CCN Payer Forum: United Healthcare

- Thursday, August 25th, 2016
- DoubleTree by Hilton Hotel, Binghamton
Agenda

• Welcome and Introductions
• Today's Objectives
• Care Compass Network Updates
• Payer Presentation
• Questions & Answers
• Closing
Today’s Objectives

• Obtain high-level CCN program updates

• Learn about United Healthcare’s plans for Value-Based Payment arrangements for the Medicaid Population for 2017

• Learn how your organization can participate in value-based payment arrangements such as those being pursued by UHC

• Opportunity to ask questions about VBP to UHC representatives
Care Compass Network Updates
The DSRIP Timeline

We Are Here

- **DY0**
  - 4/14
  - Build Infrastructure

- **DY1**
  - 4/15
  - Implement Programs

- **DY2**
  - 4/16
  - Monitor Performance

- **DY3**
  - 4/17
  - Incent Outcomes

- **DY4**
  - 4/18
  - Engage in VBP

- **DY5**
  - 4/19
You’ve Helped Us Grow...

• From 0 Contracts to 70
• From 0 Employees to 20
• From 0 Policies & Procedures to 41
• From 0 Locations to 1 for PCMH Level 3 2014 (2 pending)
  • 68 Providers in pursuit (North RPU)
• From 3,984 square feet to 6,864
Innovation Fund Update

- 23 proposals valuing $7.1 million
  - Ranging $27,000 to $1.6 million

<table>
<thead>
<tr>
<th>Category</th>
<th># Proposals Submitted</th>
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<tbody>
<tr>
<td>Behavioral Health</td>
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<td>Disease Management</td>
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<td>Navigation</td>
<td>5</td>
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<tr>
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<td>Tele-Medicine</td>
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<td>Transportation</td>
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<tr>
<td>Value-Based Payment</td>
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<td>Other</td>
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## Original Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Objective</th>
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<tbody>
<tr>
<td>08/05/2016</td>
<td>Categorize Responses &amp; Summarize</td>
</tr>
<tr>
<td>08/19/2016</td>
<td>Review Draft Selection &amp; Evaluation Committee with PAC EC</td>
</tr>
<tr>
<td>08/23/2016</td>
<td>• Selection Committee Meeting to agree on evaluation method</td>
</tr>
<tr>
<td></td>
<td>• Distribute scoring grid &amp; proposals to selection committee</td>
</tr>
<tr>
<td>08/26/2016</td>
<td>Review proposals - 2 teams</td>
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<tr>
<td>09/02/2016</td>
<td>Final Review &amp; Selection – entire team</td>
</tr>
<tr>
<td>09/07/2016</td>
<td>Board Presentation Preparation</td>
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<tr>
<td>09/13/2016</td>
<td>(Anticipated) Board Approval of Recommendations</td>
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<tr>
<td>09/14/2016</td>
<td>Award Announcement</td>
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# Revised Timeline

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<td>• Selection Committee Meeting to agree on evaluation method</td>
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<td></td>
<td>• Distribute scoring grid &amp; proposals to selection committee</td>
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<td>Week of 09/12/2016</td>
<td>Review proposals - 2 teams</td>
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<tr>
<td>Week of 09/19/2016</td>
<td>Final Review &amp; Selection – entire team</td>
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<tr>
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## VBP Roadmap / Timeline

<table>
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<tr>
<th>Date</th>
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<tr>
<td>09/30/2016</td>
<td>Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.</td>
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<tr>
<td>03/31/2017</td>
<td>Finalize a plan towards achieving 90% value-based payments across the network by year 5 of the waiver at the latest</td>
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<tr>
<td>03/31/2018</td>
<td>Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation</td>
</tr>
<tr>
<td>03/31/2019</td>
<td>Contract 50% of care costs through Level 1 VBP with $\geq$ 30% of those costs through Level 2 VBP or higher</td>
</tr>
<tr>
<td>03/31/2020</td>
<td>Contract 90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBP with 70% of total costs captured through Level 2 VBP or higher (minimum 35%)</td>
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Latest News from the RPUs

Regional Performing Unit (RPU) by County

- **North RPU** – Cortland, Tompkins, & Schuyler Counties
- **South RPU** – Broome & Tioga Counties
- **East RPU** – Chenango & Delaware Counties
- **West RPU** – Steuben & Chemung Counties
Past & Upcoming Events

• Past Events
  • Provider Engagement Event at Binghamton Club on 06/16/2016
  • Innovative Readiness Training Event in Cortland, July 15-24
  • Innovative Readiness Training in Norwich, July 15-24
  • Gannett Behavioral Health Event on 07/28/2016

• Upcoming Events
  • PCMH DSRIP Project Forum on 08/31/2016 in the North RPU
  • INTERACT Overview for SNF Leadership on 09/07/2016
  • INTERACT Training on 09/08/2016 & 09/09/2016
  • Performance Management Class on 09/16/2016
  • Health Coach Training for Care Transitions (Mid-September)
  • CBO Engagement Event at Traditions on 09/23/2016
  • CCN/FLPPS Health Home Event
    • 09/28/2016 at CareFirst
    • 09/30/2016 at Arnot-Ogden Medical Center
Contracting Update

- 70 Contracts signed with 44 partner organizations!
  - 2.b.iv. Care Transitions – 11
  - 2.b.vii. INTERACT – 10
  - 2.c.i. Navigation – 13
  - 2.d.i. PAM Survey – 24
  - 3.a.i. Integration of Behavioral Health & Primary Care – 5
  - 3.a.ii. Crisis Stabilization – 2
  - 3.b.i. Cardiovascular Disease Management – 1
  - 3.g.i. Palliative Care – 1
  - 4.a.iii. Mental Health & Substance Abuse Infrastructure – 1
  - 4.b.ii. COPD Disease Management – 2
The DSRIP Timeline

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Presentation
UnitedHealthcare
Medicaid Redesign Projects

Care Compass Network Payer Forum

8/25/2016
Agenda

United’s current footprint

Our role in Medicaid Reform Projects

Value Based Contracting
UHC in the Southern Tier

Membership:

Broome: 3,271  
Chemung: 2,608  
Chenango: 1,263  
Tioga: 799

Total: 7,941

5 dedicated field representatives

Sprinter van that rotates between different sites in those counties two times per week.

Pop-up office in Elmira; Chemung county.
Community Engagement

- The goal of outreach is to engage community partners and individuals in activities that help to promote access and availability of health insurance programs offered by UHC.
- A key component is the relationships that we build with community based organizations and other key stakeholders. These interactions enable us to partner on events and activities that draw the community.
- Year to date we have participated in 63 events throughout the Southern Tier.
  - Major events this year include:
    - Dicks Sporting Goods Golf Outing
    - National Night Out Against Violence
    - Cornell Cooperative Extension FAME event
    - Catholic Charities of Broome County Gala
    - Broome Tioga Job Fairs
    - New York State Department of Labor Rapid Response
    - Boys and Girls Club events
    - Binghamton Senators Career Fair
Why are we here?
NYS Medicaid in 2010: the crisis

Above 10% growth rate had become unsustainable, while quality outcomes were lagging.

Costs per recipient were double the national average.

NY ranked 50th in country for avoidable hospital use.

21st for overall Health System Quality.
In 2011, Governor Cuomo created the Medicaid Redesign Team (MRT).
- Made up of 27 stakeholders representing every sector of healthcare delivery system
- Developed recommendations to lower immediate spending and propose reforms
- Closely tied to implementation of Affordable Care Act (ACA) in NYS

On April 14, 2014 Governor Andrew M. Cuomo announced that New York has finalized terms and conditions with the federal government for a groundbreaking waiver that will allow the state to reinvest $8 billion in federal savings generated by MRT reforms.

The waiver will:
1. Transform the State’s Health Care System
2. Bend the Medicaid Cost Curve
3. Assure Access to Quality Care for all Medicaid Members
4. Create a financial sustainable Safety Net infrastructure
The $8 billion reinvestment will be allocated in the following ways:

$500 Million for the Interim Access Assurance Fund – temporary, time limited funding to ensure current trusted and viable Medicaid safety net providers can fully participate in the DSRIP transformation without disruption (Equity Programs and VBP QIP)

$6.42 Billion for Delivery System Reform Incentive Payments (DSRIP) – including DSRIP Planning Grants, DSRIP Provider Incentive Payments, and DSRIP Administrative costs

$1.08 Billion for other Medicaid Redesign purposes – this funding will support Health Home development, and investments in long term care, workforce and enhanced behavioral health services

In addition, the special terms and conditions also commit the state to comprehensive payment reform and continuing New York’s effort to effectively manage its Medicaid program within the confines of the Medicaid Global Spending Cap. (VBP and the VBP roadmap)
Reform Projects: DSRIP

5 MCO related measures

2ai, Milestone 9: Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform

2biv, Milestone 2: Engage with the MCOs and HH to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed

2di, Milestone 6: Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member’s MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP.
3bi, Milestone 19: Form agreements with the Medicaid MCOs serving the affected population to coordinate services under this project

2ai, Milestone 8: Contract with Medicaid MCOs and other payers as an integrated system and establish *value-based payment* arrangements
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
Value Based Contracting Goals

New York State has committed to reaching 80% value based payments (VBP) by the end of the waiver period (end of Q1 2020).

<table>
<thead>
<tr>
<th>NY DSRIP Goals and Penalties</th>
<th>Level 1+ Target</th>
<th>Level 2+ Target</th>
<th>Penalty*</th>
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<tbody>
<tr>
<td>CY 2017</td>
<td>10%</td>
<td>N/A</td>
<td>0.50%</td>
</tr>
<tr>
<td>CY 2018</td>
<td>50%</td>
<td>15%</td>
<td>1.00%</td>
</tr>
<tr>
<td>CY 2019</td>
<td>80%</td>
<td>35%</td>
<td>1.50%</td>
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* Penalty will be marginal difference between Goal% of Medicaid Managed Care expenditure and total expenditure on Level 1/2 or above VBP contracts
NY DSRIP VBC Models

VBP contractor assumes responsibility for the total care of its total attributed population. The default method for attribution is MCO-assigned PCP.

Integrated Primary Care (IPC)

MCO contracts Patient Centered Medical Homes (PCMH) or Advance Primary Care (APC) arrangements and rewards the VBP contractor based on the savings and quality outcomes achieved. IPC contracts can include additional payments for practice transformation, care management, and can tie additional rewards to progression towards APC status, for example. All attributed members are included.

Bundles of Care

VBP contractor assumes responsibility for both the outcomes and the costs of the care across the continuum of the patient’s trajectory. NYS has prioritized two key bundles: Maternity Care (spanning the pregnancy, delivery and first month of the baby’s care) and the Chronic Care Bundle (including the chronic conditions with the highest prevalence in NYS).

Total Care for Special Needs Populations

For these subpopulations, a capitated model (a per member per month (PMPM) payment) is best suited. HIV/AIDS, HARP, Managed Long-Term Care, Care for the Developmentally Disabled (DD). When members are eligible for more than one subpopulation (e.g. HARP and HIV/AIDS), the MCO/SNP decides with the VBP contractor(s) which VBP subpopulation prevails.
# VBC Level Definitions

<table>
<thead>
<tr>
<th></th>
<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 VBP contractor)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Care for General Population</strong></td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings when quality scores are sufficient</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>Global capitation (with quality-based component)</td>
</tr>
<tr>
<td><strong>Integrated Primary Care</strong></td>
<td>FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores</td>
<td>FFS (plus PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when quality scores are sufficient)</td>
<td>FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>PMPM capitated payment for primary care services (with quality-based component)</td>
</tr>
<tr>
<td><strong>Bundles</strong></td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings based on bundle of care (savings available when quality scores are sufficient)</td>
<td>FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>Prospective bundled payment (with quality-based component)</td>
</tr>
<tr>
<td><strong>Total Care for Subpopulation</strong></td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings based on subpopulation capitation (savings available when quality scores are sufficient)</td>
<td>FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>PMPM capitated payment for Total Care for Subpopulation (with quality-based component)</td>
</tr>
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</table>
Partnering on Value Based Initiatives

To achieve success, all components of the New York State Medicaid program must understand the fundamental shift that DSRIP and VBP represent.

**PPS, Health Systems, Providers, CBO’s**

PPS as the contracting entity

Contracting with Health Systems

Options for individual Providers

CBO involvement
Providers/provider networks and MCOs should invest in effective interventions that have a meaningful impact on the overall population health and the overall wellbeing of the community in which it serves.

The nature of the intervention(s) should be negotiated between the VBP contractor and MCO, taking into account population health and preventative health needs identified by the community. Providers/provider networks and MCOs may wish to collaborate with CBOs to support, develop, and broaden their reach to more communities.

Networks may want to consider larger partnerships and advocate for systemic improvements that might not be easily quantified on the individual member level immediately or in the short-term. Ultimately the goal should be to track the impact of interventions, not just on an individual level, but on a population level.
Food for thought

~ What is the CBO’s current ability to take on VBC? Is there an opportunity to work directly with the MCO?

~ How well do partner providers understand the CBO’s admissions/intake/program requirements? Is there an opportunity to train or be part of the provider care management team?

~ How are the CBO and the United Community Outreach team working together?

~ Does the MCO have a good understanding of the program, services, and how to refer? Are printed materials available? In a variety of languages etc?

~ What are the data exchange capabilities of the CBO to support VBC risk deals?
From the Roadmap – SDH and CBO

“This subcommittee will be focused on identifying the how community based organizations can successfully support the broader VBP strategy. The State recognizes that these providers play a critical role in the desired health care delivery system, however CBOs are very diverse in their ability to fully take on VBP. The group will make recommendations to the State and draft an action plan designed to make available the technical assistance and training necessary to bring the CBOs up to speed.”

Thank you for coming!

Please contact the Care Compass Network Provider Relations and Outreach Coordinators with questions or concerns.

South RPU
- Julie Rumage – 607.240.2555 or JRumage@carecompassnetwork.org
- Jessica Grenier – 607.240.2559 or JGrenier@carecompassnetwork.org

East RPU
- Kris Bailey – 607.240.2562 or KBailey@carecompassnetwork.org

North RPU
- Carrie Stock – 607.252.3680 or CStock@cayugamed.org

West RPU
- Penny Thoman – 607.240.2577 or PThoman@carecompassnetwork.org