NEW YORK STATE | Department of Health | Medicaid Redesign Team

Value Based Payment

All Plan Meeting

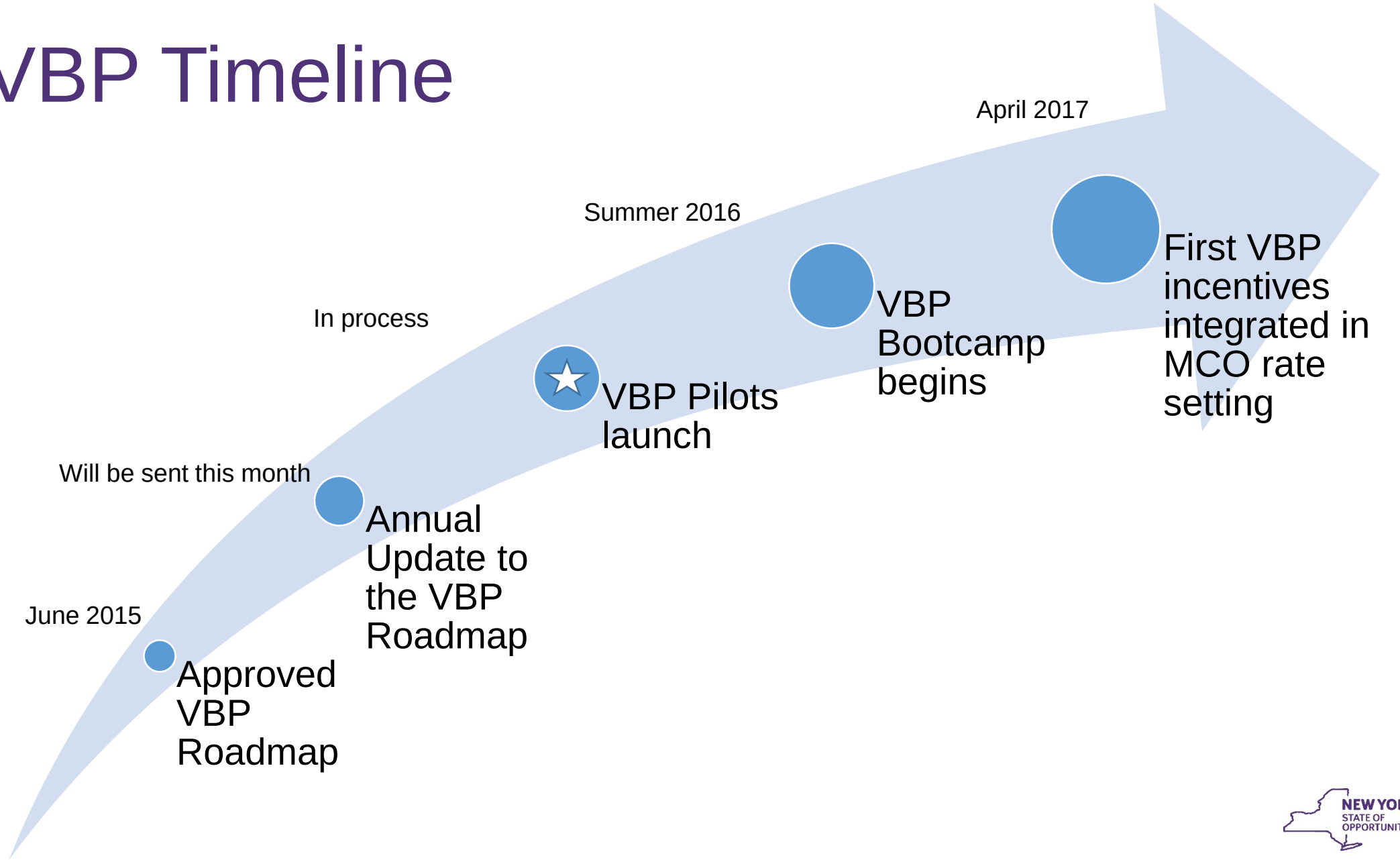
May 12, 2016

Agenda

- Latest VBP Updates
- VBP Pilot Program Updates
- Quarterly Performance Reports & 2017-2018 MCO Incentives

VBP Updates

VBP Timeline



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VBP Updates

- Baseline Survey
  - Initial analysis indicates that approx. 27-28% of spending is Levels 1-3 and approx. 7% Level 0 (quality bonus/withhold)[1]
  - Currently working with plans to refine understanding of current contracts
- VBP Workgroup has discussed last version of the Roadmap Update
  - Currently finalizing last minor changes
  - Will be sent to CMS this month
- Most Clinical Advisory Groups have finalized their reports
  - Closely aligned with current QARR measures, with addition of key outcome measures
  - OQPS is currently reviewing CAG reports
  - After review, reports will be posted on the DSRIP VBP website
  - Behavioral Health and DD CAGs are ongoing

1. Inclusive of Mainstream, MLTC, MAP, and HIV SNP plans

Flexibility for MCOs and Providers

- Some parts of the Roadmap will be *Standard* across the State, e.g.:
  - Definition of VBP arrangements
    - Services to be included and excluded from each VBP model[1]
    - Members eligible for attribution to each model[1]
  - Quality measures

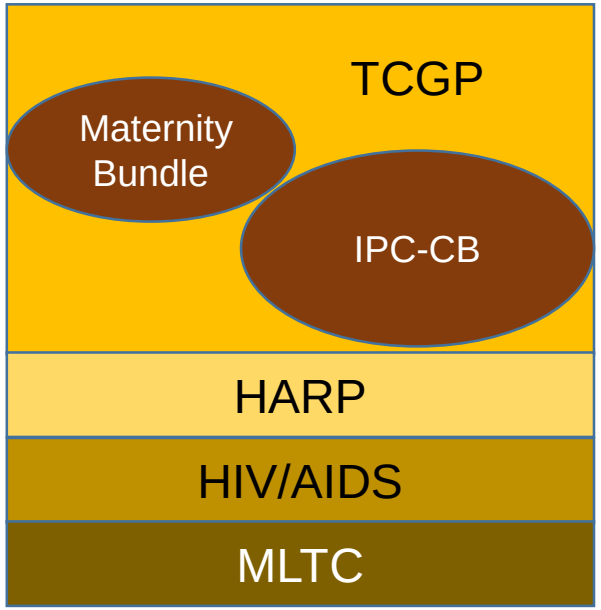
- For many parts of the Roadmap, DOH will provide *Guidelines* for MCOs and VBP contractors e.g.:
  - Negotiating the Target Budget for a VBP arrangement
  - Rewarding high value VBP contractors; penalizing poor performers (cost/quality)
  - Determining Shared Savings/Losses percentages

1. Episodes are defined by the inclusion criteria and grouping methodology of the HCI3/Prometheus logic, and by the NYS coverage criteria for mainstream managed care. Subpopulations are defined by the NYS inclusion and coverage definitions of the corresponding SNPs. Total Care for the General Population is defined by the NYS inclusion and coverage criteria for mainstream managed care.

The VBP Arrangements

- **Total Care General Population (TCGP)**
- **Integrated Primary Care with Chronic Bundle (IPC-CB)**
- **Maternity Bundle**

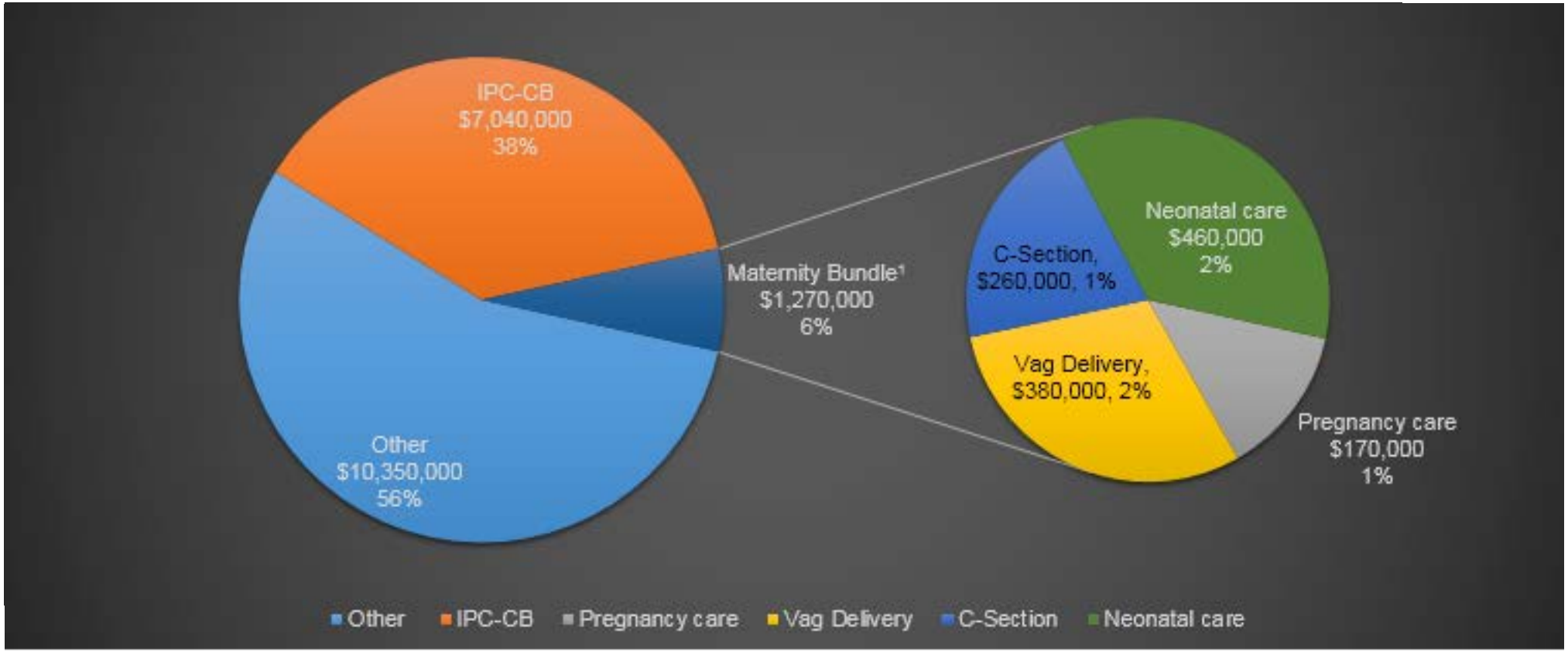
- **HARP**
- **HIV/AIDS**
- **MLTC**
- **(DD**)



In 2016, VBP Arrangements do not yet include Dually Eligible members

Disclaimer:
Preliminary Data, work in progress
2014, real-priced data

Overview costs of care in General Population
(Medicaid Only)



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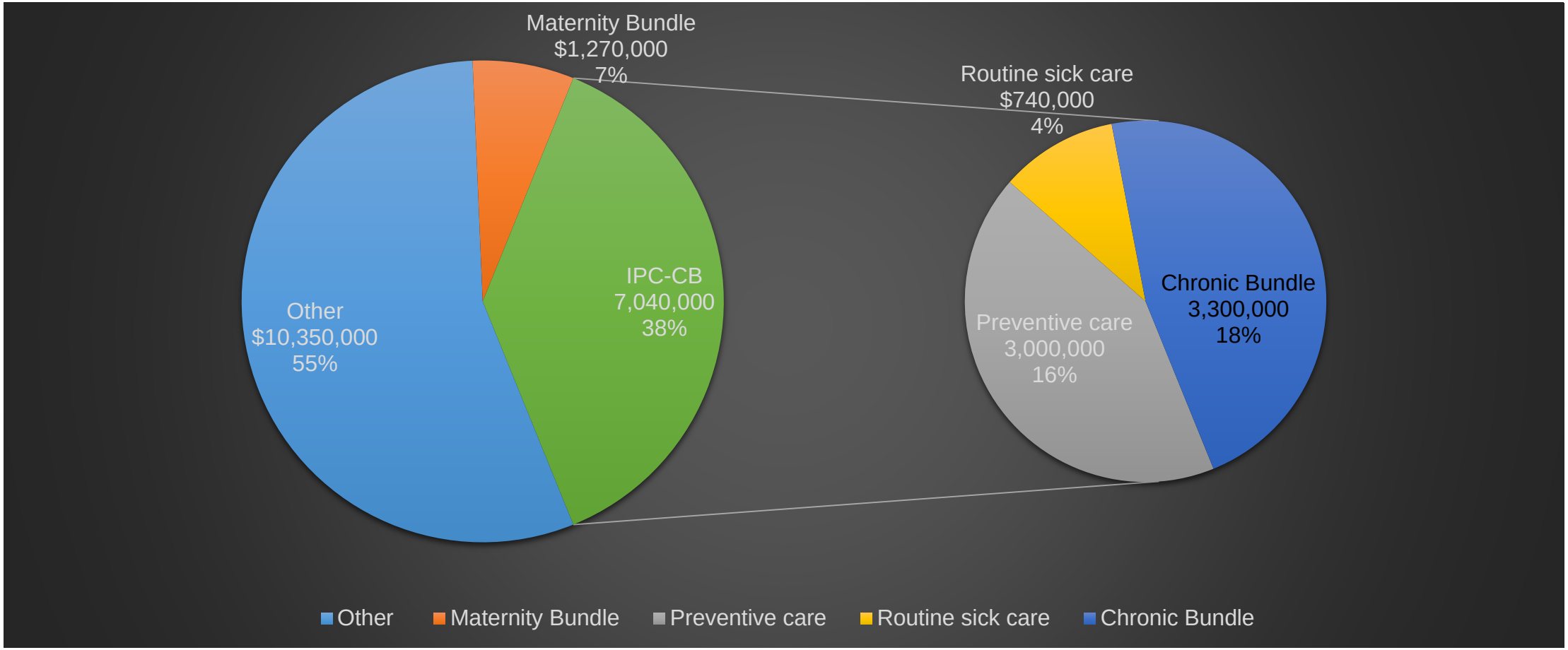

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VBP Bootcamps

- Regional based training sessions for plans, providers, and all stakeholders
- Objectives:
  - Educate stakeholders on the VBP work to date
  - Provide focused session to assist with readiness
  - Highlight best practices and lessons learned

Region	**Preferred Dates** **(note - there will be three modules in each region)**
Capital Region, Southern Tier, Mid-Hudson	June 2nd, June 15th, July 7th
Mohawk Valley, North Country, Tug Hill Seaway	June 29th, July 13th, July 27th
New York City (excluding Queens)	July 20th, August 17th, September 12th
Central, Finger Lakes, Western	August 31st, September 21st, October 6th
Long Island and Queens	September 27th, October 19th, October 26th

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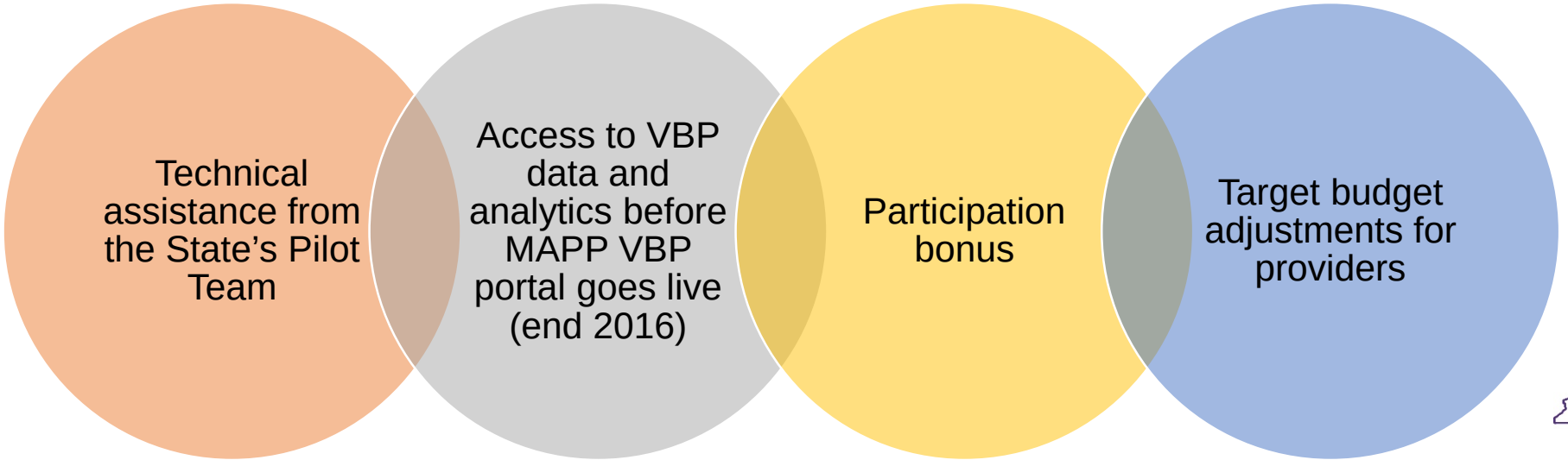
VBP Pilots

VBP Pilot Program

- Intended to:
  - create momentum in the move from FFS to VBP
  - establish early successes and best practices
  - learn from implementation challenges, identify and address obstacles to implementation
  - test new outcome measures, where necessary improve design of VBP arrangements
- Benefits of participating in the pilot program for MCOs:



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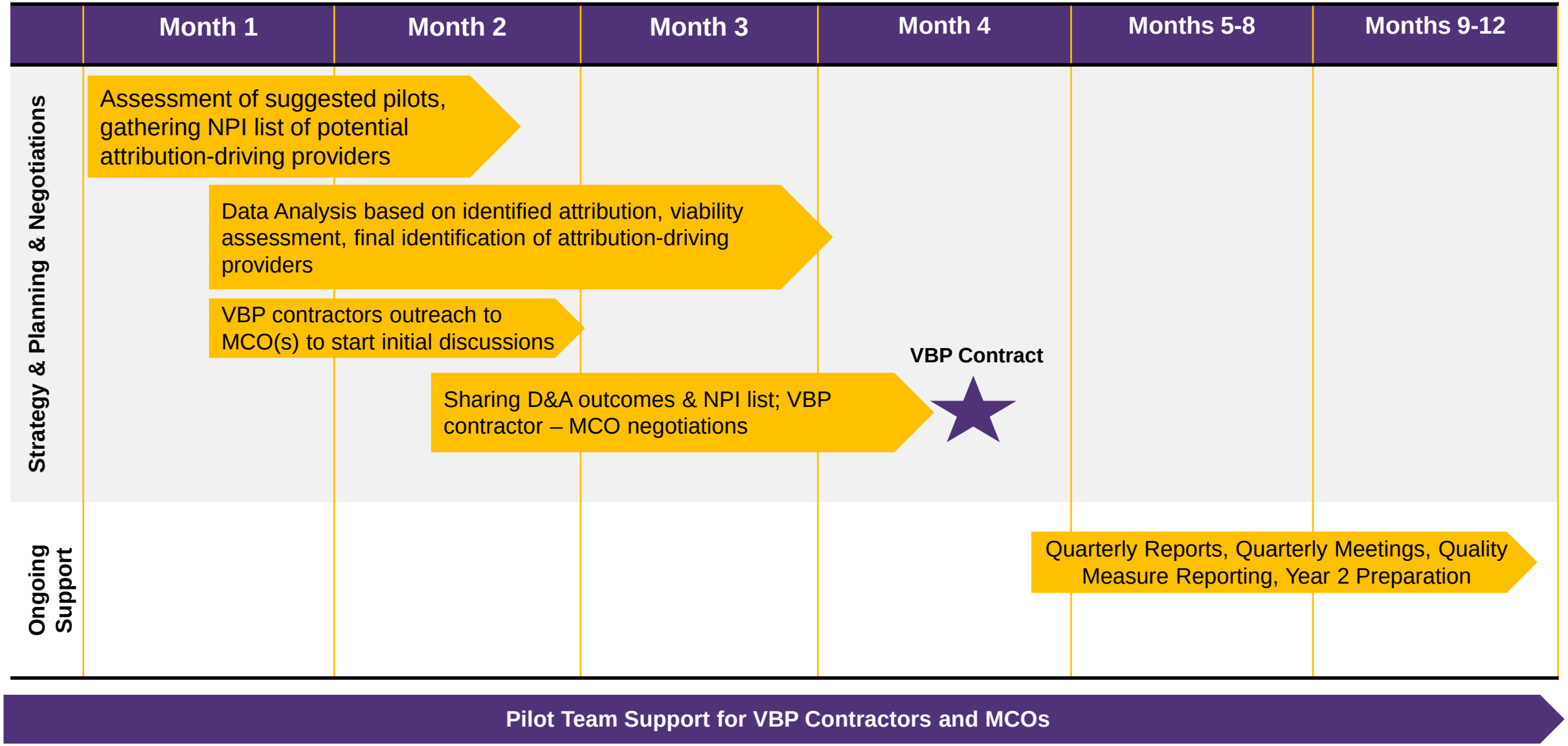
VBP Pilot Recap

- In the first year of Pilots (SFY17), the State will provide administrative support to help MCO's manage the Pilot programs.
- In SFY17, the State will set Target Budget Adjustments for the Pilots, and fund these through rate adjustments for the MCOs involved
- In the second year of the Pilots (SFY18), MCOs are expected to take over Pilot administrative support to continue these VBP contracts.
- All providers and plans are invited to participate in the pilots. DOH reserves the right to select those pilots that it deems to be most relevant to actively support.
- VBP Pilot participation is required for 2 years. No new pilots will be started in 2017 except for MLTC and DD.
- VBP Pilot arrangements must move into a Level 2 or higher agreement by the second year of participation.
- MCOs are expected to facilitate successful launch of the pilots.
- Participation bonus: 3.5M is available for SF16. Participating MCOs receive a $100K bonus and remaining funds will be distributed based on the ratio of an MCO's total Pilot program's member volume and the Pilot program's total member volume.
- *Definition: VBP Pilot = VBP contractor contracting one or more VBP arrangements with one or more MCOs*

VBP Pilots: process



VBP Pilots: current State

- Some 15 VBP pilots currently in different stages of preparation
- Sharing of performance data and improvement opportunities with potential VBP Pilots and MCOs has begun

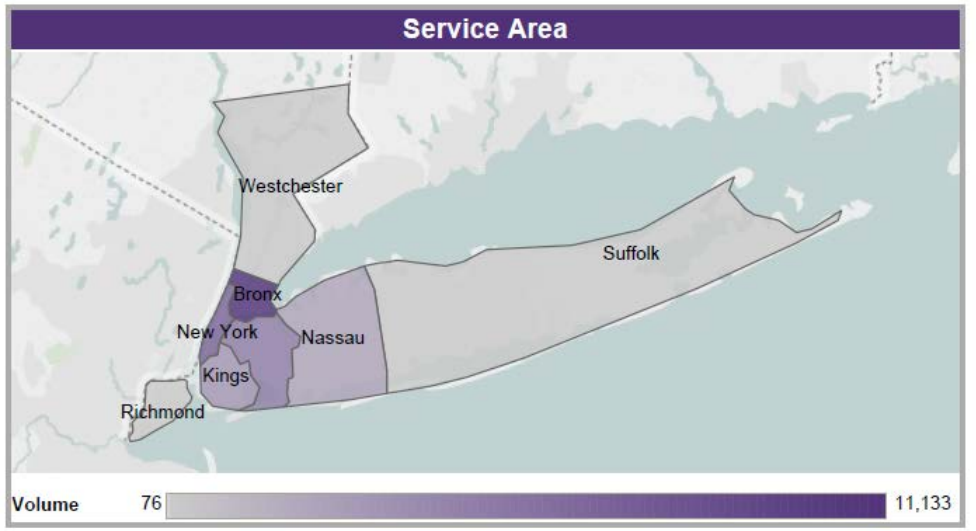
- **Total Care General Population (TCGP)**: 3-4 pilots
- **Integrated Primary Care with Chronic Bundle (IPC-CB)**: 3-4 pilots
- **Maternity Bundle**: 3-4 pilots

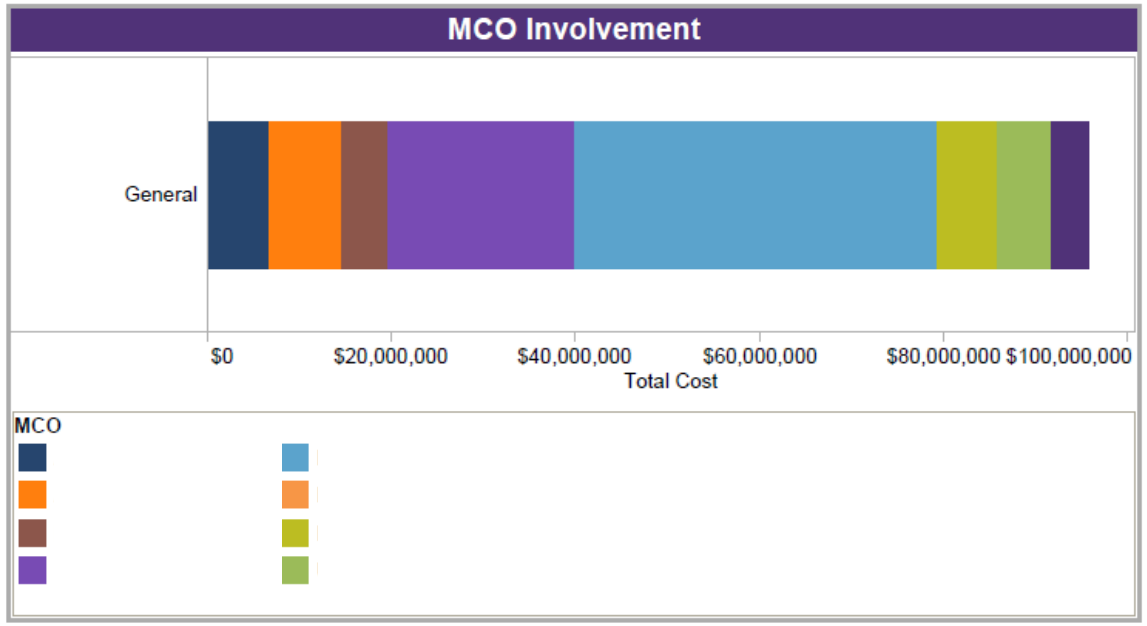
- **HARP**: 1-2 pilots
- **HIV/AIDS**: 1-2 pilots
- **MLTC and DD**: pilots start end 2016 / early 2017

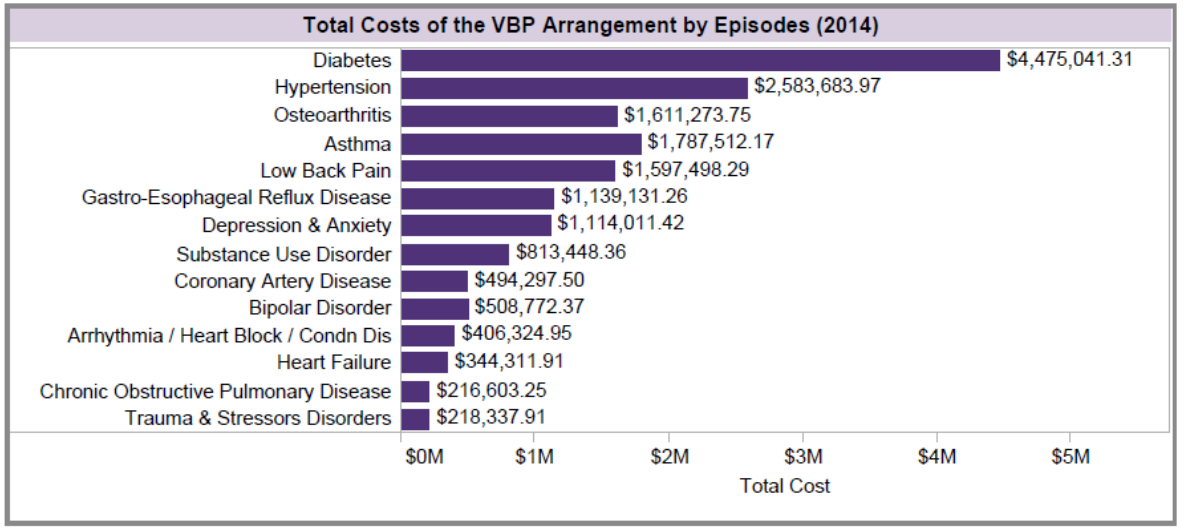
Data for illustration purposes only

VBP Pilots: process in practice

- Based on initial NPI list, pilot team validates attribution and basic D&A outputs with potential VBP contractor
- Example is IPC-CB arrangement: PCP drives attribution
- Subsequently, MCO-specific views are validated with MCO(s)







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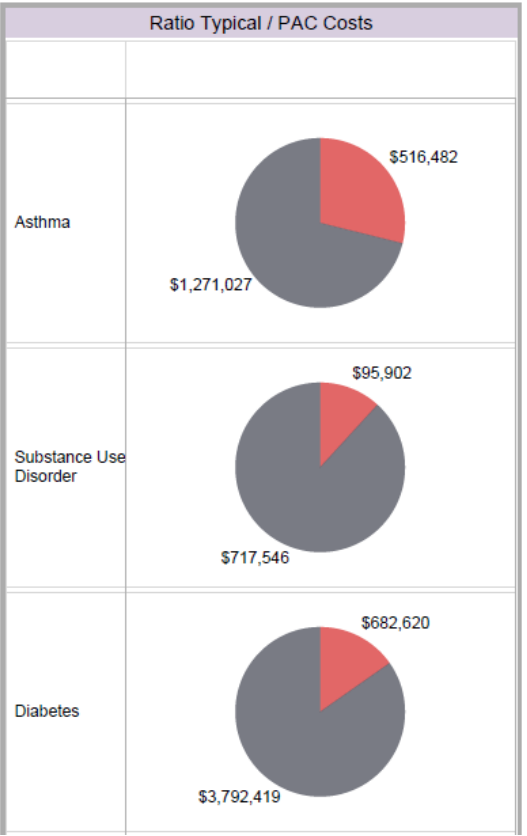
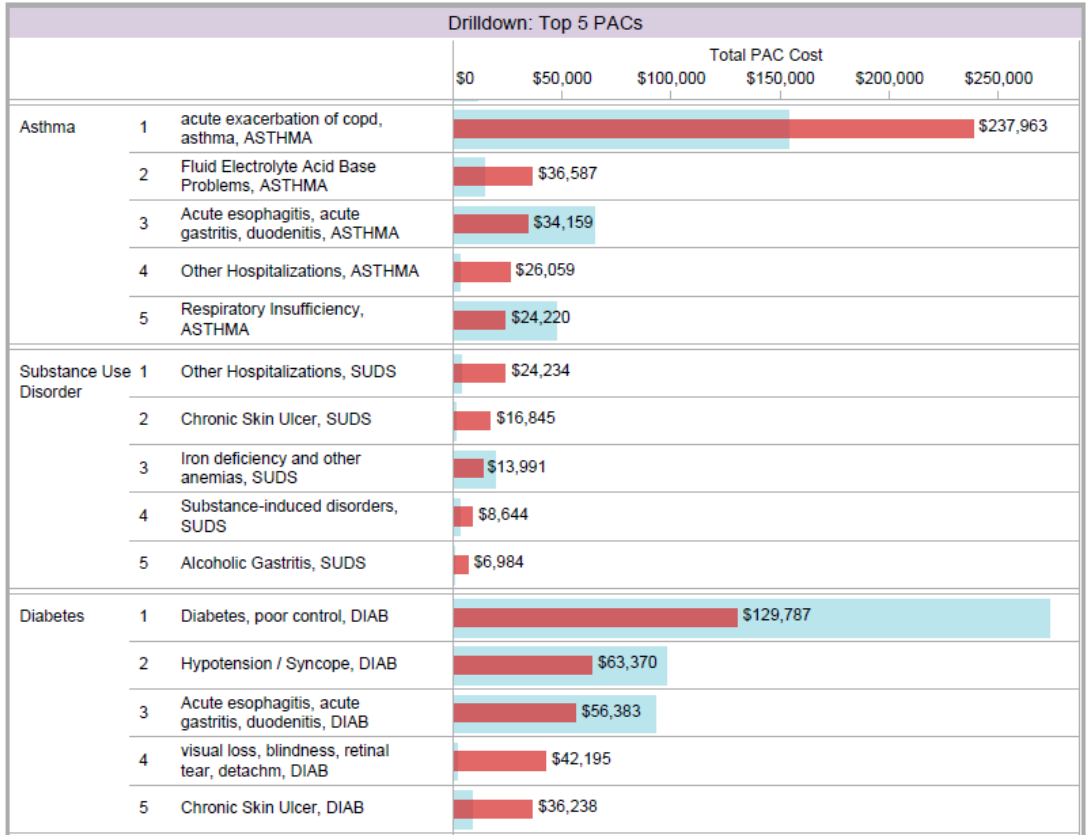
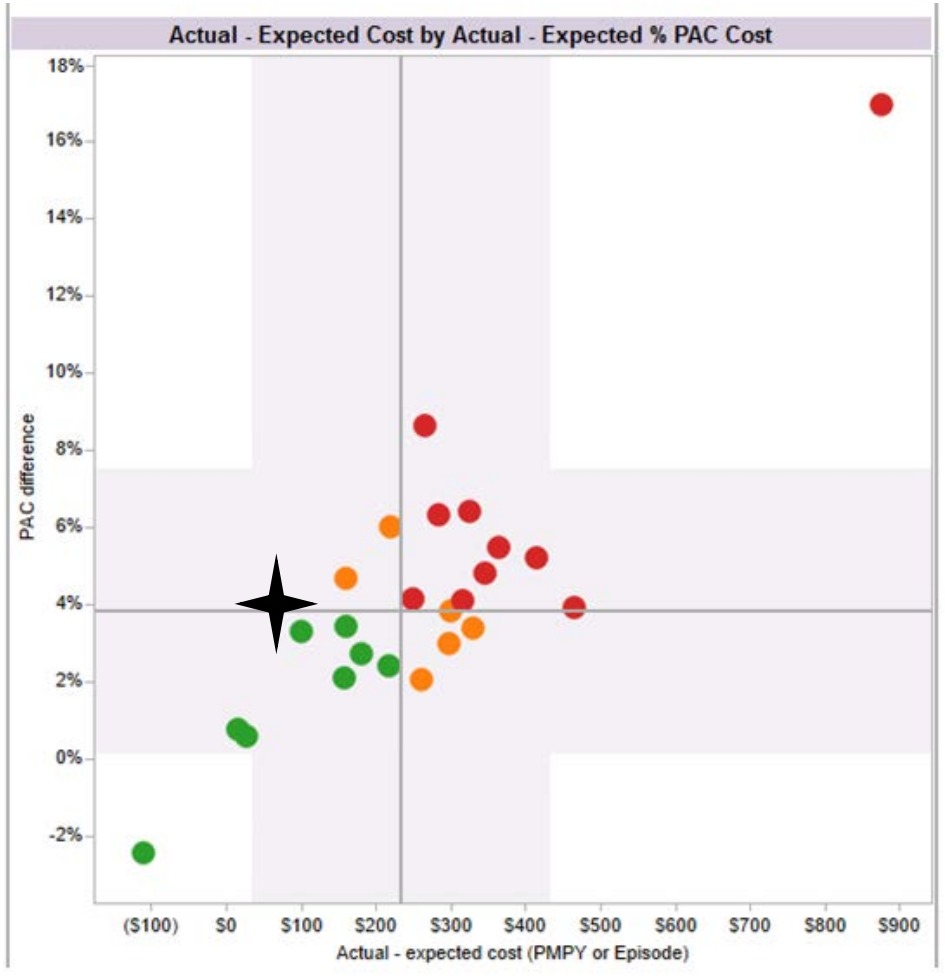
VBP Pilots: process in practice

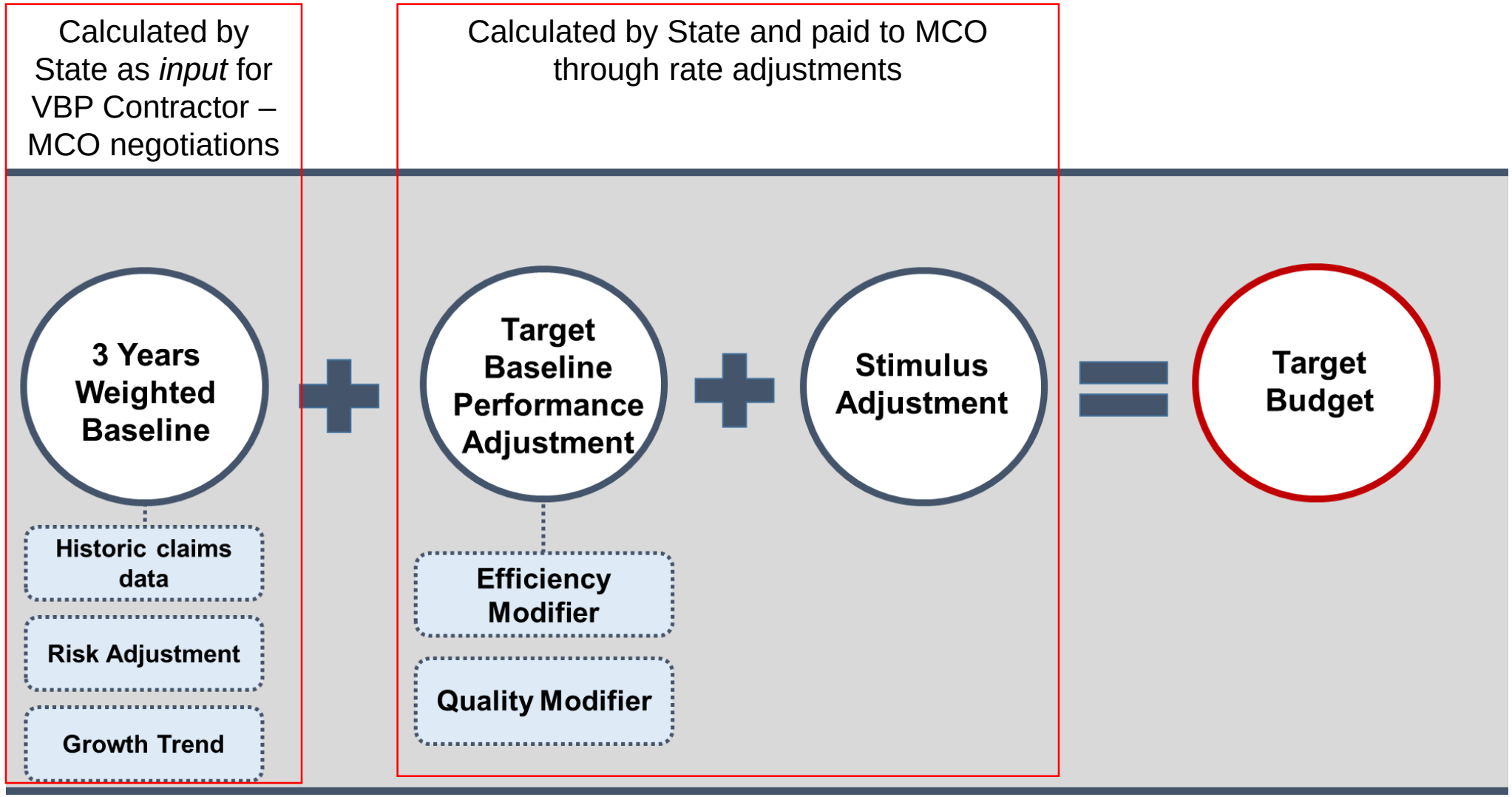
- Current performance and potential for improvement of potential VBP contractor is established with Pilot team
- Performance is compared with performance of PPSs until the number of VBP contractors is sufficient
- Performance ranking may lead to performance adjustment







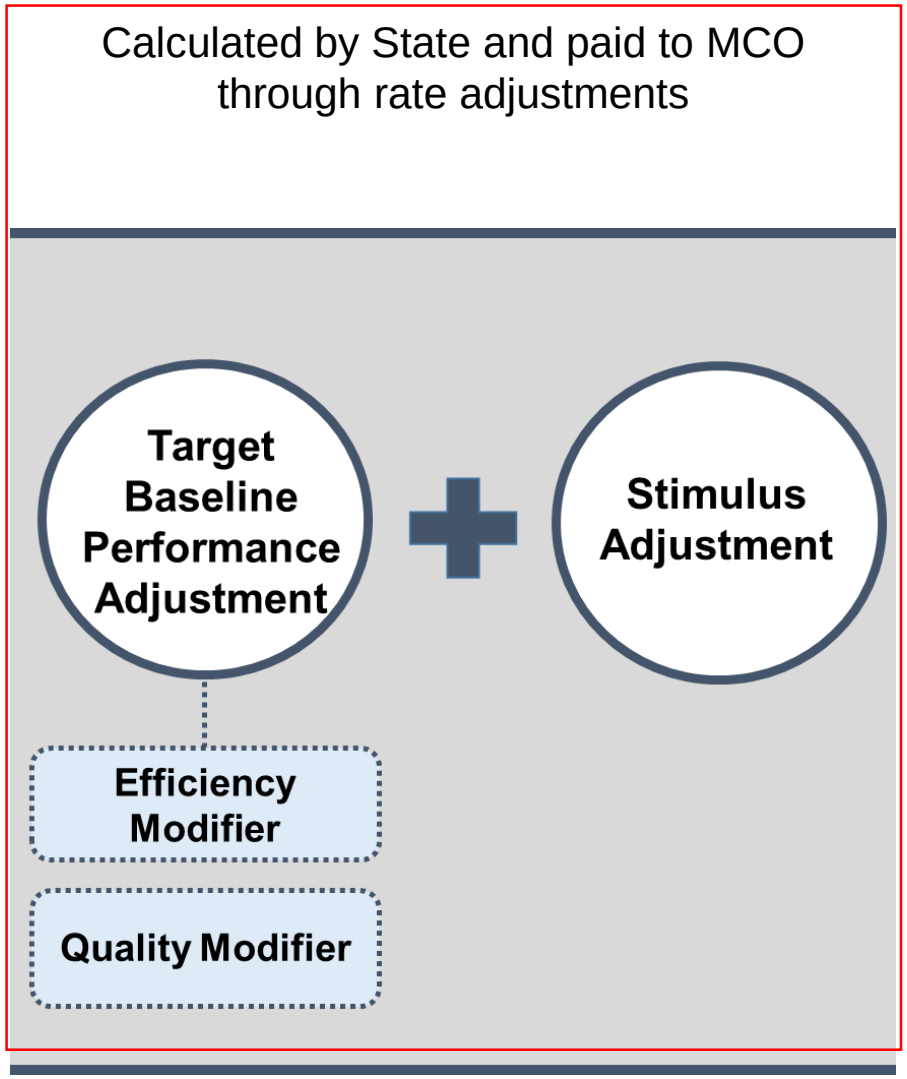
VBP Pilots: calculation of target budget



VBP Pilots: calculating the baseline

- Based on VBP contractor's historical costs for the VBP arrangement to be contracted
- MCO-specific
- Risk Adjustment is relevant when the risk profile of the members within the VBP arrangement is differs between the baseline period and the start of the contract
- ***More details in forthcoming webinar***

VBP Pilots: calculating the adjustments



- Based on example above:
  - Efficiency ranking above 80th percentile: 2% of baseline (as calculated by State)
  - Quality score is between 50th and 80th percentile: no additional adjustment
  - Stimulus adjustment applies because VBP contract starts in Level 2: IPC-CB arrangement receives 1% of baseline[1]
- If Baseline calculated by the state is e.g. $50M for the participating MCO, the MCO will receive 3% ($1.5M)
- Following the guideline, the MCO will retain more or less of this $1.5M depending on level of contract and performance of VBP contractor in contract year
  - MCO and VBP contractor can also decide to use (part of) these funds to increase payments to VBP contractor upfront (to invest in care management, for example)
- ***More details in forthcoming webinar***

1. See Updated Roadmap section on Target Budgets.

VBP Pilots: contracting – IPC-CB example

- An MCO can leverage existing contracting models - an addendum is usually sufficient
- For IPC-CB, existing contracts with PCPs sometimes include capitation, add-ons, or mixed models – the State does not prescribe preferred forms
- *The current arrangement between MCO and PCPs can be the starting point*
  - The Target Budget is set by projecting the historical costs of the total IPC/Chronic Bundle of the VBP contractor forward (risk-adjusted, adjusted for growth-rate)
  - Importantly, this is a virtual budget – nothing has to change in how payments are currently made
  - If the VBP contractor manages to keep the actual spend under target budget, savings are shared
  - IPC-CB arrangement is powerful way to create significant savings opportunities yet make accepting downside risk feasible for PCPs
  - No obligation to move to Level 2 with all chronic episodes in the Bundle at the same time
- An increase in PCP-related spend should be expected and – if done appropriately – should reduce downstream costs.
  - The Preventive Care component from the IPC-CB arrangement is excluded when comparing efficiency.
  - If total costs are not reduced, no savings are available to be shared; in Level 2, VBP contractor is responsible for part of the losses

MCO Quarterly Reports and 2017-2018 Incentives Changes

Aligning MCO incentives with VBP Roadmap

Type of Adjustment	Range
Performance adjustments (Efficiency and Quality) per VBP arrangement applied to total premium • whether included in VBP arrangements or not	Aligning with VBP Contracting Guidelines, range will growing to +/- 6% in 2018
Stimulus adjustments for new level 2 or 3 contracts – applied to VBP contract value	0.575-1.15%
Penalties for not meeting Roadmap goals – applied to gap between actual and target contract value captured in VBP arrangements	Growing to -2% in 2019

Performance Adjustments

2017 is transition year:

- Efficiency adjustments are ramped up; current efficiency adjustments (LANE/PPA) are ramped down
- Quality adjustments remain largely unchanged (QARR)
- Data quality will be key focus – across both Mainstream MCOs and SNPs

From 2018 on:

- Efficiency adjustments fully in place
- Quality adjustments, including QARR, further aligned with roadmap
- *All changes are budgetary neutral*

To adequately prepare for these changes, MCOs will receive Quarterly Report Cards starting this Quarter

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Quarterly Performance Report

Each actual - expected column will have a symbol:
- ▼ If more than 10% under expected
- ▲ If more than 10% over expected
- ■ Close to expected

	Costs[1]							
	General		Costs (PMPY or episode) - real pricing			Costs (PMPY or episode) - proxy pricing		% PAC costs (episode)	
	Number of members or episodes 2	Total Cost	Actual Cost	Actual / Expected Ratio	Actual / Statewide Ratio	Actual / Exprcted Ratio	Actual / Statewide Ratio	Total % PAC Costs	Actual - Exp % PAC Costs
Total Care General Population			$4,148	▼-12.4%	■-4.8%	■-6.8%	■0.9%	12.2%	
IPC CB			$1,737						
IPC			$992	▲11.7%	▲14.9%	▲28.4%	▲31.1%	3.0%	■-0.1%
Chronic Bundle			$2,351	■-2.5%	■-2.1%	■2.4%	■3.8%	22.9%	▼-3.4%
Maternity Care			$12,917	▲10.7%	■7.6%	■5.1%	■-0.2%	2.4%	▲1.3%
Total Care HIV/AIDS			$33,001		■-9.3%		■-6.1%	15.1%	
Total Care HARP			$22,988		■4.2%		■6.3%	27.6%	

Drilldown: Chronic Bundle

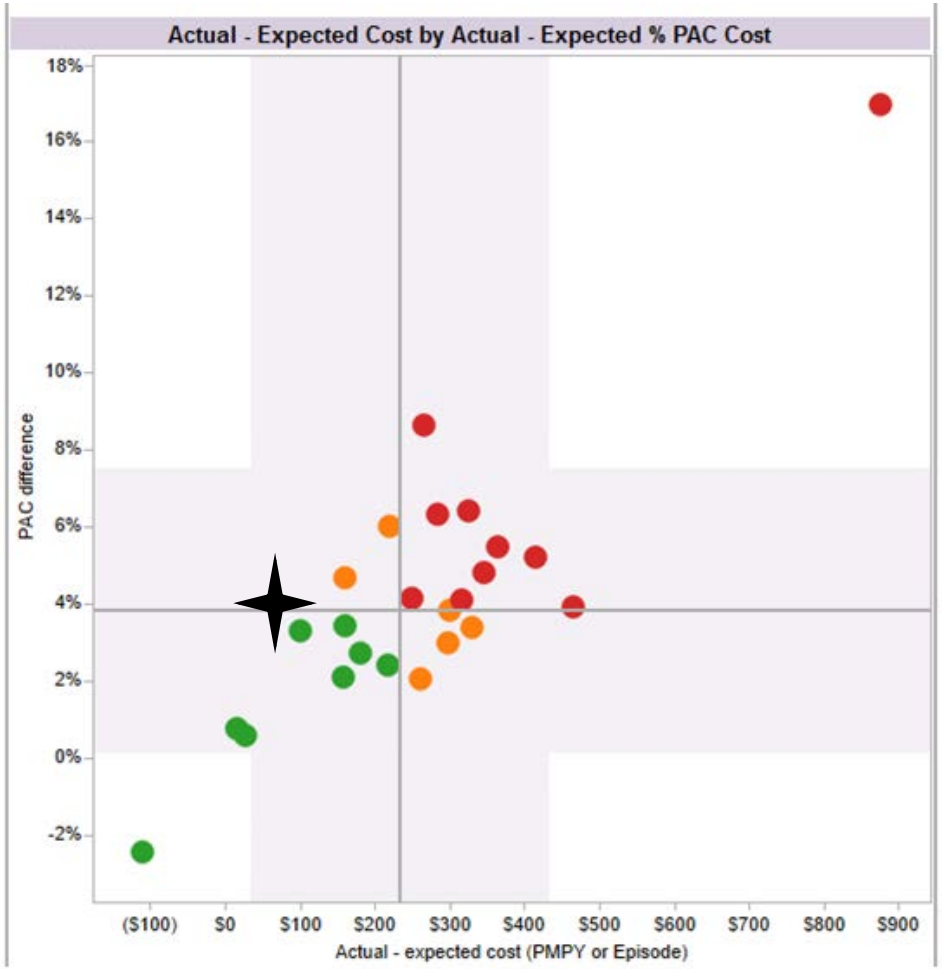
Arrhythmia / Heart Block / Condn Dis			$1,729	■-5.9%	■2.1%	▼-3.8%	■3.5%	44.1%	■-3.4%
Asthma			$903	■-1.2%	■7.4%	■5.6%	▲15.9%	33.2%	■0.1%
Bipolar Disorder			$4,447	▼-18.7%	■-3.4%	▼-16.5%	■-1.8%	11.5%	▼-8.0%
Chronic Obstructive Pulmonary Disease			$1,001	▼-25.8%	▼-18.3%	▼-17.9%	▼-11.5%	32.8%	▼-12.2%
Coronary Artery Disease			$1,890	■-5.6%	■-6.2%	▼-6.4%	■-5.6%	35.9%	▼-6.1%
Depression & Anxiety			$1,161	■8.7%	■9.4%	■10.3%	■9.8%	8.3%	■0.4%
Diabetes			$3,484	■1.1%	■5.2%	■4.4%	■9.1%	19.9%	■-2.2%
Gastro-Esophageal Reflux Disease			$488	■-0.6%	■-4.6%	■6.3%	■3.0%	14.5%	■-0.6%
Heart Failure			$3,631	▼-13.5%	▼-11.3%	▼-12.2%	■-9.6%	38.2%	▼-10.6%
Hypertension			$894	■-3.9%	■-2.6%	▼6.6%	▲10.0%	31.5%	▼-4.3%
Low Back Pain			$731	▲17.2%	■2.4%	▲23.3%	■10.0%	25.2%	▲2.8%
Osteoarthritis			$2,682	■-0.5%	■2.6%	■3.4%	■7.4%	14.4%	▼-1.7%
Substance Use Disorder			$2,675	▼-12.5%	■4.6%	▼-8.3%	▲10.2%	18.3%	▼-15.6%
Trauma & Stressors Disorders			$655	■-7.5%	■-1.6%	▼-5.6%	■0.2%	4.6%	▼-1.3%

In 2016, all MCOs will receive quarterly reports

- For validation
- To support VBP strategy

Quarterly Performance Report

- Performance Comparison:
  - Total cost of bundle/member (risk-adjusted, proxy priced)
  - Quality
- For TCGP, IPC-CB, HARP and HIV/AIDS: a key quality measure will be the percentage of total costs that are associated with Potentially Avoidable Complications (PACs)
  - Maximal alignment with DSRIP and State Policy Goals & professional motivation
- For Maternity Care, PACs percentage is not a valid measure (too low)
  - Composite measure based on CAG and pilot lessons will be determined



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Performance adjustment: based on comparison with other MCOs

Risk-adjusted, proxy priced

Example – SFY18:

- Total premium dollars included in IPC-CB for MCO A is $500M
  - Efficiency ranking above 80th percentile: 2% upward adjustment
  - Quality score average: no adjustment

  → $10M
- Total premium dollars included in Maternity Care is $80M
  - Efficiency ranking below 30th percentile: 1% downward adjustment
  - Quality score below average: .5% downward adjustment

  → ($1.6M)
- Total premium dollars in remaining TCGP is $750M
  - Efficiency ranking (of total TCGP) above 70th percentile: 1% upward adjustment
  - Quality score (of total TCGP) significantly above average: 1% upwards adjustment

  → $15M

Total Performance Adjustment for MCO A: $23.4M (+ 1.8%)

More details in forthcoming webinar

Q&A