# VBP Innovator Program Components: Options and Considerations

## Executive Summary

The Value-Based Payment (VBP) Innovator Program was designed as part of the VBP Roadmap as a mechanism to allow for innovators and experienced providers to chart the path into Value Based Payments. It is intended for provider groups who are prepared to take on mature Level 2 or 3 Value-Based arrangements in 2016 or (to be determined) in 2017. The Department of Health (DOH) along with the Technical Design subcommittees will identify the program components and DOH will monitor performance and provide oversight of these Innovators on an ongoing basis, applying learnings from the Innovators to support other groups entering VBP arrangements.[1] As is detailed in the New York State Roadmap for Medicaid Payment Reform, the Technical Design Subcommittee (in this case Technical Design II) has been asked to build out the design of the Innovator Program.

The following are key Innovator Program components, which the Subcommittee has been asked to design:

1. Which VBP risk arrangements are eligible for the Innovator Program?
2. What is the review/assessment process for the Innovator Program?
3. What are the criteria for participating in the Innovator Program?
4. Is there an appeals process and what should it include?
5. What are the Innovator Program benefits?
6. How is the Innovators' performance measured?
7. What is the status maintenance and contract termination/program exit criteria?
8. In the case of poor performance, should there be contract cooling off periods?

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.

## Introduction

The Innovator Program is a voluntary program for VBP contractors[2] prepared for participation in Level 2 and 3 value-based arrangements by Year 2 (2016) of the Delivery System Reform Incentive Payment Program (DSRIP). The State aims to promote Total Care for Total Population (TCTP) and Subpopulation value-based arrangements by rewarding the Program's participants with up to 95% of the total dollars which have been traditionally paid from the State to the MCO.

[1] DFS will be involved in Level 3 VBP innovator programs.
[2] A VBP contractor can be an ACO, IPA, or an individual provider.

The Innovator Program is intended to encourage and reward early adoption of VBP arrangements, supporting those groups who have made investments in moving towards population health management.

What the Innovator Program is NOT:

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

## Innovator Program Components: Options and Considerations

### 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.

In addition, the Regulatory Impact Subcommittee is concurrently designing a three-tiered system for contract approval, aligning the level of required review with the amount of risk that VBP contractors assume. The three tiers include: an intense review by both DFS and DOH (Tier 3), a moderate review by only the DOH (Tier 2), and no approval required (Tier 1). Level 2 VBP contractors should meet the Tier 2 risk and review requirements in order to be counted as VBP Innovators.

### Component 2: What is the review/assessment 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). 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.<br><br>This option would be best to scrutinize each provider's scale and capacity on an individual basis. | Depending on the number 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).<br><br>This option can also result in inconsistent Program acceptance outcomes potentially viewed as unfair by other applicants. |
| 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 number 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 who are approved will have a better chance at program acceptance since minimum criteria have been satisfied. | Additional resources will still be expended during the State's 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, the amount of providers able to participate in the Program might be limited. |

*Possible criteria is discussed in Component 3.

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

The criteria for participating in the Innovator Program is contingent upon the review process selected by the Subcommittee in Component 2. Should the Subcommittee wish to design acceptance into the Program using Options 2 and 3 outlined above, a set of participation criteria must be developed. The following is a list of potential participation criteria:

a. Confirmation of provider network adequacy based on the appropriate provisions of the NYS laws and regulations;
b. Number of Medicaid members:
    i. Option 1: Minimum number of members (e.g. DSRIP defines a meaningful presence as a minimum of 5,000 Medicaid members for a PPS); or
    ii. 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)
c. Maturity level and proven success in VBP contracting for TCTP and Subpopulations:

i. Option 1: A standard criteria based on timeline applies, e.g. minimum of X months of successful VBP contracting is required
ii. Option 2: Timeline is considered but each provider is reviewed on an individual basis

**Component 4: Is there an appeals process and what should it include?**

In order to fully design the approval process for the Innovator Program, it must also be decided whether providers should be able to appeal their admission into the Program should they not be accepted.

| # | 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 at the State level. |
| **2** | No appeals process | Resources would not need to be allocated to an appeals process. | Providers who may have been unjustly denied participation in the Program will not be able to prove their eligibility.<br><br>Unjustly denied providers will not receive Program benefits that could potentially be reinvested in the quality of healthcare delivered In NYS. |

If it is determined that an appeals process should be established, then the process itself must be designed by the Subcommittee.

Several considerations for establishing an appeals process are as follows:

a. Will every provider have the opportunity to appeal or will there be an approval process to be considered for an appeal?
b. Who should review the appeal?
c. What is the time period for appeal?
d. What is the time period for appeal review?
e. What will be the appeals process?

The below language highlights a *sample* appeals process:

Provider(s) can appeal their Innovator Status in writing to Program Administration within 30 days of receiving the response to its application. The Provider(s) submitting their appeal documentation must also submit documented proof highlighting how they meet the criteria for which their status was denied. The Program Administration will have 30 days to respond to the appeal.

**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.

The Subcommittee may also consider recommending additional incentives for groups participating in the Innovator program. Those incentives may include data and analytics support from the Department of Health, and the ability to obtain a quality/efficiency bonus.

**Component 6: How is the Innovators' performance measured?**

The performance measures 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. These performance measurements must be defined prior to contract execution. The performance measures that may pertain to Innovators include the following:

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

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

*Status Maintenance*

In order for Innovators to remain a participant 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:

i. Option 1: The participant is placed on a probation period and with a set time line to improve performance; or
ii. 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.

**Component 8: In the case of Program exit, should there be contract cooling off periods, and if so, how should they be designed?**

The following are two options for consideration for cooling off periods:

| # | Options | Pros | Cons |
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|---|---|---|---|
| **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 administer the cooling off period. | A more difficult transition out of the Program. Providers may not be ready for reduction of payments (Program benefits). |

Should the Subcommittee decide that a cooling off period should be applied to the Innovator Program, the cool off period must also be defined. The current NYS Medicaid Managed Care cooling off period agreement states that the terms of the contract will be abided by for two months after the termination date, and this existing agreement should be considered when making decisions regarding the Innovator Program's design.