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VBP 202

Strategy and Progress from a Managed Care Organization

Speaker Bios

Theresa Riordan - Vice President of Hospital Engagement

Theresa Riordan is the Vice President of Hospital Engagement at Healthfirst, a hospital-sponsored, not-for-profit health insurance company that serves more than 1.3 million New Yorkers. In her current role, Theresa leads a team that provides consultative support for risk-taking hospitals as they track and manage performance in value based payment arrangements. She also leads a team that works collaboratively with the PPS' and NYS in support of the DSRIP program.

Theresa joined Healthfirst in 2014. She has also held hospital and physician network management roles at UnitedHealthcare and Empire Blue Cross Blue Shield. Theresa earned a Bachelor's degree from SUNY New Paltz and a Masters in Healthcare Administration from Baruch College/Mount Sinai School of Medicine.

Speaker Bios

Susan Beane, M.D. - Vice President & Medical Director

Dr. Susan Beane joined Healthfirst in 2009, bringing with her extensive professional experience in managed care. Currently Vice President and Medical Director, Dr. Beane focuses on care management and clinical provider partnerships, which are specifically designed to improve the delivery of vital, evidence-based healthcare to Healthfirst's members. Dr. Beane, a dedicated primary care physician and board certified internist, is a strong proponent of collaborating with and engaging providers to improve health outcomes. She leads Healthfirst in collaborating with major healthcare delivery systems, as well as local and national policy experts on the design, implementation, and dissemination of innovative outcome-focused models of care. Her contributions to research include studies on the health of caregivers, obesity, and maternal health.

Prior to joining Healthfirst, Dr. Beane served as Chief Medical Officer for Affinity Health Plan for five years—during which time she helped Affinity's plan become a top performer in quality and member satisfaction. Earlier in her career, she also served as Medical director for AmeriChoice and HIP USA. Dr. Beane is a graduate of Princeton University and Columbia University College of Physicians and Surgeons.

Disclaimer

This training is an educational initiative designed to improve providers' knowledge of New York State's Value-Based Payment Roadmap initiatives. Any contracting and/or reimbursement decisions are to be made by the provider and their respective MCOs.

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Value Based Purchasing

Theresa Riordan
Vice President, Hospital Engagement

Value Based Payments (VBP)

Value-Based-Payment (VBP) models reward value over volume which promotes population health initiatives. The goal is to incentivize providers to deliver high quality care, such as preventative care and care coordination, obtain better patient outcomes and lower avoidable costs

Fee-for-Service (FFS)

- Encourages quantity that may compromise quality
- Missed opportunities for care coordination
- Can be a cost driver for high utilization of avoidable costs

Value Based Purchasing (VBP)

- Encourages quality over quantity
- Facilitates care coordination, care management, and population health management
- Increased savings through improved performance and quality

Encourage the provision of high quality care at the right time and the right place

VBP Arrangements

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Broad range of VBP arrangements with varying degrees of provider risk

Quality Incentive Programs

- Providers are generally paid fee for service (FFS) and receive a quality bonus when they meet specific quality measures

Shared Savings

- When medical costs for a defined population are lower than target budgets, and outcome scores are sufficient, providers have the opportunity to share in a % of that surplus as negotiated between the parties

Shared Risk

- In this type of VBP arrangement, providers have the opportunity to share in a % of any surplus like shared savings arrangements, but would also take downside risk for a portion of the deficit for that population

VBP Arrangements (continued)

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Bundled Payments

- A bundled payment occurs when a payer provides a single payment to a providers for all services related to an episode of care. (e.g., when a provider is given a budget for all costs related to maternity care)

Global Capitation - prepaid or not (aka Total Cost of Care)

- In this type of VBP arrangement, providers take full risk on a defined population. They are given a budget for all of the services provided to the population, and are at full risk (both upside and downside) for all costs of that population

NYS VBP Roadmap

The VBP Roadmap lays out specific goals for transition to VBP arrangements. This is intended to make sure that the savings generated through delivery transformation goes back to the provider community who is making the investments. The roadmap defines four levels of VBP, which are shown below.

Options*	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP
	Not considered a sufficient departure from traditional FFS payments, i.e. not true VBP	*"Upside only" shared savings incentives*	*"Upside and downside" risk-sharing arrangement. Stop loss arrangements are under consideration for Level 2*	*Per member per month (PMPM) / single bundled payments. Stop loss arrangements may remain to reduce providers risk*
All care for total population	FFS with bonus and/or withholding 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 withholding 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 withholding 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 withholding based on quality scores	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	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)

VBP Roadmap Timeline

The New York Department of Health has outlined high-level milestones for transitioning to value based payments (VBP) by DSRIP demonstration year (DY).

By the end of 2020, it is the state's expectation that 80-90% of Plan expenditures will be contracted through a Level 1 VBP and 35% through Level 2 or higher.

DY 3	Apr. 1, 2017 – Mar. 31, 2018	By end of DY 3, at least 10% of total MCO expenditures will be captured in Level 1 or above
DY 4	Apr. 1, 2018 – Mar. 31, 2019	By end of DY 4, at least 50% of total MCO expenditures will be contracted through Level 1 VBP or above and at least 15% of of total MCO expenditures will be contracted through Level 2 VBP for full capitation plans
DY5	Apr. 1, 2019 – Mar. 31, 2020	By end of DY 5, 80-90% of total MCO expenditures will be contracted through at least a Level 1 VBP and at least 35% of total MCO expenditures will be contracted through Level 2 VBP or higher for full capitation plans

VBP Partners

VBP Arrangements can be entered into with different types of providers or entities. These providers or entities are often referred to as VBP Contractors or VBP Partners.

Hospitals

- An example: Global Cap/Total Cost of Care arrangement

Physician groups – IPAs, FHQCs and Community Based Practices

- An example: Shared savings or shared risk arrangement

Other providers, e.g. Managed Long Term Care (MLTC) providers

- An example: Bundled payment for Home Health services following a hospital discharge

Combinations

- An example: Bundled payments for maternity within a total cost of care arrangement

Population Health Initiatives

VBP arrangements incentivize high quality and cost effective care. In addition to providing healthcare services, VBP Partners engage in a variety of population health initiatives, such as:

Utilization Management

- Review claims and financial date to identify areas of unnecessary spend and ensure patients are getting the right care at the right time and place

Care Management

- Identify high risk patients and implement care management programs to provide needed care and avoid hospitalization
- Create care plans for patients with multiple chronic diseases

Access and availability of appropriate providers

- After hour access to non-emergency care, in-network specialists

Social Determinants of Health

- Work with community based organizations to implement social determinants of health interventions such as support to establish housing

NYS VBP Roadmap and Social Determinants of Health (SDH)

Effective January 1, 2018, all new and existing Level 2 VBP arrangements must include at least one Tier 1 CBO* contract focused on at least one SDH intervention.

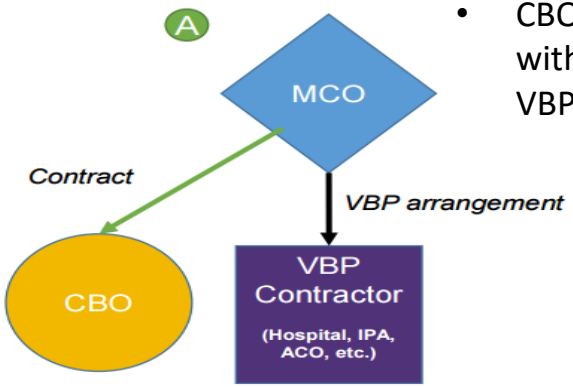
SDH Intervention Area	Examples of Interventions	Example of a Tier 1 CBO
Economic Stability	Referral to child care, Rental assistance, Legal services, Housing services.	God's Love We Deliver
Neighborhood & Environment	Air conditioning, Housing condition assessments, Pest management	A.I.R.NYC
Education	Health literacy/Adult education, Translation/Interpreter services	Foundation for Healthy Hispanic Families
Social, Family, & Community	School and community-based mentoring programs, Social and adult day care/ home care, CBT for child trauma/ PTSD therapy	Get Focused
Health & Healthcare	Community-based care coordination/ coaching, Chronic disease self-management programs, School-based health centers	Health People

The list of CBOs are available on the NYS DOH website at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/docs/cbo_survey.xlsx

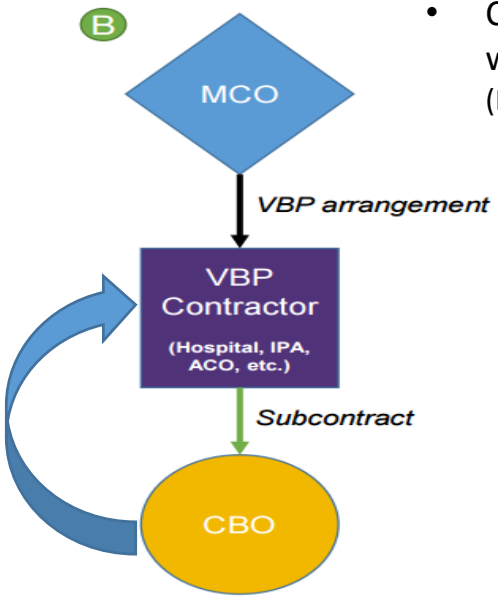
*Non-profit, non-Medicaid Billing community based social and human service organization.

NYS VBP Roadmap and Social Determinants of Health (SDH)

Either the MCO or the VBP Contractor can have the contractual arrangement with the CBO in one the four following ways:



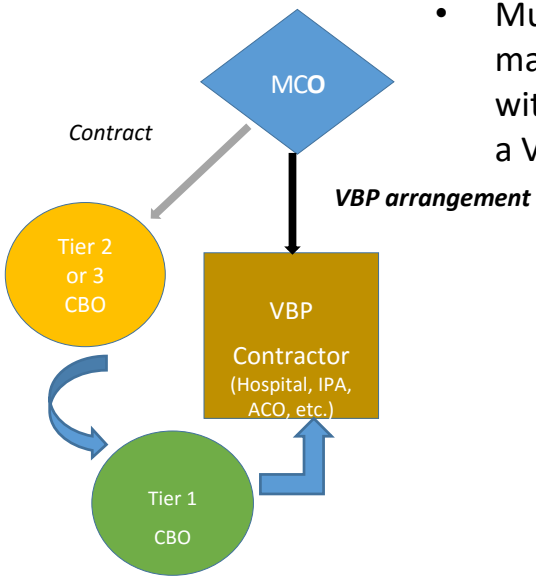
- CBOs may contract directly with an MCO to support a VBP arrangement



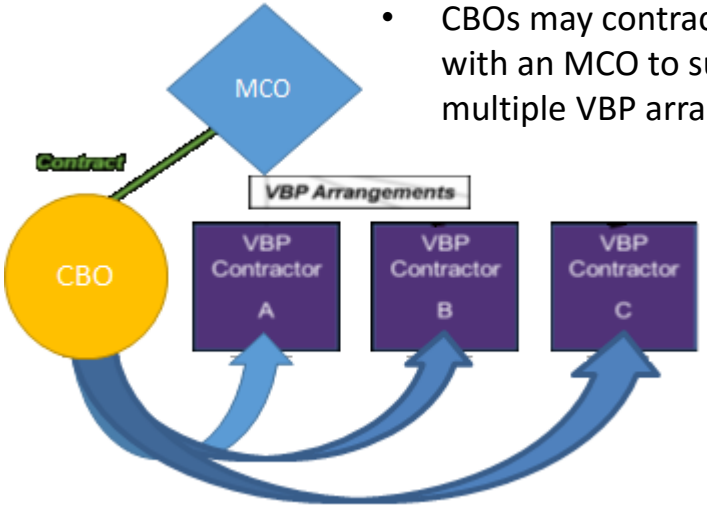
- CBOs may subcontract with a VBP contractor (Hospital, IPA, ACO, etc.)

NYS VBP Roadmap and Social Determinants of Health (SDH)

Contracting options cont.



- Multi-tier CBO partners may contract directly with an MCO to support a VBP arrangement



- CBOs may contract directly with an MCO to support multiple VBP arrangement

VBP Challenges in the Market

VBP are a great way of promoting population health initiatives and driving the right incentives, but there are a variety of challenges that plans and providers face in progressing towards the goals in the VBP roadmap:

Analytics and Reporting

- In order to drive change, providers need clear, actionable data. Many plans are not prepared to provide the right information to drive that change.

Provider Infrastructure

- Even with the right information, providers need the resources to utilize that data to drive change. Not all providers have the staff or support to do so.

Size/Scale

- The smaller the population, the more likely it is to have unpredictable costs that fluctuate significantly. Not all providers have a population that is credible enough to take risk on.

Financial Resources

- Everyone likes risk when there is surplus. Most providers cannot handle full downside risk. Certain VBP models require that risk providers post reserves to cover potential losses, and not all providers can afford to do so.

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Building the Business Case for Addressing Determinates of Health

Susan Beane, MD
Vice President Medical Director, Clinical Partnerships

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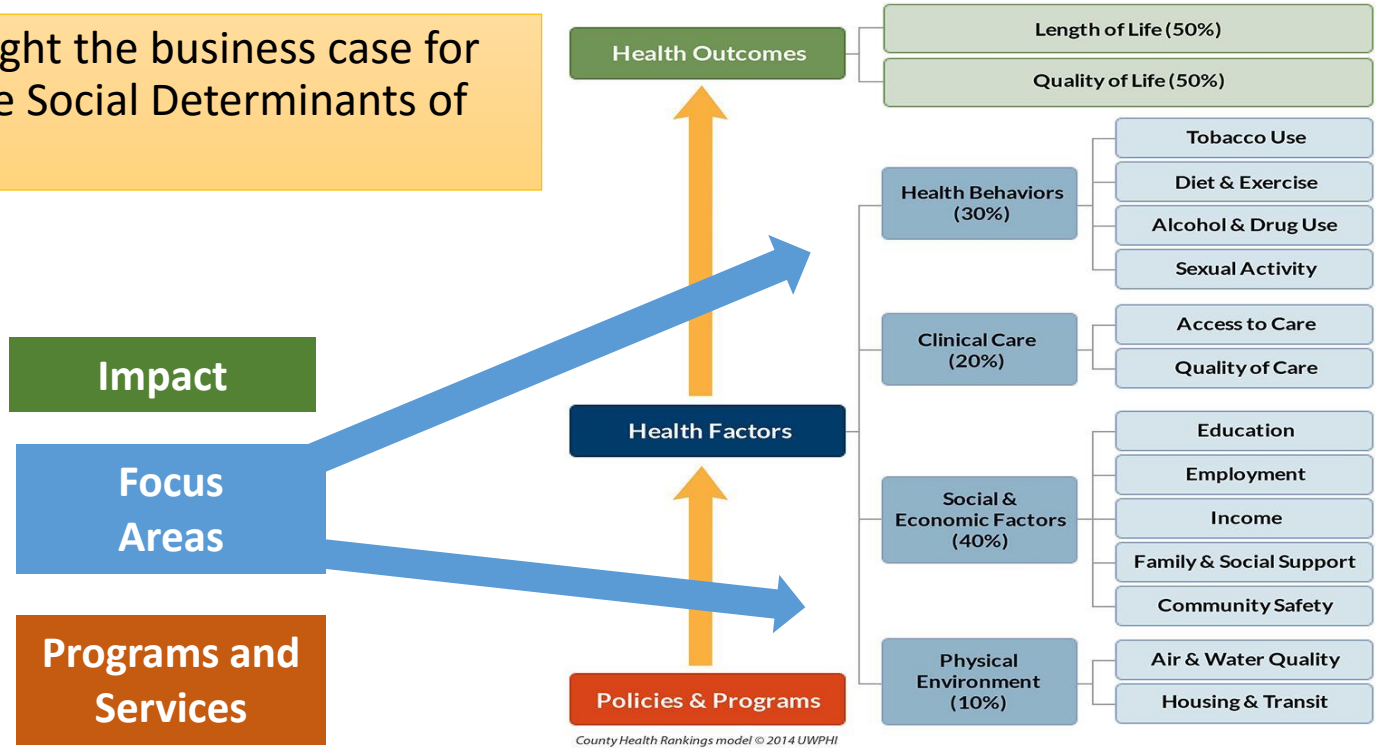
The Problem

Aim: Addressing all determinants and driving value

AIM: To highlight the business case for addressing the Social Determinants of Health



2018 Context

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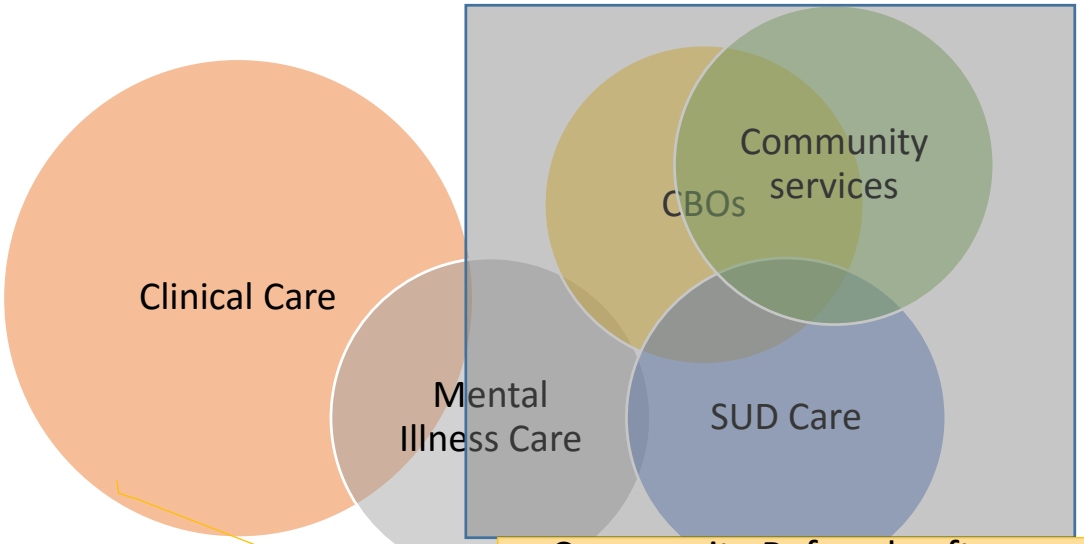
A steadily increasing body of evidence confirming the impacts of various structural, environmental, socioeconomic, and psychosocial factors on the health trajectory of people and patients

NY has a rich network of community based organizations (CBOs) and agencies that work with our members, but these efforts are opaque to us and we do not know which needs continue to go unmet	Through VBP guidelines, NYS DOH has challenged MCOs to enter into contracts with Community Based Organizations to address social determinants	DSRIP & Performing Provider Systems	CBOs operate in an less regulated environment guided by mission and philanthropy, often without an infrastructure for working with MCOs and health care provider

Community Referral Software can help

Care that occurs outside of the traditional health care delivery system is often opaque to MCOs and Provider based organizations



Community Referral software can align with clinical providers to track referrals and major milestones

Understanding impact

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Performance: over 1-2 years

Risk Stratification

Disease Burden

Provider & Delivery System: Enhance member outcomes to improve cost and utilization

6+ months

PCP centric Utilization

Medical Cost

Members: address social determinants to optimize:

Clinical outcomes

(Viral Suppression, postpartum visit, HEDIS)

Engagement in care

(Viral Load Test, Medication Adherence, Medical Care)

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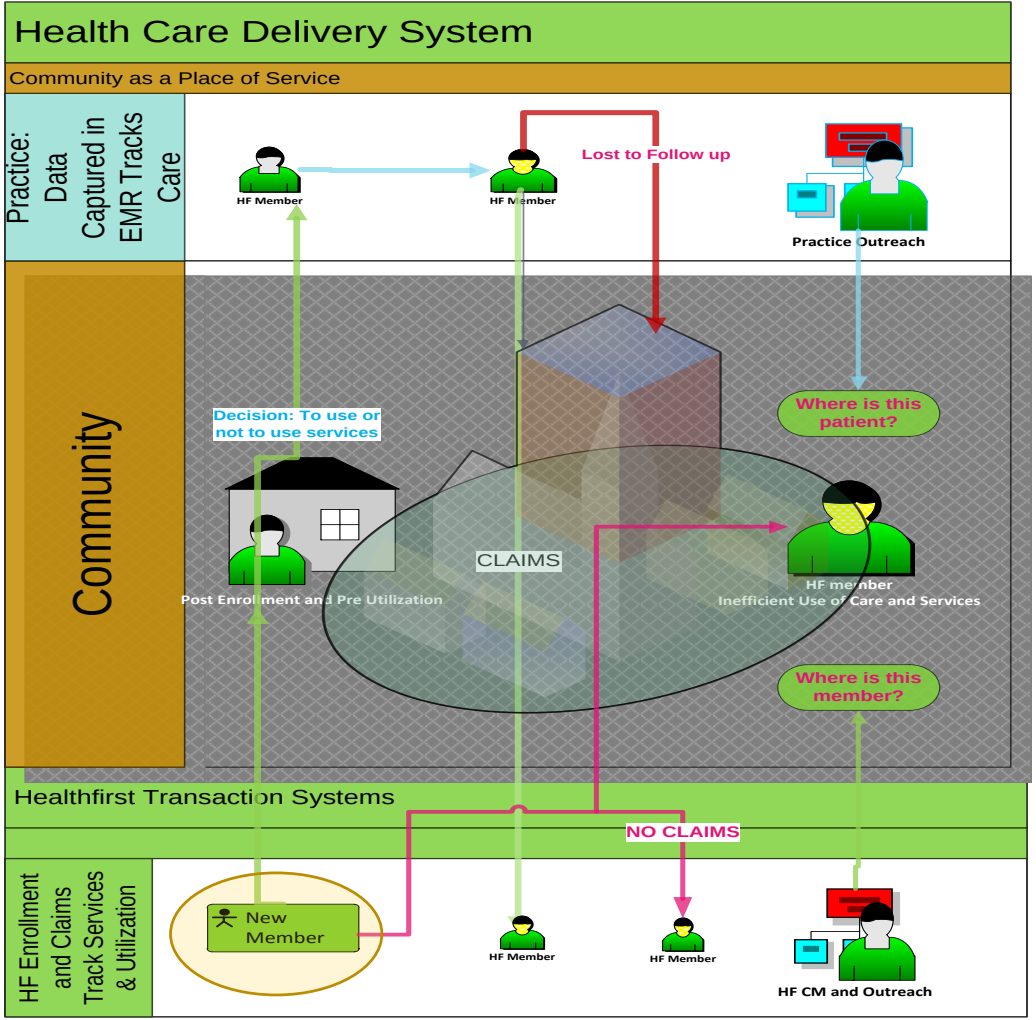
The Reality



Health plan or practice membership does not ensure efficient use of care

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- If we assume that access to a PCP and practice tools and resources is a key marker for effective, efficient and satisfying care . . .

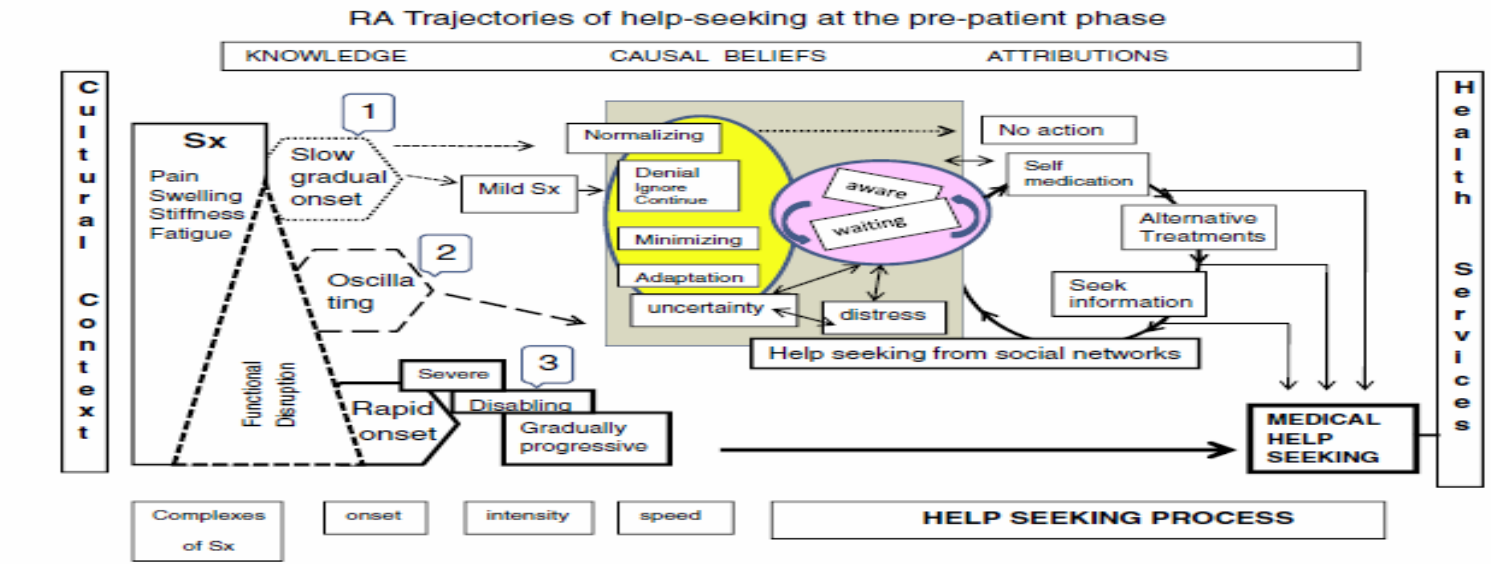
  . . . The majority of plan members achieve that milestone.

- Some do not use their benefits or end up in the ED or inpatient for potentially avoidable reasons or "give up" on care

- Plans and providers outreach these patients, often without successful engagement

Why and when people seek medical help?

Using Rheumatoid Arthritis as an example, how might people respond to illness?



From (Pelaez, Infante, & Quintana, 2015) Three RA Trajectories of help-seeking at the pre-patient phase

Trajectories of help-seeking: Competing contexts

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Culture Context and Community

- What am I feeling and how am I functioning?
- What do I believe is happening to me?
- Why is this happening to me?
- Is it worth seeking medical help?

Clinical Signs and Symptoms

- How long, hard and fast are the symptoms affecting me?
- Should I just accept this? Get help from family / friends? Search the web? Ignore?
- Can I get away with doing nothing? Herbs or supplements? What did others that I know do? are things bad enough that I / my network is pushing me that I must get help?

From (Pelaez, Infante, & Quintana, 2015) Three RA Trajectories of help-seeking at the pre-patient phase

Is the medical system ready for "help-seekers?"

Through help-seeking the patient essentially expands the "social network" to include the physician and practice team.

This extended "social network" provides, from the clinical point of view "a social identity … emotional support, material aid, services, information and interpersonal relations."

(Pelaez, Infante, & Quintana, 2015)

- Just as a social network is a "fit" for the patient's individual and population based characteristics, the medical care delivery system will meet a patient's "help-seeking" needs if it is accessible in the following dimensions:
  - Geography
    - The patient is able to travel to the medical site and has the means to do so
  - System entry and continuity
    - The medical system chosen presents no struggle for initial and subsequent appointments. The medical caregivers provide a timely response to the patient's illness trajectory
  - Cost effective
    - The patient is not economically burdened by medical fees, or by loss of time due to waiting, service interruptions, medication access, lab testing and time out of work

Knowledge can be power:
What can help me achieve my health goals?

People [want to] assume more responsibility for their own health by [knowing what] *health services to request when such services can be of help and avoiding them when they cannot.*

- ❑ I don't want to smoke
- ❑ I don't want to consume alcohol to excess
- ❑ I want to Exercise Regularly
- ❑ I want to eat wisely
- ❑ I want to Use my seat belts
- ❑ I want my hypertension control under control
- ❑ I want ALL of my preventive health services
- ❑ After I have lived as long a life as possible, I want die my way.

Adapted from: Fries, J. F., Koop, E., Beadle, C. E., Cooper, P. P., England, M., Greaves, R. F., et al. (1993, July 29). Reducing Health Care Costs by Reducing the Need and Demand for Services. *NEJM, 329*(5), 321.

Case Studies

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Case Study: Testing software as a tool for efficient and affordable collaboration

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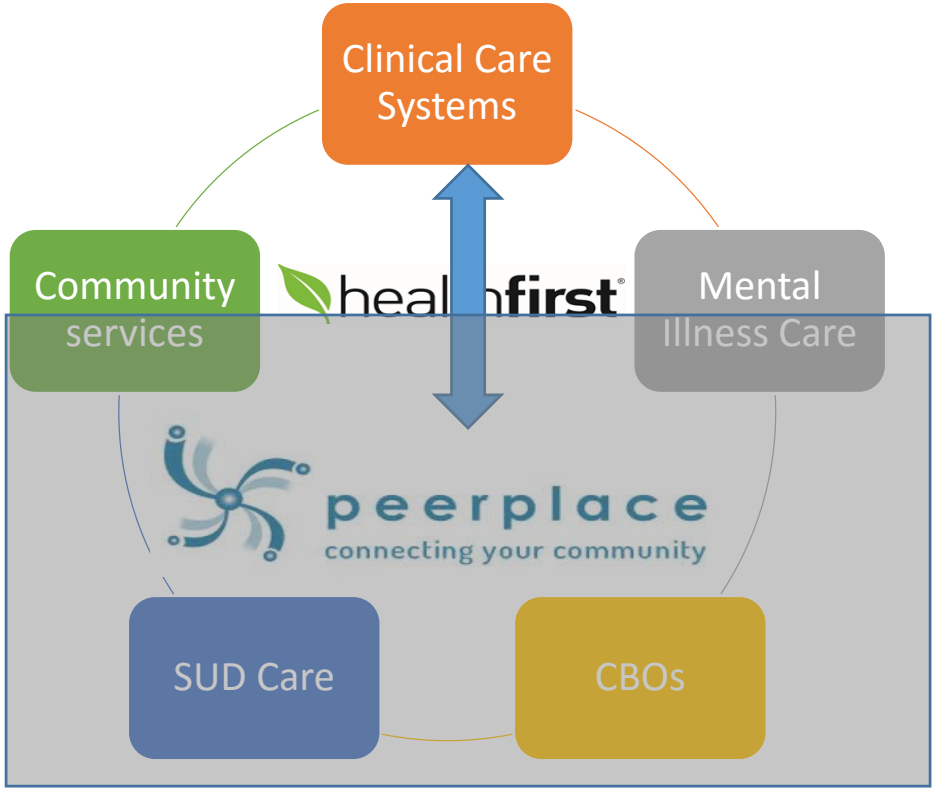
- Software sits in the center of programming with each health care organization managing its own client base and program
- Seamless experience for the "consenting" client
- Robust data collection for all entities connected to the client
- Promotes "apples" to "apples" comparisons between interventions



Case Study: Grant funded CBO outreach with and without connectivity platform

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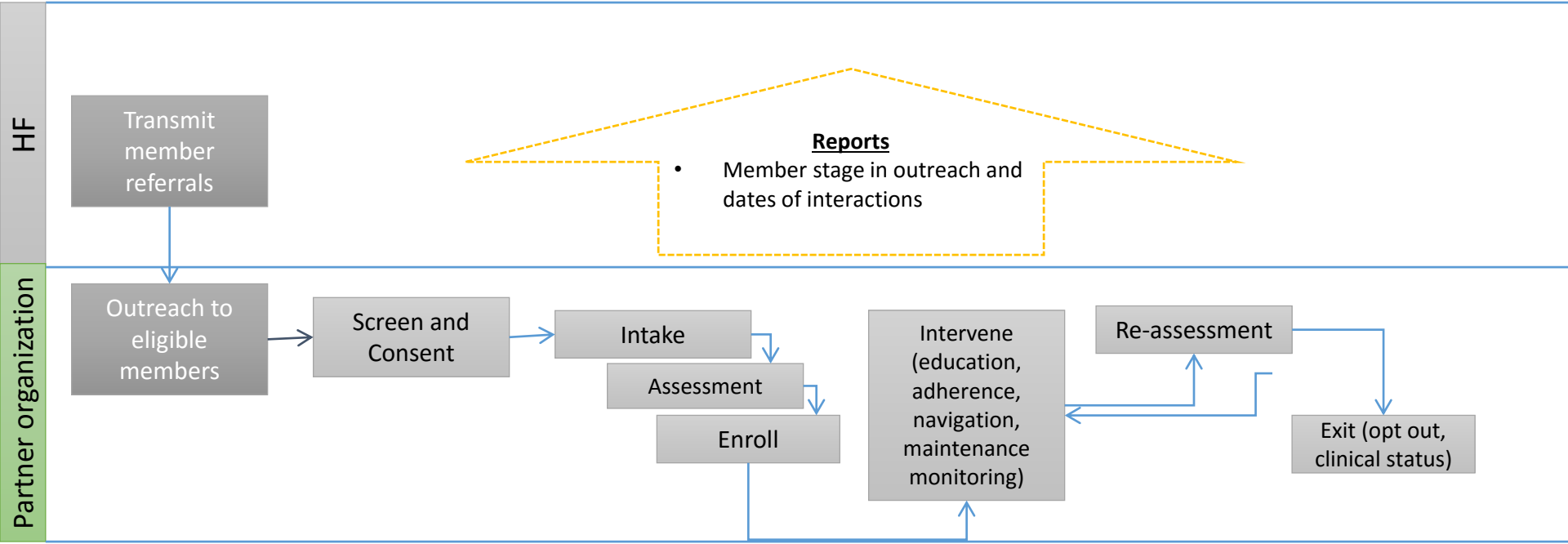
CAMBA: Outreach to high risk pregnant moms in Central Brooklyn	Alliance for Positive Change: Peer outreach to members with HIV
▪ Lack of real time knowledge of activities ▪ Spreadsheets with PHI out in the field ▪ Tough to maintain consistency from expected scripts and workflows ▪ Hard to find a path to sustainability beyond initial 2-month pilot	▪ Data entry on program activities completed daily ▪ Deviations from expected/contracted workflows caught early and addressed ▪ Program in operation since 2016, has impacted **400+** members ▪ 2018: HF received permanent federal funding for HIV programs

CBO Peer Navigator Outreach Workflow

Web-based case management tool keeps client data secure and allows HF to know member status at any time



Addressing social factors through the Alliance for Positive Change

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Funding from NYS DOH AIDS Institute (2016-2018) to improve viral suppression in our Medicaid members living with HIV

Peer navigation activities

- Home visits & phone calls to locate members
- Health promotion messages and education
- Screening, enrollment and consent forms to participate in services
- Navigation to appointments
- “Warm hand-off” to care coordination (health home)
- Referrals to services (housing, workforce, harm reduction, support groups)

Photo: David Nager/Alliance

Timeline: Peer Navigator Outreach and Engagement

Lessons learned:

- **6 to 8** months ramp up is worthwhile investment

Jan – June 2016

- Contracting
- Workflow development
- PeerPlace development
- Alliance Program staffing

June-July 2016

- Training of Peers in ETE workflows and use of PeerPlace

Aug 2016-April 2017

- Healthfirst refers 514 members
- Alliance conducts outreach to all members

May 2017

- 39% engagement

Understanding Impact

Time from first outreach attempt to first contact	# Found	Avg. Attempts Before Found	% of Found Clients
< 1 Week	129	1.3	65%
< 1 Month	23	1.7	12%
< 2 Months	22	2	11%
< 3 Months	9	2.2	5%
< 6 Months	10	2.8	5%
< 9 Months	5	2.6	3%

MCO OUTREACH FOUND N=198	# Outreach Activities	# MCO Patients Engaged	% MCO Patient Engagement
Face to Face	255	145	73%
Phone	290	53	27%
Total Outreach	545	198	100%

How might we measure success?

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Testing a VBP Model

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Example: What Value can CBOs bring to a Managed Care/Value Driven Health Care marketplace?

Milestone	Payment	Budget	Goal
Outreach (often by Peers to find someone)	Non MCO		1200 members
Assessment (asking the key questions)	FFS	X% budget	400 members
Engagement (willingness of client to connect)	FFS	X% budget	300 members
Intervention (includes navigation, hand holding initially, independence eventually)	FFS with cap	X% budget	300 members
Ongoing alignment (willingness of client to stay connected to provider of choice)	PMPY	X% budget	250 members
Improved Clinical Outcomes	Incentive Payment	Bonus X%	125 members

Summary

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Collaboration to address health determinants

- To achieve their health goals, patients benefit from evidence-based care that is fostered by consistent and strong relationships with a trusted provider of their choice.
- For a health care organization, an aligned patient identifies closely with a practice, and that practice is equally committed to serving that patient.
- Collaboration requires commitment to supporting CBOs in journey to contract
- That journey must be efficient as well as effective if we will achieve the goal of sustainability

Final Thoughts

- Opportunities:
  - Alignment between all stakeholders provides a perspective beyond the traditional model of care
  - Creating pathways for stakeholders to inter-operate in achieving health goals.
  - Alignment is about health system partnerships – members, communities, providers, and payors

- Challenges:
  - Evaluating the alignment process in traditional metrics.
  - Creating alignment models that are robust enough to drive health outcomes.
  - Connecting disparate worlds of care and service in an efficient manner

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Thank You!