Department of Health | Medicaid Redesign Team

Technical Design I Subcommittee

Meeting # 3

October 1, 2015

Welcome Back

Today's Agenda includes the following:

Agenda Item	Time
Welcome	2:00
Draft Recommendations: 1. Attribution Methodology 2. Methodology for Setting the Target Budget and Calculating Shared Savings/Losses (previously 'Benchmarking') a. Distribution of shared savings 3. Practical Approach to Retrieve Overpayment	2:05
Break (15 minutes)	3:30
Introduction to: 1. How should the Stop Loss/Risk Corridor mechanism be designed for Level 2 (and 3) VBP?	3:45

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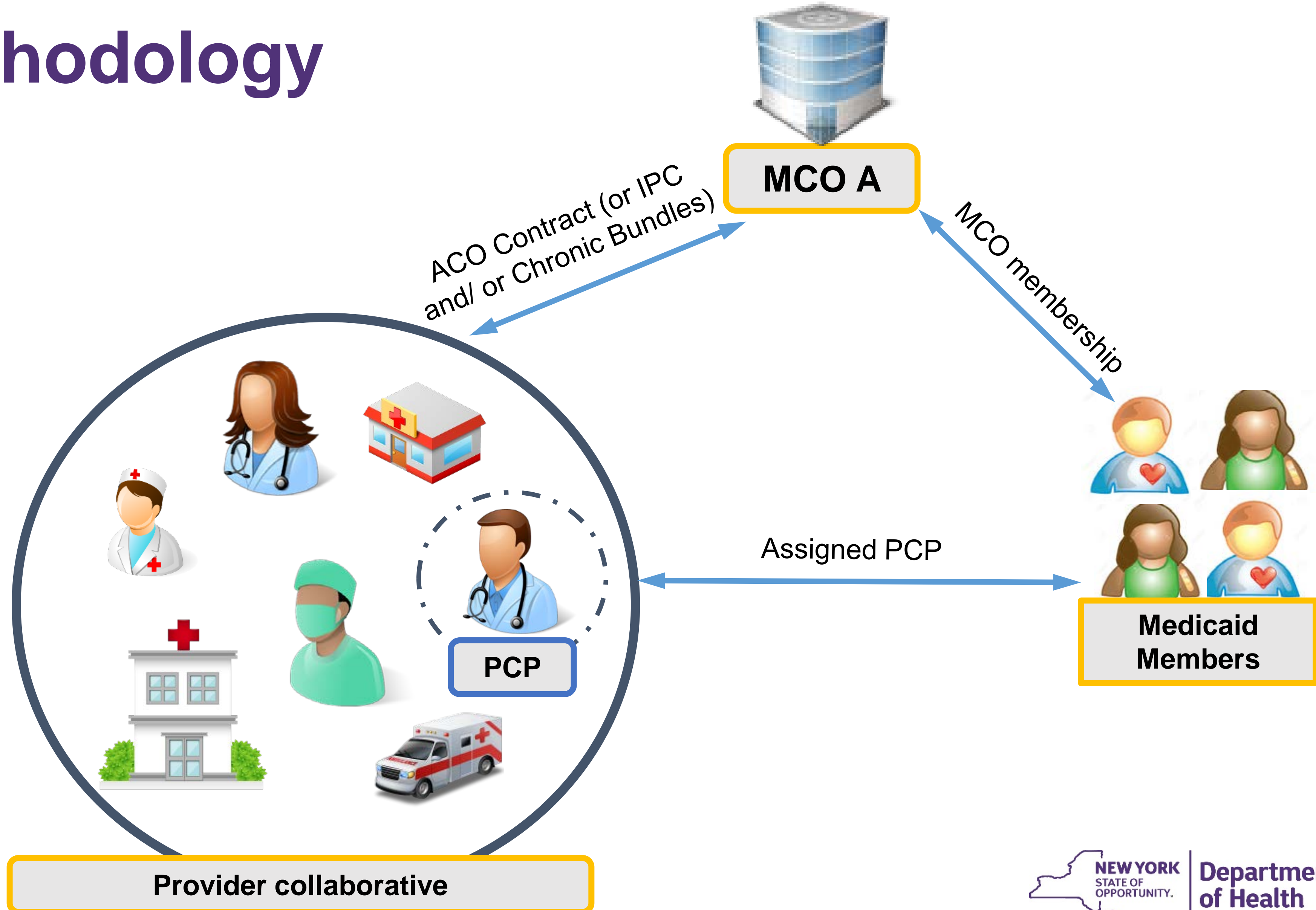
Attribution Methodology

Draft Recommendation
Technical Design Subcommittee I, NYS Value Based Payment Workgroup

Attribution Methodology

Practical example:

Attribution to an ACO or Integrated Primary Care Provider



Attribution Methodology – *Guideline*

These methods will be used by the State for its analyses of costs and outcomes of VBP arrangements to inform Providers and MCOs.

#	Topic		Recommendations	
			i	ii
1a	Attribution	What provider/entity drives the attribution for: • Total Care Total Population • Integrated Primary Care • Chronic Bundles • Non-Chronic Bundles	• MCO assigned PCP • For non-chronic bundles, the provider delivering the core services that 'trigger' the bundle drives attribution	MCOs and providers can select different provider (e.g. cardiologist for arrhythmia). *MCOs will be required to provide a list of assigned providers to DOH.*
1b	Attribution	What provider/entity drives the attribution for the total care for the subpopulations: • HARP • HIV/AIDS • MLTC	• MCO assigned Health Home • HIV/AIDS center • MLTC provider assigned by MCO	MCOs and providers can select different provider (e.g. consortium of BH providers for HARP). *MCOs will be required to provide a list of assigned providers to DOH.*
2	Timing	Are members attributed prospectively or retrospectively?	Prospective (through assignment) *To be investigated if changes to assignments should be made possible mid-year or even more frequently. No retrospective reconciliation with actual use patterns (to avoid complexity).*	

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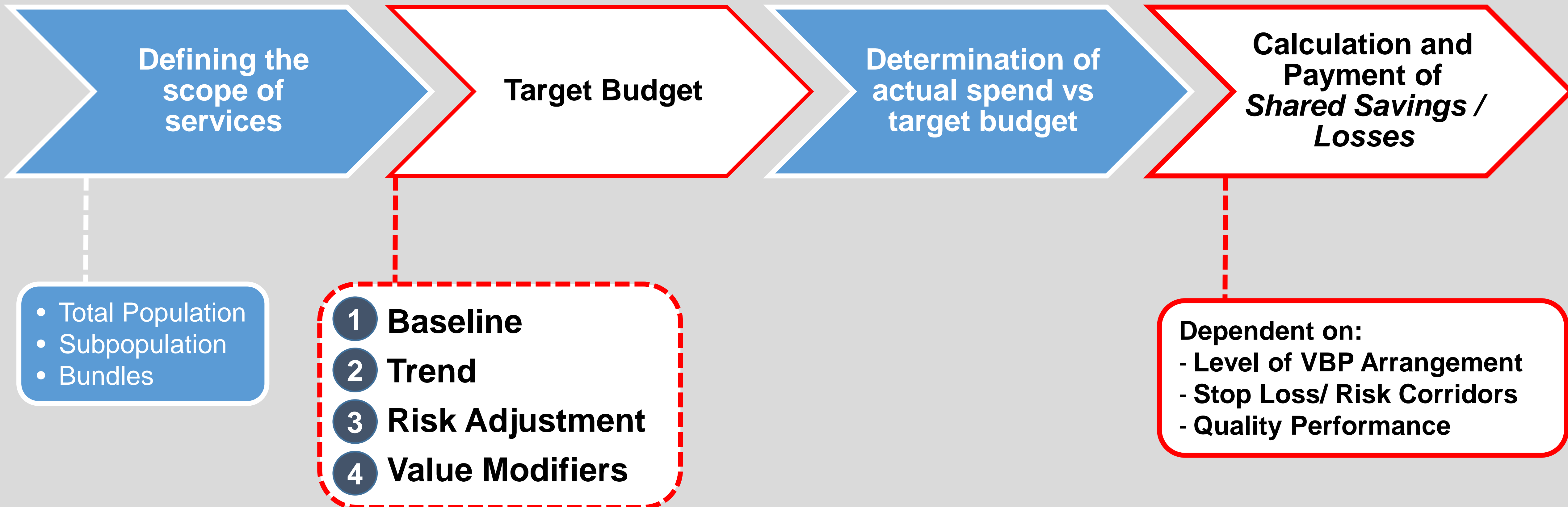
Methodology for Setting the Target Budget and Calculating Shared Savings/Losses

Summary of Draft Recommendation
Technical Design Subcommittee I, NYS Value Based Payment Workgroup

Setting Target Budget is a Key Step in the Determination of Shared Savings/Losses



Target Budget Setting Methodology – *Guideline*

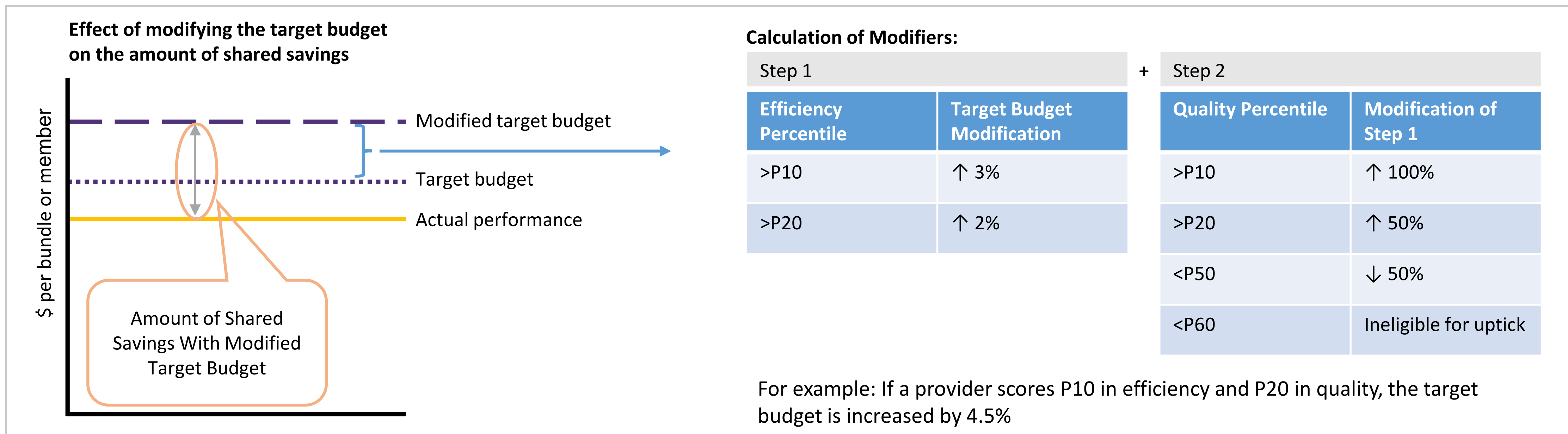
This method will be used by State for its analyses of costs and outcomes of VBP arrangements, including potential shared savings, to inform Providers and MCOs.

#	Topic	Recommendations
1	How to set the Baseline	Using 3 years of provider-specific, historic data • 'Provider' is the group of providers contracting the VBP Arrangement • Using the provider's network information (list of attribution-driving providers (e.g. PCPs)) for the forthcoming contracting year, historic average costs are calculated per year • Years are weighted with the recent year impact baseline most (50%-35%-15%)
2	How to set the Growth Trend	Using 3 years of provider-specific, historic data • Using same dataset as in #1, determine avg. growth percentage of bundle or PMPM cost • Using Statewide datasets, determine avg. regional growth percentage (separately for Upstate and Downstate) of bundle or PMPM cost • Regional and provider-specific growth trend weighted at 50% each • Baseline * growth trend = target budget (non-risk adjusted)
3	Risk Adjustment	For Total Care for Total Population: 3M risk adjustment (using CRGs; similar to DOH method to fund MCOs) For Bundles: HCI3 risk adjustment For Subpopulations: as MCO risk adjustment methodology (if any) • Determine case-mix factor of current attributed population (for forthcoming contracting year) • Non-risk adjusted target budget * case-mix factor = risk-adjusted target budget.

Unforeseen future developments (e.g. pending changes in pharmacy benefits) may lead to MCOs and VBP contractors adjusting the target benchmark

Target Budget Setting Methodology – *Guideline for Modifiers (upward adjustments)*

In the first 2 years (2016 and 2017), these uptick adjustments will be only available for VBP contractors entering into Level 2 or 3 contracts. The specific percentages and operational details mentioned below are directional. The State has the flexibility to adjust these in accordance with the integrity of the Medicaid Global Cap.



Calculation of Modifiers:

Step 1 +

Efficiency Percentile	Target Budget Modification
>P10	↑ 3%
>P20	↑ 2%

Step 2

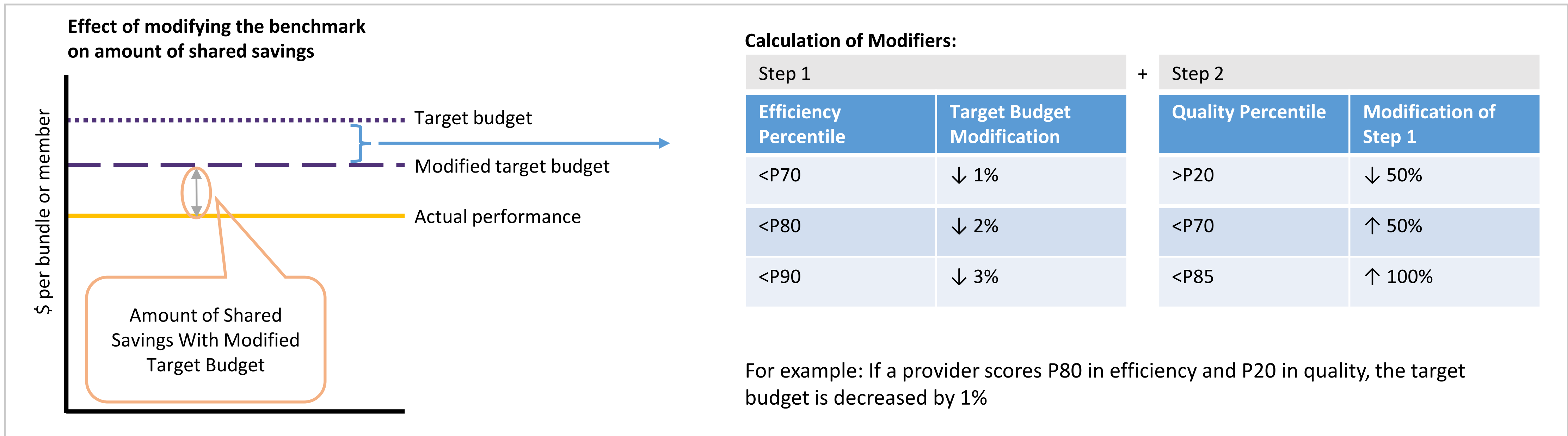
Quality Percentile	Modification of Step 1
>P10	↑ 100%
>P20	↑ 50%
<P50	↓ 50%
<P60	Ineligible for uptick

For example: If a provider scores P10 in efficiency and P20 in quality, the target budget is increased by 4.5%

Efficiency and Quality Percentile Calculation: The efficiency percentile is calculated by comparing the provider specific risk-adjusted historical per capita baseline (Step 1 and Step 3 of calculating the target budget) to a risk-adjusted state-wide per capita baseline. The difference is ranked state-wide and computed into a percentile. The quality percentile is a comparison of the number of outcome targets met by the provider compared to the regional average. Providers are ranked on the number of outcome targets met and this is computed into percentiles. Additional details are forthcoming.

Target Budget Setting Methodology – *Guideline for Modifiers (downward adjustments)*

At the start of 2018, (giving providers two years to improve and potentially begin earning sharing savings), downwards adjustments may be introduced. The specific percentages and operational details mentioned below are directional. The State has the flexibility to adjust these in accordance with the integrity of the Medicaid Global Cap.



Calculation of Modifiers:

Step 1		+ Step 2	
Efficiency Percentile	**Target Budget Modification**	**Quality Percentile**	**Modification of Step 1**
<P70	↓ 1%	>P20	↓ 50%
<P80	↓ 2%	<P70	↑ 50%
<P90	↓ 3%	<P85	↑ 100%

For example: If a provider scores P80 in efficiency and P20 in quality, the target budget is decreased by 1%

Modifiers in a VBP World: When the PMPM or episode costs for a specific VBP arrangement converge around the State average, this State average can become the starting point for target setting, and these efficiency modifiers would no longer be used.

Setting Shared Savings/Losses Percentages – *Guideline*

VBP Arrangement	Recommendations
Level 1	• Starting point for shared savings percentage negotiations should be **50%** of savings to be retained by providers.
Level 2	• Starting point for shared savings percentage negotiations should be **90%** of savings to be retained by providers. • Shared savings and losses percentages may be modified dependent on the type of risk protection mechanisms (such as stop loss or risk corridors) that are implemented to limit total provider risk.

Quality Adjustment to Shared Savings/Losses Percentages - *Guideline*

Outcome Targets % Met	Level 1 VBP Upside only	Level 2 VBP Up- and downside When actual costs < budgeted costs	Level 2 VBP Up- and downside When actual costs > budgeted costs
> 50% of Outcome Targets met	50% of savings returned to PPS/ Providers	90% of savings returned to PPS/ Providers	PPS/ Providers are responsible the negotiated % of losses.
<50 % of Outcome Targets met	Between 10 – 50% of savings returned to PPS/ Providers (sliding scale in proportion with % of Outcome Targets met)	Between 10 – 90% of savings returned to PPS/ Providers (sliding scale in proportion with % of Outcome Targets met)	PPS/ Providers responsible for an increased % of losses (sliding scale in proportion with % of Outcome Targets met)
Outcomes Worsen	No savings returned to PPS/ Providers	No savings returned to PPS/ Providers	PPS/ Providers responsible for 90% of losses. For Stop Loss see text.

The above percentages reflect the proposed guidelines from slide 11. It is important to keep the existence of a stop loss and other risk-mitigating mechanism in mind while reviewing this chart: higher protections of providers will result in lower shared saving percentages.

Distribution of Shared Savings/ Losses Amongst Providers - *Guideline*

Guiding Principles:

- Funds are to be distributed according to provider effort and provider performance in realizing the overall efficiencies, outcomes, and savings.
- Required investments and losses are taken into consideration.
- The relative budget of the comparative providers should not be the default distribution mechanism.
- The distribution of shared savings should follow the same principles as the distribution of shared losses.
- For shared losses, smaller providers, financially vulnerable providers or providers with a regulatory limitation on accepting certain losses (e.g. FQHCs) may be treated differently to protect these individual providers from financial harm. It is legitimate that this 'special treatment' would weigh in as an additional factor in determining the amount of shared savings that these providers would receive

Public Reporting

The allocation of shared savings *percentages* among providers, broken down by provider type (e.g. primary care, hospital, specialists), in each VBP arrangement must be made publically available by the VBP contractor. Additionally, the VBP contractor should indicate the percentage of savings retained to be reinvested in infrastructure.

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Level 2: Overpayment by Plan to Provider

What should be the practical approach to retrieving overpayments?

Draft Recommendation prepared for
Technical Design Subcommittee I, NYS Value Based Payment Workgroup

In Level 2: What Should be the Practical Approach to Retrieving Overpayment by Plan to Provider?

As providers and/or provider groups enter into Level 2 VBP arrangements there may be instances in which the MCOs make overpayments to providers.

The New York State Department of Financial Services (DFS) already provides requirements around the retrieval of overpayments. Barring instances of fraud or misconduct, plans have a timeframe in which to request a return of funds. No additional guideline or standard seems to be required.

Draft Recommendation

The State regulatory guidance currently in place for the retrieval of provider overpayments does not require changes at this point. When setting up value-based contracts, plans and providers can continue to build off existing practices and regulation and agree upon additional details of overpayment recovery in their contracts.

Break - 15 mins

Stop Loss and Risk Corridors: Financial Protection Mechanisms for MCOs and Providers

Overview of stop loss options outlined in Methodology Considerations and Options for the Technical Design Subcommittee I, NYS Value Based Payment Workgroup

Remember: Key Questions for all Topics

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.

Stop Loss and the Risk Corridors will not be included in the dynamic information solution that the State will provide for MCOs and providers. These risk-mitigating mechanism will be at the discretion of the stakeholders. However, due to the State's responsibility to protect the Medicaid Safety Net, the Regulatory Subcommittee will describe three tiers of risk, each requiring different processes for approval. The lowest tier will allow providers and MCOs to engage in VBP contracting without obtaining approval by DOH.

Terminology

‘**VBP-contractor**,’ the entity that contracts the VBP arrangement with the MCO. This can be:

- ACO
- IPA
- Individual provider (either assuming all responsibility and upside/downside risk or subcontracting with other providers)
- Individual providers brought together by an MCO to create a Level 1 or 2 VBP arrangement through individual contracts with these providers

Objectives for Stop Loss and Risk Corridors

How much risk should the State allow the VBP Contractor to accept in VBP arrangements?

The **Regulatory Subcommittee** to determine three Tiers of risk and establish a ***standard*** for the approval process involved. The lowest Tier will not require approval by the DOH.

What policy mechanisms are available to manage risk in VBP arrangements?

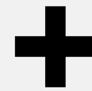
The **Technical Design I Subcommittee** to review and take note of the options for stop loss and risk corridors. No guideline seems required.

The State does not require a guideline on the options for stop loss and risk corridors once a risk standard has been implemented. MCOs and providers may use any combination of mechanisms to adhere to the risk standards.

Levels of Financial Protection

Stop Loss

- Limits VBP contractor losses at the level of an ***individual episode or member***
- Removes the highest cost outliers (providers are not at risk for costs significantly above the estimated budget per individual episode or member)



Risk Corridors

- Financial protection across ***all of the VBP arrangements and contracts between an MCO and VBP contractor*** (including non-VBP contracts)
- Ensures providers do not lose more than fixed percentage of their total revenue per MCO

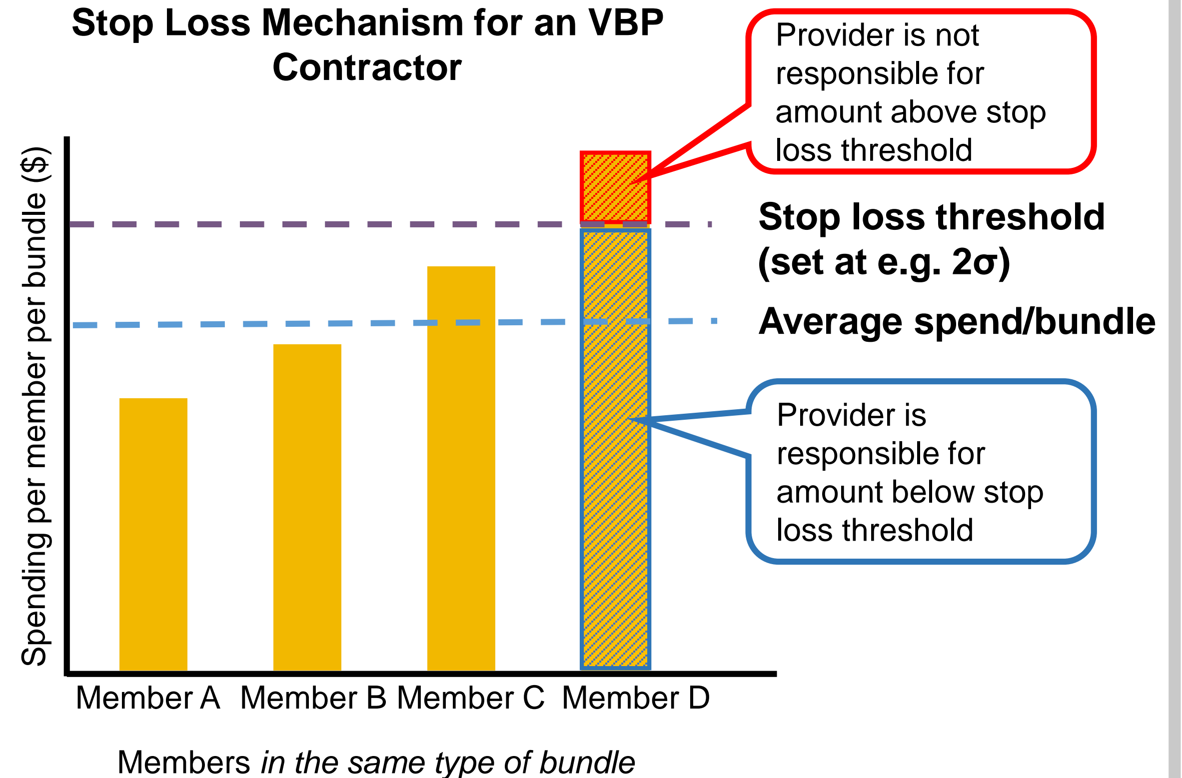
Stop Loss

Goal

Financial protection for providers against insurance risk, which encourages participation in risk sharing VBP arrangements.

How it works

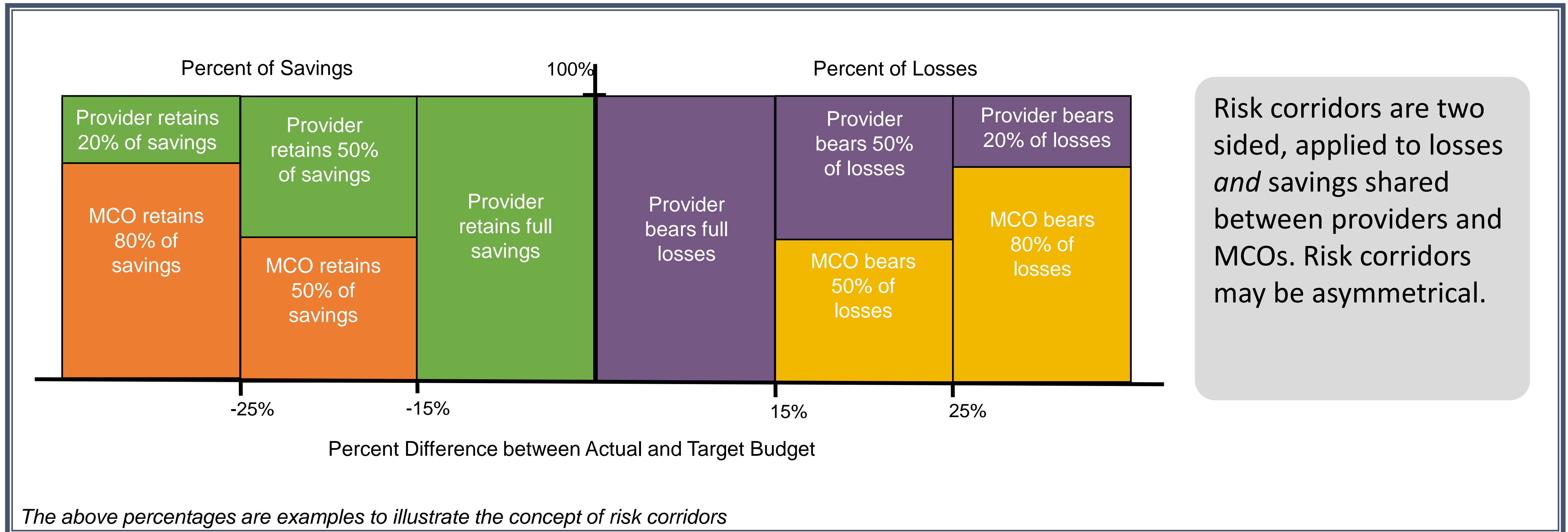
The stop loss threshold is the maximum amount of loss a VBP contractor is responsible for *per episode* or, in the case of (sub)population contracts, *per member*. Costs above the threshold are excluded from the calculation of the overall savings/losses.



Other Programs: In Next Generation and MSSP ACOs, a member's total annual expenditures are capped at the 99th percentile of national Medicare Fee-For-Service expenditures, approximately $100,000 annually.

Risk Corridors in Level 2 & 3 VBP Arrangements

In addition to stop loss, risk corridors ***protect VBP contractors for the risk across an entire budget between them and an MCO.*** The total savings/losses across all bundles, subpopulations/populations, and non-VBP contracts between an MCO and VBP Contractor are aggregated to ensure the integrity of the overall financial health of the provider.[1]



The above percentages are examples to illustrate the concept of risk corridors

1. Individual providers that are part of an entity contracting a VBP arrangement may contribute their own total contract value with the MCO to this calculation of the total VBP contractor contract value. (This may of course have consequences for the way savings/ losses are distributed within the contracting entity)
2. In MSSP ACOs, the 'cap' is set at 15% of overall budget for the 'upside' (total gains), and 5-10% for the 'downside' (total loss). In Next Generation ACOs the 'cap' is set at 15% for total gains / loss.

Next Meeting

When: October 21th at 11:00 AM

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

Agenda:

Introduction to
1. Medicaid Budget from VBP Perspective 2. What should be the approach to and risk adjustment methodology for TCTP and what happens with the 'remainder' of TCTP costs when bundles/IPC are subcontracted? How does this work conceptually and in practice? 3. Incentivizing the MCOs to contract VBP arrangements and High Value providers 4. Criteria for Hospitals to Receive 50% of Shared Savings in IPC Contracting

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