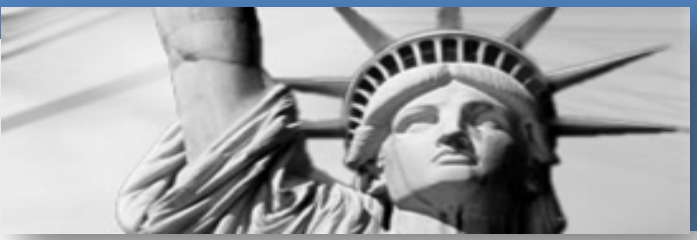


NEW YORK state department of HEALTH

Redesigning THE MEDICAID PROGRAM

New York Medicaid Redesign

Payment Reform & Quality Measurement Work Group

September 27th, 2011
New York State Department of Health
4th Floor Conference Room A/B
Flanigan Square,
547 River Street,
Troy, New York 12180

Dan Sisto, Co-Chair
Dr. William Streck, Co-Chair

MRT Payment Reform & Quality Measurement Work Group Members

Co-Chair: Dan Sisto, President, Healthcare Association of NYS	Co-Chair: William Streck, MD, Chair, NY State Public Health and Health Planning Council
Rick Abrams, Executive VP, Medical Society of the State of NY	**Phyllis Lantos**, Executive VP & CFO, NY Presbyterian Hospital
Elizabeth Benjamin, VP of Health Initiatives, Community Service Society	**Art Levin**, Director, Center for Medical Consumers
Scott Cooper, MD, President & CEO, St. Barnabas in the Bronx	**Joseph McDonald**, President & CEO, Catholic Health Services of Western NY
Michael Cropp, MD, President & CEO, Independent Health	**Joe Quagliata**, President & CEO, South Nassau Communities Hospital
Joanne Cunningham, HCA, President, Home Care Association of NYS	**Steven M. Safyer, MD**, President & CEO, Montefiore Medical Center
Emma DeVito, President & CEO, Village Care of NY	**Susan Stuard**, Executive Director, Taconic Health Information Network and Community
Paloma Izquierdo-Hernandez, MS, MPH, President & CEO, Urban Health Plan	**James R. Tallon, Jr.**, President, United Hospital Fund
Sneha Jacob, MD, MS, Assistant Professor of Clinical Medicine, Columbia University & Assistant Medical Director, NY Presbyterian System Select Health	**Pat Wang**, President & CEO, Healthfirst
James Knickman, President & CEO, NYS Health Foundation	**Marlene Zurack**, Senior VP, Finance, NYC Health and Hospitals Corporation
Ronda Kotelchuck, Executive Director, Primary Care Development Corporation	

Agenda

- Introductions
- DSH (New Yorker's Indigent Care)
- Safety Net Providers
- Follow-up to September 20th Work Group Meeting
- Adoption of Guiding Principles
- Potential Recommendations
- Next Steps

Follow-up to the September 20th Work Group Meeting

Health Homes

Case Management - What We Have Now: 2010 FFS Case Management Claims

Service Category Case Management	2010 MA Services Paid	Unique Recipients	Savings Opportunity at 90% FFP
OMR SERVICE COORD-ENHANCED VOLUNTARY	$131,112,960	50,143	$26,095,133
OMR SERVICE COORD-BASIC VOLUNTARY	$68,834,024	67,630	$13,741,327
OMR SERVICE COORD STATE	$55,947,683	11,157	$11,180,368
AIDS/CASE MANAGEMENT	57,600,136	12,539	$11,176,583
OMH - 2ICM/1SCM	$27,648,845	6,670	$5,482,925
CMCM/EARLY INTERVENTION SERVICES	$24,546,003	37,292	$4,894,825
OMH-ICM	$21,709,107	5,211	$4,254,851
OMH-SCM-COMMUNITY 20	$18,015,829	6,963	$3,583,453
OMH-ICM-STATE	$18,832,745	2,566	$3,577,167
OMH - 1ICM/2SCM	$14,220,732	3,853	$2,790,754
OMH-SCM-COMMUNITY 30	$12,292,414	5,236	$2,445,965
OMR SERVICE COORD-INTERMEDIATE VOLUNTARY	$6,557,305	5,524	$1,311,017
TASA	$6,362,540	4,349	$1,260,504
OMH - 1ICM/1SCM	$4,042,998	1,379	$799,592
CIDP MCCF-MONTHLY CARE COORDINATION FEE	$3,285,762	1,671	$637,848
OMR SERVICE COORD-WILLOWBROOK VOLUNTARY	$2,319,412	685	$463,675
OMH - ICM TEAM	$2,198,550	569	$433,985
CMCM/NBA	$334,439	171	$66,780
SYRACUSE COMMUNITY HLTH PERINATAL 1/4 HOUR	$331,913	228	$66,214
NFP TARGETED CASE MANAGEMENT	$140,165	499	$26,116
OMH - 2ICM/1SCM STEPDOWN	$25,517	153	$5,080
OMH- ICM STEPDOWN	$15,869	118	$3,174
OMH - SCM STEPDOWN	$12,534	87	$2,450
OMH - SCH STEPDOWN 1:30	$8,112	60	$1,622
OMH - 1ICM/1SCM STEMDOWN	$1,547	9	$309
OMH - 1ICM/2SCM STEPDOWN	$1,438	12	$288
Totals	**$476,398,578**	**169,881**	**$94,302,005**
All OMH	**$119,026,237**	**32,886**	**$23,381,615**
All OMR	**$264,771,384**	**135,139**	**$52,791,520**

2010 Health Home CRG Group – MH/SA Top 25

Diagnosis Grouping	Sum of Spend	Sum of MH/SA Recips
(blank)	$ 7,270,312,543	411,980
Schizophrenia	$ 1,064,324,943	71,796
Schizophrenia and Other Moderate Chronic Disease	$ 987,483,578	51,021
HIV Disease	$ 896,305,908	22,252
Dementing Disease and Other Dominant Chronic Disease	$ 323,686,677	11,961
Diabetes - Hypertension - Other Dominant Chronic Disease	$ 237,735,446	11,303
Diabetes and Other Dominant Chronic Disease	$ 160,873,540	7,826
Psychiatric Disease (Except Schizophrenia) and Other Moderate Chronic Disease	$ 156,625,537	15,842
Schizophrenia and Other Dominant Chronic Disease	$ 140,336,943	5,809
Diabetes and Other Moderate Chronic Disease	$ 139,516,879	11,583
Asthma and Other Moderate Chronic Disease	$ 138,597,650	11,757
Diabetes - 2 or More Other Dominant Chronic Diseases	$ 137,828,720	4,185
Depressive and Other Psychoses	$ 136,096,859	13,809

Diagnosis Grouping	Sum of Spend	Sum of MH/SA Recips
Two Other Moderate Chronic Diseases	$133,721,190	16,691
Moderate Chronic Substance Abuse and Other Moderate Chronic Disease	$130,702,804	10,031
One Other Moderate Chronic Disease and Other Chronic Disease	$128,258,771	16,832
Bi-Polar Disorder	$104,845,381	7,233
One Other Dominant Chronic Disease and One or More Moderate Chronic Disease	$97,316,553	6,436
Diabetes - Advanced Coronary Artery Disease - Other Dominant Chronic Disease	$90,245,930	3,303
Schizophrenia and Other Chronic Disease	$89,393,330	5,494
Chronic Obstructive Pulmonary Disease and Other Dominant Chronic Disease	$85,555,831	4,328
Diabetes and Hypertension	$83,038,235	9,638
Diabetes and Asthma	$79,170,754	5,484
Diabetes and Advanced Coronary Artery Disease	$57,899,075	3,577
Dialysis without Diabetes	$55,750,739	904
Grand Total (All)	**$12,925,623,816**	**741,075**

Health Homes: Rates

- Rates were developed using three main variables:
  - **Caseload Variation** (scaled from 11 to 1 at highest intensity end and 150 to 1 at lowest intensity end),
  - **Case Management Cost**, and
  - **Patient Specific Acuity**.

- The acuity groups were established from the 3M™ Clinical Risk Group software – with some adjustment to collapse some sicker patient groups (Catastrophic and Malignancies) into Pairs and Triples and HIV groups.

- The clinical risk group software puts each patient in each health status group into severity groups.

- Rates will be adjusted for functional status when such data becomes available.

- Until functional status adjustments can be done - acuity factors were “up-weighted” for patients in groups likely to have lower functional status scores (MH/SA) and for patients in the mid and higher severity groups.

Health Homes: Payment

- A lower fee (80 % of full fee) may be paid during outreach and engagement.
- A portion of the fee may be retained (10%) against achievement of core quality measures.
- Gainsharing on the state share will be at 30% of demonstrated State share savings (up from the preliminary 15%). Gainsharing can be measured against case mix matched controls that did not receive HH services. Controls get more difficult as program matures so new benchmarks need to be developed.
- Gainsharing on federal share of both Medicaid and Medicare is under discussion with CMS. Federal Gainsharing on Medicare will be difficult.

Projected Average Health Home Payments by Base Health Status and Severity of Illness - Excludes LTC and OPWDD Populations

- DRAFT FOR REVIEW AND INPUT ONLY - THESE RATES AND PROJECTIONS ARE NOT FINAL -

		Downstate						Upstate					
Base Health Status[1]	Severity of Illness	Eligible Recipients[2]	Est. SFY 11/12 Percent Enrolled in HH[3]	Estimated Enrolled Recipients SFY 11/12[4]	Average CRG Acuity Score[5]	Average Monthly Payment[6]	Patient to Case Manager Ratio Range[7]	Eligible Recipients[2]	Est. SFY 11/12 Percent Enrolled in HH[3]	Estimated Enrolled Recipients SFY 11/12[4]	Average CRG Acuity Score[5]	Average Monthly Payment[6]	Patient to Case Manager Ratio Range[7]
Single SMI/SED	Low	50,346	25%	12,587	6.3406	$129	From 51 to 107	25,182	25%	6,296	6.3382	$104	From 51 to 92
	Mid	18,790	35%	6,577	8.0879	$165	From 41 to 71	9,772	35%	3,420	8.0252	$132	From 34 to 71
	High	260	50%	130	16.5942	$339	From 12 to 47	60	50%	30	16.6197	$273	From 16 to 16
Single SMI/SED Total		**69,396**	**28%**	19,293	**6.8709**	**$140**	**From 12 to 107**	**35,014**	**28%**	9,746	**6.8423**	**$112**	**From 16 to 92**
Pairs Chronic	Low	276,712	5%	13,836	3.1258	$59	From 51 to 150	89,006	5%	4,450	4.0091	$63	From 51 to 150
	Mid	103,983	10%	10,398	6.4856	$126	From 34 to 115	36,731	10%	3,673	7.0554	$111	From 34 to 115
	High	18,169	20%	3,634	10.9546	$217	From 11 to 63	6,031	20%	1,206	11.4332	$183	From 11 to 63
Pairs Chronic Total		398,864	7%	27,868	4.3674	$83	From 11 to 150	131,768	7%	9,330	5.2068	$82	From 11 to 150
Triples Chronic	Low	15,593	20%	3,119	5.4311	$102	From 51 to 149	5,155	20%	1,031	5.7358	$86	From 51 to 149
	Mid	21,559	30%	6,468	8.5150	$161	From 34 to 104	7,608	30%	2,282	8.7613	$134	From 34 to 104
	High	7,527	50%	3,764	14.7479	$296	From 11 to 45	2,609	50%	1,305	14.9846	$238	From 11 to 45
Triples Chronic Total		44,679	30%	13,350	8.4374	$162	From 11 to 149	15,372	30%	4,618	8.7675	$135	From 11 to 149
HIV/AIDS	Low	18,667	30%	5,600	2.5262	$52	From 103 to 143	1,686	30%	506	2.8538	$47	From 103 to 143
	Mid	19,157	40%	7,663	8.6321	$177	From 51 to 108	2,215	40%	886	8.6106	$142	From 51 to 108
	High	2,069	50%	1,035	17.3074	$344	From 11 to 22	247	50%	124	17.5890	$280	From 11 to 22
HIV/AIDS Total		**39,893**	**36%**	**14,297**	**6.2746**	**$128**	**From 11 to 143**	**4,148**	**37%**	**1,515**	**6.8588**	**$112**	**From 11 to 143**
Grand Total		**552,832**	**14%**	**74,808**	**5.1310**	**$100**	**From 11 to 150**	**186,302**	**14%**	**25,209**	**5.8331**	**$93**	**From 11 to 150**

[1] Mutually exclusive categories based on Clinical Risk Grouping. SED and OASAS Children are included in price model but will be excluded from initial assignment.

[2] Includes members that may currently be enrolled in care management programs (OMH TCM, COBRA, MATS and CIDP).

[3] Possible percentage of patients in a given rate/severity group assigned to Health Home services. This percentage is for planning and illustration purposes only - actual number of patients will be based on predictive modeling, ambulatory connectivity and regional Health Home capacity analyses.

[4] Total HH recipients times the percent enrolled for SFY 11/12 - this includes individuals currently in care management programs (OMH TCM, COBRA, MATS and CIDP) that may not be paid at the Health Home rate level during the first year. This is a draft planning and illustration number only.

[5] The acuity scores are draft. While based on actual data, the acuity scores may be rescaled. This rescaling should not effect the average monthly payment.

[6] Average health home payment for the members in the given rate/severity group - these groups are for illustration purposes - actual payments to health home provider will be based on a blend of a given provider's health home patients from across all applicable rate/severity cells. Actual payments are calculated at the patient level based on the predicted service intensity (staff to patient ratio) required for each patient and then rolled up to a blended amount (i.e., one HH rate per provider for a given timeframe) for the entire group of patients assigned to the health home provider and include a Wage Equalization Factor of 1.2437 (ratio of "CRG score neutral" downstate payment to upstate payment). These payments will eventually be recalculated (and any changes will be paid prospectively) based on service intensity and functional status data. DOH will closely review payment adequacy during health home implementation.

[7] Range of staff to patient ratio variation for the selected group of patients - (for example high severity SMI/SED rate would support a range of staff to patient ratios from 1:12 to 1:47).

Draft Health Home PMPMs for Selected CRGs*

Projected Average Health Home Payments – Sample Populations

Base Health Status	Dx Description	Severity of Illness	CRG Acuity Score	Downstate Monthly Payment
Pairs Chronic	Diabetes and Hypertension	Low	0.8114	$17
Pairs Chronic	Diabetes and Asthma	Low	4.0729	$83
Triples Chronic	Diabetes - Hypertension - Other Dominant Chronic Disease	Low	5.3524	$110
Triples Chronic	Cystic Fibrosis	Low	5.6337	$115
Single SMI/SED	Conduct, Impulse Control, and Other Disruptive Behavior Disorders	Low	5.6522	$116
Pairs Chronic	Schizophrenia and Other Chronic Disease	Mid	6.9474	$142
Pairs Chronic	Diabetes and Advanced Coronary Artery Disease	High	7.0289	$144
Triples Chronic	Congestive Heart Failure - Diabetes - Cerebrovascular Disease	Mid	7.4909	$153
Single SMI/SED	Schizophrenia	Mid	7.9318	$163
Pairs Chronic	Asthma and Other Moderate Chronic Disease	Mid	8.3686	$171
HIV/AIDS	HIV Disease	Mid	10.0992	$207
Triples Chronic	Diabetes - 2 or More Other Dominant Chronic Diseases	High	12.3349	$253
Triples Chronic	Non-Hodgkin's Lymphoma	High	15.7499	$323
Single SMI/SED	Schizophrenia	High	16.6288	$341
HIV/AIDS	HIV Disease	High	17.7378	$363
Triples Chronic	Brain and Central Nervous System Malignancies	High	25.1181	$515

** These payments are under revision based on advisory committee feedback*

Health Homes: Payment

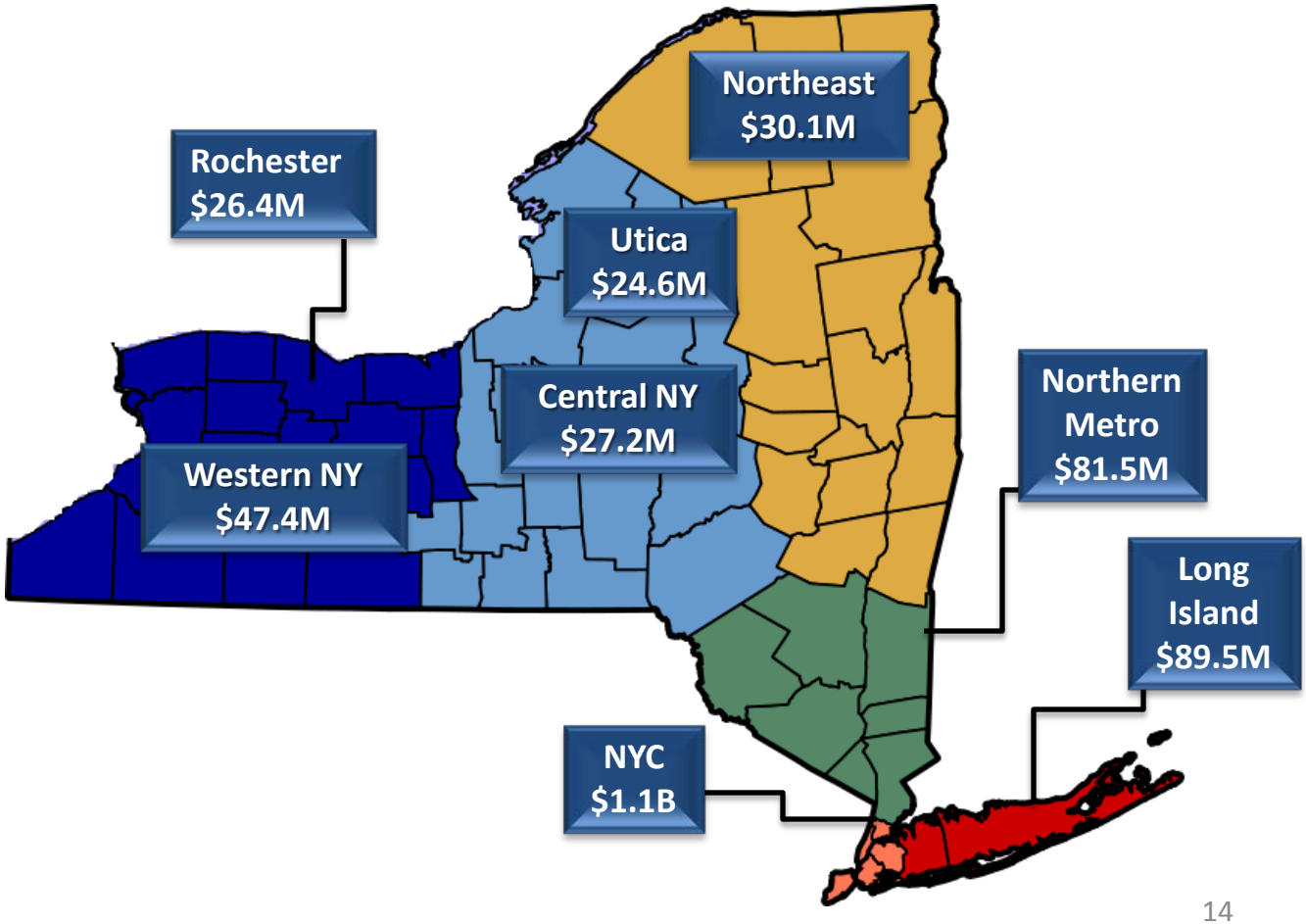
Feedback From Advisory Committee:

- AIDS Low Intensity Payment is too low
- Acuity is not best predictor of care management need
- Functional Status Adjustment is needed but no real validated tools for MH population
- Perhaps should adjust acuity factors further by utilization factors on top of or instead of functional status factors

PPAs
&
PPRs

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*

PPAs & PPRs in New York City

County / Borough	PPA Rate*	PPA $	PPR Rate*	PPR $
Bronx	21.1	$187.1M	8.5	$112.8M
Kings	17.7	$195.0M	6.5	$122.4M
New York	16.7	$98.4M	10.4	$81.2M
Queens	18.5	$112.7M	6.4	$69.3M
Richmond	15.5	$16.9M	9.4	$12.7M
NYC	**18.5**	**$610.1M**	**7.7**	**$398.4M**

PPR and PPA rates shown per 100 admissions

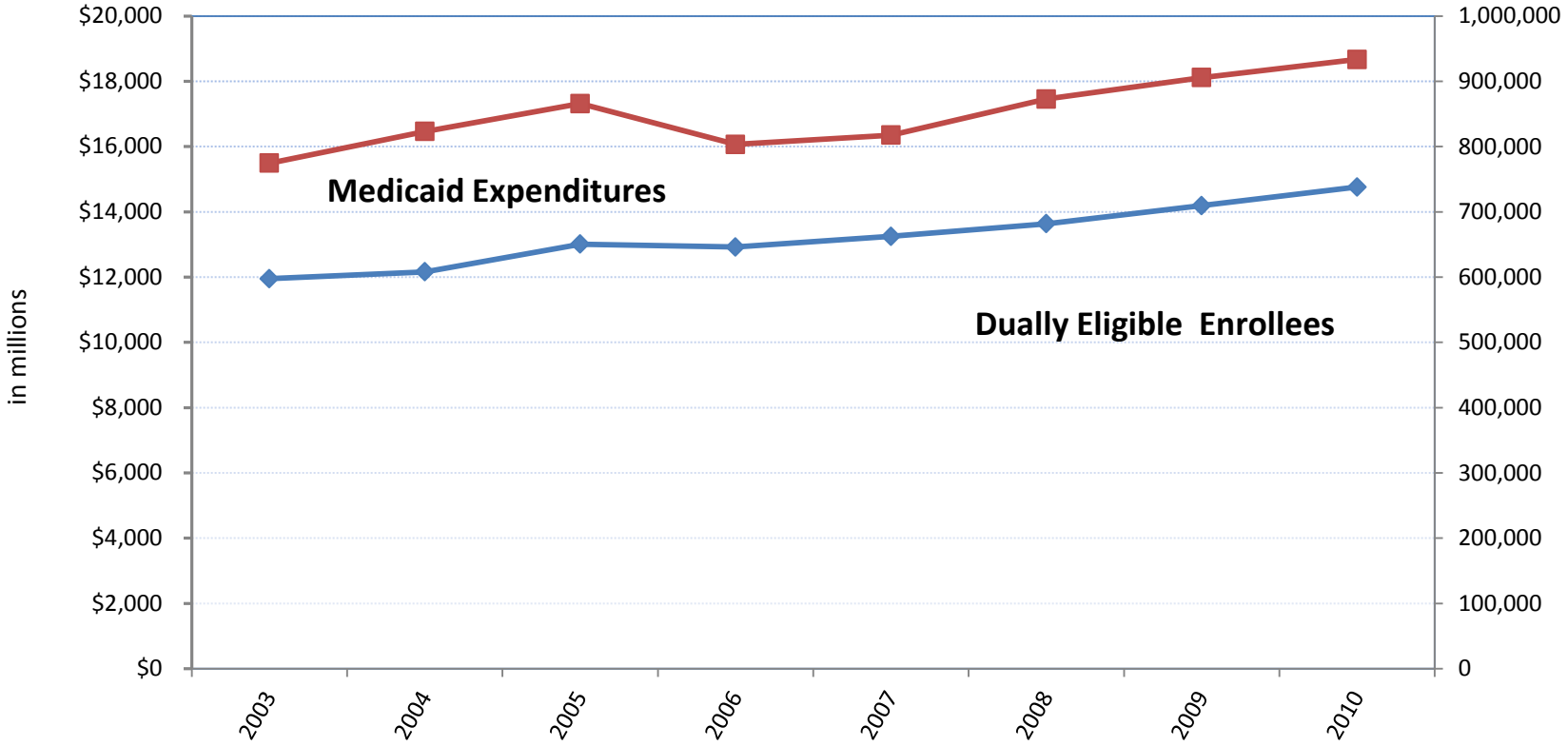
Geographic Comparison: Bronx v. Rochester

County / Region	PPA Rate*	PPR Rate*
Bronx	21.1	8.5
Rochester	12.3	6.2

**PPR and PPA rates shown per 100 admissions*

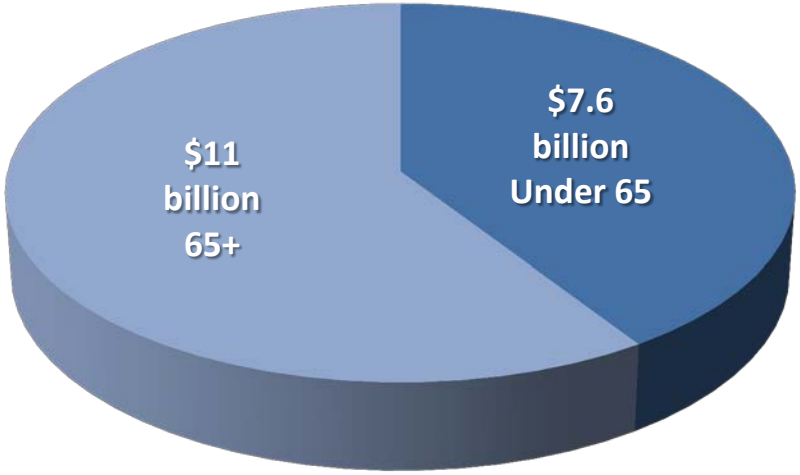
Dual-Eligible Populations

Medicaid Expenditures and Enrollment for Dually Eligible Calendar Year 2003 - 2010

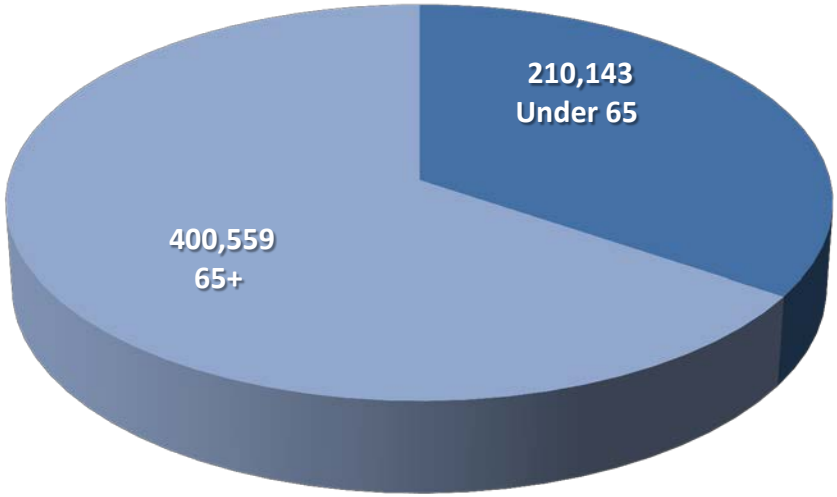


Source: NYS DOH/OHIP Medicaid Datamart

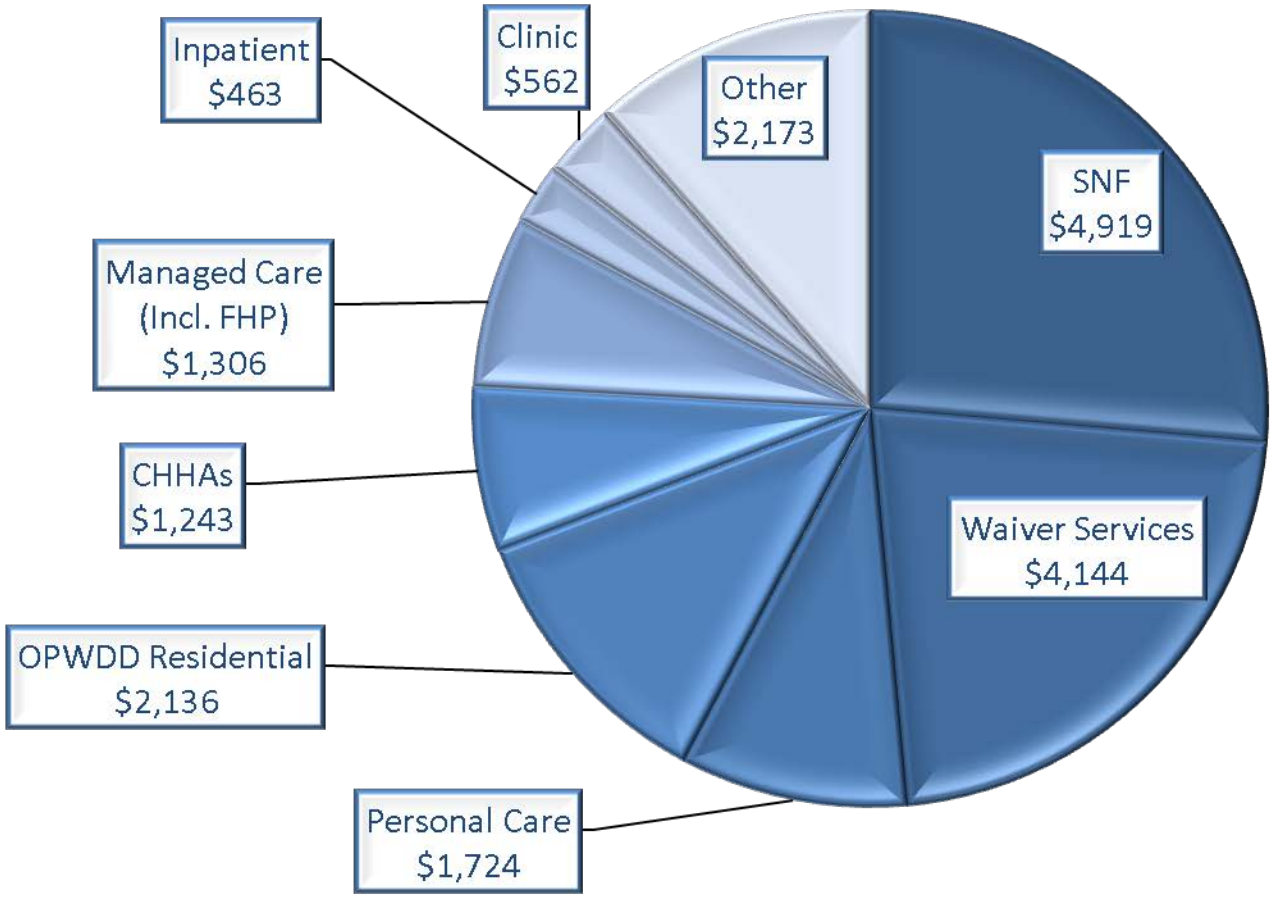
Medicaid Expenditures for Age Under 65 and 65+
Calendar Year 2010



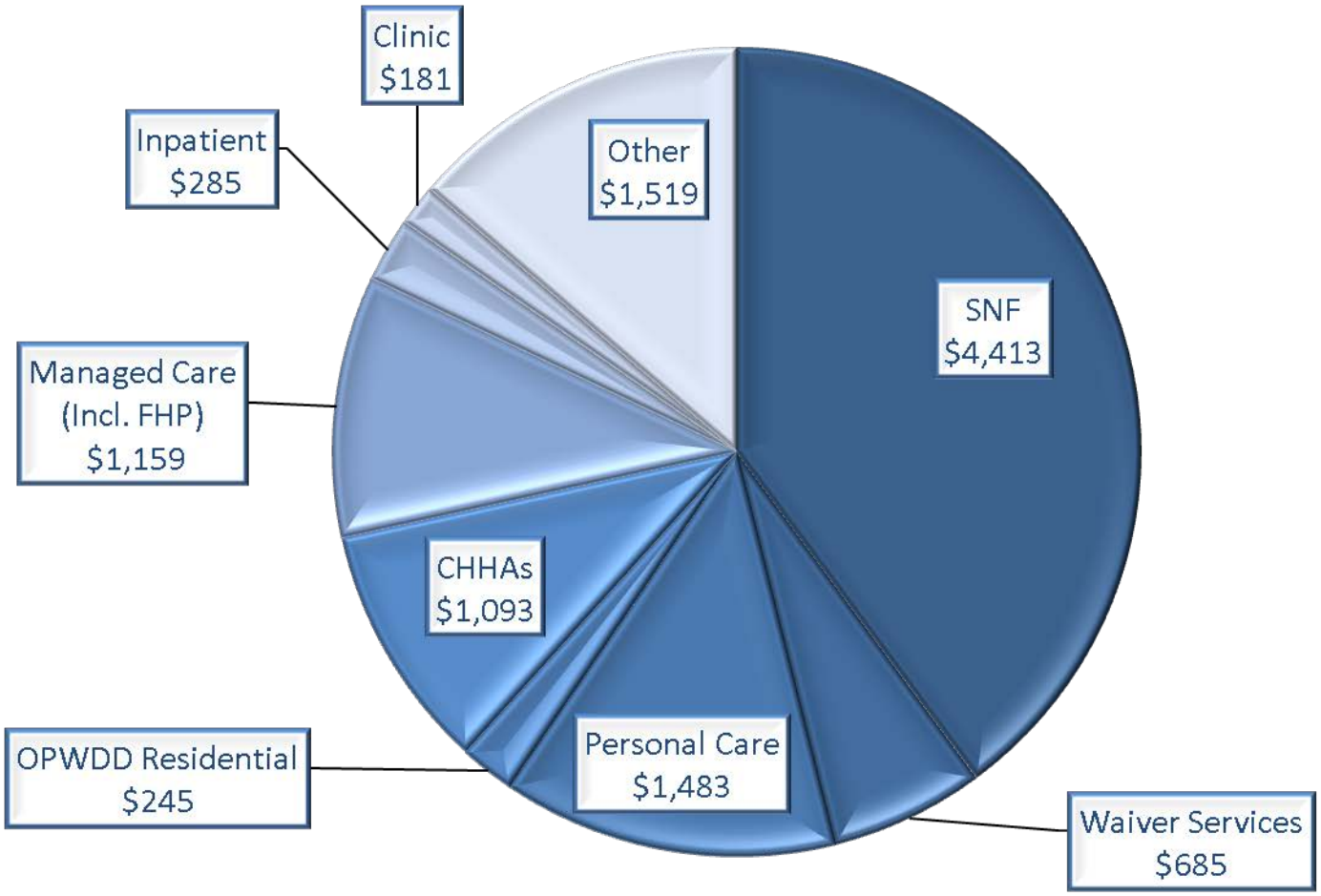
Dually Eligible Counts for Age Under 65 and 65+
Calendar Year 2010



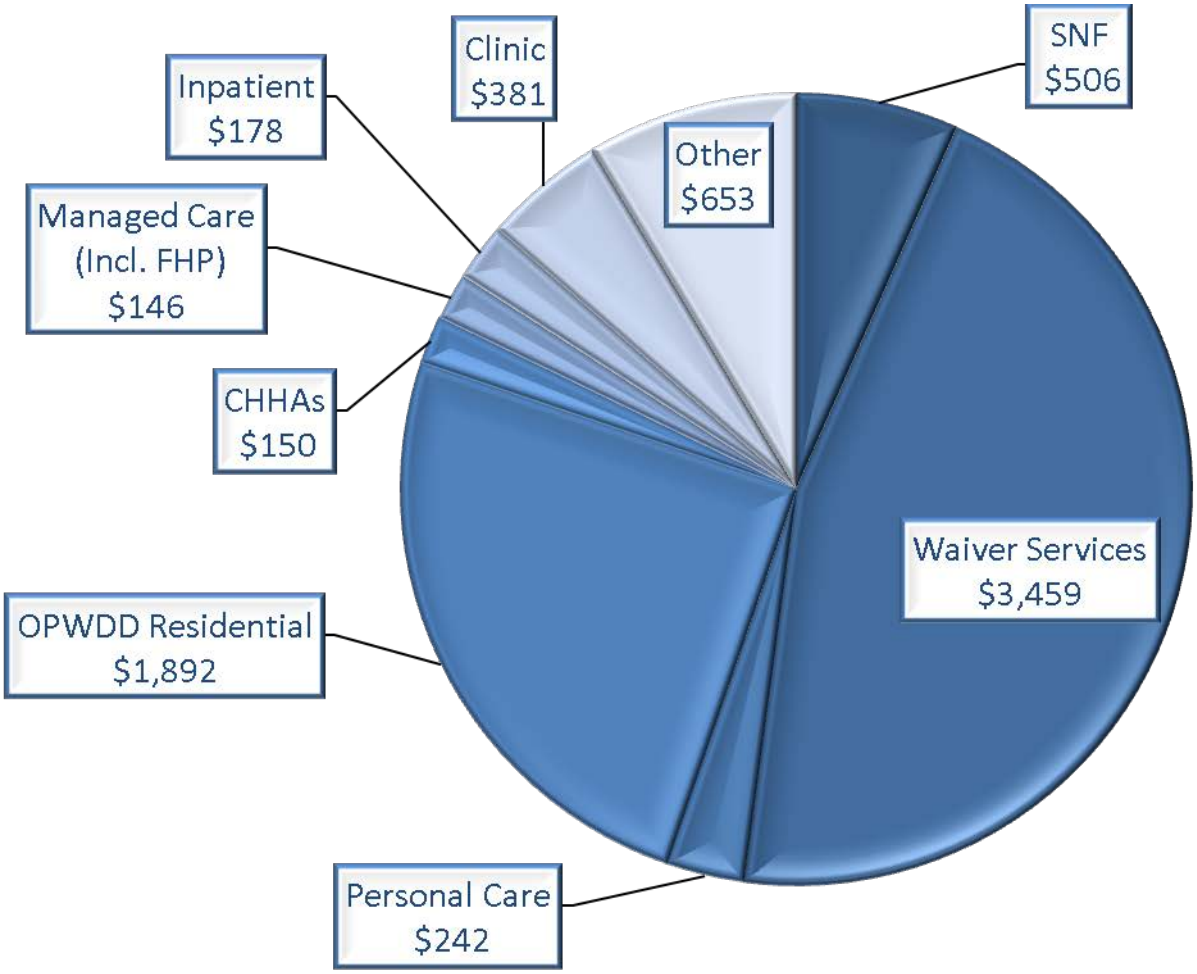
Top 8 Service Categories for All Ages Calendar Year 2010



Top 8 Service Categories for Age 65+ Calendar Year 2010



Top 8 Service Categories for Under Age 65 Calendar Year 2010



Adoption of Guiding Principles

General Guiding Principles

Innovative payment models & quality initiatives should:

- Be transparent, fair & stimulate broad participation by providers & payers.
- Promote high value quality driven health care services in the proper setting.
- Create opportunities for both payers & providers to share savings generated if established benchmarks are achieved.
- Create opportunities for stronger collaboration & goal sharing with Medicare & other payers.
- Be scalable & flexible to allow all providers & communities (regardless of size) to participate.
- Advance other MRT objectives including placing all Medicaid patients into a care management setting within 3 years.
- Reinforce health system planning and preserve Medicaid safety net providers/care.
- Re-align legal, regulatory and financial barriers to be consistent with reform objectives.
- Allow for flexible multi-year phase in of reform initiatives due to additional systems requirements (i.e., IT).
- Enable the alignment of quality measures with policy goals.

General Guiding Principles

Quality measures should:

- Be based on a standard of care or evidence-based science. Pay-for-performance incentives or penalties must rely on measures that are supported by an evidence-base.
- Promote payment approaches that provide due consideration for positive incentives and align with state and federal policies.
- Accurately identify those aspects of care that are under the health care organization's control and be appropriately risk-adjusted to reflect factors influencing outcomes that are beyond the control of providers.
- Be risk-adjusted where appropriate when used for provider comparisons. Providers should be incentivized for improvement over time and/or comparison with other organizations.
- Align and incentivize provider responsibilities across the continuum.
- Promote patient participation and responsibility in health care decision-making.
- Be based on data that is linked across time, place, and setting and be available for provider use in evaluating and managing patient care and services.

Potential Recommendations (For Discussion Purposes)

Potential Recommendation #1 (Payment Reform)

Pursue a partnership agreement with CMS to integrate Medicaid & Medicare programs and financing for the dual-eligible population under a capitation approach.

Goals:

- Achieve "*triple aim*" as defined by CMS: improve patient care experience; improve the health of populations; and reduce the per capita cost of health care.
- Create opportunities for providers/payors to realize financial benefits as system efficiencies are achieved and quality benchmarks attained.
- Secure upfront investment of resources from CMS which are required to implement our waiver plan. Such funds need to be flexible and could be used for continued funding of care management beyond the two year incentive period; HIT; ACO development. (**Are there other potential needs?**)
- Incorporate strong evaluation component & technical assistance to assure successful implementation. (Dartmouth researchers/academics recently indicated that they may be interested in collaborating with New York State on this effort.)

Potential Recommendation #2 (Quality Measurement)

Develop series of performance measures for health homes, consistent with federal requirements, and apply similar measures to the evolving delivery systems such as ACOs, Managed LTC and BHOs.

Goals:.

- Quality and efficiency measures, once deemed reliable and accurate, will be applied to financially reward high performing providers and networks within the various service delivery systems..

Potential Recommendation #3 (DSH)

Develop general principles that can be applied towards revising the New York State DSH/Indigent Care program.

These principles will be applied once CMS provides guidance for determining how state allocations of federal DHS funding will be reduced as part of federal reform.

Goals:

- Develop a new allocation methodology (consistent with CMS guidelines) to ensure that New York State does not take more than its share of the nationwide reduction.
- Fair & equitable approach to allocate funds across hospitals with a greater proportion of funds allocated to those hospitals that provide services to un/underinsured.
- Simplify allocation methodology and consolidate pools.

Potential Recommendation #4 (Safety-Net Providers)

Create financing mechanisms that advance recommendations from the MRT Health Systems Redesign: Brooklyn Work Group and strengthen financial viability of the New York State safety-net provider network.

Goals:

- A portion of savings generated from reforms and downsizing should remain within an impacted community to maintain that community's health care delivery system.

- Encourage other payers to appropriately support safety net providers and share in the cost of reconfiguring the health care system in those communities.

Next Steps

Next Meeting:

- **TBD: October, 10:30 am – 3:30 pm**

Please visit our website:

http://www.health.ny.gov/health_care/medicaid/redesign/payment_reform_work_group.htm

Please feel free to submit any comments or inquiries to the following email address:

paymentreform@health.state.ny.us