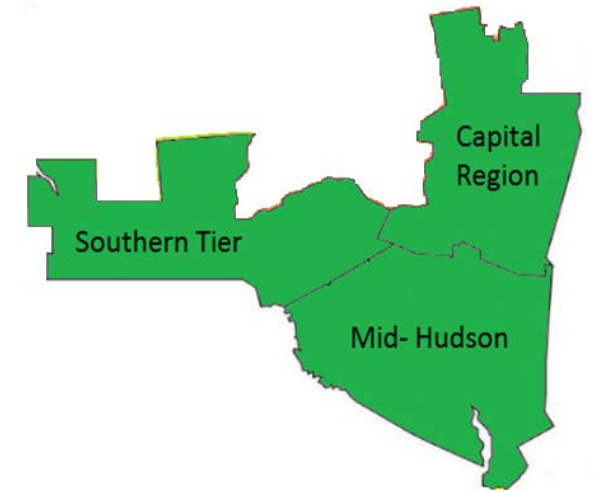




# VBP Bootcamp Series

## Session 1

Region 1: Capital Region, Mid-Hudson, Southern Tier



# Welcome

NYS Medicaid Director Jason Helgeson

# Today's Agenda:

Agenda Items		Time	Duration
Morning Session	Welcome & Bootcamp Overview	9:00	30 mins
	Introduction to Value-Based Payment Reform	9:30	75 mins
	Break	10:45	15 mins
	VBP Arrangements: A Menu of Options	11:00	60 mins
Break	Lunch	12:00	60 mins
Afternoon Session	We Are All in This Together: Financial Incentives	1:00	60 mins
	VBP Standards	2:00	30 mins
	Break	2:30	15 mins
	VBP Readiness Assessment	2:45	45 mins
	Closing	3:30	15 mins

**You can do it!**

VALUE BASED PAYMENTS

1:04 / 2:00

Health NYSDOH

Subscribe 806

3,711 views

+ Add to Share More

6 0

Link: <https://www.youtube.com/watch?v=9D4M-QsaNfM>

# VBP Bootcamp Series Overview

# What are VBP Bootcamps?

- This learning series will provide **foundational** knowledge about Value-Based Payment (VBP) structure and prepare you for VBP implementation
- Bootcamps will be held in 5 regions across NYS between June and October of 2016
  - Each Bootcamp will consist of 3 all-day sessions held approximately one month apart in a centralized location
  - You are highly encouraged to attend all 3 sessions
  - If unable to attend a session in your region, you may register for sessions in other regions. Also, webcast recordings are going to be available in the VBP Library
  - With the exception of the Regional data overview in Session 1, the content of sessions are applicable statewide
- There will be a networking event at every session, so please bring appropriate staff to extract the most value out of these sessions. These will include: business and clinical leadership, contracting staff, finance staff, IT staff, etc.

# VBP Bootcamp Regions

Region 1: Capital Region, Southern Tier, Mid-Hudson

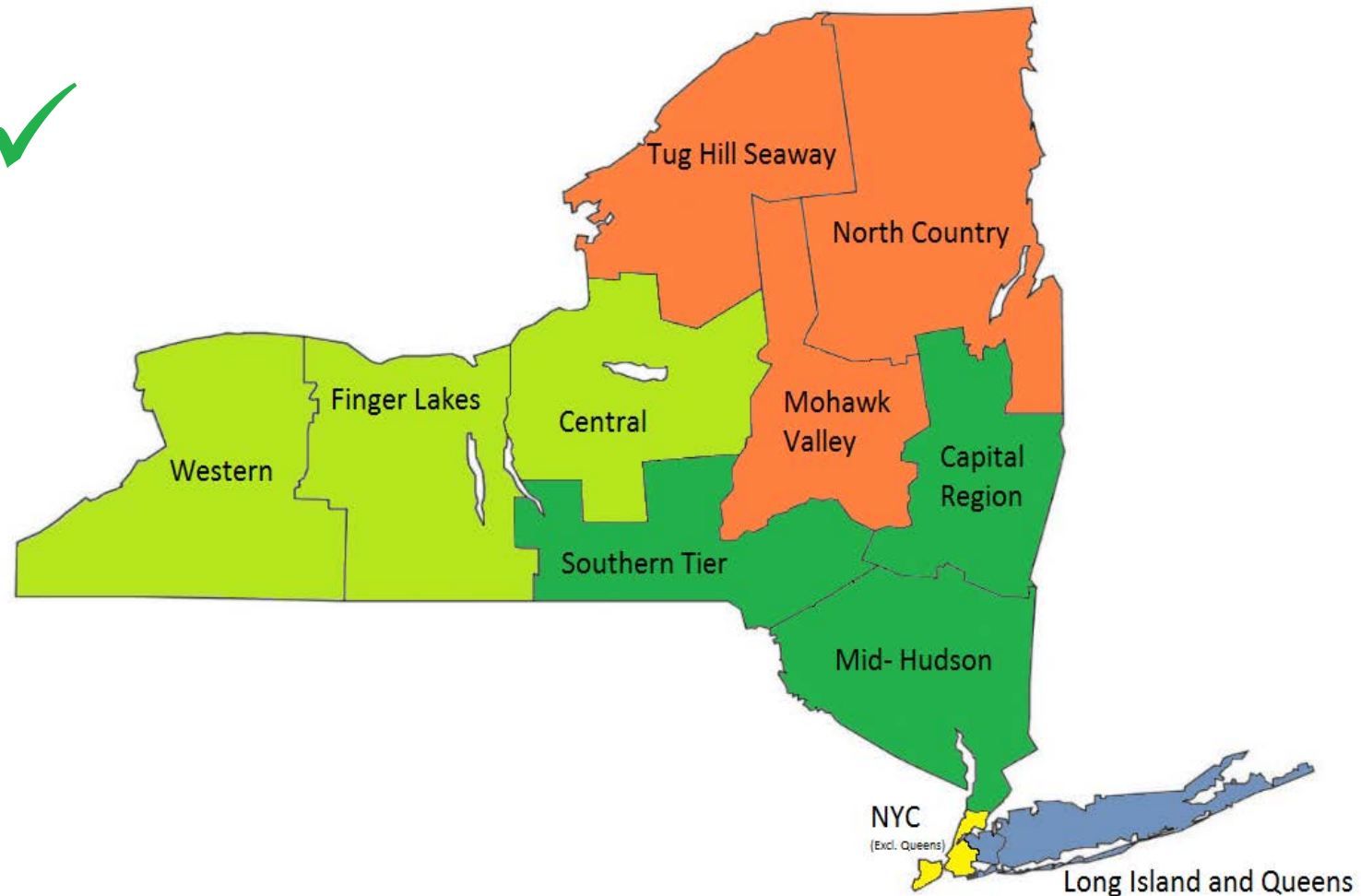


Region 2: Mohawk Valley, North Country, Tug Hill Seaway

Region 3: New York City (excluding Queens)

Region 4: Central NY, Finger Lakes, Western NY

Region 5: Long Island and Queens



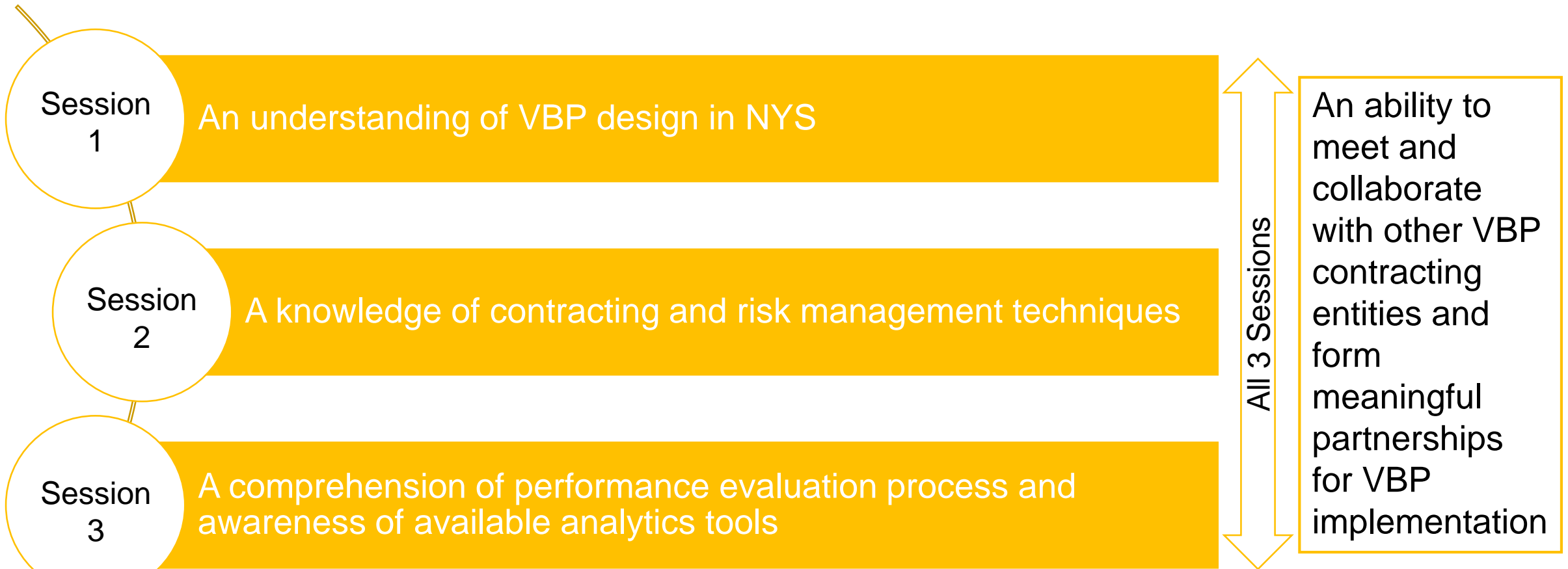


# VBP Bootcamp Curriculum & Schedule

Session	Topics covered	Date & Time	Locations
Session 1	Introduction to VBP <ul style="list-style-type: none"> <li>- VBP Design Overview</li> <li>- High Level Readiness Assessment Considerations</li> </ul>	Thursday, June 2, 2016 9AM - 4.30 PM	University at Albany: Performing Arts Center, Recital Hall
Session 2	Contracting & Risk Management <ul style="list-style-type: none"> <li>- VBP Contracting: How-To</li> <li>- Contract Risk Management Techniques</li> </ul>	Wednesday, June 15, 2016 9.30AM – 4 PM	
Session 3	Performance Measurement <ul style="list-style-type: none"> <li>- Impact of Performance on Target Budget</li> <li>- Information Management Guidance</li> </ul>	Thursday, July 7, 2016 10AM - 3PM	

# Bootcamps Goal: Improve Knowledge for Program Success

At the end of the Bootcamp series, you will have:



# Explore the VBP Bootcamp Website

The Website will provide access to the following:

- Bootcamp Schedules
- Bootcamp Registration
- Session Materials
- VBP Resource Library

DSRIP Program

Home

CMS Official Documents

FAQs

Medicaid Analytics Performance Portal (MAPP)

Performance Data

Performing Provider Systems (PPS)

Value Based Payment Reform (VBP)

Vital Access Provider Assurance Program

Webinars & Presentations

Archives

Contact

- Question? Check-out the DSRIP FAQ
- Email dsrip@health.ny.gov
- DSRIP LinkedIn Group

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Search Medicaid Redesign:

MIRT Home

Medicaid Redesign Team (MRT) Home Page

**DSRIP - VBP Bootcamps**

**About VBP Bootcamps**

**Description:** The Value Based Payment (VBP) Regional Bootcamp learning series will be provided by the Department of Health to the plan and provider communities within the State to deliver necessary information about VBP and ensure a successful transition to its implementation. The series will be completed over the course of three all-day sessions in every region, approximately one per month. The State has been divided into five regions where each session will occur (please see map below).

**Target Audience:** These sessions will be directed towards all parties that will be implementing Medicaid payment reform. However, the content addressed will be most relevant to those who have little to no experience in executing value-based contracts.

**Objectives:** These Bootcamp sessions will aim to give an in-depth look at Value Based Contracting in New York State Medicaid. They will provide an overview of VBP arrangements, focusing on what it means to be a VBP contractor and how to make a VBP contract successful. The sessions will highlight the data and analytical capabilities that the State will make available, how Medicaid providers can move responsibly into accepting downside risk, what health plans are expected to do, and what the financial incentives in the VBP world will look like for both payers and providers. The Bootcamp sessions will also aim to facilitate networking between plans and providers.

**Bootcamps Regions**

To find information about your Bootcamp region, select your location from the map below.

Region 4

Region 2

Region 1

Long Island and Queens

Tug Hill Seaway

North Country

Capital Region

Mohawk Valley

Southern Tier

Mid-Hudson

Finger Lakes

Central

Western

**Path:** DSRIP Homepage → Value Based Payment Reform → VBP Bootcamps

**Link:** [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/vbp\\_bootcamp/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_bootcamp/index.htm)

**Network, network, network!**

# Networking Activity: Scavenger Hunt

Rules: Throughout the day, make an effort to find a person:

Who works/worked in Behavioral Health

Who was born in the month of June

Who works/worked for a health plan/MCO

Who works/worked for a CBO

Whose first name begins with R

Whose last name begins with G

Who works/worked in the OB/GYN field

Who has been out of the country in the past two months

Who works/worked in Internal Medicine

Who is wearing striped socks

First 3 individuals to have found people matching all **10 descriptions** should come forward with your list of names to be recognized!

Please continue networking throughout the day.

## Session Logistics

- Remember to network
- For Q&A: please tweet your questions to **@NYSMedicaidVBP**
  - There will be multiple breaks for Q&A throughout the day

# Introduction to Value Based Payment Reform

# Background

## NYS Medicaid in 2010: The Crisis

- > 10% growth rate had become unsustainable, while quality outcomes were lagging
  - Costs per recipient were double the national average
  - NY ranked 50<sup>th</sup> in country for avoidable hospital use
  - 21<sup>st</sup> for overall Health System Quality

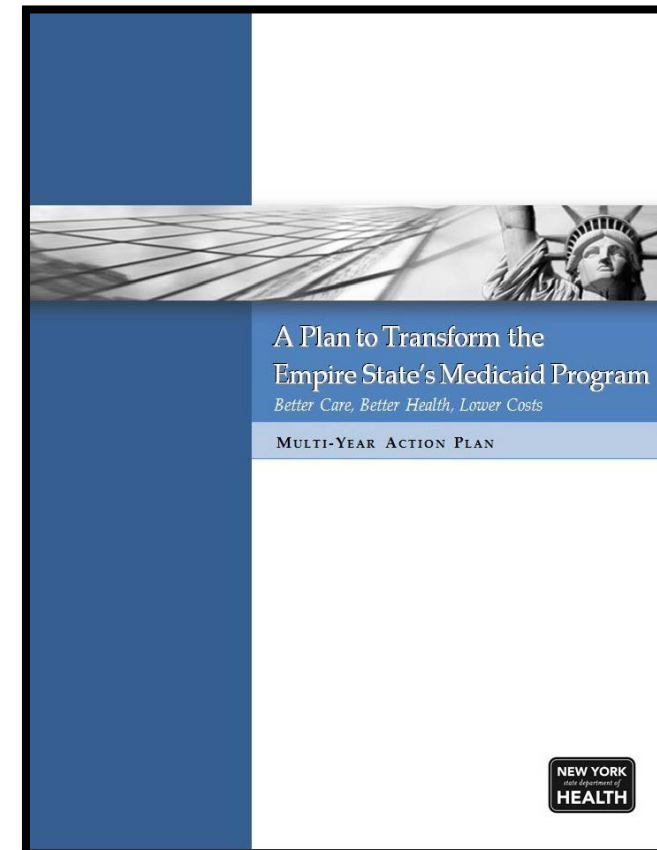
### 2009 Commonwealth State Scorecard on Health System Performance

<u>CARE MEASURE</u>	<u>NATIONAL RANKING</u>
<b>Avoidable Hospital Use and Cost</b>	<b><u>50<sup>th</sup></u></b>
✓ Percent home health patients with a hospital admission	49th 34th
✓ Percent nursing home residents with a hospital admission	35th
✓ Hospital admissions for pediatric asthma	40th
✓ Medicare ambulatory sensitive condition admissions	50th
✓ Medicare hospital length of stay	



# Creation of Medicaid Redesign Team – A Major Step Forward

- In 2011, Governor Cuomo created the *Medicaid Redesign Team (MRT)*.
  - Made up of 27 stakeholders representing every sector of healthcare delivery system
  - Developed a series of recommendations to lower immediate spending and propose reforms
  - Closely tied to implementation of ACA in NYS
  - The MRT developed a multi-year action plan. We are still implementing that plan today



# The 2014 MRT Waiver Amendment furthers New York State's Reform Goals

- Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York's health care delivery system
- In April 2014, New York State and CMS finalized the Waiver Amendment
  - Allows the State to reinvest \$8 billion of \$17.1 billion in Federal savings generated by MRT reforms
  - \$7.3 billion is designated for **Delivery System Reform Incentive Payment Program (DSRIP)**
- The waiver will:
  - Transform the State's health care system
  - Bend the Medicaid cost curve
  - Assure access to quality care for all Medicaid members
  - Create a financial sustainable safety net infrastructure

# Delivery Reform and Payment Reform: Two Sides of the Same Coin

- A thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well
- Many of NYS system's problems (fragmentation, high re-admission rates) are rooted in how the State pays for services
  - Fee-for-Service (FFS) pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
  - Current payment systems do not adequately incentivize prevention, coordination, or integration

Financial and regulatory incentives drive...

a delivery system which realizes...

cost efficiency and quality outcomes: **value**

## The Old World: Fee for Service; Each in its Own Silo

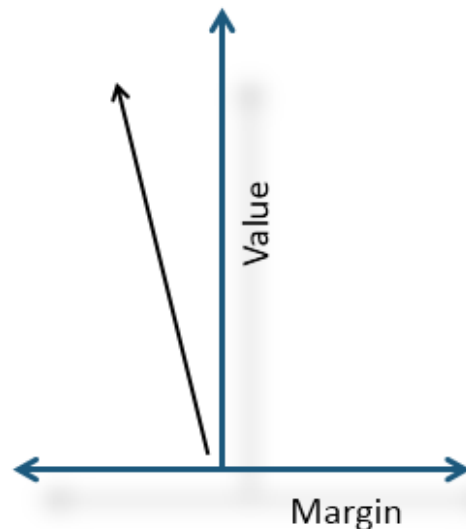


- There is no incentive for coordination or integration *across* the continuum of care
- Much Value is destroyed along the way:
  - Quality of patient care & patient experience
  - Avoidable costs due to lack of coordination, rework, including avoidable hospital use
  - Avoidable complications, *also* leading to avoidable hospital use

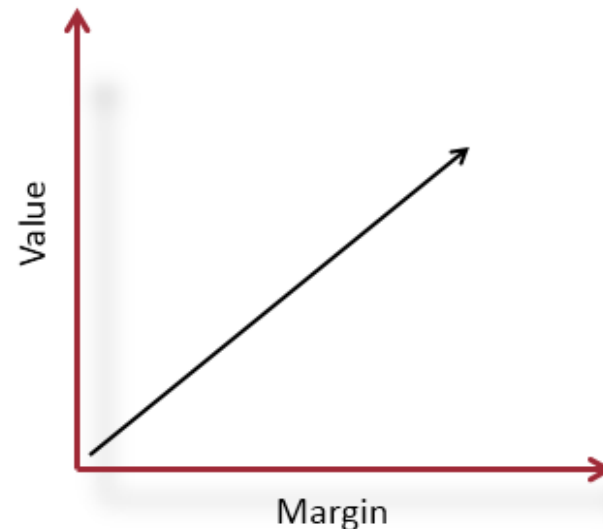
# Moving to a New World

VBP arrangements are not intended primarily to save money for the State, but to *allow providers to increase their margins by realizing value*

**Current State**  
*Increasing the value of care delivered  
more often than not threatens  
providers' margins*



**Future State**  
*When VBP is done well, providers'  
margins go up when the value of  
care delivered increases*



**Goal – Pay for Value not Volume**

# Payment Reform: Moving Toward VBP

- A Five-Year Roadmap outlining NYS' plan for Medicaid Payment Reform was required by the MRT Waiver
- By DSRIP Year 5 (2019), all Managed Care Organizations must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the *Special Terms and Conditions* of the waiver)
- The State and CMS are committed to the Roadmap
- Core stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap
- If Roadmap goals are *not* met, overall DSRIP dollars from CMS to NYS will be significantly reduced

# How DSRIP and VBP Work Together

## Old world:

- FFS
- Individual provider was anchor for financing and quality measurement
- Volume over Value

## DSRIP:

Restructuring effort to prepare for future success in changing environment

## New world:

- VBP arrangements
- Integrated care services for patients are anchor for financing and quality measurement
- Value over Volume

2013

2014

2015

2016

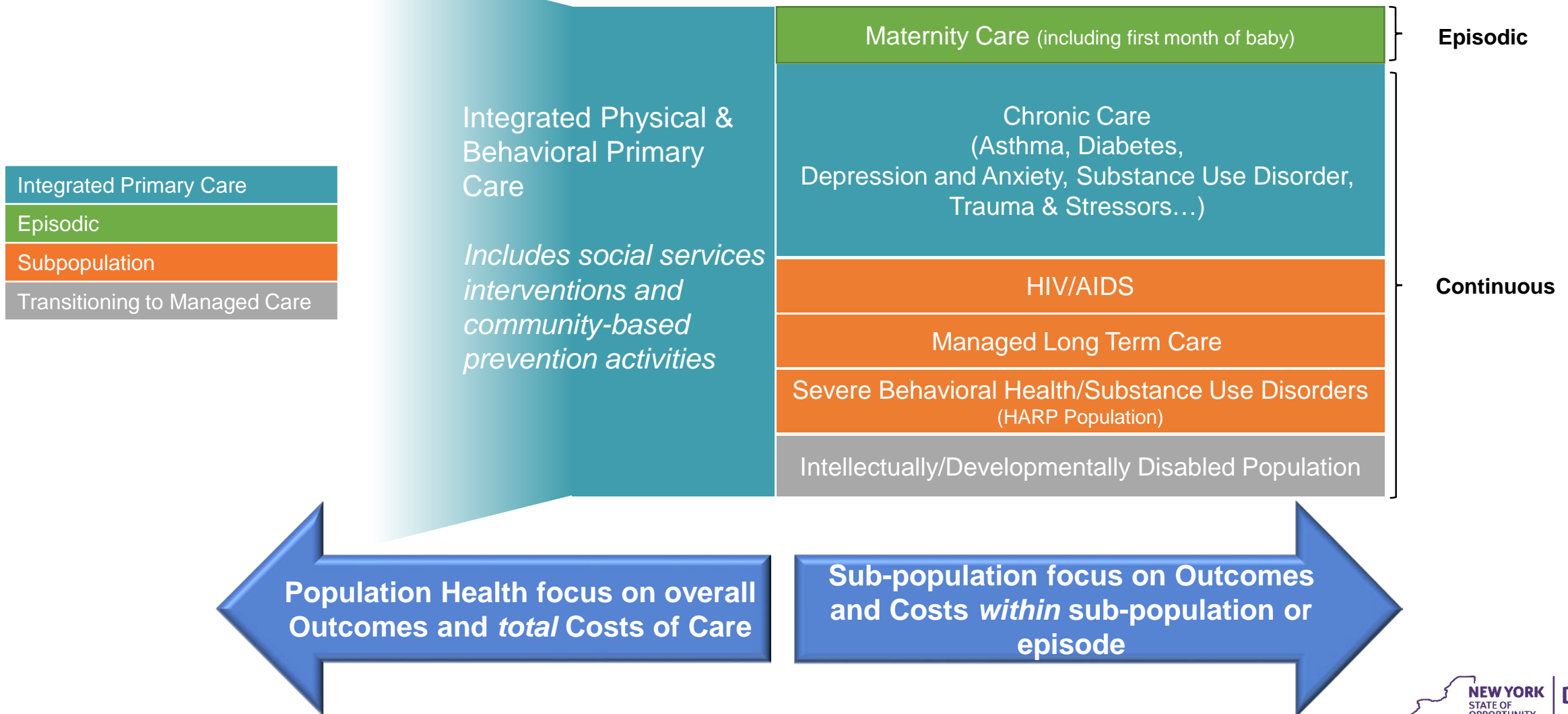
2017

2018

2019

2020

# How an Integrated Delivery System should Function





# MCOs and Contractors can Choose Different Levels of Value Based Payments

In addition to choosing which integrated services to focus on, the MCOs and contractors can choose different levels of Value Based Payments:

Level 0 VBP*	Level 1 VBP	Level 2 VBP	Level 3 VBP (feasible after experience with Level 2; requires mature contractors)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/IPC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)
FFS Payments	FFS Payments	FFS Payments	Prospective total budget payments
No Risk Sharing	↑ Upside Risk Only	↑↓ Upside & Downside Risk	↑↓ Upside & Downside Risk

\*Level 0 is not considered to be a sufficient move away from traditional fee-for-service incentives to be counted as value based payment in the terms of the NYS VBP Roadmap.

# Myths and Truths about Payment Reform

## Myths

1. Everyone must eventually contract at Level 3
2. You can only reimburse innovative services if you are in a Level 3 contract
3. You are supposed to do more with less
4. VBP is about reducing the Medicaid Global Cap spend
5. Only PPSs can contract VBP arrangements
6. VBP is about reducing services offered to Medicaid members and limiting networks
7. All VBP policies within the Roadmap must be followed exactly as they are written

## Truths

1. MCOs (and providers) will be penalized if the Roadmap goals are not achieved
2. The State will be providing analytical support to the VBP stakeholders
3. VBP provides flexibility in contracting - it is not a 'one size fits all'
4. The goal of VBP is to improve the quality of care and shift spending to keep members as healthy as possible and integrated in their community
5. VBP implementation is an iterative process - the State will keep learning as the process moves forward (pilots will play an important role in this learning)
6. VBP is focused on transparency around costs and outcomes

# VBP Contractor Definition



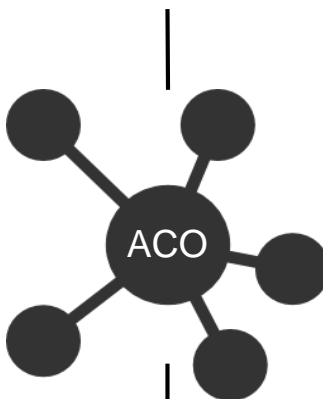
A **VBP contractor** is the entity that contracts the VBP arrangement with the MCO. This can be:

- Accountable Care Organization (ACO)
- Independent Physician Association (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 VBP arrangement through individual contracts with these providers

**Note:** A PPS is not a legal entity and therefore cannot be a VBP contractor. However, a PPS can form one of the entities above to be considered a VBP contractor.

# Example of Contracting Options in VBP

Health Plan contracts with an ACO or IPA

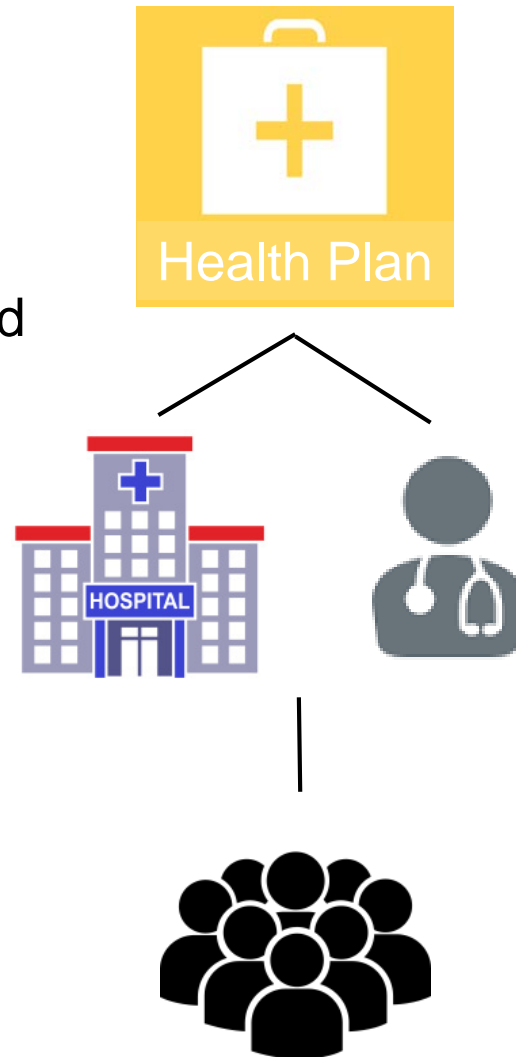


ACO / IPA is responsible for the total cost of care and outcomes for the specific population

*Note: 'ACO' refers to a NYS Medicaid ACO as defined under PHL § 2999-p*

# Example of Contracting Options in VBP

Health Plan contracts  
*separately* with a hospital and  
a clinic



While the contracts are *separate*,  
the providers' performance is seen  
as a whole for total cost of care  
and outcomes for a specific  
population

*In practice, this is ordinarily only feasible for a Level 1 VBP Arrangement and is often a temporary step during IPA / ACO formation.*

# Questions

**Break – 15 mins**

# VBP Arrangements: A Menu of Options



# The Menu of Options in Practice

**There is not a single path towards Value Based Payments. Rather, there are a variety of options that MCOs and providers can jointly choose from.**

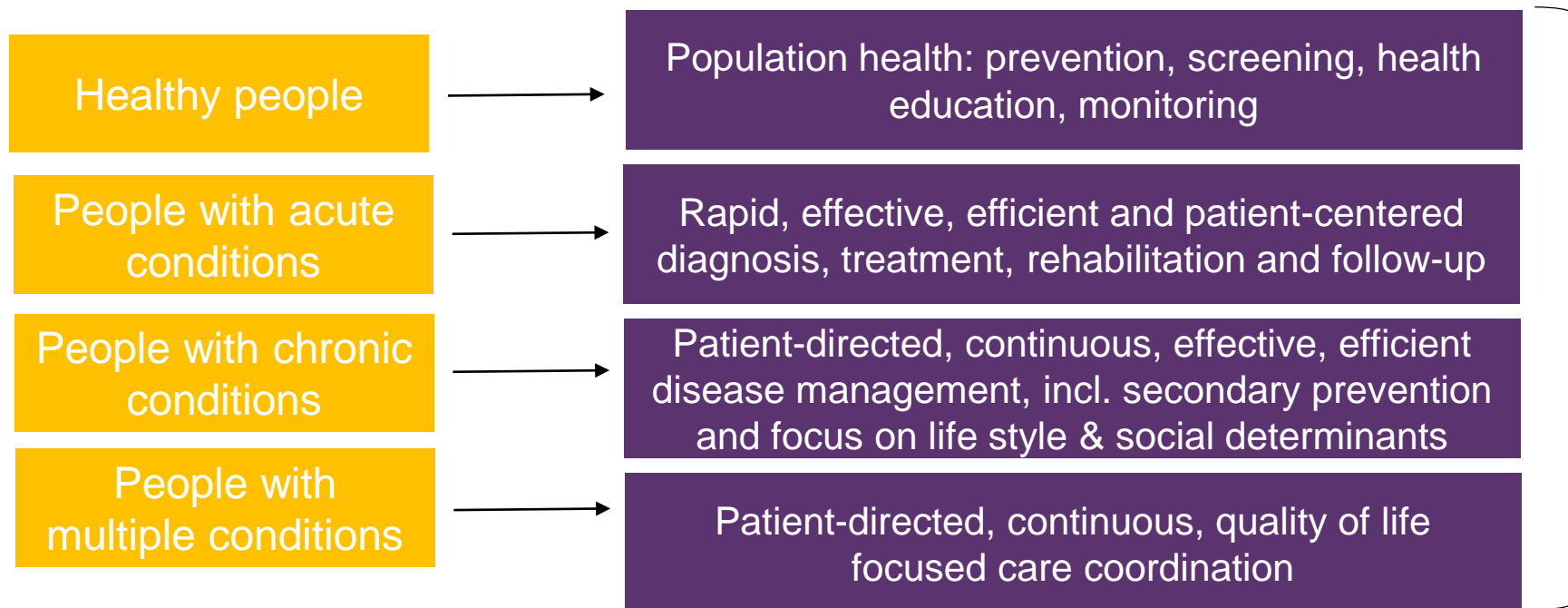
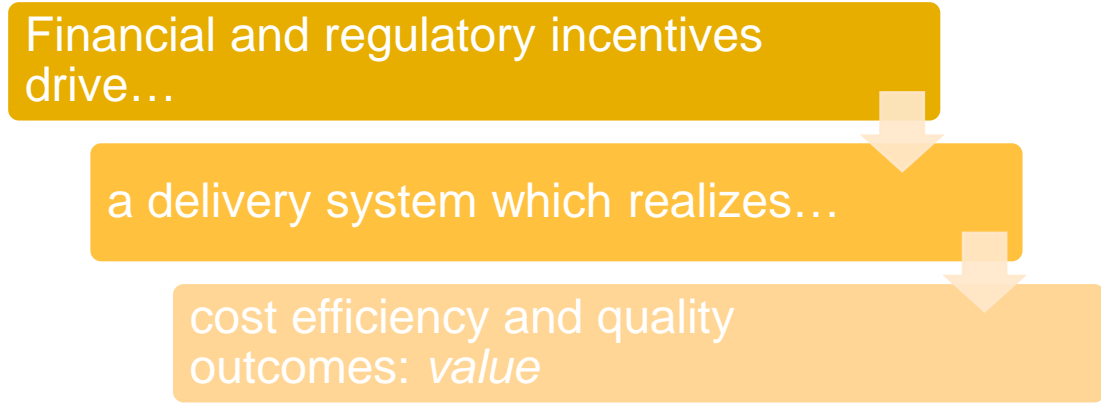
- Total Care for General Population (TCGP)
- Total Care for Special Needs Population
- Per integrated service for specific condition: Maternity Care bundle
- For Integrated Primary Care (IPC): includes Chronic Care bundle

*These VBP arrangements are limited to Medicaid-only members.  
Duals will be integrated in the VBP arrangements from 2017 on.*



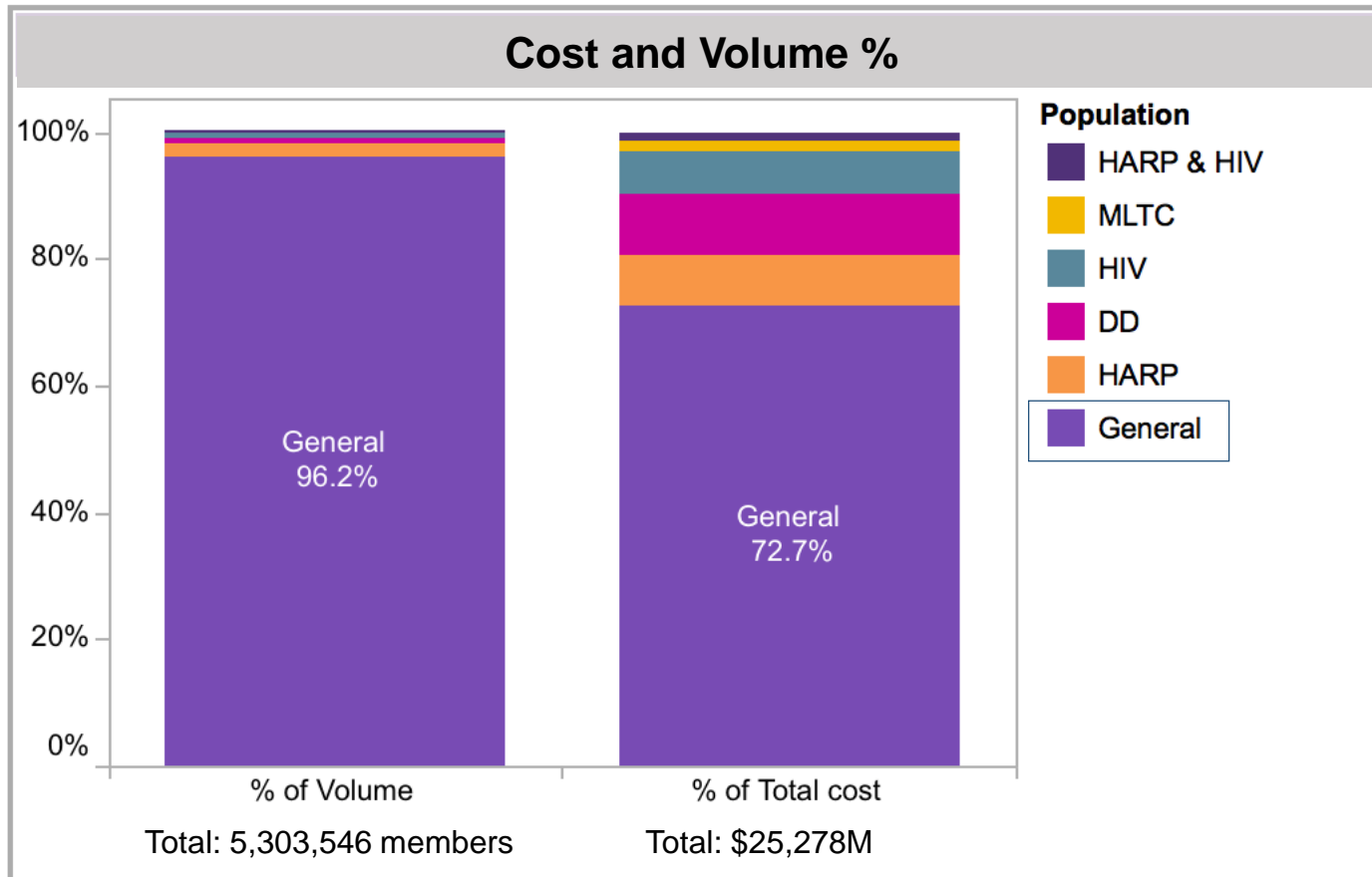
# Vision Behind This Approach

- Flexibility for Providers and MCOs
- Local circumstances differ:
  - Provider readiness
  - Demographics & geography
- Health care is very heterogeneous



- Different types of *outcomes* that are relevant
- Different role for the *beneficiary/patient*
- Different *models of care*
- Different *organizational forms*
- Different *payment models*

# Total Care for General Population (TCGP) Definition



Total Population  
Subpopulations\*

Total Care for General Population

In this arrangement the VBP Contractor assumes responsibility for the care of the entire attributed population. Members attributed to this arrangement cannot be covered by a different arrangement.

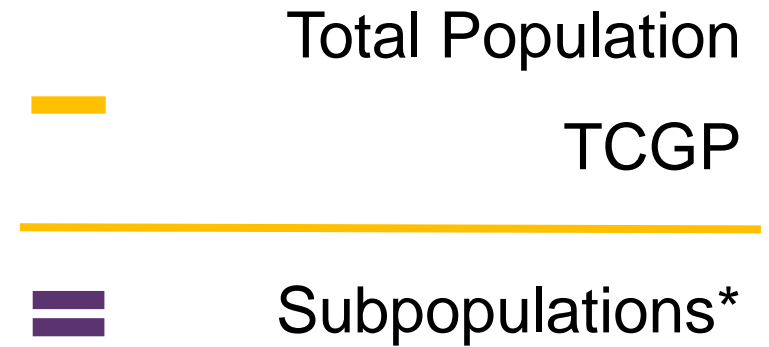
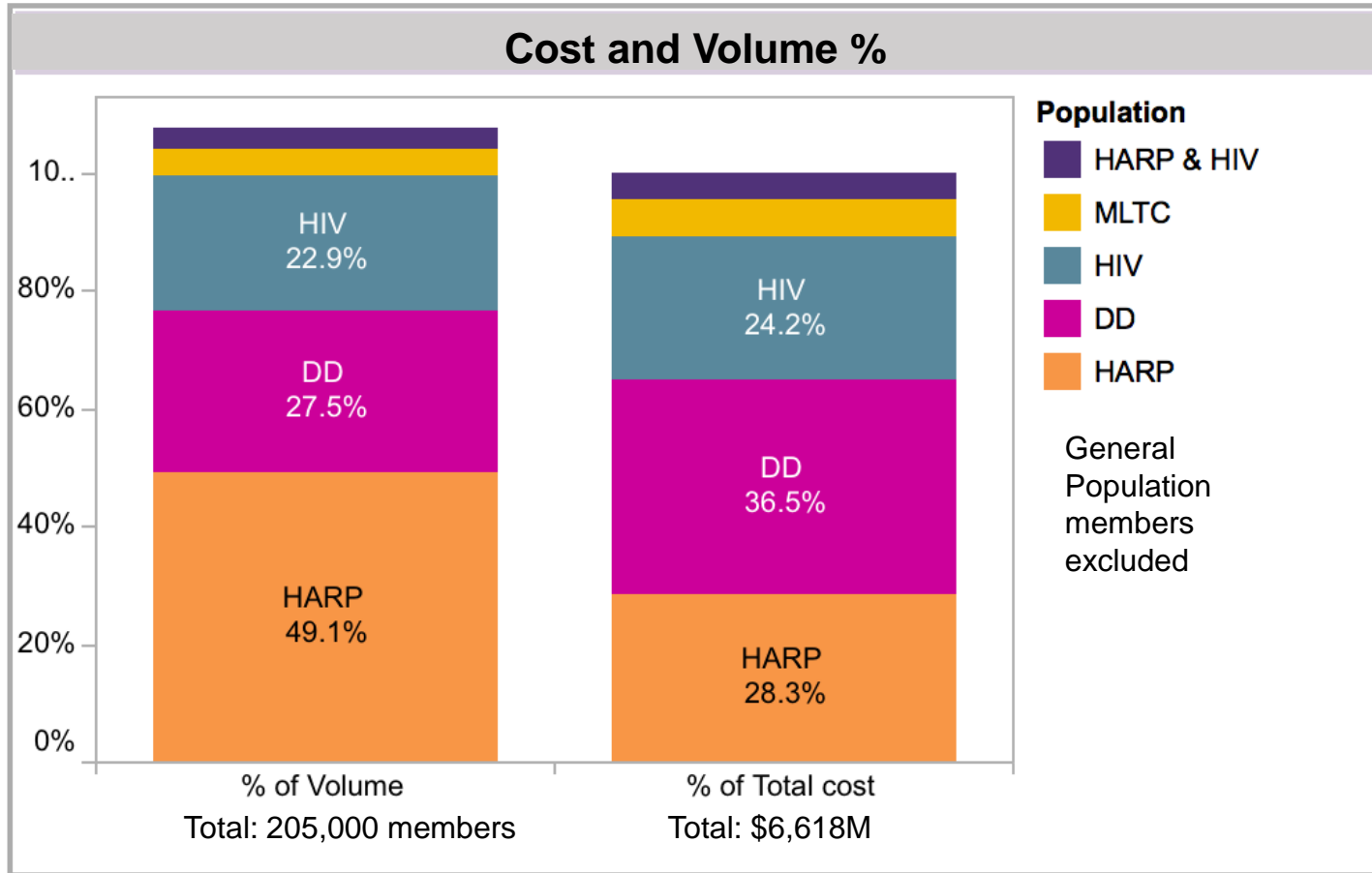
**Disclaimer:** Preliminary Data, work in progress; 2014, real-priced data

\*Note: VBP Contractors and MCOs are free to add one or more subpopulations to their TCGP contracts.

## Why TCGP Can Be Attractive

- Maximum impact for health systems focusing on both population health and streamlining specialty and inpatient care across the different types of care
  - Reduce inefficiencies and potentially avoidable complications throughout the entire spectrum of care
- The larger the budget, the more opportunity for shared savings
- Larger budgets and control across the spectrum of care implies more opportunities to (re-)invest and restructure the delivery system and invest in Community Based Organizations & the social determinants of health

# Total Care for Special Needs Population Definition



In this arrangement the VBP Contractor assumes responsibility for the care of the specific population, where co-morbidity or disability may require specific and costly care needs, so that the majority (or all) of the care is determined by the specific characteristic of these members.

\*Note: VBP Contractors and MCOs are free to add one or more subpopulations to their TCGP contracts.

# Why Total Care for Subpopulations Can Be Attractive

- Dedicated focus on these subpopulations can get lost in larger Total Care for Total Population models (such as Medicare ACOs)
- Dedicated incentive to reduce the significant inefficiencies and potentially avoidable complications within these subpopulations creates maximum positive impact for these subpopulations
- The significant budgets of these subpopulations and the significant potential for shared savings become available for these groups of dedicated providers
- Rather than relying on separate and often small grants to improve housing and other social determinants of health, a large budget is now available to (re-)invest and restructure the delivery system and invest in Community Based Organizations & the social determinants of health
  - For these subpopulations (HARP, HIV/AIDS, MLTC, DD), these social determinants are especially important

## Scope of Care within TCGP and Subpopulation Arrangements

1. TCGP and Subpopulation agreements include comprehensive care for their respective populations, so members that are already in these arrangements cannot simultaneously receive care as part of the IPC or Maternity bundles
2. Vice versa, members included in IPC or Maternity arrangements are excluded from TCGP or Subpopulation agreements

*A contract can include both the general population and one or more sub-populations for a contract approaching the total population.*

*Similarly, VBP contractors can combine non-overlapping elements of different agreements, often at different Levels: e.g., IPC and the 'remainder' of TCGP.*

*This is relevant when the VBP contractor wants to go at risk for IPC but not for TCGP.*

# Questions



# Bundles of Care

A bundled payment is a single payment to providers for all services related to a single condition.



# Bundles of Care: Maternity Care Example

Maternity-related obstetrician fees



Delivery facility fee



Inpatient stay post-delivery



Maternity-related medication



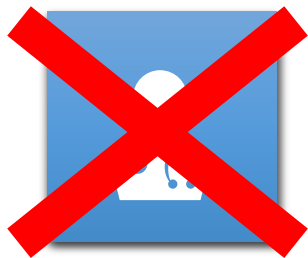
Echo



ER visit for abdominal pain during pregnancy



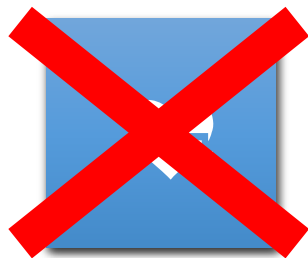
Sum of group services  
*(based on encounter data)*



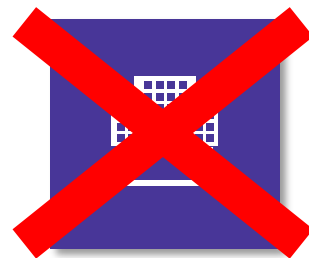
Routine wellness visit



Antibiotics for throat infection



COPD care



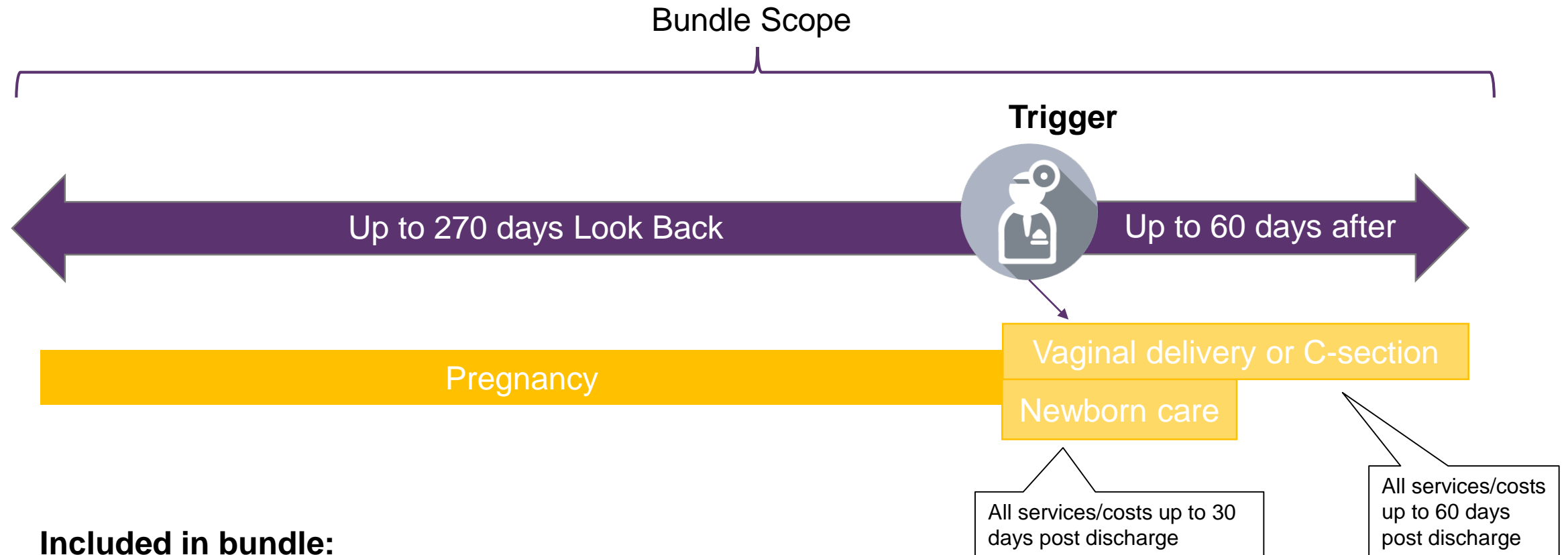
Readmission after appendectomy



Diabetes care

- Included when pregnancy related
- Not included when diabetes pre-dates pregnancy

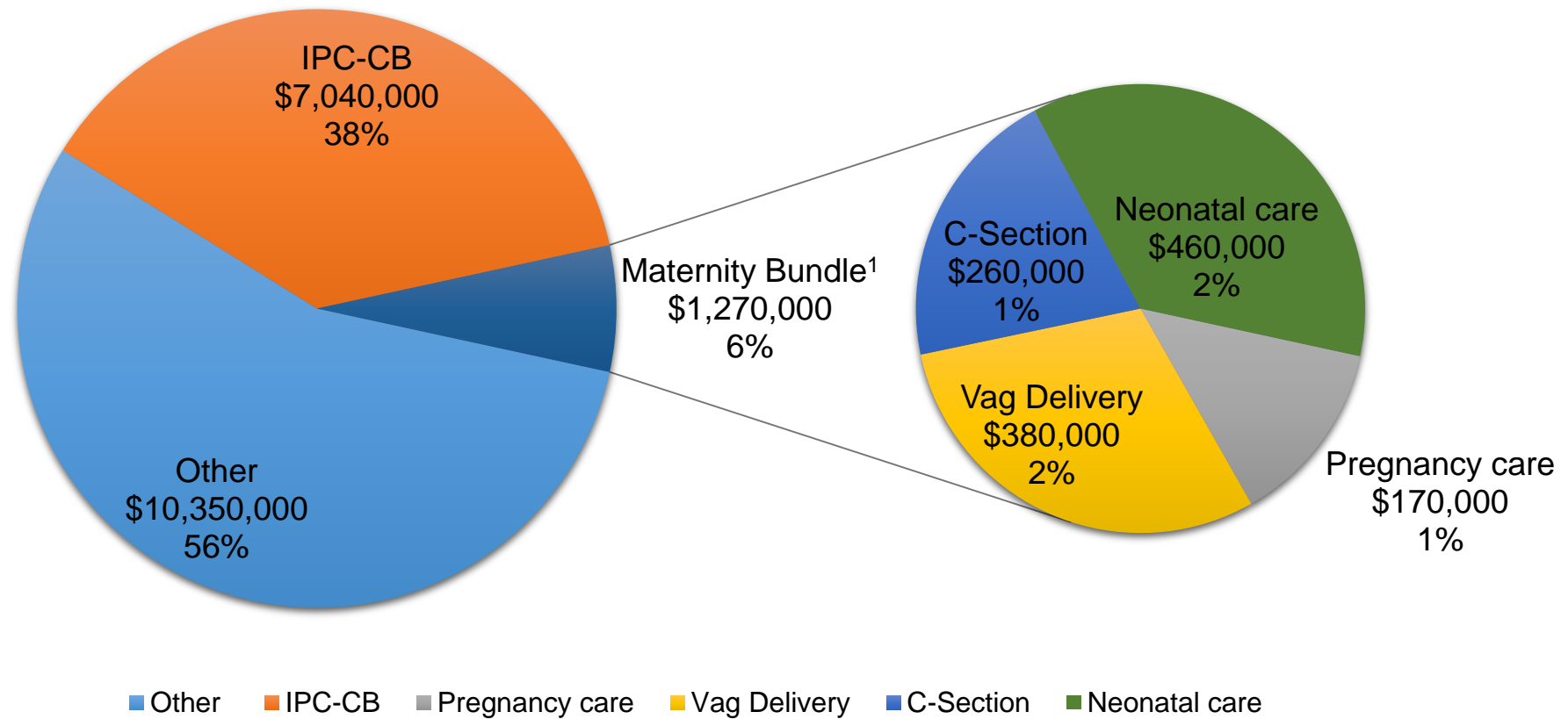
# Maternity Bundle



## Included in bundle:

- Both low risk and high risk pregnancies with severity markers
- **For the mother:** all related services for delivery including post discharge period (60 days post discharge) and entire prenatal care period (270 days prior to delivery)
- **For the infant:** initial delivery stay and all services/costs up to 30 days post discharge

# Overview Costs of Care in General Population (Medicaid Only)



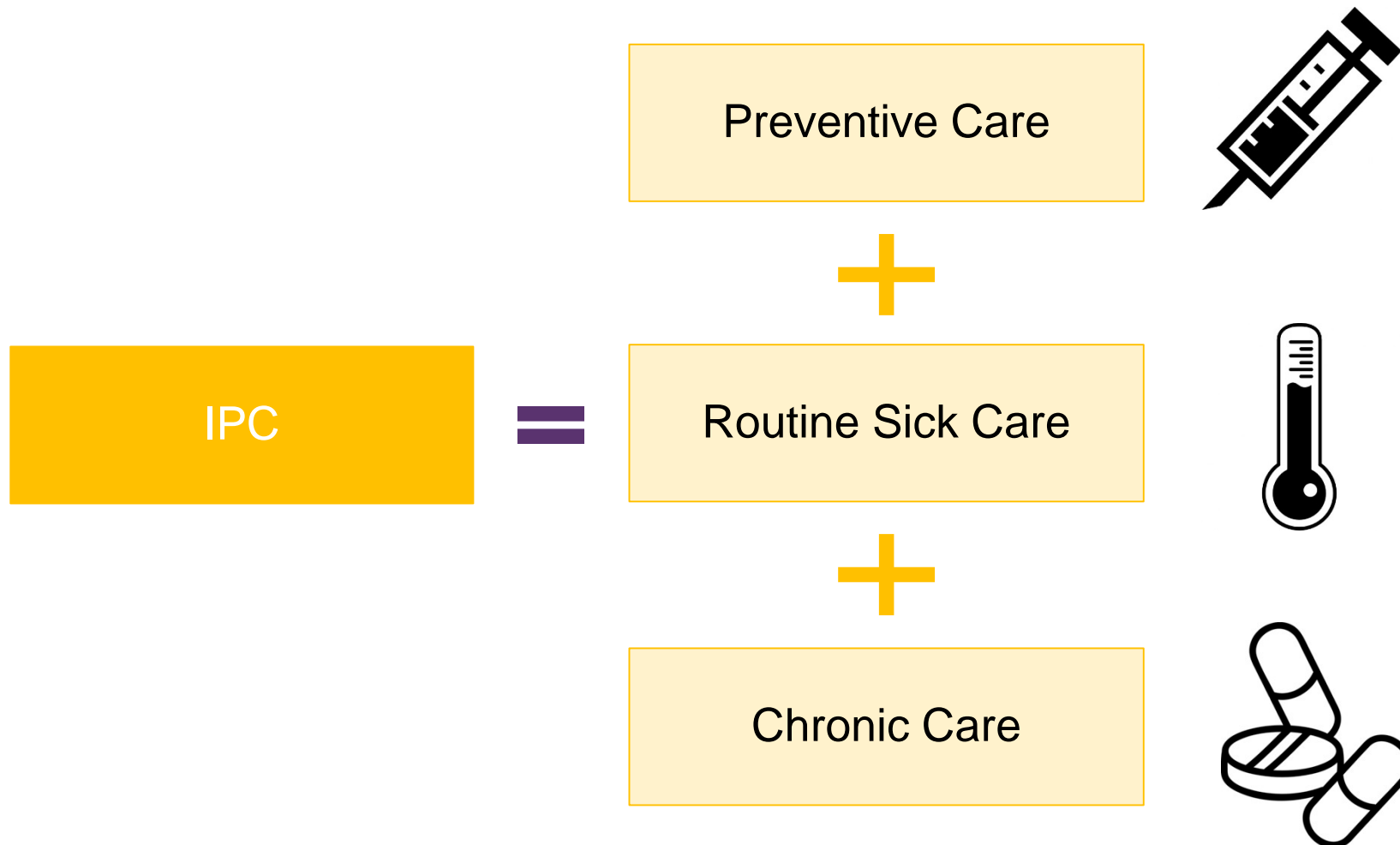
**Disclaimer:** Preliminary Data, work in progress; 2014, real-priced data

## Why the Maternity Bundle Can Be Attractive

- Dedicated focus on specific conditions can get lost in larger Total Care for Total Population models
- Dedicated incentive to streamline the total spectrum of maternity care creates significant focus on reducing unnecessary C-sections, emphasizing the 'right care at the right place' and improving dedicated health education, low-birth weight and teenage pregnancy prevention.
- Such a focused approach creates maximum positive impact for these subpopulations
- The budgets of this bundle and the potential for shared savings become available for these groups of dedicated providers

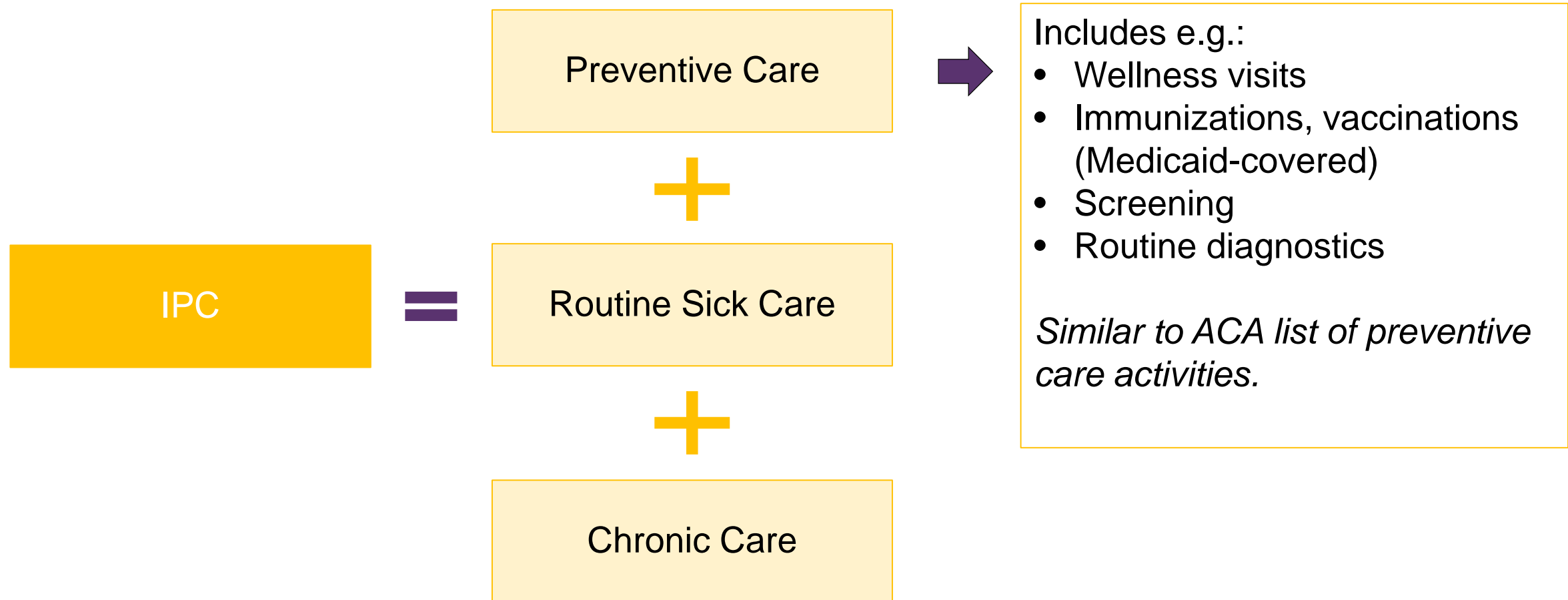
# Questions

# Integrated Primary Care



*Note: Patients that are attributed to subpopulations are excluded.*

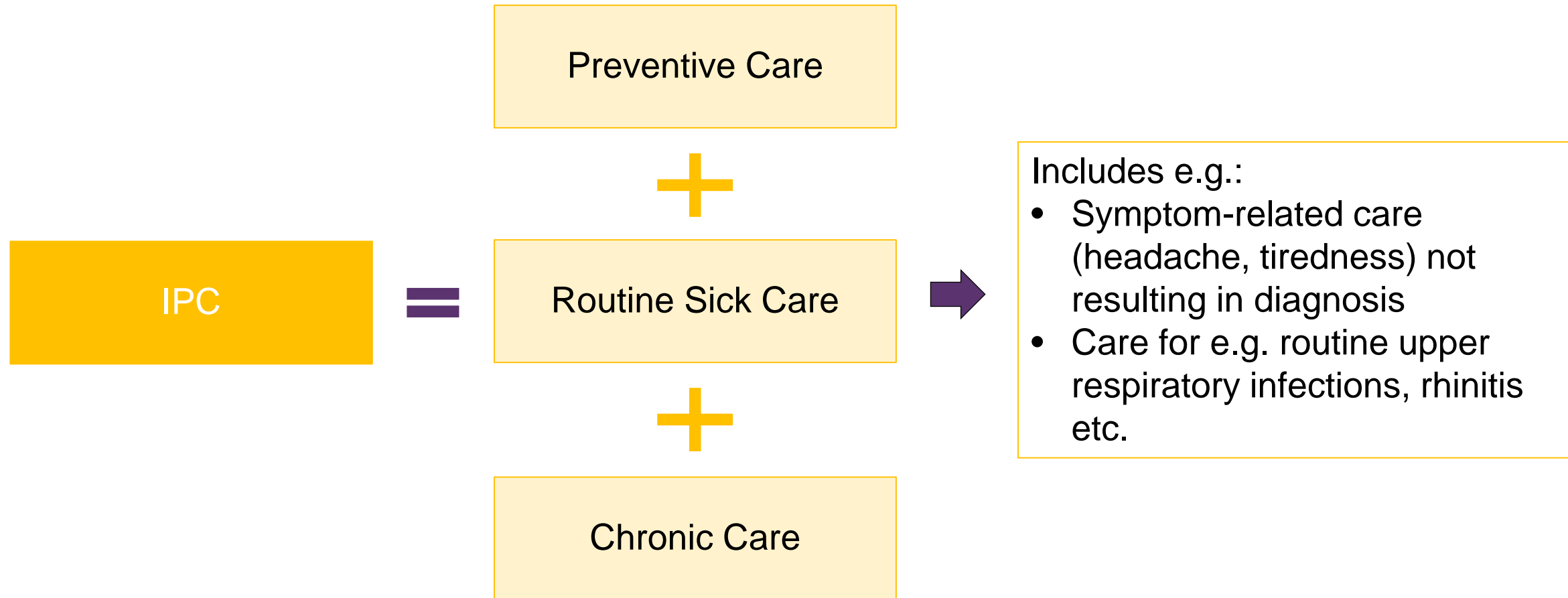
# Integrated Primary Care



*Note: Patients that are attributed to subpopulations are excluded.*

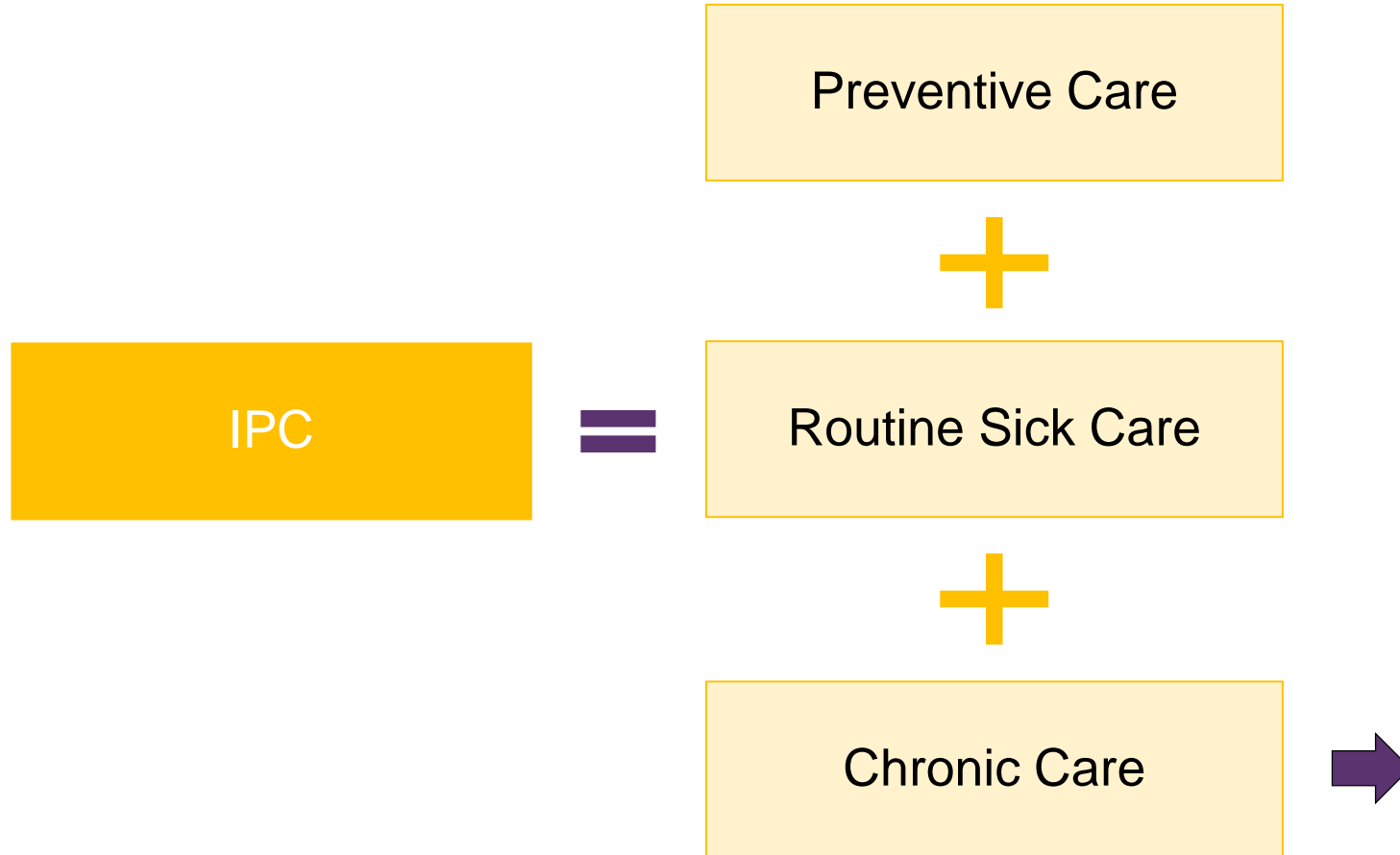


# Integrated Primary Care



*Note: Patients that are attributed to subpopulations are excluded.*

# Integrated Primary Care



Two criteria determined the current list of chronic conditions:

1. Lead provider is, should and/or can be part of Integrated Primary Care (coordination with specialty care when needed is key)
2. Highest volume and costs within Medicaid program

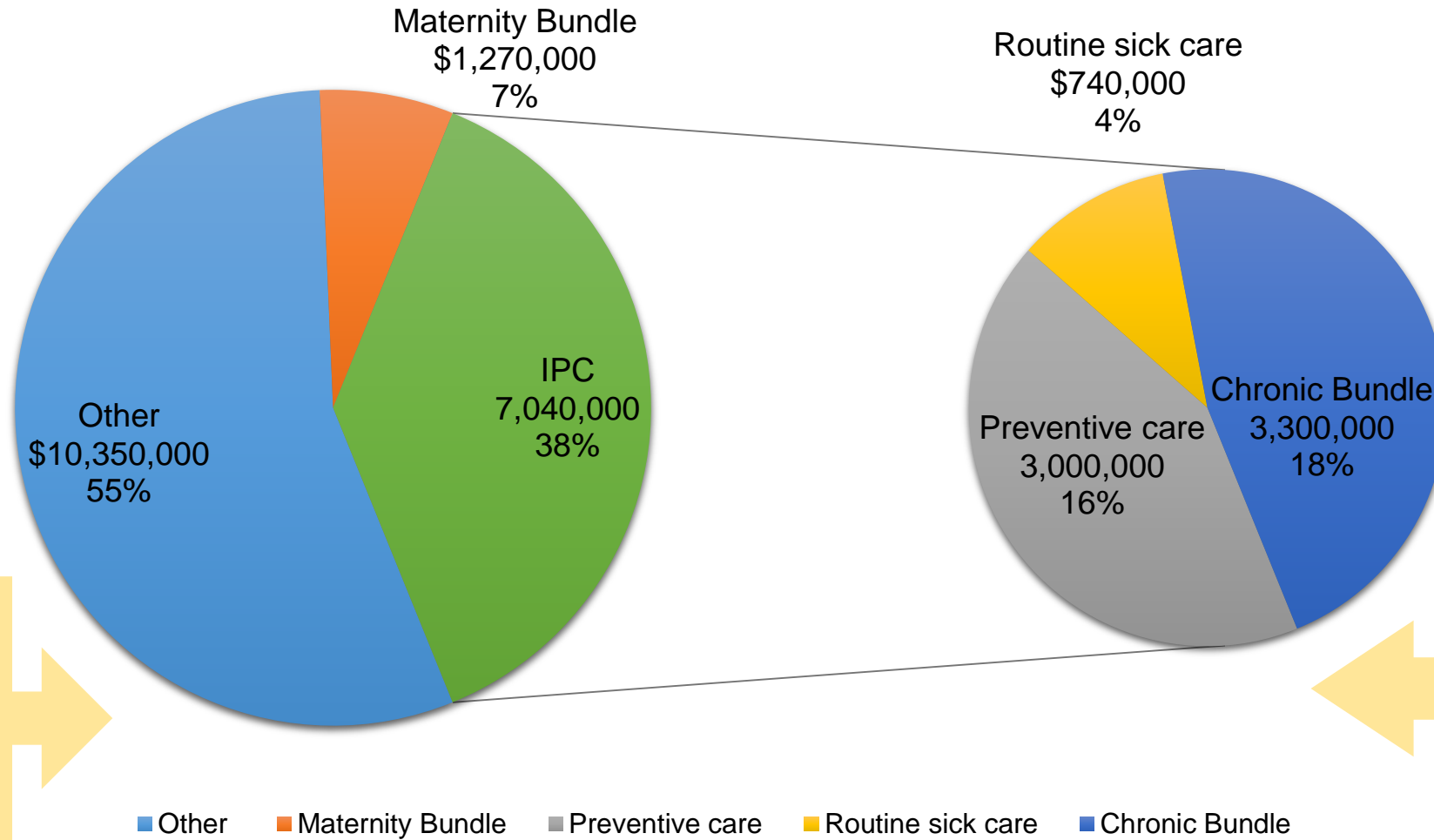
Includes 14 chronic conditions:  
 Asthma, Bipolar, Diabetes, Depression and Anxiety, COPD, CHF, CAD, Arrhythmia, Heart Block/Conduction Disorders, Hypertension, Substance Use Disorder, Lower Back Pain, Trauma and Stressors, Osteoarthritis, Gastro-Esophageal Reflux

*Note: Patients that are attributed to subpopulations are excluded.*

# Why the Integrated Primary Care Bundle Can Be Attractive

- Maximum impact for primary care groups of health systems focused on the spectrum of integrated primary care: population health, routine sick care and chronic care
  - Reduce inefficiencies and potentially avoidable complications throughout the entire spectrum of care for routine sick care and chronic care
  - No risk for types of care where specialty and inpatient care is leading (cancer, trauma, surgical care)
- From the perspective of integrated primary care practices, the opportunity for quality improvement and shared savings is very significant
- More than other VBP models, IPC puts community based professionals in the lead

# Why the Integrated Primary Care Bundle Can Be Attractive



Rather than being 'at risk' for total downstream costs...

... VBP contractor is at risk for that component that s/he most controls, and where the potential savings are high.

**Disclaimer:** Preliminary Data, work in progress; 2014, real-priced data

# Off-menu Arrangements

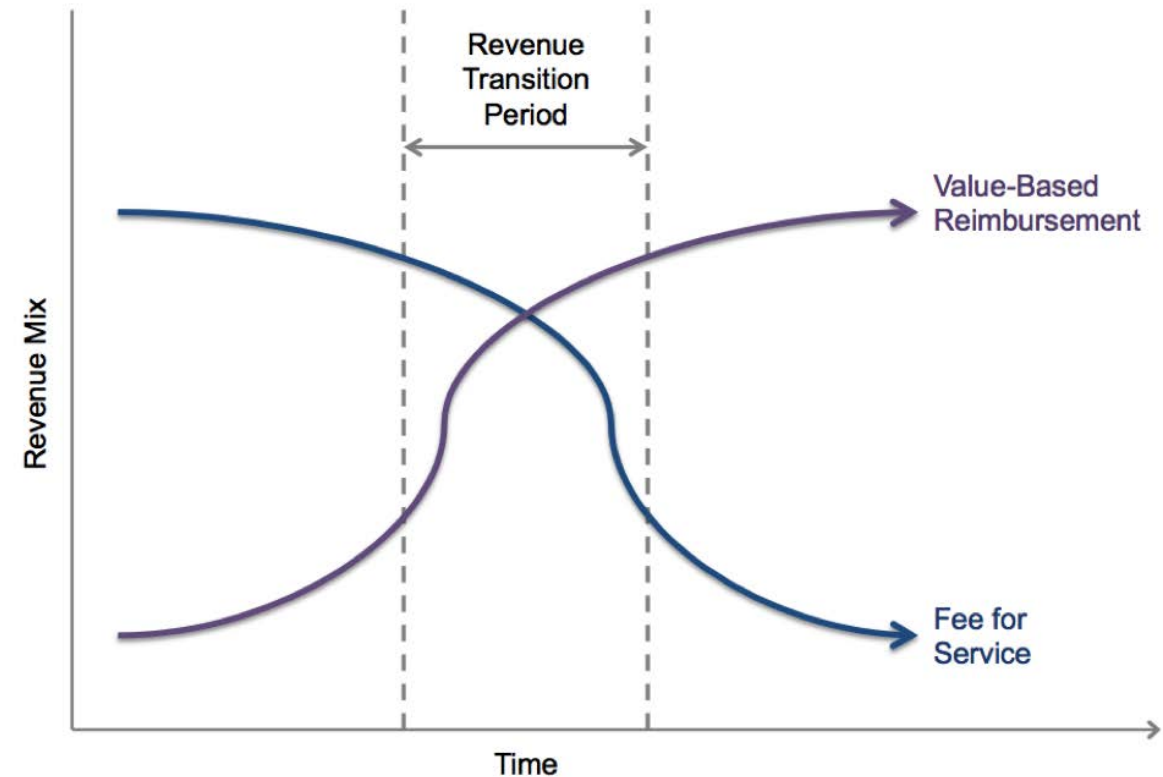
MCOs and providers may agree to contract off-menu arrangements\*. The following criteria need to be fulfilled:

1. Reflect the underlying goals of payment reform as outlined in the Roadmap and sustain the transparency of costs versus outcomes
2. Focus on conditions and subpopulations that address community needs but that are not otherwise addressed by VBP arrangement in the Roadmap
3. Patient rather than provider centric
4. Through sharing savings and/or losses, off-menu VBP arrangements include a focus on both components of 'value': outcomes and cost of the care delivered
5. 'Off-Menu' VBP arrangements should utilize standard definitions and quality measures from the Roadmap where possible

*\*For detailed information please refer to Appendix II of the Roadmap.*

# Financial Incentives for VBP Contractors and Other Providers: Shared Savings and More

- Potential for shared savings: incentives for a reduction in net spending for a defined patient population/bundle, and reinvestment of those savings back into the provider system
- Performance adjustments for those VBP contractors that are high value performers before the contract year starts
- Stimulus adjustments for those VBP contractors moving to Level 2 or higher
- *All these incentives have their opposites: shared losses, downward performance adjustments, penalties for providers that could but are not moving to VBP*



# Questions

**Lunch Break – 60 mins**

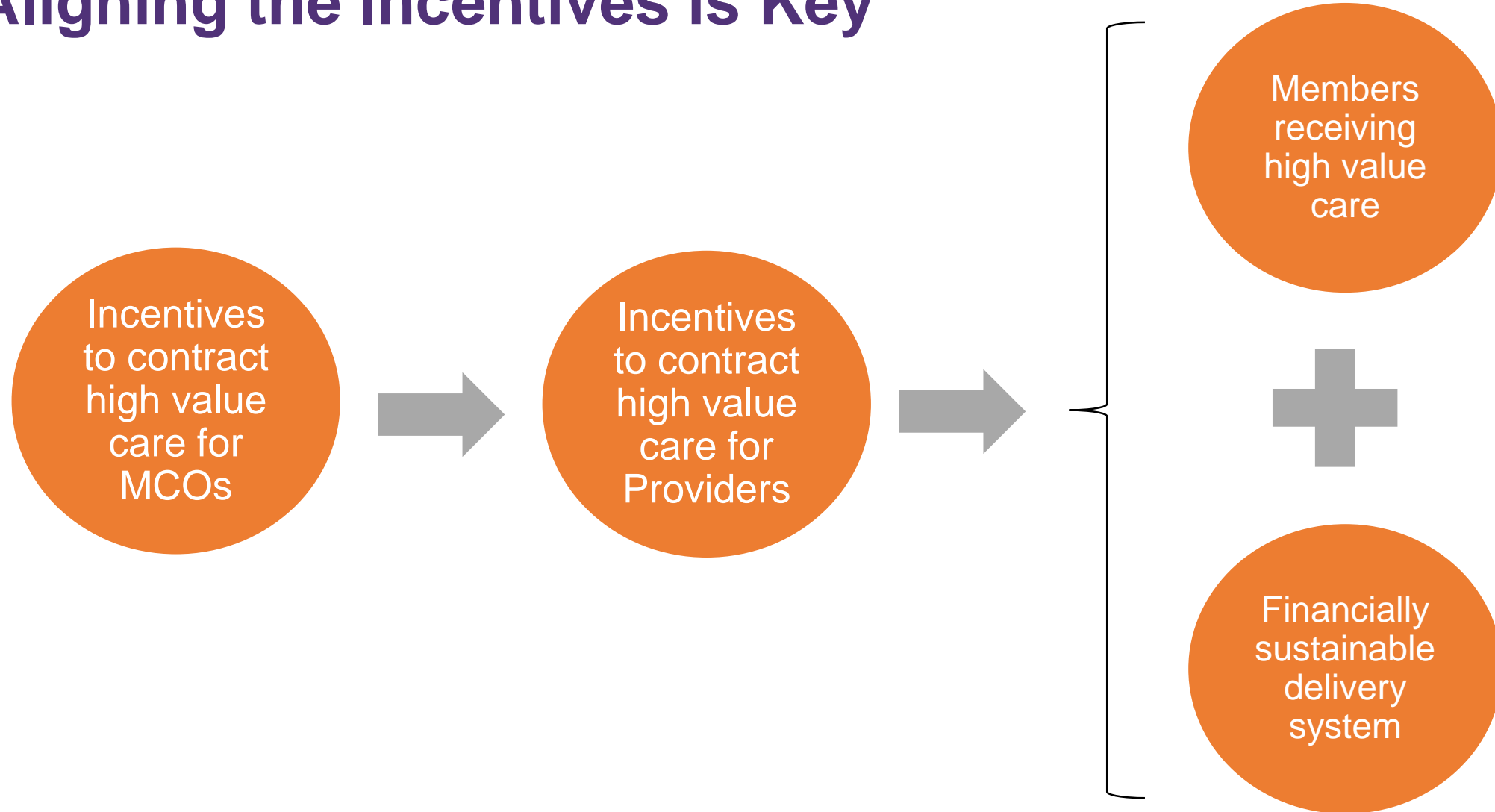


# **We Are All in This Together**

*The role of the MCO & what that means for providers*



# Aligning the Incentives is Key



# Alignment Will Be Implemented From 2017 Onwards

The **State** will adjust MCO premiums based on value delivered to their total membership per VBP arrangement type (whether actually contracted or not) and on meeting yearly targets to move to 80-90% VBP.

**MCOs** will subsequently drive providers to improve this value of care. VBP arrangements and insight in the potential performance of providers will be actionable entry point for MCOs

**Providers:** Deliver better quality and efficient care for Medicaid beneficiaries, allowing for further re-investment into the delivery system

Feedback-loop facilitates control of the overall Medicaid spend

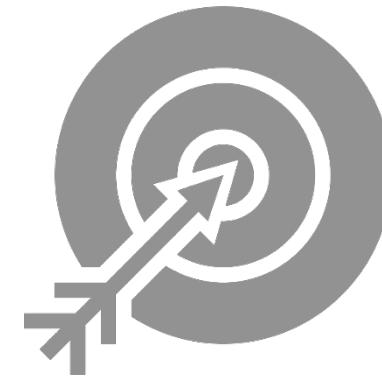
## How MCOs Can Improve the Value of Care

- Contract and reward high value care, and incentivize improvement
- Help bolster lower value providers where possible
- Move beneficiaries to higher value providers where possible and increase their volume
- Discontinue contracts with low value providers where no improvement is deemed feasible
- Adapt to new contracting mechanisms through compensating them for start up costs

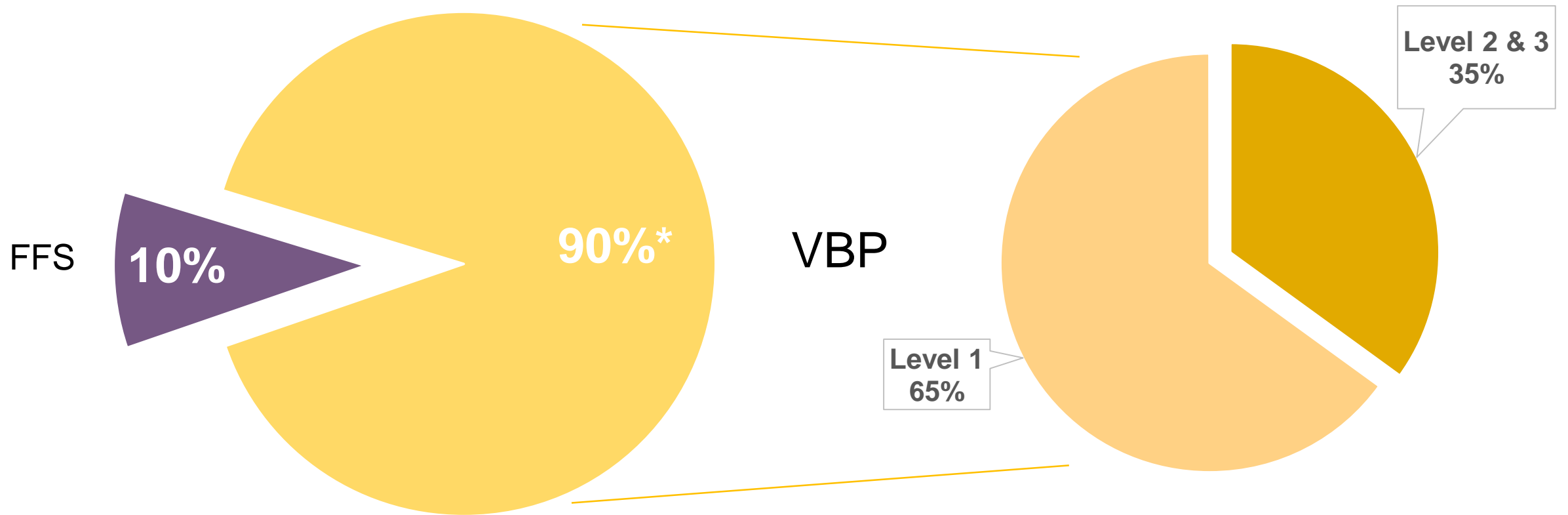
*From 2018 on, MCOs can pass on potential downwards adjustments to providers.*

# Questions

# NYS Medicaid Goals and Progress



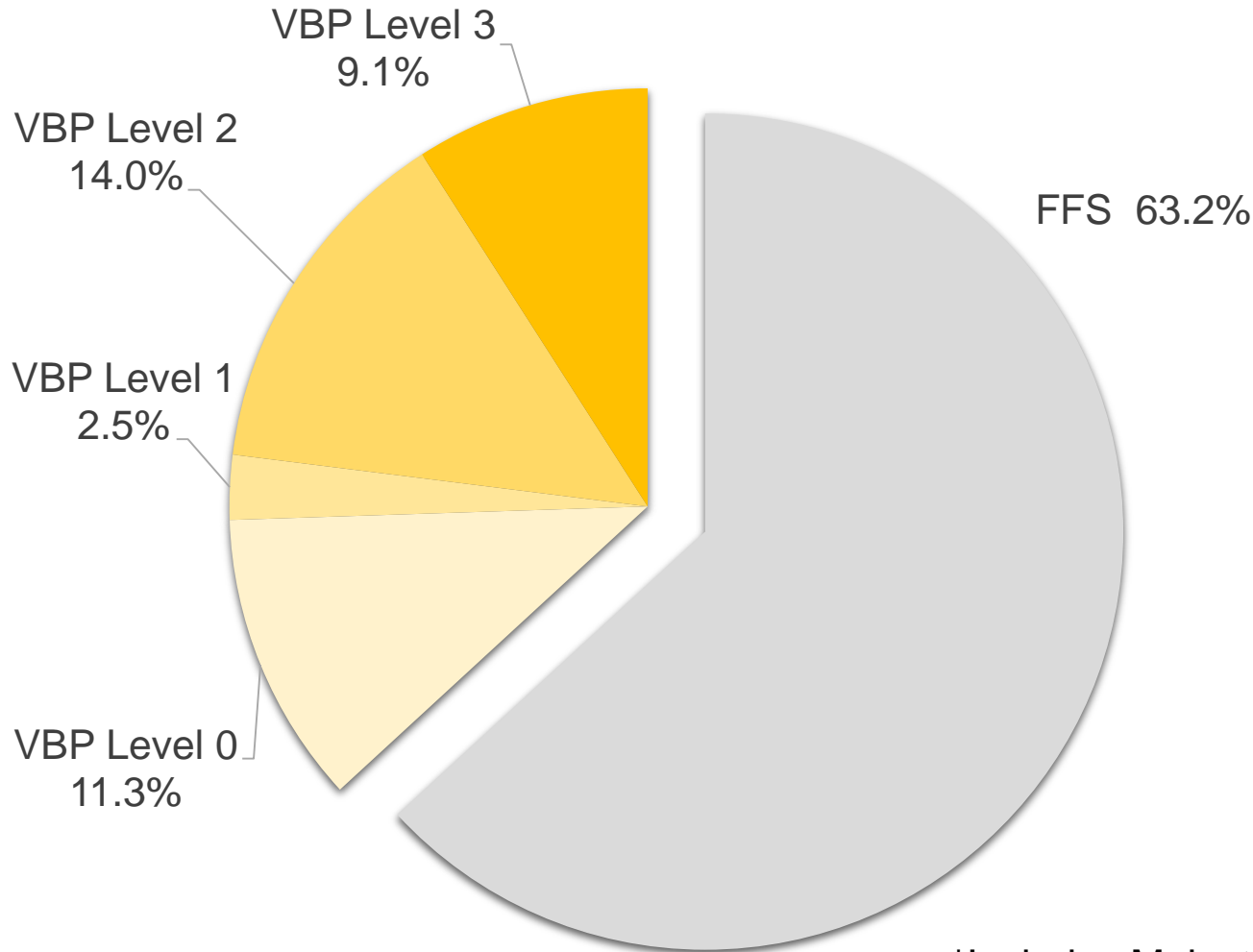
# By April 2020, 80-90%\* of Medicaid Managed Care Spend (Plan to Provider Payments) Will Be in VBP Level 1 and Higher



\*Minimum of 80%; includes MLTC and (depending on move to Managed Care) I/DD

# Today: >25% of Medicaid Spend is in VBP Level 1 or Higher

Per Survey, VBP Baseline of Levels 1 - 3 for CY 2014: **25.5%\***

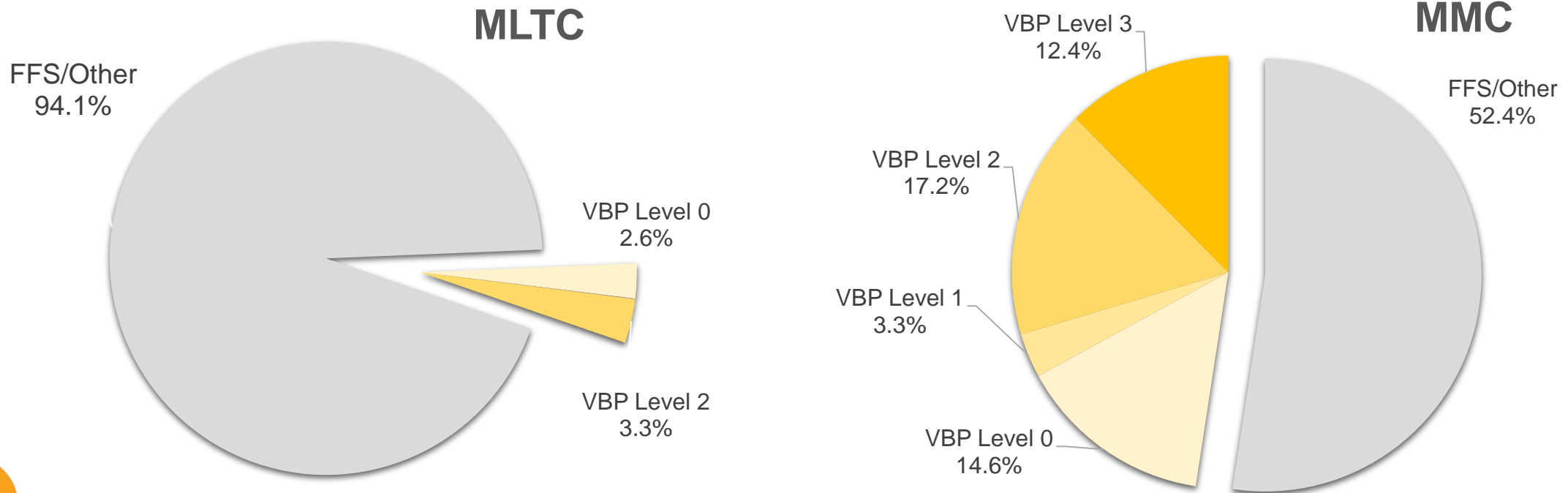


VBP Level	Spending or %
Total Spending	\$ 22,741 M
FFS	\$ 14,372 M 63.2%
VBP Level 0	\$ 2,576 M 11.3%
VBP Level 0 Quality	\$ 2,036 M 9%
VBP Level 0 No Quality	\$ 539 M 2.4%
VBP Level 1	\$ 567.5 M 2.5%
VBP Level 2	\$ 3,172 M 14%
VBP Level 3	\$ 2,062 M 9.1%

\*Includes Mainstream, MLTC, MAP, and HIV SNP plans.



# Managed Long Term Care (MLTC) Contracts Lag Behind



MLTC plans represent \$5.1 out of \$22.7 billion within the Managed Care Program. Today MLTC plans primarily operate in the FFS world. Key challenge is that DSRIP's key goal - avoidable hospital use – creates savings in Medicare. Level 1 VBP arrangements in MLTC will include regular shared savings (within Medicaid) but also a bonus for reducing avoidable Medicare funded hospital use.

# Implementation Efforts

# VBP Implementation Efforts

The State is providing additional financial incentives and support for early adoption of Value-Based Payment as well as for execution of higher-risk contracts through:

## VBP Pilot Program

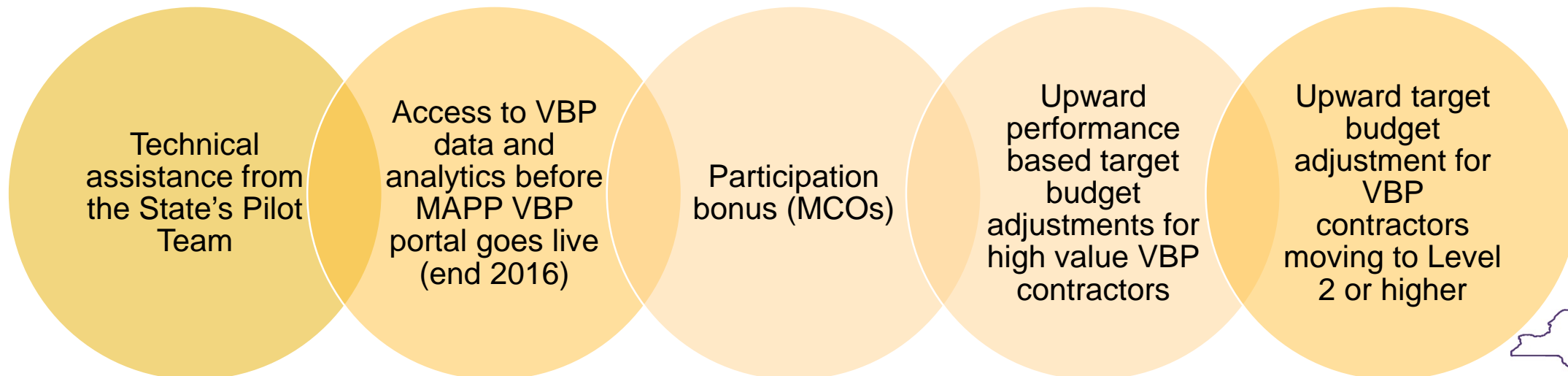
- The goal of the Pilots is to help the State and its participating organizations learn how VBP transformation will work in practice as well as to incentivize early adoption of VBP. This is a voluntary 2-year program. DOH reserves the right to restrict enrollment to those pilots that it deems to be most relevant.

## VBP Innovator Program

- The goal of the Innovator Program is to recognize providers that contract high risk Level 2 or Level 3 total cost of care for general and subpopulation arrangements by allowing up to 95% premium pass through.

# VBP Pilot Program

- Intended to:
  - create momentum in the move from FFS to VBP
  - establish early successes and best practices
  - learn from implementation challenges, identify and address obstacles to implementation
  - test new outcome measures, where necessary improve design of VBP arrangements
- Benefits of participating in the pilot program for MCOs and providers:



# Questions

# VBP Standards

## Most Important VBP Standard

- The VBP arrangement definitions & the accompanying quality measures are defined in the NYS VBP Roadmap:
  - “Consistency in VBP arrangement definitions has been identified as a key success factor in VBP implementation both nationally and globally. This includes:
    - Services to be included and excluded from each VBP model;
    - Members eligible for attribution to each model;
    - Selection and specifications of quality and outcome measures for each model; and
    - Methods to calculate the risk-adjusted cost of care in each model and in benchmarks used by the State to reflect changes in the clinical and demographic mix of attributed members.”
- ‘Off menu’ options are possible – see above slide 50.

# Criteria for Hospitals to Share in Savings

In the case of professional-driven VBP arrangements, what should be the criteria for downstream hospitals to share in savings generated in Integrated Primary Care (IPC), Total Care for General Population (TCGP), and Total Care for Subpopulation arrangements?

## Summary

In Level 1 & 2 arrangements, there are three categories of criteria for determining shared savings between hospitals and professional-led practices:

- (1) data management and data sharing;
- (2) innovation and care redesign; and
- (3) quality and engagement.

If the hospitals meet all of these criteria and professional-led practices generate savings in IPC arrangements, the hospitals will receive 50% of the savings in Level 1 arrangements and 25% in Level 2 arrangements. Hospitals must meet all three criteria in order to receive savings.

*This standard does not apply when the hospital in question is part of or contracted by the VBP entity.*



# Financially Challenged Provider Status

Question: What is Financially Challenged Provider (FCP) status and how is it defined?

## Summary

If a provider (both inpatient and outpatient) is deemed financially challenged, the following limitations apply: such FCPs cannot enter a Level 2 or higher VBP arrangement in a VBP contractor role, though they can be part of Level 2 or higher VBP arrangements, as long as they themselves are protected from any downside risk.



This exclusion from being a VBP contractor or bearing downside risk under a Level 2 or higher agreement will not apply to FCPs participating in the State's Value Based Payment – Quality Improvement Program (VBP QIP), provided those FCPs comply with all other relevant provisions of VBP QIP.

# Exclusions from VBP

Question: Should certain services or providers be excluded from VBP?

## Summary

1. Financially challenged providers that require thorough restructuring can be excluded from VBP.

Definition:

A provider(s), including safety net providers, is deemed financially challenged if the DOH determines that the provider is unlikely to be sustainable as a freestanding provider, which is evidenced by the following :

- less than 15 days cash and equivalents;
- no assets that can be monetized other than those vital to the operation; and
- the provider has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

2. (Emergency) services performed by a provider for a Medicaid member who is not attributed to a VBP arrangement in which this provider participates will not be seen as costs to that VBP arrangement.

# Implementation of SDH Interventions

## Summary\*

Providers and MCOs in Level 2 and 3 VBP arrangements should implement interventions on a minimum of one SDH\*.

# Rewarding SDH Intervention Implementation

## Summary

MCOs and the State should incentivize and reward providers (including CBOs) for taking on member and community-level SDH.

# Contracting with CBOs

## Summary\*\*

Every Level 2 or 3 VBP arrangement will include a minimum of one Tier 1 CBO (non-profit, non-Medicaid billing, community-based social and human service organization) starting January 2018. The State will, however, make financial incentives available immediately for plans and providers who contract with Tier 1 CBOs.

*\*This recommendations is not a standard but a guideline for providers and MCOs in Level 1 arrangements.*

*\*\*Note: The State recognizes that CBOs may not exist within a reasonable distance to providers in some regions of New York. In such situations, providers/provider networks can apply to the State for a rural exemption.*

# Member Incentive Cap Elimination

Member incentives should assist and encourage members to make effective choices and improve lifestyle when appropriate.

Question: how to create appropriate incentive?

## Summary

The State should eliminate the \$125 incentive cap in the current New York State (NYS) Medicaid managed care model contract. *Subject to CMS approval.*

# Fee-for-Service as VBP

Question: What activities/services should remain Fee-for-Service (FFS) but considered value-based?

## Summary\*

A limited set of preventive services will be counted as value-based when reimbursed through Fee-for-Service if they have a quality measure attached. *Pending CMS approval*

\*An earlier version of this standard was rejected by CMS.

# Questions

**Break – 15 mins**

# VBP Readiness Assessment



# VBP Readiness Assessment

- The first step towards VBP is a *Level 1* VBP arrangement:
  - No risk
  - Only upsides: nothing to lose
    - ... but MCO will likely retain 50% or more of the savings
- The second step towards VBP is a *Level 2* VBP arrangement:
  - Assuming risk
  - Up- and downsides: potentially significant losses
    - ... but VBP contractor receives majority of the savings
  - Only in Level 2 can MCOs stop doing Utilization Review & ask for Pre-Authorizations
  - Only if you commit to going to Level 2 after maximally one year after the start can you be a NYS VBP Pilot
- Just how to deal with and contract for Risk ('risk mitigation') will be a topic at the next Bootcamp day
- Key question: *what is wise for me to do?*

# VBP Readiness Assessment

Am I ready to assume risk?

A **readiness assessment** is recommended to evaluate current state and capabilities, identify and prioritize financial and operational gaps. Suggested assessment areas include but are not limited to:



# Care Delivery

Before entering a VBP agreement, ask:

- Especially for IPC and TCGP arrangements: are existing population health efforts adequate?
- Is clinical staffing adequate?
- Is the organization ready to engage patients?

Recommended ideal/perfect state is when you:

- Have experience managing care for groups of members and/or populations with various conditions
- Have experience managing high-utilizer/high cost members
- Have experience providing robust care coordination
- Have linguistic and cultural competency at all levels of the organization
- Have care standardization processes in place
- Demonstrate excellent chronic care management and post-discharge follow-up
- Offer integrated behavioral health and primary care services
- Have engagement, activation, and outreach strategies in place to connect with attributed population

**The delivery of care model must change to satisfy requirements of payment reform**

# Financial Stability

Before entering a VBP agreement, ask:

- Do you recognize your data; do they seem accurate and complete?
- Do you understand your part of the total cost of care / episode of care?
- Do you see ways to improve patient outcomes that would realize savings? Or realize savings while keeping care quality at the same level?
- Based on your own insights and the data, do you see opportunities to increase revenue for you and your partners through realizing shared savings, either through:
  - Increasing your own efficiency
  - Realizing savings downstream (i.e., outside of the group of partners you're working with)
- What is your current financial situation?
- Would you see yourself taking risk for a specific VBP arrangement? As a lead, as a partner? Or perhaps joining a Level 2 arrangement while yourself taking minimal risk?
- Are you able to draw your own administrative and clinical data to monitor progress and outcomes of the VBP arrangement you are interested in?

**Organizations lacking financial strength and understanding will find it difficult to set up and maintain VBP contracts**

## Financial Stability (Cont.)

Recommended ideal/perfect state if when you:

- Have a clear understanding of up-front costs you will incur with implementation and an estimated return on investment
- When considering Level 2, have cash reserves on-hand appropriate to manage the relative risk of your VBP arrangement
- Have considered / included innovative ways to realize upfront investment (DSRIP, MCOs, other health care providers, banks, investors, etc.)
- Have (a clear growth path to) the ability to track and report on system-level utilization and cost data (coding accuracy is very important)
- Have a clear strategy in place for transforming your business model towards paying for value across business lines
- Have a strategy in place to coordinate the inevitably varying approaches towards VBP across payers?
- Demonstrate an understanding of the quality metrics that drive patient outcomes rather than volume
- When considering Level 2, have the ability to engage in risk-based contracts, supported by legal and compliance expertise

**Organizations lacking financial strength and understanding will find it difficult to maintain VBP contracts**

# Organizational Readiness

Before entering a VBP agreement, ask:

- Is the board of directors knowledgeable about payment reform efforts and their implications for the organization's mission and services? Are they supporting the transition?
- Does the organization have the experience with and capacity to implement the organizational changes required?

Recommended ideal/perfect state is when you:

- Have a shared organizational vision for and commitment to involvement in payment reform amongst administrative and clinical leadership (from staff to C-suite level)
- Promote an overall organizational culture that prizes value and patient outcomes
- Have leadership tools and processes in place to monitor performance (robust technical infrastructure)
- Have identified specific opportunities in relation to the existing mission, service area, and scope of services
- Have change management practices in place to aid the transition

**Significant organizational change must take place to accommodate payment reform. Everyone in the organization must understand what is changing and why to ensure a smooth transition**

# IT & Data Analytics Capabilities

Before entering a VBP agreement, ask:

- Does the organization have an IT strategy for the transition to payment reform?
- Has a current systems hardware and software analysis been performed to ensure the organization's IT capabilities are sufficient to participate successfully in VBP?

Recommended ideal/perfect state is when you:

- Staffed IT departments adequately and have the capacity to support payment reform efforts
- Have appropriate hardware and software systems in place with trained staff
- Demonstrate and utilize interoperability and real-time data access
- Have your Health Information Technology (HIT) reliably achieving performance targets and allowing for the continuous quality improvement (CQI), management of population/members through provider alerts, decision tools/dashboards, registries, enhanced access to data, etc.

**Organizations must be able to collect and analyze large amounts of clinical and claims data to inform decisions related to VBP**

# Partnerships

Before entering a VBP agreement, ask:

- Has the organization developed partnerships to address service area needs and take advantage of opportunities in the local healthcare marketplace?
- Is data sharing among partners sufficient?
- Are all contracting entities ready to participate in payment reform?
- Which providers do you want to contract with – and which not, or perhaps, later?
- How can you engage CBOs – and not because the State asks you to?

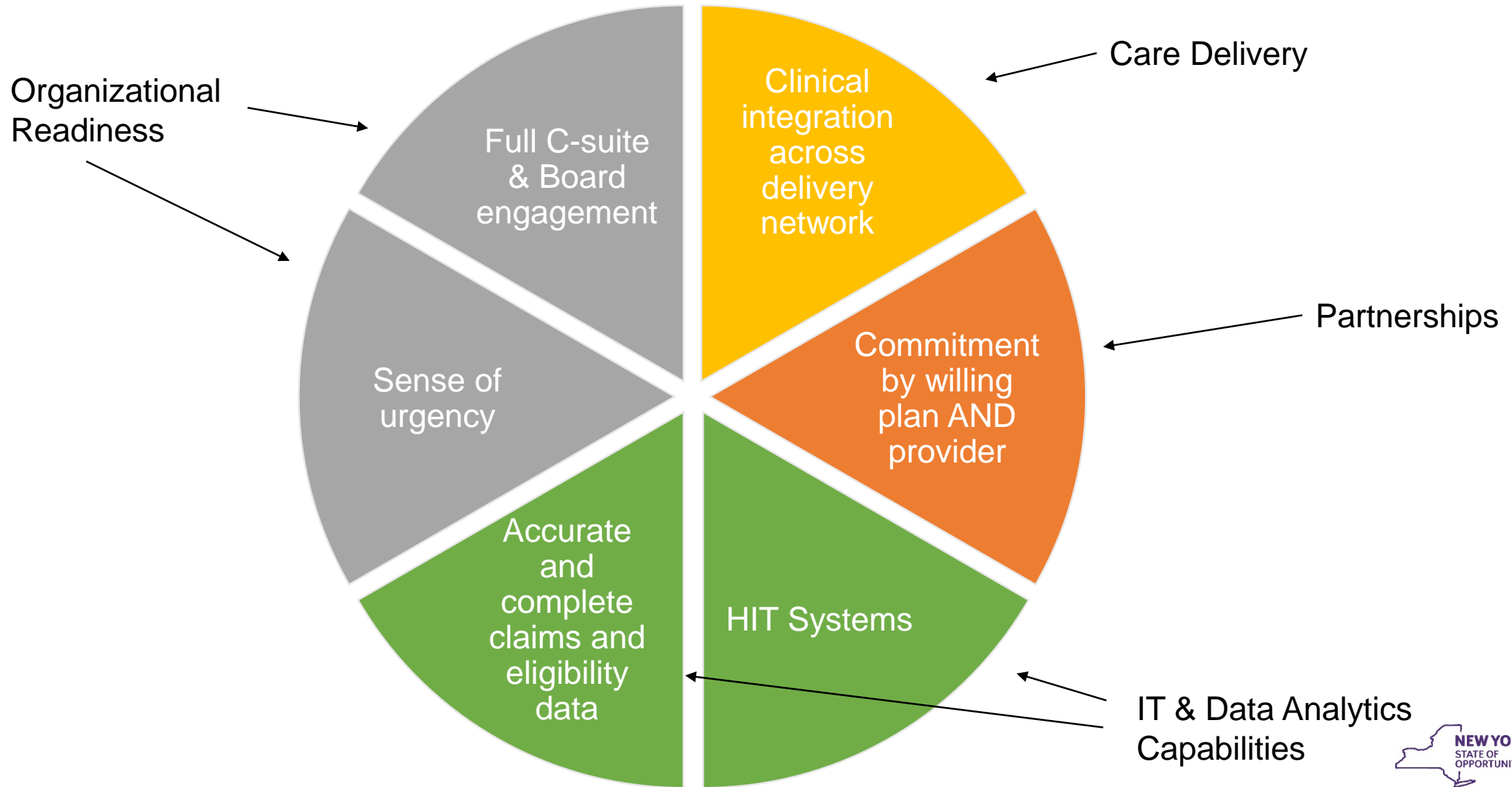
Recommended ideal/perfect state is when you:

- Have established appropriate partnerships with other providers in order to execute and meet the goals of your arrangements
- Have established relationships with social services and/or other organizations in the community in order to develop community-level systems of care
- Have begun developing new products and services in order to meet target population needs
- Have a clear understanding of the cost effectiveness and outcomes of partnership efforts

**Smart partnerships between plans and providers are vital to the success of VBP**



# Key Success Factors and Capabilities



## Top 4 Steps for Beginners

1

Assess your readiness; address issues to be able to start at Level 1 and Level 2 if capable

2

Understand what types of contracts you want to engage in based on the services you provide, the attributed population and outcome measures that impact savings, and the potential for realizing savings

3

Choose the partners that will help you succeed and that are adequate for the contracts you chose – build your partnerships

4

Familiarize yourself with and utilize available resources (data from the State, technical assistance from potential partnering contractors, etc.)

# Top 4 Steps for Experienced Contractors

1

Understand your current VBP contracts and what adjustments have to be made based on new VBP framework: check definitions, adjust quality measures, check levels of risk, partner with CBOs, etc.

2

Re-assess your capabilities and network partnerships; and gain understanding in readiness for advancement in VBP risk levels and expansion in scope

3

Consider re-investing savings in other innovative interventions to continually improve member health and consequently generate further savings

4

Keep current with yearly benchmarks and modify strategy and risk arrangements based on performance

## Current Contracts – VBP Compliance

If you already have VBP contracts in place, how do you achieve compliance with the new VBP Design rules?

DOH is in the process of updating the Managed Care Model Contract & Provider Contract Guidelines

Current contracts can be brought up to speed through amendments

VBP Contractors and MCOs may choose to create new contracts

MCOs and providers are encouraged to enter into new VBP contracts to realize more shared savings and align with all roadmap objectives.

*Ultimately, VBP contracts will need to comply with roadmap standards to count towards statewide goal.*

# Questions

# Do we have the Scavenger Hunt Winners?

If you found ten people that fit the criteria below, please come forward!

You had to find a person:

Who works/worked in Behavioral Health

Who was born in the month of June

Who works/worked for a health plan/MCO

Who works/worked for a CBO

Whose first name begins with R

Whose last name begins with G

Who works/worked in the OB/GYN field

Who has been out of the country in the past two months

Who works/worked in Internal Medicine

Who is wearing striped socks

## Recap & Closing: What Have We Learned?

- Learned what Value-Based Payment Reform is: background and future goals
- Learned about the Menu of Options for VBP arrangements
- Learned about the VBP Financial Incentives
- Went over the high level Readiness Assessment
- Learned about the new VBP Standards

## Next Session

Registration for Session 2 is open. It will close on June 8<sup>th</sup>.

Link to Registration - click here:

<https://www.eventbrite.com/e/vbp-bootcamp-series-region-1-session-2-registration-24783699713>

Session	Topics covered	Date & Time	Locations
Session 2	Contracting & Risk Management <ul style="list-style-type: none"><li>- VBP Contracting: How-To</li><li>- Contract Risk Management Techniques</li></ul>	Wednesday, June 15, 2016 9.30AM – 4 PM	University at Albany: Performing Arts Center



# VBP Bootcamps Contact Info

***Website:***

[www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/vbp\\_bootcamp](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_bootcamp)

***Twitter Account:***

**@NYSMedicaidVBP**

**Thank you**