**Meeting #2**

**Date: July 23, 2015 2:00 PM**

**Location: School of Public Health, 5 University Place, Rensselaer NY**

**Attendees:**

TD I Subcommittee Attendance_072320:

**Overview**

This was the second meeting in a series of meetings for the Technical Design I Subcommittee (SC). The purpose of the meeting was to review the topics introduced in the Subcommittee's first session, attribution and benchmarking methodology, and then continue on to discuss shared savings and provider overpayments.

The specific Agenda for this meeting included the following:

1. Welcome
2. Deep Dive into Meeting #1 Topics:
    a. Attribution Methodology
    b. Benchmarking Methodology
3. Introduction to Meeting #2 Topics:
    a. When considering shared savings, what should the risk percentages be?
    b. What should be the practical approach to retrieving overpayment by plan to provider?
4. Next Steps and Action Items

**Key Discussion Points**

**1) Welcome and Introductions**

**2) Deep Dive into Attribution Methodology** (Reference slide deck "Technical Design I Subcommittee Meeting #2" and options paper "VBP Member Attribution Methodology: Options and Considerations")

The Subcommittee began the meeting with a review of the attribution methodology, which is necessary in order to determine which providers will be responsible for which Medicaid members, both in terms of outcomes and costs.

Several areas of consensus emerged after the initial discussion around attribution in Meeting #1, and each of these points was reviewed once again. The first decision reviewed was around the default attribution methodology used by the State. Though the State needs to set one attribution method as the default, there is no need for a standard to be put into place as long as MCOs and providers can share attribution

lists with the State when alternative methods are utilized. So the recommendation will be to set a *guideline*. The second area of emerging consensus on attribution methodology is that for the Total Care for the Total Population (TCTP), Integrated Primary Care (IPC) and Chronic bundles, the MCO-assigned PCP should be the driver of the attribution.

Further discussion centered on the need for an attribution methodology guideline to be developed for MCOs and providers. The issue of assigning members based on a PCP spurred a number of follow up questions from members of the SC. Some members were concerned that this attribution methodology could be a reduction in consumer choice, which is particularly of concern for behavioral health clients, who may be more successful within existing provider relationships. This issue was clarified as PCP assignment is a core part of existing Medicaid managed care structure, and consumers will continue to have the ability to both select their MCO and work with other in-network providers. Plans also have processes in place for members to select specialty providers as their PCP, and networks are tested and refreshed on a quarterly basis to ensure adequacy. The State will share utilization data in order for providers to look at patterns and develop effective partnerships. Attribution methodology is more focused on contracting in a manner that enables value-based payments, providing backend structure that remains invisible to the consumer.

Attribution methodology will be further discussed in the third meeting of this subcommittee; a draft recommendation will be shared with the committee prior to the discussion.

3) **Deep Dive into Benchmarking Methodology** (Reference slide deck "Technical Design I Subcommittee Meeting #2" and options paper "Benchmarking Methodology: Considerations and Options")

The Subcommittee reviewed the need for benchmarking, and the four components of which benchmarking is composed: baseline setting, trend determination, risk adjustment and value modifiers. Per discussion in the first meeting of this subcommittee, setting a *guideline* for benchmarking methodology will be key, as the State needs a default methodology from which to perform data analysis and other tasks, but the State will not impose these guidelines on the MCO-provider contracts. Guidelines will, however, be helpful for educating providers and framing negotiations for new entities enrolling in VBP arrangements.

The Subcommittee discussed each of the benchmarking components. Review of the first component, baseline setting, resulted in agreement that aggregated provider specific baselines looking at over a year of claims would be most beneficial. In conversation around the second component, trend determination, the recommendation was made to look at both provider specific and regional historic rates. For the third component, risk adjustment, it was explained that the State is using 3M CRG methodology to look at risk adjustment options for sub populations and HCI3 methodology to look at risk adjustment options for bundles of care.

The overview of the fourth benchmarking component, value modifiers, was presented. A number of questions arose as to how value modifiers would relate to the level of risk that a provider or group has taken on. The SC discussed the goal of using value modifiers as part of the benchmarking methodology is to both reward efficient providers and stimulate those providers who need to close performance gaps. There was discussion whether it would be easier to adjust shared savings percentages, however, it was clarified that modifying the benchmark helps standardize the VBP program by impacting how the baseline

may be calculated in future years ('rebasing'). For those providers who may be underperforming, the State will help share data to help identify areas of opportunity.

The SC requested to have future conversations around risk adjustment and patient acuity. The Subcommittee's comments and concerns around benchmarking methodology will be included in draft recommendations and shared back with the group.

**4) Introduction to Shared Savings** (Reference slide deck "Technical Design I Subcommittee Meeting #2")

The Subcommittee reviewed the introduction of shared savings, reminding the Subcommittee of the outstanding question around what shared savings percentages should be established. It was clarified that shared savings could be used as an investment into additional cost saving mechanisms, such as funding for addressing social determinants of health.

Concern was raised that smaller providers might not have large enough reserves to safely participate in VBP arrangements with higher percentages of shared savings/losses. It was noted that shared loss caps will be discussed, and risk can be mitigated with stop loss mechanisms. The SC also raised questions as to how shared savings would be distributed between providers and larger entities, as those providers creating efficiencies may not be individually rewarded. These shared savings discussions will need to take place in contracting negotiations, and the shared savings guidelines developed by the State may serve as a source of reference. Members of the subcommittee noted that although many shared savings decisions will be made within contractual relationships, there is a desire for some transparency around tracking of shared savings.

The Subcommittee requested to see examples of approaches to shared savings/losses, and the group was reminded that the State is also developing pilots for additional learnings. Also, the topic of addressing criteria for hospitals for achieving sharing and savings generated by integrated primary care (IPC) groups will remain for discussion in the next meeting.

**5) Introduction to Overpayment** (Reference slide deck "Technical Design I Subcommittee Meeting #2")

There was not sufficient time in the meeting to delve into issues of overpayment. This topic will be addressed in Meeting #3.

**6) Next Steps and Action Items**

Recommendations around benchmarking and attribution methodologies as well as on shared savings will be shared with the Subcommittee prior to the next meeting.

**Materials that have been distributed during the meeting:**

| # | Document | Description |
|---|---|---|
| 1 | Technical Design I Subcommittee Meeting #2<br>  <br>VBP Technical Design I_Meeting 2_ | A presentation deck reviewing attribution and benchmarking methodologies, and introducing the topics of shared savings and overpayment. |

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| 2 | Benchmarking Methodology: Considerations and Options<br>  <br>NYS VBP_Technical Design I SC_Benchm | In depth analysis of approaches to benchmarking methodology. |
| 3 | VBP Member Attribution Methodology: Considerations and Options<br>  <br>NYS VBP_Technical Design I SC_Attribut | In depth analysis of approaches to attribution methodology. |

**Key Decisions**

Consensus decisions on the two agenda items will be finalized in the next meeting.

**Conclusion**

In the next meeting the SC will continue to have in-depth discussions on the topic of shared savings, introduce the subject of overpayment, as well as the following agenda topics:

1. How should the Stop Loss mechanisms be designed?
2. What should 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