastructure, lack of behavioral and physical health integration) are rooted in how we pay for services

- 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

Current Fee For Service – deeply embedded, double fragmentation

FFS *and* Silo's



Challenge to change:

Providers, Payers and Governments have embedded this fragmentation in their culture, organization & systems

The DSRIP Challenge – Transforming the Payment System

DSRIP will be as much about payment reform as about delivery reform

Financial and regulatory incentives drive…

a delivery system which realizes…

cost efficiency and quality outcomes: *value*

Payment Reform: Moving Towards Value Based Payments (VBP)

By waiver Year 5, all MCOs must employ non-fee-for-service payment systems that reward value over volume for at least 90% of their provider payments

- Required by the Special Terms & Conditions of the Waiver
- Required to ensure that realized transformations in the delivery system will be sustainable
- Required to ensure that value-destroying care patterns (avoidable admissions, ED visits, etc) do not simply return when the DSRIP funding stops in 2020
- *Requested by successful PPSs as a means to alleviate predicted losses in FFS revenue due to improved performance on DSRIP outcomes (reduced admissions, reduced ED visits).*

VBP approach is based directly on MRT Payment Reform & Quality Measurement Work Group Recommendations

General Guiding Principles

1. Be transparent and fair, increase access to high quality health care services in the appropriate setting and create opportunities for both payers & providers to share savings generated if agreed upon benchmarks are achieved.
2. Be scalable and flexible to allow all providers and communities (regardless of size) to participate, reinforce health system planning and preserve an efficient essential community provider network.
3. Allow for flexible multi-year phase in to recognize administrative complexities including system requirements (i.e., IT).
4. Align payment policy with quality goals
5. Reward improved performance as well as continued high performance.
6. Incorporate strong evaluation component & technical assistance to assure successful implementation.
7. Engage in strategic planning to avoid the unintended consequences of price inflation, particularly in the commercial market

How should an integrated delivery system function – the DSRIP Vision

Evidence-based, outcome-focused care pathways experienced by patients as a smooth, coordinated process

Integrated Physical & Behavioral Primary Care

Includes social services interventions and community-based

Strong, integrated Primary Care Infrastructure
Advanced Primary Care Model

- Prenatal and Maternity Care*
- Elective Care (Hip-, Knee replacement, …)
- Behavioral Health Care (Depression, …)
- Acute Cardiovascular care
- Cancer Care
- …

Episodic

Evidence-based, outcome-focused disease management, self-management strategies, integrated care coordination

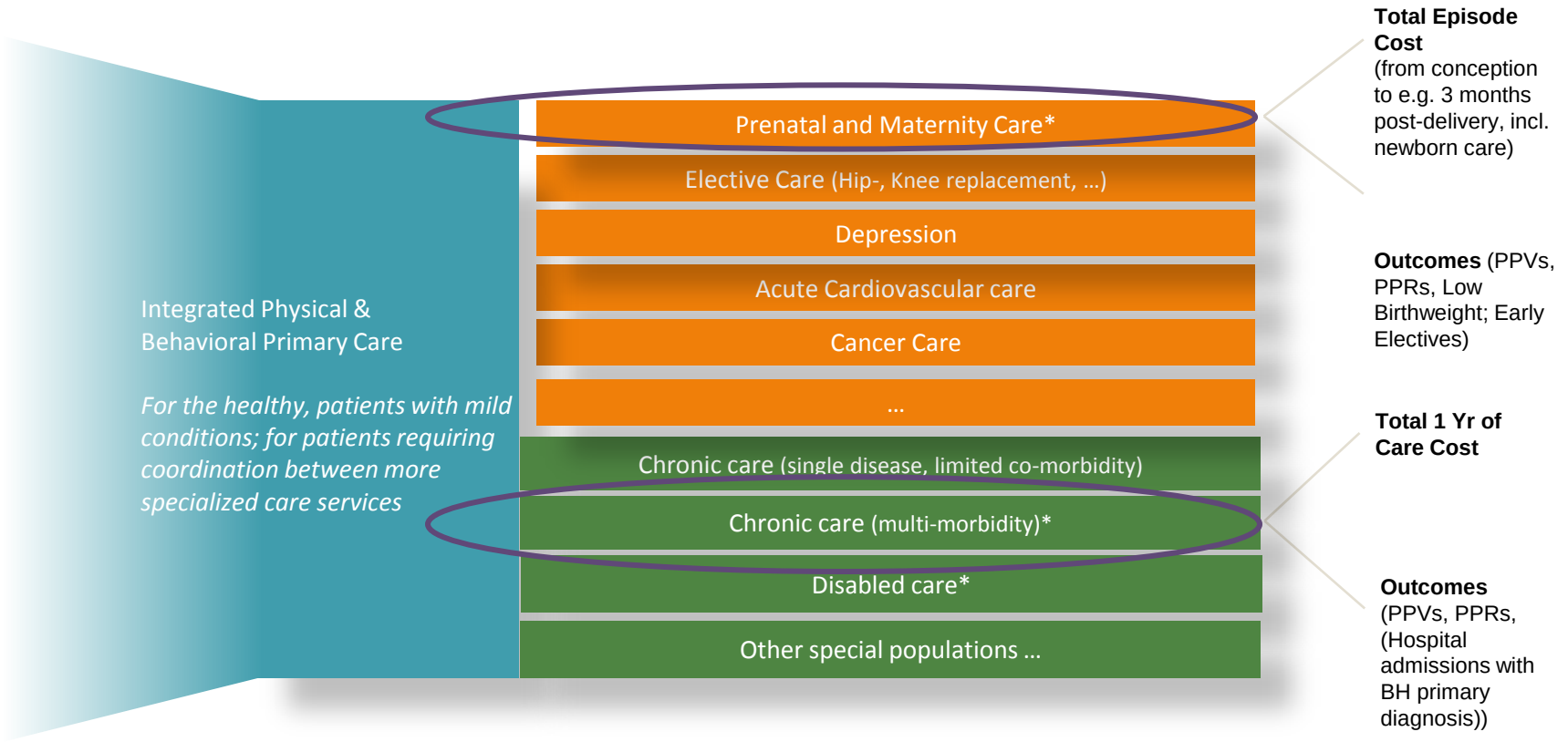
- Chronic care (single disease, limited co…mor…
- Chronic care (multi-morbidity, HARP, …)*
- Disabled care*
- Other special populations (HIV, …)

Continuous

Population Health focus on overall Outcomes and *total* Costs of Care

Focus on Outcomes and Costs *within* episodes of care or sub-population

We will provide PPSs and MCOs with outcomes and total cost of care for these patient-centered, integrated services



We will provide PPSs and MCOs with outcomes and total cost of care for these patient-centered, integrated services

Integrated Physical & Behavioral Primary Care

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

Total Cost for APC Services (PMPM)

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

Elective Care*

Drill down

- Total Joint (Hip / Knee) + 90 days post discharge
- Cholecystectomy + 90 days post discharge
- …

Total Episode Cost

Outcomes (PPVs, PPRs, Low Birthweight; Early Electives)

Chronic care (single disease, limited co-morbidity)

Drill down

- Diabetes
- Asthma
- Hypertension
- Renal Care
- HIV/AIDS

Bundle for 1 yr of care

Outcomes (PPVs, Diabetes-specific PQIs, HbA1c/LDL-c values)

The Path towards Payment Reform

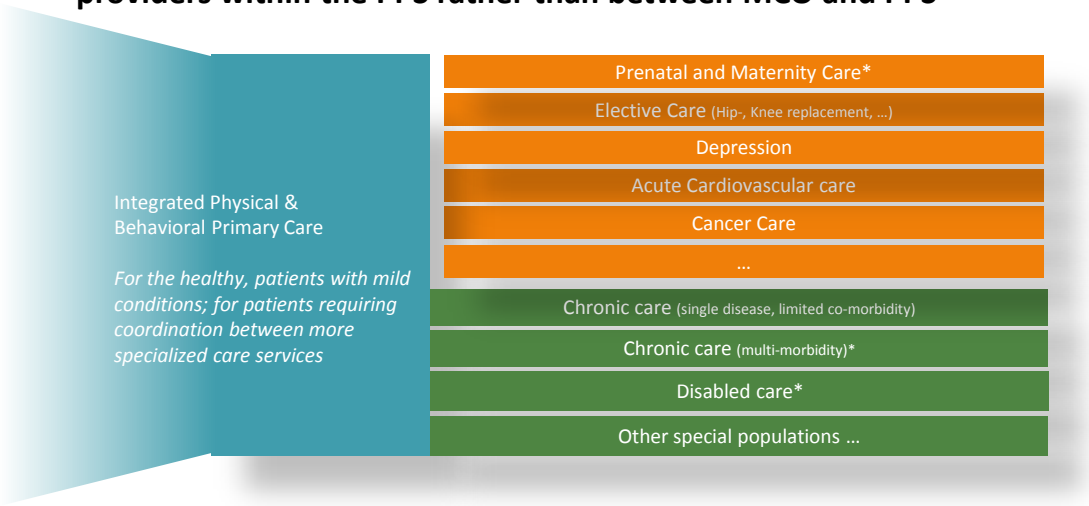
There will not be one path towards 90% Value Based Payments. Rather, there will be a menu of options that MCOs and PPSs can jointly choose from

PPSs and MCOs will be stimulated to discuss opportunities for shared savings arrangements (often building on already existing MCO/provider initiatives):

- For the total attributed population of the PPS

- Per integrated service for specific subpopulation (integrated PCMH/APC; maternity care; diabetes care; HIV/AIDS care; care for HARP population,…) within the PPS

MCOs and PPSs may choose to make shared savings arrangements for the latter types of services between MCOs and providers within the PPS rather than between MCO and PPS



The Path towards Payment Reform

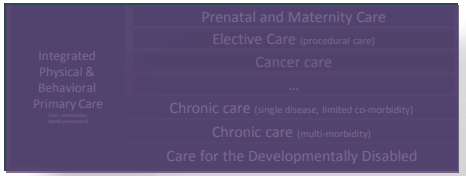
In addition to choosing *what integrated services* to focus on, the MCOs and PPSs can choose different levels of Value Based Payments:

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)

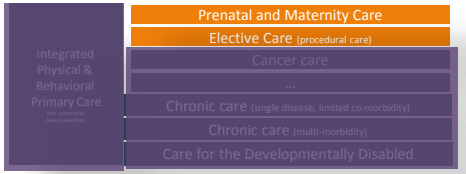
- **Guiding principles (tentative):**
  - ≥90% of total MCO-PPS payments (in terms of total dollars) to be captured in VBPs Level 1 or higher at end of DY5
  - ≥ 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher
  - The more dollars are captures in higher level VBP arrangements, the higher the PMPM value MCOs may receive from the State

What could possible combinations look like? A MCO may agree with a PPS to:

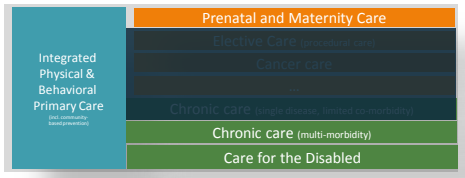
create a Level 2 (up and downside) shared savings arrangement for the total attributed population



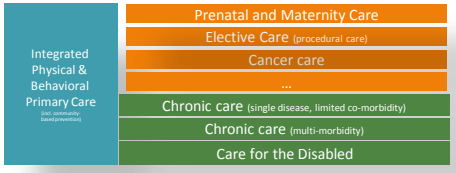
create a Level 2 shared savings arrangement for the total attributed population, excluding integrated services for Maternity care and Elective Care. For the latter, Level 2 shared savings arrangements may be made with individual (groups of) providers within the PPS



create a Level 2 shared savings arrangement for PCMH/APC care and Health Home and HARP care with the PPS, create a separate arrangement with the Disabled Care providers within the PPS, and leave the remainder of care FFS with Level 1 VBP (upside shared savings only) (if total cost of that care is < 30% of overall MCO dollars received)



create Level 2 shared savings arrangements for all PCMH/APC care and condition-specific episodes/subpopulations, with some Level 1 arrangements where the maturity of the providers is not ready for risk-sharing



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