



**Department
of Health**

**Office of
Health Insurance
Programs**

MRT Update – Progress-to-Date, DSRIP and the Road to Value-Based Payment

Health Foundation for Western & Central New York
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New York State Medicaid Director

Overview

- Background and Brief History
- Delivery System Reform and Payment Reform: two sides of the same coin
- NYS Medicaid Payment Reform – brief overview
- NYS Medicaid Payment Reform – policy levers and strategy
- Value-Based Payment – contracting options

New York State Medicaid

- Approximately **6 million** individuals in New York State are Medicaid beneficiaries (ranking 2nd in the nation, after CA)
- Current Medicaid spend in New York is approximately **\$59 billion** annually (also 2nd in nation)

NYS Medicaid in 2010: the crisis

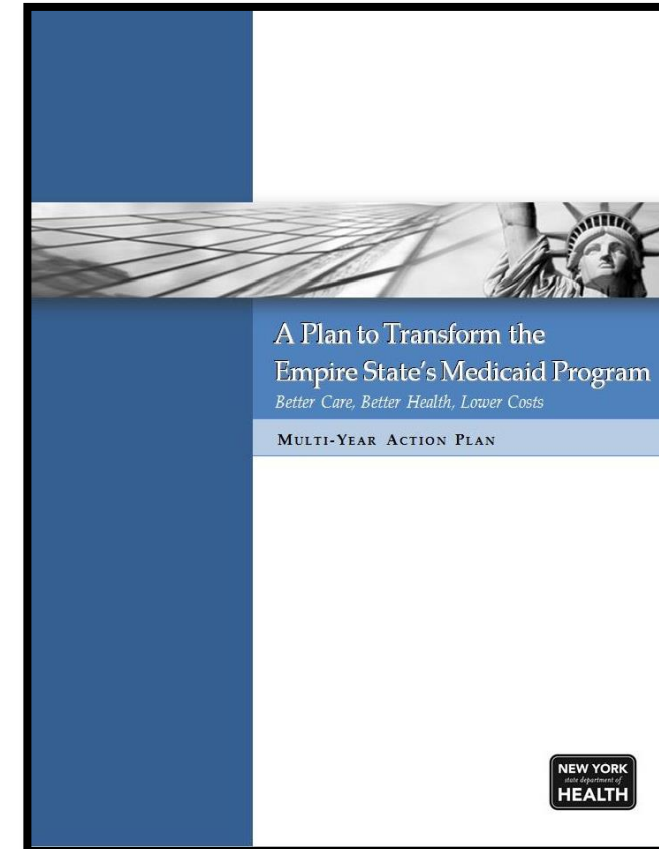
- > 13% anticipated growth rate had become unsustainable, while quality outcomes were lagging
 - Costs per recipient were double the national average
 - NY ranks 50th in country for avoidable hospital use
 - 21st for overall Health System Quality
- Attempts to address situation had failed due to divisive political culture around Medicaid and lack of clear strategy

2009 Commonwealth State Scorecard on Health System Performance

<u>CARE MEASURE</u>	<u>NATIONAL RANKING</u>
Avoidable Hospital Use and Cost	<u>50th</u>
✓ Percent home health patients with a hospital admission	49 th
✓ Percent nursing home residents with a hospital admission	34 th
✓ Hospital admissions for pediatric asthma	35 th
✓ Medicare ambulatory sensitive condition admissions	40 th
✓ Medicare hospital length of stay	50 th

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.)

MRT Project Status: Progress to Date

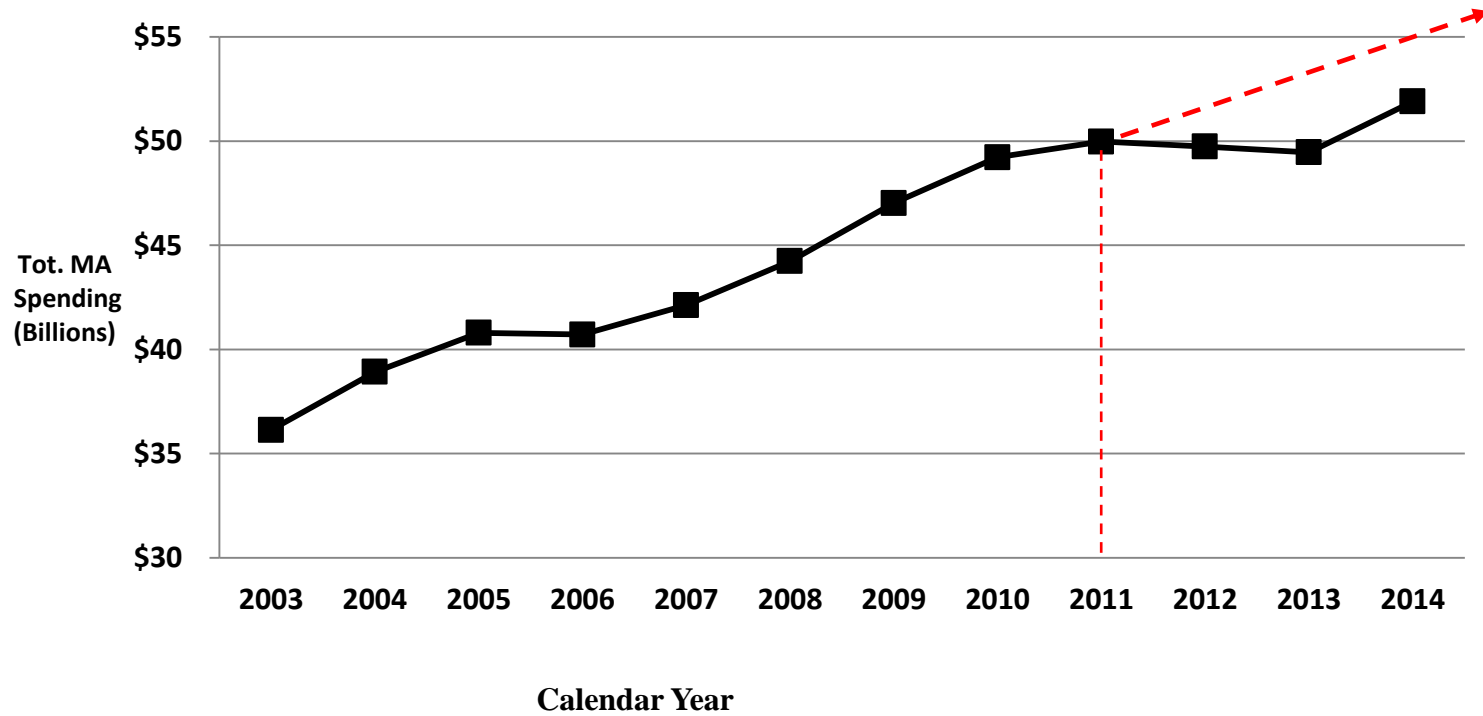
- MRT is now in 5th year - Phase 5
- More than 350 projects
- Nearly 60% complete or substantively complete
- All project workplans and status available at www.health.ny.gov/mrt

MRT Project Status: Progress to Date

	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Total
Complete/ Substantively Complete	73	88	32	17	2	212
In Progress	4	16	13	17	46	96
Cancelled/ Suspended	1	8	1	1	0	11
Total	78	112	46	35	48	319

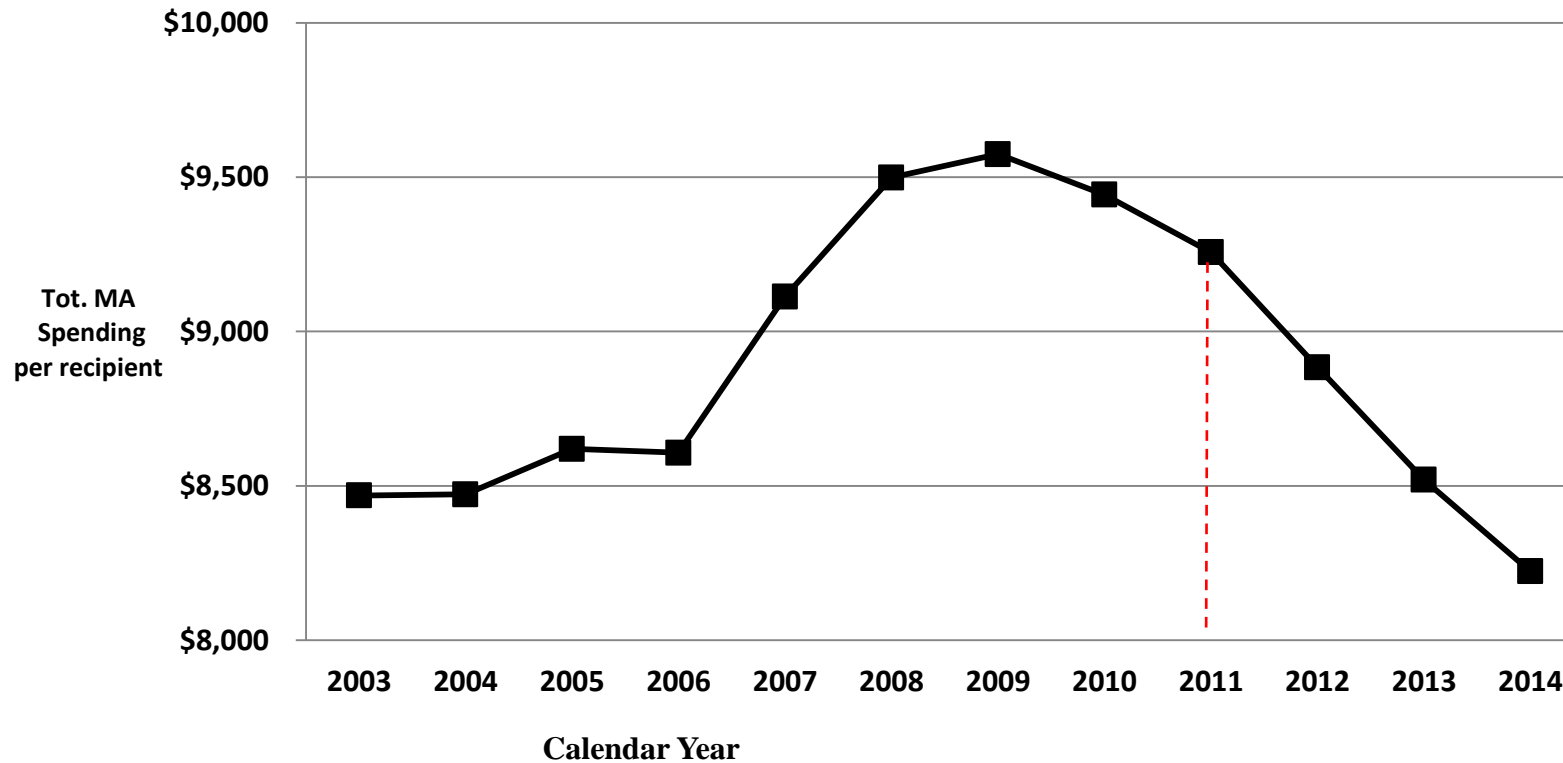
Medicaid Redesign Initiatives Have Successfully Reduced Costs

NYS Statewide Total Medicaid Spending (CY2003-2014)



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
# of Recipients	4,267,573	4,594,667	4,733,617	4,730,167	4,622,782	4,657,242	4,911,408	5,212,444	5,398,722	5,598,237	5,805,282	6,311,762
Cost per Recipient	\$8,469	\$8,472	\$8,620	\$8,607	\$9,113	\$9,499	\$9,574	\$9,443	\$9,257	\$8,884	\$8,520	\$8,223

Medicaid Redesign Initiatives Have Successfully Brought Back Medicaid Spending per Beneficiary to 2003 Levels



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Source: NYS DOH OHIP DataMart (based on claims paid through April 2015)

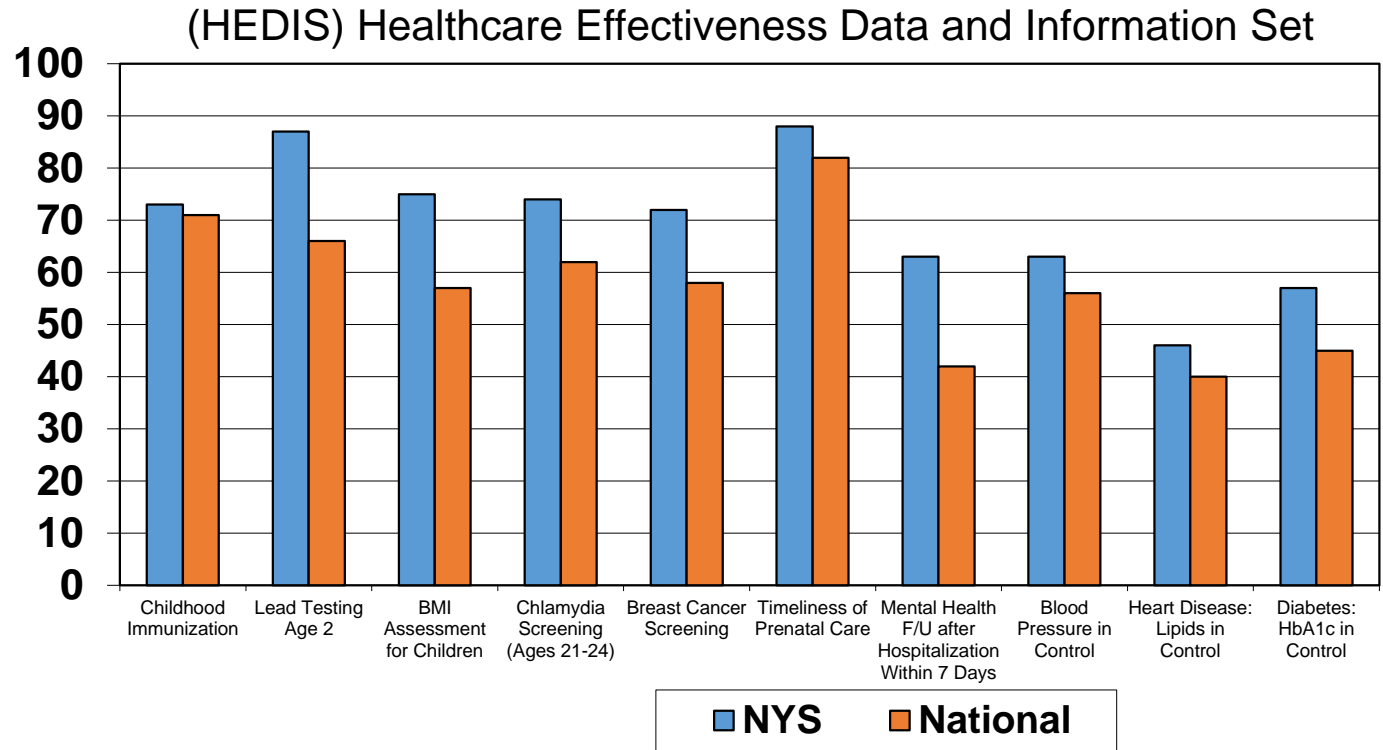
State of Quality - Medicaid

- New York has a well-established system to monitor quality of care for Medicaid managed care enrollees. Over time, measures have evolved from preventive care to measures of chronic care and outcomes.
- Since 2001, a managed care pay for performance program has been a driver of improved care and has focused on quality and patient satisfaction measures.
- The rates of Medicaid performance have:
 - improved over time;
 - 96% of measures exceeded national benchmarks* based on 2013 data; and
 - seen a reduction in the gap in performance between Medicaid and commercial managed care.

** National benchmarks are based on 2014 State of Healthcare Quality report from the National Committee for Quality Assurance (NCQA).*

State of Quality: Medicaid

New York State Medicaid meets or exceeds the national average on most HEDIS measures



Data compiled from the 2014 report of Health Plan Comparison in New York State.

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
- \$7 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

Patient-Centered

- Improving patient care & experience through a more efficient, patient-centered and coordinated system.

Transparent

- Decision making process takes place in the public eye and that processes are clear and aligned across providers.

Collaborative

- Collaborative process reflects the needs of the communities and inputs of stakeholders.

Accountable

- Providers are held to common performance standards and timelines; funding is directly tied to reaching program goals.

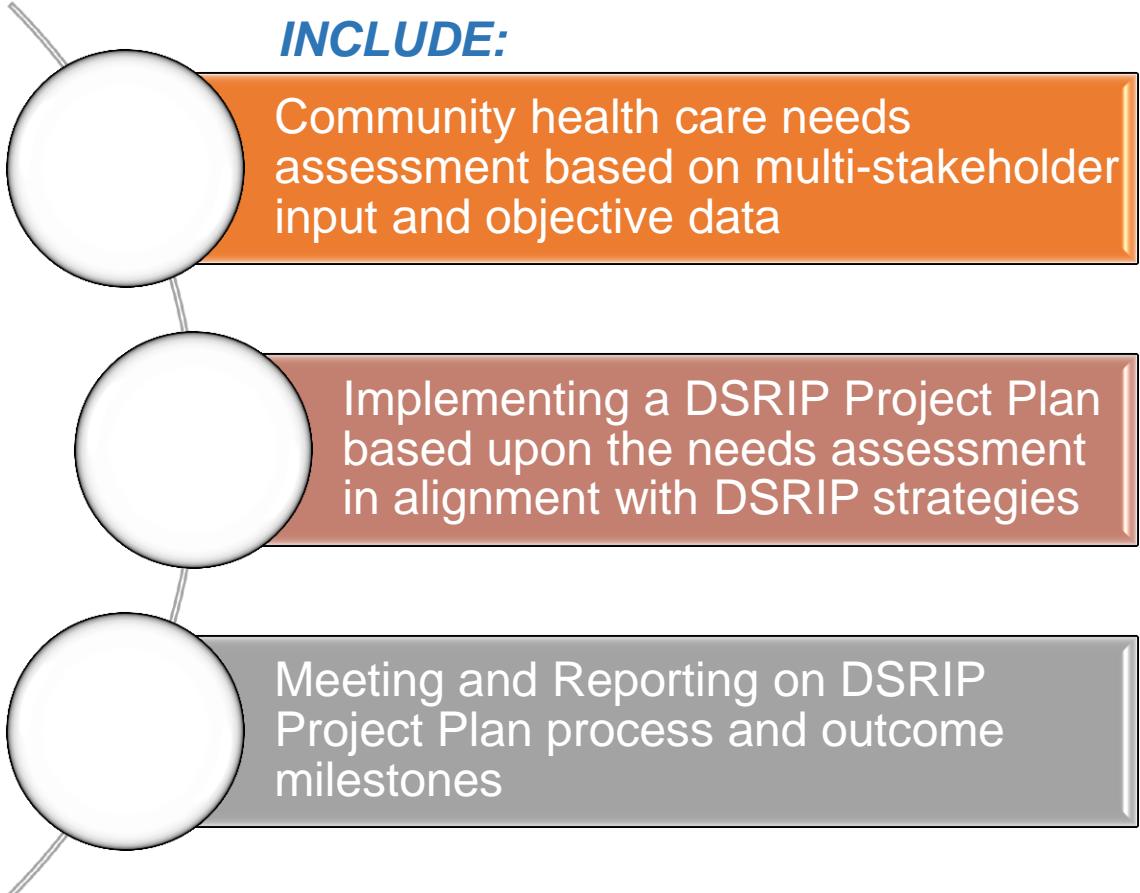
Value Driven

- Focus on increasing value to patients, community, payers and other stakeholders.

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
- Current State – Work in progress

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...

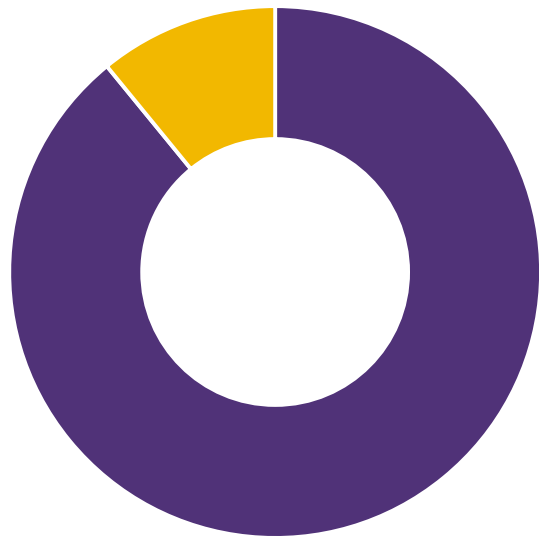
a delivery system which realizes...

cost efficiency and quality outcomes: *value*

NYS Medicaid Payment Reform: A Brief Overview

Healthcare CEO's show strong support for Value Based Payments

VBP Should Play a Dominant Role



■ Agree ■ Disagree

78%

of top Healthcare CEO's polled by Modern Healthcare indicated that VBP should play *the dominant role in reimbursement.*

“

Everybody feels that the days of fee for service are coming to an end; We need to bring everyone together. We need one glide path.

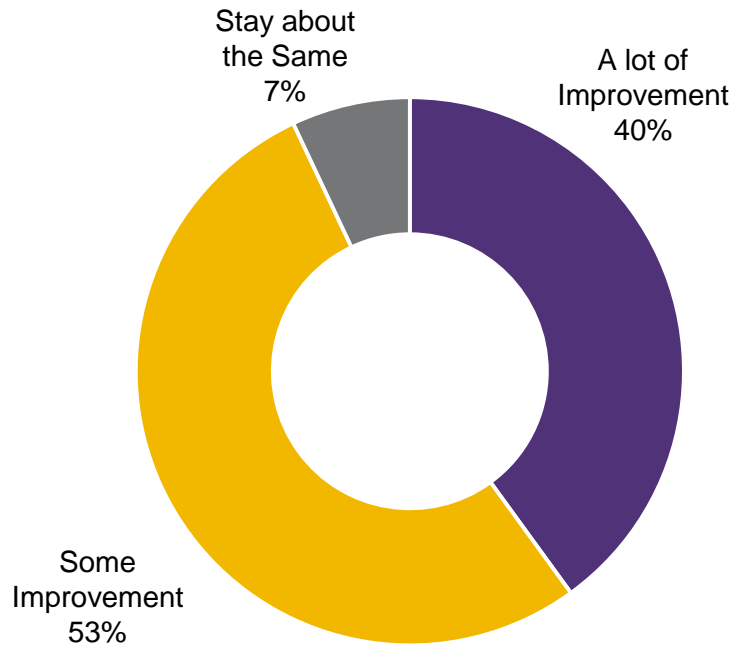
”

– Dr. Ram Raju
President of NYC Health and Hospitals Corporation

**CEO Power Panel Shows Broad Support for VBP, Modern Healthcare*

Healthcare leaders anticipate a positive impact on quality from Value Based Payments

The Impact of VBP on Quality



93%

of CEO's that were polled believe that the quality of **care delivered to Americans will improve** with value based payments.

“

I don't see our current system leading to better care.

This certainly isn't a slow evolution. Right now, I think we're bordering on a revolution.

”

– Dr. Joseph Vasilie
CEO of the Greater Rochester Independent Practice Association

**CEO Power Panel Shows Broad Support for VBP, Modern Healthcare*

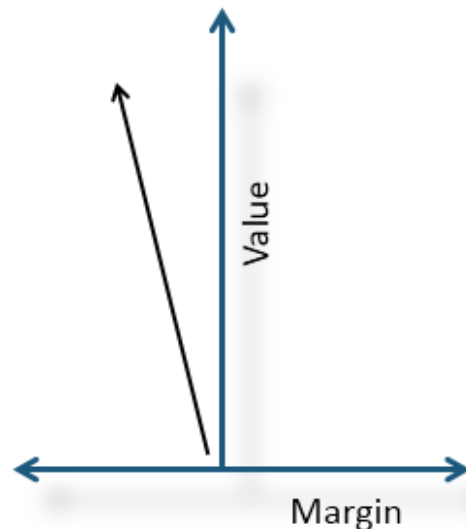
Payment Reform: Moving Towards Value Based Payments

- 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

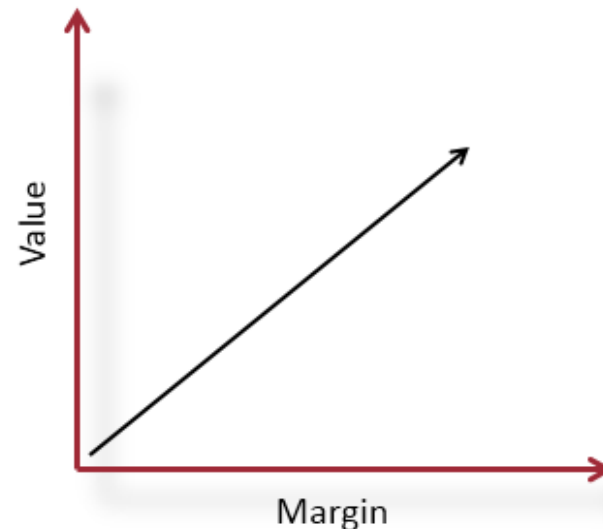
Learning from Earlier Attempts: VBP as the Path to a Stronger System

VBP arrangements are not intended primarily to save money for the State, but to allow providers to increase their margins **by realizing value**

Current State
*Increasing the value of care delivered
more often than not threatens
providers' margins*



Future State
When VBP is done well, providers' margins go up when the value of care delivered increases



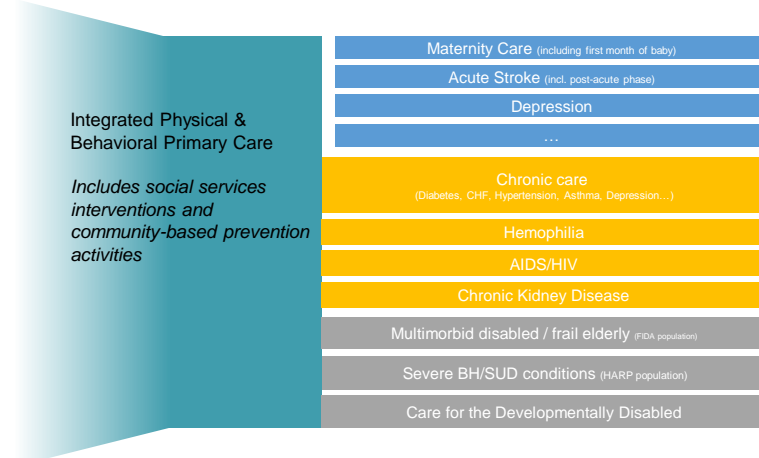
Goal – Pay for Value not Volume

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:

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)

- 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

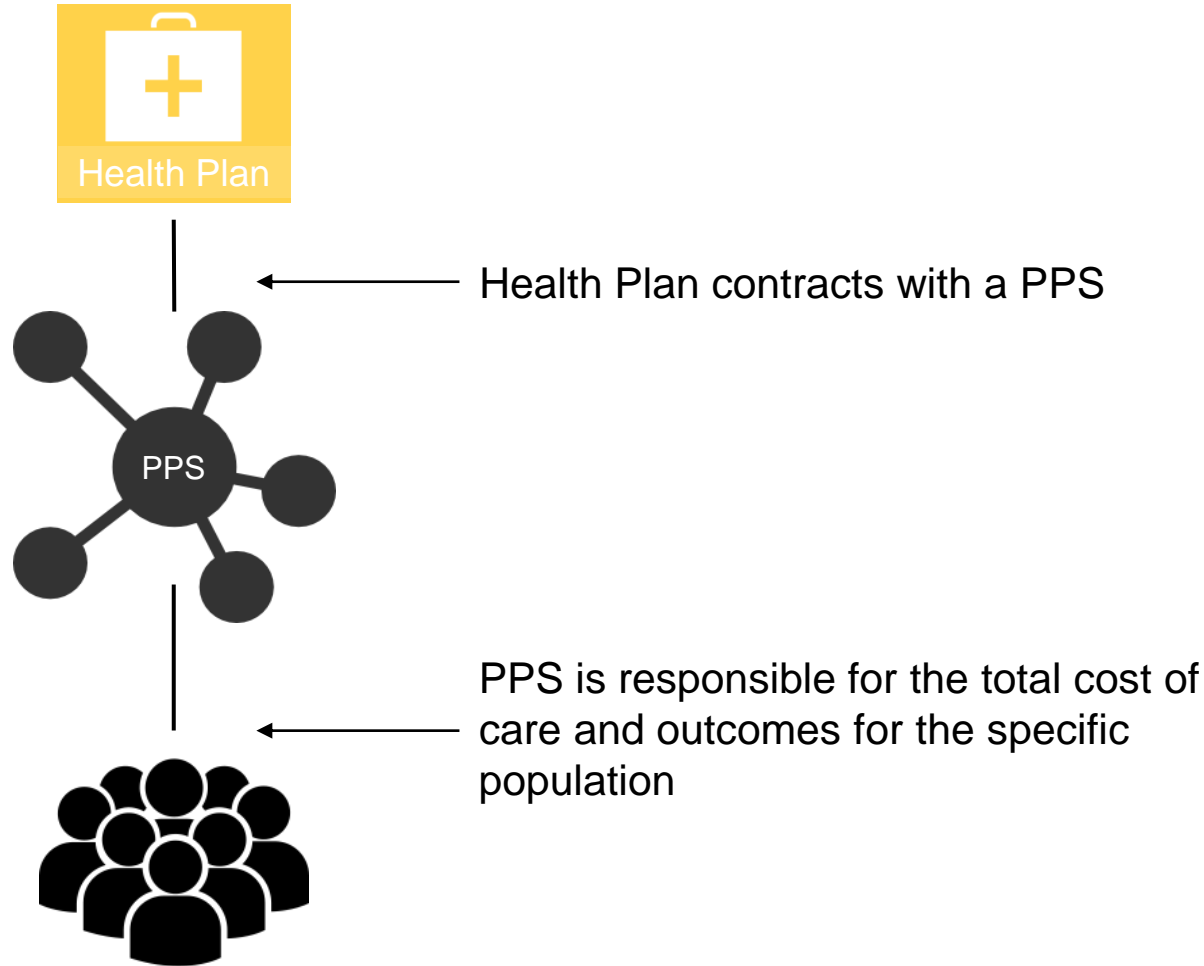
NYS Medicaid Payment Reform: Policy Levers and Strategy

Key Defining Factors our the New York VBP Approach

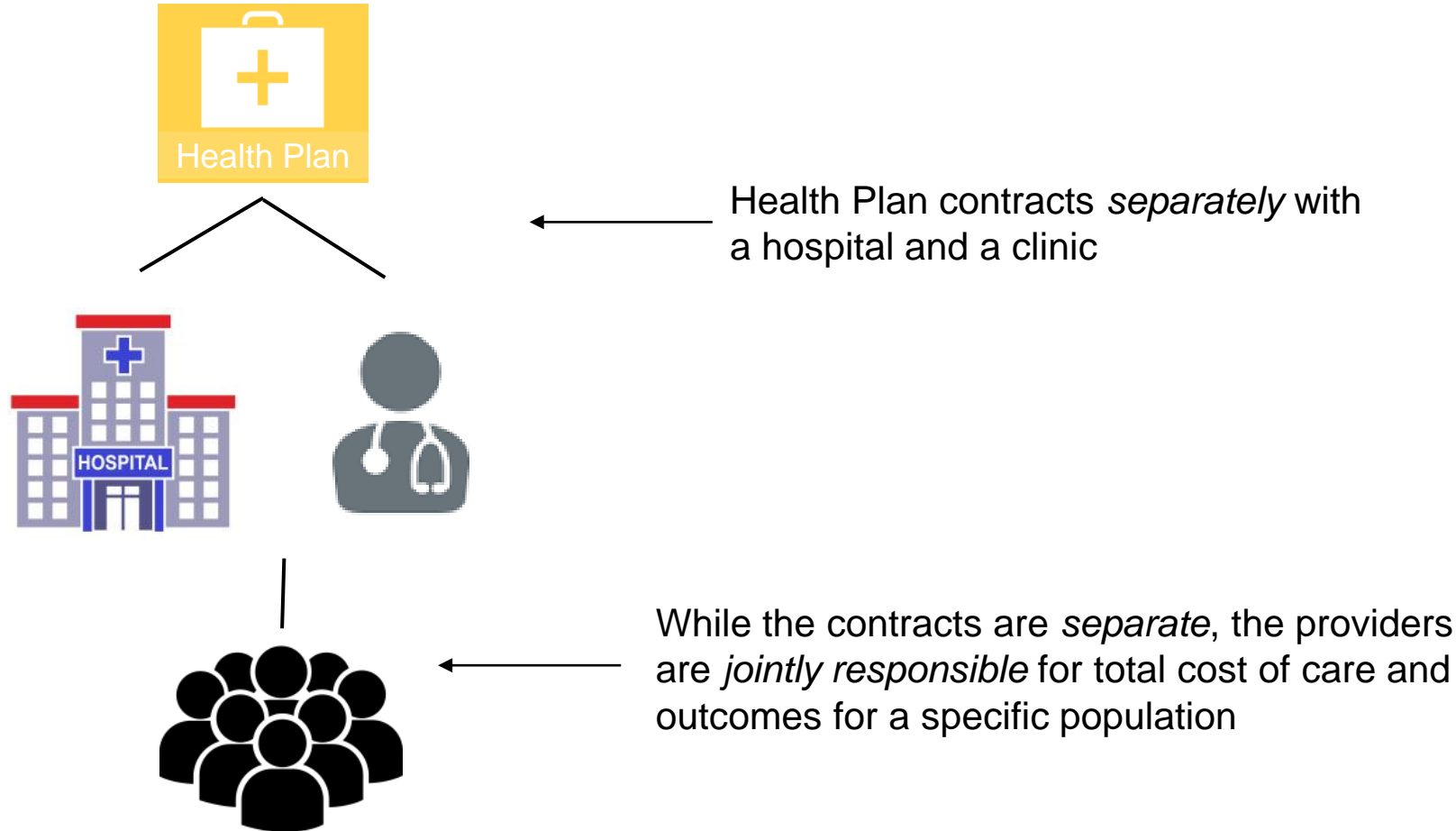
1. Addressing all of the Medicaid program in a holistic, all-encompassing approach rather than pilots or individual VBP projects without overall framework
2. Leveraging the Managed Care Organizations (MCO) to deliver the payment reforms
3. Avoiding negative financial incentives for stakeholders moving towards VBP
4. Allowing for maximum flexibility in the implementation for stakeholders, while maintaining a robust, standardized framework
5. Maximum focus on transparency of costs and outcomes of care

Value-Based Payment Contracting Options

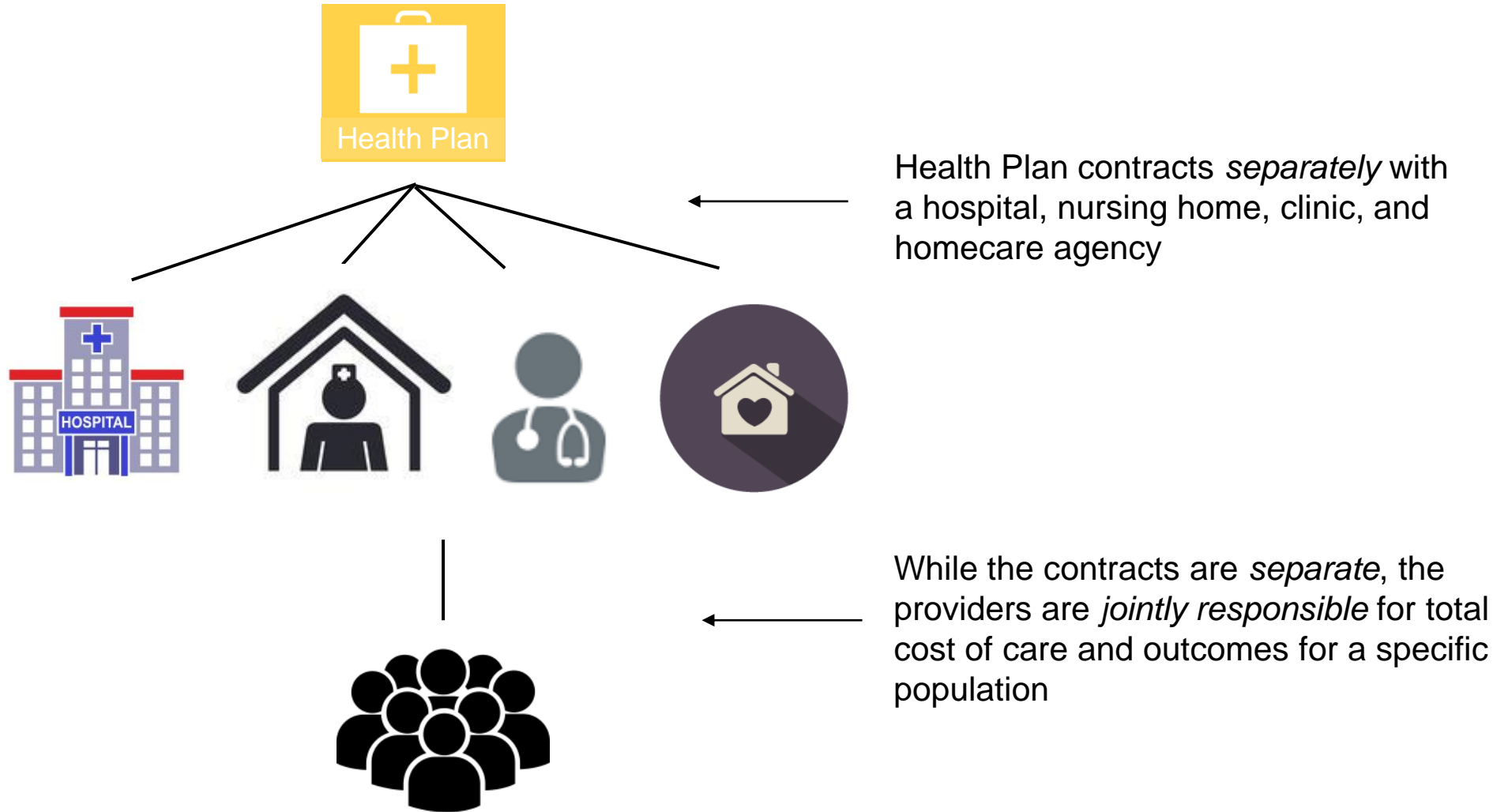
Example of Contracting Options in VBP



Example of Contracting Options in VBP



Example of Contracting Options in VBP



Questions?

Additional information available at:

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

DSRIP e-mail:

dsrip@health.ny.gov