NEW YORK STATE | Department of Health | Medicaid Redesign Team

Managed Long Term Care (MLTC) & Value Based Payment (VBP) – Discussion of Level 2

Stakeholders Meeting

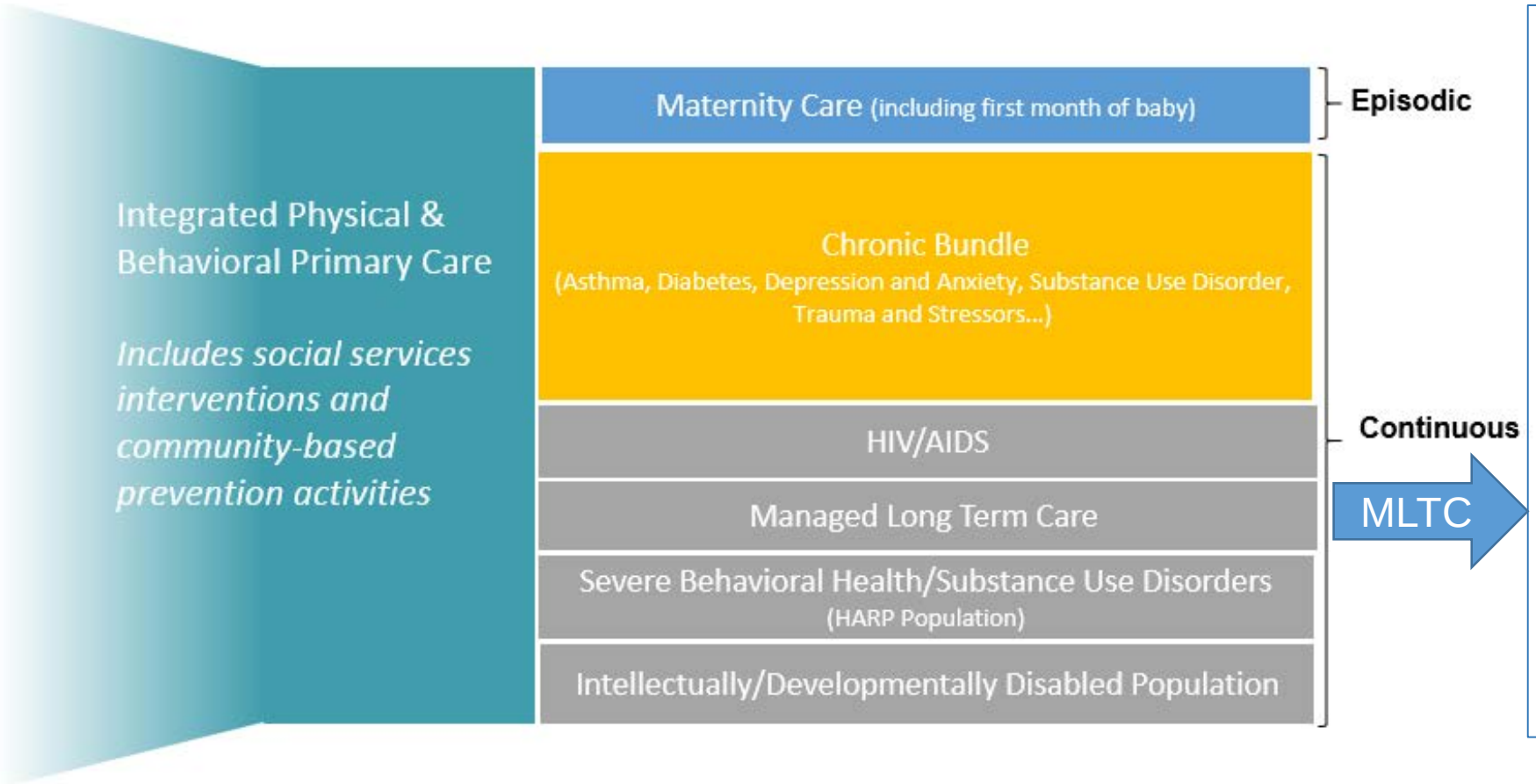
February 20, 2018

Agenda

1. Review of VBP Roadmap Arrangement for MLTC
2. Discussion of Key Features of VBP
3. Guiding Principles for the Discussion
4. Discussion of Options for Level 2
5. Implementation Considerations Discussion
6. Next Steps

Review of VBP Roadmap Arrangement for MLTC

MLTC is a Designated Total Cost of Care Subpopulation Arrangement in the VBP Roadmap



Specialized Continuous Care – For these members, including MLTC, personalized goal setting and intensive care coordination become more dominant than disease management. In both examples of care, a focus on maximizing a member's capability for self-management and personal autonomy in the most integrated settings (e.g. home and community) appropriate to a person's needs, is central.

MLTC VBP Vision: Total Cost of Care

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

- New York State Department of Health (DOH) has identified three subpopulations with their own distinct, dedicated managed care arrangements:
  - **MLTC;**
  - HIV/AIDS;
  - HARP.
- A fourth subpopulation, to include specialty services provided by the Office for Persons with Developmental Disabilities – I/DD – is under development as these services are not included in managed care.

In total cost of care subpopulation arrangements VBP Contractors take responsibility for all care needed by the Medicaid member.

Total Population

– TCGP

Subpopulations

Acronyms: HARP = Health and Recovery Plans; TCGP = Total Care for the General Population; I/DD = Intellectual/Developmental Disabilities

Discussion of Key Features of VBP

Level 1 VBP Definition for Partially Capitated MLTC Plans

Until such time as alignment with Medicare is possible, Level 1 VBP for partially capitated MLTC plans will be a pay-for-performance (P4P) program based on the Potentially Avoidable Hospitalization (PAH) quality measure.

"If the Medicare dollars cannot be (virtually) pooled with the State's Medicaid dollars, and savings in Medicare cannot be shared with Medicaid providers (or vice versa), the impact of payment reform for this population threatens to be limited, and long term care providers will have difficulty achieving scale in VBP transformation. To remedy this, the State is working with CMS to create aligned shared savings possibilities within Medicaid and Medicare.

In anticipation, the State aims to treat potentially avoidable hospital use as 'quality outcomes' for this subpopulation, improving the quality of life for these members, and rewarding MLTC providers when certain levels of reduced avoidable hospital use are reached. Such arrangements could be treated as Level 1 VBP arrangements, and would be eligible for financial incentives. Improved quality and reduced overall costs can also be realized by delaying or avoiding nursing home admissions through targeted interventions amongst the MLTC population residing at home."

New York State Department of Health, *A Path toward Value Based Payment: New York State Roadmap for Medicaid Payment Reform, Annual Update June 2016: Year 2 (CMS-Approved April 2017),* p. 18.

VBP Levels for Plans and VBP Contractors

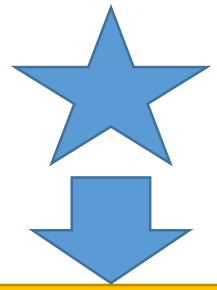
Managed care plans can choose different levels of VBP with their VBP Contractors. Level 1 as a pay-for-performance contract is available only to partially capitated MLTC plans.

VBP Levels 1, 2, and 2 in the NYS VBP Roadmap			
MLTC Partial Level 1	Level 1 VBP	Level 2 VBP	Level 3 VBP
Bonus for quality scores	Upside-only shared savings when quality scores are sufficient	Risk sharing (upside available when quality scores are sufficient)	Prospective capitation PMPM (with quality-based component)
Payment not tied to budget	FFS Retrospective Reconciliation	FFS Retrospective Reconciliation	Prospective total budget payments
Limited bonus payment or withhold	**↑ Upside Only**	**↑ Upside** & **↓ Downside Risk**	**↑ Upside** & **↓ Downside Risk**

- VBP Levels for Medicaid Advantage Plus (MAP), Fully Integrated Duals Advantage (FIDA), and Programs of All-Inclusive Care for the Elderly (PACE) comport to the selections available to Mainstream managed care
- At Level 2 VBP Contractors take on downside risk

Quality and Shared Savings for Mainstream Levels 1 & 2

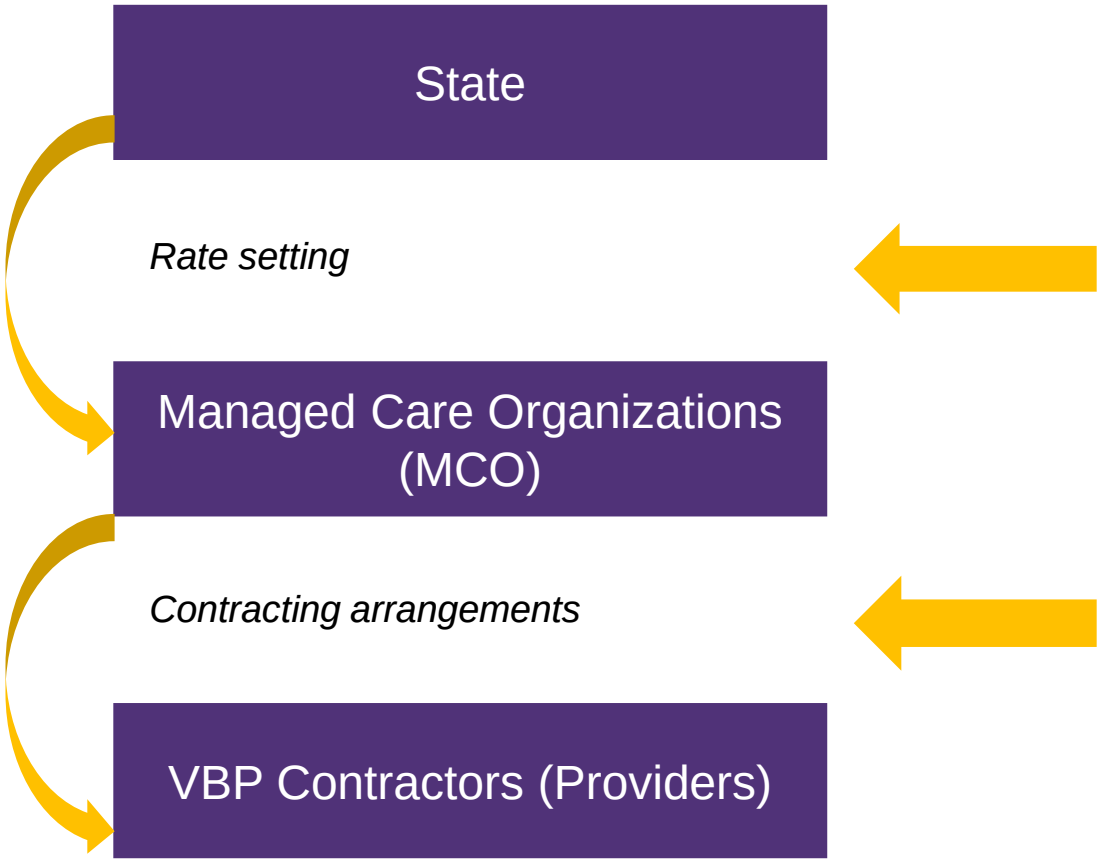
Quality Targets % Met	Level 1 VBP Upside only	Level 2 VBP Up- and downside when actual costs < budgeted costs	Level 2 VBP Up- and downside when actual costs > budgeted costs
> 50% of Quality Targets Met	50% of savings returned to VBP contractors	Up to 90% of savings returned to VBP contractors	VBP contractors are responsible for up to 50% of 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



Key Concept: Providers that deliver high quality care at the lower cost will grow more rapidly; ones that do not will shrink

Source: Roadmap June 2016: Year 2 CMS approved version. pg. 19

State – Plan – VBP Contractor Relationships



Examples of VBP Contractors:

- *Independent Practice Associations (IPA)*
- *Accountable Care Organizations (ACO)*
- *Individual Providers*

- Quality of **all** contracted care (whether VBP or not) is rewarded through up- and downwards adjustments of premiums received by managed care plans from the State
  - Includes the MLTC VBP Quality Incentive (QI) ($50 million)
- Managed care plans and VBP Contractors select quality measures to include in their VBP Contracts.
  - These are selected from the measure sets recommended for VBP but can include other measures at the preference of the contracting parties
- Quality Performance *during contract year* determines percentages of savings / losses shared with VBP Contractors and performance payments for Level 1 for partially capitated MLTC plans

Types of VBP Contracting Entities – VBP Contractors

1. Independent Practice Associations (IPAs)
2. Accountable Care Organizations (ACOs)
3. Individual Providers
   - 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. Managed Care Organizations (MCOs) may want to create a VBP arrangement through individual contracts with these providers

MLTC VBP Level Targets & Penalties for Partial Plans

2018

If by 4/1/2018 less than **10%** dollars of total MLTC plan expenditures are **Level 1** or higher, a penalty of 0.5% on the marginal difference between 10% target for Level 1 and the total actual expenditures in Level 1 will be assessed

Penalty determined based on one quarter of spending for 2018

2019

If by 4/1/2019 less than **50%** of total MLTC plan expenditures are in **Level 1** or higher, a penalty of 1.0% on the marginal difference between 50% target for Level 1 and the total actual expenditure on Level 1 will be assessed

If by 4/1/2019 less than **5%** of total MLTC plan expenditures are in **Level 2** or higher, a penalty of 1.0% on the marginal difference between 5% target for Level 2 and the total actual expenditure on Level 2 will be assessed

Penalty determined based on annual spending for 2019 & 2020

2020

Level 1 target is 80%

Level 2 target is 15%

Guiding Principles for the Discussion

Principles to Guide the Discussion

- Level 2 must include some “downside” risk for providers/VBP Contractors
  - 20% shared losses is the minimum for Level 2 per the VBP Roadmap

- The VBP Roadmap compliant arrangement definition for MLTC is a Total Cost of Care Subpopulation Arrangement. The intention is to incentivize care coordination across provider “silos”
  - Single provider P4P contracts will not meet the definition
  - Skilled Nursing Facilities (SNFs) will be included in the MLTC VBP (whether the Fiscal Year 2018-19 Executive Budget proposal passes or not) so efforts to integrate those services in total care arrangements continues to be a priority
  - Lack of Medicare data/alignment is noted as a limiting factor

- MLTC Clinical Advisory Group (CAG) discussion focused on the creation of a lower risk “learning curve” option to allow for an interim step between P4P in Level 1 for partially capitated MLTC plans and Level 2 described in the VBP Roadmap for mainstream managed care plans

Discussion of Options for Level 2

Options Discussion

Option 1: PAH Included, Mainstream Level 2 Option

Option 1.a.: PAH Included, VBP Roadmap, Less Upside/Downside

Option 2: PAH Designated P4P, with Minimal Upside/Downside

Key for Considering the Options:

- The VBP Roadmap allows flexibility for Plans and VBP Contractors to negotiate shared savings and risk according to their own preferences. Hence, the “up to…” language in the Level descriptions.
- Continued use of the PAH measure as a separate P4P measure in Level 2 is a variable in creating the Level 2 definition. PAH may be “included” on the list of measures for Plan-to-VBP Contractor use. Or PAH may be separated and retained as a P4P measure.
- Risk levels vary in proportion to reward levels – the greater the upside, the greater the downside. One party to the contract should not bear significantly more risk in the relationship than the other.
- These options highlight some of the key variables – other combinations are possible.

Option 1: PAH Included, Mainstream Level 2

Use of the PAH – Contracting parties could select PAH from the list of measures or not*

Quality Targets % Met	Level 2 VBP Up- and Downside Actual Costs < Budgeted Costs	Level 2 VBP Up- and Downside Actual Costs > Budgeted Costs
Quality Improves **>50% of Quality Targets Met**	Up to 90% of shared savings returned to VBP Contractor	VBP Contractors are responsible for up to 50% of losses
Quality Worsens	No savings returned to VBP Contractor	VBP Contractors responsible for up to 90% of losses

*NYS will continue to pay VBP quality incentives based on PAH from NYS to MLTC plan

Example of Option 1: 90% Shared Savings/Losses

Scenario

- MLTC Plan & VBP Contractor agree to a 1,000 member arrangement based on 7 quality measures including the Community PAH
- The target budget for the attributed group of members is set at $47,000 for the 12-month contract

Quality Targets % Met	Level 2 VBP Up- and Downside Actual Costs < Budgeted Costs	Level 2 VBP Up- and Downside Actual Costs > Budgeted Costs
Quality Improves **>50% of Quality Targets Met** • **4 of 7 Selected Measure Targets Met**	Actual Costs = $45,000 per member ($2,000 below $47,000 target budget) VBP Contractor would receive **$1.8 million in shared savings** (90% x $2,000 x 1,000 members)	Actual Costs = $49,000 per member ($2,000 above $47,000 target budget) VBP Contractor would receive **$1 million less** (50% x -$2,000 x 1,000 members)
Quality Worsens	No shared savings for VBP Contractor	VBP Contractor would receive **$1.8 million less** (90% x -2,000 x 1,000 members)

Option 1 – Pros and Cons

- **Pros**
  - Fully aligns partially capitated MLTC with Mainstream managed care
  - Provides substantial upside and opportunity for growth
  - Ties losses to scale of the arrangement (budget) to align incentives to improve cost effectiveness
  - Does not mandate the use of the PAH measure, allowing for flexibility in measure selection (NYS will continue to include the PAH in the VBP QI)

- **Cons**
  - Allows providers to take on substantial risk
  - Provides little opportunity to transition from MLTC Level 1 P4P environment

Option 1.a.: PAH Included, VBP Roadmap, Less Upside/Downside

Use of the PAH – Contracting parties could select PAH from the list of measures or not*

Quality Targets % Met	Level 2 VBP Up- and Downside Actual Costs < Budgeted Costs	Level 2 VBP Up- and Downside Actual Costs > Budgeted Costs
	Permissible Option in the Roadmap	
>50% of Quality Targets Met	Up to 50% of shared savings returned to VBP Contractor Reduced Upside	VBP Contractors are responsible for up to 20% of losses (minimum level to meet Level 2 definition)
Quality Worsens	No savings returned to VBP Contractor	VBP Contractors responsible for up to 50% of losses Reduced Downside

*NYS will continue to pay VBP quality incentives based on PAH from NYS to MLTC plan

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Example of Option 1.a.: 50% Shared Savings/Losses

Scenario

- MLTC Plan & VBP Contractor agree to a 1,000 member arrangement based on 7 quality measures including the Community PAH
- The target budget for the attributed group of members is set at $47,000 for the 12-month contract

Quality Targets % Met	Level 2 VBP Up- and Downside Actual Costs < Budgeted Costs	Level 2 VBP Up- and Downside Actual Costs > Budgeted Costs
Quality Improves **>50% of Quality Targets Met** ▪ **4 of 7 Selected Measure Targets Met**	Actual Costs = $45,000 per member VBP Contractor would receive **$1.0 million in shared savings** (50% x $2,000 x 1,000 members)	Actual Costs = $49,000 per member VBP Contractor would receive **$400,000 less** (20% x -$2,000 x 1,000 members)
Quality Worsens	No shared savings for VBP Contractor	VBP Contractor would receive **$1.0 million less** (50% x -2,000 x 1,000 members)

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Option 1.a – Pros and Cons

- **Pros**
  - Risk is more limited - provides a step up for plans transitioning from P4P Level 1
  - Permissible in the current the VBP Roadmap for partially capitated MLTC
  - Ties losses to scale of the arrangement (budget) to align incentives to improve cost effectiveness
  - Does not mandate the use of the PAH measure, allowing for flexibility in measure selection (NYS will continue to include PAH in the VBP QI)

- **Cons**
  - More limited opportunity for growth

Option 2: PAH Designated P4P, with Minimal Upside/Downside

Use of the PAH – Contracting parties mandated to use PAH as a P4P Measures & Select Others*

Quality Targets % Met	Level 2 VBP Up- and Downside Actual Costs < Budgeted Costs	Level 2 VBP Up- and Downside Actual Costs > Budgeted Costs
>50% of Quality Targets Met **PAH Target Met**	Up to 20% of shared savings returned to VBP Contractor + PAH bonus payment	VBP Contractors responsible for PAH Penalty/Subtraction only
Quality Worsens **PAH Target Not Met**	No savings returned to VBP Contractor No PAH bonus payment	VBP Contractors responsible for 20% of losses (minimum to meet level 2 definition) + PAH Penalty/Subtraction

Reduced Upside

Reduced Downside

*NYS will continue to pay VBP quality incentives based on PAH from NYS to MLTC plan

Example of Option 2: 20% Shared Savings/Losses + PAH P4P

Scenario

- MLTC Plan & VBP Contractor agree to a 1,000 member arrangement based on 7 quality measures including the Community PAH
- The target budget for the attributed group of members is set at $47,000 for the 12-month contract
- A $200 per member performance payment is conditioned on meeting PAH targets

Quality Targets % Met	Level 2 VBP Up- and Downside Actual Costs < Budgeted Costs	Level 2 VBP Up- and Downside Actual Costs > Budgeted Costs
Quality Improves **>50% of Quality Targets Met** • **4 of 7 Selected Quality Measure Met & PAH Target Met**	Actual Costs = $45,000 per member VBP Contractor would receive **$400,000 in shared savings + $200,000 bonus = total upside of $600,000** (20% x $2,000 x 1,000 members) + ($200 x 1,000 members)	Actual Costs = $49,000 per member VBP Contractor would receive **$200,000 less (PAH penalty)** (-$200 x 1,000 members)
Quality Worsens	No shared savings for the VBP Contractor	VBP Contractor would **receive $400,000 less** + a PAH penalty of $200,000 = total downside of $600,000 ((50% x -2,000 x 1,000 members) – ($200 per member)

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Option 2 – Pros and Cons

- **Pros**
  - More limited downside risk for providers
  - Two, separate potential opportunities for upside
    - Against budget AND against PAH target
      - VBP Contractors could negotiate to receive PAH bonuses even in the event that the other quality measure targets are not met
  - Continues heightened emphasis on PAH measure to help prepare for care coordination that integrates Medicare

- **Cons**
  - Minimal upside/opportunities to reinvest
  - More complex measure methodology to include PAH as a separate measure

Implementation Considerations Discussion

Key Implementation Considerations

- Integrated care – constituting a Total Cost of Care Subpopulation Arrangement
- Shifting from P4P bonus payments to shared savings/losses budgeting – contracting options & target budgets
- Attribution of members to VBP Contractors
- Addressing size and scale considerations in moving to risk
- Social Determinants of Health (SDH) interventions in an MLTC context

Constituting a Total Cost of Care Subpopulation Arrangement

Goals of a Total Cost of Care Subpopulation Arrangement: Integration of care, care coordination across a continuum of services, and the most effective deployment of care resources (e.g., elimination of duplicative services, least restrictive/community-based care, etc.) and delivery of care centered on the individual, organized around the individual's needs and preferences.

- The State is committed to integration/alignment with Medicare and continued dialogue with CMS
- In the meantime, the VBP arrangement for partially capitated MLTC plans is total long-term care with the PAH measure as a P4P measure proxy for Medicare costs
- Efforts to "cross" provider silos and form provider networks are an important Level 2 feature and help prepare for a fully integrated/Medicare aligned approach
- Licensed Home Case Services Agencies (LHCSAs), Community Home Health Agencies (CHHAs), and SNFs comprise 80-85% of total partially capitated MLTC plan spending and can form the basis for a total cost of care arrangement

Discussion of Provider Network Combinations

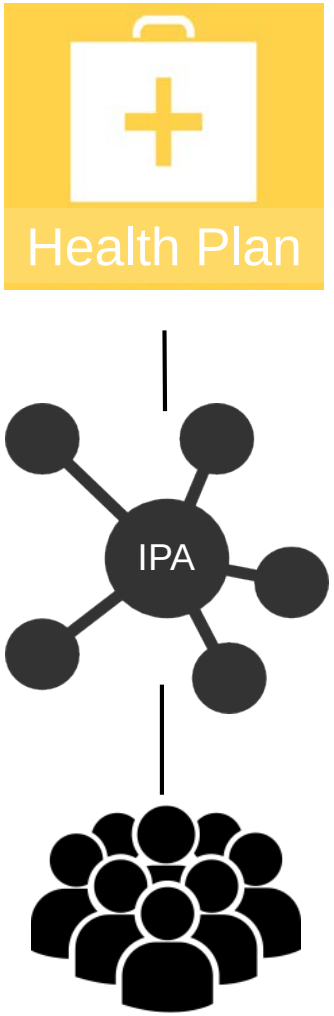
List of Services Covered in Partial Capitation MLTC Plans

Adult Day Health; Audiology/Hearing Aids; Care Management; Consumer Directed Personal Assistance Services; Dental Services; Home Care (nursing, home health aide, occupational, physical, and speech therapies); Home Delivered Meals and/or Meals Delivered in a Group Setting; Durable Medical Equipment; Medical Social Services; Non-Emergency Transportation to Receive Medical Services; Nursing Home Care; Nutrition; Vision Care; Personal Emergency Response System; Podiatry (Foot Care); Private Duty Nursing; Prostheses/Orthotics; Rehabilitation Therapies Outpatient; Respiratory Therapy; Social Day Care; Social/Environmental Supports (e.g., home modification)

- Home care agencies or nursing home groups are likely to partner with other service providers
- Small providers such as transportation, meal providers, and respiratory therapists can remain in the “downstream” for services rendered and do no have to take VBP arrangements on themselves

One Contracting Option for Total Cost of Care: An IPA or ACO Takes Responsibility for a Network

Health Plan contracts with an ACO or IPA



In the case where there is an ACO or IPA that has organized other providers in a network

ACO / IPA is responsible for the total cost of care and outcomes for the specific population

Note: 'ACO' refers to a NYS Medicaid ACO as defined under PHL § 2999-p

An Alternative Contracting Option to Provide for Total Cost of Care: MLTC Plan Creates the Budget

Health Plan contracts ***separately*** with a home care agency and an adult day health center

Plan would connect the individual providers

Key shift is formation of virtual budget created to capture total care delivered to the member

While the contracts are *separate*, the providers' performances **are seen as a whole for total cost of care and outcomes for a specific population**

In practice, this option is often a temporary step during IPA / ACO formation.

Transitioning from P4P to Target Budgets – Key Concepts

- Historical claims data forms the basis for budget setting for the members/providers attributed to the VBP arrangement
  - At Level 2 retrospective reconciliation is performed for same group of attributed members
- Transparency of data provides a level playing field
  - Data sharing relationship should be explicitly described in VBP contract
- Methodology should be described in contracts
  - Between MLTC plan and IPA/ACO
  - And between each individual participating provider for MLTC plan-provider contracts and for IPA/ACO-provider contracts
- Methodology described in the VBP Roadmap is a guideline, not a requirement
  - Contracting parties can determine appropriate method for their particular circumstances as long as the minimum definition are met

State Monitoring of Data Sharing

- The State will make available to providers: (1) the State to MCO rate schedules, and (2) stimulus and adjustment information
  - The information provided by the State is not a requirement for contracting purposes
- For Level 2 and 3 arrangements, the State will monitor the data and information that is exchanged between MCOs and Lead VBP Contractors for the purpose of negotiating their target budgets and distribution of shared savings/loss

Data Sharing Survey

- Under development by the Division of Health Plan Contracting and Oversight (DHPCO) and DLTC
- The Survey is intended to capture the current status of data sharing

Attribution of Members to VBP Contractors

Key Distinctions for Level 2:

- Attribution is to the IPA or ACO
- A member can only be attributed to one VBP arrangement because the total cost of care budget is calculated at the member level

- Current attribution methodologies will remain in place for Level 1
- For Level 2, the Office of Quality and Patient Safety (OQPS) will need to identify providers/VBP contractor combinations by National Provider Identifier (NPI) or another unique identifier for an IPA/ACO group taking responsibility for a grouping of members together as a network
- DOH is investigating how to facilitate quality data collection for the variety of contracting parties/networks

Scale Considerations for Risk Levels in VBP

- The size of the attributed population matters – larger samples provide a better understanding of cost trends and population behaviors
- Risk for smaller numbers of attributed members should be more limited

Key:
To meet Roadmap targets, the key is to pursue Level 2 arrangements with VBP Contractors more capable of bearing downside risk. Risk can be more limited for smaller scale arrangements.

Remember: Only 5% of Expenditures are Required to Move to Level 2 by 2019

Level 2 and 3 Arrangements Require a Social Determinants of Health Intervention

- The requirement can be fulfilled as plans submit Level 2 contracts
  - A social determinants template and the contract with at least 1 Tier 1 CBO is required to be submitted
  - Contracts with Tier 1 CBOs may be for “services rendered” and do not need to carry risk

- Many MLTC plans and providers are already providing SDH interventions
- These activities may include providing home modifications, nutrition, home delivered meals, facilitating community-based activities/integration, and any other home and community based services/supports

Questions on SDH Interventions can be directed to: SDH@health.ny.gov

For more information, please visit the VBP Resource Library:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/index.htm

Next Steps

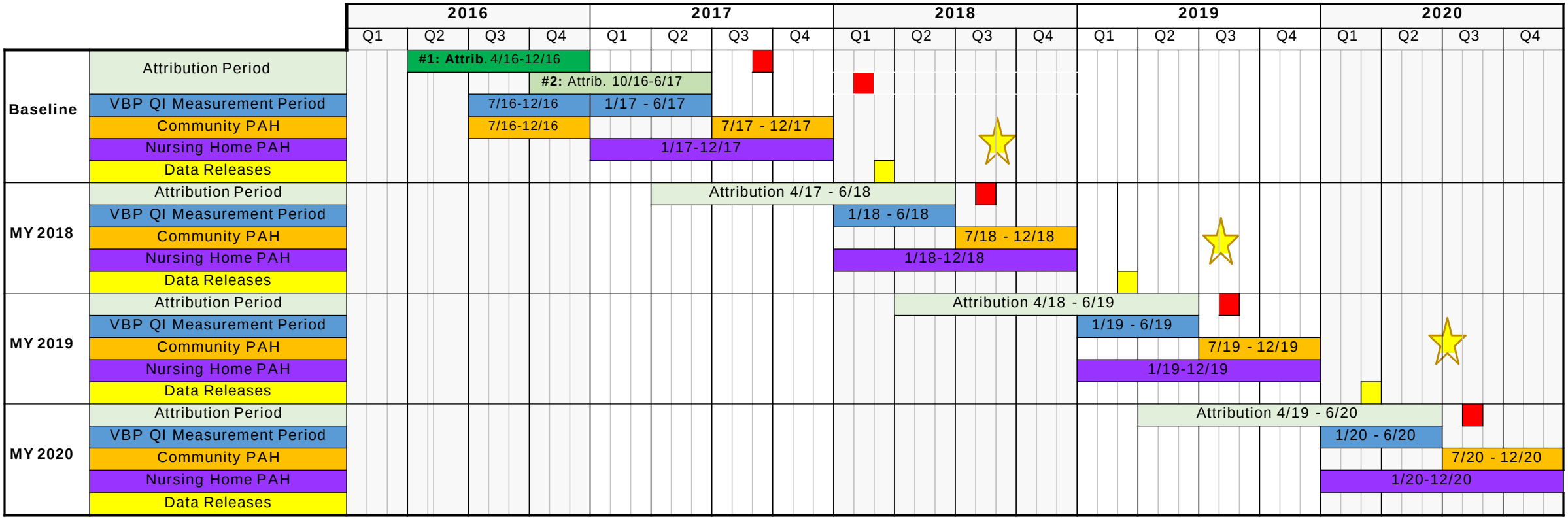
Next Steps

- Please submit any comments within the next two weeks, by **Friday, March 2**
  - Comments may be submitted to **mltcvbp@health.ny.gov**

- The State's goal is to post Level 2 guidance to the VBP Resource Library by **April 1**

Appendix

MLTC VBP Quality Measure Data Reporting Timeline



Legend

- Attribution file due to DOH
- Preliminary Community Potentially Avoidable Hospitalizations (PAH) data released
- Final VBP Quality Incentive (QI) and PAH data released

Thank you!

Please send questions and feedback to:

mltcvbp@health.ny.gov