KPMG

Learning from New York State's Medicaid Reforms

Healthcare

Foreword

New York State's Medicaid system – which provides healthcare for individuals and families on the lowest incomes – is not unlike the NHS. The Empire State believes firmly in the social value of its Medicaid system but, just like the UK, is faced with meeting the triple aim of better health, better care, and lower costs.

At KPMG in the US, we have been honoured to work with state officials and care providers to help realise that aim. Our work has helped unite previously disparate institutions, supporting them to collaborate and become systems rather than silos. That is a process which has been underpinned by payment reform – changing the rules of the game to encourage joint working – and by efforts to engage frontline clinical staff in the case for change.

It is a major transformation, and the journey is far from over: in many ways, it is just starting. But we have already learnt a great deal, and much of it will be applicable to those working in the NHS. Healthcare leaders across the service will be familiar with the struggles and challenges we have faced in New York State, and will I hope derive encouragement from the progress made so far.

Learning from one another is surely a way to make these challenging transformations somewhat easier; to help ensure healthcare remains accessible to those who need it. This report is a contribution to that crucial knowledge transfer.

Marc Berg
Principal
KPMG in the US

A tax-funded healthcare system challenged by escalating demand and changing needs. Financial constraints which hinge on the decisions of politicians at the highest level. A plan for change, based on new care models, which has been developed at the top level but which is being implemented locally.

If you live in the UK, you will immediately identify this description of the National Health Service. Yet it is a characterisation which equally applies to the Medicaid system in New York State. Five years ago, healthcare leaders across the Atlantic embarked on a radical redesign of the Medicaid system. Spending was capped, efficiencies driven, and the money saved directed towards better care for the state's six million Medicaid beneficiaries.

This report outlines the project so far and how KPMG in the US is supporting New York State in the transformation. In so doing, it offers important lessons for those of us working to make similar transformations in the NHS. I hope you find it useful and inspiring.

John Howard
Partner, Healthcare
KPMG in the UK

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Overview

- What is New York State aiming to achieve?
- The New York State approach to change
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- How is KPMG in the US supporting New York?

What is New York State aiming to achieve?

New York State has set up a nine-year programme (2011– 2020) to improve health outcomes, efficiency of service delivery and value for money for the state's six million Medicaid beneficiaries.

Context

- With New York State's Medicaid services facing spiraling costs, disjointed care and quality challenges, in 2011 the state governor published a bold case for change[1].
- Designed in collaboration with clinicians and healthcare professionals from across providers and payers, the reforms focused on achieving the triple aim – better health, better outcomes and lower costs[1].
- The Medicaid Redesign Team (MRT) crucially introduced a global spending cap, which fundamentally changed how healthcare expenditure was managed. Everything had to be viewed in terms of its impact on finite Medicaid resources, with the state healthcare commissioner being granted new 'super powers' to change reimbursement rates and implement utilisation controls.
- The MRT team also proposed a series of recommendations that not only lowered immediate spending but also created opportunities to improve healthcare outcomes and generate shared savings ($2.2bn in FY11/12)[1].
- By sticking to the MRT plan, the state was able to curb Medicaid spending growth and bring it back under a global cap. Estimates show that approximately $17bn in future expenditures were avoided over the next five years.
- Under a waiver from the federal government, New York State was able to reinvest nearly half ($8bn) of the future savings back into the system in the form of the Delivery System Reform Incentive Payment (DSRIP) Program.
- The waiver was approved in 2014, thus allowing the state to embark on its DSRIP journey, which will last until the second quarter of 2020.
- Through the $8bn investment, New York will implement changes that will fundamentally transform the way healthcare is delivered and paid for[2].
- With many similarities to the UK's New Care Models Programme, DSRIP is creating new models of provider integration and implementing value-based payments for more than 80% of its services[4].
- Payment reform, workforce transformation and sophisticated analytics are at the heart of this on-going transformation journey.

The programme timeline

2011 New York publishes 'A plan to transform the Empire State's Medicaid Program'

2011
New York implements Medicaid Redesign Team (MRT) action plan and initiates efforts to bring expenditure growth back in line with the Consumer Price Index

2014
New York receives DSRIP waiver and gains approval to reinvest $8bn back into the Medicaid system. In its first year, 25 provider networks are formed, each of which will receive part of the DSRIP funds to carry out transformation efforts

2014
From 2014 onwards, provider networks must demonstrate measured improvements on selected metrics to maintain their transformation funding streams

2015
Provider networks continue implementation and begin workforce transformation

2016
Formal mid-point assessment of workforce and payment reforms in provider networks

2020
The program runs until the end of Q1 2020. This also marks the date by which payment reform efforts and specific targets within the DSRIP programme must be met (e.g. >80% of payments value-based and tied to outcomes)

Source: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

The New York State approach to change

Goals: Delivering the Triple Aim – better health, better care, lower costs.

Pillars	**1**	**2**	**3**	**4**	**5**
	Improve access to care for all Medicaid beneficiaries	**Integrate care to address patients' needs seamlessly**	**Make the cost and quality of care transparent to empower decision making**	**Pay for healthcare value, not volume**	**Promote population health**
	Elimination of financial, geographic, cultural, and operational barriers to accessing appropriate care in a timely way	Integration of primary care; mental health; acute, post-acute and supportive care for those that require it	Information to enable beneficiaries, providers and payers to gain greater transparency over programme and provider performance	Creating incentives for providers to deliver higher quality care with an improved patient experience while controlling costs	Improve screening and prevention through closer linkages between primary care, public health, and community-based support
Enablers	**Workforce strategy**		**A**	Matching the capacity and skills of the healthcare workforce to the evolving needs of New York's communities	
	Health information technology		**B**	Health data, connectivity, analytics and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovations	
	Performance measurement and evaluation		**C**	Standard approach to measuring the plan's impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation	

Source: https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf | https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf
https://www.health.ny.gov/technology/innovation_plan_initiative/docs/06-19- 15_hit_wrkgrp_slides_final.pdf

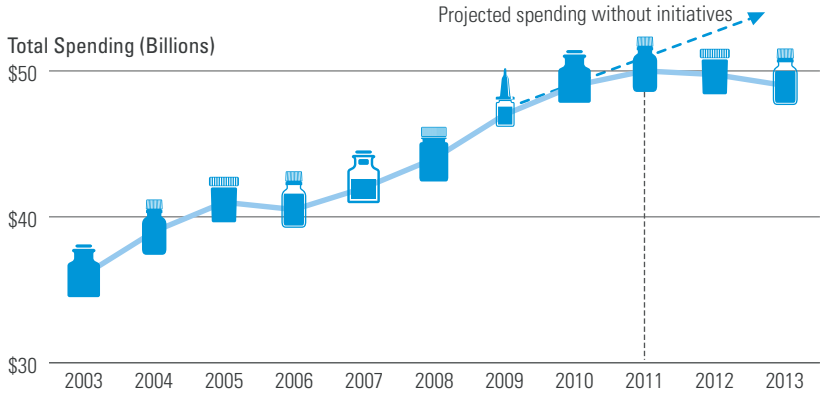
Transparency is at the heart of New York State's Medicaid reforms, and the state publishes key planning and policy documents online. This publication draws on and reproduces information from the New York State Department of Health, which are cited throughout this document and in the endnotes:

Laying the foundations for change

From 2011 to 2014, New York State implemented a range of projects to bend the curve in Medicaid spending and prepare the ground for the longer-term transformation.

New York State total spend on Medicaid services

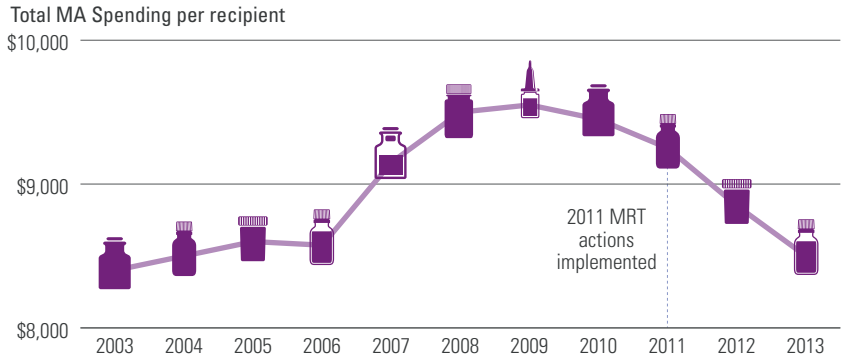
- Medicaid spending was growing at an unsustainable rate of 10% year-on-year
- Quality outcomes were worsening
- In 2011, New York implemented its Medicaid Redesign Team (MRT) action plan and initiated efforts to bring expenditure growth back in line with the Consumer Price Index
- Following the introduction of the 2011 MRT cap, Medicaid spending fell successively for the following two years despite a 12% increase in demand



Source: http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2015-12-02_opt-out_webinar.pdf

New York State spend Medicaid per beneficiary

- To stabilise spend and "flatten the curve", New York implemented changes suggested in the Medicaid Redesign Team's plan
- This included improved care management for patients with long-term conditions and a strategy to address housing and improve prevention



Source: http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2015-12-02_opt-out_webinar.pdf

How is KPMG in the US supporting New York?

KPMG in the US is New York State's strategic advisor for the transformation programme. Working hand-in-hand with New York State officials and with local provider networks, they have helped to design the key programmes of work that underpin the change and are providing specific support to aid implementation.

Four programmes of work

Care system redesign – Support for provider networks

25 newly-formed provider networks have been set the complex challenge of designing and delivering system reform, including introducing new models of care. KPMG is providing direct support to the provider networks to help them achieve their transformational goals. This has included providing support in developing detailed transformation plans and guidance on practical implementation.

Data and analytics

New York is using data and analytics to deliver improved transparency in cost and outcomes[4]. KPMG is helping transform the state's approach to data collection and management by supporting the development of data warehousing and analytical capabilities. This support is helping the state and provider networks make more effective decisions about the future of healthcare. Without these sophisticated analytics, the desired change simply would not happen.

Payment reform

New York is using payment reform to drive change and promote collaboration[5]. KPMG is helping the state to design its ground-breaking approach to value-based payments, with work ranging from policy development to the design of innovative payment mechanisms.

Workforce transformation

New York knows that changing healthcare requires changing the workforce through the introduction of new roles and training schemes[6]. KPMG in the US is helping local provider networks address the workforce challenges of this major system transformation.

State support, local delivery

New York has a clear state-wide strategy, with the support of State leadership behind their five-year vision.

25 provider networks are designing and delivering local change, much like the UK's Vanguards.

KPMG is helping ensure provider networks have the packages of support they need so that local initiatives adhere to state-level policy.

02

Overview

- The payment reform strategy
- How does the strategy promote collaboration and integration?
- Putting the strategy into action
- Guiding principles behind payment transformation
- What will the payment system look like?
- What might the risk and reward payments look like?
- Maternity Care: An example of value-based payments
- Next steps for payment reform

The payment reform strategy

New York State's objectives for payment reform are about aligning incentives for payers and providers with the strategic aims of improving population health and quality of care and reducing avoidable hospital utilisation[7]. This involves strengthening incentives for investment in prevention and primary care and encouraging collaboration to improve care coordination and provide better integrated support. Crucially, it also involves rewarding success in reducing avoidable hospital use and not penalising hospitals for playing their part in helping to achieve this.

New York State has set a clear long-term direction to transition towards capitation-based payments[4] for a population's total cost of care, moving away from a predominantly 'fee for service' model. But, New York State has recognised that attempting to change too quickly could result in significant risk of disengagement, destabilisation and potential deterioration in access to care, quality and outcomes. That is why New York is pursuing a transition that starts with addressing volume-based incentives, to encourage collaboration and reward outcomes. By incrementally shifting greater risk to providers through reformed financial incentives, the programme is aiming to develop a system that delivers greater patient value in the long term.

However, payment reform alone is not sufficient for driving transformation and the state has recognised this through its broader strategies, including investment in data analytics, workforce transformation and supporting provider collaboration.

Four pillars of the payment reform strategy

1 Capping growth in total payments

New York State's first step in its payment reform journey was to introduce a cap on growth in Medicaid payments.

Why? This encouraged providers to deliver greater value care. By working with payers and the state, providers reduced costly, avoidable hospital use and improved health outcomes.

2 Paying for integration and transformation

New York State is now investing non-recurrent, funding in a 'pay for transformation process' scheme. This funding is only made available to provider networks that have established collective governance and agreed joint plans[8]. A significant proportion is then paid out according to performance against prescribed outcomes or lead indicators.

Why? This provides the funding and incentives needed to improve provider infrastructure so they can implement new and improved models of care.

3 Rewarding outcomes and sharing savings

In parallel New York State is offering providers (whether engaged in networks or individually) opt-in incentives to share in the gains of better health and better care that reduces avoidable hospital use. In this way, providers have the opportunity to improve their bottom line by sharing in the financial benefits of transformation.

Why? This further strengthens incentives for providers to engage early and builds momentum.

4 Transferring risk incrementally

Over the transition period, New York State is transferring risk to providers incrementally.

Why? This approach is giving payers and providers the time they need to redesign care so they can be sustainable in a capitated payments system with managed long-term growth in overall funding.

Source: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

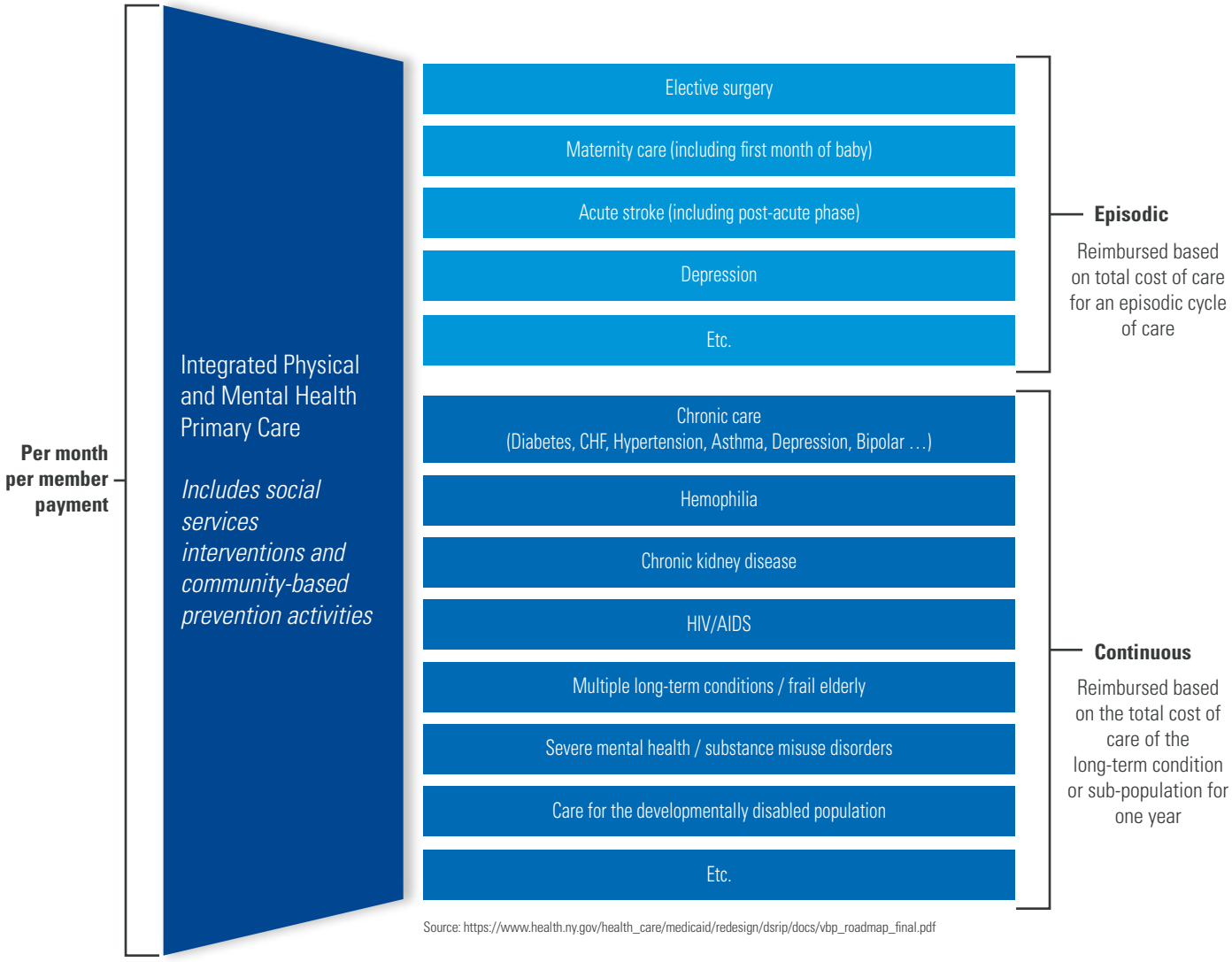
Payment reform realigning incentives

How does payment reform realign incentives to promote collaboration, integration and improved outcomes? Payment reform is essential to New York's strategy for improving the quality of care, delivering better health outcomes and reducing avoidable hospital use.

Payment reforms are key to correctly aligning incentives and payment mechanisms so that providers across the health and social care continuum to deliver care aligned to patients' needs. The New York approach is not 'one size fits all'. It recognises the need to address different types of healthcare needs in different ways, striking the balance between those that are preventative, episodic or continuous[4].

The scale of opportunity for improvement is greatest in managing complex and continuous health needs, and the role of care coordination becomes increasingly important. The correct payment incentives are crucial to supporting this agenda by rewarding providers in a way that encourages more integrated efforts. For example, New York recognises that collaboration and integration are essential for addressing the social determinants of health (such as low quality housing) and for improving outcomes for people with complex mental and physical health needs[1].

New York State's payment model for different healthcare needs



Source: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

Putting the value-based payment (VBP) strategy into action

To make the strategy a reality, New York needed strong stakeholder buy-in, especially from the provider networks. KPMG in the US helped the state set out a clear vision for what the strategy is – and isn't – aiming to achieve.

What are they trying to do?

Prioritise value over volume

Payment incentives are designed to deliver improved health outcomes for the state's Medicaid population, reducing potentially avoidable admissions and managing expenditure.

Move towards 80-90% of payments to managed care organisations being value-based

By 2020, at least 80% of Medicaid payments will be value-based[4].

Incentivising collaboration

New York's strategy offers providers opportunities to improve financial margins by opting in to incentive schemes which offer performance bonus payments that reward providers for working together to improve outcomes.

Ensure maximum flexibility

The state has created a menu of options that provider networks can choose from when creating value-based payment arrangements based upon the network's risk appetites and local population's healthcare needs.

What they're not trying to do

Do everything at once

The DSRIP programme, whilst substantial, only relates to one segment of the New York population – Medicaid beneficiaries. Although it may serve as a future model for payments through Medicare and private insurance, they're making the change more manageable by focussing on Medicaid first[1].

Limiting VBP arrangements to specific types of provider

All groups of providers that can deliver integrated care services are able to enter into the value-based payments schemes.

Make providers do more for less

In fact, the intent is the opposite – so long as overall spending stays within the cap. Under the state's VBP approach, reducing lower value care and increasing higher value care should improve margins for providers and create opportunities to reinvest.

Make one size fit all

Provider networks can choose from a variety of options in New York's VBP roadmap, including contracting for total populations and care bundles or taking a capitation approach[4].

Guiding principles behind payment transformation

New York State sees payment reform as the main driver for change within Medicaid and has identified eight principles to underpin change.

Eight Principle drivers for change

1	**Transparency**	Increase access to high quality healthcare services in the appropriate setting and create opportunities for both payers and providers to share the savings.
2	**Scaleable and flexible**	Allow all providers and communities (regardless of size) to participate, reinforcing the importance of health system planning and preserving an efficient community provider network.
3	**Multi-year phases**	Recognise the importance of looking at payments over and above a usual one-year cycle and the importance of thinking strategically over a longer period of time.
4	**Alignment**	Ensure that DSRIP change policy is aligned with quality outcome targets, cost reduction goals and wider federal and state health policies.
5	**Reward improvement, not just continued excellence**	Ensure that providers with improving outcomes are rewarded as well as those who continue to deliver excellent outcomes.
6	**Evaluation and measurement**	Incorporate a strong evaluation component and technical assistance from the start of the programme to assure successful implementation.
7	**Strategic planning**	Engage in strategic planning to avoid the unintended consequences of policy and pricing decisions.
8	**Reward prevention**	Reward providers for emphasising prevention, coordination, and best patient outcomes, including interventions that address underlying social determinants of health.

Source: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

What will the payment system look like?

New York recognises that the shift to value-based payments will take time. The state has created a payment system roadmap that allows provider networks to move through four levels of VBP maturity and use different payment structures for different categories of care. They are currently working on the roadmap for a fourth category, 'total care for sub-populations'.

Example payment categories	Level 0 VBP	Level 1 VBP (upside only risk)	Level 2 VBP (upside/downside risk)	Level 3 VBP (capitation)
All care for total population	Fee For Service (FFS) with bonus and/or withholding based on quality scores	FFS with upside-only shared savings when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient)	Global capitation (with outcome-based component)
Capitation (integrated primary care)	FFS (plus per member per month (PMPM) subsidy) with bonus based on quality scores	FFS (plus PMPM subsidy) with upside- only shared savings based on total cost of care (savings available when outcome scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient)	PMPM capitated payment for primary care services (with outcome-based component)
Acute and chronic bundles	FFS with bonus and/ or based on quality scores	FFS (plus PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when outcome scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient)	Prospective bundled payment (with outcome-based component)

Source: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

What might the risk and reward payments look like?

New York State and KPMG in the US are helping provider networks plan for different eventualities by suggesting frameworks for moving through the different VBP levels and working through structured examples of how the transition to new payment models can be implemented.

Categories	**Level 1 VBP** (upside only risk)	**Level 2 VBP** (upside/downside risk)	**Level 3 VBP** (capitation)
≥ 50% of outcome targets met	50-60% of savings returned to providers	90% of savings returned to providers	Providers responsible for 50% of losses
< 50% of outcome targets met	Between 10% and 50% of savings returned to providers (sliding scale in proportion to percentage of outcome targets met)	Between 10% and 90% of savings returned to providers (sliding scale in proportion to percentage of outcome targets met)	Providers responsible for 50% to 90% of losses (sliding scale in proportion to percentage of outcome targets met)
Overall outcomes worsen	No savings returned to providers	No savings returned to providers	Providers responsible for 90% of losses

Source: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

Further developments are required

The precise percentages will be further defined in close collaboration between the providers to find the best balance between incentive and risk.

The state may set ranges to the incentives and risks that providers can realise in their contracts.

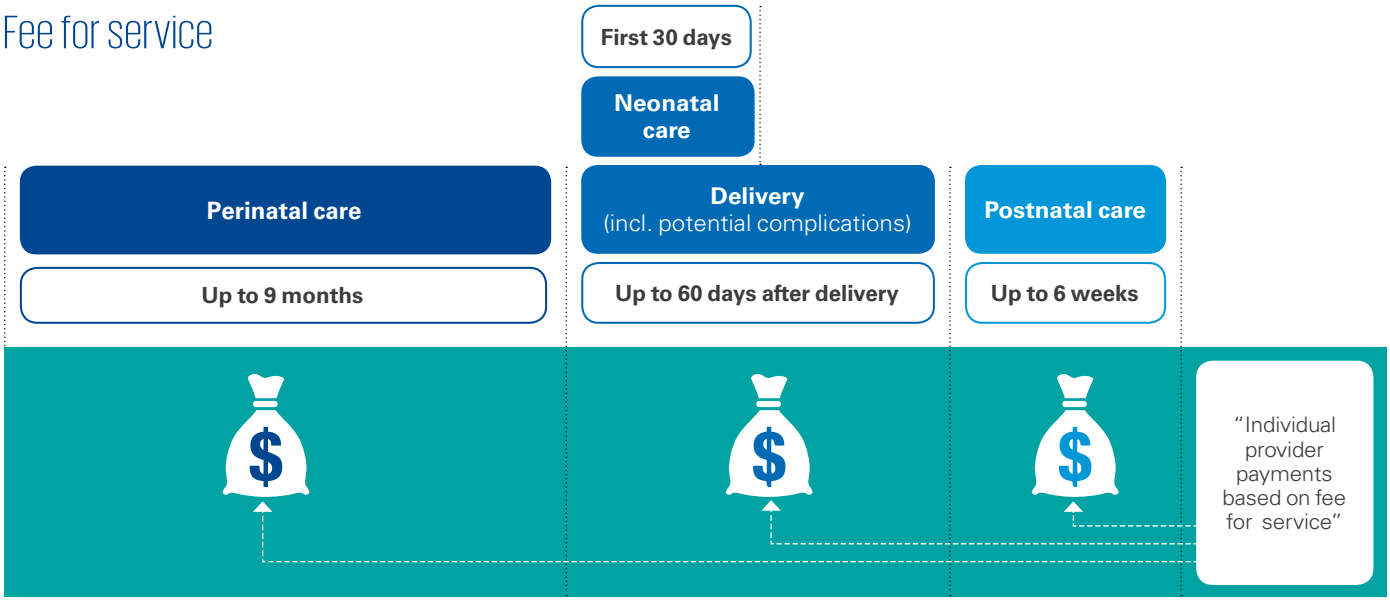
For example, to stimulate providers to move toward Level 2 VBP arrangements, the shared savings percentage may be lowered each year that a Level 1 arrangement is extended.

Similarly, to reduce real or perceived risks, the aggregate loss in the first year of a Level 2 arrangement may be set low and gradually increase over time.

Maternity Care: An example of value-based payments

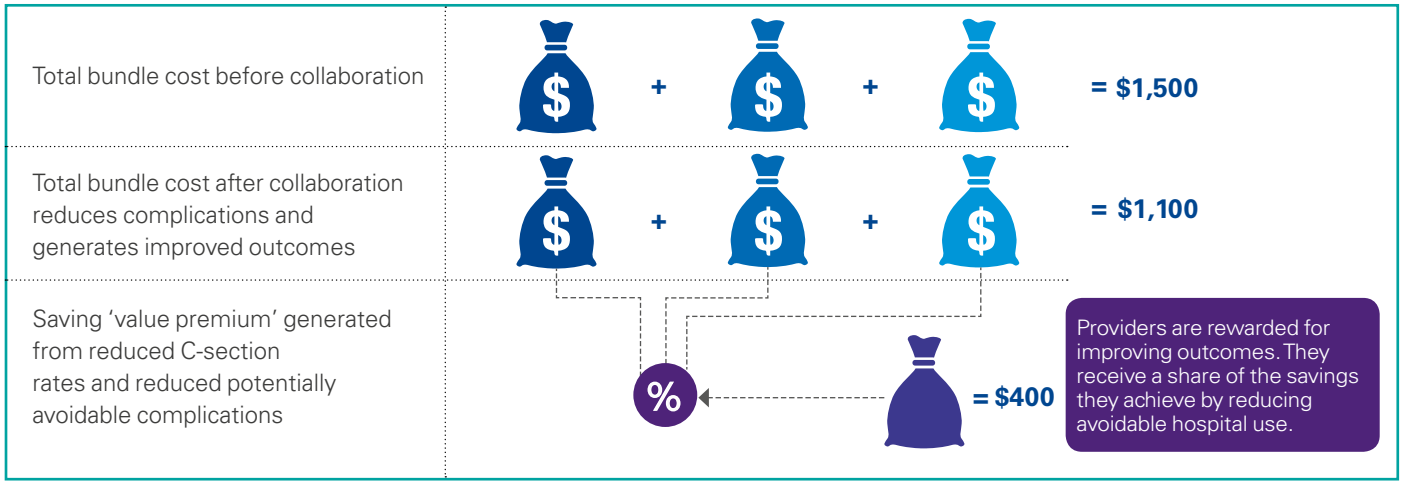
New York State believes that its approach to moving from fee-for-service to value-based payments will aid collaboration, leading to reduced cost and improved health outcomes.

Fee for service



Moving to value-based payments

Through improved collaboration the new approach will pay for perinatal care, delivery and postnatal care as a 'bundle of care'



Source: Thomson et al. op.cit. 38; Schmidt, H. and E. J. Emanuel (2014). "Lowering medical costs through the sharing of savings by physicians and patients: inclusive shared savings." JAMA Intern Med 174(12): 2009-2013 Baicker, K. and M. Rosenthal (2014). "Shared savings, shared decisions, and incentives for high-value medical care." JAMA Intern Med 174(12): 2014-2015.

Next steps for payment reform

New York State is working with KPMG in the US to focus on developing six areas within value-based payments. Subcommittee groups have been set up, and progress is being published regularly on New York's VBP website[5].

VBP Technical Design I

The next steps will involve addressing the financial and methodological policy questions included in the VBP Roadmap and producing a recommendation report for the VBP Workgroup with suggested approaches.

VBP Technical Design II

The team will address quality, support and design policy questions included in the VBP Roadmap and produce a recommendation report for the VBP Workgroup with suggested approaches.

Regulatory implications

The team will look to overcome regulatory and contractual barriers to implementing value-based payments. In addition, they will review current mandates and assess the need for future change.

Clinical Advisory Groups

KPMG helps facilitate the meeting of these important groups for each medical condition, bringing together experts across the state with:

- Clinical experience and knowledge focused on the specific care or condition being discussed (e.g. COPD, CHD, stroke, diabetes, maternity, etc.)
- Industry knowledge and experience
- Experience across the whole care continuum for the specific care or condition

The CAG groups have many objectives, including:

- Understanding the state's vision for the roadmap to value-based payments
- Understanding the HCI3 data grouper and underlying logic of the bundles (see section 4)
- Reviewing clinical bundles that are relevant to New York State Medicaid
- Making recommendations to the state on:
  - Appropriate outcome measures for care bundles
  - Data and other support required for providers to be successful
  - Other implementation details related to each bundle

Social Determinants of Health and Community Based Organisations

This team will focus on social determinants of health, such as beneficiaries housing and employment status. They will work closely with other teams in DSRIP and make recommendations on how to drive patient engagement, choice, and person-centred health and wellbeing.

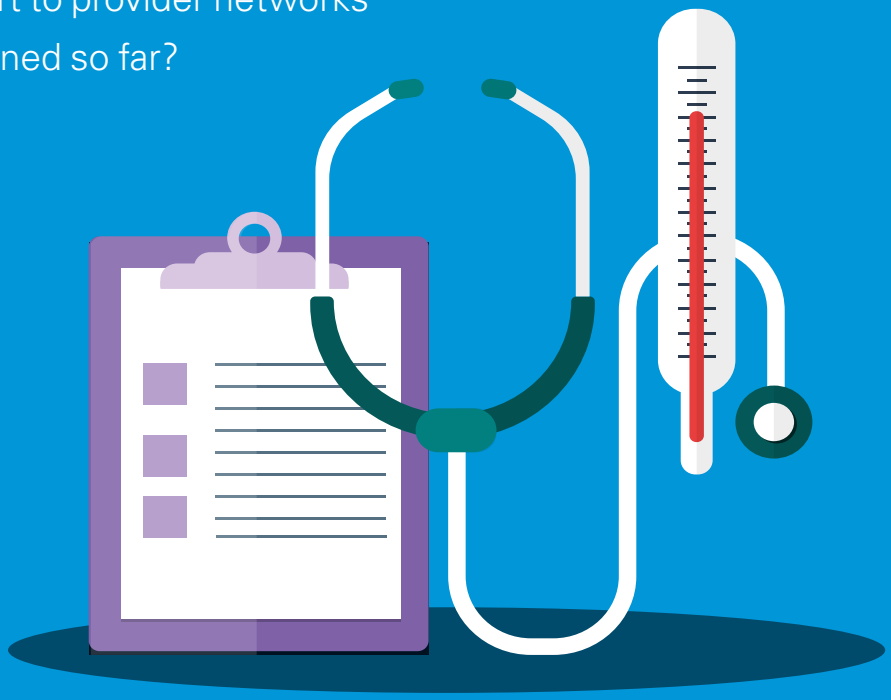
Advocacy & engagement

The team will help design a programme that incentivises patients to make lifestyle choices proven to improve health and reduce downstream costs (i.e. reduce emergency room visits). It will also focus on effectively engaging patients in the reform process. The team's work helps ensure that changes are transparent and effectively communicated so patients understand how providers are being incentivised and how they are performing.

03

Overview

- What does New York's health workforce look like?
- What is New York trying to achieve?
- What changes is New York State making?
- How did they get started?
- Overview of the initial support to provider networks
- What lessons have been learned so far?



What does New York's health workforce look like?

The big picture

Healthcare employment is a vital component of New York's economy and continues to grow faster than most other employment sectors, especially in areas outside of New York City. However, to implement DSRIP reforms, the state will have to overcome key workforce challenges relating to staff shortages and distribution. For example, there is a shortage of GPs, certain specialists and dentists. Dental hygienists are in short supply in key areas. There is an immediate over-supply of registered nurses.

- Between 2000 and 2013, healthcare employment grew by over 18% across the state compared to around 1% in all other sectors.
- Between 2000 and 2013, healthcare employment grew by 17% in areas outside of New York City while employment in other sectors declined by 6%.

Over
1 million people

or **12%**

of New York's workforce is employed in the healthcare sector.

Source: http://chws.albany.edu/archive/uploads/2014/08/nytracking2014.pdf

Key workforce issues

- There are primary care practitioner **shortages which are prevalent in specific regions** across the state.
- The **health workforce is not as diverse as the population** it serves.
- **Workforce training programmes do not currently meet the needs of the healthcare system.** Many health professionals are not currently trained in emerging roles and responsibilities. For example, there are few health workforce education programmes that train in team-based models of care.
- Effective team-based care cannot be delivered due to **current regulatory barriers.**
- Health professionals are **often not allowed to practice to the full scope of their professional competence.**
- There is **incomplete data on the state's health workforce** especially in **three areas:**

Source: https://www.health.ny.gov/technology/innovation_plan_initiative/docs/06-19-15_hit_wrkgrp_slides_final.pdf

What is New York trying to achieve?

Emerging patient care delivery models will demand new strategies to better prepare the health workforce to deliver these models of care. Traditional silos will need to be broken down, staff will need to work more collaboratively in multi-disciplinary teams, and better information on the workforce will be required[6]. Changes will include:

Preparing the workforce to focus on chronic disease management and care coordination by training and retraining clinical and non-clinical workers, as well as training new providers.

Adopting team-based approaches to care. The team composition and roles will vary, depending on the patient population. Teams could include registered nurses, social workers, medical assistants and community health workers, among others.

Breaking out of traditional silos working together to make better use of medical evidence and independent research to inform decision making.

Broadening and changing workforce roles. This will include expanding the scope of practice for certified nurse practitioners, dental hygienists, home care aides and advanced aides. Within primary care, team member roles will expand to include mental health and oral health assessments.

Obtaining better data on the state's health workforce. In particular, changes as a result of DSRIP will require more accurate and timely information regarding supply and distribution of the workforce, education and qualification attainment as roles become more flexible, and practice characteristics.

Taking a more inclusive approach with key stakeholder groups including the broader healthcare community, legislature and state department of education.

What changes is New York State making?[6]

Improving data and information — 01

In response to the new requirements for more accurate and timely data, New York is undertaking two key initiatives: strengthening the state's health workforce monitoring system and developing better models of forecasting workforce demand in the new care delivery model.

Increasing the workforce capacity to cater for the growing demand — 02

- Increasing the attractiveness of primary care careers throughout the state, with a particular focus on underserved areas to try to address the misaligned distribution.
- Increasing care coordination capacity as part of the new model of care.
- Developing a regionalised approach to make the best use of workforce resources.

Encouraging collaboration among providers — 03

For example helping small providers create networks of pooled training resources. The state is also investigating peer credentialing models and collaborating with existing healthcare institutions and other organisations to address clinical and non-clinical training gaps.

Assisting providers — 04

By providing technical assistance to undertake the ambitious transformation agenda. The state is also providing support for the existing workforce in building team-based health, mental health, prevention, performance management and health IT skills.

Improving workforce training — 05

To develop the current workforce's clinical and patient care capabilities. To ensure the workforce is able to deliver the new model, the state is clarifying job roles related to care coordination and associated competencies for the new delivery system and is working to ensure training is available.

How did they get started?

New York State developed a two stage, seven-step process to help the provider networks develop their workforce transformation plans.

First, the state identified the skills required to support the provider networks, set up a programme structure to support workforce transformation and engaged extensively with key stakeholders. The state then provided the 25 provider networks with an implementation support package that included tools, requirement analysis techniques, data collection approaches and delivery support.

Using those tools and support, provider networks developed and submitted their detailed implementation plans within six months. The state team then began the process of reviewing and assuring the plans.

Stage 1 – Laying the foundation	**1**	**Engage and assemble dedicated project team**
	2	**Engage key stakeholders**
Stage 2 – Building the implementation plans	**3**	**Perform workforce impact analysis**
	4	**Perform new hire analysis**
	5	**Perform training needs assessment**
	6	**Perform revised budget analysis**
	7	**Develop engagement and comms plans**

Source: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2014-11-20_workforce_strategy_webinar.pdf

Overview of the initial support to provider networks

As well as providing tools and an approach for the 25 provider networks, New York State also delivered support in six other ways.

Workforce webinars[10]

A webinar that outlines the key requirements and processes for developing implementation plans and other workforce-related activities.

Workforce workshops[11]

Facilitated workshops with the provider networks to help them think through and develop their implementation plans. Provider networks are able to walk through their workforce strategies and have access to some of the leading experts within the New York State team.

Workforce companion guide[9]

An example of a best-practice workforce implementation plan, including key activities, milestones and their sequencing.

Workforce discussions

Calls between the provider networks and the state's workforce team to understand what been completed to date, provider networks' concerns and the approach to developing workforce implementation plans.

Workforce reviews

Workforce reviews of provider networks' draft implementation plans. The New York State team provides feedback and recommendations for additional detail and/or activities in order to finalise the implementation plans.

Workforce FAQs[12]

A FAQ guide that answers the provider networks' most frequent questions about workforce implementation planning.

What lessons have been learned so far?

There are four main lessons from New York State following the first year of workforce change.

Four lessons

Joint responsibility

The State and provider networks both have important roles to play in achieving workforce transformation. The State's responsibility is to co-design a logical approach and provide tools to allow provider networks to lead the delivery of workforce changes in their local health systems.

A step-by-step approach

New York State developed a clear approach to prepare for workforce transformation. By setting out indicative activities and providing tools for provider networks to use, they ensured consistency across the networks.

Help when its needed

Rather than overwhelming the provider networks with a whole host of support offers and tools, New York State provides an indicative list of tools and support available, and the provider networks can use them as and when they need them.

Data and metrics to support each step

New York State defined a consistent set of metrics and data that each provider network should collect to help inform workforce planning. By establishing a baseline set of metrics, the central team has ensured that the provider networks can measure the impact of their transformation.

Source: https://www.health.ny.gov/technology/innovation_plan_initiative/docs/06-19-15_hit_wrkgrp_slides_final.pdf

04

Overview

- The pillars of effective analytics
- DSRIP analytics: How does it work
- An example: Delivering value for COPD patients
- Before and after: Creating patient-centred analytics
- What can the UK learn from DSRIP analytics?

The pillars of effective analytics

'What you can't measure, you can't manage'. Analytics plays a pivotal role in the DSRIP programme. Without the right data and relevant insights, realising the aims of the DSRIP programme would be impossible. Measuring and monitoring the data at the medical condition level is critical to the delivery of value-based and patient-centred care.

1 Drive provider accountability for patients

- DSRIP is using patient-level Medicaid data covering all care settings for 6m beneficiaries.
- Sophisticated patient attribution algorithms are run against this data to fairly determine which PPS a patient should be assigned to, based upon their most recent healthcare activity and geographic location.
- Understanding the complete activity and costs of patients is giving providers incentives to take greater responsibility for holistic patient care.

2 Identify quality improvement and cost reduction opportunities

- By bringing together a state-wide patient level dataset, DSRIP analytics can benchmark performance across a range of areas.
- Analytics helps to highlight areas of unwarranted variation, including the greatest opportunities for cost and quality improvement in areas like:
  - Potentially avoidable admissions and complications
  - C-section rates
  - ER admission rates

3 Focus on value-based care for conditions

- DSRIP has mapped 90+ 'care bundles', which group related activity for clinical conditions or patient sub-populations (e.g. diabetes, maternity).
- Rich patient-level data is analysed to determine activity and cost baselines for those care bundles.
- Through extensive consultation with clinical advisory groups, quality measures are being identified for each care bundle.
- This establishes cost and activity baselines while also linking cost and quality.
- Opportunities to improve patient value are flagged.

4 Deliver insights to support transformation

- To deliver actionable insights, it is important that the right infrastructure and analytical capability are firmly in place.
- A resilient and scalable analytics infrastructure is required to support the delivery of reliable intelligence to multiple users including the DOH, providers and patients.
- KPMG in the US is programme managing a consortium of suppliers including data management, clinical coding, data visualisation and data science experts responsible for building the long-term business intelligence system for the state.

DSRIP analytics: How does it work?

Linked patient data that cuts across all care settings, identifying all clinically-related activity and cost

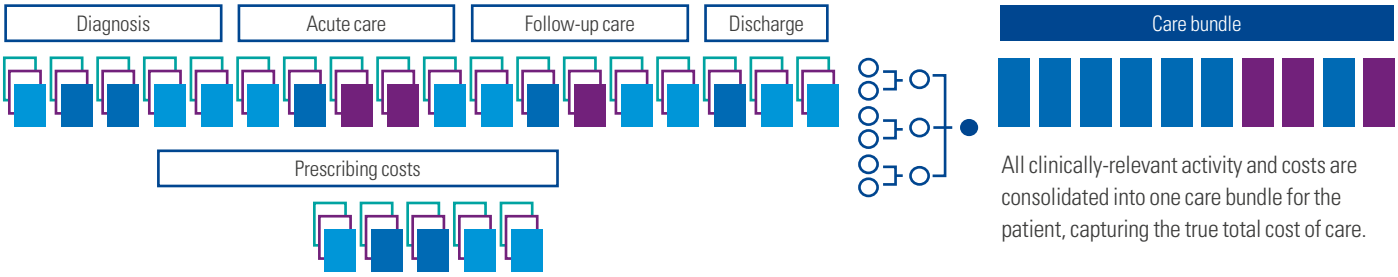
Sophisticated data mining capability using an agile cloud-based data warehouse, providing a treasure trove of analytical possibility

The New York DSRIP analytics programme is unique in its scale, applying the sophisticated HCI3 grouper technology to a massive dataset covering three years of activity for millions of patients. It enables patient-level analysis across care bundles – irrespective of where the care is delivered – to provide a true understanding of the 'total cost of care'.

KPMG in the US has supported New York State to rapidly develop an agile analytics platform, managing the significant task of integrating three years' worth of data across all care settings into a central repository. This data is being continuously mined to provide the insights required to support the VBP agenda.

DSRIP data analytics has grouped claims into over 90 care bundles. The information produced through the HCI3 episode grouper informs performance measurement and contract negotiations between payers and providers.

How does it work?



All clinically-relevant activity and costs are consolidated into one care bundle for the patient, capturing the true total cost of care.

The DSRIP data analytics system applies the logic of the HCI3 grouper on medical claims data covering the State's six million Medicaid beneficiaries.

Trigger codes	Sub-types	Relevant diagnoses, procedures and services	Potentially avoidable complications (PACs)
The tool searches diagnoses codes for markers of the designated medical condition (e.g. COPD, diabetes, maternity).	Episodes often have sub-types or variants, which are useful to adjust for the severity of the episode, helping with fairer comparisons.	Every related medical condition diagnosis, procedure and service is flagged and bundled into a single cycle of care. This helps to provide a complete picture of patient journeys through the system.	The HCI3 analysis for potentially avoidable complications is used to distinguish between 'typical' and PAC costs.

An example: Delivering value for COPD patients

While there is no cure for Chronic Obstructive Pulmonary Disease (COPD), there are lots of treatments available to help patients manage their condition, improve their symptoms and live active lives. The effective delivery of care, therefore, is crucial, as it can make all the difference.

The DSRIP programme is using sophisticated analysis techniques to get to the heart of value-based COPD care. By understanding the true costs of the disease and by helping to identify the best and worst providers, it is creating opportunities to improve standards of care.

With KPMG in the US support, New York is deploying HCI3 grouper technology to track COPD patient journeys across the healthcare system. It is benchmarking providers and regions to identify unwarranted variation in both cost and quality and going one step further to specifically highlight key cost and quality drivers of the disease. This insight is helping to highlight provider strengths and failings and to understand the key socio-demographic drivers of the illness.

Applying the HCI3 Grouper

The DSRIP programme has developed an automated method to run the HCI3 grouper technology across all Medicaid claims for the last three years. This has, for example, enabled the State to develop a unique state-wide understanding of the total costs of care for its COPD patients. This analytics technology applies the sophisticated grouping methodology from HCI3 to pull together all associated activity and costs for a single COPD patient care cycle, linking disparate data across providers and care settings. By applying this technology systematically for data across the state, New York has access to a treasure trove of comparative data at patient level.

Understanding COPD patient journeys

The application of the HCI3 grouper enables the deep dive analysis of costs and activity from primary care, acute and community health settings. It also integrates relevant prescribing costs. Patients are identified as suffering from COPD through selected ICD 'trigger' codes in their claims data. The technology then searches for over 200 codes (amongst thousands) to bring the individual patient care cycle together. It uses ICD codes for acute activity, and the American Medical Association-maintained Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding for other activity. COPD drugs groups are also flagged to get as complete a picture as possible. The connected patient journey enables true cost baselines to be established.

Benchmarking COPD

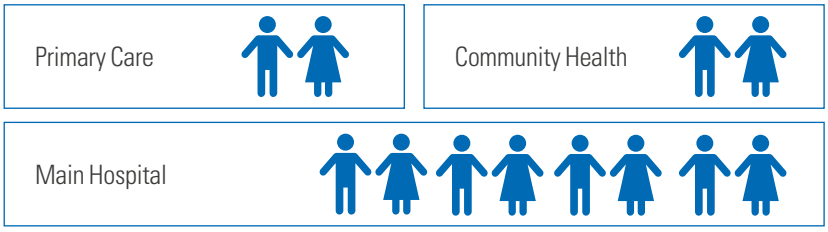
New York is using this data to establish bundled cost baselines for medical conditions like COPD. This provides the first key driver for value-based payment conversations. The analysis, however, goes one step further by splitting all costs into typical and potentially avoidable complications (PACs) after adjusting for the relative severity of individual patient episodes. Comparative PAC data for every COPD patient allows the state and its provider networks to fairly compare relative costs. It also crucially provides a trusted and reliable proxy measure for the value of care delivered at the medical condition level. Lower PAC costs are indicative of better care, presenting opportunities for the best providers to expand service provision and for weaker ones to improve or divest.

Before and after: Creating patient-centred analytics

Before: New York's State analytics prior to DSRIP

New York had a fragmented view of the cost and quality of patient care, focused on departments and silos within care settings

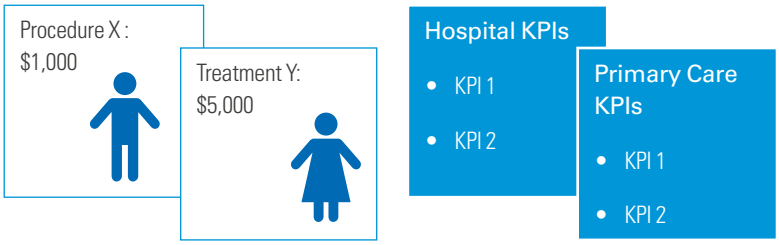
Disparate, disconnected data for related episodes of care was stuck in data silos



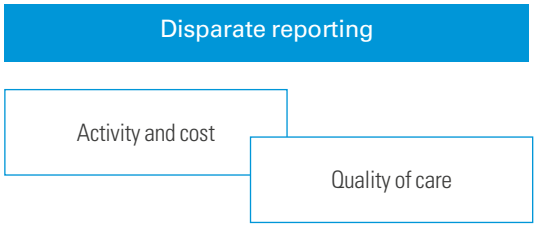
No understanding of the total costs of care

Analysis of activity and costs that did not explain the whole patient pathway or reflect the quality of care provided

Analysis focused on treatment areas instead of patient journeys, with no direct link to quality of care

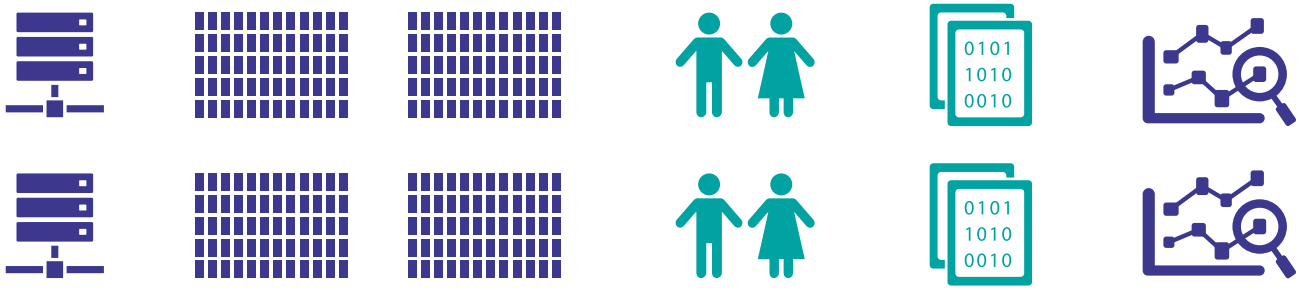


Reporting does not cover the care bundle or link quality to cost and activity



Disparate reporting on multiple systems, making benchmarking and comparative analysis difficult and inaccessible

Data across provider networks was siloed with no common dataset. Analysis and reporting were ad hoc and served specific organisational purposes, rather than helping drive collaboration, transformation and value-based care.



After: Patient-centered analysis to underpin medicaid reforms

Patient-centred analysis explores data across care settings for 90+ care bundles that cover key conditions and services

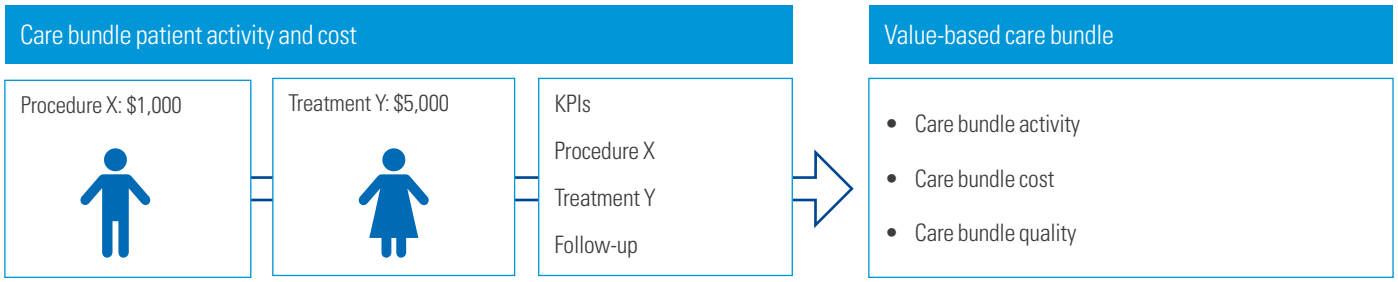
Connected data tells the whole story regarding a patient's care across a provider network

Total cost of care is well understood

Analysis of both quality and costs for care bundles across all providers and patients, which promotes care of the greatest value

Analysis covers related activity for a care bundle focusing on the patient journey

Total cost of care and quality are understood



A single analytics infrastructure which enables consistent reporting and facilitates sophisticated benchmarking and analytics for all

Working on New York State's behalf, KPMG in the US manages five separate vendors to provide the right analytics infrastructure. Working with the latest technology, healthcare experts and data scientists are constantly collaborating on a common platform to provide the required insights.

What can other health systems learn from DSRIP analytics?

The DSRIP analytics programme addresses the same challenges that other healthcare systems face when trying to promote better-value care. It uses similar datasets in a powerful way to address key questions and challenges.

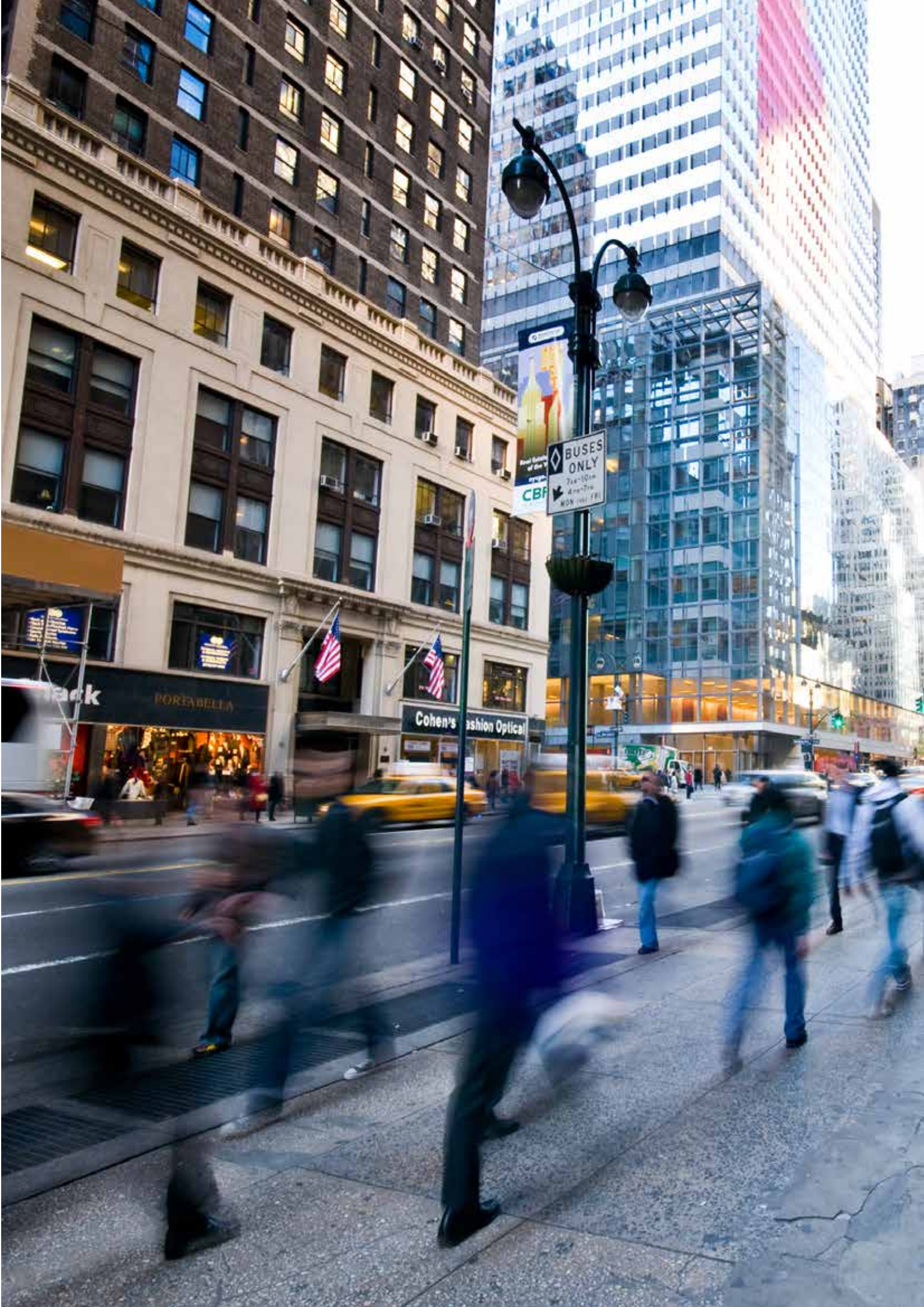
How can a health system system provide better incentives for value-based care?

What information and insights are needed to promote the value agenda?

How can you create a system for reporting and analytics in value-based care ?

A payment reform programme needs to give healthcare systems improved opportunities to organise themselves into being more efficient and effective. This requires an advanced analytics approach that shines a light on best practice and pushes providers across the system to focus on their strengths.

Common Healthcare Data Challenges	Current analytics and reporting tend to focus on healthcare activity and the measurement of performance at the wrong level. Instead of looking at medical conditions, health systems tend to have a siloed perspective, focusing on the individual provider service lines and specialities rather than treatment of patients' overall medical conditions. This entrenches a mind-set of payment for activity rather than payment for value delivered to patients.	Healthcare activity data is separated within distinct care settings, making it difficult to follow the patient journey through the primary, acute, community and mental health settings. The absence of linked datasets at the medical condition level makes it difficult to identify best practice and opportunities for the system to improve. We struggle to identify for example who is managing diabetes or stroke care the best.	There are limited instances where provider financial, activity and clinical quality performance is compared at the medical condition level. The disparate nature of clinical quality, financial and activity reporting makes it difficult to answer the question of value. Unwarranted variation is not identified, hiding significant improvement opportunities. System reform has no real way of knowing who the best providers are.
How NY DSRIP Analytics is helping to address these data challenges	Analysis and reporting focuses on healthcare activity at the medical condition level. This creates a clear incentive framework, directing providers' energies to the areas where the most value can be created for patients. Analysis highlights how provider networks are delivering complete episodes of care for specific conditions, splitting costs into typical and potentially avoidable complications (PACs). Benchmarking PACs provides clear incentives to improve performance at the point where patient value can be realised.	Further, these disparate data sets and unlinked costs fail to provide insight into the total cost of care, which can help better align care management and pathways for patient subpopulations, and is one of the key elements of the value-based payment equation. Linked patient-level datasets that cut across care settings are continuously analysed and reported on. These datasets link medical cost, activity and clinical quality data. They tell the whole patient story. This ensures a more complete understanding of the relative value of services, with cost and activity baselines for key medical conditions. Payers now have the insights to commission for value, and providers are incentivised to focus on how they can improve the delivery of care.	Consistently measuring, benchmarking and reporting care bundle cost, activity and quality promotes competition for improved care of medical conditions. DSRIP uses HCI3 grouper technology to provide a powerful proxy indicator for the relative quality and costs of care. By splitting patient-level costs into typical and potentially avoidable for every care bundle, opportunities to improve are clearly identified, with the ability to drill into the specific providers and patients causing the highest PACs.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What Works is a series of thought leadership reports addressing the world's most pressing healthcare challenges. Learn more: kpmg.com/whatworks

WhatWorks: Partnerships, networks and alliances

Partnerships, networks and alliance are now essential to realising cost-effective, high-quality and sustainable healthcare. Based on two years of extensive research into healthcare consolidation from around the world, this report reveals, "healthcare with a purpose" – the intersection of improved service quality and cost effectiveness.

WhatWorks: Paths to population health – Achieving coordinated and accountable care

This report describes the practical steps that organisations need to go through to reshape themselves and their services. We look at both coordinated and accountable care – systems designed across a defined population.

WhatWorks: As strong as the weakest link – Creating value-based healthcare organisations

Organising care to deliver value for patients requires change in five main areas. This report focuses on the different lessons drawn from work done with clients and discussions with providers from all over the world. **kpmg.com/valuebasedcare**

WhatWorks: Success stories in global healthcare

KPMG gathered together 65 healthcare leaders from 30 countries across six continents to discuss effective strategies for successful transformation. These discussions were centered around seven key themes ranging from population health and accountable care to clinical and operational transformation. **kpmg.com/stayingpower**

WhatWorks: Creating new value with patients, carers and communities

Globally some parts of healthcare are beginning to make the changes that will involve patients, carers and communities more fully in their own healthcare. Using our experience across the world, this report outlines the answers that you need to fully realise the value inherent in better patient involvement and communities to improve care. **kpmg.com/patientvalue**

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CRT047908 | July 2016

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