NEW YORK STATE | Department of Health | Medicaid Redesign Team

VBP Bootcamp Series
Session 2

NYC (excl. Queens)

Region 3: New York City (Bronx, Brooklyn, Manhattan, Staten Island)

August 2016

Welcome

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Today's Agenda:

Agenda Items		Time	Duration
Morning Session	Welcome	9:00 AM	20 mins
	VBP Contracting Overview	9:20 AM	100 mins
	Break	11:00 AM	15 mins
	VBP Contracting Overview (Cont.)	11:15 AM	45 mins
Break	Lunch	12:00 PM	60 mins
Afternoon Session	VBP Contracting Panel with Q&A	1:00 PM	60 mins
	Financial Risk Management	2:00 PM	60 mins
	Break	3:00 PM	15 mins
	Target Budget Setting	3:15 PM	60 mins
	Closing	4:15 PM	5 mins

VBP Bootcamp Session 1 Summary

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
  - The content of sessions are applicable statewide
- Networking is highly encouraged, 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

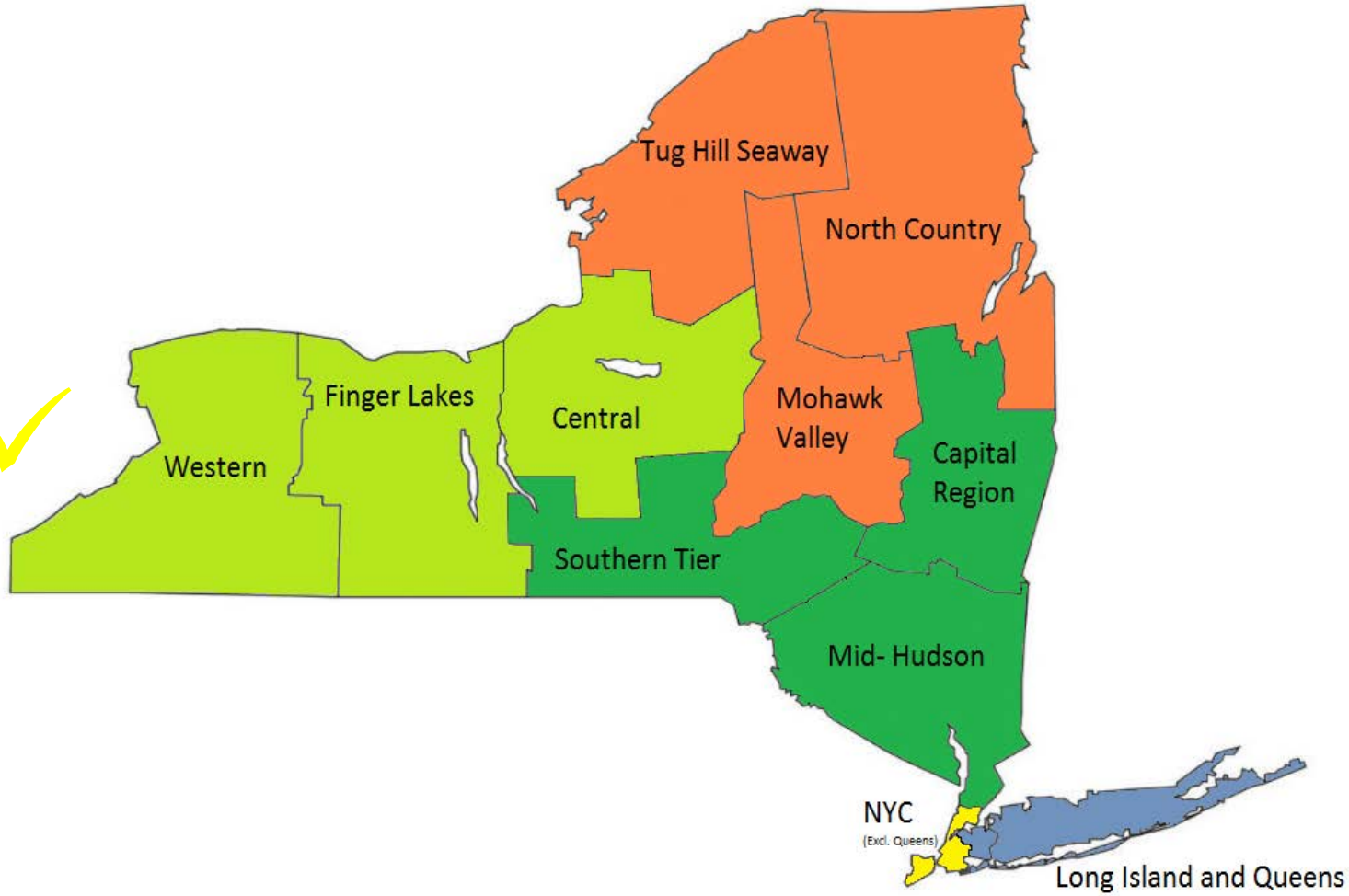
Region 1: Capital Region, Southern Tier, Mid-Hudson

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



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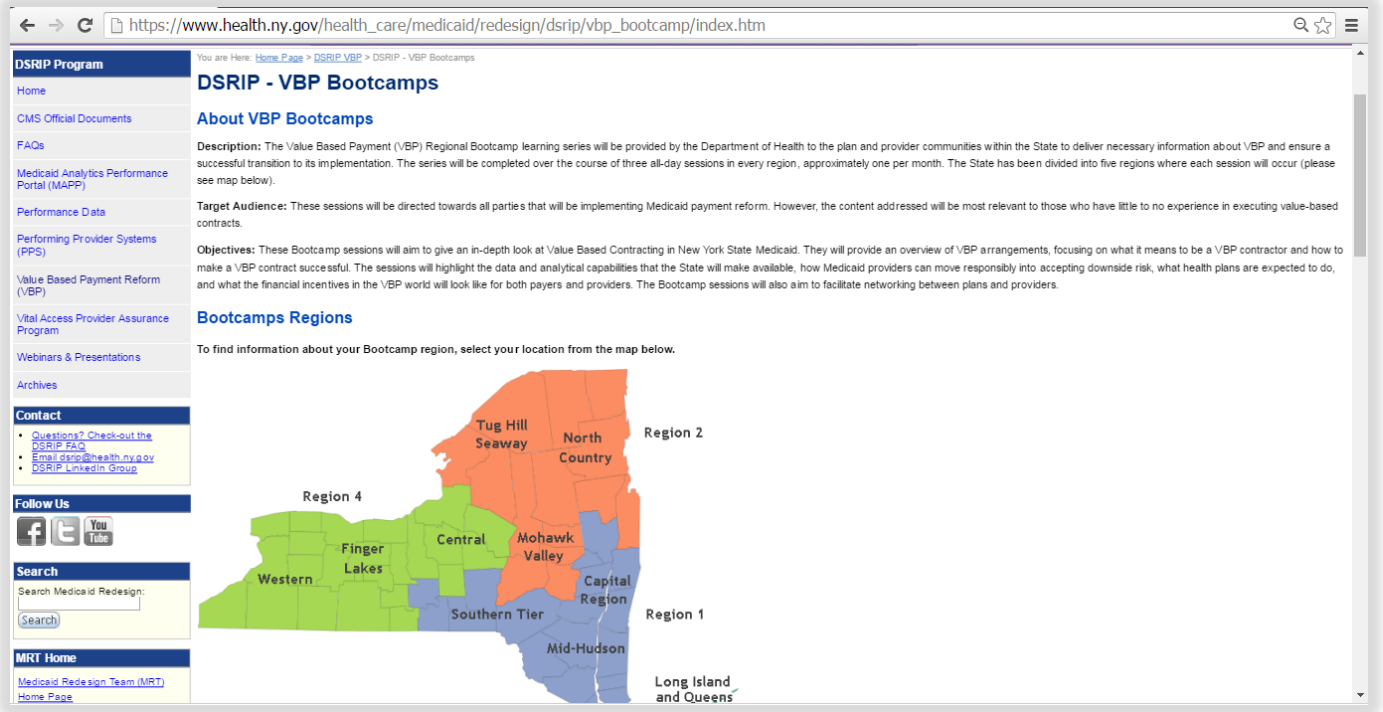
Explore the VBP Bootcamp Website

The Website will provide access to the following:

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



Path: DSRIP Homepage → Value Based Payment Reform → VBP Bootcamps
Link: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_bootcamp/index.htm

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Session 1 Summary

In Session 1 ‘Introduction to VBP’, the following was covered:

- Purpose of the Bootcamp series
- Introduction to Value-Based Payment Reform
- Overview of VBP Arrangement Types
- VBP Standards
- VBP Readiness Assessment

If you were unable to attend Session 1, you may attend in another region or watch the recorded session/go over the presentation posted in the VBP Library. Link: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/index.htm

VBP Bootcamp Curriculum & Schedule

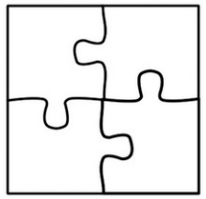
Session	Topics covered	Date & Time	Locations
Session 1	Introduction to VBP - VBP Design Overview - High Level Readiness Assessment Considerations	Wednesday, July 20, 2016 9AM – 4PM	Bronx Community College
Session 2	Contracting & Risk Management - VBP Contracting - Target Budget Setting - Financial Risk Management	Wednesday, August 17, 2016 9AM – 4PM	
Session 3	Performance Measurement - Quality Measures - Understanding your performance: a data-driven approach - MAPP and the VBP Dashboards	Monday, September 12, 2016 10.30AM - 3PM	

Network, network, network!

VBP Contracting Overview

Contracting Overview

The following topics will be covered in this section:



Overview of Arrangement Types

VBP Contracting Entities

Key Components of a VBP Contract

Contracting with Downstream Providers and CBOs

Contract Review Process

Types of VBP Arrangements

Different Types of VBP Arrangements

Types	Total Care for General Population (TCGP)	Integrated Primary Care (IPC)	Care Bundles	Special Need Populations
Definition	Party(ies) contracted with the MCO assumes responsibility for the total care of its attributed population	Patient Centered Medical Home or Advanced Primary Care, includes: • Care management • Practice transformation • Savings from downstream costs • Chronic Bundle (includes 14 chronic conditions related to physical and behavioral health related)	Episodes in which all costs related to the episode across the care continuum are measured • Maternity Bundle	Total Care for the Total Sub-pop • HIV/AIDS • MLTC • HARP
Contracting Parties	IPA/ACO, Large Health Systems, FQHCs, and Physician Groups	IPA/ACO, Large Health Systems, FQHCs, and Physician Groups	IPA/ACO, FQHCs, Physician Groups and Hospitals	IPA/ACO, FQHCs and Physician Groups

Contracting Entities/VBP Contractors

Contracting Entities/VBP Contractors

1. Independent Practice Associations (IPA)
2. Accountable Care Organizations (ACO)
3. Individual Providers
   - Hospital Systems
   - FQHCs and large medical groups
   - Smaller providers including community based organizations (CBOs)

1. Individual provider could either assume all responsibility and upside/downside risk or make arrangements with other providers; or
2. MCOs may want to create a VBP arrangement through individual contracts with these providers

VBP Contractors: Independent Practice Association

- An Independent Practice Association is a corporation (nonprofit or for-profit) and/or LLC that contracts directly with providers of medical or medically related services, or another IPA in order to contract with one or more MCOs to make the services of such providers available to the enrollees of an MCO.
- Who negotiates the IPA contract?
  - What is the governance of the IPA?
  - Who should the individual provider look to if there are questions and/or concerns?

VBP Contractors: Independent Practice Association

- **IPAs facilitate network development and access**
  - Single signature authority
    - Typically for a category of services amongst competing providers (could be with providers across the care continuum)
  - Allows providers to maintain independence regarding governance and clinical decision-making
- **IPAs are not unions or guilds**
  - Antitrust concerns related to collective negotiation
  - To avoid antitrust concerns, IPAs are usually entities that share risk or are clinically integrated
- **IPAs can provide administrative services to providers who participate in the IPA and/or management services to MCOs**

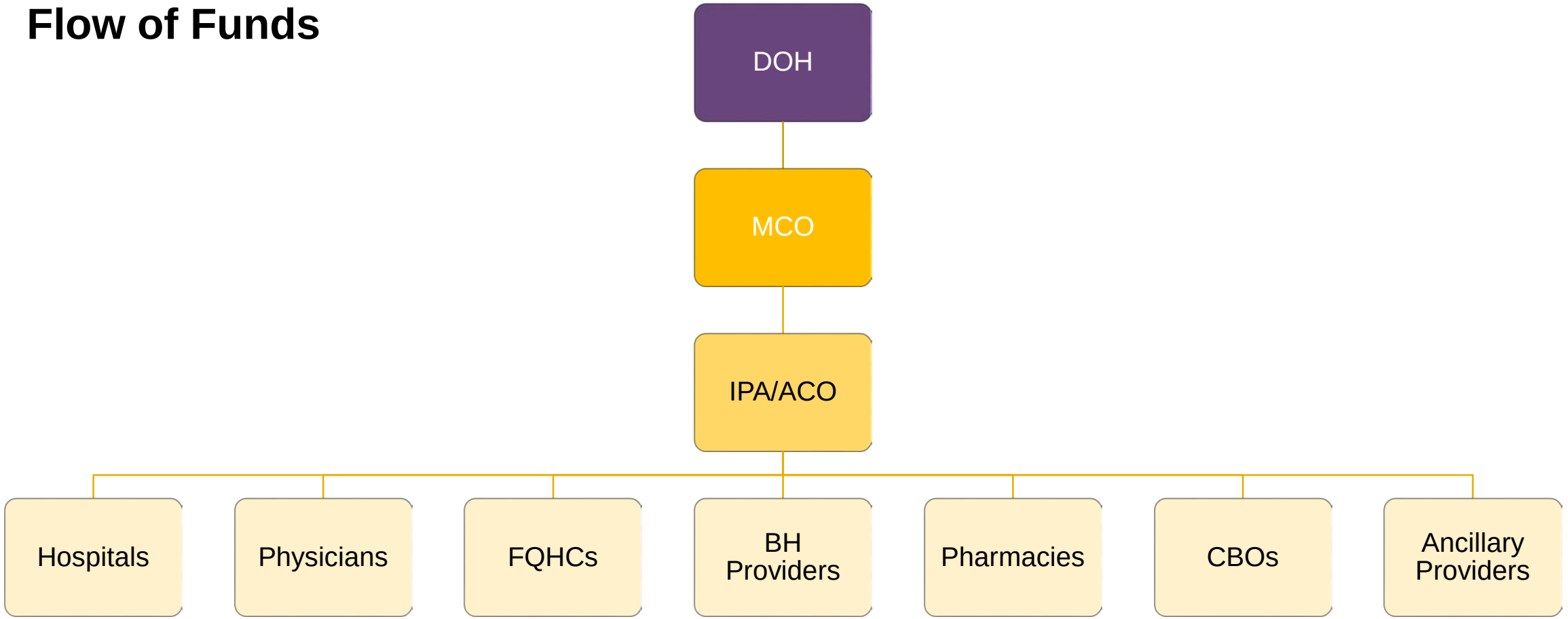
VBP Contractors: Accountable Care Organization

- An Accountable Care Organization is an organization of clinically integrated health care providers that work together to provide, manage, and coordinate health care (including primary care) for a defined population; with a mechanism for shared governance; the ability to negotiate, receive, and distribute payments; and accountability for the quality, cost, and delivery of health care to the ACO's patients
  - Medicare-only ACO (approved by CMS) for Medicare population
  - Medicare ACO does not make you a Medicaid ACO and vice versa*
  - IPAs may be certified by DOH as an ACO

**There is an expedited approval process for Medicare ACOs to become Medicaid ACOs.*

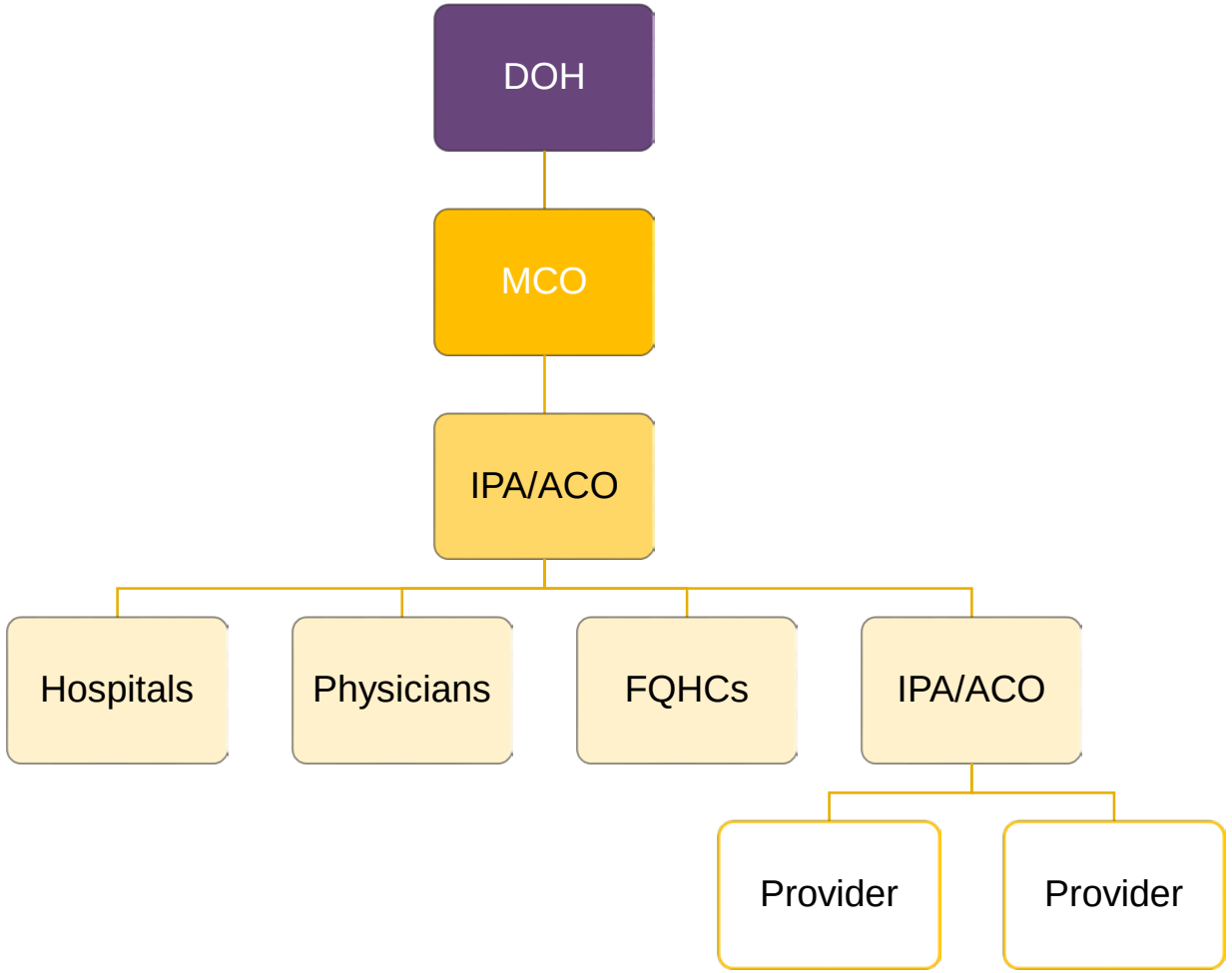
Where Do You Fit in the Structure of a VBP Arrangement: Total Care for General Population

Flow of Funds



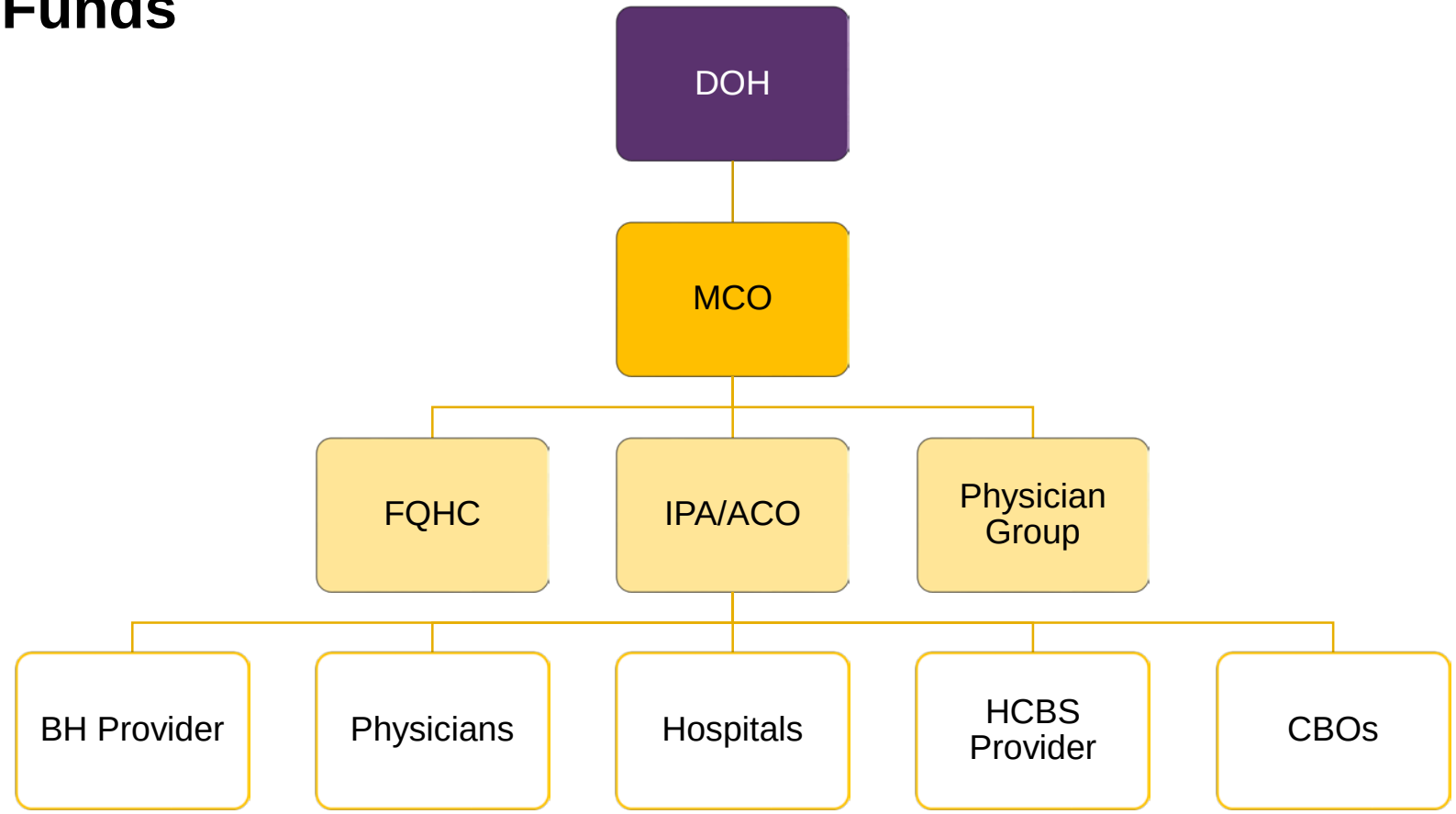
TCGP: Flow of Funds

IPA/ACO to IPA/ACO Contract



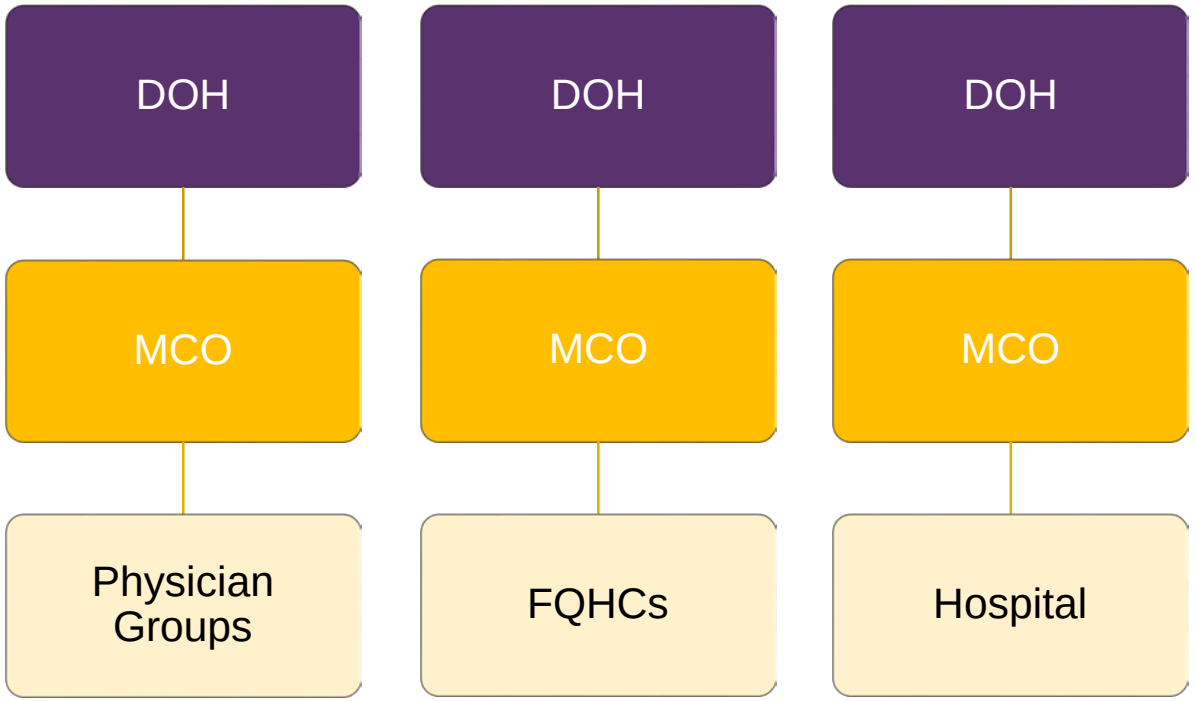
Where Do You Fit in the Structure of a VBP Arrangement: Total Care for a Subpopulation

Flow of Funds



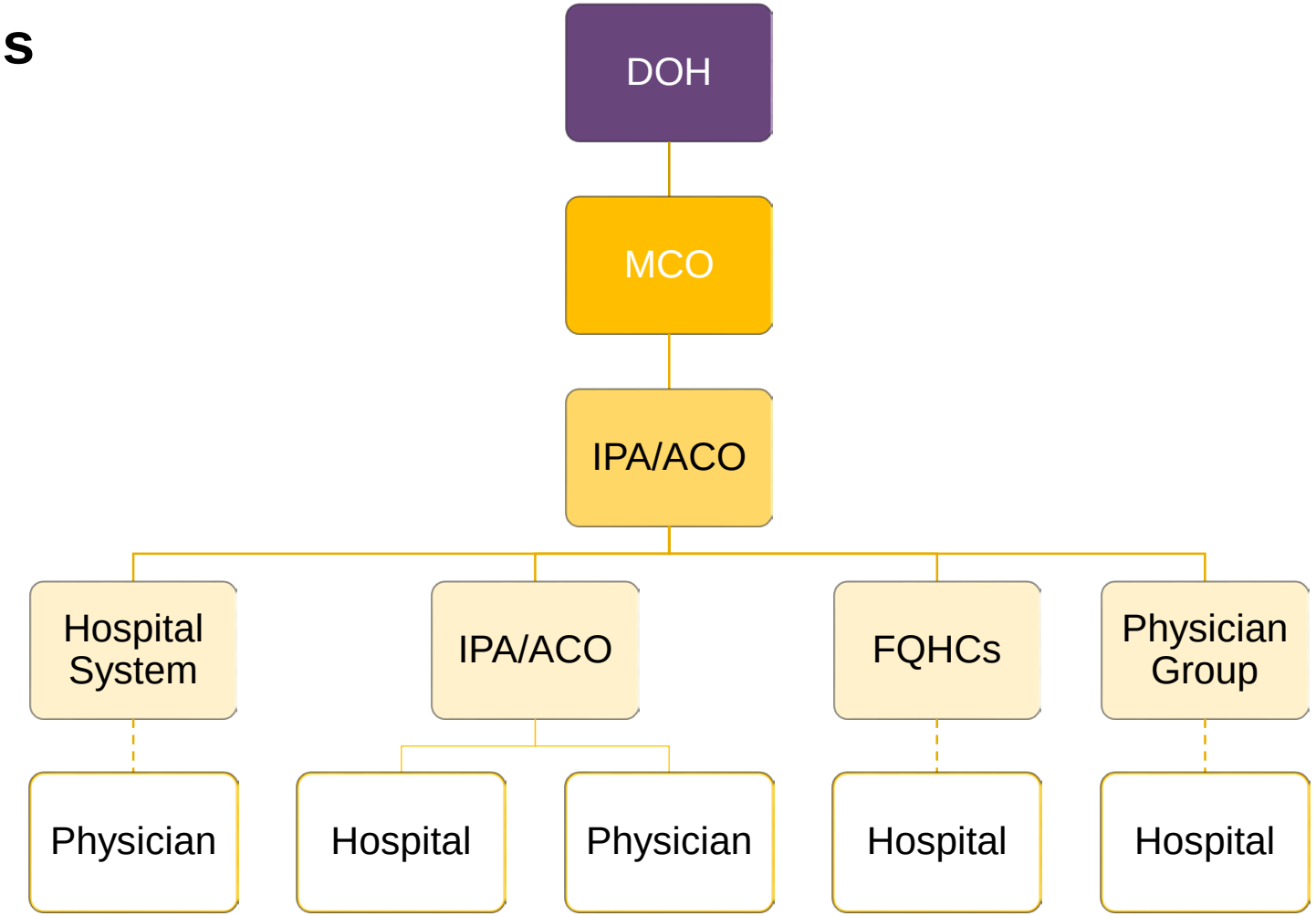
Where Do You Fit in the Structure of a VBP Arrangement: Integrated Primary Care (IPC)

Flow of Funds



Where Do You Fit in the Structure of a VBP Arrangement: Maternity Care Bundle

Flow of Funds



Components of a VBP Contract

Components of VBP Contract

1. Measurement Period
2. Targeted Medical Budget
3. Services Included
4. Calculations
5. Savings and Losses
6. Reporting
7. Financial Protections
8. Quality Measures

Components of a VBP Contract

1. **Measurement Period**
   - Annual
2. **Targeted Medical Budget**
   - Percentage of Premium
   - Set dollar amount
   - Medical Loss Ratio
   - Risk Adjustment
3. **Services Included**

Components of a VBP Contract

4. **Calculation Determination**
   - Use of Incurred But Not Reported (IBNR) claims vs. Waiting for Expiration of Claims Run-Out
5. **Savings and Losses**
   - How much will the MCO and Contracting Provider share in savings and losses?
   - Risk and Savings is typically shared proportionally
6. **Reporting**
   - How often will reports be generated?
     - Final determination is typically 18 months after the measurement period
   - What reports will be generated so the VBP Contractor can ascertain its status and have time to make adjustments in service delivery patterns?
   - Will the Contracted Provider have an opportunity to object?

Risk adjustment methodology, services, and specifics on quality outcomes and measures are set by DOH and required for the Contracting Parties.

Components of a VBP Contract

7. **Financial Protections**
   - Letter of Credit
   - Reserve Fund
   - Stop Loss
   - Certified Financials
8. **Quality Measures**
   - Reports
   - Submission of data
   - Payment

Quality Measures*

VBP Arrangements are conditioned upon meeting certain quality outcomes or targets:

- **Outcome measures**
  - Reducing medically unnecessary services – e.g., inpatient hospitalizations and readmissions
- **Process measures**
  - Providing proper follow-up care with a Behavioral Health/Substance Use Disorder provider after inpatient hospitalization
  - Medication adherence
- **Reporting of data**

**This topic will be covered in depth in Session 3 on Performance Measurement.*

Negotiable Items

- Attribution
- Target Budget
- Shared savings and losses
- Reconciliation Time Periods
- Financial Protections

Questions

Contracting with Downstream Providers

More on Contracts with MCOs

- **The contract between the IPA/ACO and its Participating Providers ("downstream entities")**
  - Contain similar provisions as a provider agreement
- **The contract between the MCO and IPA/ACO**
  - Key Issues:
    - Governance of the IPA/ACO
    - Payment of claims
    - Exclusivity with the MCO and the MCO's ability to exclude certain downstream providers
    - Credentialing
    - Risk sharing

Typical Provider Contract Terms

1. Parties and Definitions
2. Scope of Services and Access to Services
3. Payment Adjustments
4. MCO Administrative Requirements (i.e. timely filing)
5. Insurance
6. Indemnification and Liability
7. Compliance with all laws and Medicaid Model Contract
8. Term and Termination
9. Representations and Warranties
10. Amendment
11. Assignment
12. Notices to MCO
13. Dispute resolution or litigation
14. Audits, monitoring and oversight

Provider Contract Key Terms

Out of the entire list of terms these are the most important:

1. **Payment Adjustments**

   Need to understand how these activities will be handled (for example, the timeframe and notice requirements and payment implications)

   - Timely filing of claims
   - Adjustments to payments
   - Claim disputes and dispute resolution
   - Retroactive enrollments
   - Recoupments

Provider Contract Key Terms

2. **Insurance**
   - MCOs will require providers to have malpractice insurance and general liability insurance
   - Provider should understand its insurance limits and policy restrictions (Is contractual indemnification allowed?)
3. **Indemnification and Liability**
   - Contractual indemnification - mutuality
   - An MCO can’t transfer liability for its own acts onto a health care provider
   - Joint and several liability

Provider Contract Key Terms

4. **Term and Termination**
   - Automatic renewal or defined contract term
   - "For cause" versus "without cause" termination
     - Standard for material breach
   - Length of notice for termination and non-renewal
   - Due process rights
5. **Representations and Warranties**
   - Valid corporation and properly licensed, certified or designated by DOH, OMH or OASAS (licensure obligations can also apply to employees of the provider)
   - Legally binding and enforceable
   - Neither provider nor employees have been suspended or terminated from a federal health care program or convicted of a criminal offense related to Medicaid or Medicare

Provider Contract Key Terms

6. **Amendment**
   - Mutual agreement, automatic or upon 30 days' notice without objection
   - Changes due to regulatory requirements
7. **Assignment**
   - On notice or with consent
   - Change of control
8. **Notice to MCO in the event the provider has:**
   - Any lapse, revocation, termination or suspension of license
   - Any lapse, revocation or cancellation of insurance
   - A disciplinary action initiated by a government agency
   - Excluded, suspended, debarred or sanctioned from a federal program
   - A grievance or legal action filed by an enrollee against the provider
   - An investigation, conviction or plea for fraud, a felony, or a misdemeanor

Provider Contract Key Terms

9. **Dispute Resolution / Litigation**
   - **Claim disputes vs. other disputes**
   - **Venue and choice of law**
   - **Internal dispute resolution mechanism**
     - Timeframe for resolution
     - Identify key management titles with the authority to resolve disputes
   - **Alternative dispute resolution or mediation**
     - Binding or non-binding
     - American Arbitration Association, American Health Lawyers Association, etc.
10. **MCO's right to monitor and audit its participating providers**

Provider Contract Key Terms

Below are some of the key provisions covered by Law. Providers should expect their MCO to include these in the VBP Contracts.

- Provisional credentialing
- Medical necessity appeals
- External appeals
- Limits on prior authorization
- Prudent layperson
- Prompt pay – timeframes and interest
- Overpayments
- Claim submission timeframes and exceptions
- No balance billing of consumers
- Continuity of Care
- Term and Termination
- Sharing of enrollee medical records and other personal health information, including HIV, substance abuse, and mental health records
  - Consent obtained on Medicaid enrollment application

Reminder: Contracting with CBOs

Standard 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.**

The SDH & CBO Subcommittee put forth several additional recommendations focusing on CBO involvement in VBP networks and the integration of SDH interventions into clinical care. While the recommendations are not requirements, contract language could include details on the intentions of the provider network and MCO regarding these initiatives.

**Please refer to the Master Subcommittee Recommendation Report to review the complete language of this Standard recommendation.* Link: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-feb_sub_comm_recommend_rpt_consol.pdf

***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.*

Questions

Break – 15 mins

VBP Contract Review Process

Contract Review Process Moves from 5 to 3 Tiers

The existing five contract review levels per the existing Provider Contract Guidelines have been collapsed into three tiers.

Tier 1	Tier 2	Tier 3
• **The File and Use Tier** includes all VBP Level 1 arrangements (upside only arrangements) and all other arrangements that do not meet the minimum review thresholds for DOH Review (Tier 2) or Multi-Agency Review (Tier 3).	• **The DOH Review Tier** includes VBP Level 2, VBP Level 3, and all other arrangements that do not trigger Regulation 164, but contain over $1,000,000 of potential payments at risk AND ANY of the following factors listed on Slide 29.	• **The Multi-Agency Review Tier** includes all contractual arrangements which trigger Regulation 164.

Note: Regardless of which Tier a particular agreement falls in, the financial and/or programmatic reviews referenced here only apply from the State's perspective to assess financial and programmatic risks to the Medicaid program. The State is not providing legal advice to either plans or providers nor is the State determining whether the contractual arrangement is a fair business deal between the parties.

Reminder: MCOs and Contractors can Choose Different Risk Levels of VBP Arrangements

There are different levels of risk that the providers and MCOs may choose to take on in their contracts:

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.*

DFS Regulation 164: Background

- 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.

Future Financial Review: Arrangements Included in Tier 1

Individual Contract Comes in for Review

More than $250,000 of **annual** payments to provider prepaid capitation (triggers Regulation 164)?

No

More than $1,000,000 of **annual** payments to provider at risk (shared losses, withhold)?

Yes

- More than 25% of **annual** payments to provider at risk?
- More than 15% provider's Medicaid Revenue?
- Off Menu VBP Arrangement?

No to All

No

All contracts may be subject to Programmatic Review in addition to Financial Review.

Tier 3

Multi-Agency

Tier 1 *DOH Review* will include the following arrangements:

- VBP Level 1 Arrangements (upside only arrangements)
- All other arrangements that do not meet the minimum review thresholds for a Multi-Agency Review (Tier 3) or DOH Review (Tier 2).

Tier 1

File and Use

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Future Financial Review: Arrangements Included in Tier 2

Tier 2 *DOH Review* will include the following arrangements:

- VBP Levels Two and Three Prepaid capitation arrangements that do not exceed the $250,000 threshold; **OR**
- VBP Level Two FFS arrangements (no prepaid capitation); **OR**
- Off-menu VBP arrangements that are either FFS or do not exceed the $250,000 prepaid capitation threshold;

AND:

- Exceed the $1,000,000 at risk payment threshold; **AND**
- Meet one of more of the three highlighted criteria

Individual Contract Comes in for Review

More than $250,000 of **annual** payments to provider prepaid capitation (triggers Regulation 164)?

No

More than $1,000,000 of **annual** payments to provider at risk (shared losses, withhold)?

Yes

More than 25% of **annual** payments to provider at risk?

More than 15% provider's Medicaid Revenue?

Off Menu VBP Arrangement?

Yes to Any

Tier 2

DOH Review

Tier 1

File and Use

All contracts may be subject to Programmatic Review in addition to Financial Review.

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Summary of DOH Review Tier Payment Thresholds

$1M

This $1,000,000 annual payment threshold is applied to:

- Only the individual contract that is coming in for review
- Medicaid Managed Care components of the contracts only

15%

This 15% revenue threshold is applied to:

- All MCOs that contract with the provider
- All Medicaid (inclusive of Medicaid Managed Care and Medicaid FFS) contracts

The ratio is expressed as:

$$\frac{\text{Value of This Contract's Projected Medicaid Revenue}}{\text{Total Projected Annual Medicaid Revenue for Provider}}$$

25%

This 25% payment threshold is applied to:

- Only the individual contract that is coming in for review
- Medicaid Managed Care components of the contracts only

The ratio is expressed as:

$$\frac{\text{Annual Medicaid Payments at Risk for this Contract}}{\text{Total Value of All Medicaid Contracts between this MCO and Provider}}$$

Future Financial Review for DOH Review Tier (Tier 2)

VBP Contracts which are determined to fall under DOH Review Tier 2 will undergo both programmatic and financial review prior to approval.

	Services provided directly by contracting provider	Services paid through a participating provider network (IPA, ACO, etc.)
Demonstration of Provider financial viability	For all Contracts that fall under the DOH Review Tier, the financial viability of the contracting provider must be demonstrated.	
Financial Security Deposit (FSD)	FSD only required when providers in this column fail to demonstrate financial viability	FSD required for all arrangements involving participating provider networks

Financial Viability and Financial Security Deposits

- **Provider financial viability** will be determined by demonstrating a positive net worth. Accepted documentation includes but is not limited to:
  - Certified audited financial statements, or comparable means, such as an accountant's compilation;
  - Positive net worth of the guaranteeing parents' certified audited financial statements;
  - Other.
- **Financial Security Deposits (FSD) criteria***: the provider/IPA must establish and provide evidence of a FSD equal to 12.5% of the estimated annual medical costs for the medical services covered under the risk arrangement
  - The FSD is provider funded, must consist of cash and/or short-term marketable securities, and will be held "in escrow" by the plan
  - Under limited circumstances, a parental guarantee may be allowed
  - Out of network services already retained by the plan are not subject to the FSD
  - The above requirements may be mitigated to the extent that limits on the amount of financial risk are imposed

**This is not a new regulation.*

Future Financial Review: Arrangements Included in Tier 3

Individual Contract Comes in for Review

More than $250,000 of **annual** payments to provider prepaid capitation (triggers Regulation 164)?

More than $1,000,000 of **annual** payments to provider at risk (shared losses, withhold)?

More than 25% of **annual** payments to provider at risk?

More than 15% provider's Medicaid Revenue?

Off Menu VBP Arrangement?

Yes

Tier 3

Multi-Agency Review

Tier 3 *Multi-Agency Review* will include the following arrangements that exceed the $250,000 prepaid capitation threshold:

- VBP Level Three arrangements; **OR**
- VBP Level Two partial capitation arrangements; **OR**
- Off-menu VBP options that include prepaid capitation

Tier 2

H

ew

Tier 1

File and Use

Program Review will be completed in addition to Financial Review for all contracts

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Future Financial Review: Bucketing into Tiers

Individual Contract Comes in for Review

More than $250,000 of **annual** payments to provider prepaid capitation (triggers Regulation 164)?

Yes

No

More than $1,000,000 of **annual** payments to provider at risk (shared losses, withhold)?

Yes

No

More than 25% of **annual** payments to provider at risk?

More than 15% provider's Medicaid Revenue?

Off Menu VBP Arrangement?

Yes to Any

No to All

All contracts may be subject to Programmatic Review in addition to Financial Review.

Tier 3

Multi-Agency Review

Tier 2

DOH Review

Tier 1

File and Use

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Possible Risk Contract Review Tiers by VBP Arrangement Levels: Tier 3

	Level 0 VBP*	Level 1 VBP**	Level 2 VBP**	Level 3 VBP**
Tier 3: Multi-Agency Review (DOH, DFS)	An arrangement that triggers Reg 164 but has NO quality component.	⊘	A risk arrangement that triggers Reg 164 but is NOT fully prepaid.	A fully prepaid arrangement that triggers Reg 164.

* = Level 0 VBP arrangements include a cost-savings component or a quality component, but not both.
** = Level 1, 2, and 3 VBP arrangements must include a quality component in addition to a cost-savings component.
*** = There are a few exceptions such as P4P where there is a FFS arrangement with a quality bonus, but no cost-savings component.
⊘ = This type of VBP arrangement will not be subject to this particular Tier of contract review.

Possible Risk Contract Review Tiers by VBP Arrangement Levels: Tier 2

	Level 0 VBP*	Level 1 VBP**	Level 2 VBP**	Level 3 VBP**
Tier 2: DOH Review	An arrangement that does NOT trigger Reg 164, has NO quality component, and contains: 1) >$1,000,000 of potential provider payments at risk; AND 2) At least one of the following: a) >25% of annual Medicaid MC or MLTC payments at risk; OR b) >15% of a provider's total Medicaid revenue; OR c) An Off-Menu arrangement.		A risk arrangement that does NOT trigger Reg 164 and contains: 1) >$1,000,000 of potential provider payments at risk; AND 2) At least one of the following: a) >25% of annual Medicaid MC or MLTC payments at risk; OR b) >15% of a provider's total Medicaid revenue; OR c) An Off-Menu arrangement.	

* = Level 0 VBP arrangements include a cost-savings component or a quality component, but not both.

** = Level 1, 2, and 3 VBP arrangements must include a quality component in addition to a cost-savings component.

*** = There are a few exceptions such as P4P where there is a FFS arrangement with a quality bonus, but no cost-savings component.

⊘ = This type of VBP arrangement will not be subject to this particular Tier of contract review.

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Possible Risk Contract Review Tiers by VBP Arrangement Levels: Tier 1

	Level 0 VBP*	Level 1 VBP**	Level 2 VBP**	Level 3 VBP**
Tier 1: File and Use	An arrangement that does NOT trigger Reg 164, has NO quality component***, and contains: 1A) ≤$1,000,000 of potential provider payments at risk; OR 1B) >$1,000,000 of potential provider payments at risk; AND 2B) None of the following: a) >25% of annual Medicaid MC or MLTC payments at risk; OR b) >15% of a provider's total Medicaid revenue; OR c) An Off-Menu arrangement.	An upside-only shared savings arrangement (usually FFS) based on a target budget.	A risk-sharing arrangement that does NOT trigger Reg 164 and contains: 1A) ≤$1,000,000 of potential provider payments at risk; OR 1B) >$1,000,000 of potential provider payments at risk; AND 2B) None of the following: a) >25% of annual Medicaid MC or MLTC payments at risk; OR b) >15% of a provider's total Medicaid revenue; OR c) An Off-Menu arrangement.	A fully prepaid payment arrangement that does not trigger Reg 164.

* = Level 0 VBP arrangements include a cost-savings component or a quality component, but not both.
** = Level 1, 2, and 3 VBP arrangements must include a quality component in addition to a cost-savings component.
*** = There are a few exceptions such as P4P where there is a FFS arrangement with a quality bonus, but no cost-savings component.
⊘ = This type of VBP arrangement will not be subject to this particular Tier of contract review.

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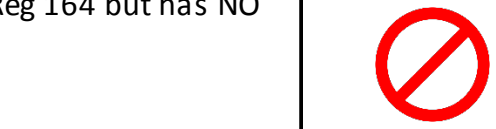
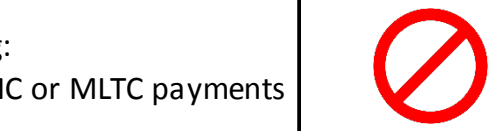
VBP Arrangement Level Examples by Risk Contract Review Tiers

	Level 0 VBP*	Level 1 VBP**	Level 2 VBP**	Level 3 VBP**
Tier 3: Multi-Agency Review (DOH, DFS)	An arrangement that triggers Reg 164 but has NO quality component.		A risk arrangement that triggers Reg 164 but is NOT fully prepaid.	A fully prepaid arrangement that triggers Reg 164.
Tier 2: DOH Review	An arrangement that does NOT trigger Reg 164, has NO quality component, and contains: 1) >$1,000,000 of potential provider payments at risk; AND 2) At least one of the following: a) >25% of annual Medicaid MC or MLTC payments at risk; OR b) >15% of a provider's total Medicaid revenue; OR c) An Off-Menu arrangement.		A risk arrangement that does NOT trigger Reg 164 and contains: 1) >$1,000,000 of potential provider payments at risk; AND 2) At least one of the following: a) >25% of annual Medicaid MC or MLTC payments at risk; OR b) >15% of a provider's total Medicaid revenue; OR c) An Off-Menu arrangement.	
Tier 1: File and Use	An arrangement that does NOT trigger Reg 164, has NO quality component***, and contains: 1A) ≤$1,000,000 of potential provider payments at risk; OR 1B) >$1,000,000 of potential provider payments at risk; AND 2B) None of the following: a) >25% of annual Medicaid MC or MLTC payments at risk; OR b) >15% of a provider's total Medicaid revenue; OR c) An Off-Menu arrangement.	An upside-only shared savings arrangement (usually FFS) based on a target budget.	A risk-sharing arrangement that does NOT trigger Reg 164 and contains: 1A) ≤$1,000,000 of potential provider payments at risk; OR 1B) >$1,000,000 of potential provider payments at risk; AND 2B) None of the following: a) >25% of annual Medicaid MC or MLTC payments at risk; OR b) >15% of a provider's total Medicaid revenue; OR c) An Off-Menu arrangement.	A fully prepaid payment arrangement that does not trigger Reg 164.

Possible Risk Contract Review Tiers by VBP Arrangement Levels

	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP
Tier 3: (Multi-Agency Review)	Possible	Never	Possible	Likely
Tier 2 (DOH Review)	Possible	Never	Possible	Never
Tier 1 (File and Use)	Possible	Likely	Possible	Possible

DOH and DFS Will Sign a Memorandum of Understanding

- DOH and DFS are coming together to agree on a Memorandum of Understanding (MOU) to clarify and distinguish the responsibilities of both DOH and DFS related to Tier 3 Contract Review (Multi-Agency Review).

- Approval of this MOU is forthcoming and is expected this summer.

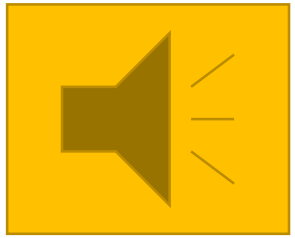
Questions

Lunch Break – 60 mins

VBP Contracting Panel

Contracting Panel – Real Life Experience

Contracting and risk management through the eyes of VBP contractors.



Please listen to hear challenges, best practices and lessons learned from the VBP panelists on strategizing and implementing VBP arrangements.

Panelists

Panelist	Role	Organization	Details
June Keenan, MS, MPH	Senior VP, Delivery System Transformation Executive Director	Westchester Medical Center, Regional Healthcare Innovation Center	Provider, Healthcare Network
Theresa Riordan	Vice President, Strategic Alliances	Healthfirst	Not-for-profit health insurance company
John Kastan, Ph.D.	Chief Program Officer	The Jewish Board	A large community-based social services and behavioral health organization, we provide a wide range of ambulatory and residential services to individuals, (and often entire families), of all ages.
Paloma Hernandez	President and CEO	Urban Health Plan, Inc.	Federally qualified community health center providing primary and specialty care.

Panel Questions

1. What has your organization done to get ready for VBP?
2. Can you please share a success story, challenge faced/overcome, and/or lessons learned from your organization's current experience with VBP/ VBP-like contracts?
3. What is the best advice that you would give to entities that are beginning the VBP contracting process?
4. In your opinion, what made your organization most successful – any specific "Dos and Don'ts" that you would like share?

Questions

Financial Risk Management

Financial Risk Management Overview

The following items will be reviewed in this section:

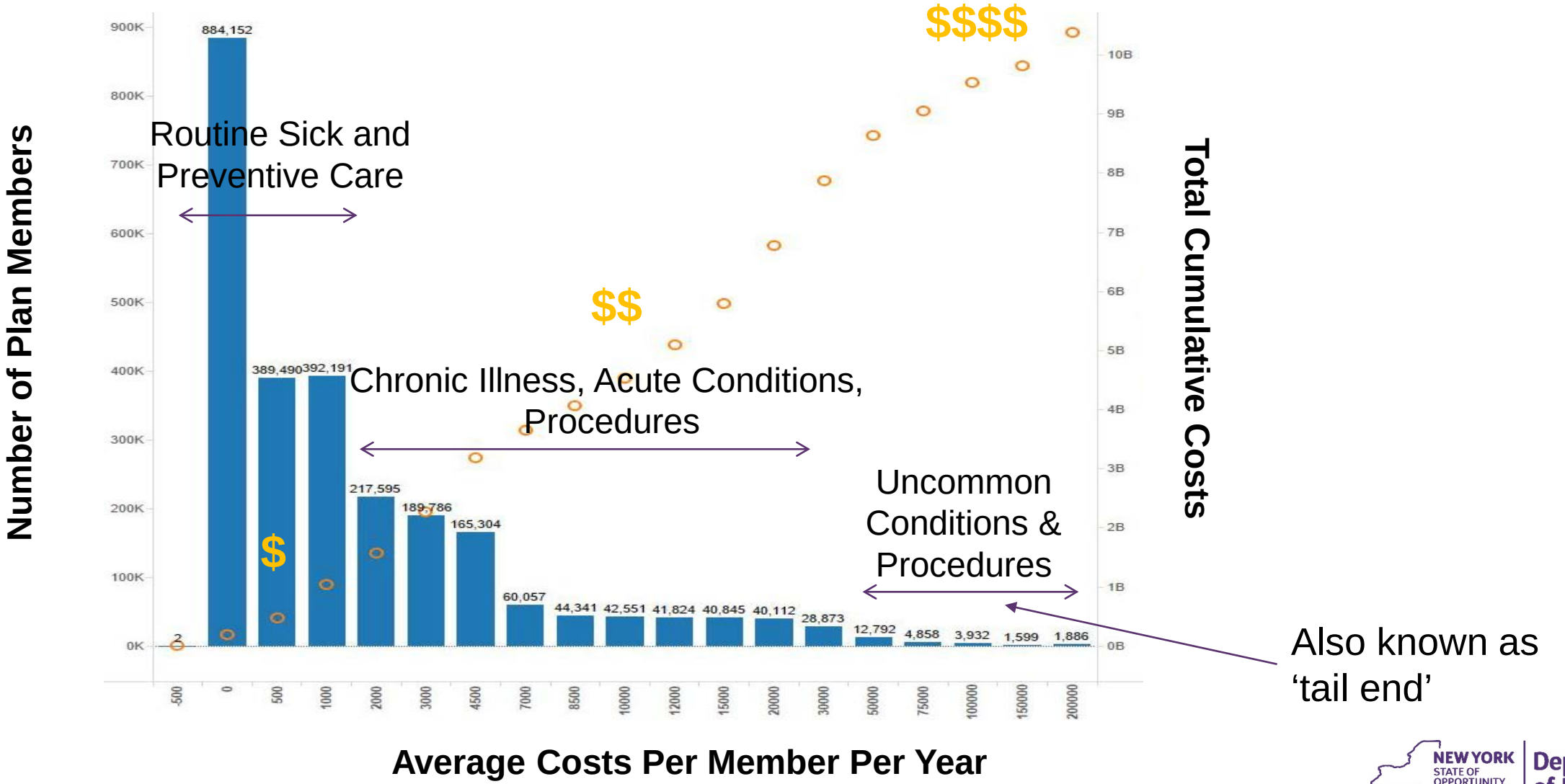
1

- Understanding the financial risk curve:
  - At the population level
  - At the episode/bundle level

2

- Using the risk management levers:
  - Upside and downside risk sharing
  - Stop loss limits
  - Margins

The Different Zones of Health Care Spending



Also known as ‘tail end’

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How it Plays Out in DSRIP and VBP Pilots

The table below contains a random sample of 50K plan members, 2014 Medicaid Claims (numbers rounded up):

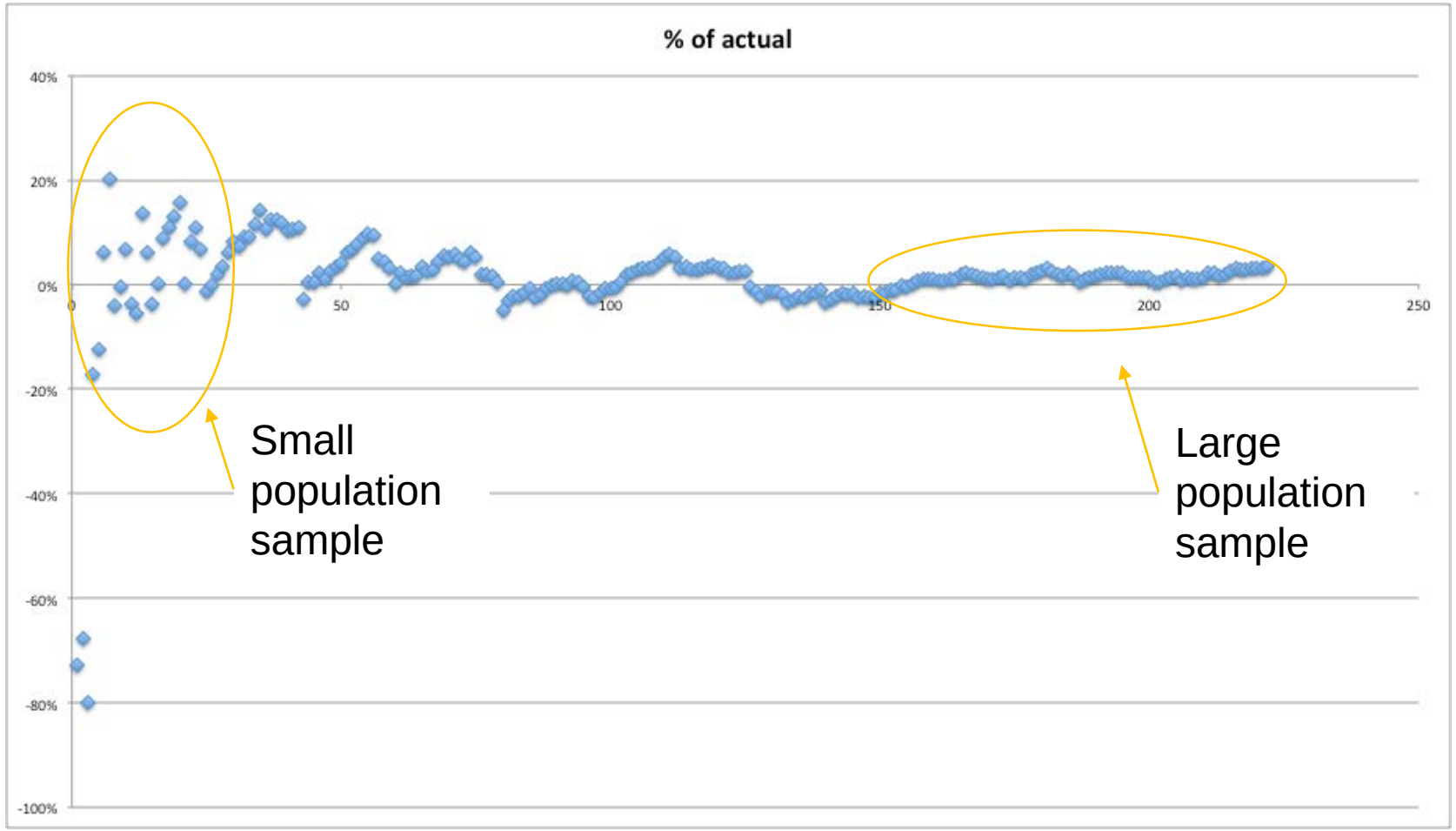
PMPY	TCGP	IPC-CB		Maternity	HIV/AIDS	HARP
		IPC	CB			
Volume	45,000	35,000	15,000	2,000	500	1,000
Average	$5,000	$700	$2,700	$10,500	$32,250	$20,750
10th %ile	$200	$0	$0	$6,400	$6,300	$2,100
25th %ile	$450	$60	$121	$7,500	$13,700	$5,600
75th %ile	$3,750	$800	$2,500	$11,200	$41,000	$25,750
90th %ile	$10,150	$1,500	$7,000	$15,300	$55,200	$45,000
Coefficient of Variation	**4.6**	**2.4**	**2.6**	**0.7**	**0.8**	**1.2**

Each cohort has its own distribution of costs and the coefficient of variation provides an indication of the length of the “tail” of the distribution. The longer the tail, the more variation and high cost cases. Small swings in high cost cases can impact the rest of the cohort.

The Effect of Small Samples on Financial Results

Sample Size: Number of Patients With Asthma

Cumulative Variance of Expected-to-Actual Costs of Asthma as a Percent of Actual



Population Size Considerations

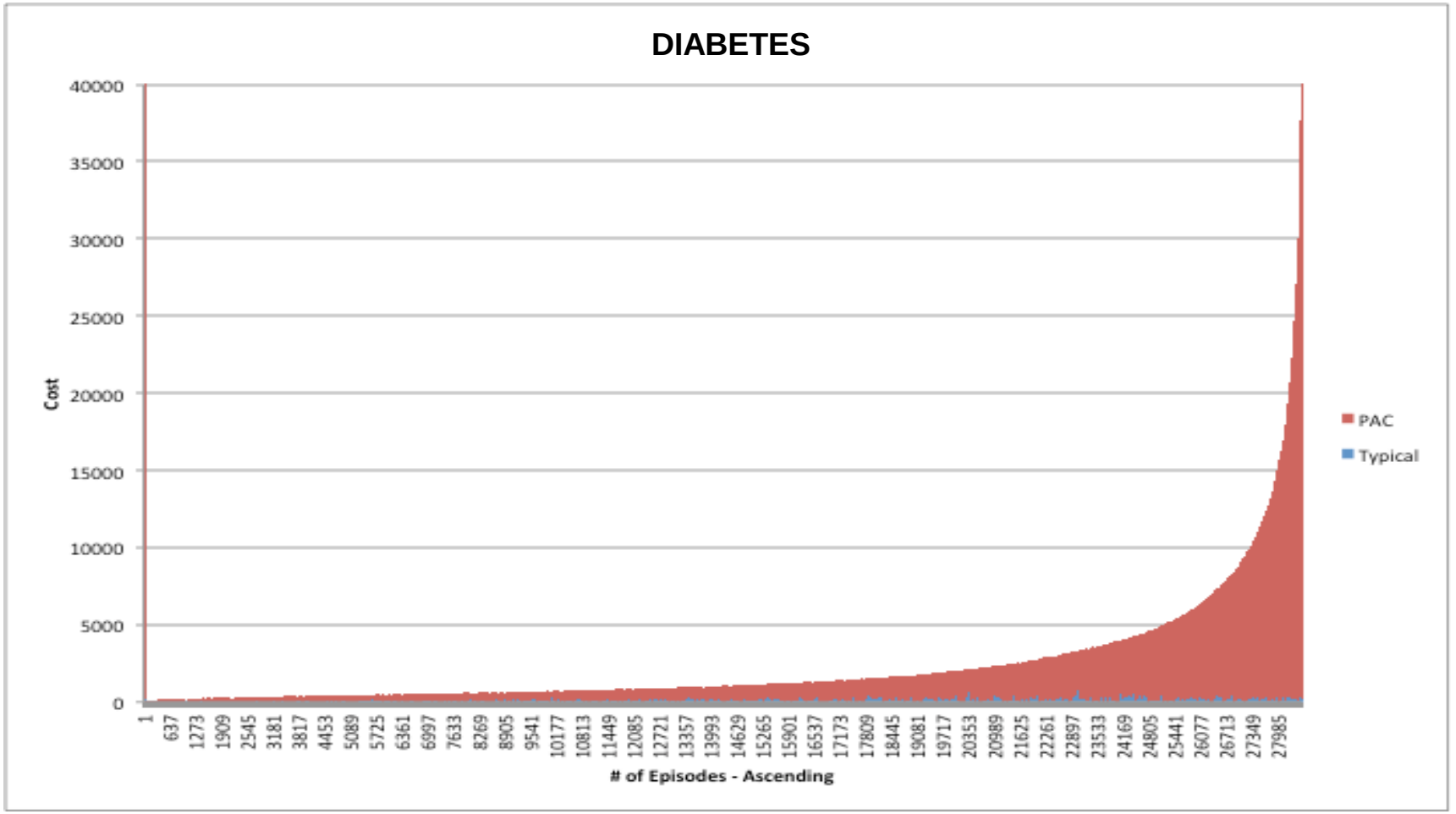
- The size of your population matters – larger samples help better understand cost trends and population behaviors
- That said, more people doesn't mean less individual case variation
- It is not recommended to contract VBP arrangements for small population groups
- Severity adjustment does work when applied properly (on larger population samples)

Cost Distribution of Episodes

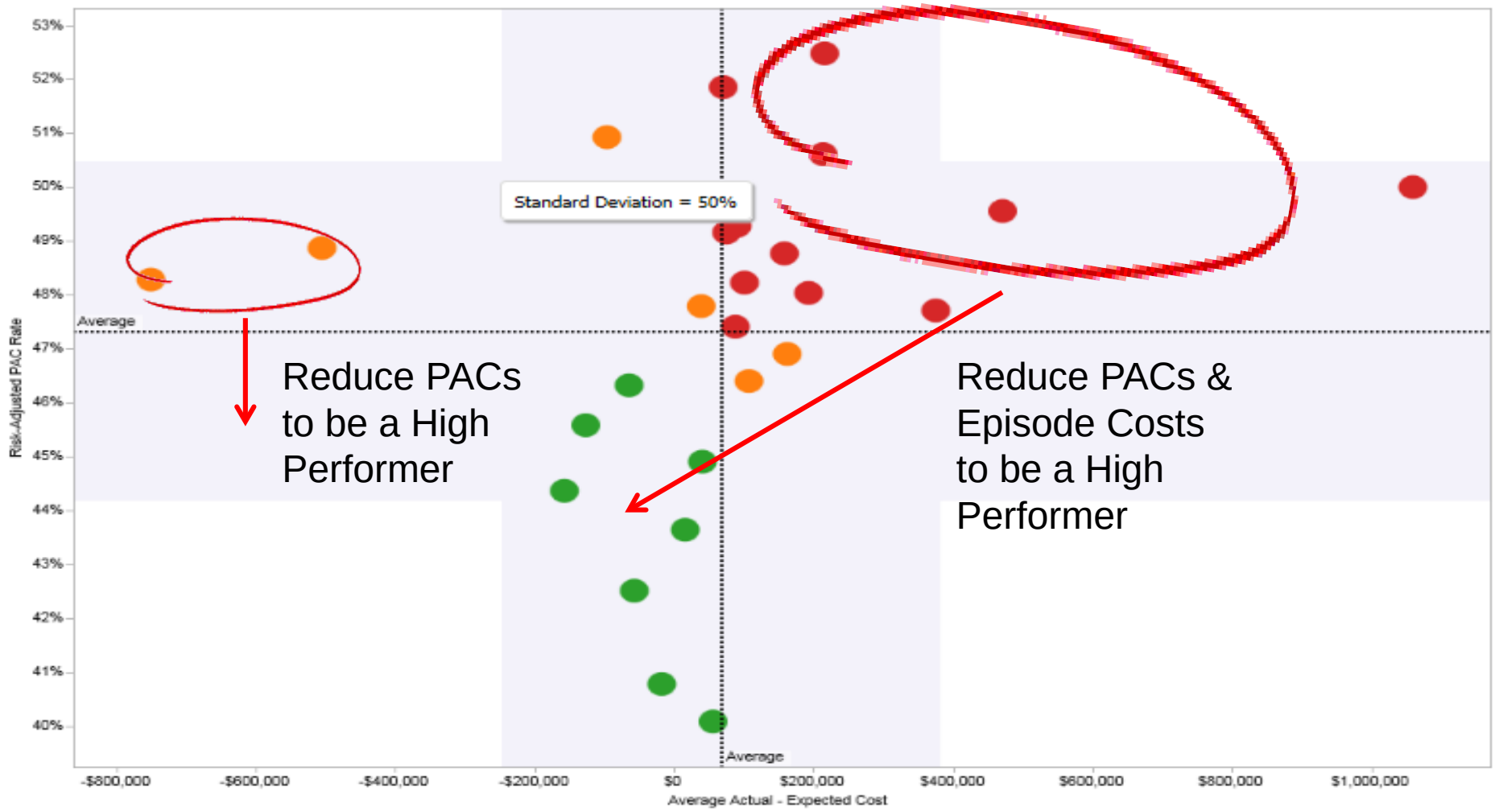
Financial risk is asymmetrical:

- you can't produce care for an episode for $0 (meaning there are limited savings)
- but you can potentially lose a lot on a single case.

The majority of high costs in an episode is driven by Potentially Avoidable Complications (PACs).



There are Significant Opportunities to Increase Value

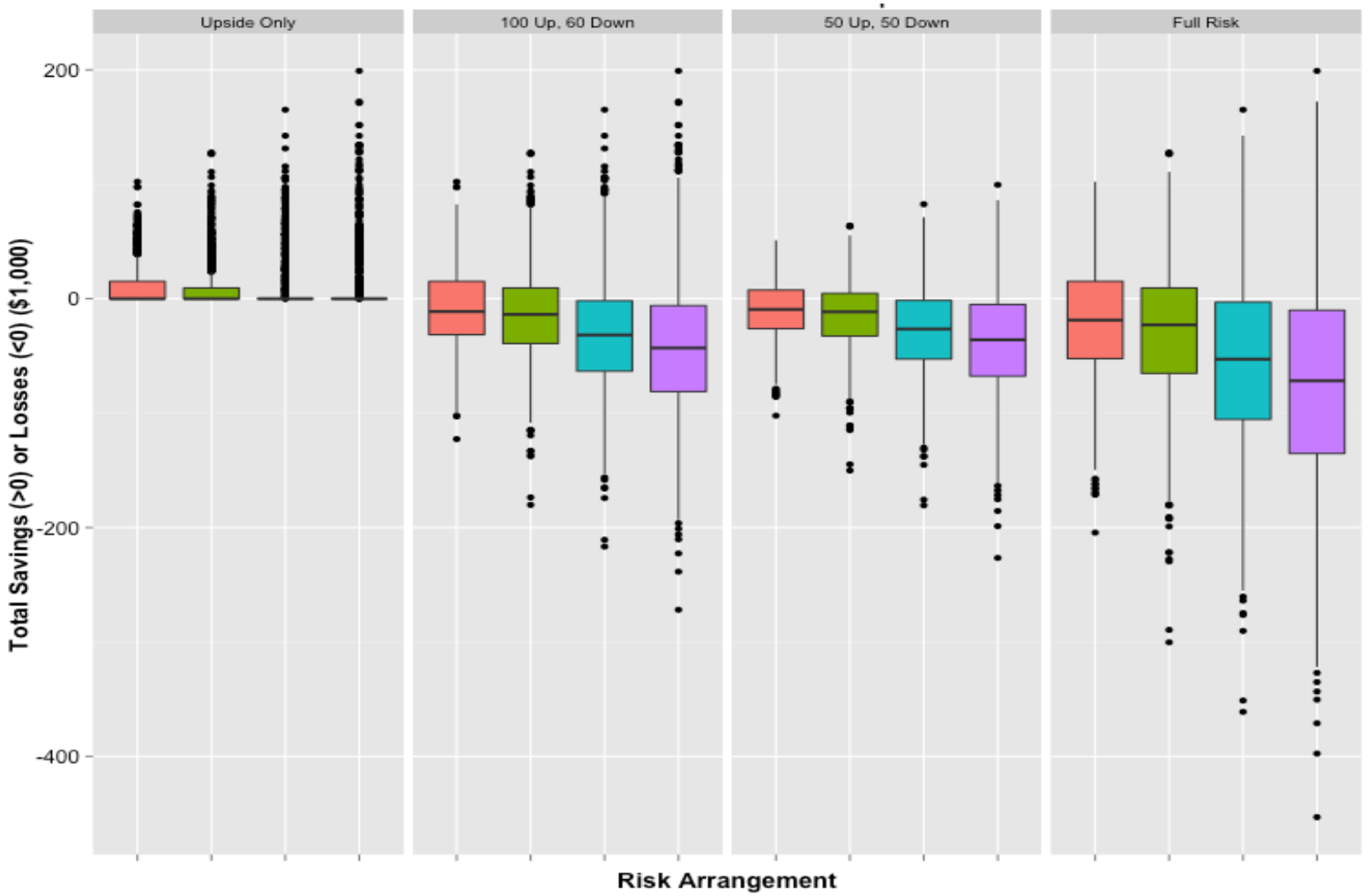


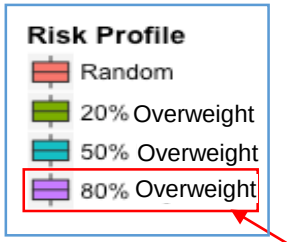
Questions

Understanding Asymmetrical Risk – Case Study

- We randomized 200 patients in 1000 physicians, created severity adjusted budgets and compared the budget to actual, and netted out the variance across all 200 patients to end up with a net saving or loss.
- We then simulated the effect on providers based on four different types of risk contracts – upside only, 100% upside/60% downside, 50/50 up/down, 100/100 up/down.
- We then simulated the effect when (a) patients are randomly distributed, (b) the provider has a moderately higher rate of severe patients, (c) a much higher rate of severe patients, and (d) a very high rate of severe patients.

Potential for Savings/Losses by Provider for Diabetes

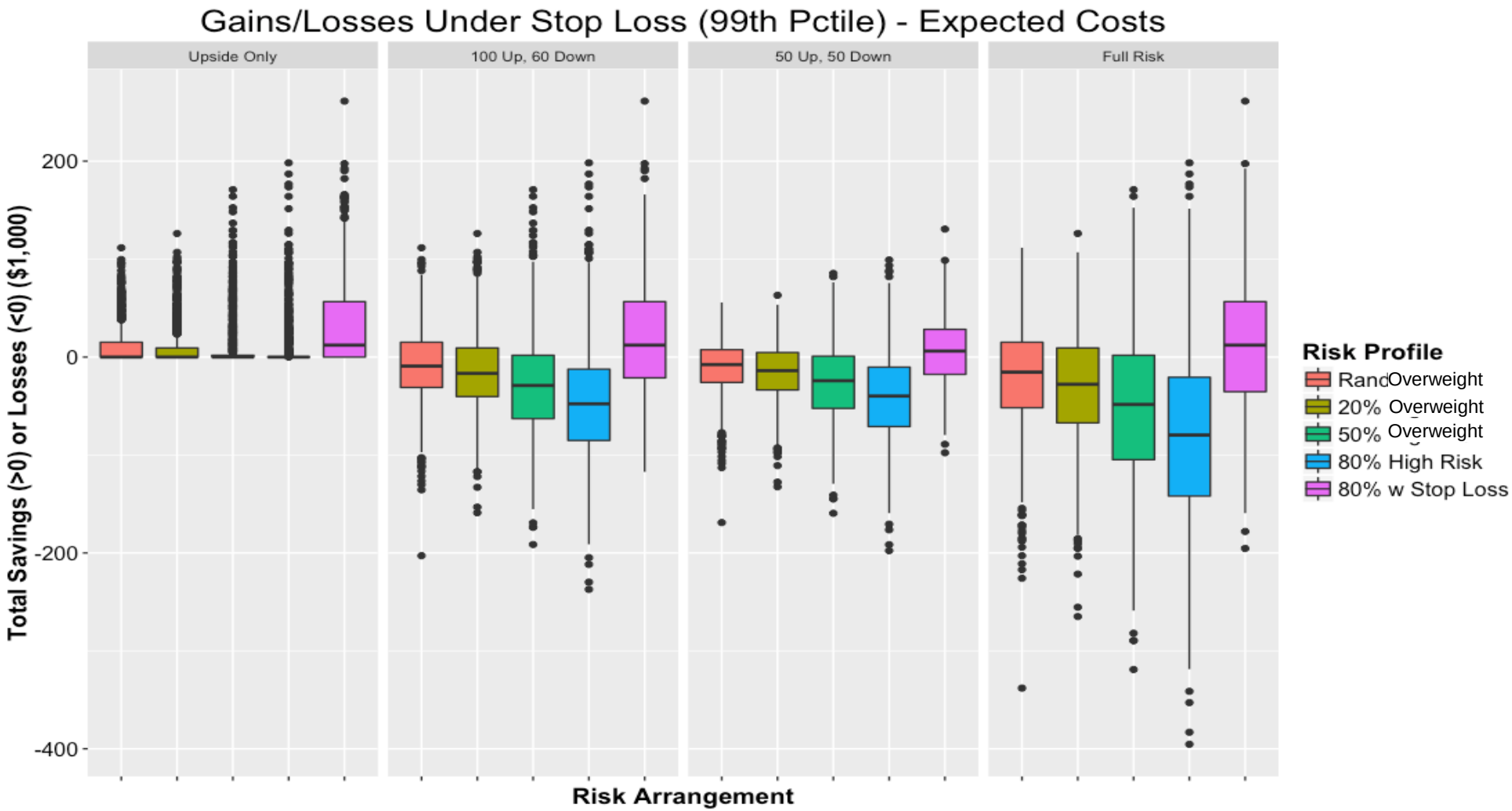




This graph depicts a scenario with highly unlikely negative population health characteristics

Almost impossible case scenario

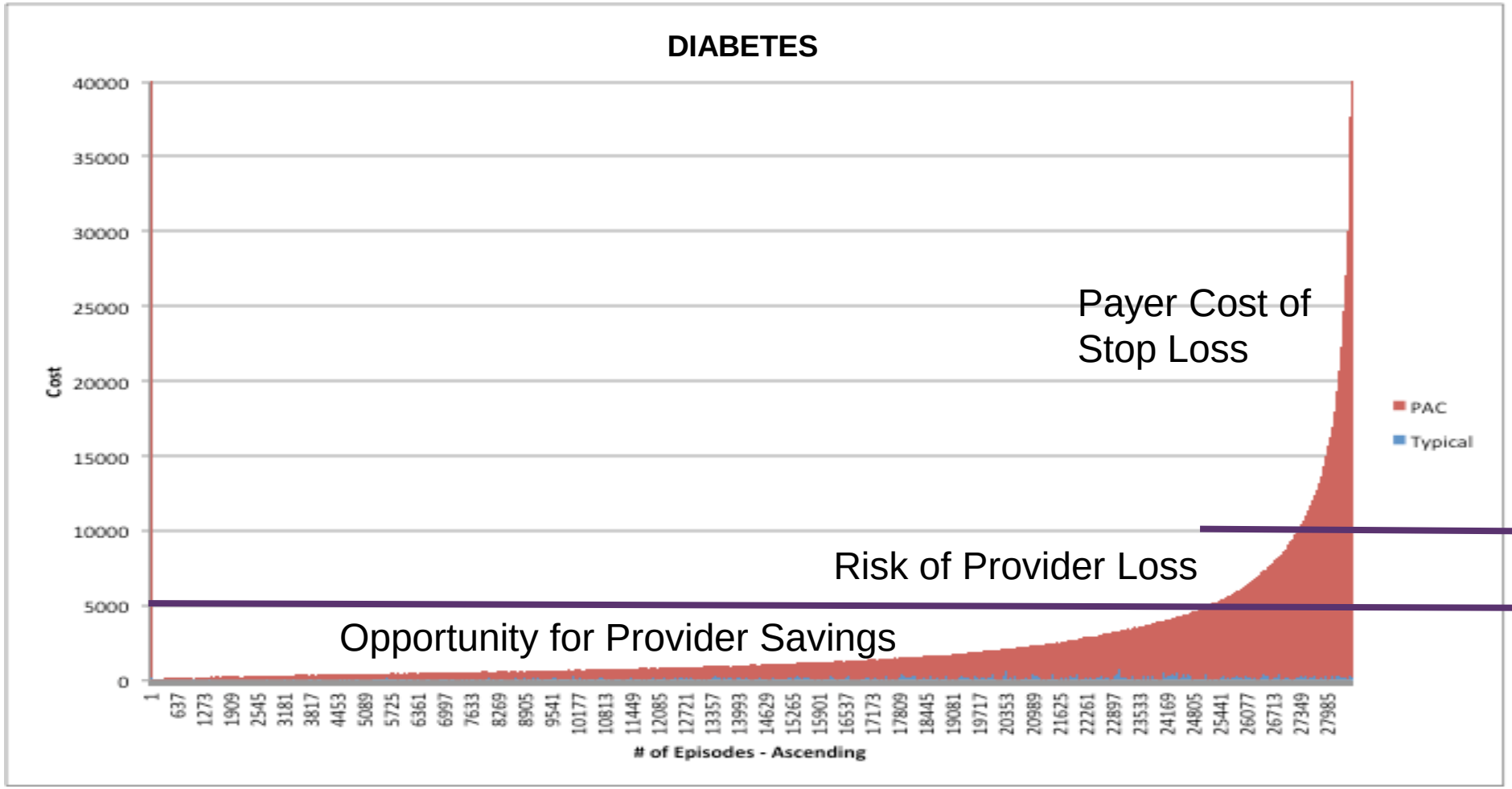
Potential for Savings/Losses by Provider for Diabetes (cont.)



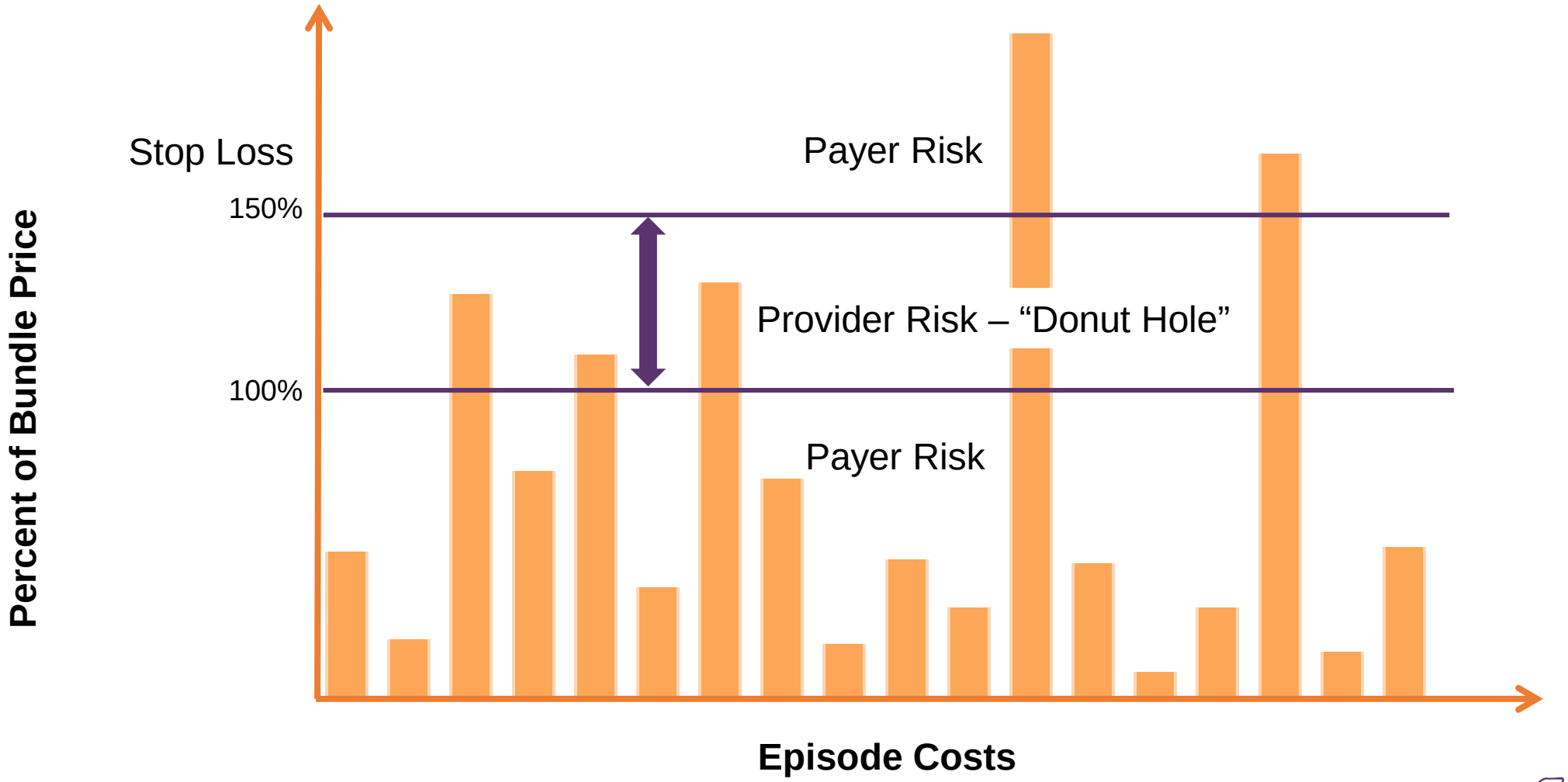
Implications for Equal Saving/Loss Sharing

- Even when adjusting for patient severity, a random assignment of patients yields a slightly greater potential for losses than savings because of the asymmetrical nature of savings/losses.
- A slight overweighting of greater than average severe patients can cause a greater imbalance in the potential for savings/losses by provider.
- A large overweighting of very severe patients will almost always result in provider losses. The opposite is also true.
- It’s possible to level the playing field up front, and then provider performance does the rest.

Cost Distribution of Episodes when Instituting a Stop-Loss



The “Donut Hole”



Managing Financial Risk in a Fixed Price Contract

- The provider is at risk for the excess costs over the prospective budget, up to the stop loss per episode
  - The budget is severity adjusted
  - The extent to which a provider is already highly efficient, a margin can be negotiated
  - The “Donut Hole” contains manageable risk
- There can be an aggregate stop loss in addition to a per episode stop-loss
- In the Level 1 “upside only risk” model, the **stop loss = budget**
  - But there is a cost to stop-loss for the payer

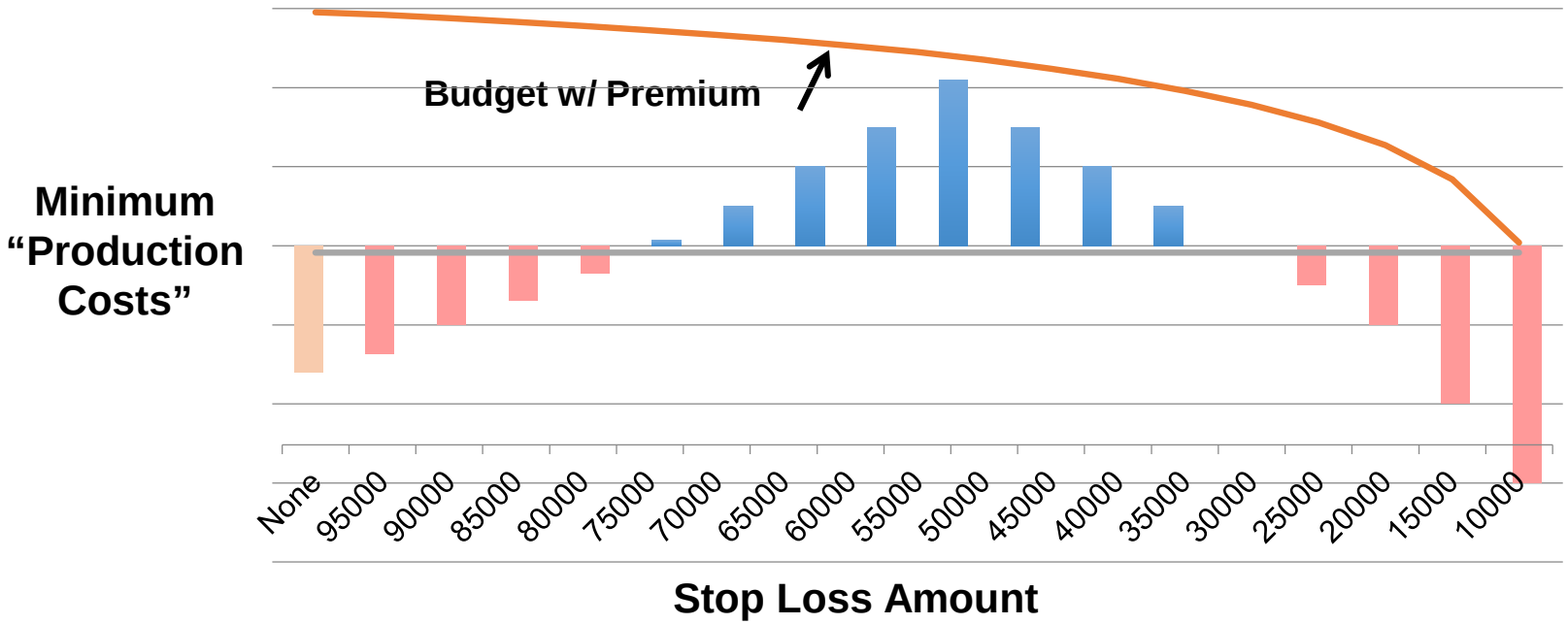
Considerations on Stop Loss

1. Payers and providers have to think thoroughly about the stop loss amount. Providers should be ready to pay stop loss premiums or reconsider their % of shared savings in order to stay protected
2. It is important to remember that the lower the stop loss threshold, the higher the stop loss “premium” and vice versa
3. Payers and providers can negotiate a “premium” for the stop loss, which would be equivalent to the payer’s estimated costs for instituting the stop loss, spread across all of a provider’s bundles and result in a budget reduction.

Considerations on Stop Loss (cont.)

4. The payer cost of stop-loss can be estimated by calculating the total costs in the tail of the episode cost distribution above the individual episode stop-loss
5. The potential for provider loss (the “Donut Hole”) can be estimated by calculating the area of the episode cost distribution above the average bundle price and the stop loss limit
6. The potential for provider savings can be estimated by calculating the area of the distribution above the actual and up to the average bundle price

Effects of Stop Loss on Budget and Savings/Losses



Reducing the stop-loss has two effects:

1. Budgets are reduced because past high cost cases are trimmed
2. Budgets are further reduced by the "excess stop-loss" insurance

There is a point of diminishing returns in reducing stop-loss limits.

- The potential for savings decreases as the budget is lowered towards the minimum production costs of the arrangement, and
- The potential for losses increases to the point where all cases could generate a loss

Margins Could be Considered for Highly Efficient Providers

A margin is a percentage negotiated by the payer and provider, which is added to the expected or budgeted typical costs (not to costs of potentially avoidable complications).

You can’t produce a bundle for $0, and there is an absolute floor that could be calculated. Providers close to the floor need a margin to reinvest in continuous performance improvement.

Summary of Financial Risk Management Strategies

1	Upside/downside risk sharing arrangements don't have to be symmetrical
2	Stop losses are for individual cases and can be in aggregate. There is a cost to a stop loss because the payer assumes the risk. "Excess" stop-loss insurance should come in reduction of the target budget/price
3	Defined margins are important to insulate providers from incurring losses because their potential for achieving further efficiencies is low
4	Quality scorecards can be used to encourage continued quality improvement even when providers have a bad financial year, and can be used to limit upside risk when quality doesn't improve or fails to meet a certain threshold performance

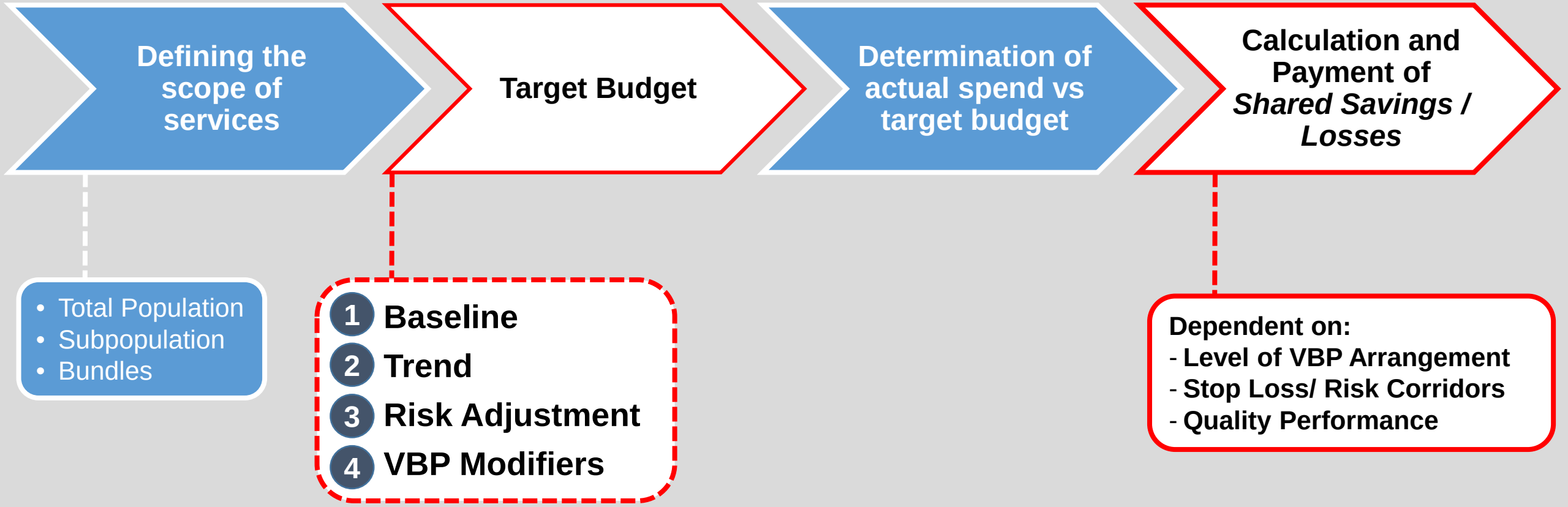
Questions

Break – 15 mins

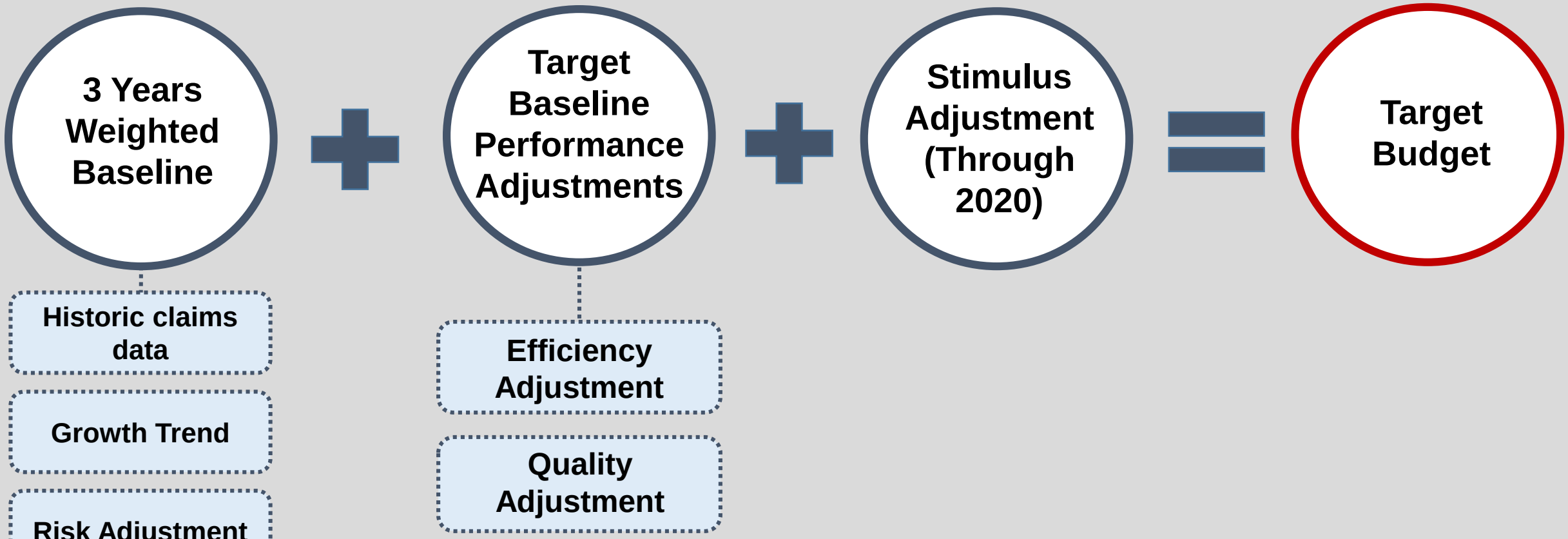
Guidance on Setting Target Budget for a VBP Arrangement (between MCO and Provider)

Methodology

Setting Target Budget is a Key Step in the Determination of Shared Savings/Losses



Target Budget Components



Note: The Target Budget Setting process outlined here is only a guideline. Plans and VBP Contractors are free to negotiate their own Target Budget Setting Methodology.

Baseline – Example

Baseline Input	Year 3	Year 2	Year 1
Preventive Care	$ 250	$ 750	$ 250
Sick Care	$ 1,000	$ 750	$ 500
Chronic Care (Diabetes)	$ 1,500	$ 1,000	$ 750
IPC Total	**$ 2,750**	**$ 2,500**	**$ 1,500**
Other Care	$ 1,500	$ 0	$ 1,500
Total	**$ 4,250**	**$ 2,500**	**$ 3,000**
Baseline Cost Weights	15%	35%	50%

Year 3:

$250 in Preventive Care
$1,000 in Sick Care
$1,500 in Diabetes-related Care

$1,500 ER visit (accident at gym)

Baseline – Example

Baseline Input	Year 3	Year 2	Year 1
Preventive Care	$ 250	$ 750	$ 250
Sick Care	$ 1,000	$ 750	$ 500
Chronic Care (Diabetes)	$ 1,500	$ 1,000	$ 750
IPC Total	**$ 2,750**	**$ 2,500**	**$ 1,500**
Other Care	$ 1,500	$ 0	$ 1,500
Total	**$ 4,250**	**$ 2,500**	**$ 3,000**
Baseline Cost Weights	15%	35%	50%

Year 2:

$750 in Preventive Care
$750 in Sick Care
$1,000 in Diabetes-related Care

No other care provided

Baseline – Example

Baseline Input	Year 3	Year 2	Year 1
Preventive Care	$ 250	$ 750	$ 250
Sick Care	$ 1,000	$ 750	$ 500
Chronic Care (Diabetes)	$ 1,500	$ 1,000	$ 750
IPC Total	**$ 2,750**	**$ 2,500**	**$ 1,500**
Other Care	$ 1,500	$ 0	$ 1,500
Total	**$ 4,250**	**$ 2,500**	**$ 3,000**
Baseline Cost Weights	15%	35%	50%

Year 1:

$250 in Preventive Care
$500 in Sick Care
$750 in Diabetes-related Care

$1,500 in IP for Migraines

Baseline – Formula

Purpose: *to determine the weighted member-specific historical costs over a three year period.*

Formula	Year 3	Year 2	Year 1 (most recent)
Baseline Cost Weights	15%	35%	50%

Example Data	Year 3	Year 2	Year 1 (most recent)
Baseline Cost: TCGP	$ 4,250	$ 2,500	$ 3,000

Formula:

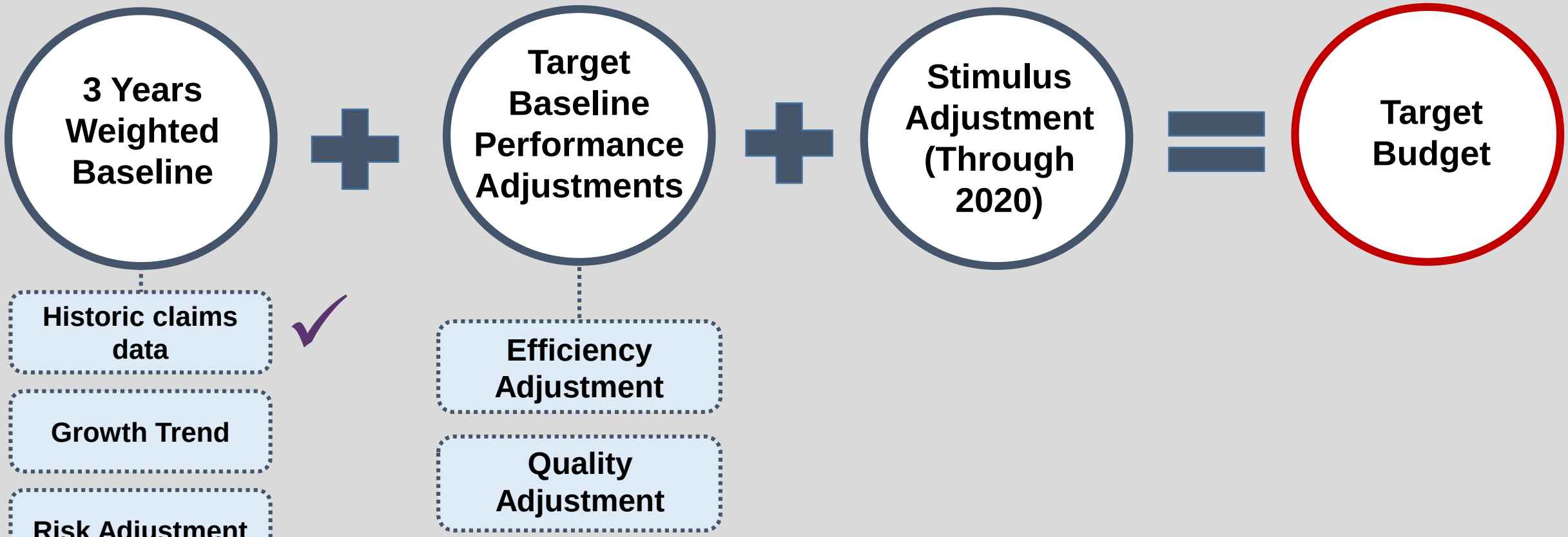
(**Year 3** *0.15) + (**Year 2***0.35) + (**Year 1***0.50)

Formula: TCGP

(**4,250***0.15) + (**2,500***0.35) + (**3,000***0.50) = **$ 3,012**

The baseline cost is a **weighted average** of actual per-member per-month (PMPM) or per-bundle payments **over 3 years** with the most recent year, “Year 1,” weighted the most.

Target Budget Components

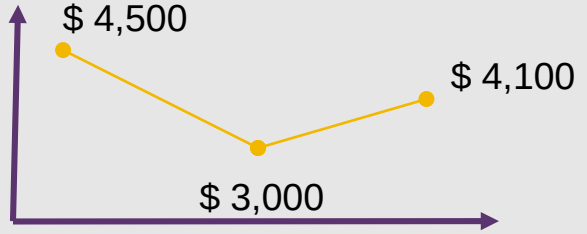


Note: The Target Budget Setting process outlined here is only a guideline. Plans and VBP Contractors are free to negotiate their own Target Budget Setting Methodology, provided it meets the State's

Growth Trend – Example

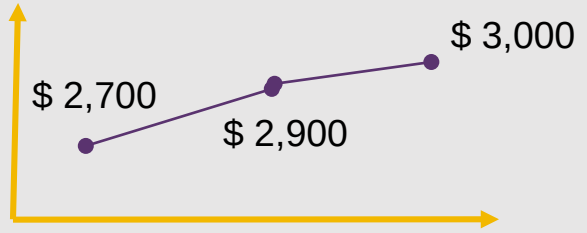
VBP Contractor Growth Trend

Example Data	Year 3	Year 2	Year 1 (most recent)
Baseline Cost: TCGP	$ 4,500	$ 3,000	$ 4,100



Regional Growth Trend

Example Data	Year 3	Year 2	Year 1 (most recent)
Baseline Cost: TCGP	$ 2,700	$ 2,900	$ 3,000



Note: The Downstate Region consists of the five counties comprising New York City, and the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The Upstate Region consists of all counties in the State other than those counties included in the Downstate Region. This aligns with NYS' ambulatory patient groups definitions for up/down state

Growth Trend – Example

VBP Contractor Growth Trend

Example Data	Year 3	Year 2	Year 1 (most recent)
Baseline Cost: TCGP	$ 4,500	$ 3,000	$ 4,100

Growth Trend = Year 1 / Year 3

VBP Contractor Growth Trend = 4,100 / 4,500 = **0.911**

Regional Growth Trend

Example Data	Year 3	Year 2	Year 1 (most recent)
Baseline Cost: TCGP	$ 2,700	$ 2,900	$ 3,000

Growth Trend = Year 1 / Year 3

Regional Growth Trend = 3,000 / 2,700 = **1.111**

Note: The Downstate Region consists of the five counties comprising New York City, and the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The Upstate Region consists of all counties in the State other than those counties included in the Downstate Region. This aligns with NYS' ambulatory patient groups definitions for up/down state

Growth Trend – Formula

Purpose: *to account for changes in cost of delivering care by applying a growth trend to the weighted baseline cost*

Formula:

Weighted Baseline * (Regional Growth Trend + VBP Contractor Specific Growth Trend) * .5

Example:

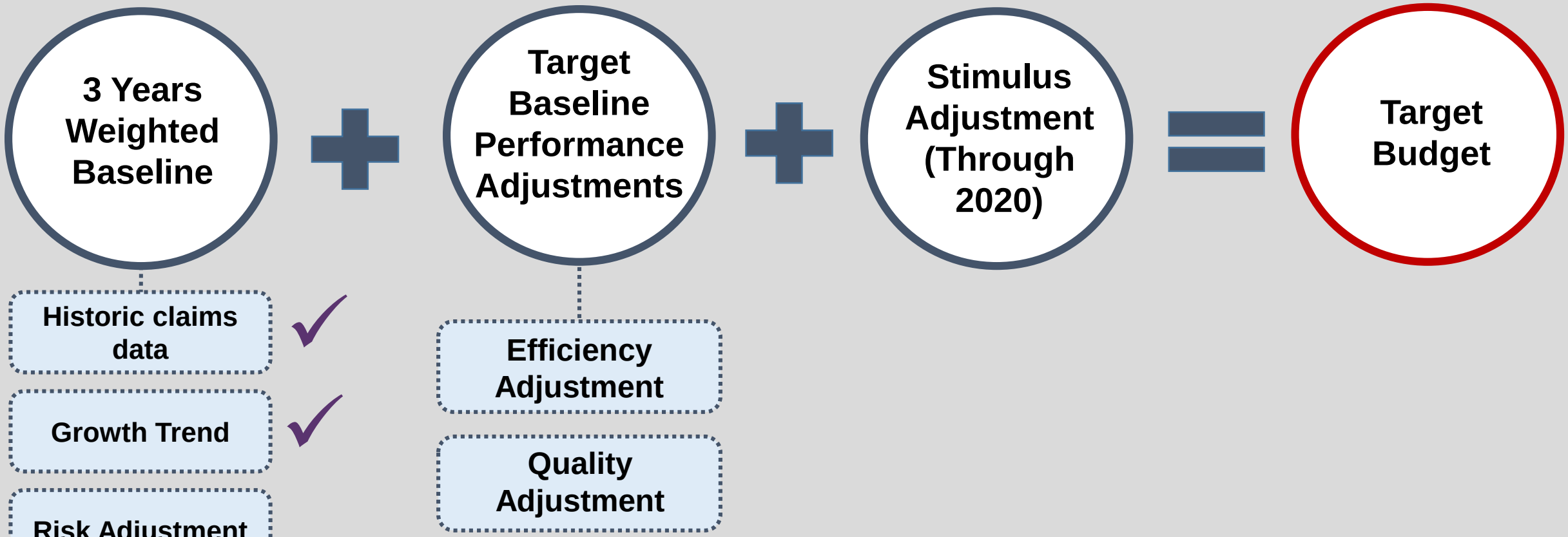
$ 3,012 x (1.111 + 0.911) x .5
$ 3,012 x 1.011

$ 3,012 x 1.011 = **$ 3,045.13**

- The growth trend of costs during the performance period is calculated by averaging the regional growth trend (upstate or downstate) and a VBP contractor-specific growth trend.
- The trend is computed over the same three years as the baseline.

Note: The Downstate Region consists of the five counties comprising New York City, and the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The Upstate Region consists of all counties in the State other than those counties included in the Downstate Region. This aligns with NYS' ambulatory patient groups definitions for up/down state

Target Budget Components



Note: The Target Budget Setting process outlined here is only a guideline. Plans and VBP Contractors are free to negotiate their own Target Budget Setting Methodology, provided it meets the State's

Risk Adjustment – Methods

***Purpose**: At the start of the contract year the risk-profile of the population may be different from the historical baseline. The target budget may therefore need to be adjusted accordingly. This ensures that variance in the risk profile of member populations does not skew the target budget calculation.*

Methods:

Comparing 3M CRG or HCI3 Risk Adjustment Coefficient of Baseline data to attributed population at start of contract.

- If the risk adjustment coefficient is different, the target budget is changed accordingly. This only happens at the start of the contract year.

Risk Adjustment

***Purpose**: At the start of the contract year the risk-profile of the population may be different from the historical baseline. The target budget may therefore need to be adjusted accordingly. This ensures that variance in the risk profile of member populations does not skew the target budget calculation.*

Method:

Compare 3M CRG or HCI3 Risk Adjustment Coefficient of Baseline data to attributed population at start of contract.

Case Mix Factor x Target Budget = Risk-adjusted Target Budget

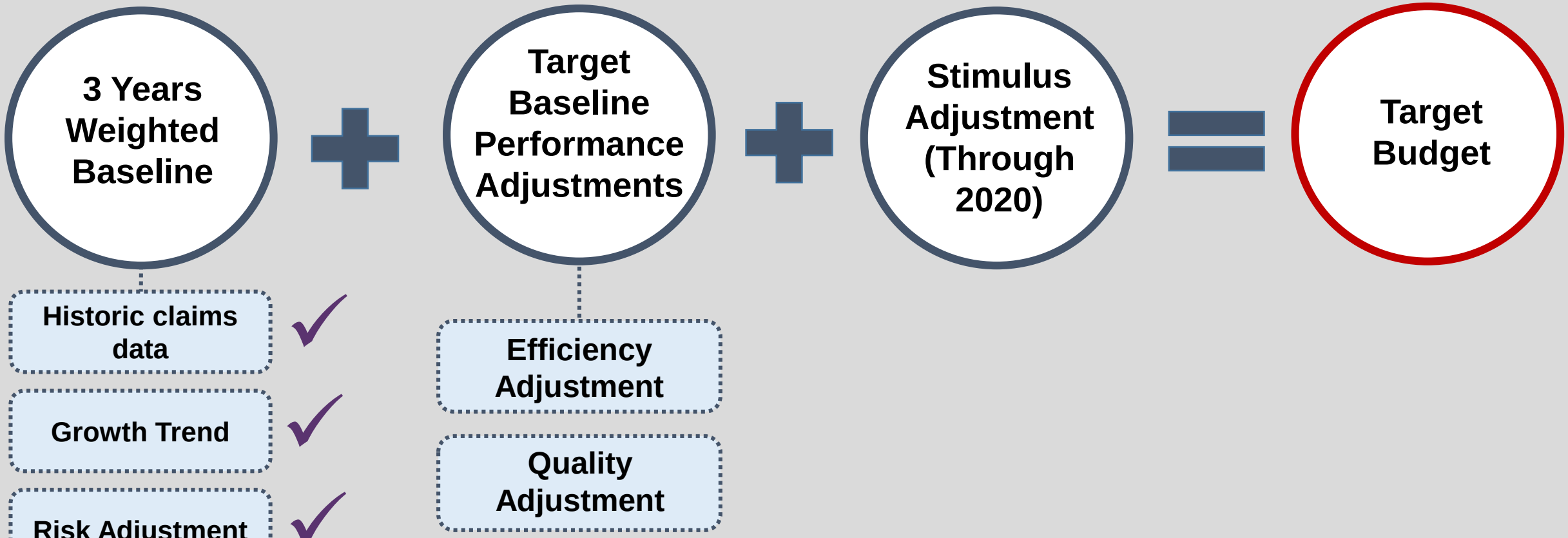
Example:

Case Mix Factor x Target Budget = Risk-adjusted Target Budget

1.025 x $ 3,045.13 = **$ 3,121.26**

This only happens at the start of the contract year.

Target Budget Components

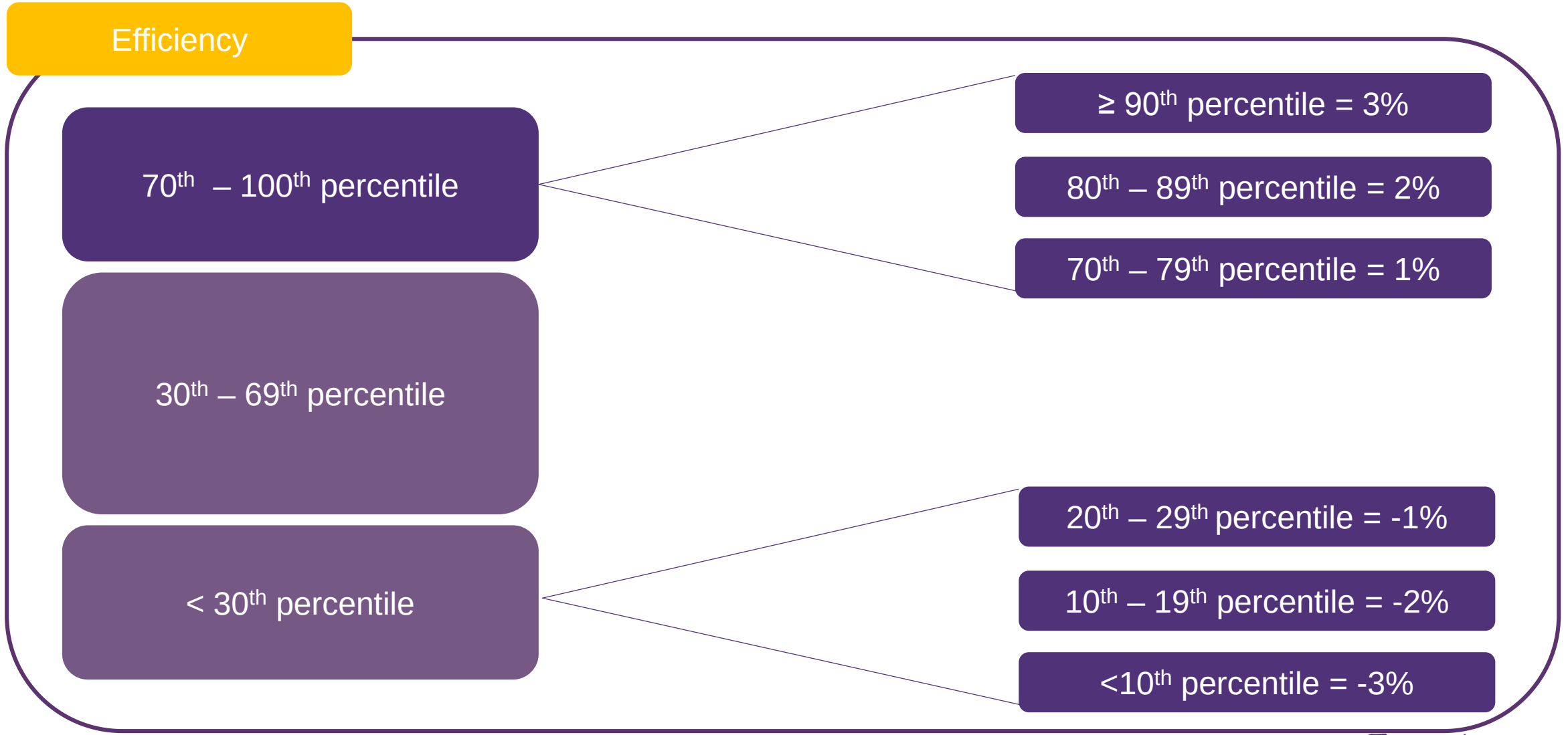


Note: The Target Budget Setting process outlined here is only a guideline. Plans and VBP Contractors are free to negotiate their own Target Budget Setting Methodology, provided it meets the State's

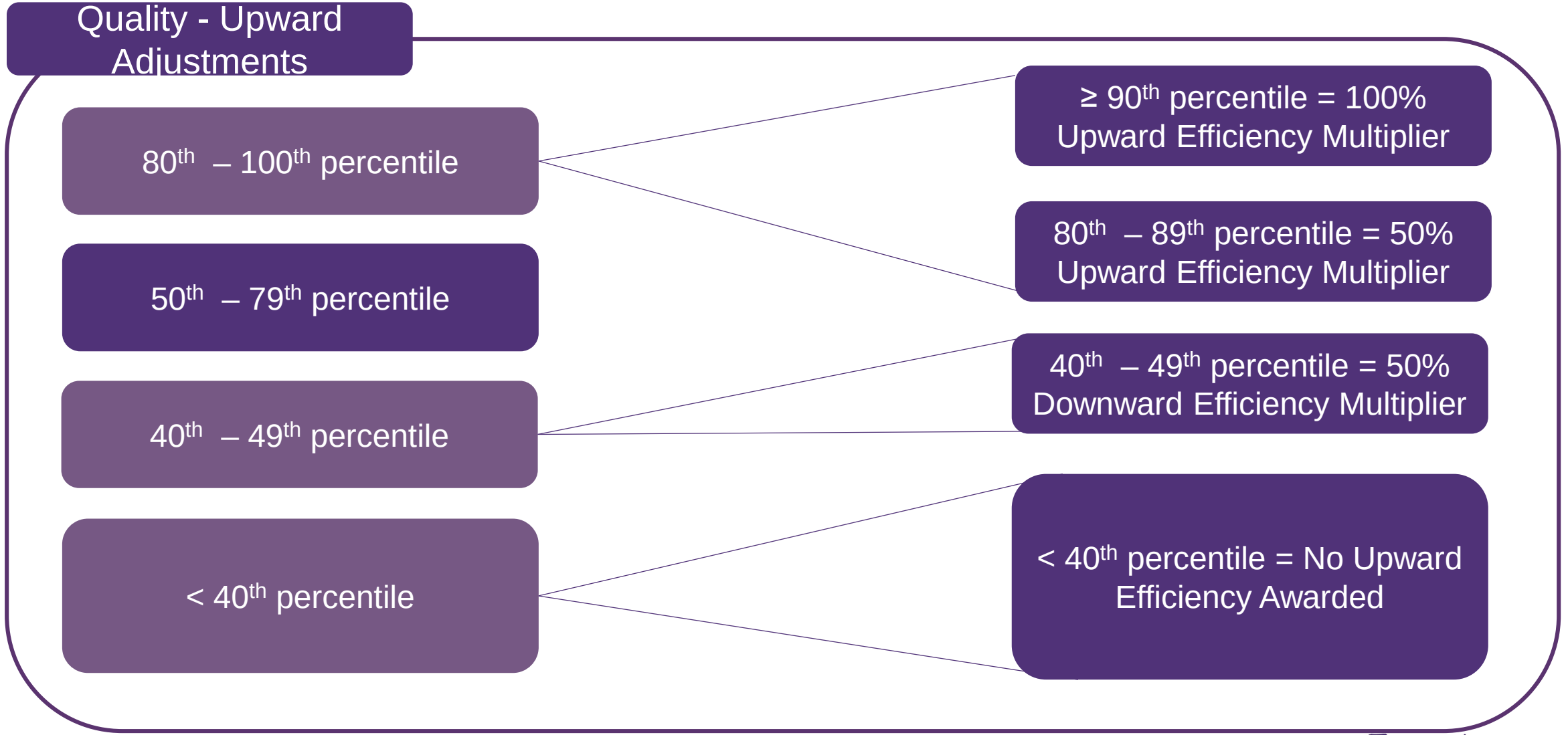
Questions

Performance Adjustments

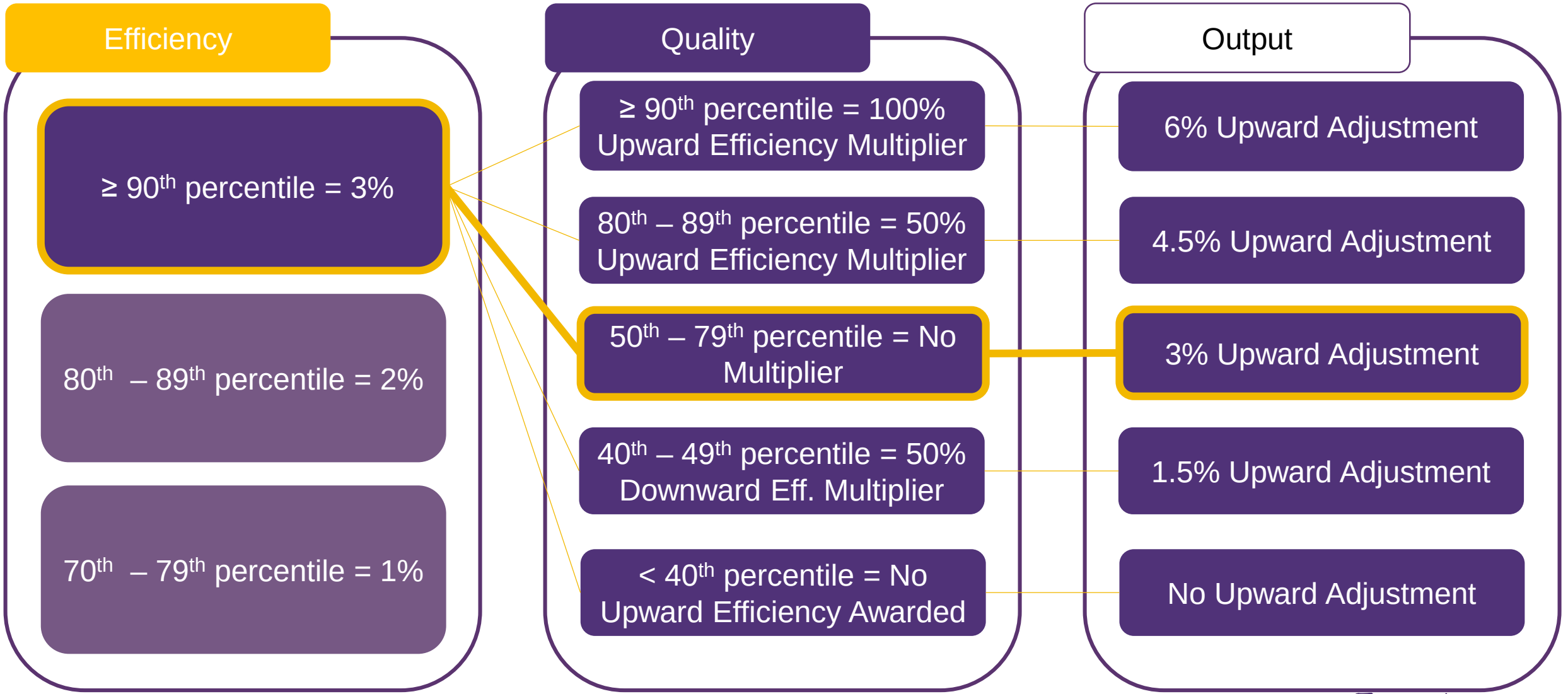
VBP Contracts Performance Adjustments - Efficiency



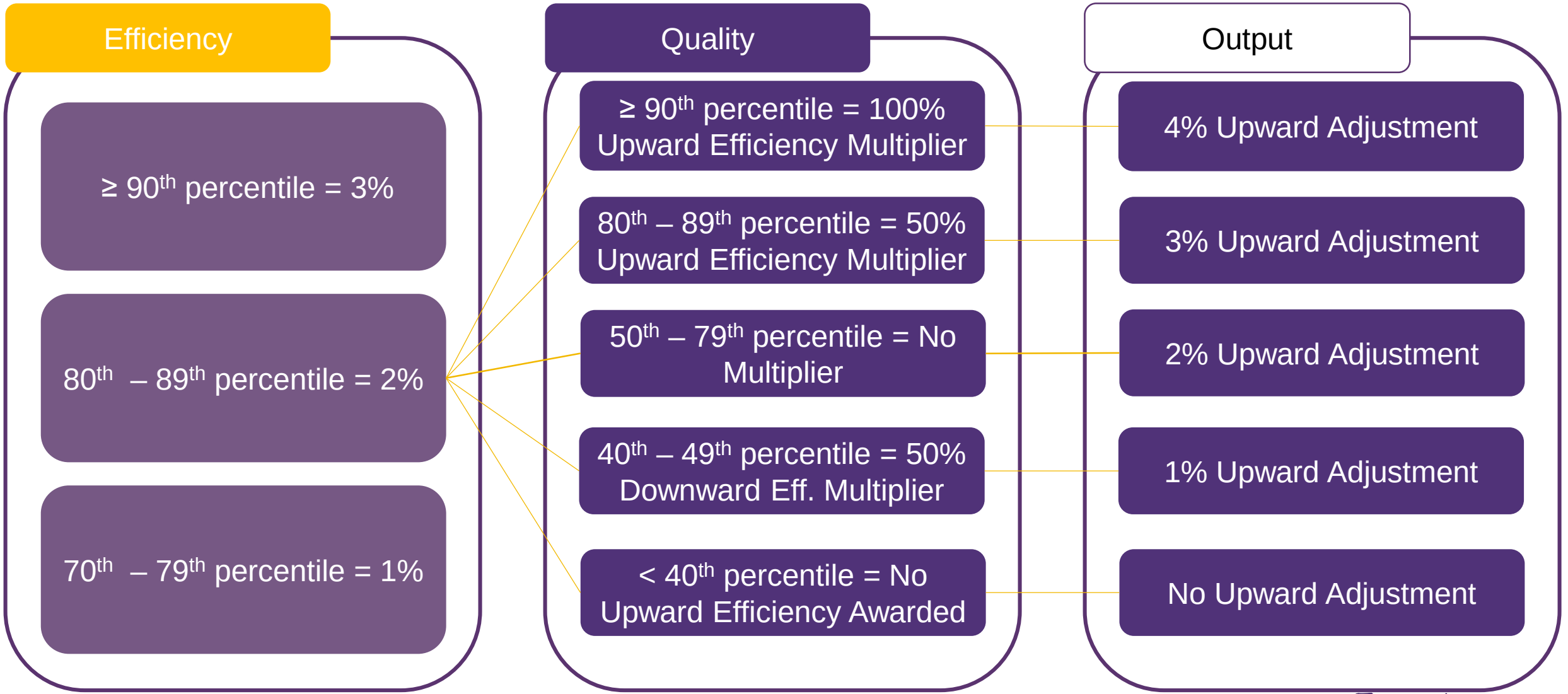
VBP Contracts Performance Adjustments - Quality



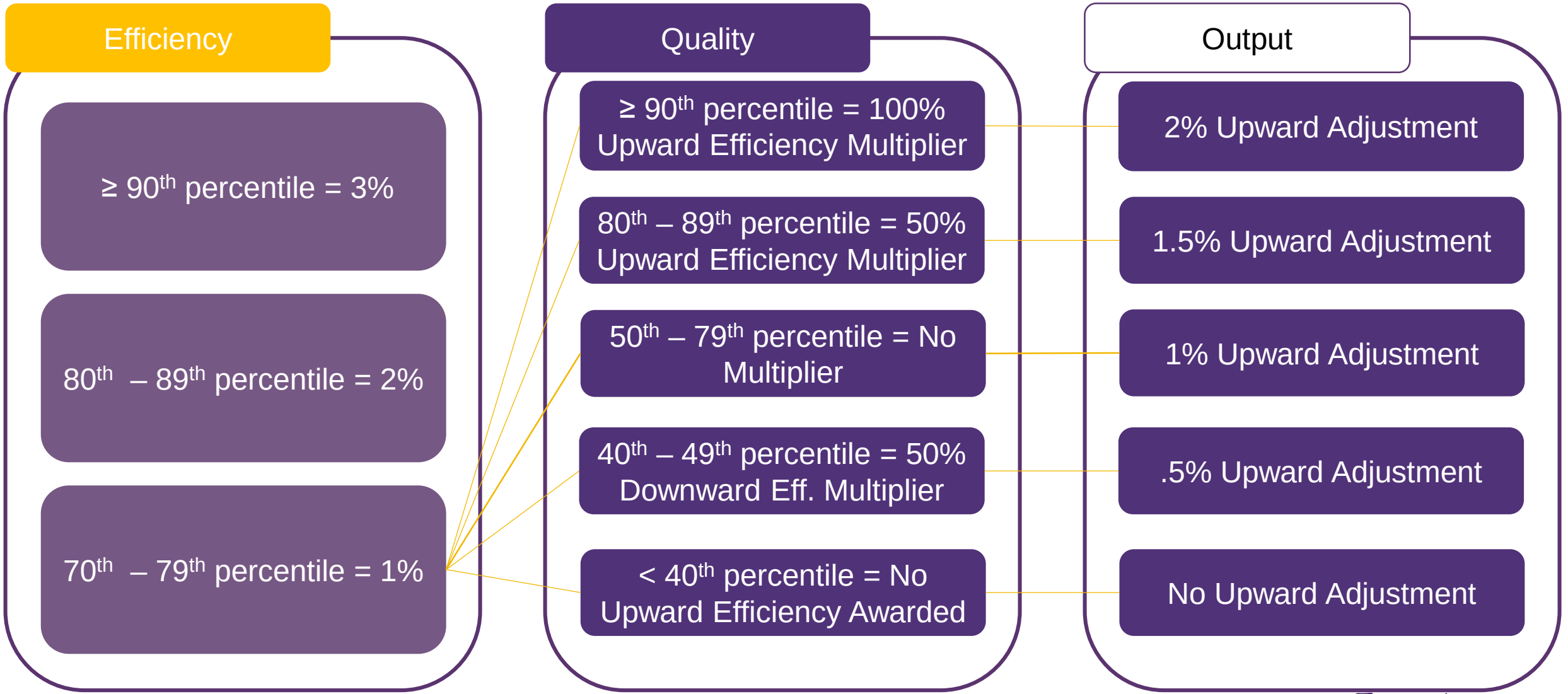
VBP Contracts Performance Adjustments - Upwards Adjustment



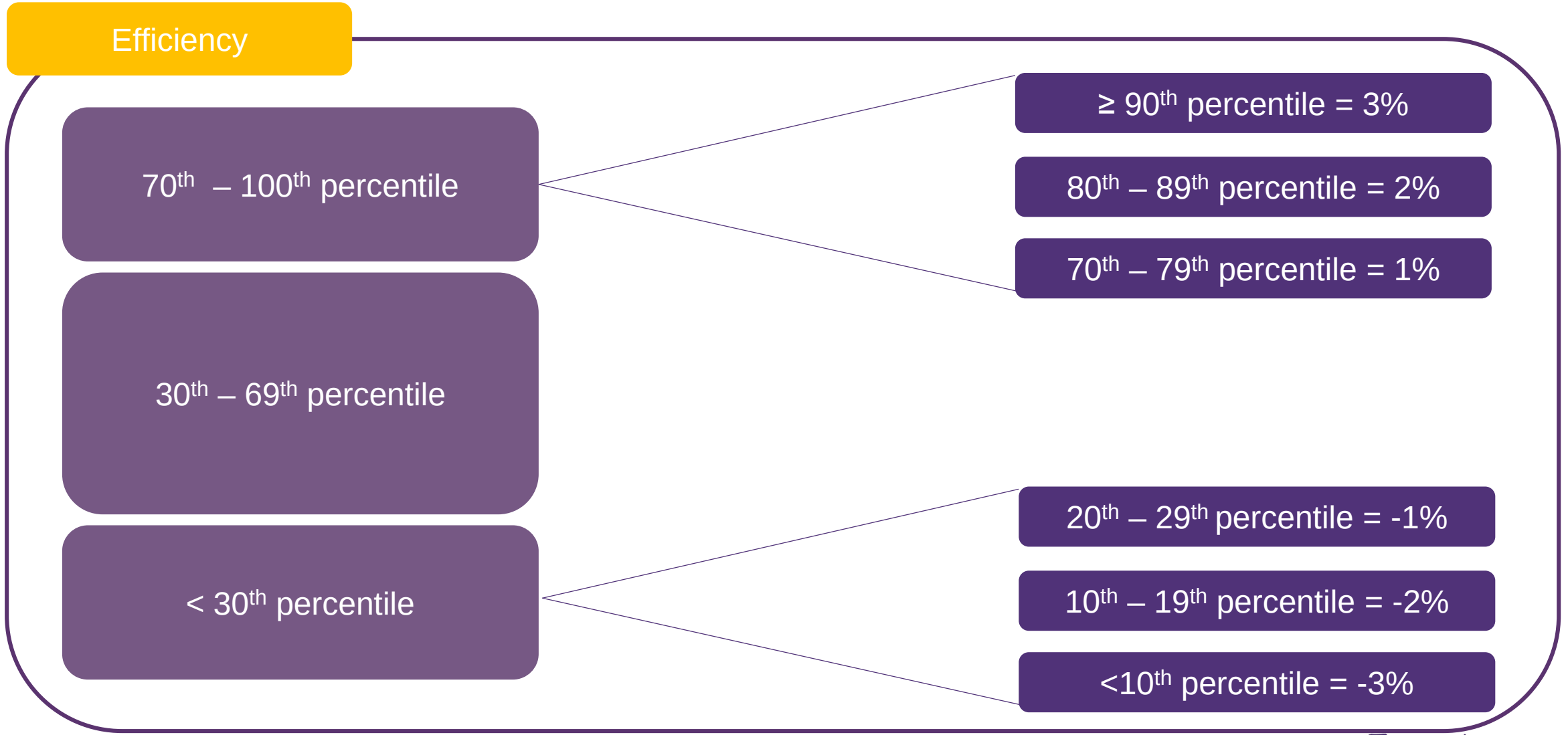
VBP Contracts Performance Adjustments - Upwards Adjustment



VBP Contracts Performance Adjustments - Upwards Adjustment



VBP Contracts Performance Adjustments - Efficiency

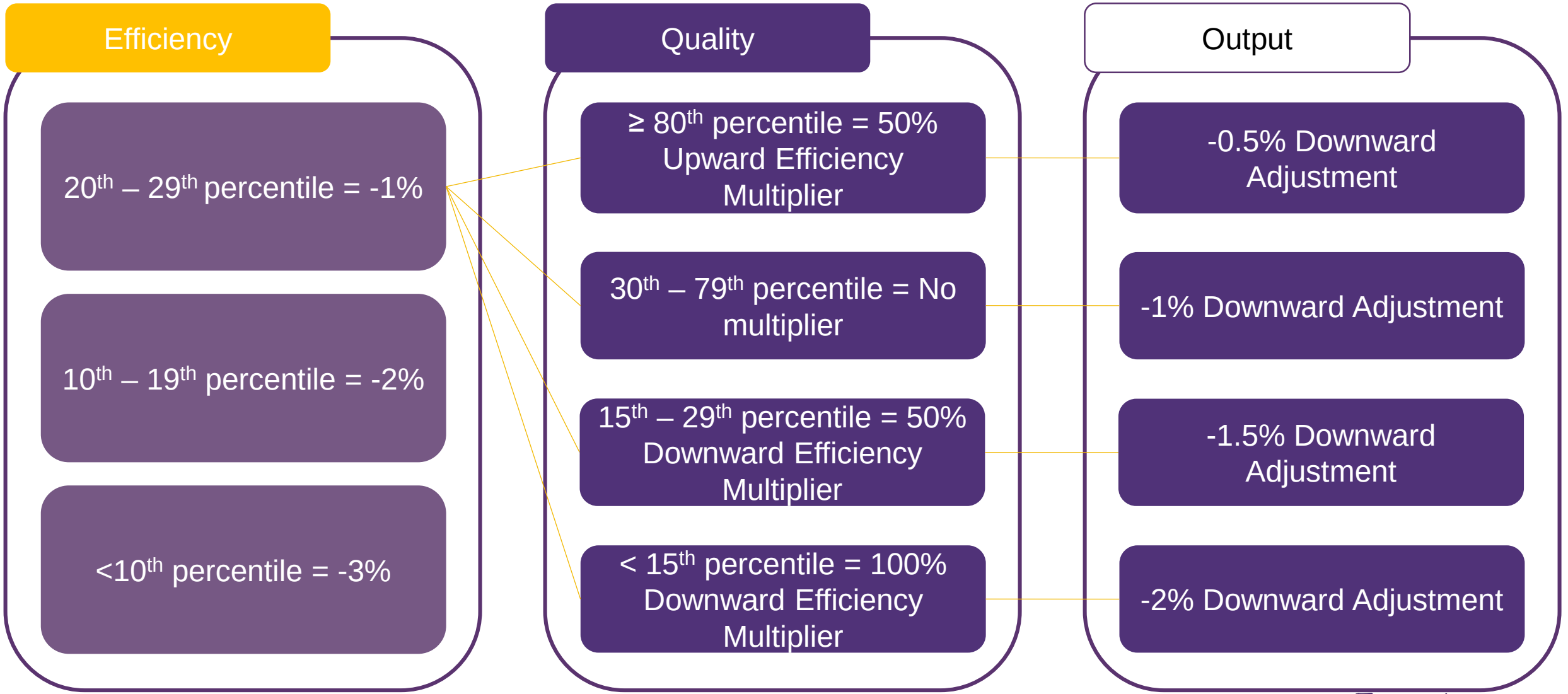


VBP Contracts Performance Adjustments - Quality

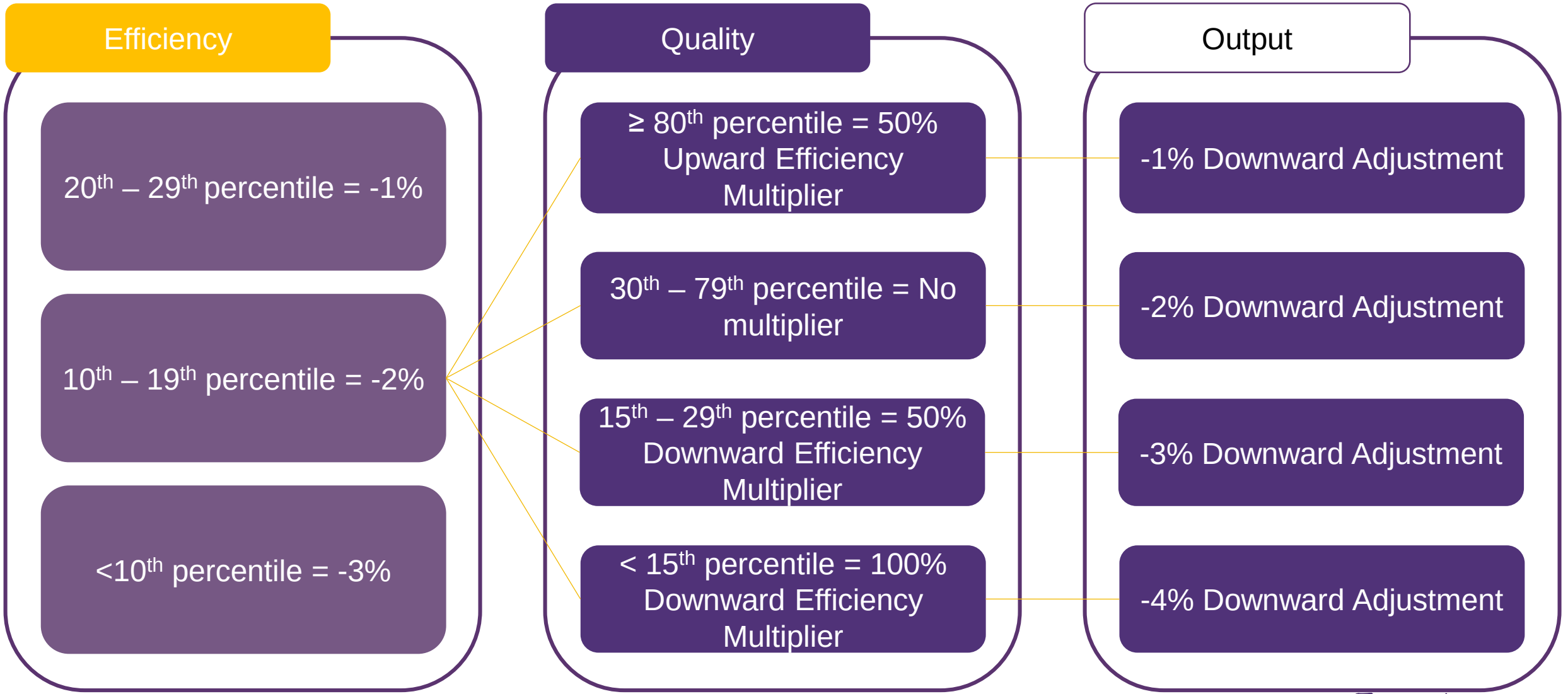
Quality - Downward Adjustments

- ≥ 80th percentile → ≥ 80th percentile = 50% Upward Efficiency Multiplier
- 30th – 79th percentile
- < 30th percentile → 15th – 29th percentile = 50% Downward Efficiency Multiplier
- < 30th percentile → < 15th percentile = 100% Downward Efficiency Multiplier

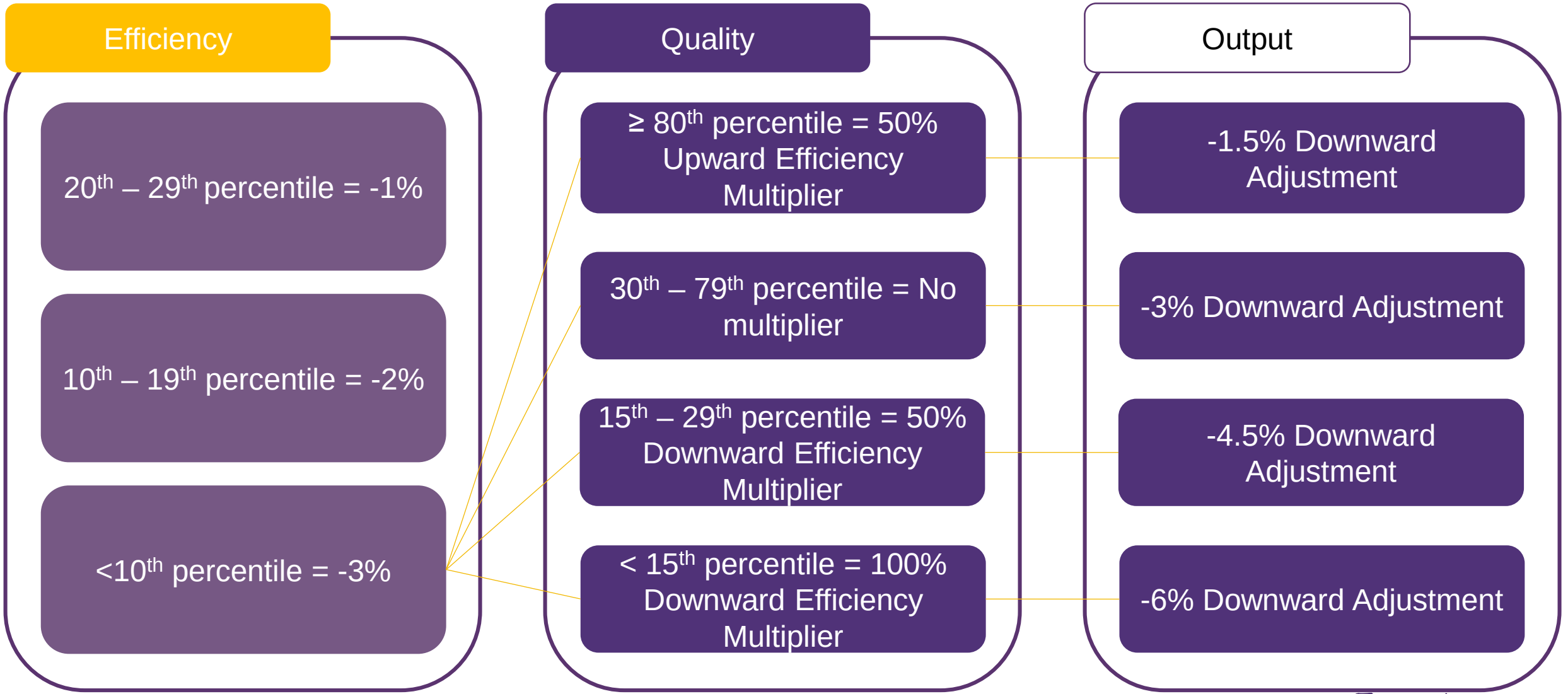
VBP Contracts Performance Adjustments - Upwards Adjustment



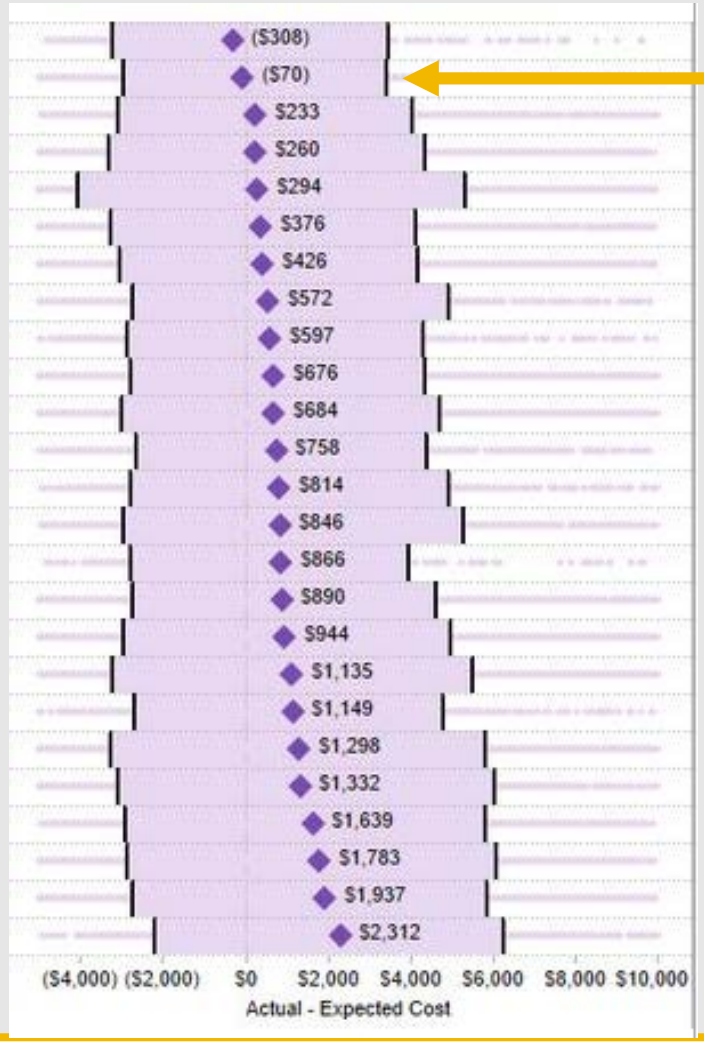
VBP Contracts Performance Adjustments - Upwards Adjustment



VBP Contracts Performance Adjustments - Upwards Adjustment



First Target Budget Adjustment: Efficiency Ranking



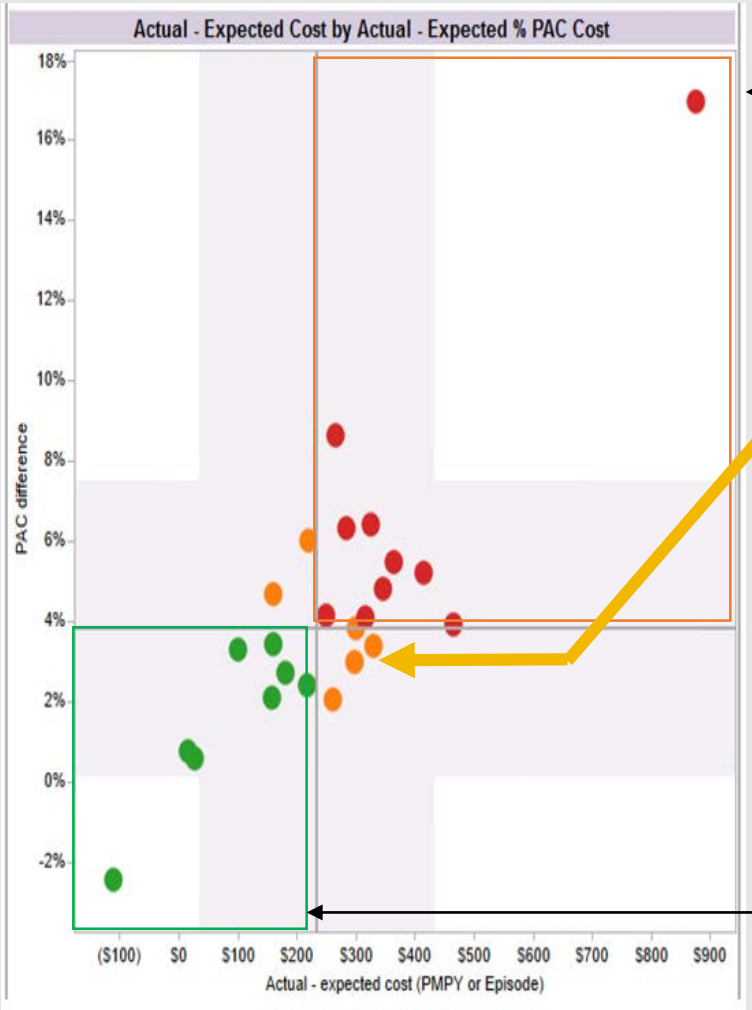
VBP Contractor in the example. Above the 90th Percentile in efficiency.

Purpose: *An efficiency ranking is applied to the baseline to reward providers that exhibit lower historic costs to keep them in VBP arrangements while bringing higher cost providers closer to the State average.*

Example:

For this example, the VBP Contractor is in the ***90th Percentile for Efficiency.*** *Thus there is a 3% efficiency adjustment.*

First Target Budget Adjustment: Quality Ranking



← Low performing

VBP Contractor in the example. Between the 70th and 80th percentile

Purpose: *The quality ranking rewards historically high-quality providers but also discourages providers from reducing costs to the point where there is a deterioration of care.*

Example:

For this example, assume the VBP Contractor is in the ***70th Percentile for Quality.*** *Thus there is no quality multiplier.*

High performing →

First Target Budget Adjustment: Example Efficiency and Quality Calculation

Efficiency

> 90th percentile = 3%

Quality

40th – 80th percentile = No Multiplier

Output

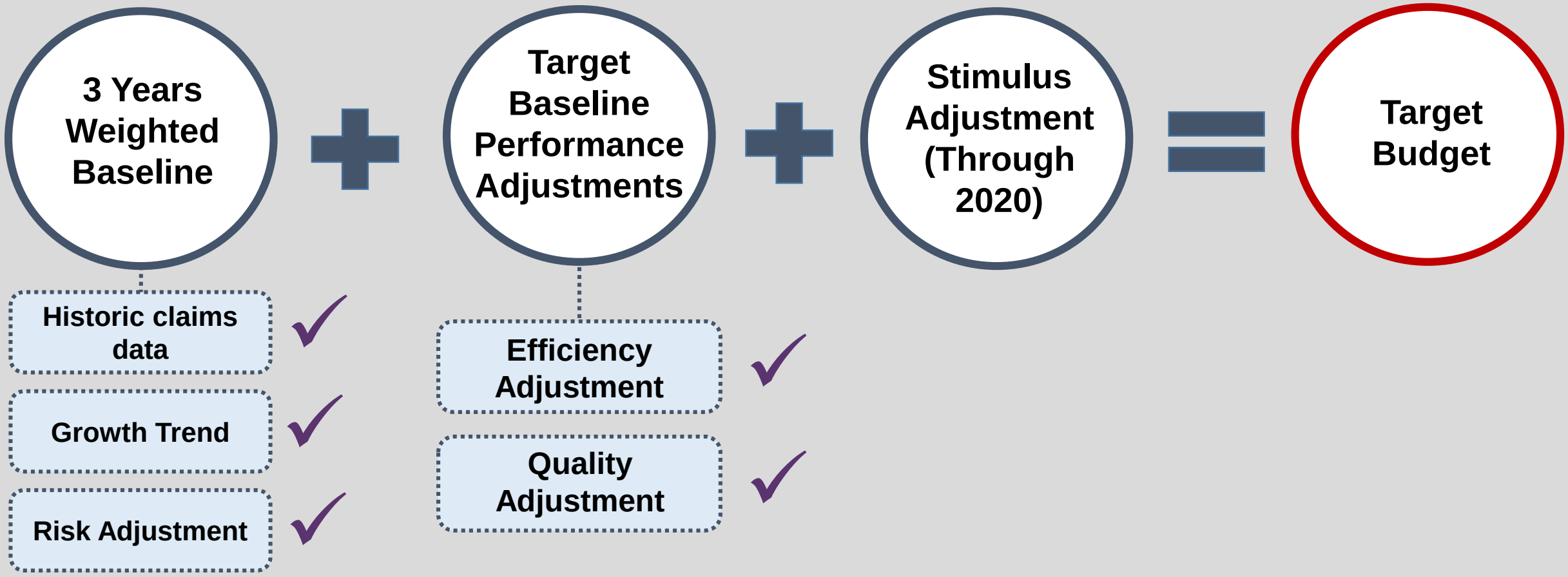
3% Upward Adjustment

Example:

$$\textit{Performance Adjustment} = 3\% \text{ x } \$\ 3{,}121.26 = \mathbf{\$93.64}$$

$$\textit{Target Budget (excluding Stimulus)} = \ \$\ 3{,}121.26 + \$93.64 = \mathbf{\$3214.90}$$

Target Budget Components



Note: The Target Budget Setting process outlined here is only a guideline. Plans and VBP Contractors are free to negotiate their own Target Budget Setting Methodology, provided it meets the State's

Second Target Budget Adjustment: Stimulus Adjustment

Purpose: *To incentive providers to undertake more risk and engage in high levels of risk, the stimulus adjustment rewards providers in Level 2 or Level 3 arrangements by creating greater potential for generating shared savings.*

VBP Arrangement	Stimulus Adjustment Amount
Total Care for General Population	0.5%
Integrated Primary Care – Chronic Bundle	1.0%
Maternity Care	1.0%
Total Care for HARP Subpopulation	0.5%
Total Care for HIV/AIDs Subpopulation	0.5%

- Stimulus adjustments are computed using arrangement specific contracts.
- The stimulus adjustment will be paid as an adjustment to the target budget in level 2+ contracts (conditional on the VBP Contractor being > 50th percentile in efficiency and quality) to incentivize movement into higher levels.
- The duration of adjustment is two years.

Second Target Budget Adjustment: Example Stimulus Adjustment

VBP Arrangement	Stimulus Adjustment Amount
Total Care for General Population	0.5%

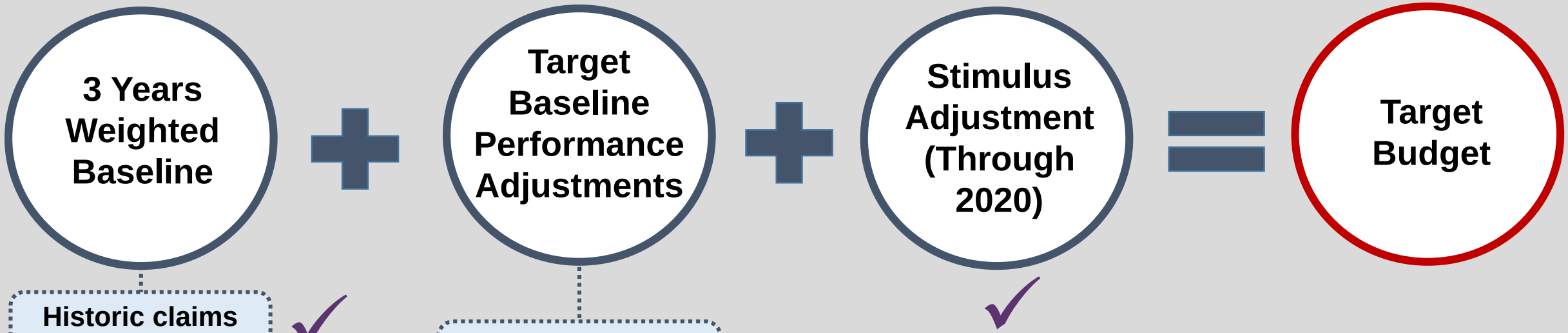
Formula:

$$Stimulus\ Adjustment\ Amount = Stimulus\ Adjustment\ Percent\ \text{x}\ 3\ Year\ Weighted\ Baseline$$
$$Final\ Target\ Budget = 3\ Year\ Weighted\ Baseline + Perormance\ Adjustment + Stimulus\ Adjustment$$

Example:

$$Stimulus\ Adjustment\ Amount = (0.005 * \$\ 3{,}121.26) = \mathbf{\$\ 15.61}$$
$$Target\ Budget = \$\ 3{,}121.26 + \$93.64 + \$15.61 = \$\ \mathbf{3230.51}$$

Target Budget Components



Note: The Target Budget Setting process outlined here is only a guideline. Plans and VBP Contractors are free to negotiate their own Target Budget Setting Methodology, provided it meets the State's

Questions

Setting Shared Savings/Losses Percentages

Below is a guideline for the distribution of the shared savings. This should be subject to contract negotiations.

VBP Arrangement	Guideline
Level 1	• Starting point for shared savings percentage negotiations should be **50%** of savings to be retained by providers, other 50% - by MCO
Level 2	• Starting point for shared savings percentage negotiations should be **90%** of savings to be retained by providers, 10% by MCO • Shared savings and losses percentages may be modified dependent on the type of risk protection mechanisms (such as stop loss or risk corridors) that are implemented to limit total provider risk.

Distribution of Shared Savings/Losses Amongst Providers

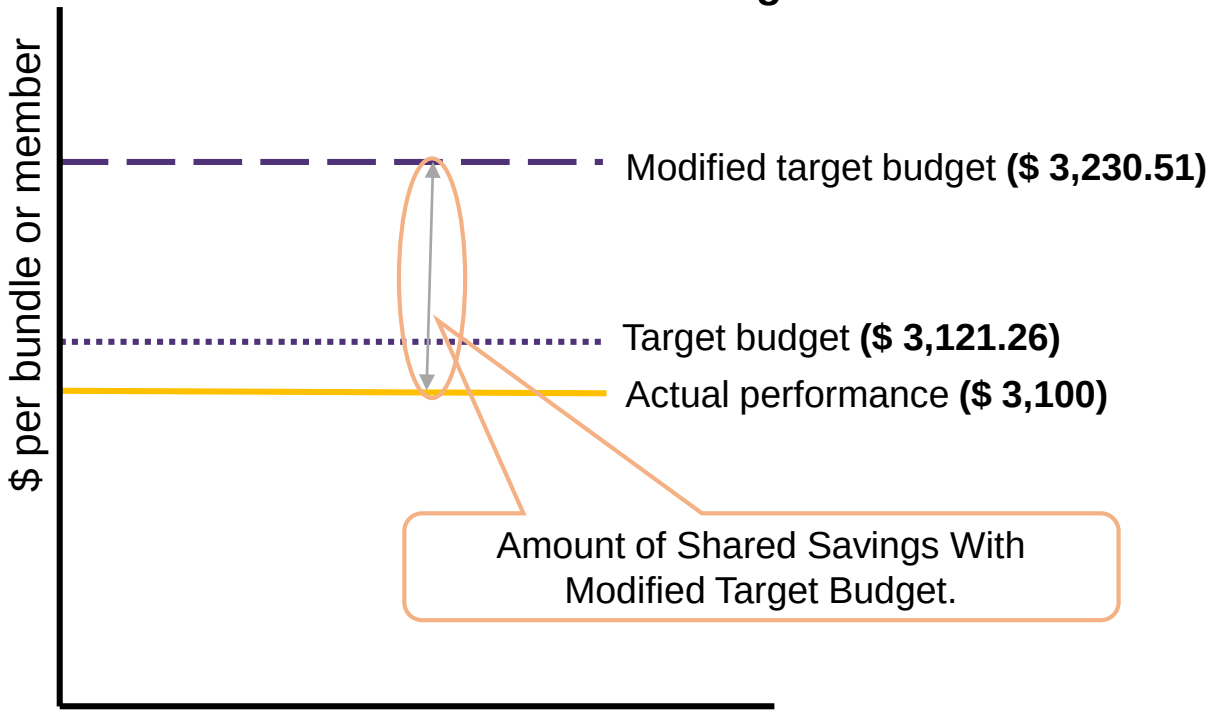
Guiding Principles:

- Funds are to be distributed according to provider effort and provider performance in realizing the overall efficiencies, outcomes, and savings.
- Required investments and losses are taken into consideration.
- The relative budget of the comparative providers should not be the default distribution mechanism.
- The distribution of shared savings should follow the same principles as the distribution of shared losses.
- For shared losses, smaller providers, financially vulnerable providers or providers with a regulatory limitation on accepting certain losses (e.g. FQHCs) may be treated differently to protect these individual providers from financial harm. It is legitimate that this ‘special treatment’ would weigh in as an additional factor in determining the amount of shared savings that these providers would receive

Performance Adjustment & Shared Savings

In the first year (2017), only uptick adjustments will be available for VBP contractors entering into VBP contracts. The specific percentages and operational details mentioned below are directional. The State has the flexibility to adjust these in accordance with the integrity of the Medicaid Global Cap.

Effect of modifying the target budget on the amount of shared savings



Example:

Shared Savings with out adjustments = $ 3,121.26 - $ 3,100 = **$ 21.26**

Shared Savings with adjustments = $ 3,230.51 - $ 3,100 = **$ 130.51**

Questions

Recap & Closing: What Have We Learned?

Today, we have shared information on the following:

VBP Contracting Overview	Guidance on Target Budget Setting	Financial Risk Management	VBP Contracting Panel
• Types of contracting entities • Types of VBP arrangements • Contract Key Components • Contracting with CBOs • New Contract review process	• Setting the Budget • Performance Adjustments	• Understanding the financial risk curve • Manageable Provider Risk • Stop Loss	• Shared Lessons Learned • Key Considerations for Success

Next Session

Registration for Session 3 is open. It will close on September 5th.

Links to Registration – click here:

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_bootcamp/index.htm

Session	Topics covered	Date & Time	Locations
Session 3	Performance Measurement - Quality Measures - Understanding your performance: a data-driven approach - MAPP and the VBP Dashboards	Monday, September 12, 2016 10.30AM - 3PM	Bronx Community College

VBP Bootcamps Contact Info

Website:

www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_bootcamp

Twitter Account:

@NYSMedicaidVBP

Thank you