Proposal To The NYSDOH Medicaid Redesign Team-Regulatory Impact Subcommittee

Starting With The Details: Classification of Review Tiers and 12 Example VBP Methods

FOR REVIEW ON 9/21/2015

Create 3 Regulatory Review “Tiers”

- **Going forward, the 3 regulatory review and oversight tiers would be:**
  - Highest - Reg. 164 applies (as is).
  - Middle - Regulatory review applies prior to implementation. Similar to current DOH Level 3/4 review. No cash deposit applies unless provider has negative net worth.
  - Lowest - No regulatory review applies - for either financial aspects or contractual aspects.
    - Health plan simply files a standard form informational certification with DOH.
    - DOH can conduct audits to assure reports are accurate.
    - DOH can always ask questions or request documents and health plans (and providers via the health plans) must respond.
- **In effect, the 4 existing DOH “levels” of review would be collapsed into only two tiers of DOH review**
  - Middle tier and lowest tier as listed above.
  - The DOH provider contract guidelines would be edited to reflect the new tiers and posted on the DOH website to facilitate understanding by all parties.
- **The new rules should apply uniformly to all types of providers and all types of intermediaries (IPAs, ACOs, etc.)**
  - For the purposes of this document, the term “provider” includes both providers and intermediaries (such as IPAs, ACOs, etc.) even though DOH sometimes distinguishes those entities.

The "Guiderails" Which Limit Or Manage the Risk

There are numerous factors typically included in VBP contracts which constrain the financial risk borne by the provider. Thus generic discussions of "risk" may unduly imply potentially extensive financial burdens which in fact are far less than might appear.

- **Contractual terms of the financial arrangement may include:**
  1. Exclusion of high cost cases (from the base year and the performance year). Example-claims costs greater than $100,000 (?) per person per year. Health plan thus retains all risk for cases above the designated threshold.
  2. Risk adjustment to account for variations in the population between the base year and the performance year. Examples are use of average CRG score or use of expected costs for contracted bundles.
  3. Maximum % risk of shared losses to be absorbed by the provider. Example-75% (?) is maximum % provider can assume.
  4. Maximum % variation from the target/benchmark. Example-provider cannot be responsible for variation of more than 15% (?) above target/benchmark.
  5. Claims payments are made by the health plan. In the instances where this applies, all premium funds are held by the health plan until funds are dispensed in the form of claims payments after the provider has already rendered the services to the patient/enrolled member.
  6. Responsibility for only a portion of a patient's total cost of care. The main example here is high-cost drugs, where the risk can remain with the plan.

Terms of the VBP contract must include at least a combination of the above. Some VBP methods (such as those where revenues to providers from payors fluctuate with volume—such as FFS bundles) may require fewer guiderails than others.

Most of the items listed above will be translated into technical guidelines by the Technical Workgroup #1, drawing upon the discussion in the Regulatory workgroup.

The "Guiderails" Which Limit Or Manage the Risk (Continued)

Additional Guiderails include:

- **Contractual terms for payment of losses (in addition to lump sum payment by provider to health plan of shared losses):**

  7. Reduction of future standard fee for service payments to extinguish the obligation.

  8. Set aside a portion of current shared savings receipts to create an informal rainy day fund to be used to pay potential future shared losses. In effect this is a one year lag on distribution of a portion of the shared savings receipts. Rainy day fund can be held by the provider.

  Terms must include at least one (?) of the above

- **Other protections for payment of losses:**

  9. Purchase of a provider stop-loss insurance policy from an insurer.

  10. Obtain bank letter of credit.

  Although the two items above are always possible options, the expense of procuring them often renders these options very unattractive to providers.

  11. Although cash deposits or escrow accounts are typically unattractive to providers, there may be certain instances where the provider prefers the cash deposit or escrow account. In that case there should be no prohibition on voluntary use of cash deposits or escrow accounts under the same terms and conditions as DOH has typically required to date.

Regulatory Review Tiers Are Different From The Roadmap

- In the pages that follow, note that the "tier" of regulatory review does not necessary equate with the Roadmap's level of transformation stimulus and "risk" to the provider in the health care reform sense of that word
- The reason is that providers can be significantly stimulated by payment models to change their behavior, while not necessarily posing insurance-type risk that poses concerns to regulators
- In some cases there is both a high level of health reform stimulus AND a high level of insurance-like risk
  - Example: Full risk capitation and Regulation 164- See Row A below
- In other cases the high level of health reform/roadmap stimulus toward delivery system reform is NOT commensurate with a high level of insurance-like risk
  - Example: FFS payments by the health plan with a year-end tabulation to determine a range of shared savings or shared losses- See Rows C and E below

EXAMPLE

Highest Tier of Regulatory Review

The list of VBP methods below is not exclusive or exhaustive. The parties could negotiate terms as they might mutually agree. However, DOH/DFS would then need to determine which of the 3 review tiers above best matched with nature of parties' negotiated terms.

VBP Payment Methods	Relevant VBP arrangement	Key Features Affecting Level of Review	Proposed Standards For Review and Approval	Proposed Key Changes to Current Review Processes	Roadmap Level
A-Full risk "actual" capitation for total cost of care (actual cash payment from health plan to provider; provider pays claims or otherwise subdivides capitation $ among various providers).	Total Care for Total Population Total Care for Subpopulation	Transfer of funds from health plan to provider	Reg. 164 continues to apply, with same current exemptions and processes	Not clear any changes are necessary	3
B-Full risk "actual" capitation for <u>less than total cost of care</u> (such as hospital care only or RX only). Could also include integrated primary care (full risk for PCP and specified chronic care costs only.)	*This arrangement would not be admitted as a VBP arrangement because it does not include the full spectrum of care for a condition/patient group.* *Exception:* Integrated Primary Care (w or w/o chronic bundle)	Same as above Transfer of funds from health plan to provider	If less than $1M contract is already exempt from Reg. 164. If for one service only (such as primary care) no financial review or deposit is currently required by DOH. Include inpatient hospitalization and IPAs/ intermediaries, so long as have positive net worth (or parent does).	Not clear any changes are necessary	3

EXAMPLE

Middle Tier of Regulatory Review/New DOH Tier 2

VBP Payment Methods	Relevant VBP Arrangement	Key Features Affecting Level of Review	Proposed Standards For Review and Approval	Proposed Key Changes to Current Review Processes	Roadmap Level
C-"Virtual Capitation" All claims paid FFS by health plan; year end-reconciliation where provider has 100% risk for all variations above or below predetermined target spending/benchmark. For total cost of care.	Total Care for Total Population Total Care for Total Subpopulation Integrated Primary Care (w or w/o chronic bundle)	Health plan continues to pay all claims; therefore not same regulatory concerns as under full risk capitation where there is transfer of funds from health plan to provider.	NOT subject to Reg. 164. No deposit requirement unless provider has negative net worth. (Would be similar to current DOH Level 3 review.)	Must have several of the guiderails from page 3. For example, a particular VBP might have: • Exclude claims costs greater than $100,000 per patient per year. Health plan always holds risk of claims costs > $100,000 per patient per year. • Provider is at risk only for a maximum of 5% variation from the target/benchmark. • Provider is at risk for only 50% of shared losses. • If shared losses occur, provider has option to pay health plan via future year reduction of FFS payments (reduced fee schedule) until debt is extinguished.	2
D- "Major" Shared Losses--All claims paid FFS by health plan; year end-reconciliation where provider has 50% (or more) share of risk of losses for spending <u>more than 15% above</u> predetermined target spending/benchmark). For total cost of care.	Total Care for Total Population Total Care for Total Subpopulation Integrated Primary Care (w or w/o chronic bundle)	Same as above	Same as above	Same as above	2

EXAMPLE

Lowest Tier of Regulatory Review/New DOH Tier 1

For all methods in lowest tier: It is proposed that no VBP at lowest tier requires providers to demonstrate financial resources. Reason is that it is proposed that all VBP methods at the lowest level must have several of the guiderail protections and repayment options listed on the Guiderail page (page 3).

VBP Payment Methods	Relevant VBP Arrangement	Key Features Affecting Level of Review	Roadmap Level
E-"Low" Shared Losses-- All claims paid FFS by health plan; year end-reconciliation where provider has 50% (or more) share of risk of losses for spending up to a maximum of 15% above predetermined target spending/benchmark.	Total Care for Total Population Total Care for Total Subpopulation Integrated Primary Care (w/wo chronic bundle)	Health plan continues to pay all claims; therefore not same regulatory concerns as under full risk capitation when there is transfer of funds from health plan to provider. Proposal: Requires several "guiderail" options from page 3. For example—assume same guardrail selections as Row C above. • Note that magnitude of potential losses at this level is far less. Example: assume target/benchmark of $1 million in aggregate health plan paid claims expenses. Assume actual provider performance is 5% over target/benchmark = aggregate claims cost of $1,050,000. Losses are $50,000. Assume provider's obligation is 50% of losses = shared loss obligation of provider to health plan of $25,000. This is so measured at master contract between health plan and IPA/lead provider. It is also true for downstream contracts between IPA/lead provider and participating provider. • Thus the financial impact on IPA or provider is reduced provider revenue of 2.4% compared to standard fee for service revenue. While provider may be disappointed, the actual "risk" to the provider is small in comparison to provider's annual gross revenues or compared to full risk capitation (highest regulatory review tier).	2

EXAMPLE

Lowest Tier of Regulatory Review/New DOH Level 1

VBP Payment Methods	Relevant VBP Arrangement	Key Features Affecting Level of Review	Road map Level
F-Shared Losses for Care Mgmt Fee only. All claims paid FFS by health plan; year end-reconciliation where provider has shared risk obligation solely to return care mgmt. fee (if any) paid by health plan to that provider for that same year if spending is above predetermined target spending/benchmark. For total cost of care.	*This is a non-standard VBP arrangement but could be approach to negotiate shared savings / losses. (See forthcoming Guidelines).* Total Care for (Sub) Population Integrated Primary Care	Same as above, but risk of downside losses is nominal by definition	2
G-Shared Savings only. No shared losses. All claims paid FFS by health plan; year end-reconciliation where provider has no risk of losses for spending above predetermined target spending/benchmark). Health plan pays provider a % of savings if aggregate claims expenses are below target/benchmark. For total cost of care OR less than total cost of care.	All VBP Arrangements	No downside risk of provider loss; therefore no regulatory financial concerns	1
H- Shared Losses <u>For Less Than Total Cost of Care</u>. Applies where target/benchmark is estimated to affect less than 50% of total cost of care. All claims paid FFS by health plan; year end-reconciliation where provider has 50% (or more) share of risk of losses for spending up to a max. of 15% above predetermined target spending/benchmark).	Total Care for Population Total Care for Subpopulation Integrated Primary Care *Due to limited scope:* Bundles	Not major source of regulatory concern since health plan still pays all claims and provider has financial risk for only a small portion of patient's total cost of care.	2
I- Prospectively determined fixed price for bundled claims payments for 2 or more providers (example: knee replacement includes hospital inpatient + surgeon + rehab facility + home care). Claims are paid by health plan after the care is rendered. <u>Type 1. All claims paid FFS by health plan directly to each individual provider within the bundle</u>; year end-reconciliation to agreed bundled price to all affected providers.	Bundles	Little downside risk in proportion to total cost of care paid by health plan to other providers. Revenues to provider still fluctuate with volume – therefore less risk to provider than most total cost of care methods even in this same lowest tier. Health plan continues to pay all claims; therefore not same regulatory concerns as under full risk capitation when there is transfer of funds from health plan to provider.	3 if full risk 2 if shared losses

EXAMPLE

Lowest Level of Regulatory Review/New DOH Level 1

VBP Payment Methods	Relevant VBP Arrangement	Key Features Affecting Level of Review	Roadmap Level
J-Prospectively determined fixed price for bundled claims payments for 2 or more providers (example: knee replacement includes hospital inpatient + surgeon + rehab facility + home care). Claim (lump sum) is paid by health plan after the care is rendered. **Type 2. Health plan pays lump sum bundle to a single designated provider; that designated provider pays claims or otherwise subdivides bundle $ among various affected providers.**	Bundle	Similar to above. Although health plan does relinquish claims paying role, risk shift to providers is not significant in regulatory terms because bundles only apply to certain medical procedures (i.e. nowhere near total cost of patient's care). Revenues to provider still fluctuate with volume – therefore less risk to provider than most total cost of care methods even in this same lowest tier.	3 if full risk 2 if shared losses
K- FFS payments with initial withhold from claims payment of more than 25%; health plan returns some or all of withheld funds (+ possible bonus) at year end based on based on aggregate claims payments compared to target/benchmark expenditures.	*To count as VBP arrangement, withhold/bonus should be linked to shared savings/losses in addition to quality.* All VBP Arrangements	Health plan pays all claims and holds all incentive funds. Thus no risk on providers for handling funds. Distinction between this K and Row L below is that >25% triggers federal PIP regulations. Already expressly excluded from Reg. 164. [May require DOH prior review due to federal PIP regulations.]	2
L. FFS payments with initial withhold from claims payment of less than 25%; health plan returns some or all of withheld funds (+ possible bonus) at year end based on based on aggregate claims payments compared to target/benchmark expenditures.	*To count as VBP arrangement, withhold/bonus should be linked to shared savings/losses in addition to quality.* All VBP Arrangements	Health plan pays all claims and holds all incentive funds. Thus no risk on providers for handling funds. Already expressly excluded from Reg. 164.	2
M. FFS payments with bonus and/or withhold based on quality scores. No shared savings based on spending targets.	*Level 0; would not count as VBP*	No significant financial risk	0

Downstream Contracts

- **In some cases there are two separate contracts:**
  - "Master contract" is defined as the contract between health plan and IPA or lead provider
  - "Downstream contracts" are defined as the contracts between the IPA or lead provider and other participating providers subject to a particular VBP arrangement pursuant to the master contract
- **DOH already has, and will continue to have, jurisdiction over the text of all "downstream" provider participation contracts which implement the master contract**
  - DOH jurisdiction is not limited to the "master" contract between the health plan and the provider or IPA/ACO which enters into the contract with the health plan
- **While DOH has jurisdiction over the text of the downstream contracts, including the VBP methodology used in the downstream contracts for all providers:**
  - DOH should NOT engage in determining which individual providers signing a downstream contract should be prohibited from accepting financial risk under a downstream contract (levels of risk which other participating providers in that same VBP arrangement are permitted to accept)
  - The principles of "skin in the game" for VBP apply equally to all providers in the same VBP contract, regardless of their respective financial condition
  - Providers which have weak financial resources to accept downstream risk for VBP (for their respective proportionate share of the risk under that particular master contract):
    - Have the same guiderails as in the master contract, and
    - May negotiate supplemental terms in their particular downstream contract with the IPA or lead provider
  - DOH should not go down the "slippery slope" of deciding which providers within a particular VBP deal (which DOH has approved at the master contract level) should be exempted from risk sharing commensurate with other providers subject to the same VBP master contract
- **If DOH has questions related to providers under downstream contracts, providers must respond to DOH via the health plans (as occurs now)**
  - Applies to financial issues, as well as all other contractual issues

The Full Universe Of Regulatory Review "Tiers"

- **All downstream VBP or other financial incentives from a licensed health plan to a provider or intermediary (IPA, ACO etc.) will fall under one of the three regulatory review tiers above**
- **If a new VBP method is created which does not obviously fall into one of the 3 tiers, DOH and DFS will determine which of the 3 tiers that new method most closely fits into**
  - For example, as noted in the Roadmap, the parties can negotiate VBP terms for which they might mutually agree. DOH/DFS would then need to determine which level of regulatory review best matched with the terms the parties negotiated.
  - No VBP or other financial payment or provider incentive method from a licensed health plan to a provider/IPA/ACO (whether listed in this document or a "one-off" created by the parties during negotiations) would be outside of the 3 tiers above.
- **If necessary, DOH and DFS could create an additional, 4th tier of regulatory review, but that should be avoided if possible**

Prerequisites

- **Provider generally may not proceed to higher risks without some prior success at a lesser level of risk.**
  - Example: provider can not assume more than 50% share of losses and/or above 5% variation from benchmark, unless provider has had prior success at lesser amounts of risk.
  - That prior success can be with another health plan—it does not have to be with the same health plan.

- **However, provider is not obligated to begin with a Tier 1 VBP. Provider can always request permission from DOH to begin at Tier 2 or Tier 3.**

Computing Sum Total Of Risk $

- **When evaluating to sum total of financial risk borne by a provider, computing the total funds at risk will vary based on the nature of the VBP method and the nature of the downstream contracts**
  - For example- A health plan contract with an IPA for total cost of care under VBP with FFS and shared savings/shared losses (Row E). Total projected risk of loss is at the IPA level. If a downstream provider receives 10% of the VBP FFS claims payments, then that provider holds 10% of the potential shared losses of that particular VBP arrangement.
  - Bundled fee for services payments may be different. Examples-bundles for OB/delivery or knee replacements. Will depend on whether all risk is passed from IPA down to a particular hospital or provider.
- **Evaluation of a provider's total level of risk subject to VBP must also include in the denominator the sum total FFS payments NOT subject to VBP**
  - Example- significant financial risk on 10% of provider's patients and revenues may not be significant financial risk to provider as a whole.

Clarification of Reg. 164

- **There have been a few instances where it was unclear if Reg. 164 applies. That uncertainty should be resolved.**
  - Prepaid capitation payment or percentage of premium paid prior to the last day of the month in which services are rendered and the payment is only covering the providers own services.
    - Does the financial security deposit apply, but the other requirements related to an out-of-network bank account would not be applicable?
  - Cases (other than hospitals?) where the provider is directly providing the services or if the services are provided by an intermediary or the provider uses subcontractors.
    - For example, pre-paid capitation to an FQHC and the FQHC employs all of the health care providers directly or pre-paid capitation to a CHHA, but the CHHA contracts with a LHCSA for some of the services.
    - Does Reg. 164 apply?
- Any other instances to be clarified?
- **DOH and DFS will enter into an MOU to clarify their respective roles, and to clarify the instances where Reg. 164 applies.**
  - That MOU will be circulated in draft form so that all stakeholders are aware of (and can comment upon) the nature of the intended interactions.

Related Regulatory Review Issues

- **To date the DOH regulatory reviews sometimes apply to contract issues other than financial terms**
  - Management contracts etc.
  - Do not include care coordination agreements (Is this correct?)
- **Some changes to current DOH review practices should occur regarding the other contracts which may accompany a VBP contract:**
  - For contracts subject to Regulation 164, "full delegation" of medical management and related functions from the health plan to the provider (or affiliate) continues to require a formal management contract. Approval shall be presumed (for a NYS provider or IPA controlled by NYS provider) subject to appropriate paperwork.
  - Under many VBP options under the "middle" or "lowest" regulatory review category, the health plan may choose to suspend or alter its own current utilization review processes-but the health plan does not formally or legally relinquish that role.
  - In these cases no management contract is required to accompany a VBP contract by virtue of the fact the provider (or affiliate) will play a more proactive role in the care coordination and the health plan intends to bit a bit more "hands-off."
  - However, the parties may agree to a formal delegation which requires a management contract. Approval shall be presumed (for NYS provider or IPA controlled by NYS provider) subject to appropriate paperwork.