

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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State Demonstrations Group

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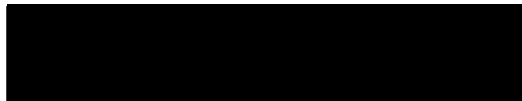
Donna Frescatore
Director
Office of Health Insurance Programs
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Empire State Plaza
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Albany, NY 12237

Dear Ms. Frescatore:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the annual update (Year 3) of the Value Based Payment (VBP) Roadmap update for New York's section 1115(a) demonstration (Project No. 11-W-00304/0), titled "Medicaid Redesign Team" (MRT). We have determined that the submission dated December 8, 2017 meets the requirements set forth in the Special Terms and Conditions and, therefore, hereby approve the MRT's VBP Roadmap.

If you have any questions, please do not hesitate to contact your project officer, Mr. Adam Goldman. Mr. Goldman can be reached at (410) 786-2242, or at Adam.Goldman@cms.hhs.gov.

Sincerely,



Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Michael Melendez, Associate Regional Administrator, CMS New York Region
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Maria Tabakov, State Lead, CMS New York Region



A Path toward Value Based Payment: Annual Update

November 2017: Year 3

New York State Roadmap

for Medicaid Payment Reform

November 2017



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Introduction

CMS approved the New York State Roadmap for Medicaid Payment Reform in July of 2015. The Roadmap was conceptualized as a living document that would be updated annually to ensure that best practices and lessons learned throughout implementation would be leveraged and incorporated into the State's overall vision. This document represents the second annual update to the VBP Roadmap. The primary structure and content of the Roadmap remain consistent, however as work over the past year provided additional details needed for implementation, those updates have been made accordingly throughout the document.

Year 3: Annual Roadmap Update - November 2017

Upon CMS approval of the Roadmap in July 2015, the work of operationalizing the vision for payment reform commenced. New York State has committed to reaching 80% value based payments (VBP) by the end of the waiver period. To achieve success, all components of the New York State Medicaid program must understand the fundamental shift that DSRIP and VBP represent. Recognizing the far reaching impact of the State's ambitious goal, in Year 1 of DSRIP and the VBP Roadmap, the State developed and initiated what became one of the single largest stakeholder engagement processes ever undertaken by the State. With assistance and expertise from the VBP Workgroup, the formal stakeholder group, the State implemented a robust engagement process that resulted in over 500 stakeholders across the State participating in this critical work.

The State and the VBP Workgroup created subcommittees and advisory groups of stakeholders who were charged with moving the VBP Roadmap towards implementation. This work was carried out by VBP subcommittees, Clinical Advisory Groups, and ongoing policy work at the State level.

VBP Subcommittees

The VBP subcommittees were charged with developing detailed recommendations for the design and implementation of VBP based on outstanding questions and considerations outlined in the 2015 VBP Roadmap. The output of these subcommittees was a recommendations report, the contents of which have been included in the VBP Roadmap. The recommendations came in the form of both statewide standards, which must be followed, and guidelines, which serve as an indication of the best practices and lessons learned. The State will continue to monitor the VBP environment and the impact of implementing these recommendations, with the understanding that the need for modification may arise. Five VBP subcommittees were created to focus on specific scope that was deferred from the 2015 Roadmap. Through a series of 4-6 meetings, these subcommittees developed recommendations that were submitted to the VBP Workgroup in January 2016 for approval.¹ The five subcommittees included the following:

- 1 Technical Design I: addressed remaining financial and methodological policy questions.
- 2 Technical Design II: addressed remaining quality, support and design policy questions.
- 3 Regulatory Impact: addressed remaining regulatory policy questions.
- 4 Social Determinants of Health & Community Based Organizations: formulated and provided specific recommendations that drive VBP by addressing social determinants of health, addressed the training needs for CBOs, and ensured all pertinent organizations were involved.

¹ For the full recommendations, please refer to the VBP Subcommittee Recommendation Report available online at https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/2016/docs/2016-feb_sub_comm_recommend_rpt_consol.pdf.



- 5 Advocacy and Engagement: assisted in the design of member incentives to promote lifestyle choices proven to improve health and reduce downstream costs, and discussed the members' right to know about the incentives that affect their care.

Clinical Advisory Groups

In addition to the subcommittees, Clinical Advisory Groups (CAGs) were created to review the care bundle design and subpopulation definitions most relevant to NYS Medicaid. The CAGs made recommendations to the State on quality measures, data and support required for providers to be successful, and addressed other implementation details related to specific VBP arrangements, including bundles (episode-based) and subpopulations. For CAG participation, VBP Workgroup members nominated individuals with specific skillsets including: clinical experience and knowledge focused on the care or condition being discussed; industry knowledge and experience; geographic diversity knowledge; and total care spectrum experience as it relates to the specific care or condition. The CAGs convened throughout Year 1, 2015, and continue in year 3, 2017. The CAGs include:

- Maternity
- Chronic Heart Conditions
- Diabetes
- Chronic Pulmonary Conditions
- Behavioral Health (ongoing)
- HIV/AIDS
- Managed Long-Term Care (MLTC) (ongoing)
- Health and Recovery Plans (HARP)

In addition, a CAG representing those with intellectual/developmental disabilities and another for children have met to inform the arrangements and recommend measures for performance. The aforementioned processes were orchestrated in order to drive payment reform in New York State towards a successful implementation. The output of this important work is included throughout this Roadmap, which will continue to serve as the guiding framework for VBP.² Additional work refining outstanding details and assessing the potential impact of VBP implementation performed by the workgroup, subcommittees and CAGs will continue through Year 3. VBP implementation will also focus on pilot initiatives to establish and encourage movement towards VBP. The State and its stakeholders continue to be fully committed to successful implementation of VBP, and present this updated Roadmap to highlight its advancement toward Medicaid payment reform and DSRIP goals.

² This update is intended to be readable as a 'stand alone' document. To facilitate readability, some sections of the original Roadmap have become integrated with newer parts.



Background

On April 14, 2014, the State of New York (the State or NYS) and the Centers for Medicare and Medicaid Services (CMS) reached agreement on a groundbreaking waiver that allows the State to invest \$8 billion for comprehensive Medicaid delivery and payment reform primarily through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program promotes community-level collaboration and aims to reduce avoidable hospital use by 25 percent over five years, while financially stabilizing the State's safety net. A total of 25 Performing Provider Systems (PPSs) have been established statewide to implement innovative projects focused on system transformation, clinical improvement and population health improvement. All DSRIP funds are based on achievement of performance goals and project milestones.

The State will continue working with CMS to optimally align NYS efforts with the goals of the U.S. Department of Health and Human Services on value based purchasing and alternative payment models.³ Over the next five years, many lessons will be learned from DSRIP and VBP implementation efforts in New York; nationally, CMS' priorities might evolve, and initiatives such as the Health Care Payment Learning and Action Network will yield new best practices. Therefore, this Roadmap was developed as and will remain a living document. It will be updated annually throughout the DSRIP period, so as to not lock in policies that may require adjustment in the future, and also to ensure that the New York DSRIP remains a national leader in committing towards the national goals of the U.S. Department of Health and Human Services (DHHS) on VBP and alternative payment models.

To ensure the long-term sustainability of the improvements made possible by the DSRIP investments in the waiver, the Terms and Conditions (T&Cs) (§ 39) require the State to submit a multiyear Roadmap for comprehensive Medicaid payment reform, including how the State will amend its contracts with Managed Care Organizations (MCOs). The T&Cs required the Roadmap address the following topics:

1. What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the State will plan and implement its stated goal of 90% of managed care payments to providers using value based payment (VBP) methodologies.
2. How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.
3. How the State will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.
4. How and when plans' current contracts will be amended to include the collection and reporting of DSRIP objectives and measures.
5. How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The State should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other State funding; and how they differ from any services or administrative functions already accounted for in capitation rates.

³ Burwell, S. M. (2015). "Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care." [N Engl J Med](#).



6. How the State will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks.
7. How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how timely data will be incorporated into capitation rate development.
8. How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the State will use benchmark measures (e.g. medical loss ratio (MLR)) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for State review and approval by January 31 of each calendar year.

The State Health Innovation Plan (SHIP) and Medicaid Payment Reform

DSRIP, Medicaid Payment Reform and SHIP form a coordinated whole. A core goal of SHIP, funded as part of the CMS' State Innovation Models Initiative (SIM), is the strengthening of primary care in New York through the Advanced Primary Care model (see p. 9). The effort aligns fully with DSRIP and is the delivery platform for the Integrated Primary Care (IPC) VBP arrangement discussed below. To ensure consistent development, the Medicaid VBP team meets with the SHIP team and regularly participates in the Integrated Care Workgroup charged with developing the APC model.

In terms of payment reform, the State and stakeholders have determined that a gradual approach, starting with Medicaid, and subsequently ensuring that Medicare's reform efforts maximally align with the Medicaid reforms, is the preferred way forward. A full description of the State's work related to Medicare alignment is included on page 61. It is anticipated that payers and providers will learn from their Medicaid VBP experience and these learnings will influence their other contracting arrangements as they develop VBP strategies that best meet their private sector needs.



What New York State’s Medicaid Value Based Payment Plan is Not

During the development of the Roadmap, stakeholders expressed concerns about the pace and scope of the changes that VBP represents. Throughout a series of detailed stakeholder discussions, it became clear that there were some misperceptions about the intent of the State’s Roadmap. As such, to ensure all stakeholders understand the true direction the State is undertaking, the State has explicitly outlined what is not included in VBP.

What New York State’s Medicaid VBP Plan is Not:

A new rate setting methodology: *The State will show benchmarks and give guidance, but it will not set rates or dictate detailed terms for value based payment arrangements.*

One size fits all: *There are a variety of options outlined in the Roadmap, and many details to negotiate between MCOs and providers. Also, MCOs and providers can jointly agree to pursue different or ‘off-menu’ VBP arrangements as long as those arrangements reflect the Medicaid VBP principles described herein. In addition, the State’s VBP goals will be measured at the State’s level, not at the individual PPS level, allowing for differences in adaptation between PPSs.*

The State backing away from adequate reimbursement for Federally Qualified Health Centers (FQHCs) and other community based providers: *Outlined in the figure on p.7, the State is committed to ensuring adequate reimbursement aligned with the value provided for the Medicaid population consistent with federal statute.*

An attempt to make providers do more for less: *In fact, the intent is the opposite. Under the State’s VBP approach, reducing lower value care and increasing higher value care in equal proportions should lead to higher margins rather than lower margins.*

An attempt to make PPS leads responsible for all PPS providers’ contracting: *The responsibilities providers delegate to their PPS is decided by themselves through the emerging PPS governance structure. Delegating contracting responsibility to the PPS is an option, which would, however, require the PPS to become a legal contracting entity in New York State.*

An attempt to require MCOs to contract with PPSs for VBP Arrangements: *MCOs are free to continue to build upon their existing direct provider contracts or Independent Practice Association (IPA)/Accountable Care Organization (ACO) arrangements to achieve the VBP goals.*

A requirement that only PPSs can enter Medicaid VBP Arrangements: *All (groups of) providers that can deliver integrated care services, including, but not limited to, IPAs, ACOs and PPSs (if structured as a legal contracting entity), are intended to be able to enter into VBP arrangements.*

A Roadmap for all future payment reform: *This Roadmap pertains only to Medicaid payment reform and does not apply to payment reform in the commercial marketplace. A separate policy discussion will determine the future of payment reform concepts contemplated by the State Health Innovation Plan.*

1. Towards 80-90% of Value Based Payments to Providers⁴

Issue 1: What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the State will plan and implement its goal of 80-90% of managed care payments to providers using value based payment methodologies by end of demonstration year five (DY 5).

Sustainable Delivery Reform Requires Matching Payment Reform

DSRIP is a major collective effort to transform the State's Medicaid health care delivery system from a fragmented, inpatient care focused system, to an integrated and community based system focused on providing care in or close to the home. Where the delivery system is currently predominantly reactive and (acute) provider-focused, DSRIP aims to create a more proactive and member-focused system, with a vibrant workforce throughout the continuum of care, emphasizing population health and closely involving social services.



These objectives have broad stakeholder support and are made measurable by a set of DSRIP metrics on potentially avoidable (re)admissions, emergency department (ED) visits and other potentially avoidable complications, as well as patient experience. Underlying these overall outcomes is a broader range of project-specific process and quality measures.

Reducing avoidable (re)admissions, ED visits and other potentially avoidable complications through more effective clinical and service models that partner primary, acute, home and community based care will improve health, while further stabilizing overall Medicaid expenditures. This will further allow the State to remain under the Global Cap without curtailing eligibility, strengthen the financial viability of the safety net, support continued investment in innovation, and improve outcomes.

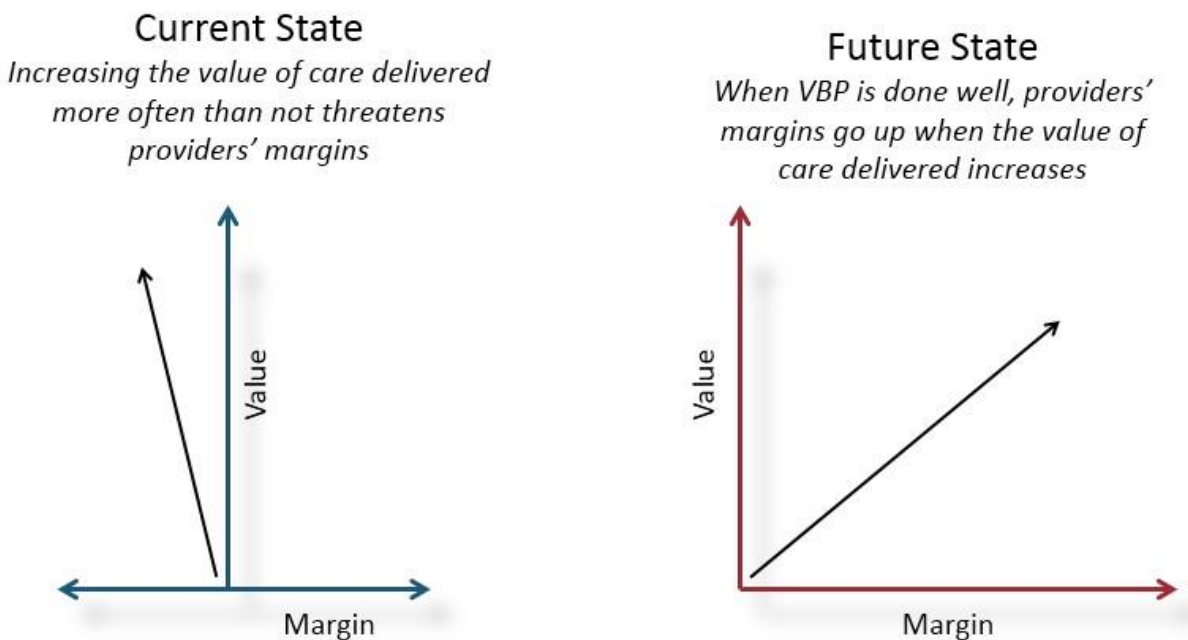
Such a thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well. Many of the Medicaid delivery system's problems (fragmentation, high (re)admission rates, poor primary care infrastructure, lack of behavioral and physical health integration) are rooted in how providers are reimbursed. In most cases, siloed providers are still being paid fee-for-service (FFS) by their MCOs, incentivizing volume over value, and creating a focus on inputs rather than realizing adequate outcomes. To this day, an avoidable readmission is often rewarded more than a successful transition to integrated home care or a nursing home; likewise, prevention, coordination or integration activities are rarely reimbursed adequately, if at all.

In addition, the current FFS system and the diversity of contracting regimes between individual providers, individual MCOs, and other non-Medicaid payers, creates an administrative burden on providers that would be unfathomable in any other health care sector in the world – or in any other US industry. Often, payment

⁴ As expressed in the Terms and Conditions (T&Cs) (§ 39), the State's ultimate goal is 90%. Because NYS' definition of VBP has become more ambitious than originally contemplated, the State has agreed with stakeholders to lower the official target for the Roadmap to 80-90%.

reform initiatives initially seem to increase the administrative burden; they necessarily constitute a change from the way current administrative processes and systems operate. They may require upfront investment for redesign and may require providers to temporarily straddle different payment systems simultaneously. Yet well-executed payment reform can significantly offset this complexity by reducing the need for micro-accountability (such as the need for utilization review throughout the care process), by not only standardizing rules and incentives across providers, but also by increasing transparency.⁵

In essence, the State’s Medicaid payment reform goals attempt to move away from a situation where increasing the value of the care delivered (preventing avoidable admissions, reducing administrative waste) has a *negative* impact on the financial sustainability of providers, towards a situation where the delivery of high value care can result in *higher* margins (see figure below).



Payment reform, then, is required to ensure that the changes in the care delivery system funded by DSRIP are sustained well beyond the waiver period, so that member engagement and care coordination activities, including peer-based activities, can be reimbursed, value-destroying care patterns (avoidable (re)admissions, ED visits) do not simply return when the DSRIP dollars stop flowing, a stable and well-trained primary and community based workforce is maintained, and dollars currently lost in non-value-added administrative processes become available for member care. Importantly, payment reform is equally essential *to ensure that the savings realized by DSRIP can be reinvested in the Medicaid delivery system*. Without payment reform, savings would accrue to MCOs, whose yearly rates would, in the current payment system, subsequently be revised downwards. In fact, many PPSs are already actively discussing the importance of payment reform as a means to alleviate predicted losses in FFS revenue due to improved performance on DSRIP outcomes (reduced admissions, reduced ED visits, etc.).

Payment reform must also maintain or improve funding and incentives for essential and mandatory costs

⁵ Cutler, D., E. Wikler and P. Basch (2012). "Reducing administrative costs and improving the health care system." *N Engl J Med* 367(20): 1875-1878.



within the system that includes provider/system for public goods, critical infrastructure support, and fulfillment of state/federal public health and compliance requirements. These components include such input costs as: hospital/clinic/home care, indigent care, graduate medical education, federal conditions of participation, health information technology (HIT) capacity and interoperability, health care worker training and certification, quality assurance, emergency preparedness, community public health (e.g., immunization, disease response), and other vital needs.

Payment Reform Guiding Principles

This Roadmap is built upon the foundation already put in place by the State’s Medicaid Redesign Team (MRT) Payment Reform & Quality Measurement Work Group. In 2012, that Workgroup concluded that innovative payment reform and quality initiatives should:

1. Be transparent and fair, increase access to high quality health care services in the appropriate setting, and create opportunities for both payers and providers to share savings generated if agreed upon benchmarks are achieved.
2. Be scalable and flexible to allow all providers and communities (regardless of size) to participate, reinforce health system planning, and preserve an efficient and essential community provider network.
3. Allow for a flexible multi-year phase in to recognize administrative complexities including system requirements (i.e. Information Technology).
4. Align payment policy with quality goals.
5. Reward improved performance as well as continued high performance.
6. Incorporate a strong evaluation component and technical assistance to assure successful implementation.
7. Engage in strategic planning to avoid the unintended consequences of price inflation, particularly in the commercial market.
8. Financially reward, rather than penalize, providers and plans who deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes, including interventions that address underlying social determinants of health.

Starting Point: How Should an Integrated Delivery System Function from the Consumer/Member’s Perspective?

The fundamental vision of NYS DSRIP is the creation of integrated delivery systems capable of meeting the diverse needs of Medicaid members. Different types of members require different types of care. As foreseen in DSRIP, a high performing care delivery system encompasses three types of integrated care services, with optimal coordination between them:

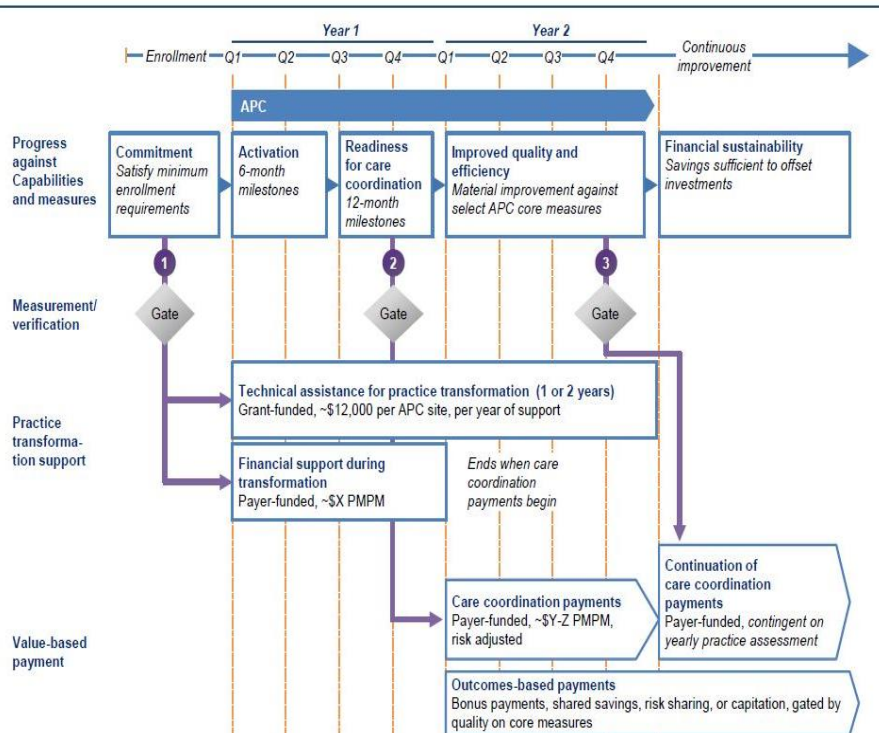
1. **Integrated Primary Care (IPC)** including behavioral health, primary care, effective management of chronic disease, medication management, community based prevention activities, and clear alignment with community based, home, and social services agencies (Patient Centered Medical Home (PCMH)/Advanced Primary Care (APC) models). This type of care is continuous in nature, strongly population-focused, based in the community, culturally sensitive, oriented towards primary and secondary prevention, and aims to

act as the primary source of care for the majority of everyday care needs.

New York State’s Vision on Advanced Primary Care

Advanced Primary Care (APC) plays a core role in the State’s Health Innovation Plan (SHIP) and within DSRIP. The figure below briefly explains how NYS sees the progression towards achieving Advanced Primary Care (APC) status from commitment to fulfillment of all capabilities, which fully aligns with DSRIP’s end goals for Integrated Primary Care (see the SHIP plan for more details).

APC VBP Payment Model



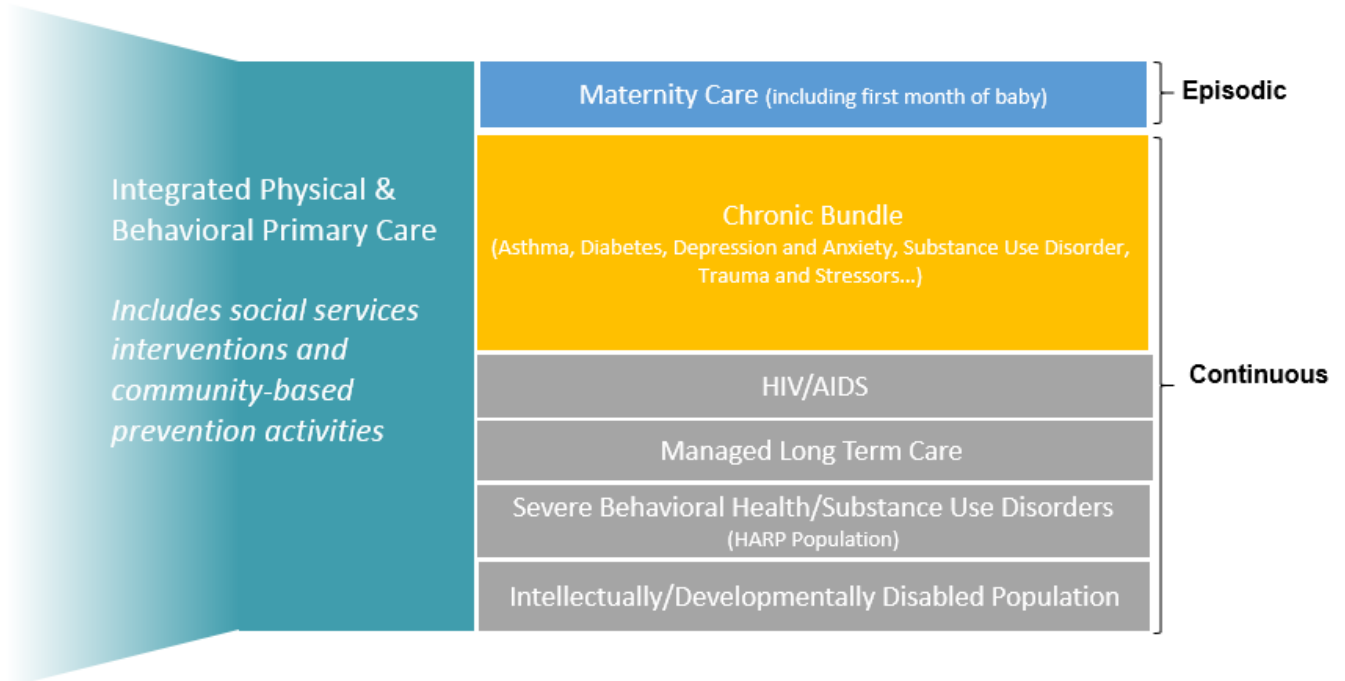
The State has had extensive experience with what will later be described as Level 0 Value Based Payments, FFS with quality bonus payments, during the early and ongoing support of the PCMH model, and involvement in medical home demonstrations in a variety of settings across the State. As these initiatives have progressed, it has become clear that transformation of primary care practices to an APC model will include three (3) broad phases during which the practices require different types of financial support:

1. Initial investment in practice transformation, including support for technical assistance, and for the costs of new programs and staff (or re-training existing staff).
2. Interim support for increased operating costs for a period of time (experience indicates 2-3 years), as practices improve quality and population health, but before realizing reductions in preventable utilization and other costs needed to support shared savings payment. In the early years of the APC’s operation, providers will be taking on new functions and costs, improving quality, patient access and experience, but not (yet) generating cost savings.
3. Ongoing support once the APC model has begun to have a measurable impact on total cost of care and to generate measurable savings. The practice and payers may choose to reduce the basic program support and shift compensation to shared savings and/or risk sharing.

From the perspective of Medicaid, phase 1 and 2 will be funded through DSRIP; phase 3 is the transition toward Level 1 (and higher) VBP for IPC, as discussed in the Roadmap.



- 2. **Episodic care services** are utilized for circumscribed periods of time when people require more specialized services for a specific health problem or condition. Within the Medicaid population and DSRIP, maternity care may be the best example; for elderly members, hip and knee replacement episodes are the most prevalent examples. These services, which may involve a single service or combination of services across the continuum of care, should be tightly integrated with multidisciplinary teams working with evidence-based care pathways, organized around these members’ specific needs, resources (including community resources), and cultural sensitivities.
- 3. **Specialized continuous care services** are required for those individuals who require ongoing, dedicated, and specialized interdisciplinary services for their health problem(s) or condition(s). This type of care can involve both evidence-based specialty care for individual conditions (e.g. diabetes, Chronic Obstructive Pulmonary Disease (COPD) , Serious Mental Illness (SMI) and/or Substance Use Disorders (SUD)), as well as care for severely co-morbid and/or special needs populations (e.g. the Health and Recovery Plan (HARP) and Managed Long-Term Care (MLTC)/Fully Integrated Duals Advantage (FIDA) populations, members with significant developmental disabilities and members with HIV/AIDS). For the latter groups of members, personalized goal setting and intensive care coordination become more dominant than disease management. In both examples of care, a focus on maximizing a member’s capability for self-management and personal autonomy in the most integrated settings (e.g. home and community) appropriate to a person’s needs, is central.





Facilitating the Development of an Optimally Functioning Delivery System through Value Based Payments: A Variety of Options

Following the spirit of the DSRIP program, the State does not foresee a single path towards payment reform. Rather, the State aims to give PPSs, providers, and MCOs a comprehensive range of VBP options to consider. This allows providers and MCOs to select those types of value based payment arrangements that fit their strategy, local context, and ability to manage innovative payment models, which has been proven to be a critical success factor in successfully realizing payment reform.⁶

When entering into such arrangements, organizations become 'VBP contractors'; a VBP contractor is defined as an entity that contracts VBP arrangements with an MCO, and can be an Accountable Care Organization (ACO), an Independent Practice Association (IPA), or an individual provider (either assuming all responsibility and upside/downside risk or subcontracting with other providers). Multiple providers can contract a VBP Level 1 arrangement by cooperating clinically and operationally, and making individual shared savings agreements with the MCO. Jointly, VBP contractors and MCOs can create VBP arrangements around:

- Total Care for General Population (TCGP); and/or
- Integrated Primary Care Arrangement (which includes all care for the most prevalent chronic conditions in NYS Medicaid), (IPC); and/or
- the Maternity Care Arrangement; and/or
- Total Care for Special Needs Subpopulations.

The *population based* arrangements include the total care and costs of that care for the included members, irrespective of where, how, or for what reason, the care was delivered. VBP contractors assume responsibility for the outcomes and costs across all conditions and types of care for these members. Based on the existing categories in New York State Medicaid, the prioritized special needs subpopulations are HIV/AIDS, members included in a Health and Recovery Plan (HARP), Managed Long-Term Care (MLTC) members and members with significant developmental disabilities.

A *bundle or episode*, on the other hand, is a VBP arrangement in which costs of a patient's office visits, tests, treatments and hospitalizations associated with a patient's illness, medical event, or condition are grouped together. A VBP contractor assumes responsibility for both the outcomes and the costs of the care across the continuum of the patient's trajectory for that condition.⁷ There are different categories of episodes: acute episodes that focus on the integrated care around an acute stroke, for example, or trauma; procedural episodes that focus on the care around gall bladder surgery, for example, or hip- and joint replacement; and chronic episodes that focus on the care for chronic conditions such as diabetes or bipolar disorder. The former categories have a clear start and end date, starting, for example, at the time of admission and ending 3 months after surgery; the latter are continuous. In an episode-based arrangement, several related episodes can be brought together. Based on prevalence in Medicaid, total costs of care, observed variability in costs and outcomes and prioritization in DSRIP, NYS has prioritized the Maternity Care Arrangement (spanning the pregnancy, delivery, sixty days postpartum for the mother, and the first month of the baby's care) and the

⁶ Ginsburg, P. B. (2013). "Achieving health care cost containment through provider payment reform that engages patients and providers." *Health Aff (Millwood)* 32(5): 929-934; Miller, H. D. (2009). "From volume to value: better ways to pay for health care." *Health Aff (Millwood)* 28(5): 1418-1428.

⁷ NYS uses the HCI3 Evidence-informed Case Rate (ECR) grouper (also known as 'Prometheus'). Playbooks will be made available with details on definitions and indicators per bundle. See also <http://www.hci3.org/programs-efforts/prometheus-payment>.



Integrated Primary Care Arrangement.⁸ The State will follow the internationally emerging best practices to treat chronic conditions as full-year-of-care bundles, emphasizing the continuous nature of this care, including all condition-related care costs.⁹

In searching for the right balance between flexibility and standardization, consistency in VBP arrangement definitions has been identified as a key success factor in VBP implementation both national and globally. This includes:

- Services to be included and excluded from each VBP model;
- Members eligible for attribution to each model;
- Selection and specifications of quality and outcome measures for each model; and
- Methods to calculate the risk-adjusted cost of care in each model and in benchmarks used by the State to reflect changes in the clinical and demographic mix of attributed members.

Such consistency enables transparency in performance between MCOs and VBP contractors, adequate monitoring of the quality and expenditures of the overall Medicaid system, and significantly reduces the administrative burden for both MCOs and providers.¹⁰ Especially for smaller providers, varying definitions of a VBP arrangement between MCOs and/or differences in reporting requirements could cripple their ability to fulfil their role. The statewide definitions and quality measures have been set based on national standards and the recommendations from the Clinical Advisory Groups and the Technical Design Subcommittees.¹¹ Measure results at VBP Contractor level will be made available between MCO and Contractor on a regular basis for monitoring. MCOs have to report these measures to the State.¹² MCOs are encouraged to share quality measure reporting with VBP contractors to enable provider and MCO partnerships to improve the quality of care.

Providers and MCOs are, however, free to jointly agree to other types, or 'off menu' versions of VBP arrangements, including currently existing arrangements, as long as those arrangements reflect the underlying goals of payment reform as outlined above, and sustain the transparency of costs versus outcomes as detailed in Appendix II. Such arrangements will not require separate approval from the Department of Health (DOH) beyond the contract risk review process, but will require attestation from the parties, and be subject to periodic audits. NYS will report annually to CMS and other stakeholders on the progress and content of these 'off menu' VBP arrangements.

Most other components of the VBP contracting process, such as how to attribute members, setting and adjusting target budgets, rewarding performance, sharing savings and/or losses and so forth are left to the MCOs and providers to design and negotiate. The *guidelines* that have been developed to facilitate this will be

⁸ Integrated Primary Care (IPC) and Maternity Care are the two VBP arrangements proposed by the State that are episodic in nature. The other VBP arrangements are population-based.

⁹ de Bakker, D. H., J. N. Struijs, C. B. Baan, J. Raams, J. E. de Wildt, H. J. Vrijhoef and F. T. Schut (2012). "Early results from adoption of bundled payment for diabetes care in the Netherlands show improvement in care coordination." *Health Aff (Millwood)* 31(2): 426-433; De Brantes, F., A. Rastogi and M. Painter (2010). "Reducing potentially avoidable complications in patients with chronic diseases: the Prometheus Payment approach." *Health Serv Res* 45(6 Pt 2): 1854-1871.

¹⁰ This standardization is also required to allow realizing the statewide information support strategy for providers and payers to facilitate VBP contracting as well as statewide transparency and cost- and outcomes-reporting.

¹¹ Playbooks detailing these definitions and outcome measures per VBP arrangement will be made available.

¹² Claims based measures will be calculated by the State as necessary.



discussed below.

Total Care for the General Population (TCGP)

In this model, the VBP contractor assumes responsibility for the total care for its total attributed population. This excludes members who fall into a ‘subpopulation’ category described below, although VBP contractors and MCOs are of course free to add one or more subpopulations to their contract. All services covered by mainstream managed care are included (for exclusions see p. 30), and all attributed members are included (see p. 23). The default method for attribution is the MCO-assigned PCP. Investing in population health, care coordination, referral patterns and discharge management are some of the DSRIP-enabled capabilities that will make VBP contractors successful.¹⁴

Integrated Primary Care (IPC)

In this model, the MCO contracts Patient Centered Medical Homes (PCMH) or other primary care providers for preventive care, routine sick care and the care and coordination for patients with chronic conditions. Preventive care includes care activities such as wellness visits, check-ups, immunizations, screening and routine tests; sick care includes care for symptoms such as headache or abdominal pain, as well as minor acute conditions such as flu, rhinitis and so forth. The Chronic Condition Component consists of 14 chronic episodes that have been prioritized on the basis of prevalence and total costs (see textbox, and p.33 for more details on the selection process). Given the prevalence of chronic co-morbidity, VBP contractors by default include the Chronic Care Component as a whole within IPC, rather than selecting one or more of the individual chronic conditions.

The default method for attribution for this VBP arrangement is the MCO-assigned PCP (see p. 23). All preventive and sick care services covered by mainstream managed care are included¹⁵, as well as those services included in the Chronic Care Component definitions. Members eligible for one of the subpopulations (p. 14) are excluded. As is the case today, IPC contracts can include additional payments for practice transformation, care management, and can tie additional rewards to progression towards APC status, for example.

The IPC arrangement emphasizes population health, the integration of physical and behavioral health, care coordination, adequate referral management (including actively working with hospitals on discharge management), amongst others.

Savings in an IPC contract are primarily based on reductions of so-called ‘downstream’ costs: expenditures for sick care and chronic care that would be reduced when integrated primary care is functioning optimally. Avoidable ED visits and hospital admissions due to a lack of care coordination or ease of primary care access are good examples, as are exacerbations of chronic conditions or the occurrence of complications due to poor secondary prevention. Cancer care costs and significant trauma care, on the other hand, are not included in preventive care, routine sick care nor the chronic care episodes and are thus not included when calculating potential downstream savings.

¹⁴ Professional-led TCGP VBP contractors are expected to cooperate with downstream providers. See the section on ‘Integrated Primary Care’ and Appendix III.

¹⁵ See textbox on p. 37 for additional details.



Such savings can substantially increase funding to primary care practices because the potential downstream savings are much larger than the practices' total current revenues. To maximize shared savings in this model, professional-led practices are encouraged to collaborate with hospitals and other providers on activities such as outreach, care management, and post-discharge care. Because shared savings will derive in large part from avoided hospital use, earned savings should be shared evenly between professional-led practices and associated hospitals, provided that the hospitals work cooperatively with the practices to better manage their patient populations (see Appendix III for more detailed criteria).¹⁶

Similarly, compared to TCGP arrangements, moving to risk-based contracts in an IPC VBP arrangement is much more feasible for primary care professionals and organizations. Although the total costs included in an IPC arrangement are significant (about 40% of the total costs of care for the general population), the risk is limited to those costs that most primary care providers consider to be within their control: preventive care, and costs associated with sick care and chronic care.

Maternity Care

In this model, the MCO contracts with a VBP contractor (usually a hospital and/or professionals involved in maternity care, who may also work with community based organizations¹⁷) for care from onset of the pregnancy, delivery, post-delivery and the first month of the newborn's care.¹⁸ All maternity services covered by mainstream managed care are included. Members eligible for one of the subpopulations are excluded. Episodes with a total cost above a certain threshold (so called 'stop-loss') are held to that stop-loss limit to protect the VBP contractor from the insurance risk of high-cost NICU admissions. The member is attributed to the core pregnancy care provider. VBP contractors who focus on health education, increased uptake of prenatal care, pre- and inter-conception counseling, appropriate C-section rates and resource utilization, screening for post-partum depression, evidence-informed maternal/infant home visiting and so forth have the opportunity to further improve maternity care outcomes while realizing shared savings.

Total Care for Special Needs Subpopulations

For some specific subpopulations, severe co-morbidity or disability may require highly specific and costly care needs, so that the majority (or even all) of the care delivery and costs are determined by the specific characteristics of these members. For these subpopulations, including the total care (and thus total costs) for these often vulnerable members is best suited. As part of the movement towards managed care, the State has already identified several special needs subpopulations that have their own dedicated managed care arrangements:

- HIV/AIDS
- Health and Recovery Plan (HARP)
- Managed Long-Term Care (MLTC)
- Intellectual and/or Developmental Disabilities (I/DD)

¹⁶ These criteria also apply to the Total Care for General Population VBP arrangement if it is contracted by professional-led VBP contractors.

¹⁷ This could be any variety of CBO providing prenatal support services, education around infant/maternal health, lactation consulting, etc.

¹⁸ Post-delivery care is included to 60 days after discharge of the mother; the care for the newborn is included to 30 days after discharge of the newborn. Pregnancies that do not result in a vaginal delivery or c-section are excluded. (See the Maternity Care Playbook for more details.)



The transition of the last subpopulation, those with intellectual and/or developmental disabilities, to managed care and VBP will be included in the next update of the VBP Roadmap.

For these special needs subpopulations, VBP contractors can contract Total Care for the Total Subpopulation. All services covered by the associated managed care plans are included, and all members fulfilling the criteria for eligibility to such plans are included. HIV/AIDS members are by default attributed to the MCO assigned PCP; HARP members are by default assigned to the MCO assigned Health Home (see p. 23). Members cannot be assigned to multiple subpopulations. 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. As mentioned above, VBP contractors and MCOs are free to combine e.g. the HIV/AIDS and/or HARP subpopulation with a TCGP arrangement.

Programs of All-Inclusive Care for the Elderly

Programs of All-Inclusive Care for the Elderly (PACE) provide comprehensive medical and social services to certain frail, community-dwelling individuals, ages 55 and older and eligible for nursing home care, most of whom are dually eligible for Medicare and Medicaid benefits. A PACE is responsible for directly providing or arranging all primary, inpatient hospital and long-term care services required by a PACE participant. An interdisciplinary team of health professionals provides PACE participants with coordinated care. For most participants, the comprehensive service package enables them to remain in the community rather than receive care in a nursing home. PACE becomes the sole source of services for Medicare and Medicaid members and receives federal approval from the federal Centers for Medicare and Medicaid Services (CMS). PACE is considered a model of managed long-term care (MLTC) in New York.

Because financing for PACE is capped, providers can deliver all services participants need and are not limited to those reimbursable under Medicare and Medicaid fee-for-service plans. This payment methodology – a global payment for all services required by members – is consistent with a Level 3 VBP arrangement whereby providers receive a prospective global payment for the total cost of care.

To fully qualify as a Level 3 VBP arrangement consistent with the NYS VBP Roadmap, the prospective payment must include a quality component. The quality component will be based on the quality measures identified and recommended by the MLTC Clinical Advisory Group (CAG) and approved by the State. The MLTC CAG will consider appropriate and feasible primary and acute care quality measures for inclusion in PACE, and ultimately, other MLTC arrangements.

The VBP Roadmap establishes requirements for Level 2 and 3 VBP risk-sharing arrangements. For example, VBP contractors that enter into Level 2 or 3 agreements must:

- Include at least one Tier 1 CBO¹⁹ in their agreement, and,
- Implement at least one social determinants of health intervention. The VBP Social Determinants of Health (SDH) Subcommittee developed a SDH intervention menu, which provides examples of interventions that address economic stability, education, social, family and community well-being, health care and neighborhood and environment well-being²⁰.

PACE plans should review the VBP Roadmap to become familiar with the requirements of Level 2 and 3 agreements.

Although direct care services may be provided by employees of a PACE, care may also be provided by agencies and organizations under contract with a PACE, where PACE fulfills the role of the payer. To the extent a PACE relies on contractual providers, these contracts should be considered for VBP and are subject to the same requirements as mainstream managed care plans. Individual VBP contracts between PACE and providers under contract with the PACE may be Level 1, 2, or 3 VBP arrangements, according to the preference of the contracting parties. Quality measures for use in VBP contracts with these providers will be determined by the MLTC CAG for review and approval by the State.

¹⁹ Additional information on Tier 1 CBO contracting is located in the ‘Contracting with Community Based Organizations’ section of the Roadmap.

²⁰ The SDH intervention menu can be found here.

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/vbp_subcommittee_info.htm



Possible Contracting Combinations

There are various VBP arrangement options for MCOs to choose when contracting with a VBP contractor. As noted previously, a VBP contractor is defined as an entity that contracts VBP arrangements with an MCO, and can be an Accountable Care Organization (ACO), an Independent Practice Association (IPA), or an individual provider (either assuming all responsibility and upside/downside risk or subcontracting with other providers). When contracting at the PPS level, it is important to note that a PPS in its current structure is not a legal entity, and thus cannot enter into VBP contracts. The PPS would have to evolve to one of the first two options above, in order to contract on behalf of the entire PPS.

Within mainstream managed care, MCOs and VBP contractors may opt to contract Total Care for the General Population with or without other Subpopulations (ACO models), or they can, for example, combine a risk-based IPC arrangement with a savings-only TCGP arrangement. The latter not only increases the chances of increased savings; it also helps providers, MCOs and the State achieve the percentage of value based payments required by the waiver. Some MCOs and VBP contractors may prefer to contract for IPC separately to optimize the chances of successful primary care reinforcement; other VBP contractors may want to contract Total Care for the General Population and ‘carve out’ a Maternity Arrangement to create a dedicated drive to improve outcomes for maternity care.

Because of the comprehensive care needs on which the Total Care for Total Subpopulation VBP arrangements focus, IPC or other bundle arrangements within these subpopulation arrangements cannot be separately contracted.²¹

Both providers and health plans have suggested that although joint contracting at the higher level (e.g. PPS as a VBP contractor) for the most vulnerable, multi-morbid subpopulations could be highly beneficial, joint contracting at such a level for more circumscribed and prevalent types of care – such as maternity care – would stifle competition. Some PPSs (in the form of an ACO or IPA) might consist of 2-3 hubs that would prefer contracting for Total Care for the General Population separately rather than as a single PPS. While in some cases, contracting at the PPS or hub level for Integrated Primary Care may be the best path to rapidly develop region-wide APC model capabilities, in other cases it may disrupt locally grown collaboration patterns that require differential treatment to truly blossom.²²

The State does not limit providers and MCOs from introducing additional arrangements ‘below’ a recognized VBP arrangement, such as existing Pay for Performance contracts with hospitals or primary care providers. In fact, such contracts can be used synergistically to achieve the overall goals of the VBP arrangement: rewarding PCPs to prevent avoidable ER visits, for example, can help a health system achieve its TCGP targets.

It is important to note that because PPSs/hubs do not legally participate as contracting entities in VBP arrangements without becoming an IPA or ACO, there are concerns about maintaining the population health-focused infrastructure, patient-centered integration and associated overall workforce strategy that DSRIP sets out to build. To address this concern, the PPS or its hubs will have to submit a plan outlining how this infrastructure will be sustained. In addition, impacts on patient-centeredness, population health, social determinants of health and workforce infrastructure, will be measured at the overall delivery system level (PPS, hub or otherwise). These measures will remain in place after DSRIP funding stops, and will be considered a component of the overall outcomes of care contracted within the different VBP arrangements.

²¹ For HARP and HIV/AIDS, when a specific subpopulation in a MCO or provider’s service area is not contracted (because of low numbers of eligible members for example), MCOs and providers are free to make the additional arrangements they deem necessary to adequately cover the needs of these members.

²² What care the PPS can actively contract for on behalf of the providers in the PPS is decided through the governance structure the PPS has put in place.



From Shared Savings towards Assuming Risk

In addition to choosing the integrated services on which to focus, the MCOs and VBP contractors can select different levels of VBP arrangements. While assuming risk is a fundamental part of VBP, contractors should focus first on building out their DSRIP projects, maturing their capabilities, and creating strong networks, before focusing on potential downside risk-sharing arrangements. Combining the different types of VBP arrangements with different levels of VBP creates the following options:

Options	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature VBP contractor)
Total Care for General Population	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when quality scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	Global capitation (with quality-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM add-on) with upside-only shared savings based on bundle of care (savings available when quality scores are sufficient)	FFS (plus PMPM add-on) 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)	PMPM capitated payment =(with quality-based component)
Maternity Care	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when quality scores are sufficient)	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)	Prospective bundled payment (with quality-based component)
Total Care for Subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when quality scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	Global capitation (with quality-based component)



Level 0 is not considered to be a sufficient move away from traditional fee-for-service incentives to be counted as value based payment in the terms of this Roadmap (with the exception of select preventive services, see p.31, and Managed Long-Term Care, see textbox).

Level 1 consists of ‘upside only’ shared savings arrangements.²³ Here, the capitation and bundled payments exist only virtually. When the accrued fee-for-service payments for the integrated care service are lower than the virtual PMPM capitation or bundle budget, the MCO can share the savings with the parties in the contract (‘retrospective reconciliation’).²⁴ Potential provider losses are not shared; contractors are not ‘at risk’ in Level 1. For example, if a provider or a combination of providers meets most of its contracted quality outcomes, MCOs can return more of the savings; when fewer goals are met, the shared savings percentage is reduced (see table on page 19). When outcomes worsen, no savings are shared.²⁵

Level 2 consists of ‘upside and downside’ risk-sharing arrangements. Again, the capitation and bundled payments exist only virtually, and the percentage of contracted quality outcomes affects the amount of savings and losses shared.²⁶ In Level 2, because the contractors share in the risk, if a contractor meets most of its contracted quality outcomes, the MCOs can return most or all of the savings. Conversely, if a contractor exceeds the virtual PMPM capitation or bundle budget, and a smaller percentage of outcome goals are met, then these providers may be held responsible for the majority of this difference (see table below).²⁷

Managed Long-Term Care (MLTC), Dual Eligibles and Shared Savings

The dual eligible population may seem relatively small (some 15% of Medicaid members are also eligible for Medicare), but these 700,000 individuals comprise 27% of total Medicaid spending. Many of these individuals use long term care services (LTCS) as well as hospital and other services; the former costs are covered by Medicaid (often through a MLTC plan), the latter are generally covered by Medicare. Preventing avoidable hospital use in this population is part of DSRIP’s goals, and should be equally incentivized through payment reform. Improving palliative care, for example, can greatly enhance the quality of care and quality of life for some patients. If the Medicare dollars cannot be (virtually) pooled with the State’s Medicaid dollars, and savings in Medicare cannot be shared with Medicaid providers (or vice versa), the impact of payment reform for this population threatens to be limited, and long term care providers will have difficulty achieving scale in VBP transformation.

To remedy this, the State is working with CMS to create aligned shared savings possibilities within Medicaid and Medicare (see p. 61). In anticipation, the State aims to treat potentially avoidable hospital use as ‘quality outcomes’ for this subpopulation, improving the quality of life for these members, and rewarding MLTC plans and providers when certain levels of reduced avoidable hospital use are reached. Such arrangements could be treated as Level 1 VBP arrangements, and would be eligible for financial incentives. These financial incentives are anticipated to be passed from State-to-Plan to Plan-to-Provider. Even if the savings would primarily accrue to Medicare, the State will not pass on the opportunity to make significant strides in meeting the needs of this part of the dual eligible population. Improved quality and reduced overall costs can also be realized by delaying or avoiding nursing home admissions through targeted interventions amongst the MLTC population residing at home.

The MLTC CAG which is exploring these options is underway.

²³ A minimum amount of savings should be shared for an arrangement to be counted as a Level 1 VBP arrangement. See Appendix VIII.

²⁴ Alternatively, shared savings can be distributed through inter-organizational arrangements within or by the VBP contractor. In practice, however, Level 1 and 2 arrangements usually leave the distribution of savings/losses to the payer (based on pre-agreed upon sharing formulas).

²⁵ Savings should be allocated appropriately among providers; behavioral health, long term care, and other community based providers should in particular not be disadvantaged.

²⁶ A minimum amount of risk is required to be able to be labeled a ‘Level 2’ VBP arrangement (see Appendix VIII).

²⁷ The State suggests not imposing a minimum savings/losses threshold before savings/risk sharing begins.



To reduce unwarranted insurance risk for providers, the State suggests using stop loss, risk corridors and/or other risk-mitigation strategies. The following table reflects the shared savings percentages that the State and the Technical Design Subcommittee established as a guideline to support providers and plans in their VBP contracting negotiations. Plans and providers may, however, decide on other percentages in their VBP agreements.

Quality Targets % Met	Level 1 VBP Upside only	Level 2 VBP Up- and downside	Level 2 VBP Up- and downside
		when actual costs < budgeted costs	when actual costs > budgeted costs ²⁸
> 50% of Quality Targets Met	50% of savings returned to VBP contractors	Up to 90% of savings returned to VBP contractors	VBP contractors are responsible for up to 50% of losses
<50 % of Quality Targets Met	Between 10 – 50% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)	Between 10 – 90% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)	VBP contractors responsible for 50-90 % of losses (sliding scale in proportion with % of Quality Targets met)
Quality Worsens	No savings returned to VBP contractors	No savings returned to VBP contractors	VBP contractors responsible for up to 90% of losses

The following general guiding principles for the distribution of shared savings amongst providers by the VBP contractor have been established:

- i. Funds are to be distributed according to provider effort, provider performance and utilization patterns in realizing the overall efficiencies, outcomes, and savings.
- ii. Required investments and losses of the involved providers can be taken into consideration in calculating and distributing available savings.
- iii. The relative budgets of the providers involved should not be the default mechanism for making the distribution of savings/losses (i.e. distributing the savings among providers by the relative size of each provider’s budget).
- iv. The distribution of shared savings should follow the same principles as the distribution of shared losses.

²⁸ The percentages for the Level 2 arrangements will depend on, amongst other factors, the risk-mitigation strategies chosen. In many cases, especially when more ‘focused’ VBP arrangements are contracted (e.g. an episode-based arrangement vs a TCGP contract), actuarial analysis shows that the percentages of savings returned to providers can be higher than the percentages of losses shared with providers. There is currently no mechanism in place to determine whether VBP contractors enter into a ‘focused’ versus ‘non-focused’ VBP agreements. VBP contractors and plans are free to enter into the agreements that they mutually decide best serve their respective populations.



- v. For shared losses, smaller providers, financially vulnerable providers, or providers with a regulatory limitation on accepting certain losses may be treated differently by the VBP contractor to protect these individual providers from financial harm. It is legitimate that this ‘special treatment’ would weigh in as an additional factor in determining the amount of shared savings that these providers would receive.²⁹

In Level 3, the underlying FFS payment system is replaced by prospective PMPM and/or prospective bundled payments. Consistent with the provisions of the VBP Roadmap, the financial methodology must maintain the link between quality and efficiency. Examples include: adjusting the capitated arrangement payments up and down based on previous quality performance and/or including a bonus and penalty based on previous quality performance. The method for including a quality component in level 3 is subject to the negotiations between MCO and provider. Depending on how the MCO and provider agree to execute the prospective capitation payment with a quality component, retrospective reconciliation may or may not be necessary. As in Level 2, stop loss arrangements may remain to prevent providers from inadvertently taking on insurance risk.

There is a possibility that situations may arise where a MCO and a VBP contractor enter into a value based payment arrangement, but the parties fail to agree upon the terms of a contract. The State, MCOs and providers will collectively monitor whether action or additional guidelines may become necessary in the future.

Further, the State will plan an assessment of progress toward the end of DSRIP Year 3 of participation in VBP contracting, as well as of the market dynamics, which will better equip plans, providers/contractors and the State to address challenges that arise as VBP accelerates. The State will work with the VBP Workgroup to define the details of the assessment in calendar year 2016. This time frame will allow for the finalization of the amendments to the Medicaid Managed Care Model Contract (Model Contract) and the Provider Contract Guidelines.

Pharmaceutical Costs and the Role of the Pharmacist

Costs for drugs and the dispensing of drugs (including adequate pharmaco-therapeutic management) are included in the value based payment arrangements described. Pharmacists can add great value in managing polypharmacy, for example, or in enhancing proper medication usage and compliance. As adverse reactions to medication is a key driver of avoidable hospital use, state of the art Medication Therapy Management (MTM) can improve outcomes and reduce overall costs. Many innovative contracting models are available for MCOs as well as PPSs and (groups of) providers to incorporate the benefits that MTM can bring into the value based arrangements discussed here. The Regulatory Subcommittee reviewed the current state of comprehensive medication management in the State and recommended amending the Public Health Law to create a voluntary program for collaboration between qualified pharmacists and physicians ruled by a written protocol that would enable physicians to refer certain patients with chronic conditions who (1) have not met the goals of therapy, (2) are at risk for hospitalization or (3) otherwise considered to be in need of CMM services, to qualified pharmacists.

²⁹ Shared savings and losses calculations will not be included in the VBP dynamic analytics platform that the State will make available for the providers and the MCOs.



Contract Risk Review Process

Overview

In order to ensure that appropriate safeguards are in place for providers entering into VBP contracts (with a focus on protecting providers from taking on more risk than is financially sustainable), the State will implement a new contract review process. To the extent possible, the updated contract review process will coordinate and standardize the review of the Department of Health and the Department of Financial Services (DFS).

Three review Tiers have been created to reflect the new VBP Levels as per the Roadmap (see Appendix VI, Figure A for definitions of the Levels). These Tiers will be used to determine the type of review required for all provider contracts.³⁰ DOH will collapse the existing five contract review levels per the existing Provider Contract Guidelines into three Tiers.

The third Tier will be comprised solely of prepaid capitation arrangements that are currently subject to DFS's Regulation 164, and will continue to be reviewed and approved by DFS in accordance with the terms of Regulation 164³¹, which provides guidance concerning Financial Risk Transfer arrangements and outlines the requirements for providers to enter into such arrangements. Prepaid capitation will include all prepayments made to one or more health care providers, in any form and for any arrangement, in exchange for one or more covered health care services to be rendered referred or otherwise arranged by such providers and by its participating providers. DOH will continue to conduct a programmatic review of the contracts in this third Tier.

The application of the three Tiers will apply uniformly to all types of VBP contractors and will apply to all types of provider contracts.

Summary of the Three Tiered Approach

Multi-Agency Review Tier (Tier 3)

The Multi-Agency Review Tier (Tier 3) includes all contractual arrangements where at least one of the following is true:

- i. the contract implicates Regulation 164; or
- ii. the provider's Prepaid Capitation payments are more than \$250,000; or
- iii. at the request of DOH.

DFS shall conduct a financial review for all contracts in this Tier. In accordance with current policy, DOH may conduct its own financial review in its sole discretion, but may also defer to the DFS financial review. DOH will conduct a programmatic review for all contracting arrangements within this Tier whether or not DOH also performs a financial review.

DOH Review Tier (Tier 2)

The DOH Review Tier (Tier 2) includes VBP Level 2, VBP Level 3, and all other contractual arrangements (whether fee-for-service, value based, or otherwise) where the provider's annual prepaid capitation payments from the health services plan do not trigger DFS Regulation 164, but represent more than \$1,000,000 of the

³⁰ Regardless of which Tier a particular agreement falls, the financial and/or programmatic reviews referenced here only apply from the State's perspective to assess financial risk and programmatic risks to the Medicaid program. The State is not providing legal advice to either plans or providers, nor is the State determining whether the contractual arrangement is a fair business deal between the parties.

³¹ 11 NYCRR Part 101.



provider's annual at risk payments (of any type), and at least one of the following is true³²:

- i. more than twenty-five percent (25%) of the annual Medicaid Managed Care or Medicaid Managed Long Term Care payments are at risk; or
- ii. the payments consist of more than fifteen percent (15%) of the provider's overall Medicaid revenue; or
- iii. the contract contains a value based payment arrangement that is off-menu (see Appendix II) and not previously approved by DOH.

DOH shall conduct both a financial and programmatic review for contracting arrangements which fall within this DOH Review Tier. DFS will not conduct a financial review for contracts falling within this Tier unless DOH requests an additional review from DFS.

For contracts that fall into this DOH Review Tier, DOH will continue to develop a framework for determining which type(s), if any, of financial viability will be required. Once developed, this framework will be publicly available. While the framework will be used for guidance and predictability for contracting plans and providers, DOH will review each contract on a case-by-case basis with discretion to require more or less demonstration of financial viability depending on the specific facts and circumstances of the contract.

File and Use Tier (Tier 1)

The File and Use Tier (Tier 1) includes all VBP Level 1 arrangements (upside only arrangements) and all other arrangements that do not meet the minimum review thresholds for a Multi-Agency Review (Tier 3) or DOH Review (Tier 2).

DOH will conduct a programmatic review only for contracts that fall within this File and Use Tier. This programmatic review will be an abbreviated review as compared to the DOH Review Tier, but will ensure that certain requirements are met including, but not limited to, ensuring the mandatory provisions are present and the financial attestations are complete. Generally, neither DOH nor DFS will conduct a financial review for contracts falling within this Tier.

³² See Appendix VI, Figure B for a detailed description of the formulas and calculations.



Attribution and Target Budget Setting Guidelines

To ensure a consistent approach in implementing VBP, the Technical Design Subcommittees have recommended several guidelines to assist MCOs and VBP contractors in negotiating VBP arrangements. Essential components of any VBP arrangement are attribution and the setting of the target budget for the VBP contractor.

The paragraphs below outline the methodologies that the State recommends VBP contractors and MCOs use for attribution and target budget setting. Although plans and providers may choose different methodologies in their implementation, these guidelines will be used by the State for its analyses of costs and outcomes of VBP arrangements, including the information and data and analytics support disseminated by the State to both MCOs and providers.

In addition, key components of the target budget setting process, including risk adjustment, performance adjustments (from 2017 through 2020), and stimulus adjustments, are closely aligned with how the State pays MCOs (including modifications foreseen for 2017).

Attribution

Medicaid member attribution determines which members a VBP contractor will be responsible for (in terms of quality outcomes and costs). Attribution allows for the calculation of the total costs of care, patient-centered outcomes, and potential shared savings per member or episode of care - measures that are essential for the continual monitoring of VBP arrangements.

a. *Assignment*

- i. The MCO assigned Primary Care Physician (PCP) drives attribution in Total Care for the General Population, Integrated Primary Care, and the HIV/AIDs subpopulation.
- ii. For non-chronic arrangement the provider delivering the core services that 'trigger' the bundle drives attribution. In maternity care, that provider is the obstetric professional delivering the pregnancy care.
- iii. The MCO assigned Health Home drives the attribution for the HARP subpopulation.
- iv. The MLTC assigned home care provider or nursing home (depending on the residential status of the member) drives attribution for the MLTC subpopulation.

An MCO and VBP contractor may deviate from this guideline and agree on a different type of provider to drive the attribution on the condition that the State is adequately notified.³³ In most cases, the State will not be able to adapt alternative attribution methods in the information and data it provides to MCOs and VBP contractors. The attribution entity does not need to be the same provider or provider-type as the VBP contractor, but must be part of the VBP arrangement (i.e. a hospital system could be the contractor for a TCGP population while its associated PCPs would drive the attribution). MCOs and providers can utilize multiple factors in establishing attribution.

b. *Timing*

- a. Members are prospectively attributed to a provider through assignment (PCP, Health Home) or start of care (e.g. contract year). If the member switches their assigned PCP/Health Home within the first six months of the year, the member will be attributed to the VBP arrangement of the

³³ For example, in a chronic care episode attribution may be performed by a specialist group rather than a PCP. In this case, cardiologists may be the point of attribution for an arrhythmia episode.



latter PCP/Health Home. To reduce complexity and assure predictability for the VBP contractor, the Subcommittee recommends not attempting retrospective reconciliation of members through an analysis of actual PCP or Health Home use.³⁴

Through prospective attribution, the State will be able to monitor quality and costs of care, and provide MCOs and VBP contractors with their risk-adjusted and proxy-priced³⁵ costs, real-priced costs, outcomes, target budgets and savings opportunities per VBP arrangement.

Establishing Target Budgets

To determine whether savings or losses are made in Level 1 and 2 arrangements, a ‘virtual budget’ needs to be agreed upon for a episode-based arrangement or a (sub)population. A well-designed target budget, coupled with appropriate quality metrics, continuously incentivizes the improvement of quality and cost effectiveness for both historically high performing and poor performing VBP contractors. To facilitate transparency and to support engagement between MCO and VBP Contractors entering into a VBP arrangement, that utilizes a target budget setting or prospective payment methodology, the State will make available to providers: (1) the State to MCO rate schedules, and (2) stimulus and adjustment information. The information provided by the State is not a requirement for contracting purposes.

For Level 2 and 3 arrangements, the State will monitor the data and information that is exchanged between MCOs and Lead VBP Contractors for the purpose of negotiating their target budgets and distribution of shared savings/loss. Monitoring will help ensure that these financial methodologies are based on timely, frequent and complete data being shared between MCO and VBP Contractor. As a Statewide standard, MCOs must include an overview of the data and information the MCO made available to the VBP Contractor for the purposes of negotiating a target budget and distribution of shared savings/loss, when submitting their (MCO) contracts to the State.

Providers and MCOs should also consider the type of data and information that will be shared throughout the performance year(s) to assess ongoing performance. Access to timely and frequent data will enable providers to adjust their approach by identifying areas for improved care delivery, and drive quality and greater efficiency.

The method outlined below is modeled on the Center for Medicare and Medicaid Innovation’s Next Generation ACO approach:³⁶

- Starting from the VBP contractor’s own historical baseline
- Including risk adjustment to account for differences in patient population between the baseline period and the contract period
- Including ‘performance adjustments’ which account for existing efficiency and quality (or lack thereof)

The latter component is key because realizing shared savings is difficult for those providers who are already

³⁴ The VBP contractor may choose to use a similar approach for downstream contractors joining or leaving at various points of the contract period (joining late or terminating early), as for Medicaid members joining or leaving the attribution pool.

³⁵ Previously called ‘price-standardized’. Both mean that price differences between providers for similar services are excluded from the calculations.

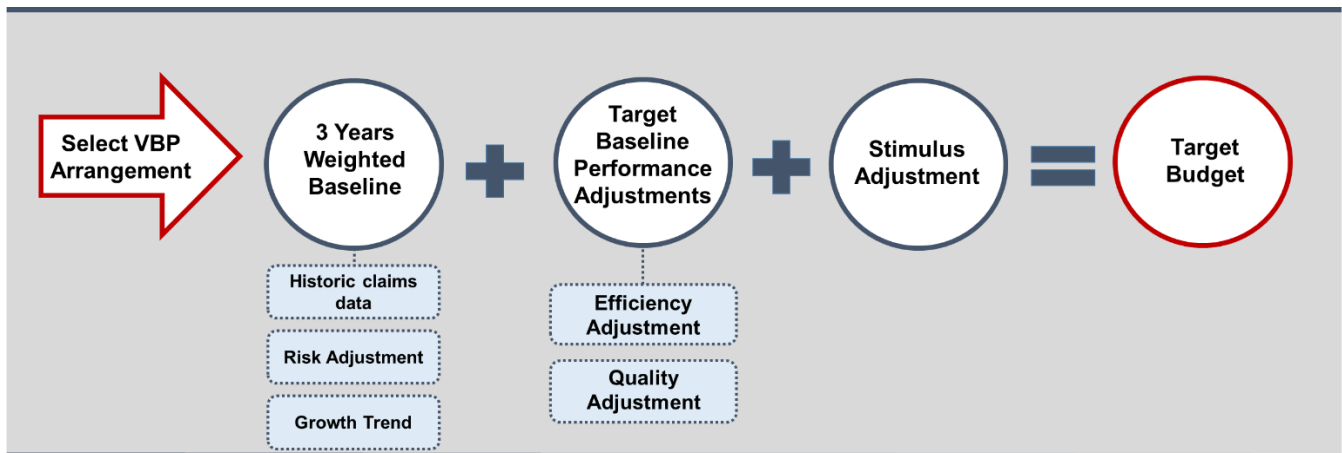
³⁶ innovation.cms.gov/files/x/nextgenacorfa.pdf

highly efficient compared to the State’s average. Likewise, inefficient providers can realize savings relatively easily, and it would be unfair if a VBP methodology punished the former and rewarded the latter. Performance adjustments reward providers who are highly efficient (and of high quality) by adjusting their target budget upwards, thus increasing their potential for shared savings. Vice versa, VBP contractors who deliver much lower value may see their target budgets adjusted downwards.³⁷

In addition to the performance adjustments, the guideline includes ‘stimulus adjustments’ to incentivize VBP contractors to move to higher level VBP contracts. Building on the current quality and efficiency incentives, similar adjustments will become part of the MCO incentive structure from 2017 onwards.³⁸

The method is *prospective*: the target budget is set based on historical performance. The expected PMPM or episode budget is determined at the start of the contract year or the episode – not reassessed during the year/episode. This ensures that an unforeseen shift in population characteristics does not unfairly (dis)advantage the VBP contractor while avoiding gaming and increase predictability.

Using this methodology, the MCOs and VBP contractors can negotiate target budgets per arrangement to disincentivize above-average avoidable complication rates, or invest additionally in underserved areas of care.



The Roadmap proposes the following approach to setting up a target budget:

Baseline

- i. The VBP contractor’s own historic claims under the VBP arrangement are aggregated to create the baseline of the target budget and allow for a comparison to prior VBP contractor experience.
- ii. The baseline is calculated on the basis of the most recent three years of claims data, with the latest year weighted at 50% of the baseline and the proceeding years accounting for 35% and 15% respectively.

³⁷ To allow lower value (potential) VBP contractors to improve in time, downward adjustments for VBP contractors are not supposed to be made until 2018.

³⁸ In the guideline created by the Technical Design I subcommittee, the ‘performance adjustments’ were called ‘value modifiers’. The stimulus adjustment as well as some other details were added to this guideline after the subcommittee finished its work to create a stimulus for VBP contractors to further align the guideline with the intentions of the Roadmap and with the adjustments MCOs will receive from the State from 2017 on.

- iii. To avoid unwarranted rebasing once savings have been made, the historical costs of care of a VBP contractor are calculated *including* the shared savings reimbursed (or losses reclaimed) to the provider.

Growth Trend

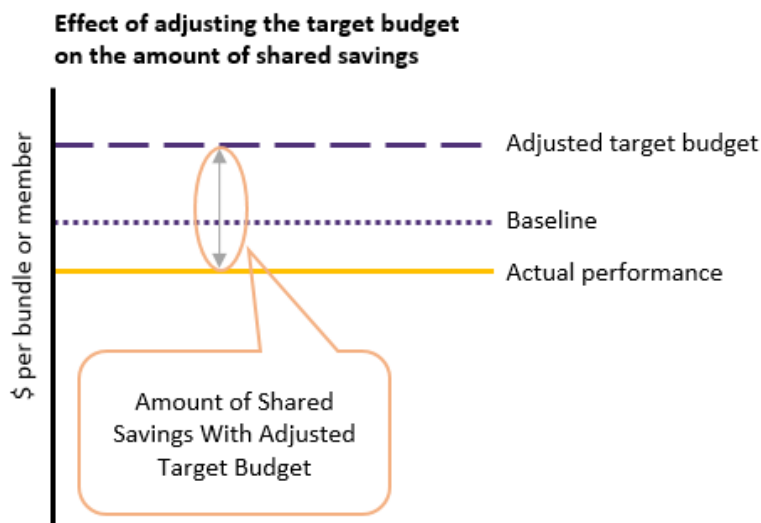
- i. The growth trend of costs during the performance period is calculated by averaging the regional growth trend (upstate or downstate) and a VBP contractor-specific growth trend.

Risk Adjustment

- i. The 3M Clinical Risk Grouping (CRG) methodology is utilized for risk adjustment in TCGP. For the subpopulations, the default is to follow the risk adjustment methodology used for setting the plan’s rates. (The State is currently developing risk adjustment methodologies for both HIV/AIDS and HARP.)
- ii. The most recent HCI3 methodology is utilized for risk adjustment of bundles of care.³⁹
- iii. The target budget is set at the beginning of the contract period for the duration of the bundle or one year. Changes in risk-profile during the contract period do not lead to a change in the target budget.

As adjustment methodologies improve over time (including better sensitivity to pre-existing disparities), the State will adjust accordingly.

Performance Adjustments



- i. After applying the risk adjustment factors, the performance adjustments are applied based on the efficiency and quality of VBP contractors in the most recent year for which claims are available.

³⁹ <http://www.hci3.org/content/ecrs-and-definitions>



- a. Efficient VBP contractors ranked above the 70th percentile⁴⁰ in Efficiency receive a 1% target budget increase:
 - i. If the Quality score is above the 80th percentile: the upward adjustment will be increased by 50% resulting in a 1.5% increase to their target budget
 - ii. If the Quality score is above the 90th percentile: the upward adjustment will be increased by 100% resulting in a 2% increase to their target budget
 - iii. If the Quality score is below the 50th percentile: the upwards adjustment is decreased by 50% resulting in a 0.5% target budget increase
- b. Highly efficient VBP contractors ranked above the 80th percentile in Efficiency receive a 2% target budget increase:
 - i. If the Quality score is above the 80th percentile: the upward adjustment will be increased by 50% resulting in a 3% increase to their target budget
 - ii. If the Quality score is above the 90th percentile: the upward adjustment will be increased by 100% resulting in a 4% increase to their target budget
 - iii. If the Quality score is below the 50th percentile: the upwards adjustment is decreased by 50% resulting in a 1% target budget increase
- c. The most efficient VBP contractors above the 90th percentile in Efficiency receive a 3% target budget increase:
 - i. If the Quality score is above the 80th percentile: the upward adjustment will be increased by 50% resulting in a 4.5% increase to their target budget
 - ii. If the Quality score is above the 90th percentile: the upward adjustment will be increased by 100% resulting in a 6% increase to their target budget
 - iii. If the Quality score is below the 50th percentile: the upwards adjustment is decreased by 50% resulting in a 1.5% target budget increase
- d. If Quality is below the 40th percentile: the VBP contractor will be ineligible for any upward adjustments despite their Efficiency ranking

The State will make funds available to MCOs for these adjustments, and will reward the plans as well. The actual percentages that the State will be able to provide to the MCOs will be determined on a yearly basis by the State.

- ii. At the start of 2018 (giving providers two years to improve and potentially begin earning shared savings), in addition to upwards adjustments, VBP contractors' efficiency and quality may produce target budget decreases:
 - a. VBP contractors below the 30th percentile in Efficiency receive a 1% decrease to their target budget:
 - i. If the Quality score is below the 30th percentile: the downwards adjustment will be increased by 50% resulting in a 1.5% target budget decrease
 - ii. If the Quality score is below the 15th percentile: the downwards adjustment will be increased by 100% resulting in a 2% target budget decrease

⁴⁰ Efficiency is measured as the risk-adjusted cost of care per VBP arrangement (per member/episode), using 'proxy-priced' data (proxy-priced data implies that variability in costs due to negotiated prices is excluded from the analysis). The percentile is based on a state-wide ranking of VBP contractors per VBP arrangement. Higher percentiles indicate greater efficiency (lower costs) and higher quality. To emphasize the importance of building out population health, and to stimulate prevention, preventive activities should not be taken into account when comparing efficiency between IPC VBP contractors.



- iii. If the Quality score is above the 80th percentile: the downwards adjustment will be reduced by 50% resulting in a 0.5% target budget decrease
- b. Inefficient VBP contractors below the 20th percentile in Efficiency receive a 2% decrease to their target budget:
 - i. If the Quality score is below the 30th percentile: the downwards adjustment will be increased by 50% resulting in a 3% target budget decrease
 - ii. If the Quality score is below the 15th percentile: the downwards adjustment will be increased by 100% resulting in a 4% target budget decrease
 - iii. If the Quality score is above the 80th percentile: the downwards adjustment will be reduced by 50% resulting in a 1% target budget decrease
- c. Highly inefficient VBP contractors below the 10th percentile in Efficiency receive a 3% decrease to their target budget:
 - i. If the Quality score is below the 30th percentile: the downwards adjustment will be increased by 50% resulting in a 4.5% target budget decrease
 - ii. If the Quality score is below the 15th percentile: the downwards adjustment will be increased by 100% resulting in a 6% target budget decrease
 - iii. If the Quality score is above the 80th percentile: the downwards adjustment will be reduced by 50% resulting in a 1.5% target budget decrease
- iii. To prevent unwarranted target budget adjustments, the target budget will not be adjusted when the variability in performance between VBP contractors is below a certain (to be determined) threshold.
- iv. When certain future developments can be foreseen to become relevant in the target year (i.e. pending changes in pharmacy benefits), and of course within the context of the development of MCO rates, MCOs and VBP contractors can adjust the target benchmark accordingly.

Stimulus Adjustment

- i. To stimulate the progress towards Level 2 and higher VBP arrangements, VBP contractors can receive an upwards adjustment to their target budget (for a duration of two years) when moving into a Level 2 VBP arrangement. Similarly, when moving into a Level 3 arrangement, the same adjustment would apply.
- ii. Arrangements that focus on IPC or Maternity Care will receive a higher Stimulus Adjustment (1% upward adjustment of VBP contract's target budget) than Total Cost of Care for the General (Sub)Population (0.5% upward adjustment) because: a) infrastructure costs for these former arrangements will be relatively higher compared to the total dollar amount of the VBP contract and b) the State believes the total impact on quality, efficiency and sustainability of the Medicaid delivery system will be higher when a more differentiated VBP approach is taken. These Stimulus Adjustments will end in 2020.
- iii. The State will make funds available to MCOs for these adjustments, and will reward the plans as well. The actual percentages that the State will be able to provide to the MCOs will be determined on a yearly basis by the State.
- iv. As explicated in Section 3 of this Roadmap Update, from 2018 on, MCOs may receive a penalty when falling behind the goals of the VBP Roadmap (i.e. when the percentage of value based payments to providers is lagging behind the yearly Roadmap targets). In such situations, it is to be expected that MCOs may pass through such downward adjustments to e.g. inefficient providers who resist entering into VBP arrangements or otherwise work towards reaching their goals.



Future Adjustments

- i. When the price-standardized and risk-adjusted PMPM or episode costs for a specific VBP arrangement start to converge around the State average, that State average can become the starting point for target setting, and these efficiency adjustments would no longer be used. The quality-based performance adjustments would become bonus- and/or malus- payments.

The stimulus adjustment amounts were determined by weighing the strength of the potential incentives against budgetary constraints. To account for higher relative infrastructure costs in the Integrated Primary Care (IPC) and Maternity Care arrangements, the upward adjustment was pegged higher for these (1%) than for the population or subpopulation arrangements (0.5%). The State may change the suggested percentages for up- and downward adjustment over time, based on lessons learned, the desire to keep Medicaid dollars maximally available for high value care delivery, as well as the integrity of the Medicaid Global Cap.⁴¹

Transparency of Outcomes and Cost as the Foundation for Value Based Payments

Through its Medicaid Analytics Performance Portal (MAPP), the State has already made it possible for PPSs to use state of the art data and analytics (D&A) tools to explore their performance on key quality measures, identify members, providers or zip-codes responsible for high or low scores, monitor trends, and explore some of the common drivers of better or poorer performance. In the first half of 2016, the State will make the total risk-adjusted cost of care available per PPS and MCO for the total population, as well as per integrated care service delineated above (Maternity Care, IPC, HIV/AIDS, HARP). This tool will combine both 3M CRG groupers (for population-based analyses) as well as the HCI3/Prometheus episode grouper, including the appropriate risk-adjustment methodologies. Potential shared savings, estimated, for example, by comparing potentially avoidable complications, will be available at both the total population level and per care bundle and subpopulation. This tool will allow providers and MCOs to have secure, direct analytical access to the Medicaid Data Warehouse, including any future data additions (based on e.g. linked clinical registries).

Having these costs and the outcomes of these services available and transparent is crucial for any transformation towards payments based on value rather than volume.⁴² First and foremost, this tool will provide VBP contractors and MCOs with the same dataset, thus facilitating VBP contracting negotiations. Second, it will help VBP contractors and MCOs start with the required analytical deep-dives in the data without immediate or additional investments in D&A infrastructure. Except for perhaps the smaller MCOs and VBP contractors, most parties will likely want invest in their own D&A infrastructure to facilitate Medicaid VBP contracting over the next several years. In those cases, the State's analytical platform will still be useful to help validate outcomes or allow insight into comparative data that is not available for the MCO or VBP contractor itself.

As stated at the beginning of this section: at any given time, providers and MCOs are free to jointly agree to 'off menu' options of VBP arrangements as long as they support the underlying goals of payment reform and sustain the transparency of value (costs versus outcomes) (see Appendix II for more details).

Current Progress Towards VBP

⁴¹ If, at any time, the State is on track to exceed the appropriated dollar amount within the Medicaid Global Spending Cap, efforts will be taken by the Health Commissioner to rein in spending and ensure total spending does not exceed the cap.

⁴² All comparisons between VBP contractors and MCOs will be made using risk-adjusted, 'proxy-priced' data. 'Proxy-priced' data implies that variability in costs due to negotiated prices is excluded from the analysis. For the risk-adjustment methodologies used see the target budget setting process guideline.



As has been stated previously, the State's goal is to have 80-90% of total MCO/contractor payments (in terms of total dollars) made using at least Level 1 value based payment methodologies by the end of DSRIP Y5. To optimize the incentives, and allow providers to maximize their shared savings so as to build toward a financially stronger Medicaid delivery system, the State aims to have \geq 50-70% of total managed care payments tied to VBP arrangements at Level 2 or higher. The target here is not to achieve the percentage per se, but rather the underlying goals that the State, the providers, MCOs and members collectively seek to realize through payment reform. The minimum target for the end of DY5 is 35% of total managed care payments (full capitation plans only)⁴³ tied to Level 2 or higher.⁴⁴

Using the definitions of VBP as set by this Roadmap, the starting point for NYS Medicaid VBP has been calculated through the VBP Baseline Survey. The DOH surveyed Mainstream Managed Care Organizations, Health and Recovery Plans (HARP) and HIV Special Needs Plans in New York State during 2017. The survey allows the State to monitor progress toward VBP contracting within the Medicaid Managed Care program. The survey includes spending information related to contracting across the VBP Levels and arrangement types established in this Roadmap and further developed by the Clinical Advisory Groups, as well as qualitative questions around the use of quality measures and patient incentives. Results from the survey found that per 2015 data, 33.8% of the respondents' total Medicaid Managed Care payments were in VBP Levels 1-3, with this number rising to 49.1% when including payments in Level 0 with related quality measures.⁴⁵

Exclusions

In principle, the State does not want to wholly exclude any cost categories from the VBP arrangements. Generally speaking, excluding defined services and provider types undermines the principle of value based payment as outlined here. The State must, however, ensure that there are no structural barriers to achieving the statewide goals, and the following narrow list of services and providers either *are* excluded (i.e. they cannot be included) or *may be* excluded by MCOs and VBP contractors. Services not mentioned here or elsewhere in the VBP arrangement definitions, in other words, cannot be excluded.

1. Financially Challenged Providers

To successfully participate in VBP arrangements, particularly those at higher levels of risk sharing, providers need corresponding levels of financial and organizational stability. DOH will exclude specific financially challenged providers (FCP) from being (a parent or risk-carrying member of) a VBP contractor. Payments to providers falling in any of the below categories that are not part of, or contractually related to, VBP contractors according to the guidance above will be excluded from VBP target goal calculations during the planning, restructuring and/or phase-out period.

A provider(s), including safety net providers, is deemed financially challenged if the DOH determines that the provider is unlikely to be sustainable as a freestanding provider, which is evidenced by the following⁴⁶:

- Less than 15 days cash and equivalents;
- No assets that can be monetized other than those vital to the operation; and
- The provider has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

⁴³ For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans from this minimum target.

⁴⁴ The State will deduct the total dollar amounts associated with the services and providers that are excluded Statewide (see p. 30 [subsection on 'exclusions']) from the denominator in calculating its progress to the VBP goals.

⁴⁵ These results are inclusive of Mainstream Managed Care Organizations, HARP, and HIV Special Needs Plans in NYS.

⁴⁶ Aligned with the Interim Access Assurance Fund (IAAF) program criteria of severe financial distress.



Such providers should be in the planning process with DOH to:

- Be absorbed under the umbrella of another health care system,
- Be transitioned to another licensure category/service line, or
- Discontinue operations.

Furthermore, providers who are deemed financially challenged cannot enter a Level 2 or higher VBP arrangement in a VBP contractor role, though they can be part of Level 2 or higher VBP arrangements, as long as they are protected from any downside risk. This exclusion from being a VBP contractor or bearing downside risk under a Level 2 or higher agreement will not apply to FCPs participating in the State's Value Based Payment – Quality Improvement Program (VBP QIP), provided those FCPs comply with all other relevant provisions of VBP QIP.

2. Services to Non-Attributed Members

(Emergency) services performed by a provider for a Medicaid member who is not attributed to a VBP arrangement in which this provider participates will not be seen as costs to that VBP arrangement.

In addition to the services excluded above, which will be excluded as a statewide standard in the VBP calculation, plans and providers have the option to jointly decide to exclude the following:

3. High Cost Specialty Drugs

MCOs and providers may exclude high cost specialty drugs from their VBP arrangements if they so choose, as including specialty drugs may shift too much insurance risk to the provider.

Under Medicare Part D, CMS defines specialty drugs as those costing \$600 or more per month, and has maintained this definition since 2008. This \$600 threshold will also be used for evaluating high cost drugs in Medicaid VBP in order to be aligned with existing CMS definitions.⁴⁷

Should plans and providers decide to include high cost specialty drugs in their VBP arrangements, however, they are able to do so.

4. Transplant Services

MCOs and contractors may choose to exclude the cost of organ transplant services from their arrangements.

5. Dental Services

MCOs and contractors may choose to exclude the cost of dental services from their arrangements.

6. Vision Coverage

MCOs and contractors may choose to exclude the cost of vision services from their arrangements.

Fee-for-Service as Value Based Payment

In addition to the exclusions for VBP described above, the State aims to utilize fee-for-service as a value based payment mechanism for a limited set of preventive care activities, provided that adequate quality measures are included. Especially for the NYS Medicaid population, preventive services need to be stimulated and are

⁴⁷ With its stakeholders, the State will monitor the pharmaceutical market to prevent an undue financial burden on VBP contractors.



broadly underutilized. Since FFS incentivizes volume, paying FFS for high quality preventive services could arguably be seen as paying for value.

As a counterargument, stakeholders argued that many VBP arrangements (such as Total Care for the General Population and Integrated Primary Care) already incentivize preventive activities, because investing in those will lead to increased quality outcomes and reduced costs when seen at the level of the total costs of care.

Based on the recommendation of the Technical Design II Subcommittee, the State suggests that there are two instances in which the argument for fee-for-service as a VBP model for preventive care still stands:

- 1) Preventive activities to prevent disease that require widespread implementation whose impact will be mid- to long term. (The financial return on investment for a Total Care for the General Population arrangement, for example, could be too remote in such a situation.) These would be limited to the list of preventive activities included in the ACA, and would exclude those preventive activities that are currently not covered by Medicaid. Examples:

Routine childhood preventive activities:

1. Vaccines
2. Measurements, like BP, height and weight
3. Screenings: hearing and vision
4. Developmental/Behavioral assessments, such as autism and depression screening
5. Physical examination
6. Procedures, like newborn screenings, lead screening, STI screening and Pap smears
7. Oral health, like water fluoridation

Routine adult preventive activities:

1. Vaccines
2. Behavioral health screens, like for alcohol use or depression
3. Physical health screens, in sub-categories:
 - a. Physical examination related activities, like BP screening
 - b. Lab tests, like diabetes or cholesterol screening
 - c. Cancer screenings, like colonoscopy, Pap smear and mammography
 - d. STI screenings
 - e. Tobacco smoking cessation, behavioral and pharmacotherapy interventions
4. Counseling services, like dietary counseling and tobacco cessation counseling
5. Well visits

Some of these activities (such as blood pressure monitoring, tobacco cessation counseling) can also be part of disease management. In those instances, these activities not considered to be *preventing* disease, but will be included in e.g. the value-based payment arrangement for chronic care.

- 2) Preventive activities that are relatively high cost whose impact may well be felt outside the scope of the VBP contractor. (Similarly, here the financial return on investment may be too uncertain for the VBP contractor to make the investment.) These activities are generally directed at at-risk populations, but cannot meaningfully be included in the value-based payment arrangements for those conditions:
 1. High-cost contraceptive interventions, such as long-acting reversible contraceptive (LARC). (To reduce probability of e.g. low-birth weight neonates)
 2. Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer
 3. Pre-Exposure Prophylaxis (PrEP) for individuals at risk for HIV/AIDS



The dollars associated with these FFS payments would count towards the statewide goal of 80-90% of payments from MCOs to providers in VBP arrangements. For each suggested preventive service, the State will look at associated quality measures. In the case of LARC, for example, the LARC intervention is not part of the VBP Maternity Care Arrangement (and thus remains FFS), but the intervention is included in the overall quality measure set for Maternity Care. If approved, the State will review its list on an annual basis with CMS. The intent is to keep abreast of the current state of affairs in NYS health care, assessing, for example, the need for more or new immunizations and vaccinations, etc. Priority will be given to the areas where NYS needs improvement according to the Prevention Agenda 2013-2017: New York State's Health Improvement Plan.



2. Ensuring Alignment between DSRIP Goals and Value Based Payment Deployment

Issue 2: How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.

Selecting and Defining Integrated Care Services and their Key Quality Measures: the Clinical Advisory Groups (CAGs)

The starting point for this Roadmap is sustaining the achieved DSRIP results. The overall goals of the DSRIP program and payment reform are the same: to improve population health and individual health outcomes and to reward high value care delivery. The selection of the VBP arrangements, and the selection of accompanying quality measures, therefore, needed to be closely aligned.

Engaging the professional community in New York State through Clinical Advisory Groups proved key for this alignment. The task of the CAG was to: review the State's vision for the Roadmap to Value Based Payment, validate the proposed bundle (episode-based) or subpopulation definition and corresponding analysis, and decide upon a set of quality measures for each arrangement. The CAGs met on average three times to discuss each bundle (episode-based) or subpopulation, and will reconvene annually to assess the respective measures. Each CAG is comprised of clinicians and professionals with specific knowledge and industry experience with the condition and/or subpopulation. Members were nominated through recommendations from VBP Steering Committee members, other NY State agencies (such as the AIDS Institute and Office of Mental Health), and other professional groups and associations. Specific consideration was given to the composition of the CAG to ensure that it not only represented geographic diversity (both downstate and upstate), but also the total spectrum care as it related to the specific condition/subpopulation discussed. For example, the Maternity CAG consisted of stakeholders from midwives to neonatologists to health plans.

The following criteria were used to prioritize and select the episode-based care arrangements and subpopulations (see Appendix V for the quantitative analyses underlying this selection):

1. Large proportion of total Medicaid costs
2. High number of Medicaid members included in these Integrated Care Services
3. Cost Variation
4. Quality Variation (such as variability in potentially avoidable complications)
5. Prioritized within DSRIP

This led to the installation of the following CAGs:

- Maternity Care
- Behavioral Health & Substance Use Disorders (covering HARP and BH/SUD related chronic episodes)
- HIV/AIDS
- Chronic Heart Conditions
- Chronic Pulmonary Conditions
- Diabetes
- Managed Long-Term Care (MLTC)
- Intellectual and/or Developmental Disabilities (I/DD)



There was no CAG created for Integrated Primary Care, as the SHIP workgroup was in the process of developing the structure of Advanced Primary Care (see p. 4, 9) and its related quality measures.

The total dollar amount associated with these care services is \$32.2 billion, thus covering approximately 82% of the total payments between MCOs and PPSs/providers (excluding the Medicare component of the FIDA payments).⁴⁸ When including the Total Care for the General Population VBP arrangement, up to 100% inclusion of MCO payments can be achieved. A small number of CAGs will continue in Year 2, and new CAGs may be formed around additional priorities, such as Special Needs Children. The State is currently investigating whether a specific VBP focus on this population would be beneficial to the value of this care. Next steps will be identified following the conclusion of these efforts. Clinician engagement will, however, remain a hallmark of NYS's approach to VBP throughout the DSRIP period.

Quality Measures

The DSRIP program is geared towards the realization of outcomes (reduced potentially avoidable (re)admissions, visits and complications, better patient experience, reduced number of uninsured and members not using preventive and primary care services). The State's Medicaid Payment Reform strategy embraces these same goals, structurally rewarding outcomes over inputs.

For each prioritized VBP arrangement, the Clinical Advisory Groups began the quality measure selection process using the relevant DSRIP Domain 2 and 3 measures. They also considered applicable NYS Quality Assurance Reporting Requirements (QARR) measures, relevant measures from CMS measure sets, the National Quality Forum (NQF), the National Committee for Quality Assurance (NCQA), and CAG specific measure sets (e.g. the American Thoracic Society for pulmonary measures and the NYS AIDS Institute's measures for HIV/AIDS). CAG members also suggested measures that were appropriate for review and discussion.

Based on an analysis of clinical relevance, reliability and validity, and feasibility, each CAG ranked their respective measures into one of three categories:

Category 1: Selected by the CAG as clinically relevant, reliable and valid, and feasible.

Category 2: Seen as clinically relevant, valid, and likely reliable, but with problematic feasibility. These measures will be further investigated in the VBP Pilots.

Category 3: Rejected by the CAG on the basis of a lack of relevance, reliability and validity, and/or feasibility.

The Category 1 quality measures identified by each CAG and accepted by the State are to be reported by MCOs as required by the State. These measures are also intended to be used to determine the amount of shared savings that VBP contractors are eligible for (based on their chosen level of VBP and actual performance; see table "Quality Targets % Met" p. 19). The list of quality measures agreed upon for calculating shared savings and losses must be included in the MCO's contract. At least one Category 1 pay for performance quality measure, that has been approved by the State, must be used to determine shared savings or losses and listed in the contract. VBP Contractors and MCOs may negotiate to use additional Category 1 and/or Category 2 measures if they choose to do so. The State will make the outcomes of these measures transparent to stakeholders.

⁴⁸ Estimates based on extrapolations to future state MCO coverage; total dollars based on 2012-2014 expenditures. See also Appendix V.



The CAGs will reconvene to review measures and discuss whether to include current Category 2 measures in Category 1. The sets will be dynamic: deletions, additions or modifications will be made to optimally capture the key outcomes that matter to members per VBP arrangement. Where quality metrics and reporting imposed by State and Federal policies lack alignment and, in some respects, are in conflict with one another, the State will explore in the appropriate CAG a process for improved alignment and elimination of conflict.

One key goal is the inclusion of Patient Reported Outcome Measures (including quality of life metrics), a key missing link in assessing the outcomes of care for many health problems and conditions. Similarly, measures focusing on rehabilitation and individual recovery including housing stability and vocational opportunities, as well as cultural competency and penetration of specific minority groups, are as yet underrepresented (see also further).⁴⁹ Finally, the State will include sufficient measures to assess the competence and stability of the workforce upon which patient access and quality services depends.

List of Prioritized VBP Arrangements

The overview below lists the current set of VBP arrangements, including underlying episodes, if applicable. For every VBP arrangement besides Total Care for the General Population, a Playbook will become available with details on both the definitions of the VBP arrangement and the associated quality measures. These Playbooks will be updated yearly by the CAGs. New CAGs may be convened in 2016 for new VBP arrangements.

VBP Arrangement	Episodes included in the definition	Definition
Total Care for General Population⁵⁰	–	All Medicaid covered services for all members eligible for mainstream managed care and not eligible for one of the subpopulations (excluding duals)
Total Care for HIV/AIDS Subpopulation⁵¹	–	All Medicaid covered services for all members eligible for HIV/AIDS SNP (excluding duals)
Total Care for HARP Subpopulation⁵²	–	All Medicaid covered services for all members eligible for HARP (excluding duals)

⁴⁹ NQF (2013). Patient Reported Outcomes (PROs) in Performance Measurement. For especially the FIDA, HARP, and DISCO subpopulations measures will be developed which reward quality of life and rehabilitation outcomes, and PROs should be considered for broader use within VBP. These measures will help New York State achieve Olmstead, Americans with Disability Act and Home and Community based setting requirements.

⁵⁰ Risk-adjustment and measuring potentially preventable readmissions (PPR) and potentially preventable visits (PPV) for this VBP arrangement is driven using 3M CRG and potentially preventable events (PPE) groupers. Using the HCl3/Prometheus grouper, prevalence and costs of episodes within the Total Care for General Population arrangement can be analyzed by VBP contractors (and MCOs) for purposes of targeting interventions, etc. The State will make these analyses dynamically available to the MCOs and VBP contractors through the MAPP portal.

⁵¹ As previously stated, episodes of care are not to be contracted within subpopulations. Using the analytical resources mentioned in the previous footnote, risk adjustment for the HARP and HIV/AIDS subpopulation will be developed. The list of potentially avoidable complications will be further developed for the HARP and HIV/AIDS subpopulations. Prevalence and costs of episodes within especially the HARP and HIV/AIDS subpopulation can be analyzed by VBP contractors (and MCOs) for purposes of for example targeting interventions through the MAPP portal in.

⁵² See previous footnote.



Total Care for MLTC Subpopulation	–	All Medicaid covered services for all members eligible for MLTC (including Medicaid component of duals)
Total Care for I/DD Subpopulation	–	In Development
Maternity Care	<u>Episodes:</u> <ul style="list-style-type: none"> ▪ Pregnancy ▪ Vaginal Delivery ▪ C-Section ▪ Newborn 	All Medicaid covered services included in the episodes (following HCI3/Prometheus) for all pregnant women (and their newborns) eligible for mainstream managed care (excluding duals)
Integrated Primary Care⁵³	<u>Episodes:</u> <ul style="list-style-type: none"> ▪ Preventive Care ▪ Routine Sick Care ▪ Hypertension ▪ Coronary Artery Disease (CAD) ▪ Arrhythmia, Heart Block and Conductive Disorders ▪ Congestive Heart Failure (CHF) ▪ Asthma ▪ Chronic Obstructive Pulmonary Disease (COPD) ▪ Bipolar Disorder ▪ Depression & Anxiety ▪ Trauma & Stressor ▪ Substance Use Disorder (SUD) ▪ Diabetes ▪ Gastro-esophageal reflux disease ▪ Osteoarthritis ▪ Lower Back Pain <p><i>The latter 14 episodes are brought together in the Chronic Condition Component.</i></p>	All members eligible for mainstream managed care (excluding duals) are included. All Medicaid covered services included in preventive and sick care are included, as well as all services included in the Chronic Condition component (following HCI3/Prometheus).

⁵³ To support IPC contracting, the analytical resources mentioned in the previous footnotes will allow MCOs and VBP contractors to analyze/stratify their populations through e.g. CRGs. The HCI3/Prometheus grouper also includes a preventive episode (including a broad range of preventive activities), sick care (including diagnostic and/or therapeutic activities for conditions not leading to a specific diagnosis (headache, fatigue, dizziness, etc.)), and additional minor episodes that could be identified as part of or managed by primary care. This information will be made available to support MCO and IPC decision making, but MCOs and VBP contractors are not required to use these analytical constructs in their IPC contracting.



Contracting Integrated Primary Care in Practice

Providers, plans and the State have invested significantly in advancing the position and functioning of primary care in New York. Many pay-for-performance, shared-savings and risk-based payment arrangements exist between MCOs and primary care providers. With this Roadmap, NYS wants to build upon and further stimulate what has already been achieved. In the view of NYS Medicaid and the all-payer SHIP Integrated Care workgroup, chronic care and primary care are two sides of the same coin; likewise, physical and behavioral care are (or should be) two sides of the same coin in the primary care setting.

For setting the target budget for Integrated Primary Care, the guidelines discussed above apply: the historical costs of this care will form the baseline for the target budget going forward. In Level 1 and 2 VBP arrangements, however, this is a virtual budget: nothing needs to change in how the PCPs are paid at this moment. For example, the PCPs as VBP contractors could receive a primary care capitation, primary care FFS, potentially receive a prepaid per member per month (PMPM) amount for the entire IPC, or any of the above combined with a care coordination fee. It is key that during and at the end of the contract year, shared savings are calculated by comparing the actual *overall* costs of IPC care (including all downstream costs that are not included in the PCP payments) to the virtual budget which was agreed upon.

MCOs and providers can then build upon their current contracting arrangements with primary care providers. The State will provide MCOs and providers with standardized information on Medicaid costs and quality metrics related to Integrated Primary Care (such as claims-based quality measures and total costs of IPC care as defined by the groupers (see footnote 54)).

Contracting for IPC gives the VBP contractor deep insight into overall quality and cost (including the significant costs associated with potentially avoidable complications) for preventive care, routine sick care and chronic care, collectively and per individual condition. This allows for a better understanding of where (which neighborhoods, which subpopulation, which age-group) value-improvements are most needed and possible. In addition, contracting the IPC allows the VBP contractor to realize and receive shared savings across the entire care continuum of the patient for all the episodes included. For primary care-focused VBP contractors considering Level 2 arrangements, IPC allows the contractor to take on risk for those downstream costs that are most within the sphere of influence of the primary care practice. Simply put, contracting IPC is the next step in the development of VBP for primary care, with increased opportunities for shared savings and feasible ways to take on risk. (See p. 13-14 on IPC; see also Appendix VIII.)



Incentivizing the Member: Value Based Benefit Design

DSRIP aims to transform the Medicaid delivery system in part by becoming more member-focused; population health outcomes can only be improved by supporting and enabling members to access the appropriate levels of care at the right time. Payment reform is, therefore, incomplete without considering financial incentives for Medicaid members regarding both lifestyle choices (affecting future health care costs) and provider choices (choosing higher or lower value providers). Financial incentives for the former (stimulating behavior that will lead to healthier lives) are becoming common, however, incentives to stimulate high value care utilization are less widespread. Yet the problems DSRIP set out to address have their roots in inadequate financial incentives for members as well. Absence of coverage, leading to emergency department use as the only realistic location for care, is the most obvious and is being addressed by New York's Medicaid expansion, among other initiatives. Yet, once a member is enrolled in a Medicaid managed care plan, indiscriminate choices of providers and persistent use of the ED as the first line of care are more often than not similarly covered as judiciously as selecting a PCP and high value care. If providers' and members' financial incentives are not fully aligned with the value of health care services, the likelihood that DSRIP will realize (and sustain) its goals will decrease if these behavioral patterns are not adequately addressed. Value based benefit design should thus be a core aspect of any payment reform.⁵⁴

In the State's Medicaid program, burdening disadvantaged members by introducing co-pays or co-insurance as disincentives for poor choices is not a policy option. On the other hand, *positively* incentivizing desired behavior, including allowing access to previous inaccessible high value care benefits can be a very powerful tool. To continue to positively incentivize desired behavior, providers/provider networks and MCOs are encouraged to implement member incentive programs, whose driving purpose should be the well-being of individuals, families and communities. Member incentives should assist and encourage members to make effective choices and address:

- **Member Activation** (e.g. selecting/contracting a primary care provider, engaging with a patient navigator)
- **Proper System Utilization** (e.g. use of "in-network" high value providers)
- **Preventive Care** (e.g. setting health goals, attending workshops and information sessions)
- **Healthy Lifestyles** (e.g. proper nutrition, smoking cessation)
- **Disease Management** (e.g. taking ownership of care, including mental health, palliative/end of life care and transition care)

Learning from the rapidly growing experience in incentivizing members, the State aims to maximally focus on *outcomes* rather than efforts or process steps. With this focus, members could be incentivized, for example through cash payments or subsidies, for making lifestyle choices proven to improve health and reduce downstream costs, or for choosing high value care. While member incentives can be a powerful tool, these programs need to be thoughtfully designed to ensure there are no unintended consequences, for example increasing disparities or limiting access. To this end, the State has developed guidance to encourage all MCOs and providers to take into account the following set of guiding principles in their design and implementation

⁵⁴ Thomson, S., L. Schang and M. E. Chernew (2013). "Value-based cost sharing in the United States and elsewhere can increase patients' use of high value goods and services." *Health Aff (Millwood)* 32(4): 704-712; Choudhry, N. K., M. B. Rosenthal and A. Milstein (2010). "Assessing the evidence for value-based insurance design." *Health Affairs (Project Hope)* 29: 1988-1994; Antos, J., K. Baicker, M. Chernew, D. Crippen, D. Cutler, T. Daschle, F. d. Brantes, D. Goldman, G. Hubbard, B. Kocher, M. Leavitt, M. McClellan, P. Orszag, M. Pauly, A. Rivlin, L. Schaeffer, D. Shalala and S. Shortell (2013). *Bending the Curve. Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth.* Washington DC, Brookings Institute.



as building blocks of member incentives:

- a. *Provide information about the program* – Providers will share detailed information with members concerning any incentive program they implement
- b. *Culturally sensitive* – Ensuring cultural sensitivity⁵⁵ is necessary to provide successful outcomes, as cultural norms differ and may need to be incentivized differently
- c. *Unbiased* – Creating unbiased incentives is necessary to comply with federal laws. Incentives must not leave out any groups on the basis of ethnicity, education, race, social class etc.)
- d. *Possess equity* – Equality is not enough when providing incentives, rather maintaining equity should also be considered (equality would be providing a pair of size 10 shoes to everyone; equity is providing a pair of the correct size shoes to everyone)
- e. *Does not promote negative behavior* – Incentives should not promote behaviors that could harm or have the possibility of producing poor outcomes (e.g. incentivizing members not to use the ED could have negative outcomes if the member has a medical emergency when the ED would be a proper choice for treatment)
- f. *Provide reward as promised in a timely manner from when it is earned* – Members should not have to wait lengthy amounts of time to receive their incentive. Timely reward redemption is critical to success
- g. *Communicated appropriately in a timely manner* – Incorporate the most appropriate and farthest-reaching vehicle to communicate the incentive so as not to exclude members (e.g. lack of literacy and technology should be considered). Appropriate messaging should capture high quality outcomes
- h. *Be relevant* – If barriers exist that prevent the members from using the incentive, the incentive will not hold much value (e.g. a member is given a gym membership as an incentive but does not have the transportation to get to the gym)
- i. *Measurable* – Tracking metrics will aid in proving efficacy

The State will make financial incentives available to reward plans and providers who develop and offer member incentive programs. The State is also supporting edits to the Model Contract, including the removal of the \$125 cap on member incentive payments. The \$125 limit was a state-specific restriction, whose removal would afford health plans more flexibility in developing programming around health outcome improvement. This change would effectively align the NYS Medicaid program with all Federal laws, regulations, and guidance whereas it previously was consistent with, but more stringent than, Federal standards. The State will assess whether a new cap should be implemented. These changes will allow for creativity and innovation to further develop and document best practices for member incentives.

Providers will have the flexibility to experiment/test various incentive programs across different member populations and have the ability to opt out of the incentive program if the program does not meet the expected outcomes. Any incentive, regardless of form, should not impact a member's Medicaid or other State Health or Human Service eligibility status (e.g. Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF)) with regards to income or asset thresholds. Rather, this should be a form of 'inclusive shared savings', where members' incentives to choose wisely become fully aligned with professionals and providers aiming to reduce avoidable hospitalizations and improve population

⁵⁵ Cultural competence is not limited to geographic, linguistic, and normative preferences, but also includes disability status, employment, and transportation needs, for example.



health.⁵⁶

It is important to note that the process of designing member incentives is complex and will need to consider underlying disparities and social determinants of health including community needs, and local planning efforts. Above all, member incentives must not reinforce disparities or perpetuate inequality within or between communities, particularly in terms of how disparate subpopulations access wellness services and support.

To ensure success and sustainability of the incentive programs, the VBP Pilot sites will consider piloting incentive programs as a way to evaluate and measure the success of improving health outcomes. Given the potential variations of incentive programs, and the need to continue to develop the evidence supporting these efforts, the State will look to analyze any collected data and identify best practices on, at least, an annual basis, and will make this information publically available. The State will also convene a group of experts and consumers to create more detailed guidance for the development of incentive programs, with a particular focus on achieving cultural competency in program design.

⁵⁶ 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.



Public Health and Social Determinants of Health

The overall well-being of individuals, families, and communities should be the driving purpose of a health care system. Viewed from that lens, addressing social determinants of health (SDH) should come naturally to health care providers. Specific interventions have been shown to improve outcomes for members facing acute and/or chronic health conditions, and even prevent some health conditions before they develop. Since social determinant (SD) interventions are often less costly than medical interventions, which will be necessary as a person’s disease progresses, the benefit of addressing SDs would seem self-evident. However, these

Capturing Savings across all areas of Public Spending

Addressing the social determinants of health is a critical element in successfully meeting the goals of DSRIP and VBP. The State is fully committed to exploring ways to capture savings accrued in other areas of public spending when social determinants are addressed (e.g. reduced recidivism rates). Three mechanisms have been identified by which resources can be leveraged in the context of VBP arrangements to capture savings across the public sector. VBP contractors could:

1. Participate in a co-investing model,
2. Participate in innovative contracting,
3. Invest in social impact bonds.

interventions are traditionally seen as being beyond the scope of health care. The VBP effort by NYS provides a unique opportunity to transform this perception and practice.

At the same time, however, the DSRIP journey has only just begun, and it is in general difficult to truly move the needle on a population-wide basis within a few years. Hence the DSRIP Domain 4 population health measures are Pay for Reporting only. In the near future, though, the State envisions culturally competent community based organizations (CBOs) actively contracting with primary care organizations and health systems to take responsibility for achieving the State’s Prevention Agenda. DSRIP starts to build the infrastructure to take on housing, job placement, community inclusion, and criminal justice alternatives as levers to increase population health. The State foresees that VBP will become a vehicle to maintain this infrastructure.

The core mechanism here is the financial incentive that VBP contractors will have to keep the populations they are responsible for as healthy as possible, to prevent at-risk

populations from becoming chronically ill, and to prevent further morbidity and avoidable complications in members with chronic conditions. Realizing savings and high quality scores in the different NYS VBP arrangements maximally incentivizes providers to focus on the core underlying drivers of poor health outcomes – whether traditionally within the medical realm or not.

Addressing Social Determinants of Health

To stimulate VBP contractors to venture into this crucial domain, VBP contractors in Level 2 or Level 3 agreements will be required, as a statewide standard, to implement at least one social determinant of health intervention VBP Contractors must select a social determinant of health intervention that aligns with at least one of the 5 key areas of social determinants of health, as outlined in the SDH Intervention Menu and SDH Recommendation Report^{57,58}. The five key areas are 1) Economic Stability, 2) Education, 3) Health and Healthcare, 4) Neighborhood and Environment, and 5) Social, Family, and Community Context.

⁵⁷ The SDH Intervention Menu and SDH Recommendation Report is available here: https://www.health.ny.gov/health_care/medicaid/redesign/dsrrip/vbp_library.

⁵⁸ For example, interventions addressing issues of food insecurity and housing instability could be categorized as Economic Stability or interventions addressing environmental conditions (i.e. housing and community design) could be categorized as Neighborhood and Environment.



MCOs contracting with VBP Level 2 providers/provider networks will share in the costs and responsibilities associated with the investment, development, and implementation of the intervention(s). Provider/provider networks in VBP Level 3 arrangements are expected to solely take on the responsibilities and risk. Providers/provider networks/MCOs may also contract with community based organizations to satisfy this recommendation. Contracted CBOs should expect the inclusion of a value based component in the contract, such as pay for performance, and be held to performance measure standards.

The contractors will have the flexibility to decide on the type of intervention (from size to level of investment) that they implement, and several best practice guidelines have been created to support an effective implementation.⁵⁹ The guidelines recommend that selection be based on information including (but not limited to): SDH screening of individual members, member health goals, the impact of SDH on their health outcomes, as well as an assessment of community needs and resources. The contractors should also create a report explaining a measureable reason why the SDH was selected, and identify metrics that will be used to track its success. This could follow a similar process/procedure used by the current Vital Access Provider (VAP) program, where the provider selects what they want to focus on, develops metrics, and reports back to the State.

Since providers (including CBOs) who successfully address SDH at both member and community levels may not see savings in the short term, they will be incentivized by MCOs upfront to identify one (or multiple) social determinant(s) and be financially rewarded for addressing them. This standard will be included in the Model Contract:

- Level 1 providers will get an additional bonus if they address at least one SDH.
- Level 2 and 3 providers will receive a funding advance (investment or seed money) if they commit to addressing one or more SDs. This funding advance will provide financial assistance to the provider investing in an intervention. The provider may benefit financially if the intervention is successful in lowering the health care costs of its respective members. If the interventions are successful, the savings generated can encourage reinvestment.

Payouts will be made by the VBP contractor based on the terms of each individual contract. In order to ensure that funding advances are put toward addressing SDH, all recipients of this funding will need to report on fund utilization to NYSDOH.⁶⁰

Contracting with Community Based Organizations

Though addressing SDH needs at a member and community level will have a significant impact on the success of VBP in New York State, it is also critical that community based organizations be supported and included in the transformation. It is therefore a requirement that starting January 2018, all Level 2 and 3 VBP

⁵⁹ Best practice guidelines are available in the VBP Subcommittee Recommendation Report and also in a “Social Determinants of Health Intervention Menu” tool, both available for download on the NYS [VBP Resource Library](#). Additionally, trainings and webinars that will highlight the role of the CBOs and the importance of focusing on SDH are being developed for public release. The State does not intend to limit the number of social determinants addressed by VBP contractors.

⁶⁰ Recipients of Accountable Health Communities awards will also be eligible to participate.



arrangements include a minimum of one Tier 1 CBO⁶¹⁶². This requirement does not preclude VBP contractors from including more than one CBO (including Tier 2 and 3 CBOs) in an arrangement to address one or more social determinants of health.

Many CBOs have years of experience improving SDH. This expert understanding of community needs, coupled with support and clinical expertise of a provider network, could make a significant positive impact on population health and generate savings for the entities involved. Providers/provider networks and MCOs should partner with organizations that have objectives aligning with their own, the community needs, and member goals. The CBO should work with the providers/provider networks and MCOs to deliver interventions that support SDH and advance DSRIP goals. The State will create a process, which would include an independent retrospective review of the role of the CBO, to determine if the VBP providers are adequately leveraging community based resources in SFY 2019. This review should also identify best practices and determine if further guidance, technical assistance, or other resources are needed to maximize utilization of community resources.

Measuring Program Success

In an effort to ensure sustainability after the next five years, providers and MCOs will be encouraged to measure success of the programs implemented. This may include an assessment tool for VBP contractors and MCOs to measure and (at least) annually report on SDs that affect their members. This helps to track successful interventions and the way in which they are measured. Ultimately, the State will evaluate the feasibility of incorporating SDH measures into Quality Assurance Reporting Requirements (QARR) performance measures. It is also recommended that providers incorporate the patient perspective in quality measurement and improvement, through e.g. Patient Reported Outcome (PRO) measures. This further stimulates providers to become more attuned to members' needs, treatment, and goals. Providers may utilize PRO measures in their practice, using tools to assess the member's symptoms, functional status, and quality of life. The State recognizes that providers may need to incentivize members to complete PRO measure questionnaires as a way to encourage participation and completion of the survey. It is recommended that the current VBP Pilot Programs be used as a vehicle for piloting the use of PRO measures.

The State will monitor progress on the Prevention Agenda targets, including how VBP contractors (aim to) impact these targets. The State intends to introduce a dedicated value based payment arrangement for pilot purposes in 2018 to focus specifically on achieving potentially trailing Prevention Agenda targets through CBO-led community-wide efforts.

Implementation of the VBP Roadmap and the significant delivery system reforms underway in DSRIP requires a thoughtful and strategic approach to communicating to both stakeholders and Medicaid members. Explicit recognition of the rights and role of the individual enrollee is critical throughout the VBP development and implementation process. Consumer rights to know the incentives that affect their care must be considered when developing strategies around what and when information related to VBP and DSRIP more broadly, will be communicated to members. The State utilized the Advocacy and Engagement Subcommittee to develop a plan to identify the most appropriate way to provide information around VBP and the incentives that could

⁶¹ Tier 1 - Non-profit, non-Medicaid billing, community based social and human service organizations (e.g. housing, social services, religious organizations, food banks). Tier 2 – Non-profit, Medicaid billing, non-clinical service providers (e.g. transportation, care coordination). Tier 3 – Non-profit, Medicaid billing, clinical and clinical support service providers (licensed by the NYS Department of Health, NYS Office of Mental Health, NYS Office for Persons with Developmental Disabilities, or NYS Office of Alcoholism and Substance Abuse Services).

⁶² The State recognizes that CBOs may not exist within a reasonable distance to providers in some regions of New York. In such situations, providers/provider networks can apply to the State for a rural exemption.



impact members. In addition to creating guidelines around what should be communicated to Medicaid members, the State will also update the Managed Care Patient Bill of Rights to include information relevant in the VBP context.



3. Amending Contracts with the MCOs to Realize Payment Reform

Issue 3: How the state will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.

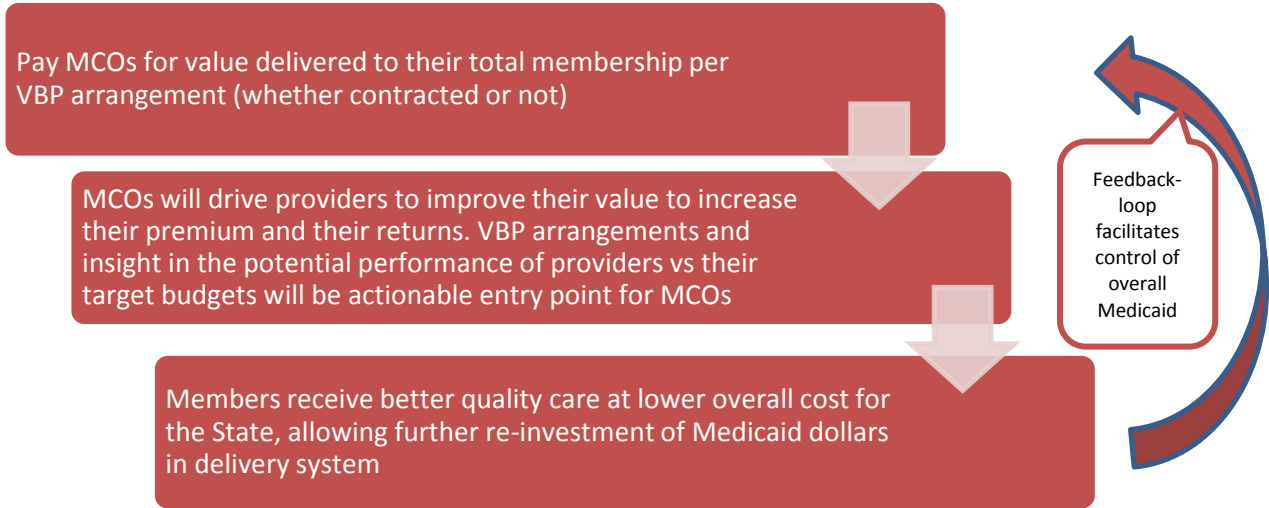
Aligning Incentives

Through updates to the Medicaid Managed Care Model Contract, the State will add the following incentives and regulations in its contracts with MCOs to stimulate their adoption of VBP arrangements:

- The State will implement a Performance Adjustment for MCOs in the 2017 rate setting process so as to maximally align the incentives for MCOs with the incentives for VBP contractors. The Performance Adjustment is a rate adjustment based on the relative efficiency and quality delivered by the MCO per VBP arrangement; though the metrics selected for these rate adjustments are new, the methodology of applying said rates remains consistent. For quality, the current QARR methodology will be continued and, where relevant, adapted to optimally align with the quality measures the State has adopted on the basis of the CAG’s input.
- Mainstream MCOs will have three main integrated care categories to drive quality and efficiency:
 - Total Care for the General Population⁶³
 - Integrated Primary Care
 - Maternity Care
- Performance (quality and efficiency) of the HIV/AIDS, HARP, MLTC and I/DD VBP arrangements will all be assessed separately as well.⁶⁴
- Performance adjustments will be applied to all MCO members eligible for a particular VBP arrangement, whether part of a VBP contract or not.
- The State will implement a Stimulus Adjustment for MCOs included in the 2018 rate setting process. This will serve to increase the managed care capitation premium for those MCOs that have captured more provider-payment dollars in VBP arrangements at higher levels. This adjustment will be for a duration of two years for MCOs and also mimics the MCO-VBP contractor guidelines. Arrangements that focus on IPC or care episodes will receive a higher Stimulus Adjustment than Total Cost of Care for the General (Sub)Population because: a) infrastructure costs for these former arrangements will be relatively higher compared to the total dollar amount of the VBP contract and b) the State believes the total impact on quality, efficiency and sustainability of the Medicaid delivery system will be higher when a more differentiated VBP approach is taken. These Stimulus Adjustments will end in 2020.

⁶³ To ensure that the adjustments are applied to the total MCO contract value (and not more or less), the ‘Total Care for General Population’ adjustments will be applied only to the dollars not attributed to the other VBP arrangements

⁶⁴ The I/DD population will only become part of VBP after the transition of the I/DD population to managed care.



- From 2018 on, based on the prior year’s VBP contracts, MCOs that fall behind the goals for VBP contracting as outlined in the Roadmap will receive a penalty⁶⁵:

Year	Penalty
2018	If by 4/1/2018 less than 10% dollars of total MCO expenditure are captured in Level 1 or above VBP contracts, a penalty of 0.5% on the marginal difference between 10% of Medicaid Managed Care expenditure and their total expenditure on Level 1 or above VBP contracts will be assessed.
2019	<p>Fully Capitated MCOs: If by 4/1/2019 less than 50% of the of total MCO expenditure is not captured in a Level 1 or higher arrangement, a penalty of 1.0% on the marginal difference between 50% of Medicaid Managed Care expenditure and their total expenditure on Level 1 or above VBP contracts will be assessed.</p> <p>If by 4/1/2019 less than 15% of total MCO expenditure is captured in Level 2 or higher contracts, a penalty of 1.0% on the marginal difference between 15% of Medicaid Managed Care expenditure and their total expenditure on Level 2 or above VBP contracts will be assessed.</p> <p>If both penalties are incurred, then only the larger penalty will be applied.</p> <p>Not Fully Capitated MCOs: If by 4/1/2019 less than 50% of total MCO expenditure is captured in Level 1 or higher contracts, a penalty of 1.0% on the marginal difference between 50% of Medicaid Managed Care expenditure and their total expenditure on Level 1 or above VBP contracts will be assessed.</p> <p>If by 4/1/2019 less than 5% of total MCO expenditure is captured in Level 2 or higher contracts, a penalty of 1.0% on the marginal difference between 5% of Medicaid Managed Care expenditure and their total expenditure on Level 2 or above VBP</p>

⁶⁵ The State will ensure network adequacy and access to care throughout the VBP implementation process.



	<p>contracts will be assessed.</p> <p>If both penalties are incurred, then only the larger penalty will be applied.</p>
2020	<p>Fully Capitated MCOs: If by 4/1/2020 less than 80% of total MCO expenditure is captured in Level 1 or higher contracts, a penalty of 1.0% on the marginal difference between 80% of Medicaid Managed Care expenditure and their total expenditure on Level 1 or above VBP contracts will be assessed</p> <p>If by 4/1/2020 less than 35% of total MCO expenditure is captured in Level 2 or higher contracts, a penalty of 1.0% on the marginal difference between 35% of Medicaid Managed Care expenditure and their total expenditure on Level 2 or above VBP contracts will be assessed.</p> <p>If both penalties are incurred, then both will be applied.</p> <p>Not Fully Capitated MCOs: If by 4/1/2020 less than 80% of total MCO expenditure is captured in Level 1 or higher contracts, a penalty of 1.5% on the marginal difference between 80% of Medicaid Managed Care expenditure and their total expenditure on Level 1 or above VBP contracts will be assessed.</p> <p>If by 4/1/2020 less than 15% of total MCO expenditure is captured in Level 2 or higher contracts, a penalty of 1.5% on the marginal difference between 15% of Medicaid Managed Care expenditure and their total expenditure on Level 2 or above VBP contracts will be assessed.</p> <p>If both penalties are incurred, then only the larger penalty will be applied.</p>

From 2018 on, when MCOs cannot achieve their VBP goals because providers are unwilling to enter VBP agreements and/or move to higher level VBP agreements, MCOs may pass on such penalties to incentivize providers who can reasonably be expected to make this transition to work with the plans towards realizing these common goals.⁶⁶

The State assures that it will not hold MCOs accountable when providers, to no fault of the MCO, run into financial difficulty because of underperformance on a Level 2 or higher value based contract.

All these changes will be incorporated into the Model Contract 2017.

VBP Innovator and VBP Pilot Programs

In addition to the incentives discussed above, the State will implement a VBP Innovator Program for experienced VBP contractors as a mechanism to allow experienced providers to continue to chart their path into value based payments. The Innovator Program is a voluntary program for VBP contractors prepared for participation in Level 2 (full risk or near full risk) and Level 3 value based arrangements. These providers will be entering into Total Care for General Population and/or Subpopulation arrangements, and will be eligible for up to 95% of the total dollars that have been traditionally paid from the State to the MCO. The Innovator Program is not intended to limit provider networks or member choice. The Department of Health (DOH) will

⁶⁶ Penalty application to providers is at the sole discretion of the MCO. The application of penalties to providers is an item that is to be negotiated between MCO and provider along with target budget parameters, and performance adjustments, etc.



administer the Innovator Program on an open enrollment basis.

The providers must pass a strict set of criteria to be deemed an ‘innovator’ and once they have reached Innovator status, all MCOs will be required to participate in these arrangements. The specifics of the Innovator Program will be outlined in the updated Managed Care Model Contract in 2016.

It is important to note that because IPC and episode-based VBP arrangements cannot readily be translated in a percentage of premium, and because these arrangements would not include significant task-shifting between MCOs and these VBP contractors, these contracts are not included in the Innovator Program. For these arrangements, pilot support and financial rewards will be available in 2016 and 2017.

The Pilot Program is available for all VBP arrangements, and allows contractors to enter into an arrangement at Levels 1, 2 or 3. The VBP Pilot Program will include technical and administrative support for implementing VBP arrangements, along with financial incentives including an MCO incentive bonus, upward adjustments based on performance, and the benefit of no downward adjustments for the first two years of the pilot. A pilot is expected to last for two years, with the commitment to move to (at least) Level 2 by year two. There is also the commitment to share and discuss lessons learned and support the DOH in a webinar after the first year of the pilot. VBP Pilots and the Innovator Program are separate and distinct in two ways:

1. While the Innovator Program provides benefits (90-95% premium pass-through) to the providers and is limited to specific types of arrangements, the pilots do not warrant premium pass-through benefits (though they do receive financial incentives) and are open to all types of arrangements set forth in the VBP Roadmap. The goal of the pilots is to help the State and its participating organizations learn how VBP transformation will work in practice, and to incentivize participants for early adoption of VBP. The goal of the Innovator Program is to recognize those providers who start implementing VBP by contracting high risk, Level 2 or 3 total cost of care for (sub)population arrangements.
2. The Innovator Program is a standard component of the VBP program. In contrast, the VBP Pilot program is only available in State FY 2016. The pilots will run for two years.

The full design of the Innovator Program, including the details below, can be found in Appendix VII:

1. Risk arrangements eligible for the Innovator Program
2. Review/assessment process for the Innovator Program
3. Criteria for participating in the Innovator Program
4. Appeals process for Innovator participation
5. Innovator Program benefits
6. Innovators’ performance
7. Maintenance and contract termination/program exit criteria

Specific Regulatory Amendments

Successful transformation of the existing payment system requires restructuring of contractual arrangements that clearly define metrics and the ability to share savings and risk. Regulatory alignment and streamlining (between providers and MCOs, and between partnering providers) to support VBP models is imperative to facilitate both the clinical and efficiency goals of VBP, freeing resources for member and community needs. Based on the input of the subcommittees and the VBP Workgroup, the existing regulations within the DOH and the DFS have been thoroughly reviewed and are being amended as necessary. Regulatory restructuring will occur through several implementation mechanisms:

Changes to the Medicaid Managed Care Model Contract and State Provider- Contractor Guidelines



The Medicaid Managed Care Model Contract is a key vehicle for the formal implementation of Medicaid VBP, through which the State manages its relationships with the managed care plans. The State also publishes the Provider Contract guidelines, which govern the relationship between managed care plans and their downstream providers. Changes to the Medicaid Managed Care Model Contract have been proposed and will be edited following a holistic DOH review. The changes will operationalize recommendations from the subcommittees, as well as additional proposed changes developed through a robust comment period on any existing requirements that may interfere with VBP implementation. There remain a few outstanding considerations that DOH will further evaluate, including contractual safeguards that may need to be included around prompt payment in the VBP environment (as bonus payments, downside reconciliations, and reimbursements of withholds are not specifically addressed in current regulations). The DOH will take the Regulatory Impact Subcommittee comments into account when developing the Medicaid Managed Care contract changes and discuss with the health plan contractors. The documents will reflect and accommodate changes occurring in the new VBP environment, and will be updated in 2016. Additional revisions will be made over the next few years as needed.

Several subcommittee recommendations may also impact the State's MCO-Provider contracting guidelines. The State will take these recommendations into account, along with other comments as it looks to update the State MCO Provider Guidelines⁶⁷. These are formulated as guidelines, as MCOs and VBP contractors are better equipped than the State to take local circumstances and particular challenges of certain populations or provider groups into account. For example, the State will not enforce how MCOs and VBP contractors set the target budgets, what quality measures they reward, and whether they reward actual performance or improvement.

The following key components of the VBP Roadmap are foreseen to be included in the Model Contract 2016:

- The definitions of the VBP arrangements and outcome measures (p. 12-15 and further and the forthcoming Playbooks per VBP arrangement)
- The definitions of the VBP Levels (see Appendix VIII)
- Definition of what can be included in 'off menu' VBP arrangements (p. 12, Appendix II).
- Contract risk review process (see p. 21-22)
- The VBP Innovator Program (see p. 46-47)

In 2017, the following additional components are foreseen to be included in the Model Contract:

- VBP reporting requirements
- MCO VBP incentives (see p. 44)
- Additional

DOH will negotiate these proposed changes with the health plans, and the updated Model Contract document will be posted on the DOH public website once approved by CMS.

Proposed Changes to New York State Law

Alignment of Federal and State Stark Laws and Anti-kickback Statutes

In order to give providers increased flexibility for forming networks and entering into VBP contracts with MCOs, the State will propose amending its Stark Law and Anti-kickback Statute to fully align with federal

⁶⁷ https://www.health.ny.gov/health_care/managed_care/hmoipa/docs/guidelines.pdf



provisions. Changes to State law should include language that incorporate future amendments to federal laws and regulations. These amendments will increase flexibility for providers entering into agreements, but it is not necessary that these amendments occur in order for VBP contractors to begin a variety of currently permissible contracting mechanisms.

Stark Law (Self-Referral)

Federal and State laws prohibit physicians from referring patients for certain designated health services if the physician (or immediate family member) has a financial interest. A violation can be triggered through prohibited referral arrangements, splitting of fees, leases of office space, as well as other ownership and compensation arrangements. The federal rules apply to physicians only, and allow for several exceptions. NYS's version of the federal law broadens it to different provider types, all payers, and does not include several exceptions that are in federal law. Aligning the NYS regulation to fully align with federal Stark rules will allow for more flexibility for providers to engage in VBP contracting.

Anti-kickback Statute

Federal Anti-kickback statute (AKS) prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals (including self-referrals) or generate federal health care program business. Unlike Stark law, AKS is intent-based and can carry both civil and criminal penalties. Federal and State AKS laws are largely similar (unlike Stark law). The State law is broader and has a lack of safe harbors (exemptions) or exceptions to the general prohibitions. There are several 'safe harbors' that act as exemption to AKS, but VBP arrangements are not currently included at either the federal or State level. Fully aligning NYS law to federal AKS laws would also allow for more flexibility for providers to engage in VBP contracting.

Changes to Laws Related to Professional Service Entities

Currently, there are some obstacles to collaboration for some clinical groups in New York State. The current Business laws and Corporate Practice of Medicine (CPOM) laws present the following barriers in a value based payment setting:

- Restrictions regarding which professionals can have ownership interests in professional entities;
- Constraints on how medical professionals structure their corporate entities to optimize VBP implementation; and
- Limitations on which professionals and entities can split fees (e.g. bundled payments for services including physicians and non-physicians).

These limitations may prevent different types of providers from collaborating and integrating in the spirit of the DSRIP program, and inhibit the implementation of the NYS Value Based Payment Roadmap. A bill has been introduced (S.5862/A.8153) in June of 2015 that addresses several of the Business Law issues mentioned above. *Updates to Physician-Pharmacist Collaboration Laws*

Current NYS Public Health laws and regulations allow a certain degree of collaboration between the physicians and pharmacists, however, they do not provide for the full spectrum of benefits that patients (including Medicaid members) could realize in terms of improving their health and quality of services received. By allowing a higher degree of collaboration⁶⁸ between physicians and pharmacists on Comprehensive Medication Management (CMM), the State would be able to achieve an enhanced service integration

⁶⁸ Currently, collaboration is already permitted in all hospitals and limited nursing home settings in New York. This recommendation promotes voluntary collaboration in community practice settings as well.



environment that will result in reduction of hospitalization rates in NYS, thus helping achieve the goals of the Payment Reform, and the DSRIP program overall.

The Public Health Law should be amended to create a *voluntary* program for collaboration between qualified pharmacists⁶⁹ and physicians ruled by a written protocol that would enable physicians to refer certain patients with chronic conditions who (1) have not met the goals of therapy, (2) are at risk for hospitalization or (3) are otherwise considered to be in need of CMM services, to qualified pharmacists.

The written protocols would describe the nature and scope of services to be provided; they would be made available to the Department of Health (DOH) for review to ensure compliance with the requirements in the law. Such protocols could cover services including but not limited to the following:

- ongoing evaluation of a patient's condition and medication adherence, including ordering/performing routine patient monitoring functions;
- adjusting or managing a drug regimen of a patient;
- accessing the patient's medical records;
- other.

Further, the pharmacist would be required to notify the treating physician in a timely manner of the recommendations made to the patient, and of any adjustments made to the patient's prescribed medications.

Although the proposed legislative changes mentioned in this section will help the NYS Medicaid VBP program, potential delays in realizing these changes will not impede its successful implementation.

Ongoing Regulatory Review

The State is currently in the process of refining outstanding policy decisions around the following topics:

HIPAA and State Privacy Laws

Current New York State (NYS) privacy laws and regulations are more restrictive and provide less flexibility than federal HIPAA laws and regulations. These additional restrictions may prevent providers from sharing information for the purpose of coordinating care and evaluating the outcome of care, both of which are critical to successful VBP arrangements (See additional guidance on the DOH website^{70,71}).

Program Integrity

As VBP will fundamentally change the way health care services are delivered, paid, and measured, the guiding principles underlying NYS's Medicaid Program Integrity strategy (Program Integrity) must also change. Many of the foundational activities and strategies in a fee-for-service environment to ensure that quality health care is delivered at a reasonable cost while protecting stakeholders may not be effective in VBP. As the payment model shifts from FFS to value based, so too will the avenues of fraud, waste, and abuse (FW&A) in the system. The State is working to conceptualize which avenues of fraud

⁶⁹ Qualified pharmacists would be pharmacists who hold an unrestricted license and have completed accredited programs in the management of chronic disease(s). Their qualifying credentials would be reviewed by physicians who are interested in CMM programs offered by qualified pharmacists to which they could refer selected patients.

⁷⁰ [HIPAA Rules and Regulations](#)

⁷¹ [HIPAA and State Patient Privacy: Options and Considerations](#)



will be implicated, while also considering future safeguards.

Improving integrity at all levels of health care delivery will be considered. Questions raised will include considerations of where current FW&A issues fall in a VBP environment, what new fraudulent incentives can/will arise amidst a shift to VBP, and deliberation on how FW&A can be meaningfully quantified and measured in a VBP environment. Recommendations may come in the form of changes to State laws and regulations, contracting requirements between the State and MCOs or providers, and other contracting guidelines between parties. Using these recommendations as a framework, a robust plan for Program Integrity in the move toward VBP must be developed proactively to minimize risks and monitor compliance. It is essential that this plan be in place at the outset of VBP contracting arrangements.

Program Reform

Current NYS health care regulations were created to safeguard the legitimate interests of the State, providers, payers, and especially Medicaid members in a fee-for-service environment. Implementing the DSRIP program and moving to VBP introduces new methods of collaboration, contracting, and delivery of health care services that may be at odds with existing regulations. Similarly, certain regulations may no longer be required in a context where VBP contractors assume responsibility for the entire cycle of care.

Regulatory hurdles will be evaluated and changes proposed changes to the State. In addition, as currently exists in the DSRIP program, the DOH will create a formal process where MCOs and (potential) VBP contractors can submit written requests to the DOH for the waiving of regulations that hinder VBP contracting. The workgroup(s) will help design that process and provide recommendations to the State.

The State has decided to address all of the above topics (HIPAA and State Privacy Laws; Program Integrity; and Program Reform) through the establishment of two separate workgroups in September 2016: (1) the Patient Privacy and Confidentiality Workgroup (covering HIPAA and State Privacy Laws), and (2) the Program Integrity Workgroup (focused on Program Integrity and covering many of the same concepts as Program Reform).

The State, prior workgroup members, and other major stakeholders may recommend that an individual be a member of the workgroups. The State must then approve the recommendation to formalize the appointment of a member to the workgroup. The workgroup appointments were made to include, but not be limited to:

- Representatives from each of the major New York State Medicaid agencies (OHIP, OMH, OASAS, etc.);
- Representatives from payer and provider associations;
- Relevant Medicaid program integrity stakeholders;
- Relevant Medicaid patient confidentiality stakeholders.



4. Amending Contracts with the MCOs: Collection and Reporting of Objectives and Measures

Issue 4: How and when plans' current contracts will be amended to include the collection and reporting of DSRIP objectives and measures.

The State currently includes quality and efficiency incentives in contracting with MCOs that are directly aligned with DSRIP. Many of its Quality Assurance Reporting Requirements (QARR) metrics, for example, are identical to the metrics selected for DSRIP. 2015 was the first year that the State incorporated efficiency measures for MCOs, aimed at reducing ED visits and avoidable admissions through the same measures used within DSRIP. Such changes further align MCO's incentives with DSRIP's desire to realize a lasting, sustainable transformation of the safety net system.

As is noted in the previous section (Section 3), the DOH is amending the Model Contract before contracting year 2017 to reflect changes to MCO reporting requirements. MCOs will also be obligated to report on a standard set of VBP quality measures as recommended by the Clinical Advisory Groups, and accepted by the State. Where discrepancies exist between the QARR measure set and the VBP arrangement specific measures, the State may modify the QARR measure set to optimally align how MCOs are scored.

As part of the reform, the State will provide VBP contractors and MCOs with a dynamic data and analytics tool that provides cost and outcome information of the different VBP arrangements, by MCO, by geography and by VBP contractor(s) (p. 28). This will support MCOs and (emerging) VBP contractors to start negotiating VBP contracts, and to identify areas for improvement.

Finally, the State will work with stakeholders to improve the quality of encounter data provided by providers to plans and from plans to the State as this data is foundational for the measurement of quality and costs. Poor quality data delivery may be financially penalized.



5. Creating Synergy between DSRIP Objectives and Measures and MCO Efforts

Issue 5: How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The State should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other State funding; and how they differ from any services or administrative functions already accounted for in capitation rates.

Currently, the base administrative PMPM amounts are calculated for each of the State's nine managed care rating regions using plan Medicaid Managed Care Operating Reports (MMCORs). The regional PMPM amounts are calculated by dividing the total allowable administrative cost for each plan in a given region by the plan reported member months. Each plan PMPM amount is then subject to the Department's administrative PMPM cap and adjusted downward if necessary. Additionally, the Department of Health also incorporates an administrative component into capitated premiums for all new populations and benefits moving into the benefits that are not reflected in the two year MMCOR base. This additional administrative component is developed by the State's actuary. The administration component is then adjusted by a plan specific risk score (see Section 7). The Performance and Stimulus Adjustments, as well as potential penalties (see Section 3), will be incorporated in this process from 2017 on.

As with all new requirements, the Department and its actuary will review what will be expected of plans under DSRIP with regards to providing technical assistance/support, new activities, workforce development, etc. to achieve waiver goals. This analysis will also take into consideration activities already accounted for in plan premiums to ensure duplication of payment is avoided. Ultimately, the State's actuary will certify an actuarially sound premium range that takes into account the factors above which the State will pay for within the range to meet federal requirements (see Section 8).

New requirements under DSRIP may result in additional administrative costs for plans and providers which will need to be evaluated by the State and its actuary. Two specific areas where this will likely occur are: 1) workforce planning where, under the waiver, plans are responsible for developing and implementing various workforce strategies; and 2) value based payment requirements which will necessitate plan/provider contract modifications. While there will likely be increases for these items, the Department believes they will not be excessive as it intends to set benchmark payment levels for use by plan/provider that recognize these additional costs. Further, it is not the intention of the State to exclude plans (or providers) that have been proactive and have already made investments to develop VBP from this additional support.

Maximum alignment between DSRIP and VBP is achieved, first and foremost, by the fact that the activities required by providers to be successful in DSRIP or VBP are two sides of the same coin. Because the outcome measures of the VBP arrangements and the DSRIP program will overlap to a large extent, additional administrative efforts are minimized here as well. Finally, the State will provide providers and MCOs with data and cost and outcome information of the different VBP arrangements, by MCO, by geography and by VBP contractor(s), thus reducing the need for MCOs and providers to immediately duplicate these efforts.



6. Assuring that Providers Successful in DSRIP are included in Networks

Issue 6: How the state will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks

VBP is *not* designed to limit member options or to lock providers out of the system. The State will maintain current managed care network requirements, which ensures both adequate member choice and provider inclusion. Within DSRIP, PPSs have and will continue to have opportunities to enhance their networks as needed to ensure that all vital providers are included, particularly community based behavioral health and social service providers who have been previously excluded from the formal Medicaid payment system. While there is no requirement for a provider to join a PPS network, these networks have been growing extensively since DSRIP Year 0. This growth will help to ensure that VBP is applied widely.

Because high performing (combinations of) providers will be visible to providers, MCOs and the public alike, and MCOs will be financially incentivized to contract with high value providers, it is highly unlikely that providers who are successful in delivering high value care would not be contracted by MCOs. The State will monitor this development and, where necessary, develop additional approaches to ensure the inclusion of providers who demonstrate successful performance.

It is likely that some providers may need assistance engaging in VBP. Smaller, less prepared providers may need access to resources and support to develop the sophistication to succeed, and DSRIP funds are explicitly intended to facilitate this progress. These providers may include community and home based organizations who may have challenges related to infrastructure, technology, and workforce. To support the integration of community based organizations into VBP and as VBP contractors, the State has adapted several standards, recommendations and guidelines to assist CBOs. These recommendations include: creating a self-assessment process for groups to assess their readiness for VBP participation; State funding and the creation of additional workgroups to address the capacity, monetary, and infrastructure deficits impacting numerous organizations; convening a team of experts with whom CBOs could consult on VBP participation; and evaluating the feasibility of creating a bi-directional system for provider/provider network and CBO communication. The subcommittees created robust guidelines for the implementation of VBP that are important for all stakeholders. A full set of the recommendations made by these subcommittees throughout this process can be accessed online.⁷²

VBP contracts between the providers and MCOs provide a strong incentive for the MCOs to offer technical support, given the potential financial benefit to both parties. In addition to the support that MCOs can provide, health care providers participating in DSRIP have the ability to use program funds to employ third party services for further education and technical support on VBP arrangements. Providers may also seek assistance within their PPS. The State, MCOs and providers will collectively monitor whether in later years additional support for low performing providers within VBP arrangements is necessary.

Large scale VBP Pilots will start in 2016 to create momentum and provide learning opportunities for the providers and MCOs involved, but also for other potential VBP contractors in the State. The State will actively support these pilots in 2016. Finally, the State will organize statewide 'VBP bootcamps' for both providers and MCOs to provide further opportunities for learning.

⁷² https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/2016/docs/2016-feb_sub_comm_recommend_rpt_consol.pdf



7. Amending Contracts with the MCOs: Adjusting Managed Care Premiums to Improve Population Health and Care Utilization Patterns

Issue 7: How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development

Under the Department's Mainstream Managed Care risk adjusted capitation premium methodology, all plans are paid at the same regional average premium, adjusted by a plan specific risk adjustment factor that accounts for differences in enrollee acuity across plans. The regional premiums are developed using two years of plan reported MMCOR data (as described in Section 5). Using collected encounter data, risk scores are calculated using 3M's CRG model and cost weights developed by the Department. In simple terms, these two pieces are multiplied together to get plan specific risk adjusted premiums. The Department and its actuary incorporate changes in case mix, utilization and cost of care on an annual basis as the data becomes available to incorporate in premium development. The inclusion of DSRIP into this process will be a continuation and expansion of the work being done. Furthermore, as the Department implements its *Care Management for All* initiative and new populations and services (especially for chronic conditions including the MLTC, behavioral health and intellectually and/or developmentally disabled populations) move into managed care, it has engaged 3M and plans to make refinements to the current risk adjustment methodology. This effort is also a significant element of the FIDA demonstration. Ultimately, the goal is to have one risk adjustment system that incorporates the needs of the entire Medicaid managed care population.



8. Amending Contracts with the MCOs: Ensuring Alignment between DSRIP Objectives and Measures and MCO Premium Setting

Issue 8: How actuarially sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the state will use benchmark measures (e.g. MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.

As discussed in Sections 5 and 7, making appropriate rate adjustments to account for VBP expectations in New York's program will be dependent on many things, but none more critical than (i) flexibility within the current (and even proposed) Federal regulatory framework, and (ii) accurate and complete data to support the multitude of different VBP arrangements that are possible between the health plans and providers.

Under current Federal managed care regulations and Actuarial Standard of Practice No. 49, actuaries may only include costs for expenditures associated with services defined in the State's approved Medicaid State plan that are covered under the contract. With rates being based solely on encounters or claims, the payment to the health plan is not likely to adequately recognize the State's policy goal to pay for high-quality and cost-efficient care achieved through system transformation, clinical improvement and population health improvement.

While the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rule Making (NPRM) on June 1, 2015 identified VBP arrangements as an allowable strategy in a managed care contract under managed care regulations, it currently does not provide detailed guidance regarding how the value of VBP arrangements should be reflected in plan payment rates and actuarially sound rate ranges. Indeed, the NPRM increases the requirements that rates be built off of historical utilization (volume) and cost (not value). The NPRM also proposes to remove the current flexibility in certifying to rate ranges by proposing that states provide a certification of a specific rate for each rate cell. Because VBP arrangements are expected to evolve at a different pace by health plan and provider, certifying a specific rate for each rate cell may be difficult. There will likely be a need to widen rate ranges (at least during the developmental period of VBP initiatives) in order to be able to reasonably capture additional variations in experience from plan-to-plan within regions. These issues illustrate the concern that the NPRM will not provide the necessary flexibility to permit rate-setting to account for value instead of volume.

Some states have already experienced difficulty in developing rates that utilize global budget strategies that retain savings for reinvestment by providers in the health care system. While arguably existing frameworks could be used to estimate savings (e.g. the framework used for efficiency adjustments), it is unclear if these models can be sufficiently tailored to measure value. It is also unclear if there are expectations about how savings estimates are determined in VBP arrangements and/or the documentation that should be provided.

In changing the framework from counting "volume" to "value", it will be necessary to collect additional data from the health plans and providers. Encounter data will continue to be important, but additional information to capture the cost of total cost of care arrangements, episodic bundles, integrated primary care models, special needs subpopulation arrangements and any off-menu VBP arrangements will be critical. When the VBP arrangements are embedded in data used to establish rate-setting based data, it will also be necessary to determine what costs need to be included – and how that differs for each VBP arrangement.

As VBP strategies are evolving, (i) flexibility within the current (and even proposed) Federal regulatory



framework, and (ii) accurate and complete data to support the multitude of different VBP arrangements that are possible between the health plans and providers will be critical, as well as continued guidance from CMS. To that end, support from CMS for aligning other State health initiatives, such as SIM, APC, and VBP QIP will also help ensure that the State has the flexibility to adapt VBP implementation as needed over the life of the waiver.

Stakeholder Engagement

Since 2014, New York State has been working diligently on involving various stakeholder groups in the policy development, design and implementation of VBP as outlined in this Roadmap. The level of engagement has been unprecedented; over 500 stakeholders across the State participated in the 16 subcommittees and Clinical Advisory Groups held in 2015. Stakeholders will continue to be closely involved with the VBP implementation process in 2016, as their participation is a critical component and a hallmark of the Medicaid Redesign Team tradition. Stakeholders engaged included: New York State health plans, managed care organizations, representative organizations including the health plan associations, professional associations, hospital associations, legal firms specializing in health care contracting, New York State Health and Human Services agencies, community based providers, patient advocates, Performing Provider Systems and other industry and VBP experts. These stakeholders have been critical to the design of VBP in New York State, and contributed through their active participation over the past two years.

The State is committed to supporting the Medicaid health care system on the path to payment reform and ensuring the sustainability of the DSRIP program. The input that the stakeholders provided to date has been invaluable, and crucial to not only developing the plan to transition from fee-for-service to value based payment, but most importantly, the way to improve health care delivery to over six million individuals in NYS. Recognizing the value of continuous stakeholder input, the State will continue to rely on the VBP Workgroup as well as the formed Subcommittees and Clinical Advisory Groups at any time, for additional support or when guidance is needed to meet VBP goals, further enforcing the overall commitment to the Program's success.



Next Steps

This Roadmap has been conceived as a living document. It is not a blueprint; but rather an attempt to demonstrate the State's ambition and to outline what the State and its stakeholders consider the payment reforms required for a high quality, financially sustainable Medicaid delivery system.

The updates to this Roadmap reflect the significant work and accomplishment over the course of the last year related to moving VBP closer to implementation. The next year will hold the same promise, with a focus on moving from concept into actual implementation and statewide focus on reaching our VBP goals. The work for the next year is outlined below and includes:

1. *VBP Pilot Implementation:* The State has invited providers and MCOs to test the VBP arrangements (outlined in this Roadmap) through a VBP Pilot Program. The State aims to launch an estimated 15 pilots throughout 2016:
 - a. Total Care for the General Population (2-3 pilots)
 - b. Integrated Primary Care(2-3 pilots)
 - c. Maternity Care (2-3 pilots)
 - d. HIV/AIDS (1-2 pilots)
 - e. Health and Recovery Plans (1-2 pilots)

Due to the need for integrated Medicare and Medicaid data (planned to be operational later this calendar year), the MLTC pilots will likely not start before 2017. Similarly, an I/DD pilot will not start until this care has been transitioned into managed care.

These pilots will be aligned with the arrangements detailed by the Clinical Advisory Groups, and will receive technical assistance from the State on design and analytics to support VBP implementation. In addition, all pilot participants (plans and providers) agree to participate in a learning diffusion process where they commit to assist in developing lessons learned for VBP implementation and reengagement with the CAGs as needed.

2. *Statewide Readiness Preparations (VBP Bootcamps):* In order to both support and promote a smooth and transparent shift to VBP, the State will also be running an educational series for providers and plans across the State. These trainings or 'boot camps' will help ensure that the health care community is educated on the details of the VBP design that were developed throughout 2015. Other relevant topics, including risk management and contracting for VBP, will also be included. Learnings from the VBP Pilot participants and leading providers and plans engaging in VBP will be leveraged and shared by the Department of Health, promoting transparency and operational support on the VBP implementation process.
3. *Mid-Point Assessment Planning:* The State will collaborate with the VBP Workgroup to define the details of an assessment of VBP progress, based in part on the output for the Baseline Assessment completed in early 2016.
4. *Implementation of Workgroup Recommendations:* To fully implement the required changes identified by the VBP Workgroup, the Medicaid Model Contract and Provider Contract guidelines will be updated to reflect many of the technical design and regulatory recommendations developed throughout 2015. Numerous State agencies, such as the Department of Health and the Department of Financial Services, will make updates to their internal policies and help support legislative changes within the State. Additionally, analytics and performance tools have been updated to support access to relevant data and further



transparency for providers and MCOs. This focus on data transparency will be critical for successful implementation of VBP and is a cornerstone of the State's vision for the future of Medicaid.

5. *Ongoing Clinical Advisory Groups:* Clinical Advisory Groups are in various stages of completion, with the goal of finalizing all quality and clinical measures by mid-2016. While the majority of the CAGs are complete (Maternity, Chronic Heart, Diabetes, Pulmonary, HIV/AIDS, Integrated Primary Care), some CAGs that will continue through mid-2016 (Behavioral Health and Managed Long-Term Care). The Behavioral Health CAG, which has reviewed the HARP subpopulation and Bipolar Disorder, has been extended to accommodate enhancements to specific episodes (such as Depression and Anxiety) and develop additional ones (Trauma and Stressors, Substance Use Disorder). In addition to the continuation of certain CAGs, CAGs for Managed Long-Term Care and the Intellectually and/or Developmentally Disabled have begun in 2016. As discussed, additional CAGs will be launched as needed to address the remaining Medicaid population.

Formation of New Workgroups: Recommendations of the Regulatory Impact Subcommittee and the Advocacy and Engagement and Social Determinants of Health Subcommittees included requests for the development of new workgroups to continue and deepen the work charged to the subcommittees. Additional regulatory workgroups will be formed around HIPAA and State Privacy Laws, Program Integrity, and Regulatory Reform. These proposed workgroups will focus on staying abreast of any unanticipated regulatory challenges to VBP implementation, and ensuring that the appropriate safeguards for members, plans and providers are in place. The output of these workgroups will be findings and recommendations, which will be submitted to the VBP Workgroup for approval.

The Advocacy and Engagement and Social Determinants of Health Subcommittees also recommended the development of several workgroups, in order to dig deeper into a number of critical issues. Areas for follow up may include: a taskforce focused on children and adolescents in the context of VBP; a taskforce to identify standard data sources and data points for reliable tracking of social determinant-related metrics; a workgroup to review the opportunity for development of a communication system for providers and CBOs to better address members' SDH needs; and workgroups to update the current Managed Care Patient Bill of Rights to include information relevant to VBP and provide information on VBP to Medicaid members.



Timeline

The core goals of VBP implementation and the DSRIP program, as well as the speed of implementation remain unchanged. The timeline has been updated to reflect the changing role of the Performing Provider System, which may, but is not required, to be the entity contracting VBP arrangements.

In DY 2 (April 1st, 2016 – April 1st, 2017), PPSs will be requested to submit a growth plan outlining the path of their network towards 90% value based payments. All growth plans will be weighed in terms of ambition level (speed of implementation, level of risk, total dollars at risk, opting for a differentiated approach rather than total cost of care for total population).

End of DY 3 (April 1st, 2018), at least 10% dollars of total MCO expenditure are captured in Level 1 or above.⁷³

End of DY 4 (April 1st, 2019), at least 50% of total MCO expenditure will be contracted through Level 1 VBPs or above. At least 15% of total payments contracted through Level 2 VBPs or higher (full capitation plans only)⁷⁴.

End of DY 5 (April 1st, 2020), 80-90% of total MCO expenditure (in terms of total dollars) will have to be captured in at least Level 1 VBPs. At least 35% of total payments contracted through Level 2 VBPs or higher for fully capitated plans and 15% contracted in Level 2 or higher for not fully capitated plans.⁷⁵

⁷³ This goal was rephrased to make the target more measurable.

⁷⁴ For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans, from this minimum target.

⁷⁵ The State's ambition is to stimulate MCOs and VBP contractors to move to Level 2 contracting as soon as possible, because it is at Level 2 (or 3) that the most impact on outcomes is seen. Even more important, however, is the need to ensure that VBP contractors are ready to assume risk, especially in a system with safety net functions and providers who often start from a financially fragile position.



Coordination with Medicare

In October 2015, the State submitted a Medicare Alignment proposal to CMS that outlined the State's efforts to maximally align CMS payment reform efforts for Medicare to the NYS Medicaid Payment Reform Roadmap. Alignment between Medicare and Medicaid is beneficial for members, providers, the State and CMS alike. The significant benefits of this alignment are focused on important outcomes such as: increasing opportunities to create shared savings for NYS providers; a reduction of risk of divergence and distraction caused by diverging payment models and incentives; thoroughly reducing administrative burden; reducing barriers and increasing incentives to 'make the jump' to a new business model for providers; increasing opportunities for stabilization of the safety net, especially upstate; increasing overall value delivered to members and payers, including Medicaid; and increasing value delivered, especially to the dual eligible population.

The Alignment proposal was drafted with the support of the VBP Workgroup, and was posted for a public comment period. The State has had preliminary discussions with CMS, and is committed to continuing to maximize synergy and benefit between the programs and minimize complexity for members, providers and plans. The Medicare Alignment proposal requests that the State receive approval to: 1) allow its providers and Managed Care Organizations on a voluntary basis to include Medicaid members in CMS innovative payment models (these have already been included in the Roadmap as off-menu options that would be automatically accepted as valid Level 1 or higher VBP arrangements); and 2) in parallel, NYS requests that CMS allow NYS providers on a voluntary basis to include Medicare FFS members in the VBP arrangements outlined in the NYS Payment Reform Roadmap.

In January 2016, the Health Care Payment and Learning Network (initiated in 2015 by DHHS), published its new Alternative Payment Model (APM) Framework⁷⁶, which distinguishes four categories of health care payments:

Category 1: Fee-for-service with no link of payment to quality

Category 2: Fee-for-service with a link of payment to quality

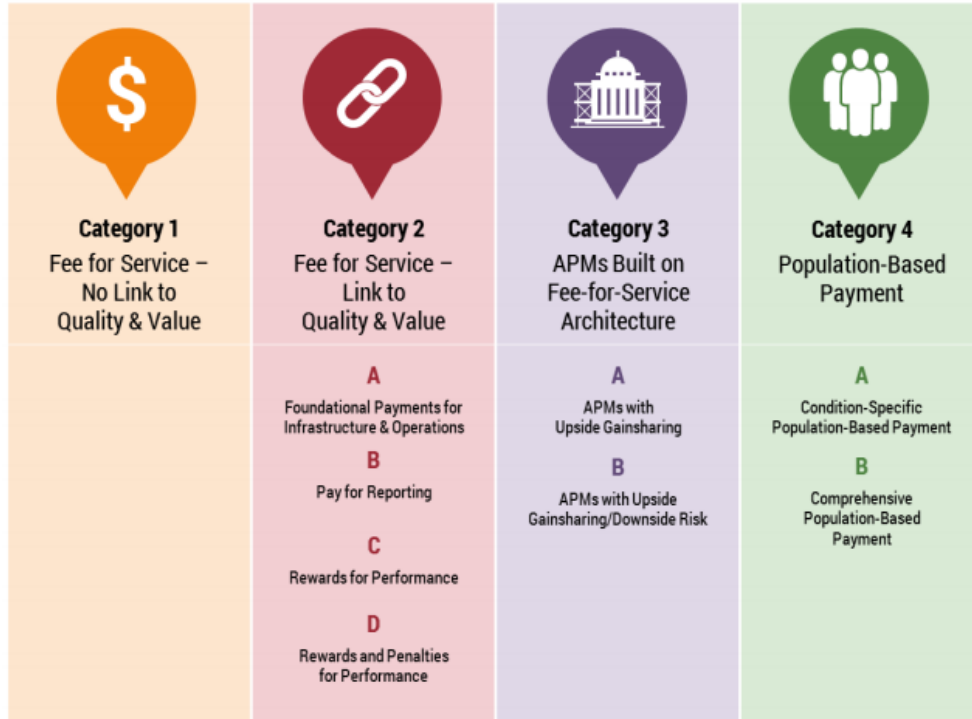
Category 3: Alternative payment models built on fee-for-service architecture

- a) APMs with upside gainsharing
- b) APMs with upside gainsharing and downside risk

Category 4: Population-based payment

- a) Condition specific population-based payment
- b) Comprehensive population-based payment

⁷⁶ Alternative Payment Model (APM) Framework, Final White Paper. The Health Care Payment Learning & Action Network (LAN). January 2016. <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>



This new APM Framework is fully aligned with the NYS Roadmap:⁷⁷

HCPLAN APM Framework	NYS Roadmap
Category 1	FFS
Category 2	Level 0
Category 3a	Level 1
Category 3b	Level 2
Category 4	Level 3

CMS has announced the goal of having 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018 (Category 2). Perhaps even more important, the CMS target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018 (Category 3 or 4)⁷⁸.

As CMS embarks down the path of VBP for Medicare with explicit goals for alternative payment models and value based payments, New York State is committed to ensuring alignment of the goals between both VBP programs by mapping the DHHS goals to the NYS Medicaid levels. New York State Medicaid will also continue to be a national leader by committing to meeting or surpassing the DHHS goals as defined under the Health

⁷⁷ CMS has numerous Advanced Payment Models (APMs). VBP Contractors and MCOs should review each APM or Advanced APM to determine specific requirements.

⁷⁸ Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume. CMS Fact Sheet, 01-25-2015. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html>



Care Learning and Action Network.

Conclusion

The recommendations for VBP implementation captured in this Year 2: 2016 Annual VBP Roadmap Update have been made based on significant stakeholder input and engagement. Through the implementation process, providers and PPSs in successful DSRIP programs will see a significant shift in reimbursement dollars. DSRIP funds will allow them to compensate for lost revenues while investing in new infrastructure. Similarly, DSRIP funds will be used to pay for care activities that are currently not funded or underfunded, especially important as innovative, outpatient and community-focused care models are being introduced. As quality outcomes improve, and avoidable admissions and visits are reduced, the current fee-for-service model will be increasingly ill-fitted to sustain the new delivery models. After five years, when the DSRIP funding stops, gains realized will be impossible to maintain unless significant steps are made to align payment mechanisms with these new care models. Importantly, without payment reform, improved outcomes and efficiency will lead to reduced reimbursements, and a downward rebasing of MCO premiums, reducing Medicaid dollars and weakening rather than improving the viability of the safety net.

Building upon the infrastructure that DSRIP will help put in place, this Roadmap outlines a transformation towards payment reform which:

- Aligns the payment incentives with the aims and goals of DSRIP and population health management;
- Rewards value over volume;
- Ensures reinvestment of potential savings in the delivery system;
- Allows for reimbursement of innovative care models not currently funded or underfunded;
- Allows for increased margins for providers when delivering value and an increased viability of the State's safety net;
- Allows for more sustainable workforce strategies; and
- Reduces the percentage of overall Medicaid dollars spent on administration rather than care.

The State realizes that this plan is ambitious. Yet without this ambition, these aims, vital to members, the provider and plan communities, and the Medicaid delivery system as a whole, cannot be realized. It is encouraging to see this plan's ambitions reflected in the broad and extensive stakeholder participation and the Medicaid community's commitment to realizing this plan over the next five years.



Appendix I: T&Cs Par. 39

In recognition that the DSRIP investments represented in this waiver must be recognized and supported by the State's managed care plans as a core component of long term sustainability, and will over time improve the ability of plans to coordinate care and efficiently deliver high quality services to Medicaid members through comprehensive payment reform, strengthened provider networks and care coordination, the State must take steps to plan for and reflect the impact of DSRIP in managed care contracts and rate-setting approaches. Prior to the State submitting contracts and rates for approval for the April 1, 2015 to March 31, 2016 contract cycle, the State must submit a roadmap for how they will amend contract terms Recognizing the need to formulate this plan to align with the stages of DSRIP, this should be a multi-year plan, and necessarily be flexible to properly reflect future DSRIP progress and accomplishments. This plan must be approved by CMS before the State may claim FFP for managed care contracts for the 2015 State fiscal year. The State shall update and submit the Managed Care DSRIP plan annually on the same cycle and with the same terms, until the end of this demonstration period and its next renewal period. Progress on the Managed Care DSRIP plan will also be included in the quarterly DSRIP report. The Managed Care DSRIP plan should address the following:

What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the State will plan and implement its stated goal of 90% of managed care payments to providers using value based payment methodologies.

How and when plans' current contracts will be amended to include the collection and reporting of DSRIP objectives and measures.

How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The State should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other State funding; and how they differ from any services or administrative functions already accounted for in capitation rates.

How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.

How the State will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks.

How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development.

How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the State will use benchmark measures (such as the MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for State review and approval by January 31 of each calendar year.

How the State will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.



Appendix II: Criteria for ‘Off-Menu’ Options

‘Off-menu’ options will have to be initiatives embraced by both the MCO and the involved providers. In addition, they have to fulfill certain criteria to be considered (at least) Level 1: they must reflect the underlying goals of payment reform as outlined in this Roadmap and sustain the transparency of costs versus outcomes. ‘Off-menu’ approaches also, at a minimum, must meet DHHS’ definitions of Alternative Payments Models (APMs). The following outlines the criteria the State will use when it assesses whether off menu options reflect the goals of Medicaid VBP reform.

VBP models work only if the ‘value’ at heart of the model can be measured objectively and compared with other providers/MCOs. To allow transparency and proper benchmarking, then, calculations of ‘costs’ and ‘outcomes’ require a certain level of statewide standardization. If provider-MCO combinations define similar bundles or (sub)populations differently, the current inability to compare costs and outcomes across meaningful units of care would simply have been replaced by a similarly opaque situation, and the State would be hampered in its responsibility to monitor the value of care delivered to its most vulnerable populations.⁹⁰ In addition, standard VBP arrangement definitions significantly reduce the administrative burden for both MCOs and providers. Especially for smaller providers, varying definitions of a VBP arrangement between MCOs and/or differences in outcome measures to report would cripple their ability to fulfill their role.

This implies the following criteria:

1) Off-menu VBP arrangements that focus on conditions and subpopulations that address community needs but that are not otherwise addressed by VBP arrangement in the Roadmap

MCOs and VBP contractors are invited to focus on conditions and subpopulations that are locally highly relevant yet not identified as such by the VBP Roadmap. ‘Off-menu’ arrangements are not intended to be used for making variations to the VBP arrangements that have been prioritized by the State.

Example of an acceptable ‘Off-Menu’ option:

- An arrangement that focuses on a bundle or subpopulation that the Roadmap and the State are not supporting analytically, but that has significant local impact would satisfy this criterion. For example, a cancer treatment arrangement in an area with poor outcomes for cancer patients would constitute a potentially acceptable ‘Off-Menu’ arrangement.

2) Off-menu VBP arrangements should be member centric

The delivery of such care services will almost always require different provider types working together. All VBP arrangements should be member centric and span the full continuum of care as appropriate for the target condition or subpopulation. The VBP arrangements outlined in the Roadmap offer clear examples. ‘Costs’ and ‘outcomes’ are measured across the entire spectrum of the care services.

Example of an acceptable ‘Off-Menu’ option:

- A TCGP arrangement that excludes dental services but that does include the continuum of covered services for all members eligible for mainstream managed care would satisfy this criterion, as dental services are outside of the set of covered services for these members.

Examples of an unacceptable ‘Off-Menu’ option:

⁹⁰ To maximize alignment across payers, the State will except certain alternative models such as Medicare ACOs and Medicare BCPI (Bundled Payments for Care Improvement) bundles; see further.



- A TCGP arrangement that excludes hospital costs would not satisfy this criterion. Urgent and tertiary care services are a necessary component of the continuum of care for the general Medicaid population due to the variability and unpredictability of medical needs.
- A Maternity Care arrangement that excluded obstetric services would fail this criterion. Obstetric services are a core component of the support provided to this cohort, and an arrangement that omitted these services would be unable to provide adequate care to its members.

3) Through sharing savings and/or losses, off-menu VBP arrangements should include a focus on both components of 'value': the quality and cost of the care delivered

VBP contractors take responsibility for the total costs and quality delivered to the patient included in the APM. These total costs as well as the quality-based outcome measures need to be clearly defined; both the VBP arrangement definition as well as the outcomes need to be available to stakeholders so as to stimulate uptake by other providers and MCOs if desired. MCOs will need to report their scores on the quality metrics as is the case for on-menu VBP arrangements.

Every VBP arrangement must satisfy this criteria through focusing on both cost and quality.

4) 'Off-Menu' VBP arrangements should utilize standard definitions and quality measures from the Roadmap where possible

The arrangement definitions and quality measures appearing in the Roadmap have been carefully developed by the CAGs and represent a highly collaborative and evidence-based approach to policy development. As such it is important for them to be implemented consistently across the state to enhance the ability for all stakeholders to monitor progress and success across the state.

Variations on the defined arrangements may be allowable, but will be reviewed and approved by the Department. These variations may include adjustments to target population parameters, covered services, or performance measures.

Examples of a potentially acceptable 'Off-Menu' option:

- An arrangement that proposes carving out one or more conditions from the Chronic Care arrangement in the short term in order to expedite their ability to implement a VBP contract for IPC.

Note: the integration of primary care and behavioral health care is core to the aims of enhanced patient-centered care and therefore the separation of primary care and behavioral health will not be an acceptable example of a carve out for the IPC arrangement

- A HARP arrangement that includes new quality measures that have been developed after the HARP CAG report was published and that will assist the VBP contractor in monitoring outcomes in an enhanced manner.

Note: the consistency of quality measures across similar arrangements state-wide is an important aspect of monitoring the progress and results of the VBP program. VBP Arrangements should not omit quality measures recommended by the CAGs. Alternative quality measures outside of those recommended by the CAGs will be considered as long as they are consistent with the aims of the VBP program and are supported by a compelling argument for their use.

Examples of a potentially unacceptable 'Off-Menu' option:

- An IPC arrangement that carves out the depression and anxiety episode.
- An arrangement that omits CAG-recommended quality measures without approved rationale and/or inclusion of approved alternatives.



Appendix III: Criteria for Shared Savings in IPC and TCGP Contracting

To clearly define the expected level of cooperation between professional-led VBP contractors and downstream hospitals, three main criteria (listed below) have been identified. These criteria will serve as a statewide standard in determining equitable shared savings in IPC and TCGP VBP arrangements.⁹¹ To provide flexibility, hospitals and professional-led VBP contractors may agree to alternative sub-criteria measures and specifics where appropriate, provided the State is notified and the MCO contracting the Level 1 and/or 2 VBP arrangements agrees. They may also include more detailed criteria than those listed below. It is the responsibility of the contractor to notify downstream hospitals of its intent to negotiate value based arrangements with an MCO. Subsequently, it is the responsibility of the hospital to initiate conversations with the VBP contractor based on a plan created by the hospital conforming to the statewide standard.

If a Level 1 arrangement is contracted, the hospitals qualify for 50% of the savings realized by the professional-led practice. If a Level 2 arrangement is contracted, the hospitals will qualify for 25% of the savings; 75% will remain with the professional-led practice (as the VBP contractor) as it has now accepted downside risk.⁹²

The criteria for determining that hospitals have sufficiently demonstrated their cooperation in Level 1 and 2 IPC arrangements are separated into three categories: 1) Data Management and Data Sharing, 2) Innovation and Care Redesign, and 3) Quality and Engagement. If the hospitals meet all of the three criteria and savings are generated in the VBP arrangements, the hospitals will receive 50% or 25% of the savings depending on the arrangement VBP Level. Hospitals must meet all three criteria in order to receive savings. Partially met criteria will not result in shared savings for the hospital. The DOH will work closely with stakeholders to monitor the implementation of these criteria.

1) Data Management and Data Sharing

Provide real time direct data feeds to professional-led VBP contractors for emergency room utilization, admissions, and discharges (including behavioral health and substance use).

⁹¹ Clarification: the amount of savings subject to an equitable split with hospitals does not include the MCO share of the total savings. In addition, a downstream hospital only shares in the savings proportionally to its loss of revenue (i.e., the amount in which savings generated by the professional-led contractor were based on lost revenue to the hospital). For downstream hospitals to share in the savings, no causal relation between the VBP contract and the revenue loss has to be established.

⁹² Costs for risk-mitigation such as reinsurance to prevent excessive insurance risk may be subtracted from 'VBP contractor's shared savings' before the 25% calculation is applied.



<p>2) Innovation and Care Redesign</p>	<p>Fulfill at least one of the three following measures:</p> <ol style="list-style-type: none"> 1) Develop standardized care plans based on evidenced-based guidelines and practices to reduce inappropriate variation in the organization for at least one of the following service areas: high cost imaging, emergency room care, oncology treatment, diagnostic testing, behavioral health treatment, substance use treatment, etc. 2) Enhance care transitions to post-acute settings such as mental health treatment facilities, substance use disorder treatment facilities, Skilled Nursing Facilities, home, etc. to reduce readmission rates and potential complications. 3) Implementation of palliative care and collaboration with hospice.
<p>3) Quality and Engagement</p>	<p>Collaborate with professional-led VBP contractors on DSRIP Domain 2 and 3 metrics quality indicators affecting population health⁹³.</p>

Disagreement between the hospital and the professional-led VBP contractor will not prevent the MCO and the VBP contractor from moving forward with the contract. When disagreement on the interpretation of the criteria or disagreement on whether a hospital has met the criteria persists, the parties may choose to solicit assistance from the Department of Health during this mediation process. During the first year of VBP implementation (CY 2016), the State and the VBP Workgroup will continue to monitor these situations closely to validate the need for an appeals process.

⁹³ See Appendix A of DSRIP Measure Specification and Reporting Manual for the extract of Domain 2 and 3 DSRIP measures. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/dsrip_specif_report_manual.pdf



Appendix IV: Value Based Payments and the Forestland PPS in 2019

During the DSRIP application process, the State facilitated the creation of a Prototype application, designed to provide emerging PPSs with an example of what a successful DSRIP application would look like. To create this prototype a fictional PPS “Forestland” was created. Building upon this narrative, the following provides an example of what the future state of VBP in the fictional Forestland PPS could look like. (It is not necessary to have read these earlier Forestland materials).

The Forestland PPS has been a successful PPS. It has met the bulk of its performance targets over the DSRIP years, and has been one of the State’s most successful PPSs in addressing diabetes and cardiovascular disease related hospital admissions, leading to several high-performance fund payments. While thinking through its Value Based Payment strategy in 2015, the Executive Body of the Forestland Health Provider Partnership (FHPP, the NewCo created during those last hectic months of 2014) decided that it would not attempt to create one integrated contracting entity for the total PPS. Big is not always beautiful, they had argued. Their MCOs, with whom they had always had a good relationship, had also been clearly concerned about having to negotiate with such a unified group of providers. In addition, there had always been a natural distinction in culture, focus and also patient populations between the east and the west parts of the Forestland providers.

In East Forestland, home of the poorer parts of this geographical area and two of the PPSs three hospital systems, the providers and MCOs had decided during 2016 to focus on their significant HARP and MLTC/FIDA populations for value based payments. Analysis of the outcome versus cost measures (that had become available and comparable statewide that year as part of the State’s VBP Roadmap) had shown them that potential improvements in both quality and overall costs were significant. Maternity care, on the other hand, was selected because their outcome versus cost measures showed what they had thought all along: they were one of the best performers statewide. In the FFS system, however, they were still losing money on maternity care, and a contract that focused on value could be the solution.

The pre-existing Health Home had linked up with the other Advanced Primary Care initiatives that were expanding in the region, and had proposed to contract Integrated Primary Care throughout most of East Forestland. They had been impressed with the potential reduction in potentially avoidable complications that the data had shown, especially with those patients who weren’t quite HARP eligible, but whose combinations of behavioral and physical chronic conditions led to poor outcomes overall.

For Maternity Care, the two hospitals joined forces with the obstetricians and community based providers, and opted for a Level 1 arrangement in 2017. This increased the dollar amount available for this care (based on their high performance statewide, and on the State’s incentive for MCOs and providers to move to higher levels of VBP arrangements). Because this arrangement also included the care and costs of the first month of the baby, significant savings were realized by a further reduction of the already low NICU admission rates.

With the 50% of these savings that the MCO returned to them based on the Level 1 contract, improvements were made in the ability of community based providers to reach out to the most underserved populations, which helped reduce smoking and other substance abuse during pregnancy. The shared savings helped the hospital as well, and was a welcome addition to the obstetricians’ income.



Inspired by this result, they agreed to move to Level 2 in 2018 so as to be able to capture 100% of the shared savings, and profit from the further increase in VBP incentive dollars). The hospitals and the obstetricians formed a Maternity Care IPA, aimed at ultimately taking full risk. The obstetricians pushed to hire midwives to further decrease overall cost of care, safely increase the percentage of homebirths, and increasing the overall hands-on time that delivering mothers would experience. Increased patient satisfaction led to an influx of patients from the wider region, which further helped stabilize the financial results for the hospital, which was now receiving its maternity care related income through a contract with the Maternity Care IPA. Sensing the alignment of their own professional drives with the new financial incentives, and witnessing the disappearance of prior authorizations and MCO's utilization reviews, morale surged amongst the staff members.

The Health Home and other Advanced Primary Care practices had realized that if they would maximally strengthen the synergies between the different projects they had selected (IDS (2.a.i), medical village (2.a.iv), ED (2.b.ii), readmission reduction (2.b.iv), their 'project 11' (2.d.i), and their Domain 3 and 4 projects), all these projects would help drive the same results: an improved focus on housing, adequate nutrition, smoking cessation and obesity prevention throughout the community, improved adequate utilization of primary and preventive care, improved disease management and care coordination. One of their magic bullets, they had decided, was to build upon the success of their Health Home. Its focus on and infrastructure for care management and physical and behavioral care integration was the platform upon which they rolled out their approach to first the HARP population and subsequently the broader at-risk population. A second magic bullet had been the idea to work closely together with the home health care and visiting nurse providers, which greatly improved their ability to be pro-active in terms of addressing patients' problems and allow these patients to live more independently, reduce hospital use, and overall consume less costly care resources. This cooperation subsequently proved highly successful for the FIDA population as well, reducing the need for inpatient long term care, and improving quality of life.

They moved to Level 1 for Integrated Primary Care in 2017 and Level 1 TCGP for the HARP population as well. Getting a good grip on the HARP population proved harder than expected, and not much difference in outcomes or costs was realized in 2017. Their integrated approach, however, was highly successful in reducing admissions for especially diabetes and all cardiovascular chronic conditions that were being measured statewide: hypertension, angina/coronary artery disease, congestive heart failure (CHF), and arrhythmia. Contrary to their expectations, 2017 saw a drop not only in the admissions for CHF and uncontrolled diabetes, but also in long-term complications: diabetic lower-limb amputations and cardiovascular events, especially myocardial infarctions and strokes.

The savings resulting from fewer potentially avoidable complications were significant. Following the State's guidelines, they had agreed to split these savings 50/50 with the hospitals within their PPS, helping them further reduce inpatient capacity to the newly modeled demand. For the Health Home and the Advanced Primary Care practices, even 50% of 50% of savings amounted to a significant increase in revenue. They used this revenue increase to make several improvements: increase payment levels for the primary care docs and the home care organizations; expand their use of visiting nurses to further prevent hospitalizations in at-risk individuals; invest in new staff across all levels (some of whom were transferred from inpatient care organizations through the DSRIP workforce retraining programs they had put in place). Building upon the DSRIP programs, they paid much attention to ensuring cultural competency within their staff, adequately reflecting the cultural and ethnic diversity of the populations they served.



They moved to Level 2 in 2018 for IPC, with an increased stop-loss provision just to “get used to the risk”, as they called it. They moved to Level 1 for the MLTC population that year, and remained in Level 1 for the HARP population. When their interventions for the HARP populations seemed to bear fruit throughout 2018, they shifted to Level 2 for that population as well. For the remainder of the care within the PPS, a Level 1 Total Cost for the General Population arrangement was agreed upon in 2018 that would suffice until further notice. There was no risk involved in such an arrangement, and the MCOs had agreed to simply distribute potential savings (according to overall involved Medicaid dollars) amongst the East Forestland PPS providers, with the option to negotiate different arrangements in the future.

In West Forestland, the Forestland Hospital Center and its neurologists had realized its potential to be an early adopter of integrated Stroke care. It had long been a center of excellence for stroke care, and its own analyses showed that optimizing the acute phase of stroke care, starting rehabilitation during day one, and working with a select group of specialized post-acute rehabilitation and home care providers would yield significant improvements in mortality and long term outcomes. They were aware that the bulk of stroke care costs, when seen across the total cycle of care, were long term care costs. Improving quality of acute stroke care, they were convinced, would improve the number of stroke patients recovering fully and thus reduce the number of patients left with impairments and corresponding life-long care dependency. Their own analyses had shown them that much of these potentially avoidable downstream costs were incurred outside of their PPS: nursing homes, other post-acute care providers and hospitals that were not part of their PPS.

They decided to opt in the VBP Innovator Program, moving immediately to a fully-fledged Level 2 model. The incentive associated with this Innovator Program was significant, but – as they had predicted – the savings that they were able to realize, largely without impacting any of their PPS provider colleagues, were greater. The public attention their work received led to an increase of patients being brought to them for acute stroke care, including Medicare and commercial patients. In 2018, Forestland Hospital Center was the first organization in the State to enroll in the aligned Medicaid-Medicare stroke bundle, which extended the rules of engagement of the Medicaid bundle to the duals and the Medicare FFS population. This was part of a broader alignment between CMS and New York State on the Medicaid and Medicare payment reform, which allowed for adaptation of New York State’s Medicaid VBP models in Medicare, and selected Medicare Innovation Models within Medicaid.

Contrary to East Forestland, there initially was not much focus on value based payment arrangements in the remainder of the West Forestland provider community. Triggered by the success of the Stroke Program, and the bristling of activities in their sibling ‘hub’ within the PPS, they decided to try out a Level 1 Total Care for the General Population program in 2018 (which excluded only stroke care). Because they were successful in meeting most of their DSRIP goals, overall costs of care dropped somewhat, which became an unexpected source of additional revenue (they had booked a significant sum of lost revenue compensation within the DSRIP funds for 2018). Emboldened by that result, and perhaps also somewhat driven by competition with the West Forestlanders, they moved to Level 2 in 2019, while planning to realize an integrated Medicaid-Medicare ACO in 2020.



Appendix V: Quantitative Analysis per Integrated Care Service

The following table gives an estimate of total dollar amounts per integrated care service. Dual eligible members are included only for the MLTC and the I/DD population (total Medicaid costs only). The cost categories below are mutually exclusive (i.e., the ‘chronic care’ costs for people within the HARP population are included in the HARP total cost of care; not also in the Chronic Care). The total dollar amount associated with these care services is 32.2 billion dollars, thus covering approximately 82% of the total payments between MCOs and providers (excluding the Medicare component of the FIDA payments).⁸³ The remainder are costs incurred for members that are not included in one of the four subpopulations, for conditions that are not part of primary care nor of the bundles discussed here. (These costs include e.g. cancer care, acute trauma care, and other specialty care with a relatively low prevalence in the Medicaid only population.) Providers contracting Total Care for the General Population can achieve up to 100% inclusion of MCO payments.

VBP Arrangement	Dollars (billions)	% of Total MCO-Provider Dollars
<ul style="list-style-type: none"> - Mutually exclusive - Unless explicitly stated otherwise, dual eligible members excluded 		
Special Needs Subpopulations	22.26	56.7%
MLTC (incl. Duals)	11.02	28.1%
I/DD (incl. Duals)	8.05	20.5%
HARP	1.52	3.9%
HIV/AIDS	1.67	4.3%
Mainstream Managed Care	9.89	25.2%
Integrated Primary Care (excl. chronic care)	3.43	8.8%
Chronic Care	4.92	12.5%
Maternity Care (incl. first 60 days of newborn)	1.53	3.9%
Total Covered	32.23	82.0%
Unbundled / Not in Any Arrangement (General Population)	7.08	18.0%

Zooming in on Chronic Care, for example, the graph below illustrates three of the criteria mentioned in Section 2 of the Roadmap (p. 33) used to select episode-based care arrangements or subpopulations:

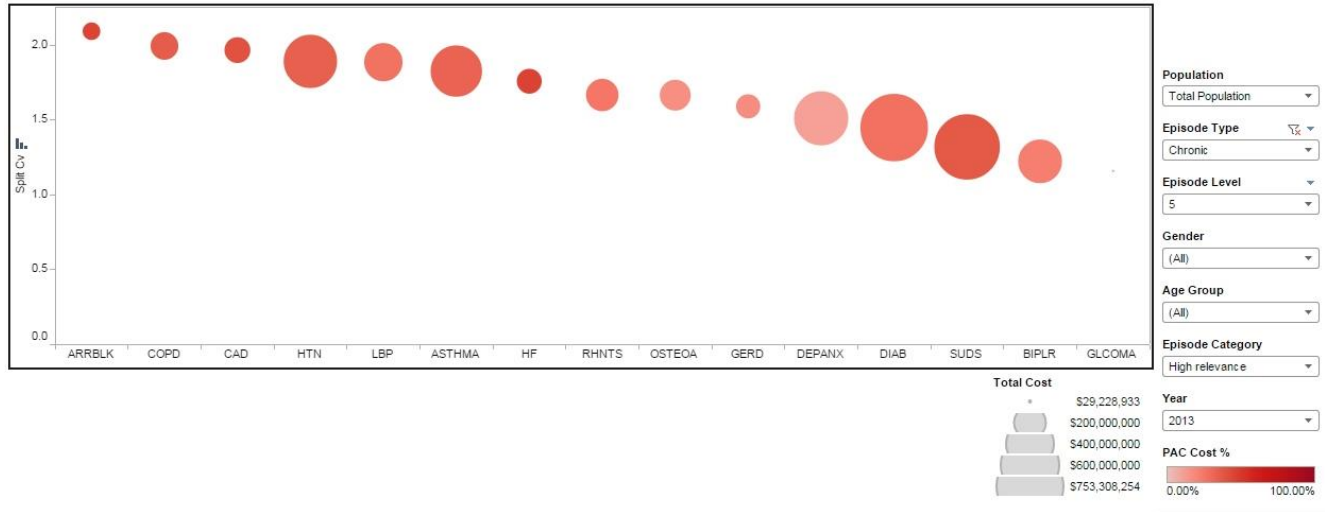
- Proportion of total Medicaid costs (size of the bubble)
- Variability in costs (Y axis)
- Rates of potentially avoidable complications (color of the bubble)

⁸³ Estimates based on extrapolations to future state MCO coverage; total dollars based on 2012-2014 expenditures.



Cost, PACs and Variation

This page is designed to find improvement opportunities. The best episodes to look at are those with a high volume, a high PAC % and with a large variation in PAC costs. Volume is shown by the size of the bubbles, PAC % by color and variation by placement on the y-axis. The largest opportunities for improvement can hence be found by searching for large and dark red bubbles in the left upper corner.



More detailed analyses of improvement potential and baseline situation per subpopulation and selected bundle, as well as progress of performance over time will be included in later updates.

Appendix VI: Contract Risk Review Process

Figure A

The flowchart below illustrates the contract review process:

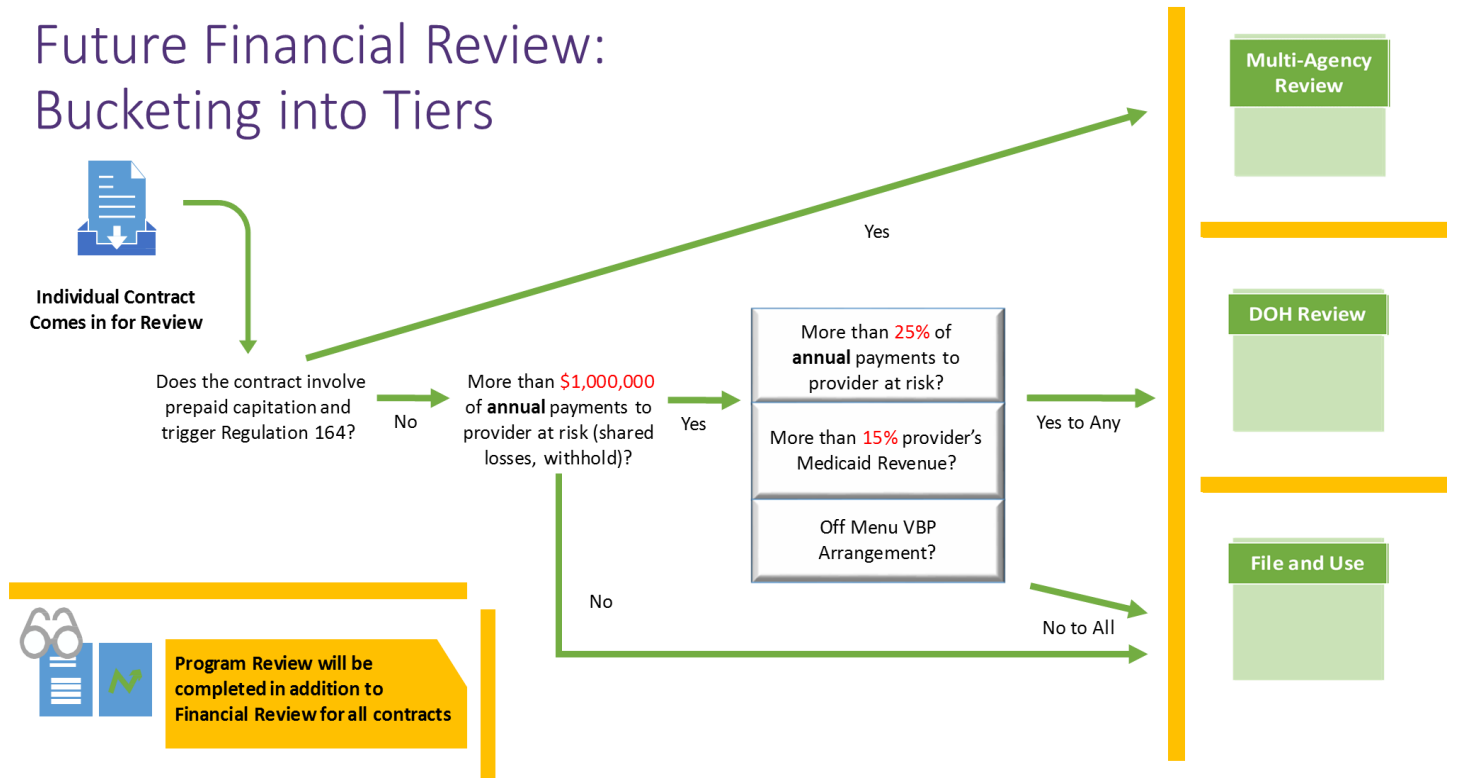


Figure B

- **This \$1,000,000 annual payment threshold is applied to:**

- Only the individual contract that is coming in for review
- Medicaid Managed Care components of the contracts only

- **This 25% payment threshold is applied to:**

- Only the individual contract that is coming in for review
- Medicaid Managed Care components of the contracts only

- The ratio is expressed as:

$$\frac{\text{Annual Medicaid Payments at Risk for this Contract}}{\text{Total Value of All Medicaid Contracts between this MCO and Provider}}$$

- **This 15% revenue threshold is applied to:**

- All MCOs that contract with the provider
- All Medicaid (inclusive of Medicaid Managed Care and Medicaid FFS) contracts

- The ratio is expressed as:

$$\frac{\text{Value of This Contract's Projected Medicaid Revenue}}{\text{Total Projected Annual Medicaid Revenue for Provider}}$$



Appendix VII: Innovator Program

1. Risk arrangements eligible for the Innovator Program

VBP contractors who aim to engage in Level 2 (full risk or near full risk) and Level 3 TCGP and subpopulation arrangements will be eligible to apply for the Innovator Program, provided they pass the tiered contract review process. Level 2 contracts are only be considered eligible if the total risk assumed by the provider (and therefore also the potential savings) is comparable to a Level 3 arrangement level of risk.⁸⁴ It will be possible for a VBP contractor to enroll in the Innovator Program with a slightly lower risk Level 2 contract, as long as the contractor demonstrates that it will be ready to transition to the required Level 3 (or high-risk Level 2) the following year.

2. Review/assessment process for the Innovator Program

The assessment process for entering into the Innovator Program will be aligned with the aforementioned contract review process detailed on page 21. This process focuses on ensuring that VBP contractors can safely take on higher levels of risk, and on the alignment of the VBP arrangements with the Roadmap.

3. Criteria for participating in the Innovator Program

In order for VBP contractors to participate in the Innovator Program, they should meet the following four criteria (at a minimum):

1. Uphold health plan network adequacy requirements based on the appropriate provisions of NYS laws and regulations.
2. Demonstrate proven success in VBP contracting for TCGP and subpopulations, determined during the review process on a case by case basis.
3. To ensure impact as well as reasonable size to be able to assume significant risk⁸⁵, the VBP contractors should have a minimum number of 25,000 Medicaid members (excluding dual eligible members) attributed for a TCGP contract, or 5,000 Medicaid members (excluding dual eligible members) attributed for a total care for a subpopulation contract. For the MLTC subpopulation contract, the minimum number of dually eligible members is recommended to be 5,000. Providers and MCOs should be cognizant of the number of Medicaid members served in the Program – it should be large enough to justify the investments and make substantial positive impact on population health.
4. Be financially solvent and have appropriate net worth as per the DOH analysis.

4. Appeals process

VBP contractors will be unable to appeal their Innovator status. Decisions on acceptance into the Innovator Program will be based on the DOH/DFS review process. The State will monitor whether the need for a comprehensive appeals process becomes necessary in the future.

⁸⁴ To be counted as a Level 2 VBP agreement, the minimum percentage of potential losses to be allocated to the provider score is 20%, with a minimum cap of 3% of the target budget in the first year of the Level 2 contract and 5% from the second year on. To be considered a high risk Level 2 arrangement, the minimum percentage of potential losses to be allocated to the provider is 60%, with a minimum cap of 35% of the target budget.

⁸⁵ With low numbers of attributed lives, chance determines financial outcomes more than actual performance.



5. Innovator Program benefits

The Innovator Program rewards providers with up to 95% of premium pass-through for total risk arrangements as the prime Program benefit. The pass-through percentage will be determined by analyzing the amount of the risk and administrative tasks taken on by the providers: more delegation results in higher percentage of premium (between 90% and 95%).

Delegable functions include the following: utilization review, utilization and care management, drug utilization review, appeals and grievances, quality, claims administration, member/customer service, network management, risk adjustment and reinsurance, disease management, member/provider services, provider relations, credentialing, and data sharing. Additional functions, which are unlikely to be delegated, include member enrollment/advertising, fraud, waste and abuse, legal, and compliance. In addition, some tasks may still require some sign off or have other process limitations from MCOs, while the providers can be responsible for the majority of the actual work. The resulting list of administrative functions that can be fully or partially delegated, as well as those that cannot be delegated, is displayed below.

To be eligible for 90% premium pass-through, functions 1, 2 and 10, listed in the table below for reference, should be fully delegated to the provider, while at least half of the tasks listed as "shared" should be partially delegated. To be eligible for the 95% premium, tasks 1, 2, 6, 10 and 13 should be fully delegated to the provider, while all the other tasks should be delegated to the maximum amount possible. Percentages may be set between 90 and 95% depending on the exact delegation of tasks negotiated.

Optimum			
#	MCO Administrative Functions	MCO	Provider
1	Utilization Review (UR)		●
2	Utilization and Care Management (UM)		●
3	Drug Utilization Reviews (DUR)	●	●
4	Appeals and Grievances	●	●
5	Quality	●	●
6	Claims Administration		●
7	Member/Customer Service	●	●
8	Network Management	●	●
9	Risk Adjustment & Reinsurance	●	●
10	Disease Management		●
11	Provider Services Helpdesk	●	●
12	Provider Relations	●	●
13	Credentialing		●
14	Data Sharing	●	●
15	Member Enrollment/Advertising	●	
16	Fraud, Waste and Abuse	●	
17	Legal	●	
18	Compliance	●	

Legend	
●	Sole Responsibility
●	Shared Responsibility
	Can't be delegated

It is important to note that this Program does not imply any changes to the current NYS law and regulations with respect to any licensing or certification requirements.



6. *Innovators' performance*

Innovator Program will be required to comply with the relevant VBP quality measures, as recommended by the Clinical Advisory Groups and adopted by the State. No specific Innovator Program measures will be created. Innovators will be asked to report on these measures and cannot perform below average in order to maintain their Innovator status⁸⁶. The performance measures of the VBP arrangements that pertain to the Innovator Program will become available as soon as they have been approved by the VBP Workgroup.

7. *Maintenance and contract termination/program exit criteria*

If performance measurements are below average, or if the MCOs are concerned about the financial stability of the VBP contractor or if it faces operational challenges, the MCO may consider contacting the State (after having informed the VBP contractor) to assess whether the Innovator should be placed on probation. In case of probation, a 6 – 12 month timeline to improve performance with no surplus payments to the Innovator will be applied, until the measurements are above average again. In a Level 3 arrangement, the VBP contractor will share in any costs or penalties imposed on the health plan, if the contractor's failure to meet quality standards negatively affects the health plan's quality scores. If a provider operates at a loss so that the costs exceed the percent of premium paid by a health plan, the provider will not have any recourse against the health plan or any of its members.

Should Innovators need to exit the program (for reasons surrounding mergers and acquisitions, or failure to improve, other reasons), it is recommended that a transition period be included in the contract. This will be a set period of time during which the provider and respective MCO ensure a smooth transition out of the Innovator Program.

⁸⁶ Additional guidance will be provided on measure calculation and reporting.



Appendix VIII: Definitions of Level 1, 2 and 3 VBP Arrangements

Level 1: FFS with Retrospective Reconciliation - Upside Only

A Level 1 VBP arrangement continues the existing FFS payment⁸⁷ methodology from MCO to providers, but allows the VBP contractor to receive shared savings based on a ‘target budget’ set for the VBP arrangement. When the total spend on the services included in the VBP arrangement remain below the target budget, these savings are shared between MCO and VBP contractor. To be counted as a Level 1 VBP agreement, the minimum percentage of potential savings to be allocated to the VBP contractor is 40%.

Level 2: FFS with Retrospective Reconciliation – Up- and Downside

A Level 2 VBP arrangement also continues the existing (usually FFS) payment methodology from MCO to providers, but allows the VBP contractor to receive more shared savings than in a Level 1 arrangement, because the VBP contractor also shares in potential losses. To be counted as a Level 2 VBP agreement, the minimum percentage of potential losses to be allocated to the provider is 20%, with a minimum cap of 3% of the target budget in the first year of the Level 2 contract and 5% from the second year on.^{88,89}

Below these levels, the VBP arrangement is counted as a Level 1 arrangement.

Level 3: Prospective Payments (PMPM or Bundled Payments)

Level 3 arrangements are fully capitated PMPM arrangements or prospectively paid bundles. The presence of risk-mitigation strategies (stop-loss, risk-corridors etc.) does not affect the Level 3 classification.

The difference between Level 2 and Level 3 is the way the payment is effectuated: continuation of current payment mechanisms (with or without additional payments for e.g. coordination activities that do not currently have an existing billing code) versus prepaid payment arrangements. In terms of assuming risk by the VBP contractor, a Level 2 arrangement can be equal to a Level 3 arrangement.

⁸⁷ For purposes of the NYS VBP program, the existing payment mechanisms referenced here include Diagnosis Related Groups and Enhanced Ambulatory Patient Groups.

⁸⁸ For Level 2, certain situations may warrant a lower cap, as in the case of an Integrated Primary Care arrangement where the VBP contractor may be PCPs or FQHCs or other providers with an operating budget that may be significantly smaller than the total downstream costs they are held to account for. In those cases, the cap set should be proportional to the overall budget of the PCP / FQHC. Minimally, for PCPs or FQHCs engaged in Level 2 IPC or Chronic Care arrangements that have received shared savings in year t should be able to lose the same amount of dollars in year t+1.

⁸⁹ VBP contractors may re-insure against potential losses, which will not affect the categorization as Level 2 as long as the costs for that re-insurance are born by the VBP contractor. (I.e. if the MCO pays for the re-insurance, that will be interpreted as reducing the risk born by the VBP contractor and may thus prevent the VBP arrangements to be classified as Level 2.)