



Redesign Medicaid in New York State



DSRIP, Shared Savings, and the Path towards Value Based Payment

New York State Department of Health
New York, New York





The DSRIP Challenge – Transforming the Delivery System

DSRIP is a major effort to collectively and thoroughly transform the NYS Medicaid Healthcare Delivery System

- From fragmented and overly focused on inpatient care towards integrated and community, outpatient focused
- From a re-active, provider-focused system to a pro-active, community- and patient-focused system
- Reducing avoidable admissions and strengthening the financial viability of the safety net

Building upon the success of the MRT, the goal is to collectively create a future-proof, high-quality and financially sustainable care delivery system



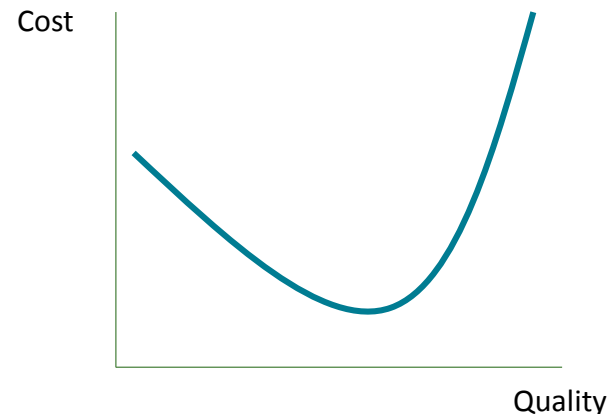
The DSRIP Challenge – Transforming the Delivery System

DSRIP aims to improve core population and patient outcomes:

- Reducing potentially avoidable (re)admissions
- Reducing potentially avoidable ER visits
- Reducing other potentially avoidable complications (diabetes complications, patients at-risk for becoming multi-morbid, crisis stabilization)
- Improving Patient experience (CAHPS)

In a fascinating reversal of common sense economics, improving health care quality more often than not makes the delivery of health care less rather than more expensive – even in Medicaid

This will allow NYS to remain under the Global Cap, without curtailing eligibility, while continuing to invest in innovation and improving outcomes





The DSRIP Challenge – Transforming the Payment System

A thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well

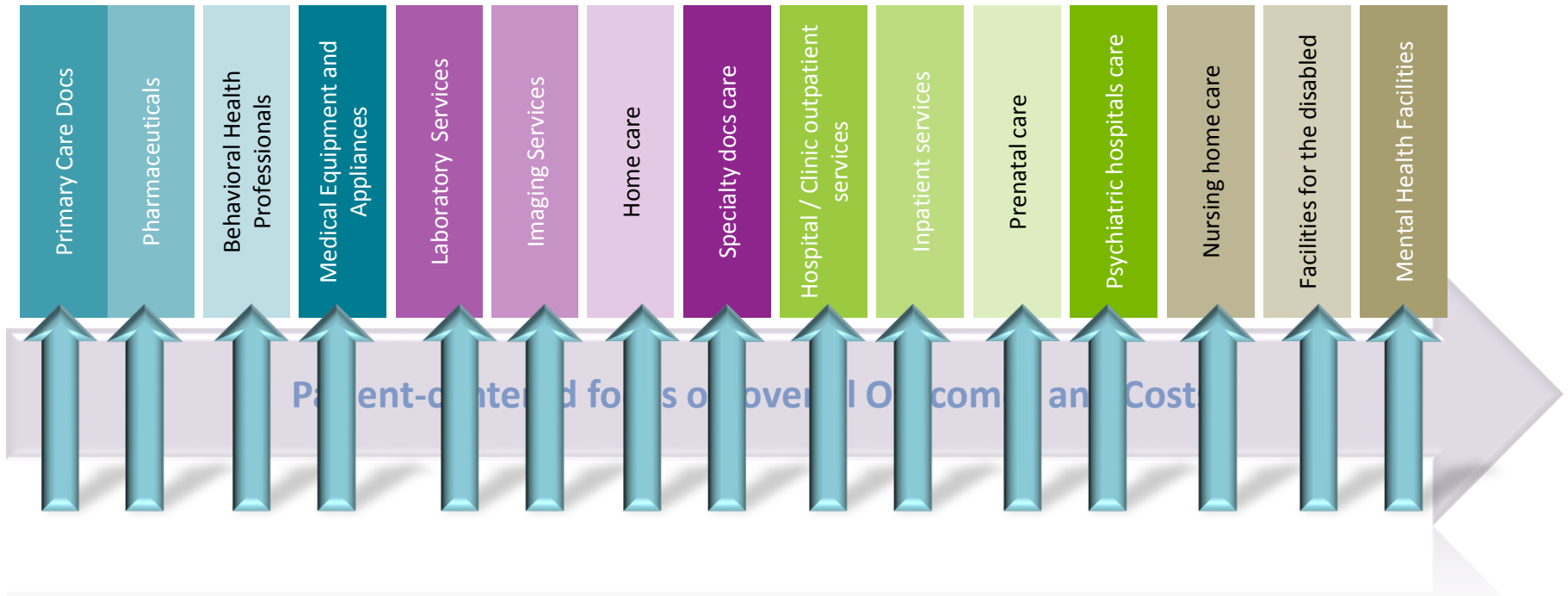
Many of our system's problems (fragmentation, high (re)admission rates, poor primary care infrastructure, lack of behavioral and physical health integration) are rooted in how we pay for services

- Paying providers Fee For Service incentivizes volume over value, pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
- Our current payment system does not adequately incentivize prevention, coordination or integration



Current Fee For Service – deeply embedded, double fragmentation

FFS and Silo's



Challenge to change:

Providers, Payers and Governments have embedded this fragmentation in their culture, organization & systems





The DSRIP Challenge – Transforming the Payment System


DSRIP will be as much about payment reform as about delivery reform

Financial and regulatory incentives drive...

a delivery system which realizes...

cost efficiency and quality outcomes: *value*





Payment Reform: Moving Towards Value Based Payments (VBP)

By waiver Year 5, all MCOs must employ non-fee-for-service payment systems that reward value over volume for at least 90% of their provider payments

- Required by the Special Terms & Conditions of the Waiver
- Required to ensure that realized transformations in the delivery system will be sustainable
- Required to ensure that value-destroying care patterns (avoidable admissions, ED visits, etc) do not simply return when the DSRIP funding stops in 2020
- *Requested by successful PPSs as a means to alleviate predicted losses in FFS revenue due to improved performance on DSRIP outcomes (reduced admissions, reduced ED visits).*





VBP approach is based directly on MRT Payment Reform & Quality Measurement Work Group Recommendations

General Guiding Principles

1. Be transparent and fair, increase access to high quality health care services in the appropriate setting and create opportunities for both payers & providers to share savings generated if agreed upon benchmarks are achieved.
2. Be scalable and flexible to allow all providers and communities (regardless of size) to participate, reinforce health system planning and preserve an efficient essential community provider network.
3. Allow for flexible multi-year phase in to recognize administrative complexities including system requirements (i.e., IT).
4. Align payment policy with quality goals
5. Reward improved performance as well as continued high performance.
6. Incorporate strong evaluation component & technical assistance to assure successful implementation.
7. Engage in strategic planning to avoid the unintended consequences of price inflation, particularly in the commercial market



How should an integrated delivery system function – the DSRIP Vision

Integrated Physical & Behavioral Primary Care

Includes social services interventions and community-based prevention activities

Prenatal and Maternity Care

Elective Care (Hip-, Knee replacement, ...)

Depression

Acute Cardiovascular care

Cancer Care

...

Episodic

Chronic care (single disease, limited co-morbidity)

Chronic care (multi-morbidity)

Care for the Disabled

Other special populations ...

Continuous

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

Sub-population focus on Outcomes and Costs *within* sub-population/episode

How should an integrated delivery system function – the DSRIP Vision

Integrated Physical
Behavioral Pro

*Includes social
interventions
community-based
prevention activities*

**Evidence-based, outcome-
focused disease
management, self-
management strategies,
integrated care
coordination**

Prenatal and Maternity Care

Elective Care (Hip-, Knee replacement, ...)

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How should an integrated delivery system function – the DSRIP Vision

Evidence-based, outcome-focused care pathways experienced by patients as a smooth, coordinated process

interventions and community-based prevention activities

Prenatal and Maternity Care

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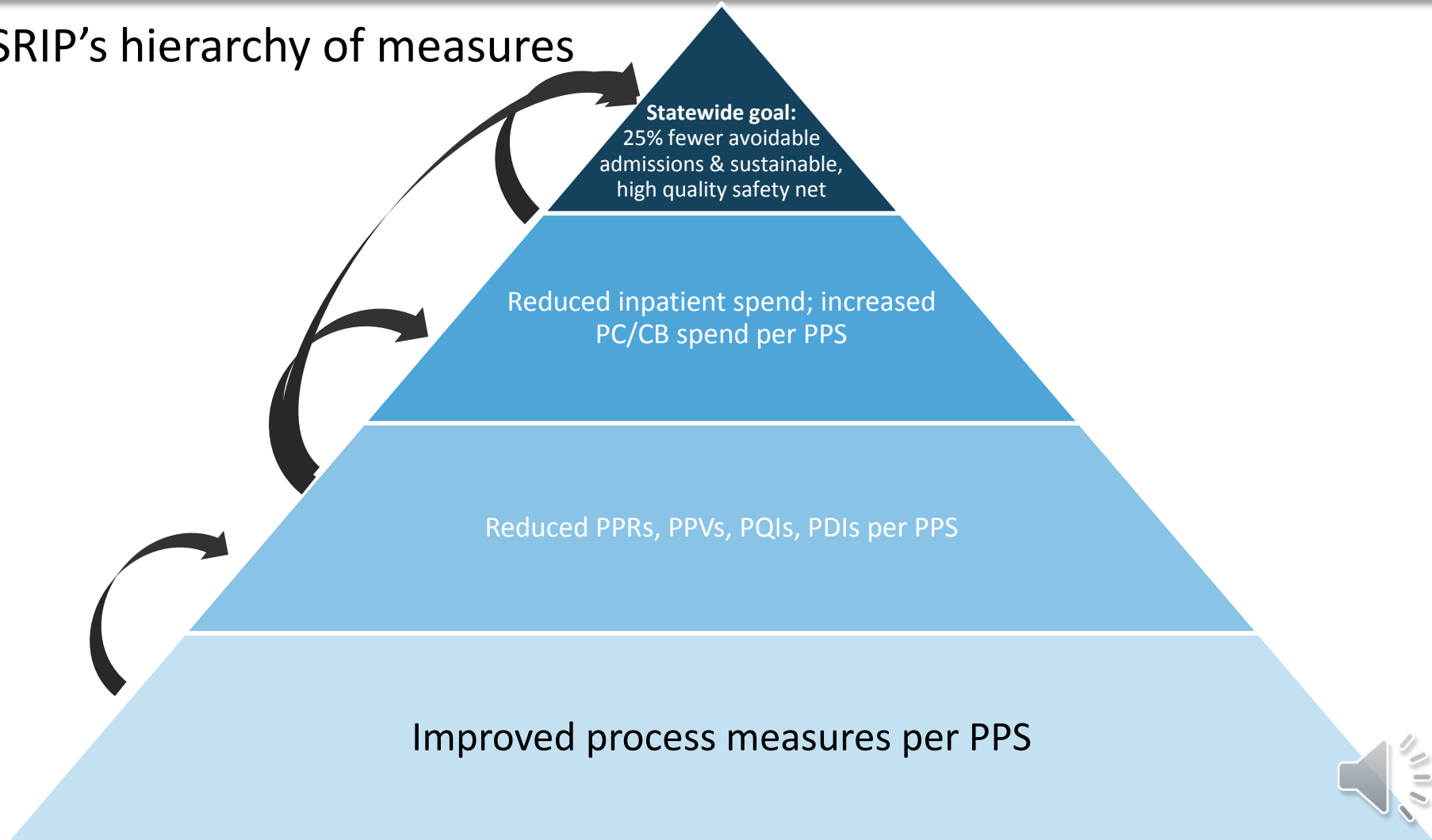
Sub-population focus on Outcomes and Costs *within* sub-population/episode

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



Transparency as the Basis for Delivery and Payment Reform

DSRIP's hierarchy of measures





Transparency as the Basis for Delivery and Payment Reform

The scores on the measures per PPS will be made publically available, following the measure specification and reporting manual:

- For the total attributed population of the PPS
- Per project-specific population (depression, HIV/AIDS, perinatal care, ...) within the PPS

In addition, the total costs of care per PPS will be made publically available, adequately risk-adjusted:

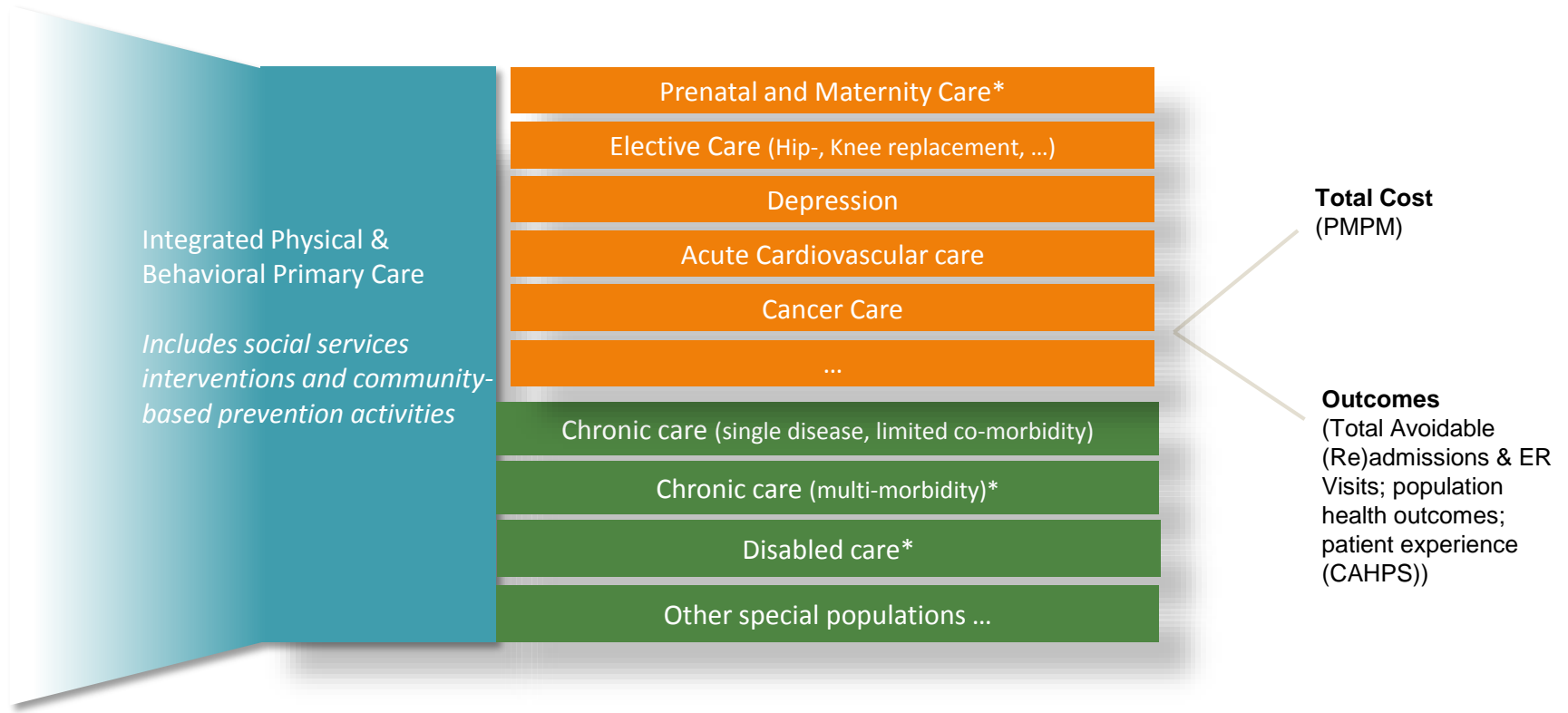
- For the total attributed population of the PPS
- Per project-specific population (depression, HIV/AIDS, perinatal care, ...) within the PPS
- Including costs related with avoidable (re)admissions, ER visits and complications, and potential savings

The potential savings are a starting point for discussions with MCOs on shared savings arrangements

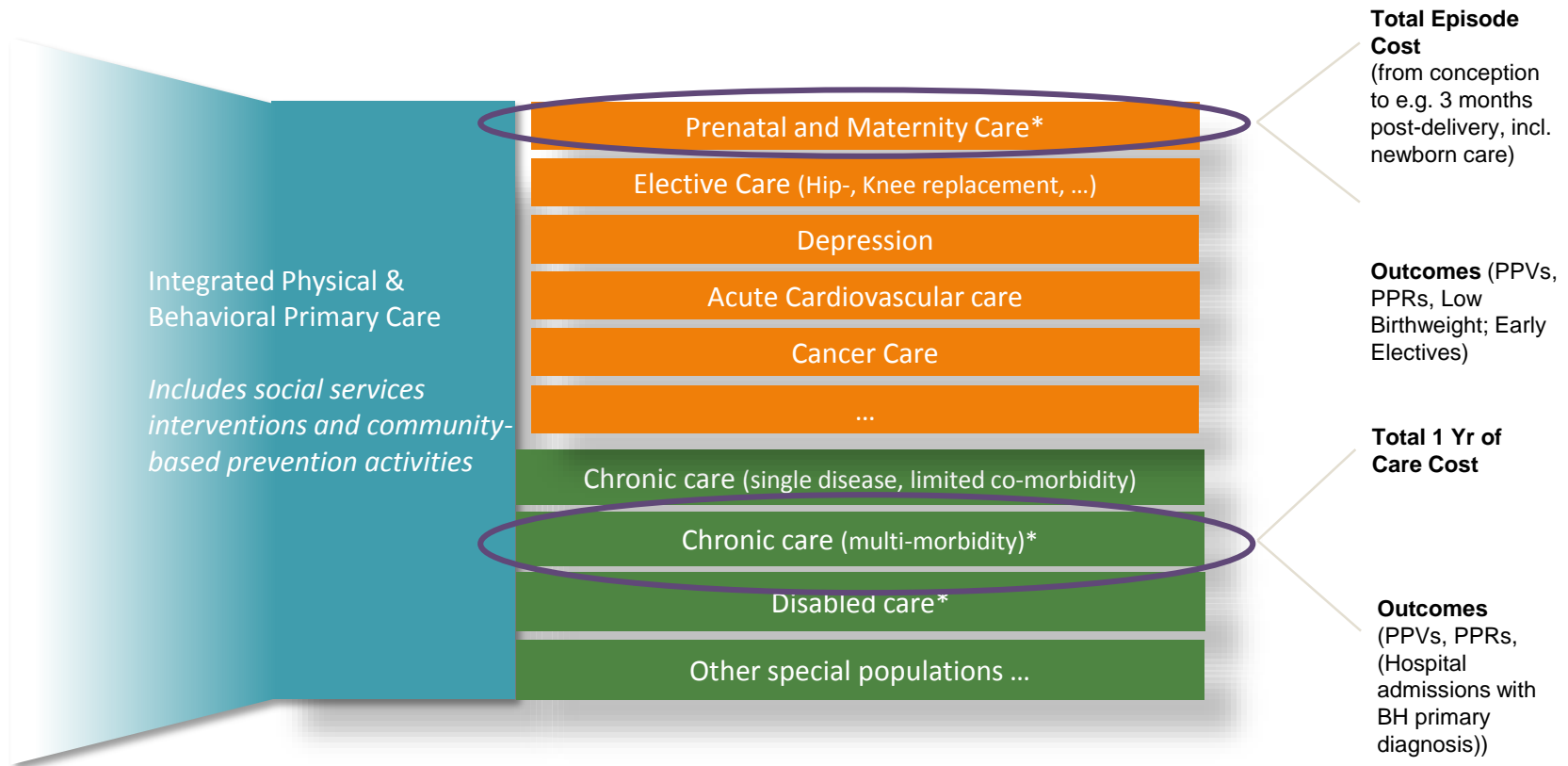




Focus on total attributed population



Focus on (integrated) services for relevant subpopulations



Focus on (integrated) services for relevant subpopulations

Integrated Physical & Behavioral Primary Care

For the healthy, patients with mild conditions; for patients requiring coordination between more specialized care services

Elective Care*

Drill down

Total Cost for APC Services (PMPM)

Total Joint (Hip / Knee) + 90 days post discharge

Cholecystectomy + 90 days post discharge

...

Total Episode Cost

Outcomes (PPVs, PPRs)

Outcomes (PPVs, PPRs, PQIs, PDIs, Total Downstream Cost)

Chronic care (single disease, limited co-morbidity)

Drill down

Diabetes

Asthma

Hypertension

Renal Care

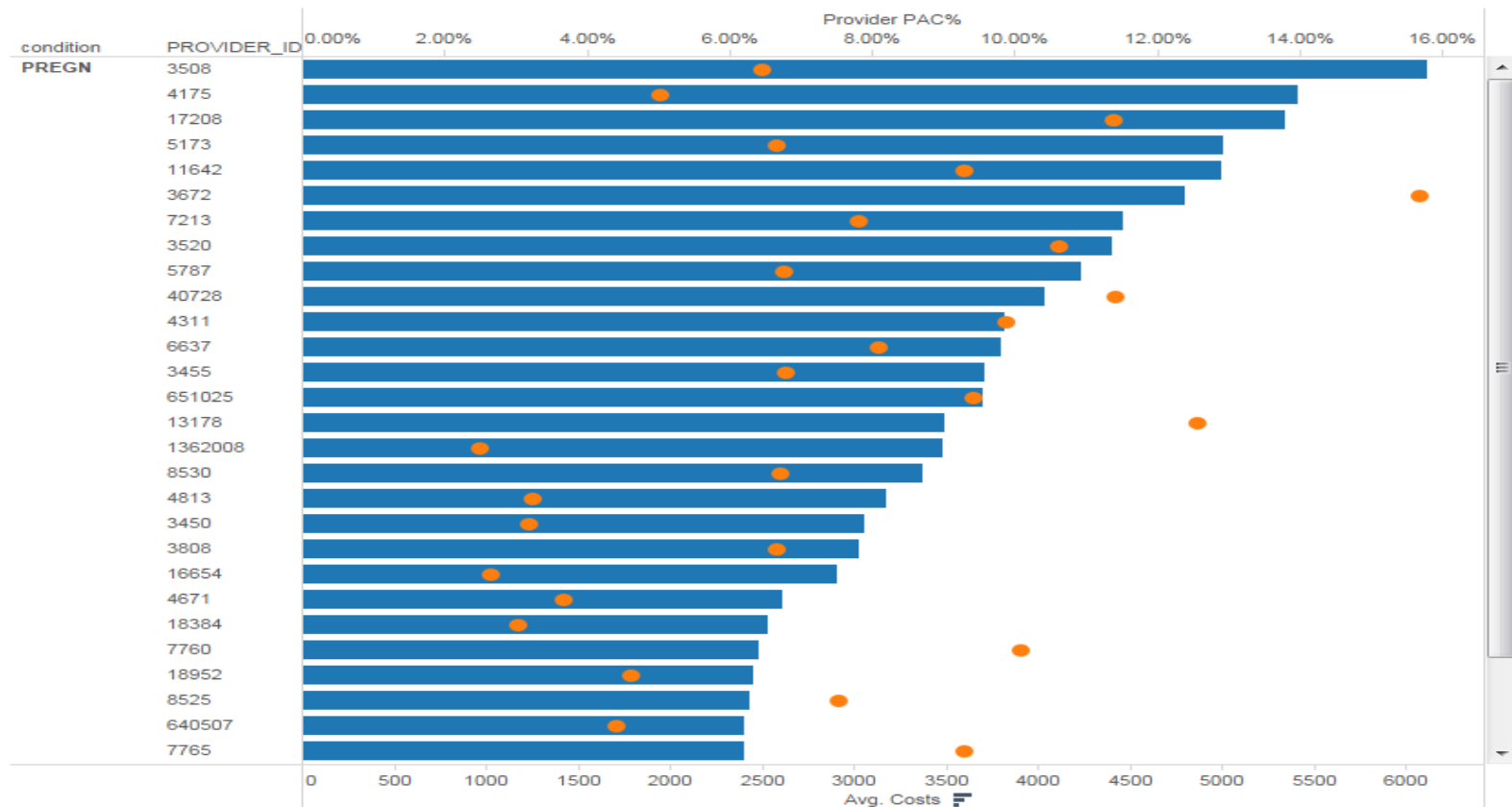
HIV/AIDS

Bundle for 1 yr of care

Outcomes (PPVs, Diabetes-specific PQIs, HbA_{1c}/LDL-c values)

Example: total cost vs potentially avoidable admissions & complications (perinatal care)

Provider Costs Comparisons (Bar)



Source: HCI3; example based on dummy data



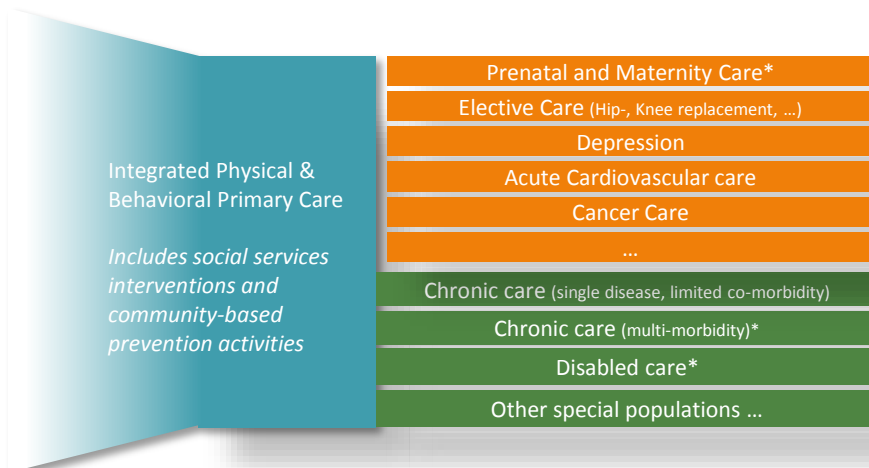
The Path towards Payment Reform

There will not be one path towards 90% Value Based Payments. Rather, there will be a menu of options that MCOs and PPSs can jointly choose from

PPSs and MCOs will be stimulated to discuss opportunities for shared savings arrangements (often building on already existing MCO/provider initiatives):

- For the total attributed population of the PPS
- Per integrated service for specific subpopulation (integrated PCMH/APC; maternity care; diabetes care; HIV/AIDS care; care for HARP population,...) within the PPS

MCOs and PPSs may choose to make shared savings arrangements for the latter types of services between MCOs and providers within the PPS rather than between MCO and PPS



The Path towards Payment Reform

In addition to choosing *what integrated services* to focus on, the MCOs and PPSs can choose different levels of Value Based Payments:

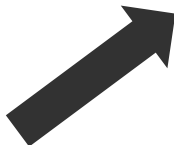
Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

- **Guiding principles (tentative):**
 - $\geq 90\%$ of total MCO-PPS payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
 - $\geq 70\%$ of total costs captured in VBPs has to be in Level 2 VBPs or higher
 - The more dollars are captured in higher level VBP arrangements, the higher the PMPM value MCOs may receive from the State





What could possible combinations look like? A MCO may agree with a PPS to:



create a shared savings arrangement for the total attributed population



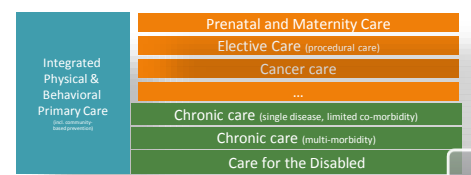
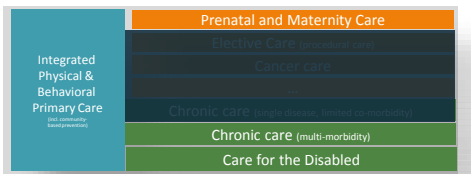
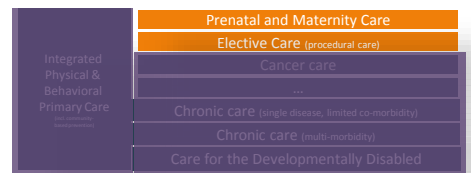
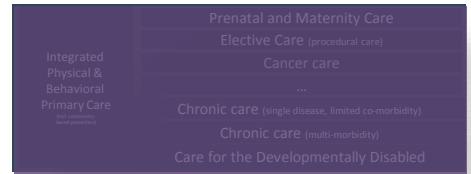
create a shared savings arrangement for the total attributed population, excluding integrated services for Maternity care and Elective Care. For the latter, shared savings arrangements may be made with individual (groups of) providers within the PPS



create a shared savings arrangement for PCMH/APC care and Health Home and HARP care with the PPS, create a separate arrangement with the Disabled Care providers within the PPS, and leave the remainder of care FFS with Level 1 VBP (upside shared savings only; if total cost of that care is < 30% of overall MCO dollars received)



create shared savings arrangements for all PCMH/APC care and condition-specific episodes/subpopulations





We want to hear from you

Please send us your thoughts and feedback, your participation is critical to our success

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