Department of Health

Medicaid Redesign Team

Regulatory Impact Subcommittee Meeting #2

August 27, 2015

Today’s Agenda

Today’s Agenda include the following:

Agenda Item	Time
Welcome and Introduction	1:00 pm
Recap: Provider Risk Sharing and Default Risk Reserves (DRR)	1:10 pm
Policy Questions and Options: Risk Sharing and DRR	1:40 pm
Introduction to Contracting Entities and The Medicaid Managed Care Model Contract and Provider Contracting Guidelines	2:30 pm
Closing	3:45 pm

Recap of Meeting # 1: 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. Both the NYS Department of Financial Services and the Department of Health have standards that govern Default Risk Reserves.

VBP Levels Two and Three involve provider risk

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)

Reconciliation Based vs. Prospective Arrangements

- VBP Level Two involves upside and downside reconciliation for providers. Both savings and financial risk are shared under these arrangements.
- VBP Level Three arrangements require establishing prices at the beginning of the contracting period.

Current 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 currently governs financial risk transfers that involve prepaid capitation only.

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

Providers must be ‘financially responsible’ and comply with default reserve requirements

- **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.*

State Examples

This table summarizes five other states' designed programs, similar to New York's VBP arrangements, which are allowing providers to take on downside risk:

State*	How is the system protected against provider risk?	How are they restricting provider's ability to risk share?
Oregon	The providers are licensed insurers.	They do not; CCOs are fully responsible (page 2 CCO Model).
Tennessee	None identified.	Risk sharing is only allowed for a menu of "episodes."
Colorado	The providers are licensed as an alternative LSLPN that provides various requirements.	Only provider networks that desire to provide a limited health service and only assume the level of risk commensurate with those limited benefits can apply as an LSLPN.
California	Certain requirements must be met quarterly for a provider to remain a RBO.	Only those providers that meet certain solvency standards are able to partake in risk sharing.
Massachusetts	Providers must apply to become a RBPO which includes various requirements.	Only those providers that meet the requirements to become an RBPO can partake in risk sharing.

** Refer to State Example handout for full details*

Level 2 Example – Maternity Bundle

A provider group contracts with an MCO under a Level 2 arrangement for a maternity bundle. The parties agree on the following terms:

- The budgeted (target) price for each bundle is $XX,XXX
- The provider group will share up to XX% of savings above the budget
- The provider group will be responsible for up to YY% of claims that exceed the budget (losses)

At the end of the performance year, the MCO calculates a loss of YY%. The entire loss will be recovered by the MCO directly from the provider via the following options:*

- A reduction of future claims payments
- Prospective withhold of current claims
- Drawdown of a contractually agreed upon deposit amount
- A combination of the above options

** Providers may be liable for multiple years or "layers" of losses depending on contract terms*

Provider Risk Sharing Policy Discussion

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

- Leave Regulation 164 as it currently stands. Apply the requirements of Regulation 164 to VBP Level Three Arrangements but not to Level Two arrangements. The DOH review process for risk-sharing arrangements would remain in place, but would be modified to address the VBP Levels.

Option 2

- Create Alternative Arrangements for VBP Level Two that do not Include Provider Financial Security Deposits.

Option 3

- Employ the Existing Default Risk Reserve Requirements to Both VBP Level Two and Level Three Arrangements.

Provider Risk Sharing
Draft Recommendation: Option 1

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

Level Two arrangements would be excluded from Regulation 164 definition of *financial risk transfer and could require DOH approval, but there wouldn't be an FSD requirement.*

Provider Risk Sharing: Policy Option 1

Leave Regulation 164 as it currently stands. Apply the requirements of Regulation 164 to Level Three Arrangements but not to Level Two arrangements. Level Two arrangements would be excluded from Regulation 164 definition of *financial risk transfer and could require DOH approval, but there wouldn't be an FSD requirement.*

Pros	Cons
Providers would not be subject to the risk sharing requirements with MCOs and, if excluded from the definition of *financial risk transfer*, providers who engage in Level Two arrangements would be absolved of the FSD risk sharing requirement.	There would be uncertainty regarding a providers' ability to repay insurers for underperformance which could drive up future healthcare delivery costs.
There would be a reduced likelihood of excess cash reserves sitting idle.	New regulations or considerations would need to be considered and developed to address this gap.

Default Risk Reserve Policy Discussion

Default Risk Reserve Policy Options

Should State laws and regulations be amended to re-structure financial security deposits, escrow accounts, and contingency reserves to ensure adequate safeguards exist for the delivery system without inefficient cash reserves?

Option 1
- Reduce MCOs’ Contingent Reserve Requirement and/or Escrow Deposit Requirements When Sharing Financial Risk.

Option 2
- Create Alternative Arrangements for VBP Level Two that do not Include Provider Financial Security Deposits.

Option 3
- Employ the Existing Default Risk Reserve Requirements to Both VBP Level Two and Level Three Arrangements.

Default Risk Reserves
Draft Recommendation : Option 2b

Allow providers to engage in VBP Level Two arrangement without a financial security deposit, but require additional safeguards to mitigate risk.

Safeguards might include protections against catastrophic events or withholds to relieve the burden of cash flow fluctuations.

Default risk reserve: Policy Option 2b

The sub-options listed below consider alternative requirements for providers engaging in VBP Level Two arrangements.

Allow providers to engage in VBP Level Two arrangement without a financial security deposit, but require additional safeguards to mitigate risk. Safeguards might include protections against catastrophic events or withholds to relieve the burden of cash flow fluctuations.

Pros	Cons
This sub-option would encourage participation in VBP because Providers would be able to participate without bearing the financial burden of satisfying the full insurance/Reg 164 requirements.	A State imposed withhold could be duplicative or unnecessary if there is a contractually imposed withhold from the plan.
This would avoid the complications that would arise from having to calculate appropriate reserve requirements based upon VBP Level Two arrangements.	Providers may be reluctant to move from VBP Level One to VBP Level Two if there are too many restrictions beyond the downside risk (e.g., a withhold from FFS payments could reduce cash flow compared to VBP Level One and make it less desirable).

Introducing The New Policy Questions

Policy Question Three

- *What regulatory changes and policies should be implemented to establish or govern VBP contracting entities such as PPSs?*

Policy Question Four

- *What changes should be made to the Medicaid Managed Care Model Contract (MMC) and Provider Contract Guidelines to address the implementation of VBP?*

VBP Provider Contracting Entities

- The VBP Roadmap emphasizes the importance of structuring VBP contracts in a way that brings providers from across the care continuum into one contractual arrangement
- This will require contracting in way that measures performance and tracks payments across provider types. Potential contracting entities include:
    - Performing Provider System (PPS)
    - Independent Practice Association (IPA)
    - Discrete but integrated contracts directly from MCOs to providers
    - Accountable Care Organization (ACO)
    - New entity developed specifically for this purpose

Performing Provider Systems and VBP Contracting

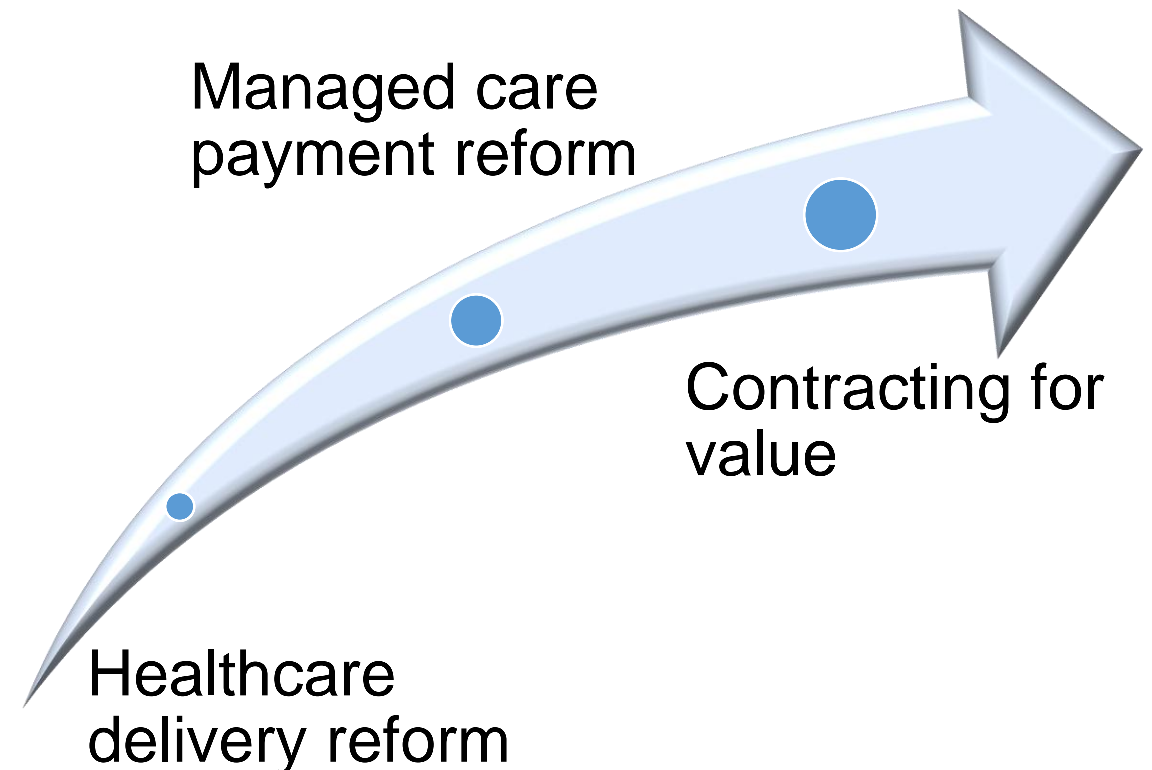
One of the challenges of transitioning from DSRIP to VBP is how best to leverage PPS infrastructure in VBP Contracting.

Some options for moving forward might include:

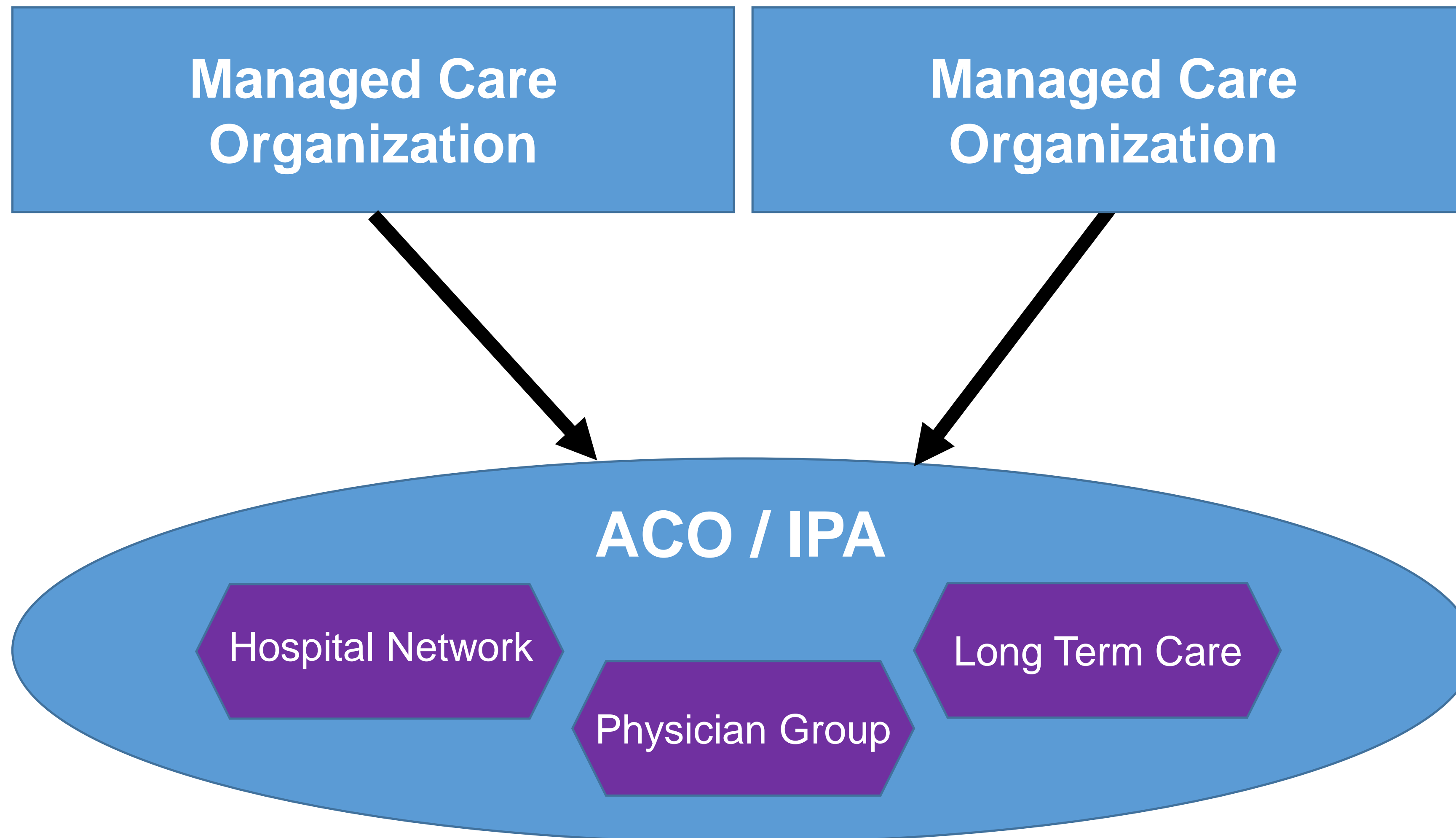
- PPS becoming certified as an IPA or ACO
- Legislative or administrative action granting PPS legal status to contract with plans
- Providers within a PPS contracting through other means

** Contracting entities are not mutually exclusive. PPSs may have subsets of multiple IPAs or other contracting entities*

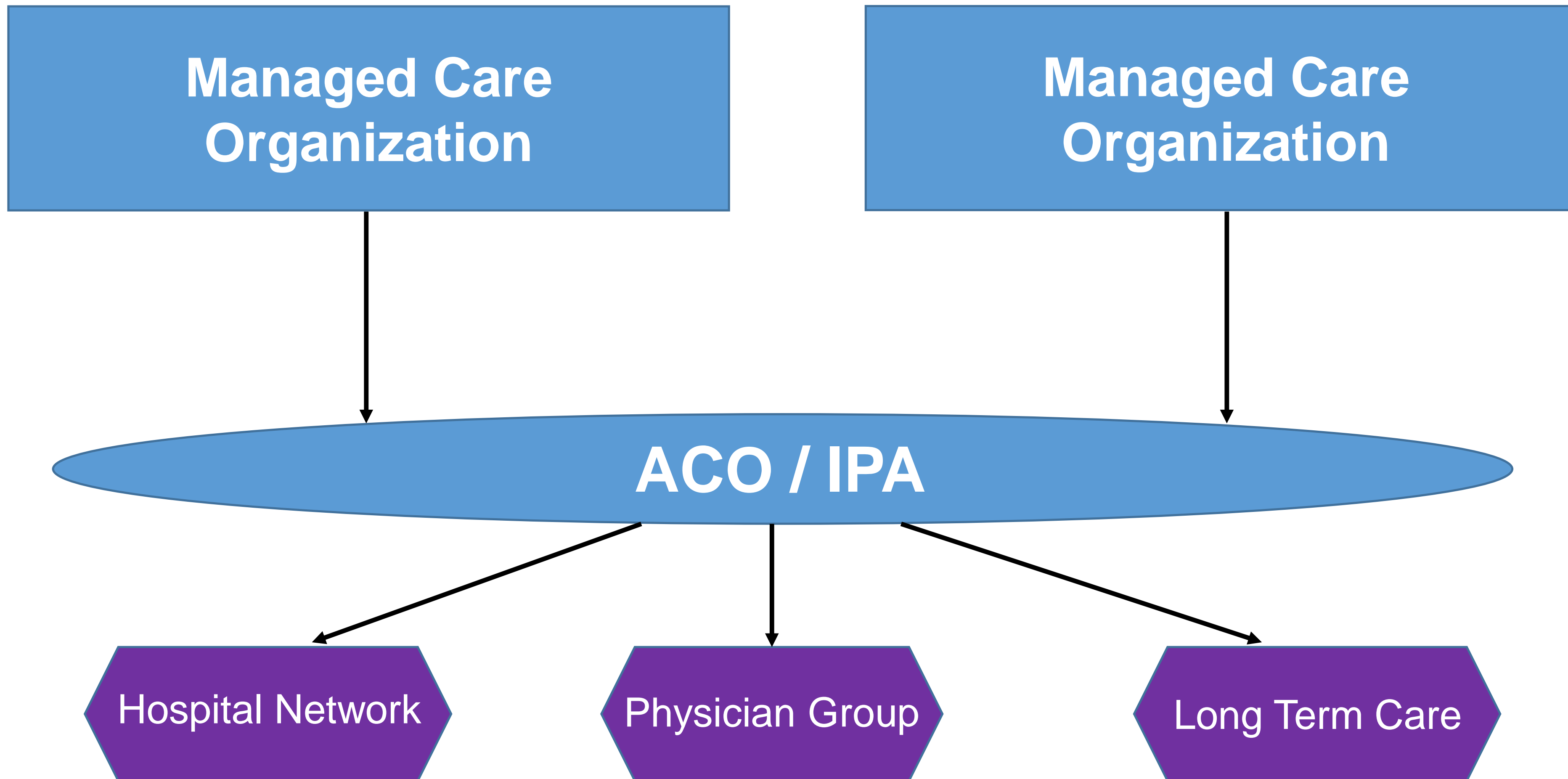
DSRIP and VBP



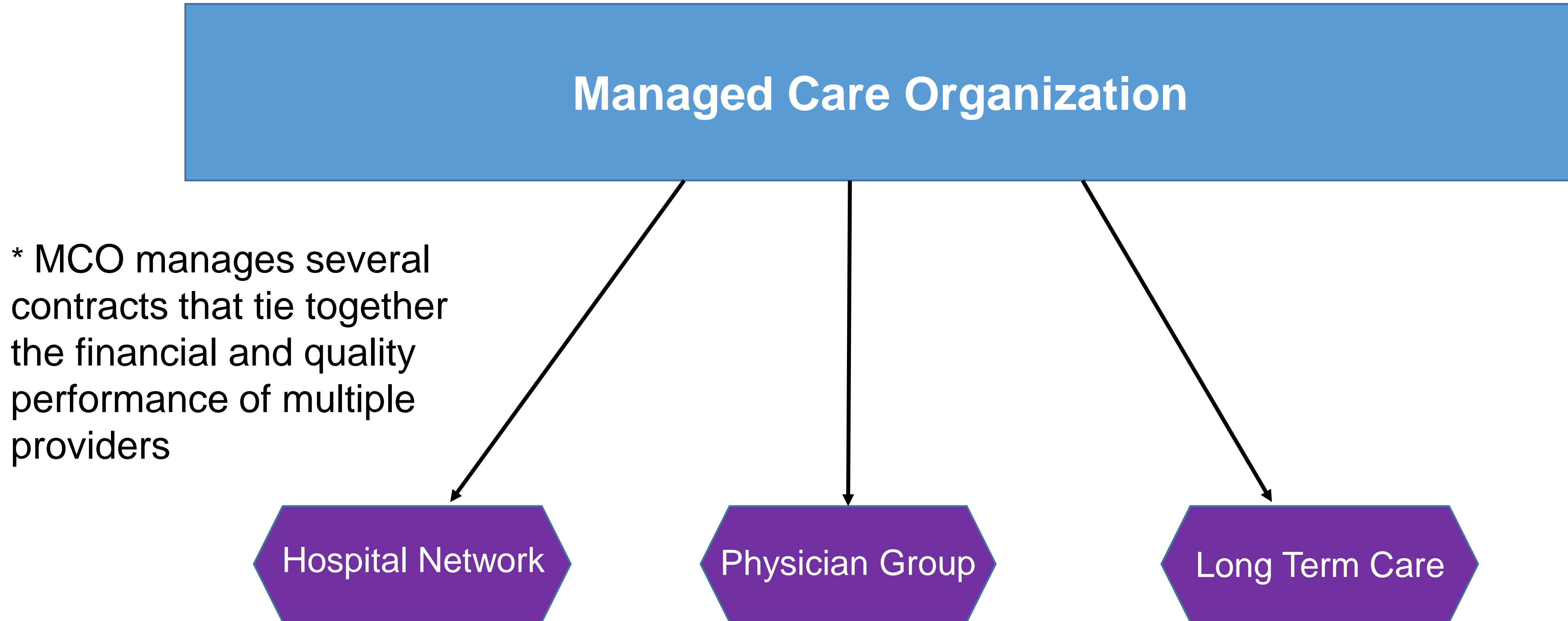
Integrated Model: Jointly Governed IPA



Intermediary Model: IPA Coordinates Providers



Interrelated Contracts



Modifications to the Medicaid Model Contract

- The Medicaid Model Contract is the principal document that DOH uses to govern the relationship between the state and MCOs
- The implementation of the VBP Roadmap will require alterations to these documents. DOH is seeking recommendations specifically around:

Contractor Reporting	Audit Rights	Performance Measurement	Target Price Setting
Attribution	Network Adequacy	Default Risk Reserves	Risk Sharing

Modifications Provider Contracting Guidelines

- The Provider Contracting Guidelines is a principal document that DOH uses to govern the relationship between MCOs and providers
- The implementation of the VBP Roadmap will require alterations to these documents. DOH is seeking recommendations specifically around:

Contracting Entities

Categorization of Arrangements (VBP Levels 1, 2, 3)

Reimbursement Methodology

Risk Sharing

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Appendix Slides

Provider Risk Sharing: Policy Option 2

Create or amend regulations to include alternative risk sharing requirements, particularly for Level Two. Modify Regulation 164 or enact new regulations to develop separate requirements for VBP Level Two arrangements that mitigate business and cash flow risk.

Pros	Cons
Developing separate, less burdensome requirements for providers sharing risk under a VBP Level Two arrangement would encourage provider participation by allowing flexibility from the insurance and/or Regulation 164 requirements.	This method will require the development of new or revised regulations, safeguards, and may even require legislative support. It may be difficult to obtain consensus on the requirements from all stakeholders.
Developing specific safeguards that mitigate risks inherent to a VBP Level Two arrangement would still ensure that providers are capable of fulfilling their obligations to Medicaid members.	

Provider Risk Sharing: Policy Option 3

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

Pros	Cons
Providers under Level Two arrangements could utilize Regulation 164 to avoid the potential application of full insurance requirements.	There is a risk of duplicative coverage for the same risks depending on how the “financial risk transfer” is defined.
There would be a reserve in place to cover potential losses (downside risk) and help protect the provider and MCO.	Providers may have a financial security deposit requirement despite payments from MCOs occurring on a retrospective, FFS basis.

Default Risk Reserve: Policy Option 1

Reduce MCOs' Contingent Reserve Requirement and/or Escrow Deposit Requirements When Sharing Financial Risk to reflect the added security that providers contribute to ensure their ability to meet their obligations in risk sharing arrangements.

Pros	Cons
This option would allow plans greater flexibility to use premium dollars to invest in additional programs or other business activities. Having lower reserve requirements may also decrease the pressure for higher premiums.	Decreasing reserve requirements for insurers may increase the State's risk exposure if insurers default on their obligation to reimburse providers for medical services. This risk is compounded if several providers in risk based arrangements with the same plan default on their obligations. The risk of provider default is somewhat mitigated by the financial security deposit requirement placed on providers.

Default Risk Reserve: Policy Option 2a

The sub-options listed below consider alternative requirements for providers engaging in VBP Level Two arrangements.

Allow providers to engage in VBP Level Two arrangement without any financial security deposit.

Pros	Cons
This sub-option would encourage participation in VBP because providers would be able to participate without bearing the financial burden of satisfying this requirement.	There are still financial risks on providers associated with VBP Level Two arrangements. Providers who underperform in VBP Level Two may experience cash flow problems compared to FFS or VBP Level One.
This would avoid VBP Level Two complications that would arise from having to calculate appropriate reserve requirements.	

Default Risk Reserve: Policy Option 3

Employ the Existing Default Risk Reserve Requirements on Both VBP Level Two and Level Three Arrangements.

Pros	Cons
The escrow deposit and the contingent reserve requirement placed on MCOs help ensure that MCOs are in adequate financial position to fulfill their obligations to reimburse providers once they receive premium payments from the state.	Especially in Level Two, these requirements represent restrictions on MCOs' use of assets and limit their ability to use those assets in other business activities. Higher reserve requirements may also require higher premiums for MCOs to fund those reserves.
The FSD ensures that MCOs have a financial backstop in cases where providers default on their obligations and the MCO must step in to ensure uninterrupted patient care.	It may be duplicative to require providers to develop a financial backstop for their prepaid obligations from plans when plans are also required to develop a financial backstop for their obligations to the state.
	Currently, for Level Two arrangements, there is not a method available for calculating a provider or MCO's risk exposure.