Recap of Key Considerations for Chief Medical Officers in Value Based Payment

New York State Department of Health – VBP U Semester 1

This document recaps key value based payment (VBP) elements as well as key considerations and resources for Chief Medical Officers (CMO) at Managed Care Organizations (MCO).

Opportunities to Support VBP Implementation

Suggested Approaches:

- **Plan and drive VBP strategy to implement the VBP Roadmap:** Work together with key MCO leadership to support VBP implementation and establish clear goals related to clinical aspects of arrangements and associated quality measures – ensure these are understood by both the plan and providers – and facilitate provider alignment around VBP goals and alignment with other federal programs such as MACRA. Develop and maintain open lines of communication around funds flow, performance, and operational challenges across the organization.
- **Build care transformation capabilities and data-driven insights to create value:** Collaborate with providers to share data and information to advance VBP uptake and success. Invest in analytics, capabilities, and business model changes to adapt to the changing healthcare landscape.
- **Understand quality measures and the link to target budget setting:** Understand quality measures and the attributed patient population as well as reporting requirements. Work closely with the Chief Financial Officer (CFO) to understand the link between quality measure submissions and the target budget setting process.
- **Support strategies to improve health outcomes:** Identify and understand the most appropriate measures to improve health outcomes and support MCO provider network in the implementation of strategies to achieve key metrics.
- **Engage stakeholders and facilitate education session:** Engage stakeholders and meet with contracting partners. Understanding that there are numerous providers, consider a broad approach and meet with representatives. Facilitate targeted education sessions across the care continuum, including with behavioral health partners, and identify physician champions. Consider the impact of VBP on current workflows and repurpose existing roles as well as build capabilities and skills.

Value Based Payment (VBP): Recap

1. The core principle behind VBP is to move the payment structure away from a volume-driven, fee-for-service (FFS) system towards a value-driven system.
2. Payment is concurrently tied to both cost (i.e. efficiency) of care provided (either total per member cost or total cost of an episode) as well as the quality of care delivered.
3. As the provider understands which performance metrics are most important to the MCO, the provider can support the MCO in improving efficiency and quality resulting in a mutual gain for both parties.

VBP Levels: Overview and Key Considerations

VBP Level	Key considerations
Level 1: Fee-for-service (FFS) with upside-only shared savings available when outcome scores are sufficient	Providers who are new to VBP contracting are recommended to start their journey into VBP through Level 1 contracts with their partner MCO. In a Level 1 VBP contract, the payment mechanism remains FFS.
Level 2: FFS with risk sharing (upside available when outcome scores are sufficient)	As providers become more experienced with operating under a VBP contract and building out the infrastructure and insight needed to better manage risk, they may choose to gradually take on more risk in a Level 2 contract. In a Level 2 VBP contract, the payment mechanism remains FFS.
Level 3: Prospective capitation Per Member Per Month (PMPM) or Bundle (with outcome-based component)	Level 3 is the only type of contract where the payment mechanism is no longer FFS. Providers entering a Level 3 contract will receive a prospective, capitated payment (either for the total costs of care, or for the projected costs of the episode).

VBP Arrangements: Definitions and Goals

Arrangement Type	Total Care for the General Population (TCGP)	Episodic Care: Integrated Primary Care (IPC)	Episodic Care: Maternity Bundle	Total Care for Special Needs Populations
Arrangement definition	Provider assumes responsibility for all costs and outcomes of care of its attributed population, excluding special needs populations (HIV/AIDS, HARP, and Managed Long-Term Care (MLTC)).	Provider assumes responsibility for all costs and outcomes associated with primary care, sick care, and a set of chronic conditions selected due to high volume and/or cost.	Provider assumes responsibility for episodes associated with pregnancy, including delivery and up to 60 days post-discharge for the mother and 30 days post-discharge for the newborn.	Provider assumes responsibility for costs and outcomes of total care for all members within a subpopulation, excluding TCGP. These populations include HIV/AIDS, MLTC and HARP.
Arrangement goal	To improve population health through enhancing the quality of the total spectrum of care.	To improve the quality of preventive care, sick care and the most prevalent chronic and high-cost conditions.	To improve the quality of care for both the mother and the newborn.	To improve population health through enhancing the quality of care for subpopulations that require highly specific care.

Understanding Member Attribution

Arrangement	Attribution Driving Provider
TCGP	MCO-Assigned Primary Care Provider (PCP)
IPC	MCO-Assigned PCP
HIV/AIDS	MCO-Assigned PCP
Maternity	1°. Obstetric professional who delivered the majority of pregnancy care 2°: If no prenatal care, then the obstetric professional performing the delivery
HARP	1°: MCO-assigned Health Home 2°: If no MCO-assigned Health Home, then MCO-Assigned PCP

Selecting quality measures

1. Review quality measure sets for the selected arrangement and ensure the network is designed to address them.
2. Providers must meet agreed-upon quality thresholds during the contract year in order to be eligible for shared savings.
3. **MCOs must report required Category 1 measures to NYS**

Defining risk levels and shared savings/losses

Selecting a VBP Risk Level is required to contract. These risk levels must align with VBP Roadmap definitions: each VBP Level has a corresponding set of minimum shared savings and losses that must be met in order to qualify as on-menu.

VBP Level	Minimum % of shared savings to align with VBP level definitions, as per the VBP Roadmap
Level 1	Minimum of 40% of shared savings must be allocated to the provider.
Level 2	Minimum of 20% of potential losses must be allocated to the provider. In the first year of the contract there is a maximum cap of 3% of the target budget that can be put at risk, with the cap rising to 5% in year two and subsequent years. Below these levels, the VBP arrangement is counted as a Level 1 arrangement.
Level 3	Minimums are not applicable as provider has assumed full risk.

Target budget setting

Target budgets are used to evaluate a provider's performance and determine whether shared savings (or losses in Level 2 and 3 agreements) have been earned at the end of the year.

Baseline Setting → **Trend Determination** → **Risk Adjustment** → **Performance Adjustment**

Guideline: Historic claims data
3 year look back. Recent years are weighted more.

Guideline: Growth Trend
1 year look back weighted evenly by two factors:
- *VBP contractor specific growth trend (50%)*
- *regional growth rate (50%)*

Guideline: Risk Adjustment Factor
- *TCGP = 3M Cinical Risk Grouping (CRG) methodology*
- *Subpopulations = risk adjustment methodology used for Plan rate setting*
- *Bundles of Care (IPC, Maternity) = Altarum's episode severity adjustment*

Guideline: Performance Adjustments (Efficiency / Quality)

Adjustment to target budget with combined range of -6% to 6% for quality and efficiency.

A Target Budget is created between **the MCO** and **the Provider**

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Provider is responsible for reporting **all** Category 1 measures deemed "reportable" per the VBP measure manual for a given year to the MCO.

CATEGORY 1
Approved quality measures that are felt to be both clinically relevant, reliable and valid, and feasible.

CATEGORY 2
Measures that are clinically relevant, valid and probably reliable, but where the feasibility could be problematic.

CATEGORY 3
Measures that are insufficiently relevant, valid, reliable and/or feasible.

It is important to note that in VBP, Providers are responsible for reporting measures on the ENTIRE attributed population and not just a sample

Addressing social determinants of health (SDH) and building community based organization (CBO) partnerships

VBP contractors in Level 2 or Level 3 agreements must meet the following additional requirements. While not mandatory for Level 1, providers entering into Level 1 arrangements are free to explore these contract inclusions as well.

1. Implement at least one SDH intervention
2. Contract with a minimum of one Tier 1 CBO

Implement at least one SDH intervention; an SDH Intervention template must be submitted by the MCO with the Contract Statement and Certification form.
- There are 5 key areas of SDH that can be addressed: education, social and community context, health and health care, neighborhood and environment, economic stability
- Depending on the contract level, the cost of the CBO and related intervention can be shared between the contractor and the MCO

Contract with a minimum of one Tier 1 CBO; this contract must also be submitted by the MCO with the final contract**.** Tier 1 CBOs are defined as non-profit, non-Medicaid billing community based social and human service organizations (e.g. housing, social services, religious organizations and food banks). **This requirement does not limit participation with Tier 2 or Tier 3 CBOs.**
- CBOs can contract directly with an MCO or with the VBP contractor to meet this requirement

VBP Resources

Visit the DOH VBP Resource Library for additional resources on VBP. Below are key resources by topic.

VBP Contracting

General VBP Contracting Checklist
On-Menu VBP Contracting Checklist (by specific arrangement)
Off-Menu VBP Contracting Checklist
2018 VBP Bootcamps: Contracting Course

VBP Arrangements

VBP Resource Library: VBP Arrangement Fact Sheets
2018 VBP Bootcamp Series: VBP Arrangements and Quality Measurements Class 1

Attribution

VBP Resource Library: Measurement Year 2018 VBP Arrangement Fact Sheets

Quality Measures

2018 VBP Bootcamp Series: VBP Arrangements and Quality Measures Class 2
VBP Resource Library: VBP Quality Measures and 2018 VBP Quality Measure Sets by Arrangement
Quality Measure Public Comment Overview and Draft Technical Specifications

SDH and CBOs

VBP Social Determinants of Health (SDH) & Community Based Organizations (CBOs) Informational Webinar
2018 VBP Bootcamp: SDH and CBO Class 1
2018 VBP Bootcamp: SDH and CBO Class 2
VBP Resource Library: SDH and CBO Community Based Organization Directory
SDH Intervention Template
SDH Intervention Menu