NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Medicaid in New York State: Engineering High-Quality and Financially Sustainable Healthcare

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Overview

- The Medicaid landscape in New York State
- Medicaid Redesign – Progress to Date
- Innovation through DSRIP
- The move to Value Based Payment
- Lessons Learned from New York

Medicaid in New York

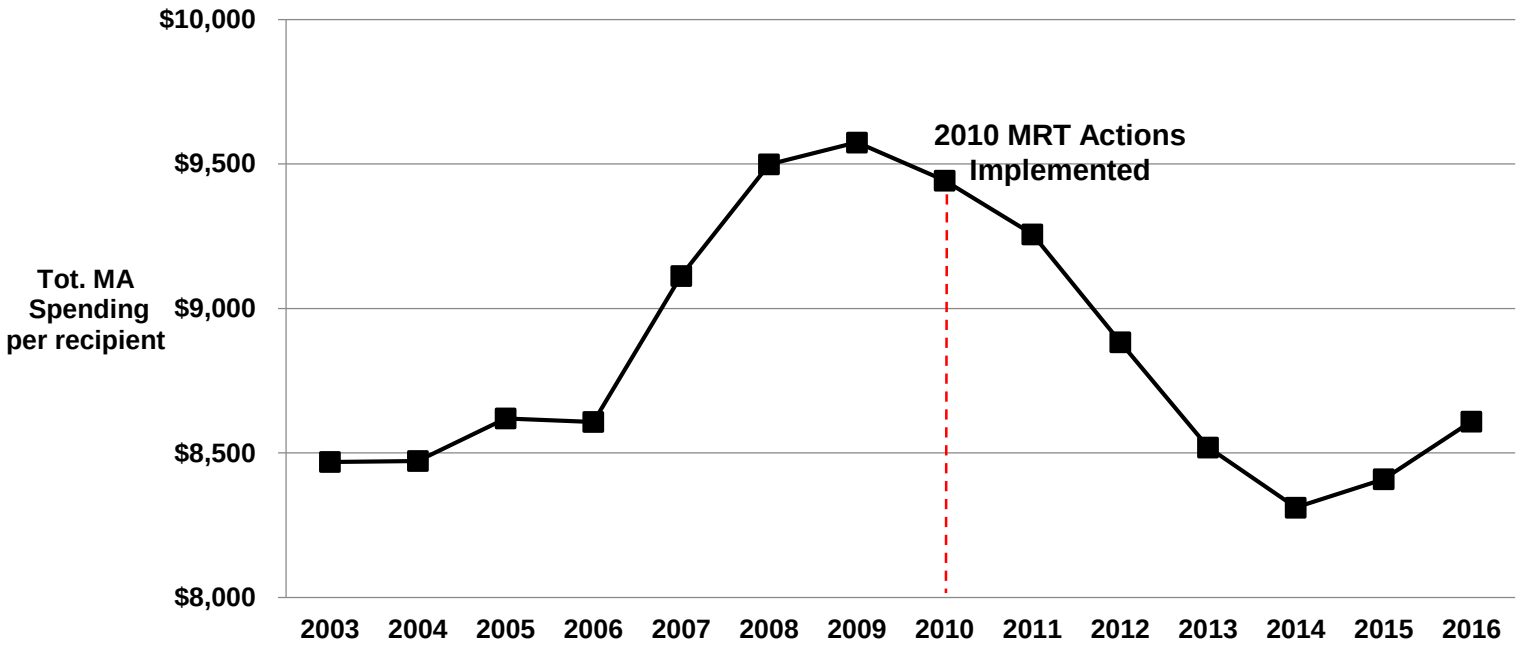
- **6.6 million people on Medicaid (1/3 of the State's population)**
- **Annual budget of $68 billion-2nd largest in the country**
- **Medicaid is the largest purchaser of healthcare services in the State**

The Medicaid Crisis in 2010

- > 13% anticipated growth rate had become unsustainable, while quality outcomes were lagging
  - Costs per recipient were double the national average
  - NYS ranked 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

The Medicaid Redesign Team

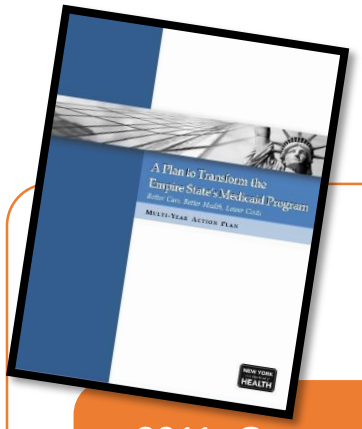
NYS Statewide Total Medicaid Spending per Recipient (CY2003-2016)



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
# 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	6,327,708	6,708,697	6,682,542
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	$8,312	$8,409	$8,609

Source: NYS DOH OHIP DataMart (based on claims paid through July 2017)

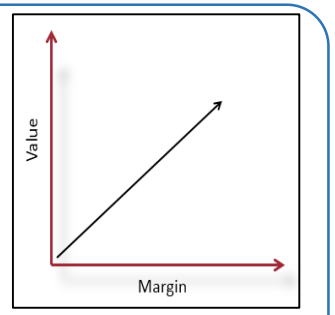
New York State Medicaid Transformation Since 2011



2011: Governor Cuomo created the Medicaid Redesign Team (**MRT**) which developed a series of recommendations to **lower immediate spending and propose future reforms**.

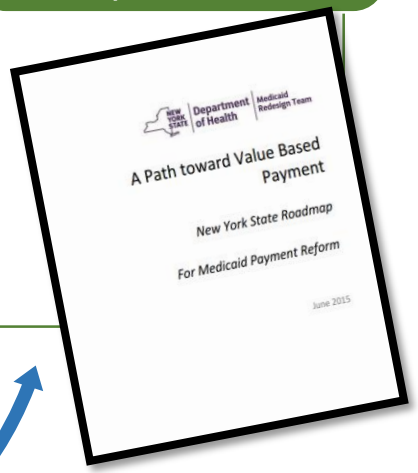
2014: As part of the MRT plan **NYS obtained a 1115 Waiver** which would reinvest MRT generated federal savings back into redesigning New York's health care delivery system known as Delivery System Reform Incentive Payment Program (**DSRIP**).

NEW YORK STATE DSRIP



2015: As part of DSRIP, NYS undertakes an ambitious payment reform plan working towards **80% value based payments by the end of the waiver** period.

June 2015: **NYS publishes a multi–year VBP Roadmap**, a living document that **outlines** the State's **payment reform goals** and program requirements.



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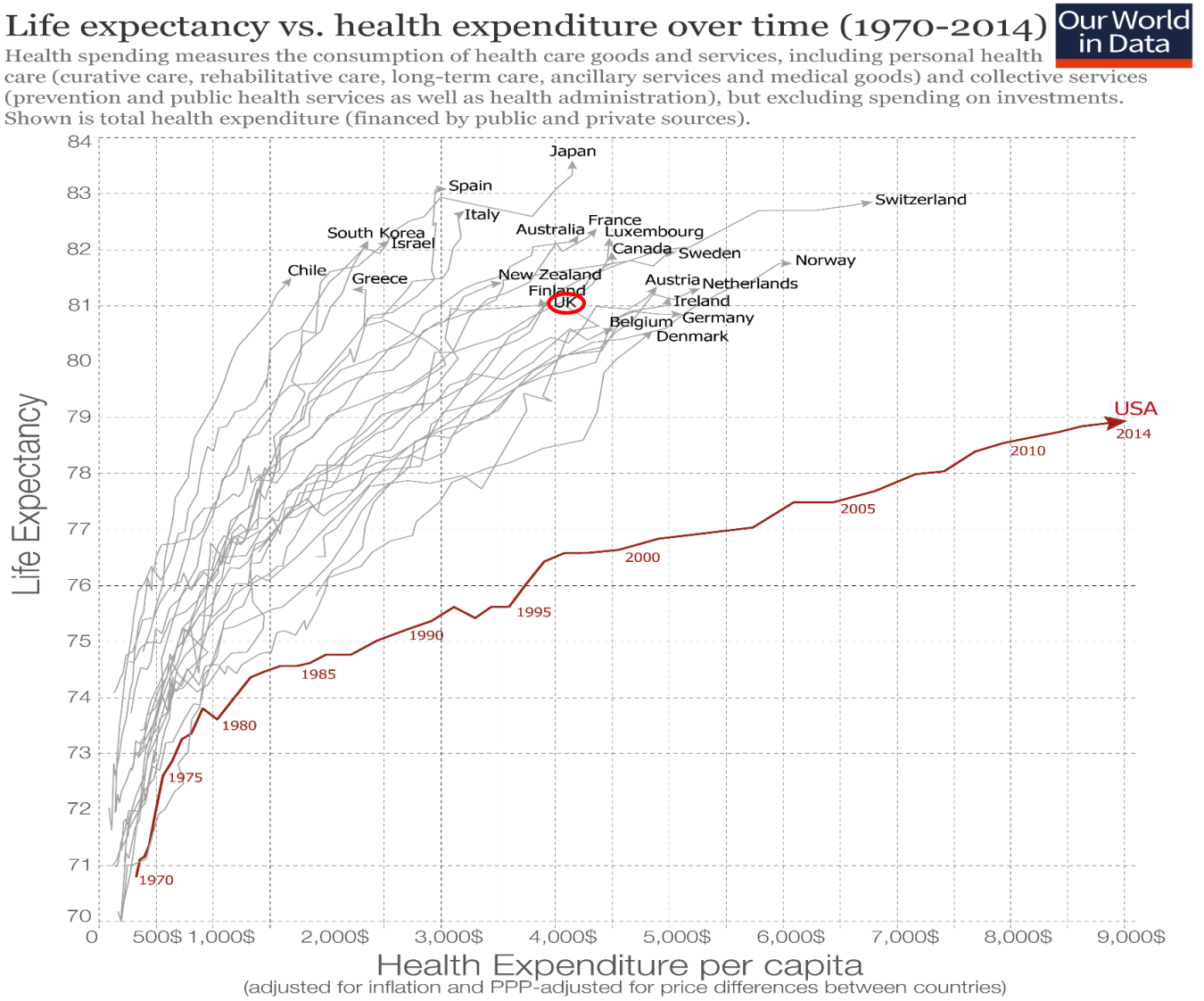
We Still Have Work To Do:



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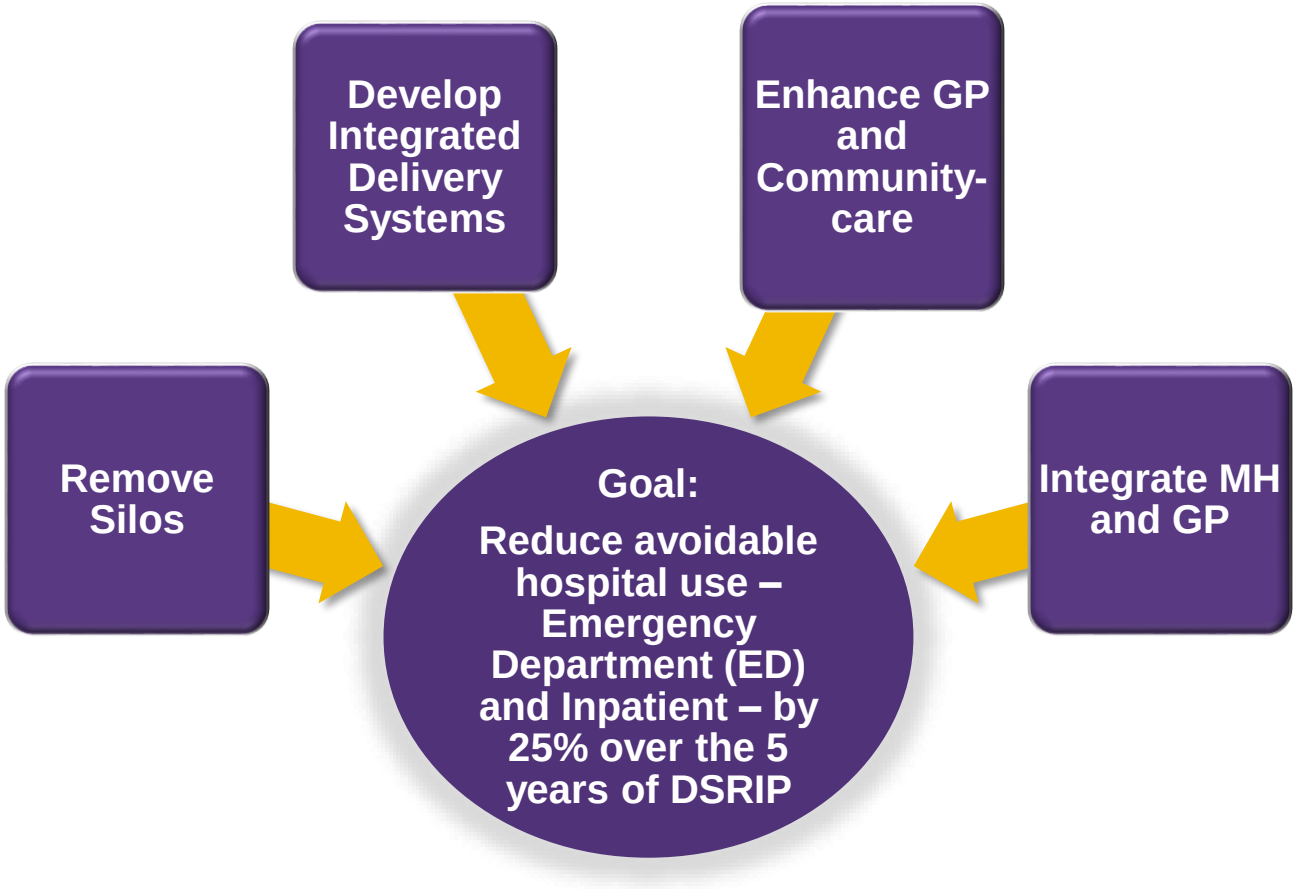
The Delivery System Reform Incentive Payment Program (DSRIP)

DSRIP Program Objectives

$7.3 Billion Investment Over Five Years



The DSRIP Challenge – Creating an Integrated Delivery System

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 processes are clear and aligned across providers.
Collaborative	• Collaborative process reflects the needs of the communities and input 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.

The DSRIP Solution: 25 Performing Provider Systems (PPS)

Over 5 Years, 25 Performing Provider Systems Will Receive Funding to Drive Change

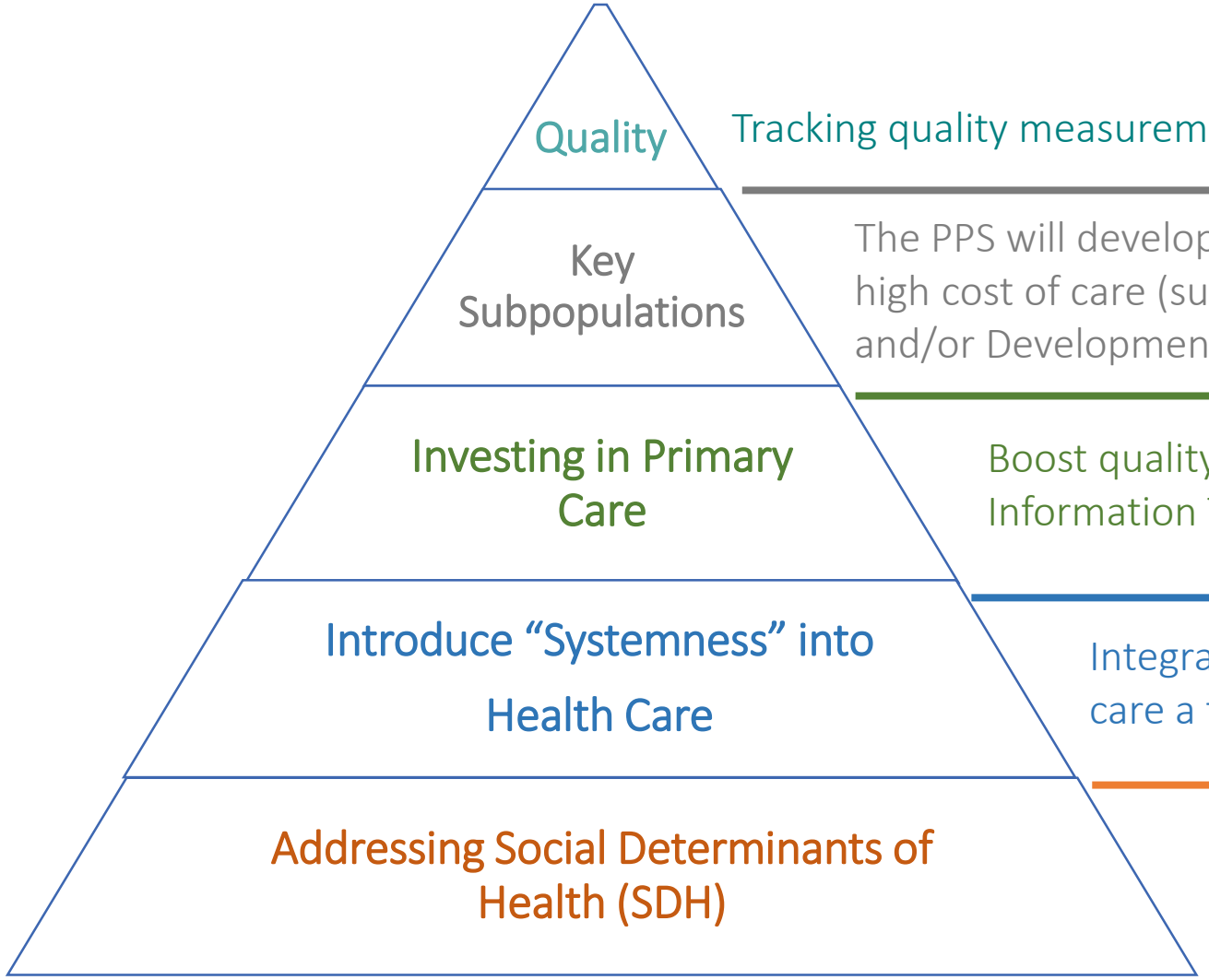
- A PPS is composed of regionally collaborating providers who will implement DSRIP projects over a 5-year period and beyond

- Each PPS must include providers to form an entire continuum of care
  - Hospitals
  - GPs, Health Homes
  - Skilled Nursing Facilities (SNF)
  - Clinics
  - Mental Health/Substance Abuse Providers
  - Home Care Agencies
  - Social Care Organizations

- Statewide goal:
  - reduce avoidable hospital use by 25% (re-admissions and ER visits)
  - Activating New York State's fragile safety-net network
  - 80-90 percent of Medicaid managed care payments shift from fee-for-service payments to value based payments

- Current State – Pay for Performance Phase

PPS Holistic Approach to System Transformation



Tracking quality measurement will occur at all levels of care.

The PPS will develop initiatives targeting populations with high cost of care (such as HIV/AIDs, or those with Intellectual and/or Developmental Disabilities).

Boost quality and access to primary care. Invest in Health Information Technology and Patient Centered Medical Home.

Integrate providers, share data in real time; make health care a team sport.

Integrate social care providers into PPS activities. Address social determents in a culturally competent manner.

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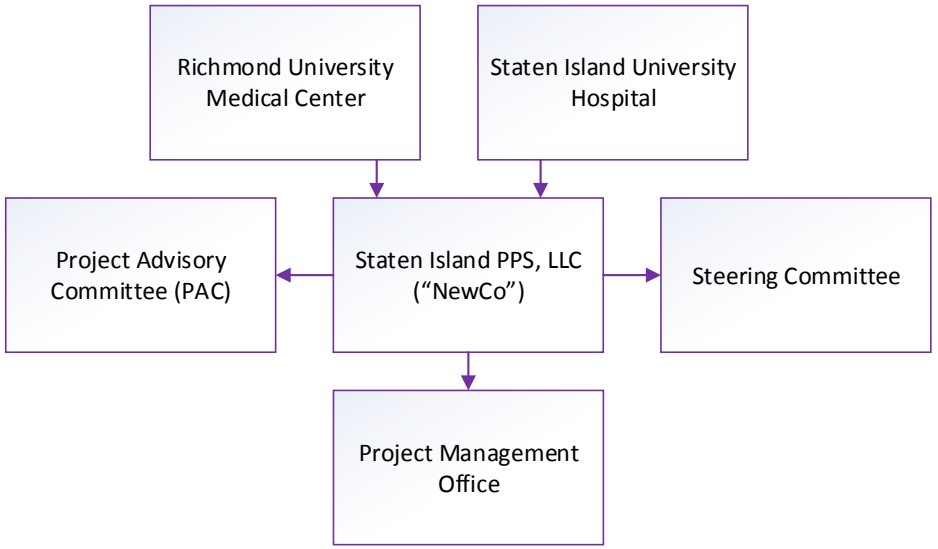
Staten Island Performing Provider System

Governance Structure



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DSRIP Projects Being Implemented

75
Partners in SIPPS Network

180,000
Staten Island Residents with Medicaid or Uninsured

$217,087,986
Total Possible Award Dollars

DSRIP In Action on Staten Island

- Created 24/7 Crisis Stabilization and Respite Centers for Behavioral Health needs
- Created a Emergency Department Warm Handoff Pilot of reduce avoidable substance-use related ED visits
- Created a Heroin Overdose Prevention & Education (HOPE) Program in partnership with the Local Government
- Created Community Health Worker and Care Management Credit Certificate Programs at College of Staten Island (CSI) to enable the workforce to sustain healthcare transformation

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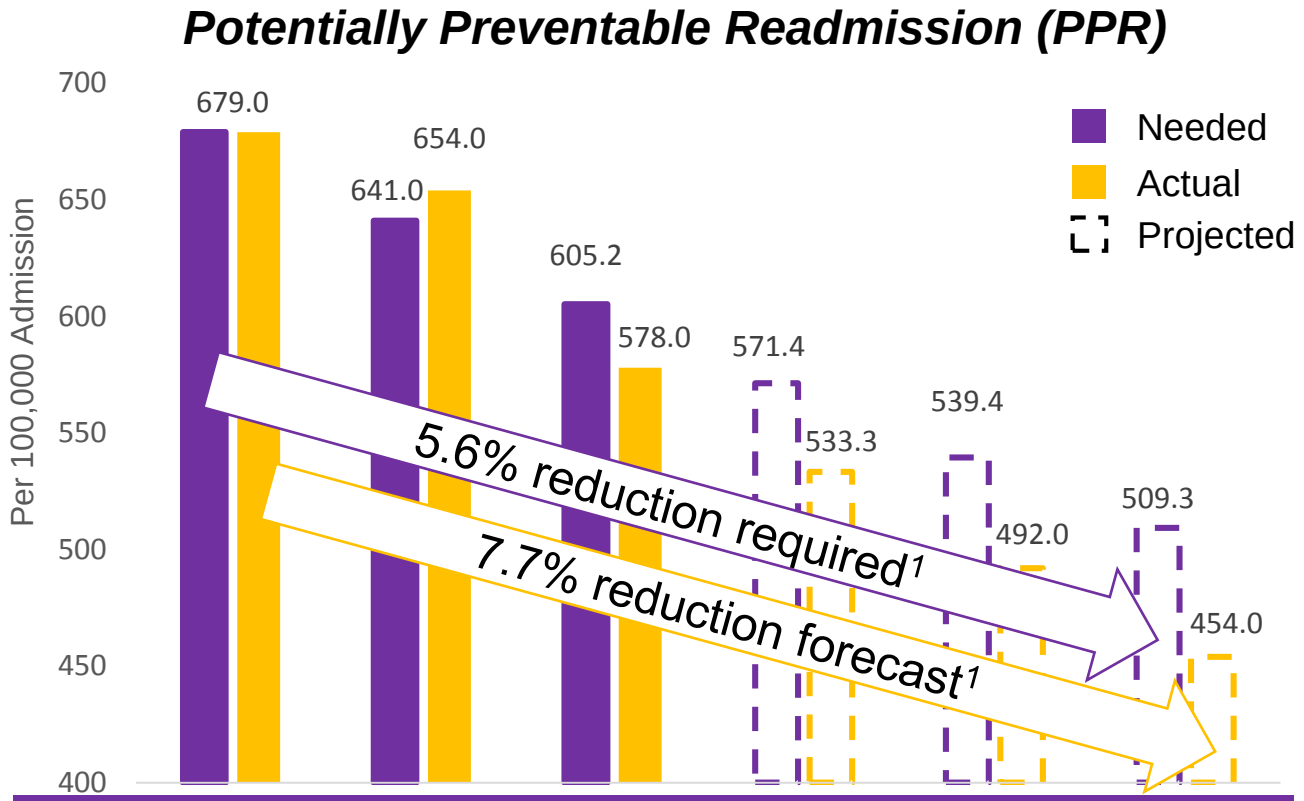
DSRIP: Where Are We Now?

- DSRIP Year 3
- PPS Must Focus on Performance: Are the health outcomes of members improving?
- **95%** of all available funds have been earned
- We have to work collectively to ensure performance improves: Providers, local partners & state agencies
- DSRIP is a once in a lifetime opportunity
- 4,827,487 Medicaid patient engagements through DSRIP

Readmissions Are Down

Pursuing the goal of 25% reduction …

- If all PPS maintain current reduction rates, the State **will achieve** a 33.14% reduction over baseline.
- PPS performance ranges from a reduction of 30% to an increase of 1%



	MY0	MY1	MY2	MY3	MY4	MY5
Needed	679.0	641.0	605.2	571.4	539.4	509.3
Actual	679.0	654.0	578.0	533.3	492.0	454.0
Delta	0.0	13.0	-27.2	-38.1	-47.4	-55.3

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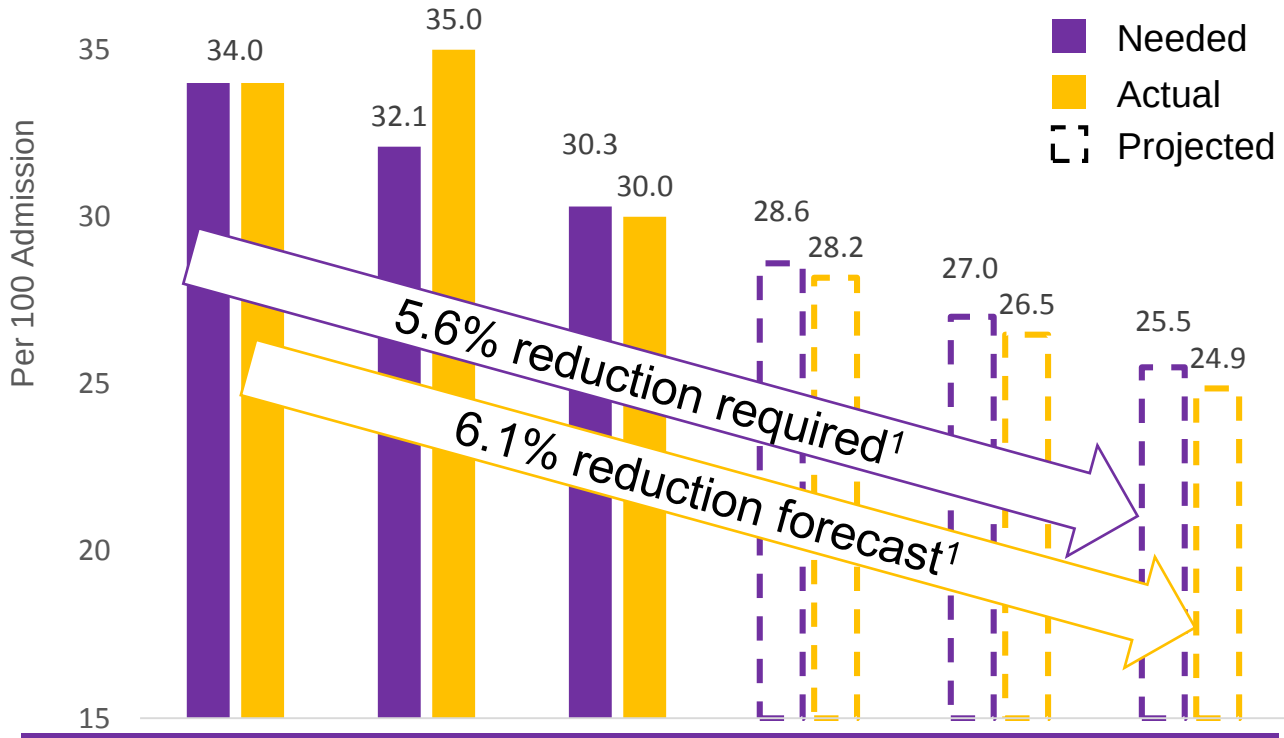
Emergency room utilization is declining

Pursuing the goal of 25% reduction …

- If all PPS maintain current rates, the State **will achieve** a 26.9% reduction over baseline.
- PPS performance ranges from a reduction of 20% to an increase of 1%

Potentially Preventable Emergency Room Visits



	MY0	MY1	MY2	MY3	MY4	MY5
Needed	34.0	32.1	30.3	28.6	27.0	25.5
Actual	34.0	35.0	30.0	28.2	26.5	24.9
Delta	0.0	2.9	-0.3	-0.4	-0.5	-0.6

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Value Based Payment (VBP) in a Changing System

What Are Value Based Payments?

- **Goal**: To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.
- By DSRIP Year 5 (2020), 80 – 90% of provider payments must be value based.
- Currently, 38.32% of Medicaid payments are value based.

Value Based Payments (VBP)

An approach to Medicaid reimbursement that rewards value over volume	An approach to incentivize providers through shared savings and financial risk	A method to directly tie payment to providers with quality of care and health outcomes	A component of DSRIP that is key to the sustainability of the program

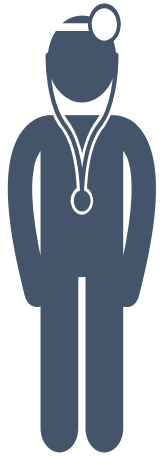
VBP Transformation: Timeline

2017	2018	2019	2020
April 2017	***April 2018***	***April 2019***	***April 2020***
Performing Provider Systems (PPS) requested to submit growth plan outlining path to 80-90% VBP	≥ 10% of total Managed Care Organization (MCO) expenditure in Level 1 VBP or above	≥ 50% of total MCO expenditure in Level 1 VBP or above. ≥ 15% of total payments contracted in Level 2 or higher *	80-90% of total MCO expenditure in Level 1 VBP or above ≥ 35% of total payments contracted in Level 2 or higher *

Contracting in VBP

Allocation

Payment



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Managed Care Organization

ACO, IPA, or Provider

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NHS England

Clinical Commissioning Groups

Accountable Care Systems

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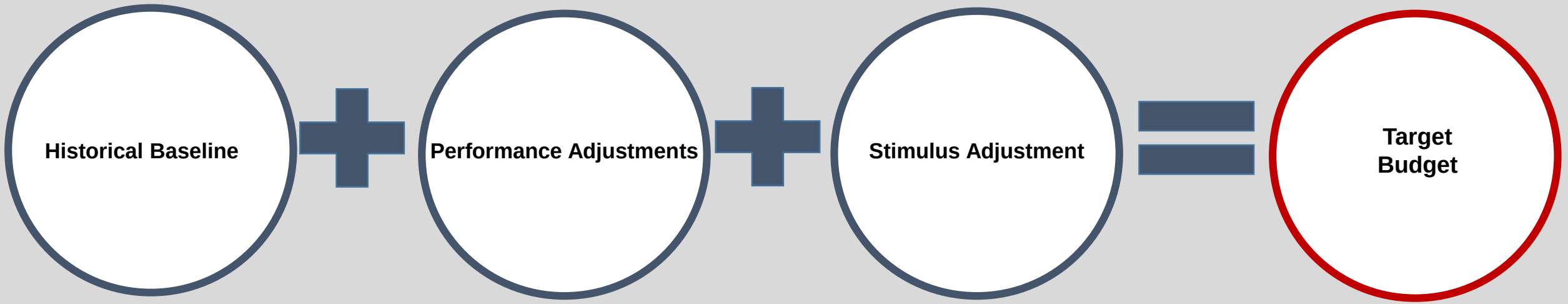
VBP Arrangements

Category of Arrangement	Type of Arrangement
Population-Based Arrangement	-Total Care for General Population -Total Care for Special Needs Population (there are 4 special need population based arrangements)
Episode-Based Arrangement	-Maternity Care -Integrated Primary Care (includes Chronic Care conditions)

Levels of Risk in Value Based Payments

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP
Activity Based Payments (ABP) with quality bonus	ABP with upside-only shared savings available when outcome scores are sufficient	ABP with risk sharing	Prospective capitation bundle
Activity Based Payments	Activity Based Payments	Activity Based Payments	Prospective total budget payments
No Risk Sharing	↑ Upside Only	↑ Upside & ↓ Downside Risk	↑ Upside & ↓ Downside Risk

To determine if shared savings/losses is generated, a target budget needs to be developed



VBP In Action

Example 1: Accountable Health Partners ACO

MCO and Provider	• Accountable Health Partners Accountable Care Organization (ACO) • 1,900 General Practice Physicians • MVP Healthcare Managed Care Organization
VBP Arrangement and Risk	• Total Cost General Population VBP Arrangement • VBP Level 1 Risk-upside only bonus capped at no more than 25% of the total payments made to the ACO and the ACO providers for medical services.
Cohort	• 27,023 Patients (Commercial and Medicare Insurance) • Rochester, New York
VBP Intervention	• Implemented a pharmacy program that monitors utilization of high-cost drugs • Developed a robust Care Management program that supports high-risk patients • Used a data platform that centralizes data from 12 different EHR systems and allows them to actively close gaps in care and coordinate upcoming visits.
Results/Outcomes	• 2015-2016, there was improvement in 11 of the 15 measures for the Commercial members and 9 of the 11 measures for Medicare members • 2015-2016, over $2.9 Million was generated in savings for both populations for both years. • In addition, the ACO between 2014-2017 has received over $3.7 Million in care management fees for services to members enrolled in all of the plans products.

Example 2: Mount Sinai Health System

MCO and Provider	• Mount Sinai Health System • HealthFirst Managed Care Organization
VBP Arrangement and Risk	• Total Cost General Population VBP Arrangement • VBP Risk Level 2
Cohort	• Medicare patients with specific acute medical conditions who would otherwise be admitted to a hospital within the Mount Sinai Health System
VBP Intervention	• MCO will pay Mount Sinai an up-front set amount of an episode of care handled by the Mobile Acute Care Team (MACT) • Mount Sinai patients receive hospital-level care for selected conditions and post-surgical care in their home instead of an ER
Results/Outcomes	• Over 600 patients treated. Data has shown MACT has reduced 30-day ER readmissions, earned high patient satisfaction, and reduced the cost of care • In process of expanding MACT to all commercial, Medicaid and Medicare insurances and a broader range of conditions

Example 3: St. Barnabas Health System

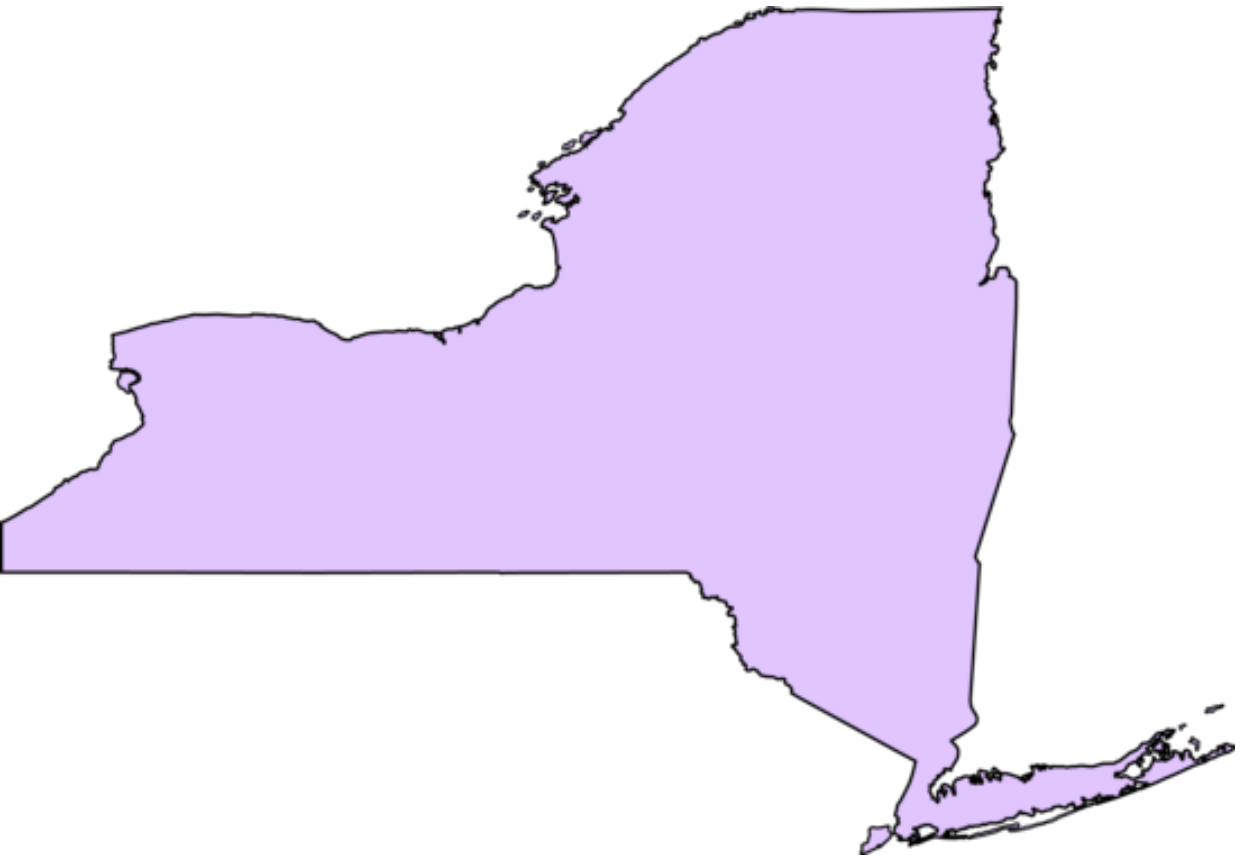
MCO and Provider	• St. Barnabas Health (SBH) System • Healthfirst Managed Care Organization
VBP Arrangement and Risk	• Total Cost General Population VBP Arrangement • VBP Risk Level 2
Cohort	• 80% (nearly 384,000) of the health system's patients are covered by Medicaid or are uninsured with relatively poor health status.
VBP Intervention	• Sold part of SBH campus to build 314 unit supportive housing complex that will include: urgent care, women's and pediatric services, a fitness center, a rooftop farm, a greenhouse, a teaching kitchen, and a pharmacy that does not sell cigarettes or alcohol.
Results/Outcomes	• Under a VBP contract, SBH can decide where to spend it's money to reduce healthcare costs-including the social determinants of health • St. Barnabas will have below-market rent on the development to keep operating costs for urgent care and other facilities low

Example 4: Montefiore Health System

MCO and Provider	• Montefiore Health System • Various Managed Care Organizations
VBP Arrangement and Risk	• Total Cost General Population VBP Arrangement • VBP Risk Level 3
Cohort	• 1000 full time employees managing 235,000 challenging, high-cost patients
VBP Intervention	Multiple: • Montefiore educates doctors on electronic health record utilization, leverages data analytics to better focus care and partners with community organizations to address the social determinates of health • Air conditioners for frequent ER visitors with lung disease
Results/Outcomes	• Sustainable delivery system despite 85% government payer mix

Lessons From New York

New York State of Mind: Lessons Learned So Far



- The cost curve can be bent, but success depends on stakeholder buy in and consistency in government policy.
- Delivery system transformation is difficult, but the best path forward is system “integration” and incentive alignment to improve quality and cost effectiveness. Make health care a team sport.
- Don’t define “system” narrowly. Partnerships with other systems (social services, criminal justice, local government, education) is necessary for success especially with the most vulnerable patients.
- System transformation will only happen when change occurs at the point of care. Empower local problem solving through rapid cycle continuous improvement.
- Measure results and feed data back to providers in “actionable” ways.
- Don’t be afraid to innovate!

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Go Change The World!

Additional information available at:

www.health.ny.gov/dsrip

www.health.ny.gov/vbp

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