Lessons Learned: Implementing Medicare and Medicaid Value Based Payment Models

New York Medicaid Population Health Symposium
November 19, 2019
Who’s Who

• Jim Burnosky: Vice President, Strategic Initiatives, Fidelis Care

• Monica Gould: Senior Manager, Value-Based Payment Contracting, Population Health, Maimonides Medical Center

• Caroline D. Greene: SVP and Chief Administrative and Financial Officer, Population Health, Maimonides Medical Center

• Tina Hansen Pickett: Senior Director, Sustainability and Strategic Initiatives, Population Health, Maimonides Medical Center

• Laurie Ward, MD: Director, Population Health, Wyckoff Heights Medical Center
Today’s Agenda

- Why are we here?
- What are we doing?
- Where are we going?
- Implications and Next Steps
The Promise of VBP…?

The “why” is easy to understand:

• Continued pressure to control cost of gov’t-sponsored programs
• Delivery system and provider networks with limited margins for investment in transformation
• Little room for cost-shifting to employer-sponsored plans
• Impact of benefits costs on total compensation and ability to recruit talent

It’s the “how” that we are here to discuss…

Source: Kaiser Family Foundation Health System Tracker
DSRIP and VBP

“Investing in population health, care coordination, referral patterns and discharge management are some of the DSRIP-enabled capabilities that will make VBP contractors successful.” – NYS VBP Roadmap

DSRIP

Achieve 25% reduction in avoidable hospital use

Structure:
- Network: CCB PPS
- Attribution: NYS DSRIP “swim lanes” – by NPI
- Payment: P4R and P4P
- State administered pursuant to Federal waiver

VBP

Implement payment arrangements that reward value vs. volume

Structure:
- Network: CCB IPA
- Attribution: Assigned PCP – TIN/NPI specific
- Payment: savings subject to quality
- Payor-administered, with regulatory oversight

1. Improve health
2. Lower costs
3. Provide better care

- Reduce avoidable readmissions and ER visits
- Expand access to high quality primary care
- Focus on integration and coordination of care
Community Care of Brooklyn IPA, Inc.

CCB IPA is an integrated network of health and social services partners committed to improving the health and well-being of diverse communities across Brooklyn, keeping care local wherever and whenever possible.

Key components of the CCB IPA approach:

- Diverse network of providers
- Focus on care coordination
- Commitment to achieving efficiencies
- All-payor approach to ensure broad adoption
- Investment in training and workforce development
- Leverage tools and processes built for DSRIP to support transformation
VBP Initiatives and DSRIP Support

**2018**
- **January**
  - CCB IPA established
- **March**
  - BPCI-A application submitted
- **June**
  - Shared savings VBP contracts with 5 MCOs finalized
- **October**
  - BPCI-A implementation begins

**2019**
- **July**
  - Start of Year 2 for certain Medicaid VBP contracts
  - CCB IPA begins participating in Medicare Shared Savings Program as an ACO
- **December**
  - Selection of BPCI-A episodes for Year 3

**2020**
- **January**
  - Start of Year 3 for certain Medicaid VBP contracts
  - Start of BPCI-A Year 3
  - Start of MSSP Year 2

DSRIP investments in Care Transitions, PCMH Initiatives, Community Engagement, Workforce Development, Management Infrastructure (2015-2020+)
VBP Enhances Existing Contracts with Payors

Participants would continue to have direct contracts for reimbursement directly with payors.

- **IPA Participation Agreement**: Allows Participant to join IPA network to help improve quality and care coordination.
- **Value-Based Payment Contract**: Sets quality and spending targets with an opportunity to earn shared savings.
- **Direct Contract**: Includes basic contract terms & payment rates.

CCB IPA

CATEGORICAL PAYMENT AGREEMENTS

- Value-Based
- Delivery System
- Performance
- Outcome

EMERGENT PAYMENT CONTRACTS

- Value-Based
- Delivery System
- Performance
- Outcome
### Bundled Payments for Care Improvement – Advanced (BPCI-A)

<table>
<thead>
<tr>
<th>Start Date</th>
<th>10/1/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payor</td>
<td>Medicare Fee-for-Service</td>
</tr>
<tr>
<td>CCB IPA Participants</td>
<td>6 hospitals (“episode initiators”)</td>
</tr>
<tr>
<td>Attribution</td>
<td>~3,000 episodes per year at participating hospitals</td>
</tr>
<tr>
<td>VBP Model</td>
<td>Total costs over 90-day episodes of care, 11 selected bundles</td>
</tr>
<tr>
<td>Risk Level</td>
<td>Upside and downside</td>
</tr>
<tr>
<td>Financial Target</td>
<td>Target prices by episode set by CMS</td>
</tr>
</tbody>
</table>
| Quality Measures | 10% of savings dependent on quality:  
- PQI 90 – Patient Safety Indicator  
- All-cause Readmissions  
- Advanced Care Planning  
- Perioperative Care – Selection of Antibiotic  
- CABG Mortality  
- AMI-Excess Days |
| Results to Date | Savings earned; CMS reconciliation report pending |
Network Participation Varies by Program

- Care Management
  - Health Home
- Specialists
- Social Services & CBOs
- FQHCs
- Primary Care Practices
  - Adult Medicine
  - Pediatrics
- Hospitals
  - Bundled Payments for Care Improvement - Advanced
- Skilled Nursing Facilities
## Medicare Shared Savings Program (MSSP)

<table>
<thead>
<tr>
<th>Start Date</th>
<th>7/1/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payor</td>
<td>Medicare Fee-for-Service</td>
</tr>
<tr>
<td>CCB IPA Participants</td>
<td>65 organizations/practices</td>
</tr>
<tr>
<td>Attribution</td>
<td>~10,000 beneficiaries attributed to ACO</td>
</tr>
<tr>
<td>VBP Model</td>
<td>Total cost of care</td>
</tr>
<tr>
<td>Risk Level</td>
<td>Upside only (BASIC Level A) with path to shared risk</td>
</tr>
<tr>
<td>Financial Target</td>
<td>Target PMPM set by CMS</td>
</tr>
</tbody>
</table>
| Quality Measures | 23 measures across 4 domains:  
  - Patient/Caregiver Experience (CAHPS)  
  - Care Coordination/Patient Safety  
  - Preventive Health  
  - At-Risk Population |
| Results to Date | To be determined |
Network Participation Varies by Program

- Care Management
- Health Home
- Specialists
- Social Services & CBOs
- FQHCs
- Primary Care Practices
- Hospitals
- Skilled Nursing Facilities
- Adult Medicine
- Pediatrics
- Bundled Payments for Care Improvement - Advanced
- Medicare Shared Savings Program
# Medicaid Managed Care Value-Based Payment Contracts

<table>
<thead>
<tr>
<th>Start Date</th>
<th>7/1/18</th>
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</thead>
<tbody>
<tr>
<td>Payors</td>
<td>Medicaid Managed Care Plans:</td>
</tr>
<tr>
<td></td>
<td>[Images of healthcare logos]</td>
</tr>
<tr>
<td>CCB IPA</td>
<td>106 organizations/practices</td>
</tr>
<tr>
<td>Participants</td>
<td>~60,000 patients (PCP-based)</td>
</tr>
<tr>
<td>Attribution</td>
<td>Total cost of care</td>
</tr>
<tr>
<td>VBP Model</td>
<td>Upside only (Level 1)</td>
</tr>
<tr>
<td>Risk Level</td>
<td>Target PMPM negotiated with MCO</td>
</tr>
<tr>
<td>Financial Target</td>
<td>Total of 35 HEDIS measures; 3 PPE measures</td>
</tr>
<tr>
<td>Quality Measures</td>
<td>Strengthened collaborative framework; access to plan data; progress towards shared savings</td>
</tr>
</tbody>
</table>

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Network Participation Varies by Program

Medicare Shared Savings Program

Medicaid Managed Care Value-Based Payment Contracts

Bundled Payments for Care Improvement - Advanced

Care Management
Health Home

Specialists

Social Services & CBOs

FQHCs

Primary Care Practices

Hospitals

Skilled Nursing Facilities

Adult Medicine

Pediatrics
Similar But Different…

Varied target budgets highlight the differences in membership across VBP contracts

Measurement Year Costs vs. Target (PMPM)
Financial and Quality “Gates”

If savings are generated (beyond a specified financial target), the opportunity to earn a portion of the savings pool is subject to quality performance.

**Step 1:**
Financial Performance

- Baseline Performance
- Target
- Measurement Year Performance
- “Cap” or maximum savings threshold

**Potential shared savings**
- 50% of 2% = 1%

**Step 2:**
Adjustment for Quality

- Total Quality Points
- Quality Points Earned
- No Points Earned
- Potential shared savings
  - 70% of 1% = Actual Savings Shared
  - MCO savings not subject to quality (1% of Target)

- 70% of 1% = Actual Savings Shared
### Quality Performance ≠ Quality Score

Similar performance across MCOs can result in very different quality scores

<table>
<thead>
<tr>
<th>Code</th>
<th>Quality Measure</th>
<th>Count of VBP Arr.</th>
<th>MCO 1</th>
<th>MCO 2</th>
<th>MCO 3</th>
<th>MCO 4</th>
<th>2018 NYS Benchmark Percentiles</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50th</td>
</tr>
<tr>
<td>BCS</td>
<td>Breast Cancer Screening</td>
<td>5</td>
<td>66.4%</td>
<td>65.2%</td>
<td>63.1%</td>
<td>62.0%</td>
<td>68.04%</td>
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<tr>
<td>AWC</td>
<td>Adolescent Well-Care Visits (Ages 12-21)</td>
<td>4</td>
<td>70.6%</td>
<td>63.0%</td>
<td>64.0%</td>
<td></td>
<td>66.67%</td>
</tr>
<tr>
<td>W34</td>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</td>
<td>4</td>
<td>85.9%</td>
<td>82.5%</td>
<td>81.5%</td>
<td>88.0%</td>
<td>82.77%</td>
</tr>
<tr>
<td>ADV</td>
<td>Annual Dental Visit (Ages 2-20)</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>62.09%</td>
</tr>
<tr>
<td>CCS</td>
<td>Cervical Cancer Screening</td>
<td>3</td>
<td>72.5%</td>
<td>74.3%</td>
<td></td>
<td></td>
<td>71.63%</td>
</tr>
<tr>
<td>CHL</td>
<td>Chlamydia Screening (Ages 16-24)</td>
<td>3</td>
<td>80.3%</td>
<td></td>
<td>82.8%</td>
<td></td>
<td>71.71%</td>
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<tr>
<td>COL</td>
<td>Colorectal Cancer Screening (Ages 50-75)</td>
<td>3</td>
<td>44.7%</td>
<td></td>
<td></td>
<td>71.0%</td>
<td>54.74%</td>
</tr>
<tr>
<td>CDC</td>
<td>Diabetes Care- Eye Exam</td>
<td>3</td>
<td>57.0%</td>
<td></td>
<td></td>
<td>52.0%</td>
<td>64.52%</td>
</tr>
<tr>
<td></td>
<td>% of Potential Quality Points Earned</td>
<td></td>
<td>100%</td>
<td>25%</td>
<td>14%</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>
A Multitude of Challenges

- Complexity of contracts/models
- Numerous quality measures
- Timeliness of information, disparate data sources/systems (claims, EMRs)
- Pressure on provider partners to transform absent resources
- Need for rigorous assessment of relative value and “scalability” of alternative approaches
- Reality of demographics – aging population, gentrification, racism, poverty affecting persistent disparities in access and outcomes

Improve outcomes

Lower costs

Increase patient satisfaction
Guiding Principles / Near Term Priorities

- Further expand and integrate the network
- Maintain payor-agnostic, pop health-focused approach to VBP efforts
- Streamline and simplify reporting across VBP programs, where possible
- Work to update EMRs, workflows, and shared clinical protocols
- Implement, evaluate, and adapt DSRIP interventions to address additional opportunities to improve outcomes and/or reduce costs
- Leverage investments in technology and connectivity to QEs
- Engage CBOs and others to address social determinants of health
- Identify and adopt best practices for documentation and coding
- Partner with payors to jointly identify areas of opportunity
Discussion

Alignment of DSRIP programs & support for VBP

Using information & tools to support transformation

Importance of payor and provider collaboration
For additional information, or to follow up on today’s discussion, please contact us at Support@CCBiPA.org.

Thank you!