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VBP Roadmap: Year 2 Update Draft

OVERVIEW

New York State has released an updated draft of the Delivery System Reform Incentive Payment (DSRIP) Value Based Payment (VBP) Roadmap (available here). The document outlines the State's plan to make 80% of managed care Medicaid payments through VBP arrangements by the end of the DSRIP waiver period in 2020. The updated draft has been revised with more detailed information based on the recommendations of the five VBP Subcommittees and the VBP Clinical Advisory Groups (CAGs) during DSRIP Year 1. It also includes new appendices that outline specifics of VBP arrangements, such as criteria for shared savings and a process for contract risk review.

Below is a summary of some major updates in the document. The State has also released a guide to all updates and changes, which can be found here. Comments on the draft will be accepted through April 18th at dsrip@health.ny.gov.

VBP CONTRACTING

The Roadmap has been updated to clarify that DSRIP Performing Provider Systems (PPSs) are not legal entities with contracting authority. In order for a PPS to contract into a VBP arrangement directly, it must first form an accountable care organization (ACO) or an independent practice association (IPA).

Contract Risk Review

The State will create a new Contract Risk Review process to ensure that appropriate safeguards are in place when providers and payers enter into VBP contracts. The five existing tiers of review will be collapsed into three tiers. These roughly correspond to the State-defined levels of VBP arrangements (see below):

- Tier 3 (Multi-Agency Review): primarily for Level 3 VBP arrangements and/or contracts with significant prepaid capitation payments (more than $250,000 annually).
  - DFS will conduct a financial review, while DOH will conduct a programmatic review.
- Tier 2 (DOH Review): for Level 2 and some Level 3 VBP arrangements or other contracts with less than $250,000 in prepaid capitation payments but more than $1 million in payments at risk.
  - DOH will conduct a financial and programmatic review.
- Tier 1 (File and Use): for Level 1 arrangements and all other contracts that do not fall into higher tiers.
  - DOH will conduct a programmatic review only.

MCO Model Contract Amendments

The State will be amending the 2017 Model Contract to implement performance-based adjustments in the rate-setting process. These adjustments will be applied to all MCO members eligible for a given VBP arrangement. The State will also implement a stimulus adjustment to reward MCOs that make more payments through VBP arrangements.

Starting in 2018, the State will begin to penalize MCOs that do not meet goals for VBP contracting. The penalty will be between 0.5% and 1.5% of the difference between the goals and the amount of actual

MCO expenditures on VBP contracts. In general, the amount of the penalty increases in later years and depends on whether the MCO is a partially or fully capitated plan.

If MCOs incur these penalties because providers are unwilling to engage in VBP arrangements, MCOs may be able to pass the penalties on to providers.

VBP Innovator Program

Appendix IX outlines more details of the VBP Innovator Program, which allows advanced providers to take on full or nearly-full risk through a Total Care model (either for a general population or a subpopulation). This would require a minimum attribution of 25,000 members in a TCGP contract, or 5,000 members for a subpopulation. Providers would be paid between 90% and 95% of the total premium.

CHANGES TO VBP MENU OPTIONS

VBP Subcommittees and CAGs have been creating standardized definitions and guidelines for the four main VBP arrangements that are published in the roadmap. These include:

- Which services are included and excluded from each VBP model;
- Which members are eligible for attribution to each model;
- What quality and outcome measures will be used for each model; and
- Methods to calculate risk-adjusted cost of care for each model and for State benchmarks.

Total Care for the General Population (TCGP) and Integrated Primary Care (IPC)

The State has updated the definition of the TCGP and IPC models to emphasize that they both focus on mainstream Medicaid managed care (MMC) and exclude special needs subpopulations. By default, IPC contracts will include providing the Chronic Bundle (see below). It has also proposed rules for distribution of shared savings to "downstream" hospitals (see below).

Bundles of Care

The State has prioritized two specific care bundles to be implemented: maternity care and care for chronic conditions. The Maternity Care bundle will cover pregnancy, delivery, and the first month of care for the infant. The bundle includes the provision of all maternity services included in the MMC benefit. It would exclude special needs subpopulations and infants who require admission to a NICU. The Chronic Care bundle covers all MMC services related to a set of 14 highly-prevalent chronic conditions. Because patients often have multiple comorbid conditions, VBP contractors will contract for the whole set of conditions.

Total Care for Special Needs Subpopulations

The State has identified the following subpopulations with dedicated managed care arrangements that will be eligible for this type of VBP arrangement:

- Individuals with HIV/AIDS;
- HARP-eligible individuals;
- Individuals enrolled in managed long-term care (MLTC); and
- Individuals with intellectual and/or developmental disabilities (I/DD).

VBP contractors would contract to provide all services covered by the associated special needs MCO.

Off-Menu Options

Off-menu options should not be simply variations of the "on-menu" VBP arrangements, and they may not include carve-outs of services within bundles or subpopulations. For example, off-menu models that focus on primary care must include behavioral health services, unless the arrangement is part of an established commercial model or existing projects such as Medicare bundles. Off-menu options should focus on conditions or subpopulations not prioritized in the VBP Roadmap.

LEVELS OF VBP ARRANGEMENTS

The State has added the following specifications for the various levels of VBP arrangements:

- Level 1 upside-only risk arrangements must allocate at least 40% of potential savings to a VBP contractor that meets a sufficient number of quality score benchmarks.
- Level 2 upside-and-downside risk arrangements must allocate at least 20% of potential losses to a VBP contractor that does not meet a sufficient number of quality score benchmarks. A risk corridor may be implemented, but is limited to a 3% cap in the first year and a 5% cap in subsequent years. Below these levels, the model is a Level 1 arrangement.
- Level 3 arrangements are either fully capitated per member per month (PMPM) payments or prospectively paid bundles. There are no limits on risk corridors or stop-losses.

SHARED SAVINGS

While the State's recommended shared savings percentages based on provider performance are largely unchanged from the previous Roadmap, the new draft emphasizes that providers and plans are free to establish their own percentages in their contracts. The State has proposed the following guidelines:

- Funds should be distributed based on provider performance and utilization patterns;
- Distributions may take into account required provider investments and losses;
- The default distribution should not be made solely based on the relative budgets of providers;
- Shared savings and shared losses should be distributed on the same principles; and
- When contracts protect certain providers from shared losses due to special circumstances (e.g., financial vulnerability), this protection may be taken into account in determining shared savings.

Under the TCGP and IPC model, savings are primarily based on reductions of downstream costs (e.g., avoided hospitalizations). Appendix III outlines the State's suggested criteria for the distribution of shared savings between professional-led TCGP/IPC contractors and downstream hospitals that will face reduced utilization under these models, and offers the State's mediation should a professional-led VBP contractor and downstream hospital be unable to resolve disagreements.

ATTRIBUTION AND BUDGETING

The State has established guidelines concerning how to attribute members to VBP arrangements and how to establish target budgets for the cost of care (pp. 24-30). Providers and plans may choose different methodologies, but the State intends to base its analyses of costs and outcomes on these guidelines.

In most arrangements, individuals will be attributed based on their MCO-assigned primary care physician (PCP). For specific care bundles like the Maternity Care bundle, individuals would be

assigned instead based on the provider of "core" services (e.g., the OB/GYN in the Maternity Care bundle). Certain subpopulations may also have their own attribution process:

- For the HARP population, attribution will be based on the MCO-assigned Health Home.
- For the MLTC population, attribution will be based on the home care provider or nursing home.

The State's guidelines for establishing a target budget are set based on the following adjustments from the VBP provider's historical baseline costs:

1) Regional and provider-specific growth adjustments;
2) Risk adjustment to account for population differences;
3) Performance adjustments to account for the existing quality of care; and
4) Stimulus adjustments to incentivize providers to move to higher levels of VBP contracts.

In the first half of 2016, the State plans to make cost data available to providers and payers through the Medicaid Analytics Performance Portal (MAPP). This will include the total risk-adjusted cost of care per PPS and MCO for the total population and the specific subpopulations and services included in the VBP menu.

EXCLUSIONS

The State intends to categorically exclude only the following services from VBP calculations and arrangements:

- Services provided by financially challenged providers; and
- Services to non-attributed members (i.e., emergency services).

Providers and plans forming a VBP contract also have the option to exclude the following:

- High-cost specialty drugs; and
- Transplant services.

The State also intends to count fee-for-service (FFS) payments for certain preventive services, such as immunizations or long-acting reversible contraceptives, as VBP payments. Generally, these would be services with effects that are either too long-term or broad to be adequately represented in VBP calculations.

REGULATIONS AND LAWS

The VBP Subcommittees have recommended the following regulatory or legal changes:

- Changing New York's laws on self-referrals and anti-kickback statutes to fully align with federal standards (currently, State law is more restrictive in both cases);
- Changing various State laws related to professional service entities and the corporate practice of medicine to make it possible for certain types of providers to collaborate;
- Creating a voluntary program to allow physicians to refer certain patients with chronic conditions to pharmacists for Comprehensive Medication Management (CMM);
- Considering possible changes to New York's privacy laws to facilitate VBP arrangements; and
- Reviewing the Medicaid Program Integrity strategy and other regulations that have been designed for a FFS system and not a value-based system.

TIMELINE AND NEXT STEPS

In the coming year, the State plans to launch an estimated 15 pilots among the various VBP menu options, including TCGP, IPC, Maternity Care, the HIV/AIDS subpopulation, and the HARP subpopulation. An MLTC pilot will not likely start before 2017, and an I/DD pilot will not start until the I/DD population has been moved into managed care.

Finally, some of the VBP Roadmap goals and milestones have been revised:

- By the end of DSRIP Year 3 (April 2018), at least 10% of total Medicaid MCO payments should be in Level 1 VBP arrangements or above. This replaces the requirement that each MCO should have a VBP arrangement in place.
- By the end of DSRIP Year 4 (April 2019), at least 15% of total Medicaid MCO payments should be in Level 2 VBP arrangements or above. This requirement is the same as in the previous roadmap, but now explicitly includes only fully-capitated plans.
- By the end of DSRIP Year 5 (April 2020), at least 35% of total Medicaid MCO payments should be in Level 2 VBP arrangements or above, as in previous versions, for fully-capitated plans. However, for partial capitation plans, the requirement has been reduced to 15%.