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 considerations and resources for Chief Medical Officers (CMO) at provider organizations.

Opportunities to Support VBP Implementation

Suggested Approaches:

- **Plan VBP strategy:** Work with organizational leadership to plan VBP strategy and outline goals to ensure they are in line with the DSRIP vision.
- **Integrate value based care practices into workflows and daily operations:** Develop and maintain open lines of communication around funds flow, performance, and operational challenges within the organization – for example, some organizations have developed physician scorecards for added transparency around quality. Share policies, leading practices, and support capability building around new skills or repurpose existing roles.
- **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 reporting/results and the target budget setting process.
- **Leverage available data:** Leverage available data, including that from plans, as well as existing relationships. Understand the organization’s ability to track and monitor total cost of care.
- **Support the establishment of a clear clinical documentation process:** Ensure the clinical documentation process allows for an accurate portrayal of quality of care provided and patients treated in an effort to reduce insufficient documentation, medically unnecessary services, and incorrect coding.
- **Identify and support opportunities for process improvement:** Outline care processes within the organization as well as with external partners to understand gaps and inefficiencies. This may include using data to identify high leverage opportunities, such as a high utilizers of the hospital. Less wasted time, fewer risks, and greater employee satisfaction will boost patient quality of care.
- **Partner to promote cross-continuum care and drive community-wide goals:** Promote integrated, high quality, patient-centered care that both recognizes and leverages the full continuum of care to address medical and social needs, focuses on prevention and intervention, and uses leading practices to ensure appropriate utilization.
- **Support stakeholder engagement:** Facilitate provider alignment around VBP goals and engage stakeholders – share lessons learned, successes, and transition obstacles.
- **Support patient engagement:** As higher patient engagement leads to better outcomes, investigate strategic initiatives including patient portals, mobile devices, and electronic health records to support patient education.

Assessing VBP Readiness

1. Evaluate your existing Medicaid Managed Care Contracts.
2. Understand your population.
3. Conduct an infrastructure assessment.
4. **Move into developing VBP contracts.**

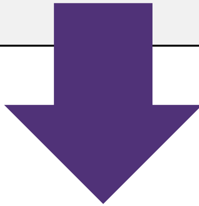
Department of Health | Medicaid Redesign Team

A Path toward Value Based Payment

New York State Roadmap

For Medicaid Payment Reform

June 2015



Key VBP Elements

1. Selecting an **arrangement** and defining the scope of services.
2. Understanding member **attribution.**
3. Selecting **quality measures** and determining reporting requirements.
4. Defining **risk levels** and shared savings/losses.
5. Setting a **Target budget.**
6. Addressing **social determinants of health (SDH)** and contracting with **community based organizations (CBO)** if contracting a Level 2 or 3 risk-sharing arrangement..

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. **Report on all Category 1 & Category 2 measures agreed to in the target budget between the Provider and MCO.**

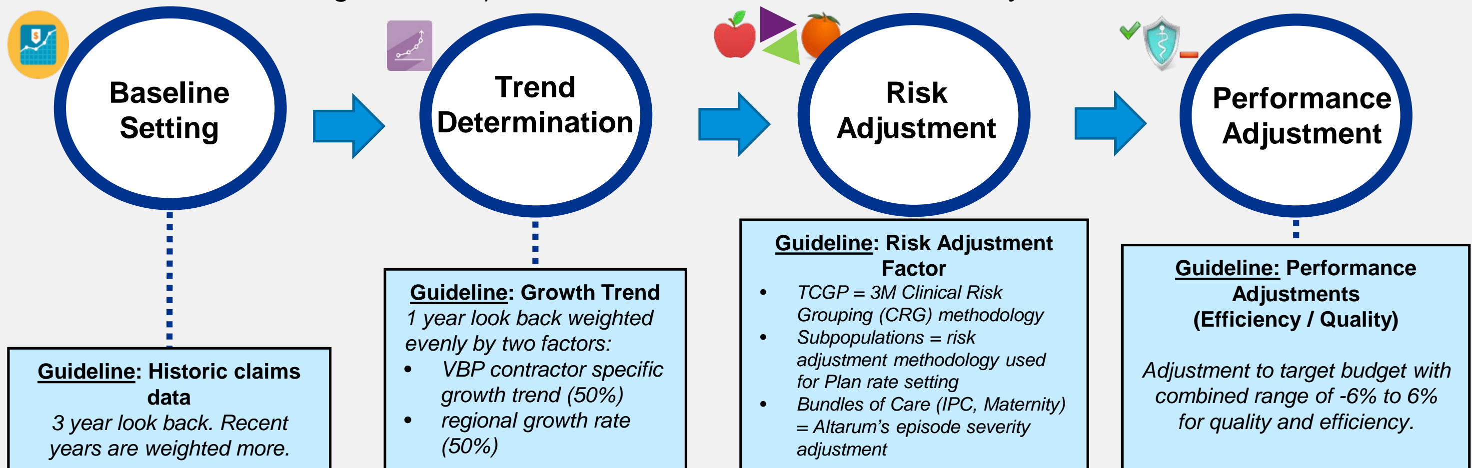
Defining risk levels and shared savings/losses

Providers must select a VBP Risk Level 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.



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

Requirements

Provider is responsible for including **at least one NYS-designated** Category 1, Pay-for-Performance measure from designated NYS measure list in its arrangement.

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 their Contract Statement and Certification form.**

- The DOH has an SDH Intervention Menu available to help with the selection of an intervention
- 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
- An intervention should be selected based on attributed population and community needs
- 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
- Contracts may be payments for rendered services, or also include risk components (though CBOs are not required to take on risk)
- CBOs may be contracted to assist with an SDH intervention, thus satisfying both the SDH and the Tier 1 CBO requirements

True integration - integrating behavioral health and primary care

Organizations will benefit from integrated and coordinated care settings, and CMOs may help facilitate strategies to achieve care integration of behavioral health (BH) and primary care (PC).

By integrating primary care and behavioral health, organizations can:

1. Improve identification and recognition of patient needs
2. Increase partnerships and working relationships with CBOs
3. Improve collaboration between clinicians and BH providers
4. Establish a better connection with their health network
5. Improve patient access

To do this, it is critical to:

1. Establish a shared vision and goals
2. Consider care planning and coordination as a first step
3. Build trust with providers
4. Identify champions
5. Spotlight data to identify opportunities to facilitate change
6. Educate staff – integration requires knowledge and persistence

Examples of integration:

- Team meetings (real-time huddles) between BH and PC providers
- Warm hand-offs between BH and PC
- Co-location
- Multidisciplinary case conferencing
- Shared care plan between BH and PC

For more examples on BH and PC integration, read the MAX Series Final Report on integrating behavioral health and primary care services.

Key Next Steps

Beginning Phase	Implementation Phase	Maturity Phase
– Evaluate data capabilities for quality measure reporting – Engage local providers currently in or interested in entering VBP – Understand Medicaid patients and target populations – Understand differences between VBP arrangements – Ensure that your care continuum network aligns with your selected VBP arrangement – Consider how you will contract and share savings with any downstream providers	– Measure quality of care – Understand attribution – Choose VBP Arrangement that best aligns with population – Determine whether your care delivery model aligns with patient needs, or if clinic hours or staffing models need adjustment – Conduct internal trainings to share information about VBP and its focus on key quality metrics – Share performance data with your clinical staff on a regular basis to engage them in VBP contracting	– Maintain high quality of care – Reevaluate performance at the end of the contract – Reevaluate reportable quality measures – Review Medicare Access and CHIP Reauthorization Act (MACRA) inclusion possibilities – Consider VBP for another arrangement

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