NEW YORK STATE | Department of Health | Medicaid Redesign Team

Regulatory Impact Subcommittee

Meeting #6

December 7, 2015

Today's Agenda – Last Subcommittee Meeting

Agenda Item	Time
Welcome and Introduction	10:30 am
Recap: Recommendations from Meeting #5 1. Business Laws and Corporate Practice of Medicine; 2. Program Integrity; 3. HIPAA and State Privacy Laws; and 4. De-regulation	10:40 am
Discussion of Provider Contract Review Process	11:30 am
Discussion of Other Issues and Next Steps	12:30 pm
Closing	1:15 pm

Recap of Meeting #5: Draft Recommendations*

<u>Recommendation</u> – Business Laws – Taking into consideration the bill recently introduced, the Subcommittee recommends including similar language in the Article VII Budget Bill*;

**Language may need to be amended to preserve physicians' control over clinical decision-making.*

<u>Recommendation</u> – CPOM – The Subcommittee recommends that future discussions occur, as needed, to address whether changes should be made to CPOM laws and regulations. These discussions should take into account changes to Business Laws as indicated above.

**Subcommittee members were emailed the full written recommendations ahead of this meeting.*

Recap of Meeting #5: Draft Recommendations*

<u>Recommendation</u> – Program Integrity – A new workgroup comprised of program integrity stakeholders (e.g., the State, providers, and payers) is recommended to be created to specifically address important changes to overall program integrity.

VBP will fundamentally change how healthcare services are delivered, paid, recorded, and measured. Certain compliance requirements and methods under FFS may not be effective under VBP. The current program integrity infrastructure will need to be thoroughly analyzed and updated to ensure compliance integrity under VBP. This process must be transparent and involve all stakeholders for program integrity to be successful. The State will work towards identifying members for a new workgroup over the next few months with work beginning in early 2016.

**Subcommittee members were emailed the full written recommendations ahead of this meeting.*

Recap of Meeting #5: Draft Recommendations*

<u>Recommendation</u> – HIPAA and State Privacy Laws – A separate workgroup should be created to address these issues on an issue by issue basis. The group may be comprised of various NYS departments and stakeholders to follow these issues and implement recommendations throughout the development of VBP.

Some of the scenarios to consider:

Scenario 1 – DSRIP Opt-Out and DEAA Process
Scenario 2 – Care Management
Scenario 3 – RHIO and SHIN-NY Data
Scenario 4 – Scope of Medicaid Consent
Scenario 5 – Vital Statistics

**Subcommittee members were emailed the full written recommendations ahead of this meeting.*

Recap of Meeting #5: Draft Recommendations*

<u>Recommendation</u> – De-regulation – A new workgroup comprised of stakeholders (e.g., the State, providers, and payers) is recommended to be created to specifically address specific VBP de-regulation opportunities.

Because of the broad nature of identifying areas of regulatory relief, a separate workgroup is a more efficient method to formally address the issue. The State will work towards identifying members for a new workgroup over the next few months with work beginning in early 2016.

**Subcommittee members were emailed the full written recommendations ahead of this meeting.*

Future Financial Review: Bucketing into Tiers

Individual Contract Comes in for Review

More than $250,000 of **annual** payments to provider prepaid capitation (triggers Regulation 164)?

Yes → **Multi-Agency Review**

No → More than $1,000,000 of **annual** payments to provider at risk (shared losses, withhold)?

Yes → **DOH Review**

- More than 25% of **annual** payments to provider at risk?
- More than 15% provider's Medicaid Revenue?
- Off Menu VBP Arrangement?

Yes to Any → **DOH Review**

No → **File and Use**

No to All → **File and Use**

Program Review will be completed in addition to Financial Review for all contracts

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Future Financial Review: Arrangements Included in Tier 3

Individual Contract Comes in for Review

More than $250,000 of **annual** payments to provider prepaid capitation (triggers Regulation 164)?

More than $1,000,000 of **annual** payments to provider at risk (shared losses, withhold)?

Yes

Medicaid Revenue?

Off Menu VBP Arrangement?

- **Tier 3 *Multi-Agency Review* will include** the following arrangements that exceed the $250,000 prepaid capitation threshold:
  - VBP Level Three arrangements; **OR**
  - VBP Level Two partial capitation arrangements; **OR**
  - Off-menu VBP options that include prepaid capitation

Multi-Agency Review

File and Use

Program Review will be completed in addition to Financial Review for all contracts

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Future Financial Review: Arrangements Included in Tier 2

- **Tier 2 *DOH Review* will include** the following arrangements:
  - VBP Levels Two and Three Prepaid capitation arrangements that do not exceed the $250,000 threshold; **OR**
  - VBP Level Two FFS arrangements (no prepaid capitation); **OR**
  - Off-menu VBP arrangements that are either FFS or do not exceed the $250,000 prepaid capitation threshold;

    AND:
  - Exceed the $1,000,000 at risk payment threshold; **AND**
  - Meet one of more of the three highlighted criteria

Individual Contract Comes in for Review

More than $250,000 of **annual** payments to provider prepaid capitation (triggers Regulation 164)?

No

More than $1,000,000 of **annual** payments to provider at risk (shared losses, withhold)?

Yes

More than 25% of **annual** payments to provider at risk?

More than 15% provider's Medicaid Revenue?

Off Menu VBP Arrangement?

Yes to Any

File and Use

Program Review will be completed in addition to Financial Review for all contracts

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Summary of DOH Review Tier Payment Thresholds

- **This $1,000,000 annual payment threshold is applied to**:
  - Only the individual contract that is coming in for review
  - Medicaid Managed Care components of the contracts only

- **This 25% payment threshold is applied to**:
  - Only the individual contract that is coming in for review
  - Medicaid Managed Care components of the contracts only

- The ratio is expressed as:

$$\frac{Annual\ Medicaid\ Payments\ at\ Risk\ for\ this\ Contract}{Total\ Value\ of_{All}\ Medicaid\ Contracts\ between\ this\ MCO\ and\ Provider}$$

- **This 15% revenue threshold is applied to**:
  - All MCOs that contract with the provider
  - All Medicaid (inclusive of Medicaid Managed Care and Medicaid FFS) contracts

- The ratio is expressed as:

$$\frac{Value\ of\ This\ Contract's\ Projected\ Medicaid\ Revenue}{Total\ Projected\ Annual\ Medicaid\ Revenue\ for\ Provider}$$

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Financial Review Tier Examples and Clarifications

The determination of "annual payments to provider at risk" is based on the amount the provider would forfeit or return to the health plan under an estimated worst case scenario. It is not based on the sum total estimated paid claims from the health plan to the provider under the contract which contains the VBP risk provisions.

Example 1- Assume the sum total annual Medicaid claims payments from the health plan to the provider under this one contract are estimated at $8 million per year under a VBP Level 2 arrangement. Assume the risk of shared losses is capped by contract at 10%. The amount at risk is $800,000, not $8M. Thus, this arrangement would not trigger the $1M threshold and would fall under the File and Use Tier.

Example 2 - Assume the sum total annual Medicaid claims payments from the health plan to the provider are estimated at $80 million per year under this one contract. Assume the risk of shared losses under this contract is capped by contract at 10%. Thus the amount at risk is $8M. Also assume there is a second Medicaid contract between these two parties which involves $20M in estimated annual paid claims with no downside risk. The amount at risk under this one contract is $8M out of a total of $100M combined Medicaid revenue under all Medicaid contracts between this health plan and this provider (8%). Thus, this arrangement would not trigger the 25% annual payments at risk threshold.

The 15% test is focused solely on Medicaid revenues and does not address potential loss amounts. It is a volume test (see next example).

Example 3 - Assume the sum total annual Medicaid claims payments from the one health plan to the provider is estimated at $80 million per year under this one contract. Assume the provider's sum total annual revenue from NYS Medicaid is $800 million, consisting of all revenues from all Medicaid Managed Care plans of all types (mainstream, MLTC, etc.) plus all revenues from NYSDOH conventional fee for service (non-managed care) Medicaid. The $80M (10%) would not trigger the 15% revenue threshold.

Future Financial Review for DOH Review Tier (Tier 2)

VBP Contracts which are determined to fall under DOH Review Tier will undergo both programmatic and financial review prior to approval.

	Services provided directly by one contracting provider	**Services paid through a participating provider network (IPA, ACO, etc.)**
A.) Demonstration of Provider financial viability	For all Contracts that fall under the DOH Review Tier, the financial viability of the contracting provider must be demonstrated.	
B.) Financial Security Deposit (FSD)	FSD only required when providers in this column fail to demonstrate financial viability	FSD Required for all arrangements involving participating provider networks

Financial Viability and Financial Security Deposits

Provider financial viability will be determined by demonstrating a positive net worth. Accepted documentation includes:

- Certified audited financial statements, or comparable means, such as an accountant's compilation
- Positive net worth of the guaranteeing parents' certified audited financial statements

Financial Security Deposits (FSD) criteria: the provider/IPA must establish and provide evidence of a FSD *up to* 12.5% of the estimated annual medical costs for the medical services covered under the risk arrangement

- The FSD is provider funded, must consist of cash and/or short-term marketable securities, and will be held "in escrow" by the health plan
- Under limited circumstances, a parental guarantee may be allowed
- Out of network services already retained by the plan are not subject to the FSD
- The above requirements may be reduced or adjusted to the extent that other limits on the amount of financial risk are present. Such limits include, but are not limited to, contractual "guardrails" such as the health plan continues to pay all claims, exclusion of high cost claims (such as > $100, 000 per person per year) from the cost computations, risk adjustment (such as CRGs) between the population covered in the base year compared to the population covered during the performance year, etc.

Other Issues and Comments Summary

Workgroups:

- Each issue specific workgroup (e.g., Program Integrity; Patient Privacy) will begin in early 2016.

Comments from SC Members:

- The Subcommittee has received several comments across many of the issues covered over the past six months. These comments are very valuable to the process and will be compiled and provided to DOH for review and consideration in moving toward VBP.

Other Issues:

- Pharmacist and Physician Collaboration (next slide)

Other Issues: Pharmacist & Physician Collaboration

- **Amend the Pharmacy Practice statute (section 6801 of education law)** to allow physicians to voluntarily collaborate with pharmacists in all settings.
- **Amend Paragraph 1 of Section 579 of the public health law** to include "pharmacist" as a licensed health profession authorized to perform laboratory tests "solely as an adjunct to the treatment of his or her own patients."
- **Recommended Policy Guidance that assures that data-sharing is bi-directional and that pharmacists and pharmacies have access** to RHIOs/SHIN-NY and other electronic records specific to a patient's care plan.
- **Recommended Policy Guidance that encourages managed care plans to contract directly with pharmacies/pharmacists for care management and clinical services** as a medical benefit for CMM and other direct-care services

Question: Should the SC create a formal recommendation on this topic?

Next Steps and Closure

Recommendations issued by the SC will be compiled in the final report to the VBP Workgroup

- The VBP Workgroup together with DOH will issue the final decision on each recommendation
- The finalized report will be available once approved

Thank You!

Contact Us

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