Department of Health | Medicaid Redesign Team

Technical Design II Subcommittee

Meeting #3

September 29, 2015

Agenda

Today’s Agenda includes the following:

Agenda Item	Time
Welcome & Introductions	1.00
Review Recommendations: 1. What activities/services should remain FFS and be considered VBP? 2. Should certain services or providers be excluded from VBP? Deep Dive into: 1. What should be the criteria and policies for the VBP Innovator Program?	1:15
Break	3:00
Introduction to New Topics: 1. Financially Challenged Provider status: what does it mean? 2. What will be included in the planned assessment of progress made in VBP participation and market dynamics? **3. What should be the process for addressing impasse situations during VBP contract negotiations?**	3:15

Technical Design II Tentative Agenda

Workgroup II (Quality/Support/ Design)	
Discussion	**Introduction to**
Meeting 1	
VBP Introduction	1. How to continue to incentivize preventive activities within VBP? (What activities/services should remain FFS and will be considered VBP?) 2. How will the technical assistance be provided to those providers that run into performance challenges in VBP arrangements?
Meeting 2	
Topics from previous meeting – Deep Dive	1. Should certain services or providers be excluded from VBP? 2. What should be the criteria and policies for the VBP Innovator Program?
Meeting 3	
Topics from previous meeting – Deep Dive	1. Financially challenged provider status: what does it mean? 2. What will be included in the planned assessment of the progress made in the VBP participation and market dynamics? 3. What should be the process for addressing impasse situations during VBP contract negotiations?
Meeting 4	
Topics from previous meeting – Deep Dive	1. What should be the Quality and Outcome measures in the TCTP arrangement? 2. How should the workforce measures (generic level) be defined? 3. What will be the best way to align MCO measures with VBP measures?
Meeting 5	
Topics from previous meeting – Deep Dive	1. TBD

Key Questions for all Topics

Per option, the Subcommittee should recommend whether the State should set a **Statewide Standard** or a **Guideline** for the methodologies employed between MCOs and the providers. The State will consistently employ a standard in its own approaches regarding methodologies and data dissemination to both MCOs and providers. The Subcommittee should recommend whether MCOs and providers should adopt the same standard or are free to vary, using the State's methods more as a guideline.

- A **Standard** is required when it is crucial to the success of the NYS Medicaid Payment Reform Roadmap that all MCOs and Providers follow the same method.
- A **Guideline** is sufficient when it is useful for Providers and MCOs to have a starting point for the discussion, but MCOs and Providers may deviate without that harming the overall success of the Payment Reform Roadmap.

Technical Design II Meeting Schedule

Meeting	Date	Time	Location
Meeting 1	7/20/15	2:00 pm	Albany
Meeting 2	8/17/15	2:30 pm	Albany
Meeting 3	**9/29/15**	**1:00 pm**	**NYC**
Meeting 4	10/22/15	1:00 pm	NYC
Meeting 5	11/18/15	1:00 pm	Albany School of Public Health

NYC Location: MetLife Building, 200 Park Avenue, 15th floor

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What activities/services should remain FFS and be considered VBP?

Subcommittee Recommendation

Recommendation

It is proposed that the Subcommittee recommends a *standard* to be set for paying a defined set of preventive services on a fee-for-service basis as a form of Value-Based Payment.

- The State will develop a list of key preventive services and related quality measures for CMS's consideration
  - Such services may include: immunizations, high-cost contraception
  - Quality measurements are required in order to count such activities as value-based

- The State will evaluate this list of services on an annual basis in order stay in line with population health needs and new services/medications on the market
- Priority will be given to the areas where NYS needs improvement according to the Prevention Agenda 2013-2017: New York State's Health Improvement Plan.

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Are there any services that should be excluded from VBP?

Subcommittee Recommendation

Recommendation

It is proposed that a narrow list of services and providers be considered for exclusion from VBP calculations. These services include:

1. High Cost Specialty Drugs

- High cost specialty drugs are defined as those costing ≥ $600/month[1]
- It is proposed that such drugs be reviewed for exclusion by the DOH on a case by case basis
- Exclusion of these drugs from VBP contracts is optional

2. Financially Challenged Providers

- It is recommended that providers be excluded from VBP during specific and limited durations of time, under the following circumstances:
  - the provider is going through a major transformation
  - the provider is being absorbed into a stronger healthcare system
  - the provider is transitioning to an outpatient facility or discontinuing operations

[1] Centers for Medicare & Medicaid. *Medicare Part D Specialty Tier.* Retrieved from https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/CY-2016-Specialty-Tier-Methodology.pdf on August 20, 2015.

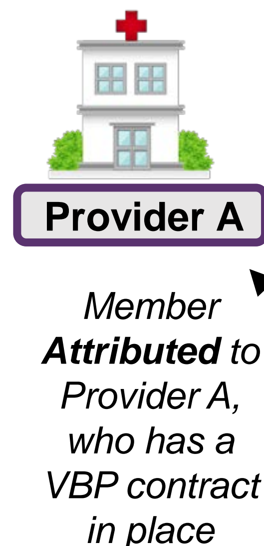
Recommendation (continued)

It is proposed that a narrow list of services and providers be considered for exclusion from VBP calculations. These services also include:

3. Services to non-attributed members (Out of Network Services)	• (Emergency) services performed by a provider for a Medicaid member that is not attributed to a VBP arrangement in which this provider participates will not be seen as costs to that VBP arrangement.

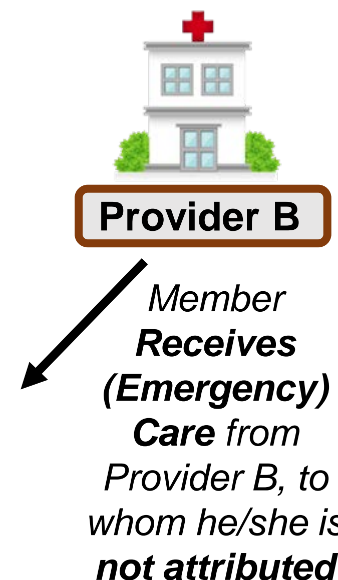
Sample scenario

Provider A
The cost of the member's services with Provider B will count towards the cost per member/episode of Provider A.



*Member **Attributed** to Provider A, who has a VBP contract in place*

Member



*Member **Receives (Emergency) Care** from Provider B, to whom he/she is **not attributed***

Provider B
Provider B is paid for the care delivered as today.

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VBP Innovator Program: how should it be designed?

Deep Dive

Roadmap Language

"Prior to implementation of the Innovator Program, a subcommittee, including plan representatives, provider representatives, patient advocates, DOH and DFS shall jointly set criteria to ensure the providers involved are ready to take on this risk and discuss safeguards such as cooling off periods after contract termination and an appeal process. The subcommittee may consider criteria such as, but not be limited to, determining the appropriate reserves for participating providers which shall be comparable to the corresponding reserves for plans who assume such risk; ensuring the ongoing financial solvency of the provider and measuring performance for Innovator participants, including a process for a participant to lose Innovator status if they fail to attain certain defined goals."

What the Innovator Program is NOT

- The Innovator Program (IP) is not intended to limit provider networks or member choice when choosing appropriate health care.

The Innovator Program Components

Components of the Program include but are not limited to the following:

- Program eligibility
- Applicant review process
- Criteria for participation
- Appeals process
- Program benefits
- Performance measurements
- Status maintenance and program exit criteria
- Cooling off periods

Program Eligibility

Component 1: Which VBP risk arrangements are eligible for the Innovator Program?

#	Options	Pros	Cons
1	Level 2 (high risk) & 3 TCTP and Subpopulations Arrangements	Broader eligibility would allow more groups to apply for Innovator status. Greater support of Level 2 groups may expedite their movement to Level 3.	Could dilute the group of Innovators.
2	Level 3 only TCTP and Subpopulations Arrangement	This would make the VBP Innovator program more selective and focused on a smaller core group of innovators	May exclude provider groups who have proven their ability to manage total cost of care arrangements but are not ready for Level 3.

The Subcommittee recognizes that some of the VBP arrangements can go beyond the one year timeframe, which will not preclude those providers from applying for the Innovator status.

Applicant Review Process

Component 2: What is the review process for the Innovator Program?

#	Options	Pros	Cons
1	Any provider in eligible VBP arrangements that applies undergoes further eligibility and program readiness assessment (based on the universal program criteria developed). In this scenario each applicant is reviewed and approval is granted on a case by case basis.	Each provider is different (population served, size, maturity level, etc.) and may not meet a universal criteria. This option provides the opportunity to assess each applicant's strengths and weaknesses to determine individualized program eligibility. This option would be best to scrutinize each provider's scale and capacity on an individual basis.	Depending on the amount of applicants this could become an overwhelming and lengthy review process that could require substantial resources that may be unavailable at the State level (e.g. as an underfunded or unfunded process). This option can also result in inconsistent Program acceptance outcomes potentially viewed as unfair by other applicants. When universal criteria will not apply each provider may be assessed on different criteria.
2	Program applicants must meet a set of minimum predetermined criteria* for Program consideration (before applying). If minimum criteria are met then they are qualified to undergo a readiness assessment for program entrance approval.	A smaller amount of providers will apply because the initial assessment will become a responsibility of the provider. This option can save resources that would be expended if there were more applications to review. The providers that are approved will have a better chance at program acceptance since minimum criteria have been satisfied.	Additional resources will still be expended during the assessment process.
3	Each applicant must meet strict predetermined Program criteria. If met, acceptance is granted into Program.	This option would greatly reduce the expense of assessment resources as the review would be minimal compared to the first two options.	Depending on the predetermined criteria set, the amount of providers able to participate in the Program might be limited.

Criteria for Participation

Should there be other/additional criteria?

Component 3: What are the criteria for participating in the Innovator Program?

- Confirmation of provider network adequacy based on the appropriate provisions of the NYS Laws and regulations;
- Number of members:
  - Option 1: Minimum number of Medicaid members (e.g. DSRIP defines a meaningful presence as a minimum of 5,000 Medicaid members for a PPS); or
  - Option 2: Percentage of Medicaid members in a particular region (e.g. DSRIP currently measures as a minimum of 5% of attributed Medicaid members in a county)
- Maturity level and proven success in VBP contracting for TCTP and Subpopulations.
  - Option 1: A standard criteria based on timeline applies, e.g. minimum of X months of successful VBP contracting is required
  - Option 2: Timeline is considered but each provider is reviewed on an individual basis.

Appeals Process

Component 4: Is there an appeals process?

#	Options	Pros	Cons
1	An appeals process in place	Provides a chance for providers to demonstrate a possibly overlooked strength that would determine potential eligibility for the Program.	The utilization of an appeals process would require additional resources on the State level.
2	No appeals process	Resources would be saved from being allocated to an appeals process.	Providers whom may have been unjustly denied (in case of poorly conducted assessment) participation in the Program will not be able to prove their eligibility. Unjustly denied providers will not receive Program benefits that could potentially be reinvested in the quality of healthcare delivered In NYS.

Appeals Process (cont.)

Considerations for establishing the IP appeals process*:

- Will every provider have the opportunity to appeal or will there be an approval process to be considered for an appeal?
- Who should review the appeal?
- What is the time period for appeal?
- What is the time period for appeal review?
- What will be the appeals process?

** The briefing paper that was distributed to the SC contained an example.*

Program Benefits

Component 5: What are the Innovator Program benefits?

The Roadmap lists the potential Innovator Program benefit as rewarding providers with up to 95% of premium pass-through for total risk arrangements. The Subcommittee is requested to discuss whether this formulation is adequate or whether another guideline is required.

Performance Measurements

Component 6: How is the Innovators' performance measured?

The performance measurements for the Innovator Program will be aligned with existing DSRIP measures. No new measurements will be recommended, however, Innovators will be expected to meet the applicable measures in order to maintain their Innovator status. Performance measurements must be defined by the time contract is executed.

The performance measures that may pertain to Innovators include the following:

- All DSRIP measures applicable to PPSs, including reporting requirements in Domains 2 and 3
- Quality and outcome measures being developed by this Subcommittee for Total Care for Total Population arrangements (to be discussed in Meeting #4); and
- Any relevant measures being developed by the Social Determinants of Health and Community Based Organizations Subcommittee and by the Clinical Advisory Groups (CAGs)

Status Maintenance and Program Exit Criteria

Component 7: What is the status maintenance and contract termination/program exit criteria?

Status maintenance: In order for Innovators to remain in the Program it is necessary to meet performance measurements during the contracting period. If performance measurements are not met there are two (2) possible options:

a. Option 1: The participant is placed on a probation period and with a set time line to improve performance; or
b. Option 2: The participant exits from the Program.

Program exit criteria: An Innovator may need to exit the program due to poor performance or loss of confidence in ability to participate. In order for the Innovator to exit the Program, it should be determined if one or both parties must give consent to exit.

Cooling off Periods

Component 8: In the case of poor performance, should there be contract cooling off periods?

#	Options	Pros	Cons
1	Cooling off period after contract termination*	A set period of time between the end of the contract and when the terms of the Innovator Program are still adhered to by the provider ensures a more seamless exit, especially regarding payments to the provider.	A cooling off period will add additional administrative work to maintain.
2	No cooling off period after contract termination	No need to administering the cooling off period.	A more rough transition out of the Program. Providers may not be ready for reduction of payments (Program benefits).

Financially Challenged Provider status: what does it mean?

Financially Challenged Providers (FCPs)

The following definition was developed by the SC:

A provider(s), including safety net providers, is deemed financially challenged if the DOH determines that the provider is unlikely to be sustainable as a freestanding inpatient facility even with value based payment reform, and the provider is in a planning process with DOH to:

- *Be absorbed under the umbrella of a stronger health care system,*
- *Transitioned to an outpatient facility, or*
- *Discontinue operations.*

Should the definition include inpatient facilities only or should it be open for other (ambulatory) facilities as well?

What does the status mean for VBP participation

If a provider is deemed financially challenged, the subcommittee recommends that the following limitations apply:

- Such FCPs cannot enter a Level 2 or higher VBP arrangement in a VBP contractor role.
- Such FCPs can be a part of Level 2 or higher VBP arrangement, as long as they themselves are protected from any downside risk.

Question for the SC:

Does the SC agree with the formulation of this recommendation?

What will be included in the planned assessment of progress made in VBP participation and market dynamics?

Roadmap Language

…the State will plan an assessment of progress toward the end of DSRIP Year 3 of participation in VBP contracting as well as of the market dynamics which will provide plans, providers, and the State with information to be better equipped to address any challenges that arise as VBP accelerates.

VBP Progress Assessment

- As part of the Waiver terms and conditions, the State is responsible for producing an annual VBP progress report to CMS
- It is proposed that the VBP Workgroup convene at least annually (not just at Year 3 mark) to perform the evaluation of said report and assess the following:
  - Current state of VBP in NYS in terms of %
  - Implementation risks and concerns
  - Need to adjust the course of implementation
  - Changes to the VBP Roadmap
- At any point the VBP Workgroup would be able to request additional data/information from the State for assessment and progress evaluation purposes to supplement the information provided in the report

What should be the process for addressing impasse situations during VBP contract negotiations?

Roadmap Language

In situations where there is a desire of an MCO and PPS/providers/IPAs/ACOs to enter into a value-based payment arrangement, but the parties fail to agree upon the terms of a contract, the State, together with MCO and provider representatives will develop a process designed to assist all parties in addressing the impasse.

Impasse Discussion Considerations

- It is challenging to predict today what those conflict situations are going to be
  - By observing the pilots the State and the VBP Workgroup will have a better idea that will be based on concrete examples
- Given the lack of information it seems to be premature to conceptualize a specific process
- Important to note that currently plans and providers negotiate and enter into contracts without the involvement of the State. However, historically the State was able to get involved and assist in these situations on various occasions in the past.

Next meeting

Meeting	Date	Time	Location
Meeting 4	10/22/15	1:00 – 4:00 pm	NYC
Address: MetLife Building, 200 Park Avenue, 15th floor			

Contact Us

Co-Chair
Lynn Richmond
LRichmon@montefiore.org

Co-Chair
Denise Gonick
DGonick@mvphealthcare.com

Zamira Akchurina
KPMG Lead
ZAkchurina@kpmg.com