February 9, 2018

Jason Helgerson
Deputy Commissioner and Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza Albany, New York 12210

Re: Comments on the VBP for Integrated MLTC Plans

Dear Mr. Helgerson:

Thank you for the opportunity to comment on the Department's approach to value-based payment (VBP) for Medicaid Advantage Plus (MAP) plans, Fully Integrated Duals Advantage (FIDA) plans, and Programs of All-Inclusive Care for the Elderly (PACE) (collectively integrated managed long-term care or MLTC plans), as presented to the VBP Work Group on January 31 and outlined further in FAQs published late last week. On behalf of the provider-sponsored MLTC plans and the long-term/post-acute care providers represented by LeadingAge New York, we would like to raise the following concerns and questions in relation to the ambitious integrated plan VBP strategy proposed by the Department.

Deadline for VBP Contracts Should be Delayed: Integrated MLTC plans were notified of the requirement to enter into VBP arrangements in early January and given only three months to submit executed VBP contracts to the Department. This tight deadline is particularly challenging because the Department is requiring much more complex contracts than those required of the partially-capitated MLTC plans. The Department has asked integrated plans to enter into VBP contracts with IPAs, ACOs, or single providers "to cover the total cost of care using a target budget methodology that establishes a budget inclusive of all services."[1] Notably, integrated plans cover an expansive array of primary, acute, post-acute, behavioral health, pharmaceutical, and long-term care services, as well as non-traditional supports. Moreover, the Department is requiring that the contracts provide for at least a Level 1 shared savings arrangement (not the pay-for-performance contracts permitted for MLTC plans). These contracts will be extraordinarily complex to develop. They will require the negotiation of target budgets, risk adjustment, quality measures, and attribution rules for an all-inclusive set of benefits. If pay-for-performance arrangements or smaller bundles of services were permitted, integrated MLTC plans could execute VBP contracts within this calendar year. However, the existing requirements will demand a more extended delay, probably into 2019.

FIDA Plans Should be Exempted from VBP Contracting Requirement: The FIDA program is scheduled to sunset in 2019. The two largest FIDA plans have approximately 970 and 1,500 members respectively; other plans have enrollment ranging from approximately 1 to 500 members.[2] It is unreasonable to expect FIDA plans to expend limited resources on trying to develop total cost of care shared savings arrangements for very small cohorts of members, when those arrangements will be in

[1] NYS Department of Health, Value-Based Payment Frequently Asked Questions (VBP FAQs), Feb. 2018, Question 1.
[2] NYS Department of Health, Monthly Medicaid Managed Care Enrollment, Jan. 2018.

effect for approximately 20 months. If FIDA plans are required to enter into VBP arrangements, the mandated arrangements should be no more complex than simple pay-for-performance arrangements based on a subset of services and costs.

Total Cost of Care Model is Not Feasible in Near Term: As noted above, the Department is requiring integrated plans to enter into arrangements that incorporate the entire MAP, FIDA or PACE benefit package on at least a shared savings basis. It anticipates that VBP Contractors will include "Independent Practice Associations (IPAs), Accountable Care Organizations (ACOs), and/or single providers willing/able to take responsibility for the total cost and quality of all care provided to the member.[3]"

As you know, the FIDA, MAP and PACE benefit packages are extraordinarily comprehensive – covering primary, acute, post-acute, long-term, and behavioral health care, pharmacy, and non-traditional services and supports. We are not aware of a single IPA or ACO that is currently taking responsibility for the cost of all of the integrated plan benefits. For example, Medicare Shared Savings Program ACOs are not required to assume responsibility for Part D costs or Medicaid-covered services. Further, ACOs and IPAs that are currently engaged in VBP arrangements are generally not contracting for a population that is composed entirely of individuals with functional limitations and complex medical conditions.

Thus, in order to create the VBP arrangements envisioned by the Department, existing IPAs and ACOs would have to expand their models to cover new services and costs, and/or providers would have to form new ACOs and IPAs. Moreover, in order to contract jointly on behalf of multiple providers without running afoul of antitrust laws, the IPAs or ACOs would have to be clinically and financially integrated, with shared clinical protocols, shared data, and shared risk. All of this takes a great deal of time and resources. Generally, two or more years of data is required to develop a risk arrangement. Even if there were a handful of IPAs and ACOs that would currently be willing to contract for the entire benefit package of an integrated plan, it is doubtful that (a) a critical mass of beneficiaries in any plan would be attributed to a single contractor; and (b) an ACO or IPA would want to invest the resources to create this type of arrangement for a small number of beneficiaries.

Notably, the Department has not required mainstream plans, which have much larger enrollments, to contract with VBP contractors for their entire benefit package. The Total Care for the General Population (TCGP) arrangement is just one category of VBP arrangement available to mainstream plans under the Roadmap. It is unclear, based on the information available in the VBP Resource Library, whether even the TCGP arrangement includes long-term care services. Even if VBP contractors under TCGP arrangements are responsible for long-term care services, the numbers of attributed mainstream members are sufficiently large, and the proportion of members using long-term care sufficiently small, that the impact of these costs is limited.

Current Enrollment Numbers for Integrated Plans Present Challenges for VBP Arrangements: Total integrated plan enrollment statewide is approximately 19,000 beneficiaries. As noted above, the

[3] NYS Department of Health, Value-Based Payment Frequently Asked Questions (VBP FAQs), Feb. 2018, Question 1.

two largest FIDA plans enroll 970 and 1,500 members respectively. The two largest MAP plans have 5,500 and 1,300 members respectively; the remainder of the plans have between 1 and 400 members. The two largest PACE programs enroll 3,000 and 720 members respectively; the others enroll between 100 and 670.[4]

While we are hopeful that enrollment in integrated plans will continue to grow, low enrollment presents challenges for VBP arrangements in the short term. Not only are total enrollment numbers low, but the number of members in MAP and FIDA plans attributed to any single primary care or long-term care provider is even lower. Thus, it will be difficult to enlist the participation of any large health system, IPA or ACO in a complex VBP arrangement involving a wide array of services, including non-traditional long-term services and supports. These small numbers also inhibit the development of two-sided risk arrangements. Shared savings and two-sided risk arrangements should not be required unless a minimum threshold of enrollment and member attribution to a specific provider or VBP contractor is reached.

PACE Approach is Unclear: The Department appears to be applying the new PACE measures to PACE programs themselves, rather than to network providers. These measures are categorized as "Pay for Reporting." However, the Department has not indicated how PACE programs will be paid for reporting these measures. Will these measures be incorporated into the MLTC Quality Incentive Pool, or will there be another financial incentive mechanism?

The Department's guidance requires PACE programs to enter into contracts with independent CBOs to implement social determinants of health interventions. However, the guidance does not indicate whether PACE programs will be paid additional amounts to implement these interventions. To the extent that PACE programs are required to contract for these interventions, adequate funding to support the interventions should be made available to PACE programs.

The programmatic basis for the PACE-CBO contracting requirement is unclear and inconsistent with the Roadmap's structure. It appears that the Department is treating the PACE program as a VBP contractor or provider that receives prospective global capitation from the State for the total care for a subpopulation. Based on this logic, the State is acting as the plan and would be required to assume the responsibilities of the plan, such as contracting with an independent CBO to address social determinants of health. We do not think this is what was intended by the Level 3 arrangement described in the Roadmap.

Rather, the Level 3 arrangement was intended to refer to the global capitation contracts between managed care plans and providers; not between the State and plans or the State and providers. It is highly unlikely, given the structure and size of PACE programs, that a PACE program would enter into prospective global capitation arrangements with network providers. Further, unlike large mainstream plans that may rarely see a member or his/her caregivers in person, PACE programs' frequent contact with members and caregivers through the PACE centers enable them to address social determinants of health directly. While some PACE programs may opt to contract with independent entities to address social determinants, it is unreasonable to mandate PACE programs to do so. If the Department

[4] NYS Department of Health, Monthly Medicaid Managed Care Enrollment, Jan. 2018.

maintains this requirement, PACE programs require sufficient funding to support it and additional guidance to determine whether existing contracts with related entities for social determinants interventions would satisfy this requirement.

Integrated Plans Should be Eligible for Performance Funds: We urge the Department to set aside additional funds for performance payments for integrated plans and their providers. Given the complexity of these arrangements and the absence of existing models, adequate funding is needed to ensure their success.

Integrated Plans Should Not Be Penalized Retrospectively: Integrated plans were notified of the requirement to enter into VBP arrangements in January and given three months to develop and submit complex contracts to the Department. It is unreasonable to penalize them for failing to have contracts in place that cover the period in which the requirement was announced, especially when specifications for those contracts were released only last week in FAQs. It is also unfair to providers to impose contractual requirements with financial and operational implications retroactively. Finally, it is worth noting that mainstream plans were given much more detailed information about the applicable VBP models and requirements well in advance of the penalty period.

More Flexibility in Quality Measures is Needed: Several of the quality measures adopted for MAP and FIDA plans were designed for individuals between ages 18 and 75 or ages 50 and 75. Thus, they may be inapplicable to a sizeable portion of the enrolled population. We recognize the challenges the Department faced in identifying appropriate, validated quality measures for an aged, dually-eligible population. However, we are concerned that the selected measures may not be capable of credibly measuring provider performance in relation to the enrolled population of some plans. We request that the Department allow plans to select other approved or validated quality measures, if they are more relevant to their membership.

Thank you again for the opportunity to comment. We look forward to continuing discussions with the Department on VBP for enrollees in PACE, FIDA and MAP, and otherwise refining the MLTC VBP initiative. If you have any questions on our comments, please contact me at (518) 867-8383 or klipson@leadingageny.org.

Sincerely,

Karen Lipson

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