Value-Based Payment Program Integrity (PI): Issues and Considerations

Executive Summary

Value Based Payments (VBP) are the future delivery platform of New York State's (NYS) Medicaid program. VBP will fundamentally change the way health care services are delivered, paid, and incentivized. Congruently, NYS' Medicaid Program Integrity (PI) strategy must change.

VBP models are premised upon the *value* of care delivered. Fee for service ("FFS") payment models are premised upon the *instance* of care delivered. The former provides increasing financial rewards as the *value* of care delivered increases, the latter provides increasing financial rewards as the *volume* of care delivered increases. Accordingly, VBP models incentivize high-value care delivery whereas FFS models incentivize high-volume care delivery.

As NYS' Medicaid delivery platform shifts to payment for value and away from payment for volume, NYS's Medicaid PI model must likewise shift to measuring the value of care delivered and move away from validating volume (ensuring the instances of care reported were in fact delivered and appropriate). Where traditional FFS and managed care program integrity models are applied to VBP payment systems two (2) problems manifest: (1) the relevant metric, the value of care delivered, is measured through multiple sources, including DSRIP measures, existing quality measures, and CAG measures. Further, (2) measurements solely querying the volume of care delivered are wasteful—they provide little actionable information as volume is less relevant in VBP payment systems and as incentives, and therefore Program Integrity models, will need to adapt.

The shift to a VBP delivery systems from a FFS delivery system is driven by a fundamental shift from FFS payment arrangements to value-based payment arrangements. As the payment incentives change, the Program Integrity model and its risk management strategy will need to anticipate and address new scenarios for billing or reporting errors and fraud, waste, and abuse (FWA) schemes. Under VBP, changing incentives mean that FWA is not only a detrimental force to the Medicaid Program, but also explicitly and adversely impacts compliant payors and providers. Payors, providers, and the State stand to benefit from defining agreed upon rules that determine fair play under this new payment model in an effort to avoid inadvertent FWA. By issuing clarifying guidance and/or identifying behaviors that need to be corrected to uphold the spirit of VBP, the State is encouraging collective success and efficient care delivery.

Accordingly, the VBP-PI system must detect high-likelihood instances of FWA at different delivery levels and geographies. Where directed and revealed, the VBP-PI system permits data-informed, actionable, and defensible risk management and review of these transactions by oversight and enforcement authorities. This permits resources to most effectively be deployed to high-value targets.

Lastly, as reimbursement becomes linked to value, the data quality of measures that inform value must be managed to ensure the delivery of a true reflection of the value delivered and to appropriately analyze potential FWA. Data quality requires current state analysis, gap to goal strategy and execution and ongoing data-integrity review and calibration.

The Program Integrity Workgroup's Mission: *Identify what changes can be made to the current program integrity infrastructure to ensure a robust program integrity model is in place that protects providers', payors', enrollees', and the State's objectives under a VBP environment.*

In addressing this broad question, the Workgroup should consider recommending options that are not focused singularly on FWA, but consider an enterprise-wide view of VBP PI. While FWA is a large and traditional component of PI, holistically VBP

PI should consider the following three parameters:

I. **Data Quality—**Considerations related to the availability of cost and quality of care data that is accurate, timely, and complete. This is accentuated under VBP since reimbursement becomes increasingly linked to quality measures.

II. **Policy Design—**Considerations related to the mitigation of any undesirable results that are contrary to the objectives of the NYS VBP program and policy decisions and the mechanisms whereby policy will be accordingly adjusted.

III. **Risk Management**—Considerations related to the new potentials for billing and reporting errors and avenues for FWA that will exist in a Medicaid environment under VBP.

The policy questions in this brief will relate to the aforementioned considerations.

Introduction

The Workgroup will focus on developing policy recommendations related to VBP PI. These issues will require coordination between both the New York State Department of Health (DOH) and the New York State Office of the Medicaid Inspector General (OMIG), other New York State Offices, as well as payors, providers, and other stakeholders.

This brief will provide an overview of the future program integrity policy issues that will emerge through a VBP environment and will present potential policy options for the Workgroup's consideration. The brief will focus on program integrity issues related to: (1) Data Quality, overarching (2) Policy Design, and (3) Risk Management. The issues and options included in the brief are not exhaustive, nor are they mutually exclusive.

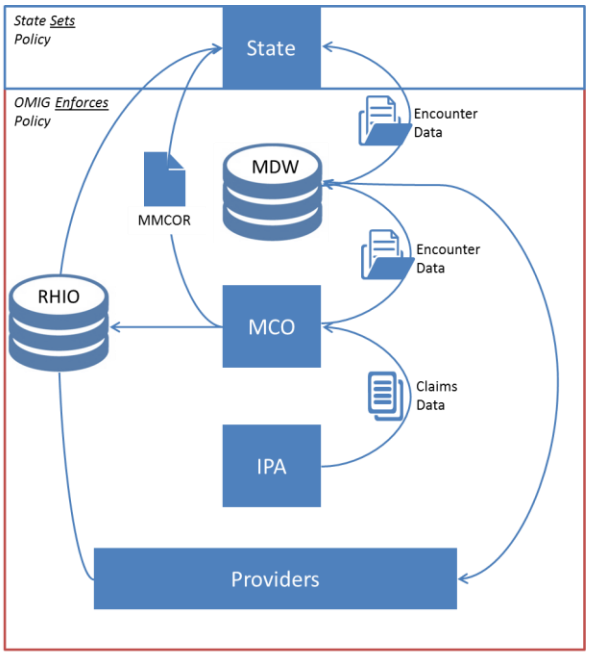
Data Quality

In order for a VBP framework to function successfully, data quality measures should be developed and implemented to capture a true reflection of the value of care delivered and to ensure overall program integrity. Within such a framework, it is critical to be able to measure *both* the cost and quality of care delivered.

Encounter Data

States are required by federal law to develop comprehensive encounter data reviews and report this data to CMS as part of their quarterly Medicaid Statistical Information System (MSIS) submissions. Under federal regulations (42 CFR §438.242 *et seq.*), MCOs are required to collect this encounter data, ensure its accuracy and completeness, and to submit it to the State.

The current state high-level process data flow under Medicaid Managed Care is as follows:



** Reflects a high level data flow; not intended to represent detailed Medicaid MCO data transmission*

In an effort to ensure the quality of the encounter data, NYSDOH currently evaluates the data submitted by each plan according to the following measures:

- Timeliness: Percent of accepted dental, institutional and professional, and encounter data files accepted twice a month, and the percent of accepted pharmacy encounter data file submitted daily
- Accuracy: Percent of files that have rejected among all files that have been submitted
- Completeness: Percent change of accepted encounters submitted PMPM based on service date

Because encounter data provided from providers-to-plan and from plans-to-State is foundational for the measurement of value and FWA through the VBP environment, both CMS and New York State have enacted financial penalties for encounter data that lacks accuracy, timeliness, or completeness:

- Recently finalized CMS rule requires that the state report encounter data to CMS that is complete, timely, and accurate in order to receive federal matching payments on MCO contract expenditures
- Recently passed Article VII DOH budget initiative will levy a 1.5% penalty to premiums of MCOs that submit encounter data that is inaccurate, late, or incomplete

These punitive measures, notwithstanding the technical success of New York State's VBP, are contingent on the completeness and quality of the data that is used to source quality, cost, and FWA measures. Accordingly, proactively developing these measures and reporting protocol benefits all stakeholders.

Other Data Sources

While accurate encounter data is critical to the success of the program, program integrity efforts need to be further enhanced through access to additional data sources, including MMCOR reporting, clinical quality data, and additional

data measures laid out in model contracts that pertain to FWA. Data found in the RHIOs has also been identified as a potential source for information on quality of care. However, these data sets would need to be incorporated into any developing program integrity initiatives in order to be impactful.

New York State may also leverage the additional External Quality Review (EQR) activities related to validation of encounter data reported by an MCO to the State.*
** as per Federal Regulation 42 CFR §438.358 Protocol 4*

Goal: Ensure access to reliable data sources that can provide insights into the cost and quality of care.

Policy Question: How does New York State attempt to ensure that it collects timely, accurate, and complete data for care, quality, and costs?

a) Could the existing encounter reporting and enforcement process be leveraged more effectively in support of VBP?
   a. Are there potential enhancements or alterations to current monitoring efforts for accuracy, timeliness and/or completeness?
   b. What supplemental monitoring efforts could be implemented to monitor quality?
   c. Other

b) Aside from the encounter data, are there other sources of data, or potential enhancements to data sources, that could potentially serve to ensure that NYS is able to collect high quality submissions? (i.e. MMCOR, RHIO, other)
   a. Can NYS more effectively leverage data sources such as the MMCOR, and RHIO to create a robust framework for PI and bring NYS into compliance with CMS rule?
   b. How can NYS ensure access to datasets for all relevant stakeholders?
   c. Other

Policy Design

As NYS' Medicaid delivery platform shifts to payment for value and away from payment for volume, NYS's Medicaid PI model must likewise shift to measuring the value of care delivered and move away from validating volume. The alignment, measurement and quantification of the policy and goals outlined through the VBP Roadmap to incentivize high-value healthcare delivery is a key component of VBP PI—the accuracy of this information is paramount to understanding the impact of NYS' VBP delivery platform. Further, such measurement permits informed policy adjustment. Indeed, as with any enterprise-wide delivery transformation, policy design may create unintended consequences contrary to original intent. Below is an example of the type of incentive that could occur if not controlled or prevented with an effective policy design:

> *<u>Example of a Provider Incentive</u>: Under a FFS environment, a physician is paid based on volume—the more care provided to Medicaid members the more revenue earned. Under VBP, the physician moves into a Level 3, prospective, fully capitated arrangement. Because the physician is receiving a prospective Per-Member Per-Month (PMPM) payment, there is no longer an incentive to serve patients with the same frequency. Consequently, the physician decides to limit office hours, therein limiting Medicaid members'*

access to care.

Without an appropriate safeguard in place, the undesired result of limiting access to care is inaugurated.

Example of a Payor Incentive: Misreported encounters could lead to the calculation of a more favorable efficiency score for a given MCO resulting in greater bonus payments for MCOs presenting inaccurate data. Under VBP, this would decrease the bonus payments available to MCOs presenting accurate data, thereby propagating the incentives for false, inaccurate or incomplete reporting.

Without policy safeguards in place to mandate accurate reporting, incentives could be misaligned with the goals of VBP.

Monitoring and making informed response to any unintended consequences of the VBP policy design will be paramount to NYS and all VBP stakeholders.

Goal: Identify appropriate safe-guards that can control adverse behavior in a VBP framework, and ensure patient and provider protection.

Policy Question: What safeguards should be enacted to ensure that the transition to VBP does not create incentives that are not in the spirit of the program?

a) Considering the various Payor and Provider incentives that need to be guarded against, and the contractual framework of stakeholder relationships, what are the desired types of safeguard actions that should be taken?
   a. Are there anticipated discrepancies between VBP policy objectives and realized access and quality of care that could be mitigated through additional reporting requirements being specified in the Model Contract?
   b. Do any of the potential adverse incentives necessitate regulatory change?
   c. What types of data-driven measures could be captured on contractor exception reports to monitor divergent behavior and trends?
   d. Are there adverse incentives that could be guarded against by providing guidance to plans and/or contractors on best practices?

Risk Management

State Medicaid program areas develop and implement risk management strategies that are included in the operations of the program. Medicaid risk management enforcement initiatives are primarily carried out through the OMIG. However, in order for these efforts to be successful, and ultimately support NYS's goals of a successful transition to VBP, they will need to advance in-step with program and policy decisions that are being considered by OHIP. Non-NYS stakeholder cooperation will also be necessary to support Program Integrity during this transition. The OMIG has previously shifted resources and processes to match the changing direction of the Medicaid program, *e.g.,* FWA efforts have shifted from a

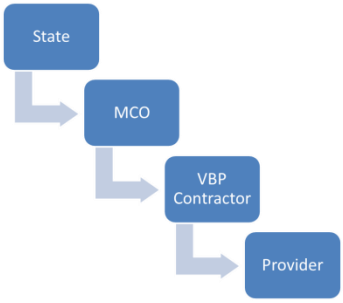
FFS focus to Medicaid managed care (MMC) focus. With the imminent transition to VBP, the OMIG, the DOH, and Payors and Providers (who are potentially more adversely impacted by FWA under VBP) will face new compliance requirements, risk management, and FWA prevention efforts.

Goal: Identify existing and novel collaborative practices, and the elements required to make them successful, in order to position New York State to evolve risk management efforts over time, as VBP is adopted.

Policy Question: What Program Integrity infrastructure needs to be put into place that establishes a solid foundation for Medicaid risk management as it relates to VBP implementation in NYS?

a) Where should accountabilities for risk management responsibilities lie in relation to Medicaid Program Integrity?
   1. How will OMIG, OHIP, and other stakeholders define their agency roles and support each other's distinct efforts to control FWA?
   2. It is feasible for an audit readiness assessment to be conducted on select plans and contractors to evaluate potential compliance and signals what future audit expectations will be?
   3. Would there be value in establishing a thought sharing symposium with the OMIG/DOH and private insurers to discuss VBP risk management lessons learned?
   4. Other

b) Are the existing policies, laws, and regulations adequate to allocate responsibility for risk management and program integrity enforcement among stakeholders?
   1. Where are the gaps in relevant statutes that will impact the assignment and subsequent fulfillment of these responsibilities?
   2. Should a written protocol be developed wherein safeguards are developed and issued in a manner which can be legally enforced and where either the OMIG and/or DOH identifies high-likelihood targets for enforcement actions?
   3. Placeholder for MCO Final Regulation/MCO Model Contract language[1]



[1] Network adequacy (27658); MLR (27758); Alignment of CHP/Medicaid (27755); Addition of Quality → Change to "Quality Assurance Standards" (27764); FWA (27891)