The Pharmacists Society of the State of New York

Gregory S. Allen
Agenda

• The DSRIP Challenge: Transforming The Delivery System
• Moving Towards Improved Quality Through Value Based Payments
• Examples of What a VBP Arrangement Looks Like for Pharmacies
• The Future of MAPP Dashboards to Support VBP Arrangements
• Data Integration for the Implementation of MAPP dashboards
• Sustaining The Momentum
The DSRIP Challenge: Transforming The Delivery System
**DSRIP Program Principles**

This is the largest effort to transform the New York State (NYS) Medicaid health care delivery system to date

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-Centered</td>
<td>• Improving patient care &amp; experience through a more efficient, patient-centered and coordinated system.</td>
</tr>
<tr>
<td>Transparent</td>
<td>• Decision making process takes place in the public eye and processes are clear and aligned across providers.</td>
</tr>
<tr>
<td>Collaborative</td>
<td>• Collaborative process reflects the needs of the communities and input of stakeholders.</td>
</tr>
<tr>
<td>Accountable</td>
<td>• Providers are held to common performance standards and timelines; funding is directly tied to reaching program goals.</td>
</tr>
<tr>
<td>Value Driven</td>
<td>• Focus on increasing value to patients, community, payers and other stakeholders.</td>
</tr>
</tbody>
</table>

**Better Care, Better Health, Lower Costs**
DSRIP Goals & PPS Roles and Responsibilities

• Over 5 Years, 25 PPS will receive DSRIP funds to target three key statewide goals

• A Performing Provider System (PPS) is composed of regionally collaborating providers who will implement DSRIP projects over a 5-year period and beyond

• Each PPS must include providers to form an entire continuum of care

Statewide goals:
1. Reduce avoidable hospital use by 25%
2. Activating NYS’ fragile Safety-Net network
3. 80-90% of Medicaid managed care payments shift from Fee-for-Service (FFS) payments to Value Based Payments (VBP)

RESPONSIBILITIES MUST INCLUDE:

- Community health care needs assessment based on multi-stakeholder input and objective data
- Implementing a DSRIP Project Plan based upon the needs assessment in alignment with DSRIP strategies
- Meeting and reporting on DSRIP Project Plan process and outcome milestones
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
Pharmacy has been the fastest growing component in the Medicaid program. The annual growth rate has been more than double the total Medicaid growth rate over the last two years.

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medicaid</td>
<td>2.8%</td>
<td>10.9%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>4.8%</td>
<td>22.7%</td>
<td>12.2%</td>
</tr>
</tbody>
</table>

(1) 2015-16 pharmacy expenditures were estimated by separating Hep C drugs, Brands, Generics and OTCs. The trend was determined by taking the average of six months of year over year trend (Jan - Jun 2015). Total Medicaid expenditures include DOH and OSA spending, but exclude Essential Plan spending.

(2) Pharmacy expenditures are reflected prior to rebate offsets (approximately 45% of expenditures).

(3) Managed Care spend based on encounter data, plan reported pharmacy claim cost. Based on Date of Service, reported as of 01/15/2016.
DSRIP and VBP Work Together to Drive Sustainable Change

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

DSRIP:
Restructuring effort to prepare for future success in changing environment

January 2017
Moving Towards Improved Quality Through Value Based Payments
Value Based Payments: Why is this important?

- By DSRIP Year 5 (2020), all Managed Care Organizations (MCOs) must employ VBP systems that reward value over volume for at least 80 – 90% of their provider payments.

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYSDOH DSRIP Website. Published March 2016.
# Types of VBP Arrangements

<table>
<thead>
<tr>
<th>Types</th>
<th>Total Care for General Population (TCGP)</th>
<th>IPC</th>
<th>Care Bundles</th>
<th>Special Need Populations</th>
</tr>
</thead>
</table>
| **Definition**                | Party(ies) contracted with the MCO assumes responsibility for the total care of its attributed population | Patient Centered Medical Home (PCMH) or Advanced Primary Care (APC), includes:  
• Care management  
• Practice transformation  
• Savings from downstream costs  
• Chronic Bundle (includes 14 chronic conditions related to physical and behavioral health related) | Episodes in which all costs related to the episode across the care continuum are measured:  
• Maternity Bundle | Total Care for the Total Sub-pop  
• HIV/AIDS  
• MLTC  
• HARP |
| **Contracting Parties**       | IPA*/ACO**, Large Health Systems, FQHCs, and Physician Groups                | IPA/ACO, Large Health Systems, FQHCs***, and Physician Groups         | IPA/ACO, FQHCs, Physician Groups and Hospitals                              | IPA/ACO, FQHCs and Physician Groups    |

*IPA= Individual Provider Association  
**ACO= Accountable Care Organization  
***FQHC = Federally Qualified Health Center  
MLTC = Managed Long Term Care  
HARP = Health and Recovery Plan
# VBP Contracting

In addition to choosing which integrated services to focus on, Managed Care Organizations and contractors can choose different levels of VBP:

<table>
<thead>
<tr>
<th>Level 0 VBP</th>
<th>Level 1 VBP*</th>
<th>Level 2 VBP*</th>
<th>Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)</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>
<tr>
<td>No Risk Sharing</td>
<td>↑ Upside Risk Only</td>
<td>↑↓ Upside &amp; Downside Risk</td>
<td>↑↓ Upside &amp; Downside Risk</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
- Aim of ≥ 35% of total costs captured in VBPs in Level 2 VBPs or higher

**Acronym Definitions:** Fee for Service (FFS), Patient Centered Medical Home (PCMH), Advanced Primary Care (APC), Per Member Per Month (PMPM), DSRIP Year (DY)
Example 1: VBP Arrangement between the Health Plan (MCO) and Provider (ACO/IPA)

MCO contracts with an Accountable Care Organization (ACO) or Independent Practice Association (IPA)

ACO / IPA is responsible for the total cost of care and outcomes for the specific population

Note: ‘ACO’ refers to a NYS Medicaid ACO as defined under PHL § 2999-p
Example 2: VBP Arrangement between the Health Plan (MCO), Hospital and/or Provider

Health Plan contracts *separately* with a hospital and a clinic.

While the contracts are *separate*, the providers’ performance is seen as a whole for total cost of care and outcomes for a specific population.

*In practice, this is ordinarily only feasible for a Level 1 VBP Arrangement and is often a temporary step during IPA / ACO formation.*
Vision Behind This Approach

- Flexibility for Providers and Health Plans
- Local circumstances differ:
  - Provider readiness
  - Demographics & geography
- Health care is very heterogeneous

Financial and regulatory incentives drive…

a delivery system which realizes…

cost efficiency and quality outcomes: value

- Different types of outcomes that are relevant
- Different role for the beneficiary/patient
- Different models of care
- Different organizational forms
- Different payment models

Healthy people

People with acute conditions

People with chronic conditions

People with multiple conditions

Population health: prevention, screening, health education, monitoring

Rapid, effective, efficient and patient-centered diagnosis, treatment, rehabilitation and follow-up

Patient-directed, continuous, effective, efficient disease management, incl. secondary prevention and focus on life style & social determinants

Patient-directed, continuous, quality of life focused care coordination
Alignment Will Be Implemented From 2017 Onwards

The **State** will adjust MCO premiums based on value delivered to their total membership per VBP arrangement type (whether actually contracted or not) and on meeting yearly targets to move to 80-90% VBP.

MCOs will subsequently drive providers to improve this value of care. VBP arrangements and insight in the potential performance of providers will be actionable entry point for MCOs.

**Providers:** Deliver better quality and efficient care for Medicaid beneficiaries, allowing for further re-investment into the delivery system.

Feedback-loop facilitates control of the overall Medicaid spend.
Today: >25%* of Medicaid Spend is in VBP Level 1 or Higher

<table>
<thead>
<tr>
<th>VBP Level</th>
<th>Spending or %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Spending</td>
<td>$ 22,741 M</td>
</tr>
<tr>
<td>FFS</td>
<td>$ 14,372 M</td>
</tr>
<tr>
<td>$</td>
<td>63.2%</td>
</tr>
<tr>
<td>VBP Level 0</td>
<td>$ 2,576 M</td>
</tr>
<tr>
<td>$</td>
<td>11.3%</td>
</tr>
<tr>
<td>VBP Level 0 Quality</td>
<td>$ 2,036 M</td>
</tr>
<tr>
<td>$</td>
<td>9%</td>
</tr>
<tr>
<td>VBP Level 0 No Quality</td>
<td>$ 539 M</td>
</tr>
<tr>
<td>$</td>
<td>2.4%</td>
</tr>
<tr>
<td>VBP Level 1</td>
<td>$ 567.5 M</td>
</tr>
<tr>
<td>$</td>
<td>2.5%</td>
</tr>
<tr>
<td>VBP Level 2</td>
<td>$ 3,172 M</td>
</tr>
<tr>
<td>$</td>
<td>14%</td>
</tr>
<tr>
<td>VBP Level 3</td>
<td>$ 2,062 M</td>
</tr>
<tr>
<td>$</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

Includes Mainstream, Managed Long Term Care (MLTC), Medicaid Advantage Plan (MAP), and HIV Special Needs Plans (SNP)

Acronym Definitions: Fee for Service (FFS) * Survey of CY2014 = 25.5%
Future State: 80-90%* of Medicaid Managed Care Spend (Plan to Provider Payments) in VBP Level 1 and Higher

By April 2020

*Minimum of 80%; includes MLTC and (depending on move to Managed Care) I/DD = Intellectual/Developmental Disability
Examples of what a VBP arrangement looks like for pharmacies
VBP Arrangements for Pharmacies

• Example 1: Pharmacy as subcontracted provider to VBP contractor
• Example 2: Pharmacy as an upside only partner in a VBP contract
• Example 3: Pharmacy as an upside and downside partner in a VBP contract
Example 1: Pharmacy as subcontracted provider

**Situation**

- An IPA has signed a Level 1 or 2 VBP arrangement with one of the pharmacy’s payers
- The pharmacy signs a subcontractor agreement with the IPA to provide enhanced care management/communication services* for the VBP arrangement’s attributed population (MtM, Med Reconciliation)

**Implication**

- The pharmacy may receive a monthly payment from the IPA for each member attributed to that VBP arrangement that the pharmacy serves, could be paid based on activities, or any combination thereof
- The pharmacy’s relationship with the payer does not change, and they continue to receive FFS payments for services

**Outcome**

- Members receive enhanced care management services which may improve outcomes and reduce overall cost of care
- Reductions in cost of care lead to savings that are shared by the payer and the VBP contractor; this allows the contractor to provide the payments to the pharmacy
- Pharmacy realizes no shared savings, but also takes on no risk

---

*For Illustrative purposes only – does not necessarily represent a model endorsed by NYS

---

Acronym Definition: Independent Practice Association (IPA), Medication Therapy Management (MtM), Fee-For-Service (FFS)
Example 1: Pharmacy as subcontracted provider to Level 1 or 2 VBP contractor

* TCGP = Total Care for the General Population; there is no restriction on the arrangement types that could be eligible for this type of agreement

** For calculation of shared savings/losses, cost of care includes all Medicaid reimbursed costs including pharmacy costs

** Acronym Definition: Independent Practice Association (IPA), Medication Therapy Management (MtM), Fee-For-Service (FFS)

For Illustrative purposes only – does not necessarily represent a model endorsed by NYS
Example 2: Pharmacy as an upside only partner

**Situation**
- The pharmacy contracts with an IPA that has signed a Level 1 or 2 VBP arrangement with one of the pharmacy’s payers
- In the case of a Level 2 contract, a separate provision restricts the pharmacy’s risk from shared losses

**Implication**
- The pharmacy continues to receive FFS payments for services from the managed care organization
- The pharmacy takes part in distribution of any shared savings at the end of the year once actual cost for the attributed population has been determined

**Outcome**
- Members receive enhanced care management services which may improve outcome and reduce overall cost of care (MtM, Med Reconciliation)
- The pharmacy now stands to benefit from savings at each step in the continuum of care
- The pharmacy MAY NO LONGER receive payment (or may receive reduced payment) for ancillary services provided, but now shares in savings if realized

**For Illustrative purposes only – does not necessarily represent a model endorsed by NYS**

Acronym Definition: Independent Practice Association (IPA), Medication Therapy Management (MtM), Fee-For-Service (FFS)
Example 2: Pharmacy as an upside only partner

* TCGP = Total Care for the General Population; there is no restriction on the arrangement types that could be eligible for this type of agreement
** For calculation of shared savings/losses, cost of care includes all Medicaid reimbursed costs including pharmacy costs

** Acronym Definition:** Independent Practice Association (IPA), Medication Therapy Management (MtM), Fee-For-Service (FFS)

For Illustrative purposes only – does not necessarily represent a model endorsed by NYS
Example 3: Pharmacy as an upside and downside partner

**Situation**

- The pharmacy contracts with an IPA that has signed a Level 2 or 3 VBP arrangement with one of the pharmacy’s payers
- The pharmacy’s level of exposure to shared savings/losses may vary according to the terms of their contract

**Implication**

- The pharmacy may receive FFS or capitated payments for services from the IPA OR MCO depending on the terms of their contract
- The pharmacy may take part in distribution of any shared savings or losses at the end of the year once actual cost for the attributed population has been determined (note that the pharmacy may also engage in a “Level 3” arrangement with the IPA and not reconcile shared savings or losses)

**Outcome**

- Members receive enhanced care management services which may improve outcome and reduce overall cost of care ((MtM, Med Reconciliation))
- The pharmacy now stands to benefit from (or be penalized for) savings (or losses) at each step in the continuum of care
- The assumption of risk increases the value of the shared savings for which providers are eligible

For Illustrative purposes only – does not necessarily represent a model endorsed by NYS

**Acronym Definition:** Independent Practice Association (IPA), Medication Therapy Management (MtM), Fee-For-Service (FFS), Managed Care Organization (MCO)
Example 3: Pharmacy as an upside and downside partner

**Acronym Definition:** Independent Practice Association (IPA), Medication Therapy Management (MtM), Fee-For-Service (FFS), Managed Care Organization (MCO)

* TCGP = Total Care for the General Population; there is no restriction on the arrangement types that could be eligible for this type of agreement

** For calculation of shared savings/losses, cost of care includes all Medicaid reimbursed costs *including* pharmacy costs

For Illustrative purposes only – does not necessarily represent a model endorsed by NYS
The Future of MAPP Dashboards to Support VBP
Both DSRIP and VBP require fundamental changes to the performance management system

**DSRIP**
Shifting PPS incentives from Process Measures to Outcome Measures over time.

**VBP**
Tracking Value delivered of both MCOs and providers in the State with claims-based as well as clinical data

- Compliance
- Outcomes
- Clinical reporting
- Prevention
- Satisfaction
- Efficiency
- Disease management
VBP Dashboards in MAPP: Functionality

• The VBP Dashboards will allow users to access and view total service volume and dollars per county.

• Development Status: The test environment and validation have launched for this dashboard.

The MCO spend on **pharmacy costs** based on claim activity.
VBP Dashboards in MAPP: Functionality (continued)

- The VBP Dashboards will allow users to view the volume and cost by claim provider type and name
- Development Status: The test environment & validation have launched for this dashboard
VBP Dashboards in MAPP: Functionality (continued)

- VBP Dashboards will allow users to review cost based on claim activity.
- Development Status: The test environment & validation have launched for this dashboard

Pharmacy costs based on claim activity. This dashboard shows total ($) cost in proportion to other services.
Data Integration for the Implementation of MAPP Dashboards
Data Integration projects underway to realize the vision of MAPP VBP Dashboards’ utility

In this section…

• The growing number of users is driving current data integration projects
• Disparate data sources are organized in MAPP for advance analytics
• Regional Health Information Organizations (RHIOs) Pilots are testing Clinical and claims data integration
• Medicare data is needed for duals analysis
• Electronic Medical Record (EHR) clinical data feeds are being explored
Projects were started in support of local population health management and wider data integration efforts.
Collaboration with pharmacy data sources will be needed to address the demand for advanced analytics.
RHIO/QE Pilots to explore clinical and claims data integration for population health improvement

Example:
Bronx RHIO is integrating clinical and claims data into the HIE

Develop an actionable data set to support providers’ population health management efforts

Claims Data
- Clinical encounters
- Other healthcare procedures
- Prescription drugs

Clinical Data
- Clinical encounters
- Lab and imaging results
- Other

Pharmacy Data
- Prescription history
- Closed loop order entry

Eligibility Data
- Consumed state services next to Medicaid (e.g., unemployment benefits)

Homeland Security Data
- Recent visits to foreign countries with specific diseases (health surveillance)
Data Connectivity throughout the State

Example: Bronx RHIO and Bronx Partners for Health Community describe the high level IT Infrastructure required to gather and organize data sources.

DOH’s Medicaid Data Warehouse (MDW) is envisioned to function as a node off the RHIO HIE from which providers can consume data for VBP and population health management.
Integration of Dual Eligible Populations

- Another effort in progress is the integration of Medicare data to allow for population efforts on the Duals, which make up 41% of total Medicaid expenditure annually.

An integrated Medicaid-Medicare claim will allow:

- Better insight into health outcomes of the Duals population
- Inclusion of Duals in Value Based Payment arrangements
- Inclusion in Master Data Management efforts
VBP efforts have identified new priorities for EHR clinical data integration

Clinical Advisory Groups

Value Based Payment Measure Set

EHR Systems

Physician Behavioral Health

FQHC

Health Home

Skilled-nursing Facilities (SNFs)

HIE

RHIO

MDW

eClinical Quality Measures

January 2017
eCQM elements from the EHRs are required to calculate clinical VBP measures

![Clinical Advisory Group Report](image)

**Example of a recommended measure**

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

<table>
<thead>
<tr>
<th>Data Element</th>
<th>CMS Measure ID</th>
<th>eMeasure Type</th>
<th>eMeasure ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above Normal Follow-up</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>Above Normal Medications</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>BMI Encounter Code Set</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>BMI LOINC Value</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>Below Normal Follow up</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>Below Normal Medications</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>Medical or Other reason not done</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>ONC Administrative Sex</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>Overweight</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>Patient Reason refused</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>Payer</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>Pregnancy Dx</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>Race</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>Referrals where weight assessment may occur</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
<tr>
<td>Underweight</td>
<td>CMS69v6</td>
<td>EP</td>
<td>69</td>
</tr>
</tbody>
</table>
Timely and Accurate Data is Mission Critical

Data Sources
- Providers
- Claims
- Labs, Radiology, & Pharmacy
- Hospital
- Security
- Data Quality
- Data Cleansing
- Data Standardization
- Consent

Integrated Dataset

Data Elements
- ED Visit
- Demographics
- Imaging
- Admissions
- DX
- Labs
- RX

Formatted Output

Data Needs

Identify gaps

Measure Reporting

VBPI

Discover resource to Address data gaps

January 2017
Next Steps
VBP Transformation: Overall Goals and Timeline

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

DSRIP Goals

April 2017
PPS requested to submit growth plan outlining path to 90% VBP

April 2018
≥ 10% of total MCO expenditure in Level 1 VBP or above

April 2019
≥ 50% of total MCO expenditure in Level 1 VBP or above.
≥ 15% of total payments contracted in Level 2 or higher

April 2020
80-90% of total MCO expenditure in Level 1 VBP or above
≥ 35% of total payments contracted in Level 2 or higher

Acronym Definition:
Value Based Payment (VBP)
Performing Provider System (PPS)
Managed Care Organization (MCO)
Sustaining the Momentum

From 2016 – 2019

• Committed $8+ billion to:
  • Building infrastructure
  • Providing ongoing education and consultation
  • Supporting continuous, collaborative learning and sharing of best practices
  • Committed to the development and implementation of a VBP system to pay for infrastructure and services previously not supported by FFS payment methods

Beyond 2019

• Ongoing commitment to VBP system of payments
• Providers, VBP contractors and PPSs will not be “left on their own” … but they must own their operations / businesses
• DOH will provide a “bridge to sustainability” – not an endless flow of dollars to prop up existing systems
• DOH will continue to invest in innovation and support transitions to new systems and models of care

Source: Value Based Payment Roadmap. June 2015. NYS DOH Website.
Questions
Additional Information:

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

VBP Website:

Contact Us:

DSRIP Email:
dsrip@health.ny.gov
Thank you