

Value Based Payment Arrangements Involving Risk Sharing

Contracting Arrangement Examples

CMS recently approved the VBP Roadmap. This brief contains two examples of potential VBP arrangements from the menu of options laid out in that VBP Roadmap. For each example there are four questions which identify the types of risks and contracting entities involved.

Example 1: VBP Level Two Maternity Bundle

An OB/GYN group that is affiliated with a hospital is confident in its ability to improve the quality of the care it provides to patients while efficiently managing the costs associated with that care. This group decides to enter into a contractual arrangement with a Managed Care Organization (MCO) that involves a VBP Level Two maternity bundle (an episodic bundle).

This arrangement is administered by the MCO and governed by individual agreements with providers. Each provider agreement includes contract terms that detail how claims associated with maternal care will be tracked through the contracting period. A spending benchmark or “virtual budget” that reflects historical claims data, a trend, risk adjustment, and other potential modifications will be negotiated between the providers and MCO. During the contracting period, claims are paid to all participating providers on a fee-for-service (FFS) basis. At the end of the contracting period, the actual claims paid will be compared to the negotiated benchmark.

Savings or losses that are incurred will be allocated to the providers according to the terms of their provider contract. Bonus payments will be modified based upon quality performance. Losses will be reconciled either through returned payment from providers or a set reduction of future rates of payment from the MCO to that provider.

In this example the performance of other providers directly impacts the savings or losses of other providers because the savings or overspending that any individual provider incurs will impact the comparison of actuals to the ‘virtual budget’ or benchmark.

Questions

- 1.) Does the role of an Independent Practice Association (IPA) or any intermediary between the MCO and providers involve the determination of reimbursement for medical services or absorbing downside risk?

There isn't an IPA involved in this transaction.

- 2.) Where would this example fall under the current DOH and DFS oversight and approval procedures?

This arrangement would fall under the purview of DOH because it does not involve prepaid capitation. DOH would not require a Financial Security Deposit under current regulations because this arrangement does not involve capitation or an intermediary entity, not directly involved in the provision of services, which is taking on risk.

- 3.) Does this example place providers at risk for the financial and quality performance of providers that they do not control?

Yes, because the calculation of savings or losses is based up on the performance of every provider in the arrangement. The maternity care bundle is considered as a whole and includes the services of all providers involved in treating that Medicaid member throughout the pregnancy, delivery, and specified post-birth period.

- 4.) Does this example involve risk for material adverse developments that are outside of providers' control and potentially require protections from such risk?

Yes, any material development that occurs in the region which the providers operate may increase the demand for their services and the FFS revenue that they incur. This additional reimbursement may adversely impact the reconciliation at the end of the performance period (i.e., the quality scores may decrease and/or the costs may increase).

Example 2: VBP Level Three Prepaid Capitation Total Cost Arrangement

A large hospital system that has experience with population health management and the sharing of clinical data across provider types enters into a Level Three contract for the total cost of care for a set population. The hospital system forms an IPA with physician groups, diagnostic and treatment centers, and a home health provider in the region. Under this contract the IPA receives capitation payments from the MCO for the total cost of care for a population of 10,000 members that have been attributed to the IPA. The associated providers negotiate within the IPA for payments from the capitation revenue. The IPA holds a percentage of the capitation revenue that it receives in a pool to support network-wide quality and incentive payments.

Under this arrangement the capitation amount will be based on the price that is negotiated between the IPA and the MCO. This price will be based on historical claims data and other modifications that are part of the benchmark setting process. Through targeted interventions and increased coordination, the providers reduce unnecessary visits and avoidable complications for their Medicaid members as compared to the benchmark.

As their variable costs decrease due to a lower demand for their services from this population and their capitation

revenue remains constant, their margins increase in the short term and they are able to make additional investments in interventions to improve health outcomes.

In this example health outcomes of the patients are directly linked to their demand for services and, therefore, the performance of one provider has financial implications for the other providers within the same arrangement. This is particularly true for physician specialists and the providers of inpatient and emergency department services.

Quality measures for the participating providers will also be tracked and a minimum standard will be required for continued participation in the arrangement. These measures may also be tied to other components of the flow of funds from State → MCO → IPA → Provider.

Under the current regulations, this IPA would fall under DFS Regulation 164 as having engaged in a capitated financial risk transfer. The IPA would be required to meet the Financial Security Deposit requirements outlined in that regulation to protect the contracting MCO from default on the part of the IPA.

Questions

- 1.) Does the role of an IPA or any intermediary between the MCO and providers involve the determination of reimbursement for medical services or absorbing downside risk?

Yes.

- 2.) Where would this example fall under the current DOH and DFS oversight and approval procedures?

This arrangement would fall under DFS Regulation 164 because it involves prepaid capitation payments to an IPA.

- 3.) Does this example place providers at risk for the financial and quality performance of providers that they do not control?

Yes, because the demand for medical services is linked among the providers that are reimbursed through the prospective capitated rate.

- 4.) Does this example involve risk for material adverse developments that are outside of providers' control and potentially require protections from such risk?

Yes, any material development that occurs in the region that the providers are operating may increase the demand for their services and result in excessive costs that make the prospective



capitated rate insufficient. Alternatives to protect the providers and the IPA from these developments should be considered by the subcommittee.