NEW YORK STATE | Department of Health | Medicaid Redesign Team

Technical Design I Subcommittee

Meeting # 2

July 23, 2015

Welcome Back

Today's Agenda includes the following:

Agenda Item	Time
Welcome	2:00
Deep Dive: 1. Attribution Methodology 2. Benchmarking Methodology	2:05
Break (15 mins)	3:45
Introduction to: 1. When considering shared savings, what should the risk percentages be? 2. What should be the practical approach to retrieving overpayment by plan to provider	4.00

SC Decision – Making

- The goal of the SC is to come to a consensus on each of the agenda topics
- However, if the SC reaches an impasse, the final decision will then be made by the Department of Health

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Attribution Methodology

What methodology should be adopted?

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

Attribution

Attribution is necessary to determine which providers will be responsible for which members - both in terms in outcomes and costs.

Three (3) Facets to Consider:

#	Facet	Methodological Aspect
1	Who	To **whom** the member is assigned (i.e. the type of provider to whom a member can be assigned).
2	How	**How** the member is assigned to a provider (i.e. the technique or “rule” used to assign a member).
3	When	**When** during the contract period the member is assigned (retrospective or prospective).

Attribution Methodology – emerging consensus in last meeting - I

The State requires one method as the default attribution methodology per VBP arrangement to realize comparable information, benchmarks etc. to:

- inform providers and MCOs
- monitor overall quality and costs

Yet as long as MCOs and providers are able to provide attribution lists to the State when an alternative method is utilized, there is no need for more than a *Guideline.*

Attribution Methodology – emerging consensus in last meeting - II

For TCTP, IPC and the Chronic Bundles, a practical and theoretical ideal practice is to have the MCO assigned PCP be the driver of the attribution.

- *I.e.: the MCO assigns a member to a TCTP, IPC or Chronic Bundle provider through the already existing practice of assigning the member to a PCP*

Attribution Methodology – Consensus Needed

In the last meeting the SC has reached the consensus that with respect to the Attribution Methodology, a Guideline should be developed for MCOs and providers to follow.

#	Topic		Choice		
			i	ii	iii
1a	Who/How	What provider drives the attribution for TCTP, IPC and the Chronic Bundles	MCO Assigned PCP	Actual PCP as determined by claims data analysis	Other (e.g. cardiologist for arrhythmia)
1b	Who/How	What provider drives the attribution for Total Care for Subpopulations: HARP, HIV/AIDS, MLTC	Resp. Health Home, HIV/AIDS center, MLTC provider Assigned by MCO	Actual HH, HIV/AIDS center, MLTC provider as determined by claims data analysis	Other
2	When	Are beneficiaries attributed prospectively or retrospectively for TCTP, TCSP, IPC and the Chronic Bundles?	Prospective	Prospective with retrospective reconciliation	

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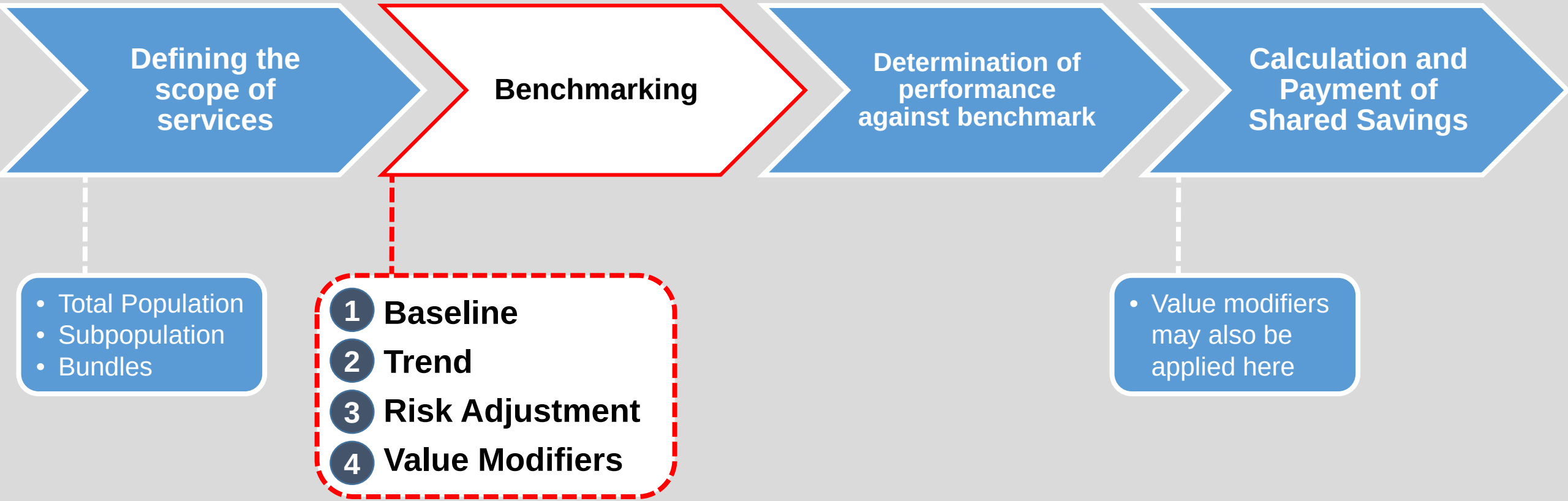
Benchmarking Methodology

What methodology should be adopted?

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

Benchmarking is a Key Step in the Determination of Shared Savings/Losses



The Benchmarking Process Consists of Four Components

Baseline Setting

- Historic claims data

Trend Determination

Risk Adjustment

Value Modifiers

- Quality Modifier
- Cost Modifier

Note: During at least the first year of the VBP implementation, the State will use standardized costs in its benchmark setting process. This standardization removes the effect of price on cost comparisons, leaving the differences observed between providers the result of either service mix and/or volume effects.

Benchmarking Methodology - emerging consensus in last meeting - I

The State requires one method as the default benchmarking methodology to realize comparable information, calculate shared savings/losses etc. to:

- inform providers and MCOs
- monitor overall quality and costs

Yet if MCOs and providers want to deviate from a benchmark, for example, or reward quality differently, that is up to them. So, a *Guideline* is sufficient.

Benchmarking Methodology – emerging consensus in last meeting - II

For the first three steps, the issues seem clear

Baseline Setting

Historical claims are aggregated within a Value Based Payment (VBP) arrangement into virtual episodic bundles, or capitated payment baseline expenditures, to produce an overview of prior costs without any adjustments. It enables a basic comparison of similar provider groups and serves as an initial point of reference at the end of the performance period.

Options for Aggregation Level

- Provider Specific Baselines

- Regional or Statewide Baselines

Options for Look Back Period

- One Year of Claims (1)
- More than One Year of Claims (>1)

Trend Determination

The annual increases in healthcare costs between the baseline period and the performance period must be incorporated into the benchmark evaluation. There are several options varying from historic increases to fixed standards for how to predict cost growth within the benchmark.

Options for Predicting Growth

- Provider Specific Historic Rate
- ?
- Regional Historic Rate
- Industrial Growth Trend

Risk Adjustment

Risk adjustment is necessary to ensure a fair comparison between baseline and performance year financial performance. Risk Adjustment allows for an “apples to apples” comparison of the member populations over the two periods of time by adjusting the benchmark to account for the relevant risk factors that influence the cost of providing care.

Risk Adjustment Options for (Sub)populations

- 3M CRG Methodology
- Other Methods

Risk Adjustment Options for Bundles of Care

- HCI3 Methodology
- Other Methods

Benchmarking Methodology – the more complicated part

For the last steps, several key considerations are at play

Value Modifiers

Value modifiers increase or decrease a provider's benchmark according to their previous cost and quality performance as compared to a regional or statewide average. Value modifiers ensure previously efficient providers are not disadvantaged from receiving future shared savings and previously inefficient providers do not have a disproportionately higher opportunity for shared savings. Value modifiers may be applied in the benchmark setting process, during the determination of shared savings, or while performing rebasing.

Inclusion of Cost Modifier

- Inclusion of Cost Modifier in Benchmark/Rebasing
- Inclusion of Cost Modifier in Shared Savings Percentage

Inclusion of Quality Modifier

- Inclusion of Quality Modifier in Benchmark/Rebasing
- Inclusion of Quality Modifier in Shared Savings Percentage

Total Amount of Savings / Losses = (**Benchmark** - **Actual Costs**) x **Percentage of Shared Savings**

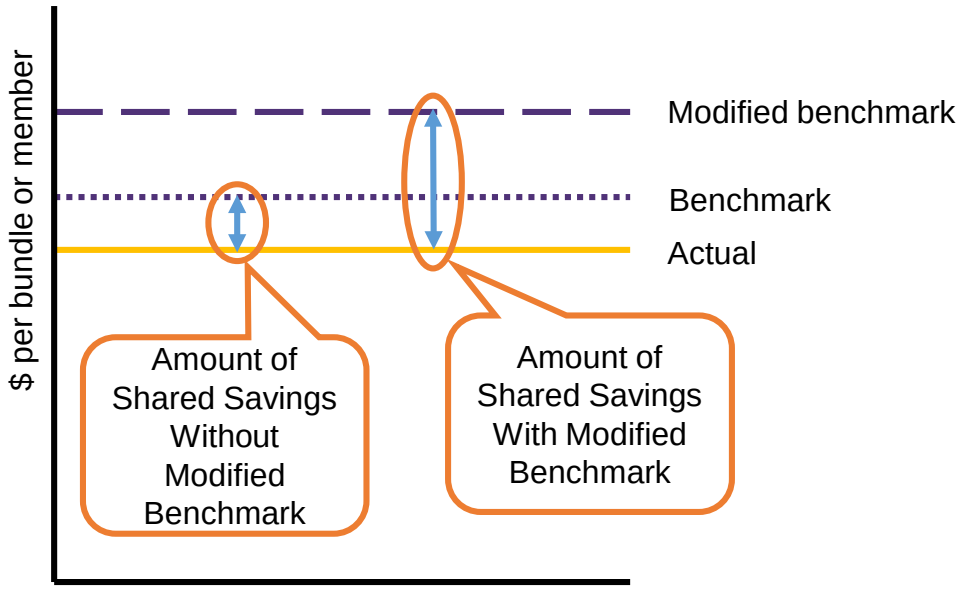
Adjust Amount of Savings/Losses by Modifying the Benchmark or Rebasing

Adjust Amount of Savings/Losses by Modifying the Percentage of Shared Savings

Standardized Costs used for benchmark calculation

Total Amount of Savings / Losses = (**Benchmark** - **Actual Costs**) x **Percentage of Shared Savings**

Modifying the Benchmark

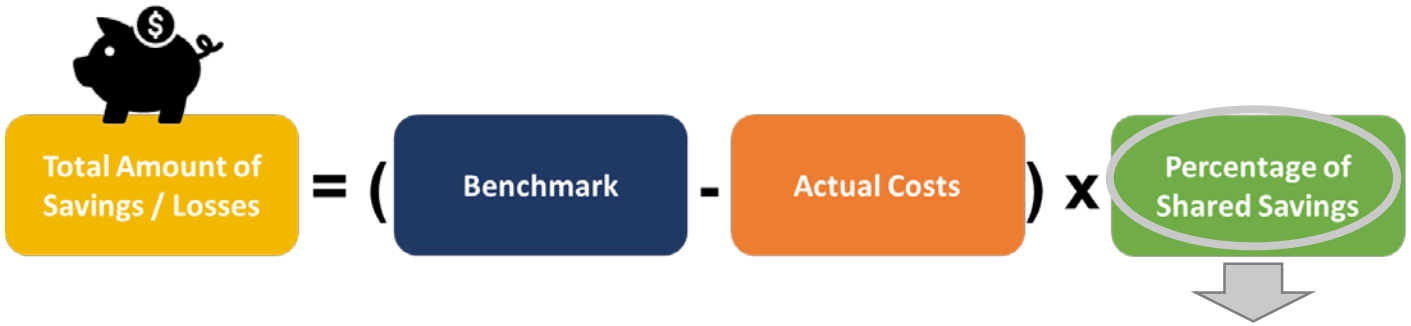


Scenario

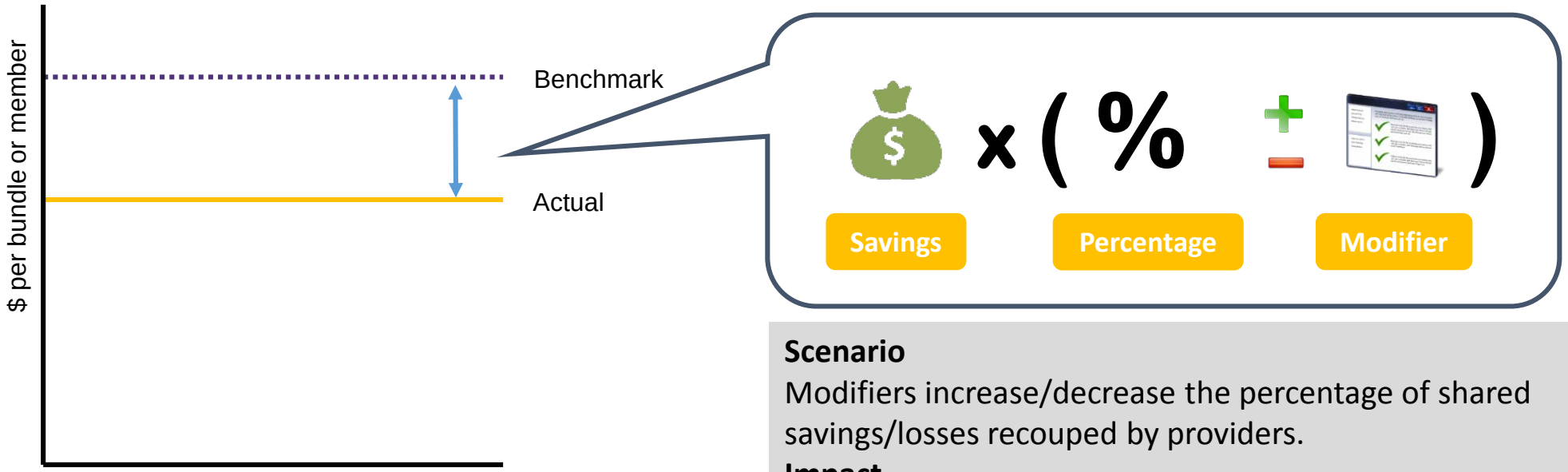
An efficient or high quality provider receives a modifier to increase their benchmark 2-3%, thereby enlarging the amount of shared savings eligible to be realized.

Impact

Modifying the benchmark is equivalent to a rate increase/decrease.

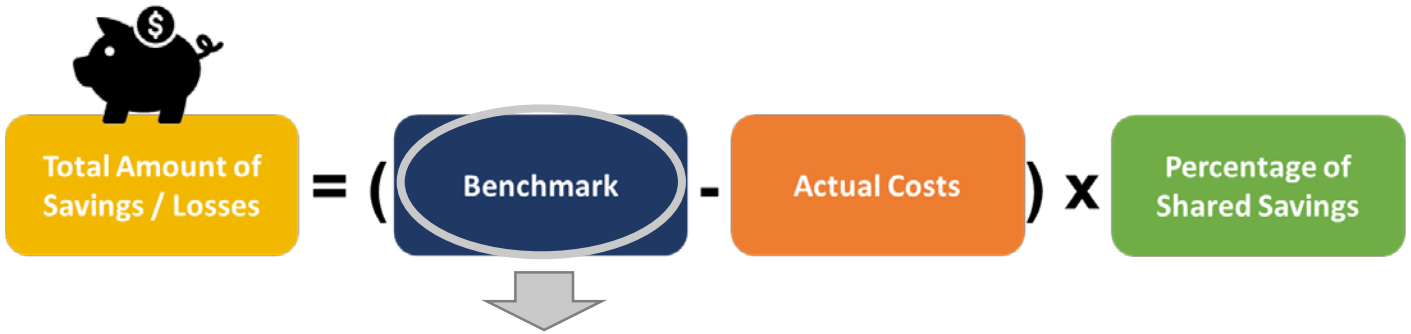


Modify the Shared Savings/Losses Percentage

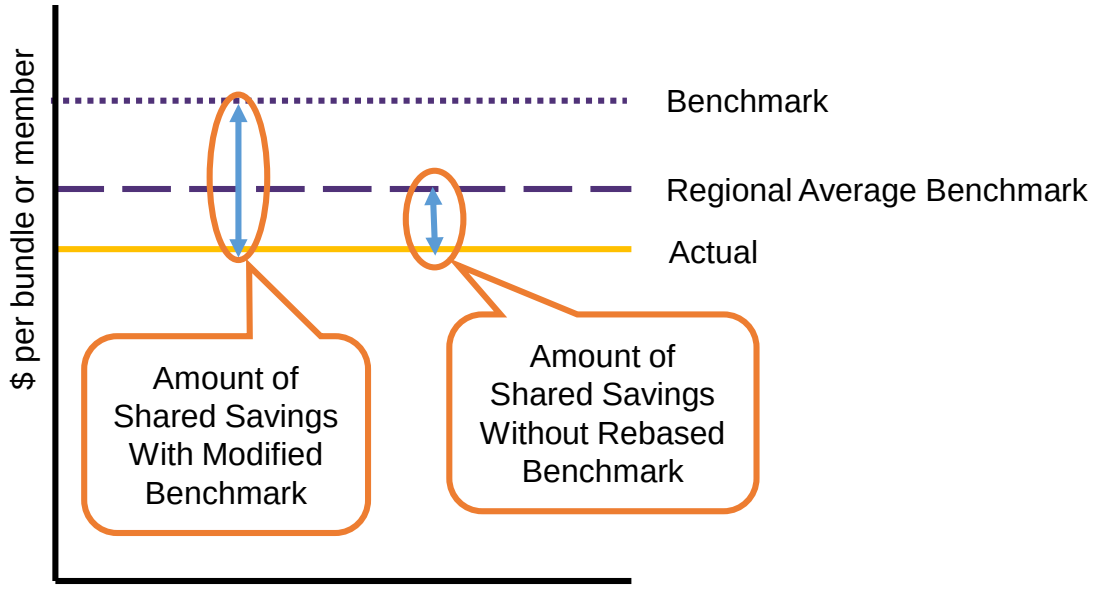


Scenario
Modifiers increase/decrease the percentage of shared savings/losses recouped by providers.

Impact
More modest than changing the benchmark itself. Also, when there are no shared savings, this modifier has no effect



Rebasing Prior to the Next Performance Period



Scenario

Baseline in a future year incorporates the savings already made, which may push the benchmark downwards. *Suggestion:* do this only for those providers above regional avg.

Impact

Rebasing of under performing providers encourages them to quickly become more efficient, but it doesn't hurt in the first one/two years. It also doesn't allow low performing providers to reap long-term benefits from current inefficiencies.

Total Amount of Savings / Losses = (**Benchmark** - **Actual Costs**) x **Percentage of Shared Savings**

Adjust Amount of Savings/Losses by Modifying the Benchmark or Rebasing

Uptick in Benchmark for most Cost Efficient Providers:
+ 1% for P20 (e.g.)
+ 2.5% for P10 (e.g.)
If also top quality: 50-100% extra uptick

Downwards adjustment for low efficiency providers: < P65 after 2 yrs. If also poor quality: 50-100% extra adjustment

Adjust Amount of Savings/Losses by Modifying the Percentage of Shared Savings

Quality Value Modifier (as in roadmap)

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Break - 15 mins

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Shared Savings Percentages

What percentages should be established?

An overview of options for establishing shared savings percentages prepared for the Technical Design Subcommittee I, NYS Value Based Payment Workgroup

Determining Magnitude of Shared Savings/Losses

Defining the scope of services

- Total Population
- Subpopulation
- Bundles

Benchmarking

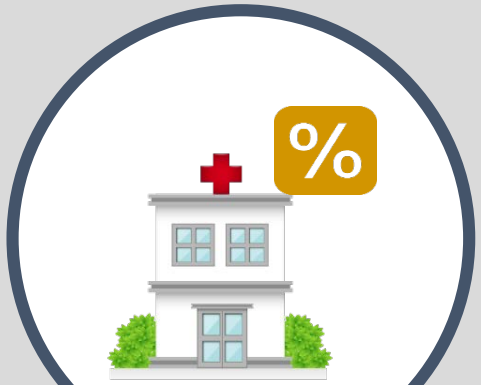
1. Baseline
2. Trend
3. Risk Adjustment
4. Value Modifiers

Determination of performance against benchmark

Calculation and Payment of *Shared Savings*

The amount of risk a provider accepts magnifies the savings/losses retained

Considerations for Setting Shared Savings Percentages



Shared Savings % – VBP Level 1 and 2

~~Shared Savings Cap~~ and **Shared Losses Cap**

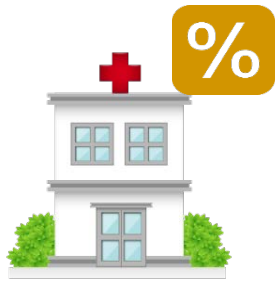
Stop Loss: to be discussed separately

Outcome Targets

Remember: 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.



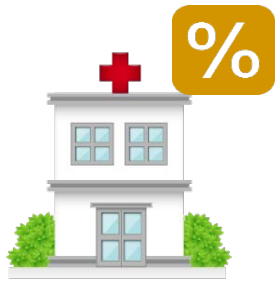
VBP LVL 1

Shared Savings Percentages in VBP Level 1

Level 1 VBP arrangements are 'upside' only and providers are not at risk for losses. The shared savings percentage pertains only to the eligible amount of the shared savings retained by the provider. Newer VBP arrangements in other programs have elected more aggressive percentages than in the past to encourage provider participation, while other programs allow the providers to chose their percentage from a defined range (e.g. 30-60%).

Options for Shared Savings % in VBP Level 1

- Shared Savings range between (e.g.) 30-60%
- Shared Savings set at 50%
- No Guideline



VBP LVL 2

Shared Savings Percentages in VBP Level 2

In Level 2 VBP arrangements provider share ‘upside and downside’ risk for both savings and losses. In order to encourage providers to migrate to Level 3 VBP, or full capitation, the eligible percentage of shared savings can be greater than that of shared losses. For example, providers that achieve savings may retain percentage 90% of these savings while providers that experience losses are responsible for 50% of these costs.

Minimum exposure in Level 2 is 20% of shared losses

Options for Shared Savings % in VBP Level 2

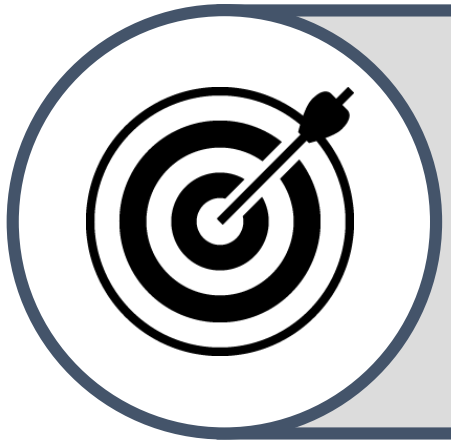
If Downside Risk is limited, upside may also be lower

Shared Savings & Losses set between 70-100%

Shared Savings/Losses set at e.g. 100%

Stop Loss mechanism prevents insurance risk

No Guideline



Outcome Targets

The VBP Roadmap outlines the use of outcome targets that establishes a threshold in order to participate in shared savings or reduce shared losses. Providers achieving fewer outcome targets will be eligible for less savings and responsible for a larger share of losses. There are several methods for how outcome targets can be compared to determine the percentage of shared savings/losses.

Options for Calculating Outcome Targets

- **Absolute Threshold (hit a fixed target)**
- **Relative Threshold (comparison to other providers)**
- **Comparison to Personal Outcome History**

Roadmap Examples of VBP Arrangements

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	50-60% of savings returned to PPS/ Providers	90% of savings returned to PPS/ Providers	PPS/ Providers responsible for 50% of losses. For Stop Loss see text. For Integrated Primary Care see IPC textbox.
<50 % of Outcome Targets met	Between 10 – 50/60% of savings returned to PPS/ Providers (sliding scale in proportion with % of Outcome Targets met)	Between 10 – 90% of savings returned to PPS/ Providers (gliding scale in proportion with % of Outcome Targets met)	PPS/ Providers responsible for 50%-90% of losses (gliding 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.

Dividing Shared Savings

Key Question:

Should a guideline be developed with respect to how providers divide the shared savings/ losses amongst themselves?

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Level 2: Overpayment by Plan to Provider

What should be the practical approach to retrieving overpayments?

An overview of for the overpayment by plans to providers 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.

There are a variety of mechanisms by which overpayments can be mitigated and prevented, however, there should be a set of guiding principles or standardized rules governing how overpayments should be retrieved.

Next Meeting

When: August 17th at 11:00 AM

Location: Albany; School if Public Health Café Conference Room (same as today)

Agenda:

Deep Dive
1. When considering shared savings, what should the risk percentages be? Also, how should shared savings be split? 2. In Level 2, what should be the practical approach to retrieving overpayment by plan to provider?
Introduction to
1. How should the Stop Loss mechanism be designed? 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

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