NEW YORK STATE | Department of Health | Medicaid Redesign Team

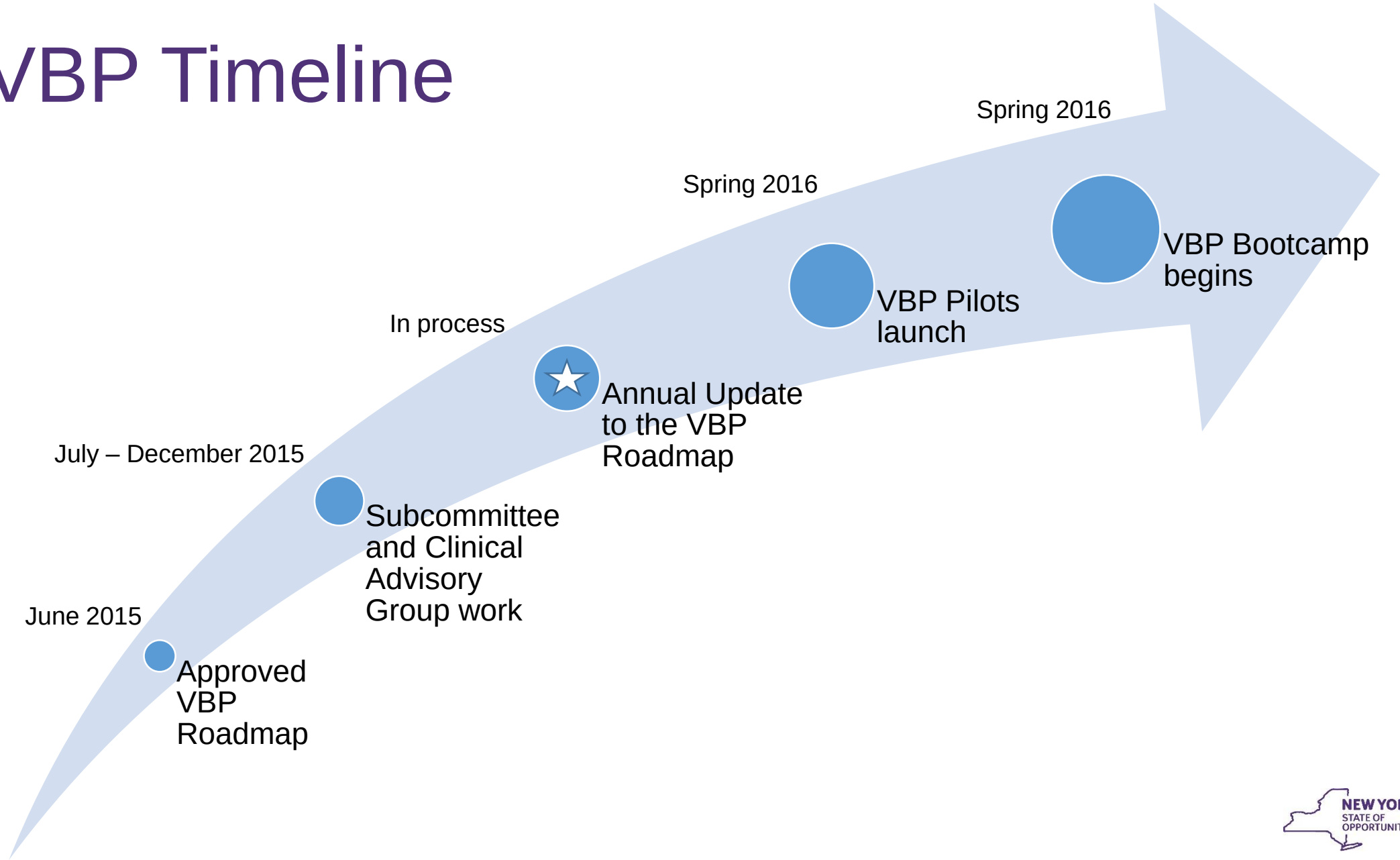
All Plan Value Based Payment Meeting

February 10, 2016

Agenda

- Introduction
- VBP Recap and Updates
- VBP Pilot Program Details
- VBP and MCO Incentives

VBP Timeline



NEW YORK STATE OF OPPORTUNITY. Department of Health

VBP Updates

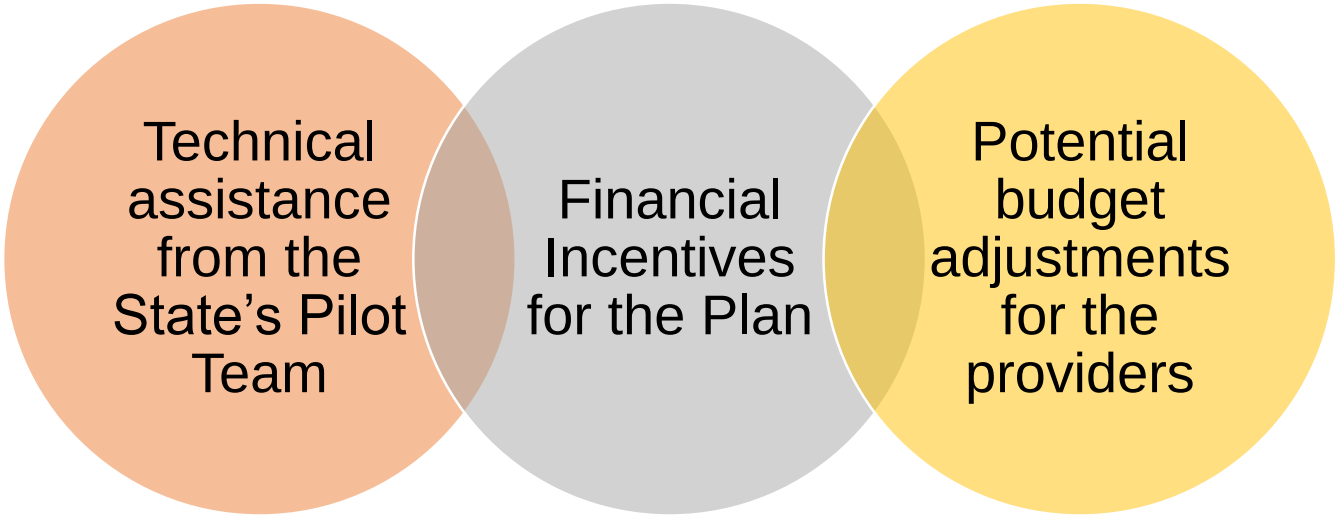
- Baseline Survey
  - MCOs will be receiving a survey to assess the baseline measure of contracts in VBP arrangements
    - Includes detailed definitions of each level
- VBP Subcommittees have completed their work and have presented recommendations to the VBP workgroup for acceptance
  - Recommendations will be added to the VBP Roadmap as appropriate
- Clinical Advisory Groups are ongoing and are responsible for defining VBP arrangements and required outcomes measures
  - Maternity, HIV, Pulmonary, Chronic Heart, Diabetes, and IPC are complete. CAG reports will be publically available online once finalized.
  - DD, MLTC, and Behavioral Health are ongoing

VBP Boot Camps

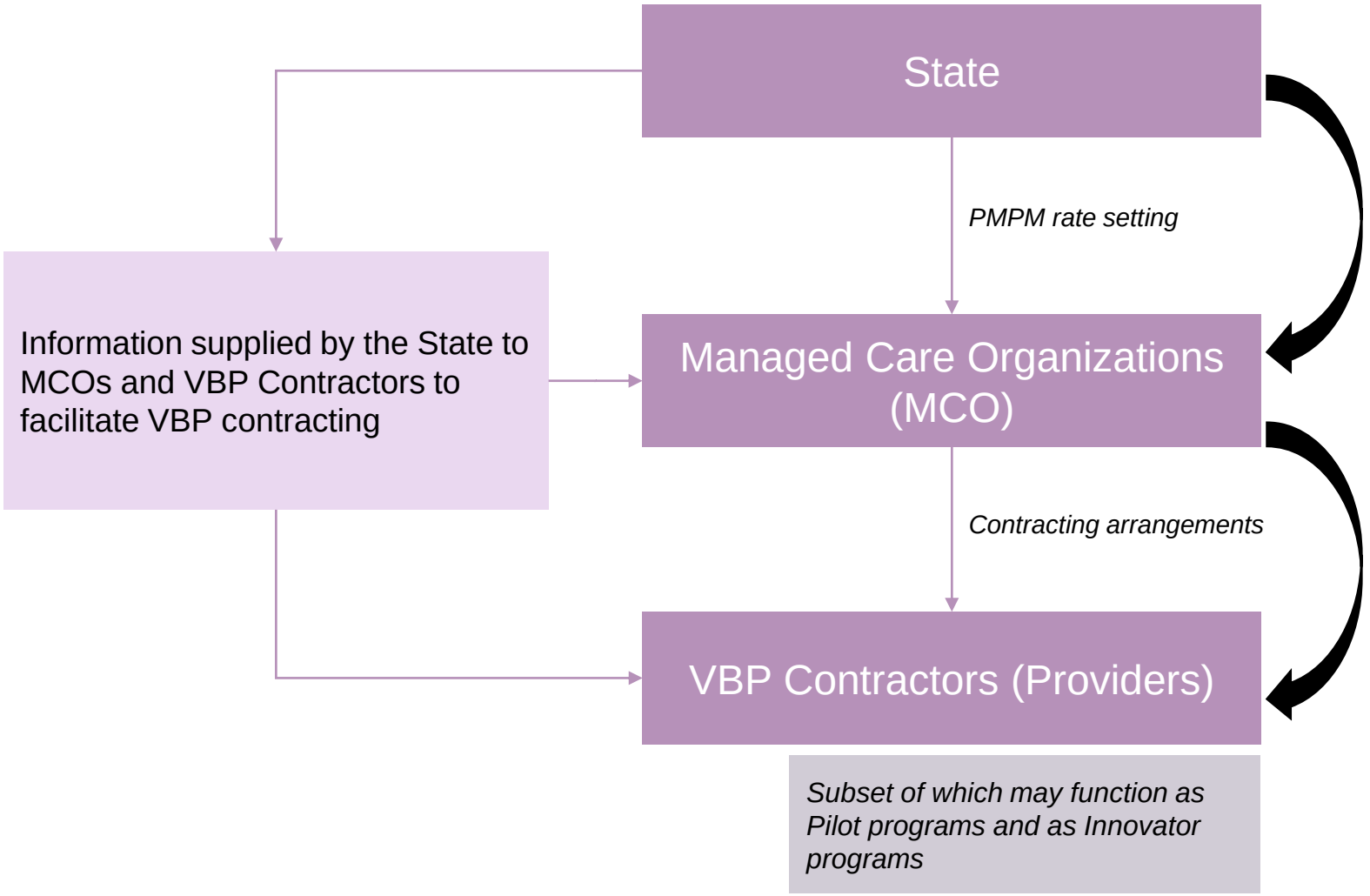
- Regional based trainings for plan, providers, and all stakeholders
- Objective
  - Educate stakeholders on the VBP work to date
  - Provide focused session to assist with readiness
  - Highlight best practices and lessons learned
- Dates forthcoming- will start in Spring 2016

VBP Pilot Program

- Intended to create momentum in VBP in all the different VBP arrangements as well as establish early successes and best practices.
- The goal is to start 15 pilot arrangements aiming at 2-3 pilots per arrangement. (No off-menu pilots).
- Benefits of participating in the pilot program



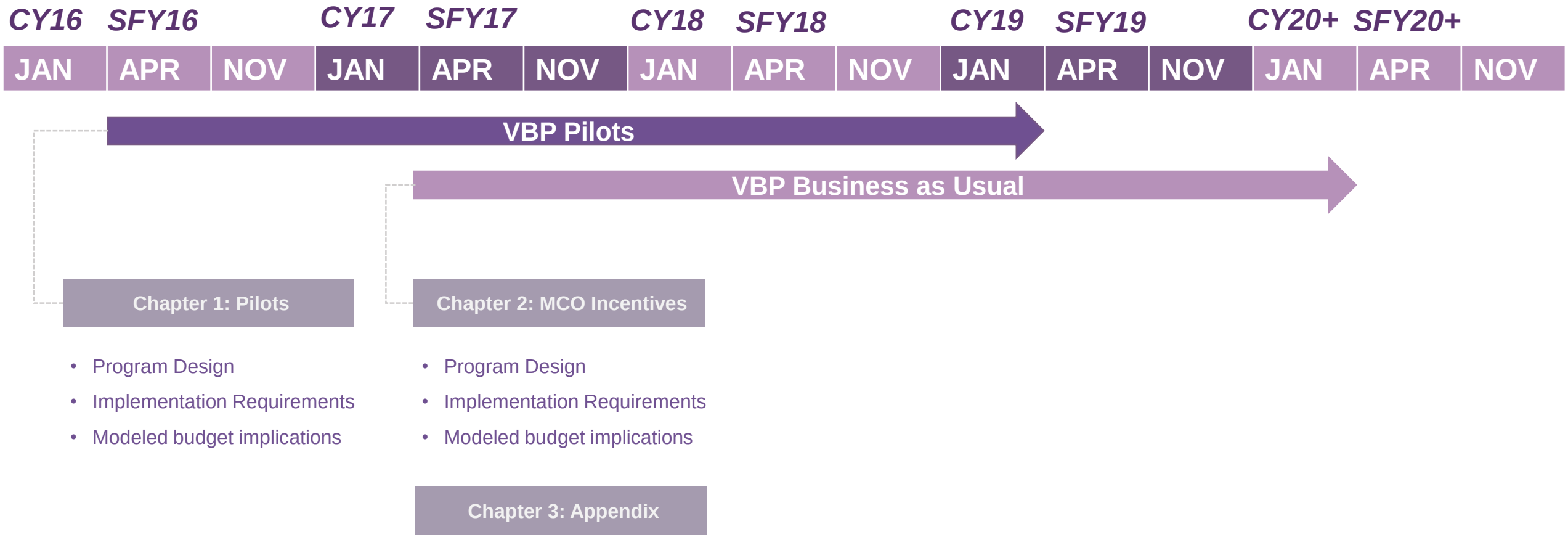
Recap - VBP Process in Practice



New MCO Incentive structure: to be introduced from 2017 onwards. Closely aligned with the Technical Subcommittee recommendations. All incentives to be integrated into the standard MCO rate setting process.

Technical Subcommittee recommendations: guidelines for contracting VBP arrangements between MCOs and providers.

How is this presentation structured



NEW YORK STATE | Department of Health | Medicaid Redesign Team

Chapter 1: Pilots

- Program Design
- Implementation Requirements

VBP Pilot: Goals, Practical Points, and Requirements

Goal of the VBP pilots

- Creating Momentum in VBP in all the different VBP arrangements.
- Creating Early Success and Best Practices: learning what works in practice to allow for more effective scaling.
- Studying/developing the VBP Quality Measures defined by the CAGs.

Practical Points

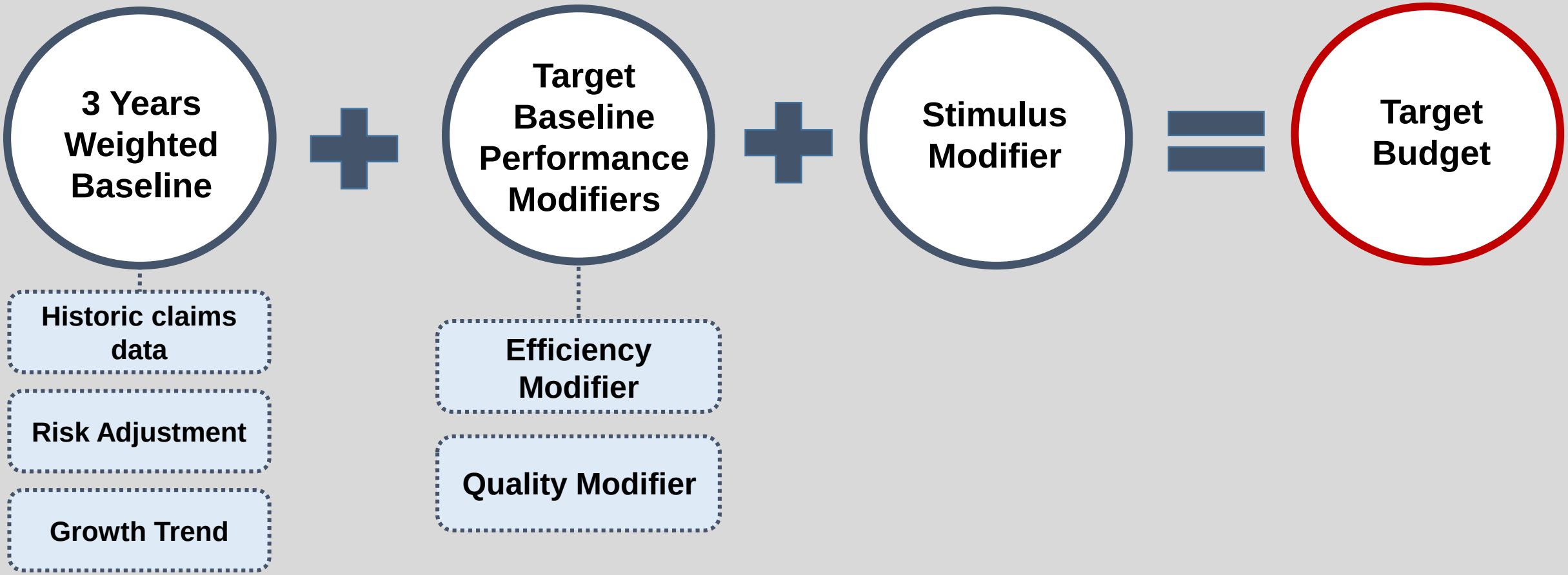
- In the first year of Pilots, the State will provide administrative support to help MCO's manage the Pilot programs.
- In the second year of the Pilots, the MCOs are expected to take over Pilot administrative support to continue these VBP contracts. These updates will be reflected in the Model contract.
- From 2018 onwards: all VBP contracts from that point onwards are considered 'business as usual'.

Requirements for VBP pilot participation

- VBP Pilot participation is voluntary. DOH reserves the right to select those pilots that it deems to be most relevant to actively support.
- VBP Pilots must be significant*. The goal is to start 15 pilot arrangements aiming at 2-3 pilots per arrangement. (No off-menu pilots).
- VBP Innovator Providers may not also participate in the Pilot Program.
- VBP Pilot participation is required for 2 years. The aim is to start all pilots in 2016. No new pilots will be started in 2017.
- VBP Pilot arrangements initiated in 2016 can start at any Level of contract risk (1,2, or 3) however, all participating pilots must move into a Level 2 agreement by the second year of participation, or 2017 whichever is first.
- The upward performance and stimulus adjustments for the pilots selected by the State will be funded by the State in 2016 through rate adjustments for the MCOs involved.

*10,000 members (excluding dual eligible members) for a TCTP or IPC contract
3,000 members (excluding dual eligible members) for a HIV/AIDS contract
1,000 members for a Maternity bundle or HARP contract
5,000 members for a chronic bundle contract

Primary Target Budget Components



1) Provider Target Baseline Performance Modifiers

	Year 1	Year 2
Description	As stated in the Technical Design I Subcommittee Recommendations, upwards adjustment to the target budget are rewarded to providers that demonstrate efficient and quality care in previous years.	
Calculation Method	Upward Adjustment **Efficiency Adjustment:** • + 1% for the top 30% most efficient Pilots • + 2% for the top 20% most efficient Pilots • + 3% for the top 10% most efficient Pilots **Quality Adjustment** (on top of Efficiency Modifier): • 50% extra upward adjustment for the top 20% highest quality (i.e., a 3% adjustment would become 4.5%) • 100% extra upward adjustment for the top 10% highest quality (i.e., a 2% adjustment would become 4%). • No upward adjustment for those in the bottom 40% of the quality ranking (<P40). *Calculated performance is based on the most recent full year of proxy price and risk adjustment data available.*	
Implemented Ranges	0% to 6%	
Exclusions	Arrangements must be in DOH recognized VBP Pilots to qualify for the state-funded 2016 performance adjustments.	
Rate Cycle	April 2016 (assumes April start date) based on most recent data available.	April 2017 (assumes April start date) based on most recent data available.
Notes	In 2017, a possible imbalance exists because MCOs pay out only upward adjustments to providers yet may receive downward adjustments in their revenue. The State needs to carefully monitor potential unjust negative effects on MCO incomes, and will reserve a dedicated budget to accommodate these effect (TBD end 2016).	

*Method here described is the method recommended by the TD I Subcommittee with the addition of the 1% increase to the target budget for the top 30% of efficient MCOs.

2) Provider Stimulus Adjustment

	Year 1	Year 2
Description	Upwards adjustment of target budget over two year to reward VBP Contractors entering in Level 2 VBP contracts or Level 3 VBP contracts.	
Calculation Method	For Total Care for Total (Sub)Population arrangements, pilots will receive a 0.5% upward adjustment of a VBP contract's target budget. For all other VBP arrangements, pilots will receive a 1 % upward adjustment of a VBP contract's target budget. Pilots will only receive these adjustments if their performance for the VBP arrangement ranks in the top 50% for efficiency and quality (i.e., >=P50 for efficiency and >=P50 for quality). Each stimulation adjustment lasts two years.	
Implemented Ranges	0.5% to 1% depending on arrangement	
Exclusions	Arrangements must be in DOH recognized VBP Pilots to qualify for the state-funded 2016 stimulus adjustments. A pilot that moves to a higher level in 2017 should get its stimulus adjustment through the MCO (from 2017 on, State – MCO payments include similar incentives).	
Rate Cycle	April 2016 (assumes April start date) based on SFY2016 Pilot arrangements	April 2017 (assumes April start date) based on SFY2017 Pilot arrangements
Notes		

3) MCO Pilot Participation Bonus

	Year 1	Year 2
Description	Participating MCOs will receive a bonus for each arrangement in VBP Pilots via the PMPM rate to encourage participation and reward administrative support of Pilots.	
Calculation Method	In aggregate the state will set aside approx. 3.5M dollar for MCO participation bonus. The exact calculation is yet to be finalized and will include both a per-pilot reward but also a member-volume based component.	TBD.
Implemented Ranges		
Exclusions	Arrangements must be in VBP Pilots to qualify for the bonus.	
Rate Cycle	Year 1 based on contracts signed in SFY 2016	Year 2 based on contracts signed in SFY 2017
Notes		

MCO Pilot Participation

Benefits

- MCOs will be eligible for funds via the MCO Pilot Participation Bonus and in potential shared savings.
- MCOs will get a head start in participating in a VBP structure that only has upward adjustments and imitates the VBP future state where penalties will begin to apply. This is a great opportunity for MCOs to fine tune administrative functions to align with VBP.

Challenges

- Accepting a portion of the financial risk associated with VBP arrangements that are novel to certain providers.
- Navigating and establishing new administrative functions and contracts necessary to run VBP arrangements.

MCO Minimum Requirements

- MCOs will have to enter into VBP arrangements as defined in the Roadmap with VBP contracting entities. (No off-menu arrangements in the pilot phase)
- MCOs will be responsible for calculating the target budget in the second year of the pilot and will be expected to take over the pilot-support team tasks (i.e., quarterly progress reports, etc.)

Payment Details State-MCOs

- All payments from the State to the MCO are in the rates. The payments from the MCO to the VBP contracting entity is to be determined between the MCO and the contracting entity themselves, however the State has suggested guidelines for the MCOs to follow.
- Provider Target Baseline Performance Modifiers – Rate adjustment in April (assuming April start) based on the most recent data available. The rate adjustment acts as a modifier to the target budget.
- Provider Stimulus Adjustment – Rate adjustment in April (assuming April start) based on that year's contracts. The rate adjustment acts as a modifier to the target budget.
- MCO Participation Bonus – Rate adjustment in April (assuming April start) based on that year's contracts. The rate adjustment as a bonus to the MCO.
- Reconciliation occurs six months after the completion of the VBP performance year.

NEW YORK STATE | Department of Health | Medicaid Redesign Team

Chapter 2: MCO Incentives

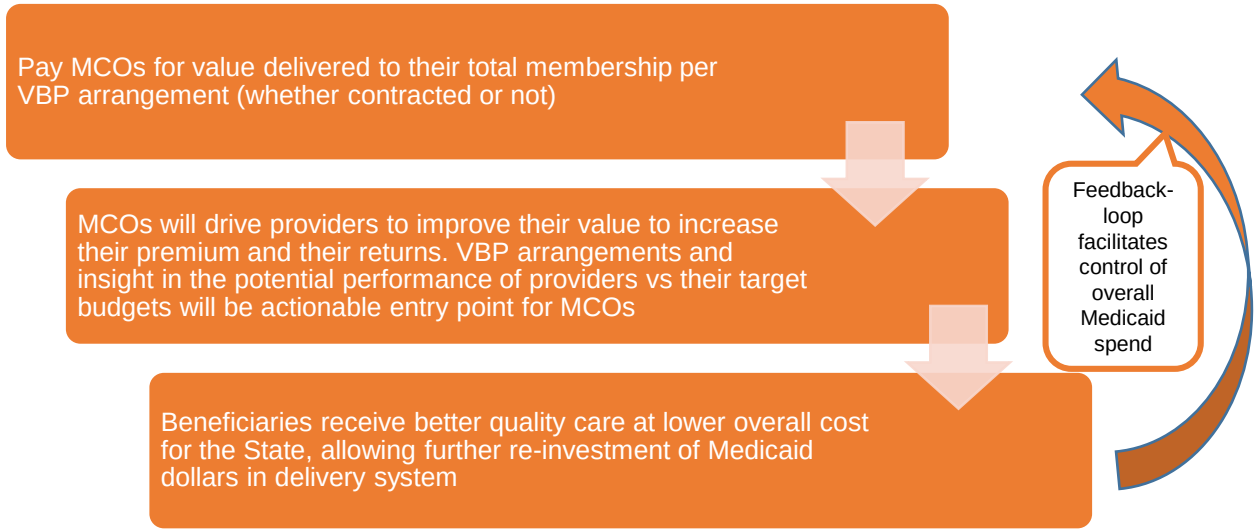
- Program Design
- Implementation Requirements
- Example Scenario

MCO Incentives: Goals and Requirements

Goal of the MCO Incentives

- The long term success of VBP is dependent on the contracting behavior of MCOs. They should be incentivized to:
  - contract and reward high value care, and incentivize to get even better.
  - help improve lower value providers where possible.
  - move beneficiaries to higher value providers where possible and increase their volume.
  - discontinue contracts with low value providers where no improvement is deemed feasible.
  - to compensate the MCOs for start up costs to adapt to new contracting mechanisms.
- The solution is to closely align incentives for MCOs with the aims for VBP.

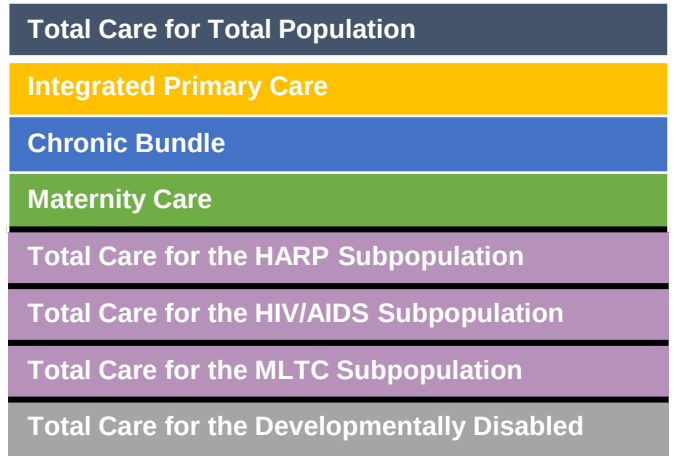
Aligning incentives – feedback loop



Design of the MCO Incentives

- The MCO Incentive adjustments will be deployed from SFY 2017 onwards.
- Like the incentives for VBP contractors, the MCO incentives similarly consist of performance adjustments and stimulus adjustments. In addition, MCOs that fail to meet the Roadmap VBP milestones can be penalized.
- The upwards and downwards adjustments ensure overall Medicaid budget control while ensuring available dollars under the Cap are maximally spent on care. Therefore, the incentive structure for MCOs has to become a zero sum loop from 2017 onwards.
- To create maximum incentive to optimize value, the adjustment and stimulus adjustments will be applied per VBP arrangement (see below), including all members that are eligible for that VBP arrangement (i.e., whether or not the MCO is actually contracting these VBP arrangements).
- To reduce complexity and ensure appropriate focus for MCOs, the number of different VBP arrangement is reduced by compiling all chronic episodes into the Chronic Bundle, which will be assessed as a whole.
- Mainstream MCOs will thus have four main integrated care categories to drive quality and efficiency.

- To ensure that the adjustments are applied to the total MCO contract value (and not more or less), the '**Total Care for Total Population**' adjustments will be applied only to the dollars not attributed to the other VBP arrangements.
- The adjustment percentages and the calculation method are the same as those for the VBP contractors, except for the Quality component
- For the Quality component, the current Quality Incentive program, largely based on QARR, will be the starting point.
- Quality measures and related incentives may be modified over time where alignment of VBP contractor incentives and MCO incentives appear to diverge



The PMPM Rate Setting Process will include 3 additional steps to implement VBP

NOTE: schematic to illustrate the various components of the rate setting process as they are relevant for the VBP adjustments. May not include all other components of rate setting. Also, formula may be more complex than presented below: schematic simplified to illustrate the steps. Current steps (no change!) in white. New steps in blue.

Current rate setting process (excluding any other adjustment steps)

New PMPM rate (total MCO population) = Base Data + Trend + Managed Care Adjustment + Acuity + Program Changes + Non-Risk Payments + Non-Medical Expenses

VBP-specific adjustments (percentage adjustments)

Weighted product across all VBP arrangements of:

\+ **1) Performance adjusters** per VBP arrangement — **2) Applicable penalties** per VBP arrangement category will differ each year + **3) Stimulation adjustment** per VBP arrangement 2017-2019 only

*VBP-specific adjustments may be included as a part of the current rate setting process (as a part of 'Program Changes' for example

1) Performance Adjustment

	SFY2017	SFY2018	SFY2019	SFY2020+
Description	The Performance Adjustment is a rate change based on the relative efficiency and quality delivered by the MCO per VBP arrangement This is potentially both an upward and downward adjustment. With upward adjustments for MCOs that contract with high quality and efficient providers (See Appendix B).			
Calculation Method	Upward Adjustment **Efficiency Adjustment:** • + 0.5% for the top 30% most efficient MCOs • + 1.0% for the top 20% most efficient MCOs • + 1.5% for the top 10% most efficient MCOs **Quality Adjustment:** • Current Quality incentive program (largely based on QARR), with potential modifications Downward Adjustment Efficiency Modifier: • - 0.5% for the bottom 30% least efficient MCOs (>P70) • - 1.0% for the bottom 20% least efficient MCOs (>P80) • - 1.5% for the bottom 10% least efficient MCOs (>P90) *Calculated performance is based on the most recent year for setting rates.*	Upward Adjustment **Efficiency Adjustment:** • + 1% for the top 30% most efficient MCOs • + 2% for the top 20% most efficient MCOs • + 3% for the top 10% most efficient MCOs **Quality Adjustment** • Current Quality incentive program (largely based on QARR), with potential modifications Downward Adjustment Efficiency Modifier: • - 1% for the bottom 30% least efficient MCOs (>P70) • - 2% for the bottom 20% least efficient MCOs (>P80) • - 3% for the bottom 10% least efficient MCOs (>P90) *Calculated performance is based on the most recent year for setting rates.*		When cost-variation has reduced, the target budget may be set to the State average; performance adjustments would then be based on quality only (See Appendix C for additional details).
Implemented Ranges	-1.5% to 3%	-3% to 6%		
Exclusions	Not applied to MCO rate adjustments where there are < 200 patients in them for episode/bundle arrangements or < 500 patients for subpopulation arrangements.			
Rate Cycle	April 2017 (assumes April start date) based on SFY16 data	April 2018 (assumes April start date) based on SFY17 data	April 2019 (assumes April start date) based on SFY18 data	April 2020 (assumes April start date) based on SFY19 data and etc.
Notes				

*Method here described directly follows the guideline recommended by the TD I Subcommittee for MCO- provider contracting with the addition of the 1% increase to the target budget for the top 30% of efficient

2) Stimulus Adjustment

	SFY2018	SFY2019	SFY2020
Description	MCOs will receive an upward stimulation adjustment for two years across the dollars in their contracts that are in Level 2 or Level 3 arrangements.		
Calculation Method	MCOs will receive a 0.575% upward adjustment of a VBP contract's target budget in a total population or subpopulation (e.g. HARP, HIV/AIDs) arrangement and a 1.15% upward adjustment of a VBP contract's target budget in a bundle (e.g. Chronic, Maternity) or IPC arrangement as calculated by the State if the VBP contract is Level 2 or 3 and if the VBP contractor's performance ranks in the top 50% for efficiency and quality (i.e., >=P50 for efficiency and >=P50 for quality). This includes a 15% admin fee for MCOs. Each stimulation adjustment lasts two years. From **2021 on**, no more new upward adjustments for moving into VBP will be available. Method here described directly follows the method recommended for MCO-VBP contracting, including an administrative fee (stimulus) for the MCO		
Implemented Ranges	The stimulus adjustment will be recalculated annually based on available state funds. *Tentatively: 0.575% to 1.15% depending on arrangement*		
Exclusions	Is not available for VBP Contracts that were already in Level 2 or Level 3. Is not available for those not in the top 50% for efficiency and quality.	Is not available for VBP Contracts that were already in Level 2 or Level 3. Not available for those in the not in the top 50% for efficiency and quality.	
Rate Cycle	April 2018 (assumes April start date) based on SFY2017 contracts	April 2019 (assumes April start date) based on SFY2018 contracts	April 2020 (assumes April start date) based on SFY2019 contracts
Notes			

*Method here described directly follows the adapted guideline for MCO-VBP contracting, including an administrative fee (stimulus) for the MCO.

3) Penalty Adjustment

	SFY2018	SFY2019	SFY2020+
Description	To ensure that the State meets the goal of 80-90% of managed care spending be associated with VBP arrangements by 2020, MCOs will receive a rate decrease, or Penalty, for not contracting a minimum threshold of VBP arrangements. The Penalty will be assessed on the previous SFY VBP contracts. The parameters for the minimum number of VBP Level 1 and 2 arrangements will increase each year to reflect the requirement to move larger portions of the MCO's contracted dollars into VBP contracts.		
Calculation Method	If less than 10% dollars of total MCO expenditure are captured in Level 1 or above VBP contracts then there is an adjustment of -0.5% for their total costs not captured in Level 1 or above VBP contracts.	Fully Capitated MCOs: If at least 50% of the of total MCO expenditure is not captured in a Level 1 or higher arrangement and 15% in a Level 2 or higher arrangement then there is an adjustment of -1.0% for their total costs not captured in Level 1 VBP contracts (also when only the Level 2 target is missed). Not Fully Capitated MCOs: If the MCO does not have at least 50% of the dollars captured in a Level 1 or higher arrangement and 5% in a Level 2 or higher arrangement (tbd) then an adjustment of -1.0% for their total costs not captured in Level 1 VBP contracts (also when only the Level 2 target is missed).	Fully Capitated MCOs: If the MCO does not have at least 80% of the dollars captured in a Level 1 or higher arrangement and 35% in a Level 2 or higher arrangement then there is an adjustment of -1.0% for their total costs not captured in Level 1 contracts and another -1% for the total costs not captured in a Level 2 contract. Not Fully Capitated MCOs: If the MCO does not have at least 80% of the dollars captured in a Level 1 or higher arrangement and 15% in a Level 2 or higher arrangement (tbd) then an adjustment of -1.5% for their total costs not captured in Level 1 VBP contracts (also when only the Level 2 target is missed).
Implemented Ranges	-0.5%	-1%	-1% to -2%
Exclusions	N/A		The State may decide to continue the penalties after 2020 when the goals of the Roadmap have not been met.
Rate Cycle	April 2018 (assumes April start date) based on 2017 Contracts	April 2019 (assumes April start date) based on 2018 Contracts	April 2020 (assumes April start date) based on 2019 Contracts
Notes	Penalties apply to the Medicaid Managed Care spending of each MCO not captured in VBP arrangements.		

*This follows the Roadmap milestones as close as possible (important: the 2017 Roadmap goal, translated in the 2018 penalty, does not mention a percentage).

MCO Incentive Timeline