Board of Directors Education Session
Value-Based Care at
NYC Health + Hospitals

March 2, 2020

At

Jacobi 1400 Pelham Pkwy S, The Bronx, NY 10461

Simulation Center, Building 4 - 2nd floor

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AGENDA

1:00 – Introduction and Lunch

1:10 – Value Based Care Presentation

2:45 – Simulation Center Site Visit

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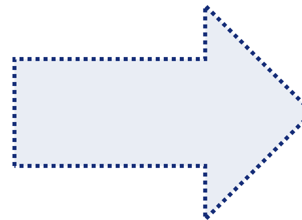
Value-Based Care Enables Delivery System Transformation

Current State

- Fragmented state of care delivery with little coordination across the continuum of care
- Payment system that rewards volume over value
- Inadequate ambulatory and community-based care
- Limitations in sharing data and information with patients and providers
- Limitations in addressing social determinants of health



Future State

- Coordinated, patient-centered care that improves patient outcomes as well as the patient experience
- Payment system that rewards value
- Team-based ambulatory care with members practicing at ‘top of their license’ to improve care delivery
- Flow of data across providers, patients, payers, and CBOs
- Fully integrated role of CBOs in addressing social determinants of health

Value-Based Care Enables Delivery System Transformation

Click picture to open video in new window

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Value-Based Care via Value-Based Payment Models and Risk

Despite differences in Federal and State terminology, the concept remains the same: paying for outcomes (e.g. around clinical conditions or specific populations) across increasing degrees of risk.

CMS-MEDICARE VBP CATEGORIES		DOH-MEDICAID VBP LEVELS[17]	
Category Name	**Description**	**Category Name**	**Description**
Category 1	Fee-for-Service (FFS) with no link to quality	Level 0	FFS with bonus/withhold for quality outcomes (not VBP)
Category 2	FFS with a link to quality	Level 1	FFS with only upside risk
Category 3	Alternative payment models built on FFS methods	Level 2	FFS with risk sharing (upside and downside)
Category 4	Population health-based payments	Level 3	Global capitation

Source: Greater New York Hospital Association (2018)

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Key Market Characteristics

- **Value-based payments are increasingly becoming the norm.**
  - Increasing momentum among payers, both public and private, towards value based arrangements.
  - In particular, ramp-up among Medicaid MCOs as they move towards at least 80-90% of provider payments in value-based arrangements by 2020.
  - New incentives available to reduce hospital utilization and promote population health across a wide spectrum of distinct arrangements.

- **Continued consolidation of providers into fully-integrated, highly competitive delivery systems that assume risk for their patient populations.**
  - Fueled by technological advances, systems are moving towards ambulatory and home-based service delivery, aligned with a broader shift towards patient-centered, data-driven care.
  - Issuers adapting as providers get closer to first premium dollar.

- **Uncertain regulatory landscape at the Federal and State level.**
  - Reduction in DSH payments will force systems to adapt to broader payment landscape.
  - Lack of clarity at the State level as DSRIP conclusion nears.

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Vision, Participation, and Opportunities

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Vision for Value-Based Care at H+H

Improve patient outcomes and maximize revenue by:

1. Enhancing quality and improving coordination across the full continuum of care.
2. Delivering timely, actionable insights to frontline staff and central office teams via a centralized data platform.
3. Managing the execution and performance of multiple, distinct contracts and networks.

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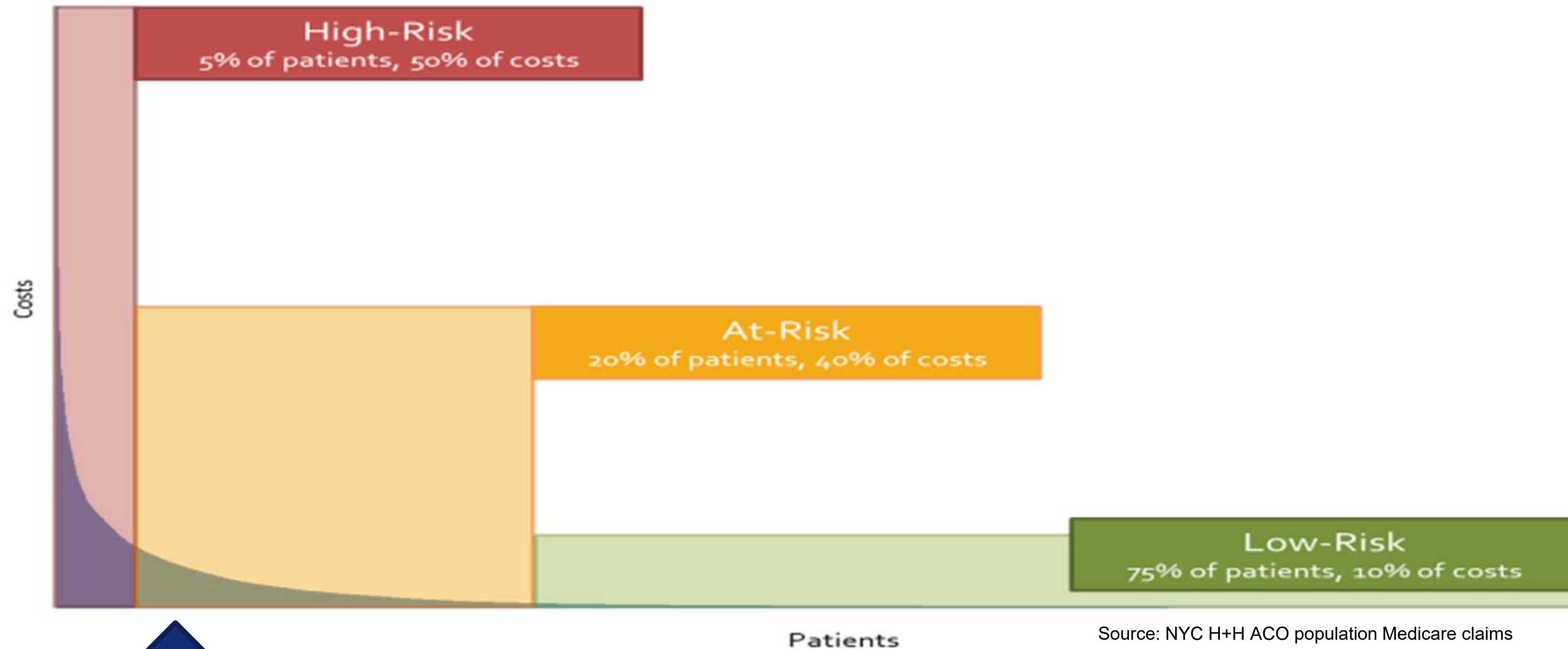
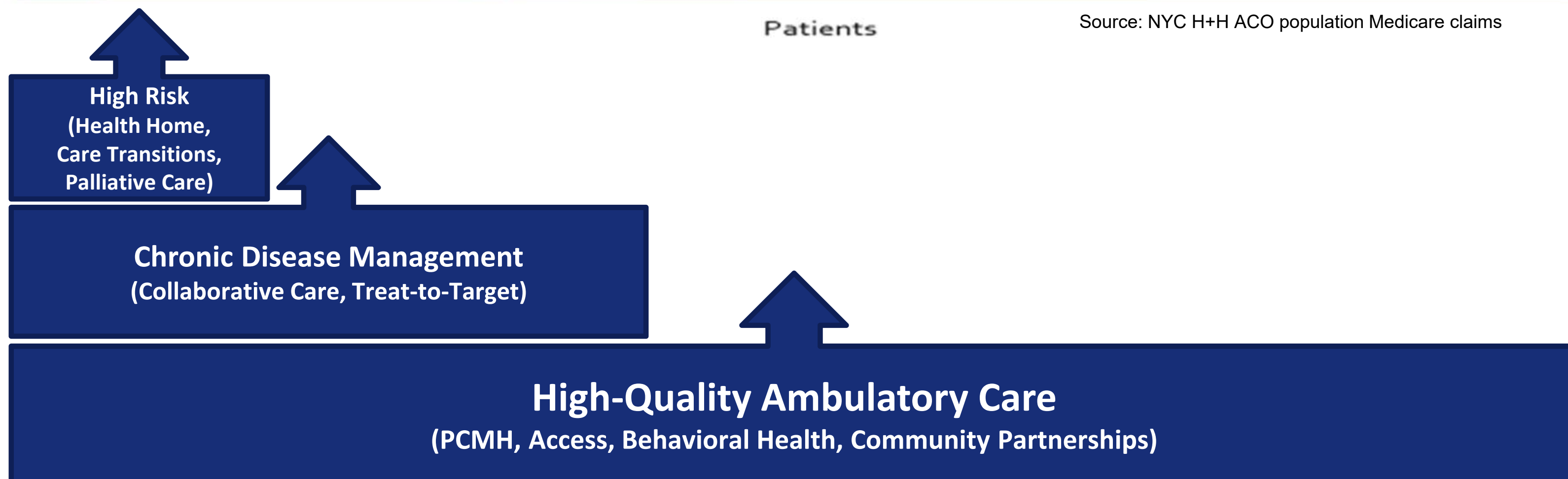
Scaling Value-Based Care

From Incentives to Interventions



Source: NYC H+H ACO population Medicare claims



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H+H has been a pioneer in Value-Based Care

H+H has been in a fully capitated risk arrangement with MetroPlus since 2000, with Healthfirst since 2006, and with Medicare (ACO) since 2013.

- Aligns financial incentives with patient care and quality.
- Reduced medical expenses translates to risk surplus flowing to H+H for reinvestment

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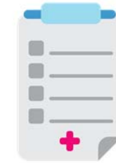
Current Participation in NYS VBC Programs

Total potential award

$1.165B	$600M	$432.2M	$274M	$3.2B



Delivery System Reform Incentive Program (DSRIP)

- Delivery system transformation
- Goal of reducing avoidable hospital use by 25% over 5 years
- Shifting 80% of Medicaid managed care payments to value rather than FFS

Value-Based Payment Quality Improvement Program (VBP-QIP)

Quality-based incentive payments to support safety-note hospitals in the transition to vale-based payment, improve quality of care and work towards financial sustainability

Care Restructuring Enhancement Pilots (CREP)

Enhance workforce's ability to serve the needs of Managed Long-Term Care and Behavioral Health-Home and Community Based populations and close gaps in services inside and outside of the hospital.

Capital Restructuring Financing Program (CRFP)

- Helps health care providers fund critical capital and infrastructure improvements as well as integrate and further develop health systems
- Combination of capital and IT funding to achieve these goals.

Level II VBP Managed Care Contracts

- NYC H+H holds Level 2 VBP contracts with MetroPlus and Healthfirst, which hold a risk for approximately 601,000 lives at a total premium of $3.2B in 2018.
- Enhanced management of this population will allow NYC H+H to retain more of the at risk premium dollars via in network claims spending and surplus savings through unnecessary patient utilization.

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VBP at H+H

Current Status and Opportunity

62% ($4.4B) of H+H's revenue is capitated or fixed. The remaining 38% ($2.6B) is FFS revenue and represents potential opportunity to move to VBP.

H+H FY19 Receipts

Category	Component	Share
RISK 18%	Risk-Based Metroplus & HealthFirst	16%
	Risk-Based GME & IME	2%
FFS 38%	HealthFirst - Non Risk-Based	4%
	Insurance or Managed Care Other	13%
	Medicare	9%
	Medicaid	12%
SUPPL/WAIVER 44%	Other City / Government Grants and Revenue	17%
	DSH/UPL & Pools	22%
	VBP-QIP & CREP	3%
	DSRIP	2%

*Source: H+H Finance, FY19 Cash Receipts adjusted

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Multiple Drivers of Financial Sustainability in a VBC Environment

Maximize premium revenue

- Improve Clinical Risk Group (CRGs) assignment
- Enroll patients in highest tier
- Enable plan to achieve highest Quality ratings

Drive Costs Down

- Reduce unnecessary utilization
- Manage High-Risk Patients

Retain patients

- Reduce disenrollment
- Manage leakage outside of Health + Hospitals

Improve Quality, maximize incentive dollars

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Spotlight Initiatives

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Spotlight:
HHC ACO Inc.

Since 2013, the ACO has saved the Medicare program over **$43M**– resulting in savings of over **$19M** for H+H and our external partners– while improving the quality of care for the patients we serve.

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Inpatient Volume Declined 4%, Under One-Half is Fee For Service (FFS) Impacting Revenue

- Over one-half of the decline in discharges vs. FY18 are associated with our risk-based health plans, MetroPlus and HealthFirst, helping drive improved risk pool revenue.
- Previous uptick in self-pay has now converted to insurance.

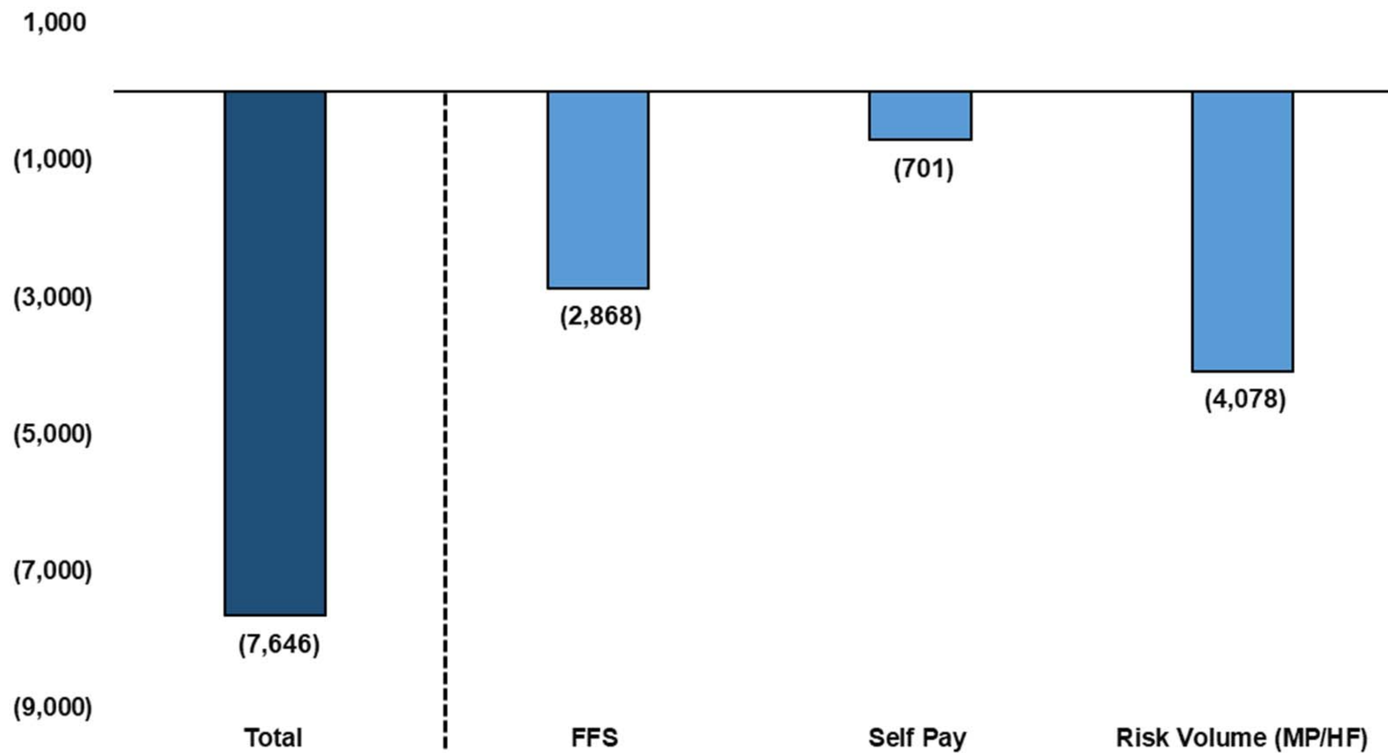

Chart includes psych and rehab.

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Spotlight: MetroPlus

MetroPlus ranks among the highest on quality of all NYC Medicaid Plans and earns robust margins in VBP (Level 2) Risk Arrangements

Plans	
Tier 4	Affinity YourCare Health Plan
Tier 3	Independent Health HIP (Emblem Health) Empire BlueCross BlueShield HealthPlus Health Now New York, Inc. WellCare of New York United Health Care Community Plan Excellus BlueCross BlueShield Molina Health Care
Tier 2	**MetroPlus Health Plan** CDPHP MVP Healthfirst PHSP, Inc Fidelis

VBP Risk Contract - Quality Measures for Calendar Year 2018
Breast Cancer Screening
Chlamydia Screening
Colorectal Screening
Asthma Medication Ratio (19-64 years) Ratio > 50%
30-Day Follow Up After Hospitalization for Mental Illness

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The Performing Provider System (PPS) brings partners together to address total patient and family care needs

Spotlight: DSRIP

PPS partner service domains

- Mental Health
- Medical and Healthcare
- Food and Nutrition
- Substance Abuse
- Financial Assistance
- Childcare and Parenting
- Dental and Vision
- Housing
- Education
- Exercise and Physical Fitness
- Family Planning and Pregnancy
- Legal
- Technology
- Immigrant Support
- Healthcare Supplies and Medicine
- Transportation
- Employment
- Hotlines
- Mobile Care Services
- Home Maintenance
- Safety and Prevention

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Payors

- CMS
- Health plans for Medicare Advantage
- Health plans for Medicare Managed Care
- Commercial plans

IPA

Ambulatory care
Behavioral health
Care management
FQHCs
Health home
NYC Health + Hospitals
CBOs
Post acute care

Behavioral health providers

Post-acute care entities

Community-based organizations

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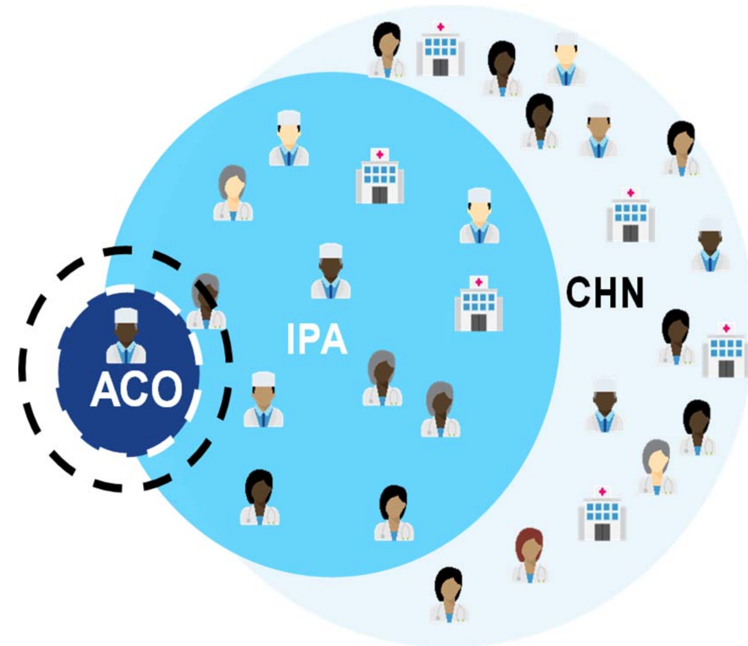
Building a High-Value Network

- **Current – Traditional Indemnity**
  - Thousands individual providers recruited years ago
- **Bridge – Partially Managed**
  - Establish an IPA that allows for a more structured and strengthened partnership than the CHN and can include selected PPS partners, IPAs and ACOs. The IPA could provide the all-payer ACO with future partners that are more advanced in managed care and willing to be exclusive partners.
- **Fully Managed**
  - The ACO is a group of providers, hospitals, IPAs, and other practices who come together voluntarily to give coordinated high-quality care



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Current Participation in Other Medicare VBC Programs

NYC H+H can continue to improve its performance across a range of CMS programs:

- Hospital Readmissions Reduction Program
  - Reduces payments to hospitals with excess readmissions
  - Payments to H+H has been reduced by $6.4M over the past 5 years

- Hospital Value-Based Purchasing Program
  - Adjusts payments to hospitals based on certain quality measures
  - Payments to H+H have been reduced by $2.3M over the past five years

- Hospital Acquired Condition Reduction Program
  - Adjusts payments to hospitals based on certain quality measures
  - Payments to H+H have been reduced by $7.8M over the past five years

- Comprehensive Care for Joint Replacement (CJR)
  - Bundled payment for hip and knee replacements
  - Payments to H+H have been reduced by $294K over the past three years

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Progress and Future

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Building Infrastructure to Optimize Opportunity in Managed Care Contracts

A Value-Based Care Steering Committee formed to build the H+H VBC Framework and Goals to optimize performance in our current risk arrangements and explore future opportunities. Each goal has various work streams, which include owners from across H+H, timelines, and measurable goals.

Part 1: Build the Capacity to Manage our Current Risk Contracts

i. Understand Medicaid member attribution and maintain up-to-date information for performance tracking
ii. Establish a clear clinical documentation process that allows for an accurate portrayal of quality of care provided and patients treated to reduce insufficient documentation, medically unnecessary services, and incorrect coding.
iii. Establish capabilities for quality performance tracking and financial management of risk.
iv. Align care delivery model to patient needs.
v. Support patient engagement and address social determinants of health.
vi. Workforce redesign/retraining.

Part 2: Assess Viability of Additional Risk-Based Arrangements

i. Establish target budgets for total costs of care.
ii. Establish and/or expand Value-Based Payment arrangements that align with attributed population, services needed, outcomes to be measured, risk-adjusted cost of care opportunities, and partners.

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Questions for Discussion

- What are the major strategic considerations for H+H to navigate with value-based care?
- How will the Medicaid Redesign Team's recommendations affect our approach?
- How can we build on our unique relationship with MetroPlus and forge deeper partnerships with other payors?