NEW YORK STATE | Department of Health | Office of Health Insurance Programs

VBP Workgroup Meeting

Friday, May 10th from 10:30 AM –1:30 PM
One Commerce Plaza, 16th floor, Conference Room 1613

Agenda

Topic	Schedule
VBP Quality Measure Utilization Analysis	10:30 am – 11:00 am
FQHC Policy Update	11:00 am – 11:15 am
VBP Progress Update	11:15 am – 11:30 am
BREAK	11:30 am - 12:00 pm
VBP Roadmap Updates	12:00 pm – 1:30 pm

VBP Contract Quality Measurement Analysis

- OQPS examined 53 VBP contracts from 16 MCOs created/modified between 2016-2018
- Reviewers extracted quality measures identified for shared savings in VBP arrangements
- The review indicated that 81% of the contracts clearly identified one or more quality measures used in determining a shared savings calculation

Specificity in Contracts	Specificity Example	Count	Count as Percent of Total (N=53)
Indicated specific quality measures used in shared savings calculations	Breast Cancer Screening, Medication Management for People with Asthma, etc.	43	81.1%
Indicated benchmarks were being utilized in shared savings calculations	“All NYS QARR Measures will be used”	10	18.9%

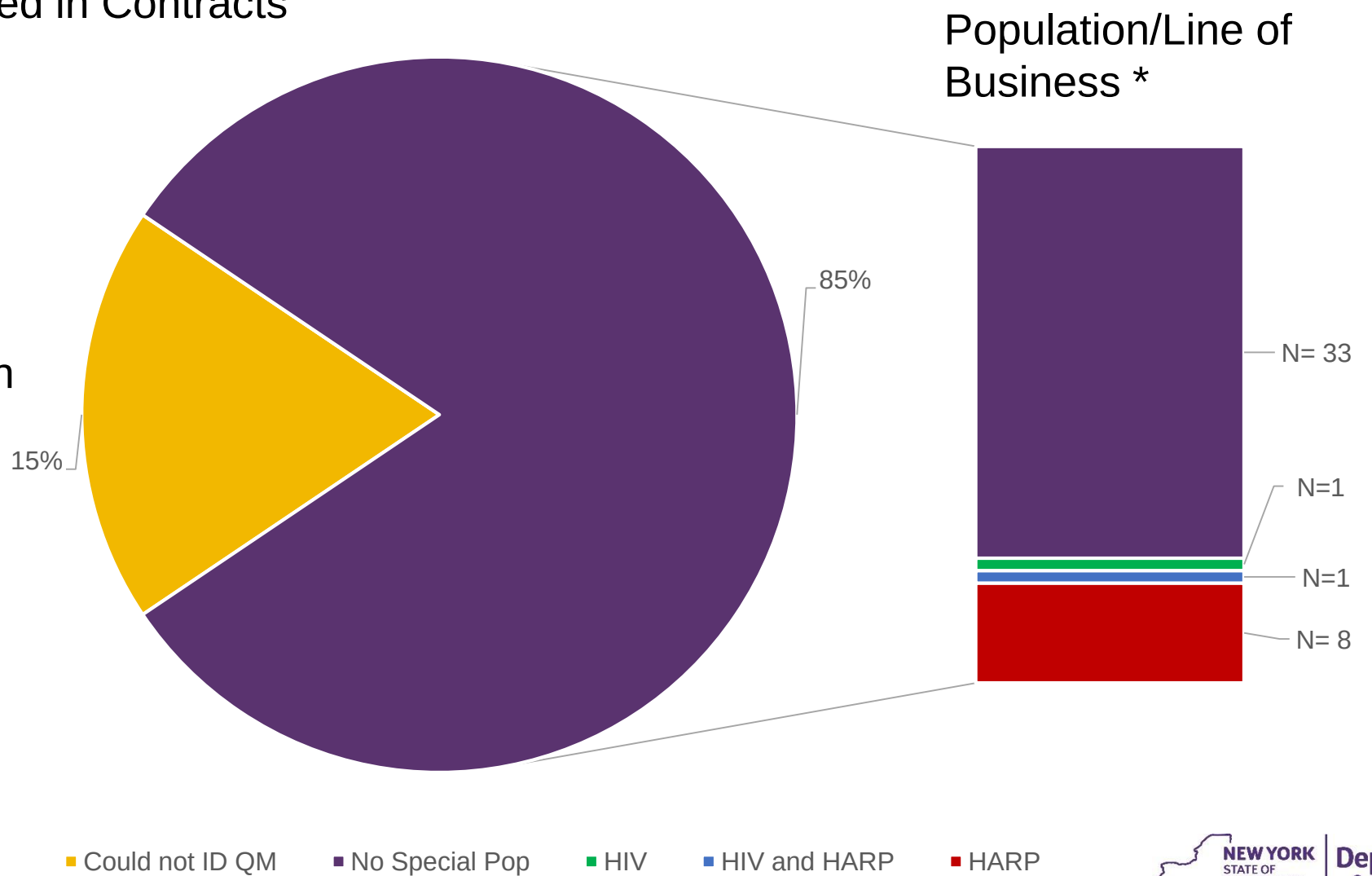
VBP Measures Most Specified in Shared Savings

NYS VBP Quality Measures	Unique Appearances in VBP Contracts	Unique Appearances as Percent of Total Contracts with Specific Shared Savings Quality Measures (N=43)
Breast Cancer Screening	34	79%
Adolescent Well-Care Visits	29	67%
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	28	65%
Colorectal Cancer Screening	24	56%
Cervical Cancer Screening	21	49%
Chlamydia Screening in Women - Total	21	49%
Annual Dental Visit (Total)	20	47%
Well-Child Visits in the First 15 Months of Life	17	40%
Comprehensive Diabetes Screening: All Three Tests (HbA1c, dilated eye exam, and medical attention for nephropathy)	14	33%
Medication Management for People with Asthma	14	33%
Comprehensive Diabetes Care - Eye Exams	13	30%
Antidepressant Medication Management	12	28%

Type of Contracts and Populations Included

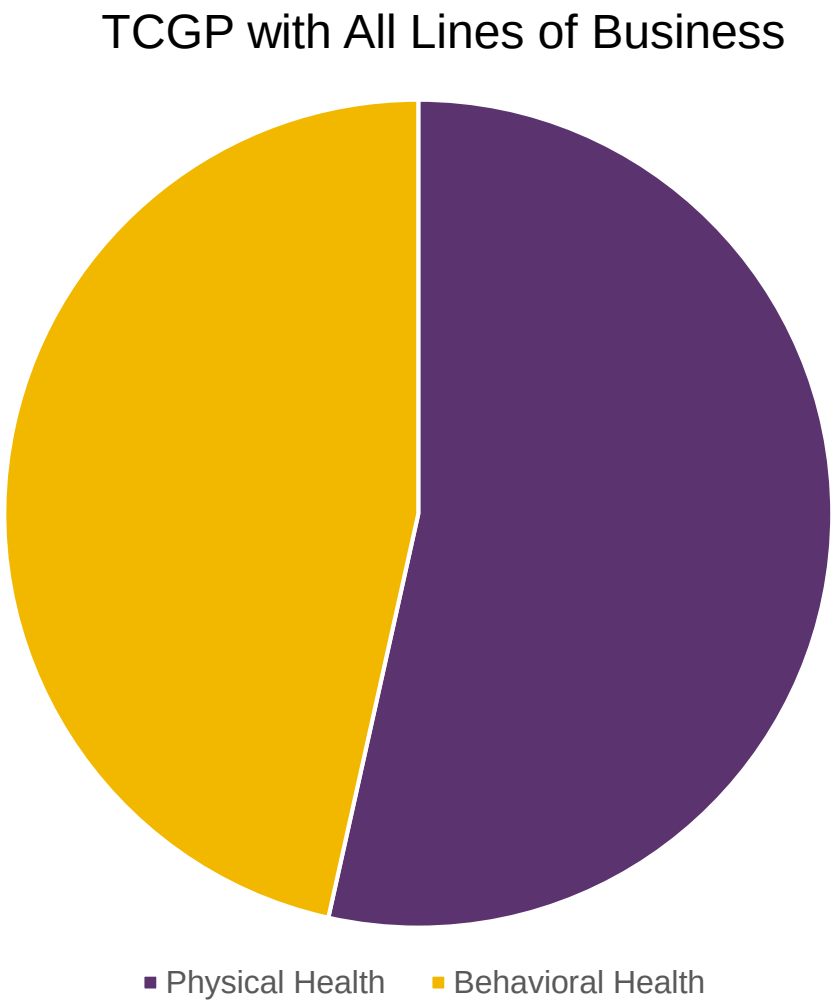
Quality Measures Identified in Contracts

- 53 Total Contracts Reviewed
- All TCGP contracts
- Most included specific quality measure used in shared savings
- Populations/Line of Business included in contract on bar chart*

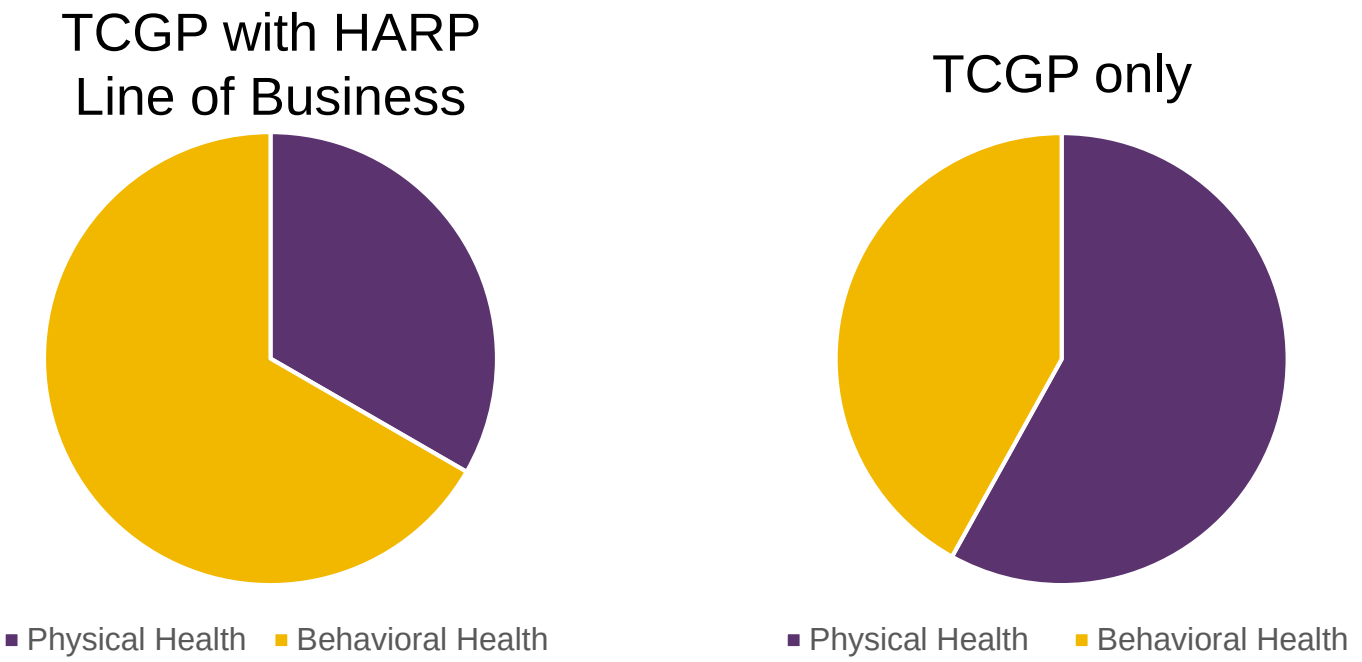


Quality Measures Used in Shared Savings by Clinical Domain

- 43 contracts with QM specified
- Measures categorized as:
  - Physical Health
  - Behavioral Health (includes IPC and HARP specific BH measures)
- **46% contracts include at least one Behavioral Health QM**



Quality Measures Used in Shared Savings – HARP Line of Business



At least 1 Behavioral Health measure is found in 67% of TCGP contracts with a HARP line of business, compared to 42% of TCGP contracts without a HARP line of business.

Most Common Behavioral Health Quality Measures in VBP Contracts

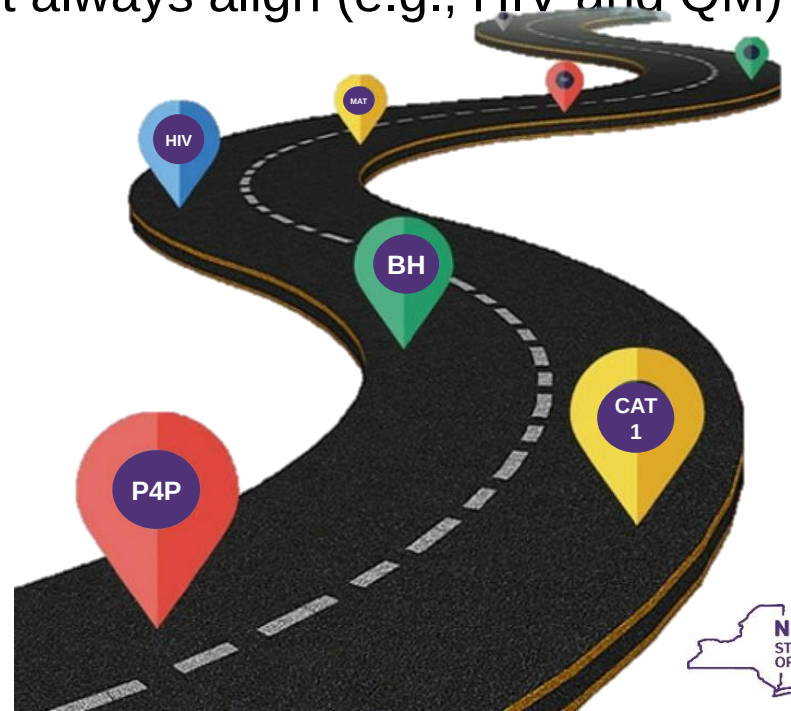
Quality Measure	Unique Appearances as % of Total Contracts with a BH QM	Categorization in Measure Sets
Antidepressant Medication Management	60%	TCGP/IPC /HIV - P4P – CAT 1
Follow-Up After Hospitalization for Mental Illness	20%	HARP – P4P – CAT 1
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	10%	HARP – CAT 2
Adolescent Preventative Care Measures	10%	TCGP/IPC – P4R – CAT 1
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	10%	TCGP/IPC/HARP/HIV – P4P – CAT 1
Follow-Up Care for Children Prescribed ADHD Medication	10%	TCGP/IPC – P4R – CAT 1
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	10%	TCGP/IPC/HARP/HIV – P4P – CAT 1
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence	10%	TCGP/IPC/HARP/HIV – P4P – CAT 1
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	10%	[NR]TCGP/IPC/Maternity/HARP/HIV – P4R – CAT 1
Use of Pharmacotherapy for Alcohol Abuse or Dependence	10%	TCGP/IPC/HARP/HIV – P4R – CAT 1

Quality Measures Used in Shared Savings- HIV Population Identified

- 3 contracts include an HIV line of business or an HIV QM
  - 1 VBP arrangement with HIV line of business does not include an HIV QM
  - 1 VBP arrangement with HIV QM does not include HIV line of business

Summary of Quality Measure Contract Review

- Findings point to how TCGP contracts are using quality measures and potential updates for Roadmap
  - Lines of business/subpopulations in TCGP may provide opportunity to apply more targeted QM
  - Use of QM and specific lines of business do not always align (e.g., HIV and QM)



Continuing FQHCs in Level 1 VBP

Ryan Ashe, Director of Medicaid Payment Reform

Nick Cioffi, Chief Health Care Mgmt Systems Analyst

Continuing FQHCs in Level 1 VBP Arrangements

The State's VBP model does not intend to back away from adequate reimbursements for FQHCs. NYS' model recognizes that FQHCs have a statutorily mandated rate as prescribed in Federal law 42 USC 1396a (bb)(5)(A) . For Level 2 and 3 arrangements, the NYS VBP model will accommodate the current payment structure of FQHCs in the following ways:

- 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.
- FQHCs that have formed an IPA remain eligible to contract Level 2 and 3 arrangements, with the understanding that risk will be held by the IPA.

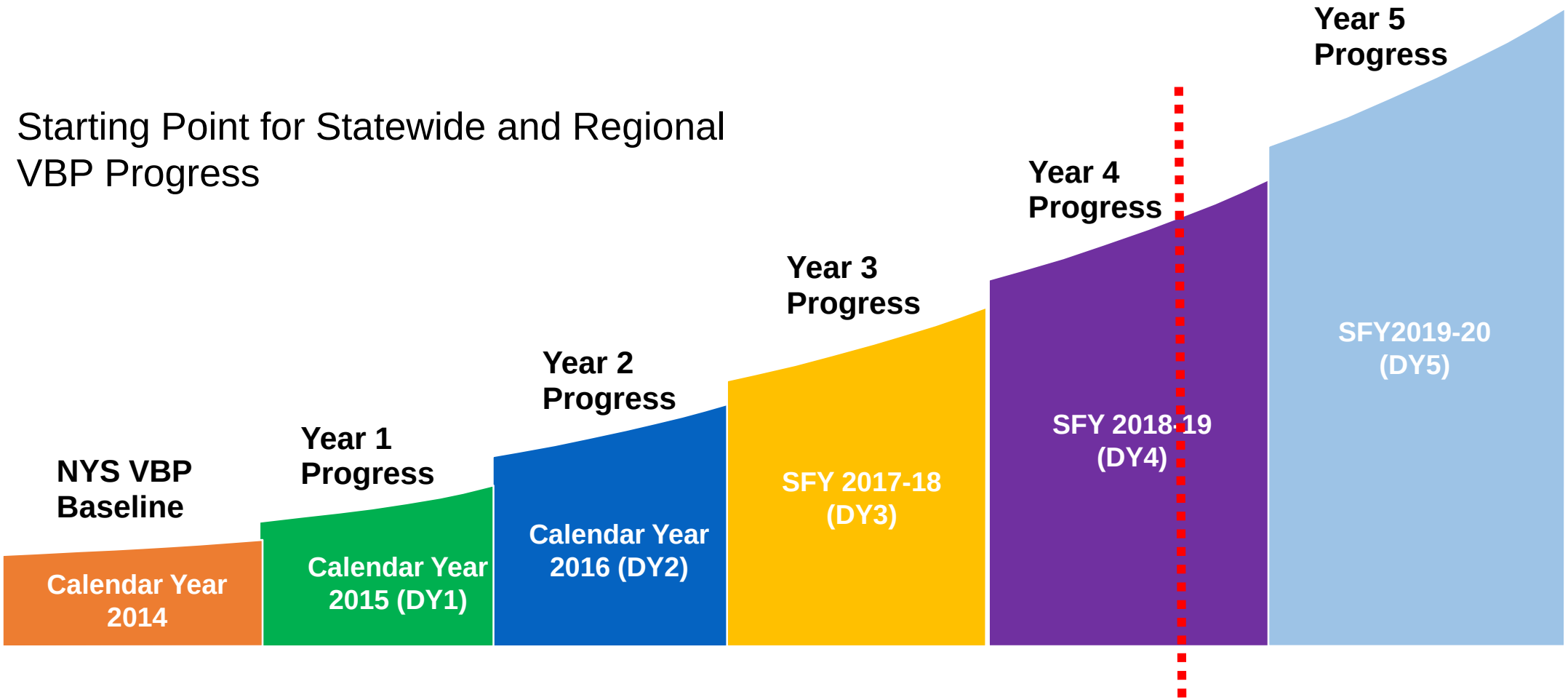
Value Based Payment Progress Report: Year 4 (SFY 2018-19)

Overview of the Managed Care Survey Results thru December 31, 2018

Anesa Brkanovic, Deputy Director – Division of Health Plan Contracting and Oversight

VBP Reform Survey Goals

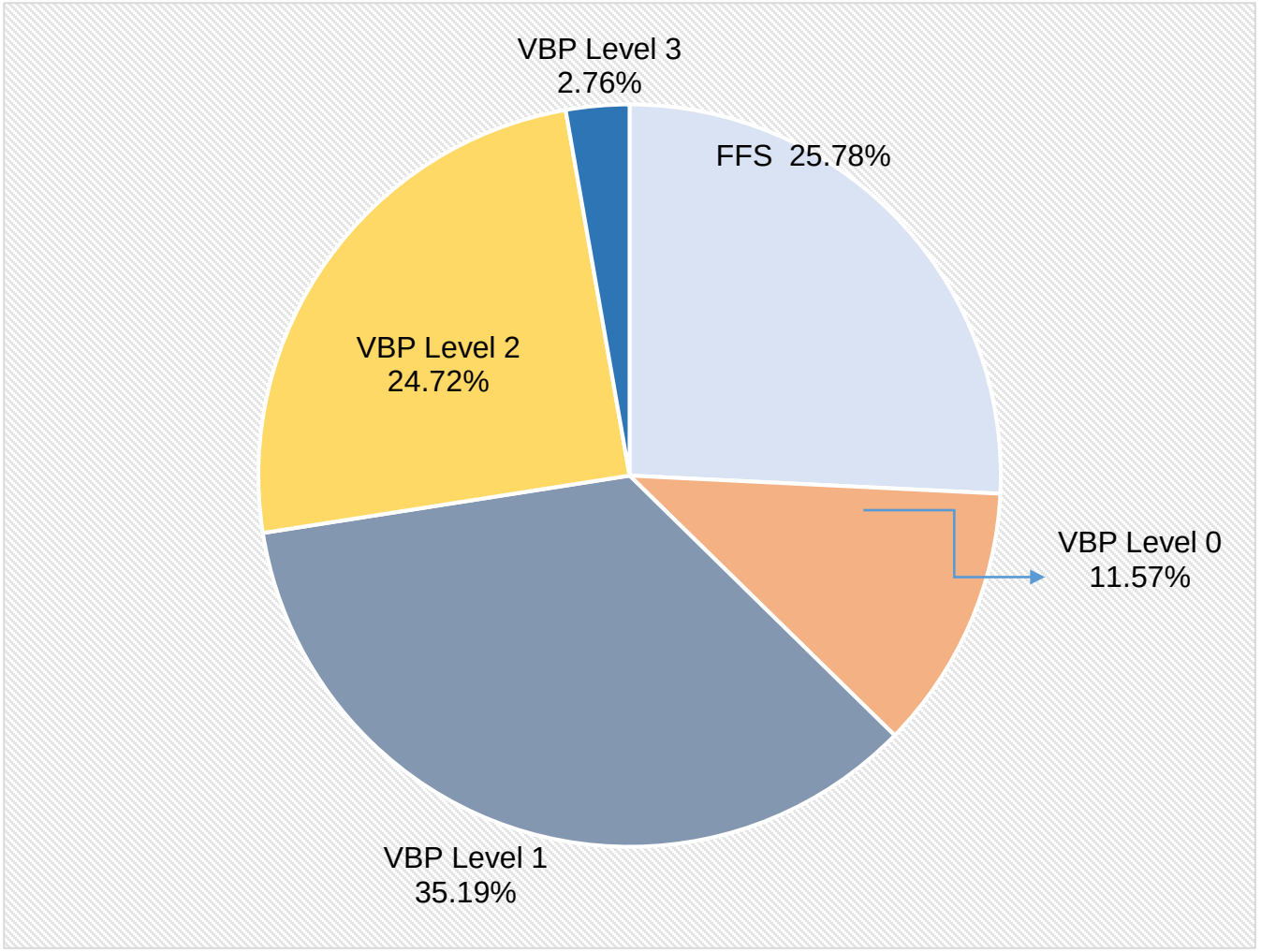
Starting Point for Statewide and Regional VBP Progress



VBPTR MCO Survey

- Measures statewide progress towards the overall **80-90% VBP Goal** and the **35% VBP Target** for Levels 2 and 3.
- 2019 Specific Goals:
  - MMC: 50% of total MCO spending in Level 1 or higher and 15% in Level 2 or higher
  - MLTC: 50% of total MCO spending in Level 1 or higher and 5% in Level 2 or higher

Overview of Results thru 12/31/2018 (across all Medicaid MC Lines of Business)

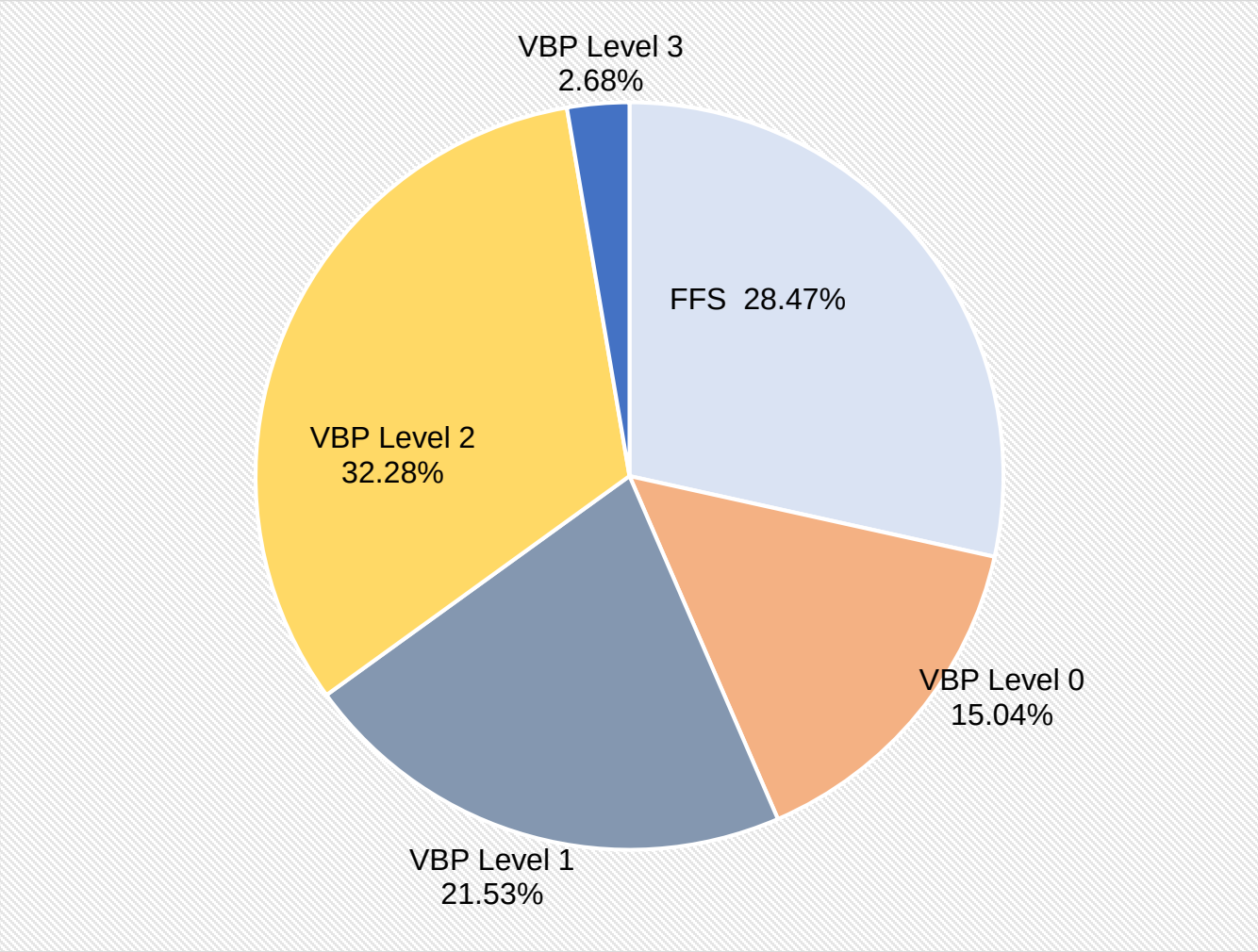


Current Overall VBP Progress: **62.66%**

TOTAL MA $	*$22,309,553,988*	
FFS	$5,750,363,457	25.78%
VBP0	$2,580,112,046	11.57%
Level 0/Quality Only	$2,255,017,678	*10.11%*
Level 0/ Cost Only	$325,094,368	*1.46%*
VBP1	$7,850,172,343	35.19%
VBP2	$5,513,812,621	24.72%
VBP3	$615,093,519	2.76%
Level 1-3	$17,051,838,452.00	*62.66%*

Overview of Results thru 12/31/18 – (MMC,HARP and HIVSNP)

Current Overall VBP Progress: **56.50%**

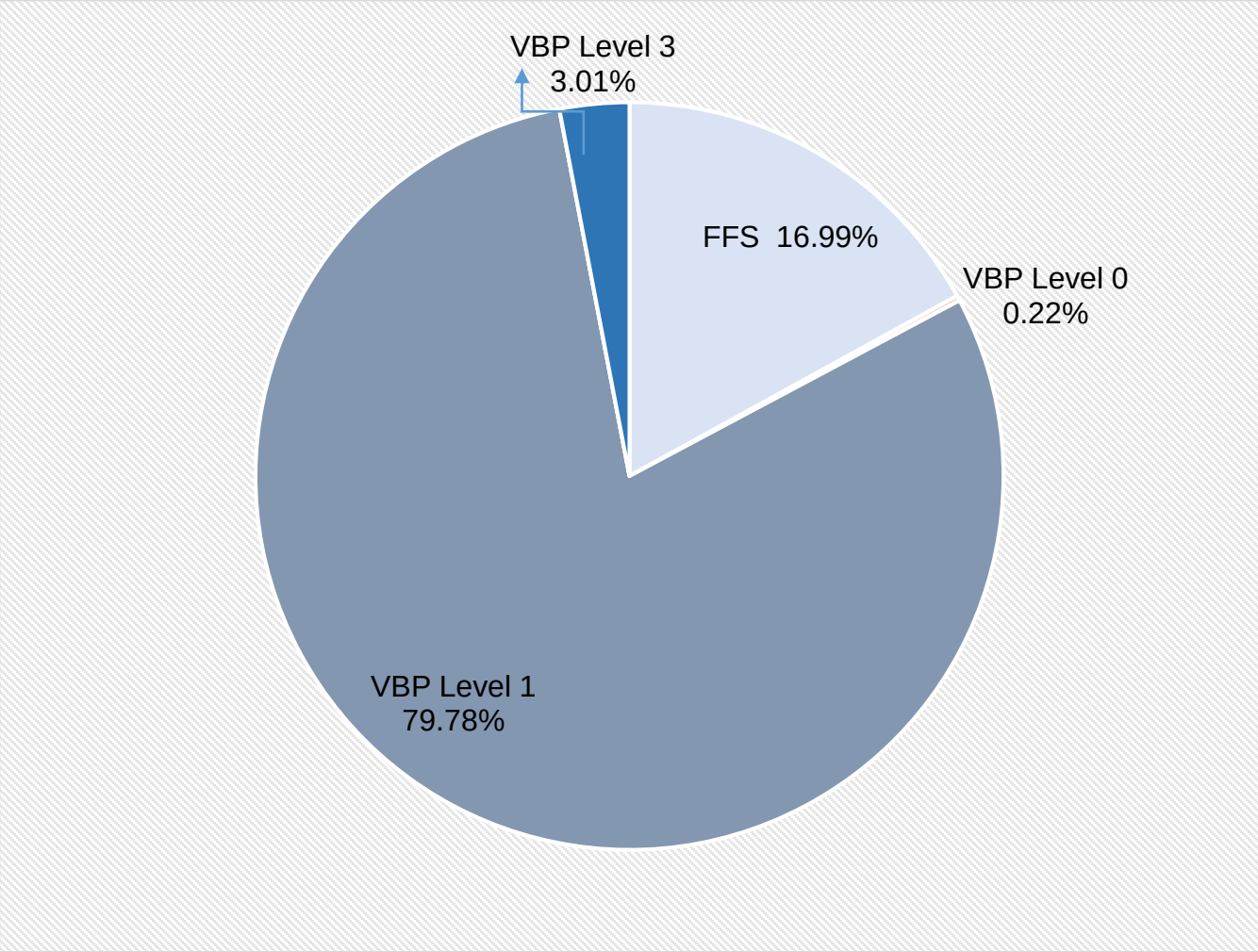


TOTAL MA $	*$ 17,079,594,041*	
FFS	**$ 4,861,725,134**	**28.47%**
VBP0	**$ 2,568,536,387**	**15.04%**
Level 0/Quality Only	*$ 2,246,587,330*	*13.15%*
Level 0/ Cost Only	*$ 321,949,057*	*1.88%*
VBP1	**$ 3,677,682,080**	**21.53%**
VBP2	**$ 5,513,812,621**	**32.28%**
VBP3	**$ 457,837,817**	**2.68%**
Level 1-3	***$ 9,649,332,518***	***56.50%***

NEW YORK STATE OF OPPORTUNITY. Department of Health

Overview of Results thru 12/31/18 – (MLTC,MAP,PACE,FIDA)

Current Overall VBP: **82.79%**



TOTAL DLTC	*$5,229,959,946*	
FFS	$888,638,322	16.99%
VBP0	$11,575,659	0.22%
Level 0/Quality Only	$8,430,348	0.16%
Level 0/ Cost Only	$3,145,311	0.06%
VBP1	$4,172,490,262	79.78%
VBP2	$-	0.0%
VBP3	$157,255,702	3.01%
Level 1-3	*$4,329,745,964*	*82.79%*

NEW YORK STATE OF OPPORTUNITY. Department of Health

BREAK

NYS VBP Roadmap

NYS VBP Roadmap 2018 DSRIP Year 4 Edition

- CMS has approved the 2018 updates to the NYS VBP Roadmap.
- The updates included:
  - Clerical updates to adjust timeframes
  - Overview of key principles on the NYS VBP model (page 5)
  - Description of efforts underway to support an I/DD and children's VBP arrangement (page 16)
  - Level 2 design for MLTC partial capitation (page 20)
  - Requirements governing the sharing of data between contracting parties for the purposes of establishing a target budget and monitoring performance throughout the performance year. (page 26)
  - Clarification that encourages the inclusion of Tier 2 and 3 CBOs in VBP arrangements. (page 46)
  - Modifies financial incentives based on MCO progress toward VBP implementation (Page 49)

NYS VBP Roadmap 2019 DSRIP Year 5 Proposed Updates

- General/Clerical Updates
- Social Determinants of Health
- Managed Long Term Care
- FQHC
- Children's Arrangement
- Quality Measures
- Network Integration

Proposed Roadmap Changes: **Clerical Edits**

Current Language	Rationale for Change
Various sections refer to certain activities or data as of a specific point in time.	The changes have been made to maintain accuracy with the current period of VBP implementation.

Proposed Language to be added to throughout the Roadmap
Various edits have been made to accurately reflect the correct dates and time periods and activities that have been conducted to date.

Social Determinants of Health and Community Based Organizations

Denard Cummings, Director - Bureau of Social Determinants of Health

Proposed Roadmap Changes: **Alternative investment in SDH**

Current Language	Rationale for Change
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. (pg.50)	The following amendment allows for and encourages alternative means for investments into social determinants of health interventions. The change encourages partnership between MCOs and third party investors where investment into SDH interventions can be shared.

Proposed Language to be added to page 50
MCOs and providers that engage in VBP arrangements are encouraged to collaborate with third party partners to identify and secure investment and support for SDH interventions. In many instances, third party partners may strengthen and supplement existing investments in SDH. Potential partners maintain an array of interests across the State, including but not limited to early childhood interventions, food security and housing, for example. Potential partnerships exist in instances where goals between MCOs and VBP Contractors align with the goals and investment strategy of third party partners. Managed Care Organizations may explore strategic and innovative partnerships with third party investors (see footnote) to secure additional investment in social determinants of health interventions. Footnote: The organizations that constitute a “third party investor” must include at least one non-Medicaid provider, for example, private “innovation or investment fund”, foundations, venture firms, PPS, philanthropic organizations, MCO Innovation Funds etc. The third party investor may also be the only investing partner with the MCO. If the MCO chooses to engage a third party investor, the MCO must identify this partnership on the SDH templates that are submitted along with the VBP contracts.

Proposed Roadmap Changes: **Scoping investment in SDH**

Current Language	Rationale for Change
“The contractors will have the flexibility to decide on the type of intervention (from size to level of investment) that they implement,…”(pg. 50)	The VBP Roadmap allows considerable flexibility to stakeholders as they develop SDH interventions. Strong interventions with the appropriate level of support will have positive impact on the health of Medicaid members. However, the investment intended to support a specific intervention does not always align with the scope of the program or project that is being contracted for delivery. It is important that the investment into an SDH intervention be comparable to its size and scope in order for the intervention to produce meaningful outcomes.

Proposed Language to be added to page 50
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. Funding provided for the SDH intervention must be appropriate for the size, scope and the specification of the project.

Proposed Roadmap Changes: **Encourage investment in SDH**

Current Language	Rationale for Change
Payouts will be made by the VBP contractor based on the terms of each individual contract. To ensure that funding advances are put toward addressing SDH, all recipients of this funding will need to report on fund utilization to NYSDOH. (pg. 51)	Allows the Managed Care Organization to account for their investment into SDH interventions that support VBP contracts.

Proposed Language to be added to page 51
Payouts will be made by the VBP contractor based on the terms of each individual contract. To ensure that funding advances are put toward addressing SDH, all recipients of this funding will need to report on fund utilization to NYSDOH. The expenses for SDH interventions being implemented within the VBP contract for which the MCO is making the investment, should be included in “Other Medical” on the MMCOR and MLTCRR.

Proposed Roadmap Changes: **Data sharing with contracted CBOs**

Current Language	Rationale for Change
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… (pg. 29)	Data and information is necessary to develop and implement successful SDH interventions. Since most CBOs included in VBP arrangements are tasked with implementing SDH interventions, plans and VBP contractors should have data sharing agreements with contracted CBOs. This will enable better targeting of members or communities that will benefit from the intervention.

Proposed Language to be added to page 29

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 share, timely, complete and accurate data with the VBP Contractors (including community-based organizations (*See footnote)*) for the purposes of negotiating a target budget and distributing of shared savings/loss.

Footnote: It is critical that CBOs being engaged by MCOs to address social determinants of health and support care delivery be provided adequate data to understand the target population that is specified in the contracts between MCOs and CBOs.

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, including community based organizations (CBOs) to adjust their approach by identifying areas for improved care delivery, and drive quality and greater efficiency. It is therefore a standard that MCOs and VBP contractors exchange timely, complete and accurate data throughout the measurement period.

Proposed Roadmap Changes: **Measuring Program Success**

Current Language	Rationale for Change
"… 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. " (p. 51)	This update is providing additional clarification on pre-existing roadmap language regarding the evaluation and reporting of interventions.

Proposed Language Change Options (add below to footnote on pg. 51)
Footnote: The State has developed a Social Determinants of Health Intervention Status Report Template for measuring success of SDH interventions implemented. MCOs with approved SDH interventions in VBP Level 2 or 3 arrangements are required to complete and submit this Status Report Template to the State annually. State will also request member level data for the purposes of evaluating the impact of SDH interventions on healthcare outcomes, cross sector impact and cost savings.

Managed Long -Term Care

Erin Kate Calicchia, Deputy Director - Division of Long Term Care

Ryan Ashe, Director of Medicaid Payment Reform

Proposed Roadmap Changes: **Clarifying MLTC Requirements**

Current Language	Rationale for Change
"Managed Long-Term Care (MLTC), Dual Eligible and Shared Savings" text box on page 20, will be modified and moved to page 17.	Formatting and clerical edit intended to simplify and clarify the requirements for VBP within MLTC, for both partial capitation and integrated products, including PACE. This change does not create new policy, but rather, clarifies existing policy.
Proposed Language to be added on page 17.	
See next slide. To be inserted on page 17 of the Roadmap.	

Proposed Roadmap Changes: **Clarifying MLTC Requirements**

MLTC Partially Capitated Plans

Many of these individuals use long term care services (LTCS), (specifically personal care, home health care, and skilled nursing services), 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 subpopulation is part of DSRIP's goals and is 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. 65). In anticipation, the State treats 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 are treated as Level 1 VBP arrangements and are eligible for financial incentives. These financial incentives are anticipated to be passed from State-to-Plan to Plan-to-Provider.

VBP Levels 1 and 2 for partially capitated plans are defined as follows:

Level 1: An arrangement that includes a performance-based quality bonus between an MLTC Partial Plan and a provider that is based on meeting performance targets for a set of specific quality measures agreed to in a VBP contract between an MLTC Partial Plan and provider. Such agreement must include the Potentially Avoidable Hospitalization (PAH) measure. These financial incentives are anticipated to be passed from State-to-Plan to Plan-to-Provider.

Level 2: Level 2 arrangements will continue to use the potentially avoidable hospital measure as the primary quality metric for Level 2 of the MLTC VBP arrangement for partially capitated plans. MLTC VBP arrangements will qualify as Level 2 when the minimum percentage of potential risk allocated to a provider is at least 1% of total annual expenditures in the contract between the plan and provider. Providers share in losses when they do not achieve a certain level of performance, based on quality metrics agreed upon between the provider and MLTC plan. Here as well, financial incentives are anticipated to be passed from State-to-Plan to Plan-to-Provider. The Level 2 contracts must include the PAH measure and *at least one* other MLTC quality measure recommended by the MLTC CAG and approved by the State. The Social Determinant of Health (SDH) and Community Based Organization (CBO) requirements as outlined on page 48 of this Roadmap, also apply to these Level 2 VBP arrangements.

Fully integrated Products (FIDA, MAP, PACE)

VBP goals and requirements for Fully Integrated plans are the same as those that apply to fully capitated Medicaid Managed Care, which includes meeting requirements for inclusion of Social Determinant of Health (SDH) and Community Based Organization (CBO) in Level 2 and 3 VBP arrangements, as outlined on page 50.

Continuing FQHCs in Level 1 VBP

Ryan Ashe, Director of Medicaid Payment Reform

Nick Cioffi, Chief Health Care Mgmt Systems Analyst

Proposed Roadmap Changes: **Continuing FQHCs in Level 1 VBP**

Current Language	Rationale for Change
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. (Pg. 36)	Federal law 42 USC 1396a (bb)(5)(A) mandates that FQHCs be reimbursed up to the PPS rate for every Medicaid visit. Any alternate payment methodology (APM) must result in payment to the FQHC of an amount which is at least equal to the PPS amount. As a result, FQHCs cannot accept risk in a VBP environment and must continue to receive their full PPS reimbursement rate regardless of the Medicaid delivery system.

Proposed Language to be added to page 37

(Under Exclusions)

7. Federally Qualified Health Centers (FQHC)

The State's VBP model does not intend to back away from adequate reimbursements for FQHCs. NYS' model recognizes that FQHCs have a statutorily mandated rate as prescribed in Federal law 42 USC 1396a (bb)(5)(A) . For Level 2 and 3 arrangements, the NYS VBP model will accommodate the current payment structure of FQHCs in the following ways:

- 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.
- FQHCs that have formed an IPA remain eligible to contract Level 2 and 3 arrangements, with the understanding that risk will be held by the IPA.

Statewide VBP goals and MCO specific goals will be modified as follows:

- Spend attributed to Medicaid members who have a FQHC designated as their primary care provider from total medical expense, when calculating MCO progress to level 2 & 3, will be excluded.
- Spend attributed to Medicaid members who have a FQHC designated as their primary care provider will continue to be included when calculating MCO progress toward Level 1 goals, and when calculating Statewide VBP goals.

Children's VBP Arrangements

Doug Fish, MD, Medical Director – Division of Medical and Dental Directors

Proposed Roadmap Changes: **Progress of Children's VBP Arrangement**

Current Language	Rationale for Change
"The State has begun work to develop a VBP arrangement specifically intended to address the unique needs of children. The children-focused arrangement would be a population-based arrangement, and would consider the full continuum of care stretching from prevention to treatment and care management for children…." pg. 16	Provides an update to the progress made in the Children's Health VBP Subcommittee & CAG.

Proposed Language to be added to page 16.
See next slide. To be inserted on page 16 of the Roadmap.

Proposed Roadmap Changes: **Progress of Children's VBP Arrangement**

Built on the work and recommendation from the initial convenings of the Children's VBP Clinical Advisory Group in 2016-17, New York State has continued work to develop a VBP arrangement specifically intended to address the unique needs of children. The children-focused arrangement would be a population-based arrangement, and would consider the full continuum of care stretching from prevention to treatment and care management for children. Different from adults, a VBP arrangement for children must also account for a relatively healthy pediatric population, where savings can generally only be realized over the long term.

During 2018, the Children's Health CAG and the New York State (NYS) Value Based Payment (VBP) Workgroup reconvened and made recommendations to the State on updated quality measures, data collection, data reporting, and support required for providers to be successful in a VBP environment in 2019 and beyond.

Additionally in 2018, NYS Medicaid's First 1000 Days Preventive Pediatric Care CAG produced recommendations as guide posts and overarching goals which are aligned with New York State's "North Star" framework that recognizes several key elements:

- The unique needs of children at different developmental stages;
- The overarching role of primary care in the delivery of healthcare services to children and promotion of overall child well-being; and
- The role of caregivers and non-medical factors that shape children's long-term health.

Future adoption of an appropriate payment model will be influenced and guided by this framework and by the American Academy of Pediatrics' "Bright Futures" guidelines for Pediatric Primary Care practices. In addition, the following goals shall remain intact for 2019 around optimizing measurement in Children's Medicaid that shall provide the appropriate underpinnings for a sound Children's arrangement:

- Aligning new and existing measures across VBP arrangements to ensure the same standard of care for all children and adolescents;
- Continuing to elevate the importance of high quality maternity care, leading up to and immediately following the delivery, in order to promote optimal child outcomes;
- Encouraging the use of quality measurement to improve clinical practice and reduce health disparities; and
- Continue States' mission to adopt more outcome-oriented quality measures that support both short and long-term goals and that are cross-sector in nature.

Proposed Roadmap Changes: **Progress of Children's VBP Arrangement**

Current Language	Rationale for Change
The State continues to explore additional pilot opportunities to support the evolution and expansion of the health system's movement toward value based payment. VBP pilot opportunities will be extended to providers and plans in New York State's health care delivery system, as the opportunities become available. (pg. 56)	Provides an update to the progress made in the Children's Health VBP Subcommittee & CAG.

Proposed Language to be added to page 56
VBP pilot opportunities will be extended to providers and plans in New York State's health care delivery system, as the opportunities become available. The State is currently supporting a number of children-centric demonstration initiatives and is exploring options to continue supporting a children's VBP arrangement through at least one VBP pilot.

VBP Quality Measures

Enhancing quality measures that support TCGP arrangements

Doug Fish, MD, Medical Director – Division of Medical and Dental Directors

Lindsay Cogan, PhD, MS - Division of Quality Measurement | Office of Quality and Patient Safety

Jonathan Bick, Director – Division of Health Plan Contracting and Oversight

Proposed Roadmap Changes: **Refining quality measures that support TCGP arrangements**

Current Language	Rationale for Change
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. (pg. 41)	At the October 4, 2018 VBP Workgroup, members raised concern about quality measure utilization in VBP arrangements, specifically to what extent subpopulation/condition specific measures are being used in VBP arrangements. The quality metrics used to support the total cost of care arrangements are evolving to mirror the populations being included in the arrangements, and more importantly, the medical and behavioral health needs of the members being included in the TCGP arrangements. This modification continues to allow MCOs and lead VBP contractors to enter into VBP arrangements for specific subpopulations where the quality measures may align only to those specific quality measure sets.
Proposed Language Change to page 42	
See next slide for the proposed language to be added on page 42 of the Roadmap.	

Proposed Roadmap Changes: **Enhancing quality measures that support TCGP arrangements**

Managed Care Organizations (MCOs) (excluding MLTC) that execute a total cost of care for general population (TCGP) VBP arrangement must base shared savings and risk distribution on the following quality measures:

At least one 1 Category 1 P4P measure from the Total Care General Population Quality Measure Set for each of the following categories, that are included in the TCGP arrangement:

i. Integrated Primary Care
ii. Mental Health
iii. Substance Use Disorder
iv. HIV/AIDS
v. Maternity
vi. Children's

If a VBP contractor and MCO are contracting for a specific subpopulation or bundle separately (i.e. pregnant members), explicitly carving them out of the TCGP arrangement, then the TCGP contract does not need to include the measure for the respective population since these measures would be incorporated in the population-specific arrangement (i.e. Maternity Care contract).

Further, the State strongly encourages MCOs and VBP Contractors to select quality measures that are appropriate for the population being served within the contract. For example, MCOs and VBP Contractors should include asthma quality measures if there is a high prevalence of asthma-related illness in the attributed population of the VBP contract.

The DOH recognizes that MCOs and providers are in the process of negotiating VBP arrangements to meet Statewide VBP goals. It is therefore a standard that all new contracts submitted on or after October 1st, 2019 must meet this requirement. All other existing contracts must be updated to meet this requirement by July 2020.

Supporting Network Integration

Greg Allen, Director – Division of Program Development and Mgmt

Ryan Ashe, Director of Medicaid Payment Reform

Proposed Roadmap Changes: **Supporting Network Integration**

Current Language	Rationale for Change
A new sub-section titled "Supporting Network Integration" will be added to the section titled "Attribution and Target Budget Setting Guidelines."	Since 2017, a majority of contracts submitted to DOH are TCGP arrangements. Instead of creating separate subpopulation arrangements, MCOs and VBP Contractors have been including subpopulations within TCGP arrangements. This is an accepted method, however MCOs and providers must clearly define separate target budgets for each subpopulation within an arrangement so that savings and losses can easily be tied back to the respective subpopulation and spend attributed to each of these subpopulations is not mixed.
Proposed Language addition for page 34	
See the next slide for the language to be added on page 34 of the Roadmap.	

Proposed Roadmap Changes: **Supporting network integration**

As VBP progresses, MCOs are structuring VBP arrangements with providers by differentiating costs attributed to distinct subpopulations within the TCGP arrangements. Some VBP contracts, although identified as TCGP, include a target budget for the general population, as well as a target budget for specific subpopulations, such as HARP-enrolled subpopulation. These contracts essentially contain two VBP arrangements; TCGP and HARP in this example. As a result, MCOs and providers, especially, can track efficiency and quality specific to these cohorts. This approach also enables providers to adopt VBP arrangements having a greater volume of membership to offset potential risk of a smaller, embedded VBP subpopulation. MCOs and providers with more than one VBP arrangement in one contract will need to continue to establish target budgets and overall performance separately for each VBP arrangement contained within a contract. This practice is therefore a standard for all VBP arrangements.

Establishing robust provider network integration and care coordination across multiple care settings, especially for populations with complex care needs, is foundational to NYS' VBP model. The Department strongly encourages MCOs to support existing and potential VBP Contractors, including providers that may not be a Lead VBP Contractor but that may partner with a Lead, by sharing data that helps different provider types identify opportunities to partner together where gaps in care or opportunities for improvement in measure outcomes may exist. Illustrating overlap in service utilization among Medicaid members and reviewing care patterns among potential provider partners will help providers understand where opportunities for partnership exist.

i. To this end, the State will support these discussions with a general analysis to illustrate opportunities for provider partnership in VBP arrangements. The State will continue these conversations with MCOs including Behavioral Health Care Continuum (BHCCs) on an ad hoc basis to encourage the evolution and development of robust provider networks capable of providing care holistically.

ii. The State will also share successful practices learned through DSRIP and PPS engagement. Ultimately, these practices will support the provider community in their successful adoption and performance in value-based purchasing.

iii. Maintaining and increasing access to critical behavioral health, substance use disorder services and other specialty care services, where appropriate, continues to be a priority for the State. The State is exploring ways in which access to these services can be more carefully monitored and measured, assessing for example, ambulatory and inpatient for HARP and Non HARP members and monitoring on a regional and plan basis for specific conditions such as substance use disorder or mental health.

Thank you!

Please send feedback on any of the agenda items, including proposed Roadmap updates, to vbp@health.ny.gov by **May 24th, 2019.**
Please identify which topic you are providing feedback on in the subject line.