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New York State Value-Based Payment Roadmap

OVERVIEW

New York's Value-Based Payment (VBP) Roadmap is a five-year plan running through April 2020 describing how the state's Medicaid managed care organizations (MCOs) and providers will move away from fee-for-service (FFS) payments and towards the statewide use of VBP methodologies. As a requirement under the Delivery System Reform Incentive Payment (DSRIP) program, the Roadmap outlines how the State plans to use VBP payment models to sustain and build upon improvements to the health care system made through DSRIP. It specifies:

- Types of permissible VBP arrangements;
- Guidelines for levels of risk, shared savings, attribution, budgeting, and partnerships;
- The State's review process for VBP contracts;
- Incentives and pilot programs for organizations taking part in VBP contracts; and
- A timeline for implementing VBP Roadmap goals.

Currently, the State estimates that the total amount of Medicaid payments for services planned to be covered through VBP arrangements is $32.2 billion, or 82% of total MCO payments. This includes four major subpopulations (MLTC, developmental disabilities, HARP, and HIV/AIDS) as well as primary care, chronic care bundles, maternity bundles, and specialty chronic care.

The Roadmap will be updated annually over the course of DSRIP and submitted to the Centers for Medicare & Medicaid Service (CMS) for approval. The current version, which was approved by CMS in July 2018, is available here.

TYPES OF VALUE-BASED PAYMENTS

The State envisions that MCOs and providers will negotiate with each other to develop VBP arrangements. Providers that enter into VBP arrangements with MCOs are referred to as VBP contractors. Eligible VBP contractors include individual providers, groups of providers, Accountable Care Organizations (ACOs), and Independent Practice Associations (IPAs). To contract at the Performing Provider System (PPS) level, a PPS must first form an ACO or an IPA. Although the State will allow significant flexibility in contracting options, it also intends to encourage the use of similar rules and conditions where possible, to reduce administrative burdens.

The State has proposed several possible models for value-based payments:

- Total Care for the General Population (TCGP)
  - Under this model, the MCO contracts with a VBP contractor to provide a global per member per month (PMPM) capitation for a mainstream Medicaid managed care (MMC) population. The TCGP model does not include special needs subpopulations. The payment will be adjusted depending on outcomes and performance metrics, similar to the ACO model.
- Integrated Primary Care (IPC)
  - Under this model, the MCO contracts with a VBP contractor to fund patient-centered medical home (PCMH) or Advanced Primary Care (APC) models of care. Services

covered will include MMC-covered preventive care, routine sick care, and treatment for 14 of the most prevalent chronic conditions (the "Chronic Condition component"). The IPC model does not include special needs subpopulations. Reimbursement would be based on cost savings that are attributable to primary care (e.g., avoidable hospital admissions related to diabetes and asthma) as well as quality outcomes.

- Maternity Care Arrangement
    - Under this model, the MCO contracts with the VBP contractor to provide a single episode-based payment for all care related to a delivery. The Maternity Care Arrangement includes all services and costs provided to a mother during the entire prenatal care period (270 days prior to delivery), delivery stay, and post-discharge period (60 days post-discharge) and to her newborn during the delivery stay and post-discharge period (up to 30 days post-discharge). To reduce excessive insurance risk for providers, these VBP arrangements will include a stop-loss that exclude episodes costing more than a threshold (to be determined).
- Total Care for Special Needs Subpopulations
    - Under this model, the MCO contracts with the VBP contractor to provide a total PMPM payment for one of the following special needs subpopulations:
        - 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).

For the IPC and maternity care models, where relevant, providers are encouraged by the State to partner with hospitals to make care management more effective (e.g., so that PCPs are notified of admissions and involved in care transitions). Accrued savings can then be evenly shared with actively cooperating hospital partners.

Program of All-Inclusive Care for the Elderly (PACE) programs may be considered to be fully-capitated (i.e., Level 3) Subpopulation models, if all other VBP requirements (as described below) are met.

As appropriate, MCOs and providers will be able to combine these options.

Off-Menu Options

MCOs and providers may also jointly develop "off-menu" payment models, as long as they meet the federal definition of alternative payment models (APMs) as well as the following standards:

- Models must be patient-centric rather than provider-centric. This will require collaboration among multiple types of providers.
- Models must focus on both outcomes and cost of care. This will involve shared savings and/or losses.
- Models must sustain cost and outcome transparency and allow comparison across different providers/MCOs. This requires the use of a minimum set of standardized benchmarks.
- Models should not be simply variations of the above "on-menu" VBP arrangements; however, carve-outs of certain services from the standard options may be acceptable under certain conditions. For example, providers may carve out a specific chronic condition from an Integrated Primary Care model in order to implement the contract more quickly.
- Models should focus on conditions or subpopulations not prioritized in the VBP Roadmap.

Within the contract review process, off-menu arrangements not previously approved by the Department of Health (DOH) will be subject to Level 2 review. Otherwise, off-menu models will not require separate DOH approval, but will require attestation from the parties and will be subject to audits.

GUIDELINES FOR VBP ARRANGEMENTS

Levels of Risk

Under each type of VBP arrangement, MCOs and providers will be able to choose between different levels of risk to the provider, as follows:

- Level 0 arrangements may involve outcome-based quality incentives, but do not give providers responsibility for the provision of integrated care. They do not qualify as VBP arrangements.
- Level 1 arrangements involve upside-only shared savings, which would be available to providers who meet a certain percentage of their outcome metrics.
    - To qualify as a Level 1 arrangement, at least 40% of shared savings must accrue to a VBP contractor that meets quality benchmarks.
- Level 2 arrangements involve shared savings with both upside and downside. As in Level 1, providers that meet enough of their contracted quality outcome metrics would be eligible for upside shared savings. If there are downside shared losses, providers who meet a significant proportion of their outcome metrics would be shielded from a portion of the risk (e.g., providers meeting more than 50% of their targets might only be responsible for 50% of the shared losses).
    - To qualify as a Level 2 arrangement, at least 20% of any shared losses must be allocated to a VBP contractor that does <u>not</u> meet sufficient quality benchmarks. A risk corridor may be implemented, but it may be no narrower than 3% in the first contract year and 5% in subsequent years. These levels may be flexible for providers with special circumstances (e.g., IPC arrangements for primary care clinics whose budgets are much smaller than total downstream costs included in the arrangement).
- Level 3 arrangements use prospective bundled or capitated payments. Arrangements should involve a quality component, as determined in negotiations between plans and providers. Retrospective reconciliation may or may not be necessary, based on the structure of the quality component. These arrangements require VBP contractors to have significant experience.

Shared Savings

Providers and plans are free to establish their own shared savings 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 models, savings are primarily based on reductions of downstream costs (e.g., avoided hospitalizations). Appendix III of the Roadmap 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, with State mediation offered in case of disagreements.

The following table provides an overview of the different types of VBP arrangements.

Options	Level 0 VBP (Non-Value-Based)	Level 1 VBP (No Downside Risk)	Level 2 VBP (Two-Way Risk)	Level 3 VBP (Capitation)
Total Care for the General Population	FFS with bonus and/or withhold based on quality scores	FFS with upside-only quality-based shared savings If quality scores met, at least 40% savings to provider (50% suggested)	FFS with quality-based risk sharing If quality scores met, up to 90% of savings and no more than 50% of losses to provider If quality scores not met, at least 20% of losses to provider, up to at least 5% of total VBP budget (3% in first year)	Global capitation (with quality-based component)
Integrated Primary Care Arrangement	FFS plus PMPM add-on, with bonus and/or withhold based on quality scores	FFS plus PMPM add-on, with quality-based upside-only shared savings based on bundle of care If quality scores met, at least 40% of savings to provider (50% suggested)	FFS plus PMPM add-on, with quality-based risk sharing based on bundle of care If quality scores met, up to 90% of savings and no more than 50% of losses to provider If quality scores not met, at least 20% of losses to provider, up to at least 5% of total VBP budget (3% in first year), unless VBP budget is significantly greater than provider's budget (in which case, proportional to provider's budget)	PMPM capitated payment for primary care and chronic component services (with quality-based component)
Maternity Care Arrangement	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care, available when quality scores are sufficient If quality scores met, at least 40% of savings to provider (50% suggested)	FFS with risk sharing based on bundle of care If quality scores met, up to 90% of savings and no more than 50% of losses to provider If quality scores not met, at least 20% of losses to provider, up to at least 5% of total VBP budget (3% in first year)	Prospective bundled payment (with quality-based component)
Total Care for Special Needs Subpopulations	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings, available when quality scores are sufficient If quality scores met, at least 40% of savings to provider (50% suggested)	FFS with quality-based risk sharing If quality scores met, up to 90% of savings and no more than 50% of losses to provider If quality scores not met, at least 20% of losses to provider, up to at least 5% of total VBP budget (3% in first year)	Global capitation (with quality-based component)

Attribution and Budgeting

Providers and plans may choose the methodology they will use to attribute members to VBP arrangements and to establish target budgets for the cost of care. However, the State has established guidelines on these processes and intends to base its analyses of costs and outcomes on them.

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.

Target budgets may be based on the provider's historical baseline costs, with the following adjustments:

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

Performance Adjustments

The exact amount of the performance adjustments may be determined by the contractor and plan, and state guidelines are also subject to change based on experience and budget availability. The Roadmap suggestion is to increase or decrease providers' target budgets by a percentage, based on their relative performance on efficiency and quality metrics, as follows:

	90th Percentile Quality or Above	80th-90th Percentile Quality	50th-80th Percentile Quality	40th-50th Percentile Quality
90th Percentile Efficiency or Above	+6%	+4.5%	+3%	+1.5%
80th-90th Percentile Efficiency	+4%	+3%	+2%	+1%
70th-80th Percentile Efficiency	+2%	+1.5%	+1%	+0.5%

Negative adjustments might also be made, as follows:

	80th Percentile Quality or Above	30th-80th Percentile Quality	15th-30th Percentile Quality	Below 15th Percentile Quality
20th-30th Percentile Efficiency	-0.5%	-1%	-1.5%	-2%
10th-20th Percentile Efficiency	-1%	-2%	-3%	-4%
Below 10th Percentile Efficiency	-1.5%	-3%	-4.5%	-6%

The amount of the positive and negative adjustments may ramp up over the course of the program. A minimum performance on both efficiency and quality may be required to be eligible for any performance bonus (e.g., contractors may earn no bonus if their quality is below the 40th percentile).

Efficiency will be measured by comparing actual costs to the expected risk-adjusted cost of care per member or episode, for each given VBP arrangement, using proxy-priced data (to adjust for negotiated costs). Quality will be measured by performance on State-approved metrics (see below).

Stimulus Adjustments

Providers may receive a stimulus adjustment for up to two years, through 2020, when they begin to enter a higher-level VBP arrangement (i.e., Level 2 from Level 1, or Level 3 from Level 2). The adjustment will be passed through by MCOs and is expected to represent an increase of 0.5% for Total Care arrangements (general population or subpopulation) and 1% for IPC or Maternity Care. The State may adjust these percentages to maintain the Medicaid Global Cap and for other reasons.

Cost Data

To facilitate budgeting, the State has made cost data available to providers and payers through the Medicaid Analytics Performance Portal (MAPP). This includes 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. Providers also will have access through MAPP to additional data and analytics on quality measures, identification of underperforming areas, and drivers of performance.

Quality Metrics

The State has convened VBP Clinical Advisory Groups (CAGs) for various possible VBP arrangements (e.g., behavioral health, maternity, etc.) to develop the sets of quality measures that will be used to calculate VBP contractors' quality scores. Each VBP contract must specifically list at least one pay-for-performance quality measure that the relevant CAG has sorted into Category 1 (i.e., clinically relevant, reliable, valid, and feasible) which will be used to help determine the amount of shared savings or losses. Based on negotiations, VBP contracts may also incorporate other measures. The State will make performance outcomes on these measures transparent to stakeholders.

Excluded Providers and Services

The following services are categorically excluded by the State 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;
- Transplant services;
- Dental services; and
- Vision services.

The State will also treat fee-for-service (FFS) payments for certain preventive services as VBP arrangements. The services in this category are considered to have long-term benefits that may not be effectively incentivized by shorter-term VBP arrangements. The services in this category include:

- Routine preventive services as defined in the Affordable Care Act that are covered by Medicaid, such as vaccines, certain types of physical and behavioral screenings, dietary or tobacco counseling services, and well visits;
- Certain other effective interventions for specific at-risk populations, such as long-acting reversible contraception (LARC), BRCA genetic testing for at-risk women, and PrEP for individuals at risk for HIV/AIDS.

Required Partnerships

Social Determinants of Health

Level 2 and Level 3 VBP contracts will be required to implement at least one intervention to improve social determinants of health (SDH). The chosen intervention should align with one of the five key SDH areas outlined in the State's SDH Intervention Menu and SDH Recommendation Report: 1) economic stability, 2) education, 3) health and healthcare, 4) neighborhood and environment, or 5) social, family, and community context.

The State intends to modify the Model Contract to provide incentives for VBP contractors to address SDH. Level 1 contractors will be eligible for a bonus if they implement an SDH intervention, while Level 2 and 3 contractors will receive a funding advance to implement their required intervention.

Community-Based Organizations

Level 2 and Level 3 VBP contracts will be required to include a partnership with at least one Tier 1 community-based organization (CBO), defined as a non-profit, non-Medicaid-billing community-based social and/or human services organization. Some rural exceptions may be made to this requirement. The State has made suggestions for CBO contracting as part of other VBP guidance (available here).

STATE REVIEW PROCESS FOR VBP CONTRACTS

Contract Risk Review

The State will use the reformed contract risk review process to ensure that appropriate safeguards are in place when providers and payers enter VBP contracts. The three tiers of reviews roughly correspond to the levels of VBP arrangements discussed above:

- Tier 1 (File and Use): DOH will conduct a programmatic review only. This level of review will be used for Level 1 arrangements and all other contracts that do not fall into higher tiers.
- Tier 2 (DOH Review): DOH will conduct a financial and programmatic review. This tier will be used for most Level 2 and some Level 3 VBP arrangements, and any contracts with less than $250,000 in prepaid capitation but more than $1 million in total payments at risk if one of the following conditions are met:
    - 25% or more of the provider's annual Medicaid managed care or MLTC payments are at risk;
    - 15% or more of the provider's annual Medicaid revenue is at risk; **or**
    - The contract contains an off-menu VBP arrangement not previously approved by DOH.

- Tier 3 (Multi-Agency Review): The Department of Financial Services (DFS) will conduct a financial review, and DOH will conduct a programmatic review and potentially a financial review. This tier will be used primarily for Level 3 VBP arrangements and/or contracts with significant prepaid capitation payments (more than $250,000 annually).

INCENTIVES AND PILOT PROGRAMS

Rate Adjustments

The State will implement several rate adjustments to encourage participation in VBP arrangements:

- Starting in SFY 2020, the State will implement a performance adjustment for MCOs, partly aligned with the provider performance adjustment described above. Plans will be sorted into five tiers, based on their quality and efficiency performance, and will receive a corresponding adjustment. SFY 2020 rates will be adjusted by up to +1% and -0.5% each for quality and efficiency (+2%/-1% total), based on CY 2017 performance. These amounts will ramp up to ±2% each in SFY 2021, and ±3% each by SFY 2022. For plans that have a negative quality adjustment but show improvement, some amount of the penalty may be mitigated. The quality adjustment will initially be aligned with the existing MMC Quality Improvement (QI) program.
- Starting in SFY 2017, the State is implementing a stimulus adjustment to reward MCOs that make more payments through higher-level VBP arrangements. A total of $85 million per year will be allocated for four years. During SFY 2017 and 2018, the funds will be a down payment to MCOs, based on size and existing participation in Level 2 or higher arrangements. During SFY 2019 and 2020, about 85% to 90% is expected to be passed through to providers as the provider stimulus adjustment, as described above.
- 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%[1] 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. Through the end of the waiver period (April 2020), only the larger of the two penalties would be applied, but afterwards, if both penalties were incurred, both would be applied. 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

The VBP Innovator program allows advanced providers to take on full or nearly-full risk in Level 2 or Level 3 VBP arrangements through a Total Care model (either general population or subpopulation).

Innovator applicants must meet the following criteria:

- Applicants must be currently or committed to participating in a high or full risk Level 2 or Level 3 TCGP or Subpopulation arrangements.
    - A “high risk” Level 2 VBP arrangement must include at least 60% of potential losses shared with the provider, with a cap on losses no smaller than 35% of the budget.

[1] Up to 1.5% in the approved Roadmap, but only 1% (subject to increase if statewide progress is insufficient) in other guidance.

    - Applicants without current experience must submit a written plan to DOH detailing how they intend to create such an arrangement. An applicant can only become an Innovator once a qualifying risk level is reached.
- The applicant should have past experience in contracting for TCGP or Subpopulation arrangements (with Medicare or commercial payers).
    - Adequate experience is defined as:
        - Either at least two years of experience in a Level 2/3 VBP arrangement, **or** at least three years of experience in a Level 1 VBP arrangement; **and**
        - Positive financial/quality outcomes in prior VBP arrangements.
    - For applicants who are new organizations, such as newly formed independent practice associations (IPAs), at most 20% of expected member attribution may come from providers without sufficient independent VBP experience. If more than 10% of attribution comes from such providers, the applicant must explain how they will mitigate this potential risk source.
- The applicant must have sufficient attributed Medicaid members (total, across all plans):
    - At least 25,000 non-dual Medicaid members for a TCGP contract;
    - At least 5,000 non-dual Medicaid members for HIV/AIDS and Health and Recovery Plans (HARP) Subpopulation contracts; or
    - At least 5,000 non-dual or dual Medicaid members for Managed Long-Term Care (MLTC) Subpopulation contracts.
- The applicant must commit to ensuring that their arrangements will not cause plans to be unable to meet network adequacy standards (i.e., by limiting patient choice); and
- The applicant must demonstrate financial solvency, by submitting current and historical financial statements and a plan for how the Innovator would remain viable if it were subject to the maximum possible loss under the proposed contract.

Providers will be paid between 90% and 95% of the total premium for individuals attributed to them. The percentage received by each Innovator will be determined based on individual negotiations and the number and scope of management functions delegated to the lead contracting entity.

Applicants must also meet all standard requirements that apply to Level 2 and Level 3 VBP contractors.

Other Incentives

The State commits to not holding MCOs accountable if providers experience financial difficulties due to their underperformance, through no fault of the MCOs, on Level 2 or Level 3 VBP arrangements.

MCOs and providers should consider introducing positive incentives for their enrollees/patients, such as wellness or lifestyle incentives. The State plans to make financial incentives available to support such initiatives.

GOALS AND TIMELINE

The State has set the following goals for the implementation of VBPs after the five-year DSRIP period:

- 80-90% of all statewide MCO provider payments to be made through Level 1 VBPs by 2020;
- 50-70% of total statewide value-based payments should be made through Level 2 VBPs by 2020. This goal may change as overall trends develop, but the State has set a hard minimum of at least 35% of all MCO payments for full-capitation plans (i.e., excluding MLTC) in Level 2 VBPs.

The planned timeline to reach these goals, along with other milestones, is as follows:

Year	Milestones
DY 2 (FY 2017)	• Each MCO-VBP Contractor combination submits a growth plan outlining its path towards 90% value-based payments. MCOs with more ambitious growth plans will receive rate bonuses in future years. • The State makes data on total risk-adjusted cost of care per VBP Contractor available. • The State finishes modifications to MCO contracts enabling VBPs.
DY 3 (FY 2018)	• At least 10% of statewide MCO payments made through Level 1 VBP models. • The State pilots a dedicated VBP for community-based organizations (CBOs) to focus on public health and Prevention Agenda targets.
DY 4 (FY 2019)	• At least 50% of statewide MCO payments made through Level 1 VBP models or above. • At least 30% of VBP costs (i.e., 15% of statewide MCO payments) made through Level 2 VBP models (fully capitated plans only). • Quality pool incentives for non-VBP rates from MCOs to providers are no longer allowed without State approval.
DY 5 (FY 2020)	• At least 80-90% of statewide MCO payments made through Level 1 VBP models. • For fully-capitated plans, at least 35% of total Medicaid MCO payments should be in Level 2 VBP arrangements. • At least 35% of total payments must be contracted through Level 2 VBPs or higher for fully capitated plans (at least 15% for partially capitated plans).