Value Based Payments in a I/DD Context


Betsy Lynam, KPMG
October 17, 2016
Presentation Overview

Part I:
• The Imperative to transform

Part II:
• Introduction to Value Based Payment

Part III
• Intellectually/Developmentally Disabled (I/DD) Advisory Group Overview

Part IV
• Provider Readiness

Part V
• Quality Measures

Part VI
• Discussion/ Q & A
Part I

The Imperative to Transform
Managed Care and VBP Platforms for Change

Transformation Panel Recommendations

VBP
Managed Care

Abundant Living
Aligning Incentives

Flexibility

Meaningful Choice

Community
Supporting Key Relationships
Building on the Successes: New York’s Overall Fiscal Effort for I/DD Services is Significantly Higher than the National Norm

Fiscal Effort for All Services and Settings: FYs 1987 and 2013

<table>
<thead>
<tr>
<th></th>
<th>FY 1987</th>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEW YORK STATE</td>
<td>$5.09</td>
<td>$10.11</td>
</tr>
<tr>
<td>UNITED STATES</td>
<td>$2.84</td>
<td>$4.40</td>
</tr>
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</table>

Building on Successes: A Larger Percentage of Caregiving Families Receive Support by I/DD Agencies in New York State

Estimated Percent of I/DD Caregiving Families Receiving Support by I/DD Agencies: FY 2013

- NEW YORK STATE: 27%
- UNITED STATES: 13%

Residential Support: New York Serves a Larger Proportion of I/DD Individuals in Supervised Residential Settings

New York State: Estimated Number of Individuals with I/DD by Living Arrangement: FY 2013
- With Family Caregiver: 43,889 (14%)
- Supervised Residential Setting: 198,592 (64%)
- Alone or with Roommate: 67,118 (22%)

United States: Estimated Number of Individuals with I/DD by Living Arrangement: FY 2013
- With Family Caregiver: 786,156 (16%)
- Supervised Residential Setting: 3,557,246 (71%)
- Alone or with Roommate: 634,509 (13%)

Residential Support: Supervised Residential Settings for I/DD Individuals in New York State More Frequently Settings with 7+ Persons

I/DD Persons in Residential Services by Size of Setting: FY 2013

## A Closer Look: Higher Use of Supervised Settings 7-15 Private ICF’s and Other Residential Placements; Less Supported Living

<table>
<thead>
<tr>
<th>Persons Served by Setting: FY 2013</th>
<th>New York State</th>
<th>United States</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td><strong>16+ Persons</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Facilities</td>
<td>4,429</td>
<td>6.6%</td>
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<tr>
<td>State Institutions</td>
<td>1,883</td>
<td>2.8%</td>
</tr>
<tr>
<td>Private ICF/ID</td>
<td>1,015</td>
<td>1.5%</td>
</tr>
<tr>
<td>Other Residential</td>
<td>952</td>
<td>1.4%</td>
</tr>
<tr>
<td><strong>7-15 Persons</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public ICF/ID</td>
<td>59</td>
<td>0.1%</td>
</tr>
<tr>
<td>Private ICF/ID</td>
<td>4,158</td>
<td>6.2%</td>
</tr>
<tr>
<td>Other Residential</td>
<td>14,447</td>
<td>21.5%</td>
</tr>
<tr>
<td><strong>6 or Fewer Persons</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public ICF/ID</td>
<td>34</td>
<td>0.1%</td>
</tr>
<tr>
<td>Private ICF/ID</td>
<td>454</td>
<td>0.7%</td>
</tr>
<tr>
<td>Supported Living</td>
<td>26,955</td>
<td>40.2%</td>
</tr>
<tr>
<td>Other Residential</td>
<td>16,582</td>
<td>24.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>67,118</td>
<td>100.0%</td>
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</table>

Employment and Life in the Community: Share of Total Spending for Family Support, Supported Living, and Supported Employment

Share of Total Spending for Family Support, Supported Living, and Supported Employment: FY 2013

<table>
<thead>
<tr>
<th></th>
<th>NEW YORK STATE</th>
<th>UNITED STATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Support</td>
<td>5.1%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Supported Living</td>
<td>3.7%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>12.8%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

Supporting Staff and Family Caregivers: A Sizeable Proportion of the Estimated I/DD Population is Living at Home with Aging Caregivers

Estimated Number of Individuals with I/DD by Family Caregiver Age Group: New York State FY 2013
- Caregiver Under 41: 50,487 (25%)
- Caregiver Ages 41-59: 78,438 (40%)
- Caregiver Ages 60+: 69,666 (35%)

Estimated Number of Individuals with I/DD by Family Caregiver Age Group: United States FY 2013
- Caregiver Under 41: 863,314 (24%)
- Caregiver Ages 41-59: 1,247,882 (35%)
- Caregiver Ages 60+: 1,446,051 (41%)


Refer to Appendix for methodology of data
New York State’s Performance on the National Core Indicators

- New York State’s performance relative to other states is reflected in the National Core Indicators (NCI)
  - NCI is a voluntary effort by state developmental disability agencies to gauge their own performance using a common and nationally validated set of measures.
  - NCI uses 100 standard performance measures (or “indicators”) to assess the outcomes of services provided to individuals and their families.

- New York State NCI Standings
  - New York State underperforms the NCI average in the domains of individual choice and work.
  - Access to transportation is also 10 points below the NCI average.
  - In the health domain, NYS does relatively well relative to the NCI average.
National Core Indicator Domains

**Individual Outcomes**
Addresses how well the public system aids adults with developmental disabilities to work, participate in their communities, have friends and sustain relationships, and exercise choice and self-determination. Other indicators in this domain probe how satisfied individuals are with services and supports.

**Health, Welfare, and Rights**
Addresses (a) safety and personal security; (b) health and wellness; and (c) protection of and respect for individual rights.

**System Performance**
Addresses (a) service coordination; (b) family and individual participation in provider-level decisions; (c) the utilization of and outlays for various types of services and supports; (d) cultural competency; and (e) access to services.

**Family Indicators**
Addresses how well the public system assists children and adults with developmental disabilities, and their families, to exercise choice and control in their decision-making, participate in their communities, and maintain family relationships. Additional indicators probe how satisfied families are with services and supports they receive, and how supports have affected their lives.

**Staff Stability**
Addresses provider staff stability and competence of direct contact staff.
## National Core Indicators: NYS Below the NCI Average

### Choice
5 points below in 5 of 9 indicators

- Chose Roommates Or Chose To Live Alone
- Chose Day Program Or Regular Activity
- Chose Staff
- Decides How To Spend Free Time
- Chooses How To Spend Money

### Work
5 points below in four indicators

- Worked 10 Of The Last 12 Months In A Paid Community Job
- Average Months At Current Paid Community Job
- Receives Benefits At Paid Community Job
- Four Most Common Fields Of Paid Community Employment- Food Preparation And Food Service

### All Other
At least 5 points below in 3 other indicators

- Has A Best Friend
- Always Has A Way To Get Places – 10 points below NCI average
- Engages In Regular, Moderate Physical Activity At Least 30 Minutes A Day 3x/week

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October 2016
National Core Indicators: NYS Above the NCI Average

All Other
3 indicators 5 or more points above the NCI average

- Went On Vacation In The Past Year
- Four Most Common Fields Of Paid Community Employment - Building And Grounds Cleaning Or Maintenance
- Volunteers
- Case Manager/Service Coordinator Calls Person Back Right Away

Health
6 of 11 indicators 5 points or more above NCI average

- Had A Dental Exam In The Past Year
- Had An Eye Exam Or Vision Screening (In The Past Year)
- Had A Hearing Test (In The Past Five Years)
- Had A Mammogram (In The Past Two Years, Women 40 And Over)
- Had A Colorectal Cancer Screening (In The Past Year, Age 50 And Over)
- Had A Flu Vaccine (In The Past Year)

See Appendix for additional detail on indicators and New York’s scores.
Part II

Introduction to Value Based Payment
Background

NYS Medicaid in 2010: The Crisis

• > 10% growth rate had become unsustainable, while quality outcomes were lagging

  • Costs per recipient were double the national average
  • NY ranked 50th in country for avoidable hospital use
  • 21st for overall Health System Quality

2009 Commonwealth State Scorecard on Health System Performance

<table>
<thead>
<tr>
<th>CARE MEASURE</th>
<th>NATIONAL RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidable Hospital Use and Cost</td>
<td>50th</td>
</tr>
<tr>
<td>✓ Percent home health patients with a hospital admission</td>
<td>49th</td>
</tr>
<tr>
<td>✓ Percent nursing home residents with a hospital admission</td>
<td>34th</td>
</tr>
<tr>
<td>✓ Hospital admissions for pediatric asthma</td>
<td>35th</td>
</tr>
<tr>
<td>✓ Medicare ambulatory sensitive condition admissions</td>
<td>40th</td>
</tr>
<tr>
<td>✓ Medicare hospital length of stay</td>
<td>50th</td>
</tr>
</tbody>
</table>
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 NYS
  • The MRT developed a multi-year action plan. We are still implementing that plan today
The 2014 MRT Waiver Amendment furthers New York State’s Reform 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 the Waiver Amendment
  - Allows the State to reinvest $8 billion of $17.1 billion in Federal savings generated by MRT reforms
  - $7.3 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 financial sustainable safety net infrastructure
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:
  - Fee-for-Service (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
The Old World: Fee for Service; Each in its Own Silo

- There is no incentive for coordination or integration across the continuum of care.
- Much Value is destroyed along the way:
  - Quality of patient care & patient experience
  - Avoidable costs due to lack of coordination, rework, including avoidable hospital use
  - Avoidable complications, also leading to avoidable hospital use
The Challenge of Integrating Services for I/DD Individuals – Distribution of 2014 Medicaid Costs

Total Cost of Care: $7.7 Billion

Source: DOH Analysis
Moving to a New World

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

Current State

Increasing the value of care delivered more often than not threatens providers’ margins

Future State

When VBP is done well, providers’ margins go up when the value of care delivered increases

Goal – Pay for Value not Volume
Payment Reform: Moving Toward VBP

• A Five-Year Roadmap outlining NYS’ plan for Medicaid Payment Reform was required by the MRT Waiver

• By DSRIP Year 5 (2019), all Managed Care Organizations must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the Special Terms and Conditions of the waiver)

• The State and CMS are committed to the Roadmap

• Core 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
How DSRIP and VBP Work Together

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

New world:
- VBP arrangements
- Integrated care services for patients are anchor for financing and quality measurement
- Value over Volume
How an Integrated Delivery System should Function

Integrated Physical & Behavioral Primary Care
Includes social services interventions and community-based prevention activities

Maternity Care (including first month of baby)
Chronic Care (Asthma, Diabetes, Depression and Anxiety, Substance Use Disorder, Trauma & Stressors…)
HIV/AIDS
Managed Long Term Care
Severe Behavioral Health/Substance Use Disorders (HARP Population)
Intellectually/Developmentally Disabled Population

Episodic

Continuous

Population Health focus on overall Outcomes and total Costs of Care

Sub-population focus on Outcomes and Costs within sub-population or episode

Integrated Primary Care
Episodic
Subpopulation
Transitioning to Managed Care
General Population and Subpopulations

- VBP arrangement for DD is a subpopulation total cost of care arrangement

- The total population is divided into the general population and four specific subpopulations
  1) HARP (Behavioral Health)
  2) HIV/AIDS
  3) I/DD
  4) MLTC

- Subpopulations are contracted for the total cost of care for their Medicaid members.
- Subpopulation design to incentivize care coordination across traditional “silos” of care
Why Total Care for Subpopulations Can Be Attractive

• Dedicated focus on these subpopulations can get lost in larger Total Care for Total Population models (such as Medicare ACOs)

• Dedicated incentive to reduce the significant inefficiencies and potentially avoidable complications within these subpopulations creates maximum positive impact for these subpopulations

• The significant budgets of these subpopulations and the significant potential for shared savings become available for these groups of dedicated providers

• Rather than relying on separate and often small grants to improve housing and other social determinants of health, a large budget is now available to (re-)invest and restructure the delivery system and invest in Community Based Organizations & the social determinants of health
  • For these subpopulations (HARP, HIV/AIDS, MLTC, DD), these social determinants are especially important
Mobilizing Change, Maximizing Incentives
Overarching Approach to Medicaid Spend in VBP

**State:** Pay MCOs for value delivered to their total membership per VBP arrangement type (whether actually contracted or not)

**MCOs:** Drive providers to improve their value by increasing their premium and their returns. VBP arrangements and insight into the potential performance of providers vs their target budgets will be actionable entry point for MCOs

**Providers:** Deliver better quality care to the Medicaid beneficiaries at lower overall cost to both provider and MCO, allowing for further re-investment of Medicaid dollars into DSRIP

Feedback-loop facilitates control of the overall Medicaid spend
Payment Reform Affects Relationships between the State and MCOs, as well as between MCOs and Providers

Updated Standard PMPM rate setting methodology will govern the relationship

New Standards and Guidelines created by the NYS stakeholders will support VBP contracting
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:

<table>
<thead>
<tr>
<th>Level 0 VBP</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient)</td>
<td>Prospective capitation PMPM or Bundle (with outcome-based component)</td>
</tr>
</tbody>
</table>

- Goal of ≥80-90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- 35% of total managed care payments (full capitation plans only) tied to Level 2 or higher For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans from this minimum target.
Participation Incentives for Providers

- Potential for shared savings: incentives for a reduction in net spending for a defined patient population, and reinvestment of those savings back into the provider system
- Increased patient volume through improved performance and patient outcomes
- Ability to reduce waste, streamline operations, and increase revenue in the long term
- Ability to track quality measures through improved data capabilities
- Potential to incur penalties passed on by the MCOs due to inability to reach VBP goals
Big Picture Evolution

• Medicare/Medicaid connection – alignment ultimately crucial

• Important to integrate full continuum of care - medical, BH, I/DD

• Align with efforts already underway – FIDA

October 2016
Part III

Intellectually/Developmentally Disabled (I/DD) Advisory Group Overview
I/DD VBP Advisory Group Objectives

- Understand the State’s vision for the Roadmap to Value Based Payment
- Review VBP arrangement for people with I/DD receiving services
- Make recommendations on:
  - Quality measures
  - Data and other support required for providers to be successful
  - Other implementation details related to VBP
- Defining the value premise for a fully integrated DD subpopulation arrangement
I/DD VBP Advisory Group Progress to Date

- Advisory Group began meeting at OPWDD in January 2016

- Three meetings out of an anticipated four meetings have been completed

- About 60 stakeholder members – ranging from ARC of Rensselaer County and NYSARC to IAC, UCP, and many others

- Examining key domains of person-centered care, life quality, and personal outcome measures
Stakeholder Driven: I/DD VBP Advisory Group Meeting Exercise

• Exercise
  • Advisory Group divided into four groups
  • Brainstormed and discussed:
    • “What is the value proposition?”
    • “How do we want to be measured?”
  • Wrote ideas on sticky notes → Ideas were grouped into thematic domains → Discussed preliminary findings

• Results indicative of a holistic focus on personal goal attainment, community participation, meaningful activities, rewarding relationships, quality of life, and socially desirable endeavors such as employment

See the “Word Cloud” for a thematic, schematic interpretation of results!
A Thematic, Schematic Interpretation of Results

The word cloud below is a visual presentation of qualitative data—words with greater prominence are words that appeared more frequently in the written submissions of the group exercise.
A More Traditional Summary of Key Quality Domains

After reviewing the Advisory Group ideas around capturing value, they were compiled into domains to ground the quality measure discussion. Quality measures will be selected specific to each domain.

- Employment/Personal Goals/meaningful day Activities
- Life in Community
- Social Roles
- Life Goal Attainment/Satisfaction
- Choice & Self-Determination/Flexibility
- Safety & Health
- Service Matching Need/Flexibility
Part IV

Quality Measures
Important considerations for VBP measures

• Breadth of measures
  • Research shows 20 percent of care currently captured in VBP arrangements

• Maturity of measurement systems

• Capturing the value beyond acute care/reductions in inpatient care

• Claims and risk adjustment

• Threshold versus Counterfactuals
  • Pros & Cons

• Nimbleness, adjustment, and real-time actionable information

• Process versus Outcome
  • Process measures: Process measures assess steps that should be followed to provide good care.

  • Outcome measures: Outcome measures assess the results of healthcare that are experienced by patients. They include endpoints like well-being, ability to perform daily activities, etc.

• System needs versus person-centered services

• Room for improvement – lagging versus leading
Person Centered, Full Continuum of Care

- Inclusive of all supportive care relationships across the spectrum of primary, acute, long-term support services, and OPWDD specialty services

- Disease-oriented care
- Clinically focused decision making
- Medical model

- Non-disease oriented
- Focus on the whole-person to ensure comprehensive, continuous and coordinated care

- Measures that capture population-specific outcomes for physical health
- For example:
  - Preventive screenings
  - BMI

I/DD VBP Advisory Group to Select Specific Quality Measures from A Wide Array of Frameworks

- Leverage prior work of stakeholders
- Systemic performance measures
- Useful domains
- 33 Broad Health Measures
- Framework with CMS
- Personal outcome survey tool
- In use by many DD providers
CQL: Personal Outcome Measures®

**My Self** - Who I am as a result of my unique heredity, life experiences and decisions. Person-Centered Life Plans

- People are connected to support networks
- People have intimate relationships
- People are safe
- People have the best possible health
- People exercise rights
- People are treated fairly
- People are free from abuse and neglect
- People experience continuity and security
- People decide when to share personal information

**My World** - Where I work, live, socialize, belong or connect.

- People choose where and with whom they live
- People choose where they work
- People use their environments
- People live in integrated environments
- People interact with other members of the community
- People perform different social roles
- People choose services

**My Dreams** - How I want my life (self and world) to be.

- People choose personal goals
- People realize personal goals
- People participate in the life of the community
- People have friends
- People are respected
Part V
Provider Readiness
Many aspects of an organization’s operations are engaged if VBP is to be successful.

A **readiness assessment** is recommended to evaluate current state and capabilities, identify and prioritize financial and operational gaps. Suggested assessment areas include but are not limited to:

- Financial Sustainability
- Organizational Readiness
- Partnerships
- Care Delivery
- IT Capabilities
Financial Stability

Financial capability/stability preparation should be geared toward:

• Developing the ability to track/report on system-level utilization & cost data
• Developing a business model oriented towards paying for value across business lines
• Understanding the quality metrics that drive patient outcomes
• Identifying up-front costs and estimating return on investment
• Employing innovative financing solutions for upfront costs (DSRIP, MCOs, other health care providers, banks, investors, etc.)
• Coordinating the inevitably varying approaches towards VBP across payers

Organizations lacking financial strength and understanding will find it difficult to maintain VBP contracts.
Organizational Readiness

Organization readiness efforts should be geared toward:

• Developing a shared organizational vision for and commitment to involvement in payment reform amongst administrative and clinical leadership (from staff to C-suite level)
• Putting leadership tools and processes in place to monitor performance (robust technical infrastructure)
• Identifying specific opportunities in relation to the existing mission, service area, and scope of services
• Utilizing change management practices to aid the transition

Significant organizational change must take place to accommodate payment reform. Everyone in the organization must understand what is changing and why to ensure a smooth transition.
IT & Data Analytics Capabilities

IT & Data analytic capability enhancement should be geared toward:

- Staffing adequately IT departments with the capacity to support payment reform efforts
- Functionality with appropriate hardware and software systems by trained staff
- Interoperability of systems and real-time data access
- Health Information Technology (HIT) that helps to achieve performance targets through continuous quality improvement and management of members (e.g. provider alerts, decision tools/dashboards, registries, enhanced access to data, etc.)

Organizations must be able to collect and analyze large amounts of clinical and claims data to inform decisions related to VBP.
Care Delivery Model

Care delivery model preparation should be geared toward:

- Managing care for groups of members and/or populations with various conditions
- Providing robust care coordination
- Achieving linguistic/cultural competency at all levels of the organization
- Employing care standardization processes to streamline wherever possible
- Identifying key transition points in care and bridging any gaps
- Implementing integrated care models across the care continuum
- Engaging the attributed population in the management of their own care

The delivery of care model must change to satisfy requirements of payment reform.
Partnership Development

Partnership development efforts should be geared toward:

- Establishing appropriate partnerships with other providers to meet the goals of your VBP arrangements
- Ensuring the adequacy of the network of providers needed to meet care needs
- Linking with other community organizations/social service agencies to provide systemic community-level supports
- Developing new products and services to meet target population needs
- Understanding the cost effectiveness and outcomes of partnership efforts

Smart partnerships between plans and providers are vital to the success of VBP
Part VI
Questions / Open Discussion
Additional Questions:
elynam@kpmg.com