KPMG

The Move to Value-Based Payment Leveraging DSRIP to Achieve Strategic Objectives

Trends and implications

October 2018

Agenda

The move to Value-Based Payment – trends and implications

- The current situation
- The transition to Value-Based Payment
- Leveraging DSRIP to achieve strategic objectives
- Life after DSRIP

The current situation

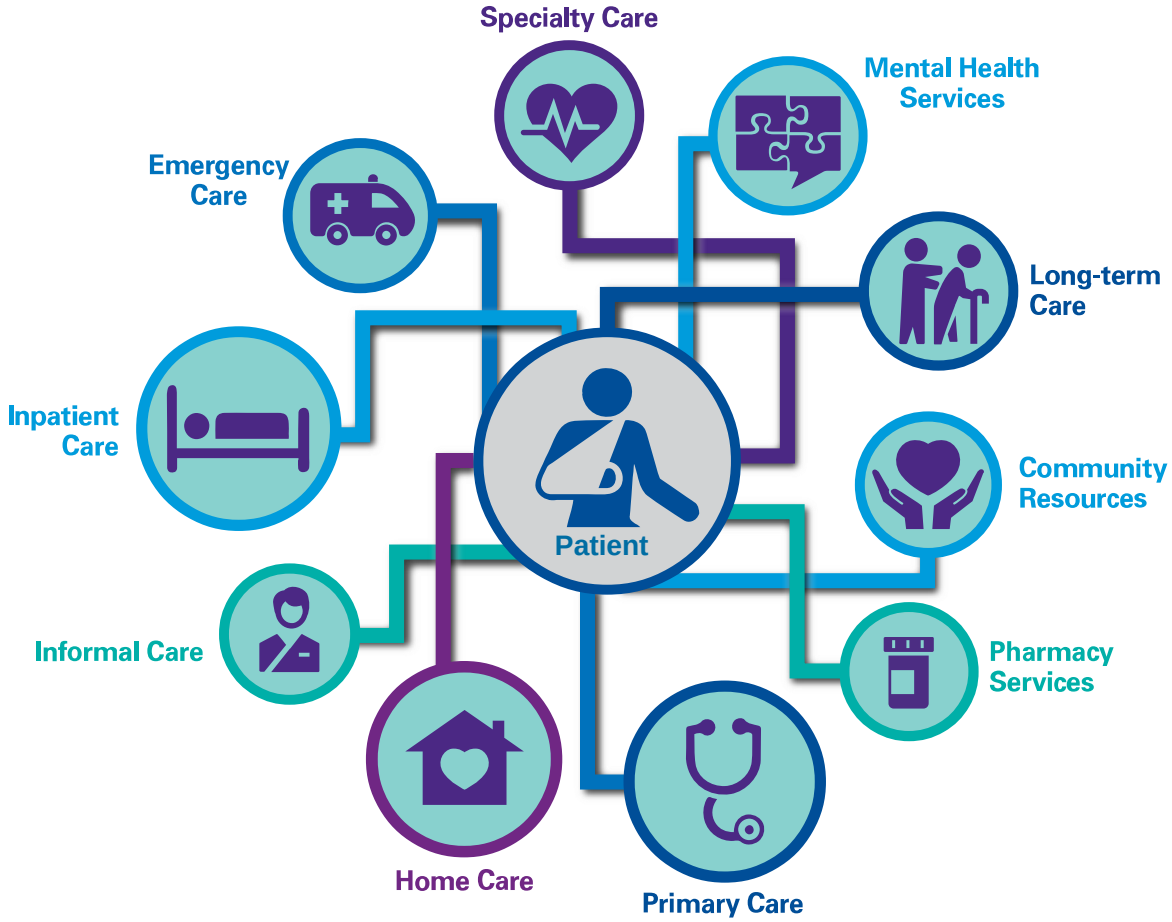
Introduction

- The **current condition of the US healthcare system** as it relates to the quality, access and cost of care delivery is **not sustainable**
- **Reform and market based initiatives** are driving the industry toward **new business and care delivery models**
- **Funding for care delivery and health management** is moving away from FFS, and toward other funding mechanisms based on outcomes, such as "**Value-Based Purchasing**"
- There are **numerous competencies required** to support risk management and alternative care delivery and business models
- The **infrastructure and investments needed** to implement these capabilities may be considerable
- There are additional enabling investments that are needed, specifically around **education and change management**

Health systems today are fragmented

Health systems today: Our fragmented healthcare delivery system is not sustainable from a cost vs. quality standpoint.

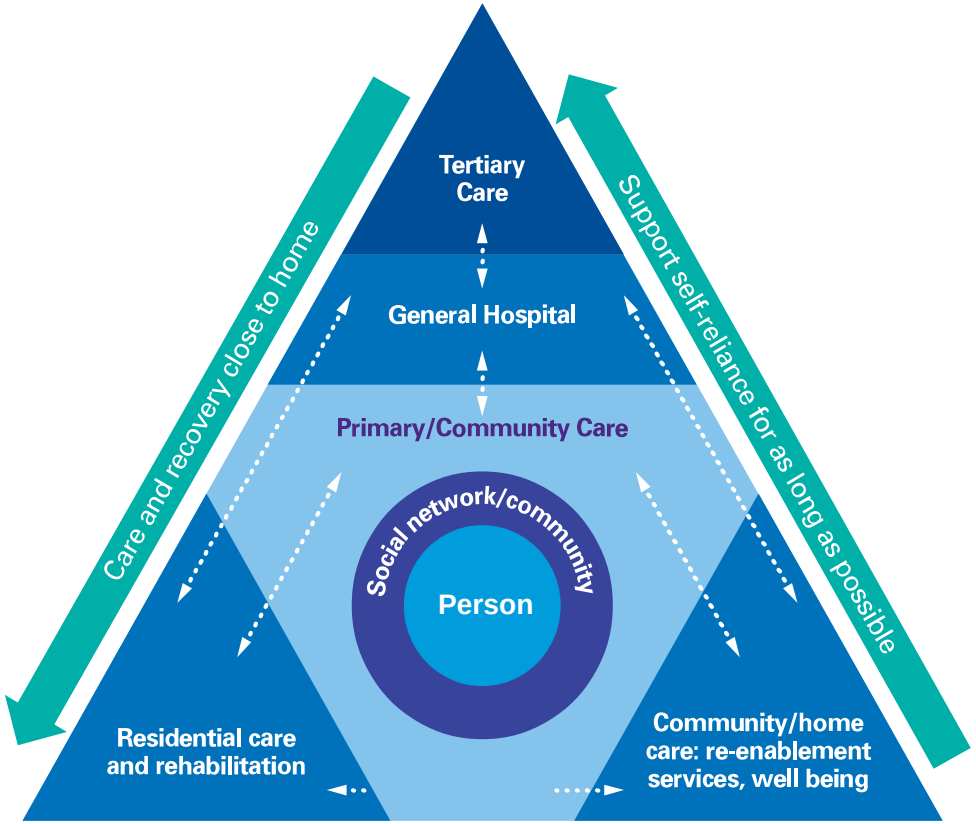
- **Care is delivered in silos** where the patient is responsible for relaying information and finding their way
- **Data is not shared** across the continuum of care
- Patients are engaged **on a reactive basis**
- Patient data is used **only when care is administered**



In the future, health systems will need to be integrated

Health systems of tomorrow: Population health is actively managed and patient care is coordinated, and provided in the appropriate settings, throughout the continuum of care via technology and process enablers**.**

- Recognize patients are complex and unique
- **Patient care is planned and coordinated** to include evidence based standards and direct care interventions across providers
- **Data is shared** in a secure manner between care providers
- **Patients are more engaged** by having access to patient portals and mobile applications
- Patient **data is used proactively** for screening through population health management tools
- Preferred provider relationships are established with community resources
- Value driven **payment models are enabled through defined contracts**

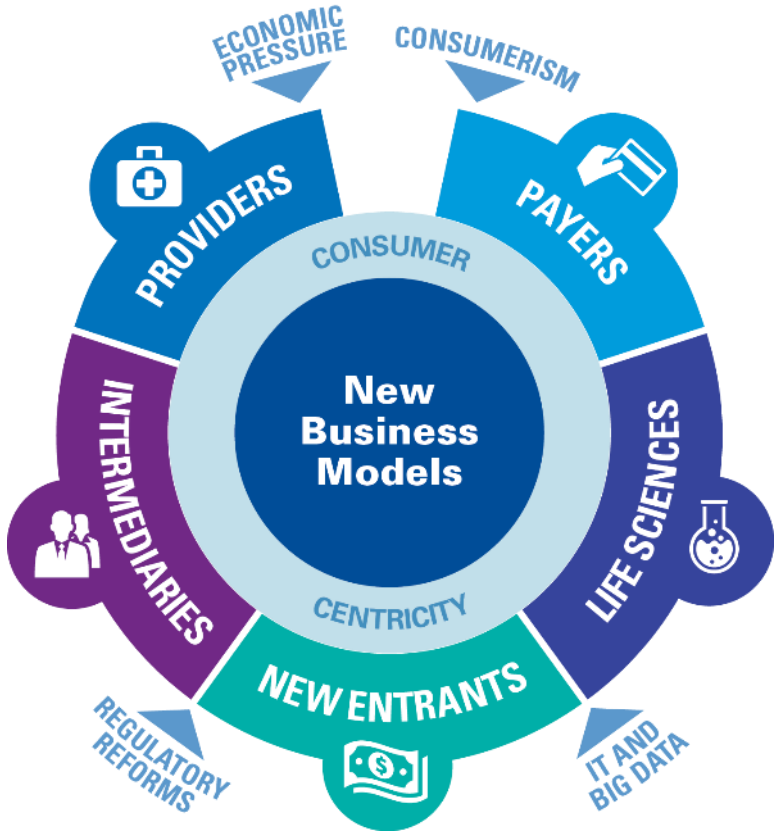


Convergence in healthcare

These dynamics are resulting in unparalleled disruption, with industry segments converging to develop new business models

Implications of convergence

- Economic **pressure to cut costs**
- **Increase in regulations** that require compliance
- Increase in **patient expectations** of services
- **Massive IT investments** underway and exponentially increasing number of solutions to evaluate – including data analytics applications
- **Enhanced care coordination** across the continuum
- Volume to **Value reimbursement models** need to be evaluated
- Provider **change fatigue**



Recent Headlines Illustrate the Transformation that is underway

Amazon, Google And Microsoft Aim To Fix Healthcare
August, 2018 | Forbes

Geisinger, Clarify Health Solutions join task force aimed at accelerating value-based care
July, 2018 | Becker's

Amazon to Buy Online Pharmacy PillPack, Jumping Into the Drug Business
June 2018 | NY Times

Walmart in Talks to Strengthen Ties to Health Insurer Humana
March, 2018 | NY Times

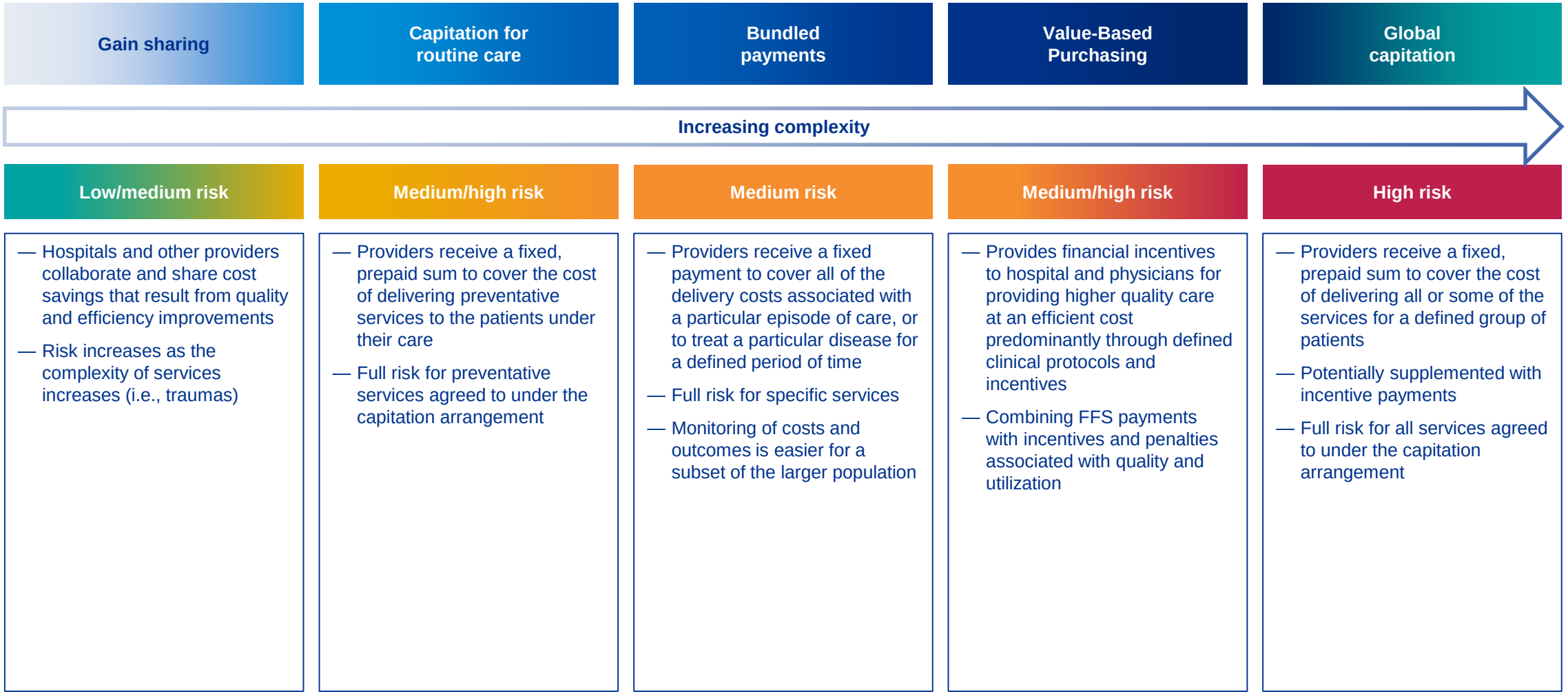
Cigna Deal Shows Being a Health Insurer Isn't Enough Anymore
March, 2018 | Wall Street Journal

Can Telemedicine Be Both Cost Efficient and High Quality?
February, 2018 | US News & World Report

KPMG

The transition to Value-Based Payment

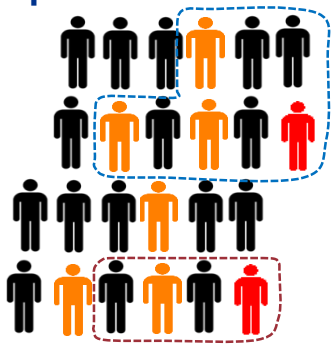
The transition to various forms of Value-Based Payment will be necessary to drive needed change



One size will not fit all - different payment models will be appropriate for different provider types and different patient groups

In designing VBP programs, payers will need to work with their providers to create a menu of options to suit providers of varying sophistication, and patient groups with different care needs

Segment and define your target populations



…by demographics

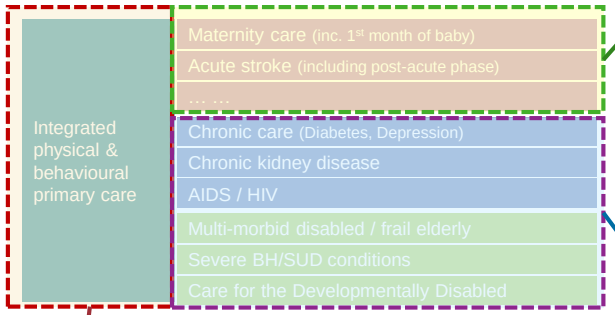
…by healthcare usage patterns

…by disease state

Identify and group types of care

Integrated physical & behavioural primary care	Maternity care (including 1st month of baby)
	Acute stroke (including post-acute phase)
	… …
	Chronic care (Diabetes, Depression)
	Chronic kidney disease
	AIDS / HIV
	Multi-morbid disabled / frail elderly
	Severe BH/SUD conditions
	Care for the Developmentally Disabled

Create payment models that match the characteristics of target groups and the sophistication of providers



Episodic care

1. Define desired patient outcomes (episode-specific)
2. Identify evidence-based care continuum for treatment
3. Calculate cost of care from incidence to outcome

Continuous care

1. Define outcomes based upon quality of care (e.g., avoidable admissions, PPVs, PPRs)
2. Identify evidence-based disease management / treatment
3. Identify cost of care for one year of management

Primary care / population health

1. Define outcomes aligned to healthy populations (e.g., avoidable admissions)
2. Identify total costs for integrated primary care use per patient per month (PMPM)

Data and analytics underpins the design and measurement of Value-Based Payment models

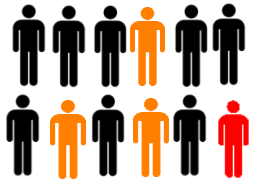
Data accessibility and analytical capability form the backbone of effective VBP creation and measurement

Datasets

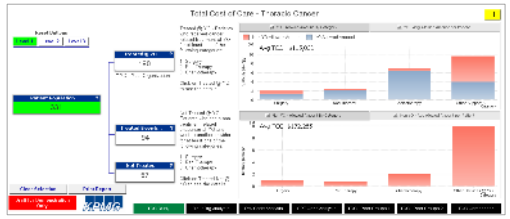
- Claims data
- Provider performance data
- Patient data and medical records

Analytical platforms

Groupers used to stratify datasets for analysis:



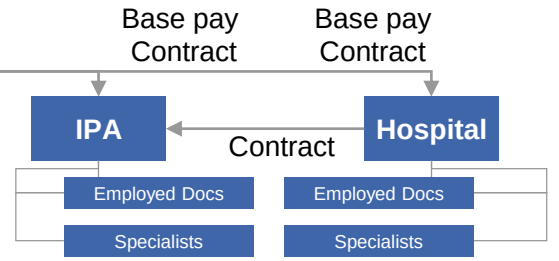
Analytic tools used to derive insights from datasets:



Dashboards

Digital solutions allow a range of different users (clinician leaders, operational administrators, C-level) to derive meaningful insights from the data to inform decision making at all levels.

A change in compensation structures and incentives will also be necessary to drive behavior



Base Pay (65% – 95%)						
	Contract type	**Payment method**	**Community**	**Acute**	**Post acute**	**LTC/ Hospice**
	Capitation	PMPM	X	X	X	X
Acuity and Risk Adjusted	Bundled Payment	Fixed $	X	X	X	
	Episode-based	Fixed $		X	X	X
	Gain sharing (2 sided)	Budget		X	X	
	Fee For Service	Variable		X		

PPO and open access products use patient attribution for PCP (preponderance of claims, number of visits, last visit, geographic proximity)

HMO and closed network products rely on assigned or enrolled patients

Performance bonus from distributable funds (5% – 35%)					
Contract type	**Weights**	**Community**	**Acute**	**Post acute**	**LTC/ Hospice**
Patient satisfaction and access	5% – 15%	X	X	x	X
Quality statistics (preventive, chronic, and acute care services)	25% – 35%	X	X	X	X
Adherence to clinical protocols	25% – 35%		X	X	
Cost efficiency	20% – 30%	X	x	X	X

Physician community

- Medical Group
- Specialists
- Facilities

Performance measures may have a minimum qualification or threshold to be entitled to a fixed percentage of savings. Additional incentive compensation may be possible as incremental performance thresholds are achieved.

Moving to alternative payment Models will require different skills and activities

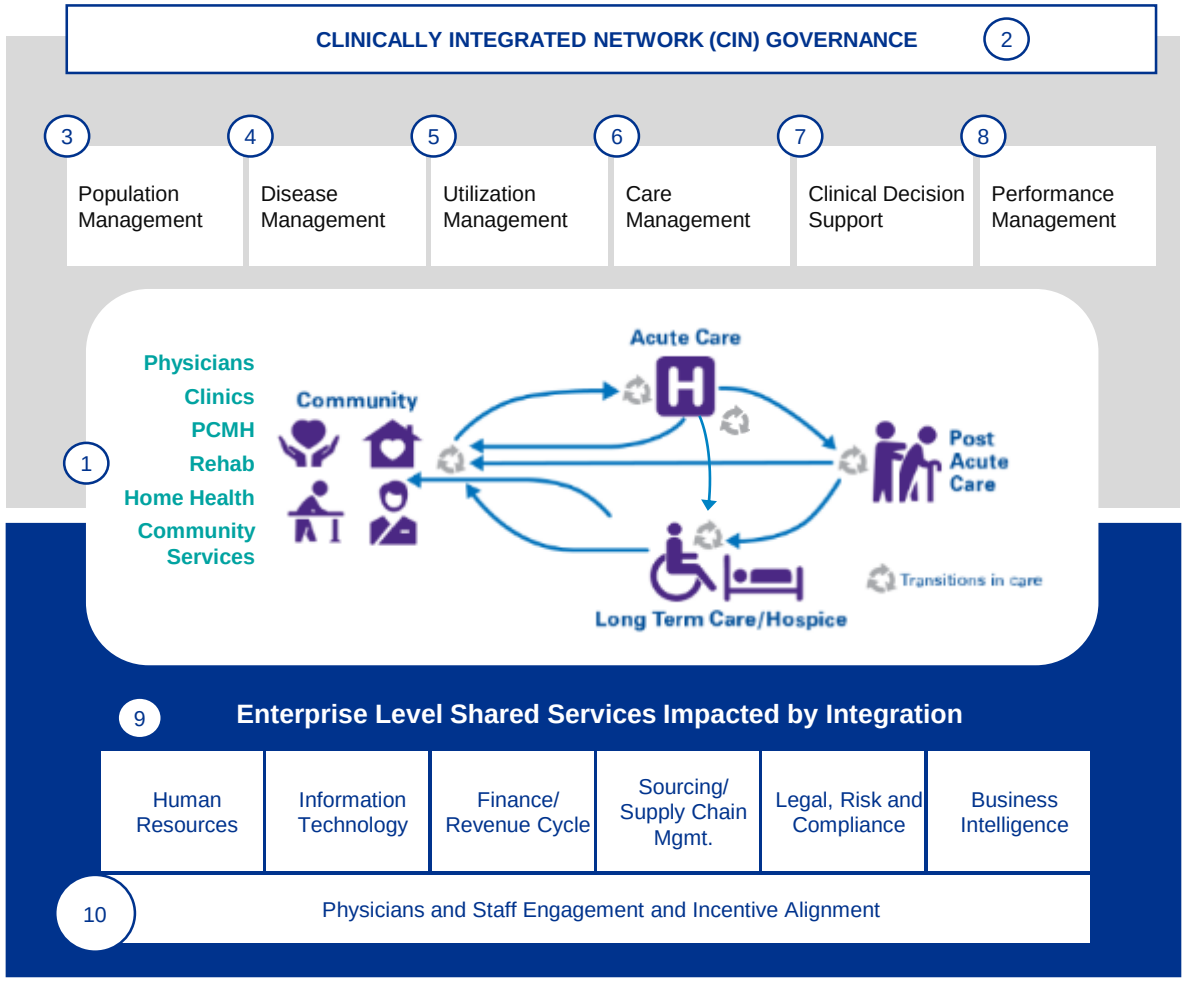
Moving to alternative (non-FFS) based payments requires different skills beyond revenue integrity (e.g., coding accuracy) and revenue recovery (e.g., denials management)

- **Analytics supporting alternative payment contracts**, such as validating risk adjustment calculations, confirming and/or analyzing episode and bundle based groupings, and validating attribution methodology
- **Tracking quality of care Key Performance Indicators (KPI)** relative to contractual terms and conditions, and monitoring expected payment (accruals) as appropriate
- Monitoring the **performance reporting** between clinical teams for consistency and accuracy, and the impact of CMI and ALOS shifts relative to incentives and contractual terms
- **Monitoring effectiveness of incentive** based reimbursements relative to quality-based (contractual) requirements
- **Activity-based costing** to improve accuracy of service-based pricing under bundles or episodic payments
- Proving **reporting transparency on performance** to the community as well as physicians within the CIN
- To the extent the Clinically Integrated Network (CIN) is mature in its capabilities, **an actuarial analysis including clinical variability, predictive modeling of population (community) needs**, and more refined risk stratification (for case management support). Also, capital based reserves against assumed risk, reinsurance analysis, and the calculation of amounts due related to performance payouts.

KPMG

The Clinically Integrated Network (CIN)

As the industry continues to converge, the Clinically Integrated Network (CIN) will be the dominant model

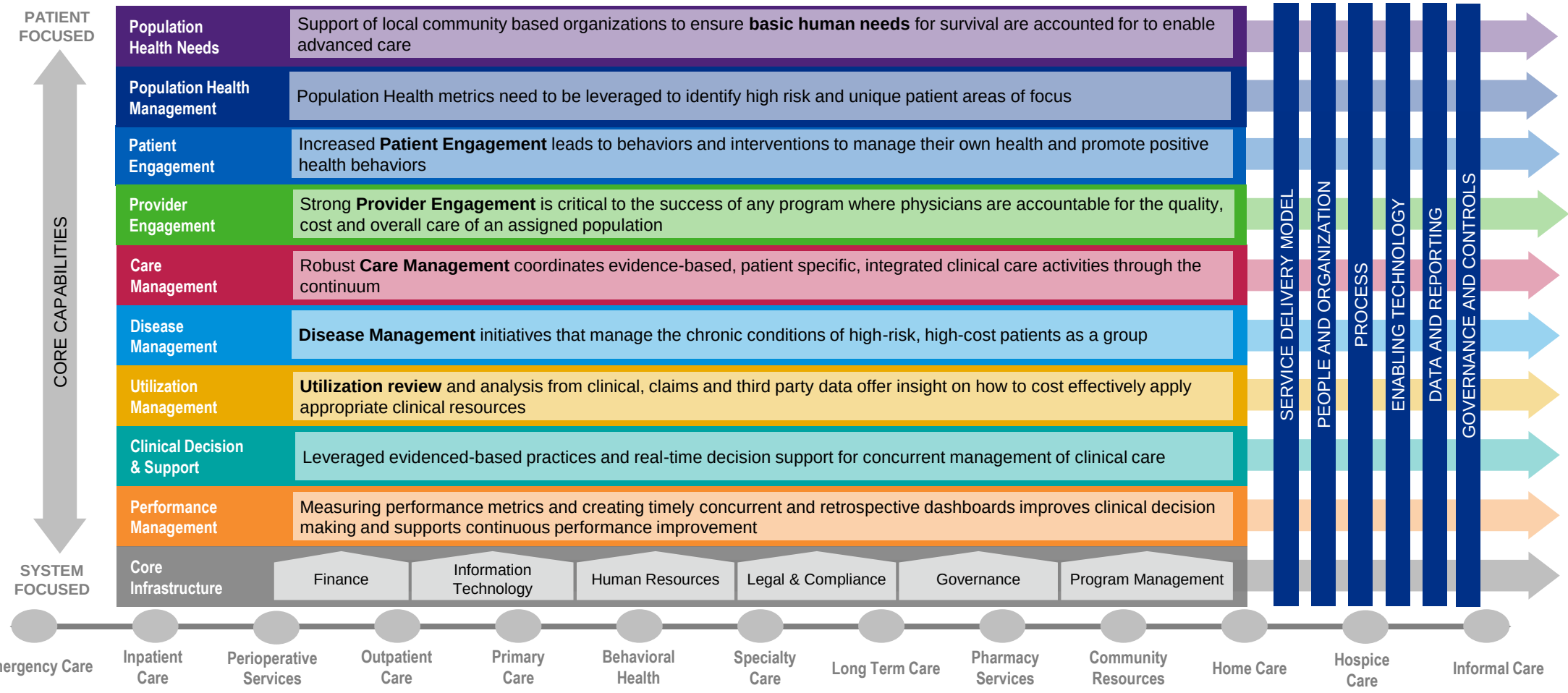


Key Success Factors for CIN

1. **Access to Full Continuum of Care:** Not all needs to be owned
2. **Governance:** Fiduciary; Clinical; Incentive Comp
3. **Population Health Management** – Leveraging data to steer clinical interventions according to risk status and disease states
4. **Disease Management** – System of coordinated healthcare interventions to manage chronic conditions in high-risk patients
5. **Utilization Management** – Evaluate appropriateness and efficacy of healthcare services for target population
6. **Care Management** – Team-based, patient-centered approach to support patients in managing medical conditions more effectively
7. **Clinical Decision Support** – Evidence-based guidance and condition-specific information built into clinical workflows to enhance care delivery
8. **Performance Management –** Establishment and tracking of clinical quality, financial, and operational KPIs
9. **Shared Services** – Governance framework and infrastructure support required for CIN / ACO administration
10. **Provider Engagement** – Process of education and including providers in key Value-Based transformation decisions to increase their accountability for the overall quality and cost of care delivered to an assigned population

Clinically Integrated Network - Capabilities

Obtaining these required elements will require significant investment and collaboration among partners



KPMG

Leveraging DSRIP to Achieve Strategic Objectives

Similar to the US overall, the New York State Medicaid program did not have ideal cost and quality indicators

New York State Medicaid

- Approx. 6 million Medicaid beneficiaries in New York State (*rank 2nd in the US, after CA*)
- Current Medicaid spend in New York is approximately $59 billion annually (*also rank 2nd*)

The situation in 2010

- > 10% growth rate had become unsustainable, while quality outcomes were lagging
  - Costs per recipient were double the national average
  - NY ranks 50th in the country for avoidable hospital use
  - 21st for overall Health System Quality
- Attempts to address situation had failed due to divisive political culture around Medicaid. and lack of clear strategy

2009 Commonwealth State Scorecard on Health System Performance

Care measure	*National ranking*
Avoidable hospital use and cost	**50th**
Percent home health patients with a hospital admission	49th
Percent nursing home residents with a hospital admission	34th
Hospital admissions for pediatric asthma	35th
Medicare ambulatory sensitive condition admissions	40th
Medicare hospital length of stay	50th

Source: *New York State Department of Health*

The Performing Provider Systems (PPS) include members of the full continuum

A PPS is composed of regionally collaborating providers who will implement delivery system reform projects over a 5-year period and beyond

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

- Hospitals
- PCPs, Health Homes
- Skilled Nursing Facilities (SNF)
- Clinics & FQHCs
- Behavioral Health Providers
- Home Care Agencies
- Community Based Organizations

Statewide goal:

- 25% of avoidable hospital use ((re-) admissions and ER visits)
- No more providers needing financial state-aid to survive

RESPONSIBILITIES INCLUDE:

Source: *New York State Department of Health*

Payment reform is a central element of New York State's DSRIP program

The high-level principles of the DSRIP program set the parameters for a shift towards Value-Based Payment for Medicaid (these are still to be finalized)

- ≥ 80-90% of total MCO-PPS payments (in terms of total dollars) to be captured in Value-Based Payments at end of the 5-year program
- ≥ 50-70% of the total costs captured in VBPs have to be in Level 2 VBPs or higher
- The more dollars that are captured in higher level VBP arrangements, the higher the PMPM value MCOs may receive from the State

The DSRIP program sets out 3 levels of Value-Based Payments. This provides the starting point for organizations to self-assess their current situation and develop a vision for transformation

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires a mature PPS)
FFS with bonus and / or penalty 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)

CMS Medicare VBP Program Overview

CMS's goal is to reduce Medicare spending by incentivizing Clinically Integrated Networks (CINs) to assume financial risk, linked with reduced unnecessary utilization and improved outcomes. CMS's Value-Based Purchasing "program" currently includes:

- Advanced Alternative Payment Models
- Accountable Care Organizations (Medicare Shared Savings Program)
- Bundled payments (Bundled Payment for Care Improvement Initiative)
- Primary care medical homes

CMS goal is to have 30% of all payments be VBP-based by 2016 and 50% by 2018

Commercial healthcare is following suit: Aetna and United Health have more than 45% of their annual spend in Value-Based contracts. Anthem has 58% of their annual spend in Value-Based contracts.

SI PPS has demonstrated the ability to operate in a Value-Based Model and built a foundation for its future state operating model

DSRIP achievements lay the foundation for future sustainability

- ***Ranked 1st*** out of 25 PPSs in PPS 360 Survey
- **5/5 achievement value** earned for 91.7% of the possible funding award on DSRIP Year 3, Quarter 2 Scorecard
- **5 High Performance Fund** targets met in Measurement Year 3 resulting in additional funding for partners
- **11 DSRIP Projects** on-track (1) or complete (10)

Progress and Accomplishments

- **Created an extensive partner network** on Staten Island comprised of **providers across the care continuum.**
- **Developed a Project management** team and an approach to **Governance** to implement programs and drive change.
- Adopted and **implemented evidence-based practices** for chronic conditions impacting the Medicaid population:
  - Care Management/Care Coordination Guidelines
  - Care Transitions Clinical Recommendation and Guidelines
  - INTERACT Principles to Reduce Nursing Home/Home Care to Hospital Transfer
  - Chronic Diseases Prevention and Management/PHIP
- **Realized results** are having a **positive impact on outcomes and cost:**
  - ★ *62% reduction in Potentially Avoidable ER Visits (PPV)*
  - ★ *52% reduction in Potentially Avoidable Readmissions (PPR)*
  - ★ *58% reduction in PPV for members with behavioral health diagnosis*
  - 25% increase in follow-up care after hospitalization for mental illness
  - 37% reduction in admissions due to diabetes related short-term complications (PQI 1)
  - 24% increase in follow-up care for children prescribed ADHD medication

SI PPS has demonstrated the ability to operate in a Value-Based Model and built a foundation for its future state operating model

- **Realized results** are having a **positive impact on outcomes and cost:**
  - ★ *62% reduction in Potentially Avoidable ER Visits (PPV)*
  - ★ *52% reduction in Potentially Avoidable Readmissions (PPR)*
  - ★ *58% reduction in PPV for members with behavioral health diagnosis*

11 Projects					
	Patient Activation	Chronic Disease Prevention Care	Integrated Primary Care & Behavioral Health	Mental Health & Substance Abuse Infrastructure	Withdrawal Management
Palliative Care in Nursing Homes	Diabetes Disease Management	Health Home At-Risk	Care Transitions	Hospital / Homes Care Collaboration	INTERACT in Nursing Homes

- **Realized results** are having a **positive impact on outcomes and cost:**
  - ★ *62% reduction in Potentially Avoidable ER Visits (PPV)*
  - ★ *52% reduction in Potentially Avoidable Readmissions (PPR)*
  - ★ *58% reduction in PPV for members with behavioral health diagnosis*

- 25% increase in follow-up care after hospitalization for mental illness
- 37% reduction in admissions due to diabetes related short-term complications (PQI 1)
- 24% increase in follow-up care for children prescribed ADHD medication

SI PPS Initiatives that have lead to its Success

Staten Island PPS has laid a solid foundation in the Staten Island Market through its DSRIP efforts which can be built upon as it considers its option to enter into the environment of Value-Based Care.

SI PPS Goals:

Improving access to high quality, culturally sensitive care

Improving population health and health literacy

25% reduction in avoidable emergency room visits

Reducing preventable hospital admissions and readmissions

DSRIP Projects	Initiatives
• Health Home At-Risk Intervention Program • Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions • Implementing the INTERACT Project • Hospital-Home Care Collaboration Solutions • Implementation of Patient Activation Activities • Integration of Primary Care and Behavioral Health Services • Development of Withdrawal Management Capabilities and Appropriate Enhanced Abstinence Services within Community-Based Addiction Treatment Programs • Evidence based strategies for disease management in high risk/affected populations • Integration of Palliative Care into Nursing Homes • Strengthen Mental Health and Substance Abuse Infrastructure across Systems • Increase Access to High Quality Chronic Disease Preventative Care and Management in Clinical and Community Settings	SI CARES Wellth Sepsis Protocol Project HOPE Asthma Home Visit Program 911 Diversion Program Staten Island Rehousing Program SDOH Assessment Tool & Resource Guide HEALTHi Asthma Coalition Diabetes Self Management Program CHW Training Pipeline A-CHESS Registered Apprentice Program Health + NYCHA Collaboration Warm Handoff Program Primary Care Gift Card Program AllazoHealth

As options for the future are considered, SI PPS is faced with challenges

- **The future is uncertain as DSRIP ends in 2020, and with it, current planned government funding**
- **To effectively manage the care for a population, data must be able to be shared between partners**
- **Success has caused disruption in the market by reducing inpatient utilization and ED volumes**
- **Managing the care of a population requires care management and coordination**
- **Stakeholders will need to be aligned on the future state of SI PPS**
- **Sophisticated IT infrastructure is required to manage the care of a target population**
- **The shift to a Value-Based Payment model may require risk to be taken.**

Feedback from partners was used to assess the perception of SI PPS's capabilities and preferences for future models

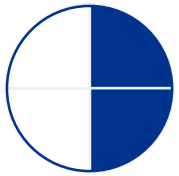
Observed Themes from Interviews and Survey Results

- SI PPS has built trust among stakeholders
- Collaboration and data sharing between "partners" is key in the future state
- Understanding and experience with Value-Based Care varies
- Partners have limited experience in accepting risk
- Most stakeholders believe service line capacity is sufficient, with some exceptions
- Investment in infrastructure and capabilities will be needed to manage population health
- Many stakeholders support being a part of a SI PPS-led network
- The most preferred future operating models for SI PPS were an IPA and ACO model
- MCOs interviewed were willing to establish Value-Based Contracts with potential partners

Several options are being considered for life after DSRIP on Staten Island (not limited to those below)

Each option is being assessed in term of:

- Knowledge & Understanding
- Technology
- Organizational Design
- Population Health Management
- Finance
- Parent Support
- Partner Support

	Overall	Knowledge & Experience	Technology	Organizational Design	Population Health Management	Finance	Parent Support	Partner Support
Medicaid Accountable Care Organization (ACO)								
Comment:	**A Medicaid ACO is a preferable option due to the support of both parent organizations. However, the ACO option may require redundant models and the most start-up cost and time.**							
Independent Practice Association (IPA)								
Comment:	**An IPA is a preferable option due to it being relatively less complex than an ACO to organize and implement.**							

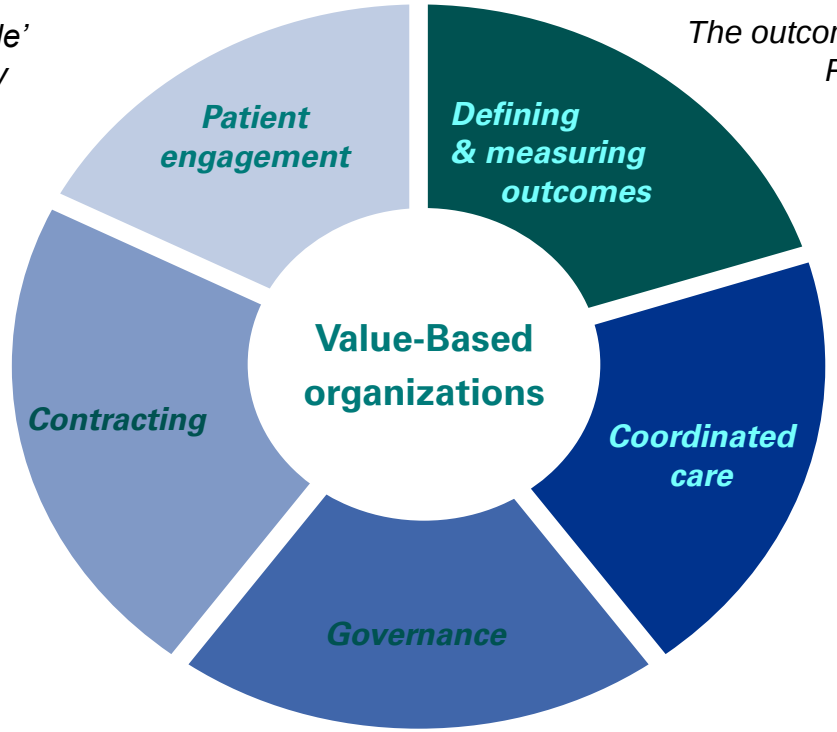
In our global thought leadership '*As Strong as the Weakest Link*' we identified *5 key success factors of value-Based organizations*

Patients provide your compass

Make sure patients are genuinely 'at the table' and not just on the receiving end of visionary documents and operational plans.

Mobilize your contractor, incentives need to change

The contractor – whether that is an insurer, government or clinical group – is your partner, not your enemy. Financial incentives that do not reward change are a key blockage in many systems.



Visible outcomes can be improved, invisible outcomes cannot

The outcomes you measure should follow what patients need. Fantastic hip replacement results are great but if the procedure is followed by a 5-week wait for rehabilitation, the outcome for the patient is questionable

Define your position in the pathway and find partners you trust

Are you looking to create a focused orthopedic surgery 'factory' or organize coordinated care across several tiers of care? The patients you care for should be your starting point for answering this question. Next, find partners you trust to complete the whole care pathway.

Centralize authority and decentralize decision making

Realizing sustainable change requires a clear vision and strong governance focused on outcomes. This must be combined with professionals empowered to improve care and collaborate across organizational boundaries.

Q&A

kpmg.com/socialmedia