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NYS Value-Based Payment Roadmap: Year 5 Submitted Updates

OVERVIEW

New York State has released the final proposed revisions to the Value-Based Payment (VBP) Roadmap for Year 5 of the Delivery System Reform Incentive Payment (DSRIP) program. The Roadmap outlines the State's plan to make 80% of Medicaid managed care payments through VBP arrangements by the end of the DSRIP waiver period in 2020. The State released the first draft of the Roadmap for public comment in June 2019, and requested comments on changes related to the following topic areas:

- Children's VBP Arrangement
- Managed Long Term Care (MLTC)
- Network Integration
- Federally Qualified Health Centers (FQHCs)
- Quality Measures
- Social Determinants of Health (SDH)

Following the receipt and review of public comments, the State made further minor changes to the Roadmap before submitting to the Centers for Medicare and Medicaid Services (CMS) for approval. These changes are shown redlined in this document

The final redlined version of the VBP Roadmap with proposed updates that was submitted to CMS is available here. Below is an overview of the proposed changes. Comments or questions may be submitted to vbp@health.ny.gov.

CHILDREN'S VBP ARRANGEMENT

The proposed updated Roadmap does not contain the finalized Children's Subpopulation Arrangement that the current Roadmap stated would be included in the next iteration of the Roadmap. Instead, the proposal implies that current measures are inadequate to support a sound population-based VBP arrangement for children, and sets the following goals for 2019 to support eventual children's VBP:

- Aligning new and existing measures across VBP arrangements, so that all relevant providers are held to the same standards;
- Promoting high-quality maternity care (before, during, and after delivery) to improve child outcomes;
- Encouraging the use of quality measurement to improve clinical practice and reduce health disparities; and
- Continuing the State's mission to adopt more outcome-oriented quality measures that support cross-sector goals, both short-term and long-term.

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The proposed update also describes other work in children's services, including the State's current plan to explore establishing one or more VBP pilots of a children's VBP arrangement. These pilots would build on the work of the Children's Clinical Advisory Group (CAG) Subcommittee and insights gathered through the First 1,000 Days Initiative.

MANAGED LONG-TERM CARE (MLTC)

MLTC Partially Capitated VBP Levels

The State proposes to define VBP Levels 1 and 2 for MLTC partially capitated plans as follows:

- **Level 1:** A contract between a partially-capitated MLTC plan and a provider that includes a performance-based quality bonus. The bonus should be based on meeting performance targets for a set of specific quality measures agreed to in a VBP contract between the two. This agreement must at minimum include the Potentially Avoidable Hospitalization (PAH) measure.
- **Level 2:** A contract between a partially-capitated MLTC plan and a provider that includes shared upside and downside risk for the provider of at least 1% of total annual expenditures, based on achieving quality performance metrics. Such arrangements will still use the PAH measure as the primary quality metric, but should also include at least one other quality measure recommended by the MLTC CAG.

In both cases, financial incentives would pass from the State to the plan and from the plan to providers. The Roadmap requires all Level 2 and Level 3 arrangements to include at least one intervention that addresses a social determinant of health (SDH) and a relationship with at least one community-based organization (CBO). This requirement continues to apply to Level 2 MLTC arrangements.

Fully Integrated Products in Managed Long Term Care

The proposed update would reconfirm that VBP requirements for fully integrated products are the same as those that apply to mainstream Medicaid managed care plans. Such products include the Fully Integrated Duals Advantage (FIDA), Medicaid Advantage Plans (MAP), and Program of All-Inclusive Care for the Elderly (PACE) programs. For example, such plans will need to meet the requirement for the inclusion of an SDH intervention and a CBO relationship in Level 2 and 3 VBP arrangements.

NETWORK INTEGRATION

The State supports the integration of provider networks, and "strongly encourages" MCOs to make data widely available to potential VBP contractors (including non-lead providers) to help them form partnerships that would address gaps in care or identify other opportunities to improve outcomes.

The State plans to support such discussions by:

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- Conducting a "general analysis to illustrate opportunities for provider partnership in VBP arrangements";
- Continuing its conversations with MCOs and other entities, including Behavioral Health Care Collaboratives (BHCCs), to encourage the development of robust integrated provider networks;
- Sharing successful practices learned through DSRIP and Performing Provider System (PPS) engagement; and
- Exploring ways to monitor and measure patient access to behavioral health, substance use disorder, and other specialty care services. For example, the State would seek to understand the availability of care for specific mental health conditions on a regional and plan basis.

Multiple VBP Arrangements in One Contract

The State acknowledges that some contracts that target the general population also include a separate target budget for a specific subpopulation. Such contracts should be considered two separate VBP arrangement, and VBP contractors should establish separate target budgets and performance measurement for the two populations.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

The revised Roadmap proposes to add FQHCs to the narrow list of services and providers that are excluded or may be excluded from VBP arrangements. Because FQHCs have a statutorily mandated rate prescribed by federal law, they may not be able to bear downside risk like other providers. Therefore, the State proposes that:

- FQHCs may continue to enter into Level 1 VBP arrangements as Lead VBP Contractors;
- FQHCs may not enter into Level 2 or Level 3 arrangements as Lead VBP Contractors; and
- FQHCs ~~that have formed an Independent Practice Association (IPA) remain eligible to contract~~may participate with a non-FQHC Lead VBP Contractor in a Level 2 ~~and~~or 3 ~~arrangements, with the understanding that risk will~~VBP arrangement. In these cases, all Medicaid members may be ~~held by the IPA.~~
- ~~Statewide VBP goals and MCO specific goals would be modified to exclude spending~~ attributed to ~~Medicaid members whose primary care provider (PCP) is an FQHC. Specifically:~~the Lead VBP Contractor.
- ~~Spend attributed to Medicaid members whose PCP is an FQHC **will** continue to be included when calculating MCO progress toward Level 1 goals, and when calculating statewide VBP goals;~~
- ~~Spend attributed to Medicaid members whose PCP is an FQHC **will not** be included in total medical expense when calculating MCO progress to Level 2 and 3.~~

QUALITY MEASURES (TOTAL CARE FOR THE GENERAL POPULATION)

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The State proposes to establish a new standard for quality measurement in Total Care for the General Population (TCGP) VBP contracts. Under the revised Roadmap, all MCOs (except for MLTC plans) engaging in a TCGP arrangement would base shared savings and risk distribution on a set of at least six Category 1 pay-for-performance (P4P) quality measures from the TCGP Quality Measure Set. This would include at least one measure from each of the following categories within the Measure Set:

- Integrated Primary Care
- Mental Health
- Substance Use Disorder
- HIV/AIDS
- Maternity
- Children's

If a specific subpopulation or bundle is carved out of the TCGP arrangement (i.e., pregnant women), the TCGP contract would not need to include the quality measure for that population since these measures would be incorporated in the population-specific arrangement. The State strongly encourages MCOs and VBP Contractors to select quality measures that are targeted towards the needs and conditions of the attributed population.

The State proposes that all new contracts submitted on or after ~~October~~January 1, ~~2019~~2020 must meet this requirement. All existing contracts would need to be updated to meet this requirement by ~~July 2020~~January 2021.

SOCIAL DETERMINANTS OF HEALTH/COMMUNITY-BASED ORGANIZATIONS

Data Sharing with Community-Based Organizations

The proposed update expands on the requirement for MCOs to share timely, complete, bi-directional, and accurate data with VBP Contractors by adding an emphasis on also sharing such data with CBOs. The State notes that CBOs that are involved in a VBP contract will also need access to population data in order for their interventions to be effective.

For MCOs, VBP Contractors, and CBOs who intend on entering into a VBP arrangement but where no contract yet exists, bi-directional data sharing may be used to support the development of impactful care delivery models within the VBP arrangement. Such data may be aggregated and deidentified to provide insights while maintaining compliance with HIPAA and Federal and State data sharing regulations.

Social Determinants of Health

The proposed changes expand on the requirement for Level 2 and Level 3 VBP Contractors to participate in at least one intervention to improve SDH. Specifically:

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- If an MCO is providing funds to implement SDH interventions in a VBP contract, they may be classified as "Other Medical" expenses (i.e., within medical loss) in the plan's Medicaid Managed Care Operating Report (MMCOR);
- MCOs with approved SDH interventions in VBP Level 2 or 3 arrangements are required to complete and submit the newly developed Social Determinants of Health Intervention Status Report Template to the State annually~~. The State will~~, including information on evaluation, quality measurement outcomes, spending, and success of implemented programs. The State may also request member-level data for the purposes of evaluating the impact of SDH interventions on health care outcomes, cross sector impact, and cost savings; and
- VBP contracts should include adequate funding to match the size and scope of the SDH project.

Additionally, the State encourages MCOs and providers participating in VBP arrangements to seek external, third-party investment in their SDH interventions. Such third-party investors, which would be non-Medicaid providers, might include:

- Private innovation or investment funds;
- Foundations;
- Venture firms;
- PPSs;
- Philanthropic organizations; and
- MCO innovation funds.

MCOs should identify any such partnerships they enter on the SDH template submitted with their VBP contracts.

OTHER ITEMS

Intellectual and Developmental Disabilities

The State has convened the Intellectual and Developmental Disabilities (I/DD) CAG to support the development of a framework for an I/DD VBP arrangement. As the I/DD population continues to voluntarily transition into managed care, this framework will support VBP opportunities and arrangements. Results from the I/DD CAG meetings will also support pilot opportunities for I/DD specific arrangements and will align with the managed care transition timeline.