Department of Health | Office of Health Insurance Programs

MLTC VBP Refresher Webinar

- VBP Risk Levels
- SDH & CBO requirements & examples
- VBP Tracking Report (VBPTR)

March 8, 2019

Agenda

I. Introductions
II. Review of MLTC VBP Risk Levels
III. SDH & CBO Requirements and Examples
IV. VBPTR Review
  - Reminders
  - Reporting Requirements
  - Reporting Examples
V. Other Contracting Questions
VI. Questions

VBP Risk Levels

MLTC VBP Risk Level Definitions

	VBP Level 0	VBP Level 1	VBP Level 2	VBP Level 3
MLTC Partial Plans	An arrangement that includes a performance based quality bonus that does not include the Potentially Avoidable Hospitalization (PAH) measure.	An arrangement that includes a performance based quality bonus between an MLTC Partial Plan and a provider that is based on meeting performance targets for a set of specific quality measures agreed to in a VBP contract between an MLTC Partial Plan and provider. Such agreement must include the Potentially Avoidable Hospitalization (PAH) measure.	A pay-for-performance agreement between MLTC Partial Plans and providers where incentive payments are based on meeting performance targets for quality measures agreed to in a VBP contract with the addition of a “downside” or quality withhold. To meet the Level 2 definition, Plans and providers should establish a minimum downside of 1% of total annual expenditures in the contract between the Plan and the provider. Requires inclusion of the PAH measure; and inclusion of *at least one State approved* long-term care measure recommended by the MLTC CAG **Requires SDH and CBO inclusion**	To be determined at a future date. NOTE: No VBP requirements are targeted at achieving specifically VBP Level 3 contracting
Fully Integrated Plans (FIDA, MAP and PACE)	Arrangements that go beyond strict FFS but do not meet the requirements of VBP Level 1. Example: A shared savings arrangement that doesn’t make shared saving contingent upon quality outcomes.	These arrangements continue the existing FFS payment methodology from MCO to providers, but allows the VBP contractor to receive a percentage of the shared savings based on meeting sufficient efficiency and quality outcomes.	These arrangements allow the VBP contractor to receive a higher percentage of shared savings than in Level 1 because the VBP contractor is also required to share a percentage of losses that result from spending more than the ‘target budget’. **Requires SDH and CBO inclusion**	Arrangements that are fully capitated PMPM arrangements or prospectively paid bundles. Includes a quality component. **Requires SDH and CBO inclusion**

Social Determinants of Health (SDH) & CBO Requirements for MLTC Programs

Quick Review of CBO and SDH Standards

All new and existing VBP Level 2 & 3 arrangements MUST include:

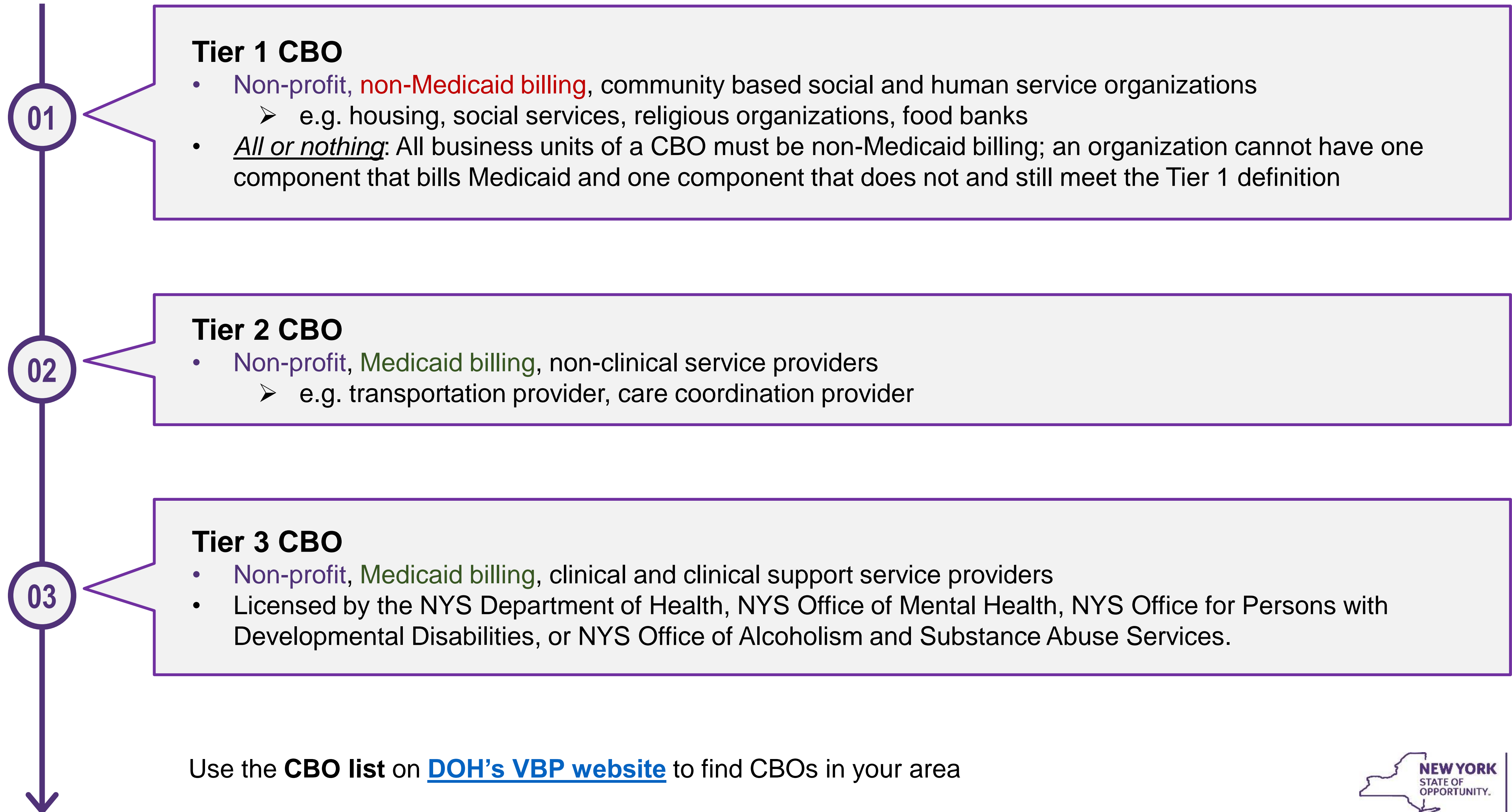
1. At least one Social Determinant of Health Intervention.

2. SDH Interventions must align with the five key areas of SDH outlined in the *SDH Intervention Menu Tool,* which includes:
   - *1) Education, 2) Social, Family and Community Context, 3) Health and Healthcare 4) Neighborhood & Environment and 5) Economic Stability*

3. Must have a contract with least one Tier 1 Community Based Organization (Non-Medicaid billing, non-profit social and human services organization).
   - The Tier 1 Community Based Organization can be subcontract with a Tier 2 or 3 Community Based organization. This requirement does not have to be paired with the SDH requirement.

*VBP Level 2 & 3 contracts without SDH and CBO requirements will be categorized as Level I (so long as all other VBP requirements are met)

Tier 1, Tier 2, and Tier 3 CBO Definitions



Use the **CBO list** on **DOH's VBP website** to find CBOs in your area

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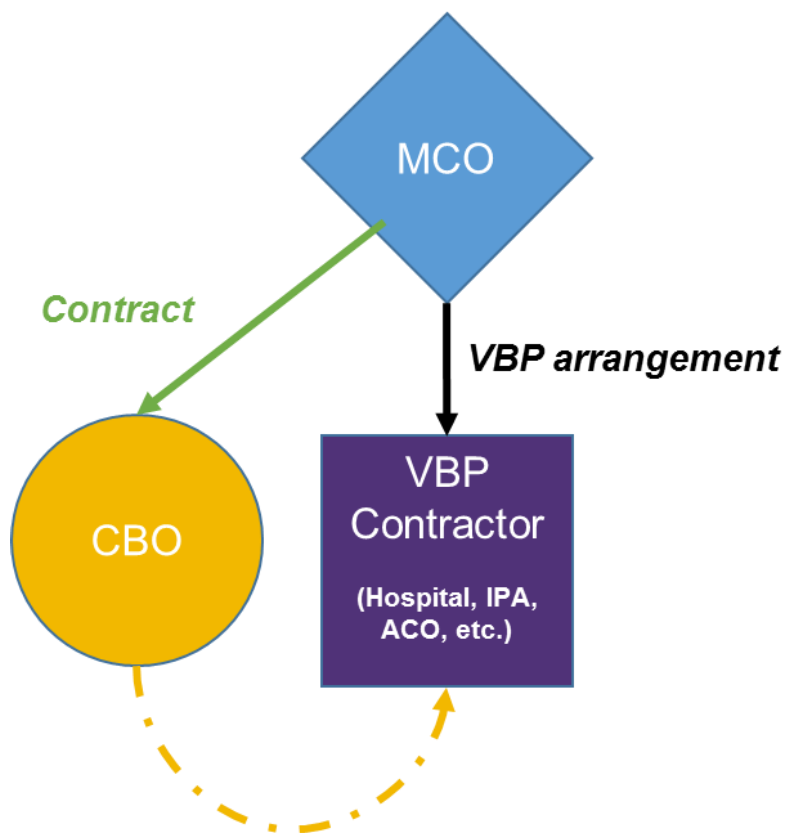
SDH Example: Medical Respite Program

- **Goal: To shorten hospital stays; decrease readmission rates, and unnecessary emergency department visits.**
- Program provides emergency shelter service for homeless adults being discharged from inpatient hospitalization with ongoing medical needs.
- Program allows plan members who are homeless or housing insecure to recover, while also working with a care manager to secure permanent housing.
- Average cost of **$140/night** per respite bed. This represents 6% of the average cost per night for a hospital admissions.
- Intervention also linked directly to reducing unnecessary hospitalizations.
- Return on investment in New York has been measured as high as 300%.

CBO Contracting Strategies

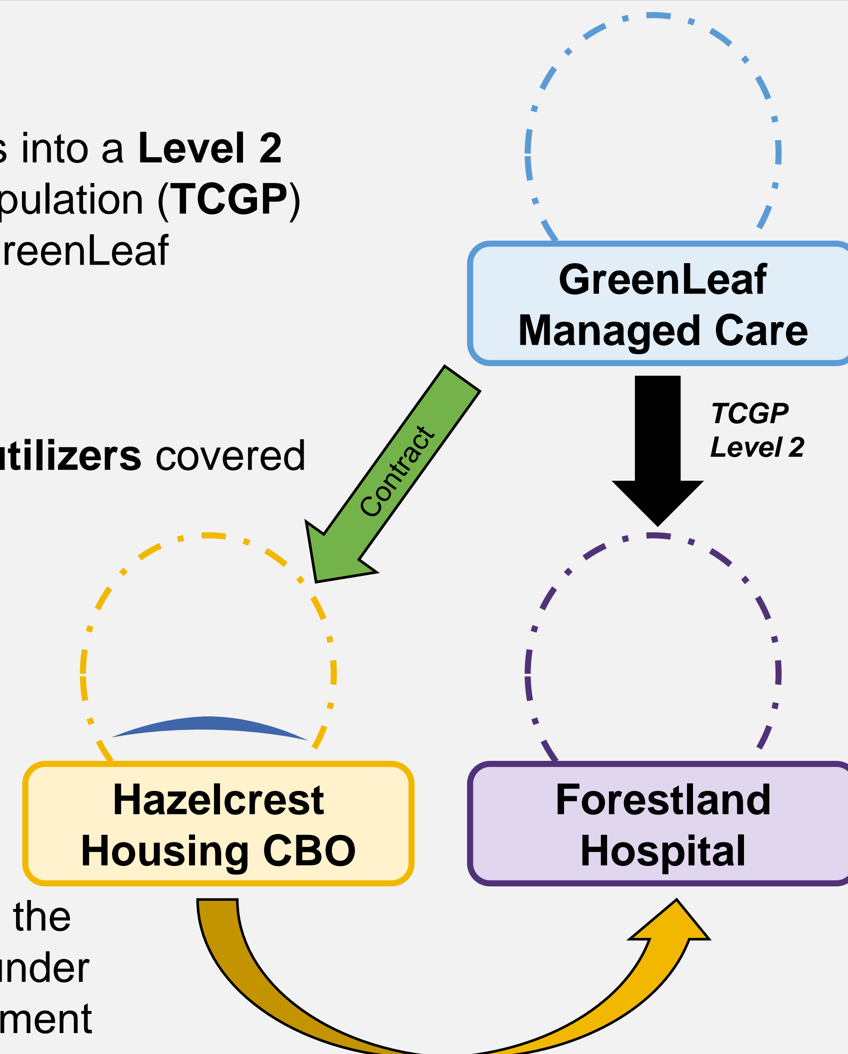
CBO Contracting Strategies – Scenario A

- **CBOs may support VBP arrangements by:**
  - **(A) contracting directly with an MCO to support a VBP arrangement**



Hypothetical Example

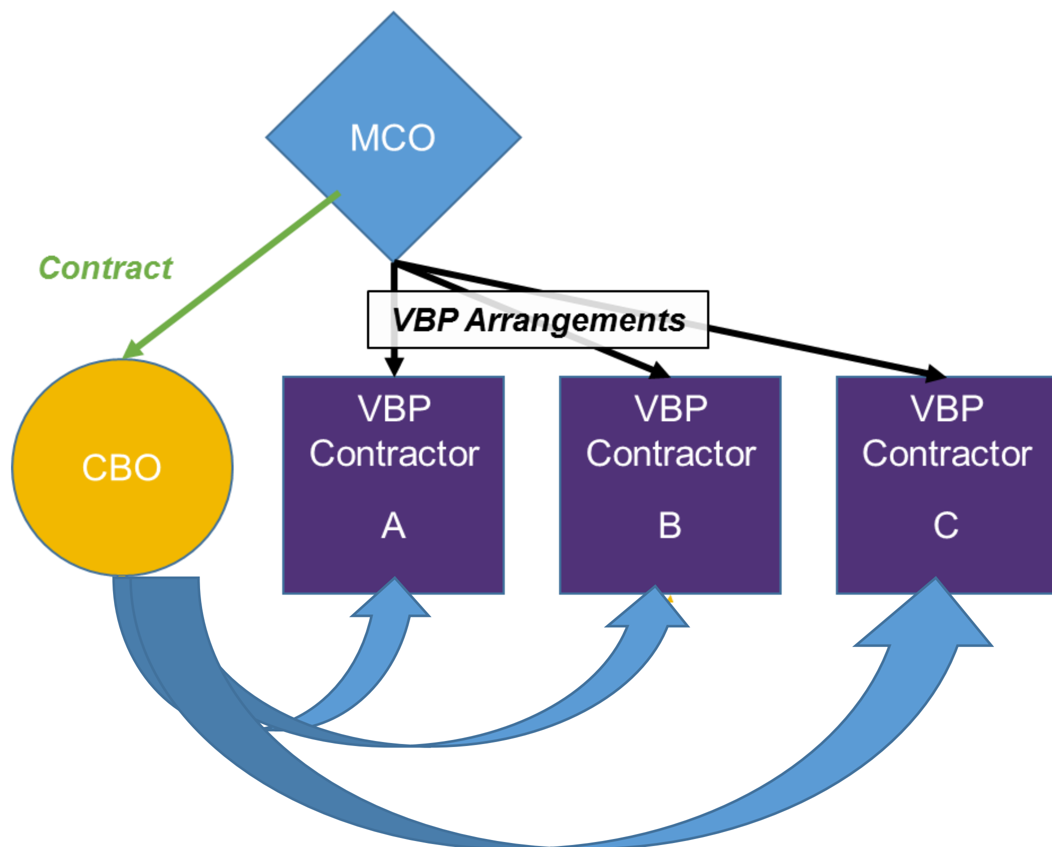
- Forestland Hospital enters into a **Level 2** Total Care for General Population (**TCGP**) **VBP arrangement** with GreenLeaf Managed Care
- Many of the **highest ED utilizers** covered under the arrangement have **lack of access to affordable housing**
- Greenleaf contracts with Hazelcrest Housing CBO to implement a **Housing Intervention** for the highest utilizers covered under Forestland's VBP arrangement



CBO Contracting Strategies – Scenario B

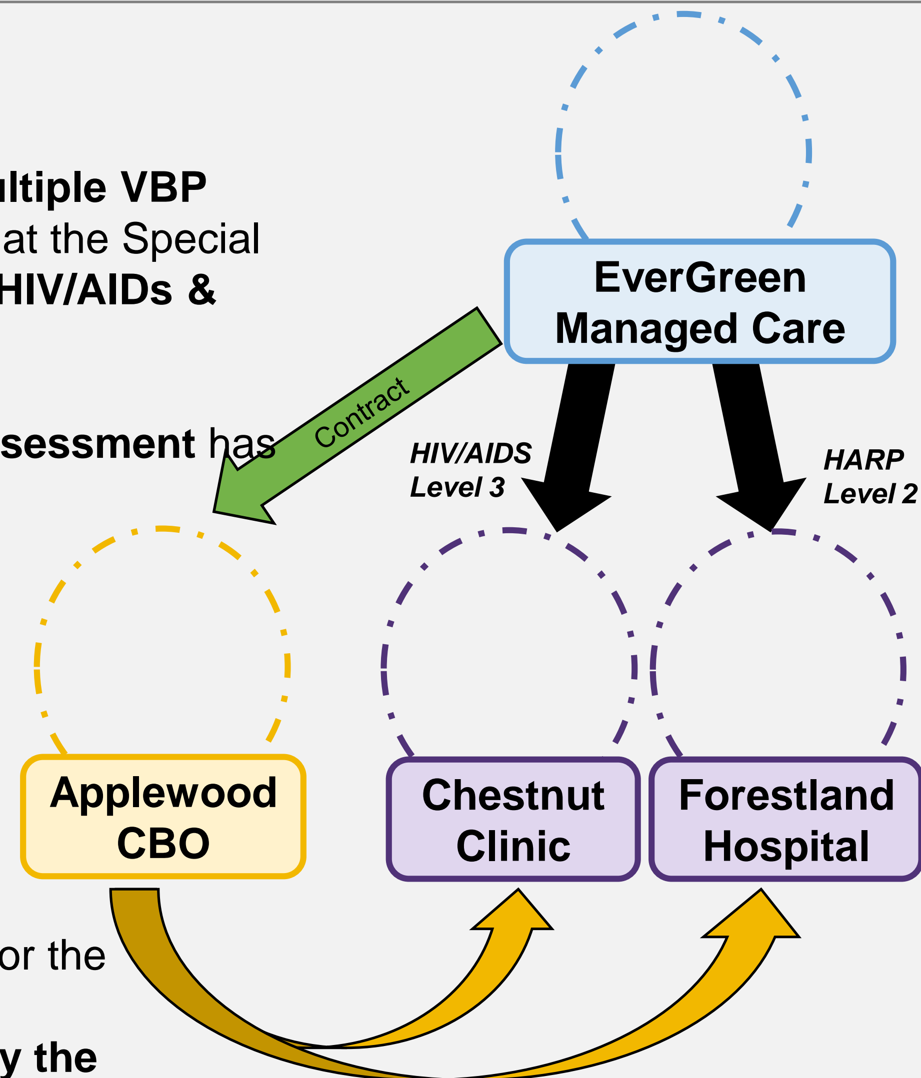
CBOs may support VBP arrangements by:

B contracting directly with an MCO to support multiple VBP arrangements



Hypothetical Example

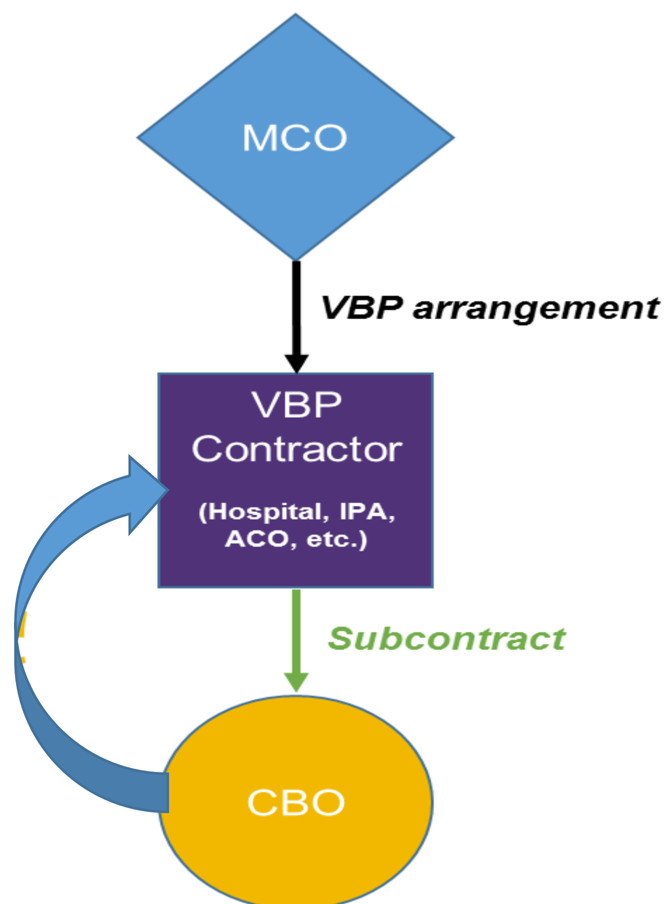
- EverGreen contracts **multiple VBP arrangements** targeted at the Special Needs Subpopulations (**HIV/AIDs & HARP**)
- A **community needs assessment** has revealed that a large **challenge** facing the local Special Needs Subpopulation **is food insecurity**
- EverGreen contracts with Applewood CBO to implement a **Nutrition Intervention** for the local Special Needs Subpopulation **served by the multiple VBP arrangements**



CBO Contracting Strategies – Scenario C

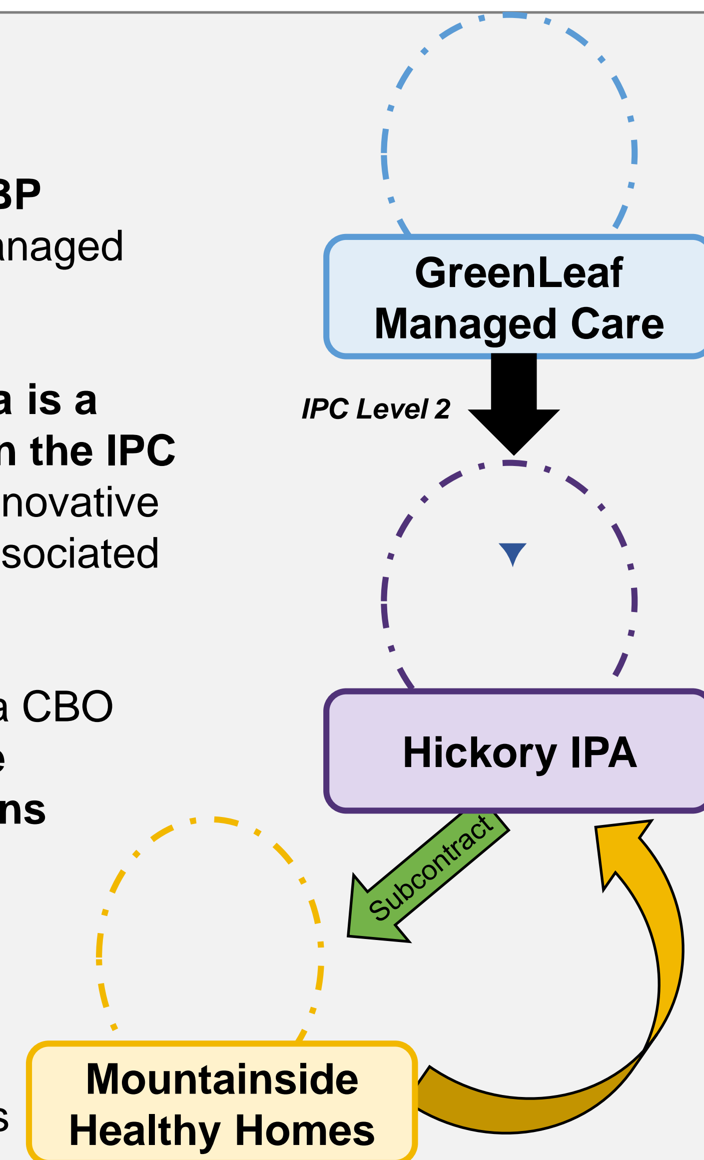
CBOs may support VBP arrangements by:

Ⓒ subcontract with a VBP Contractor (Hospital, IPA, ACO, etc.)



Hypothetical Example

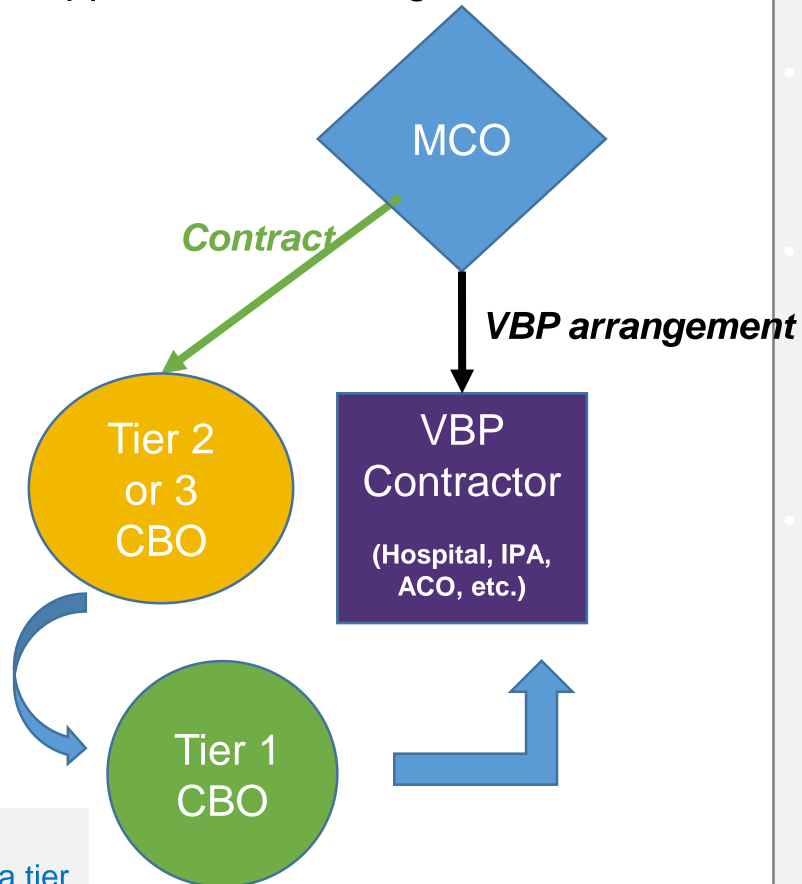
- Hickory IPA enters into a **Level 2** Integrated Primary Care (**IPC**) **VBP arrangement** with GreenLeaf Managed Care
- Hickory IPA is aware that **Asthma is a** chronic care **episode included in the IPC arrangement**, and is exploring innovative ways to prevent complications associated with asthmatics
- Mountainside Healthy Homes is a CBO that is known regionally for **home environment-based interventions**
- Hickory IPA subcontracts with Mountainside Healthy Homes to **implement home-based interventions targeted at** improving air quality in the homes of **asthmatics**



CBO Contracting Strategies – Scenario D

CBOs may support VBP arrangements by:

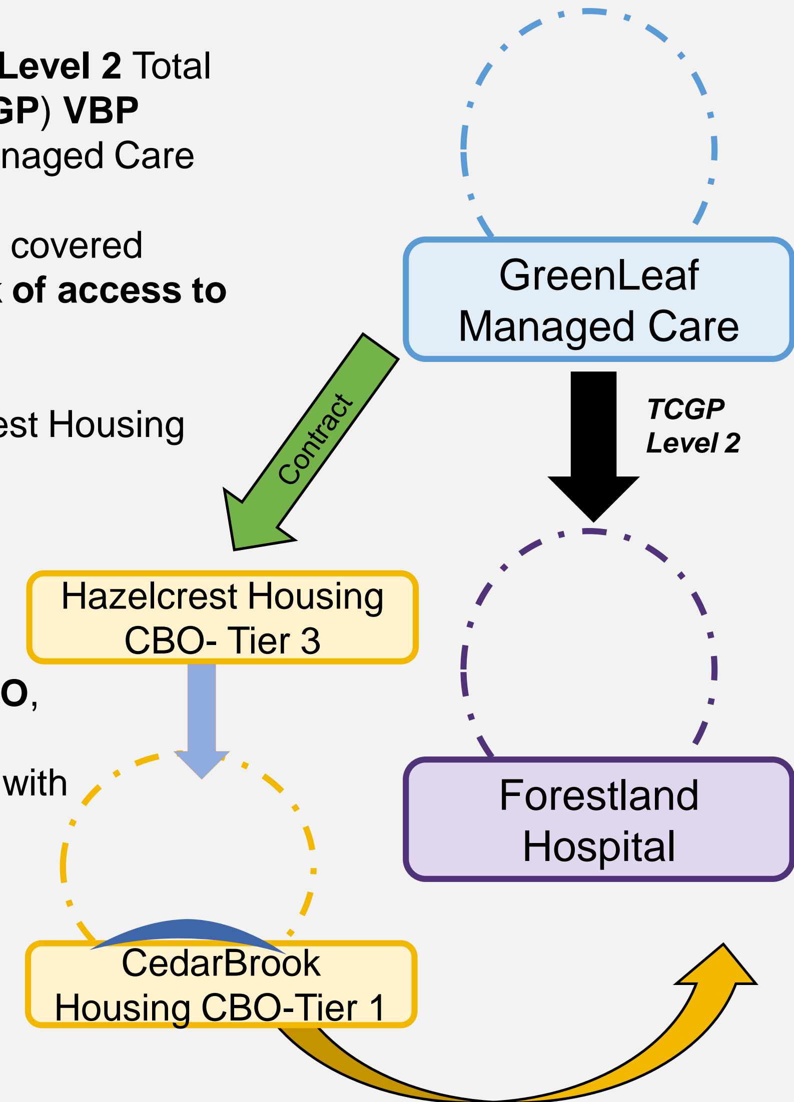
D multi-tier CBO partners contracting directly with an MCO to support a VBP arrangement



A tier 2 or 3 CBO subcontracting with a tier 1 CBO to support an arrangement.

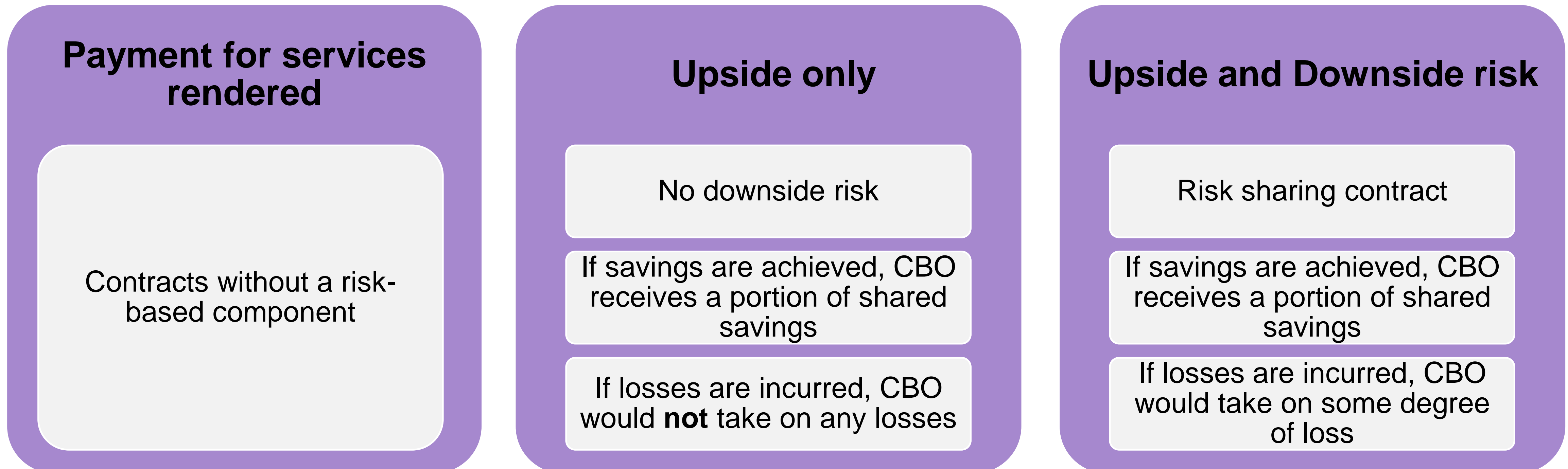
Hypothetical Example

- Forestland Hospital enters into a **Level 2** Total Care for General Population (**TCGP**) **VBP arrangement** with GreenLeaf Managed Care
- Many of the **highest ED utilizers** covered under the arrangement have **lack of access to affordable housing**
- Greenleaf contracts with Hazelcrest Housing CBO to implement a **Housing Intervention** for the highest utilizers covered under Forestland's VBP arrangement
- **Hazelcrest Housing, a tier 3 CBO**, subcontracts with **CedarBrook Housing, a tier 1 CBO**, to assist with implementation of Housing Intervention by covering a specific geographical area.



CBO Contracting Options

- CBO contracts are **not** required to include risk
- CBO contracts could be structured as:



- CBOs may be held to performance measure standards by the party they are contracting with (VBP Contractor or MCO) in order for contracting to continue

SDH Intervention Examples

SDH Example: Peer Mentoring and Wellness Coaching Program

- **Goal:** Promote the use of evidence based care to manage chronic disease using trained peers
- Peer Mentors are recruited and matched with members based on their chronic conditions, language, and culture, etc.
- In-person or telephonic outreach to participant members to provide one-on-one support and encouragement for behavior change, leading to better self management skills
- Supports include:
  - Adhering to diet while being culturally sensitive
  - Identifying and avoiding triggers that lead to negative outcomes
  - Providing follow up and increased medication adherence

SDH Examples: Continued

SDH Domain	Intervention
Social and Community Context	**Informal Support and Social Cohesion:** 1. Volunteer service program that matches members and volunteers based on shared interests, talents, and spiritual needs. Volunteers provide face to face visits and/or telephone calls. In addition to companionship, volunteers provide assistance with grocery shopping, minor home repairs. For more information, please check out ArchCare's TimeBank Program: https://www.archcare.org/community-resources/timebank
Economic Stability	**Social Transportation:** 1. Providing transportation services to social events such as; going to a place of worship, visit with family, grocery store and medication pick up.
Neighborhood and Environment	**Healthy Homes:** 1. SDH intervention focusing on comprehensive home environment assessment of members with Asthma and other Chronic Respiratory conditions to identify triggers that negatively impact health. Home remediation may include performing mold and lead abatement, or carpet removal.
Economic Stability	**Financial Security and Education:** 1. Tailored one-on-one or group education session for plan members to educate on financial literacy to promote self sufficiency and independence. 2. Life skills training to promote an independent and healthy lifestyle (i.e. how to grocery shop and cook healthy affordable meals).

VBP Tracking Report (VBPTR) Overview

VBPTR Reminders

a) DOH requires that Managed Care Plans (partially capitated and fully integrated) submit their progress toward VBP implementation on a quarterly basis. (VBPTR)

b) MCO reported Medicaid expenditure in VBP is used to:
   - Report to CMS annually on the State's progress in meeting VBP targets as defined in the Roadmap (VBP Roadmap, pg. 62)
   - Calculate MCO incentives for rate setting year SFY 2018-19, as referenced in the VBP Roadmap (VBP Roadmap, pg. 47)

VBPTR Reminders continued….

c) Responses submitted via VBPTR should ***only include Medicaid expenditures***

d) Responses submitted via VBPTR should ***not include Medicare expenditures***

- Fully Integrated products should ***not*** submit Medicare expenditures as part of their reporting

e) The DOH is assessing MCO (including MLTC Plans) total Medicaid expenditure that transitions to VBP for the following:

- Partial capitation which includes LHCSA, CHHAs, SNF spend only
- Fully integrated products including MAP, PACE, FIDA

f) Fully integrated products may have Levels 1, 2, or 3 VBP arrangements

g) Partial capitation may have Levels 1 or 2 VBP arrangements

VBPTR Reminders continued

i) An MCO's VBP progress is measured by the following:

- Partial capitation: aggregate total expenditure captured in VBP for LHCSA, CHHA, SNF (i.e. "Total Medical Expense for Line of Business" on Table 1E should reflect the total expenditures for all LHCSA, CHHA and SNF providers regardless of VBP level or participation).
- Fully Integrated: aggregate total expenditure captured in VBP for the product lines held by a Plan, for example, (PACE, FIDA and mainstream)

j) FIDA, MAP, and PACE should report all VBP dollars under "Total Care for MLTC Subpopulation" on Table 2F, 2D, and 2G, respectively. This enables the State to track spend for FIDA, MAP and PACE separately from the partial capitated spend (LHCSA, CHHA, SNF). Plans should report all of their Medicaid spending with all providers types on the respective Table 2.

* Refer to pages 47 and 62 for a description of how MCO penalties are applied and how the State assess progress toward VBP implementation

VBPTR Reporting Requirements

Table 1 – 1G: Medical Expense Summary

All Lines of Business

- Enter total Medicaid medical and hospital expenses for the reporting period on the first row of the table.
  - MLTC Partial Plans should **only** include expenses that relate to ***LHCSA, CHHA, or SNF services*** (unless the Plan has an ‘off-menu’ arrangement approved by DOH)
- Plans can use the following categories to reduce the total expenses throughout the rest of the report:
  - Financially Challenged Providers
  - Services to Non-Attributed Members
  - High Cost Specialty Drugs
  - Organ Transplant Services
  - Minimum Wage Funding Adjustment
- Total Expense – All exclusions = “reduced” total expenses

Table 1-1G for both Fully & Partially Capitated Plans

TABLE 1E - MLTC PARTIAL MEDICAL EXPENSE SUMMARY

TABLE 1E - MLTC PARTIAL MEDICAL EXPENSE SUMMARY		Expenses
00115	00116	00117
Beginning NYS FY April 1 through end of current period		
Total Medical Expense for Line Of Business	00001	510,000,000
Expenses that MUST BE Excluded from VBP Requirement		
Financially Challenged Providers	00002	
Services to Non-Attributed members	00003	
Expenses that MAY BE Excluded from VBP Requirement		
High Cost Specialty Drugs	00004	
Organ Transplant Services	00005	
Minimum Wage Funding Adjustment	00012	
Totals		
Total Exclusions	00010	
Total Medical Expense Less Total Exclusions	00011	510,000,000

This should be equal to all Plan expenses for LHCSA, CHHA and SNF provider types only.

Table 2 – 2G: Medical Expense by Arrangement

FIDA (Table 2F)
MAP (Table 2D)
PACE (Table 2G)

- Enter total expenditure of all VBP arrangements per level on “Total for MLTC Subpopulation” line
- Only Medicaid and Cost-Share amounts should be included.
- ***Exclude Medicare spending from this amount***.

MLTC Partial (Table 2E)

- Enter LHCSA, CHHA, and SNF dollars in each respective row
- No other dollars should be entered – do not fill out the “Total for MLTC Subpopulation” line.

Table 2E for Partially Capitated

TABLE 2E - MLTC PARTIAL MEDICAL EXPENSE BY ARRANGEMENT

TABLE 2E - MLTC PARTIAL MEDICAL EXPENSE BY ARRANGEMENT		Non-VBP Arrangements*	VBP Level 0 Performance Measures**	VBP Level 0 Target Budget***	MLTC VBP Level 1	MLTC VBP Level 2
00245	00246	00247	00248	00249	00250	00251
VBP Level 1, Level 2, & Level 3 Arrangements						
LCHSA	00021				300,000,000	30,000,000
CHHA	00022				10,000,000	
SNF	00023				150,000,000	
Total for MLTC	00029				460,000,000	30,000,000
Total Care for MLTC Subpopulation	00024					
Approvable Off-Menu Arrangements	00007					
Total VBP Arrangements	00008				460,000,000	30,000,000
Non-VBP and VBP Level 0 Arrangements						
Fee-For-Service	00009	20,000,000				
Prepaid or Post-Paid	00010					
	00011					
	00012					
	00013					
Total Non-VBP Arrangements	00014	20,000,000				
Total Medical Expense Less Exclusions	00015					
Percentage of Total Medical Expense Less Exclusions	00016	3.92%			90.20%	5.88%

Reminder: For partially capitated plans, plans should not enter anything in the “Total Care of MLTC Subpopulation” line

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Table 2 (D,F or G) for Fully Capitated Plans

TABLE 2D - MAP MEDICAL EXPENSE BY ARRANGEMENT								
TABLE 2D - MAP MEDICAL EXPENSE BY ARRANGEMENT		Non-VBP Arrangements*	VBP Level 0 Performance Measures**	VBP Level 0 Target Budget***	VBP Level 1	VBP Level 2	VBP Level 3	Total Paid
00236	00237	00238	00239	00240	00241	00242	00243	00244
VBP Level 1, Level 2, & Level 3 Arrangements								
LCHSA	00021							
CHHA	00022							
SNF	00023							
Total for MLTC	00029							
Total Care for MLTC Subpopulation	00024				460,000,000	30,000,000		
Approvable Off-Menu Arrangements	00007							
Total VBP Arrangements	00008				460,000,000	30,000,000		
Non-VBP and VBP Level 0 Arrangements								
Fee-For-Service	00009							
Prepaid or Post-Paid	00010							
	00011							
	00012							
	00013							
Total Non-VBP Arrangements	00014							
Total Medical Expense Less Exclusions	00015							
Percentage of Total Medical Expense Less Exclusions	00016							

Table 3 – 3G: Medical Expense by Region

All Lines of Business

- Enter spending for each risk level by region.
- The total amounts on this table should correspond with the respective totals on Table 2.

Table 4 – 4G: VBP Contract Specification Information

Table 4 – All Lines of Business

- List all contracts approved as VBP Level 1, 2, or 3 on this table. *Only DOH approved arrangements should be listed.*
- Include the DOH-Issued Contract ID, Plan-Created Unique ID, or both. *NPI numbers or other codes are not acceptable entries.*

Table 4-1 – All Lines of Business

- List all Non-VBP and Level 0 arrangements categorized by the following:
  - any physician led group (IPA,) hospital system or other provider type having significant number of PCPs or BH providers (or other attribution driving provider types), and;
  - that have a spend of at least $2 million
- Enter the total contract dollars for each arrangement
- Include the DOH Contract ID, Plan Created, Unique ID, or both. *NPI numbers or other codes are not acceptable entries.*

VBP Tracking Report (VBPTR) Examples

Examples based on contract submission and effective dates

Reporting Example 1

Scenario

Plan ABC has a VBP Level 2 contract that was approved by DOH on October 1, 2018. The total medical expense for this contract is $5 million. How will Plan ABC report these dollars?

Reporting Correctly

Updated 4/23/19:

For the annual reporting period (April 1, 2018 – March 31, 2019) the full $5 million should be reported in Table 2 under Level 2. If a contract is *submitted and effective* during the SFY reporting period, the total medical for the contract is counted as VBP.

Reporting Example 2

Scenario

Plan ABC enters into a contract with a retroactive start date of January 1, 2019. The contract was submitted on March 1, 2019 and approved on June 1, 2019. Can Plan ABC count this contract on their 4/1/18-3/31/19 VBPTR submission?

Reporting Correctly

Updated 4/23/19:

Yes. If a contract is submitted by and has an effective date on or before 3/31 of the respective SFY reporting period (April 1 – March 31), it can be counted as VBP for that annual reporting period.

The contract must be approvable within the 3 day (Tier 1 contracts) or 90 day (Tier 2 & 3 Contracts) timeframe as outlined in the Provider Contract Guidelines.

Reporting Example 3

Scenario

Plan ABC amended a Non-VBP arrangement in December 2018 and it is now considered a Level 2 arrangement moving forward. Does Plan ABC need to split the contract expenses between the two levels?

Reporting Correctly

Updated 4/23/19:

No, contract expenses should not be split among different arrangement levels.

If a contract amendment was submitted by and had an effective date on or before 3/31 of the respective SFY, then the total amount of the contract should be entered in Level 2.

Reporting Example 4

Scenario

Plan ABC, an MLTC Partial Plan, is entering information on Table 1E. What expenditure should be entered for “Total Medical Expense for Line of Business”?

Reporting Correctly

For partially capitated plans, the Total Medical Expense for Line of Business should only include total spend for LHCSA, CHHA, SNF in both VBP & non-VBP arrangements. It should NOT include other services or provider types (unless the Plan has a DOH approved Off-menu arrangement).

Other Contracting Questions

Other Questions Asked by Plans

Q: Can the VBP contract between the Plan & Provider include a contingency that the Plan receive VBP quality performance dollars from the State in order to award upside funding to the Provider?

A: No, payment cannot be contingent upon the Plan receiving VBP Quality Performance dollars from the State.

Q: To meet the Level 2 definition, the amount of risk allocated to the provider must be at least 1% of total annual expenditures in the contract between the Plan and the provider.

A: Plans and providers may use the total annual expenditure of the previous year's contract (between the same provider and Plan) to determine 1% risk, or Plans and providers may calculate 1% risk based on the annual expenditure of the current year's contract. Either method is acceptable.

Other Questions Asked by Plans

Q: How should Plans encourage Providers to enter into a Level 2 arrangement?

A: The State does not dictate how these arrangements should be set up in your Plan to provider contracts. For example, Plans may choose to increase the upside in Level 2 arrangements to incentivize provider participation. (i.e. Plans are encouraged to share more data, pass down the VBP performance adjustment, etc.)

Q: Can bonus monies or penalties be applied using retrospective lookback and assessed after the performance year?

A: The methodology for assessing provider performance to calculate upside or downside is not defined by the State and can be negotiated between the Plan & Provider.

Please direct any additional questions or feedback to:

vbp@health.ny.gov