NEW YORK STATE | Department of Health | Medicaid Redesign Team

Regulatory Impact Subcommittee

Meeting #1

July 20, 2015

Agenda

Today's Agenda includes the following:

Agenda Item	Time
Welcome & Introductions	10:30
Subcommittee Role and Charge	10:35
Introduction to VBP	10.45
Introduction to: Provider Risk Sharing/Default Risk Reserves	11.30

Subcommittee Role

How are the Subcommittees (SCs) relevant to Value Based Payment (VBP)?

- VBP **subcommittees will play a crucial role** in terms of defining the VBP implementation details
- Each subcommittee will be comprised of stakeholders who have direct interest in, or knowledge of, the specific topics related to each respective subcommittee
- Each subcommittee will have co-chairs designated from the VBP Work Group. They will manage the SCs work toward the development of a final Subcommittee Recommendation Report

Regulatory Impact Tentative Agenda

Discussion	Introduction to
	Meeting 1
VBP Introduction	1. Provider Risk Sharing 2. Default Risk reserves 3. Insurance Law
	Meeting 2
Topics from previous meeting – Deep Dive	1. Medicaid Managed Care Model Contract Changes 2. Network Adequacy 3. DOH/DFS Contract Review and Approval Process
	Meeting 3
Topics from previous meeting – Deep Dive	1. Anti-Kickback (Fee-Splitting) 2. Self- Referral (Stark Law) 3. Prompt Payment Regulations
	Meeting 4
Topics from previous meeting – Deep Dive	1. Fraud, Waste & Abuse 2. Civil Monetary Penalty 3. HIPAA/ Patient Confidentiality (NYS)
	Meeting 5
Topics from previous meeting – Deep Dive	1. De-Regulation and Administration Reduction 2. Dispute Resolution

Regulatory Impact Meeting Schedule

Meeting	Date	Time	Location
Meeting 1	7/20/15	10:30 am	Albany
Meeting 2	8/27/15	1:00 pm	NYC
Meeting 3	9/21/15	1:00 pm	Albany
Meeting 4	10/5/15	1:00 pm	NYC
Meeting 5	11/10/15	1:00 pm	Albany

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VBP Introduction

Brief background and context

NYS Medicaid in 2010: The Crisis

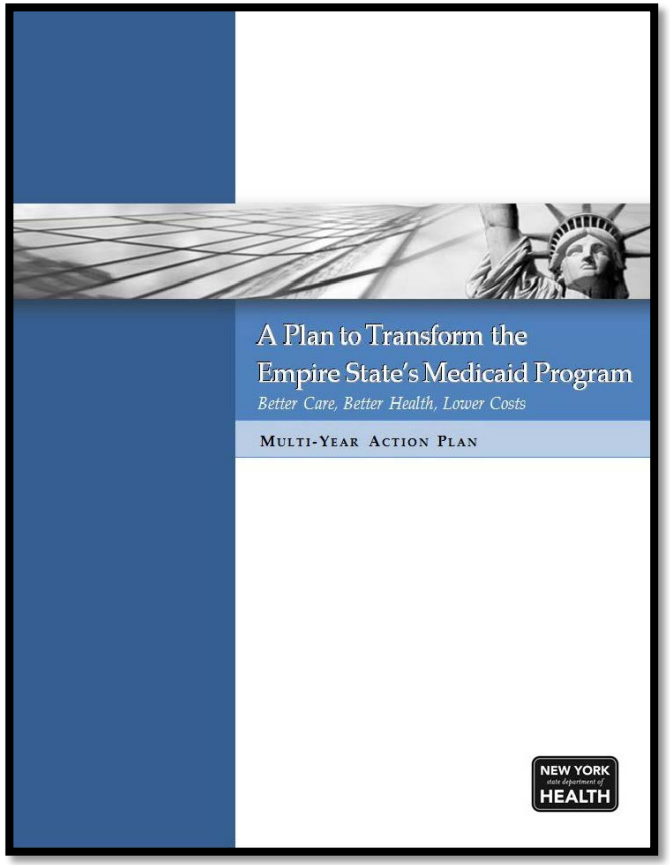
- > 10% growth rate had become unsustainable, while quality outcomes were lagging
  - Costs per recipient were double the national average
  - NY ranked 50th in country for avoidable hospital use
  - 21st for overall Health System Quality

2009 Commonwealth State Scorecard on Health System Performance

CARE MEASURE	*NATIONAL RANKING*
Avoidable Hospital Use and Cost	**50th**
✓ Percent home health patients with a hospital admission	49th
✓ Percent nursing home residents with a hospital admission	34th
✓ Hospital admissions for pediatric asthma	35th
✓ Medicare ambulatory sensitive condition admissions	40th
✓ Medicare hospital length of stay	50th

Creation of Medicaid Redesign Team – A Major Step Forward

- In 2011, Governor Cuomo created the *Medicaid Redesign Team (MRT)*.
  - Made up of 27 stakeholders representing every sector of healthcare delivery system
  - Developed a series of recommendations to lower immediate spending and propose reforms
  - Closely tied to implementation of ACA in NYS
  - The MRT developed a multi-year action plan. We are still implementing that plan today



The 2014 MRT Waiver Amendment Continues to further New York State's Goals

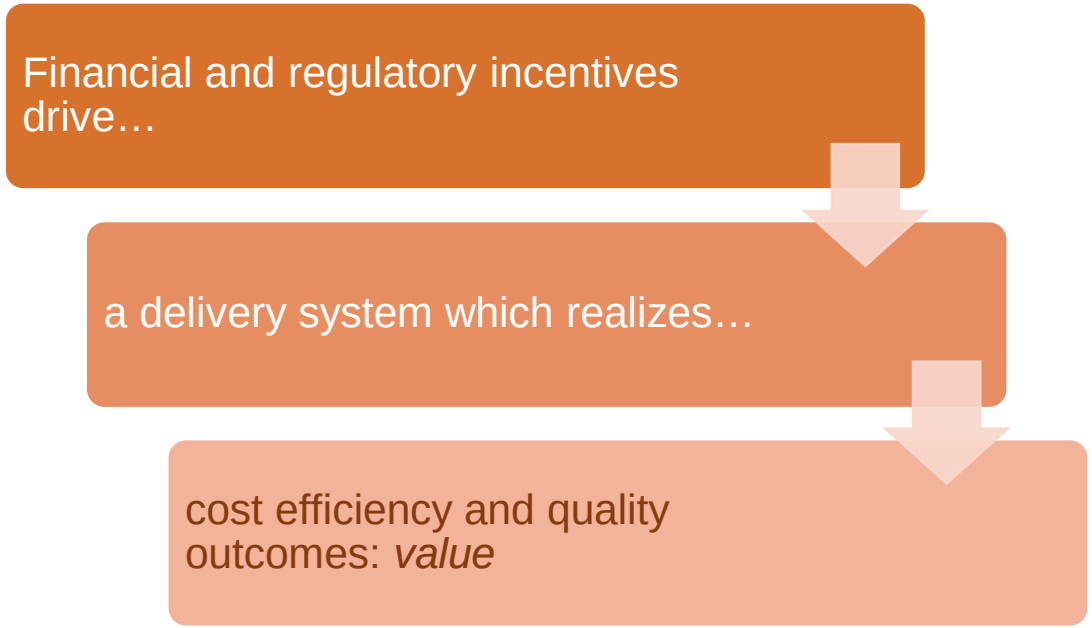
- Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York's health care delivery system
- In April 2014, New York State and CMS finalized agreement Waiver Amendment
  - Allows the State to reinvest $8 billion of $17.1 billion in Federal savings generated by MRT reforms
  - $6.4 billion is designated for **Delivery System Reform Incentive Payment Program** (DSRIP)
- The waiver will:
  - Transform the State's Health Care System
  - Bend the Medicaid Cost Curve
  - Assure Access to Quality Care for all Medicaid Members
  - Create a financial sustainable Safety Net infrastructure

Delivery Reform and Payment Reform: Two Sides of the Same Coin

- A thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well

- Many of NYS system's problems (fragmentation, high re-admission rates) are rooted in how the State pays for services

    - FFS pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
    - Current payment systems do not adequately incentivize prevention, coordination, or integration



Payment Reform: Moving Toward Value Based Payments

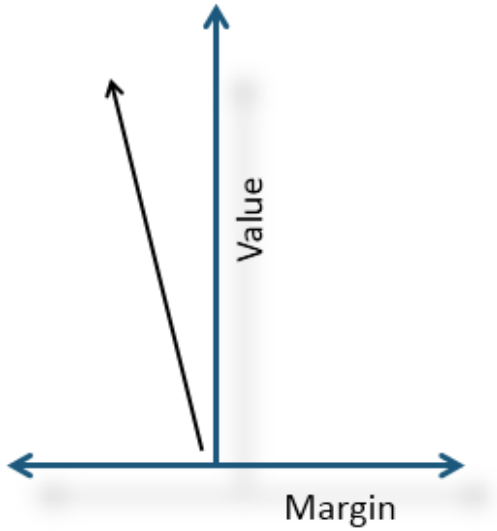
- A Five-Year Roadmap outlining NYS' plan for Medicaid Payment Reform was required by the MRT Waiver
- By DSRIP Year 5 (2019), all Managed Care Organizations must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the *Special Terms and Conditions* of the waiver)
- The State and CMS are committed to the Roadmap
- Core Stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap
- If Roadmap goals are *not* met, overall DSRIP dollars from CMS to NYS will be significantly reduced

Learning from Earlier Attempts: VBP as the Path to a Stronger System

VBP arrangements are not intended primarily to save money for the State, but to *allow providers to increase their margins* ***by realizing value***

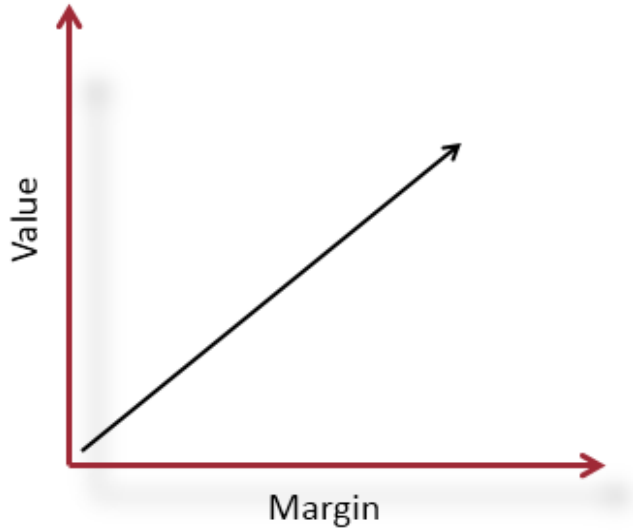
Current State

Increasing the value of care delivered more often than not threatens providers' margins



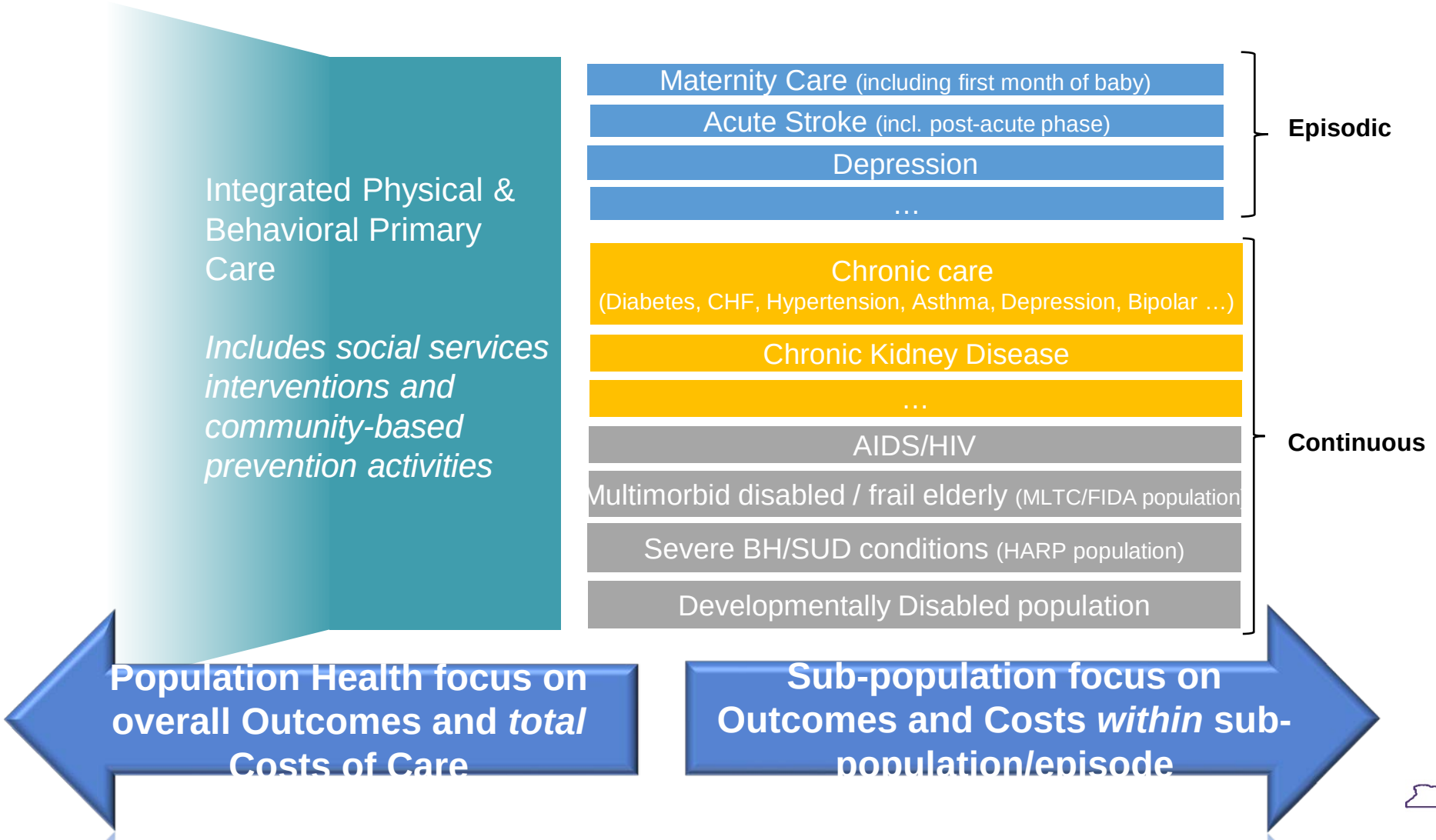
Future State

When VBP is done well, providers' margins go up when the value of care delivered increases



Goal – Pay for Value not Volume

The VBP Roadmap starts from DSRIP Vision on How an Integrated Delivery System should Function



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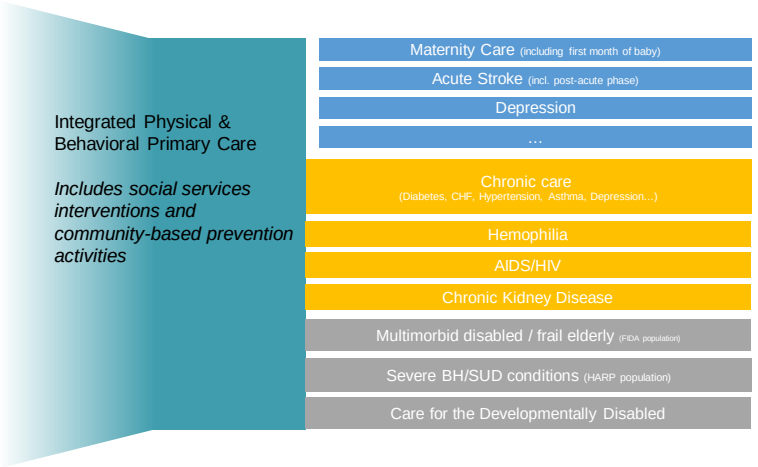
The Path towards Payment Reform: A Menu of Options

There is not one path towards Value Based Payments. Rather, there will be a variety of options that MCOs and PPSs/providers can jointly choose from.

PPSs and MCOs can opt for different shared savings/risk arrangements (often building on already existing MCO/provider initiatives):

- For the total care for the total attributed population of the PPS (or part thereof) – ACO model
- Per integrated service for specific condition (acute or chronic bundle): maternity care; diabetes care
- For integrated Advanced Primary Care (APC)
- For the total care for a subpopulation: HIV/AIDS care; care for patients with severe behavioral health needs and comorbidities



MCOs and PPSs may choose to make shared savings arrangements for the latter types of services between MCOs and groups of providers within the PPS rather than between MCO and PPS

MCOs and PPSs can choose different levels of Value Based Payments

In addition to choosing *what integrated services* to focus on, the MCOs and PPSs can choose different levels of Value Based Payments:

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

- Goal of ≥80-90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- Aim of 25% of total costs captured in VBPs in Level 2 VBPs or higher

Key Defining Factors of the New York VBP Approach

1. Addressing all of the Medicaid program in a holistic, all-encompassing approach rather than a pilot or piecemeal plan
2. Leveraging the Managed Care Organizations (MCO) to deliver payment reforms
3. Addressing the need to change provider business models through positive financial incentives
4. Allowing maximum flexibility in the implementation while maintaining a robust, standardized framework
5. Maximum focus on transparency of costs and outcomes of care

Flexible, Yet Robust Approach

- State involvement focuses on standardization of VBP principles across payers & providers to reduce administrative complexity:
  - Standardizing definitions of bundles and subpopulations, including outcomes
  - Guidelines for shared savings/risk percentages and stop-loss
  - No rate setting, but providing benchmark data (including possible shared savings)

- Allowing flexibility:
  - Menu of options
  - MCO and providers can make own adaptations, as long as criteria for ‘Level 1’ or higher are met

- No haircut when entering VBP arrangements. To the contrary, the more dollars captured in higher level VBP arrangements, the higher the PMPM value MCOs will receive from the State

VBP Transformation Overall Goals

Goal of VBP reform within the NYS Medicaid system:

To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.

By end of 5-year DSRIP plan, the State aims to have…

1. 80-90% of total MCO-PPS/provider payments (in terms of total dollars) as value based payments.

2. 25% of total managed care payments tied to VBP arrangements at Level 2 or higher in order to optimize the incentives and allow providers to maximize their shared savings.

Policy Questions

Policy Question One

- *Are the regulatory requirements that are in place for providers taking on downside risk appropriate for the transition to VBP or should some alternate regulatory vehicle(s) be developed?*

Policy Question Two

- *Should state laws and regulations be amended to re-structure financial security deposits, escrow accounts, and contingency reserves so that there are adequate safeguards for the delivery system, but excess idle cash is avoided?*

Defining Risk Sharing and Default Risk Reserves

- **What is Provider Risk Sharing?** Provider risk sharing in the context of Medicaid Value Based Payments (VBP) occurs when a provider enters into contracts with Managed Care Organizations (MCOs) and accepts the possibility of financial gain or loss dependent upon the generation of savings or excess spending. VBP Levels 2 and Level 3 both involve risk sharing on the part of providers.

- **What are Default Risk Reserves?** Default Risk Reserves are cash deposits and liquidity requirements designed to protect patients, MCOs, and providers when they are unable to fulfill their obligations due to financial distress.

Recap of the VBP Levels

Level 0	Level 1	Level 2	Level 3 (only feasible after experience with Level 2; requires mature entity)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

- **VBP Goals**
  - 80-90% of total MMCO payments (in dollars) to be in Level One VBP at end of DSRIP Year 5
  - 25% of total payments in Level Two VBP or higher (This is an aim)

Provider Risk Sharing in Medicaid VBP

Reconciliation Payments

- VBP Levels One and Two involve the development of a spending benchmarking against which actual performance is compared
- Level Two involves upside and downside reconciliation for providers. Both savings and financial risk are shared under these arrangements

Prepaid Arrangements

- VBP Level Three arrangements require establishing episodic bundle or capitation prices at the beginning of the contracting period
- Payments are made on a prepaid basis according to these prices outside of the fee-for-service system

Current State: DOH and DFS Approval Processes for Financial Risk Transfers

- DOH and DFS Regulations grant MCOs the ability to enter into incentive arrangements with providers that include the transfer of financial risk if providers are structured in a way that can support the incurring of such risk.

- ***DFS Regulation 164*** provides guidance concerning Financial Risk Transfer arrangements and outlines the requirements for providers to enter into such arrangements. DFS Regulation 164 governs financial risk transfers that involve prepaid capitation only.

- ***DOH Provider Contract Guidelines*** govern risk transfer arrangements that do not involve prepaid capitation.

DFS Regulation 164: Background

- An insurer or MCO has a contractual obligation to provide coverage to its subscribers.
- Regulation 164 allows (1) the insurer/MCO to transfer its financial risk (but not its contractual obligations) to a health care provider, and (2) the insurer/MCO to reduce its corresponding claims liabilities.
- Regulation 164 only applies to pre-paid, full capitation payments.
- The agreement must be approved by DFS.
- The insurer/MCO must demonstrate to DFS the “financial responsibility” of the health care provider.

“Financial Responsibility”

- The health care provider can demonstrate financial responsibility by establishing a financial security deposit (FSD) of at least 12.5% of the estimated annual in-network capitation revenue. The FSD can be:
  - Funds held in trust for the insurer/MCO
  - Letter of credit with the insurer/MCO as beneficiary
  - Funds held by the insurer/MCO
  - Provider stop loss insurance
- FSD can be phased in during first year of the capitation arrangement.

DFS Regulation 164: Approval Process

- Insurers must submit a plan to DFS for approval.
- DFS reviews:
  - The financial risk transfer agreement;
  - The financial statements of the health care provider;
  - The financial responsibility of the health care provider;
  - Any other applicable financial arrangement (e.g., provider stop loss coverage, parent company guarantee, etc.); and
  - Certification by the insurer and health care provider that the agreement complies with the provisions of Regulation 164.

DFS Regulation 164: Exceptions

Providers may forgo FSD requirements:

- Capitation contracts with more than one MCO:
  - liquid assets + net worth = 5% of the provider's total estimated annual in-network capitation revenue.
- Capitation contracts with more than one non-MCO:
  - Liquid assets = 5% of total estimated annual in-network capitation revenue, and
  - net worth = 12.5% of total estimated annual in-network capitation revenue.

DFS Regulation 164: Exemptions

Exemptions to Regulation 164 apply if the provider:

- Receives projected in-network capitation from an individual insurer, during any consecutive 12 month period, of no more than $250,000.
- Receives more than $250,000 but less than $1,000,000 (the financial risk sharing agreement is exempt from the need for Superintendent approval and the need to demonstrate to the Superintendent the financial responsibility of the provider and the filing of the CPA report of the provider.)

DOH Financial Review of MCO Contracts & Regulatory Framework

- **Financial Review of MCO Contract**
- DOH financial review and approval is required for all MCO agreements that transfer financial risk for services to another entity, except for prepaid capitation which falls under Regulation 164.
- DFS reviews all prepaid capitation arrangements under Regulation 164.
- **Regulatory Framework**
- The MCO always retains its statutory obligation to maintain full risk under PHL § 4403 (1) (c) on a prospective basis for the provision of comprehensive health services pursuant to a subscriber contract or governmental program.
- DOH defines “Risk Sharing” as contractual assumption of liability by a provider or IPA for the delivery of health care services and may be by means of capitation or some other mechanism such as: withhold, pooling or postpaid provisions etc.
- MCOs are obligated to obtain approval from DOH in accordance with the regulations and Provider Contract Guidelines and from DFS in accordance with Regulation 164 prior to entering into a risk sharing arrangement.
- IPAs may share risk for the provision of medical services with MCOs, and to sub-capitate or otherwise compensate providers and IPAs with which it has contracted.

DOH Financial Review Criteria For Specific Non Prepaid Risk Arrangements*

Current DOH Risk Level 1	Current DOH Risk Level 2	Current DOH Risk Level 3	Current DOH Risk Level 4
Contracts with providers or IPAs • **fee-for-service** • **including withholds or bonuses up to 25% of the payment to the provider.** • Providers do not need to demonstrate the provider's financial viability or establish a financial security deposit.	**Contracts that transfer financial risk (capitation) to providers for single specific service provided directly** • **i.e., primary care, (except inpatient hospitalization) with the provider accepting all medical risk for that service.** • Providers do not need to demonstrate the provider's financial viability or establish a financial security deposit.	**Contracts that transfer broader risk to providers (multiple services provided directly, inpatient hospitalization, or fee-for-service with withholds or bonuses of greater than 25%).** • Providers must demonstrate their financial viability. • If the provider or the parents have a positive net worth, no financial security deposit is required. • If the provider or the parents have a negative net worth, a financial security deposit must be established based on the provider's in-network cost.	**Contracts that transfer risk to IPAs for a single or multiple services.** • Such contracts must demonstrate the IPA's financial viability and establish a financial security deposit.

***In addition to the above requirements, all contracts require submission of a contract certification statement and a non-financial review for compliance with all provider contracting guidelines.**

Specific DOH Requirements for Non Prepaid Capitation

Demonstration of Financial Viability

- The MCO must provide such information as necessary to allow DOH to determine whether a provider sharing risk with the MCO, or an IPA sharing risk with the MCO, or a provider or IPA sharing risk with an IPA, is financially responsible and capable of assuming such risk, and has satisfactory reinsurance, reserves, or other arrangements to support an expectation that it will meet its obligations.
- The provider or IPA accepting risk must demonstrate sufficient capital and solvency via submission of certified audited financial statements or comparable means, such as an accountant's compilation in cases where the provider/IPA is a new entity.
- If the contract includes a provision that a provider's parent organization (such as a hospital system) guarantees the provision and payment of services, the guaranteeing parents' certified audited financial statement can be used to establish the provider's solvency.

Specific DOH Requirements – Continued

- **Financial Security Deposits (FSDs) -** *are separate and unique from the NYS Escrow Fund and the Contingent Reserve requirements.*

- If a financial security deposit is required, the provider/IPA must establish and provide evidence of a financial security deposit equal to 12.5% of the estimated annual medical costs for the medical services covered under the risk arrangement and paid to the provider/IPA.
- The financial security deposit must consist of cash and/or short-term marketable securities and be held by the MCO.
- Under limited circumstances, a parental guarantee may be allowed.
- The entire amount of the required security deposit must be available prior to contract approval.

Provider Risk Sharing Policy Options

Are the regulatory requirements that are in place for providers taking on downside risk appropriate for the transition to VBP or should some alternate regulatory vehicle be developed?

- Option 1 - Apply the requirements of Regulation 164 to all VBP Level Two and VBP Level Three arrangements but broaden the definition of Financial Risk Transfers to include VBP Level Two

- Option 2 – Leave the Regulation 164 as it currently stands. Apply the requirements of Regulation 164 to VBP Level Three Arrangements but not to Level Two arrangements

- Option 3 – Modify Regulation 164 to develop separate requirements for VBP Level Two arrangements that mitigate business and cash flow risk, but do not treat it as insurance risk

Default Risk Reserves in Medicaid VBP

- **MCO Requirements**: Required to ensure that MCOs are capable of fulfilling their obligations to reimburse providers after they have received premiums from the state
- **Provider Requirements**: Required to ensure that providers are financially stable enough to fulfill their obligations to Medicaid members after they receive prepayments from plans for providing those services
- **VBP Level Two:** VBP Level Two does not involve prepayments but does involve significant business and cash flow risk on the part of providers. The policy options will discuss potential approaches for dealing with Level Two

Default Risk Reserve Requirements

-Current MCO Requirements

- Escrow Deposit – Bank deposit
  - 5% of the annual projected medical expense disbursements (differs based on service line)
- Contingent Reserve Requirement – Liquidity Requirement
  - Statutory Net Worth must be at or above 7.25% of the Medicaid Managed Care (MMC) Premium Income

-Current Provider Requirements

Financial Security Deposit (FSD) – Required by the DFS under Regulation 164 for providers that are taking on “significant risk”. Required by DOH Provider Contracting Guidelines for certain arrangements that do not fall under DFS Regulation 164.

- 12.5% of annual estimated in-network capitation revenue

**These Amounts Represent the requirements on mainstream managed care products. Percentages may be different for HARP, MLTC, or other Medicaid products.*

VBP Levels and Default Risk Reserves under Regulation 164

	Level 1	Level 2	Level 3
Escrow (MCO)	✓	✓	✓
Contingent Reserve (MCO)	✓	✓	✓
Financial Security Deposit (Provider)	✗	?*	✓*

The above table represents the current state of Default Risk Reserves requirements under Regulation 164. A key consideration for the subcommittee will be default risk reserves around Level Two VBP arrangements.

**Subject to Exceptions and Exemptions outlined in Regulation 164*

Default Risk Reserve Policy Options

Should State laws and regulations be amended to re-structure financial security deposits, escrow accounts, and contingency reserves so that there are adequate safeguards for the delivery system, but excess idle cash is avoided?

- Option 1 – Impose all default risk reserve requirements on both VBP Level Two and VBP Level Three arrangements
- Option 2 – Reduce MCO default risk reserve requirements when they engage in financial risk transfers with providers. Apply these reductions to both VBP Levels Two and Three
- Option 3 – Do not Impose the financial security deposit requirement on providers engaging in Level Two, but develop additional protections around business and cash flow risks

Appendix A – Level 1 vs. Level 3 Example

A provider is responsible for the care of 1,000 Medicaid members in a given region. The Provider contracts with one Managed Care Organization ("MCO") to receive payments for providing care to these members. Each month, the MCO receives $100 per Medicaid member from the State of New York for a total of $100,000 ($100 x 1,000 members).

Level 1

MCO – At the beginning of the month, the MCO estimates the amount that it will pay out in claims to the Provider. The MCO has estimated that it will have to pay $90 in claims to the provider per member for the month. The MCO then books $100,000 in cash, $90,000 in IBNR and $10,000 in revenue. As claims come in and are paid, the MCO reduces IBNR and reduces cash by the same amount.

Level 3

The capitation amount agreed upon by the MCO and the provider is $90 per member per month. As soon as the MCO receives payment from the State, the MCO books $100,000 to Cash, $90,000 as a liability, and $10,000 to revenue. As soon as the MCO pays the upfront $90,000 to the provider, the MCO reduces the liability and cash by $90,000.

The MCO's Net Worth Calculation remains constant.

Appendix B – Level 2 Example

A provider has agreed on a $15,000 bundle benchmark for Maternity care with an MCO. Susan, a Medicaid member in the provider's network, visits the provider as soon as she becomes pregnant.

Scenario 1: Over the course of Susan's pregnancy, the provider bills the MCO for $10,000. Assuming the provider is entitled to 50% shared savings, the MCO will pay an additional $2,500 to the provider ($15,000 - $10,000 = $5,000 * 50% = $2,500. This will affect the MCO by decreasing its net worth and thus decreasing its contingent liability percentage.

Scenario 2: Over the course of Susan's pregnancy, the provider incurs substantial costs and bills the MCO for $30,000. Assuming the provider's risk is capped at $5,000, the provider will be required to pay $5,000 back to the MCO. This is an "after the fact" reconciliation and would be paid by the provider after Susan's pregnancy bundle has been completed.

Question: Should the provider be required to have a financial deposit to protect the MCO in case the provider cannot front the $5,000? Should the MCO be required to still have the same level of escrow deposits and contingent reserves if the provider also has a financial deposit requirement.

Question: When should a contingent liability related to the shared savings owed to the provider be booked by the MCO and how will this affect the net worth calculation?

Appendix C – Provider Entities

It is important to note that downstream risk sharing arrangements between insurer and provider may vary depending on the provider's network type or "entity type." This is not the same as the entities referred to in Reg. 164 which are insurers.

- ACO– An Accountable Care Organization is a legally bound group of providers who agree to take on a shared responsibility for patient care while assuring active management of both the quality and cost of that care.
- IPA– Similar to ACOs, an Independent Practice Organizations is a group of health care providers that have a contractual agreement to work together as health care providers; however, IPAs generally have a looser structure than ACOs.
- PPS – Performing Provider Systems are partnerships of regional care providers that collaborate to better transition from traditional fee-for-service payment for their services to the new, risk-based, VBP approach.
- PLC/PC – The traditional legal structures under which health care providers may be bound.

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