NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	December 16, 2015, 9:30am-11:30am	**Meeting Title**	NYP PPS Project Advisory Committee
Location	MSCHONY 12th Floor, Klienman Conf. Rm. 12-45	**Facilitator**	Kate Spaziani
Go to Meeting	None	**Conference Line**	Dial In: 855-640-8271 Passcode: 24545434

Attendees	
Project Advisory Committee Membership	

Meeting Objectives	**Time**
1. Welcome (Kate Spaziani) 2. Workforce Communication and Engagement Plan (Isaac Kastenbaum) 3. NYP PPS Update (Lauren Alexander) 4. NYS Health Reform Overview (Jay Gormley) 5. Community Engagement Plan (Kate Spaziani) 6. Next Steps 2016 (Kate Spaziani)	

Action Items				
Description	**Owner**	**Start Date**	**Due Date**	**Status**

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Attendees	
Julia Camagong (NYSNA)	Bradley Matthys Moore (Lenox Hill Neighborhood House)
Rosita Romero (Dominican Women's Development Center)	Sandy Merlino (Visiting Nurse Service of NY)
Steven Muchnick (Upper Manhattan Mental Health Center)	Yvonne Stennett (Community League in the Heights)
Alessia Daniele (Weill Cornell Medicine)	David Alge (NYP)
Isaac Kastenbaum (NYP)	Lauren Alexander (NYP)
Kate Spaziani (NYP)	Anne Sperling (NYP)
Yaffa Ungar (Isabella)	Lucia Capitelli (NYSPI Wash Heights Comm Svc)
Robert Basile (Metropolitan Center for Mental Health)	Daniel Lowy (Argus)
Eric Carr (NYP)	Deborah Katznelson (Y of Washington Heights)
Agnes Peterson (NYP)	Julio Batista (NYP)
Marci Allen (NYP)	Jay Gormley (MJHS)
Lydia Isaac (NYC DOHMH)	Oniyebiye Hinton (Community League in the Heights)
Anthony Ciampa (NYSNA)	Yoko Tajimi (Isabella)
Doma Atmore-Dolly (Carter Burden Center for the Aging)	Ana Garcia (NYP)
David Baily (NYS Senator Espaillat)	Eva Eng (ArchCare)
Christine Duffy (St. Mary's Hospital for Children)	Jean-Marie Bradform (NYSPI)
Jenna Tine (Washington Heights CORNER Project)	

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Action Items

Description	**Owner**	**Start Date**	**Due Date**	**Status**
Members interested in joining the NYP PPS Workforce Advisory Workgroup should e-mail ppsmembership@nyp.org	PAC Members	12/16/015		In progress
E-mail feedback on community engagement plan to ppsmembership@nyp.org	PAC Members	12/16/2015	1/29/2016	In progress
Finalize community engagement plan	L. Alexander, K. Spaziani	12/16/2015	2/29/2016	In progress
E-mail reminder to PAC re: community engagement plan and NYP PPS Workforce Advisory Workgroup	L. Alexander	12/16/2015	12/31/2015	Not started
Send 2016 PAC meeting dates to members	L. Alexander	12/16/2015	12/31/2015	Not started

MINUTES:

- K. Spaziani opened the meeting and welcomed the attendees.
- L. Alexander provided an update on NYS DSRIP efforts and the NYP PPS. The following was covered:
    - NYS DSRIP Updates -
        - Dec 11 All PPS Meeting
        - DSRIP Quarterly Reporting
        - Safety Net Equity Payments
        - Capital Funds
        - Waivers
        - Primary Care Plan
        - Workforce Strategy
    - NYP PPS Updates -
        - Recruitment
        - Collaborator Engagement
        - Information Technology
        - Project Implementation
        - Next steps
- I. Kastenbaum discussed the Workforce Communication and Engagement Plan. He requested volunteers to join the NYP PPS Workforce Advisory Workgroup which will provide guidance on all aspects of the PPS's workforce-related efforts. As with other Committees, all materials of the Workforce Advisory Workgroup will be posted to the website and support from the Project Management Office (PMO) will be made available.
    - E. Carr (NYP) and A. Ciampa (NYSNA) volunteered for the workgroup.
    - Other interested individuals were asked to e-mail ppsmembership@nyp.org.
    - A follow-up e-mail will be sent after the meeting to request volunteers.
- J. Gormley presented the following presentation: "VBP, MLTCP, FIDA, DSRIP, HARP & MORE! Deciphering the alphabet soup of Healthcare Reform in NYS." The presentation provided an overview of health reform efforts in NYS, specifically focusing on healthcare spending and cost-containment strategies. The following alternative payment models were covered:
    - Medicaid Long Term Care (MLTC)
    - Fully-Integrated Dual Advantage (FIDA)
    - Delivery System Reform Incentive Program (DSRIP)
    - Value-Based Purchasing (VBP)
    - Health and Recovery Programs (HARP)
- K. Spaziani welcomed other suggestions for presentation topics as well as volunteers to present.
- K. Spaziani presented a draft of the NYP PPS Community Engagement Plan to the group for feedback. The plan covers the following:
        - Goals of community engagement
        - Role of the community stakeholder
            - S. Munich asked if faith-based organizations were included in the plan.
            - E. Carrillo suggested that MCOs be added. He also spoke to the role that the Community Physician Forum can play in the plan.
            - S. Merlino suggested that other PPSs be added.
            - There was a suggestion to speak in more detail about the specific provider groups to be engaged.
        - Identification of stakeholders
        - Methods and frequency of engagement
    - K. Spaziani noted that additional feedback on the plan can be e-mailed to ppsmembership@nyp.org. A reminder to submit feedback will be sent via e-mail.
    - She also noted that the PPS is open to organizations taking on specific pieces of the plan if they are interested.
    - The plan must be submitted to NYS DOHMH in March 2016.
- K. Spaziani covered some housekeeping items and next steps for 2016.
    - She noted that a list of 2016 meetings will go out soon. If an organization is interested in hosting, please let us know.
    - She also announced that in 2016 she will be transitioning her role as Chair of the Project Advisory Committee to Anne Sperling, who is NYP's Vice President for City & State Government and Community

Relations. She will still be available to attend PAC meetings and answer questions during the transition period.
    - D. Alge thanked K. Spaziani for her leadership of the group.
- K. Spaziani closed the meeting.

AMAZING THINGS ARE HAPPENING HERE

NYP PPS Update

Project Advisory Committee Meeting
December 16, 2015

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NYS DSRIP Update

Domain	Update
All PPS Meeting (Dec 11)	• Meeting of PPSs across New York State in Albany, NY • General DSRIP updates • Focus on Advanced Primary Care Model, Primary Care Plan and Workforce Strategy
DSRIP Quarterly Reports (Q2, Q3)	• **Q2:** Reports submitted 10/30; remediation submitted 12/15 • **Q3:** Report due 1/30; several milestones and work plan requirements due
Safety Net Equity Payment	• Funds now contingent upon new set of criteria set forth through two systems: Equity Infrastructure Payment and Equity Performance Payment • Funds distributed through Managed Care Organizations once contracts are in place

NYS DSRIP Update

Domain	Update
CRFP	• Award letters are in the Governor's Office
Waivers	• To Be Delivered December 15th to PPS
Primary Care Plan	• New deliverable, suggested by NYS PAOP • Must outline how primary care will be integrated into the IDS, how funds flow will support this integration and strategies for integrating primary care and behavioral health
Workforce Strategy	• Revised deadlines related to workforce deliverables • Workforce spending commitments now cumulative, not annual

NYP PPS Update

Domain	Update
Recruitment	• 54 of 97 FTEs recruited, to start by January 1st • Pediatric Ambulatory ICU fully staffed as of January 2016 • Final Project Manager was hired for ED Care Triage
Collaborator Engagement	• Continued monthly meetings of the Executive, Clinical Ops, Finance, and IT / Data Governance Committees • Continued development of sub-contracts for placement of CHWs and Peers at collaborator organizations • PPS Participation Agreements being executed • First biannual Collaborator Symposium scheduled for January 2016 • Continued project-level Steering Committees and one-on-one meetings between projects and collaborators

NYP PPS Update

Domain	Update
Information Technology	• Beginning to conduct IT Readiness Assessments with collaborators in anticipation of Healthix rollout
Project Implementation	• Adult Ambulatory ICU piloting integrated visits for adults with complex care needs • Pediatric Ambulatory ICU piloting care management assessment tool • Transitions of Care developing process for warm hand offs between inpatient and outpatient settings • Behavioral Health Primary Integration project participating in MAX series focused on improving outcomes for patients with behavioral health diagnoses

Next Steps

- Implementation of Cultural Competency/Health Literacy Strategy
- Developing strategies for milestone additions and revisions
- Governance Committee rotations in March 2016
- Focus on upcoming Organizational Milestones
  - Community Engagement and Public Sector Plans
  - Workforce/Training Deliverables
  - IT Current State Assessment
  - Provider Engagement
  - Financial Health Assessment
- Implementation of project status monitoring tools

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Community Engagement Plan

Goals of Community Engagement:
The NYP PPS plans to engage a variety of community stakeholders through multiple outlets with the following goals: (1) obtaining community input on local needs in order to inform the activities of our PPS; (2) keeping the community apprised about DSRIP and the happenings of the NYP PPS; (3) increasing community skills and knowledge to support DSRIP goals; and (4) providing opportunities to share best practices.

Role of the Community Stakeholder:
Community groups will play an *advisory role* and can provide us with important feedback on programming taking place within our PPS and with information about community needs. Community stakeholders will also play a *convener* role, bringing together relevant community members to address issues faced by our PPS and helping us further strengthen our network. In addition, they will serve as *disseminators of information* to their networks about the work of our PPS. In return, they will share important resources and best practices from their organizations back with the NYP PPS and the members of our network. There are varying ways in which community stakeholders can be involved in shaping the decisions and priorities of the PPS. One important area is providing feedback on the types of collaborators and scope of services represented in our network. Community groups can play a vital role in helping us shape the scope of services we make available through our collaborator network. Our goal is to engage the stakeholder in a meaningful way, no matter the type of engagement, and to build a solid network of community members and organizations characterized by mutual trust, strong collaboration and open communication.

Identification of Stakeholders:
The NYP PPS has already engaged or plans to engage a robust group of stakeholders across the following categories:

- Community-based organizations – Community-based organizations are represented in our network, on our Governance Committees and on our Project Advisory Committee. Organizations range from food service organizations to homeless providers to mental health organizations, and are instrumental in ensuring that we are addressing the social determinants of health of our attributed population.
- Other health care providers – Community health centers, independent physicians, behavioral health and other health care providers are represented in our network, on our Governance Committees and on our Project Advisory Committee. These groups play an important role in identifying patient needs, especially those related to primary care.
- Pharmacies – We have pharmacies in our network and on our Governance Committees. These groups play a key role in ensuring issues such as medication access are being addressed by the network.
- Labor unions – We have labor unions represented in our network and on our Project Advisory Committee. These groups play an important role in identifying workforce needs, especially as it relates to training.
- Government agencies – We have government agencies represented in our network, on our Governance Committees and on our Project Advisory Committee. These agencies provide our network with information about relevant city and state policies and available resources.

- Community boards – We have community boards represented on our Project Advisory Committee. These groups are instrumental in ensuring the PPS is aware of the local community's needs.
- Faith-based and religious organizations – We have faith-based and religious organizations represented on our Project Advisory Committee. These organizations, as leaders in their communities, are key in voicing the needs of the patients and neighborhoods we serve.
- Food service organizations – We have food service organizations represented in our network, on our Governance Committees and on our Project Advisory Committee. These organizations play a vital role in ensuring patient and community food security issues are addressed by the network.
- Homeless service providers – We have homeless service providers represented in our network and on our Project Advisory Committee. These organizations ensure that the unique needs of the homeless population receive adequate attention.
- Supportive housing providers – We have organizations that provide supportive housing represented in our network, on our Governance Committees and on our Project Advisory Committee. These organizations are key to ensuring issues around housing are addressed by the network, especially as it relates to health.
- Youth-serving programs – We have youth-serving programs represented in network and on our Project Advisory Committee. These organizations serve an important role in identifying the unique health needs of youth and communicating important health information to them.
- Elderly-serving programs – We have elderly-serving programs represented in our network, on our Governance Committees and on our Project Advisory Committee. These groups ensure that issues affecting seniors and the geriatric population are addressed.
- Community members – Community members are engaged and offered information through the Community Forums, presentations, trainings and website listed in the table below.

Methods of Engagement:
The stakeholders outlined above will be engaged using the following methods:

Type of Engagement	Description	Method	Frequency
Project Advisory Committee (PAC)	The NYP PPS PAC serves as a forum for education, dialogue and community feedback on DSRIP projects, updates from NYS DOH regarding DSRIP, and on the evolving needs of the community.	In-person/conference call	Quarterly
Webinars	The PPS is developing a series of webinars on a range of educational topics that will be open to our community partners in the PPS network and on the PAC. Planned	Web-based	Bimonthly

	topics include but are not limited to: • DSRIP 101 • PPS Compliance • Cultural competency/health literacy • Various clinical topics (i.e. HIV, depression, diabetes) • Project-related topics (i.e. use of Patient Navigators/Community Health Workers)		
Collaborator Symposiums	The PPS plans to host bi-annual Collaborator Symposiums which will bring together all collaborators in the NYP PPS for network updates, education, problem-solving around shared patient needs, sharing of best practices and exploration of continued collaboration that enhances the patient experience.	In-person	Bi-annual
Newsletter	The PPS distributes a monthly newsletter which provides information to the network, PAC and interested members of the community on the happenings of the NYP PPS. The newsletter includes project updates, NYS DOH updates, NYP PPS updates, staff spotlights and collaborator spotlights.	Written	Monthly
Community Forums	The PPS will build on existing community forums to conduct direct outreach to the community around the self-management of conditions in a manner that addresses cultural, linguistic and literacy factors.	In-person	Ad hoc
Presentations	The PPS makes presentations on DSRIP or project-related activities to local organizations and community groups upon request.	In-person	Ad hoc
Web site	The website serves as a forum for collaborators, community members and the public to obtain information on the NYP PPS and is being built out to include the following: • Project descriptions and information • Governance Committee	Web-based	Ongoing

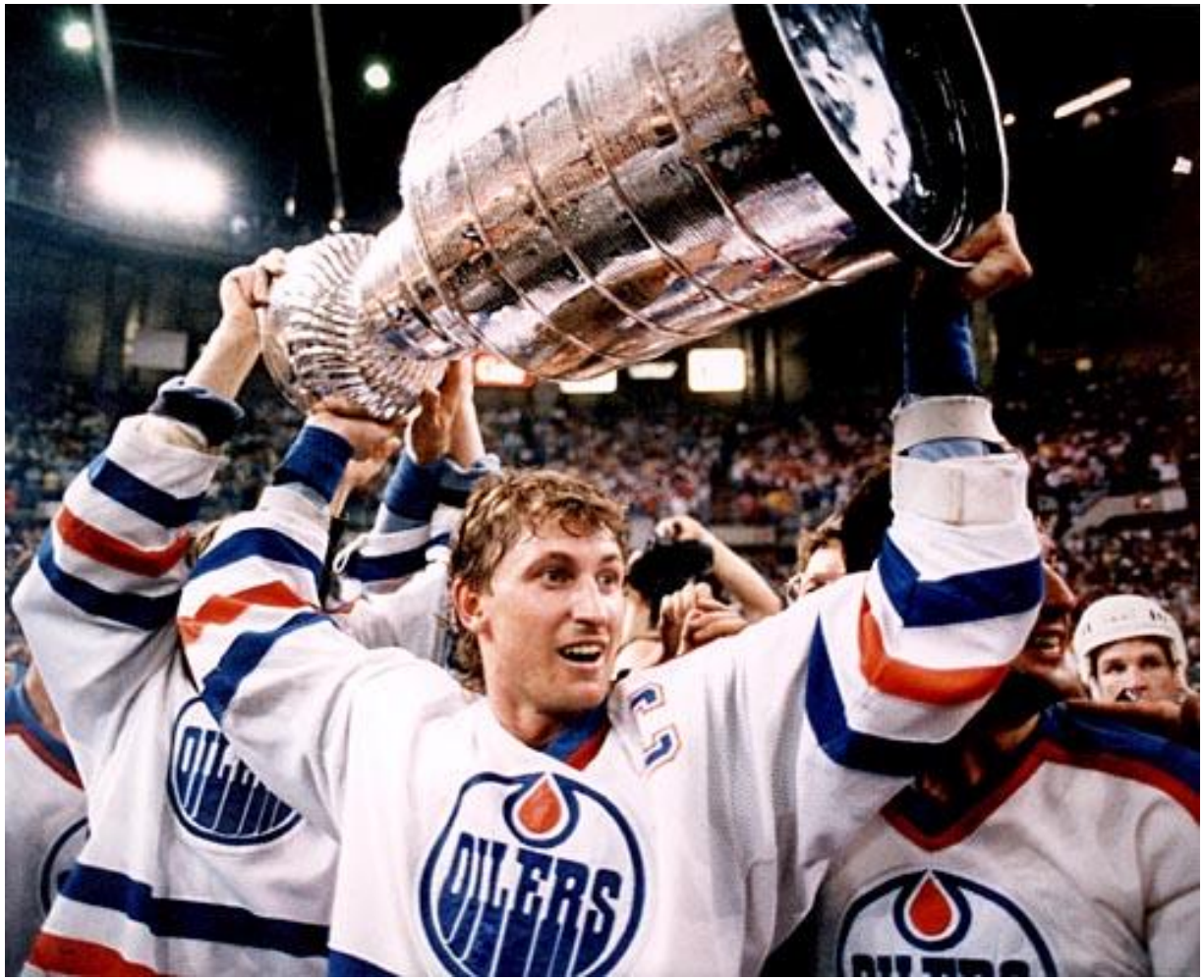
	information and meeting materials • Official NYP PPS and NYS DOH documents and information • Staff spotlights • Collaborator spotlights • Trainings and other resources (i.e. cultural competency, health literacy, compliance) • A collaborator listing • FAQs • A community page highlighting community events and happenings related to the NYP PPS		
Trainings/Workshops	The PPS either delivers or shares information about trainings and workshops planned in the community that may be of benefit to the network.	In-person	Ad hoc
Ad Hoc Meetings	The PPS project teams, Project Management Office and leadership schedules meetings as necessary with local organizations and community members to share information about DSRIP and discuss opportunities for collaboration.	In-person	Ad hoc

VBP, MLTCP, FIDA, DSRIP,HARP & MORE! Deciphering the alphabet soup of Healthcare Reform in NYS

Jay Gormley
Chief Strategy & Planning Officer

MJHS Today

- An integrated not-for-profit health system
- Comprised of 15 corporations in 4 business:
  - Home & Community Based Services
  - Hospice & Palliative Care
  - Facility Based Care
  - Health Plans (Elderplan)
- $1.1B in annual revenues
- Serves over 45,000 New Yorkers each year
- Serves all 5 boroughs of New York City, Westchester, Nassau & Suffolk counties
- Certified in 42 upstate counties for Health Plans
- Main corporate office in Brooklyn with satellite locations in:
  - Manhattan,
  - Rochester, NY &
  - Nassau County


OILERS

“Skate to where the puck is going, not to where it is.”

-Wayne Gretzky

(allegedly)


041

“Skate to where the puck is going, not to where its been”

-Walter Gretzky

“Skate to where the puck is going, not to where its been.”

-Walter Gretzky

“You’d have to be a real idiot to skate where the puck used to be”

-Herb Brooks

A Predictive Point of View

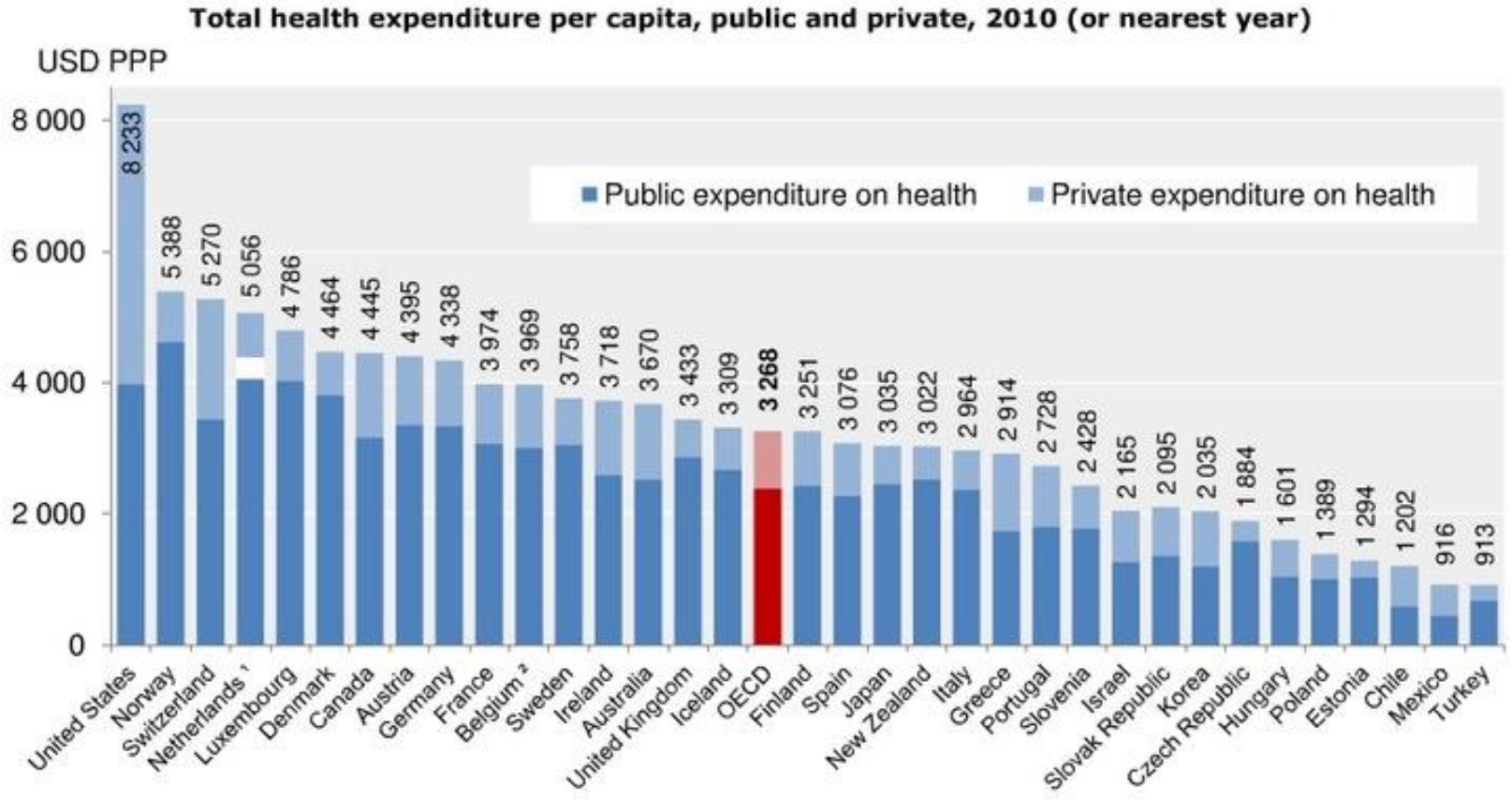
1. Provider revenues will be under severe pressure as payment mechanisms migrate toward value-based approaches
2. Inpatient and outpatient use rates will decline
3. Providers will consolidate at an accelerated pace - horizontally and vertically
4. The competitive landscape will be reshaped
5. Technology will become a major disruptive change agent in health care

The Word of the Moment (or 2009) in Health Care is "Unsustainable"

- The size of the federal budget deficit is unsustainable
- The annual increase in the Medicare budget is unsustainable
- The percentage of health care spending to GDP is unsustainable
- State Medicaid programs are unsustainable
- The continued transfer of costs to employers and consumers is unsustainable

Health Care Spending per Capita, 2011

Adjusted for Differences in Cost of Living



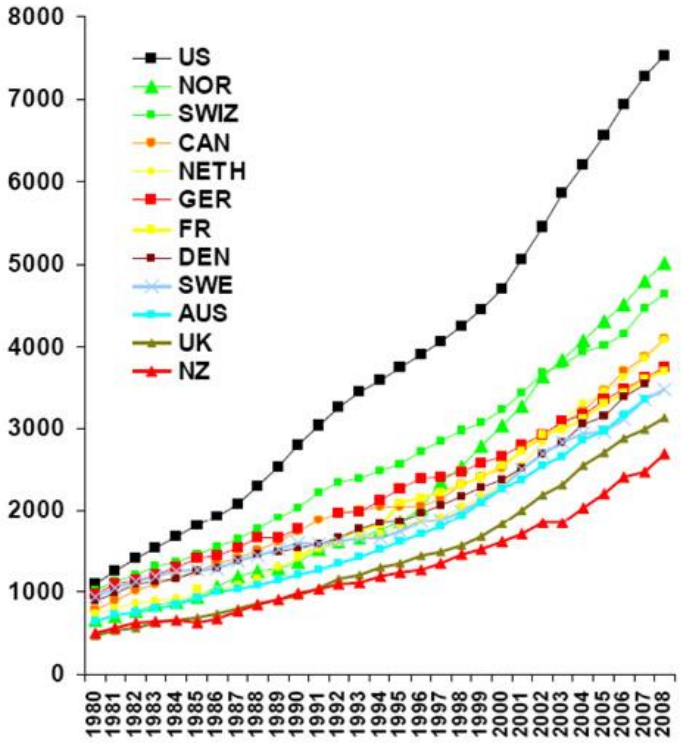
1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.
2. Total expenditure excluding investments.

Information on data for Israel: http://dx.doi.org/10.1787/888932315602.

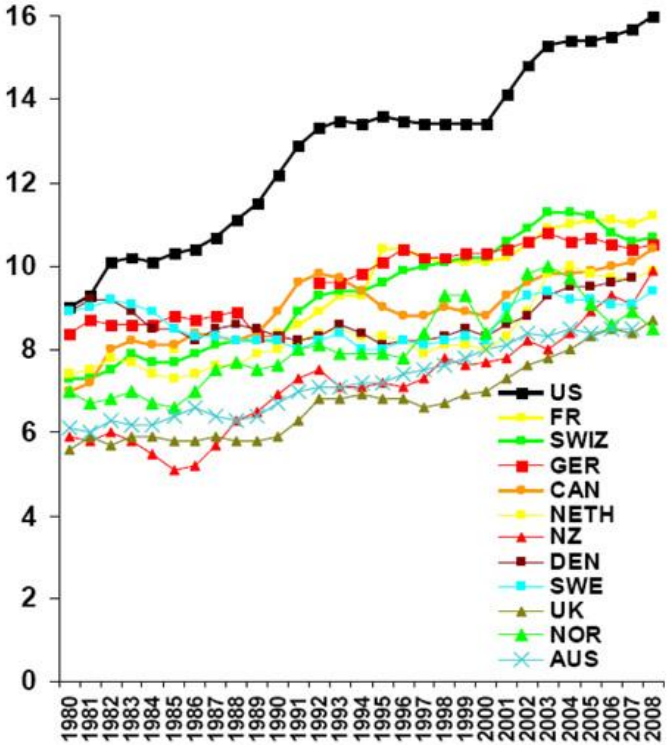
Source: OECD Health Data 2012.

International Comparison of Spending on Health, 1980-2008

Average spending on health per capita ($US PPP)



Total expenditures on health as percent of GDP



Source: OECD Health Data 2010 (Oct. 2010)

Three Microsystems Suggest Themselves Immediately

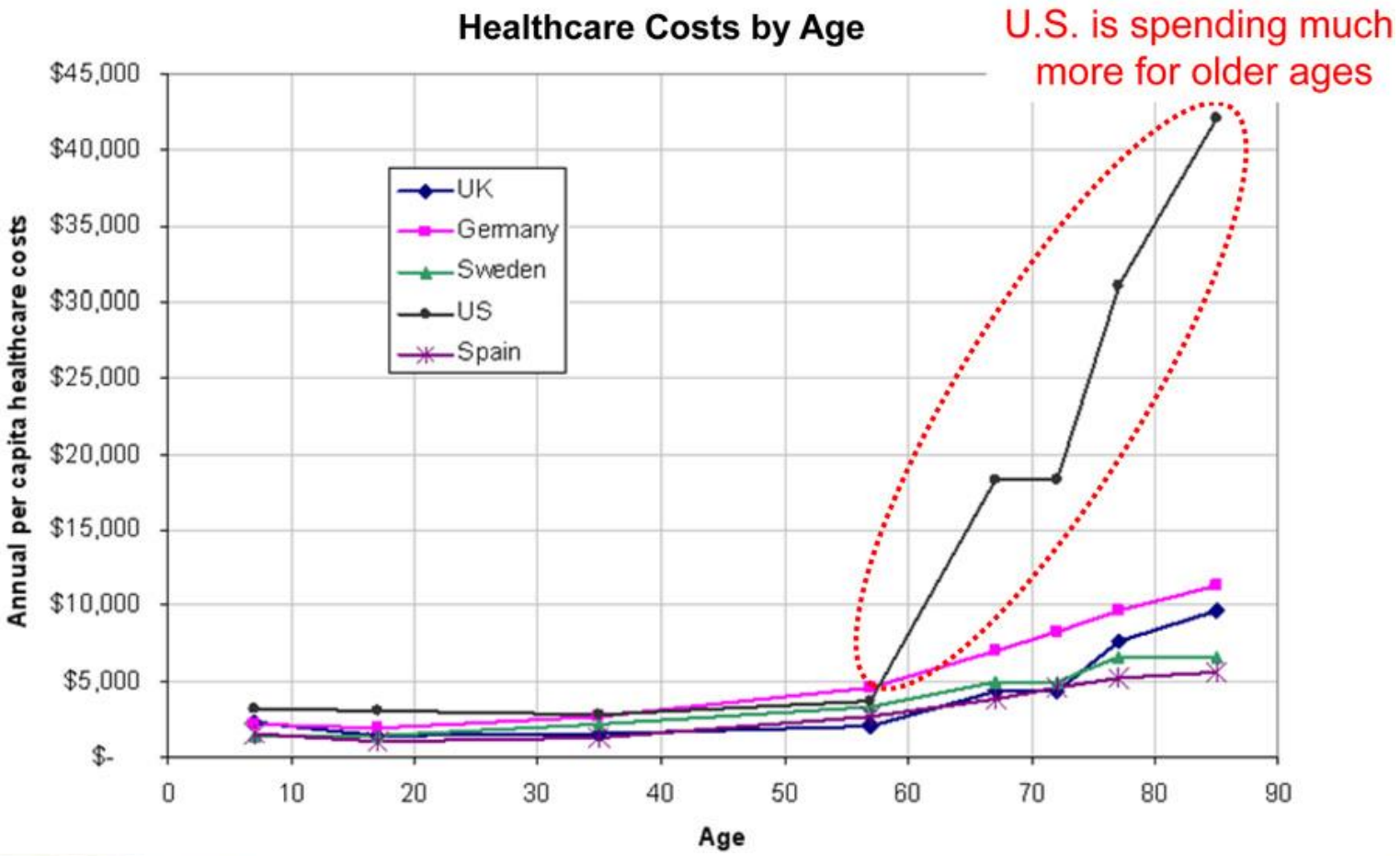
1. The general patient population
2. The general Medicare population
3. The Medicare population with multiple chronic conditions

Medicare Spending for Medicare Fee for Service Beneficiaries by Age and Number of Chronic Conditions—2008

Number of	Total Population		Less than 65 years		65 to 74 years		75 to 84 years		85+ years	
	Per capita	Median	Per capita	Median	Per capita	Median	Per capita	Median	Per capita	Median
0 to 1	$2,017	$423	$2,620	$401	$1,589	$364	$2,006	$534	$2,568	$536
2 to 3	5,592	1,921	8,391	2,545	4,683	1,679	5,215	1,976	6,409	2,179
4	10,001	3,941	14,348	5,328	8,940	3,495	9,249	3,818	10,764	4,663
5	15,271	7,068	21,312	9,456	14,305	6,232	14,128	6,588	15,477	8,430
6+	31,689	19,571	41,252	23,779	31,988	17,985	30,398	18,687	29,580	20,984

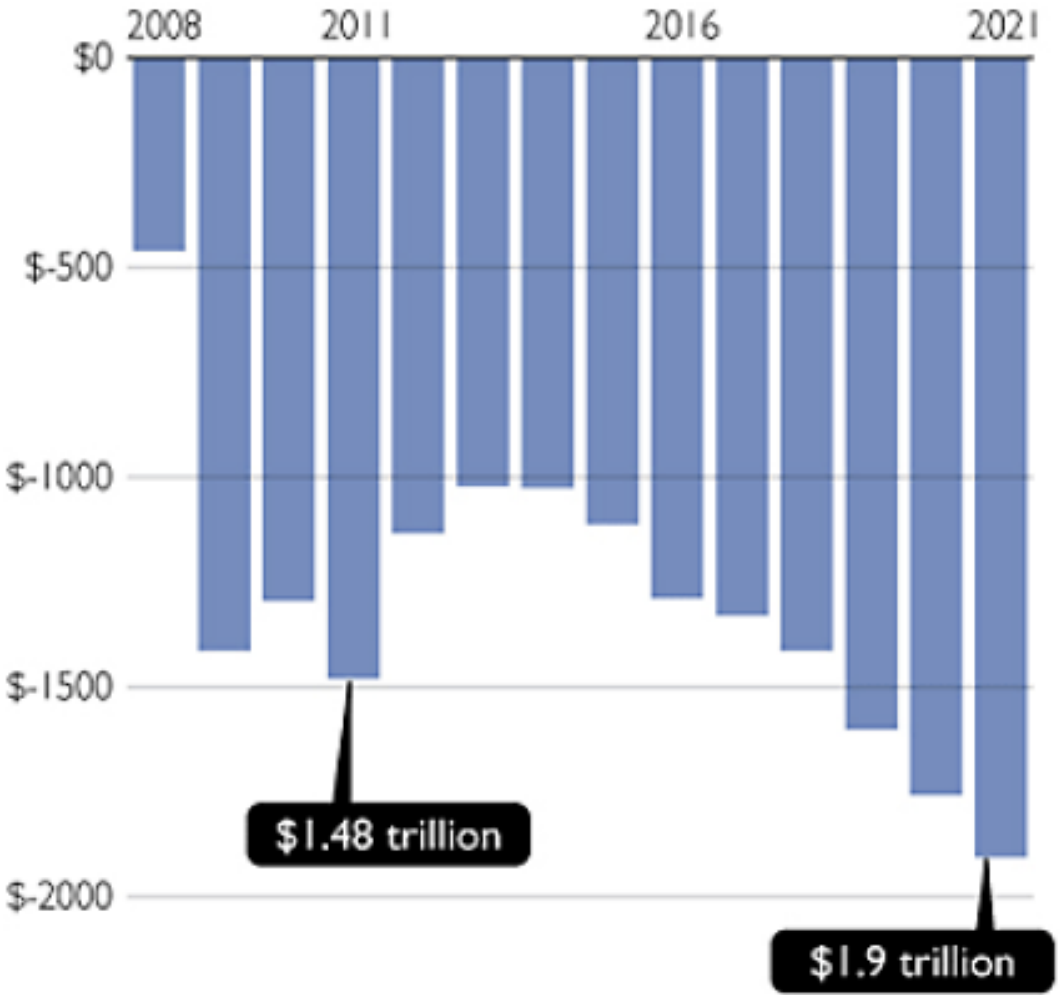
Source: Centers for Medicare & Medicaid Services:
Chronic Conditions among Medicare Beneficiaries,Chart Book. Baltimore, MD, December 2011.

Cost by Age Categories

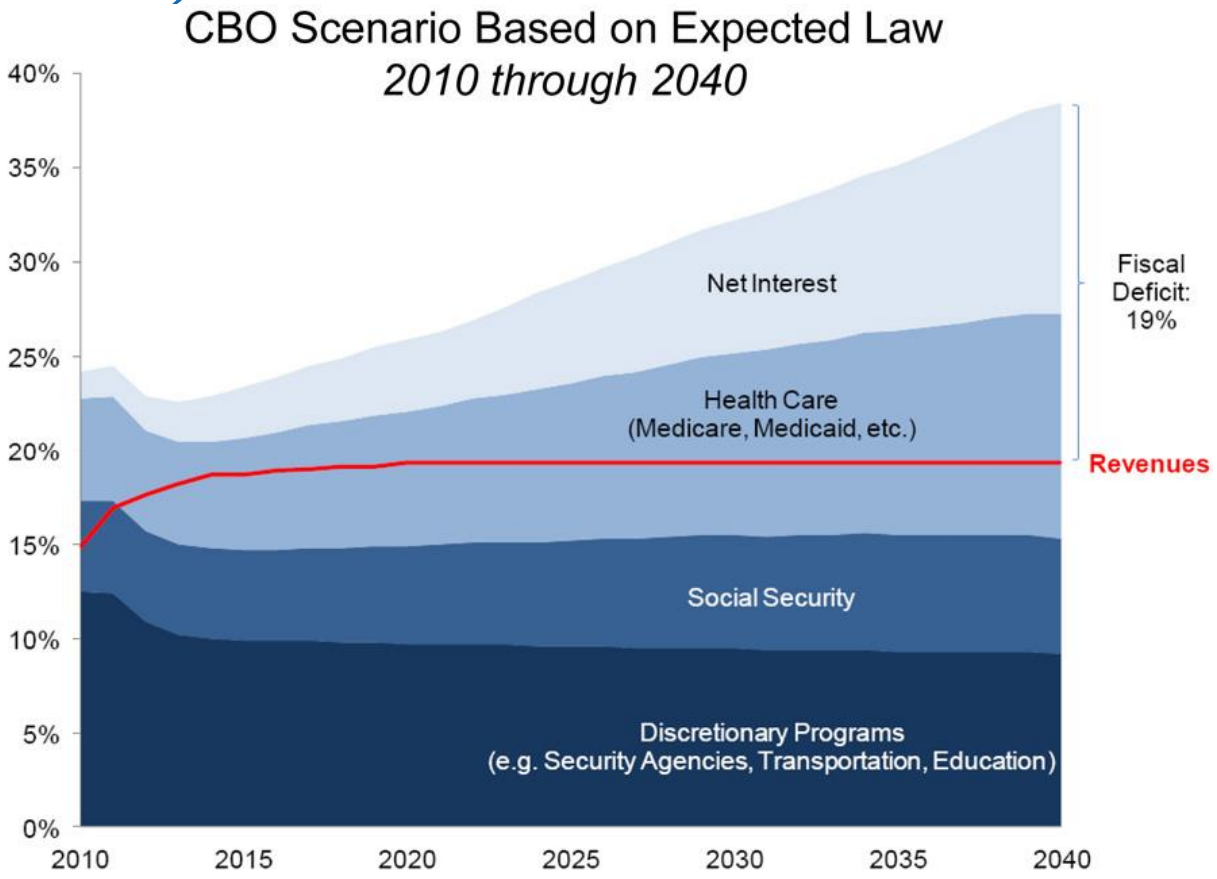


Source: Fischbeck, Paul. "US-Europe Comparisons of Health Risk for Specific Gender-Age Groups." Carnegie Mellon University; September, 2009.

Rising Federal Deficits

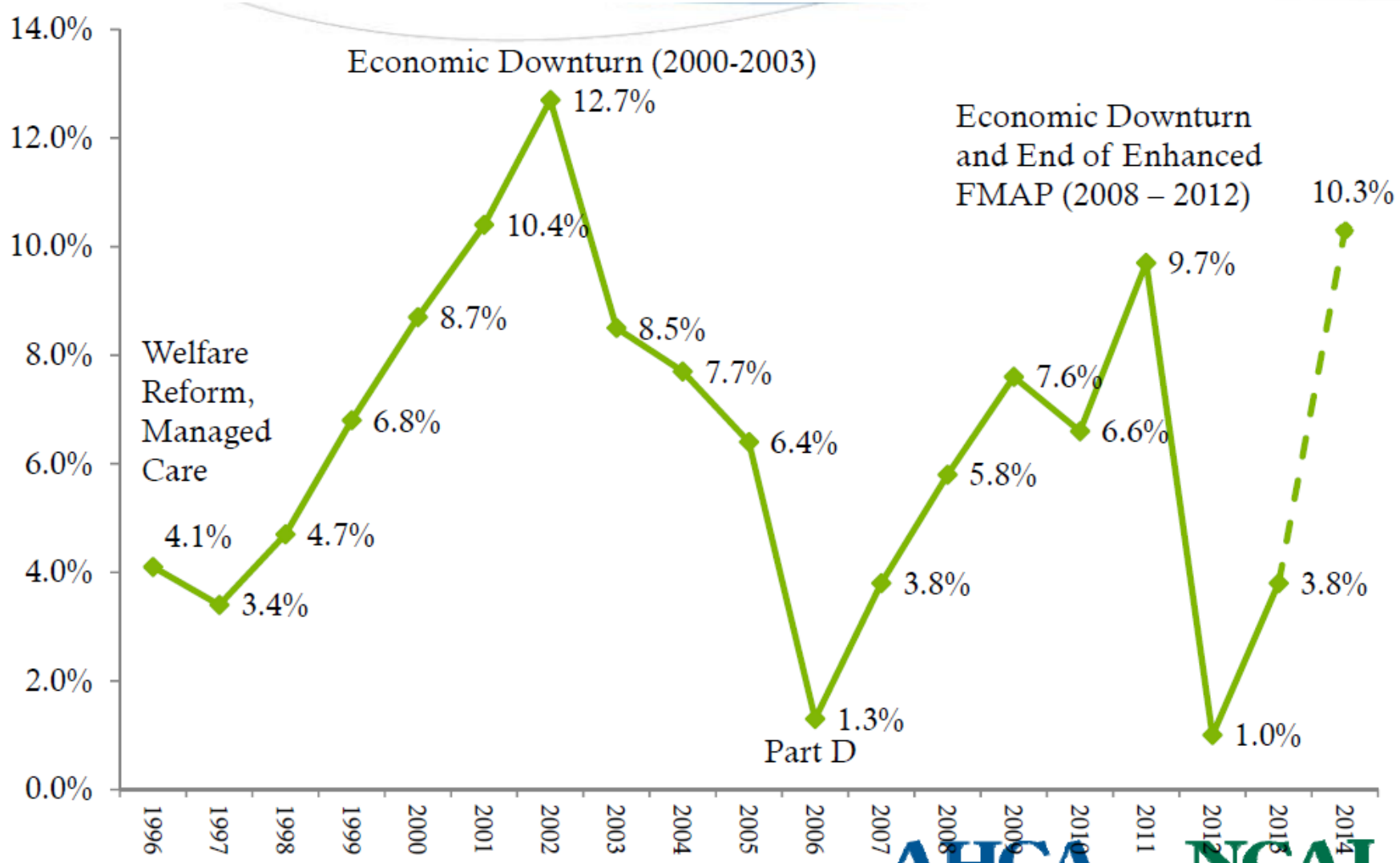


Federal Government Outlays and Revenues (% of GDP)



Source: Fischbeck, Paul. "US-Europe Comparisons of Health Risk for Specific Gender-Age Groups." Carnegie Mellon University; September, 2009.

Increases in the Medicaid Program



Source: Kaiser Family Foundation, 2013

Domains of Excess Costs

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Thematic and Contextual Changes

1. A change in the “classes” of providers
2. Dramatic change to the competitive landscape
3. The “job shop” to “manufacturing shop” challenge
4. Facing up to the variability of quality and cost

The Four Underlying Concepts of Cost Containment Through Payment Reform

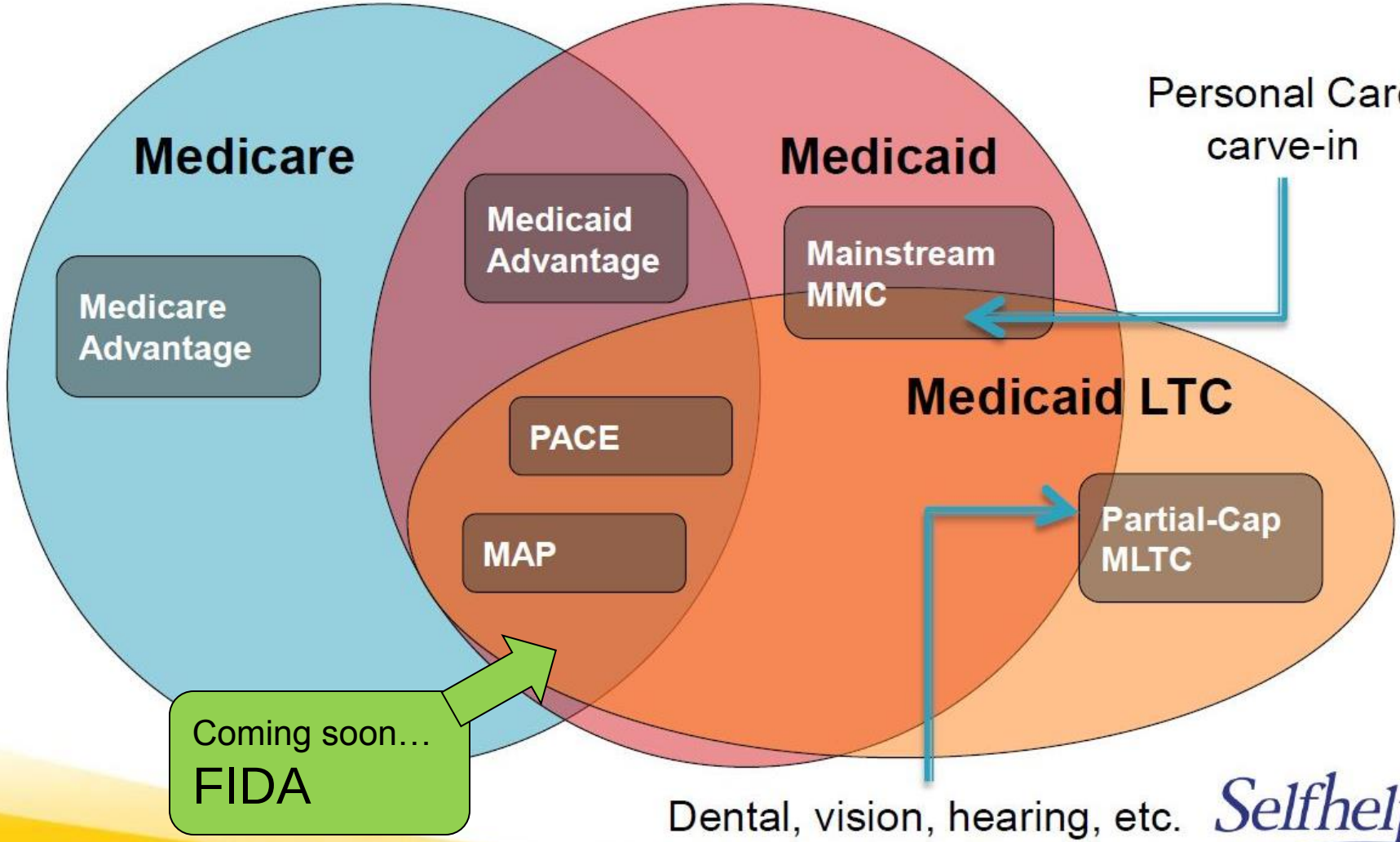
Tying payment to **evidence and outcomes** rather than per unit of service	**"Bundling" payments** for physician and hospital services by episode or condition
Reimbursement for the **coordination of care** in a medical home	**Accountability for results -** patient management across care settings

Five Emerging Trends that will influence the rise of alternative payment models

1. Redesign of the Healthcare business model
   - Move from FFS driven doctors/hospitals to “healthcare companies” managing population health and taking risk
2. Move from inpatient centric care to outpatient centric care
3. The entry of new, well funded & highly capable competitors
   - Wallgreens & CVS
   - Oscar
   - Senior Bridge
4. Healthcare as a retail good
5. Transformational changes to the Employee Insurance Market
   - Rise in high deductible health plans have made folks price conscious
   - Move from employer sponsored exchanges to private exchanges

Source: Kaufman, Hall & Assocates, HANYS Annual Meeting June 19, 2014

Map of Managed Care

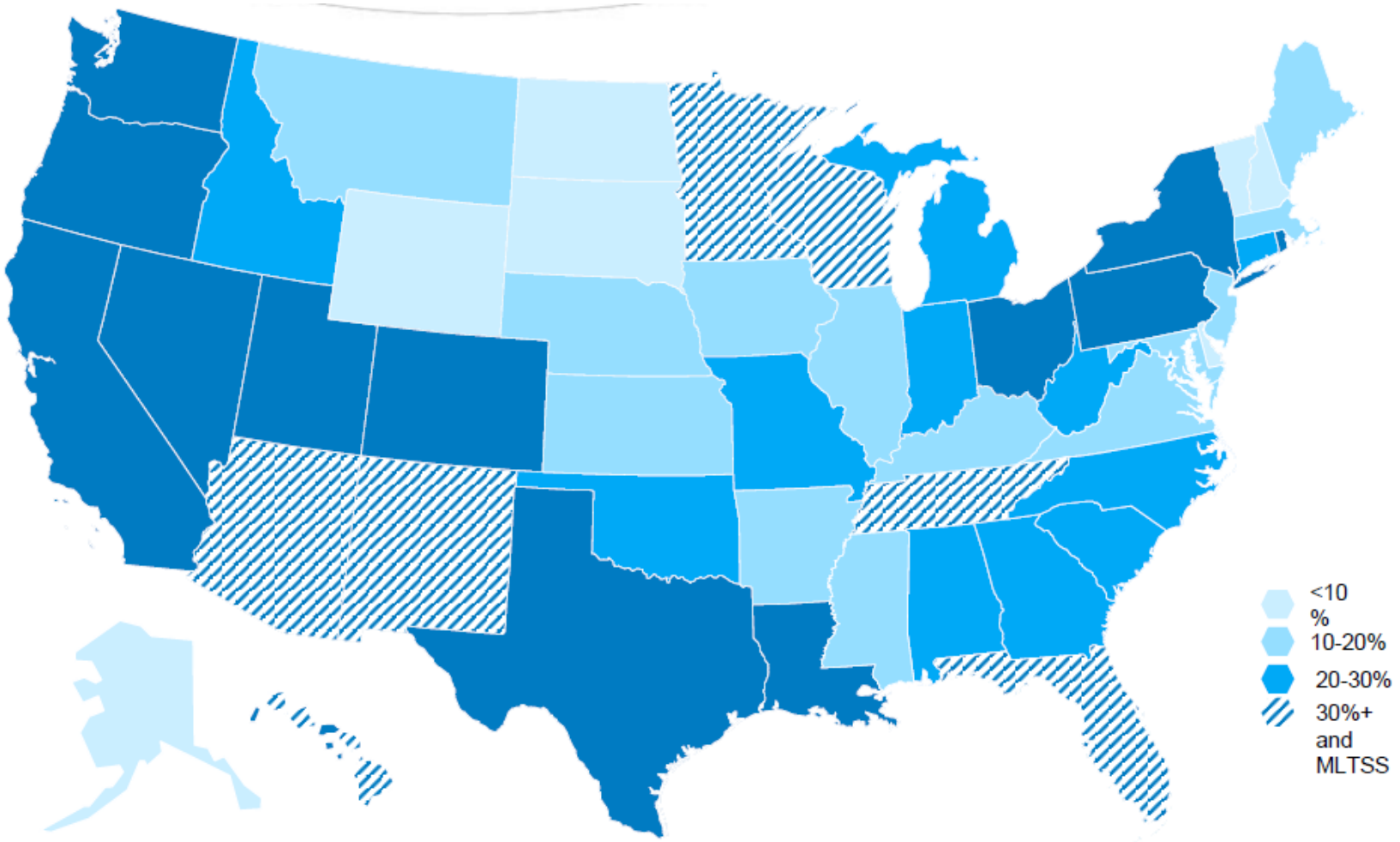


Selfhelp

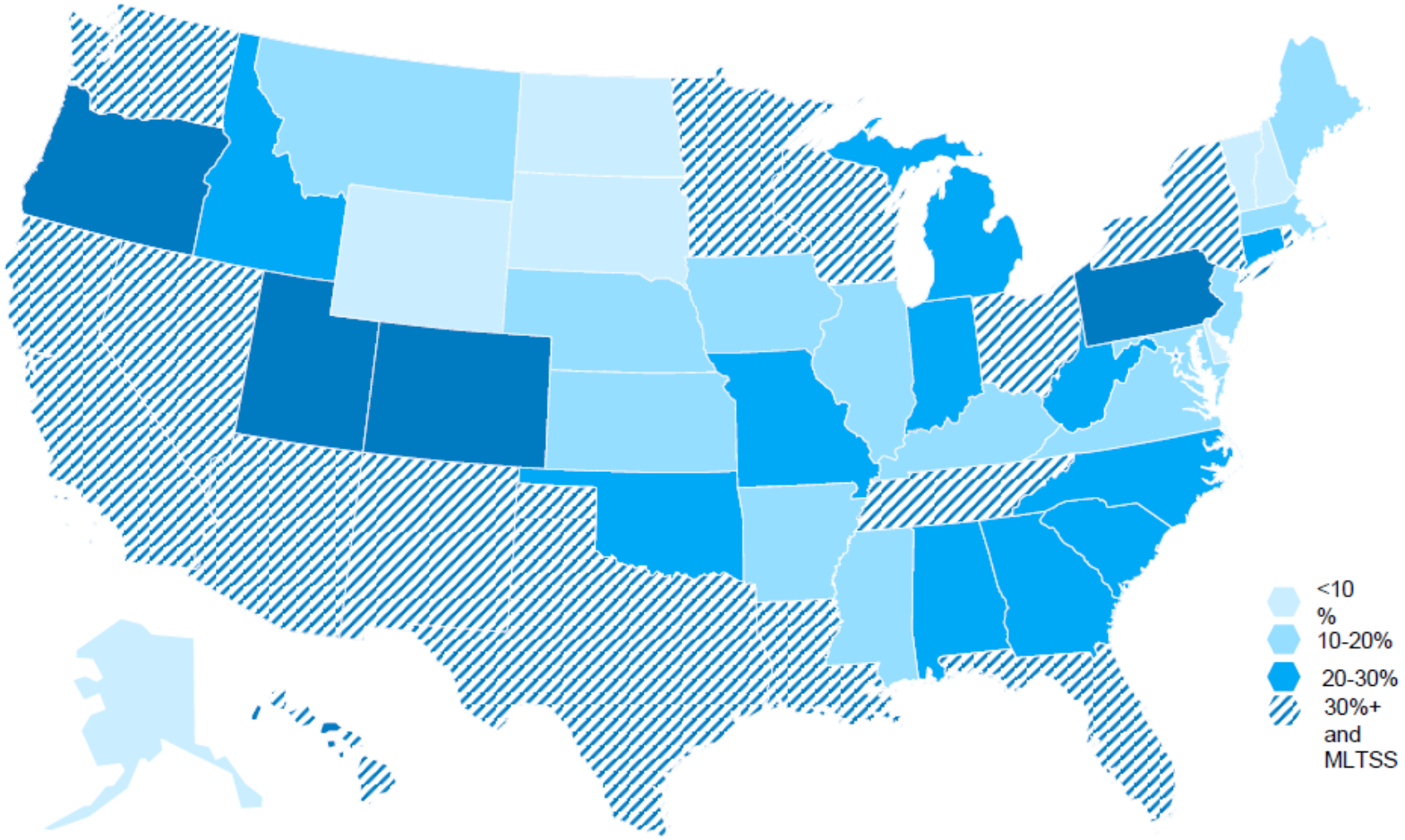
Medicaid Undergoing Changes Nationwide

- Budgetary Concerns at the state and federal level
- Aging population and the role of Medicaid in paying for long term services
- State desire for more flexibility in design and administration
- Push for coordinated care, improved outcomes, alignment across providers and person centric care
- States becoming more savvy purchasers
- Federal opportunities to test and implement new payment and delivery models
- Potential integration with the insurance exchange marketplace

Medicaid Managed Care Penetration 2014



Medicaid Managed Care Penetration 2019



Common Themes across states

State initiatives to-date share four common themes:

1. The transfer of budgetary risk away from the state through prospective payment and third party agents, particularly managed care payers;
2. The transformation of Medicaid into a "value based" payer;
3. The reduction or linkage of supplemental payments to "value," and
4. Achievement of program cost savings.

All have significant implications for nursing facilities, with the potential for severe unintended consequences as well as opportunities for enhancing care for beneficiaries.

Three Basic Models for Managed Medicaid LTC

	MODEL 1: Medicaid LTC Only	MODEL 2: Medicaid-Only	MODEL 3: Medicaid-Medicare Integration
Medicaid Services for Which Managed Care Contractor is at Risk	Home and Community Based Services (HCBS) Nursing Home Care	HCBS Nursing Home Care Medicaid-Covered Primary Care Services Medicaid-Covered Acute Care Services Medicaid-Covered Pharmacy	HCBS Nursing Home Care Medicaid-Covered Primary Care Services Medicaid-Covered Acute Care Services Medicaid-Covered Pharmacy
Medicare Services for Which Managed Care Contractor is at Risk	None	None	Medicare Acute Care benefits Medicare Prescription Drug Benefit

Dual eligibles may also be enrolled in Medicare managed care and receive Medicaid LTC services in either FFS Medicaid, or in MMLTC Models 1 or 2

The New York State Picture: Care Management for All

- Managed Long Term Care expansion
  - Mandatory enrollment downstate
  - Voluntary enrollment upstate until sufficient capacity to move to mandatory
- Mainstream Medicaid Managed Care expansion
  - Make it statewide
  - Expand the benefit package (pharmacy, personal care, SNF)
  - Expand the populations served (AIDS, homeless, SNF residents)
- Medical Homes, Health Homes
- CMS Dual Integration Demo
  - Managed FFS model 2013
  - Capitated model 2014

Why? Data Driven

Per Recipient Spending Trends by LTC Service						
	2003		2010		% change in recipients	% change in $ per recipient
	# recipients	$ per recipient	# recipients	$ per recipient		
Nursing Homes	139,080	$42,759	126,878	$50,673	-8.8%	18.5%
ADHC	16,365	16,269	17,303	18,394	5.7%	13.1%
LTHHCP	26,804	19,036	26,934	26,608	0.49%	39.8%
Personal Care	84,823	21,512	72,031	29,882	-15.0%	38.9%
Managed LTC	12,293	36,146	37,843	37,031	207.8%	2.4%
Assisted Living	3,538	14,270	5,217	17,845	47.5%	25.1%
Home Care	92,553	8,215	87,366	17,759	-5.6%	116.2%
TOTAL	318,617	$30,769	320,590	$39,498	.62%	28.4%

Mandatory Medicaid Long Term Managed Care

- Approved in writing by CMS August 31, 2012
  - State had verbal approval to start announcing the change in July.
  - As of Sept. 17, 12,800 announcement letters will have been sent to eligible residents of Manhattan, the Bronx and Brooklyn
  - Additional 3,500 announcement letters to be sent to eligible residents of Queens and Staten Island on or about Oct. 11.
- Eligible individuals given information and helped to choose a plan to enroll in
  - First group of eligibles who fail to choose a notified they were being auto-enrolled as of Nov. 1 2012.
- RHFC Delayed till Feb 1, 2014

MLTCP Enrollment

- **Mandatory** - required to enroll in MLTC:
  - Dual eligible
  - Age 21 and over
  - Require 120+ Days of Community Based Long Term Care Services (i.e. Personal Care, Nursing, ADHC, Therapy)
  - **Require permanent placement in a nursing home for custodial care on or after 2/1/2015**
    - **NH patients prior to 2/1/2015 can stay FFS**
  - Populations and Counties based on DOH Phase-In Schedule

MLTCP Population

Medicaid long term care populations being moved into Managed Care

TRANSITION COMPLETE

- PC
- LTHHCP
- CHHA
- ADHC
- AIDS ADHC
- PDN
- CDPAP

TO BE COMPLETED

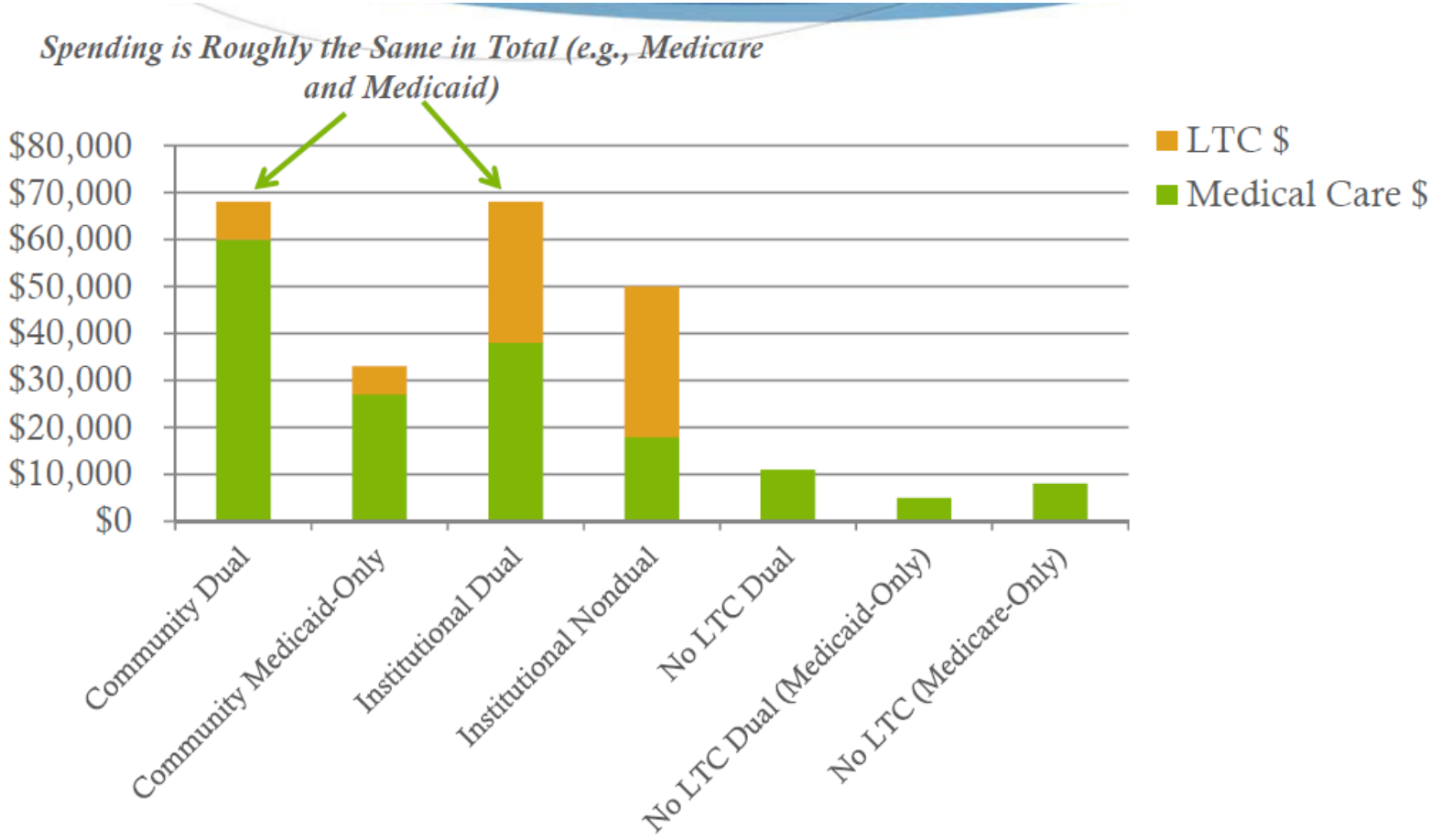
- **Nursing Home**
- NHTD
- TBI
- ALP
- Hospice
- OPWDD
- OMH
- OASAS

Other State's Experience

Level of Stakeholder Engagement	Ample opportunity for provider and beneficiary input throughout the process; input was well-received and incorporated into program design	Program implemented through Section 1115 waiver with stakeholder collaboration; MLTSS program not addressed in state legislation	Limited opportunity for meaningful stakeholder input before and during implementation process; some protections incorporated through legislative process
Pace and Scope of Implementation	Program started small in scale as a pilot and gradually expanded over time	Once enacted, program was immediately implemented statewide	Program implemented in one region and then phased in to remaining regions over the course of one year
Plan Offerings	Under State law, only non-profits are permitted to provide health insurance of any kind	For-profit corporations	Mix of non-profit and for-profit organizations
Population Served	Elderly population only; pilot with disabled population proved to be unsuccessful	Elderly and disabled populations	Elderly and disabled populations
Plan Accountability	Plans are required to return excess reserves back to the state	Limited understanding transparency of plan accountability processes	Limited understanding transparency of plan accountability processes

AHCA interviews with executives from Care Providers of Minnesota, Kansas Health Care Association, and Tennessee Health Care Association,

HCBS cost vs Facility based



Sources: Kane, R., Wysocki, A., Parashuram S., Shippee, T., Lum, T. Effective of Long-term Care Use on Medicare and Medicaid Expenditures for Dual Eligible and Non-dual Eligible Elderly Beneficiaries. Medicare & Medicaid Research Review 2013: Volume 3, Number 3.

Dual Integration Demonstration- Two National Models

- Capitated Model
  - Three way contract between States, Plans & CMS
  - Savings inure to the states for “reinvestment”
  - Must allow for Medicare FFS opt out
  - Does not preserve current reimbursement
- Managed FFS Model
  - Use “Health Homes”
  - Includes all settings
  - Preserves current reimbursement but…
    - States pursuring this model want to engage in some kind of bundle/shared savings

Dual Integration Demonstration- New York States Approach

- Create a Fully Integrated Dual Advantage (FIDA) program that builds out from MLTC.
- FIDA plans will receive both Medicare and Medicaid capitation to cover all physical health care, behavioral health care and all long term care services.
- The demonstration will involve duals in an 8-county service area: The 5 NYC counties/boroughs plus Nassau, Suffolk and Westchester counties.
- Expected to serve 123,880 duals plus 50,000 nursing home residents

FIDA Plans

Two Types of Plans:

- **Primary FIDA** – Dual eligibles, age 21 and over that require **community-based** or **institutional long term care** services for more than 120 days who are not residents of an OMH facility, and who are not receiving services from the OPWDD system.
  - *Geographic Service Area: Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk and Westchester Counties*
- **OPWDD FIDA (DISCO)** – Dual eligibles, age 21 and over, who are not residents of an OMH facility, and who are receiving services from the OPWDD system
  - *Geographic Service Area: Statewide*

- ***What About HARPs (Health and Recovery Plans)?***

FIDA Eligibility

Must be:

- Age 21 years of age or older;
- Entitled to benefits under Medicare Part A and enrolled under Part B and D and receiving full Medicaid benefits;
- Living in a demonstration county:

Region 1: Bronx, Kings, New York, Queens, Richmond, and Nassau.

Region II: Suffolk and Westchester.

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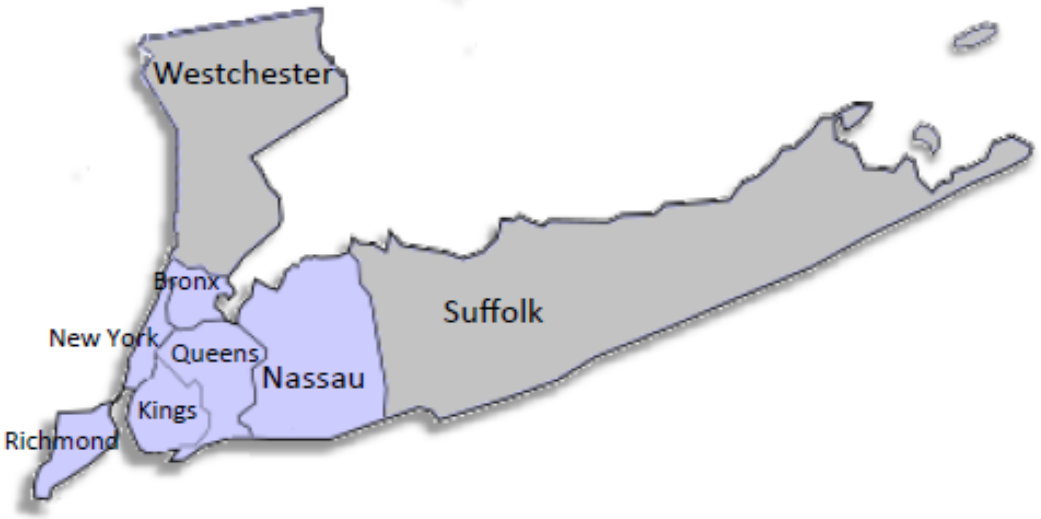


And meet one of the following three criteria:

- Are Nursing Facility Clinically Eligible and receiving facility-based LTSS,
- Are eligible for the Nursing Home Transition Diversion Waiver program, or
- Require community-based LTSS for more than 120 days.

FIDA

- FIDA Demo period January 2015 to December 2017
- All plans will be MLTC's that modify offerings to include Medicare services.
- Enrollment can be "Voluntary (Opt-in)" or "Passive"
- All enrollments will be through the Enrollment Broker, New York Medicaid Choice (Maximus).
- No change in service level for first 90 days
- Dual eligible residents in nursing homes are eligible for the demonstration
- Conversion-in-place (from MLTC to FIDA product of same Plan)
- Beneficiaries can "opt out" of the demonstration **at any time**
  - **New Duals** will be enrolled in FIDA
  - If opt out, must join an MLTCP and FFS Medicare plan (FFS Medicaid not an option)

DSRIP

- What's it stand for?
  - The Medicaid Redesign Team Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Plan
- What is it?
  - It's NYS's attempt to reinvest a portion ($6.4 billion over five years– Now $7.2B) of the federal savings already produced by MRT initiatives to change the health care system.
- What is the goal?
  - The DSRIP Plan is primarily focused on reducing avoidable hospital use by 25% in five years with an additional focus on stabilizing health care safety net providers
- How do you participate?
  - By joining a PPS
- Other affiliated Program
  - CRFP (Capital Restructuring Financing Program)

How does DSRIP fit in to VBP?

MJHS

Five Years in the Future

How The Pieces Fit Together: MCO, PPS & HH

MCO*

ROLE:
- *Insurance Risk Management*
- *Payment Reform*
- *Hold PPS/Other Providers Accountable*
- *Data Analysis*
- *Member Communication*
- *Out of PPS Network Payments*
- *Manage Pharmacy Benefit*
- *Enrollment Assistance*
- *Utilization Management for Non-PPS Providers*
- *DISCO and Possibly FIDA/MLTCP Maintains Care Coordination*

Other Providers

PPSs

ROLE:
- *Be Held Accountable for Patient Outcomes and Overall Health Care Cost*
- *Accept/Distribute Payments*
- *Share Data*
- *Provider Performance Data to Plans/State*
- *Explore Ways to Improve Public Health*
- *Capable to Accept Bundled and Risk-Based Payments*

HH #1 | HH #2 | Other PPS Providers

ROLE:
- *Care Management for Health Home Eligibles*
- *Participation in Alternative Payment Systems*

*Mainstream, MLTC, FIDA, HARP & DISCO

Eleven Payment Reform Models

HIGH

INCREASING RISK

1. Global Payment
2. ACO Shared Savings Program
3. Medical Home
4. Bundled Payment

ALTERNATIVE

Payments made to a group of providers and/or provider organizations to provide high-quality and efficient care to a defined population over time

5. Hospital-Physician Gainsharing
6. Payment for Coordination
7. Hospital P4P
8. Payment Adjustment for Readmissions
9. Payment Adjustment for Hospital Acquired Conditions
10. Physician P4P
11. Payment for Shared Decision Making

Payment used to achieve narrowly defined performance goals, and made to individual providers, rather than groups

LOW

http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR841.pdf

Eleven Payment Reform Models

- **Global Payment**
  - A single per-member per-month payment is made for all services delivered to a patient, with payment adjustments based on measured performance and patient risk.
- **ACO Shared Savings Program**
  - Groups of providers (known as accountable care organizations [ACOs]) that voluntarily assume responsibility for the care of a population of patients share payer savings if they meet quality and cost performance benchmarks.
- **Medical Home**
  - A physician practice or other provider is eligible to receive additional payments if medical home criteria are met. Payment may include calculations based on quality and cost performance using a P4P-like mechanism.
- **Bundled Payment**
  - A single “bundled” payment, which may include multiple providers in multiple care settings, is made for services delivered during an episode of care related to a medical condition or procedure.
- **Hospital-Physician Gainsharing**
  - Hospitals are permitted to provide payments to physicians that represent a share of savings resulting from collaborative efforts between the hospital and physicians to improve quality and efficiency.

http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR841.pdf

Eleven Payment Reform Models

- **Payment for Coordination**
  - Payments are made to providers furnishing care coordination services that integrate care between providers
- **Hospital P4P**
  - Hospitals receive differential payments for meeting or missing performance benchmarks.
- **Payment Adjustment for Readmissions**
  - Payments to hospitals are adjusted based on the rate of potentially avoidable readmissions.
- **Payment Adjustment for Hospital Acquired Conditions**
  - Hospitals with high rates of hospital-acquired conditions are subject to a payment penalty, or treatment of hospital-acquired conditions or serious reportable events is not reimbursed.
- **Physician P4P**
  - Physicians receive differential payments for meeting or missing performance benchmarks
- **Payment for Shared Decision Making**
  - Payment is made for the provision of shared decision making services.

http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR841.pdf

Medicare's Model for VBP

Payment Taxonomy Framework				
	Category 1: *Fee for Service—No Link to Quality*	**Category 2:** *Fee for Service—Link to Quality*	**Category 3:** *Alternative Payment Models Built on Fee-for-Service Architecture*	**Category 4:** *Population-Based Payment*
Description	*Payments are based on volume of services and not linked to quality or efficiency*	*At least a portion of payments vary based on the quality or efficiency of health care delivery*	*Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk*	*Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)*
Medicare FFS	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3-5

Value Based

Alternative

Source:https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

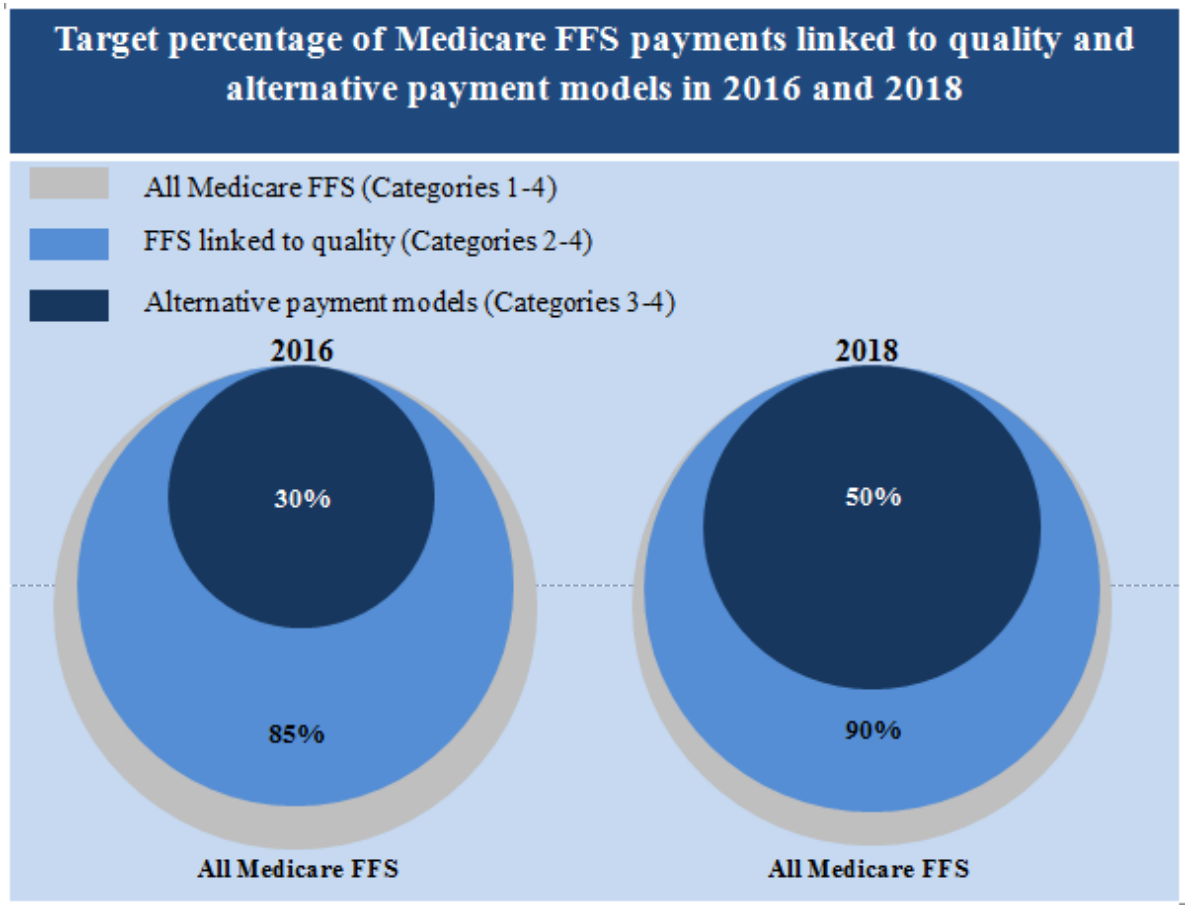
Medicare's Model for VBP CMS Timeline

January 2015

HHS Secretary Sylvia Burwell announces aggressive three year payment reform timeline for Medicare

Encourages others to follow suit:

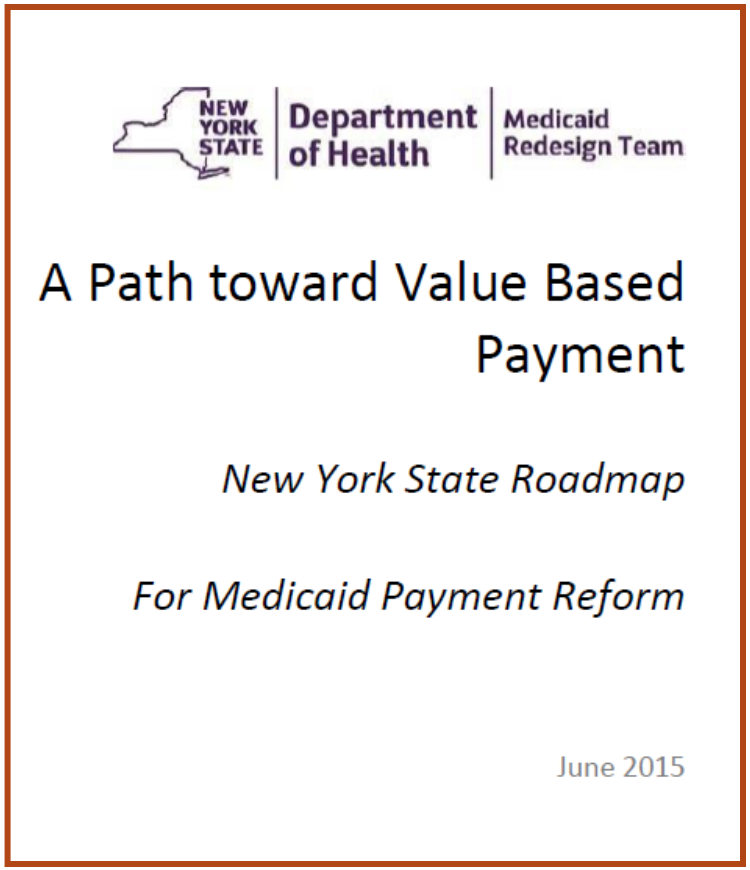
- **State Medicaid**
- **Private Payers**
  - **Health Plans**
  - **Health Insurance Market Place**
  - **Medicare Advantage**



Source:https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

NYS VBP Roadmap

Delivery System Reform Incentive Payment (DSRIP) program



- Program to invest $8 billion in Medicaid care delivery and payment reform
- Promote community level collaboration
- Reduce avoidable hospital use by 25% over five years
- Financially stabilizing safety net providers

Source:http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm

NYS VBP Roadmap

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

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

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

Source:http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

NYS VBP Roadmap

MJHS

Delivery System Reform Incentive Payment (DSRIP) program

YEAR	MILESTONE
DY2 (2016)	MCO-PPS combinations submit plans outlining path towards VBPs. Greater ambition = MCO PMPM bonus.
DY3 (2017)	MCO-PPS combinations must have Level 1 VBP arrangement for PCMH/APC care + bundle/subpopulation OR total pop Level 1.
DY4 (2018)	At least 50% of total statewide MCO payments in Level 1 VBP; aim to have 30% of VBP payments (=15% of statewide MCO payments) captured in Level 2 VBP.
DY5 (2019)	80-90% total MCO-PPS payments captured in Level 1 VBP; aim to have 70% of VBP payments (=56% of statewide MCO payments) captured in Level 2 VBP.

Options	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level; requires mature PPS)
All care for total population	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Global capitation (with outcome-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when outcome scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for Primary Care Services (with outcome-based component)
Acute and Chronic Bundles	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when outcome scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Prospective Bundled Payment (with outcome-based component)
Total care for subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (savings available when outcome scores are sufficient)	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for total care for subpopulation (with outcome-based component)

Source:http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm

NYS Health Innovation Plan (Like VBP & DSRIP…. But Not!)

New York State Health Innovation Plan

Goal Delivering the Triple Aim – Better health, better care, lower costs

Pillars					
	Improve access to care for all New Yorkers, without disparity Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way	**Integrate care to address patient needs seamlessly** Integration of primary care, behavioral health, acute and postacute care; and supportive care for those that require it	**Make the cost and quality of care transparent to empower decision making** Information to enable consumers and providers to make better decisions at enrollment and at the point of care	**Pay for healthcare value, not volume** Rewards for providers who achieve high standards for quality and consumer experience while controlling costs	**Promote population health** Improved screening and prevention through closer linkages between primary care, public health, and community-based supports

Enablers		
A	**Workforce strategy**	Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities
B	**Health information technology**	Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation
C	**Performance measurement & evaluation**	Standard approach to measuring the Plan's impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation

Source:https://www.health.ny.gov/technology/innovation_plan_initiative/docs/strategic_pillars.pdf

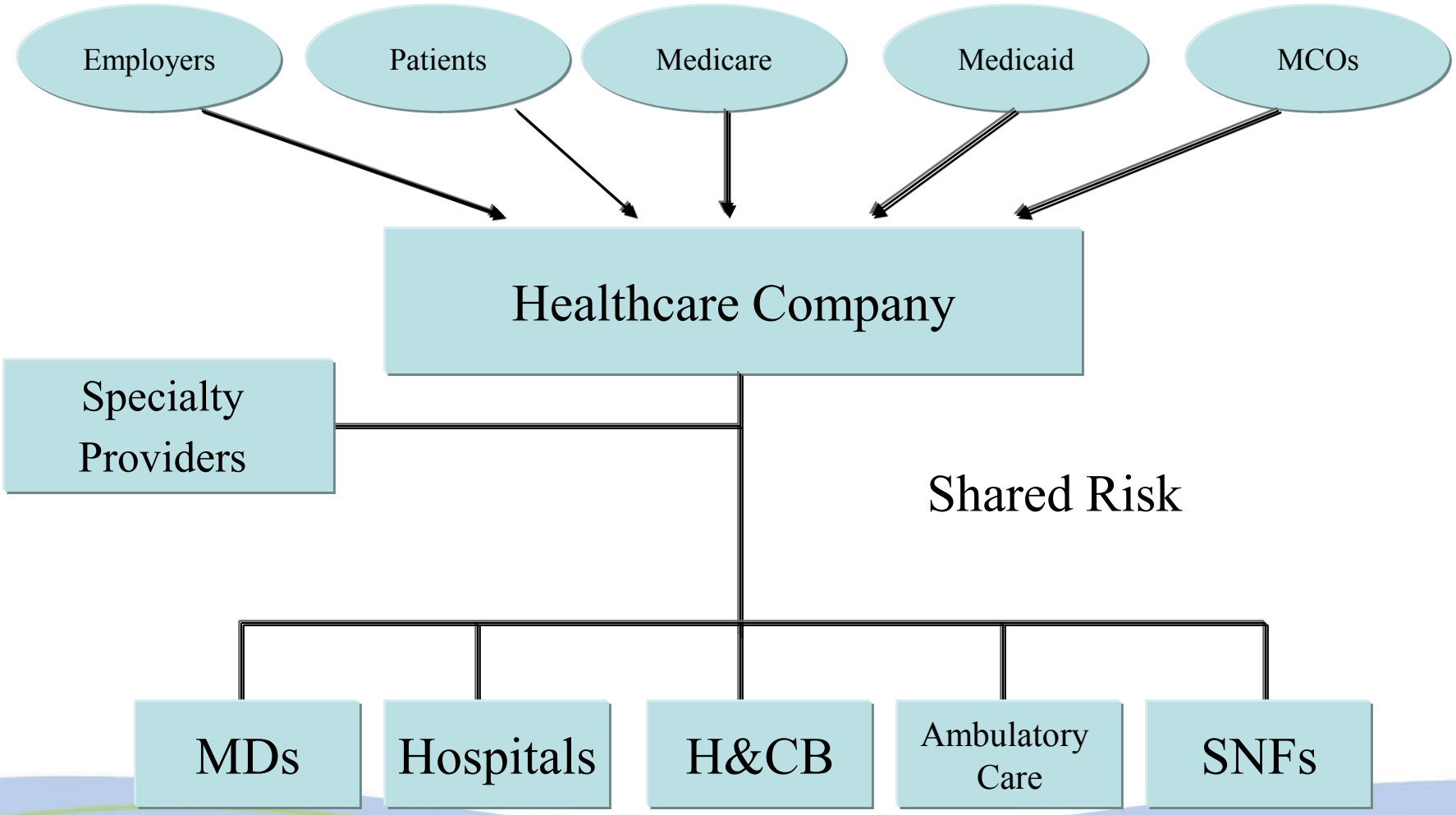
Other Health Reform Initiatives That Do/Could/Will Effect those you serve

- Health Homes
- Patient Centered Medical Homes
- Accountable Care Organizations
  - Pioneer ACOs
  - Commercial ACOs
  - Medicare Shared Savings ACOs
- Rehospitalization Penalties in FFS Medicare payments
- Value Based Purchasing-Quality Bonus Payments
- Narrow Networks
- Comprehensive Care for Joint Replacement
- Bundled Payments for Care Improvement (BPCI) Initiative
  - Model 2 (Acute Care plus Post acute)
  - Model 3 (Post Acute only)

What is Bundling?

- Payment Bundling is the use of one payment to pay for a variety of services for one type of condition
- Example:
  - Current market for a hip replacement:
    - $ to Surgeon MD
    - $ to Transportation
    - $ to Hospital for Facilty based Services
    - $ to SNF
    - $ to outpatient therapy
    - $ to DME
    - $ to CHHA
  - Under a Bundel
    - $ to “convener” (usualy a Hospital or an MD Group)

Disruptive Innovation



How Might We Get There?

- **Change the Culture**
  - Practice based on evidence
  - Reduce unexplained clinical variation
  - Reduce slavish adherence to professional autonomy
  - Continuously measure and close feedback loop
  - Engage with patients across the continuum of care

Thank You!

Questions?

Feel free to reach out

Jay Gormley
Chief Strategy & Planning Officer
MJHS
Phone: (347) 834-5868
Email: jgormley@mjhs.org