VBP Roadmap –Outline-draft

Version January 20, 2014

For discussion in Value Based Payment Work Group

Albany, January 23rd 2015

Contents

Introduction

On April 14, 2014, the State of New York and CMS reached agreement for a groundbreaking waiver that allows the state to reinvest $8 billion dollars for comprehensive Medicaid delivery and payment reform through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program promotes community-level collaborations and aims to reduce avoidable hospital use by 25% over five years while financially stabilizing the state's safety net. Safety net providers have come together in 25 Performing Provider Systems (PPSs), covering the whole State, to implement innovative projects focusing on system transformation, clinical improvement and population health improvement. All DSRIP funds are based on performance linked to achievement of project milestones.

To ensure the long term sustainability of the DSRIP investments in the waiver, the Terms and Conditions (§ 39) state that the State must submit a multi-year roadmap for comprehensive payment reform before April 1st 2015, including how the States will amend its contracts with Managed Care organizations. The T&Cs mention the following specific topics to address:

1. What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the state will plan and implement its stated goal of 90% of managed care payments to providers using value-based payment methodologies.
2. How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.
3. How the state will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.
4. How and when plans' currents contracts will be amended to include the collection and reporting of DSRIP objectives and measures.
5. How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The state should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other state funding; and how they differ from any services or administrative functions already accounted for in capitation rates.
6. How the state will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks.
7. How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development.
8. How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the state will use benchmark measures (e.g., MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.

Each of these issues will be discussed in turn.

1. Towards 90% of value-based payments to providers

Issue 1: What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the state will plan and implement its stated goal of 90% of managed care payments to providers using value-based payment methodologies.

Sustainable Delivery Reform Requires Matching Payment Reform

DSRIP is a major collective effort to transform the NYS Medicaid Healthcare Delivery System from a fragmented system, overly focused on inpatient care, to an integrated and community-based system focused on providing care in or close to the home. Where the delivery system is currently predominantly re-active and (acute) provider-focused, DSRIP aims to create a more pro-active and patient-focused system, emphasizing population health and closely involving social services.

These objectives have broad stakeholder support and are made measurable by a set of DSRIP metrics on potentially avoidable (re)admissions, ER visits and other potentially avoidable complications, as well as patient experience. Underlying these overall outcomes is a broader range of project-specific process- and outcome measures.

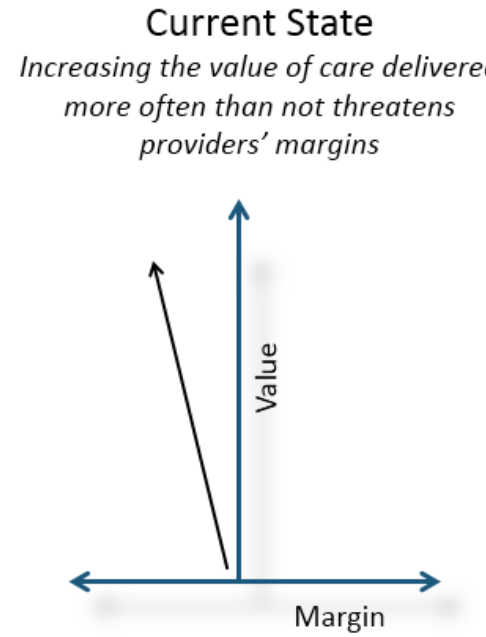
Reducing avoidable (re)admissions, ER visits and other potentially avoidable complications will further stabilize overall Medicaid expenditures. This will allow NYS to remain under the Global Cap, without curtailing eligibility, while strengthening the financial viability of the safety net and continuing to invest in innovation and improving outcomes.

Such a thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well. Many of the Medicaid delivery system's problems (fragmentation, high (re)admission rates, poor primary care infrastructure, lack of behavioral and physical health integration) are rooted in how providers are reimbursed. In most cases, siloed providers are still being paid Fee for Service (FFS) by their MCOs, incentivizing volume over value, and creating a focus on inputs rather than realizing adequate outcomes. To this day, an avoidable readmission is usually rewarded more than a successful transition to integrated home care; likewise, prevention, coordination or integration activities are rarely reimbursed sufficiently, if at all.

In addition, the current FFS system, and the diversity of contracting regimes between individual providers, individual MCOs and other, non-Medicaid payers, creates an administrative burden on providers that would be unfathomable in any health care sector in the world – or in any other US industry. Often, payment reform initiatives initially seem to increase the administrative burden: they necessarily constitute a change from the way current administrative processes and systems operate. Yet well-executed payment reform can significantly reduce this complexity by reducing the need for micro-

accountability (such as the need for utilization review throughout the care process), standardizing rules and incentives across providers, and increasing transparency.[1]

In essence, the state's Medicaid Payment reform attempts to move away from a situation where increasing the value of the care delivered (preventing avoidable admissions, reducing administrative waste) has a *negative* impact on the financial sustainability of providers towards a situation where the delivery of high value care can result in *higher* margins (see Figure below).



Payment reform, then, is required to ensure that the changes in the care delivery system funded by DSRIP are sustained well beyond the waiver period, such that patient education and care coordination activities can be reimbursed, that value-destroying care patterns (avoidable (re)admissions, ER visits) do not simply return when the DSRIP dollars stop flowing, and that dollars currently lost in non-value added administrative processes become available for patient care. In fact, many PPSs are already actively discussing the importance of payment reform as a means to alleviate predicted losses in FFS revenue due to improved performance on DSRIP outcomes (reduced admissions, reduced ED visits).

Payment Reform Guiding Principles

The roadmap is built upon the foundation already put in place by the MRT Payment Reform & Quality Measurement Work Group. In 2012, that Work Group concluded that innovative payment reform and quality initiatives should:

1. Be transparent and fair, increase access to high quality health care services in the appropriate setting and create opportunities for both payers & providers to share savings generated if agreed upon benchmarks are achieved.
2. Be scalable and flexible to allow all providers and communities (regardless of size) to participate, reinforce health system planning and preserve an efficient essential community provider network.
3. Allow for flexible multi-year phase in to recognize administrative complexities including system requirements (i.e., IT).
4. Align payment policy with quality goals
5. Reward improved performance as well as continued high performance.
6. Incorporate strong evaluation component & technical assistance to assure successful implementation.
7. Engage in strategic planning to avoid the unintended consequences of price inflation, particularly in the commercial market

New guiding principle:

8. **Financially reward rather than penalize providers that deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes.**

[1] Cutler, D., E. Wikler and P. Basch (2012). "Reducing administrative costs and improving the health care system." N Engl J Med **367**(20): 1875-1878.

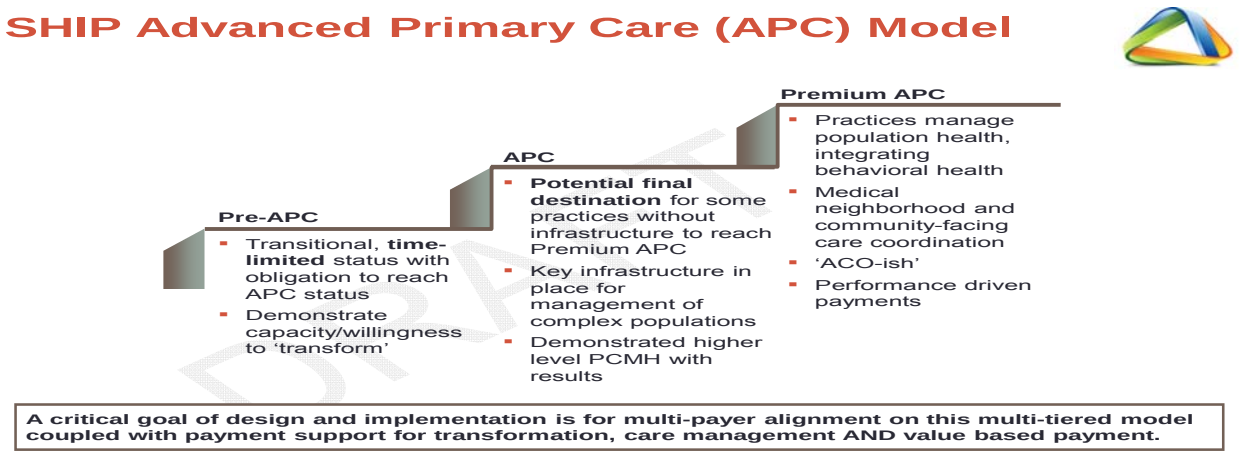
Starting point: how should an integrated delivery system function from the consumer/patient's perspective

Different types of patients require different types of care. As foreseen in DSRIP, a high performing care delivery system encompasses three types of integrated care services, with optimal coordination between them:

- **Integrated Primary Care** (including behavioral primary care, community based prevention activities and clear alignments with social services (Patient Centered Medical Home (PCMH)/Advanced Primary Care (APC) models)). This type of care is continuous in nature, strongly population-focused, based in the community, oriented towards primary and secondary prevention, and aims to act as the primary source of care for the majority of everyday care needs. (See textbox for a discussion about NYS's vision on Advanced Primary Care).

New York State's vision on Advanced Primary Care

Advanced Primary Care (APC) plays a core role in NY's State Health Innovation Plan (SHIP) as well as within DSRIP. The below Figure briefly explains how NYS sees the progression from 'pre-APC' status towards 'Premium APC' status, which fully aligns with DSRIP's end goals for Integrated Primary Care. (See the SHIP plan for more details).



NYS has extensive experience with what will later be described as Level 0 Value Based Payments, FFS with quality bonus payments, during the early and ongoing support of the PCMH model through its Medicaid program, and its involvement in medical home demonstrations in a variety of settings across the state. As these initiatives have progressed, it has become clear that transformation of primary care practices to an APC model will include three broad phases, during which the practices require different types of financial support as follows:

1. Initial investment in practice transformation, including support for technical assistance, and for the costs of new programs and staff (or re-training existing staff).
2. Interim Support. Support for increased operating costs for a period of time (experience indicates 2-3 years), as practices improve quality and population health, but before realizing reductions in preventable utilization and other costs needed to support 'shared savings' payment. In the early years of the APC's operation, providers will be taking on new functions and costs, improving quality, patient access and experience, but not (yet) generating cost savings.
3. Ongoing support. Once the APC model has begun to have a measurable impact on total cost of care and to generate measurable savings, the practice and payers may choose to reduce the basic program support and shift compensation to shared savings and/or risk sharing.

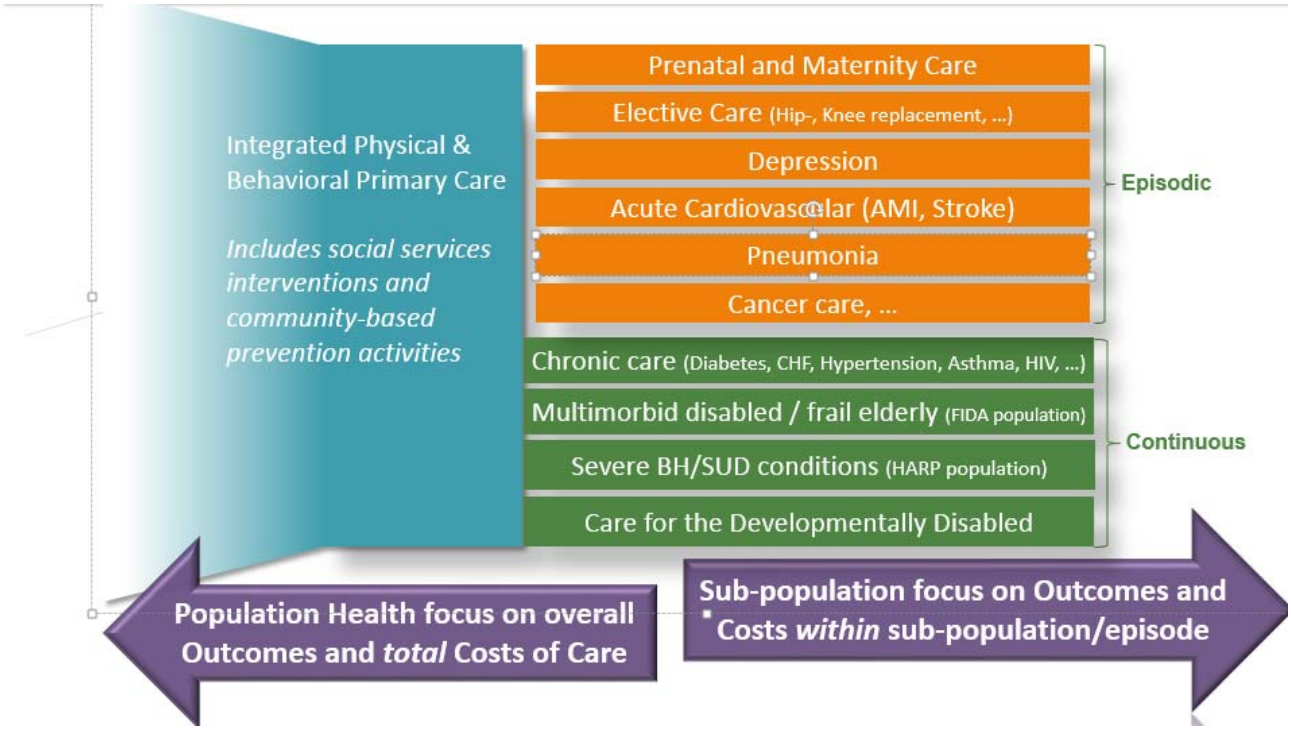
From the perspective of Medicaid, phase 1 and 2 will be funded through DSRIP; phase 3 is the transition towards Level 1 (and higher) Value-Based Payment for integrated primary care as discussed in this Roadmap.

- **Episodic care services** are utilized for circumscribed periods of time when people require more specialized services for a specific health problem or condition, for circumscribed periods of time. Within the Medicaid population and DSRIP, maternity care may be the best example; for elderly patients, hip and knee replacement episodes are the most prevalent examples. These services are tightly integrated, with multidisciplinary teams working with evidence-based care pathways, organized around these patients' specific needs.

- **Continuous care services** are required when people become chronically ill, and require ongoing, dedicated specialized services for their health problem(s) or condition(s). This type of care can involve both evidence-based disease management for individual conditions (asthma, diabetes, renal care and HIV/AIDS are the most prominent examples within DSRIP) as well as care for severely co-morbid populations. For the latter groups of patients, personalized goal setting and intensive care coordination become more dominant than disease management per se. In both, a focus on maximizing a patient's capabilities for self-management is central.[2]

Facilitating the Development of an Optimally Functioning Delivery System through Value-Based Payments: A Menu of Options

Following the spirit of the DSRIP program, NYS does not foresee one single path towards payment reform. Rather, NYS aims to give PPSs, their providers, and MCOs a Menu of Options to consider. This allows providers and MCOs to select those types of value-based payments that fit their strategy, local context and ability to manage innovative payment models, which has been proven a critical success factor in successfully realizing payment reform.[3]



[2] It is important to note that a well-developed Advanced Primary Care center could very well be responsible for delivering depression, diabetes and asthma care, for example; likewise, a hospital could be the organizational home for the delivery of integrated physical and behavioral primary care. Which particular organization becomes the prime contractor for which particular integrated care service is not prescribed and may depend on local preferences, history, geographies etc.

[3] Ginsburg, P. B. (2013). "Achieving health care cost containment through provider payment reform that engages patients and providers." Health Aff (Millwood) **32**(5): 929-934; Miller, H. D. (2009). "From volume to value: better ways to pay for health care." Health Aff (Millwood) **28**(5): 1418-1428.

Jointly, PPSs (or combinations of providers within the PPS) and MCOs can create value-based payments arrangements around:

- Total care for total population and/or
- Integrated primary care and/or
- Selected care bundles and/or
- Special needs subpopulations

Total care for the total population

In this model, the MCO contracts a value-based payment arrangement with the PPS which considers total PMPM (per member, per month) expenditure for the total attributed population (global capitation), and overall outcomes of care (potentially avoidable ER visits, hospital admissions, and the underlying DSRIP Domain 2 and relevant Domain 3 metrics). Although there is less experience with these types of models in Medicaid than in Medicare or in the commercial plan market, the opportunities are widely deemed to be significant. Aligning pre-existing Medicare ACOs with a comparable model in Medicaid, moreover, would greatly reduce both costs and risks for the providers involved.[4]

Integrated Primary Care

In this model, the MCO contracts Patient Centered Medical Homes (PCMHs) or Advance Primary Care (APC) arrangements with the PPS or the PCMHs/APCs in the PPS to reimburse these PCMH/APCs based on the savings and quality outcomes they achieved. The savings here would be focused primarily on so-called 'downstream' costs: expenditures across the total spectrum of care that would be reduced when the PCMHs/APCs would be functioning optimally. Avoidable ER visits and hospital admissions for conditions such as diabetes and asthma are good examples; cancer care costs, on the other hand, would not be included when calculating potential PCMH/APC downstream savings. Likewise, the quality outcomes would be those DSRIP Domain 2 and 3 metrics attributable to integrated primary care.[5]

Leveraging such savings can substantially increase funding to PCMHs/APCs, because the potential downstream savings are much larger than the total current revenues of the PCMH. This addresses two key issues that have been identified as limiting the potential impact of emerging integrated primary care delivery models: lack of funding to sustainably enhance both staffing and infrastructure of integrated primary care[6] and a lack of adequate incentives for primary care providers to truly impact overall costs

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[4] Kocot, S. L., C. Dang-Vu, R. White and M. McClellan (2013). "Early experiences with accountable care in Medicaid: special challenges, big opportunities." Popul Health Manag **16 Suppl 1**: S4-11.

[5] Using potentially avoidable hospital (re)admissions and ER visits as outcome indicator for primary care is an approach also used in Colorado's Accountable Care Collaborative: https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%20Annual%20Report%202013.pdf. See also Kocot et. al. op. cit. footnote 4.

[6] Nocon, R. S., R. Sharma, J. M. Birnberg, Q. Ngo-Metzger, S. M. Lee and M. H. Chin (2012). "Association between patient-centered medical home rating and operating cost at federally funded health centers." JAMA **308**(1): 60-66; Landon, B. E. (2014). "Structuring payments to patient-centered medical homes." Jama **312**(16): 1633-1634; Weissman, J. S., M. Bailit, G. D'Andrea and M. B. Rosenthal (2012). "The design and application of shared savings programs: lessons from early adopters." Health Aff (Millwood) **31**(9): 1959-1968; Edwards, S. T., M. K. Abrams, R. J. Baron, R. A. Berenson, E. C. Rich, G. E. Rosenthal, M. B. Rosenthal and B. E. Landon (2014). "Structuring payment to medical homes after the affordable care act." J Gen Intern Med **29**(10): 1410-1413.

of care.[7] DSRIP will work closely with the State Health Innovation Plan Integrated Care Workgroup on the development of the Advanced Primary Care model that promotes high value care and is better integrated across the spectrum; that promotes and supports primary care providers and that assures a more efficiently operating health delivery system that promotes optimal health and well-being for all.

Bundles of care

In this model, the MCO contracts specific, patient-focused bundles of care (such as maternity care episodes, stroke, or hip-replacement) with the PPS or (groups of) providers within the PPS. Here, the cost of a patient's office visits, tests, treatments and hospitalizations associated with a specific illness, medical event, or condition are all rolled or "bundled" into a single, episode-based total cost for the episode.[8] Because variations in utilization and potentially avoidable complications are linked to the specific episodes, this model has shown much promise in stimulating patient-focused, integrated care delivery teams to substantially increase the value of care delivered from a wide range of conditions.[9]

This model has also proven useful for chronic care, as highlighted by the inclusion of chronic condition in the CMS Bundled Payments for Care Improvement (BPCI) Initiative[10]. Whereas the BPCI program's care bundles (for now) start with a hospital admission, NYS will follow the internationally emerging consensus to treat chronic conditions as full-year-of-care bundles (emphasizing the continuous nature of this care), including all condition-related care costs.[11]

Total care for special needs subpopulations

For some specific subpopulations, severe comorbidity or disability may require highly specific and costly care needs, so that the majority (or even all) of the care costs are included in the full-year-of-care bundles. At this point, this becomes similar to a capitated model (a PMPM for a specific special needs population). As part of the development towards Managed Care, NYS has already identified several special needs subpopulations for which contracting total costs of care will be an option (see further).

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[7] Nielsen, M., J. N. Olayiwola, P. Grundy and K. Grumbach (2014). The Patient-Centered Medical Home's Impact on Cost & Quality: An Annual Update of the Evidence, 2012-2013, Patient-centered primary care collaborative.

[8] Sage, W. M. (2014). "Getting The Product Right: How Competition Policy Can Improve Health Care Markets." Health Aff (Millwood); Mechanic, R. E. and S. H. Altman (2009). "Payment reform options: episode payment is a good place to start." Health affairs (Project Hope) **28**: w262-271.

[9] Miller, D. C., C. Gust, J. B. Dimick, N. Birkmeyer, J. Skinner and J. D. Birkmeyer (2011). "Large variations in medicare payments for surgery highlight savings potential from bundled payment programs." Health affairs (Project Hope) **30**: 2107-211; Struijs, J. N. and C. A. Baan (2011). "Integrating Care through Bundled Payments — Lessons from the Netherlands." New England Journal of Medicine **364**: 990-991; Bach, P. B., J. N. Mirkin and J. J. Luke (2011). "Episode-based payment for cancer care: a proposed pilot for Medicare." Health Aff (Millwood) **30**(3): 500-509.

[10] Bailit, M., M. Burns and J. Margaret Houy (2013). Bundled Payments One Year Later: An Update on the Status of Implementations and Operational Findings. HCI3 Issue Brief, June 2013; http://innovation.cms.gov/initiatives/bundled-payments.

[11] de Bakker, D. H., J. N. Struijs, C. B. Baan, J. Raams, J. E. de Wildt, H. J. Vrijhoef and F. T. Schut (2012). "Early results from adoption of bundled payment for diabetes care in the Netherlands show improvement in care coordination." Health Aff (Millwood) **31**(2): 426-433; De Brantes, F., A. Rastogi and M. Painter (2010). "Reducing potentially avoidable complications in patients with chronic diseases: the Prometheus Payment approach." Health Serv Res **45**(6 Pt 2): 1854-1871; xx.

Possible contracting combinations

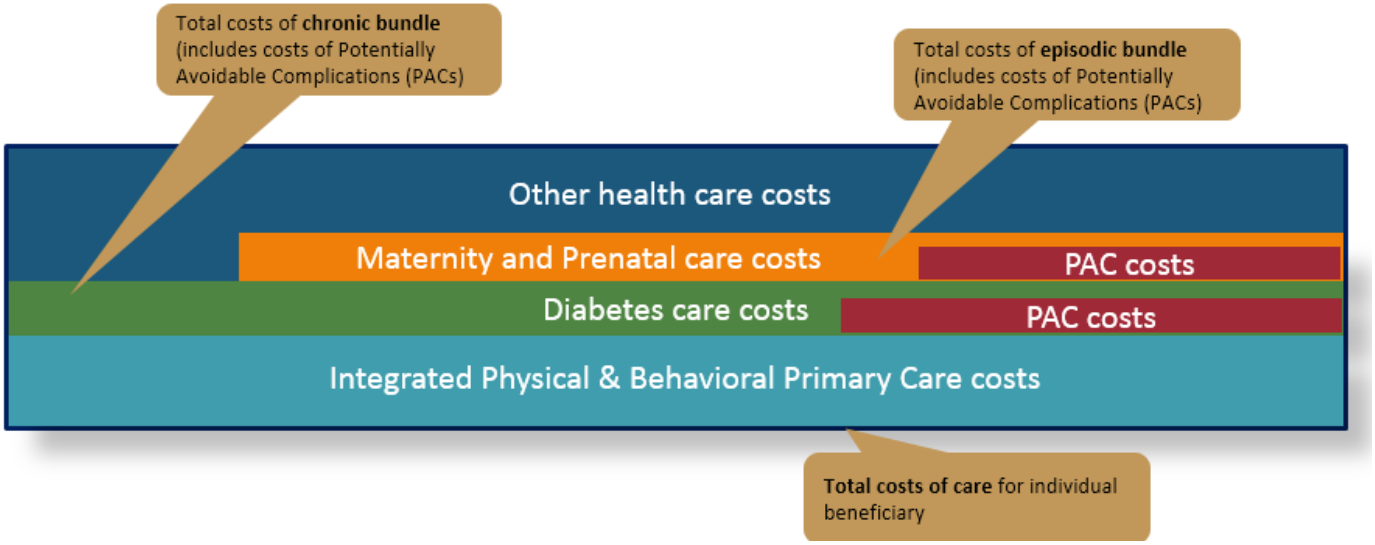
The MCOs and the PPSs/Providers may opt to either contract the total care for the total population (ACO model), or create combinations of the value-based payment arrangements discussed. Some MCOs may prefer to contract for integrated primary care (PCMH or APC) separately to optimize the chances of successful primary care reinforcement; some PPSs may want to specifically contract for fragile subpopulations and the maternity care bundle.

When combinations of integrated care services are contracted separately, it has to be clear what happens when a beneficiary requires two (or more) services. The table below outlines how these interactions would play out:

Integrated Primary Care	A beneficiary can only be attributed to one IPC provider at a time			
Episodic Bundle	A beneficiary will be expected to keep IPC services (for e.g. non-related preventive activities or complaints) during the duration of an episodic illness / condition	A beneficiary may receive two or potentially more episodes simultaneously. *In some cases, a second episode ('stroke') will be deemed to be a potential complication of a first episode ('pregnancy & delivery')*		
Chronic Bundle	A beneficiary will be expected to receive IPC services for e.g. non-related preventive activities or complaints in addition to his/her chronic care needs	A beneficiary may have a chronic condition ('diabetes') and an episode ('pregnancy'). *In some cases, the episode ('stroke') will be deemed to be a potential complication of the chronic condition ('diabetes')*	A beneficiary may have multiple chronic conditions ('diabetes' and 'copd'). Because in most instances, co-morbid patients require closely coordinated, integrated care (vs. e.g. two separate disease management programs), this care will be contracted and reimbursed in one 'chronic bundle'.	
Sub-population	This type of care is so comprehensive that a distinctive IPC role is difficult to carve out	TBD on the basis of the analyses. Some episodes (e.g. Maternity Care) may be so distinctive that they could be 'carved out'	This type of care is so comprehensive that the care for individual chronic conditions would be incorporated in the care for the subpopulation	A beneficiary can only be attributed to one sub-population at a time
	Integrated Primary Care	**Episodic Bundle**	**Chronic Bundle**	**Sub-population**

Calculations cost of care

When multiple care services are involved, calculating the total cost of care involves adding the costs of the individual integrated care services, as illustrated below.



In addition, MCOs do not necessarily have to contract these value-based payment arrangements with the PPS: they may also contract provider-combinations[12] within the PPS for integrated primary care, care bundles or specific subpopulations. Both providers and health plans have suggested that although joint contracting at the PPS level for the most vulnerable, multi-morbid subpopulations could be highly beneficial, joint contracting at the PPS level for more circumscribed and prevalent types of care – such as maternity care - would stifle competition. Likewise, in some cases contracting at the PPS level for integrated primary care may be the best answer to rapidly develop region-wide APC capabilities, while in other cases it would rather disrupt locally grown collaboration patterns that require differential treatment to truly blossom.

Only in the case of arrangements for the total care for the total population is contracting at the PPS level the only meaningful option. For care bundles, integrated primary care and total care for specific subpopulations, the following options are possible:

Contracting at the PPS level (no in-PPS competition)	Value-based arrangement on primary care, care bundles or subpopulations are contracted between MCO and PPS. All providers within the PPS delivering this care are held to these arrangements.
Contract with PPS allows direct MCO-Provider contracting (in-PPS competition)	The PPS agrees with the MCO *how* to contract with providers within the PPS on specific value-based arrangements on primary care, care bundles or subpopulations. Within that framework, MCOs can

[12] Because advanced primary care, the care for a pregnant woman (including the delivery) or a diabetes patient requires different professionals and types of providers, contracting for these types of integrated care services will more often than not involves different providers within the PPS. These providers will have to contractually agree to jointly deliver these services with the MCO and/or amongst themselves. Much like the emergence of a more integrated governance structure at the PPS level, experience shows that providers involved in jointly delivering and contracting integrated care services often tend to evolve towards having one single point of cont(r)act with the MCO. (See e.g. Bailit, M. (2014). Key Payer and Provider Operational Steps to Successfully Implement Bundled Payments. HCI3 Issue Brief, May 2014).

	contract directly with combinations of providers to deliver that care.
Integrated primary care, certain care bundles or certain subpopulations fully excluded from MCO-PPS contracting	The PPS has no responsibilities for the contracting or primary care, (certain) care bundles or subpopulations. MCOs contract that care directly with combinations of providers within the PPS.

When MCOs, PPSs and providers contract primary care, bundles and/or subpopulations, they may not be able to reach the minimum of 90% value-based payments by end of DY 5. In those instances, the MCO and the PPS will need to contract a total care for the populations and care services *not* covered by the integrated primary care, care bundles and subpopulations contracts. (In other words, a 'total care for the total population' arrangement from which the otherwise contracted populations and services are carved out).

Although both providers and MCOs have stressed the importance of flexibility in contracting options, they have also stressed the enormous benefits of a reduced administrative burden when contracts with MCOs would be more aligned. Especially smaller providers will benefit greatly if PPSs and MCOs can agree on a similar set of rules and conditions to which they will be held accountable – whether that is arranged through a single MCO-PPS contract or through the MCO and the PPS agreeing on the framework how to contract directly with groups of providers.

In addition, to further reduce administrative burden for both MCOs and providers, and to allow for transparency in performance between PPSs, the state will standardize the definitions of the integrated care services, building upon what is already outlined in DSRIP:

- the delineation of the PCMH/APC care, care bundles and specific subpopulations;
- the outcome measures to be used (payers/providers are of course free to add additional measures)
- cost of care (total PMPM, per bundle, subpopulation) methodologies will be standardized, including required risk-adjustment methodologies[13]

The state will provide MCOs and providers with extensive information detailing their data and performance (see further).

Finally, the Integrated Delivery System that DSRIP aims for can take many shapes and forms: virtual or not, centered in a strongly developed Advanced Primary Care concept or more diffusely embedded throughout the entire care delivery network. Yet there is a risk that PPSs that do not contract either the total care for their population or integrated primary care at the PPS level end up jeopardizing the population-health focused infrastructure and patient-centered integration that DSRIP sets out to build. In these cases, the PPS and the MCO will have to submit a plan outlining how the value-based arrangements that they opt for will ensure that these gains will be sustained.

From Shared Savings towards Assuming Risk

In addition to choosing *what integrated services* to focus on, the MCOs and PPSs/providers can choose different *levels* of Value Based Payments. (Assuming risk is a fundamental step; it goes without saying

[13] Standardization required to reduce administrative load for Providers, but also to allow realizing state-wide information support strategy for providers and payers to facilitate VB Contracting as well as state-wide transparency and cost- and outcomes-reporting.

that PPSs should focus first on building out the projects and strong networks in the early days before focusing on potential risk-sharing arrangements.)

Together, this creates the following Menu of Options:

Options	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level; requires mature PPS)
All care for total population*	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Global capitation (with outcome-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when outcome scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for Primary Care Services (with outcome-based component)
Episodic Care	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when outcome scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Prospective Bundled Payment (with outcome-based component)
Total care for subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (savings available when outcome scores are sufficient)	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for total care for subpopulation (with outcome-based component)

Level 0 is not considered to be a sufficient move away from traditional fee for service incentives to be counted as value-based payments in the terms of this Roadmap. Because of the need to incentivize cross-organizational coordination and integration of care, shared-savings payments to individual providers that do not or cannot take responsibility for the integrated care services described above are equally counted as 'level 0'.

Level 1 consists of 'upside only' shared savings arrangements. Here, the capitation and bundled payments exist only virtually. When the accrued Fee-for-Service payments for the integrated care service are lower than the virtual PMPM capitation or bundle budget, the MCO can share the savings with the providers ('retrospective reconciliation'). Potential provider losses are not shared; providers are not 'at risk' in Level 1. If a PPS or a combination of providers meets >90% of its contracted quality outcomes, MCOs can return between 50-60% of the savings; when fewer goals are met, the shared savings percentage is reduced. When less than 50% of the outcomes are realized, no savings are shared.[14]

Level 2 consists of upside and downside risk sharing arrangements. Again, the capitation and bundled payments exist only virtually, and only when > 50% of the contracted quality outcomes are achieved will potential savings be shared. When the accrued Fee-for-Service payments are higher than the virtual PMPM or bundle budget, these excess expenses will be compensated through reductions in the reimbursement payments to be made in the subsequent year to the PPS/providers. In level 2, because the providers share in the risk, if a PPS or a combination of providers meets >90% of its contracted quality outcomes, the MCOs can return 90-100% of the savings. Conversely, if a PPS or a combination of providers exceed the virtual PMPM capitation or bundle budget, and fewer than 50% of outcome goals are met, then these providers are responsible for 95% of this difference (see Table below).

To reduce unwarranted insurance risk for providers, there will be two types of stop-loss put in place:

- (per episode/subpopulation patient): a stop loss

Integrated primary care, shared savings and assuming risk

As mentioned above (p. 10), in the context of integrated primary care, 'shared savings' and 'assuming risk' takes on a somewhat different meaning. In the case of the other value-based payment arrangements, 'total cost of care' refers to the total costs of care of the total population, the subpopulation, or the care included in the bundle. In the case of integrated primary care, however, (the considerably larger) *downstream costs* are included in addition to the costs of the primary care itself.

Costs that are largely outside of the sphere of influence of a well-functioning PCMH/APC will be excluded, such as costs for trauma, cancer, AIDS/HIV care and other conditions requiring highly specialized treatment. Also, to avoid double-counting of savings/losses, and to fairly attribute shared savings/losses to those who have realized them, once in a PPS bundles or subpopulations are subcontracted in Level 1 arrangements or higher, the PCMH/APC can no longer receive shared savings for reductions of average cost per episode or PMPM per subpopulation patient. It can, however, still realize shared savings by *avoiding* an episode or a patient becoming eligible for a special needs subpopulation. The inverse is similarly true for incurred losses.[16] Following the same principle, if a PPS contracts total cost of care in addition to one or more integrated primary care contracts, the PCMH/APC will similarly not be accountable for average costs per episode or subpopulation for *all* care bundles/subpopulations tracked by the state that are included in the total care for total population arrangement.

For integrated primary care, the 'upside' percentages are as described, which can help further generate the substantial additional income required to further implement the infrastructure and staff required for a full-blown APC.

Because the downstream costs are relatively high compared to these providers overall revenue, and the influence primary care providers can exert on that care is necessarily limited, the stop loss per patient will be set lower, at e.g. one standard deviation above the set budget benchmark.

[14] The state will set minimum and maximum sharing percentages. The percentages mentioned here may be adapted to find the optimal balance between incentives for the PPS and actuarially responsible risk for the MCO. The percentages are set high so as to create a true economic incentive to deliver high quality care (and thus avoid the common mistake that the financial incentives to improve outcomes are insufficient). See: McKethan, A. and A. K. Jha (2014). "Designing Smarter Pay-for-Performance Programs." JAMA; Ginsburg, P. B. (2013). "Achieving health care cost containment through provider payment reform that engages patients and providers." Health Aff (Millwood) **32**(5): 929-934'.

of two or three standard deviations above the set budget benchmark

- (total assumed risk for PPS/combination of providers): a stop loss of 8% (to be determined) of the *total* Medicaid payments received by the contracting PPS or combination of providers.[15]

The percentages mentioned here, including the stop loss limits, are tentative, and will be further defined during DY 1 (2015) to find the optimal balance between incentives and risks for the PPS, actuarially responsible risk for the MCO and the desired overall outcomes for the state. The state will also consider varying percentages vary over time. For example, to stimulate providers to move towards Level 2 VBP arrangements, the shared savings percentage may be lowered by e.g. 5-10% each year a Level 1 arrangement is extended. Similarly, to reduce real or perceived risk, the aggregate stop loss in the first year of a Level 2 arrangement may be set low – say at 2-3% -, and gradually set to increase over the years. (In those cases, an aggregate ceiling for total shared savings would also be put in place). The definite choices made will be presented to CMS in the state's next update of this Managed Care DSRIP plan, early 2016.

In Level 3 the underlying Fee-for-Service payment system is largely replaced by PMPM and/or single bundled payments. No retrospective reconciliation is necessary. Because of the importance to stimulate reaching out to the whole population, purely preventative activities (such as immunizations or evidence-based screening activities) will remain reimbursed on a Fee for Service basis.[17] The Level 2 stop loss arrangements would remain to prevent providers from inadvertently taking on insurance risk.

Outcome Targets % Met	**Level 1 VBP** **Upside only**	**Level 2 VBP** **Up- and downside** *When actual costs < budgeted costs*	**Level 2 VBP** **Up- and downside** *When actual costs > budgeted costs*
> 90% of Outcome Targets met	50-60% of savings returned to PPS/ Providers	90-100% of savings returned to PPS/ Providers	PPS/ Providers responsible for 50% of losses. For Stop Loss see text. For Integrated Primary Care see IPC textbox.
50 – 90% of Outcome Targets met	Between 10 – 50/60% of savings returned to PPS/ Providers (gliding scale in proportion with % of Outcome Targets met)	Between 10 – 90/100% of savings returned to PPS/ Providers (gliding scale in proportion with % of Outcome Targets met)	PPS/ Providers responsible for 50%-95% of losses (gliding scale in proportion with % of Outcome Targets met). For Stop Loss see text. For Integrated Primary Care see IPC textbox.
< 50% of Outcome Targets met	No savings returned to PPS/ Providers	No savings returned to PPS/ Providers	PPS/ Providers responsible for 95% of losses. For Stop Loss see text. For Integrated Primary Care see IPC textbox.

[15] The State will set minimum and maximum sharing percentages for both shared savings and losses.

[16] This responsibility for the PCMH/APC not only incentivizes the primary care providers to reduce morbidity, but also effectively limits the volume-risk that can still be associated with the use of bundled payments. Miller, H. D. (2009). "From volume to value: better ways to pay for health care." Health Aff (Millwood) **28**(5): 1418-1428.

[17] Miller, H. D. (2009) op.cit. fn. 16; Chien, A. T., Z. Li and M. B. Rosenthal (2010). "Improving timely childhood immunizations through pay for performance in Medicaid-managed care." Health Serv Res **45**(6 Pt 2): 1934-1947.

As the baseline to determine the suggested budgets for the different value-based payment arrangements, the state will provide the MCOs and the PPSs/providers with the involved providers' historical data for the different arrangements (the average of the last available 2 years, allowing for a yearly growth rate similar to the growth rate used to establish NYS' Medicaid global cap). Using these suggested budgets, and armed with Statewide benchmark information, the MCOs and PPSs/combinations of providers can negotiate final target budgets to strongly disincentivize above-average avoidable complication rates, for example, or rather invest additionally in underserved areas of care.[18]

For the population-based total cost of care calculations, the state will rely on 3M CRG risk adjustment methodologies to create comparability between PPSs/providers and to adjust for historical shifts in attribution profiles within a PPSs/provider group over time.[19] For the care bundles (including chronic care), the most recent version of the open source Evidence-informed Care Rate (ECR) risk-adjustment methodology will be used, developed by the Health Care Incentives Improvement Institute.[20]

Attribution

Both the Total Care for Total Population as the Integrated Primary Care value-based arrangements require a clear definition of 'attributed lives'. DSRIP's attribution for performance mechanism will be used for these purposes, which is updated monthly and also used for calculating the DSRIP outcomes of care for the overall DSRIP targets as well as for the selected projects.

This attribution mechanism could be further improved by having members select a PPS at the time of enrolment, much like members currently choose a PCP. The state will investigate this possibility, which would have the PPS serve like a 'preferred provider network' for the patient (without restricting access to the plan's entire network). This approach could also facilitate the realization of across-PPS information sharing and patient consent.

Dual Eligibles

The dual eligible population may seem relatively small (some 15% of Medicaid beneficiaries are also eligible for Medicare), but these 700,000 individuals comprise 45% of *total* Medicaid spending (and an estimated 41% of Medicare spending in NYS).[1] Because of these high costs, NYS intends to integrate the NYS Fully-Integrated Dual Advantage program in this VBP program. (For purposes of determining the '90% of total costs' goal, however, Medicare dollars will not be included).

For the care bundles and subpopulations, patients need to be attributed to the contracting PPS (or the PPS with which the contracting providers are affiliated), and need to fulfill standardized diagnostic criteria.

Goals

- ≥90% of total MCO-PPS/provider payments (in terms of total dollars) will have to be captured in at least Level 1 VBPs at end of DY5

[18] All shared savings begin at first dollar savings, and there is no minimum savings/losses threshold foreseen before savings/risk sharing begins.
[19] For some of the selected subpopulations, 3M CRG-based rate adjustment methodologies have already been developed that will form the basis for the risk adjustment for provider payments for these subpopulations as well.
[20] http://www.hci3.org/content/ecrs-and-definitions

- ≥ 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher

Exclusions

[In principle, the state does not want to exclude any cost categories from the VBP arrangements. TBD e.g. high cost drugs for other conditions than hemophilia and hepatitis C]

2. Ensuring alignment between DSRIP goals and value based payment deployment

Issue 2: How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures

Selecting integrated care services

As discussed in the previous section, sustaining the achieved DSRIP goals is the starting point for the design of this payment reform. The overall aim to increase population health, individual health outcomes and reward high value care delivery is similar, and the outcome measures to be used in the different VBP arrangements will directly build upon the DSRIP measure set. In addition, the DSRIP objectives and measures play an important role in the selection of the care bundles and subpopulations to be prioritized. The following criteria have been used:

1. The proportion of total Medicaid costs

Focusing on those care bundles and subpopulations with the largest spent is the best way to realize maximal impact while keeping the number of care bundles and subpopulations within reason.

2. The number of Medicaid beneficiaries included in these integrated care services per county/PPS

A minimum number of patients per PPS/provider combination per integrated care service is required for these value-based payment arrangements to become meaningful. When numbers are too low, after all, it becomes impossible to reliably measure outcomes of care. In addition, the lower the number of patients per care bundle or subpopulation, the higher the risk that natural variation will inadvertently cause significant gains or losses unrelated to the quality or efficiency of the care delivered.[21]

The care bundles and subpopulations with the highest numbers of patients will be prioritized. Minimum numbers for contracting will be established in 2015.

3. Cost Variation

Variation in cost per integrated care service can be due to three factors[22]:

- Quantity of services delivered: the more admissions or expensive diagnostic tests, the higher the cost per care bundle/patient

[21] Mechanic, R. and C. Tompkins (2012). "Lessons learned preparing for Medicare bundled payments." N Engl J Med **367**(20): 1873-1875; Weissman, J. S., M. Bailit, G. D'Andrea and M. B. Rosenthal (2012). "The design and application of shared savings programs: lessons from early adopters." Health Aff (Millwood) **31**(9): 1959-1968.

[22] de Brantes, F. and S. Eccleston (2013). Improving Incentives to Free Motivation, Healthcare Incentives Improvement Institute and Robert Wood Johnson Foundation.

- Mix of services: selecting more costly diagnostic tests, prescribing specialty rather than generic drugs or opting for inpatient rather than outpatient treatment modalities drives up cost per care bundle/patient
- Price per unit of service (this variation will be low within the Medicaid domain)

Large variations in costs per care bundle or subpopulations is indicative of potential waste and thus savings, and these care bundles or subpopulations will thus be prioritized.

4. Rates of potentially avoidable complications

Because the core goal of DSRIP is reducing potentially avoidable (re)admissions and ER visits, identifying those care bundles and subpopulations with the highest rates of overall potentially avoidable complications is a crucial criteria for prioritization.

5. Prioritized within DSRIP

To ensure alignment with the DSRIP objectives, the integrated care services selected within the DSRIP program will be prioritized as well.

Applying these criteria, the following selection of integrated care services emerges (see Appendix II for the quantitative analyses underlying this selection):

Integrated Primary Care

Care Bundles

- Maternity Care
- Diabetes
- Asthma
- Hypertension
- Chronic Heart Failure
- Coronary Artery Disease
- COPD
- AIDS/HIV
- Hemophilia
- Hepatitis C
- Renal care

Total Care for Subpopulations

- Multimorbid disabled / frail elderly (FIDA population)
- Severe BH/SUD conditions (HARP population)
- Care for the Developmentally Disabled (DISCO population)

[this section to be developed further once analytics are done.]

The total dollar amount associated with these care services is xx$, thus covering approx. xx% of the total payments between MCOs and PPSs/providers (excluding the Medicare component of the FIDA payments).

This initial selection will be tested, refined and expanded further during the remainder of 2015 through further data analysis and discussions with stakeholders.

Incentivizing the Patient: Value Based Benefit Design

Payment reform is incomplete without considering the financial incentives for patients in both lifestyle choices (leading to future health care costs) but also provider choices (choosing for either higher or lower value providers). Financial incentives for the former (stimulating behavior that will lead to healthier lives) are becoming common. Incentives to stimulate high-value care utilization, however, are less widespread. Yet the problems DSRIP set out to address have their roots in inadequate financial incentives for beneficiaries as well. Absence of coverage, leading to ER use as the only realistic location for care, is the most obvious one, and is being addressed by New York's Medicaid expansion, amongst others. Yet once a patient is enrolled in a Medicaid managed care plan, indiscriminate choices of providers and persistence of using the ER as the first line of care are more often than not similarly covered as judiciously selecting a primary care physician and high value care. If these behavioral patterns are not addressed, if providers' *and* patients' financial incentives are not fully aligned with the value of health care services, the chances that DSRIP sustainably realizes its goals will be reduced. Value-based benefit design is an important part of this and should thus be a core aspect of any payment reform. [23]

In NYS Medicaid, however, adding financial burdens by introducing co-pays or co-insurance as disincentives for poor choices is not a policy option. On the other hand, *positively* incentivizing desired behavior, including allowing access to previous inaccessible high-value care benefits (such as joint weight reduction programs, post-acute care activation programs, programs to teach healthy and affordable cooking habits) can be a very powerful tool. The state will stimulate MCOs as well as PPSs and other provider combinations to introduce both types of positive incentives:

- Wellness or Lifestyle incentives, where the state can build upon its experience with its MIPCD (Medicaid Incentives for the Prevention of Chronic Disease) program. Any program that has been proven effective can be implemented by MCOs as part of their larger VBP approach. Plans are required to coordinate the approach with the PPSs to whom their populations are attributed.
- Patient incentives to make optimal health care choices, such as:
    - Actively and meaningfully using PCPs and preventive care
    - When indicated: Engaging in early Maternity care
    - When indicated: Engaging in chronic care
    - Using care In Network (ie., within IDS) rather than out-of-network (unless explicitly indicated).

In line with the levels of VBP described above, and learning from the rapidly growing experience in incentivizing patients/consumers, the state aims to maximally focus here as well on *outcomes* rather

[23] Thomson, S., L. Schang and M. E. Chernew (2013). "Value-based cost sharing in the United States and elsewhere can increase patients' use of high-value goods and services." Health Aff (Millwood) **32**(4): 704-712; Choudhry, N. K., M. B. Rosenthal and A. Milstein (2010). "Assessing the evidence for value-based insurance design." Health affairs (Project Hope) **29**: 1988-1994; Antos, J., K. Baicker, M. Chernew, D. Crippen, D. Cutler, T. Daschle, F. d. Brantes, D. Goldman, G. Hubbard, B. Kocher, M. Leavitt, M. McClellan, P. Orszag, M. Pauly, A. Rivlin, L. Schaeffer, D. Shalala and S. Shortell (2013). Bending the Curve. Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth. Washington DC, Brookings Institute.

than efforts or process-steps. In this view, patients could be awarded e.g. $500 for meeting life style choices that are proven to improve health and reduce downstream costs, or truly choosing high value care. This would be a form of 'inclusive shared savings', where patients' incentives to choose wisely become fully aligned with professionals and providers aiming to reduce avoidable hospitalizations and improve population health.[24]

Transparency of outcomes and cost as the foundation for Value Based Payments

The NYS DSRIP program is geared towards the realization of outcomes (reduced potentially avoidable (re)admissions, visits and complications; better patient experience, reduced number of uninsured and beneficiaries not using preventive and primary care services); PPSs that do not realize their goals receive less DSRIP performance payments. The NYS Medicaid Payment Reform strategy embraces these same goals, structurally rewarding outcomes over inputs. As said, the outcomes to be contracted for the different VBPs will directly aligned the DSRIP measures: the Domain 2 and 3 measures that have been selected for the DSRIP program will form the starting point. Additional measures will be added when it is deemed that outcomes of care are not optimally captured for specific care bundles or subpopulations. (One key goal is the inclusion of Patient Reported Outcome Measures, a key missing link is truly assessing the outcomes of care for many health problems and conditions).[25]

Over 90% of these measures is based on claims data, or on other data (such as surveys) that are owned by or primarily available to the state (CAHPS, UAS-NY, …). The state will make the scores of these measures available to the PPSs and the MCOs during DY 1 (2015), with the opportunity to compare between PPSs and regions, to identify providers responsible for high or low scores, and to explore some of the common drivers of better or lesser performance. In DY 2 (2016), the State will also make the total risk-adjusted cost of care available per PPS for the total population, as well as per integrated care service delineated above (Maternity care, Diabetes care, APC/PCMH care, etc). Potential (shared) savings, estimated by e.g. benchmarks on potentially avoidable complications, will be provided as well at both the total population level as per care bundle and subpopulation. Having these costs and the outcomes of these services available and transparent will allow for a true discussion on value realized and potential (shared) savings possible.[26]

To increase overall transparency, and allow beneficiaries and other citizens alike to make better choices, the information on costs of care and outcomes of care will be made publically available as well.

Public health and social determinants of health

Given the importance of the social determinants of health for the realization of the state's goals, its definition of Integrated Primary Care and its vision for the role of the PPS is explicitly population-health focused, reaching out into the community to stimulate community-based prevention activities and aligning itself with available social services. Concurrently, the framework for value-based payment will

[24] Thomson et al. op.cit. 23; Schmidt, H. and E. J. Emanuel (2014). "Lowering medical costs through the sharing of savings by physicians and patients: inclusive shared savings." JAMA Intern Med **174**(12): 2009-2013; Baicker, K. and M. Rosenthal (2014). "Shared savings, shared decisions, and incentives for high-value medical care." JAMA Intern Med **174**(12): 2014-2015.

[25] NQF (2013). Patient Reported Outcomes (PROs) in Performance Measurement.

[26] Watkins, L. D. (2014). Aligning Payers and Practices to Transform Primary Care: A Report from the Multi-State Collaborative, Milbank Memorial Fund.

maximally incentivize providers to push the envelope in focusing on the core underlying drivers of poor health outcomes – whether traditionally within the medical realm or not.

Given the current state of primary care and IDS development in the state, however, and the difficulty to truly move the needle on a population-wide basis within a few years, the DSRIP Domain 4 population health measures are Pay for Reporting only. In the near future, however, the state foresees culturally competent community based organizations actively aligning with PPSs and/or Advanced Primary Care organizations to take responsibility for achieving the state's Prevention Agenda. DSRIP starts to build the infrastructure to take on housing, job placement and incarceration pathways as levers to increase population health, and the state foresees VBPs (for PPSs as a whole or for integrated primary care) to become a vehicle to maintain this infrastructure. Specifically, the state aims to introduce a dedicated value based payment arrangement for pilot purposes in DY 3 to focus specifically on achieving Prevention Agenda targets through CBO-led community-wide efforts.

Immediately after DY 5, the state intends to turn the Pay for Reporting measures into Pay for Outcomes measures, making a part of overall PPS reimbursement dependent on the achievement of specific public health goals as identified by these measures.

3. Amending contracts with the MCOs to realize payment reform

Issue 3: How the state will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform

Aligning incentives

[section to be finalized]

The state will add the following incentives and regulations in its contracts with MCOs to stimulate MCOs towards adapting VBPs:

- The state will increase the managed care rate for those MCOs that capture more provider-payment dollars in VBP arrangements. [precise mechanism TBD]
- Part of this increase will be paid to providers as a stimulus for engaging in higher level VBP contracts.
- The state will incentivize arrangements that focus on integrated care services (APC/PCMH, care bundles or total care for selected subpopulations) more than arrangements that focus on total cost of care for the total population, because a) infrastructure costs for these former arrangements will be higher and b) the State believes the total impact on quality, efficiency and sustainability of the Medicaid delivery system to be higher when a more differentiated VBP approach is taken. [precise mechanism TBD].
- Starting DY 4, non VBP arrangements will be disincentivized. [precise mechanism TBD].
- The state will assure that it will not hold MCOs accountable when providers, to no fault of the MCO, run into financial difficulty because of underperformance on a Value Based Contract. To be able to give this guarantee, and as an additional layer of protection for the state's safety net infrastructure, the state will create a dedicated statewide fund / risk pool for distressed safety net providers that are too essential to allow to fail.

Specific regulatory amendments

[Section rough draft only]

In addition to the topics discussed above, the State will consider in its progress towards realizing the payment reform goals:

- The need for regulatory provisions protecting providers and professionals against being contracted to deliver care at rates not realistically viable for these providers and professionals;
- Address here the regulatory discussions on allowing Medicaid providers to assume Risk and the other regulatory topics discussed by the Regulatory Workgroup such as allowing for gain sharing, joint contracting negotiations etc.

[add specific text on HARP and FIDA plans: they will be included without impacting the regulatory framework that has already been established for the HARP SNPs or FIDA SNPs. The contracts between these HARP and FIDA SNPs, however, will have to allow for Level 1, 2 or 3 VBPs between these SNPs to the PPS or selected provider group in a similar vein as the other integrated care services]

[statutory changes will be realized that will help ensure the state can implement this roadmap]

- TBD: Deregulation of rules necessary in addition to adding new ones (esp regarding detailed monitoring & rate setting etc)
- The contract modifications will have to be realized before the start of DY 3 (2017) (see also the Timeline section)

4. Amending contracts with the MCOs: collection and reporting of objectives and measures

Issue 4: How and when plans' currents contracts will be amended to include the collection and reporting of DSRIP objectives and measures.

The state currently includes quality and efficiency incentives in contracting with MCOs that are directly aligned with DSRIP. Many of its QARR metrics, for example, are identical to the metrics selected for DSRIP. In addition, 2015 will be the first year the State works with Efficiency Measures for MCOs, which are aimed at reducing ER visits and avoidable admissions through the same measures used within DSRIP. This further aligns MCO's incentives with DSRIP's desire to realize a lasting, sustainable transformation of the Safety Net system. In DY 1 the State will work with MCOs to finalize the streamlining of the overall MCO quality and efficiency frameworks with the payment reform proposed here. During that year, the state will involve multi-stakeholder groups to discuss the inclusion of additional outcome measures where necessary, such as Patient Reported Outcome Measures for elective and chronic conditions, for example.

5. Creating synergy between DSRIP objectives and measures and MCOs efforts

Issue 5: How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The state should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other state funding; and how they differ from any services or administrative functions already accounted for in capitation rates

Currently, the base administrative per member per month (PMPM) amounts are calculated for each of the State's nine managed care rating regions using plan Medicaid Managed Care Operating Reports (MMCORs). The regional PMPM amounts are calculated by dividing the total allowable administrative cost for each plan in a given region by the plan reported member months. Each plan PMPM amount is then subject to the Department's administrative PMPM cap and adjusted down if necessary. Additionally, the Department of Health (DOH) also incorporates an administrative component into premiums for all new populations and benefits moving into the benefit which are not reflected in the two year MMCOR base. This additional administrative component is developed by the State's actuary. The administration component is then adjusted by a plan specific risk score.

As with all new requirements, the Department and its actuary will review what will be expected of plans under DSRIP with regards to provide technical assistance/support, new activities, workforce development, etc. to achieve waiver goals. This analysis will also take into account activities already being accounted for in plan rates to ensure duplication of payment is avoided. Ultimately, the State's actuary will certify an actuarial sound rate range that takes into account the factors above which the State will pay for within the range to meet Federal requirements.

It is anticipated that the new requirements under DSRIP may result in additional administrative costs for the plans which will need to be evaluated by the State and its actuary. Two specific areas where this will likely occur are: 1) *workforce planning* where, under the waiver, plans are responsible for developing and implementing various workforce strategies; and 2) *value based payment* requirements which will necessitate plan/provider contract modifications. While there will likely be increases for these items, the Department believes they will not be excessive as it intends to set benchmark payment levels for use by plan/provider.

6. Assuring that providers successful in DSRIP are contracted

Issue 6: How the state will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks

[Forthcoming: one-two paragraphs]

- Because high performing (combinations of) providers will be visible to both providers, MCOs and the public alike, it is highly unlikely that (combinations of) providers that are successful in delivery high value care would not be contracted by MCOs.

- Current network standards will be maintained; the department will closely monitor networks and listen to provider concerns in this area.

7. Amending contracts with the MCOs: adjusting Managed Care rates to improved population health and care utilization patterns

Issue 7: How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development

Under the Department's Mainstream Managed Care risk adjusted rate methodology, all plans are paid at the same regional average premium, adjusted by a plan specific risk adjustment factor that accounts for differences in enrollee acuity across plans. The regional premiums are developed using two years of plan reported MMCOR data. Using collected encounter data, risk scores are calculated using 3M's Clinical Risk Group (CRG) model and cost weights developed by the Department. In simple terms, these two pieces are multiplied together to get plan specific risk adjusted rates. The Department and its actuary incorporate changes in case mix, utilization and cost of care on an annual basis as the data becomes available to incorporate in rate development. The inclusion of DSRIP into this process will be a continuation and expansion of the work already being done. Furthermore, as the Department implements its "Care Management for All" initiative and new populations and services (esp. for chronic conditions including the long term care, behavioral health and developmentally disabled populations) move into managed care, it has engaged 3M and plans to make refinements to the current risk adjustment methodology. This effort is also a significant element of the CMS/DOH Fully Integrated Dual Advantage (FIDA) Demonstration. Ultimately, the goal is to have one risk adjustment system that incorporates the needs of the entire Medicaid managed care population.

8. Amending contracts with the MCOs: ensuring alignment between DSRIP objectives and measures and MCO rate setting

Issue 8: How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the state will use benchmark measures (e.g., MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year

As noted above, the state's actuary currently develops actuarially-sound rates for the state. Any new expectations or tasks associated with DSRIP that the plans will be required to undertake will be incorporated into the development process. Similarly, as new populations and services have moved into managed care the State has and will continue to deploy risk mitigation strategies such as stop loss, medical loss ratios and/or risk corridors to ensure that appropriate reimbursement is being made. The State also places a premium on timely and accurate plan encounter submissions. This information is used to not only monitor the implementation of "Care Management for All" but also as a means to measure plan profitability and rate adequacy. Furthermore, as mentioned above, the Department will

include core DSRIP metrics into plan specific reimbursement to optimally align payers' and providers' incentives. Through the transparency program described above, the Department will report outcomes of these metrics to both plans and providers on which PPSs and provider-combinations are achieving or underperforming on each of the measures.

Stakeholder Engagement

In support of the State's efforts to create a comprehensive roadmap a series of Stakeholder Engagement Interviews were conducted to share preliminary VBP concepts the State was considering, discuss key themes with regard to achieving a VBP model, identify and outline key challenges anticipated and request feedback and suggestions for the State's consideration. Stakeholder's engaged during the preliminary interview process included New York State Health Plans, managed care organizations, representative organizations including the Health Plan Associations, Hospital Associations, and legal firms, New York State Health and Human Services Agencies, and Performing Provider Systems. All of the key themes and challenges identified during this stakeholder engagement have been documented and addressed through the drafting of the Roadmap.

In addition, the State has created a formal group of Stakeholders, an expansion of the Medicaid Reform Team's Global Cap Work Group, to serve as the Value Based Payment Workgroup. The VBP includes representatives from other State Agencies, payers, providers, advocacy groups, and labor. This group will continue to be engaged throughout the development and implementation of this Roadmap.

Timeline

- In DY 1 (2015), the Medicaid VBP approach will be finalized and refined, including a detailed scoping of the required information infrastructure to support the statewide realization of this approach.
- In DY 2 (2016), every MCO – PPS combination will be requested to submit a growth plan outlining their path towards 90% value-based payments. All growth plans will be weighed in terms of ambition level (speed of implementation, level of risk, total dollars at risk, opting for a differentiated approach rather than total cost of care for total population). MCOs with more ambitious grow plans will receive a bonus on their PMPM rates from DY 3 (2016) on.
- End of DY 3 (2017), every MCO – PPS combination will have at least a Level 1 VBP arrangement in place for PCMH/APC care and one other care bundle or subpopulation (a Level 1 arrangement for the total cost of care for the total population would count as well). PCMH/APC care is selected here because of its vital role in realizing the overall DSRIP goals.
- End of DY 4 (2018), every MCO- PPS combination will have at least 50% of its care-costs contracted through Level 1 VBP VBPs, and ≥ 30% of these costs will have to be contracted through Level 2 VBPs or higher
- End of DY 5 (2019), ≥90% of total MCO-PPS payments (in terms of total dollars) will have to be captured in at least Level 1 VBPs, and ≥ 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher

Conclusion

[and next steps - follows]

Appendix I: T&Cs Par. 39

In recognition that the DSRIP investments represented in this **waiver must be recognized and supported by the state's managed care plans** as a core component of long term sustainability, and will over time improve the ability of plans to coordinate care and efficiently deliver high quality services to Medicaid beneficiaries through comprehensive payment reform, strengthened provider networks and care coordination, the state must **take steps to plan for and reflect the impact of DSRIP in managed care contracts and rate-setting approaches**. Prior to the state submitting contracts and rates for approval for the April 1, 2015 to March 31, 2016 contract cycle, the state must **submit a roadmap for how they will amend contract terms** Recognizing the need to formulate this plan to align with the stages of DSRIP, this should be a multi-year plan, and necessarily be flexible to properly reflect future DSRIP progress and accomplishments. This plan must be approved by CMS before the state may claim FFP for managed care contracts for the 2015 state fiscal year. The state shall update and submit the Managed Care DSRIP plan annually on the same cycle and with the same terms, until the end of this demonstration period and its next renewal period. Progress on the Managed Care DSRIP plan will also be included in the quarterly DSRIP report. The Managed Care DSRIP plan should address the following:

- What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the state will plan and implement its stated goal of 90% of managed care payments to providers using value-based payment methodologies.
- How and when plans' currents contracts will be amended to include the collection and reporting of DSRIP objectives and measures.
- How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The state should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other state funding; and how they differ from any services or administrative functions already accounted for in capitation rates.
- How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.
- How the state will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks.
- How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development.
- How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the state will use benchmark measures (e.g., MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.

- How the state will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.

Appendix II: Quantitative Analysis per Integrated Care Service

[forthcoming: analysis showing per integrated care service the total costs associated with that care, the # of Medicaid patients, cost variation and potentially avoidable complications.

Example of visualization to be used (showing combination of cost variation (vertical axis), total costs (size of bubble) and % of costs associated with potentially avoidable complications (hue of bubble). (example derived from output from HCI3 grouper).]