Topic: VBP Implementation
Audience: Primary Care Providers
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VBP Implementation: Primary Care Provider

Value Based Payment (VBP) Guidance Document

Preparing for the Transition to VBP

This document is intended to help providers, specifically primary care providers (PCPs), prepare for and make the transition to VBP. Although there are many activities that may support a PCP's initial steps toward VBP, this document focuses on a few activities that PCPs may consider to streamline their transition to VBP.

Governance

A primary care provider entity must consider how it will participate in a VBP arrangement when establishing a governance model. A PCP organization may choose to:

a) become a Lead VBP Contractor and contract directly with a payer

PCP organizations that intend on becoming lead VBP contractors should consider the following:

i. A provider must be a professional services Limited Liability Company (LLC) or partnership (PLLC), or professional corporation (medical group of all like professions), Accountable Care Organization (ACO) or independent physician association (IPA) to contract a VBP arrangement.

ii. Determine if your organization is able to contract Medicaid. If not, pursue the appropriate legal structure to contract Medicaid in accordance with New York State rules and regulations.

b) become a Provider Partner and contract with a lead VBP contractor; essentially becoming a subcontracted provider within a Lead VBP Contractor's larger provider network

Stakeholder Engagement

For PCPs who intend to contract a VBP arrangement, engaging payers early and often is critical. Leveraging existing contractual relationships with a payer can be a successful approach. Consider amending a pre-existing Medicaid contract to meet the NYS VBP Roadmap standards and Quality Measures as a streamlined approach toward VBP implementation. Payers contracting VBP have a vested interest in bringing providers together (whether the providers are contracted with the payer separately or together) to cover the care spectrum of the population being served. Consider the "match making" role of payers when attempting to engage and partner with other providers.

Evaluate your organization's provider network to understand gaps in care. Robust provider networks that span the complete care spectrum will likely be more successful in contracting VBP. Subcontracting with other provider types (including Hospitals, Behavioral Health providers, Substance Use Disorder (SUD) providers and Community Based Organizations (CBOs) can help ensure that all aspects of the patient care continuum are covered, including outreach, care management, and post-discharge care.

PCPs may also subcontract with a Lead VBP Contractor as a "provider partner." Depending on the terms of the contract, the provider partner may be eligible to receive a portion of shared savings (or losses). PCPs assuming the role of a provider partner will likely need to come to subcontracting discussions with a clear understanding of how they may help the Lead VBP contractor deliver low-cost, high-quality care.

Finally, whether a lead VBP contractor or a provider partner, using a Performing Provider System (PPS) to identify partnering opportunities will enable provider groups to expand and strengthen their contracting networks.

Business Strategy

A PCP functioning as a Provider Partner or Lead VBP Contractor may consider aligning the type of VBP arrangement that the PCP will contract with its business model or type of services the PCP intends on providing. PCPs should understand the technical design of the VBP arrangement being contracted. For example, a PCP may elect to engage in the Integrated Primary Care (IPC) arrangement rather than the Maternity Care arrangement because of IPC's orientation toward primary care and prevention. There are key programmatic components of the VBP program that support a PCP's value proposition. These include:

a) PCPs drive attribution in a majority of VBP arrangements. This means that lead VBP contractors that include PCPs in their network may increase their attributed population.
b) Savings in the Total Care for the General Population (TCGP) and IPC arrangements can be generated by reductions in "downstream" costs, specifically emergency department visits and inpatient hospitalizations. Key areas of focus include preventive care, sick care and care for chronic conditions.

Finance

Lead VBP contractors will need to examine their ability to take on risk. This will inform their decision to adopt a VBP contract at Levels 1, 2, or 3. A Level 1 arrangement is upside only, and incurs no potential for financial risk to the practice. As a provider moves up the levels of a VBP contract, from level 1 to level 3, the VBP contractor will assume more financial risk. However, the VBP contractor will also improve the opportunity to realize shared savings. As part of this risk assessment, the lead VBP contractor must decide if it will be assuming all of the risk (and reward) of a payer-to-provider VBP contract, or if it will push down some of the risk (and by extension, reward) to other subcontracted provider partners. Lead VBP contractors must develop a strategy to reward (or, if necessary, share risk) with their downstream provider partners.

Whether a Lead VBP Contractor or a Provider Partner, a PCP should understand the financial impact of entering into a VBP arrangement, based on the population served. While no simple task, providers should understand the total cost of their population, the needs of the population, and opportunities and areas for improvement. These factors will help providers determine their potential for shared savings.

Data

Whether a VBP Lead contractor or a subcontracted Provider Partner, data will enable PCPs to make more informed business decisions and provide a higher quality of care. PCPs should determine their own capabilities for obtaining and analyzing data. If PCPs lack their own "in-house" data infrastructure, they may explore opportunities to collaborate with other organizations to obtain and share data and establish data analytics capabilities. PCPs may consider exploring the following key areas:

a) The cost of care of their population by a selected arrangement
b) The total Medicaid members that a PCP has assigned, and therefore attributable to a particular VBP arrangement
c) Who the high utilizing, high-cost Medicaid members in their population are (the "super utilizers") and why

d) Which specific category of service has a high degree of potentially avoidable complications or high readmission rates and why

Although accessing data may be a daunting task for providers, there are options available. PCPs may engage payers or provider partners to explore options for data sharing and analytics capabilities. PPSs are also valuable resources, since relevant data outputs may have been generated by PPSs as part of its Delivery System Reform Incentive Payment (DSRIP) efforts. In these cases, PPSs may wish to share data with providers, where appropriate and feasible. The NYS VBP Roadmap also establishes opportunities for data sharing among hospitals and providers when IPC and/or TCGP arrangements are contracted. In these specific cases, hospitals can demonstrate cooperation by sharing data with providers, if the hospital receives a portion of shared savings (VBP Roadmap, p 67).