NYSRA Disability Presentation

NYS Medicaid Waiver Services & Value Based Payment System – Now and for the Future

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Agenda

• The MRT Waiver & DSRIP in New York State

• Health Services for the Developmentally Disabled (DD) & DSRIP

• Value Based Payments (VBP)
The MRT Waiver & DSRIP in New York State
NYS Statewide Medicaid Spending (CY 2003 – 2013)

**Project Spending Absent MRT Initiatives**

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Recipients</td>
<td>4,267,573</td>
<td>4,594,667</td>
<td>4,733,617</td>
<td>4,730,167</td>
<td>4,622,782</td>
<td>4,657,242</td>
<td>4,911,408</td>
<td>5,212,444</td>
<td>5,398,722</td>
<td>5,598,237</td>
<td>5,792,568</td>
</tr>
<tr>
<td>Cost per Recipient</td>
<td>$8,469</td>
<td>$8,472</td>
<td>$8,620</td>
<td>$8,607</td>
<td>$9,113</td>
<td>$9,499</td>
<td>$9,574</td>
<td>$9,443</td>
<td>$9,257</td>
<td>$8,884</td>
<td>$8,504</td>
</tr>
</tbody>
</table>
MRT Waiver Amendment

• In April 2014, Governor Andrew M. Cuomo announced that New York State and CMS finalized agreement on the MRT Waiver Amendment.

• Allows the state to reinvest $8 billion of the $17.1 billion in federal savings generated by MRT reforms.
  • $6.4 billion is designated for Delivery System Reform Incentive Payment Program (DSRIP)

• The MRT Waiver Amendment will:
  • Transform the state’s Health Care System
  • Bend the Medicaid Cost Curve
  • Assure Access to Quality Care for all Medicaid members
DSRIP Explained

• Overarching goal is to reduce avoidable hospital use – Emergency Department (ED) and inpatient– by 25% over 5+ years of DSRIP

• This will be done by developing integrated delivery systems, removing silos, enhancing primary care and community-based services, and integrating behavioral health and primary care.

• Built on the CMS and State goals in the Triple AIM
  • Improving Quality of Care
  • Improving Health
  • Reducing Costs
### DSRIP Accounts for 80% of Medicaid Waiver Amendment

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-Centered</td>
<td>Improving patient care &amp; experience through a more efficient, patient-centered and coordinated system.</td>
</tr>
<tr>
<td>Transparent</td>
<td>Decision making process takes place in the public eye, process is clear and aligned across providers.</td>
</tr>
<tr>
<td>Collaborative</td>
<td>Developed as a collaborative process with the input of community stakeholders.</td>
</tr>
<tr>
<td>Accountable</td>
<td>Providers are held to common performance standards, deliverables and timelines.</td>
</tr>
<tr>
<td>Value Driven</td>
<td>Focus on increasing value to patients, community, payers and other stakeholders.</td>
</tr>
</tbody>
</table>
25 PPSs are Receiving Funding to Drive Change

- Performing Provider Systems (PPS) are networks of providers that collaborate to implement DSRIP projects
- Each PPS must include providers to form an entire continuum of care
  - Hospitals
  - Health Homes
  - Skilled Nursing Facilities (SNF)
  - Clinics & FQHCs
  - Behavioral Health Providers
  - Home Care Agencies
  - Other Key Stakeholders

Community health care needs assessment based on multi-stakeholder input and objective data

Building and 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
25 Performing Provider Systems

Key
- Public Hospital – led PPS
- Safety Net (Non-Public) – led PPS
Health Services for the Developmentally Disabled (DD) & DSRIP
DD vs. General Population In-Patient Hospitalization – Claims & Spend Data

*Statewide averages do not include regional duplications*
## DD Medicaid Top 5 Claims and Spend – Inpatient Hospitalization

### Top 5 DRG (In-Patient 2013) Claim Frequency

<table>
<thead>
<tr>
<th>DRG Code</th>
<th>Diagnosis</th>
<th>Sum of Medicaid Service Claim Counts</th>
</tr>
</thead>
<tbody>
<tr>
<td>0053-2</td>
<td>SEIZURE</td>
<td>2,155</td>
</tr>
<tr>
<td>0720-2</td>
<td>SEPTICEMIA &amp; DISSEMINATED</td>
<td>1,265</td>
</tr>
<tr>
<td></td>
<td>INFECTIONS</td>
<td></td>
</tr>
<tr>
<td>0750-2</td>
<td>SCHIZOPHRENIA</td>
<td>1,252</td>
</tr>
<tr>
<td>0753-2</td>
<td>BIPOLAR DISORDERS</td>
<td>966</td>
</tr>
<tr>
<td>0139-2</td>
<td>OTHER PNEUMONIA</td>
<td>711</td>
</tr>
</tbody>
</table>

|                   | Top 5 total                | 6,349                                |
|                   | Full total                 | 35,485                               |
| Top 5 as % of total |                          | 17.89%                               |

### Top 5 DRG (In-Patient 2013) $ Total Paid

<table>
<thead>
<tr>
<th>DRG Code</th>
<th>Diagnosis</th>
<th>Sum of Medicaid Total Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>0750-2</td>
<td>SCHIZOPHRENIA</td>
<td>$15,906,961</td>
</tr>
<tr>
<td>0053-2</td>
<td>SEIZURE</td>
<td>$11,764,177</td>
</tr>
<tr>
<td>0720-2</td>
<td>SEPTICEMIA &amp; DISSEMINATED INFECTIONS</td>
<td>$11,449,747</td>
</tr>
<tr>
<td>0753-2</td>
<td>BIPOLAR DISORDERS</td>
<td>$ 9,647,935</td>
</tr>
<tr>
<td>0758-2</td>
<td>CHILDHOOD BEHAVIORAL DISORDERS</td>
<td>$ 4,954,447</td>
</tr>
</tbody>
</table>

|                   | Top 5 total                           | $ 53,723,269               |
|                   | Full total                            | $224,662,962               |
| Top 5 as % of total |                                  | 23.91%                     |
# DSRIP Program Vision for DD Population

| Today’s Care                                                                 | Care in DSRIP Program                                                                 |
|----------------------------------------------------------------------------|
| PCP refers developmentally disabled (DD) individual to mental health       | DD Individual sees mental health at the same place and same day as medical practitioner |
| Acute care is given as next available, and walk-ins are scheduled for another time | Open access scheduling accommodates ALL appropriate acute care and walk-ins |
| Care delivered around acute illness, IP hospital stays, and Emergency Room (ER) visits | Annual exams and preventive care shift the focus to wellness for DD population at home and in their communities |
| PCP directs Care Management                                               | Care Management needs met *a priori*, and all appointments are coordinated around Care Management |
| DD individual (or guardian) informs practitioner about what happened when hospitalized in another city | Integrated electronic network enables the practitioner to see the other providers’ labs, imaging studies, and discharge summary |
| DD care directed by a single practitioner                                 | DD care coordinated by a multidisciplinary team, each member working to the full extent of her/his scope of practice |
Value Based Payments (VBP)
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:
  - Fee for Service (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...

Cost efficiency and quality outcomes: value
Payment Reform: Moving Towards VBP

• A Five-Year Roadmap outlining NYS’ plan for Medicaid Payment Reform was required by the MRT Waiver

• By DSRIP Year 5 (2019), all Managed Care Organizations (MCOs) 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)

• The State and CMS have thus committed itself 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
VBP starts from the DSRIP Vision on how an Integrated Delivery System should Function

Integrated Physical & Behavioral Primary Care

*Includes social services interventions and community-based prevention activities*

- 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

Episodic

Continuous

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

Sub-population focus on Outcomes and Costs *within* sub-population/episode
The Path towards Payment Reform: A Menu of Options

• There is not one path towards VBP.
  • 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
  • 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, intellectual or developmental disabilities 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 VBP:

<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</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 25% of total costs captured in VBPs in Level 2 VBPs or higher
Key Defining Factors our the New York VBP Approach

1. Addressing all of the Medicaid program in a holistic, all-encompassing approach rather than a pilot or piecemeal plan
2. Leveraging the Managed Care Organizations to deliver the payment reforms
3. Addressing the need to change provider business models through positive financial incentives
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
Questions?

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