NEW YORK STATE | Department of Health | Medicaid Redesign Team

Value Based Payment Quality Improvement Program (VBP QIP)

Update Webinar

November 2016

Today's Agenda

- **VBP QIP Updates**
  - VBP QIP Timeline Update
  - VBP QIP Governance Documents
  - VBP QIP Facility Plans
  - VBP QIP Financing Update
- **Contracting for VBP**
  - VBP Contracting
  - VBP Contract Terms
  - VBP Contracting for Beginners
- **Important Information**
- **Next Steps and Q&A**

VBP QIP Updates

VBP QIP Timeline Update

Group 1 Key Upcoming Dates

Milestone	Due Date
First steps towards VBP undertaken with PPS & MCO oversight in accordance with approved Facility Plan	Ongoing
Partners must reach Level 1 VBP contracting	**March 31, 2017**

Group 2 Key Upcoming Dates

Milestone	Due Date
MCOs submit a revised VBP QIP Governance Document to DOH for review	December 9, 2016
Final Facility Plans approved by MCO in collaboration with PPS (final copies should be sent to DOH)	December 9, 2016
Partners must reach Level 1 VBP contracting	**March 31, 2017**

Note: *Although deliverables can be completed before the red dates noted on the VBP QIP Timeline, DOH encourages participants to complete them as soon as possible, as the majority* ***of VBP QIP in DY2 focuses on setting up VBP contracts, which must be in place between Facilities and MCOs by April 1st, 2017****.*

Acronyms:
MCO – Managed Care Organizations
PPS – Performing Provider Systems
DOH – Department of Health
DY – Demonstration Year

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VBP QIP Governance Documents

- A blank Governance Document Scorecard can be found on the DOH VBP QIP website.
  - The Scorecard outlines the areas DOH reviews, which MCOs can use to establish a solid approach for overseeing their program. This will reinforce the integrity of the program and will foster the parameters for MCOs to assist paired Facilities with achieving their VBP QIP objectives.
- Group 2 MCO Governance Documents are due on **Friday, December 9th, 2016**.

VBP QIP Facility Plans

- The Facility Plan Template provides guidance to participants on the information each party should consider when putting together their VBP facility plan.
  - The Facility Plan Template can be found on the DOH VBP QIP website.
- Group 1 Facility Plans were submitted to DOH on **Friday, September 16th, 2016**.
  - Finalized Facility Plans should have been approved by partnered MCOs and PPS.
  - DOH will schedule debrief calls with each of the Group 1 MCOs to discuss the VBP QIP Facility Plans and oversight responsibilities of the MCOs moving forward.
- Group 2 Facility Plans are due to DOH by **Friday, December 9th, 2016**.

VBP QIP Financing

- VBP QIP DY 2 Rates – April 2016 Rate Package
  - DOH's submission of the DY2 Rate Package to CMS & Division of Budget (DOB) was delayed
  - DOH worked with DOB to gain approval for a state-funded advance for 3rd Quarter 2016 (October 2016 – December 2016) to get VBP QIP funds to the MCOs
    - Advance until April 2016 rates are approved by CMS & DOB
  - DOH anticipates the April 2016 rate package to be approved in late December 2016

- The State recouped advances made to MCOs for the 1st & 2nd Quarters of DY2 before the State had loaded the April 2016 (DY2) rate package
  - DOH is currently working on resolving the issue and MCOs can expect to receive the funds within the coming days
  - Please e-mail bmcr@health.ny.gov with any questions that you may have regarding this issue

Contracting for VBP

(Must be achieved by April 2017)

Contracting Entities / VBP Contractors

1. Independent Practice Associations (IPA)
2. Accountable Care Organizations (ACO)
3. **Individual Providers**
   - **Hospitals and/or Hospital Systems**
   - Federally Qualified Health Centers (FQHC) 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

MCOs and Contractors Can Choose Different Levels of VBP

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

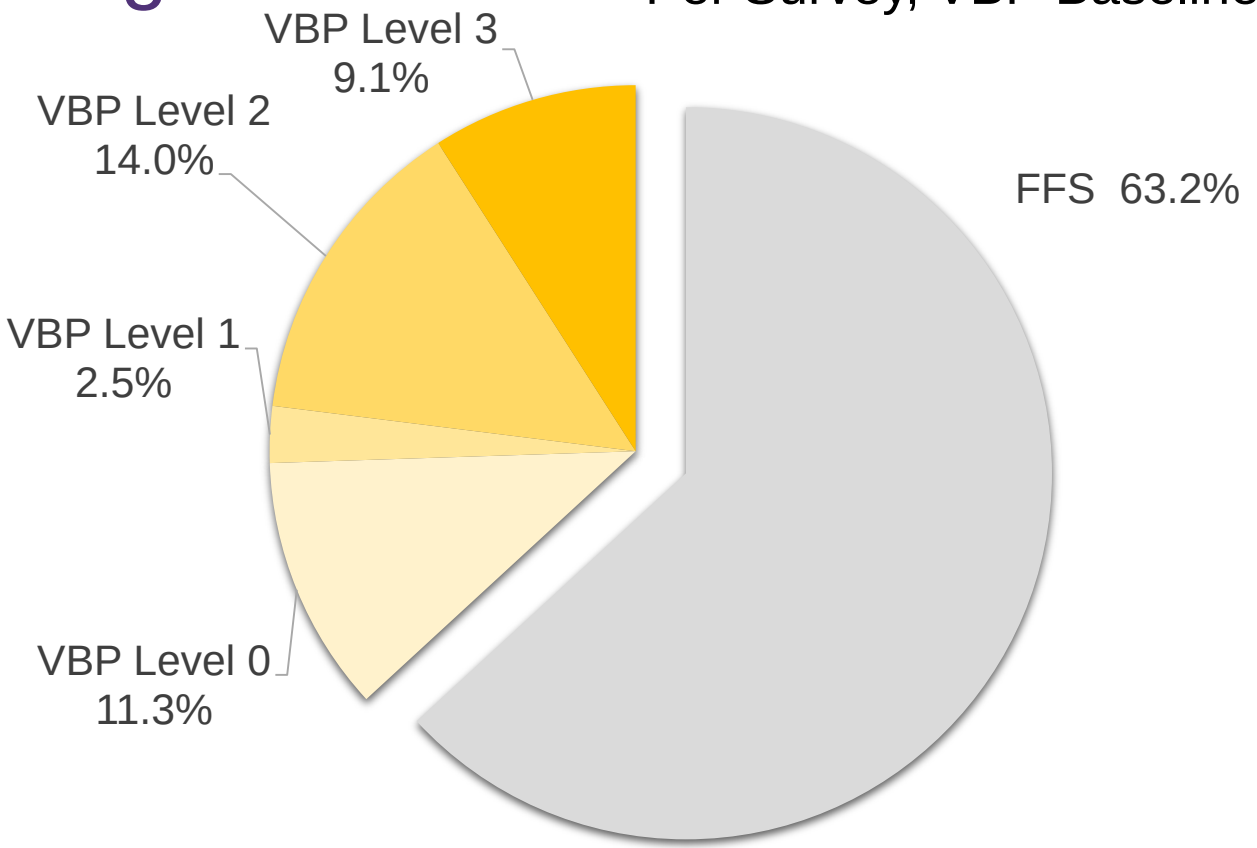
	Level 0 VBP	**Level 1 VBP***	**Level 2 VBP**	**Level 3 VBP** (feasible after experience with Level 2; requires mature contractors)
FFS with bonus and/or withhold based on quality scores		FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/ APC, FFS may be complemented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

As part of their participation in VBP QIP, Facilities must reach Level 1 VBP Contracting by April 1, 2017.

Acronyms:
FFS – Fee-for-Service
PMPM – Per Member Per Month
PCMH – Patient Centered Medical Home
APC – Advanced Primary Care

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%

Statewide, 80-90% of total MCO-PPS/provider payments (in terms of dollars) will have to be captured in at least Level 1 VBP at end of DY5.

*Includes Mainstream, Managed Long Term Care (MLTC), Medicaid Advantage Plans (MAP), and HIV Special Needs Plans (SNP) plans.

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There are Numerous Options for VBP Contracting

- There is not a single path towards VBP. 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 (HIV/AIDS, HARP)
  - Per integrated service for specific condition: Maternity Care bundle
  - For Integrated Primary Care: includes Chronic Care bundle

- These VBP arrangements are limited to **Medicaid-only members**.

- Duals will be integrated in the VBP arrangements from 2017 on.

Different Types of VBP Arrangements

Types	TCGP	IPC	Care Bundles	Special Need Populations
Definition	Party(ies) contracted with the MCO assumes responsibility for the total care of its attributed population	PCMH or APC includes: • Care management • Practice transformation • Savings from downstream costs • Chronic Bundle (includes 14 chronic conditions related to physical and BH related)	Episodes in which all costs related to the episode across the care continuum are measured • Maternity Bundle	Total Care for the Total Subpopulation • HIV/AIDS • Health and Recovery Plans (HARP) • Intellectual/ Developmental Disability (I/DD)
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

Note that the contracting parties in most of these VBP arrangements are not single entities; but rather, groups of providers working together to manage the care of a population. VBPQIP facilities, through improving quality (tied to their VBPQIP transformation plan measures) and through experience performing well in VBP Level 1 contract, will position themselves to be attractive partners in larger VBP contracting arrangements.

Achieving Financial Benefits from VBP Contracting

For Hospitals, which don't employ large numbers of community-based primary care providers, the financial benefits of participating in VBP contracting come from several different sources, driven by the VBP contract Level

Level 0: Participation in VBP QIP requires facilities to engage with a single MCO partner to earn payments based on improving quality. Qualification for payments is driven by "Pay for Performance" on achieving specific quality and process metrics outlined in the facility's VBPQIP transformation plan.

Level 1: Level 1 contracts negotiated by the VBPQIP facility (before joining a larger VBP contracting entity) with all of its Medicaid MCO partners provide two additional opportunities for hospitals to financially benefit:

- Participating in a shared saving pool by delivering care at a cost below their negotiated target budget (based on a point below their "DRG rate")
- Gain experience in VBP contracting and VBP performance with downside risk and will allow for the development of a positive VBP track-record to make the facility a more attractive partner to larger VBP contracting entities (IPA/ACO)

Levels 2 and 3: Working with IPA, ACO or other partners, sharing in savings from various VBP arrangements (e.g., TCGP, IPC)

Chronic Care Bundle

Facilities which demonstrate high quality and cost efficiency will be very attractive to provider partners contracting for VBP arrangements which include the costs related to the care and treatment of their attributed populations

- Includes 14 chronic conditions:
  - Asthma
  - Bipolar
  - Diabetes
  - Depression and Anxiety
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Congestive Heart Failure (CHF)
  - Coronary Artery Disease (CAD)
  - Arrhythmia
  - Heart Block/Conduction Disorders
  - Hypertension
  - Substance Use Disorder
  - Lower Back Pain
  - Trauma and Stressors
  - Osteoarthritis
  - Gastro-Esophageal Reflux

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

VBP Contracting for Beginners

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
15. Quality Metrics and Baseline Budget

VBP arrangements do not need to require completely new contracts. The only difference between a standard contract and a VBP contract should be the inclusion of quality metrics and the establishment of a baseline budget.

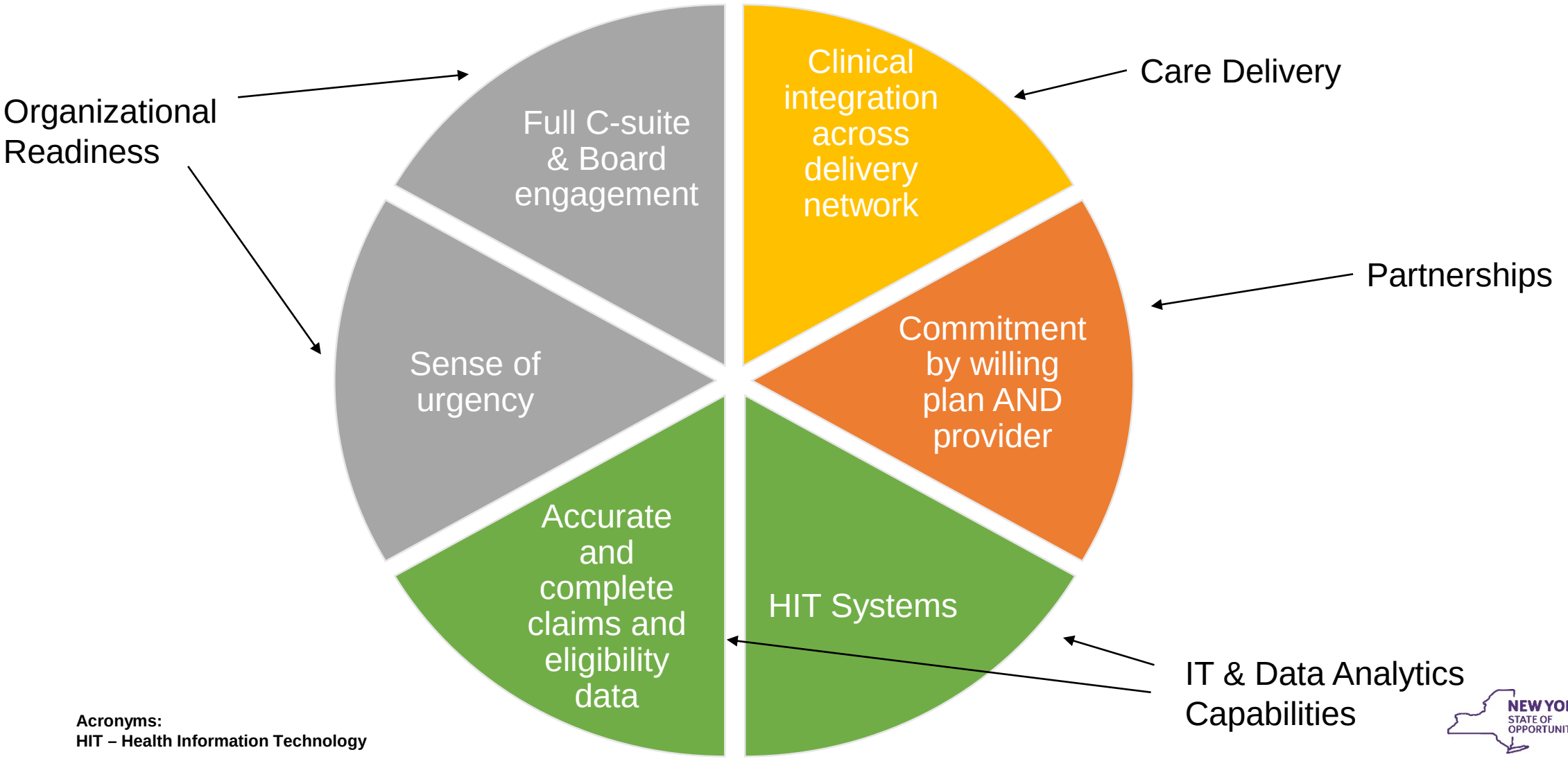
** Details of the Provider Contract Terms can be found in Appendix A*

Contracting VBP: Top 4 Steps for Beginners

1. **Assess your readiness; address issues to be able to start at Level 1**
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. **Familiarize yourself with and utilize available resources (data from the State, technical assistance from potential partnering contractors, etc.)**
4. Choose the partners that will help you succeed and that are adequate for the contracts you chose – build your partnerships

Bolded print signifies priorities that facilities should be focusing on immediately

Keys to Achieving Level 1 by April 2017



Acronyms:
HIT – Health Information Technology

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Clinical Advisory Groups (CAG) Objectives

CAG members convened to meet the following objectives:

Understand the State's visions for the Roadmap to VBP

Discuss and validate definitions of VBP arrangements

Review and recommend quality measures for the VBP arrangements

Make additional recommendations to the State on:

- Data and other support required for providers to be successful
- Other implementation details related to each arrangement

CAG Reports, available on the DOH website, contain the recommendations provided by each CAG, specific to VBP arrangement definition and quality measures.
http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/vbp_final_cag_reports.htm

Facilities Responsibilities Leading into April 2017

- Leading into the contracting deadline of March 31st, 2017, VBPQIP facilities must:
  - Review all current Medicaid MCO contracts
  - Identify provisions which need modification to meet roadmap requirements for VBP contracts of Level 1 or above
  - Negotiate with all current MCOs with which they contract/agree on which provisions need modifications
  - Review/Develop baseline budgets
  - Develop and execute contracts with each Medicaid Plan
- Facilities do not need to send their actual VBP contract(s) with other MCOs to their VBP QIP MCO partner
  - To document that there is a VBP contract in place, facilities should provide an attestation to their VBPQIP MCO partner, signed by contracting VBP MCO stating that the MCO is in a Level 1 VBP contract with the facility

Final Thoughts

Important Information

VBP Support Materials

VBP Resource Library:

- Path: DSRIP Homepage → Value Based Payment Reform → VBP Resource Library
- Link: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library

VBP Bootcamps Website:

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

VBP Website:

- Path: DSRIP Homepage → Value Based Payment Reform
- Link: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform

Thank you for your continued support with VBP QIP!

- DOH will be reaching out to Group 1 MCOs to discuss the Facility Plans
- The next VBP QIP Update Webinar is scheduled for **Wednesday, December 21st** from 2:00 pm – 3:00 pm.
- Please let DOH of any topics that you would like discussed during next month's webinar by submitting your requested topics to the VBP QIP inbox (vbp_qip@health.ny.gov).
- The remainder of this webinar is reserved for Q&A and an open forum session.

For any further questions, please contact the VBP QIP inbox:

vbp_qip@health.ny.gov

Appendix A

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 (continued)

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 (continued)

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 healthcare program or convicted of a criminal offense related to Medicaid or Medicare

Acronyms:
OMH – Office of Mental Health
OASAS – Office of Alcoholism and Substance Abuse Services

Provider Contract Key Terms (continued)

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 (continued)

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 provider**

Provider Contract Key Terms (continued)

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 (SA), and mental health (MH) records
  - Consent obtained on Medicaid enrollment application