NEW YORK STATE | Department of Health | Medicaid Redesign Team

Technical Design II Subcommittee

Meeting #2

August 17, 2015

Agenda

Today's Agenda includes the following:

Agenda Item	Time
Welcome & Introductions	2.30
Deep Dive and Draft Recommendations: 1. What activities/services should remain FFS and be considered VBP? 2. How will technical assistance be provided to those providers that run into performance challenges in VBP arrangements?	2:45
Break	4:00
Introduction to New Topics: 1. Should certain services or providers be excluded from VBP? 2. What should be the criteria and policies for the VBP Innovator Program?	4:15

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. Should a special status be created for financially challenged providers? 2. What will be included in the planned assessment of the progress made in the VBP participation and market dynamics?
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 Update: MetLife Building, 200 Park Avenue, 15th floor

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

How to continue to incentivize preventive and other positive activities within VBP?

Preventive Care Services in the Roadmap

Roadmap contained language that expressed the willingness of the State to keep Preventive Care as FFS because the volume-incentive that FFS creates may be desirable for preventive services. CMS has stricken the language from the Roadmap, concerned, amongst others, for the introduction of loopholes in the State's definitions of VBP. It is the State's intention to pursue this idea coupled with a defined list of preventive care services and adequate quality criteria.

The goal is to have another round of discussions to have a better understanding of the emerging recommendation.

Insights emerging from last meeting's discussion:

1. It makes sense to define the list of Preventive Care services to include services listed as such in the ACA (see Appendix), and potentially add more (e.g. early childhood intervention, oral health, BH screenings, etc.)
2. There should be an incentive to link prevention services to treatment (weak connection between screening and access to further treatment, e.g. positive cancer screenings)
3. In some cases, preventive services are adequately incentivized in a bundle, or total care for the total (sub)population VBP arrangement
4. In other instances, preventive services may be better reimbursed using FFS with quality measures
5. Preventive Services that are not linked to an Integrated Primary Care or Total Care for Total Population arrangement are unlikely to be meaningfully coordinated, so should probably not count as VBP.

Types of Preventive Care Services

- Screenings, assessment (ranging from depression screenings to mammography, to blood tests)
- Immunizations, vaccinations
- Counseling for at risk populations, preventive counseling, well-visits
- Contraception
- Specific medications (folic acid, Gonorrhea preventive medication for the eyes of all newborns, etc.)
- Other?

Preventive Care Services are adequately incentivized in Total Care for Total (Sub)Population arrangements

- If a Total Care for Total (Sub)Population arrangement is being contracted, preventive services should be included as part of the VBP arrangement

- ‘Carving out’ preventive services would not make much sense here for the following reasons:
  - It would increase administrative complexity
  - There is no need to pay extra for something that is already targeting reduction in downstream costs
  - There is no risk of ‘underuse’ if compliance for preventive activities are already checked in the these total care for total (sub)population arrangements
  - Providers may want the opportunity to streamline processes for preventive activities that are difficult in the existing fee structure

Most Preventive Care Services are adequately incentivized in Bundles

- As in Total Care for (Sub)Population arrangements, ‘carving out’ of those preventive services that are naturally included in bundles would equally not make much sense:
  - Preventive activities (lifestyle coaching for chronic conditions, health education during pregnancy) are typically included in these bundles *because* actively pursuing those will increase the outcomes and reduce total costs for these episodes
  - It would increase administrative complexity
  - There is no risk of ‘underuse’ if compliance for preventive activities are already checked in these bundles
  - Providers may want the opportunity to streamline processes for preventive activities that are difficult in the existing fee structure

When does it make sense to keep preventive services in FFS?

In some cases, a ‘bundle’ or ‘total care for (sub)population’ agreement does not adequately incentivize preventive activities. This is the case when the following criteria apply:

1. When the preventive service is relatively costly
2. When the potential savings generated by these preventive activities will not sufficiently accrue to the providers contracting the VBP arrangement, or will only do so after a long time
3. When the current volumes of these preventive activities are considered too low
4. When there is a structural lack of alignment across providers - behavioral health and physical health (e.g. depression screening in primary care setting).

Preventive activities in FFS: LARC and PrEP Examples

- LARC – long-acting, reversible and highly cost-effective contraceptive. It has proven success in lengthening the interconception period but also preventing teenage pregnancies
- Including the uptake of LARC as a quality measure would help the impact of the Maternity Bundle.
  - Yet including the *cost* of LARC in the bundle would create the strange incentive that doing *more* would *increase* the cost of the bundle.
  - The positive impact and potential reduction in costs would, after all, be incurred in a *next* Maternity bundle, for example.
- ***Solution:*** *keep LARC as a FFS activity, yet include quality measure in Maternity Bundle.*

- PrEP - Pre-Exposure Prophylaxis is use of ARVs by people who are HIV negative but are at high risk of contracting the infection.
  - These people are not part of the AIDS/HIV subpopulation & intervention is costly
- ***Solution:*** *keep PrEP as a FFS reimbursed activity, yet include quality measure in AIDS/HIV subpopulation care.*

Preventive Care Services in IPC* arrangements

- Preventive services make up a large part of IPC income
- The volume of these services often requires stimulation in Medicaid populations
- These preventive activities will, over time, reduce downstream costs, but this may be a reward that's too far away (in time and influence)
- It follows that keeping these services as FFS in IPC arrangements makes sense (i.e., these costs are excluded from a calculation of 'total spend (including downstream costs') for shared savings and quality bonus purposes)
- Mature providers may want the freedom of a fully capitated arrangement; MCOs and IPC providers should be able to select what is best for their specific circumstance.

* IPC – Integrated Primary Care

When Preventive Care is not VBP

Preventive Services that are not linked to an Integrated Primary Care or Total Care for Total Population arrangement are unlikely to be meaningfully coordinated, so should probably not count as VBP.

Preventive Care in the Affordable Care Act

The ACA contains a provision that specifically addresses preventive health coverage for certain services for which cost sharing requirements shall not be imposed. The inclusion of these provision highlights the fact that preventive care is a critical component of a truly comprehensive continuum of care. [1]

1. “Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; For the complete list of services please refer to Table 1 in the embedded document.

2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; For the complete list of services please refer to Table 2 in the embedded document.

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; For the complete list of services please refer to Tables 3.1 through 3.3 in the embedded document.

4. With respect to women, evidence-informed preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration”; For the complete list of services please refer to Table 1 in the embedded document.

[1]45 CFR 147.130

Quality Measures

1. In all arrangements, it will be important to measure the adequate delivery of preventives services
2. Two approaches:
   a) Measuring evidence-based use (many DSRIP and HEDIS measures do exactly this)
   b) In some cases, actual outcomes may be measured.

A list of measures (both already present/current and perhaps some suggested) will be generated for the coming meeting for the SC discussion.

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How will technical assistance be provided to those providers that run into performance challenges in VBP arrangements?

Draft Recommendation

Technical assistance to providers prior to entering VBP arrangements

- Providing technical support for providers *before* they enter into VBP arrangements will be crucial for its successful implementation
  - Data and analytical support will be provided from January ‘16 on to help MCOs and providers assess what their current performance is, where quality improvement and shared savings are possible through focusing on:
    - potentially avoidable complications per VBP arrangement;
    - higher costs than expected (risk-adjusted) per VBP arrangement;
    - variability that may be an indication of potential for improvement; and
    - areas of underinvestment / underuse of e.g. preventive or community-based interventions
  - Assessing preparedness & clear ‘how-to’ information for entering VBP arrangements
- The *Social Determinants of Health and CBOs* Subcommittee will be working through the communication and information-sharing needs associated with a transition to VBP.

Technical assistance to providers in current VBP arrangements

Emerging Consensus From Last Meeting:

- Providers experiencing performance challenges should receive assistance from their MCO, given the potential financial benefit to both parties and the framework that is already in place based on the contractual MCO/provider relationship
- MCOs have a strong incentive to support their contracted providers through all levels of VBP arrangements
- There needs to be an alignment between providers, PPSs and MCOs with respect to technical assistance
- DSRIP money may also be used to pay for various third party services to educate providers on VBP arrangements and provide technical assistance.

Suggested Recommendation:

- No standard or guideline or specific State action required at this moment; MCOs, providers and the State will collectively monitor whether action or additional guidelines may become necessary in the future.

Are there any services that should be excluded from VBP?

Roadmap Language

"In principle, the State does not want to wholly exclude any cost categories from the VBP arrangements. However, it must ensure there are no structural barriers to achieving the statewide VBP goal. Therefore, the VBP Technical Design subcommittee will analyze data on the current level of VBP activity in the Medicaid managed care program—when such data become available—and consider whether it is necessary to exclude certain services or providers for which VBP arrangements are not applicable or appropriate in order to reach the statewide VBP goal."

Excluded could be e.g.:

- financially challenged providers without an adequate restructuring plan
- fragile organizations without adequate infrastructure or financial reserves who aim to take on downside risk
- certain services provided outside of contractual arrangements such as out-of-network emergency services or other services plans are required to pay for out-of-network pursuant to transition of a benefit or population to managed care

What does exclusion mean

- Excluding certain services would mean that their provision would not be counted as VBP and thus would not impact the statewide VBP goal of 80-90% by DSRIP year 5
- Excluding certain providers would preclude the requirement of their participation in VBP arrangements, and thus also reduce the numerator for the VBP penetration goal.

Note: More than likely CMS will be reluctant to exclude anything from VBP. If the SC feels strongly that exclusions are necessary, they will have to be supported by sound policy arguments.

Exclusions considerations

Mentioned in discussions so far:

- **High-cost Drugs:** including high-cost drugs in a VBP arrangement may in many cases shift too much insurance risk to the provider. With the exception of significant Total Care for Total Subpopulation contracts, or contracts where high-cost drugs are explicitly woven into the contract, MCOs and providers may wish to exclude from their VBP arrangements.
- **Financially Challenged Providers:** these providers should be reluctant to take on downside risk, but it could be argued that any restructuring or other type of transformation required for these providers would be helped by the capability to receive shared savings through a Level 1 VBP arrangement
- **'Out of Network':** FFS expenses for providers delivering services for a VBP arrangement that are not part of the provider-group contracting for that VBP arrangement are included in the total costs for that VBP arrangement.

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VBP Innovator Program: how should it be designed?

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."

The Innovator Program Components

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

- Criteria for participation
- Status approval process: DOH and DFS
- Contract termination and cooling off periods
- Program benefits
- Measuring the Innovators' performance
- Status maintenance/program exit criteria
- Appeals process

The goal for the SC is to discuss and start defining the Innovator Program details

Considerations for Participation Criteria

Eligible VBP arrangements	• TCTP L2 & L3 vs. L3 only
Proof of network capabilities for delivery	• Provider network adequacy
Network requirements	• # of patients
Types of eligible providers	• PPS vs. hubs/groups of providers
Financial solvency requirements	• Risk reserve limits (Reg. 164)

Other Components

Status approval process: DOH and DFS

Contract termination and cooling off periods

Program benefits

Measuring the Innovators' performance

Status maintenance/program exit criteria

Appeals process

Innovator Program Considerations

An initial number of challenges and important decision requirements includes the following:

1. Regulatory:
   - Significantly large provider systems with substantial assets are exempt from Reg 164 requirements. If this is not a criteria, consideration will need to be given to Reg 164 implications.
   - If Innovators are exempt as stated above, should there be other reserve requirements or regulatory oversight for these innovators?
2. Delegation of responsibilities:
   - Are there any areas where delegation of responsibilities may become a challenge?
3. Contract timeframe
   - The Innovator program calls for multi-year contracts. Insurance Law does not limit duration of provider contracts.

DFS Regulation 164

- An insurer or MCO has a contractual obligation to provide coverage to its subscribers
- Regulation 164 allows (1) the insurer/MCO to transfer its financial risk (but not its contractual obligations) to a health care provider, and (2) the insurer/MCO to reduce its corresponding claims liabilities
- Regulation 164 only applies to pre-paid, full capitation payments
- The agreement must be approved by DFS
- The insurer/MCO must demonstrate to DFS the “financial responsibility” of the health care provider (next slide).

“Financial Responsibility”

- The health care provider can demonstrate financial responsibility by establishing a financial security deposit (FSD) of at least 12.5% of the estimated annual in-network capitation revenue. The FSD can be:
  - Funds held in trust for the insurer/MCO
  - Letter of credit with the insurer/MCO as beneficiary
  - Funds held by the insurer/MCO
  - Provider stop loss insurance
- FSD can be phased in during first year of the capitation arrangement.

Appendix

List of Preventive services as per the ACA is attached below:

List of Preventive
are Services as per

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