



**Department  
of Health**

Medicaid  
Redesign Team


# Adirondack Health Institute 2018 Summit

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September 2018

- I. **What are we doing?** 
- II. Where are we going?
- III. How will we get there?
- IV. Questions.












# Health Care Quality, Health Care Spending, and Social/SDH Spending

## COUNTRY RANKINGS

Top 2\*

Middle

Bottom 2\*

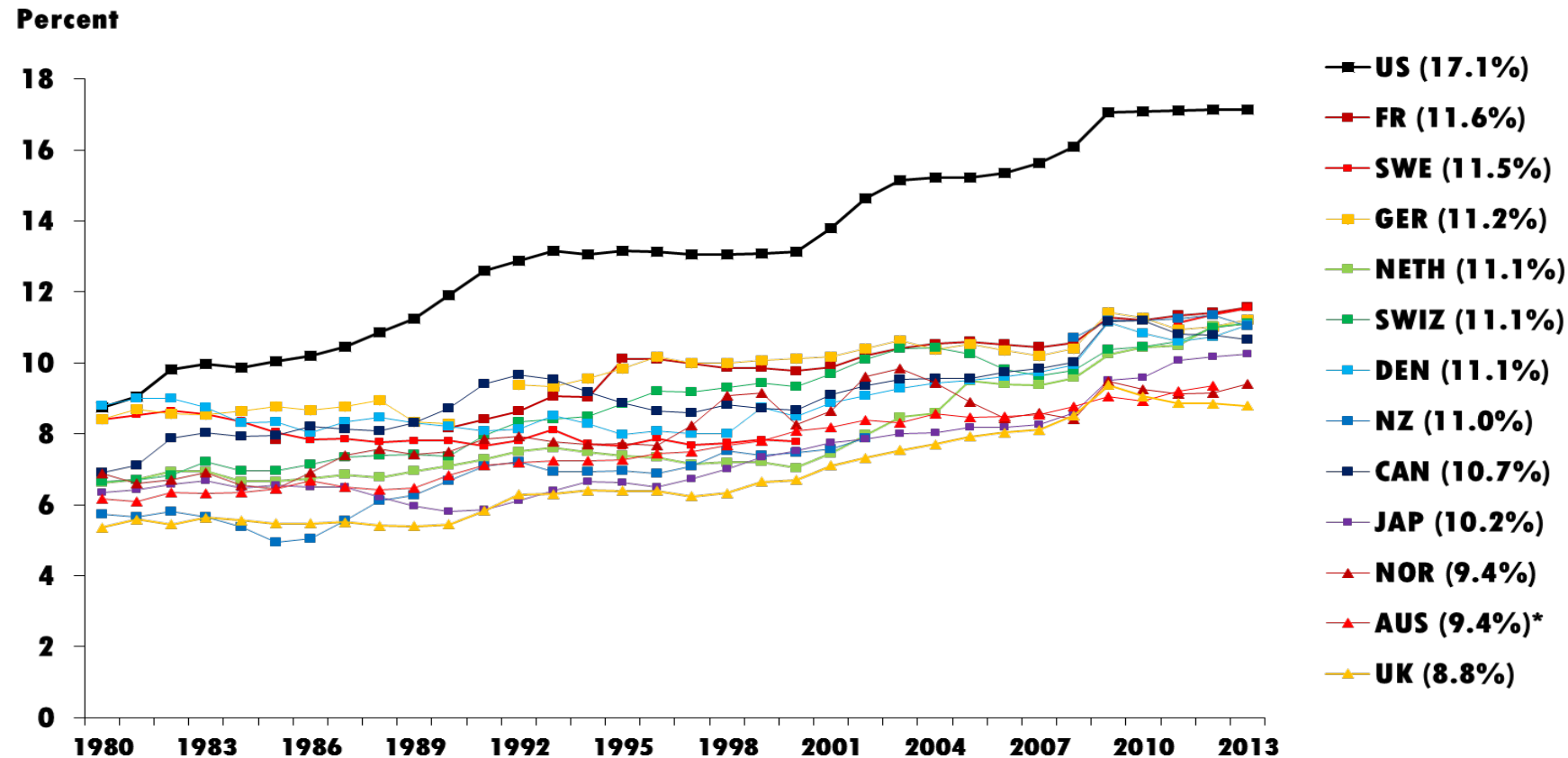
											
	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
<b>OVERALL RANKING (2013)</b>	4	10	9	5	5	7	7	3	2	1	11
<b>Quality Care</b>	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
<b>Access</b>	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
<b>Efficiency</b>	4	10	8	9	7	3	4	2	6	1	11
<b>Equity</b>	5	9	7	4	8	10	6	1	2	2	11
<b>Healthy Lives</b>	4	8	1	7	5	9	6	2	3	10	11
<b>Health Expenditures/Capita, 2011**</b>	\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,669	\$3,925	\$5,643	\$3,405	\$8,508

Notes: \* Includes ties. \*\* Expenditures shown in \$US PPP (purchasing power parity); Australian \$ data are from 2010.

Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011*; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2012* (Paris: OECD, Nov. 2013).

# Health Care Spending in US & Other Countries

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013



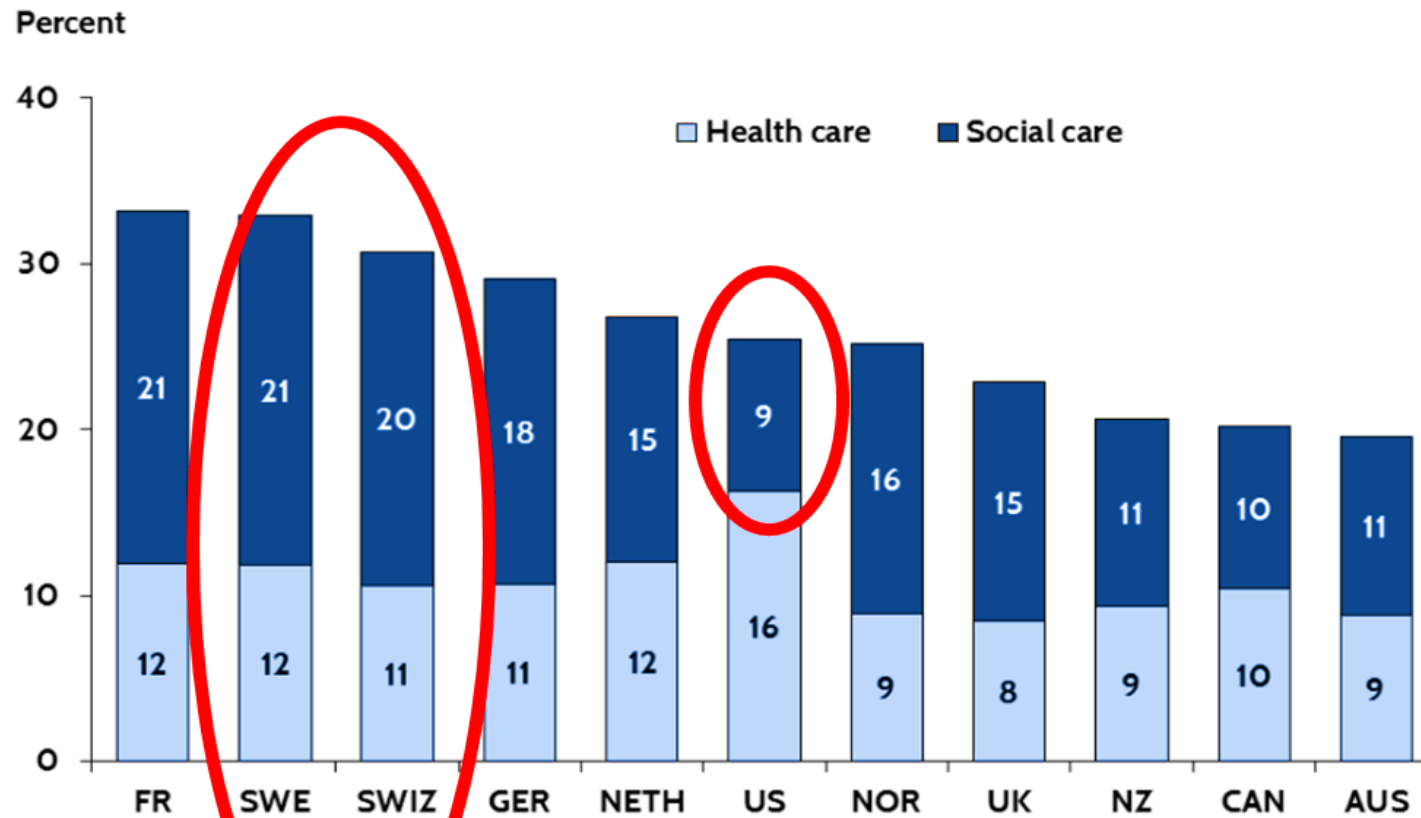
\* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

# Health Care and Social/SDH Spending

Health and Social Care Spending as a Percentage of GDP



Notes: GDP refers to gross domestic product.

Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

***PREVENTION AGENDA*****Priority Areas::**

- Prevent chronic diseases
- Promote a healthy and safe environment
- Promote healthy women, infants, and children
- Promote mental health and prevent substance abuse
- Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases, and healthcare-associated infections

***STATE HEALTH INNOVATION PLAN (SHIP)*****Pillars and Enablers:**

- Improve access to care for all New Yorkers
- Integrate care to address patient needs seamlessly
- Make the cost and quality of care transparent
- Pay for healthcare value, not volume
- Promote population health
- Develop workforce strategy
- Maximize health information technology

***ALIGNMENT:  
VBP******MEDICAID DELIVERY SYSTEM REFORM  
INCENTIVE PAYMENT (DSRIP) PROGRAM*****Key Themes:**

- Integrate delivery – create Performing Provider Systems
- Performance-based payments
- Statewide performance matters
- Regulatory relief and capital funding
- Long-term transformation & health system sustainability
- Promote population health

***POPULATION HEALTH IMPROVEMENT PROGRAM (PHIP)*****PHIP Regional Contractors:**

- Identify, share, disseminate, and help implement best practices and strategies to promote population health
- Support and advance the Prevention Agenda
- Support and advance the SHIP
- Serve as resources to DSRIP Performing Provider Systems upon request

# Better care, less cost– transforming today for a VBP tomorrow

## Old world:

- FFS
- Individual provider was anchor for financing and quality measurement
- Volume over Value

## DSRIP:

**Restructuring effort to prepare for future success in changing environment**

## New world:

- VBP arrangements
- Integrated care services for patients are anchor for financing and quality measurement
- Value over Volume

2013

2014

2015

2016

2017

2018

2019

2020

## Value Based Payment (VBP)

An approach to Medicaid reimbursement that rewards value over volume

An approach to incentivize providers through shared savings and financial risk

A method to directly tie payment to providers with quality of care and health outcomes

A component of DSRIP that is key to the sustainability of the program

# 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 outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
- Current payment systems do not adequately incentivize prevention, coordination or integration

Financial and regulatory incentives drive...

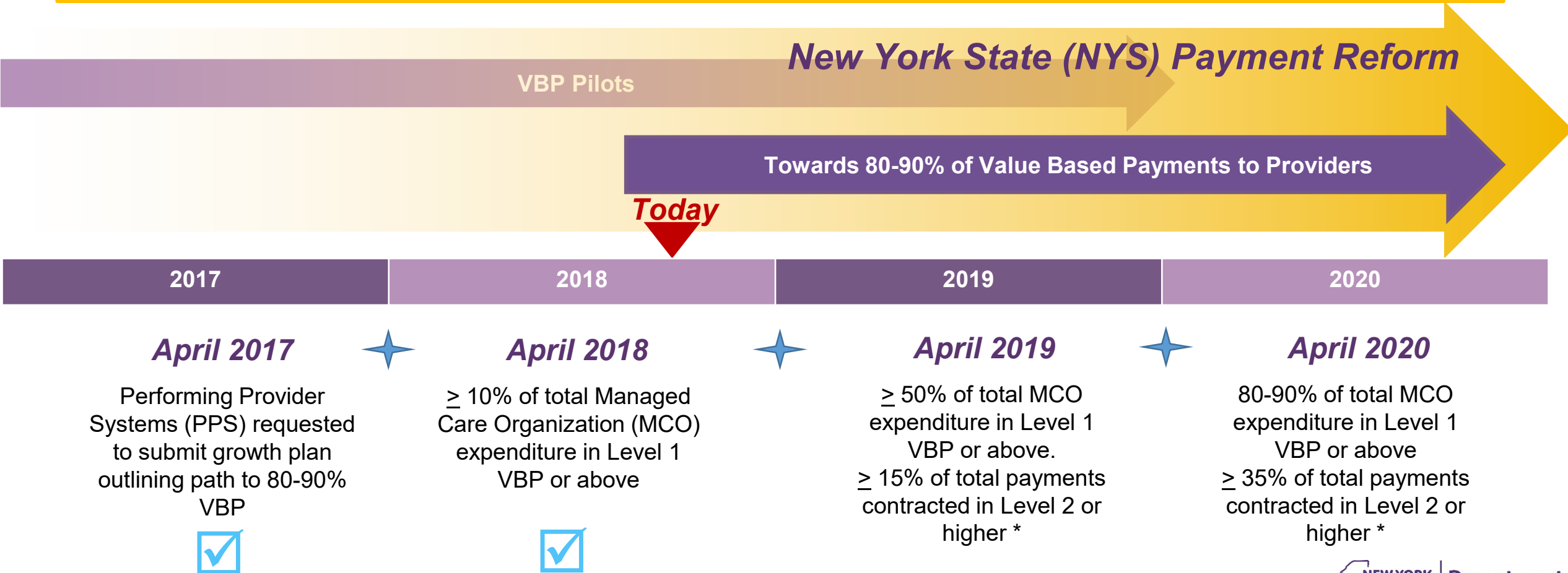
a delivery system which realizes...

cost efficiency and quality outcomes: *value*



# VBP Transformation: Overall Goals and Timeline

**Goal:** To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.



\* For goals relating to VBP level 2 and higher, calculation excludes partial capitation plans such as MLTC from this minimum target.

# VBP Arrangements

## Arrangement Types

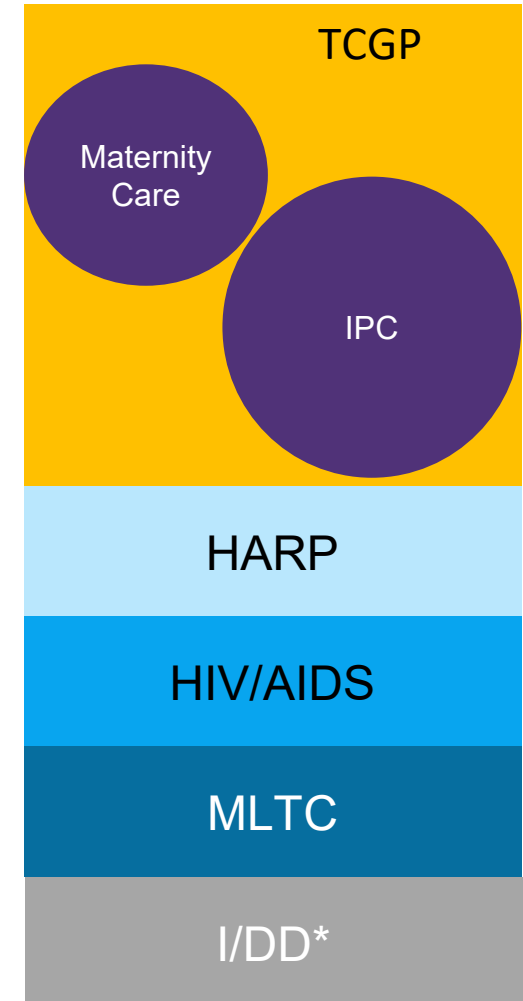
**Total Care for the General Population (TCGP):** All costs and outcomes for care, excluding MLTC, HARP, HIV/AIDS, and I/DD\* subpopulations.

### Episodic Care

- **Integrated Primary Care (IPC):** All costs and outcomes associated with primary care, sick care, and a set of chronic conditions selected due to high volume and/or costs
- **Maternity Care:** Episodes associated with pregnancies, including delivery and first month of life of newborn and up to 60 days post-discharge for mother

**Total Care for Special Needs Subpopulations:** Costs and outcomes of total care for all members within a subpopulation exclusive of TCGP

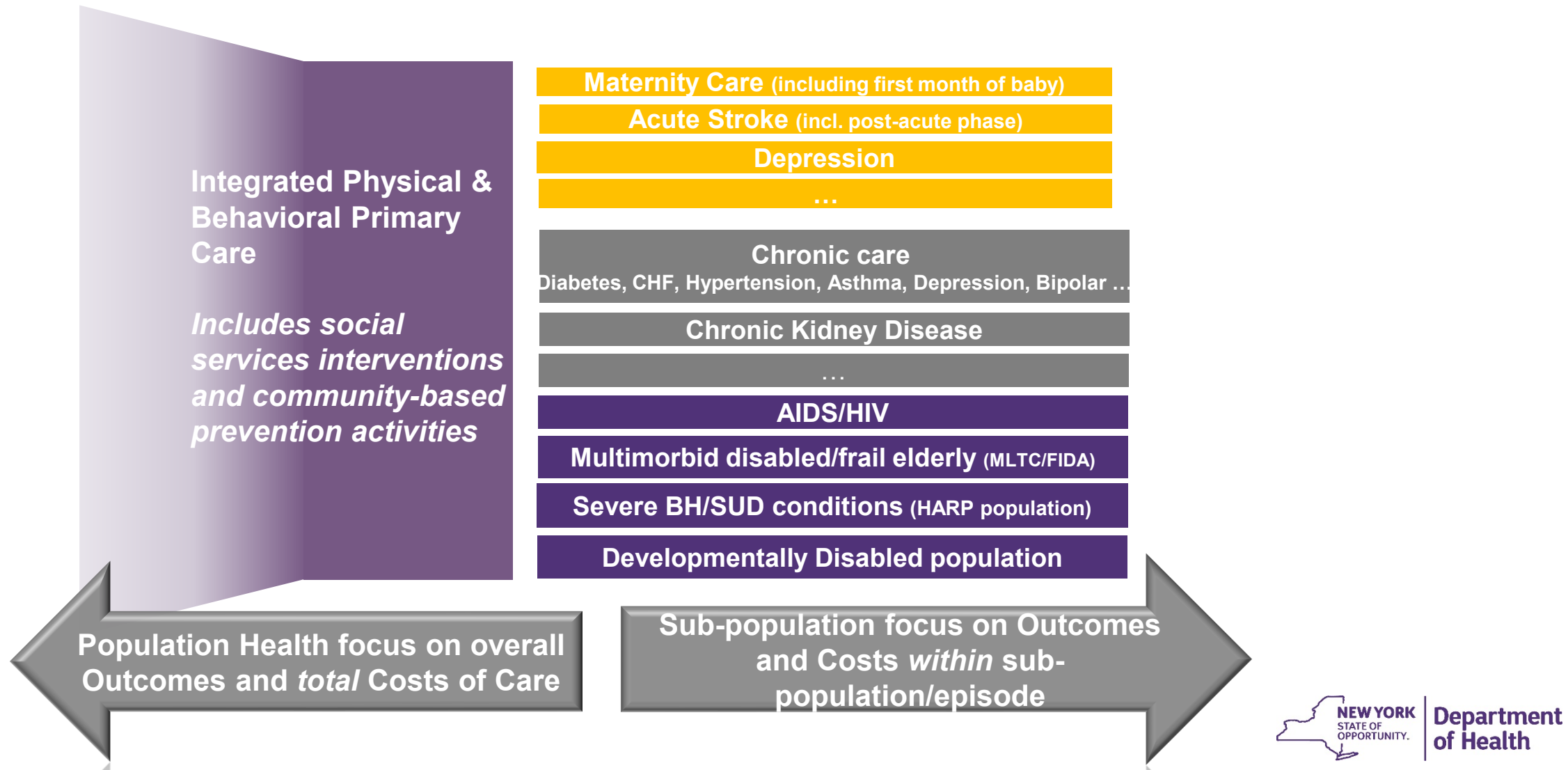
- **HARP:** For those with serious mental illness or substance use disorders
- **HIV/AIDS**
- **Managed Long Term Care (MLTC)**
- **I/DD\***



*VBP contractors can contract TCGP as well as subpopulations as appropriate; nothing mandates that the Roadmap-defined arrangement types must be handled in standalone contracts.*

\*Total Care for the I/DD Subpopulation will be available as an arrangement when the population is moved to managed care.  
 Acronyms: MLTC = Managed Long Term Care; HARP = Health and Recovery Plans; I/DD = Intellectually/Developmentally Disabled

# The VBP Roadmap starts from DSRIP Vision on how an Integrated Delivery System should function



# 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:

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

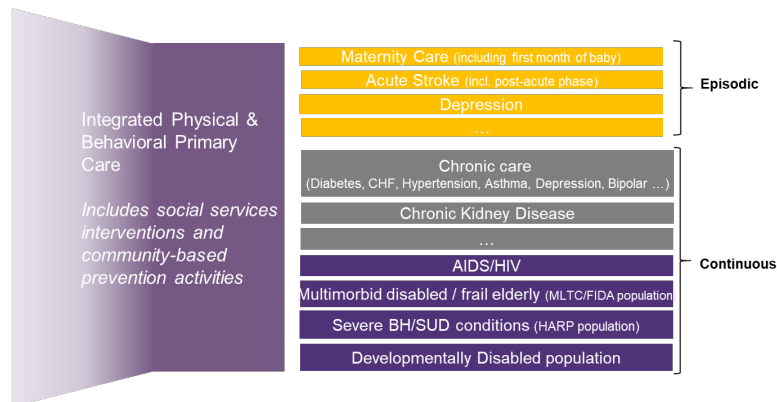
- Goal of  $\geq 80$ -90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- Aim of  $\geq 35$ % of total costs captured in VBPs in Level 2 VBPs or higher

# 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.**

**PPSs and MCOs can opt for different shared savings/risk 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
- Per integrated service for specific condition (acute or chronic bundle): maternity care; diabetes care
- For integrated Advanced Primary Care (APC)
- For the total care for a subpopulation: HIV/AIDS care; care for patients with severe behavioral health needs and comorbidities



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

# How will VBP impact practice staff on the front line?



More pressure for front staff to ensure patients are showing up for appointments, and following up with “no shows”



Clinicians will need to complete fields on the Electronic Health Records to accurately measure quality



Referrals to downstream providers (e.g. care managers) to be tracked in practice site workflow



New emphasis on engaging and collaborating with CBOs to embed Social Determinants of Health in practice site workflow



Consider staff impact on VBP participation/goals when looking at salary and performance evaluation

# For VBP Success:

Yesterday's Performance  
Payments fuel Tomorrow's  
Shared Savings

Build from DSRIP  
Infrastructure

INNOVATE: Think patient  
needs over billable  
services

Partner across the  
Care Delivery  
Spectrum

Do what you do best: Provide the highest quality  
care for those who need it most, each and every day

I. What are we doing?

**II. Where are we going?** 

III. How will we get there?

IV. Questions.



# New Horizons of Healthcare Delivery

Patient  
Centered

Innovative

Value

Transparent

Integrated

Sustainability

Accountable

Collaborative

Quality

Accessible

# New Horizons of Healthcare Delivery

Whole-  
Person Care

# What is whole-person care?



# Integrating and Collaborating Medical Care Around the Patient



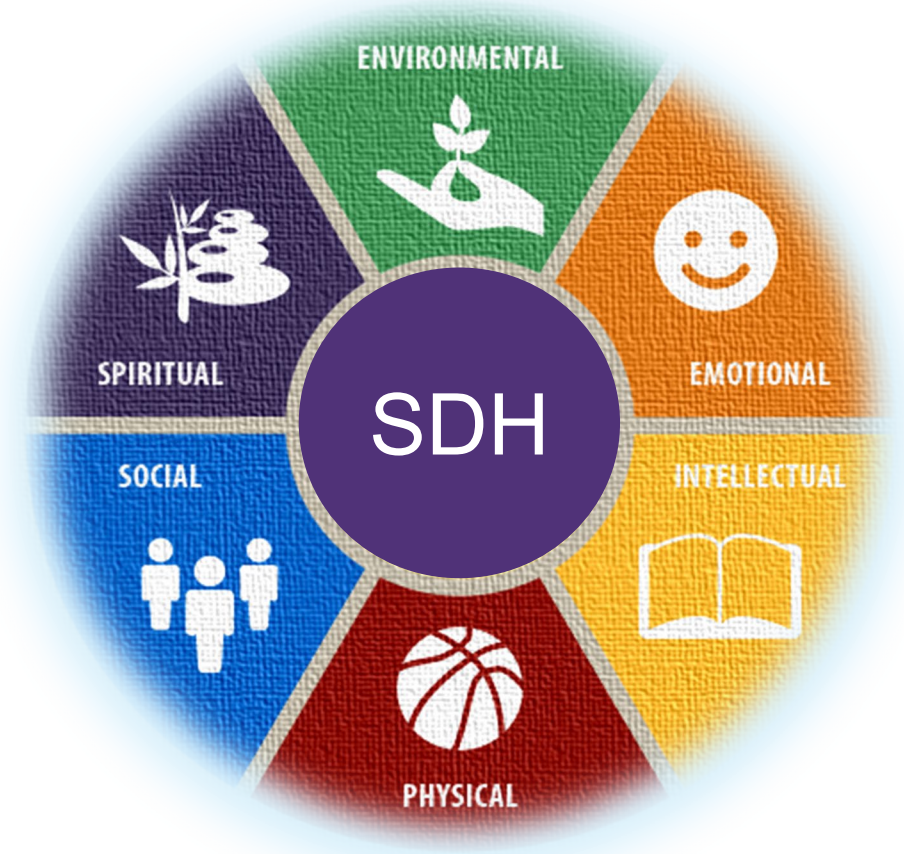


## Addressing their Social Determinants of Health

***Social determinants of health*** are defined as the ***conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.***

Experts estimate that ***medical care accounts for only 10% of overall health***, with social, environmental, and behavioral factors accounting for the rest. ***Lack of upstream investment in social determinants of health probably contributes to exorbitant downstream spending on medical care in the US.***

– *The New England Journal of Medicine (NEJM)*





**“Whole-person care can be defined as the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources.”**

~California's 1115 Waiver: An Opportunity to Move from Coverage to Whole-Person Care





Neighborhood & Environment



Social, Family, & Community



Education



Economic Stability



Access to Health & Healthcare



Pillars of Self and Patient Activation



Collaborative, Integrated Care

# Neighborhood & Environment



# Social, Family, & Community



# Education



# Economic Stability



# Access to Health & Healthcare



# Pillars of Self and Patient Activation



# Collaborative, Integrated Care





I. What are we doing?

II. Where are we going?

**III. How will we get there?** 

IV. Questions.

Measures to Celebrate



Measures to Applaud



Measures to Rally Behind



# Potentially Preventable Emergency Room Visits $\pm$

$\pm$  A lower rate is desirable



MY0 MY1 MY2 MY3 PPS Result

◆ = MY3 result met the AIT

Improving  
←

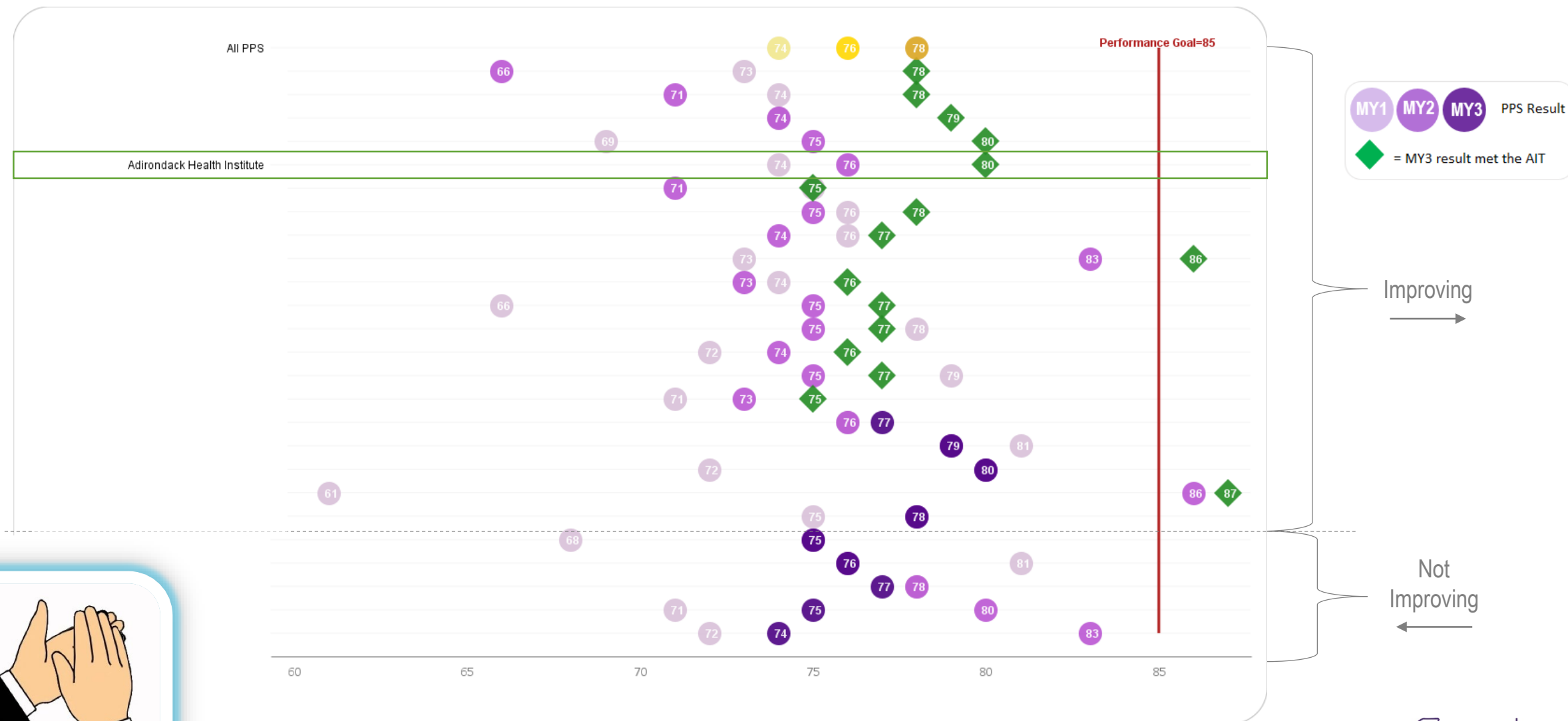
Not Improving  
→



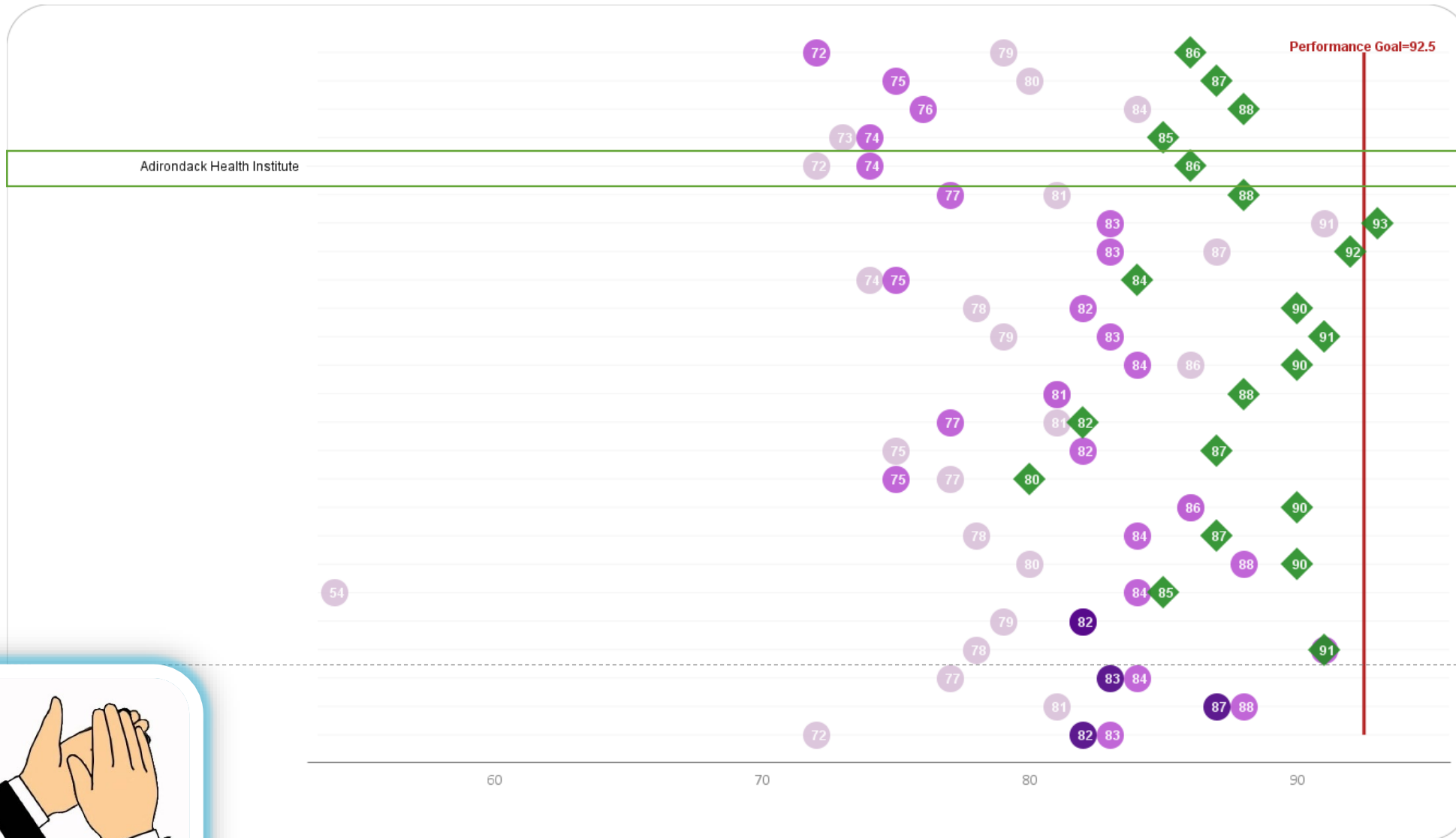
# Getting Timely Appointments, Care and Information



# Primary Care - Length of Relationship



# Primary Care - Usual Source of Care



MY1
MY2
MY3
 PPS Result  
 ◆ = MY3 result met the AIT

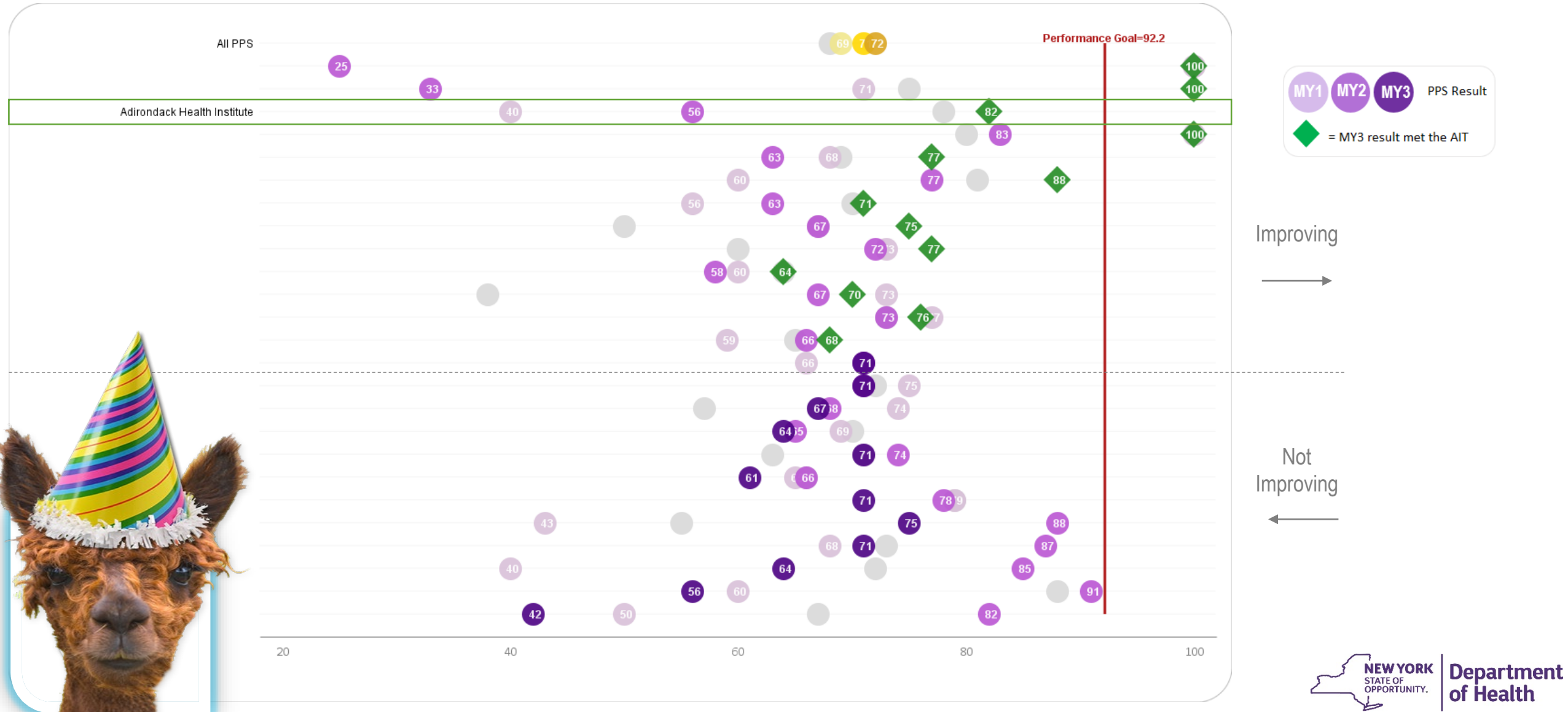
Improving  
→

Not Improving  
←



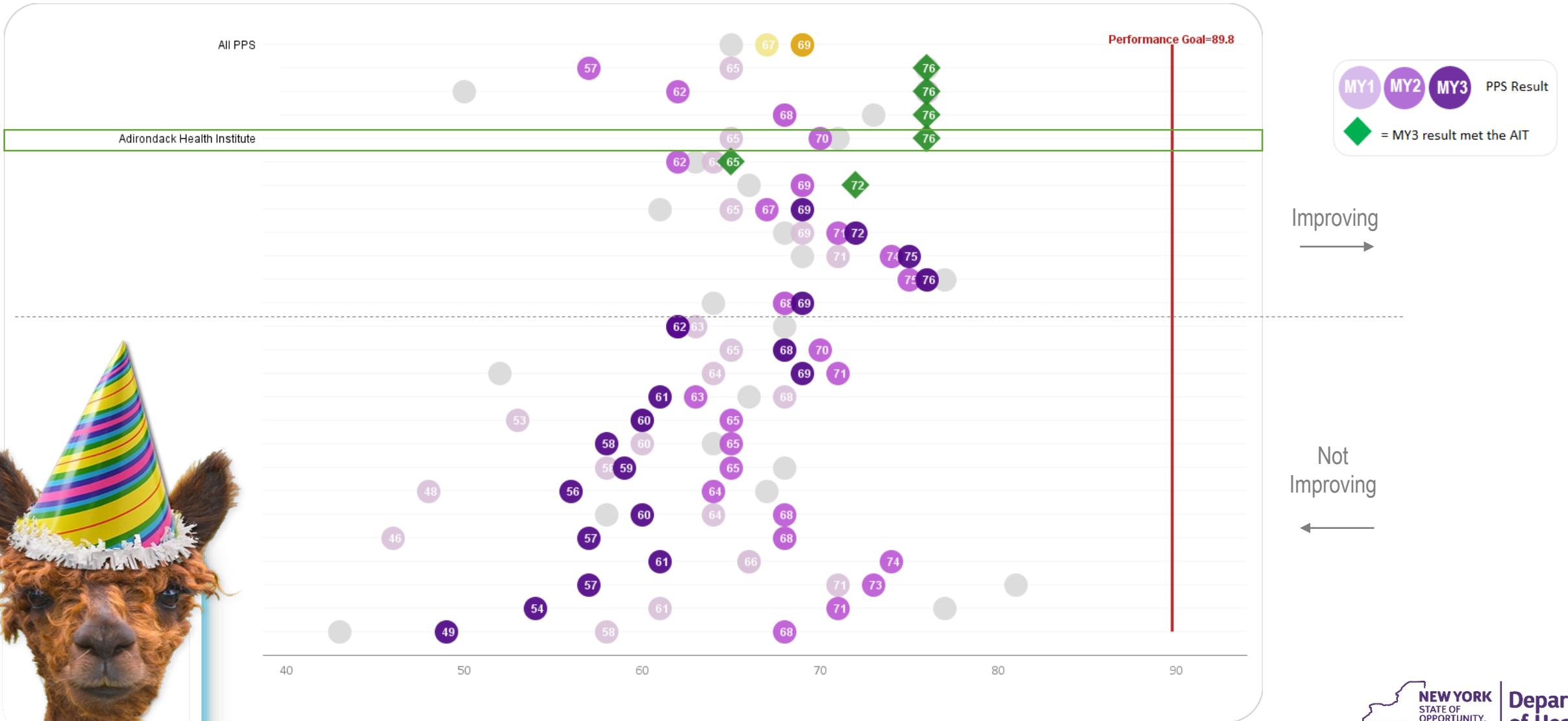
# Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia ^

^ Rates may not be stable due to small numbers (< 30) in denominator



# Diabetes Monitoring for People with Diabetes and Schizophrenia ^

^ Rates may not be stable due to small numbers (< 30) in denominator







## Seven-day Behavioral Health Inpatient Follow-up Workgroup:

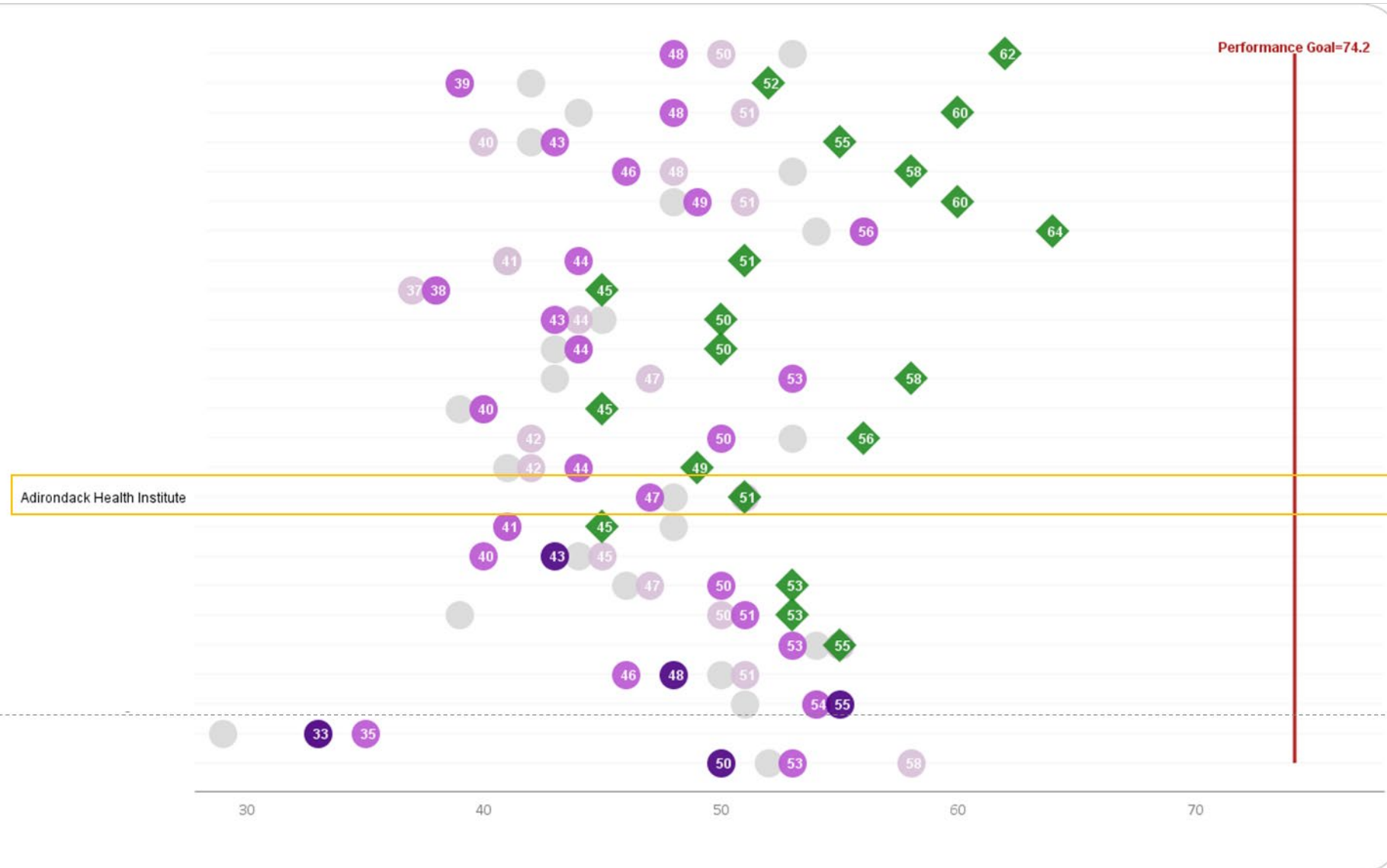
- An interdisciplinary workgroup met to identify best practices for improving follow-up care:
  1. Assuring the appointment is made with the appropriate behavioral health provider;
  2. Use peer support services to assist the patient to engage and connect to services.



Glens Falls Hospital

Evidence Based & Cost Effective

# Seven-day Behavioral Health Inpatient 7 Day Follow-up:



**MY3 P4P Funds Available  
\$8,095,289+HPF**



Improving



Not  
Improving



## Community Navigators & Health Coaches

**2016 RFP award for Community Navigators and Health Coaches:** 17 PPS partner organizations, inclusive of both CBOs and clinical partners, employing Community Navigators and Health Coaches across the nine-county catchment area.

- Connected beneficiaries to health insurance, primary and preventative care, and community-based services to address social needs
- Administered the Patient Activation Measure® (PAM®) survey

Sustainable & Interdisciplinary



## Medicaid Accelerated eXchange (MAX)

**Adirondack Health and Nathan Littauer Hospital & Nursing Home participated in the MAX series.**

**Adirondack Health collaborated with multiple community partners:**

Representatives from Citizen Advocates and Franklin County Office for the Aging were on the MAX action team and assisted with addressing social and behavioral health needs identified as drivers of utilization.

**NLH partnered with The Family Counseling Center of Fulton County:**

Community Navigators in place as a result of the RFP/Project 2.d.i played an integral role in the success of the MAX series

- High utilizers were referred to Community Navigators and Health Coaches from The Family Counseling Center of Fulton County
- This practice linked beneficiaries to services



## Medicaid Accelerated eXchange New York Series (MAXny)

### **Nathan Littauer Hospital & Nursing Home MAXny series, partnering with The Family Counseling Center of Fulton County:**

- Focused on emergency department high utilizers by embedding a Community Navigator from The Family Counseling Center
- This allowed the Community Navigator to establish a relationship with high-utilizing beneficiaries when they presented at ED.



## Medicaid Accelerated eXchange (MAX and MAXny)

- Nathan Littauer Hospital & Nursing Home first identified a 27% reduction of avoidable readmissions for HUs over a five-month period with all HUs connected to one or more services.
- NLH saw the mean time between ED visits for the HU population increase from approximately 12 days to 33 days – nearly tripling.

## Medicaid Accelerated eXchange (MAX)

### **The University of Vermont Health Network – Champlain Valley Physicians Hospital partnering with Peer Advocates from NAMI-CV:**

- In 2017, UVMHN-CVPH was awarded Innovation Funds to embed NAMI-CV Peer Advocates in their ED to function as a Community Navigator.



**Champlain Valley**

**Gouverneur Hospital (St. Lawrence Health System) is in the process of hiring a new Transition of Care Coordinator**



## Medicaid Accelerated eXchange (MAX)

### Innovation, Transformation Funds, and RFPs:

- As a result of Innovation Funding, Community Connections of Franklin County embedded two Community Navigators in Alice Hyde Medical Center's emergency department.



- Additionally, several PPS partners representing multiple service sectors received Innovation and Transformation Funds to continue the work of Community Navigators and Health Coaches whose positions were originally established through the 2.d.i RFP.

Impacting the most vulnerable in big ways





## ADK Wellness Connections:



**Built on the Unite Us software platform, ADK Wellness Connections is a coordinated referral network intended to improve cross-sector communication and linkage and promote holistic care delivery:**

- The platform establishes a unified information technology network for all types of social service and clinical providers
- The platform will also provide network partners with a data source by which they can measure their impact and inform a value proposition
- The coordinated referral network will allow for provider-to-provider referrals as well as referrals to locally-staffed coordination centers in three PPS regions.

Creating Meaningful Connections



## Addressing Homelessness in the AHI PPS:

### **Community Navigation at the Open Door Mission in Glen Falls and expanding services to include a permanent homeless shelter.**

- The shelter also provides resource navigation and a variety of support services to its guests, and serves as link between its guests and local service providers.
- The Open Door has worked diligently to make a direct impact on DSRIP goals by connecting its guests to health insurance coverage, primary and preventative care, and services to address social factors that influence health.



## Addressing Homelessness in the AHI PPS:

- Homelessness and housing instability have been proven to be major drivers of avoidable hospital use and poor health outcomes.
- Statewide and national efforts to address these social determinants of health have delivered significant results, such as the more than 300% return on investment (ROI) seen by Montefiore Health System in NYC.
- By supporting organizations like the Open Door to address homelessness and housing instability in AHI's service area, AHI hopes to achieve a similar impact.

Creating stability to support health



## Advanced Primary Care (APC) and PCMH 2014:

**The goal for each PPS was to have all eligible practices achieve 2014 PCMH Level 3 and/or APC Gate 2 status.**

- 100% of the AHI PPS practices achieved this goal (21 organizations and 74 sites).
- AHI is helping to sustain the DSRIP project by helping to transition all practices to NYS PCMH.

Evidence Based & Cost Effective



## Telehealth:

**In the last three years, the North Country Telehealth Partnership (a joint venture of AHI and Fort Drum Regional Health Planning Organization) has:**

- Overseen the implementation of more than 45 varied telehealth programs in the North Country
- Tracked more than 5,700 patient encounters
- Remotely monitored more than 65 home-bound patients to keep them out of the emergency department.

Rural Health Focused

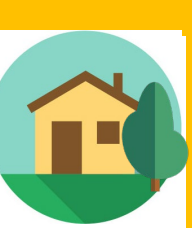


## Medication Reconciliation:

### **United Helpers in St. Lawrence County has implemented a “Red and Green Bag” program**

- Encourages patients to bring their medications with them to their appointments (a similar program is being administered at Hudson Headwaters Health Network).
- Aimed at reducing medication mismanagement, physically bringing medications to appointments eliminates the need for patients to remember off the top of their head the medications they take.

Effectively Free and Easy to Implement



## Sequential Intercept Mapping (SIM):

**The Glens Falls Region Population Health Network (PHN) created an interdisciplinary workgroup that included law enforcement, behavioral and medical health providers, and community-based organizations:**

- Crisis Intervention Team (CIT) strategy training better prepares first responders with tools to assist people in crisis.
- Pre-arraignment diversion process for our community.
- More effective jail release program that defines insurance coverage, and connection to appropriate medical, behavioral health, SUD and community services.

Cross-Agency Impact



## Connecting Eligible Patients to Health Home Care Management Services:



### PPS-wide Care Management Workshops:

- Share best practices across the PPS for both Health Home and non-Health home focusing on transitions and patient education.
  - Health Home-enrolled patients have a significant increase in preventive care, annual visit and follow up (i.e. 7-day post inpatient stay) compared to the entire PPS.
  - The enrolled patients have a decrease PPV for BH and PPR rate compared to the outreach population and contributed to the successful achievement of PPR and PPV-BH Annual Improvement targets.

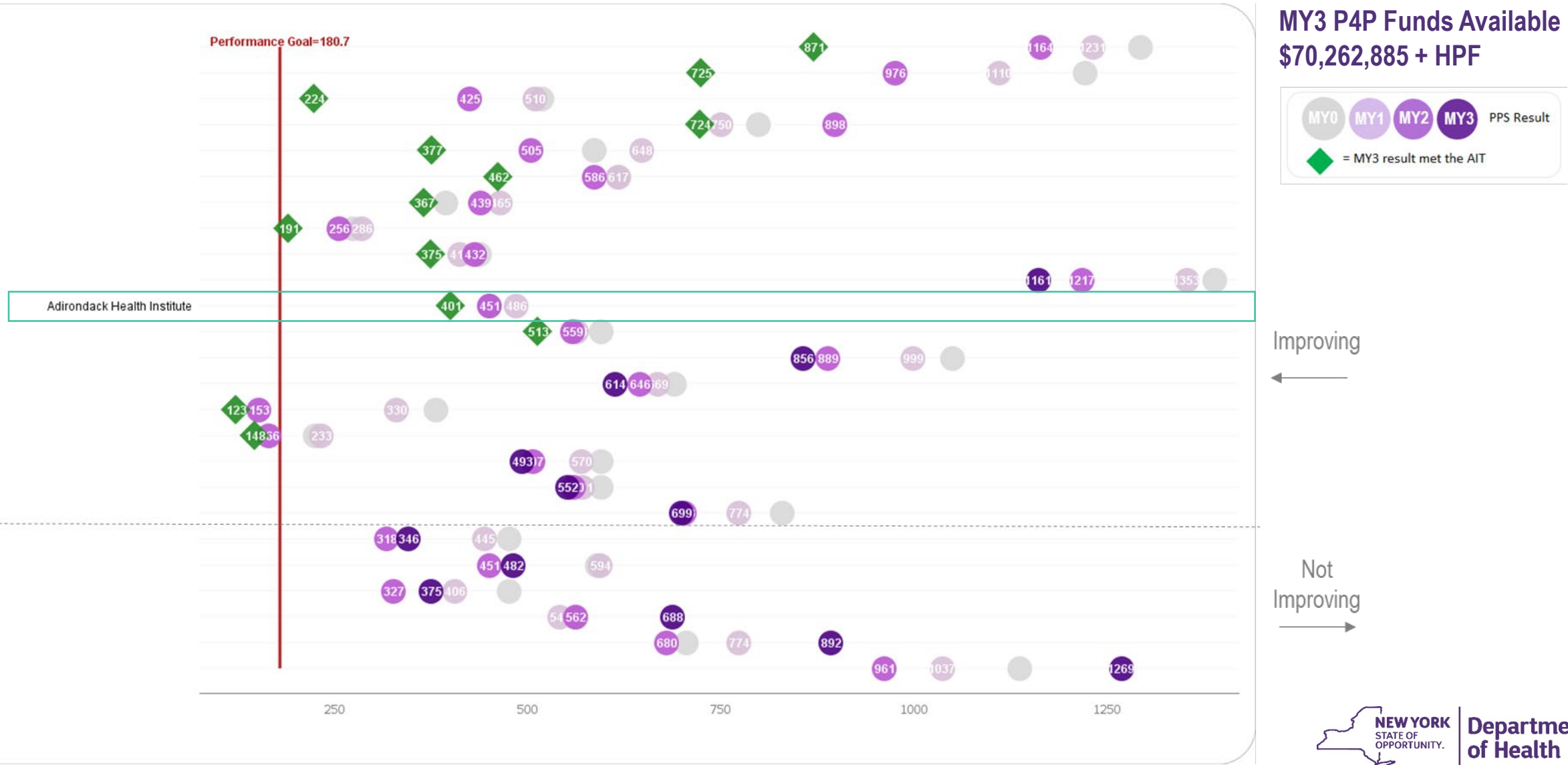


Targeting multiple DSRIP measures



# Potentially Preventable Readmissions

+ A lower rate is desirable



**MY3 P4P Funds Available**  
**\$70,262,885 + HPF**

# Potentially Preventable Emergency Department Visits (for persons with BH diagnosis) + A lower rate is desirable



MY3 P4P Funds Available  
\$16,190,577 + HPF



Improving  
←

Not Improving  
→



## Connecting People to Coverage:

### **AHI's Enrollment Assistance Services and Education (EASE) program:**

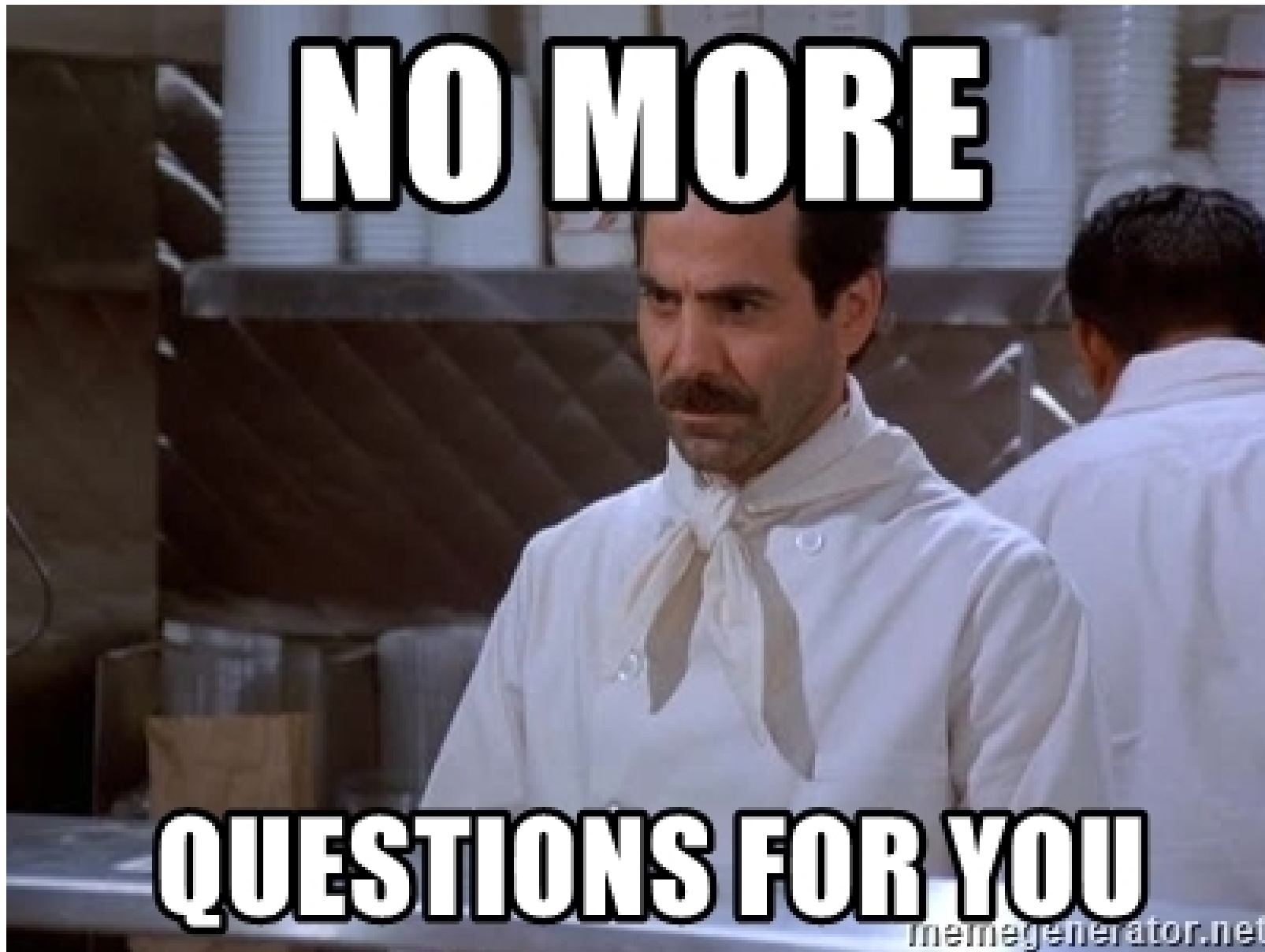
- Enrolled more than 16,000 individuals in comprehensive health coverage through NYSOH.
- Nearly 8,000 of these individuals were enrolled in NY's Medicaid program, supporting DSRIP program goals.
  - Average rate of uninsured across 7 counties reduced by nearly 7%.

Sustainable Public Health Initiative

- I. What are we doing?
- II. Where are we going?
- III. How will we get there?

**IV. Questions.** 





## For more information

### VBP Roadmap

- In depth roadmap of VBP implementation under Medicaid Payment Reform. Full descriptions of the key points addressed in the VBP University.
- [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/2017/docs/2016-06\\_vbp\\_roadmap\\_final.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/docs/2016-06_vbp_roadmap_final.pdf)

### VBP University

- Four semesters of content broken into several short (5 mins or less) videos and fact sheets providing an overview of VBP implementation.
- [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/vbp\\_u/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_u/index.htm)

### VBP Bootcamps

- The VBP Bootcamp regional learning series was provided by the Department of Health to plan and provider communities throughout the State to fill payment reform knowledge gaps and ensure successful transition to VBP implementation.
- Recordings: <https://www.totalwebcasting.com/view/?id=nysdohvbp>
- Materials: [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/vbp\\_bootcamp/2017\\_sessions.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_bootcamp/2017_sessions.htm)

**Additional information available at:**

[https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/)

***DSRIP e-mail:***

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