NEW YORK STATE | Department of Health | Medicaid Redesign Team

VBP Bootcamp

VBP Arrangements and Quality Measurement
Class 1

January 2018

Agenda

Area	Details	
Timing	Two, 1-hour sessions	
	You are here **Class 1**	**Class 2**
Topics	**Top 10 Things a Provider Should Know** **VBP Arrangement Exploration & What it Means for a Provider** - Core Components - Quality Measurement - Target Budget Adjustments and Distribution of Share Savings	**VBP Performance Periods & Timelines** **VBP Measure Set Development & Implementation** - Intro to VBP Quality Measure Set Development and Implementation: Approach and Timeline - Measure Set Development and Maintenance **Negotiating Quality Measures** - Key considerations when including quality measures in your VBP contract
Speakers	**DOH** - Douglas Fish, MD - Khalil Alshaer, MD, MPH	**DOH** - Douglas Fish, MD - Khalil Alshaer, MD, MPH

VBP Arrangements and Quality Measurement Class Syllabus

General Description: The course content will cover each of the VBP arrangements and associated quality measure sets. The content will be structured to strengthen a provider's understanding of the VBP arrangements and review key considerations when contracting an arrangement.	**Intended Audience:** Individuals who may find this course beneficial include: • Medical Directors • Clinicians • Finance (to understand how performance, taking into account quality measures, may be impacted)
Course Description: **Course 1** will review the core components of each VBP arrangement and will highlight key considerations a provider may take into account, when contracting an arrangement. The course will also discuss the types of providers that may be best positioned to implement each arrangement, and include scenarios of each Level of VBP arrangement.	**Course Description:** **Course 2** will review measure sets associated with each arrangement and will present the measure set development and maintenance cycle, so that providers are aware of performance periods and key timelines.
Class 1 Overview	**Class 2 Overview**
This class will highlight the top 10 things providers need to know related to VBP arrangements and quality measurement. The class will also explore the core components of each arrangement and key considerations a provider should keep in mind, when implementing an arrangement.	The class will review performance periods and timelines and provide an overview of quality measure reporting. This class will include a review of key considerations when negotiating quality measures.

Terminology

- **Behavioral Health** – Encompasses Mental Health **or** Substance Use conditions
- **Efficiency** – defined as ACTUAL cost /EXPECTED cost, and determines if there are savings or losses
- **Fee-for-Service** – 2 Usages: 1) Claims are submitted by the provider and paid by the plan, vs 2) Medicaid members who are not yet in Managed Care
- **Medicaid MCO** – Managed Care Organization (MCO) in Medicaid Program
- **PCP** – may be Primary Care **Provider** or Primary Care **Practitioner**, depending on the setting or usage, so be careful.
- **Provider** – can be a practice, a hospital, nursing home, community-based organization or a practitioner, as examples.
- **VBP Contractor** – An entity, either a provider or groups of providers, engaged with a Medicaid Managed Care Organization in a VBP contract.
- **VBP Roadmap** – CMS-approved document of standards, guidelines and recommendations pertaining to VBP in New York State's Medicaid Program

Top 10 Provider Considerations

Top 10 Provider Considerations

1. **Each VBP Arrangement has an associated VBP Measure Set** identified by the Clinical Advisory Groups and accepted by the State; these measures include those to be reported to the State and are those intended to be used in the determination of shared savings for which VBP contractors are eligible.

2. **VBP Contractors** should **tailor the arrangement** they contract **based on** the **services** they provide and can impact. E.g. the Total Care for the General Population (TCGP) arrangement may be more suited for larger providers, the Integrated Primary Care (IPC) arrangement for smaller providers.

3. **Quality outcomes are measured on the members/patients who are attributed to an arrangement** (in most cases via a primary care practitioner); for this **reason care coordination amongst providers is key**.

4. **VBP Contractors must decide** if they want to **contract for** arrangements that cover the **total cost of a person** (population-based agreements) **or** total cost of **clinical events** (episodic-based agreements (IPC and Maternity)); this decision may largely be informed by the arrangement type by which providers are most able to impact the generation of shared savings.

5. Quality is given a strong emphasis in VBP; even if a provider is efficient, **no savings will be earned without meeting minimum quality thresholds**.*

* This is a VBP Roadmap guideline that ultimately is subject to negotiation between Plans and Providers. Plans rates will be adjusted based on this guideline, so it anticipated that these incentives will trickle down to Plan-to-Provider contracts.

Top 10 Provider Considerations (continued)

6. **Most** of the Category 1 **quality measures** are **already reported by providers and MCOs** for other quality improvement initiatives.

7. The entirety of Measurement Year 2017 VBP Measure Sets contain **5** Category 1 P4P **measures** that are **currently not in QARR**.** This potentially means less of an administrative burden for providers.

8. **Quality performance adjusts the target budget** set by the MCO and VBP Contractor at the **beginning of the contracting period**: High/low quality = higher/lower target budget*

9. **Quality performance is a factor in determining percentages of savings / losses** shared with VBP contractor at the end of the contracting period*

10. **Providers should look at the quality measure sets** and make sure their networks are designed to address them.

* This is a VBP Roadmap guideline that ultimately is subject to negotiation between Plans and Providers. Plans rates will be adjusted based on this guideline, so it anticipated that these incentives will trickle down to Plan-to-Provider contracts.

* * New York's Quality Assurance Reporting Requirements (QARR) measures are part of the quality component of QI Program. QARR includes National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS®), and NYS-specific measures.

VBP Arrangement Exploration & What it Means for a Provider

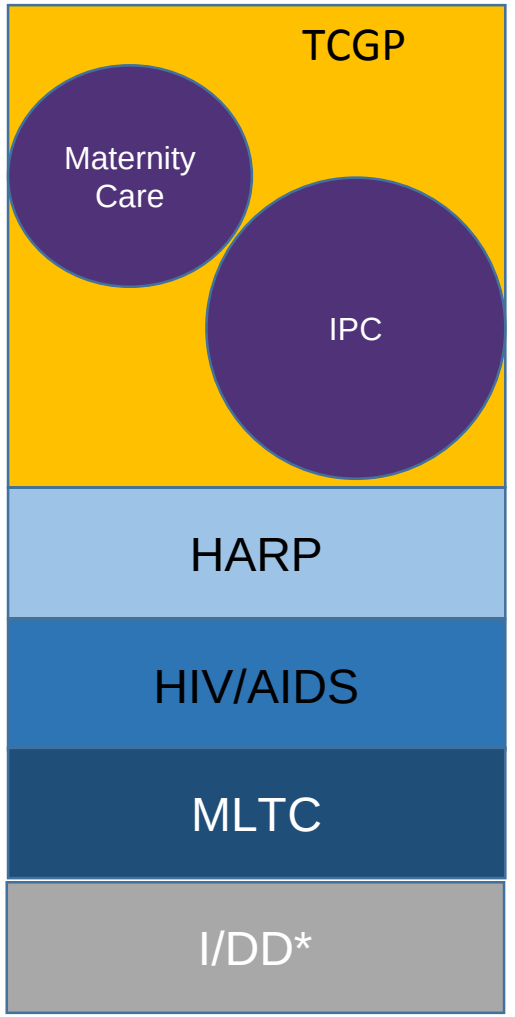
Core Components

VBP Arrangements

There is no single path towards Value Based Payments. Rather, there are a variety of options from which MCOs and providers can jointly choose:

Arrangement Types

- **TCGP:** All costs and outcomes for care, excluding MLTC, HARP, HIV/AIDS, and I/DD* subpopulations.
- Episodic Care
  - **IPC:** All costs and outcomes associated with primary care, sick care, and a set of chronic conditions selected due to high volume and/or costs.
  - **Maternity Care:** Episodes associated with pregnancies, including delivery and first month of life of newborn and up to 60 days post-discharge for mother.
- Total Care for Special Needs Subpopulations: Costs and outcomes of total care for all members within a subpopulation exclusive of TCGP.
  - **HARP:** For those with Serious Mental Illness or Substance Use Disorders
  - **HIV/AIDS**
  - **Managed Long Term Care (MLTC)**
  - **I/DD***



VBP Contractors can contract TCGP as well as Subpopulations as appropriate; nothing mandates that the Roadmap-defined arrangement types must be handled in standalone contracts.

*Total Care for the I/DD Subpopulation will be available as an arrangement when the population is moved to managed care.
Acronyms: MLTC = Managed Long Term Care; HARP = Health and Recovery Plans; I/DD = Intellectually/Developmentally Disabled

Total Care for the General Population

What to Consider as a Provider When Contracting TCGP

Goal: Improve population health through enhancing the quality of the total spectrum of care.

- Maximum impact for health systems focusing on both population health and streamlining specialty and inpatient care.
  - This means providers will need to have the capability to invest in and focus on population health efforts.
  - Providers should focus efforts on addressing inefficiencies and Potentially Avoidable Complications throughout the entire spectrum of care.
- All patients attributed to the arrangement, not just the patients a provider services, are included in TCGP.
  - Providers will likely need to invest in care coordination, referral patterns and discharge management.

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.

Total Population

— Subpopulations*

Total Care for General Population

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

Integrated Primary Care

Integrated Primary Care (IPC)

Components of Care

Preventive Care → Includes care activities such as wellness visits, checkups, immunizations, screening and routine tests.

Similar to ACA list of preventive care activities.

+

Sick Care → Includes care for symptoms such as headache or abdominal pain and minor acute conditions such as rhinitis, etc.

+

Chronic Care* → Consists of care related to 14 physical and behavioral chronic conditions that have been prioritized on the basis of prevalence and total costs.

14 episodes included in Chronic care:

1) Hypertension
2) Coronary Artery Disease (CAD)
3) Arrhythmia, Heart Block and Conductive Disorders
4) Congestive Heart Failure (CHF)
5) Asthma
6) Chronic Obstructive Pulmonary Disease (COPD)
7) Bipolar Disorder
8) Depression & Anxiety
9) Trauma & Stressor
10) Substance Use Disorder (SUD)
11) Diabetes
12) Gastro-esophageal reflux disease
13) Osteoarthritis
14) Lower Back Pain

Note: Patients who are attributed to subpopulations are excluded.

*Given the prevalence of chronic co-morbidities, VBP Contractors, by default, include the 14 chronic conditions as a whole within IPC, rather than selecting one or more of the individual chronic conditions.

Source: NYS Department of Health website: VBP Bootcamp – Session 1

What to Consider as a Provider When Contracting IPC

Goal: Improve the quality of preventive care, sick care and the most prevalent chronic and high-cost conditions.

- VBP contractor is at risk for that component that it most controls and where the potential savings are high.
  - The IPC arrangement limits the risk to those components of the costs of care within the scope of influence of the primary care professionals.
- IPC contractors may opt to also contract a Level 1 TCGP contract for their attributed population.
  - Contractors can share in the potential savings realized outside the scope of the IPC bundle without sharing in the downside risk.
- Four of the chronic care episodes are related to behavioral health.
  - Providers should focus on integration of physical and behavioral health.
  - Engage and include other providers that may provide behavioral health services.

Maternity Care

Maternity Care

Components of Care

Prenatal Care → Includes all services associated with pregnancy care, such as pre-natal care and visits, lab tests, medication, ultrasound, etc.

+

Delivery & Post-partum Care → Includes all services associated with the delivery, whether vaginal or cesarean section, up to 60 days post-discharge for the mother. Services such as facility costs, professional services, and any associated complications for mother and child are included.

+

Newborn Care → Includes all services associated with the newborn's care up to 30 days post-discharge.

What to Consider as a Provider When Contracting the Maternity Care Arrangement

Goal: Improve the quality of care for both the mother and the newborn.

- Dedicated incentive to streamline the total spectrum of maternity care.
  - Providers should focus on reducing unnecessary cesarean sections, emphasizing the “right care at the right place” and improving dedicated health education, low-birth weight, and teenage pregnancy prevention.
- Providers should consider risk: Bundles with a total cost above a certain threshold (“stop-loss”) have costs above the threshold excluded.
  - This protects the VBP contractor from the risk of high-cost NICU admissions and excludes stillbirths or multiple live births.

Episodes in Maternity Care:

1) **Pregnancy**
2) **Vaginal Delivery**
3) **C-Section**
4) **Newborn**

Total Care for the Special Needs Subpopulation

What to Consider as a Provider When Contracting for the Total Care for the Special Needs Subpopulations

Goal: Improve population health through enhancing the quality of care for specific subpopulations that often require highly specific care.

- All services covered by the associated Managed Care Organizations are included, and all members fulfilling the criteria for eligibility to such plans are included.
  - Identify who these specific members are and tailor approaches to reduce inefficiencies and Potentially Avoidable Complications.
- Specialized providers dedicated to serving these populations will be in a strong position to generate shared savings.
  - Collaborate with Community-Based Organizations and address Social Determinants of Health.

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.

Total Population

– TCGP

Subpopulations
(HIV/AIDs, HARP, MLTC, I/DD*)

*Total Care for the I/DD Subpopulation will be available as an arrangement when the population is transitioned into managed care.

VBP Arrangement Exploration & What it Means for a Provider

Quality measurement & the role of measures

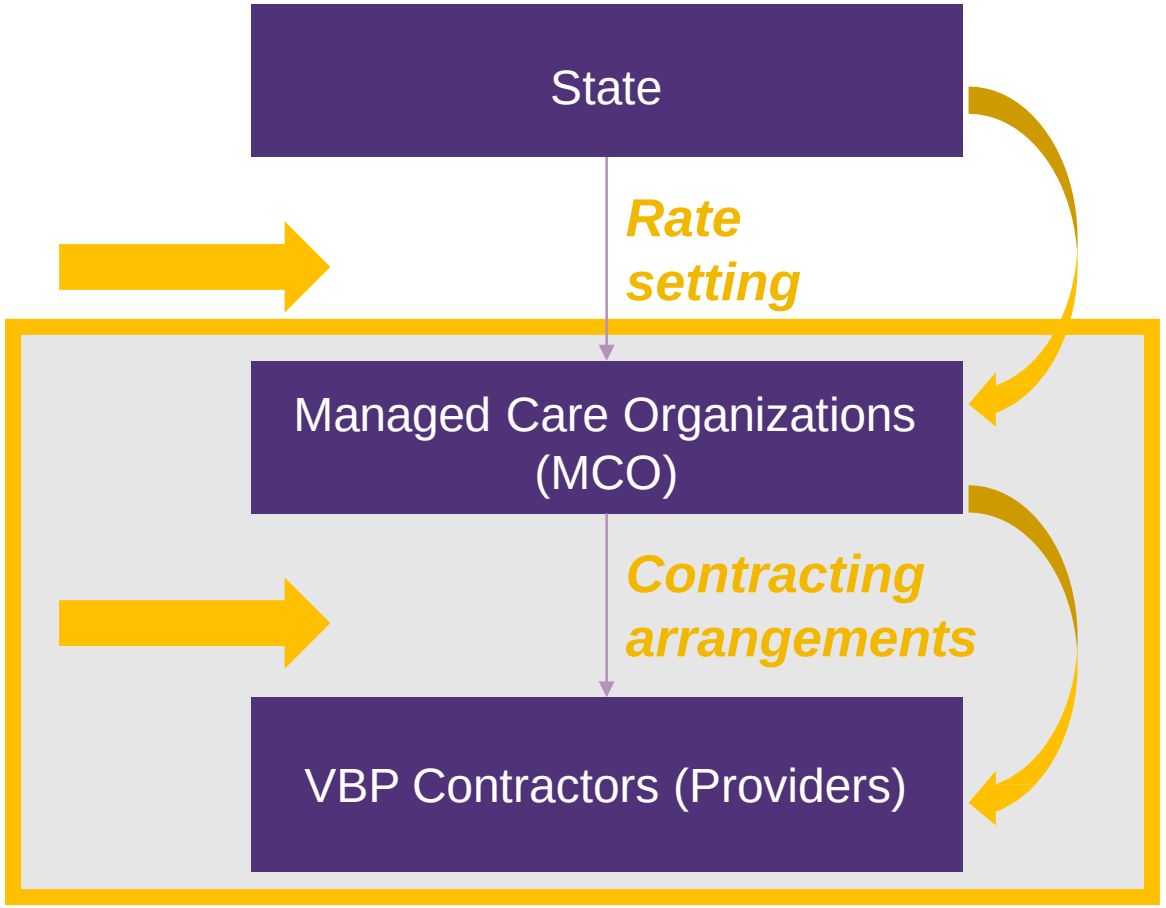
VBP Refresher: VBP Levels

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
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available **when outcome scores are sufficient**	FFS with risk sharing (upside available **when outcome scores are sufficien**t)	Prospective capitation PMPM or Bundle (**with outcome-based component**)
FFS Payments	FFS Payments	FFS Payments	Prospective total budget payments
No Risk Sharing	↑ Upside Only	↑ Upside & ↓ Downside Risk	↑ Upside & ↓ Downside Risk

Role of Quality in VBP

- Quality of **all** contracted care (whether VBP or not) is rewarded through up- and downward adjustments of premiums received by the MCO from the State *following the same guidelines as have been created by the VBP Subcommittees.*
- According to VBP Contracting Guidelines, quality performance impacts the target budget set by the MCO for the VBP Contractor.
    - High/low quality = higher/lower target budget
- Quality Performance also determines percentages of savings / losses shared with VBP contractor.



Quality Plays an Important Role in VBP Arrangements

1. MCOs and VBP Contractors select arrangements.

- Total Care for the General Population (TCGP)
- Total Care for the HARP Subpopulation
- Total Care for the HIV/AIDS Subpopulation
- Total Care for the MLTC Subpopulation
- Total Care for the I/DD Subpopulation
- Integrated Primary Care (IPC)
- Maternity Care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DRAFT MEASURE SET

IPC – Category 1 Measures

The Category 1 IPC measure set table includes measure title, measure steward, the NQF number and/or other measure identifier (where applicable), and State determined classification for measure use.

Measure
Adherence to Mc Individuals with E
Adherence to Sta Diabetes Mellitus
Antidepressant M Effective Acute P Effective Continu
Breast Cancer Sc

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DRAFT MEASURE SET

IPC – Category 2 Measures

The Category 2 IPC measure set table includes measure title, measure steward, and the NQF number and/or other measure identifier (where applicable).

Measure	Measure Steward	Measure Identifier
Continuing Engagement in Treatment (CET) Alcohol and other Drug Dependence	Washington Circle Group	-
Lung Function/Spirometry Evaluation (asthma)	The American Academy of Allergy, Asthma & Immunology (AAAAI)	-
Topical Fluoride for Children at Elevated Caries Risk, Dental Services	American Dental Association (ADA)	NQF 2528
Utilization of Medication-Assisted Treatment (MAT) for Alcohol Dependence	NYSDOH OASAS	-
Utilization of Medication-Assisted Treatment (MAT) for Opioid dependence	NYSDOH OASAS	-

2. Per the NYS VBP Roadmap, MCOs and VBP Contractors must report on quality measures associated with their selected arrangement(s).

(June 2016 NYS VBP Roadmap, p. 12)

3. The quality measure results are intended to be used to determine the amount of shared savings for which VBP contractors are eligible. Adjustments to the target budget are based on quality measure performance.

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Upside and Down Side Risk Sharing Arrangements (Guideline)

- While VBP encourages efficiency, **quality** is paramount!
- No savings will be earned without meeting minimum quality thresholds.

Quality Targets % Met goal	Level 1 VBP Upside Only	Level 2 VBP	
		Upside when actual costs < budgeted costs	Downside when actual costs > budgeted costs
> 50% of Quality Targets Met	50% of savings returned to VBP contractors	Up to 90% of savings returned to VBP contractors	VBP contractors are responsible for up to 50% losses
<50 % of Quality Targets Met	Between 10 – 50% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)	Between 10 – 90% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)	VBP contractors responsible for 50-90 % of losses (sliding scale in proportion with % of Quality Targets met)
Quality Worsens	No savings returned to VBP contractors	No savings returned to VBP contractors	VBP contractors responsible for up to 90% of losses

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYS DOH VBP website (Link) *June 2016 updated version approved by CMS March 2017.*

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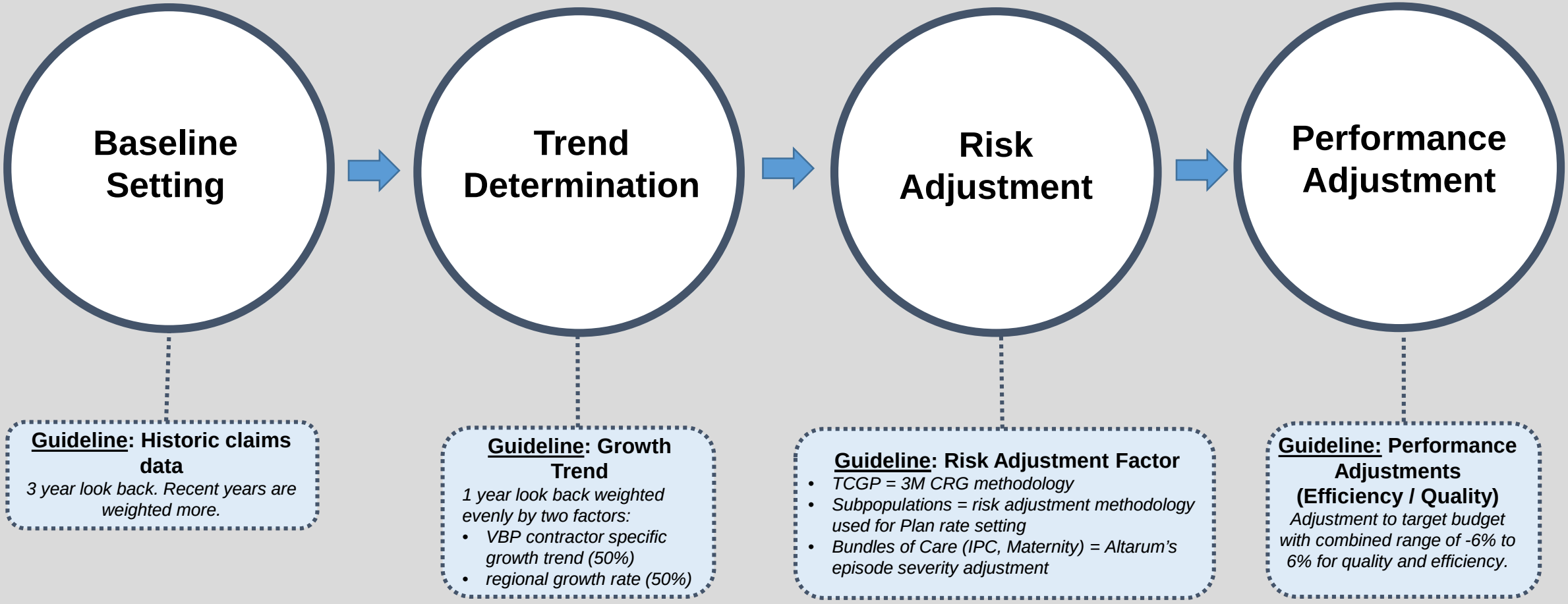
Target Budget Adjustments & Distribution of Shared Savings

Target Budget Setting Components are Flexible

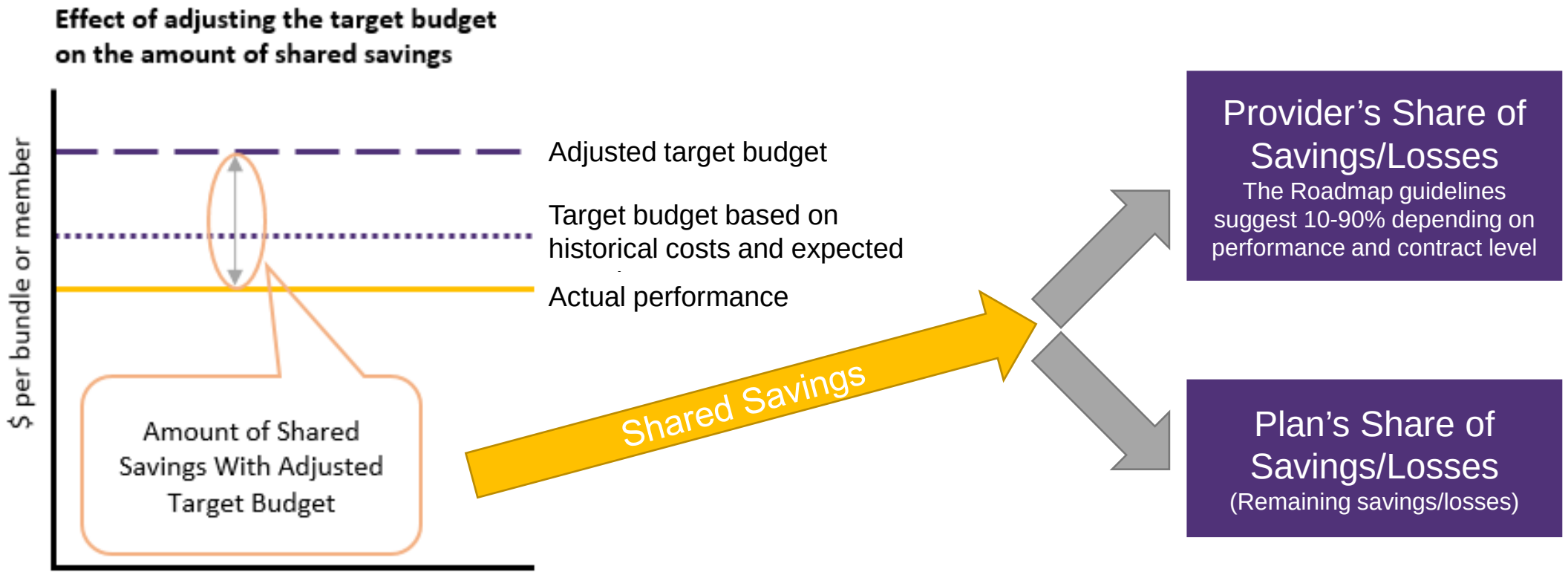
The VBP Roadmap outlines a recommended, but not required, method to establish a target budget.

The State does not mandate a specific methodology to be used to calculate a target budget for an arrangement. However, contracts should specify that a target budget will be used.



Target Budgets as a Methodology to Determine Shared Savings

VBP target budget guidelines for VBP Contractors are suggested as adjustments to the target budgets, increasing or decreasing possible shared savings.



*Plans may seek to **mimic the incentives / penalties** they are subject to **in provider's target budget methodology**, but this **is not a requirement** of the VBP program.*

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Walking Through Hypothetical Arrangements…

Level 1 Agreement

50% Shared Savings (Upside Only)
When Quality Metrics Met
SCENARIO 1

Coordinated care among team members

Payer	Forestland Care
Payer Premium	$ 6,000 ($ 500 PMPM)
Provider	New York Medical Group *(contracts a VBP arrangement)*
2014 Claims	Primary Care: $ 2,000 ER (Opioid overdose): $ 2,600 **Total: $ 4,600**
Provider Cost	$ 4,000
VBP Budget	$ 5,500

MCO Profit & Loss		
[A]	Revenue *(Premium)*	$ 6,000
[B]	Cost *(Claims)*	$ 4,600
[A-B]	*Profit*	$ 950 + $ 450 = $ 1,400
[S]	Shared Savings (50%)	$ (450)
[A – B + S]	**Total Profit / (Loss)**	**$ 950**

Provider Profit & Loss		
[B]	Revenue *(Claims)*	$ 4,600
[C]	Provider Cost	$ 4,000
[B-C]	Profit	$ 600
[S]	Shared Savings (50%)	$ 450
[B – C + S]	**Total Profit / (Loss)**	**$ 1,050**

Shared Savings Calculation		
[TB]	Target Budget	$ 5,500
[B]	Claims	$ 4,600
[TB - B]	Shared Savings	$ 900

State → **$6,000** **Premium** → **Payer/MCO** → **$4,600** **MC FFS** → **Provider**

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Level 1 Agreement

50% Shared Savings (Upside Only)
SCENARIO 2

Coordinated care among team members

Payer	Forestland Care
Payer Premium	$ 6,000 ($ 500 PMPM)
Provider	New York Medical Group *(contracts a VBP arrangement)*
2014 Claims	Primary Care: $ 2,500 ER (Opioid overdose): $ 3,500 **Total: $ 6,000**
Provider Cost	**$ 5,000**
VBP Budget	$ 5,500

MCO Profit & Loss		
[A]	Revenue *(Premium)*	$ 6,000
[B]	Cost *(Claims)*	$ 6,000
[A-B]	*Profit*	$ 0
[S]	Shared Savings (100%)	**$ (500)**
[A – B]	**Total Profit / (Loss)**	**$ 0**

Provider Profit & Loss		
[B]	Revenue *(Claims)*	$ 6,000
[C]	Provider Cost	$ 5,000
[B-C]	Profit	$ 1,000
[S]	Shared Savings (0%)	$ 0
[B – C + S]	**Total Profit / (Loss)**	**$ 1,000**

Shared Savings Calculation		
[TB]	Target Budget	$ 5,500
[B]	Claims	$ 6,000
[TB - B]	Shared Savings	$ (500)

QUESTION:
In this scenario, how many dollars are at risk for the provider?
ANSWER:
$0. Level 1 is upside only.

State **Payer/MCO** **Provider**

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Level 2 Agreement

90% Shared Savings (Upside)
50% Shared Losses (Downside)
Based on Quality Metrics Met

Coordinated care among team members

Payer	Forestland Care
Payer Premium	$ 6,000 ($ 500 PMPM)
Provider	New York Medical Group *(contracts a VBP arrangement)*
2014 Claims	Primary Care: $ 2,000 ER (Bench Press Accident): $ 2,600 **Total: $ 4,600**
Provider Cost	$ 4,000
TCGP Budget	$ 5,500

MCO Profit & Loss		
[A]	Revenue *(Premium)*	$ 6,000
[B]	Cost *(Claims)*	$ 4,600
[A - B]	*Profit*	$590 + $810 = $1,400
[S]	Shared Savings (10%)	$ (810)
[A – B + S]	**Profit / (Loss)**	**$ 590**

Provider Profit & Loss		
[B]	Revenue *(Claims)*	$ 4,600
[C]	Provider Cost	$ 4,000
[B - C]	Profit	$ 600
[S]	Shared Savings (90%)	$ 810
[B – C + S]	**Profit / (Loss)**	**$ 1,410**

Shared Savings Calculation		
[TB]	Target Budget	$ 5,500
[B]	Claims	$ 4,600
[TB - C]	Shared Savings	$ 900

QUESTION:

If, in this scenario, the total cost of claims was $6,000, how many dollars would be at risk for the provider?

ANSWER:

$250. The provider is taking risk for 50% of losses above the target budget.

Level 3 Agreement

Full Capitation

Coordinated care among team members

Payer	Forestland Care
Payer Premium	$ 6,000 ($ 500 PMPM)
Provider	New York Medical Group *(contracts a VBP arrangement)*
2014 Claims	Primary Care: $ 2,000 ER (Bench Press Accident): $ 2,600 **Total: $ 4,600**
Provider Cost	$ 4,000
TCGP Budget	$ 5,500

MCO Profit & Loss		
[A]	Revenue *(Premium)*	$ 6,000
[B]	Cost *(Target Budget)*	~~$ 4,600~~ $ 5,500
[A – B]	**Profit / (Loss)**	**$ 500**

Provider Profit & Loss		
[B]	Revenue *(Target Budget)*	~~$ 4,600~~ $ 5,500
[C]	Provider Cost	$ 4,000
[B – C]	**Profit / (Loss)**	**$ 1,500**

QUESTION:

If, in this scenario, the total cost of claims was $6,000, how many dollars would be at risk for the provider?

ANSWER:

$500. The provider is taking risk for all spending above the target budget.

State Payer Provider

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Key Takeaways

- **VBP Contractors** should select and tailor the arrangement(s) they contract based on the services they provide and can impact.
- **Quality is Key** in VBP, so even if a provider is efficient, no savings will be earned without meeting minimum quality thresholds – this is what makes it value-based.

- **A closing poem:**
  - ***Quality is Key in VBP,***
  - ***Quality is Queen in Maternity,***
  - ***Quality is King in IPC,***
  - ***And Quality is what rewards all of Thee.***

Thank you!

Please send questions and feedback to:

vbp@health.ny.gov