Minutes--DRAFT
Meeting of the MSSNY Quality Improvement Committee
September 30, 2015

A meeting of MSSNY’s Quality Improvement Committee was held through video-conference connecting attendees at Westbury and Albany. The following individuals were in attendance:

Quality Improvement & Patient-Safety Committee:
John A. Ostuni, MD, Chair, Westbury
Evelyn Dooley-Seidman, MD, Vice-Chair, Westbury
Maria A. Basile, MD, via WebEx
Clare B. Bradley, MD, Westbury
Samuel M. Gelfand, MD, via telephone
Barry Rabin, MD, via telephone
Arthur Wise, MD, Westbury
Gary Zeitlin, MD, via telephone

MSSNY Staff:
Pat Clancy, MSSNY Staff, Division of Governmental Affairs, Albany
Liz Dears, Esq., MSSNY Staff, Division of Governmental Affairs, Albany
Barbara Ellman, MSSNY Staff, Division of Governmental Affairs, Albany
Miriam Hardin, MSSNY Staff, Division of Governmental Affairs, Albany

Guests:
Meghan Gleason, KPMG, via WebEx
Jillian Kasow, Director, Legislative Commission on Rural Resources, New York State Senate, Albany

I. Welcome and Approval of Minutes
Dr. Ostuni, Chair, convened the meeting. Dr. Ostuni called for approval of the minutes for the May 20, 2015 meeting. The minutes were approved.

II. Report by the LTC Subcommittee
Dr. Dooley-Seidman reported on the meeting of the Long Term Care Subcommittee, which had met earlier that day. There had been two presentations. The first was delivered by Michelle DiBacco of the NYS DOH Division of Long Term Care, on the Fully Integrated Dual Advantage (FIDA) program. The second, on the topic of the e Prescribing Mandate, was presented by William Hallett, PharmD, MBA, CGP, President/CEO of Guardian Consulting Services. Ms. DiBacco presented statistics and answered questions. Thus far 7300 patients have been enrolled and 11,000 physicians educated and certified as FIDA providers. 13 states are participating in the demonstration project which ends 12/2017. An extension to 2019 has been requested. FIDA program has the best benefit package of all the managed care programs and is unique in that the appeals and grievance process is integrated. The major characteristic of this project for dual eligible patients is access to patient centered coordinated care.
The major goals of the project are provision of quality and efficient care and cost reduction. Ms. DiBacco provided a power point which can be accessed on the MRT website and which was provided to committee members prior to the meeting. The issues raised in the discussion were burden of education for physicians to participate, financial structure system and review of the White Paper which will be made available to the committee.

E-prescribing Mandate for Nursing Homes- Dr William Hallett (PharmD) and President & CEO of Guardian Consulting Services presented an overview of the program which is scheduled to start March 27, 2016. All medications ordered by NYS physicians must be electronically submitted directly to pharmacies. Controlled drugs will require two authorizations prior to dispensing. Each physician will be identified in the system. Prescription faxes or telephone orders will not be accepted. The major discussion centered around the unavailability of an electronic system in nursing homes. Currently 30% of NYS nursing homes do not have the electronic resources necessary to be in compliance with the mandate. Nursing homes may apply for a one-year waiver. The danger of unavailability of medications for nursing home residents appears real. MSSNY together with the NYS legislature was effective in delaying the implementation of the mandate from 2015 to 2016. This will be a follow-up agenda item as we follow how the mandate will be implemented.

MSSNY Position 217.999 which addresses reporting of serious injuries in nursing homes such as fractures and head injuries. The position statement was sent to all committee members. Current federal regulation calls for the reporting of serious injuries but without specifying type. Members will be polled again within a week to identify any objection to sun setting 217.999.

IV. Work of Commissioner’s Health Advisory Committee
Dr. Ostuni asked Dr. Bradley whether there was anything to report on the work of Commissioner’s Health Advisory Committee. There was no new activity to report.

V. Presentation on Telehealth
Jillian Kasow, Director, Legislative Commission on Rural Resources, New York State Senate, delivered a verbal presentation on the topic of telehealth in NYS. The commission is bi-cameral; there are members from both the NYS Senate and the NYS Assembly. Ms. Kasow is from the Senate side, and their chair is Senator Catharine Young, who has been promoting the issue for a number of years. The new legislation was passed in both the Senate and the Assembly; it awaits action by Governor Cuomo. Other states with similar legislation have demonstrated patients with shorter hospital stays. Patient mortality and total cost to the health care system are reduced. In passing the new legislation, NYS joins twenty-nine other states that govern private-insurer reimbursement and 47 whose Medicaid programs reimburse for some form of live video. Under the Medicaid program, NYS is one of only five states that will reimburse telemedicine store and forward and remote monitoring. The other states are Alaska, Illinois, Minnesota, and Mississippi.
Ms. Kasow explained that Telemedicine is considered a subset of telehealth. There is a trend in NYS to turn to telehealth for patients who have limited access to care due to provider shortages, geography, weather, or restricted mobility. Greater trends are seen in rural areas. Telehealth provides economic benefits to patients and their communities by reducing travel expenses, absence from work, and also easing child-care concerns. So, there are all these different components that create better access to health care that we see because of the provision of telehealth.

The legislation received a large amount of support from the Senate and the Assembly, and the Executive including the DOH, because it is a valuable tool in improving continuity, coordination, and efficiency of care. It was great to see this very important piece of legislation and policy move through as expeditiously as it did because there was support on all tables. This also tied into the Medicaid Redesign Team (MRT) directive which is to reduce costs throughout the state so the timing of this legislation was really critical here too. Obviously, telehealth access increases medical access in all communities, including rural, urban and suburban, but coming from the Commission on Rural Resources, it is helpful to give the rule of perspective of the rural communities. As an example, there was a recent report by the DOH finding that 57% of health care providers ever interviewed anticipated expanding their telehealth services and we see drastic increases in rural areas. We saw it in the North Country providers. Seventy-one percent of providers anticipated expansion of telehealth services so we see a spread and need in the rural areas specifically for this increased access. Nationwide only 10 percent of physicians practice in rural America despite nearly 1/5 of the population living in those areas so there are inherent health care disparities in rural areas throughout the United States and, of course, also in New York State. Rural Americans are also nearly twice as likely to die from unintentional injuries.

Now with the momentum behind telehealth and telemedicine in 2012, the Commission actually hosted a telehealth roundtable. There were many providers that participated as well as representatives of the DOH and that was a very productive discussion at the roundtable. At the roundtable issues were discussed, including potential benefits and impediments to telehealth coverage, the associated reduced costs which again is tied into the Medicaid Redesign Team directive, current programs and successes and also what becomes most important from the legislative perspective identifying problems and barriers implementation of the telehealth program. Obviously that served as a precursor to the legislation that was passed this year. Now there were a few bills that actually led up to the most current bill that was signed into law. In 2014, a bill was actually passed by both Houses and signed into law by the Governor pursuant to a Memorandum of Understanding. There were technical terms and issues with the bill, but to show support and collaboration the Governor signed that bill into law and then by the end of 2014 was negotiated an alternative version to give assurance to the health care community that the then effective date of January 1, 2015 would not be actually implementable and would not be enforced so that there is an overall understanding that this other bill would take over that had a new implementation deadline of January 1, 2016 which is now is just around the corner for us. So, what we now called the chapter amendment to the original bill that was passed was signed into law in March 2015. Again, the law becomes effective January 1, 2016 which is just around the corner and the idea was to give the programs and health insurers time to restructure their coverage options and build those
into their 2016 calendar year premiums. Now the telehealth bill has two components. One is the
Medicaid program; the second is a private insurer program. Not all states have both so that was
somewhat unique to New York and brings New York into the forefront of some of the momentum we
are seeing around the nation.

The first focus is on private insurers and this includes, in addition to private insurance, health and
hospital service corporations and HMO’s. The particular model that New York adopted is called a parity
provision and this requires insurers to provide coverage for services delivered via telehealth as long as
the services and providers of the services are otherwise covered under the patient’s contract or policy.
In other words coverage cannot be denied solely based on the delivery of those services via telehealth.
The idea of parity is that if everything else is the same and the delivery model is telehealth, as opposed
to in person, the insurance plans cannot deny reimbursement based on that reason alone. Also, within
the provision is a co-payment allowance in that an insurer may subject the coverage of service so that
they are delivered via telehealth to co-payments, co-insurance, or deductibles, provided that the patient
is not paying more for this service simply because it was delivered via telehealth, so it needs to be the
same payment or less. Also significant is that the definition of telehealth under the private insurer part
of the law is actually quite broad. The definition of telehealth under the private model is the use of
electronic information and communication technologies by a health care provider to deliver health care
services to an insured individual while such individual is located at a site that is different from the site
where the health care provider is located. So we are talking about “electronic information and
communication technologies” and then the geographic requirement is simply that the individual is
located at a site that is different from the site where the health care provider is located.

Moving on to the Medicaid part of the bill, Medicaid defines the following terms whereas the private
insurer part of the bill does not. Distance sites, telehealth providers who actually list the type of
providers that are eligible. A brief sampling of these are physicians, physician assistants, dentists,
nurses, speech pathologists, midwives, hospital, home care services agencies and hospices. That is just a
sampling of the full list. The Medicaid part of the bill also defines originating sites, telehealth and
telemedicine, store and forward technology and remote patient monitoring. Since the passage of the
bill in March there were two additional bills that were passed related to this original bill. The first was a
technical amendment in that under the Medicaid provision we found that a dentist’s office was not
included as an originating site. That was a technical error. It was believed that a physician’s office the
term would be sufficient to include a dentist’s office. This turned out not to be the case so we passed
this technical amendment and that was signed into law in August 2015 with ample time for the
implementation design. The second bill was passed by both the Senate and the Assembly and is waiting
for the Governor’s signature so it is not law yet. This includes the expansion of the Medicaid provision to
include occupational and physical therapists as approved telehealth providers.

In closing, I just want to refer you to the National Report that may be very helpful and that is the Center
for Connected Health Policies National Telehealth Policy Resource Center, July 2015 Report so you can
find that on the Center’s website. It profiles each state and it provides an overview comparative analysis
of all states and then breaks down each state according to specific elements identified. The next steps
here we see is that the Department of Health is in the process of writing and doing an internal review of
proposed regulations so we have not seen them yet. They are not publicly available but, once they are,
that will begin a public comment period. Timelines though should be generated first implementation. I
am aware that the Department of Financial Services has issued model language for the private insurers
for their contracts are coming up for the 2016 insurance year so that language is available and those
agreements are under way. From the outlook, obviously this is an enormous overhaul in policy. What
we are doing is waiting for the implementation period, waiting to hear from the providers and other
stakeholders, and how effective the policy is, if there are any issues, if there are any opportunities for
expansion that would be beneficial so that would constitute the next steps for telehealth in New York
State.

There was a question about whether there is anywhere in the bill that is mentioned medical license of
the provider of service”? The response was that under the Medicaid program it specifically lists out the
providers. It references each article of law under which the providers are licensed in New York State.

There was a question asked about whether a licensed New York State physician can provide telehealth
or telemedicine recommendations in another state”? The response was that it would be dependent on
the other state’s law. MSSNY staff commented by saying that the Department of Education requires
that, if a physician is located out of state, they must have a license in order to provide services to a
resident of New York State unless it is on a consultative basis.

There was a question asked about whatever happened to the AMA “compact”? MSSNY staff responded
were that compact has not yet been approved by New York. In fact, Barbara Ellman attended the last
meeting of the Board for Medicine where it was discussed and the New York Board of Regents opposed
the compact and so it is unlikely that New York will embrace the compact.

There was a question asked about whether New York State physicians can only provide telehealth here
in New York? MSSNY staff responded by saying that they could be located out-of-state but they have to
have a New York State license. There has to be a way for New York to go after bad actors. That is the
rationale. The question was clarified. Can a New York licensed physician providing services to another
state. Unless you have a license from that other state you will not be able to do it.

There were observations made on the presentation. There doesn’t seem to be any enthusiasm or heat
for telemedicine in organized or academic medicine. Telehealth has been around a long time and you
would think that the university hospitals and the big conglomerate health systems would start these
systems so that they can approve the quality of care in their systems but it mustn’t be profitable now.
You look at electronic medical records and all the money that was pumped into creating that system and
what a terrible job they did in not maintaining universal standards. There should be universal standards
adopted so that Florida doesn’t have one thing and New York another system. If you are going to create
these systems there is a lot of technology and you need a lot of seed money in developmental studies to
help these systems get going so that you can have some experimental basis of what works and doesn’t work. There just doesn’t seem to be any money out there to push to encourage the Cleveland Clinic and the Mayo Clinic or these large organizations that are really anxious to capture patients that are all over the country trying to start these systems and really do a first-class job on it to see if it has value. I just don’t see this going anywhere until someone steps up with a lot of money and makes these systems profitable and valuable to these established forces in providing healthcare in this country.

There was a question asked about what is the minimum standard for telehealth being reimbursable? Telehealth and telemedicine means different things to different people. Is remote monitoring a requirement?
The response is that it is not a requirement but a reimbursable service. Under the Medicaid provisions remote patient monitoring is one of the types of services that can be reimbursable. Telemedicine would describe the actual back and forth between the doctor and the patient and that would be real time and there is storing forward. What the legislation does is it individually defines all three to give the parameters for those activities to actually be reimbursable under Medicaid. Under the parity provision for private insurers, of course, we are working with a much broader definition so it is assumed that as a regular course of business, if this service is delivered via telehealth, that shouldn’t be a factor in determining claim reimbursement.

A question was asked about the difficulties of the electronic medical records system that is so fragmented. If this system is going to work, the electronic medical records have to talk to each other. There can’t be two records. The person that is sending the information can’t be having one record and then another record. There has to be a simultaneously created record that agrees with one another where you have a problem as far as medical liability is concerned. That means electronic medical records have to talk to one another which are not, even though Long Island is among the hospital system, you can’t talk to one another which isn’t happening now. The response was that this is an important topic. It is an issue that has been raised before. Now that we are going into the implementation process, that may provide enough momentum to look at that again. We will work with MSSNY staff in defining what the need is and possibly look at resources that are available as we go into next session to look at that issue and find some solutions.

MSSNY staff stated that this is an important issue. It really has to come from the Feds on down. New York State has not embraced it. I don’t think they felt they had the ability to tell the vendor community what to do. It has been a decade problem which is often discussed.

A question was asked about, if we do reimburse for Telemedicine, how do we continue not to reimburse for telephone consultations and Medicare says no to telephone consultations? How do you put those two things together? The new law would not be the case and, again, this is part of the implementation that we are watching to see once we have the DOH regulations to actually look at, they are going to address some of these finer points and we will be able to see how this is rolling out and look for
opportunities for improvement. Your feedback is going to be important in that part of this process
which is really going to start just this coming year.

MSSNY staff said that they have been in contact with the DOH and they are going to invite us in once
they have their regulations drafted and we will have more conversation at that point and I assume it is
going to be really soon.

VI. HOD Patient-Safety Conference April, 2016

One of the things I thought we might revisit at this meeting is physician fees. Physician fees are frozen
for the next seven years. The only way we are going to see fee increases is which is the alternative they
take part in risk contracts. They are looking for the perfect vehicle. We did have two people present to
us at our last meeting. One was Dr. Podwall. He told a story about after two years they got revenue
from Beacon ACO and they got a lot of good feedback from the insurer. They were doing real well
except at the end there was no money to distribute. I would like to see him maybe come back. A
physician at this meeting heard a physician from CMS talk about what kicks in which is 17 or 18 with the
MIPS program and the alternate payment system. To be reimbursed or to receive positive incentive
and not to be negatively impacted, you have to be either in an alternative payment system, which is an
ACO, or you submit quality data similar to PQRS, meaningful use and the value modifier and you can get
the same benefits that way.

Maybe we should have one each. We have been living in value-based payment for the past few months.
The state DSRIP program has a big workgroup and then they have five subcommittees and 12 clinical
advisory groups. How much do you pay for quality and how is it going to change a patient’s life? Are we
going to see that after seven years that a 33% decrease in reimbursement to physicians a reality even
though they didn’t see it in their paycheck? We need to differentiate between New York State’s
program, which is DSRIP, and the federal program for Medicare, which is the alternate payment and the
MIPS program, which is the next stage of the sustainable growth issue.

MSSNY staff stated that there is also the State Health Innovation Plan. They are all doing the same
thing. It’s all alternative payment.

Dr. Ostuni said that we don’t mind somebody telling us about the program but would really like doctors
who are actually in the program telling what their personal experience has been because doctors have
to get a move on because a lot of them are not getting it. They are expecting that they are going to get
an increase each year. It’s not going to happen. The movers in this problem are the big hospital systems
which decide if they are going to participate and they drag all the doctors along and we are going to see
how good a manager these hospital systems are and whether they can control costs, whether they can
control utilization, whether they can control all the expenditures that physicians normally engage in in
treating patients and how well they manage that will determine whether people get paid or not and
some people will be good at it and other people won’t be. You are taking a chance in a demographic of
an aging population with increasing costs with no control of pharmaceuticals in this country that you are
going to be able to meet the standards that somebody is imposing on you and you are actually going to make money in this system. That’s why physicians aren’t interested in participating. Dr. Ostuni stated they don’t have a choice anymore.

MSSNY staff stated that what we are more concerned about is that physicians are ceding to others. Like the hospital systems, the physician themselves are not empowered to negotiate these contracts. They are going to be accepting risks have never experienced before and yet, if they don’t accept the risk, they cannot control the negotiations. It is kind of a Catch 22 for physicians unless they are an ACO, unless they are with big players and big IPAs.

There are people who have done it up in the Adirondacks. Dr. Rugge, who is a member of MSSNY, would be an excellent presenter on this topic. He is one of the people who is driving both DSRIIP and SHIP here on the state level and then we can find someone on the national level who can talk about MIPS and APMs.

Another physician stated that physicians are very interested in economic issues and in their future and a would a topic that people would come and listen to. The problem is that when you get into it it becomes a business presentation or an accounting presentation and how can you make it more relevant to physicians and their practices. MSSNY staff was asked if we had anybody who has an idea of how to organize physicians and get them into a group like this. MSSNY staff responded by saying that we think Dr. Rugge would be really good. Dr. Page has created an ACO in Central New York and he often talks to about the difficulties he has confronted and his group manager would be good from the accountant perspective if you would like. A physician stated that there is an Indian fellow, Dr. Kappor, who has organized all the Urologists in Nassau County. I suggest you bring him as to how physicians can approach this problem. MSSNY staff responded by stating that Dr. Kapoor is excellent. He is a really good speaker and I can ask him if he would like to participate. Dr. Ostuni said that that would be one definitely. He is a doctor and they have been successful at what they are doing and that is a specialty group though. The one that you spoke about is Upstate is a more diverse group. MSSNY staff stated that it started as primary care. Dr. Ostuni stated there would be three speakers there except for the federal programs. Is Dr. Rugge in a Medicaid program or is he in Medicare? MSSNY staff responded by saying that is seven payors, one of which is Medicaid and one which is Medicare, and then there are five other commercial payors also. Dr. Ostuni asked how long have they been in doing this. Staff said that first they have been up and running for about three years now.

VII. Presentation on DSRIIP: An Overview and Update on the Delivery System Reform Incentive Program
Meghan Gleason of KPMG delivered a PowerPoint presentation on the topic of the Delivery System Reform Incentive Program (DSRIIP) (see VBP Presentation NYS Handouts.pdf).

There were questions asked about this presentation. Who are these providers? Are they people in large groups, are they people in hospital systems, are they people in community health systems? What
percentage are physicians and what percentage are non-physicians? Do you know enough now to say
that you have taken the primary care model of people going to the emergency room and shifted it to a
community-based system where someone who knows him sees him repeatedly. Has this system been
capable of doing that or is the emergency room still the primary provider of care for many Medicaid
patients? The presenter said that to your first question on who are the providers, it really could be any
combination. The physician asked if there was any data on what it is and do you know the numbers.
The presenter asked do you mean that are currently in value-based physicians? The presenter did know
that value of the 30%. I think it is predominantly hospital systems based on the data I have seen but I
don't have any specific percentages.

PPS's themselves don't exist legally outside of the services vernacular in New York State and so, if PPS's
themselves want to contract moving forward, they will have to become and ACO or an IPA. Those are
the recommendations that are coming forward. There is no requirement that there be a certain
combination of providers or that providers have go look a certain way to enter into actual value-based
payments arrangements. If providers are looking to on risks, they need to make sure they are able to
provide so, for example, if the provider wants to go into a total care arrangement, they need to be sure
that they can provide the full continuum of services for those patient and that they are in control of
what happens. The last thing you want to do is enter an agreement where you are at risk and someone
else is holding the bag in terms of what happens to those patients.

Another question asked was what has the Affordable Care Act done to the Medicare/Medicaid
population in New York State? Did it increase it or decrease it? The ACA has increased the Medicaid
population in New York for sure. It was asked by how much? The presenter did not know.

Another important piece that I will mention now is Medicare. As you know, New York State is
submitting to CMS a proposal to align the Medicare and Medicaid alternative payment and value-based
payment models. What that would do is to allow for providers to choose which model of value-based
payment they prefer, either the alternative models that exist for CMS and Medicare or the New York
State models and the other party would agree to conform to those requirements. That has been drafted
through the Workgroup and has also been available for public comment and will be submitted to CMS
this month. There has been a lot of concern around the dual eligibles population. Also of concern to
providers are the different definitions of what is value.

A question was asked by a physician in Suffolk County. They have a very organized and excellent PPS
centered around Stony Brook but engaging other hospitals and hospital systems. I still get the
impression that every time I hear a presentation about value-based payments and about DSRIP that
when the term provider is used, it really is still talking about hospitals, hospital systems. If any
physicians, they're mostly employed physicians and captive PC's. The response was that certainly the
dialog around this has morphed over time. In the beginning the thinking was that PPS's were going to
be the single entities and they were going to be able to contract and there was a lot of concern around
what that would look like. That conversation has come full circle and it has been determined that PPS's
themselves won’t be allowed to enter into contracts. They will not be considered and entity to contract unless they become a legal entity that is allowed under New York State law to do so such as a provider, an ACO or an IPA. I think we will see a couple of PPS’s try to become either an IPA or ACO predominantly PPS’s who are led by integrated healthcare systems who have been integrated for a long time. Like naturally occurring care communities on that those group of healthcare providers will come together and contract on their own.

We are starting to do a number of pilot value-based programs and we have one hospital that has put their hand up to be a pilot. We’ve had FQHC’s and we’ve had other specialty providers. The first pilot that is ready to get out the door is around maternity care and so I think there will be a fair amount of variety. We’ve seen a couple of behavioral health providers who specialize in the HARP population who have put their hand up to be a pilot. It depends a little bit on your geography and what your contact is from your PPS perspective but frankly large PPS’s contracts will be the exception, not the rule.

We are actively looking for other providers who want to be pilot sites for value-based providers to want to be pilots for value-based payments, you or your constituents or someone you work for who are far along in their thinking or if you feel like you’ve been doing integrated care for a long time and you know how to do it well and have good outcomes, please feel free to reach out to me.

MSSNY staff asked the presenter to talk a little about alignment between DSRIP and SHIP and how that is going to roll out given that both programs have pretty much the same objectives and are going to utilize the same methodologies in VBP but we haven’t yet seen that on the SHIP side.

The response is that this was something that is continually evolving and the state is working hard at and acknowledging that sometimes they are doing better than others in making sure they are in alignment and it clear around the alignment. From a DSRIP and a VBP perspective the way that we’re making sure we are aligned is we have formed what we call Clinical Advisory Groups which are CAG as some of you may be familiar with them or actually may have served on them. They are focused around different conditions. For example, we have a chronic heart disease CAQ which comes together to talk about what is integrated care really doing for chronic heart disease CAG, what is high value care and how do you measure that. The original plan was that we would have one of the CAG’s for advanced primary care to do a similar process. SHIP’s Workgroup the Integrated Care Workgroup has already done that work for us. They defined what is advanced primary care. They drafted the outcome measures and, I think, there is 18 or so now that represent how you measure high value primary care. So, what we will do is in November the Medicaid VBP payments are sort of hijacking one of the Integrated Care Services meetings to use that group to flush-out what has been developed doesn’t make sense in the Medicaid phase. Are there tweaks that need to be made but generally trying to take up all the good work that has been done from that group and carry it over onto the Medicaid side.

The only observation MSSNY staff made was that we heard about this in the various CAG’s and Subcommittees. When you have physicians primarily who are involved whether it’s with their federally
qualified health center or their IPA and say “how can you help us leverage our negotiations with the
MCO’s. Mark Berg who staffs the CAG’s keeps saying “well it’s up to the negotiations.” We are going to
leave this all to the negotiations but physicians historically, even large groups physicians, haven’t had a
level playing field. They have been in “take it or leave it situations and especially when you want them
to take on Level Two or Level Three risk. What’s in it for them? What can the state do to help here?.

The response was that this is a requirement of the MCO’s so the model contract is being changed from
the state’s Medicare plans that they must move into value-based payment. The recommendations are
coming forth from the subcommittees and CAG changes are being made to the states guidelines. They
have to get 80% value-based payments and they are going to be required to move that way. The state
has made it very clear that they are going to use certain DSRIP money to incentivize plans and providers
to move into value-based payment and move into higher levels of value-based payment. Plans that
have a higher percentage in Level Two will get a higher up tic in their reimbursement rate from the
state. There is some expectation that some of that money will be passed to providers but they would
certainly be incentivized to move that way as well. The last piece about this is that the Technical Design
One and Two but, primarily Technical Design One Subcommittee, is contemplating things like what
should the guidelines be around shared savings, what should be the guidelines around risk corridors
and other risk mitigation strategies and the thought is that those guidelines will really be the starting
point for providers negotiating with plans. Some things will be a requirement so the state makes a
differentiation between guidelines and requirements and some things will be a requirement and the
others will be guidelines but the hope is that those guidelines will represent the starting point. A Level
One shared savings agreement is going to be 50% upside shared savings and so that in a lot of ways
hopefully that is the starting point of the negotiation.

MSSNY staff commented that at the Integration Workgroup meeting over the summer, there was a slide
that showed that less than 40% of physicians on side institutions have EHR’s and there is no money,
either through DSRIP or SHIP, that is going to help to bring physicians along to adopt and increase those
adoption rates. What are the thoughts around that? If there are 60% of physicians outside of
institutions who don’t have EHR’s how are we going to ever be able to get to demonstrate quality and
participate in shared savings.

This is a little bit out of my depth but I will do my best. There is money for that and it is part of what the
DSRIP dollars are intended and that’s explicitly clear to the leads of the PPS’s. There has been a general
feeling that there hasn’t had a lot of traction yet. It is too early to see what that will result in but part of
the DSRIP money and part of the requirement of the PPS needs is that they get their partners connected
from a technology standpoint to reach out to the RHEO or the SHIN-Y. This is certainly not a silver bullet
and we will have to see what actually happens when that plays happens when that starts to play out,
but as Jason Helgerson would say is that there is money for that and it is part of what the DSRIP dollars
are intended for.
Another, just not exactly the same vein of conversation, is that there will be a CBO planning grant that's also going out that will have money explicit for community-based organizations and providers who are needing a little help and assistance from financial perspective to get ready to move into value-based payment and certainly I know you know this better than I that SHIP does have money set aside for grants as well for providers to ready themselves.

Dr. Ostuni had a question. The amount of decrease was so phenomenal that the Medicaid Redesign Team came out with $15 billion. Originally they were talking about $6.4 billion dollars being spent on savings to Brooklyn hospitals, one of which is already closed, so how has that money impacted Medicaid patients today.

The response was that it is a little bit of a complicated money trail so essentially what New York State did with MRT was that they were able to show that through their implementation of these projects, were able to save around $18 billion dollars, that was the full dollar amount. As you know, Medicaid is funded jointly from the state and the federal side. Generally all of that money just would have gone back to the Feds and they would have had to decrease spend over time. So what happened through the waiver process is the state sort of negotiated that they would get about $8 billion dollars would come back in their 1115 Waiver. About six and a half is set aside for DSRIP which is in the form of the money that the PPS's are going to get over the year and all this other stuff. There is about $2 million set aside for other activities over the course of the five-year DSRIP program. That includes things like incentivizing plans and providers to move into value-based payment but it also includes things like the Vital Access Provider (VAP) program which is sort of the new VAP app program which is the program you may referring to in terms of those failing hospitals and financially challenged providers who are sort of going under but the state was keeping afloat, sort of a program to figure out what to do with them so some of that money has gone there as well.

Dr. Ostuni asked about the 25 programs which were talked about the PPS’s. Have they already formed or are they in the process of being formed? The response was that they are already formed. MSSNY staff said that some of the planning money has started to flow. We’re actually in Year One. I think last year was a Year O, but some monies have already been cut to these PPS’s

One of the physicians asked this question. So, as far as provider engagement in it and as far as small practices and the individual physician signing up for the PPS’s, there is currently an open enrollment period for it and they actually haven’t really gone past mostly an attestation for participating in this. Is that correct?

The response was as follows. I think that when I talk to providers specifically this where the rubber hits the road. In reality, PPS’s were formed so quickly, everyone was running sort of a million miles a hour, no-one knew what they were really signing up for and to some extent these PPS’s went out and did an all call for sort of all providers and now that things are settled down a bit, PPS’s are looking at their provider networks and are going to be a little more thoughtful around who they need to partner with in
order to be successful and this is the right time for providers to step up to partners with one or more
PPS’s.

One of the physicians asked if it is too early to think that there might be some data on how care has
been improved? If it is too early, when do you think that will be possible?

The response was that New York State is going to launch this year, sometime this winter, the Medicaid
Analytics Performance (MAP) Portal which will provide all providers and all PPS’s information about their
patient population, their outcomes, how they are trending in terms of the goals that they have agreed
to from a DSRIP perspective so all that data will become available soon. In the following year that MAP
Portal will be expanded to also house cost related data for individuals who are moving into value-based
payment arrangements so this is where a physician can say that he has negotiated this virtual budget, it
is halfway through the year and I want to know where I am from a cost perspective because I am still
billing fee-for-service. The initial goal is that the MAP Portal would have outcome and patient data. The
caveat there, of course, is based on claims data. There is some lag. The state has been working hard to
come up with what they call proxy measures that would give early indication to PPS’s and providers that
things are going well or not just giving lag in the data but ultimately, the idea is that that MAP Portal
would also hold cost data.

Up on line for all the PPS’s we have done a pretty in-depth analysis of the two-year’s of Medicaid claims
data so if you are interested on things like how the state is doing overall on their integrated care for
diabetes, chronic health disease or pulmonary disease that data is all available right now.

VIII. New/Old Business

Dr. Ostuni asked if there is any new business that this Committee would like to bring up. Dr. Dooley
physician asked about looking at the effectiveness of these quality initiatives. Dr. Ostuni said that Claire
can help with that. Dr. Bradley responded by saying that if we get the federal guy I assume he will talk
about the effectiveness of the PQRS, meaningful use, the diabetics, etc. Dr. Dooley responded by saying
she was thinking more of a marketing tool to physicians in understanding and accepting these quality
initiatives and requirements based on how it can change the practice of medicine. That was more of
what I had in mind. I know some of them have not rendered any difference. It has been a struggle
getting re-hospitalization numbers down to reach the goal of 20% or 25% is almost impossible.

Dr. Ostuni said that when we started our original committee, we were only looking at five things at that
time, bedsores, trach infections and they really did well. If you look at what came back, they were
phenomenal. There was one hospital that didn’t have any trach infections. So they did really well and
they did lapse and came back a little bit.

he next industry will be the development of equipment and technology where you can assess an
individual at home and use it for telehealth visit and you can be reimbursed for the visit as well as for
any other testing that you do. That’s something that would probably appeal to a lot of physicians and
may not be a big cost item. In any case Dr. Dooley thinks it’s hard to get doctor’s turned on to reporting for quality purposes and showing them that it had a positive impact. Dr. Bradley said that two years down the road the PQRS program will not exist. It is going to be a part of the MIPS program. They are phasing it out and re-inventing it. But I think the umbrella is Quality Initiatives in your practice that will change the outcome? That’s really what the issue is. It is not the name of it so much but they are all doing the same thing and calling it a different name and everyone is confused.

Dr. Ostuni stated that NCQA has come up with a new rating system for hospitals and it apparently includes all of the things we talked about before like the HEDIS data. Can we have someone speak to us about? That will be for the next time and maybe go over that. That will be next for next time. The nursing departments that ran the QA on the original package of five, I remember there was a big controversy and everybody was measuring it. They presented to us before and they can what came back and tell us that the progress is on that. I followed the literature in that they didn’t continue its downward curve. It is bumped up and now they are trying to regenerate that. We had a nurse from HANYS who talked about their HENS program and they were just re-awarded so maybe we can see where they are at. MSSNY staff said that maybe she can talk about the NCQA as well.

VIII. Next Meeting and Adjournment

Dr. Ostuni chose January 20, 2016, 1-3 PM for the next meeting (this was subsequently rescheduled to January 27, 2016 because of a conflict). Meeting was adjourned.
Value Based Payment: Realizing the New York State Roadmap

Overview
- Background and Brief History
- Delivery System Reform and Payment Reform: two sides of the same coin
- NYS Medicaid Payment Reform – brief overview
- NYS Medicaid Payment Reform – policy levers and strategy

New York State Medicaid
- Approximately 6 million individuals in New York State are Medicaid beneficiaries (ranking 2nd in the nation, after CA)
- Current Medicaid spend in New York is approximately $59 billion annually (also 2nd in nation)
NYS Medicaid in 2010: the crisis

- 13% anticipated growth rate had become unsustainable, while quality outcomes were lagging
  - Costs per recipient were double the national average
  - NY ranks 50th in country for avoidable hospital use
  - 21st for overall Health System Quality
  - Attempts to address situation had failed due to divided political culture around Medicaid and lack of clear strategy

Creation of Medicaid Redesign Team – A Major Step Forward

- In 2011, Governor Cuomo created the Medicaid Redesign Team (MRT):
  - Made up of 27 stakeholders representing every sector of healthcare delivery system
  - Developed a series of recommendations to lower immediate spending and propose reforms
  - Closely tied to implementation of ACA in NY
  - The MRT developed a multi-year action plan – we are still implementing that plan today

Key Components of MRT Reforms

- Global Spending Cap
  - Introduced fiscal discipline, transparency and accountability
  - Limited Medicaid spending growth to 10 yr average rate for the long-term medical component of the Consumer Price Index (currently estimated at 3.8 percent)
- Care Management for All
  - NYS Medicaid was still largely FFS; moving Medicaid beneficiaries to managed care helped contain cost growth and introduced care principles of care management
- Patient Centered Medical Homes and Health Homes
  - Stimulating PCMH development and invest in care coordination for high-risk and high-cost patients through the NY’s Health Homes Program
- Targeting the Social Determinants of Health
  - Address issues such as housing and health disparities through innovative strategies (e.g., supportive housing)
Medicaid Redesign Initiatives Have Successfully reduced costs

NYS Statewide Total Medicaid Spending (CY2003-2014)

<table>
<thead>
<tr>
<th>Year</th>
<th>Spent (Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>$25,000</td>
</tr>
<tr>
<td>2004</td>
<td>$25,500</td>
</tr>
<tr>
<td>2005</td>
<td>$26,000</td>
</tr>
<tr>
<td>2006</td>
<td>$26,500</td>
</tr>
<tr>
<td>2007</td>
<td>$27,000</td>
</tr>
<tr>
<td>2008</td>
<td>$27,500</td>
</tr>
<tr>
<td>2009</td>
<td>$28,000</td>
</tr>
<tr>
<td>2010</td>
<td>$28,500</td>
</tr>
<tr>
<td>2011</td>
<td>$29,000</td>
</tr>
<tr>
<td>2012</td>
<td>$29,500</td>
</tr>
<tr>
<td>2013</td>
<td>$30,000</td>
</tr>
<tr>
<td>2014</td>
<td>$30,500</td>
</tr>
</tbody>
</table>

Medicaid Redesign Initiatives Have Successfully Brought Back Medicaid Spending per Beneficiary to 2003 Levels

<table>
<thead>
<tr>
<th>Year</th>
<th>Spent per Beneficiary (Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>$5,000</td>
</tr>
<tr>
<td>2004</td>
<td>$5,500</td>
</tr>
<tr>
<td>2005</td>
<td>$6,000</td>
</tr>
<tr>
<td>2006</td>
<td>$6,500</td>
</tr>
<tr>
<td>2007</td>
<td>$7,000</td>
</tr>
<tr>
<td>2008</td>
<td>$7,500</td>
</tr>
<tr>
<td>2009</td>
<td>$8,000</td>
</tr>
<tr>
<td>2010</td>
<td>$8,500</td>
</tr>
<tr>
<td>2011</td>
<td>$9,000</td>
</tr>
<tr>
<td>2012</td>
<td>$9,500</td>
</tr>
<tr>
<td>2013</td>
<td>$10,000</td>
</tr>
<tr>
<td>2014</td>
<td>$10,500</td>
</tr>
</tbody>
</table>

The 2014 MRT Waiver Amendment Continues to further New York State’s Goals

- Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York’s health care delivery system
- In April 2014, New York State and CMS finalized amendment to MRT Waiver which allowed the State to reinvest $10 billion of $17.1 billion in Federal savings generated by MRT reforms
- $10 billion is designated for Delivery System Reform Incentive Payment Program (DSRIP)
- The waiver will:
  - Transform the State’s Health Care System
  - Bend the Medicaid Cost Curve
  - Assure Access to Quality Care for all Medicaid Members
  - Create a sustainable Safety Net infrastructure
The DSRIP Challenge – Transforming the Delivery System

- Largest effort to transform the NYS Medicaid Healthcare Delivery System to date
  - From fragmented and overly focused on inpatient care towards integrated and community focused
  - From a re-active, provider-focused system to a pro-active, patient-focused system
  - Allow providers to invest in changing their business models

- Improving patient care & experiences through a more efficient, patient-centered and coordinated system
- Develop sustainable, value-based care delivery systems
- Develop a robust data-sharing infrastructure
- Collaborative process reflects the needs of the communities and types of organizations
- Providers are held to common performance standards and timelines; funding is directly tied to meeting program goals
- Focus on increasing access to patients, community, peers and other stakeholders

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

- A PPS is comprised of regionally collaborating providers who will implement DSRIP projects over a 5-year period and beyond
- Each PPS must include providers to form an entire continuum of care
- Providers
  - PCPs, Health Homes
  - Skilled Nursing Facilities (SNF)
  - Chronic Care Management Programs
  - Home Care Agencies
  - Separate Mental Health Organizations

- Stakeholder goals:
  - A goal to increase hospital use (less admissions and ED visits)
  - Reduce provider existing hospital shifts to service

Delivery Reform and Payment Reform: Two Sides of the Same Coin

- A thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well
- Many of NYS system's problems (fragmentation, high re-admission rates) are rooted in how the State pays for services
  - FFS pays for inputs rather than outcomes; an accountable payment mechanism is revealed more than a successful transition to integrated home care
  - Current payment systems do not adequately incentivize prevention, coordination or integration
NYS Medicaid Payment Reform: A Brief Overview

Healthcare CEO's show strong support for Value Based Payments

- 78% of CEOs believe value-based payment models will be adopted within five years.

- Everybody knows that the era of fee-for-service is coming to an end. We need to bring everyone together; we need one side with.

- "It's the right thing to do." - Insurance CEO

Healthcare leaders anticipate a positive impact on quality from Value Based Payments

- 93% of healthcare leaders believe value-based payment models will improve quality of care for patients.

- "It's not perfect, but it's better." - Hospital CEO
Payment Reform: Moving Towards Value Based Payments

- By DSRIP Year 5 (2019), all Managed Care Organizations must move away from fee-for-service payment systems that reward volume over value for at least 90-90% of their provider payments (outlined in the Special Terms and Conditions of the waiver).
- A Five-Year Roadmap outlining how NYS aims to achieve this goal was required by the MRT Waiver early May.
- The State and CMS are committed to the Roadmap.
- Stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap.
- If Roadmap goals are not met, overall DSRIP dollars from CMS to NYS will be significantly reduced.

Learning from Earlier Attempts: VBP as the Path to a Stronger System

VBP arrangements are not intended primarily to save money for the State, but to allow providers to increase their margins by realizing value.

The VBP Roadmap starts from DSRIP Vision on How an Integrated Delivery System should Function

- Vision: Population Health System or overall population's health and cost of care.
- Implementation Plan: Essential components and critical milestones.
- Resource Allocation: Allocation of resources and funding to support the vision.
- Evaluation and Outcomes Measurement: Metrics for success and continuous improvement.
The Path towards Payment Reform: A Menu of Options

There is not one path towards Value Based Payments. Rather, there will be a variety of options that MCOs and PPSs/providers can jointly choose from. MCOs and PPSs can opt for different shared savings/shrink arrangements (often building on already existing MCO/provider initiatives):

- For the total care for the total attributed population of the PPS (or part thereof) - ACO model
- For the integrated care for specific condition (ARDS or chronic biliard), maternity care, diabetes care, etc.
- For integrated Adverse Primary Care (APC)
- For the total care for a subpopulation: HIV/AIDS care, care for patients with severe behavioral health needs and addictions.

MCOs and PPSs can choose different levels of Value Based Payments

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

- II: MCOs can help pay for associated shared costs and maximum penalties
- I: MCOs can also help pay for associated shared costs and maximum penalties

- Value-based care (VBC) is defined as care that is provided to patients with an VBC program.

- Aim of 30% of total costs captured in VBP-1 or VBP-2 or higher

NYS Medicaid Payment Reform: Policy Levers and Strategy
Key Defining Factors in the New York VBP Approach

1. Addressing all of the Medicaid program in a holistic, all-encompassing approach rather than pilots or individual VBP projects without overall framework.
2. Leveraging the Managed Care Organizations (MCO) to deliver the payment reforms.
3. Avoiding negative financial incentives for stakeholders moving towards VBP.
4. Allowing for maximum flexibility in the implementation for stakeholders, while maintaining a robust, standardized framework.
5. Maximum focus on transparency of costs and outcomes of care.

Questions?

Additional information available at:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

DSRIP e-mail:
dsrip@health.ny.gov