Raising the Bar: Value-Based Purchasing to Address Population Health  NASHP Conference 2018

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Population Health…

“…a state of complete physical, mental, and social well-being and not merely the absence of disease…”

- World Health Organization
New York State Value Based Payment Model

Design a model that:

- Requires population health capabilities
- Requires a broad network of provider partners that spans the complete care spectrum

Core Components of VBP Model

- 3 Levels of risk
- Quality measures
- Attribution
- Finance and target budget setting
- VBP Arrangements
  - Population based (total care for a population)
  - Episodic (primary care and chronic condition)

Social Determinants of Health Interventions & Community Based Organizations
VBP Arrangements: Population Based & Episodic

- General Population Approach
- Specialty Population Approach
  - Behavioral Health
  - HIV/AIDS
  - Managed Long Term Care
  - Intellectually & Developmentally Disabled
- Integrated Primary Care
  - (Preventive Care, Sick Care, 14 chronic conditions)
- Maternity
  - (Pregnancy, Delivery, Post Delivery (Mom & Baby)

Being Successful in VBP Model

Investment in:
- primary care infrastructure
- care coordination
- referral pattern and discharge management activities
- care integration… partner primary, acute, home and community based care, physical and behavioral health

- Reduce health inequities or disparities among different population groups
VBP Design & Provider Partnerships

- Level 2 or Level 3 agreements will be required to implement at least one social determinant of health intervention.
- MCOs will incentivize providers upfront to identify one (or multiple) social determinants and be financially rewarded for addressing them.
- The contractors will have flexibility to decide on the type of intervention (from size to level of investment) that they implement.
- All Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO

Operationalizing the VBP Design to Support Population Health
SDH Intervention Menu

The SDH intervention menu provides examples of evidence-based interventions to address SDH.

The SDH subcommittee created the SDH Intervention Menu (the Menu) to supply providers with examples of evidence-based interventions that aim to improve certain social determinants of health (SDH).

There are five key areas of SDH addressed in the Menu:
1. Economic Stability
2. Education
3. Health and Healthcare
4. Neighborhood and Environment
5. Social, Family, and Community Context

For each key area, the subcommittee identified specific social determinants (SD) and provided relevant evidence-based and promising interventions to address those key issues.

This menu is a starting point for providers and the State to pave the way to positively affect the social determinants that have a significant negative impact on Medicaid members in the state of New York.

For more information, access the VBP Resource Library on the DOH website:

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### SDH Intervention Menu

<table>
<thead>
<tr>
<th>Social Determinant</th>
<th>VBP Funded Intervention Options</th>
<th>Health Outcomes</th>
<th>Evidence of Health Outcomes</th>
<th>Resources that can be leveraged</th>
<th>Availability of Resources that can be leveraged</th>
<th>Regulation Health Objectives</th>
<th>Social Impact</th>
<th>Identifiable Co-benefits (periodic VBP activity)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Stability</td>
<td>- Poverty - Housing Security and Stability - Employment - Food Security - Transportation</td>
<td>Improved mental and mental health status of child</td>
<td>Driving association between poverty and poor health outcomes</td>
<td>Developed by federal programs, temporary programs for New York City, DHHS and other federal entities, local intervention programs, programs of substance use and HIV health outcomes</td>
<td>Available as of available as of 1/1/2018, programs for New York City, DHHS and other federal entities, local intervention programs, programs of substance use and HIV health outcomes</td>
<td>Improved disease management and prevention, reduction in chronic disease associated with poverty, such as obesity, asthma, etc.</td>
<td>Improved economic health</td>
<td>Education, improved economic health</td>
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<tr>
<td>Educational Environment</td>
<td>- Affordable Quality Housing - Environmental Conditions - Access to Healthy Foods - Crime and Violence</td>
<td>Improved education and reduced violence</td>
<td>Increased access to housing, reduced violence in crime prevention</td>
<td>Increased access to housing, reduced violence in crime prevention</td>
<td>Limited</td>
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<td>Health and Healthcare</td>
<td>- Primary Care - Mental Health - Access to Care</td>
<td>Improved mental health status and health care access</td>
<td>Increased access to primary care, improved mental health status and health care access</td>
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The SDH template was created to assist CBOs and MCOs with contracting for SDH

The Social Determinants of Health (SDH) Template will:

- identify the contracted CBO
- identify the SDH intervention
- explain why the SDH intervention was selected
- illustrate how the intervention will be measured
- understand funds utilization

For more information, access the VBP Resource Library on the DOH website

Lessons Learned & Best Practices
Lessons Learned & Best Practices

Education, Outreach & Engagement
- Conduct reoccurring webinars, meetings and forums to consistently message design of the program and the role of SDH interventions.

Facilitate Partnerships
- Forums to introduce CBOs to MCOs and providers are incredibly helpful
- Don’t forget to include investors and foundation

Develop Tangible Examples
- Showing what a model looks like is much more helpful than talking about it
- Show how funding or contracting arrangement may look

Never Assume the Marketplace Already Knows
- As a CBO, how do I engage in VBP, who do I talk to, where do I find them, how do I develop a value add proposition

Use the State Platform
- Be innovative (Call to Innovation)

Create a Movement
- Social Media

VBP & SDH Interventions in Action
Social Determinants of Health in the Works

- Home rehabilitation to address chronic conditions
- Creating stable housing to support people living with HIV/AIDS who are homeless
- Care designed for high risk families instead of individuals
- Housing to combat avoidable ER visits

Example 1: New York City

| MCO and Provider | Several Managed Care Organizations  
<table>
<thead>
<tr>
<th></th>
<th>Large Provider Group</th>
</tr>
</thead>
</table>
| VBP Arrangement and Risk | Total Cost General Population  
|                  | Risk Level 2 |
| Cohort           | 150,000 attributed lives. Focus on high utilizers of care |
| VBP / SDH Intervention | Implementing an assessment and referral process to link members who need SDH interventions (i.e., food/housing) to care. |
### Example 2: Central New York

| **MCO and Provider** | • Hospital Health Center  
<table>
<thead>
<tr>
<th></th>
<th>• Two Managed Care Organizations</th>
</tr>
</thead>
</table>
| **VBP Arrangement and Risk** | • Total Cost General Population VBP Arrangement  
|                       | • VBP Risk Level 2 |
| **Cohort** | • 35,000 attributed lives, includes high population of refugees |
| **VBP / SDH Intervention** | • Increases health outcomes to link members to walkable space and access to farmer’s markets within their community. |