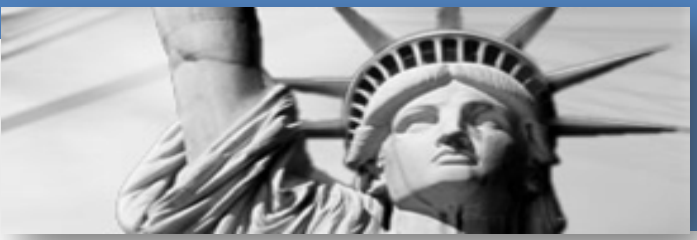


NEW YORK state department of HEALTH

Redesigning THE MEDICAID PROGRAM

New York Medicaid Redesign

Public Health and Health Planning Council Payment Reform

July 25, 2012

Historical Payment Reform

Pre-MRT Payment Reforms

- In the past 3 years, New York has shifted the operating component of the Medicaid rate from cost-based reimbursement to pricing methodologies in various sectors.
- Health Sector changes:
  - Inpatient – Rebasing/APR-DRGs (2009)
  - Outpatient/Clinic – APGs (2009)
  - Managed Care/MLTC – Regional Payment Model (2011)
  - Nursing Homes – Pricing (2012)
  - CHHAs – Episodic Payment (2012)

Medicaid Redesign Team: Payment Reform & Quality Measurement Work Group

"It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure." – Governor Andrew M. Cuomo, January 5, 2011

Payment Reform & Quality Measurement Goals

- On January 5, 2011, Governor Cuomo issues an Executive Order creating the Medicaid Redesign Team (MRT).
  - The MRT subdivided into 10 work groups to deal with more complex issues.
- The Payment Reform and Quality Measurement Work Group was created to develop a series of recommendations to :

1) Facilitate the transformation of New York's health care system;

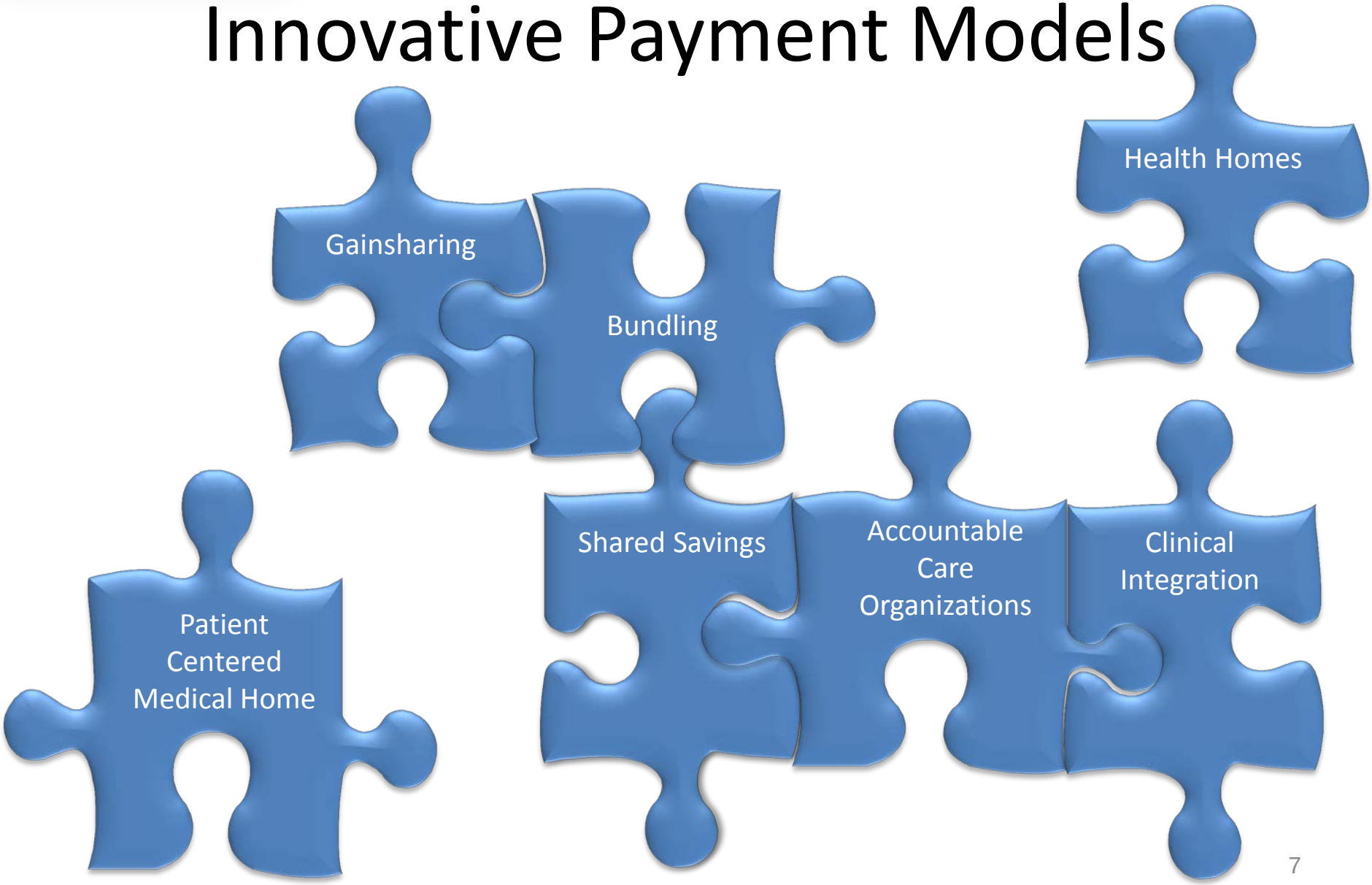
2) Encourage the development of innovative payment and delivery models;

3) Explore and identify evidence-based quality indicators to benchmark New York's Medicaid program and the provider delivery system;

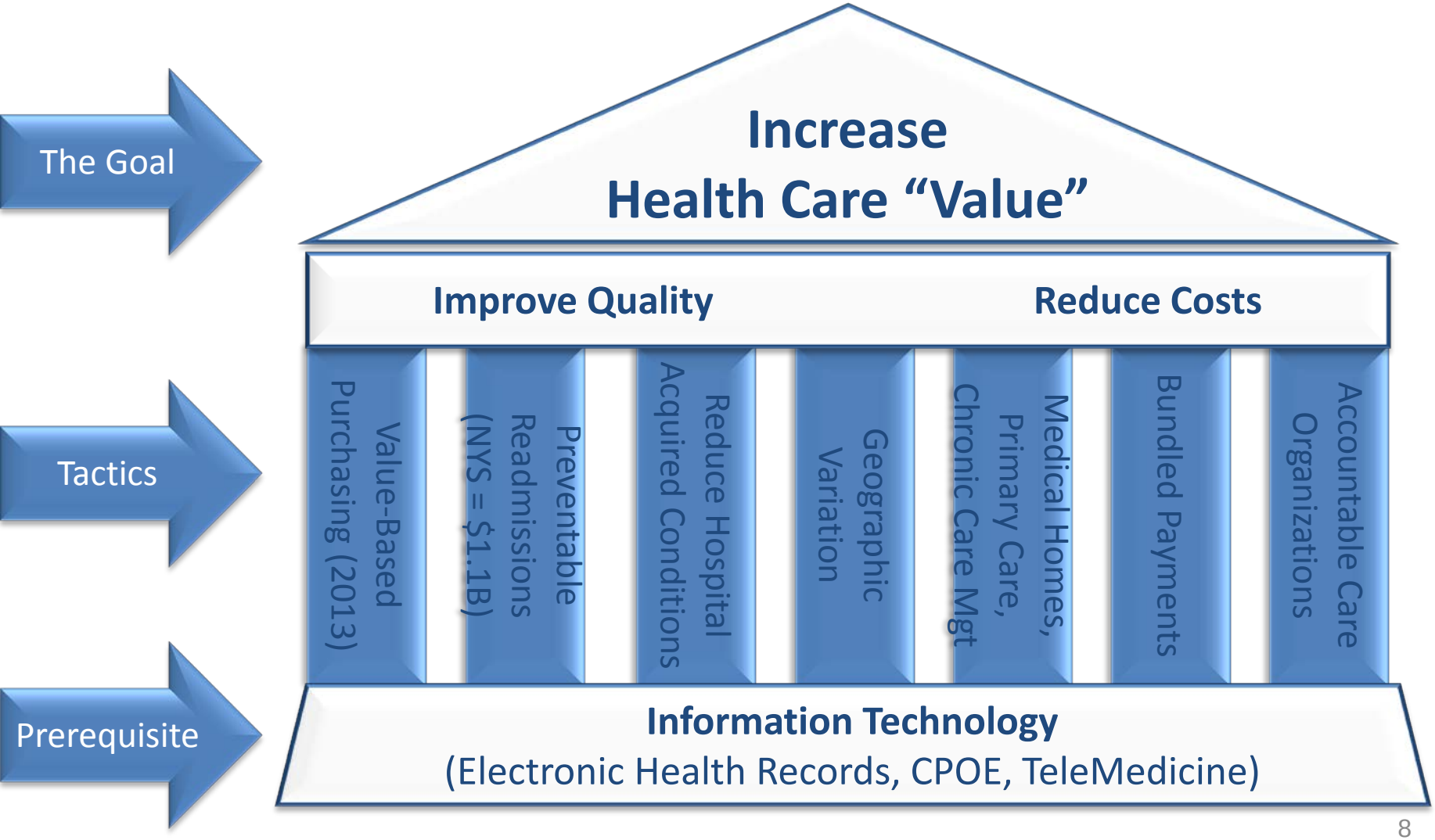
4) Incorporate Federal Health Care Reform's focus on the development of shared savings models, pioneer accountable care organizations, risk-sharing assumption demonstrations, clinical integration, and bundling of services and payment across traditional silos of delivery; and

5) Maintain a patient-centric focus on quality improvement, care coordination and patient safety.

Innovative Payment Models



Builds Health Care Delivery System Reform

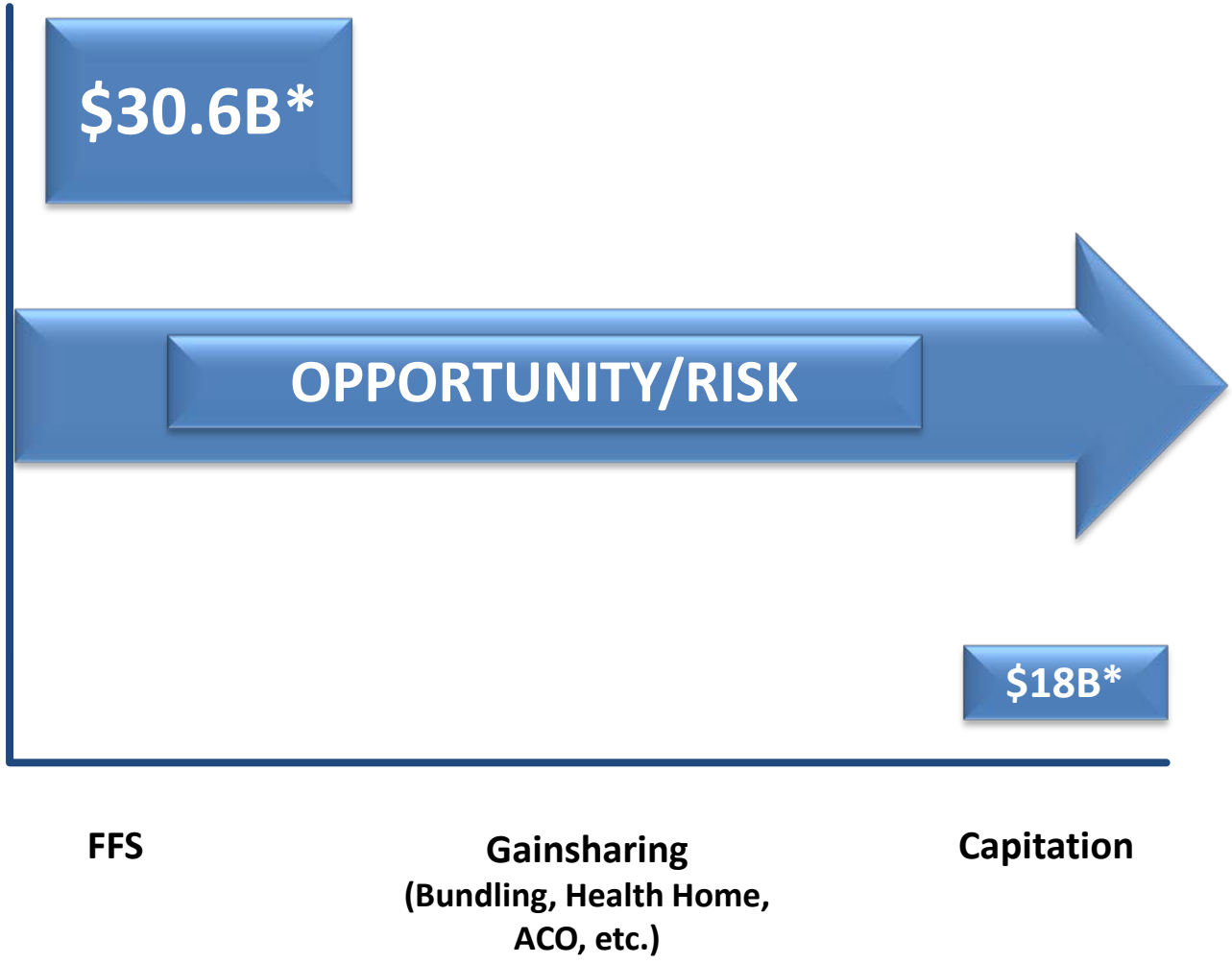


Source: HFMA-Modified

MRT Multi-Year Action Plan

- The MRT action plan, which will take five years to fully implement, is the most sweeping Medicaid reform plan in State history.
- Key elements of Plan Involving Payment Reform:
  - Global Spending Cap
  - Care Management for All
  - Health Homes, Patient Centered Medical Homes & Behavioral Health Organizations
  - Strengthening/Transforming the Health Care Safety Net
  - Supportive Housing
  - System-wide Pay-for-Performance and Quality Measures

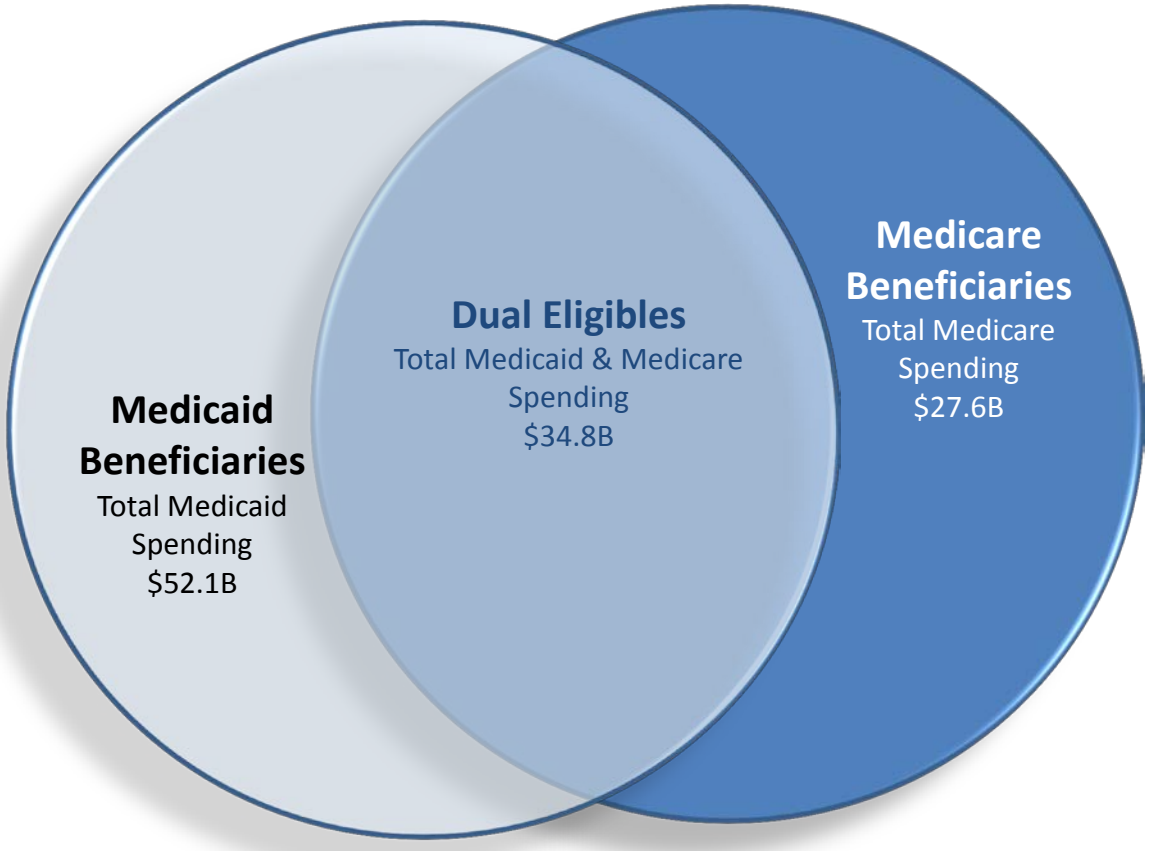
MRT Will Provide Opportunities for Shared Savings & to Shift Risks to Plans/Providers Over the Next 3 Years



*Source: Medicaid claims data from the Salient Tool (SFY 2010-11): Managed Care: $18 billion & FFS: $30.6 billion. MMC (including Family Health Plus) includes drug spending that currently occurs in the FFS system. Excludes off-line payments such as DSH.

Long Term Reimbursement Reforms: High Cost Populations and Paying for Quality

Dual Eligible Recipients (700,000 approx.)
Comprises 45% of Medicaid Spending ($23.4B)
Comprises 41% of Medicare Spending ($11.4B)



Sources: Medicare – National health expenditure data (2004) trended by Medicare market basket to 2010; Medicaid – United Hospital Fund (2010) data net administration costs; Duals – Kaiser (2005) data trended by market basket to 2010 & Kaiser (2007) dual eligibles share percentage (45%) applied to 2010 Medicaid spending estimate. Note: DOH is in the process o working with CMS to update data.

Multiyear Strategy to Integrate Care for Dual Eligible Individuals

- In March 2011, NYSDOH received a planning grant from CMS to develop a demonstration proposal around integrated care for individuals eligible for Medicaid and Medicare (Dual Eligibles)
- Individuals in need of LTSS (less than 120 days) will begin to mandatorily enroll with a health plan for Medicaid starting September 2012; Medicare capitation starts January 2014 under the Fully-Integrated Duals Advantage (FIDA) program
- Managed Fee-For-Service within a health home for dual eligibles in need of behavioral health and chronic care services
- An additional, small-scale FIDA OPWDD dual eligibles demo will provide managed care to 10,000 OPWDD dual eligibles

Looking Ahead: Payment Reform/Innovation

Areas of Payment Reform/Innovation Department of Health is Exploring

- Refining Risk Adjustments for Dual Eligibles Enrolled in Managed Care (3M/MEDPAC)
- Developing Health Systems Performance Incentives to Align and Reward Health Plans and Providers (3M/Mercer/DOH)
  - Possible Alliance with Commercial Payors
- Defining Both Medicaid and Medicare Gain Sharing Rules with CMS
  - New Analytic Tool That Will Allow DOH and Health Homes to Measure Patient-Centric Performance Against Benchmarks
- Explore Capital Pricing to Further Expand CON Reform

Future Role of DOH Rate Setting

- Eliminate Fee-For-Service Rate setting
- DOH Will Set "Benchmark" Rates for Managed Care Premium Setting and to Monitor Price Competition Within Markets:
  - APR-DRG Input
  - Nursing Home
  - Home Care
- Continue Working on New Payment Methods (e.g. Bundling)
- Measuring and Paying for Quality/Gain-Sharing


Quality

Measuring Quality of Care in Medicaid Managed Care

- Began in the 1994 measurement year, evolving ever since
- Quality Measures based on the national HEDIS data set, called QARR (Quality Assurance Reporting Requirements)
- Measures collected for Medicaid, commercial (HMO and PPO), and Child Health Plus
- Annual Data submission
- Audited data

Integrating Quality into Program: Progress over Time

- 1996: QARR was publically reported.
- 1997: The Quality Matrix began, which is a tool used to target measures/areas for improvement for managed care plans. Plans required to do a root cause analysis and action plan.
- 1997: Regional Medicaid Consumer Guides were developed. The Consumer Guides have been included as part of the managed care enrollment packet since 1997.

Integrating Quality into Program: Progress over Time

- 1999: Quality is incorporated into the annual surveillance of managed care plans, and quality staff participate in select onsite reviews.
- 2000: Quality measures were used to change the auto-assignment algorithm for Medicaid managed care enrollees.
- 2001: NYSDOH established a Quality Incentive, a pay for performance program for Medicaid managed care.

Integrating Quality into Program: Progress over Time

- 2001: Quality performance as measured in QARR becomes part of the expansion review policy for managed care plans.
- 2007: Managed care contracts now include a clause that NYSDOH can terminate a plan's contract if performance over a three-year period is substandard.

Improving Quality for Medicaid

- Selective Contracting
  - Bariatric Surgery
  - Breast Cancer Surgery
- Managed Long Term Care Measurement
- Measure development

New Measurements in Development

Efficiency Measurements

- **Preventable Hospitalizations**
- **Potentially Preventable Readmissions**
- **Potentially Preventable Complication**

Quality Measurements

- **Mental Health/Substance Abuse**
  - Early stages of measurement development with OMH
- **Long Term Care**
  - In 2012, public release of a Managed LTC Quality Report
  - Intend to align measures across LTC settings
  - UAS will be the future basis for most LTC measures

Quality and MRT

- MRT Payment Reform and Quality Subgroup

- Recommendation: Adopt a series of accepted performance measures across all sectors of health, aligning measures already being collected in New York in Medicaid managed care, including managed long term care with federal requirements.

Quality and MRT

- Developed MRT Quality Measure set across all of Medicaid
  - Aligned with:
    - NYS QARR
    - Federal Meaningful use
    - CHIPRA
    - Medicaid Adult Core Set of Measures
    - Federal Health Home Measures
    - NYS Medicaid unique population
- http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf

Paying for Quality

Paying For Quality: Incentives

- Medicaid Managed Care Quality Incentive
  - Reward high performing plans with up to 3% of premium
- Nursing Home Quality Pool (2012)
  - $50M pool to begin next year
- Proposed Quality Incentive for Managed Long Term Care

Paying for Quality: Payment System Changes

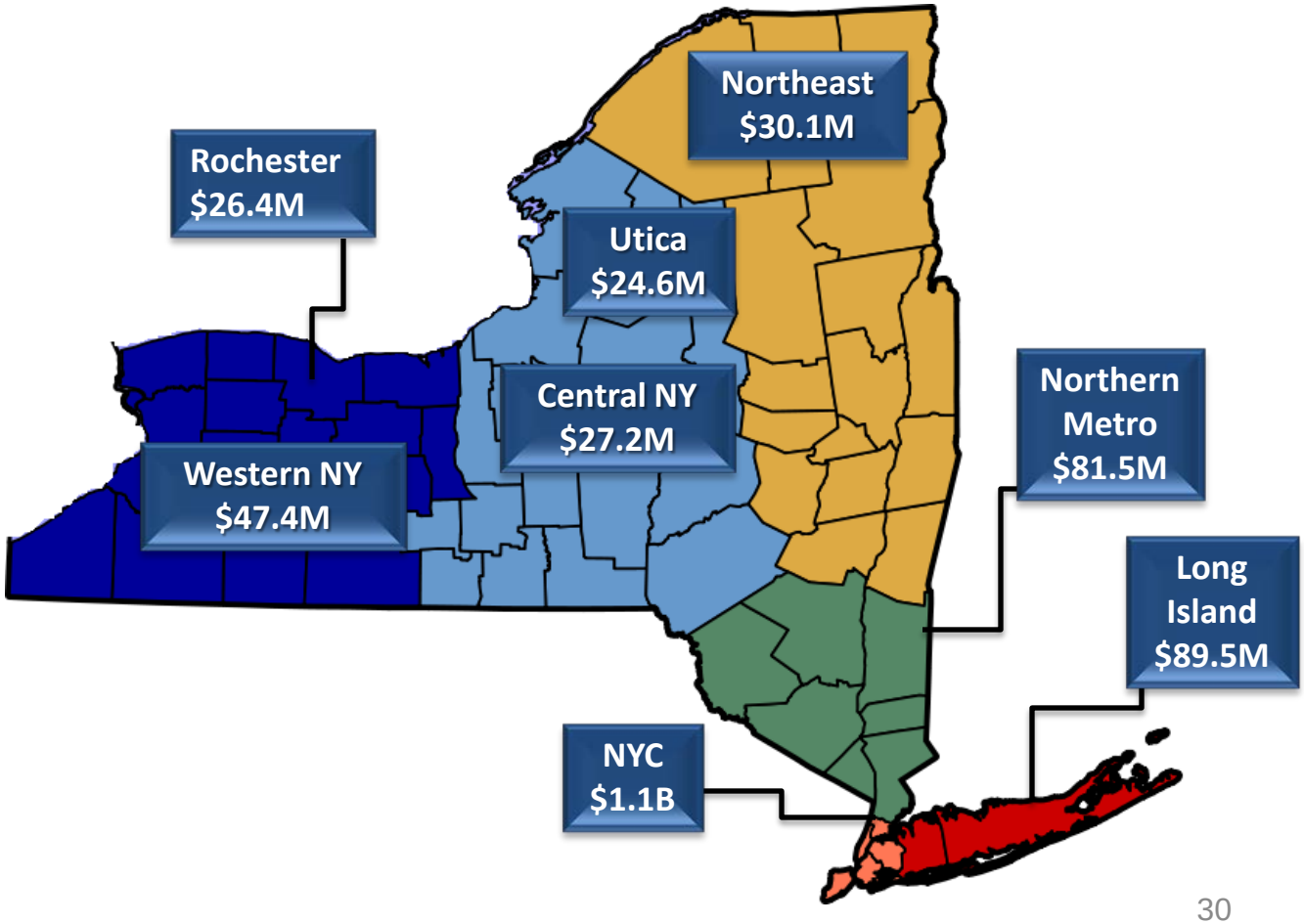
- Risk-based payment systems
  - Medicaid Managed Care
  - Managed Long Term Care
  - Home Care
  - Health Home
- Payment for systems change, that will improve quality
  - Medical home enhancement
  - Meaningful use (CMS) payment

Paying For Quality: Disincentives

- Reduction of capitation payments for poor quality, efficiencies gained on reducing:
  - Avoidable Hospitalizations
  - Potentially preventable readmissions (PPRs)
  - Potentially preventable complications (PPCs)
- FFS hospital payments reduced for high rates of :
  - PPRs
  - PPCs

Total Inpatient Medicaid Spending Related to PPAs and PPRs (Statewide Total =$1.4B)

NYPHRM-R:	PPAs (per 100 admissions)	PPRs
Long Island	15.3	6.7
NYC	18.5	7.7
Northern Metro	13.6	6.4
Northeast	13.9	7.5
Utica	13.8	6.3
Central	13	5.9
Rochester	12.3	6.2
Western	13.2	6.4
Statewide	**16.8**	**7.3**



**Data Source: 2008 SPARCS; FFS and MMC; Includes Behavioral Health admissions*