Summary of Medicaid Value Based Purchasing Workgroup, Subcommittee and Clinical Advisory Group Meetings

The State’s Value Based Payment workgroup has developed a blueprint entitled *A Path Toward Value Based Payment; New York State Roadmap For Medicaid Payment Reform* which details its premises, timeline, considerations and objectives for accomplishing Medicaid payment reform. The blueprint was approved by CMS on July 22nd.

The design of the value based payment methodologies will not just define a payment structure for the Medicaid program. It will also be used to subsequently inform the policy discussion with stakeholders regarding the commercial marketplace. While the current VBP discussions are purposefully limited to Medicaid they will potentially have implications for payment reform within the commercial market and possibly with Medicare as well.

Given the potentially significant impact that VBP payment will bring for physicians in the future, Dr. Maldonado invited MSSNY Councilors, Offices, Trustees and other member physician leaders to participate on one of the VBP Workgroup subcommittees and Clinical Advisory Groups (CAGs) which have been formed to develop detailed implementation plans to operationalize the vision of the VBP blueprint. While we can certainly argue against the merits of this strategy, the state is moving forward with VBP for the Medicaid DSRIP program. Consequently, Dr. Maldonado encouraged that the voices of physicians whom we represent to be included at the table presenting the views of organized medicine. A number of MSSNY physician leaders have to date participated at the several meetings which have been held. Below is a copy of Dr. Maldonado’s letter to physician leaders inviting them to participate on one or more of the Subcommittees and CAGs. Also below is a summary of each meeting which has taken place through the week of September 1, 2015. Many more meetings are scheduled throughout the balance of the year. Staff will keep you informed of these discussions in similar reports to the Council.

*A Message from MSSNY President Joseph Maldonado, Jr, MD, MBA, DiPEBHC:*

*Dear Physician Leader,*

*As you may know, the State received approval from CMS to invest $8B for comprehensive Medicaid delivery and payment reform through the Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program promotes community based collaborations/integration with the goal of reducing avoidable hospital readmissions by 25% over five years. 25 Performing Provider Systems (PPSs) have been established statewide to achieve improved clinical health outcomes and population health goals. It is believed that a thorough transformation of the delivery system can only be achieved and sustained when payment reform is implemented. The state’s goal is to transition traditional Medicaid managed care payment over five years to a system wherein 80-90% of MCO-physician payment contracts are based on value based payment (VBP) methodologies.*
The State’s Value Based Payment workgroup has developed a blueprint (attached) entitled A Path Toward Value Based Payment; New York State Roadmap For Medicaid Payment Reform which details its premises, timeline, considerations and objectives for accomplishing Medicaid payment reform.

The design of the value based payment methodologies will not just define a payment structure for the Medicaid program. It will also be used to subsequently inform the policy discussion with stakeholders regarding the commercial marketplace. While the current VBP discussions are purposefully limited to Medicaid they will potentially have implications for payment reform within the commercial market.

Given the potentially significant impact that VBP payment will bring for physicians in the future, I would like to invite you as a MSSNY Councilor to participate on one of the VBP Workgroup subcommittees which have been formed to develop detailed implementation plans to operationalize the vision of the VBP blueprint. We can certainly argue against the merits of this strategy but the state is moving forward with VBP for the Medicaid DSRIP program. We should at the very least assure that the voices of the physicians whom we represent are at the table presenting the views of organized medicine.

We anticipate that there will be four meetings of each subcommittee between now and early December. The schedules are currently being put together. These meetings will be held in person and by conference call for those unable to attend in person.

Below are the following subcommittees. Each will focus on the issues as detailed below.

1. **VBP Technical Design I (To focus on financial and methodological VBP design issues)**

   **Anticipated meetings. Week of: 6/29;7/27;8/24; 9/21**

   Utilizing a diverse group of stakeholders, this subcommittee will be focused on the detailed design of the State’s vision for VBP. This would include content areas related to the technical design of VBP arrangements, including, but not limited, to shared saving limits, stop-loss thresholds to prevent insurance risk from transferring to providers, threshold savings and loss levels to ensure payment models are tenable for all providers, and minimum beneficiary assignment levels for MCO VBP agreements. This group will also explore ways to provide technical assistance to providers who want to enter into VBP arrangements, as well as those provider who upon entering a VBP arrangements encounter performance challenges.

2. **VBP Technical Design II (To focus on outcome measurement and implementation VBP design issues)**

   **Anticipated meetings. Week of: 7/13; 8/10; 9/7; 10/5.**

   Utilizing a diverse group of stakeholders, this subcommittee will be focused on the detailed design of the State’s vision for VBP. This would include content areas related to the technical design of VBP arrangements, including, but not limited, to shared saving limits, stop-loss thresholds to prevent insurance risk from transferring to providers, threshold savings and loss levels to ensure payment models are tenable for all providers, and minimum beneficiary
assignment levels for MCO VBP agreements. This group will also explore ways to provide technical assistance to providers who want to enter into VBP arrangements, as well as those provider who upon entering a VBP arrangements encounter performance challenges.

3. Regulatory Impact (Will discuss regulatory hurdles as they relate to VBP implementation such as Anti-trust laws, provider risk-sharing, Anti-kickback, Self Referral, Corporate Practice of Medicine, Prompt Payment, HIPAA, Network Adequacy, Fraud, Dispute Resolution and DOH Contract Approval Process)

Anticipated meetings. Week of: 7/20; 8/17; 9/14; 10/12; 11/9.

This subcommittee will focus on identifying and overcoming regulatory and contractual barriers to implementing the full scope of VBP. In addition, this group will review the current mandates required and assess the need for them to continue in various phases of VBP implementation in NYS.

4. VBP and Social Determinants of Health (To discuss how to address social determinants ad engage community based organizations)


This subcommittee will focus on the inclusion of social determinants of health in both the payment mechanisms (e.g., paying for housing and development of vocational opportunities) as well as outcomes measurement. Amongst others, this subcommittee will:

- Integrate rewards and incentives based on utilization and outcomes related to best practices in cultural competence;
- Evaluate the reporting requirements for DSRIP leads, PPS providers, and managed care companies in terms of social determinants;
- Suggest how to evaluate and measure the effectiveness of evidence based practices for cultural groups based on their correlative impact on social determinants of health; and make recommendations on how to incentivize client activation, choice, and person-centered wellness and individual recovery for each of the care bundles/subpopulations.

5. Advocacy and Engagement (To discuss how to best inform and communicate information to all categories of Medicaid stakeholders)

Anticipated meetings. Week of: 8/10; 9/14; 10/11; 11/8.

Implementation of the VBP Roadmap and the significant delivery system reforms underway in DSRIP requires a thoughtful and strategic approach to communicating to both Stakeholders and Medicaid beneficiaries. Explicit recognition of the rights and role of the individual enrollee is critical throughout the VBP development and implementation process. Consumer rights to know the incentives that affect their care must be considered when developing strategies around what and when information related to VBP and DSRIP more broadly, will be
communicated to beneficiaries. This group, in close collaboration with consumer advocates, will assist in developing a communications strategy that will adequately address the complexities of these envisioned changes.

In addition to the VBP Workgroup subcommittees, Clinical Advisory Groups (CAGs) will be used to provide feedback on specific episodic bundles and sub-populations for VBP arrangements. Each CAG will convene over approximately 3 meetings. Final recommendations will be submitted to DOH to provide feedback on bundle and subpopulation structure. The following CAGs will be meeting over the timeline described below.

**Phase I (July – September): Maternity; HIV/AIDs: Health and Recovery Plan (HARP); and Developmental Disability (DD)**

**Phase II (August-October): Chronic Heart; Diabetes; Chronic Pulmonary; Managed LTC.**

**Phase III (August – November): Hemophilia; Substance Abuse; Advanced Primary Care; Others**

Please let me know by way of email to Liz Dears at ldears@mssny.org whether you or your colleague(s) is interested in participating on one of these subcommittees or as a clinical expert on one of the CAGs. Please respond by COB July 8th.

Thank you!

Joseph Maldonado, Jr., MD, MBA, DiPEBHC
MSSNY President

**VBP Workgroup Meetings:**

**August 3, 2015**

Jason Helgerson thanked the group for allowing NYS to obtain CMS approval of its Roadmap which was approved by CMS on July 22, 2015. DOH was appreciative of the feedback and input throughout the Roadmap’s development; CMS indicated that they are a little bit behind NYS. The roadmap will be updated each year—a living document and is hoped that members can be utilized in the future and provide input and concerns on any updates. The roadmap is on the website. One of new elements, level two or higher was modified by CMS (SNIPS, FIDA, HARPS, PACE) to 35% (fully capitated managed care). He indicated it is ambitious goal but with yearly updates he believes that this should be manageable.

He provided an update of the CAGs and indicated that they have sufficient members for each of the CAGs. He will send out to group a list of CAG/Subcommittee members, and indicated that they groups will be meeting in August. (see PowerPoint) Products from the CAGs/Subcommittees will be brought before the VBP Workgroup to achieve consensus where possible. If consensus is not achieved on recommendations, it will be referred back to the department.

Jason said CMS agrees that aligning Medicare and Medicaid is appropriate. Ultimately, it is to give providers choices and increase the likely hood of early and systematic adoption. Concerns have been expressed from the commercial market; intent is not to apply this to commercial market. Question regarding Medicare rule that suggested that 9 states would move forward for VB payment
(reimbursement) for home care and NYS was not a participant. Good suggestion and Jason said the group may want to have a further discussion of this and to see how we could move forward with this.

Mark Berg—ACO models for Medicare; learned from Medicare. NYS is a more integrated framework—ACO, Bundles, Primary Care Initiatives. Before next meeting description of bundling will be sent. Discussed slide set; inclusion of Medicare-only beneficiaries in NYS Medicaid VBP arrangements. Harold Islen—FFS population more than just a provider contract; solvency issues, select group of providers Jason Helgerson potential of regulatory conflicts or changes needed? Assemblyman Gottfried providers going bankrupt (St. Vincent’s example). No loss of coverage for consumer, the risk is for the provider. Time spent on FFS and Montefiore Health System as ACO (more information will be sent to committee members). (This discussion was between Islen and Helgerson).

Would like written comments on Medicare Alignment Proposal by Aug 14th; the proposal will be out for public comment this week.

August 28, 2015:

Andrew Kleinman, MD, MSSNY’s Immediate Past President participated on this conference call.

Jason Helgerson reviewed the work of the Subcommittees and CAGs but did not discuss the substance of those discussions. Staff will provide greater detail concerning those meetings. Material will be put on the web for everyone to peruse.

Discussed the revised VBP payment reform Medicare alignment with Medicaid VBP reforms. Jason (and the changes made to the document) re-emphasized that this is designed to be a voluntary program and therefore the document does not set a goal in terms of the percentage of VBP in Medicare. They removed reference to Medicare Advantage plans. They added language around non-institutional providers and clinics necessary to improve health outcomes and avoid hospitalizations. He asked for any additional comments by September 4th.

Montefiore proposal: it is requested that a separate meeting with Montefiore and interested VBP Workgroup members be scheduled. Takes a concept of how Medicare and Medicaid will coordinate and gives greater detail using a party (Montefiore) who has a strong track record with CMS essentially requiring the Medicare FFS to follow the VBP Medicaid guidelines. Have one set of rules, reporting requirements for VBP so that they can operate as efficiently as possible. Many questions were asked including whether are including adherence to QUAR and whether a patient gets to opt out. Jason stated that this is still just a white paper to get a framework before CMS to see if they are willing to dedicate resources to flesh out greater detail. Ken Raske is fine with having further discussions a work in progress that many people have a lot of questions; just to test to water with CMS. Workgroup did not want it attached to the Medicare VBP document. Jason said that he understands that there is concern about the Medicaid Innovator program but there will be a Medicaid Innovator program. He views the Montefiore proposal to going one shade deeper on the Innovator program.

Medicare-Medicaid VBP alignment is more important than MAP, FIDA or other separate Medicaid managed care programs.

Open to other Monte-like proposals.
Subcommittee Meetings:

Technical Design I 7/23/2015:

A brief summary of the meeting follows. Andrew Kleinman, MD was present at this meeting. On the phone were Thomas Lee, MD and Sana Bloch, MD.

The focus of the meeting was on Attribution, Benchmarking and how to calculate shared savings/losses.

Attribution: the methodology used to determine which providers are responsible for which patients (to whom is the patient assigned; how is the patient assigned; and when during the contract period is the patient assigned).

There was much discussion as to whether Medicaid patients have the ability to choose a provider. Dr. Lee pointed out that if there is no patient buy in then will have real problems. Others expressed support for patient choice of provider. It was pointed out that the rules of Medicaid managed care (MMC) will continue to apply and under those rules the patient will have the ability to choose their provider; however, if they do not choose, they will be assigned.

Consensus supported a MCO assigned PCP attribution methodology.

The question turned to whether the attribution methodology should be standardized across the board or whether it should form the basis of a guideline.

Consensus of this group (supported by Dr. Kleinman) was to apply the methodology as a guideline.

Benchmarking: the methodology by which the budget is set for a VBP arrangement. If total costs of care for the VBP arrangement is lower than the benchmark, providers may share savings; if total costs are higher than the benchmark, providers may share losses.

A benchmarking methodology has four components:

- Establish a baseline: aggregation of historic provider claims. It is noted that in Medicare, both the Next Generation ACO Model (NGAM) and Pioneer ACO Models aggregate provider specific (as opposed to regional or statewide) baselines. Also discussed was the length of the look back period (one year or more than one years. Consensus: establish provider specific baselines using 3 years of prior claims history.
- Establish a growth trend: the annual increases in healthcare costs per patient between the baseline period and the performance period. There were three options: a provider specific historic rate; a regional trend approach (Medicare NGAM uses a regional growth trend or an industry growth trend (MEI, CPI etc). Consensus: not clear that a consensus was reached although all agreed that no one wants to penalize the historically good performer (Dr. Kleinman concurred using a baseball analogy; not wanting to penalize the stronger batter). It was also noted that the trend cannot exceed the state’s global cap. They stated that the state will conduct its own analysis and then have plans review. Need more information on this issue.
- Establish risk adjustment for co-morbidity and other patient factors: allows for apples to apples comparison of patient populations over a period of time by adjusting the benchmark to account for the relevant risk factors that influence cost of care. 3M versus HCI3 models. The state uses the 3M Clinical Risk Grouping model. On an annual basis DOH and its actuary incorporate changes in case mix, utilization and cost of care into
the MMC premium. This makes 3M’s CRG the preferred risk adjustment model. The CAGs, however, are using the HCI3 Evidence-Informed Case Rate analytics and will use the HCI3 ECR analytics for those bundles (Maternity, HIV, cardiac etc).

- Establish value modifiers for cost and quality: used to balance impact of benchmarking methodology on all providers those who have been delivering highly efficient quality care and those who have been inefficient and/or been delivering poor quality care. Value modifiers ensure previously efficient providers are not disadvantaged from receiving future shared savings and previously inefficient providers do not have a disproportionately higher opportunity for shared savings. Value modifiers can be applied in the benchmark setting process, during the determination of shared savings or while performing rebasing. The Medicare NGAM methodology’s efficiency and quality modifiers change the ‘discount’ that CMS applies to the ACO specific benchmark, creating a possible range of 0.5% (for high quality and low cost) to 4.5% (for low quality and high cost ACOs) so the counter for shared savings begins at either 5% or 4.5% below historical baseline.

Under the MMC VBP initiative, beginning in Year 3, providers in the Medicaid Managed Care program who are under 20% of the benchmark will begin at a lower point. Dr. Kleinman recommended against penalizing providers. When asked what will be done between Year 1 and Year 3 to educate low performing providers to improve, Jason Helgerson said that when he did this in Wisconsin, the State Medical Society worked with the state to educate physicians. If done properly, MSSNY could take a similar approach; this could be a value-add for our members. Consensus: No consensus achieved but state clearly favored the approach of applying cost and quality modifiers to the benchmark as opposed to the determination of shared savings because that had the most favorable impact on the highly efficient quality performers.

Shared Savings: how to divide shared savings. State believes that this should be put in regulation.

The state will bring real world examples to the next meeting.

Shared examples in chart below as outlined in the State’s Roadmap to VBP:

<table>
<thead>
<tr>
<th>Outcome Targets% Met</th>
<th>Level 1 VBP Upside only</th>
<th>Level 2 Up &amp; Downside When actual costs&lt; budgeted costs</th>
<th>Level 2 Up &amp; downside When actual costs&gt; budgeted costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 50% of outcome target met</td>
<td>50-60% of savings returned to PPS/providers</td>
<td>90% of savings returned to PPS/providers</td>
<td>PPS/providers responsible for 50% or losses.</td>
</tr>
<tr>
<td>&lt;50% of outcome target met</td>
<td>Between 10-50/60% of savings returned to PPS/providers (sliding scale in proportion with % of outcome target met)</td>
<td>Between 10-90% of savings returned to PPS/providers (sliding scale in proportion with % of outcome target met)</td>
<td>PPS/providers responsible for 50-90% of losses (sliding scale in proportion with % of outcome target met)</td>
</tr>
<tr>
<td>Outcomes Worsen</td>
<td>No savings returned to PPS/providers</td>
<td>No savings returned to PPS/providers</td>
<td>PPS/providers responsible for 90% of losses.</td>
</tr>
</tbody>
</table>
Technical Design II 8/17/2015:

Four issues discussed:

- What activities/services should remain FFS and be considered VBP?
- How will technical assistance be provided to those providers that run into performance challenges in VBP arrangement?
- Should certain services or providers be excluded from VBP?
- What should be the criteria and policies for the VBP Innovator program?

Jason Helgerson led much of the early discussion on points one and two but left to take a call from the Governor and wasn’t present for the discussion of points three and four.

**What activities/services should remain FFS and be considered VBP?**

For some services it is appropriate to encourage volume like certain preventive services; but this will be an uphill battle with CMS.

Total cost of care arrangements should not carve out preventive care services because it would increase administrative complexity and there is not risk of underuse. Also, carving out those preventive services included in bundles (lifestyle coaching for chronic conditions, health education during pregnancy) doesn’t make sense because actively pursuing those will increase the outcomes and reduce total costs for these episodes.

It makes sense to keep preventive services in FFS when: (1) the preventive service is relatively costly; (2) the potential savings generated by these preventive activities will not sufficiently accrue to the providers contracting the VBP arrangement; (3) the current volumes of these preventive activities are considered too low; and (4) when there is a structural lack of alignment across providers (depression screening in primary care setting).

Some examples of services that should remain FFS and outside of VBP:

1. **LARC** (long acting, reversible and highly cost-effective contraceptive) has proven success in lengthening the interconception period and in preventing teenage pregnancies but including the cost of LARC in the bundle would create the strange incentive that doing more would increase the cost of the bundle. So the recommendation is to keep LARC as a FFS activity yet include quality measure showing the uptake of LARC in the Maternity bundle.

2. **PrEP** (pre-exposure prophylaxis) is use of ARVs by people who are HIV negative but are at high risk of contracting the infection. They are not part of the AIDS/HIV subpopulation and intervention is costly. Recommendation is to keep PrEP as a FFS reimbursed activity but include a quality measure in AIDS/HIV subpopulation care.

3. Preventive services in Integrated Primary Care arrangements. Preventive services make up a large part of IPC income. They will over time reduce downstream costs but this reward may be too far away in time and influence. Keeping preventive services as FFS in IPC arrangements and excluding these costs from a calculation of total spend is recommended. However, preventive services that are not linked to an IPC or total care arrangement are unlikely to be meaningfully coordinated so should probably not count as VBP especially where the provider does very little Medicaid.
How will technical assistance be provided to those providers that run into performance challenges in VBP arrangement?

The state wants to provide technical assistance to providers prior to their entering into VBP arrangements.

- Data and analytical support from January 2016 to help MCOs and providers assess that their current performance is, where quality improvement and shared savings are possible
  - How to enter into VBP contracts
  - Financial arrangements
  - Quality reporting

Question was asked as to whether there will be standard quality reporting metrics. Apparently, the PPS have been tasked to develop them and to provide assistance to providers.

Unanswered question as to whether state will ask the vendors to provide standard templates.

Should certain services or providers be excluded from VBP?

High cost drugs (Newer Hep C drugs)
Financially challenged providers (some financially frail hospitals including those getting IAF funding; but not those taking VAP funding (which is supposed to be used to ready themselves for VBP)
Out of network providers

Recommendation was made to exclude transplant surgery.

What should be the criteria and policies for the VBP Innovator program?

Will be creating a workgroup on this. Discussion ensued on tangential points.

Next meeting in NYC on September 29

Regulatory Impact 7/20/2015:

Jason Helgerson summarized the direction state was taking with the Medicaid program. Over the next five years $45B of the 59B of Medicaid payments will be in Medicaid managed care and of those 80-90% will involve value based payment (currently, 30% of Medicaid managed care payments are value based). He stated that research show that FFS plus bonus may positively impact on quality of care but not on overall cost of care. He said he wants to afford MCOs and PPSs flexibility to choose different levels of value based payments.

Level 1 VBP will include FFS with upside only share savings available.
Level 2 VBP will include FFS with risk sharing- both upside and downside.
Level 3 VBP will include prospective capitation PMPM or bundle.
The goal is to have >80-90% of MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBP at the end of five years with 35% of those payments captured in VBPs in Level 2 or Level 3.

Staff from DFS (John Powell) and DOH (Valencia Lloyd) then provided an overview of existing regulation of provider risk incentive arrangements. DFS Regulation 164 establishes requirements for providers transferring financial risk in the form of prepaid capitation only (what ultimately will become
VBP Level 3). DOH provider contract guidelines govern risk transfer arrangements that do not involve prepaid capitation (VBP Level 1 & 2). Specifics of the regulations are set forth in the slides.

They attempted to have a policy discussion on whether these existing regulations for providers taking downside risk are appropriate for VBP or whether an alternate regulatory vehicle should be developed. For the most part, many in the room agreed that if providers were paid after the delivery of care, no additional oversight was needed. Oversight, however, is needed when provider is prepaid. A question was raised as to whether the level of regulatory oversight should be dependent upon the entity driving the discussions ie. an IPA, PPS or ACO. No conclusions were made on any of the policy issues raised.

Jason said he would bring to the next meeting real life examples of existing payment models. He is also going to bring more information concerning VBP arrangements occurring in Tennessee and Oregon.

**Regulatory Impact 8/27/2015:**

Maria Basile, MD participated in this meeting on behalf of MSSNY.

Provider risk sharing and default risk reserves discussed.

For a long time, NY has had in place rules for financial risk transfers (DFS Reg. 164 and DOH Provider contract guidelines. Reserves required of 7.25% of next years premium payment (MCOs). Reg 164 was established to assure that providers were able to pay downstream providers. Concomitantly, discussion occurring in Tech Design1 concerning other mechanisms that the state might develop to prevent a provider entity from taking on too much risk and not meet its financial obligations.

Questions were asked as to whether prepaid bundles should be subject to Reg 164? Reg 164 is a total care capitation payment, so that prepaid bundles in and of themselves would not be seen as fully capitated arrangements. Discussion occurred because there are bundles for MH services to which 164 applied.

Bundles within a closed universe are not subject to Reg164. Might require more discussion concerning the extent of the bundles.

Need to have a backstop is important to detail. Is existing regulatory structure sufficient; where is it not sufficient. Three options:

Option 1: Must comply with Reg 164  
Option 2: Need DOH oversight  
Option 3: No oversight

Agree that must develop rules around when each of these options apply. All bundles are not equal. Might turn on the size of the bundle; number and type of providers.

Maternity and a hip replacement bundle are two totally different bundles.

Example: Level II Maternity Bundle: main intervention is to avoid pre-term births. If can reduce the percentage of low weight babies by as little as 1%, save $1000. If doing a bundle, then get almost 100% of shared savings. If do only share savings, can only get as much as 50% shared savings.
Where risk is substantial with a bundle, then the provider must have the wherewithal to handle the risk. Smaller providers in rural communities might not be able to assume risk. Want to separate the technical risk and split it from the insurance risk. Don’t want to penalize a group of providers with significant number of high risk patients. Establish a risk corridor with a stop loss to protect the providers.

Jason doesn’t think that this system should only empower the hospitals because plans don’t want a monopsony environment.

Federal rules around stop loss will be discussed at a later meeting.

**Provider risk sharing options:**
1. Leave Reg 164 as it currently stands and apply it to VBP III arrangements but not to level II.
2. Allow providers to engage in VBP Level II arrangements without financial security deposit but require additional safeguards to mitigate risk. But will need to discuss specific arrangements where there may be so much risk associated with Level 2 arrangements that will need to consider application of Reg 164. Establish guidelines.

Also want to look at the DOH review process because there are some issues there that should be addressed.

3. Have a conversation with DOH that need to be approved that will not fall under Reg 164; establish guardrails. This would give smaller players ability to contract directly with MCOs. Establish an MOU between DFS and DOH that specifies those recommendations.

Multiple providers enter into relationship with a provider who takes the risk. Those downstream providers will not achieve as much payment as the provider who assumed risk. And yet those are the providers who will assure that quality metrics will be achieved. Shouldn’t there be incentives for smaller providers to assume risk? This was not embraced. Others thought that there should be protections for someone who didn’t sign up to assume risk can actually be paid.

An individual physician could never be involved in an upside downside total cost of care arrangement.

**What Entities Should be Legally Recognized as Contracting Entities under VBP**
1. IPAs already allowed
2. ACOs are allowed
3. Individual providers

Should we change state law to allow a PPS to contract with MCOs? They could already become an ACO or an IPA. Budget proposal was to give flexibility to the provider and to allow PPSs to go into direct contracting. Will need to sustain them through managed care in order to accept full participation.

FLPPS: do not have any intention of contracting as one entity with a MCO; thinking of themselves as a support entity to other IPAs who will contract. Could allow them to become an MSOé. The group disapproved of this recommendation.

**Modifications to Provider Contracting Guidelines**
Want to apply provider contracting guidelines to ACOs which makes sense since the DOH will not be contracting only with the MCOs.
Social Determinants of Health (SD) and Community Based Organizations (CBO)  
7/30/2015:

Described the work of the MRT and the underpinnings for the 5 year Roadmap for Medicaid payment reform under DSRIP.

Population Health focuses on overall outcomes and total costs of care while sub-population focuses on outcomes and costs within the sub-population.

VBP Transformation Overall goals:  
By end of 5 year DSRIP plan,:  
1) Have 80%-90% of total MCO-PPS/provider payments as VBP and  
2) ≥35% of total managed care payments tied to VBP Level 2 or Level 3.

When asked about studies to support positive impact of VBP, state said they will get examples from around the country for where it has worked well.

Ex. 1: Described what happened at Montefiore which has a Level 3 VBP arrangement. Decided to give patients with COPD or asthma an air conditioner. Dramatically reduced ED costs and produced savings.

Ex. 2: Behavioral health clinic with Level 2 arrangement contracts with HARP population and will reinvest savings for more affordable housing which keeps population out of institution and produces additional savings.

Provided an example of difference between Level 1 (upside savings only) and Level 2 /3 (upside/downside savings/risk):

Provider receives $100 for service to patient which costs $90. Provider saves $10 and keeps $5 (50%). In another Level 1 arrangement where provider received $100 for service to patient which costs $110. Provider loses nothing. It's the plans loss.  
Versus  
Provider receives $100; service costs $110. $10 overage provider on hook for $9 (90%) and plan on hook for $1 (10%).

Discussion:  
It was noted that states that have gone from FFS to Level 3 have not fared well. Need to give providers time to build capacity to manage risk and demonstrate population health.

Population health life span impacts: Should think about social determinants of health by looking beyond the individual to a population health issue- ongoing savings because of addressing social determinant of health . Focus should be local but should be viewed against the backdrop of population health.

Poverty: Dr. Calman said that much of this is poverty related. Also wanted to discuss how to empower the CBO vs. the MCO and major hospital systems.
Need to focus on bringing other resources to allow for a comprehensive multi-dimensional look at individual interrelated problems: shouldn’t work on smaller issue of housing without working on the greater goal of employment.

Question asked as to how to incentivize other resources to accomplish multi-dimensional approach.

Who are the clients taxing the system and who is able to provide the services they need?

Are there services we want to continue as FFS because we want to drive volume ie. immunization.

**SD &CBO 8/14/2015:**

Jason described his standard vs. guideline perspective as to what plans and providers will use as part of their VBP negotiation. Guideline is a starting position. Example: could establish as a standard that a total cost of care arrangement must use a particular measure to address concern for social determinant of health (housing, economic stability, etc). Or as a financial incentive, providers at level 1 taking on measures associated with social stressing get a large share of shared savings.

Changes in law, regulation or in MCO contracts to effectuate recommendations of this group. But don’t want to do too much to deter providers from accepting risk. Don’t push the envelope too hard. But try to put markers out there to get providers to think more holistically about care delivery.

Five categories of social determinants:
- Economic Stability
- Education
- Health and Healthcare
- Social, Family and Community
- Neighborhood and Environment

Is there a measure we can use to measure performance to SDH. Are there standard metrics to use. How would the state incentivize SD of care?

One of the models for the prevention agenda is healthcare improvement model: metrics, evidenced based approach and strong collaboration.

Should develop standards for collaboration.

Different communities have different circumstances and different community needs.

Prevalence of diseases by community.

Providers must be working together. No provider can do this themselves. How to share data among providers.

Statewide Medicaid beneficiary information opt out. If they opt out, then their information won’t be shared. Key is to have providers work together and share information. Providers could come together as a PPS, or a care community of some other unit of measurement.

If address social determinants, can affect health costs accruing across many buckets.

What social determinants of health will save money? How can this be measured?
Reduced costs of incarceration
How can we work with halfway houses?
How can state get offenders to participate in programs?
How will SNAP and other programs affect health costs.

Concentrated urban policy. Certain services touch families and can generate savings. But no way historically to capture those savings, so it’s a big challenge.
Have cross sector conversation. May be easier to do in smaller communities.

Example: Connection between criminal justice and health care system. Ie. Rikers Island a significant number of people have MH and substance abuse issues cycling in and out of prison and community. When everything else fails, crimes committed and people now in criminal justice system. Need good discharge planning when people come out of county jail. Generate savings.

Advocacy and Engagement 8/13/2015:

Provided the background on value based payment.
What are we trying to incentivize?
Patient Activation (enrollment; finding a PC)
Proper System Utilization (decreasing ED visits, decrease unnecessary hospitalization)
Preventive Care (vaccines, routine appointments)
Healthy Lifestyles (tobacco, weight management, exercise)
Disease Management (intervention groups, blood glucose monitoring)

What incentives?
Monetary (debit cards)
Lottery based monetary incentives
Transportation tokens
Coupons for food, diapers
Backpacks with essential living gear for homeless
Studies show support for these for preventive services but not for long term behavior or lifestyle changes.

NY’s Medicaid Incentives for the Prevention of Chronic Diseases provides enrollees with smoking, hypertension, diabetes a $250 debit card in intervention group and $50 for control group participants. Not sure of impact as it continues operation. Similar programs filed in Florida and Wisconsin but succeeded in Idaho.

NY’s TB Directly Observed Therapy program provided incentives to motivate patients to therapy. Incentives such as snack, food coupons, subway tokens worked.

Medication Adherence program provided a daily opportunity to win cash daily to take warfarin.

Clinical Advisory Group Meetings:

Maternity 7/21/2015:

Edward Kelly Bartels, MD and Maria Czerwinski, MD participated on behalf of MSSNY.

Staff provided a summarization of the move to VBP (80-90% Level 1 upside only with 35% using level 2 and level 3).
Discussed the HCI3 grouper and the logic of the clinical bundles. Additional information can be found at the following link: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2009/rwjf41603

The grouper aggregates smaller episodes into larger wholes—claims are grouped into individual episodes which get grouped together into the bundle.

Evidence Informed Case Rates are HCI3 episode definitions—time limited episodes of care. Open sourced definitions and not proprietary. It is adaptable for New York’s purposes; easily changeable. Risk adjustment very important to the maternity bundle. Equally important is outcomes. What are the implementation issues for the providers with regard to each bundle?

(I had to leave the meeting for another conference call; missed 45 mins of meeting)

Trigger code; exclusion criteria (either patient or medical) applied to remove those cases that are so high cost as to throw off analysis (don’t want bundles to be like a lottery; want to exclude instances where the number of claims so low and the costs are extremely).

Concern expressed for regional parinatal programs. Care before they come to the perinatal program can really impact outcomes and naturally will impact on VB payment. Will really have to be careful as to whether they choose Level 2 or Level 3. Shouldn’t be a disincentive to send a mother to a regional perinatal center. Don’t want to create two-tiered system of care. Regional perinatal centers need to be managing high risk pregnancies.

Yes; but that’s not their intention. Do not want to disincent access to regional centers.

Question of how to handle non-compliant patients. Will be discussed at next meeting.

Members are concerned about hurting level 3 NICUs and help level 4 NICUs. Data will be reviewed to assure that this will not occur.

Included in the bundle is up to 270 days pre-natal care period and all services/costs up to 60 days post discharge for the mother and all services/costs for up to 30 days post discharge for the infant.

Risk adjustment was briefly discussed (much more later at next meeting). What kind of risk adjustment factors are most important to capture? Prior preterm birth; multiple gestation. Maternal age is not that positive for pre-term birth. ACOG has published risk scoring for pre-term birth and injuries which should be used. First 30 days is about half the costs associated with the bundle.

Have asked that the regional perinatal center data which can sort by complications be disseminated to those on the CAG. Will also share ACOG risk scoring data.

Also will disseminate outcome measures that members of the CAG believe are important to be brought to the table.

Discussed an intervention following birth; redefining the post partum visit so as not to lose them to the system. If there are outcomes being analyzed on the national level, should be used here.. ie. have a contraceptive visit. ACOG wants to put issue of prior pre-term birth on the table. Prevention of prior pre-term is critical.
At the second meeting, will look at actual data to get a sense of how the bundles will work and their implications for providers. Will discuss risk adjustment factors. Also will discuss outcome measures.

The third meeting will focus exclusively on outcome measures. Unique to maternity care is a short claims history (pregnant moms get on Medicaid when they become pregnant, not before) so it’s difficult to do a good risk adjustment. Outcome is also difficult to measure because of short claims history. The CAG will need to use other data besides claims history to analyze the bundle.

**Maternity 8/11/2015:**

Edward Kelly Bartels, MD, on behalf of MSSNY, attended this meeting in person.

**Bundle Criteria:**

Described the episode as the entire pre-natal care period (270 days prior to delivery); all related services for mother including post discharge period (60 days post discharge); and the baby’s hospital stay and all services up to 30 days post discharge. Will exclude high risk (level 4 NICU) care and newborns who die during first month. Also excluded from the bundle is the instance where a fetus dies prior to delivery.

Bundle is triggered by delivery and look back using as birth date found on birth certificate. Would be triggered even if the mother dies during delivery or within 60 days after discharge.

Concerned about impact of the bundle on physicians who do complicated births and become a referral source; why would they want to continue to take on those cases if they are punished financially.

**Potentially avoidable complications (PAC):** (1) complications related directly to an episode ie. sepsis occurs during pregnancy and (2) episodes which are themselves considered complications in their entirety if they occur contemporaneously to the episode ie. stroke.

There should be percentages associated with the PACs. One physician spoke up against penalizing him because he delivers in the Bronx where there are more low income individuals with more complications. Want to reward people who are performing well but not to penalize. Some concern that at least one study shows that risk adjustment isn’t doing this.

Risk adjustment: expected cost of routine care + expected cost of complication; so the PACs are baked into risk adjustment. Marc Berg stated that the data sets will always be changing, need to learn from the pilots and fine-tune the data over time. Will compare docs in pilot to their historical performance; risk adjustment likely will not always catch everything but since using the doc’s historical performance, that shouldn’t hurt analysis.

Why is C-section not considered not to be a PAC? If group feels wrong, can change. The number of PACs is small, so 1-3%. If add c-section, the number of PACs becomes very big and drowns the other PACs. Should look at it separately as a quality indicator.

Historically good providers will get a bonus and then on top of that will receive the rate devised as part of this process. No negative impact for two years and then ding the poor performers after two years.

Outcomes and process measures will weigh into the structure of the payment. The group is to define those outcomes and process measures to imbed in the payment methodology.
Long acting reversible contraception (LARC) should be included as a quality measure. Presumptive eligibility (one year of Medicaid coverage); so if the woman comes in and is pregnant, is covered through delivery plus two years. LARC is already part of benefit package.

Will have to be some exception for the Catholic Hospitals

There is a good reason to not include LARC in bundle because reduce cost savings. Recommends that create a process measure that focuses on LARC (not the cost of LARC in bundle). LARC already paid for; keep it as part of FFS.

In 2012-2013, newborn care is half the cost of the bundle, while the pregnancy itself is 9% of total costs. The delivery is at 38% of the total bundle. Downstate counties drive episode volume and are among the highest per county costs.

Four cost drivers for the bundle are: Price of service, Volume of services, PACs, and service mix. Price doesn't really impact cost. Therefore, they want to focus on the other three (volume, APCs, and Service mix).

Top pregnancy PACs NYSwide:
Pregnancy: Sepsis
          UTI
          Fetal diabetes
          Abdominal hernia

Top C-Section: Disruption wound
               Obstetrical wound complications
               UTI

Top Vaginal Delivery: Obstetrical trauma
                   Failed induction, abm forces
                   Post partum hemorrhage

The costs associated with these PACs seems to be very low to the members of the CAG.

Characteristics of the Maternity Population in the Medicaid Data:
Counts with the highest low birth weight are upstate (Monroe, Niagara, Erie, Albany)

The counties with the highest c-section rates are Niagara, Suffolk, Westchester, Queens and Ulster.

Risk Adjustment for Maternity Care: risk adjustment for costs and outcomes. Want to make “apples-to-apples” comparisons between providers by accounting for differences in patient populations and patient factors (age, co-morbidity Etc.)

The way systems like HCI3 or other groupers work with claims data to look at historical events (diagnosis) and events during episodes. This model is meticulous at looking at all individual components, typical costs, PACs etc and model expected costs. What is relevant to look at is how actual costs differ from the expected costs.

Look at demographics, risk factors (co-morbidity), subtypes (markers of clinical severity within an episode) like abnormalities of uterus, placenta previa etc).
There is a paucity of data because the women are young and they come into the Medicaid database because they are pregnant and their diabetes isn’t showing up in the data.

However, there are other sources of information like vital statistics (previous pre-term birth, weeks of pregnancy, race) and additional clinical data (standardized reporting required). Or other sources like the Perinatal data system (Which is preferred to other data sets.)

The DOH and NYC vital statistic and perinatal databases are not yet linked. ACOG argues for a uniform data set/database. There is a statewide SPARCs data which incorporates commercial and Medicaid.

In 2016, a pilot project will be started on the maternity bundle with existing risk adjustment methodologies using existing Medicaid claim data. Goal is to see what other information from the vital statistics and other risk adjustment factors should be taken into consideration. Will task a subgroup of the CAG who wants to do this. Thinking about doing a pilot upstate and a pilot downstate. Having vital statistic data available at a higher quality level will show whether can improve expected costs or not. Will refine the risk adjustment factors at end of the pilot.

Quality Measures: (will be focus of the next meeting)

There are different types of measures (structure, process and outcome). There may be process measures that we have to include (LARC). Need to find correct path between the important and the ridiculous. Look at what is already being used and then add on if necessary.

Total care episode is the focus over provider specific measures (unless all agree should include).

Looking at the 2014 Core set of Maternity Measures for Medicaid and CHP; and 2015 QARR NYC specific Performance Measures. However, there is a delay in receiving a final data set from NYC and this will cause a similar delay should they want to use that data set.

Need to find a balance between extra costs for administration and the added value for outcome measurement.

Next meeting: determine which measure are vital; and what are the key issues that are missing. For example, don’t know why prenatal care during first trimester is in QARR dataset when physician has no control over that.

Will conduct a pilot using the NYS Maternity Quality Measures to see what additional data elements should be included.

Need a wide range of different programs to participate in the pilot.

How will it work for the small group docs upstate.

Not everyone needs to do this bundle. Not forcing everyone to do this. (But small physician practices don’t have the ability to negotiate their contracts.

Berg: Nothing in this set up that precludes rural providers to be benefited from this bundle.
The plan is to roll out the bundle to the rest of the state starting in 2017. In order for this to be successful large numbers of deliveries will be needed. In other words it is unlikely that a small physician group or even an amalgamation of small physician groups will be able to team up and meet the outcome measure metrics. They estimate 500 would be the minimum number but I expect it will probably be higher in order to avoid the problem of potential high cost cases skewing a group's results.

Present at the meeting were several members of the KPMG healthcare group. They have access to a database of state statistics which they can mine very quickly from their laptop computers. They seem to be closely integrated with the state health department. Unfortunately, as was pointed out, the data is imprecise and imperfect. Amita, a physician from HCI3 said that she had had no cooperation from ACOG nationally. Donna Montalto from ACOG district 2 pointed out that ACOG has done a lot of background work and immediately offered to share this with Amita.

Mark Berg concluded by saying this is a very fluid process in that everyone is learning as they go.

**Behavioral Health (HARP, Depression, Bipolar) 8/12/2015:**

Edward Amyot, MD participated by phone and Frank Dowling, MD attended this meeting on behalf of MSSNY.

Discussed the value based payment roadmap.

Described the HCI3 grouper.

Not including ADHD and some schizophrenia in this bundle.

HARPs are a distinctly qualified, specialized and integrated managed care (Medicaid only-no dual eligible) product for adults meeting the serious mental illness (SMI) and SUD targeting criteria and risk factors.

The HARP population is a list of beneficiaries maintained by OMH of individuals older than 21 who have a target criteria or risk factors or identified by individuals case review or completion of HARP eligibility screen. Common diagnosis include: bipolar disorder, depression, schizophrenia and substance use. Generally, they suffer from illnesses that are often ineffectively treated and can have severe consequences. There are 177,000 HARP individuals in NYS. They range in number between 2%-6% in each county of the state. It is not clear why there is a threefold variation of 2-6% from county to county; concern was expressed that the reasons for variation may impact the ability of CAG to develop proper outcomes measures. They represent 3% of the Medicaid population and 14% of the Medicaid spend. Many are also in HIV, Managed LTC or Developmental Disability populations. 12,514 have double overlaps (HIV & HARP) and 2,943 (HARP & MLTC) and triple overlaps 325 (HIV &HARP &MLTC).

Using the current version of the HCI3 grouper, bipolar and depression are the two highest cost episodes for the HARP population.

Look at what episodes we see within the HARP population. Look outside that HARP for depression and bipolar for an episode or whether it's chronic care. Grouper looks at the costs of care related to the depression (not the diabetes from whom another provider will deliver care). If well managed won't see the bipolar broken out. Total cost of care model is used for the HARP. The data on cost is from
claims. In addition, while the data is mostly or exclusively on mental health claims, moving forward the bundles of care will include care of medical and psychiatric illnesses.

Only looking at bundles for depression and bipolar.

Believe that they won’t see behavioral health costs go down; they will stabilize- will see physical health costs go down as person able to manage personal health conditions.

Only get a piece of the shared savings thus need to focus on the recovery model. Performance measures should focus on outcome measures for total care.

Thinking about using QARR measures (antidepressant med adherence, potentially preventable readmission, potentially preventable ER use) and measures from BHO 1 or the collaborative care initiative. Recovery oriented measures are likely to be considered (e.g. improvement in psychosocial functioning)

The Depression and bipolar bundles trigger will be either an inpatient claim or an outpatient claim and another outpatient or professional billing claim. Will look back thirty days from the trigger and then keep it open until the end of the analysis period. A confirming claim is used to reduce false positives.

Although one of the strongest predictors of outcomes for these disorders is alcohol or substance use/abuse, substance use and substance use disorders are being looked at separately. There was a strong consensus among clinicians and clinician/administrators at the meeting that substance use/use disorders must be factored into the development of outcomes criteria and financial aspects moving forward.

Will have a set of outcomes measures for APC which they will want to match the behavioral health outcomes measures.

Will form a subcommittee to look into outcome measures.

Will facilitate a HARP pilot to refine measures, risk adjustment factors etc.

Will discuss episodes and HCI 3 grouper next meeting. Also will look at play books and to get at diagnostic bundles.

**Pulmonary 8/26/2015:**

Kira Geraci, MD attended the meeting in person.

Reviewed costs associated with pulmonary episodes (asthma and COPD) from 1/1/12-12/31/13 (excluding dual population). These episodes represent $1.16B over 2 years with Asthma comprising three quarters of both cost and volume of these episodes.

A question was asked as to what the state has done to decrease Medicaid spending. Marc Berg highlighted the 4% global cap on overall spending and the implementation of Medicaid Managed Care. These two action have caused total Medicaid spending to stabilize even while the number of Medicaid beneficiaries has grown by 12% and have caused Medicaid spending per beneficiary to decrease from over $9500 per beneficiary in 2009 to just over $8,000 per beneficiary in 2014.

Reviewed rationale for movement toward VBP. State that providers and MCOs will receive cost and quality performance overviews per VBP arrangement which will include target budgets and actual
costs. Web-based analytic tools will allow providers and MCs to drill down on this data by geography and provider and possibly over time to individual patients.

Under NYS’s VBP, there are different types of contracts depending upon the type of population being addressed:

**Vision of Chronic Care contracting in NYS VBP:** Expect providers will contract for all of the bundles but there is also the option for providers to contract only a subset of the bundles.

<table>
<thead>
<tr>
<th>Type of population/condition</th>
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<th>Type of contracting</th>
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<tbody>
<tr>
<td>Specific subpopulations:</td>
<td>HIV/AIDS</td>
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<td>needs best coordinated by</td>
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<td>specialized provider</td>
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<tr>
<td>Highly specialized chronic</td>
<td>Chronic kidney disease</td>
<td>Bundle</td>
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<tr>
<td>conditions</td>
<td>Hemophilia</td>
<td></td>
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<tr>
<td>For more common chronic</td>
<td>Asthma</td>
<td>Individual chronic bundles</td>
</tr>
<tr>
<td>conditions: integrated</td>
<td>COPD</td>
<td>are contracted together by</td>
</tr>
<tr>
<td>approach is part of APC</td>
<td>Chronic depression</td>
<td>integrated care providers</td>
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<tr>
<td>vision</td>
<td>Bipolar</td>
<td>(guideline)</td>
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<td></td>
<td>Substance use disorder</td>
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<td></td>
<td>Coronary Artery disease</td>
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<td></td>
<td>Hypertention</td>
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<td>CHF</td>
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And there is flexibility in the amount of risk providers wish to assume (Level 1, Level 2, Level 3). They want 80-90% of total MCO-provider payments to be captures in Level 1 VBPs at the end of 5 years. And at least 35% of total managed care payments tied to Level 2 and level3 or higher.

This must be put in context with what is happening with the SHIP initiative and advanced Primary Care practice where patients are proactively managed. Dr. Geraci asked what incentives are being put in place to incentivize the patients. They recognized this was important but observes that the state cannot ding the patient under Medicaid program (politically and for eligibility reasons). Group is thinking about non-monetary; example. For maternity incentivize the mother by offering certain services for mom after birth of child (like transportation).

Why would a physician choose a bundle that would complicate their lives more by having another payment interjected into the mix. Will also be a question on the behavioral health side? Adds a complicating factor into the practice. Because it allows the practice to generate money for the practice to perform optimally. The philosophy is not to treat one group of people (MA) differently. Data sets are supposed to enhance practices’ performance in order to generate additional revenue to the practice.

Described the HCI3 Grouper bundle: Claims based; more than one trigger (inpatient claim, outpatient claim, professional claim). Costs are separated by “typical” care from costs associated with potentially avoidable complications (PACs). With the data you get back, must ascertain where the opportunities for improvement are;
don’t know what actually took place because these are just claims data. Provider gets a budget for typical services and a budget for PAC. Important that the physician is not penalized. Does include pharmaceutical data.

Use the concept of leveling (1-5) in which individual episodes (90 episodes) can be grouped together into bundles as move higher up in levels associated episodes get grouped together. Can roll data up into larger bundles. All episodes are risk adjusted by taking out co-morbidities and severity of condition and patient demographics. Separate risk adjustment is conducted for typical services and PACs.

Looked at data associated with asthma and COPD. Asthma episodes account for $335M annually in Medicaid with an average cost of $1,200. COPD episodes account for $114M annually with an average $1,478 per episode cost.

Over two years, PAC costs represent $528M of all asthma and COPD costs. Bronx, Kings, Queens and New York counties have highest asthma and COPD cost and volume.

**Chronic Heart Disease 8/27/2015:**

Drs. Robert Frankel (MSSNY), Streck (HANYS), Michetto (IPRO) and Vendetti (AMC) were among those present at this meeting.

Described the five year roadmap to VBP and the underlying rational for moving to VBP focusing on the Medicaid Redesign Team especially the 4% global cap and the move toward Medicaid managed care. Efforts are to take back some of the savings achieved and reapply it to Medicaid program. Need both delivery system reform and payment reform (to reinforce the type of delivery system looking for). Goal (by end of 2019): move FFS payments to 80-90% provider payments on VBP basis and that 35% of those must be Level 2 or higher (risk sharing).

Not being asked to tailor definitions but to focus on:
Outcome measures
Data and other support required for providers to be successful.
Details around implementation

Chronic heart episodes account for $1B of non-dual Medicaid expenditures.

DSRIP imagines an integrated delivery system to function by integrating physical and behavioral health. But there is also recognition that there is a subpopulation that needs a particular focus and that is what the bundles will focus on episodic bundles (maternity) and continuous bundles (for chronic care & complex care populations AIDS/ severe MH). Today talking about the chronic health within the continuous bundles.

Payment options:
- Total care payment (ACO)
- Bundle payment for episodic or continuous care bundles
- Integrated advanced primary care
- Subpopulations (AIDS, severe MH)
Vision of Chronic Care contracting in NYS VBP: Expect providers will contract for all of the bundles but there is also the option for providers to contract only a subset of the bundles. ACO, PPS, IPA, practices will contract directly with the MCOs rather than with Medicaid.

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HCl3 Grouper methodology:
HCl been around for ten years, built the Prometheus payment system.
Open sourced
Code level detail which can be looked up on web easily (not black boxed)
Focuses on prevention for the chronic care conditions

Definition of an episode (evidence informed case rate (ECRs) is time-limited and covers all care related to a specific condition. It separates out a typical cost and a potentially avoidable complication. Based on clinical logic and evidence based guidelines (but in some cases expert opinion is used). Teams of clinicians across country have worked to develop the ECRs.

Ex. Of application of ECR: Diagnosed with coronary artery disease, all visits associated with it fall in but unrelated conditions are not included (ie. dermatological visit, broken leg).

The Chronic Heart Condition bundle is composed of:
Arrhythmia, heart block, conduction disorders
Coronary artery disease
Congestive heart failure
Hypertension

Components of an episode: (1) Triggers (hospital claim or professional claim) open the episode (more than one trigger can be used to reduce false positives)
(2) costs are separated by typical care from costs associated with potentially avoidable complications (PACs) opportunity for potential improvement . poor care coordination, medical error there is never an expectation that there will be no PACs.
Budget is split between the typical costs and the PACs. The analysis will be shared at the MCO and provider level.
Episode for a budget point of view closes in one year. Will continue to attribute claims to it past that year.

What about the instance where the action taken to avoid the PAC is extreme? Ex. Congestive heart failure

PACs attributed to the patient but the count of PACs can be used as a quality measure and thus would impact providers.

A provider will receive a listing of PACs that will be associated with management of the patient and may include PACs attributable to several providers.

Stand alone episodes are grouped into higher levels at which providers/MCOs will contract.

Episodes are risk adjusted taking out any patient factors and run separately for typical services and for PACs.

Could a primary care physician own a bundle or the cardiac physician? Its flexible. But its first come first served basis (if PCP wants the bundle then cardiac care included in there). MCO knows the landscape and will contract accordingly.

Drilled down on two years of data for each of the four conditions:

- **Hypertension**: $464M annually; ave cost of episode $2,200; 208,000 episodes annually
- **Coronary Artery**: $248.9M; ave cost of CAD episode ($6,819) significantly higher than cost of hypertension
- **Arrhythmia**: $158M; ave cost $2,468
- **Congestive Heart failure**: $157.7M; huge per episode cost $9,855

Factors driving cost of episode: price, volume of services provided, PAC, and service mix (hosp, v. outpatient point of care)

They differentiate between the percentage of costs related to typical care versus PACs. The amount attributed to PACs is the “opportunity for improvement” and the “opportunity to share in savings”.

The top ten PACs per condition: for all of these conditions the top ten drive the maturity of the costs.

- **Hypertension**: the top ten PACs count for 74.5% of all hypertension PACs; AMI is significant by volume (but not in term of cost). Question was asked as to whether all of these heart attacks could be considered avoidable; they are looking into this.

- **CAD**: the top ten PACs count for 79.6% of CAD PACs; Stroke is high in terms of volume.

They are looking at this data for the first time. Need to drill down more on the data and look at the coding practices and how that impacts this data.

Showed average actual cost, PAC rate and volume data on county by county by condition. Looking for outliers to determine whether there is something unique happening in a county that they need to drill down. Can use the data to also see more cost efficient counties. However, some counties are so small that data skews so that the analysis might need to be performed on a regional basis. Can drill down even further by zip code.

Jason has an issue with risk adjusting by zip code.
Part of what the CAG is to do is to build outcome measures which will be developed over the next two meetings.

**HIV/AIDS 9/3/2015:**

William Valenti, MD participated in this meeting on behalf of MSSNY.

Presented background on DSRIP, the work of the CAG and an introduction to Value Based Payment.

CAG’s focus is on recommending outcome measures and data and other support needed to help providers to be successful.

For HIV/AIDS: subpopulation care includes all care for the total subpopulation—condition-specific ACO model as opposed to an episodic bundle. All parts of the care derive from the HIV/AIDS condition. What if the HIV patient has diabetes? It doesn’t make sense to carve out the diabetes bundle from the overall care provided to the HIV/AIDS patient. Most overlap is between HIV/AIDS and HARP.

There will be substantial overlap and fluidity.

Originally, state wanted to create an HIV/AIDS PPS. MCOs and providers were opposed. Now focus is on HIV/AIDS ACO.

HIV special needs plans have no risk adjustment in them. Discussion as to whether they can be transformed into an HIV/AIDS ACO.

**Current costs for HIV/AIDS population—statewide:**

Subpopulation care includes all care for the total subpopulation.

Non-HIV chronic care represents 40% of all cost for HIV population; medication represents 25% for the HIV/AIDS population.

**Mapping (MA only individuals):**

- Total cost data
- Potentially avoidable complication cost data

AIDS/HIV center wants to become an AIDS/HIV ACO at a Level 2 VBP (FFS with retrospective reconciliation. Ideally, it would be responsible for total costs for all patients attributed to it. Optimally will discover where waste is in its system and invest shared savings to remove it.

A number of cost drivers that providers can look at: price (state not trying to affect this), volume of services rendered (duplication in tests), PACs (opportunistic illnesses taking advantage of weakened immune system), and mix of services and intensity of care received and place of service.

Examples:

- reducing # of doctor visits
- providing housing subsidies to reduce PACs where data show that patients who do not have stable housing have highest amount of PACs

**Ending the AIDS/HIV Epidemic:**

NYS has highest HIV prevalence in US; now 132,000.
Main goals are to: (1) identify pts with HIV who are undiagnosed; (2) link diagnosed HIV pts to healthcare and get them on anti-HIV therapy; and (3) facilitate access to PrEP for high risk populations.

**State’s Goals:**
- Reduce new HIV infections from 3,000 to 750/year
- Reduce rate at which individuals diagnosed with HIV progress to AIDS by 50%.

This initiative is aligned with New York State’s End the HIV Epidemic by 2020 initiative. Outcomes under EtE 2020 are a part of this effort - e.g. (1) HIV testing to identify those who are currently unaware of their HIV status, (2) linkage and retention in care with the goal of undetectable viral load to prevent further HIV transmission, (3) pre-exposure prophylaxis for high risk HIV negative persons.

**CAG will focus on:**
- Process measures
- Procedure measures
- Outcomes measures** primary focus over next two meetings; also data and tools needed to monitor performance. Most of measures are those already identified by AIDS Institute.

Think about PACs as it relates to HIV/AIDS care

### Summary of SIM/SHIP Integration Work Group Meetings

**Integration Work Group July 31, 2015:**

In attendance for first of these meetings is the new Deputy Secretary for Health, Mr. Paul Francis.

Discussed feedback received thus far from health plans, employers and physician listening tour. Their primary audience was commercial health plans and self insurers. They added a listening tour for physicians (thanking ACP and MSSNY for their help in organizing) and a separate tour for hospitals. They will be holding a second tour in October.

Stated that there was consistent support for the SIM direction (value based care; strengthening and changing primary care). However, there were concerns expressed regarding the scope and degree of change required. Also expressed was a need for greater awareness and engagement of employers.

- Physicians are concerned about the degree of transformation required with primary care physicians struggling, and workforce declining and small practices lacking the resources, infrastructure and time to engage in transformation. Past transformation efforts were projects and not sustaining. Payment system must support transformation.

- Strong support for consistent measures; however, different practices may need different metrics; also need to match to data available in practice EMR. How to fit with Medicare measures?

- With regard to payment, most payers are making some VBP for primary care if at least only on a pilot or regional basis with recent success in certain regions like Rochester and Adirondacks. Conceptual support for multi-payer approach but must work out attribution methodology; and must work with ACOs where payer already paying for primary care.

- It was recommended that the state increase communications particularly regarding how all the initiatives fit together and how the APC model fits with PCMH.
Discussed the revised APC measures (now 20). Added additional measure for \(\text{avoidance of antibiotic treatment in adults with acute bronchitis}\). Want to identify the right sources for these measures.

They reviewed potential payment models. What kinds of investments can a practice be expected to make prior to receiving support for APC transformation. DO practices have to achieve all elements of APC before care coordination fees kick in. At what point should outcomes based payment be included? Looked at sample milestones with no financial support and with PMPM support in the Arkansas and Delaware SIM and RI CCSI and Medicare CPCI.

Discussion ensued. One participant stated that we don't know what metrics will work and what payment will work.

Paul Maceilak focused on the need to align attribution process and payment; particularly for the PPOs. Folks in the Adirondacks and Rochester currently use a manual process. He also asked how long will it take the workforce to transform? He stated that it is too early to discuss sustainability. Not sure he can make a commitment beyond 3 years of SIM grant.

John Rugge, MD discussed care coordination stating that it depends on how fast the practice wants to make it happen. Practices starting from zero will take 3 years if they are getting help; five years if they are not.

Greg Burke (UHF) identified pre-payment pre-APC with deliverables tied to pre-assessment prior to transformation as being very important.

Question was asked as to whether it should be an all-payer structure or payer specific as for quality measures. Foster Gesten, MD prefers all payers to use same quality measures for payment but practically expects it to be more payer specific.

Discussed Transformation efforts and TCPI. Noted that less than 40% of physicians have adopted EHR in NYS. It was pointed out that if only will provide transformation monies/support to those who have adopted HER technology then doomed to fail since most physicians have not yet adopted. Need to do more such as offering other financial incentives or loan program to encourage physician adoption.

Next two meetings will focus on what elements of APC model need to be standardized and where the VBP might apply across payers and how SIM dovetails with DSRIP, NCQA and Medicare.