A Path toward Value Based Payment

New York State Roadmap

For Medicaid Payment Reform

April 2015

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Introduction

On April 14, 2014, the State of New York (the State) and the Centers for Medicare and Medicaid Services (CMS) reached agreement on a groundbreaking waiver that allows the State to invest eight billion dollars for comprehensive Medicaid delivery and payment reform through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program promotes community-level collaborations and aims to reduce avoidable hospital use by 25 percent over five years while financially stabilizing the State's safety net. A total of 25 Performing Provider Systems (PPSs) have been established statewide to implement innovative projects focused on system transformation, clinical improvement and population health improvement. All DSRIP funds are based on achievement of performance goals and project milestones.

To ensure the long-term sustainability of the improvements made possible by the DSRIP investments in the waiver, the Terms and Conditions (T&Cs) (§ 39) require the State to submit a multiyear Roadmap for comprehensive Medicaid payment reform including how the State will amend its contracts with Managed Care Organizations (MCOs). The T&Cs mention the following specific topics to address:

1. What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the State will plan and implement its stated goal of 90% of managed care payments to providers using value-based payment (VBP) methodologies.

2. How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.

3. How the State will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.

4. How and when plans' current contracts will be amended to include the collection and reporting of DSRIP objectives and measures.

5. How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The State should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other State funding; and how they differ from any services or administrative functions already accounted for in capitation rates.

6. How the State will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks.

7. How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development.

8. How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the State will use benchmark measures (e.g., medical loss ratio (MLR)) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for State review and approval by January 31 of each calendar year.

The Roadmap will address each of these issues.

Importantly, this Roadmap was developed as a living document. It is not a blueprint; but rather attempts to demonstrate the State's ambition and the elements of what the State and its stakeholders consider to be the payment reforms required for a high-quality, financially sustainable Medicaid delivery system. Working closely with MCOs, providers, beneficiaries and other stakeholders, many details will be added and changed over the next months. In addition, the State will work with CMS to optimally align these efforts with the Medicare Value-Based Payment Goals recently announced.[1] Over the next five years, many lessons will be learned from DSRIP and the emergence of PPSs. Therefore, this Roadmap will be updated yearly throughout the DSRIP period so as to not lock in policies that may require adjustment in the future.

What New York State's Medicaid Value-Based Payment Plan is Not

During the development of the Roadmap, stakeholders expressed concerns about the pace and scope of the changes that VBP represents. Throughout a series of detailed stakeholder discussions, it became clear that there were some misperceptions about the intent of the State's Roadmap. As such, to ensure all stakeholders understand the true direction the State is undertaking, the State has explicitly outlined what is not included in VBP.

[1] Burwell, S. M. (2015). "Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care." N Engl J Med.

What New York State's Medicaid VBP plan is not:

A new rate setting methodology: *the State will show benchmarks and give guidance, but it will not set rates or dictate detailed terms for value-based payment arrangements*

One size fits all: *There are a variety of options to choose from outlined in the roadmap, and many details to negotiate between MCOs and providers. Also, MCOs and providers can jointly agree to pursue different or 'off-menu' value-based payment arrangements as long as those arrangements reflect the Medicaid VBP principles described herein. In addition, the State's VBP goals will be measured at the State's level, not at the individual PPS level, allowing for differences in adaptation between PPSs.*

The State backing away from adequate reimbursement for Federally Qualified Health Centers (FQHCs) and other community-based providers: *Outlined in the Figure on p.5, the State is committed to ensure adequate reimbursement aligned with the value provided for the Medicaid population consistent with Federal statute.*

An attempt to make providers do more for less: *In fact, the intent is the opposite. Under the State's VBP approach, reducing lower value care and increasing higher value care in equal proportions should lead to higher margins rather than lower margins.*

An attempt to make PPS leads responsible for all PPS providers' contracting: *What responsibilities providers delegate to their PPS is decided by themselves through the emerging PPS governance structure. Delegating contracting responsibility to the PPS is an option, but by no means the only one.*

An attempt to require MCOs to contract with PPSs for VBP Arrangements: *MCOs are free to continue to build upon their existing direct provider contracts or IPA/ACO arrangements to achieve the VBP goals.*

A requirement that only PPSs can enter Medicaid VBP Arrangements: *all (groups of) providers that can deliver integrated care services, including, but not limited to Independent Practice Associations (IPAs), Accountable Care Organizations (ACOs) and PPSs, are intended to be able to enter into VBP arrangements*

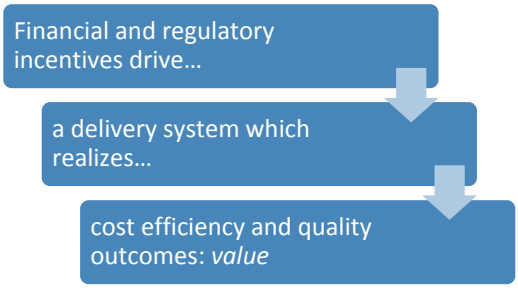
A roadmap for future all payment reform: *The roadmap pertains only to Medicaid payment reform and does not apply to payment reform in the commercial marketplace. A separate policy discussion will determine the future of payment reform concepts contemplated by the State Health Innovation Plan (SHIP).*

1. Towards 80-90% of Value-Based Payments to providers

Issue 1: What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the State will plan and implement its goal of 80-90% of managed care payments to providers using value based payment methodologies by end of demonstration year five (DY 5).

Sustainable Delivery Reform Requires Matching Payment Reform

DSRIP is a major collective effort to transform the State's Medicaid Healthcare Delivery System from a fragmented system, overly focused on inpatient care, to an integrated and community-based system focused on providing care in or close to the home. Where the delivery system is currently predominantly re-active and (acute) provider-focused, DSRIP aims to create a more pro-active and patient-focused system, with a vibrant workforce throughout the continuum of care, emphasizing population health and closely involving social services.



These objectives have broad stakeholder support and are made measurable by a set of DSRIP metrics on potentially avoidable (re)admissions, emergency department (ED) visits and other potentially avoidable complications, as well as patient experience. Underlying these overall outcomes is a broader range of project-specific process and outcome measures.

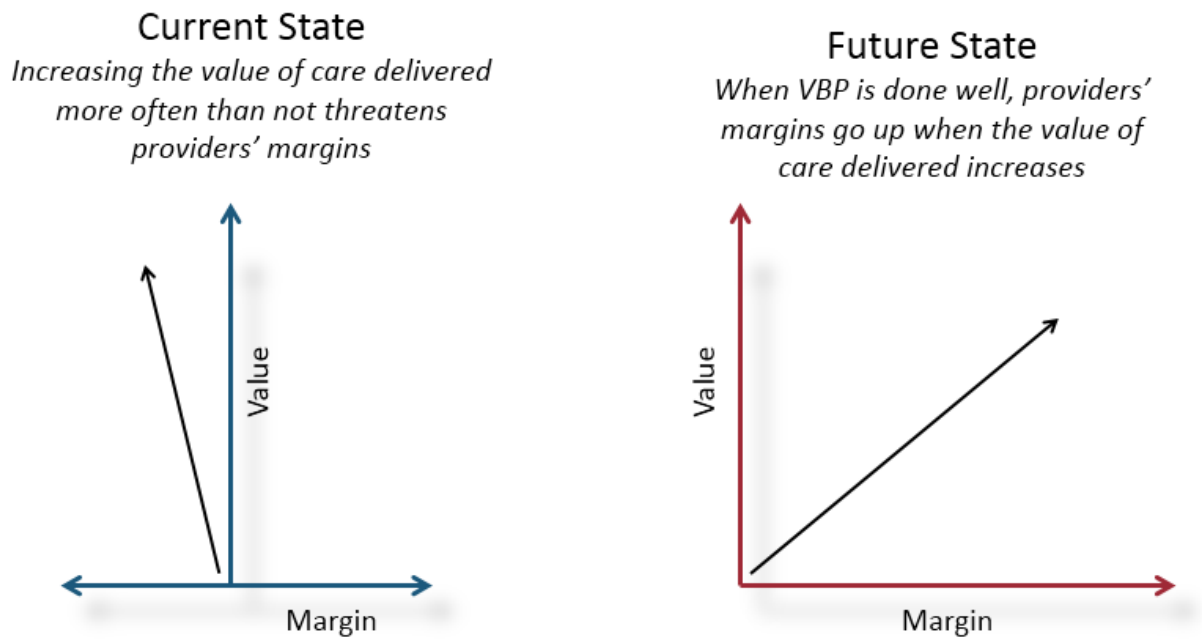
Reducing avoidable (re)admissions, ED visits and other potentially avoidable complications through more effective clinical and service models that partner primary, acute, home and community based care will improve health, while further stabilizing overall Medicaid expenditures. This will further allow the State to remain under the Global Cap, without curtailing eligibility, strengthen the financial viability of the safety net, continue to invest in innovation, and improve outcomes.

Such a thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well. Many of the Medicaid delivery system's problems (fragmentation, high (re)admission rates, poor primary care infrastructure, lack of behavioral and physical health integration) are rooted in how providers are reimbursed. In most cases, siloed providers are still being paid Fee-for-Service (FFS) by their MCOs, incentivizing volume over value, and creating a focus on inputs rather than realizing adequate outcomes. To this day, an avoidable readmission is often rewarded more than a successful transition to integrated home care or nursing home; likewise, prevention, coordination or integration activities are rarely reimbursed sufficiently, if at all.

In addition, the current FFS system, and the diversity of contracting regimes between individual providers, individual MCOs and other, non-Medicaid payers, creates an administrative burden on providers that would be unfathomable in any health care sector in the world – or in any other US industry. Often, payment reform initiatives initially seem to increase the administrative burden: they necessarily constitute a change from the way current administrative processes and systems operate. They may require upfront investment for redesign and may require providers to temporarily straddle different payment systems simultaneously. Yet well-executed payment reform can significantly offset this complexity by reducing the need for micro-accountability

(such as the need for utilization review throughout the care process), standardizing rules and incentives across providers, and increasing transparency.[2]

In essence, the State's Medicaid payment reform goals attempt to move away from a situation where increasing the value of the care delivered (preventing avoidable admissions, reducing administrative waste) has a *negative* impact on the financial sustainability of providers towards a situation where the delivery of high-value care can result in *higher* margins (see figure below).



Payment reform, then, is required to ensure that the changes in the care delivery system funded by DSRIP are sustained well beyond the waiver period, so that patient engagement and care coordination activities, including peer-based activities, can be reimbursed, that value-destroying care patterns (avoidable (re)admissions, ED visits) do not simply return when the DSRIP dollars stop flowing, that a stable and well-trained primary and community-based workforce is maintained, and that dollars currently lost in non-value-added administrative processes become available for patient care. Importantly, payment reform is equally essential *to ensure that the savings realized by DSRIP can be reinvested in the Medicaid delivery system.* Without payment reform, savings would accrue to MCOs, whose yearly rates would in the current payment system subsequently be revised downwards. In fact, many PPSs are already actively discussing the importance of payment reform as a means to alleviate predicted losses in FFS revenue due to improved performance on DSRIP outcomes (reduced admissions, reduced ED visits).

Payment reform must also maintain or improve funding and incentives for essential and mandatory costs within the system. This includes provider/system for "public goods," critical infrastructure support, and fulfillment of State/Federal public health and compliance requirements. These include such input costs as hospital/clinic/home care indigent care, graduate medical education, Federal conditions of participation, health information technology (HIT) capacity and interoperability, health care worker training and certification,

[2] Cutler, D., E. Wikler and P. Basch (2012). "Reducing administrative costs and improving the health care system." N Engl J Med **367**(20): 1875-1878.

quality assurance, emergency preparedness, community public health (e.g., immunization, disease response), and other vital needs.

Payment Reform Guiding Principles

The Roadmap is built upon the foundation already put in place by the State's Medicaid Redesign Team (MRT) Payment Reform & Quality Measurement Work Group. In 2012, that Work Group concluded that innovative payment reform and quality initiatives should:

1. Be transparent and fair, increase access to high quality health care services in the appropriate setting and create opportunities for both payers and providers to share savings generated if agreed upon benchmarks are achieved.
2. Be scalable and flexible to allow all providers and communities (regardless of size) to participate, reinforce health system planning and preserve an efficient essential community provider network.
3. Allow for a flexible multi-year phase in to recognize administrative complexities including system requirements (i.e., IT).
4. Align payment policy with quality goals.
5. Reward improved performance as well as continued high performance.
6. Incorporate a strong evaluation component and technical assistance to assure successful implementation.
7. Engage in strategic planning to avoid the unintended consequences of price inflation, particularly in the commercial market.

   New guiding principle:

8. Financially reward rather than penalize providers and plans that deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes including interventions that address underlying social determinants of health.

Starting point: how should an integrated delivery system function from the consumer/patient's perspective?

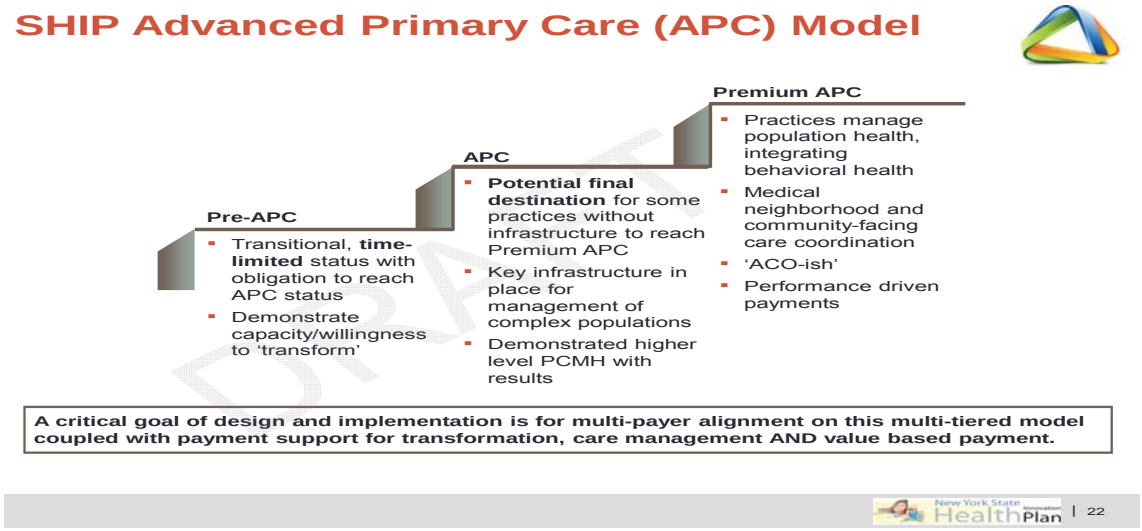
Different types of patients require different types of care. As foreseen in DSRIP, a high performing care delivery system encompasses three types of integrated care services, with optimal coordination between them:

Integrated Primary Care (IPC) including behavioral health primary care, effective management of chronic disease, medication management, community based prevention activities and clear alignments with community based, home, and social services agencies (Patient Centered Medical Home (PCMH)/Advanced Primary Care (APC) models). This type of care is continuous in nature, strongly population-focused, based in the community, culturally sensitive, oriented towards primary and secondary prevention, and aims to act as

the primary source of care for the majority of everyday care needs. (See textbox on page 7 for a discussion about State's vision on Advanced Primary Care).

New York State's vision on Advanced Primary Care

Advanced Primary Care plays a core role in the State's Health Innovation Plan (SHIP) as well as within DSRIP. The figure below briefly explains how NYS sees the progression from 'pre-APC' status towards 'Premium APC' status, which fully aligns with DSRIP's end goals for Integrated Primary Care. (See the SHIP plan for more details).



The State has had extensive experience with what will later be described as Level 0 Value-Based Payments, FFS with quality bonus payments, during the early and ongoing support of the PCMH model, and its involvement in medical home demonstrations in a variety of settings across the State. As these initiatives have progressed, it has become clear that transformation of primary care practices to an APC model will include three (3) broad phases, during which the practices require different types of financial support as follows:

1. Initial investment in practice transformation, including support for technical assistance, and for the costs of new programs and staff (or re-training existing staff).

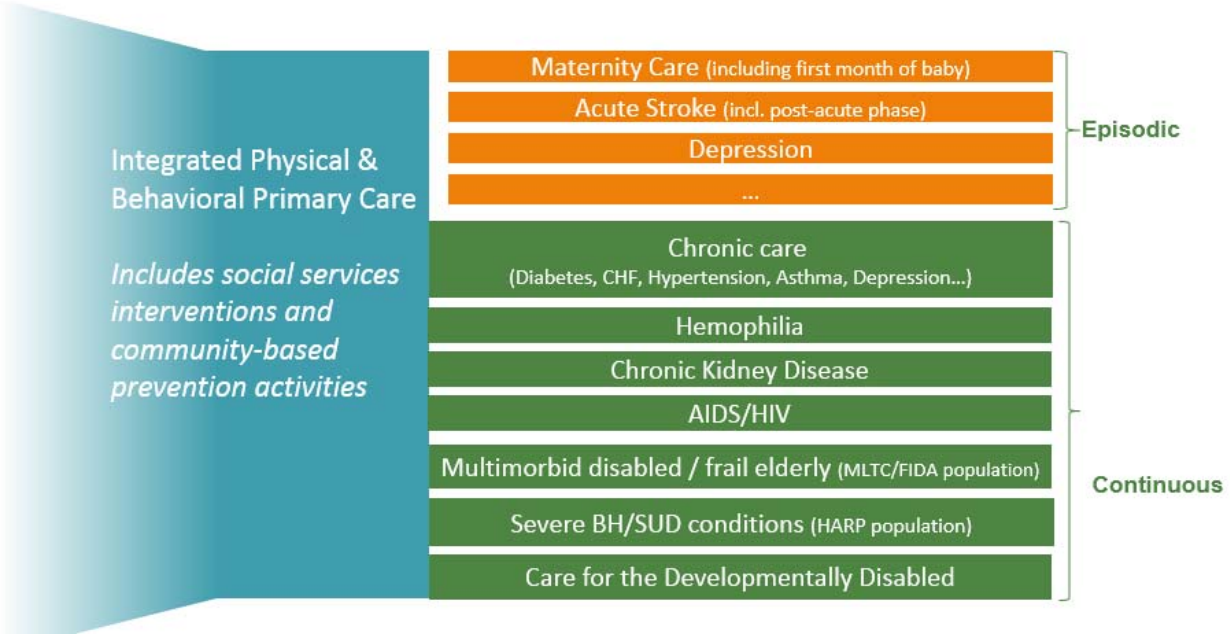
2. Interim support for increased operating costs for a period of time (experience indicates 2-3 years), as practices improve quality and population health, but before realizing reductions in preventable utilization and other costs needed to support shared savings payment. In the early years of the APC's operation, providers will be taking on new functions and costs, improving quality, patient access and experience, but not (yet) generating cost savings.

3. Ongoing support once the APC model has begun to have a measurable impact on total cost of care and to generate measurable savings. The practice and payers may choose to reduce the basic program support and shift compensation to shared savings and/or risk sharing.

From the perspective of Medicaid, phase 1 and 2 will be funded through DSRIP; phase 3 is the transition towards Level 1 (and higher) VBP for IPC as discussed in this Roadmap.

Episodic care services are utilized for circumscribed periods of time when people require more specialized services for a specific health problem or condition, for circumscribed periods of time. Within the Medicaid population and DSRIP, maternity care may be the best example; for elderly patients, hip and knee replacement episodes are the most prevalent examples. These services, which may involve any one or combination of services across the continuum of care, should be tightly integrated, with multidisciplinary teams working with evidence-based care pathways, organized around these patients' specific needs, resources (including community resources), and cultural sensitivities.

Specialized continuous care services are required for those individuals who require ongoing, dedicated specialized interdisciplinary services for their health problem(s) or condition(s). This type of care can involve both evidence-based specialty care for individual conditions (hemophilia, advanced kidney disease, serious mental health and/or substance use disorders (SUD),) as well as care for severely co-morbid and/or special needs populations (e.g. the health and recovery plan (HARP) and managed long term care (MLTC)/fully integrated duals advantage (FIDA) populations, beneficiaries with significant developmental disabilities as well as beneficiaries with HIV/AIDS). For the latter groups of patients, personalized goal setting and intensive care coordination become more dominant than disease management per se. In both, a focus on maximizing a patient's capabilities for self-management and personal autonomy in the most integrated setting appropriate to a person's needs (i.e., home and community) is central.



Facilitating the Development of an Optimally Functioning Delivery System through Value-Based Payments: A Variety of Options

Following the spirit of the DSRIP program, the State does not foresee one single path towards payment reform. Rather, the State aims to give PPSs, providers, and MCOs a comprehensive range of VBP options they can consider. This allows providers and MCOs to select those types of value-based payments that fit their strategy, local context and ability to manage innovative payment models, which has been proven to be a critical success factor in successfully realizing payment reform.[3]

[3] Ginsburg, P. B. (2013). "Achieving health care cost containment through provider payment reform that engages patients and

Jointly, PPSs (or combinations of providers) and MCOs can create VBP arrangements around:

- Total care for total population; and/or
- Integrated primary care; and/or
- Selected care bundles; and/or
- Special needs subpopulations.

Providers and MCOs are free to jointly agree to other types, or 'off menu' versions of VBP arrangements, including currently existing arrangements as long as those arrangements reflect the underlying goals of the payment reform as outlined above and sustain the transparency of costs versus. outcomes. Such arrangements will not require a separate approval from Department of Health (DOH), but will require attestation from the parties, and will be subject to periodic audits.
[4]

Total care for the total population

In this model, the MCO contracts a value-based payment arrangement with the PPS (or with 'hubs' within the PPS) which considers total PMPM (per member per month) expenditure for the total attributed population (Global Capitation), and overall outcomes of care (potentially avoidable ED visits, hospital admissions, and the underlying DSRIP Domain 2 and relevant Domain 3 metrics). While some provider systems have significant experience contracting with Medicaid managed care plans under this type of model, most do not and there are significant opportunities to reduce costs and improve quality by expanding total cost of care contracting. [5] PPSs are attributed patients based on the specific geography they serve. As a result, provider will need to look at the needs of that population and design VBP arrangements which are consistent with the needs of that geography and service area (see also the Attribution on page 22).

Integrated Primary Care

In this model, the MCO contracts Patient Centered Medical Homes (PCMH) or Advance Primary Care (APC) arrangements with the PPS or the PCMHs/APCs in the PPS to reimburse these PCMH/APCs based on the savings and quality outcomes they achieved. The savings here would be focused primarily on so-called 'downstream' costs: expenditures across the total spectrum of care that would be reduced when the PCMHs/APCs would be functioning optimally. Avoidable ED visits and hospital admissions for conditions such as diabetes and asthma are good examples; cancer care costs, on the other hand, would not be included when calculating potential PCMH/APC downstream savings. Likewise, the quality outcomes would be those DSRIP Domain 2 and 3 metrics attributable to integrated primary care, including the behavioral health, diabetes, asthma and cardiovascular health metrics.[6]

providers." Health Aff (Millwood) **32**(5): 929-934; Miller, H. D. (2009). "From volume to value: better ways to pay for health care." Health Aff (Millwood) **28**(5): 1418-1428.

4 Examples of "off-menu" arrangements might include a bundle which may not be prioritized State wide, but is of significant importance to a region or a subset of the population with high costs and poor outcomes like a Developmentally Disabled service bundle, or a cancer bundle.

5 Kocot, S. L., C. Dang-Vu, R. White and M. McClellan (2013). "Early experiences with accountable care in Medicaid: special challenges, big opportunities." Popul Health Manag **16 Suppl 1**: S4-11.

6 Using potentially avoidable hospital (re)admissions and ED visits as outcome indicator for primary care is an approach also used in Colorado's Accountable Care Collaborative:

Realizing such savings can substantially increase funding to PCMHs/APCs, because the potential downstream savings are much larger than the total current revenues of the PCMH. To maximize shared savings in this model, PCMHs/APC's are encouraged to collaborate with hospitals and other providers on activities such as outreach, care management, and post-discharge care. Because shared savings will derive in large part from avoided hospital use, earned savings should be shared evenly between PCMHs/APCs and associated hospitals, provided that the hospitals work cooperatively with PCMHs/APCs to better manage their patient populations. This would include establishing effective strategies for notifying PCMHs/ACPs on a timely basis about patient admissions and ED visits and collaborating on care transitions by sharing discharge summaries with medication information. This addresses three key issues that have been identified as limiting the potential impact of emerging integrated primary care delivery models: (1) a lack of funding to sustainably enhance both staffing and infrastructure of IPC[7]; (2) a lack of adequate incentives for primary care providers to truly impact overall costs of care[8], and (3) a lack of incentives for hospitals to engage in activities that reduce their revenue. The State will work closely with the SHIP Integrated Care Work Group on the development of the Advanced Primary Care model that promotes high value care and better integration across the care spectrum. More broadly, this model promotes and supports primary care providers and assures a more efficiently operating health delivery system that drives optimal health and well-being for all.

Bundles of care

Acute Care Bundles

In this model, the MCO contracts for specific, patient-focused bundles of care (such as maternity care episodes or stroke) with the PPS or (groups of) providers within the PPS or otherwise collaborating with the acute care facility and the MCO. Here, the cost of a patient's office visits, tests, treatments and hospitalizations associated with a specific illness, medical event, or condition are all rolled or "bundled" into a single, episode-based total cost for the episode.[9] Because variations in utilization and potentially avoidable complications are linked to the specific episodes, this model has shown much promise in stimulating patient-focused, integrated care delivery teams to substantially increase the value of care delivered from a wide range of conditions.[10]

Chronic Care Bundles

This model also applies to chronic care, as highlighted by the inclusion of chronic condition in the CMS Bundled Payments for Care Improvement (BPCI) Initiative[11]. The State will follow the internationally emerging best

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https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%20Annual%20Report%202013.pdf. See also Kocot et. al. op. cit. footnote 5.

[7] Nocon, R. S., R. Sharma, J. M. Birnberg, Q. Ngo-Metzger, S. M. Lee and M. H. Chin (2012). "Association between patient-centered medical home rating and operating cost at federally funded health centers." JAMA **308**(1): 60-66; Landon, B. E. (2014). "Structuring payments to patient-centered medical homes." Jama **312**(16): 1633-1634; Weissman, J. S., M. Bailit, G. D'Andrea and M. B. Rosenthal (2012). "The design and application of shared savings programs: lessons from early adopters." Health Aff (Millwood) **31**(9): 1959-1968; Edwards, S. T., M. K. Abrams, R. J. Baron, R. A. Berenson, E. C. Rich, G. E. Rosenthal, M. B. Rosenthal and B. E. Landon (2014). "Structuring payment to medical homes after the affordable care act." J Gen Intern Med **29**(10): 1410-1413.

[8] Nielsen, M., J. N. Olayiwola, P. Grundy and K. Grumbach (2014). The Patient-Centered Medical Home's Impact on Cost & Quality: An Annual Update of the Evidence, 2012-2013, Patient-centered primary care collaborative.

[9] Sage, W. M. (2014). "Getting The Product Right: How Competition Policy Can Improve Health Care Markets." Health Aff (Millwood); Mechanic, R. E. and S. H. Altman (2009). "Payment reform options: episode payment is a good place to start." Health affairs (Project Hope) **28**: w262-271.

[10] Miller, D. C., C. Gust, J. B. Dimick, N. Birkmeyer, J. Skinner and J. D. Birkmeyer (2011). "Large variations in medicare payments for surgery highlight savings potential from bundled payment programs." Health affairs (Project Hope) **30**: 2107-211; Struijs, J. N. and C. A. Baan (2011). "Integrating Care through Bundled Payments — Lessons from the Netherlands." New England Journal of Medicine **364**: 990-991; Bach, P. B., J. N. Mirkin and J. J. Luke (2011). "Episode-based payment for cancer care: a proposed pilot for Medicare." Health Aff (Millwood) **30**(3): 500-509.

[11] Bailit, M., M. Burns and J. Margaret Houy (2013). Bundled Payments One Year Later: An Update on the Status of Implementations

practices to treat chronic conditions as full-year-of-care bundles emphasizing the continuous nature of this care, including all condition-related care costs.[12] Those chronic conditions whose effective management is integral to New York's Advanced Primary Care model will in principle be part of the Integrated Primary Care contract. As with Integrated Primary Care providers, shared savings should be split evenly between chronic care providers and associated hospitals that work cooperatively with PCMHs/APCs to better manage their patient populations, as described above.

Total care for special needs subpopulations

For some specific subpopulations, severe co-morbidity or disability may require highly specific and costly care needs, so that the majority (or even all) of the care costs are included in the full-year-of-care bundles. At this point, it becomes similar to a capitated model (a PMPM for a specific special needs population). As part of the development towards Managed Care, the State has already identified several special needs subpopulations for which contracting total costs of care will be an option.

Fee-for-Service is a Value-Based Payment mechanism for preventive care activities

Because of the importance to stimulate reaching out to the whole population, purely preventive activities (such as immunizations, Screening, Brief Intervention, and Referral to Treatment (SBIRT) or evidence-based screening activities) can remain to be reimbursed on a Fee-for-Service basis. Combined with adequate quality measures (percent of eligible patients having received breast cancer screening, for example), FFS incentives volume where needed, and these dollars will count towards the statewide goal of 80-90% of payments from MCOs to providers in VBP arrangements. [13,14]

Possible contracting combinations

The MCOs and the PPSs/providers may opt to either contract the total care for the total population (ACO model), or create combinations of the value-based payment arrangements discussed. Some MCOs may prefer to contract for integrated primary care (PCMH or APC) separately to optimize the chances of successful primary care reinforcement; some PPSs may want to specifically contract for fragile subpopulations and the maternity care bundle. To increase the percentage of value-based payments and the opportunity for shared savings, when (groups of) providers contract primary care, bundles and/or subpopulations, the MCO and the PPS (or hubs) may contract a total care for the populations and care services *not* covered by the integrated primary care, care bundles and subpopulations contracts. In other words, a 'total care for the total population' arrangement from which the otherwise contracted populations and services are carved out.

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and Operational Findings. HCI3 Issue Brief, June 2013; http://innovation.cms.gov/initiatives/bundled-payments.

[12] de Bakker, D. H., J. N. Struijs, C. B. Baan, J. Raams, J. E. de Wildt, H. J. Vrijhoef and F. T. Schut (2012). "Early results from adoption of bundled payment for diabetes care in the Netherlands show improvement in care coordination." Health Aff (Millwood) **31**(2): 426-433; De Brantes, F., A. Rastogi and M. Painter (2010). "Reducing potentially avoidable complications in patients with chronic diseases: the Prometheus Payment approach." Health Serv Res **45**(6 Pt 2): 1854-1871; xx.

[13] Miller, H. D. (2009) op.cit. fn. 24; Chien, A. T., Z. Li and M. B. Rosenthal (2010). "Improving timely childhood immunizations through pay for performance in Medicaid-managed care." Health Serv Res **45**(6 Pt 2): 1934-1947.

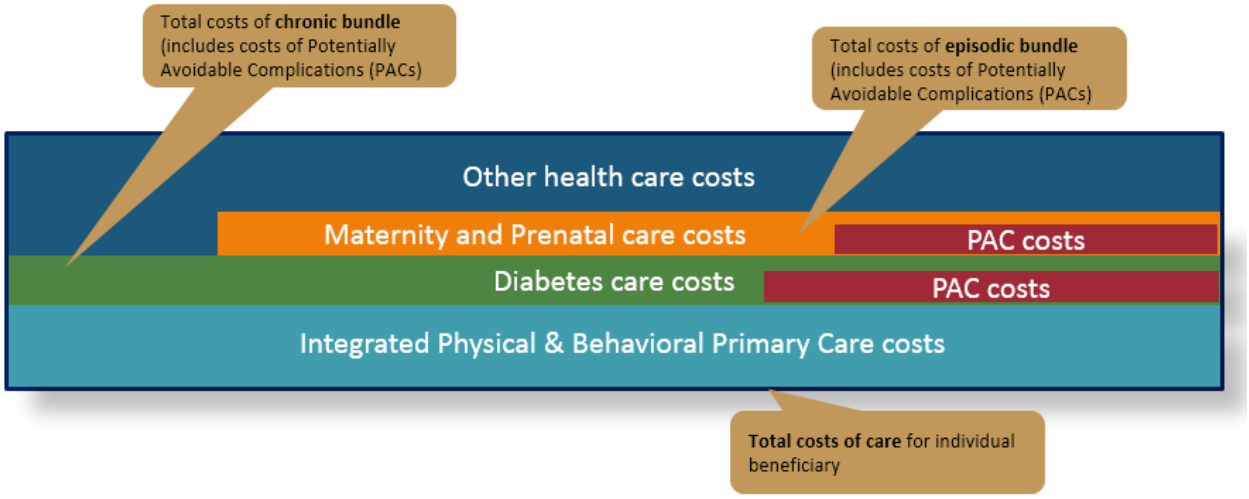
[14] The State will work with stakeholders to define the activities that fall under this category, including the associated quality measures.

When combinations of integrated care services are contracted separately, it has to be clear what happens when a beneficiary requires two (or more) services. The table below outlines an example of how these interactions could play out and serves as a potential framework for additional discussions by the Technical Design subcommittee.

Integrated Primary Care	A beneficiary can only be attributed to one IPC provider at a time		
Episodic Bundle/ Specialty Chronic Care bundle	A beneficiary will be expected to keep IPC services (for e.g. non-related preventive activities or diabetes treatment) during the duration of an episodic illness / specialty chronic condition	A beneficiary may receive two or potentially more episodes simultaneously. In some cases, a second episode (stroke) will be deemed to be a potential complication of a first episode (pregnancy & delivery)	
Sub population	This type of care is so comprehensive that a distinctive IPC role is difficult to carve out	TBD on the basis of the analyses. Some episodes (e.g. Maternity Care) may be so distinctive that they could be 'carved out'	A beneficiary can only be attributed to one sub-population at a time
	Integrated Primary Care	Episodic Bundle/ Specialty Chronic Care Bundle	Sub population

Calculations cost of care

When multiple care services are involved, calculating the total cost of care involves adding the costs of the individual integrated care services, as illustrated below.



MCOs do not necessarily have to contract these VBP arrangements with the PPS; they may also contract with (groups of) providers[15] for total care for the total population, integrated primary care, care bundles or specific subpopulations. Both providers and health plans have suggested that although joint contracting at the PPS level for the most vulnerable, multi-morbid subpopulations could be highly beneficial, joint contracting at the PPS level for more circumscribed and prevalent types of care – such as maternity care – would stifle competition. Some PPSs might consist of 2-3 hubs that would prefer contracting the total care for the total population separately rather than as a single PPS.[16]In some cases contracting at the PPS or hub level for integrated primary care may be the best answer to rapidly develop region-wide APC capabilities, while in other cases it would rather disrupt locally grown collaboration patterns that require differential treatment to truly blossom.[17] In addition, the State does not intend to limit the ability of MCOs and individual providers to create additional arrangements within e.g. a total care for the total population arrangement, such as existing Pay for Performance contracts with hospitals or primary care providers. In fact, such arrangements can be used synergistically to achieve the overall goals of providers and the MCO to realize DSRIP and VBP goals.

This leads to the following possible options:

Contracting at the PPS level	A PPS enters into a value-based arrangement (e.g. integrated primary care, total care for the total population, a bundle of care, care for a specific subpopulations) All providers within the PPS are held to the terms of that contract.
Negotiating standard VBP terms with the PPS for direct MCO-Provider contracting	The PPS works with the MCO on *how* to contract with providers within the PPS on a value-based arrangement. Within that framework, MCOs can contract directly with combinations of providers to deliver that care.
No contracting at the PPS level	The PPS has no responsibilities for the contracting of a value-based arrangement. MCOs contract that care directly with combinations of providers within the PPS.

Although both providers and MCOs have stressed the importance of flexibility in contracting options, they have also stressed the enormous benefits of a reduced administrative burden if contracts with MCOs were more aligned. Especially smaller providers will benefit greatly if PPSs and MCOs can agree on a similar set of rules and conditions to which they will be held accountable – whether that is arranged through a single MCO-PPS contract or through separate contracts between the MCO and (groups of) providers.

[15] Because advanced primary care, or the care for a pregnant woman (including the delivery) requires the cooperation of and coordination between different professionals and types of providers, contracting for these types of integrated care services will more often than not involve different providers within the PPS. These providers will have to contractually agree to jointly deliver these services with the MCO and/or amongst themselves. Much like the emergence of a more integrated governance structure at the PPS level, experience shows that providers involved in jointly delivering and contracting integrated care services often tend to evolve towards having one single point of cont(r)act with the MCO. (See e.g. Bailit, M. (2014). Key Payer and Provider Operational Steps to Successfully Implement Bundled Payments. HCI3 Issue Brief, May 2014).

[16] Importantly, when the total care for the total population is contracted at the level of a hub (or other entity) rather than the PPS, the total PPS attribution is divided over these hubs. In other words, no beneficiaries can be 'left out'.

[17] What care the PPS can actively contract for on behalf of the providers in the PPS is decided through the governance structure the PPS has put in place.

In addition, to further reduce administrative burden for both MCOs and providers, and to allow for transparency in performance between PPSs, the State will work in close collaboration with the stakeholders to standardize the following key elements pertaining to the integrated care services models, building upon what is already outlined in DSRIP:

- Services to be included and excluded from each VBP model;
- Beneficiaries eligible for attribution to each model;
- Selection and specifications of quality and outcome measures for each model; and
- Methods to calculate the risk-adjusted cost of care in each model and to adjust benchmark costs in each year to reflect changes in the clinical and demographic mix of attributed patients.[18]

The State will provide MCOs and providers with extensive information detailing their data and performance.

Finally, the Integrated Delivery System that DSRIP aims for can take many shapes and forms: virtual or not, centered in a strongly developed Advanced Primary Care concept or more diffusely embedded throughout the entire care delivery network. Yet because PPSs/hubs do not necessarily participate as a contracting entity in VBP arrangements there are concerns about maintaining the population-health focused infrastructure, patient-centered integration and associated overall workforce strategy that DSRIP sets out to build. To address this concern, the PPS or its hubs will have to submit a plan outlining how this infrastructure will be sustained. In addition, impacts on patient-centeredness, population health, social determinants of health and workforce infrastructure will be measured at the overall delivery system level (PPS, hub or otherwise). These measures will remain in place after the DSRIP funding stops, and will be considered a component of the overall outcomes of care contracted within the different VBP arrangements.

From Shared Savings towards Assuming Risk

In addition to choosing *what integrated services* to focus on, the MCOs and PPSs/providers can choose different *levels* of VBP. Assuming risk is a fundamental step, PPSs should focus first on building out the DSRIP projects and strong networks before focusing on potential risk-sharing arrangements.

18 Standardization required to reduce administrative load for Providers, but also to allow realizing statewide information support strategy for providers and payers to facilitate VB Contracting as well as statewide transparency and cost- and outcomes-reporting.

Together, this creates the following Options:

Options	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level; requires mature PPS)
All care for total population	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Global capitation (with outcome-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when outcome scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for Primary Care Services (with outcome-based component)
Acute and Chronic Bundles	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when outcome scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Prospective Bundled Payment (with outcome-based component)
Total care for subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (savings available when outcome scores are sufficient)	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for total care for subpopulation (with outcome-based component)

Level 0 is not considered to be a sufficient move away from traditional Fee-for-Service incentives to be counted as value-based payments in the terms of this Roadmap. (With the exception of preventive services, see p.11, and Managed Long Term Care, see p. 17).

Level 1 consists of 'upside only' shared savings arrangements. Here, the capitation and bundled payments exist only virtually. When the accrued Fee-for-Service payments for the integrated care service are lower than the virtual PMPM capitation or bundle budget, the MCO can share the savings with the providers ('retrospective reconciliation').[19] Potential provider losses are not shared; providers are not 'at risk' in Level 1. For example, if a PPS or a combination of providers meets most of its contracted quality

Integrated Primary Care, Shared Savings and Assuming Risk

As mentioned above (p. 9), in the context of integrated primary care, 'shared savings' and 'assuming risk' takes on a somewhat different meaning. In the case of the other value-based payment arrangements, 'total cost of care' refers to the total costs of care of the total population, the subpopulation, or the care included in the bundle. In the case of integrated primary care, however, (the considerably larger) *downstream costs* are included in addition to the costs of the primary care itself.

Costs that are largely outside of the sphere of influence of a well-functioning PCMH/APC will generally be excluded, such as costs for trauma, cancer, and other conditions requiring highly specialized treatment. Also, to avoid double-counting of savings/losses, and to fairly attribute shared savings/losses to those who have realized them, once a bundle or subpopulation are subcontracted in Level 1 arrangements or higher, the PCMH/APC can no longer receive shared savings for reductions of average cost per episode or PMPM per subpopulation patient. It can, however, still realize shared savings by *avoiding* an episode or a patient becoming eligible for a special needs subpopulation. The inverse is similarly true for incurred losses.[24] Following the same principle, if for example. a PPS or hub contracts total cost of care in addition to one or more integrated primary care contracts, the PCMH/APC will similarly not be accountable for average costs per episode or subpopulation for *all* care bundles/subpopulations tracked by the state that are included in the total care for total population arrangement.

For integrated primary care the shared savings will help further generate the substantial additional income required to further implement the infrastructure and staff required for a full-blown APC. Sharing these savings evenly with associated hospitals that work cooperatively with them on care management and coordination will maximize shared savings and performance goals. Because the downstream costs are relatively high compared to these providers' overall revenue, and the influence primary care providers can exert on that care is necessarily limited, the stop loss threshold per patient will be set closer to the set budget benchmark. Alternatively, PMPM payments could be reduced by an agreed-upon percentage of amount by which the benchmark downstream costs are exceeded.

[19] Alternatively, shared savings can be distributed through inter-organizational arrangements within the PPS/between the involved providers. In practice, however, Level 1 and 2 arrangements usually leave the distribution of savings/losses to the payer (based on pre-agreed sharing formulas).

outcomes, MCOs can return more of the savings; when fewer goals are met, the shared savings percentage is reduced. When outcomes worsen, no savings are shared.[20, 21]

Level 2 consists of 'upside and downside' risk-sharing arrangements. Again, the capitation and bundled payments exist only virtually, and the percentage of contracted quality outcomes affects the amount of savings shared. When the accrued FFS payments are higher than the virtual PMPM or bundle budget, the MCO may recoup these excess expenses through reductions in the reimbursement payments to be made to PPS/providers in the subsequent year. In Level 2, however, because the providers share in the risk, if a PPS or a combination of providers meets most of its contracted quality outcomes, the MCOs can return most or all of the savings. Conversely, if a PPS or a combination of providers exceed the virtual PMPM capitation or bundle budget, and a smaller percentage of outcome goals are met, then these providers are

Managed Long Term Care (MLTC), Dual Eligibles and shared savings

The dual eligible population may seem relatively small (some 15% of Medicaid beneficiaries are also eligible for Medicare), but these 700,000 individuals comprise 27% of total Medicaid spending. Many of these individuals use long term care services (LTCS) as well as hospital and other services; the former costs are covered by Medicaid (often through a MLTC plan); the latter are generally covered by Medicare. Preventing avoidable hospital use in this population is part of DSRIP's goals, and should be equally incentivized through this payment reform: improving palliative care, for example, can greatly enhance the quality of care and quality of life for some patients. 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 will work with stakeholders to investigate the possibility to treat potentially avoidable hospital use as 'quality outcomes' for this subpopulation, improving the quality of life for these beneficiaries and rewarding MLTC providers when certain levels of reduced avoidable hospital use are reached. Such arrangements would be treated as Level 1 VBP arrangements (performance or other quality/outcome measures that drive savings will also be considered). Even if the savings would primarily accrue to Medicare, the State will not pass on the opportunity to make significant strides in meeting the needs of this part of the dual eligible population.

In addition, the State intends to integrate the FIDA program in this VBP program. For purposes of determining the 80-90% VBP goal, however, Medicare dollars will not be included. Alignment of the State's VBP initiatives with those of Medicare is critically important to enhancing value for the dual eligible population.

[20] The percentages are set high so as to create a true economic incentive to deliver high quality care (and thus avoid the common mistake that the financial incentives to improve outcomes are insufficient). See: McKethan, A. and A. K. Jha (2014). "Designing Smarter Pay-for-Performance Programs." JAMA; Ginsburg, P. B. (2013). "Achieving health care cost containment through provider payment reform that engages patients and providers." Health Aff (Millwood) **32**(5): 929-934'.

[21] Savings should be allocated appropriately among providers; especially behavioral health, long term care, and other community based providers should not be disadvantaged.

responsible for the majority of this difference (see Table below).[22]

To reduce unwarranted insurance risk for providers, the State is considering to put two (2) types of stop loss in place described below. The detailed financing mechanism will be discussed by the Technical Design Sub-committee.

1 Per episode/subpopulation patient: a stop loss of based on a set level above the set budget benchmark;

2 Total assumed risk for PPS/combination of providers: a stop loss of a percentage of the *total* Medicaid payments received by the contracting PPS or combination of providers.[23]

The following table may serve as a framework for providers and plans and will be discussed by the VBP Technical Design subcommittee to determine precise percentages.

Examples of potential VBP Arrangements			
Outcome 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 Outcome Targets met	50-60% of savings returned to PPS/ Providers	90% of savings returned to PPS/ Providers	PPS/ Providers responsible for 50% of losses.
< 50 % of Outcome Targets met	Between 10 – 50/60% of savings returned to PPS/ Providers (sliding scale in proportion with % of Outcome Targets met)	Between 10 – 90% of savings returned to PPS/ Providers (sliding scale in proportion with % of Outcome Targets met)	PPS/ Providers responsible for 50%-90% of losses (sliding scale in proportion with % of Outcome Targets met).
Outcome Worsen	No savings returned to PPS/ Providers	No savings returned to PPS/ Providers	PPS/ Providers responsible for 90% of losses. For Stop Loss see text.

The precise percentages will be further defined in close collaboration with the stakeholders during DY 1 (2015) to find the optimal balance between incentives and risks for the providers, actuarially responsible risk for the MCO and the desired overall outcomes for the State**.** The State may set ranges within which MCOs and providers can realize in their contracts; it may also consider varying percentages over time. For example, to stimulate providers to move towards Level 2 VBP arrangements, the shared savings percentage may be lowered each year a Level 1 arrangement is extended. Similarly, to reduce real or perceived risk, the aggregate stop loss in the first year of a Level 2 arrangement may be set low, and gradually set to increase over the years. (In those cases, an aggregate ceiling for total shared savings would also be put in place). The decision will be made in close collaboration with stakeholders and will be presented to CMS in the State's next update of this Roadmap, in 2016.[24]

[22] At this time, the State does not anticipate imposing a minimum savings/losses threshold before savings/risk sharing begins.
[23] The State will set minimum and maximum sharing percentages for both shared savings and losses.
[24] This responsibility for the PCMH/APC not only incentivizes the primary care providers to reduce morbidity, but also effectively limits the volume-risk that can still be associated with the use of bundled payments. Miller, H. D. (2009). "From volume to value: better ways

In Level 3 the underlying FFS payment system is largely replaced by prospective PMPM and/or single bundled payments. No retrospective reconciliation is necessary. The Level 2 stop loss arrangements may remain to prevent providers from inadvertently taking on insurance risk.

In situations where there is a desire of an MCO and PPS/providers/IPAs/ACOs to enter into a value-based payment arrangement, but the parties fail to agree upon the terms of a contract, the State, together with MCO and provider representatives will develop a process designed to assist all parties in addressing the impasse. Further, the State will plan an assessment of progress toward the end of DSRIP Year 3 of participation in VBP contracting as well as of the market dynamics which will provide plans, providers, and the State with information to be better equipped to address any challenges that arise as VBP accelerates.

Pharmaceutical Costs and the Role of the Pharmacist

Costs for drugs and the dispensing of drugs (including adequate pharmaco-therapeutic management) are included in the value-based payment arrangements described. Pharmacists can add great value in managing polypharmacy, for example, or in enhancing proper medication usage and compliance. As adverse reactions to medication is a key driver of avoidable hospital use, state of the art Medication Therapy Management (MTM) can improve outcomes and reduce overall costs. Many innovative contracting models are available for MCOs as well as PPSs and (groups of) providers to incorporate the benefits that MTM can bring into the value-based arrangements discussed here.

Transparency of outcomes and cost as the foundation for Value-Based Payments

The DSRIP program is geared towards the realization of outcomes (reduced potentially avoidable (re)admissions, visits and complications; better patient experience, reduced number of uninsured and beneficiaries not using preventive and primary care services); PPSs that do not achieve their goals receive less DSRIP performance payments. The State's Medicaid Payment Reform strategy embraces these same goals, structurally rewarding outcomes over inputs. As said, the outcomes to be contracted for the different VBP models should align with the DSRIP measures: the Domain 2 and 3 measures that have been selected for the DSRIP program will form the starting point. The VBP Integrated Care Services subcommittees will review measures as they relate to each integrated care service periodically and suggest deletions, additions or modifications of these measures for each VBP model in accordance with these goals. Where quality metrics and reporting imposed by State and Federal policies lack alignment and, in some respects, are in conflict with one another, the state will explore in the appropriate workgroup a process for improved alignment and elimination of conflict. Additional measures may be added when it is deemed that outcomes of care are not optimally captured for specific care bundles or subpopulations. One key goal is the inclusion of Patient Reported Outcome Measures (including quality of life metrics), a key missing link in assessing the outcomes of care for many health problems and conditions. Similarly, measures focusing not so much on 'cure' but on rehabilitation and individual recovery including housing stability and vocational opportunities, as well as cultural competency and penetration of specific minority groups, are as yet underrepresented.[25] Finally, the State will include sufficient measures are in place to assess the competence and stability of the workforce upon which patient access and quality services depends. The State will also create a Performance Measurement subcommittee which will broadly review performance metrics for the implementation of this Roadmap and suggest additional measures where DSRIP measures do not sufficiently capture the needs of unique populations. While the State aims for consistency in the metrics and measures used for VBP, as

to pay for health care." Health Aff (Millwood) **28**(5): 1418-1428.

[25] NQF (2013). Patient Reported Outcomes (PROs) in Performance Measurement. For especially the FIDA, HARP, and DISCO subpopulations measures will be developed which reward quality of life and rehabilitation outcomes. These measures will help New York State achieve Olmstead, Americans with Disability Act and Home and Community based setting requirements.

measures are approved over time or additional information and objective require modifications or changes, the State will adjust accordingly.

Over 90% of these measures are based on claims data, or on other data (such as surveys) that are owned by or primarily available to the State (CAHPS, UAS-NY). The State will make the scores of these measures available to the PPSs and the MCOs during DY 1 (2015), with the opportunity to compare (risk-standardized) results between PPSs and regions, to identify providers responsible for high or low scores, and to explore some of the common drivers of better or poorer performance. In DY 2 (2016), the State will also make the total risk-adjusted cost of care available per PPS for the total population, as well as per integrated care service delineated above (Maternity care, Diabetes care, APC/PCMH care, etc.; based on the average of the involved providers' historical data over the previous 2 years). Potential shared savings, estimated for example, by benchmarks on potentially avoidable complications, will be available as well at both the total population level as per care bundle and subpopulation. Having these costs and the outcomes of these services available and transparent is crucial for any transformation towards payments based on value rather than volume.[26]

For the population-based total cost of care calculations, the State and the related VBP subcommittees will rely on 3M Clinical Risk Group (CRG) risk adjustment methodologies to create comparability between PPSs/providers and to adjust for shifts in attribution profiles within a PPSs/provider group over time.[27] To the extent possible, other patient/population attributes such as socio-economic status and cultural differences affecting care utilization will also be considered. For the care bundles (including chronic care), the most recent version of the open source Evidence-informed Care Rate (ECR) risk-adjustment methodology will be used, developed by the Health Care Incentives Improvement Institute.[28] As adjustment methodologies improve over time (including e.g. better sensitivity to pre-existing disparities), the State will adjust accordingly. As much as possible, socioeconomic, demographic, and clinical risk factors will be considered in all cost of care measures.

Establishing Benchmarks, Setting Rates and Rebasing

To determine whether savings or losses are made in Level 1 and 2 arrangements, a 'virtual budget' needs to be agreed upon for the PMPM or bundle. Using the risk-adjusted cost information, the benchmarks and the potential for shared savings, the MCOs and PPSs/combinations of providers can negotiate target budgets per arrangement to disincentive above-average avoidable complication rates, or invest additionally in underserved areas of care.[29] The State, in other words, provides information and benchmarks, but does not intend to set these target budgets, nor does it intend to set the PMPM or bundle rates once Level 3 arrangements come into view.

A common concern in shared savings arrangements is downwards resetting of the baseline once savings have become commonplace, leading to a gradual downward trend in overall provider reimbursement. As the Figure on page 5 illustrates, however, the State aims to link the realization of high value care to *increased* provider margins rather than to reduced margins. So while MCOs and providers may take into account a high existing rate of costly avoidable complications in setting a benchmark for a bundle, investments in primary and secondary prevention should lead to upward rebasing. It is important that those PPSs or combinations of providers that already deliver high value care (good to excellent outcomes and little opportunity in terms of savings) should be rewarded for doing so, while those PPSs of combinations of providers that reap significant

[26] Watkins, L. D. (2014). Aligning Payers and Practices to Transform Primary Care: A Report from the Multi-State Collaborative, Milbank Memorial Fund.
[27] For some of the selected subpopulations, 3M CRG-based capitation premium adjustment methodologies have already been developed that will form the basis for the risk adjustment for provider payments for these subpopulations.
[28] http://www.hci3.org/content/ecrs-and-definitions
[29] In projecting historical costs forwards, a price-index adjustment will be included

savings because their potentially avoidable complication levels were high can expect some downward adjustment until the value they realize is in line with the reimbursements received. The State and the VBP Technical Design Subcommittee will discuss the effects of downward adjustments to ensure necessary protections are in place to account for benchmark fluctuations as providers transition to VBP.

Again, as long as the total statewide yearly growth rate remains within NYS' Medicaid Global Cap[30], the State will merely provide the transparency for MCOs and providers to compare the total risk-adjusted costs of care per bundle and per (sub) population, including the virtual budgets, and present that information linked to the outcomes realized.

As said at the beginning of these section: at any given time, providers and MCOs are free to jointly agree to 'off menu' versions of Value-Based Payment arrangements as long as they support the underlying goals of the payment reform and sustain the transparency of value as outlined above (costs vs. outcomes). Such arrangements will not require a separate approval from DOH, but will require attestation from the parties, and will be subject to periodic audits.

Attribution

Both the Total Care for Total Population as well as the Integrated Primary Care value-based arrangements require a clear definition of 'attributed lives'. DSRIP's attribution for performance mechanism can be the starting point for these purposes. This attribution is updated monthly and also used for calculating the DSRIP outcomes of care for the overall DSRIP targets as well as for the selected projects. Alternatively, MCOs and providers may agree on alternate attribution methods and provide their patient-level attribution data to the State for appropriate cost and outcome data development. When varying attribution mechanisms are used, however, beneficiaries may either be not attributed to any provider or, alternatively, attributed to multiple providers. The preferred approach will be further discussed in the Technical Design subcommittee.

Lessons learned during DSRIP that could further improve this attribution methodology will be incorporated over time. One improvement could be having members select a PPS (or e.g. a hub) at the time of enrolment, much like members currently choose a primary care provider (PCP). The State, along with the subcommittee, will investigate this possibility, which would have the PPS serve like a 'preferred provider network' for the patient (without restricting access to the plan's entire network). This approach could also facilitate the realization of across-PPS information sharing and patient consent.

For the care bundles and subpopulations, patients need to fulfill standardized diagnostic criteria and will need to be similarly attributed to the (groups of) providers that aim to be accountable for that care.

Goals

Statewide, 80-90% of total MCO-PPS/provider payments (in terms of total dollars) will have to be captured in at least Level 1 VBPs at end of DY5. Fee-for-Service payments for preventive activities, aligned with quality measures, will be counted as VBPs

- The State recognizes that providers are at varying levels of readiness to begin transitioning to VBP. As such, the State will plan to develop separate expectations and evaluations of progress into VBP for three (3) distinct provider categories:

[30] If, at any time, the State is on track to exceed the appropriated dollar amount within the Medicaid Global Spending Cap, efforts will be taken by the Health Commissioner to rein in spending and ensure total spending does not exceed the cap.

1. Leading PPSs/Groups of Providers: These providers are ready, willing and able to enter into VBP arrangements, likely building upon current experience in VBP arrangements with payers. These providers are likely contenders for the VBP Innovator program];

2. Learning Providers: These providers are willing to enter into VBP arrangements, but may require more time and additional technical assistance to be fully prepared to enter into agreements with payers; and

3. Financially Challenged Providers: These providers would include Interim Access Assurance Fund (IAAF) providers and other providers that meet strict criteria suggested by the relevant VBP subcommittees, which would consider financial hardship and the need to restructure. These providers will be allowed to undergo the required significant restructuring before VBP steps will need to be made.

- To optimize the incentives, and allow providers to maximize their shared savings so as to build toward a financially stronger Medicaid delivery system, the State aims to have ≥ 50-70%[31] of total managed care payments tied to VBP arrangements at Level 2 or higher. The target here is not to achieve the percentage per se but rather the underlying goals that the State, the providers, MCOs and beneficiaries collectively seek to realize through payment reform. In that light, the State will incentivize responsibly moving towards Level 2 and higher, and yearly readjust this target in the light of progress made toward the overall goals.

Exclusions

In principle, the State does not want to wholly exclude any cost categories from the VBP arrangements. However, it must ensure there are no structural barriers to achieving the statewide VBP goal. Therefore, the VBP Technical Design subcommittee will analyze data on the current level of VBP activity in the Medicaid managed care program—when such data become available—and consider whether it is necessary to exclude certain services or providers for which VBP arrangements are not applicable or appropriate in order to reach the statewide VBP goal.

[31] Ibid.

2. Ensuring alignment between DSRIP goals and value-based payment deployment

Issue 2: How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.

Selecting integrated care services

As discussed in the previous section, the starting point for this Roadmap is sustaining the achieved DSRIP results. The overall goals of the DSRIP program and payment reform are the same: to improve population health and individual health outcomes and to reward high value care delivery. The outcome measures to be used in the different VBP arrangements will build upon the DSRIP measure set. Therefore DSRIP objectives and measures play an important role in the selection of the care bundles and subpopulations to be prioritized. The following criteria have been used:

1. The proportion of total Medicaid costs

Focusing on those care bundles and subpopulations with the largest spend is the best way to realize maximal impact while keeping the number of care bundles and subpopulations within reason.

2. The number of Medicaid beneficiaries included in these integrated care services per county/PPS

A minimum number of patients per PPS/provider combination per integrated care service is required for VBP arrangements to become worthwhile. When numbers are too low, it becomes impossible to reliably measure outcomes of care. In addition, the lower the number of patients per care bundle or subpopulation, the higher the risk that natural variation will inadvertently cause significant gains or losses unrelated to the quality or efficiency of the care delivered.[32]

The care bundles and subpopulations with the highest numbers of patients will be prioritized. Minimum numbers for contracting will be suggested by the VBP Technical Design subcommittee.

3. Cost Variation

Variation in cost per integrated care service can be due to three (3) factors[33]:

1. Quantity of services delivered: the more admissions or expensive diagnostic tests, the higher the cost per care bundle/patient;
2. Mix of services: selecting more costly diagnostic tests, prescribing specialty rather than generic drugs, and opting for inpatient rather than outpatient treatment modalities all drives up cost per the care bundle/patient; and
3. Price per unit of service (this variation will be low within the Medicaid domain).

[32] Mechanic, R. and C. Tompkins (2012). "Lessons learned preparing for Medicare bundled payments." N Engl J Med **367**(20): 1873-1875; Weissman, J. S., M. Bailit, G. D'Andrea and M. B. Rosenthal (2012). "The design and application of shared savings programs: lessons from early adopters." Health Aff (Millwood) **31**(9): 1959-1968.
[33] de Brantes, F. and S. Eccleston (2013). Improving Incentives to Free Motivation, Healthcare Incentives Improvement Institute and Robert Wood Johnson Foundation.

Large variations in costs per care bundle or PMPM could be indicative of potential waste and thus savings, and these care bundles or subpopulations will thus be prioritized.

4. Rates of potentially avoidable complications

Because the core goal of DSRIP is reducing potentially avoidable (re)admissions and ED visits, identifying those care bundles and subpopulations with the highest rates of overall potentially avoidable complications are crucial criterion for prioritization.

5. Prioritized within DSRIP

To ensure alignment with the DSRIP objectives, the integrated care services selected within the DSRIP program will be prioritized as well.

Applying these criteria, the following selection of integrated care services emerges (see Appendix II for the quantitative analyses underlying this selection):

Integrated Primary Care, including integrated care for:

- Diabetes
- Asthma
- COPD
- Depression
- Hypertension
- Chronic Heart Failure
- Coronary Artery Disease
- Arrhythmia
- Gastro-Esophageal Reflux Disease
- Low Back Pain
- Osteoarthrosis

Care Bundles – Episodic:

- Maternity Care
- Depression[34]

Care Bundles – Specialty Chronic:

- Hemophilia
- Chronic Kidney Disease

[34] Depression can be an episodic but also a chronic condition.

- Bipolar Disorder
- Substance Abuse

Total Care for Subpopulations[35]

- HIV/AIDS
- Multi-morbid disabled / frail elderly (MLTC/FIDA population)
- Severe BH/SUD conditions (HARP population)
- Care for the Developmentally Disabled (DISCO population)

The total dollar amount associated with these care services is xx$, thus covering approx. xx% of the total payments between MCOs and PPSs/providers (excluding the Medicare component of the FIDA payments).

This initial selection will be tested, refined and expanded further during the remainder of 2015 through further data analysis and discussions with stakeholders.

Incentivizing the Patient: Value-Based Benefit Design

Payment reform is incomplete without considering financial incentives for patients regarding both lifestyle choices (affecting future health care costs) and provider choices (choosing for higher or lower value providers). Financial incentives for the former (stimulating behavior that will lead to healthier lives) are becoming common. Incentives to stimulate high-value care utilization, however, are less widespread. Yet the problems DSRIP set out to address have their roots in inadequate financial incentives for beneficiaries as well. Absence of coverage, leading to ED use as the only realistic location for care, is the most obvious one, and is being addressed by New York's Medicaid expansion, among other initiatives. Yet once a beneficiary is enrolled in a Medicaid managed care plan, indiscriminate choices of providers and persistent use of the ED as the first line of care are more often than not similarly covered as judiciously selecting a PCP and high value care. The chances that DSRIP will realize and sustain its goals will be reduced if these behavioral patterns are not addressed, and if providers' *and* patients' financial incentives are not fully aligned with the value of health care services. Value-based benefit design is an important part of this and should thus be a core aspect of any payment reform. [36]

In the State's Medicaid program, burdening disadvantaged patients by introducing co-pays or co-insurance as disincentives for poor choices is not a policy option. On the other hand, *positively* incentivizing desired behavior, including allowing access to previous inaccessible high-value care benefits (such as joint weight reduction programs, medication management, smoking cessation, post-acute care activation programs, or programs to teach healthy and affordable cooking habits and wellness management skills) can be a very

[35] As VBP extends to all populations, performance measures will be adjusted to ensure they are appropriate and relevant for all special populations.

[36] Thomson, S., L. Schang and M. E. Chernew (2013). "Value-based cost sharing in the United States and elsewhere can increase patients' use of high-value goods and services." Health Aff (Millwood) **32**(4): 704-712; Choudhry, N. K., M. B. Rosenthal and A. Milstein (2010). "Assessing the evidence for value-based insurance design." Health affairs (Project Hope) **29**: 1988-1994; Antos, J., K. Baicker, M. Chernew, D. Crippen, D. Cutler, T. Daschle, F. d. Brantes, D. Goldman, G. Hubbard, B. Kocher, M. Leavitt, M. McClellan, P. Orszag, M. Pauly, A. Rivlin, L. Schaeffer, D. Shalala and S. Shortell (2013). Bending the Curve. Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth. Washington DC, Brookings Institute.

powerful tool. The State will financially stimulate MCOs as well as PPSs and other provider combinations to introduce positive incentives:

- Wellness or Lifestyle incentives, where the State can build upon its experience with its MIPCD (Medicaid Incentives for the Prevention of Chronic Disease) program. Any program that has been proven effective can be implemented by MCOs as part of their larger VBP approach. Plans are required to coordinate the approach with the PPSs to whom their populations are attributed.
- Patient incentives to make optimal health care choices, such as:
    - Actively and meaningfully using PCPs and preventive care;
    - When indicated: Engaging in early maternity care;
    - When indicated: Engaging in chronic care and self-management; and
    - Adherence to treatment.
- Using care in network (i.e., within Integrated Delivery System) rather than out-of-network (unless explicitly indicated).

In line with the VBP levels described above, and learning from the rapidly growing experience in incentivizing patients/consumers, the State aims to maximally focus here on *outcomes* rather than efforts or process-steps. In this view, patients could be incentivized, for example through cash payments or subsidies, for making life style choices proven to improve health and reduce downstream costs, or for choosing high-value care. Any incentive, regardless of form, would not impact a member's Medicaid or other State Health or Human Service eligibility status (e.g. Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF)) with regards to income or asset thresholds. Rather, this would be a form of 'inclusive shared savings', where patients' incentives to choose wisely become fully aligned with professionals and providers aiming to reduce avoidable hospitalizations and improve population health. To be effective, any incentive offered to consumers must be culturally competent not only in terms of geographic, linguistic, and normative preferences, but also in terms of disability status, employment, and transportation needs. It is important to note that the process of designing patient incentives is complex and will need to consider underlying disparities and social determinants of health including community needs, and local planning efforts. Above all, patient incentives must not reinforce disparities or perpetuate inequality within or between communities, particularly in terms of how disparate subpopulations access wellness services and support.[37]

[37] Thomson et al. op.cit. 36; Schmidt, H. and E. J. Emanuel (2014). "Lowering medical costs through the sharing of savings by physicians and patients: inclusive shared savings." JAMA Intern Med **174**(12): 2009-2013; Baicker, K. and M. Rosenthal (2014). "Shared savings, shared decisions, and incentives for high-value medical care." JAMA Intern Med **174**(12): 2014-2015.

Public health and social determinants of health

Given the importance of the social determinants of health for realizing the State's goals, its definition of Integrated Primary Care and its vision for the role of the PPS are explicitly population-health focused. Each PPS is expected to reach out into the community to stimulate community-based prevention activities and align itself with available social services. Concurrently, the framework for value-based payment will maximally incentivize providers to focus on the core underlying drivers of poor health outcomes – whether traditionally within the medical realm or not.[38]

Housing and Vocational Opportunities

Offering a stable, safe, and accessible housing environment can be a highly efficient and improve outcomes for vulnerable, homeless Medicaid beneficiaries. DSRIP explicitly stimulates investing in tailored housing solutions, and this VBP Roadmap aims to maintain that opportunity after the end of the DSRIP program. Similarly, DSRIP offers an opportunity to introduce credentialed positions such as Community Health Care Workers and Peers that offer a continuum of vocational opportunity to people living with chronic conditions, providing them with career opportunities within a restructured workforce.

Given the current state of primary care and the development of integrated delivery system in New York, and the difficulty in truly moving the needle on a population-wide basis within a few years, the DSRIP Domain 4 population health measures are Pay for Reporting only. In the near future, though, the State envisions culturally competent community based organizations (CBOs) actively contracting with PPSs and/or APC organizations to take responsibility for achieving the State's Prevention Agenda. DSRIP starts to build the infrastructure to take on housing, job placement, community inclusion, and criminal justice alternatives as levers to increase population health. The State foresees VBPs will become a vehicle to maintain this infrastructure. Specifically, the State aims to introduce a dedicated value-based payment arrangement for pilot purposes in DY 3 to focus specifically on achieving the Prevention Agenda targets through CBO-led community-wide efforts.

Capturing Savings across all areas of Public Spending

Addressing the social determinants of health is a critical element in successfully meeting the goals of DSRIP and health care reform more broadly. The State is fully committed to exploring ways to capture savings accrued in other areas of public spending when social determinants are addressed. For example, these might include e.g. reduced cost of incarceration and shelter care for homeless people.

Immediately after DY 5, the State intends to turn the Pay for Reporting measures into Pay for Outcomes measures, making a part of overall PPS reimbursement dependent on the achievement of specific public health goals as identified by these measures.

A dedicated group will be established to focus on these issues (see p. 36).

[38] See e.g. Doran, K. M., E. J. Misa and N. R. Shah (2013). "Housing as Health Care — New York's Boundary-Crossing Experiment." N Engl J Med **369**(25): 2374-2377.

3. Amending contracts with the MCOs to realize payment reform

Issue 3: How the state will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.

Aligning incentives

The State will add the following incentives and regulations in its contracts with MCOs to stimulate their adoption of VBP arrangements:

- The State plans to increase the managed care capitation premium for those MCOs that capture more provider-payment dollars in VBP arrangements. It is exploring the option of enhancing the existing quality incentive pool to reward plans that enter VBP contracts at Levels 1, 2 or 3, with the rewards being tied to the amount of dollars and the level (with more dollars in higher level VBP contracts generating higher premium increase). The State is currently in discussions with its actuary regarding how to determine the most appropriate and reasonable method to implement these actions.

- Part of this increase will be paid to providers as a stimulus for engaging in higher level VBP contracts. This is one of the mechanism by which the State will ensure that financial resources for providers are not depleted when savings start to accumulate.

- Additionally, the State will need to formulate a methodology to evaluate the different levels of plan and provider VBP arrangements. This method would serve as the basis for the distribution of additional quality pool funding related to this initiative.

- The State intends to include a provision that further incentivizes plan/provider arrangements that focus on integrated care services (APC/PCMH, care bundles or total care for selected subpopulations) rather than those that focus on total cost of care for the total population because: a) infrastructure costs for these former arrangements will be higher, and b) the State believes the total impact on quality, efficiency and sustainability of the Medicaid delivery system will be higher when a more differentiated VBP approach is taken.

- The State will assure that it will not hold MCOs accountable when providers, to no fault of the MCO, run into financial difficulty because of underperformance on a Value-Based Contract. To be able to give this guarantee, and as an additional layer of protection for the State's safety net infrastructure, the State will create a dedicated statewide fund / risk pool for distressed safety net providers across the continuum of care, that are too essential to allow to fail. The funding mechanism for this pool is still under development, and will be addressed in detail by the technical design subcommittee. Details will be provided to CMS prior to implementation.

VBP Innovator Program

In addition to the incentives discussed above, the State will implement a voluntary VBP Innovator Program. This program will support multi-year agreements between plans and providers for those PPSs or combinations of providers that aim to lead the way in embracing the opportunities and flexibility that come with mature Level 2 or 3 value-based arrangements. The State aims to include total care for the total population and for subpopulations in this Program. The Department of Health and the Department of Financial Services (DFS) will monitor performance and provide required oversight on an ongoing basis. The PPSs or provider combinations that meet these criteria and provide total population health for all costs of care will receive up to 95% of the

dollars paid by the State to the MCO for this care in case of total care for the (sub) population arrangements. Plans will be equally incentivized to contract with providers that participate in the Innovator Program, and will not be expected to cover any potential losses incurred within this Program.

Prior to implementation of the Innovator Program, a subcommittee, including plan representatives, provider representatives, patient advocates, DOH and DFS shall jointly set criteria to ensure the providers involved are ready to take on this risk and discuss safeguards such as cooling off periods after contract termination and an appeal process. The subcommittee may consider criteria such as, but not be limited to, determining the appropriate reserves for participating providers which shall be comparable to the corresponding reserves for plans who assume such risk; ensuring the ongoing financial solvency of the provider and measuring performance for Innovator participants, including a process for a participant to lose Innovator status if they fail to attain certain defined goals. In addition, this subcommittee should ensure that the Program does not inadvertently hamper existing leading initiatives. Plans that are leading the way in VBP initiatives will be rewarded by having immediate access to the premium increases associated with VBP contracts. Also, the leading plans will be recognized as Innovators on the exchange. The State will ensure that there is coordination of the VBP Program with other State and CMS related initiatives.

Specific regulatory amendments

Successful transformation of the existing payment system will require restructuring of contractual arrangements which clearly define metrics and the ability to share savings and risk. The existing regulations within the DOH and the DFS will be thoroughly reviewed and amended as necessary to reflect changes necessitated by the adoption of VBP. While the State has a regulatory framework for the review and approval of certain risk arrangements, additional regulations may be required. Any new or revised regulations would also be promulgated in collaboration with the DFS and health care provider industry.

Changes to the Medicaid managed care model contract and the internal policies guiding the risk sharing arrangements with MCOs and downstream providers will also be evaluated and if necessary amended to promote value-based contracting. Successful implementation of this new payment reform will ensure that existing provider and patient protections continue to be honored and provision of services to needy is not inadvertently disrupted.

To date, the State has identified the following required amendments:

Regulatory Changes – The DOH will engage and work collaboratively with the newly established PPSs, Provider Advocacy Groups and the Managed Care Industry along with the DFS to develop any regulatory changes that may be needed for VBP arrangements. Regulatory alignment and streamlining (between providers and MCOs, and between partnering providers) to support VBP models is imperative. Such support will facilitate both the clinical and efficacy goals of VBP, freeing and redirecting additional resources for patient and community needs. This may include new reinsurance provisions and reserve and risk transfer requirements to ensure arrangements are suitable and sustainable for both providers and MCOs, and setting criteria for the levels of VBP arrangements. The State will also examine its own regulatory contributions – via its current mandates, policies, and other actions.

Model Contract and other Policy Changes -- The DOH may include language in the Medicaid managed care model contract which begins to evaluate the baseline for current alternate value-based payment arrangements in order to monitor the transition of payments from Fee-for-Service to value-based over the next five years.

Medicaid managed care plans will be required to increase the percentage of value-based payments each year and must submit an annual report to DOH identifying which providers will be impacted by alternate payment arrangements and the percent of provider payments impacted. Current MCO/provider and IPA Guidelines as well as the Management Contract Guidelines will be modified accordingly and applied to all contracting arrangements with plans and providers. The contract modifications will have to be realized before the start of DY 3 (2017) (see Timeline section).

These initial regulatory implications have been identified, however the State plans to convene a Regulatory subcommittee during 2015 with the charge of identifying additional regulatory challenges related to implementing VBP, and suggested solutions for resolving these issues. As the State moves towards full Medicaid managed care coverage and VBP, for example, safety-net providers that are just now transitioning into managed care should not have to be unduly concerned that credentialing would remain a barrier to care when VBP is being rolled out. In addition, this Regulatory Impact Subcommittee will also examine current rules and regulations that may no longer be required in the future as well as any regulatory impediments to implementing the Roadmap.

4. Amending contracts with the MCOs: collection and reporting of objectives and measures

Issue 4: How and when plans' current contracts will be amended to include the collection and reporting of DSRIP objectives and measures.

The State currently includes quality and efficiency incentives in contracting with MCOs that are directly aligned with DSRIP. Many of its Quality Assurance Reporting Requirements (QARR) metrics, for example, are identical to the metrics selected for DSRIP. In addition, 2015 will be the first year the State will work with Efficiency Measures for MCOs, which are aimed at reducing ED visits and avoidable admissions through the same measures used within DSRIP. This further aligns MCO's incentives with DSRIP's desire to realize a lasting, sustainable transformation of the Safety Net system. In DY 1 the State will work with MCOs stakeholders to finalize the streamlining of the overall MCO quality and efficiency frameworks with the payment reform proposed. During that year, the State will involve multi-stakeholder groups to discuss the inclusion of additional outcome measures where necessary (see section on 'Transparency of Outcomes' above, p. 20).

As part of the reform, the State will work with stakeholders to improve the quality of data provided by providers to plans and from plans to the State as far as these data are foundational for the measurement of quality and costs.

5. Creating synergy between DSRIP objectives and measures and MCOs efforts

Issue 5: How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The State should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other State funding; and how they differ from any services or administrative functions already accounted for in capitation rates.

Currently, the base administrative PMPM amounts are calculated for each of the State's nine managed care rating regions using plan Medicaid Managed Care Operating Reports (MMCORs). The regional PMPM amounts are calculated by dividing the total allowable administrative cost for each plan in a given region by the plan reported member months. Each plan PMPM amount is then subject to the Department's administrative PMPM cap and adjusted downward if necessary. Additionally, the Department of Health also incorporates an administrative component into capitated premiums for all new populations and benefits moving into the benefits that are not reflected in the two year MMCOR base. This additional administrative component is developed by the State's actuary. The administration component is then adjusted by a plan specific risk score.

As with all new requirements, the Department and its actuary will review what will be expected of plans under DSRIP with regards to provide technical assistance/support, new activities, workforce development, etc. to achieve waiver goals. This analysis will also take into account activities already being accounted for in plan premiums to ensure duplication of payment is avoided. Ultimately, the State's actuary will certify an actuarially sound premium range that takes into account the factors above which the State will pay for within the range to meet Federal requirements.

It is anticipated that the new requirements under DSRIP may result in additional administrative costs for plans and providers which will need to be evaluated by the State and its actuary. Two specific areas where this will likely occur are: 1) *workforce planning* where, under the waiver, plans are responsible for developing and implementing various workforce strategies; and 2) *value-based payment* requirements which will necessitate plan/provider contract modifications. While there will likely be increases for these items, the Department believes they will not be excessive as it intends to set benchmark payment levels for use by plan/provider that recognize these additional costs. Further, it is not the intention of the State to exclude plans (or providers) that have been proactive and have already made investments to develop VBPs from this additional support.

6. Assuring that providers successful in DSRIP are contracted

Issue 6: How the state will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks

VBP is not designed to limit patient options or to lock providers out. The State will maintain current managed care network requirements which both ensure adequate patient choice and provider inclusion. The State will also work with PPS to enhance their networks as needed to ensure that all vital providers are included, particularly community based behavioral health and social service providers that have been previously excluded from the formal Medicaid payment system, and therefore largely excluded in PPS networks. While there is no requirement for a provider to join a PPS network, many already have during DSRIP Year 0 which helps ensure that VBP will be applied widely. Because high performing (combinations of) providers will be visible to both providers, MCOs and the public alike, it is highly unlikely that (combinations of) providers that are successful in delivering high value care would not be contracted by MCOs. In addition, the State will look to develop approaches which ensure the inclusion of providers who demonstrate successful performance. It is likely that some providers may need assistance engaging in VBP. Smaller, less prepared providers may need access to resources and support to develop the sophistication to succeed. DSRIP funds are explicitly intended to facilitate this. In addition, the State intends to form a subcommittee during calendar year 2015 explicitly focused on ensuring that Community Based Organizations can fully participate in VBP. In addition, the State will monitor providers for low performance and will provide technical assistance to gain improvements. The Technical Design subcommittee will explore ways to provide this technical assistance to both providers who want to enter into VBP arrangements, as well as those who upon entering VBP arrangements have performance challenges.

Over time, the State, in collaboration with Stakeholders, will also explore the possibility of having Medicaid members select a PPS or hub at the time of enrollment much as they do their PCP. For PCPs included in only one PPS, members would be automatically enrolled in that PPS to assure attribution alignment. If a PCP was in more than one PPS a member would be entitled to select one of the PPS. Such an option would help better connect a member with his or her preferred provider group from the beginning of Medicaid eligibility which should ensure better care coordination especially for complex patients. Such a selection process would also enhance attribution for performance measurement purposes. The State does not envision a member being limited to the providers within the selected PPS network. Individuals would still have access to all providers within the managed care network. All current rights that Medicaid members enjoy relative to provider access would be maintained within a VBP environment.

7. Amending contracts with the MCOs: adjusting Managed Care premiums to improved population health and care utilization patterns

Issue 7: How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development

Under the Department's Mainstream Managed Care risk adjusted capitation premium methodology, all plans are paid at the same regional average premium, adjusted by a plan specific risk adjustment factor that accounts for differences in enrollee acuity across plans. The regional premiums are developed using two years of plan reported MMCOR data. Using collected encounter data, risk scores are calculated using 3M's CRG model and cost weights developed by the Department. In simple terms, these two pieces are multiplied together to get plan specific risk adjusted premiums. The Department and its actuary incorporate changes in case mix, utilization and cost of care on an annual basis as the data becomes available to incorporate in premium development. The inclusion of DSRIP into this process will be a continuation and expansion of the work being done. Furthermore, as the Department implements its Care Management for All initiative and new populations and services (especially for chronic conditions including the LTC, behavioral health and developmentally disabled populations) move into managed care, it has engaged 3M and plans to make refinements to the current risk adjustment methodology. This effort is also a significant element of the FIDA demonstration. Ultimately, the goal is to have one risk adjustment system that incorporates the needs of the entire Medicaid managed care population.

8. Amending contracts with the MCOs: ensuring alignment between DSRIP objectives and measures and MCO premium setting

Issue 8: How actuarially sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the state will use benchmark measures (e.g., MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.

As noted above, the State's actuary currently develops actuarially sound capitation premiums.. Any new expectations, risks, costs, or tasks associated with DSRIP that the plans will be required to undertake will be incorporated into the development process. Similarly, as new populations and services have moved into managed care the State has and will continue to deploy risk mitigation strategies such as stop loss, medical loss ratios and/or risk corridors to ensure that appropriate reimbursement is being made. The State also places a premium on timely and accurate plan encounter submissions. This information is used to not only monitor the implementation of Care Management for All but also as a means to measure plan profitability and premium adequacy. Furthermore, as mentioned above, the Department will include core DSRIP metrics into plan specific reimbursement to optimally align payers' and providers' incentives. Through the transparency program described above, the Department will report outcomes of these metrics to both plans and providers which PPSs and provider-combinations are achieving or underperforming on each of the measures.

Stakeholder Engagement

In support of the State's efforts to create a comprehensive Roadmap a series of Stakeholder Engagement Interviews were conducted to share preliminary VBP concepts considered by the State, discuss key elements of developing a VBP model, identify and outline key challenges anticipated and request feedback and suggestions for the State's consideration. Stakeholders engaged during the preliminary interview process included New York State Health Plans, managed care organizations, representative organizations including the Health Plan Associations, Hospital Associations, legal firms specializing in health care contracting, New York State Health and Human Services Agencies, community based providers, patient advocates, Performing Provider Systems and other industry experts including national experts in VBP. This Roadmap endeavored to document and address the key themes and challenges identified during this stakeholder engagement process.

In addition, the State created a formal group of Stakeholders, an expansion of the Medicaid Reform Team's Global Cap Work Group, to serve as the Value-Based Payment Workgroup. The VBP includes representatives from other State Agencies, payers, providers, advocacy groups, and labor. This group will continue to be engaged throughout the development and implementation of this Roadmap. In addition, members of the VBP workgroup will serve in leadership roles to support the detailed work that will commence after CMS approval to operationalize the Roadmap. These workgroups are outlined in the Next Steps section.

Timeline

In DY 1 (2015), the Medicaid VBP approach will be finalized and refined, including a detailed scoping of the required information infrastructure to support the statewide realization of this approach.

In DY 2 (2016), every MCO – PPS combination will be requested to submit a growth plan outlining their path towards 90% value-based payments. All growth plans will be weighed in terms of ambition level (speed of implementation, level of risk, total dollars at risk, opting for a differentiated approach rather than total cost of care for total population). MCOs with more ambitious grow plans will receive a bonus on their PMPM premiums from DY 3 (2017) on.

End of DY 3 (2017), every MCO – PPS combination will have at least a Level 1 VBP arrangement in place for PCMH/APC care and one other care bundle or subpopulation (a Level 1 arrangement for the total cost of care for the total population would count as well). PCMH/APC care is selected here because of its vital role in realizing the overall DSRIP goals.[39]

End of DY 4 (2018), at least 50% of the State's MCO payments will be contracted through Level 1 VBPs. This aligns with the aim to have 50% of Medicare payments tied to quality or value through alternative payment models by the end of 2018. The State aims to have ≥ 30% of these costs contracted through Level 2 VBPs or higher at this time, yet this aim may be adjusted depending on the overall trend towards financial sustainability and high value care delivery as measured through overall DSRIP measures and cost of care measures for bundles and (sub) populations.

End of DY 5 (2019), 80-90% of the State's total MCO-PPS payments (in terms of total dollars) will have to be captured in at least Level 1 VBPs. The State aims to have ≥ 50-70% of these costs contracted through Level 2 VBPs or higher at this time, yet this aim may be adjusted depending on the overall trend towards financial sustainability and high value care delivery as measured through overall DSRIP measures and cost of care measures for bundles and (sub)populations.

[39] The contract does not have to include the PPS as contract partner.

Next Steps

As discussed above, this Roadmap has been conceived as a living document. It is not a blueprint; but rather an attempt to demonstrate the State's ambition and to outline what the State and its stakeholders consider the payment reforms required for a high quality, financially sustainable Medicaid delivery system.

Upon CMS approval of the Roadmap, the work of operationalizing this vision for payment reform at a more detailed level will commence. Fundamental to the success of the efforts outlined in this Roadmap is consistent and meaningful engagement of the State's stakeholders to harness their expertise and enlist their assistance in making these ambitions a reality.

The State intends to leverage the VBP Workgroup to create a number of subcommittees whose tasks will center on taking this Roadmap and developing detailed implementation plans for the work ahead. The subcommittee will have a chair from the VBP Workgroup and will report back into the full Workgroup through the development of a recommendation report at the conclusion of these efforts. The State will also invite CMS regional representatives to participate in the subcommittee process, to ensure alignment to the broader reform agenda. The State currently envisions seven (7) main areas of focus, which will be supported by an ongoing team of data and analytics staff, however will explore the option to combine subcommittees as implementation moves forward based on overlapping content areas.

1. *VBP Technical Design*

   Utilizing a diverse group of stakeholders, this subcommittee will be focused on the detailed design of the State's vision for VBP. This would include content areas related to the technical design of VBP arrangements, including, but not limited, to shared saving limits, stop-loss thresholds to prevent insurance risk from transferring to providers, threshold savings and loss levels to ensure payment models are tenable for all providers, and minimum beneficiary assignment levels for MCO VBP agreements. This group will also explore ways to provide technical assistance to providers who want to enter into VBP arrangements, as well as those provider who upon entering a VBP arrangements encounter performance challenges.

2. *Integrated Care Services*

   For each of the integrated care services that are identified through the analytical assessment, groups of clinicians, providers, payers, and State staff will work in teams to fully define that service area. This would likely include the development of appropriate parameters for each bundle, selection and specification of well-aligned, comprehensive outcome measures, and identify any regulatory changes required to allow implementation.

3. *VBP and Social Determinants of Health*

   This subcommittee will focus on the inclusion of social determinants of health in both the payment mechanisms (e,g., paying for housing and development of vocational opportunities) as well as outcomes measurement. Amongst others, this subcommittee will:

   - Integrate rewards and incentives based on utilization and outcomes related to best practices in cultural competence;
   - Evaluate the reporting requirements for DSRIP leads, PPS providers, and managed care companies in terms of social determinants;

- Suggest how to evaluate and measure the effectiveness of evidence based practices for cultural groups based on their correlative impact on social determinants of health; and
- Make recommendations on how to incentivize client activation, choice, and person-centered wellness and individual recovery for each of the care bundles/ subpopulations.

4. *Regulatory Impact*

   This subcommittee will focus on identifying and overcoming regulatory and contractual barriers to implementing the full scope of VBP. In addition, this group will review the current mandates required and assess the need for them to continue in various phases of VBP implementation in NYS.

5. *Community Based Organization*

   This subcommittee will be focused on identifying the how community based organizations can successfully support the broader VBP strategy. . The State recognizes that these providers play a critical role in the desired health care delivery system, however CBOs are very diverse in their ability to fully take on VBP. The group would make recommendations to the State and draft an action plan designed to make available the technical assistance and training necessary to bring the CBOs up to speed.

6. *Advocacy and Engagement*

   Implementation of the VBP Roadmap and the significant delivery system reforms underway in DSRIP requires a thoughtful and strategic approach to communicating to both Stakeholders and Medicaid beneficiaries. Explicit recognition of the rights and role of the individual enrollee is critical throughout the VBP development and implementation process. Consumer rights to know the incentives that affect their care must be considered when developing strategies around what and when information related to VBP and DSRIP more broadly, will be communicated to beneficiaries. This group, in close collaboration with consumer advocates, will assist in developing a communications strategy that will adequately address the complexities of these envisioned changes.

7. Performance management

   This subcommittee will focus on performing a broad review of performance metrics required and considered for the implementation of VBP. This group will be tasked with suggesting additional measures for special populations or conditions where DSRIP measures may not be sufficient. This subcommittee will work collaboratively with the integrated care subcommittees to address specific content areas.

It is the State's hope that this planning process to occur over the next 10-12 months will ensure the State's commitment to Stakeholder engagement, transparency and coordination with other Health and Human Services programs in New York State.

Coordination with Medicare

CMS's Payment Taxonomy Framework distinguishes 4 categories of health care payments:

Category 1—Fee-for-Service with no link of payment to quality

Category 2— Fee-for-Service with a link of payment to quality

Category 3—Alternative payment models built on Fee-for-Service architecture

Category 4—Population-based payment[40]

The mapping between these categories and the Levels used in this roadmap is as follows (for Category 3 and 4 the mapping is not perfect, because in CMS's taxonomy, bundles and IPC arrangements seem only to be foreseen as FFS-based (as in the State's Level 2)):

Medicare Category	NYS Medicaid Level
Category 1	-
Category 2	Level 0[41]
Category 3	Level 1 or 2
Category 4	Level 3

CMS has announced the goal to have 85% of all Medicare Fee-for-Service payments tied to quality or value by 2016, and 90% by 2018 (Category 2). Perhaps even more important, the CMS target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018 (Category 3 or 4). As CMS embarks down the path of VBP for Medicare with explicit goals for alternative payment models and value-based payments, New York State is committed to ensure coordination between both VBP programs. The State will actively engage with CMS so as to maximize synergy and benefit between the programs and minimize complexity for beneficiaries, providers and plans.

[40] Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume. CMS Fact Sheet, 01-25-2015. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html.
41 The State will consider arrangements between plans and providers that reward MLTC providers for reducing avoidable hospital use to be Level 1 VBP.

Conclusion

Providers and PPSs in successful DSRIP programs will see a significant shift in reimbursement dollars. DSRIP funds will allow them to compensate for lost revenues while investing in new infrastructure. Similarly, DSRIP funds will be used to pay for care activities which are currently not funded or underfunded when innovative, outpatient- and community-focused care models are being introduced. As quality outcomes improve, and avoidable admissions and visits are reduced, the current Fee-for-Service model will be increasingly ill-fitted to sustain the new delivery models. After five years, when the DSRIP funding stops, gains realized will be impossible to maintain unless significant steps are made to align payment mechanisms with these new care models. Importantly, without payment reform, improved outcomes and efficiency will lead to reduced reimbursements, and a downward rebasing of MCO premiums, reducing Medicaid dollars and weakening rather than improving the viability of the safety net.

Building upon the infrastructure that DSRIP will help put in place, this roadmap outlines a gradual transformation towards payment reform which:

- Aligns the payment incentives with the aims and goals of DSRIP and population health management;
- Rewards value over volume;
- Ensures reinvestment of potential savings in the delivery system;
- Allows for reimbursement of innovative care models not currently funded or underfunded;
- Allows for increased margins for providers when delivering value and an increased viability of the State's safety net;
- Allows for more sustainable workforce strategies; and
- Reduces the percentage of overall Medicaid dollars spent on administration rather than care.

The State realizes that this plan is ambitious. Yet without this ambition, these aims, vital to the beneficiaries, the provider and plans community, and the Medicaid delivery system as a whole, cannot be realized. It is encouraging to see its ambitions reflected in the recently released Medicare VBP plan and in the feedback of many leading providers and MCOs. The State looks forward to working closely with CMS and stakeholders to further build out and jointly realize this plan over the next five years.

Appendix I: T&Cs Par. 39

In recognition that the DSRIP investments represented in this waiver must be recognized and supported by the State's managed care plans as a core component of long term sustainability, and will over time improve the ability of plans to coordinate care and efficiently deliver high quality services to Medicaid beneficiaries through comprehensive payment reform, strengthened provider networks and care coordination, the State must take steps to plan for and reflect the impact of DSRIP in managed care contracts and rate-setting approaches. Prior to the State submitting contracts and rates for approval for the April 1, 2015 to March 31, 2016 contract cycle, the State must submit a roadmap for how they will amend contract terms Recognizing the need to formulate this plan to align with the stages of DSRIP, this should be a multi-year plan, and necessarily be flexible to properly reflect future DSRIP progress and accomplishments. This plan must be approved by CMS before the State may claim FFP for managed care contracts for the 2015 State fiscal year. The State shall update and submit the Managed Care DSRIP plan annually on the same cycle and with the same terms, until the end of this demonstration period and its next renewal period. Progress on the Managed Care DSRIP plan will also be included in the quarterly DSRIP report. The Managed Care DSRIP plan should address the following:

What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the State will plan and implement its stated goal of 90% of managed care payments to providers using value-based payment methodologies.

How and when plans' currents contracts will be amended to include the collection and reporting of DSRIP objectives and measures.

How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The State should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other State funding; and how they differ from any services or administrative functions already accounted for in capitation rates.

How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.

How the State will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks.

How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development.

How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the State will use benchmark measures (e.g., MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for State review and approval by January 31 of each calendar year.

How the State will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.

Appendix II: Value-Based Payments and the Forestland PPS in 2019

During the DSRIP application process, the State facilitated the creation of a Prototype application, designed to provide emerging PPSs with an example of what a successful DSRIP application would look like. To create this prototype a fictional PPS "Forestland" was created. Building upon this narrative, the following provides an example of what the future state of VBP in the fictional Forestland PPS could look like. (It is not necessary to have read these earlier Forestland materials).

The Forestland PPS has been a successful PPS. It has met the bulk of its performance targets over the DSRIP years, and has been one of the State's most successful PPSs in addressing diabetes and cardiovascular disease related hospital admissions, leading to several high-performance fund payments. While thinking through its Value-Based Payment strategy in 2015, the Executive Body of the Forestland Health Provider Partnership (FHPP, the NewCo created during those last hectic months of 2014) decided that it would not attempt to create one integrated contracting entity for the total PPS. Big is not always beautiful, they had argued. Their MCOs, with whom they had always had a good relationship, had also been clearly concerned about having to negotiate with such a unified group of providers. In addition, there had always been a natural distinction in culture, focus and also patient populations between the east and the west parts of the Forestland providers.

In East Forestland, home of the poorer parts of this geographical area and two of the PPSs three hospital systems, the providers and MCOs had decided during 2016 to focus on their significant HARP and MLTC/FIDA populations for value-based payments. Analysis of the outcome versus cost measures (that had become available and comparable statewide that year as part of the State's VBP Roadmap) had shown them that potential improvements in both quality and overall costs were significant. Maternity care, on the other hand, was selected because their outcome versus cost measures showed what they had thought all along: they were one of the best performers statewide. In the FFS system, however, they were still losing money on maternity care, and a contract that focused on value could be the solution.

The pre-existing Health Home had linked up with the other Advanced Primary Care initiatives that were expanding in the region, and had proposed to contract Integrated Primary Care including its chronic bundles throughout most of East Forestland. They had been impressed with the potential reduction in potentially avoidable complications that the data had shown, especially with those patients that weren't quite 'HARP eligible', but whose combinations of behavioral and physical chronic conditions led to poor outcomes overall.

For Maternity Care, the two hospitals joined forces with the obstetricians and with community-based providers, and opted for a Level 1 arrangement in 2017. This increased the dollar amount available for this care (based on their high performance statewide, and on the State's incentive for MCOs and providers to move to higher levels of VBP arrangements). Because this bundle also included the care and costs of the first month of the baby, significant savings were realized by a further reduction of the already low NICU admission rates. With the 50% of these savings that the MCO returned to them based on the Level 1 contract, improvements were made in the ability of community-based providers to reach out to the most underserved populations, which helped reduce smoking and other substance abuse during pregnancy. The shared savings helped the hospital as well, and was a welcome addition to the obstetricians' income.

Inspired by this result, they agreed to move to Level 2 in 2018 so as to be able to capture 100% of the shared savings, and profit from the further increase in VBP incentive dollars). The hospitals and the obstetricians formed a Maternity Care LLC, aimed at ultimately taking full risk. The obstetricians pushed to hire midwives to further decrease overall cost of care, safely increase the percentage of homebirths, and increasing the overall 'hands-on' time that delivering mothers would experience. Increased patient satisfaction led to an influx of patients from the wider region, which further helped stabilize the financial results for the hospital, which was

now receiving its Maternity care related income through a contract with the Maternity Care LLC. Sensing the alignment of their own professional drives with the new financial incentives, and witnessing the disappearance of prior authorizations and MCO's utilization reviews, morale surged amongst the staff members.

The Health Home and the other Advanced Primary Care practices had realized that if they would maximally strengthen the synergies between the different projects they had selected (IDS (2.a.i), medical village (2.a.iv), ED (2.b.ii), readmission reduction (2.b.iv), their 'project 11' (2.d.i), and their Domain 3 and 4 projects), all these projects would help drive the same results: an improved focus on housing, adequate nutrition, smoking cessation and obesity prevention throughout the community, improved adequate utilization of primary and preventive care, improved disease management and care coordination. One of their magic bullets, they had decided, was to build upon the success of their Health Home. Its focus on and infrastructure for care management and physical and behavioral care integration was the platform upon which they 'rolled out' their approach to first the HARP population and subsequently the broader 'at-risk' population. A second magic bullet had been the idea to work closely together with the home health care and visiting nurse providers, which greatly improved their ability to be pro-active in terms of addressing patients' problems and allow these patients to live more independently, reduce hospital use, and overall consume less costly care resources. This cooperation subsequently proved highly successful for the FIDA population as well, reducing the need for inpatient long term care, and improving quality of life.

They moved to Level 1 for Integrated Primary Care in 2017, including the associated chronic bundles, and did so for the HARP population as well. Getting a good grip on the HARP population proved harder than expected, and not much difference in outcomes or costs was realized in 2017. Their integrated approach, however, was highly successful in reducing admissions for especially diabetes and all cardiovascular chronic conditions that were being measured statewide: hypertension, angina/coronary artery disease, chronic heart failure (CHF), but also arrhythmia. Contrary to their expectations, 2017 saw a drop not only in the admissions for CHF and uncontrolled diabetes, but also in long-term complications: diabetic lower-limb amputations and cardiovascular events, especially myocardial infarctions and strokes.

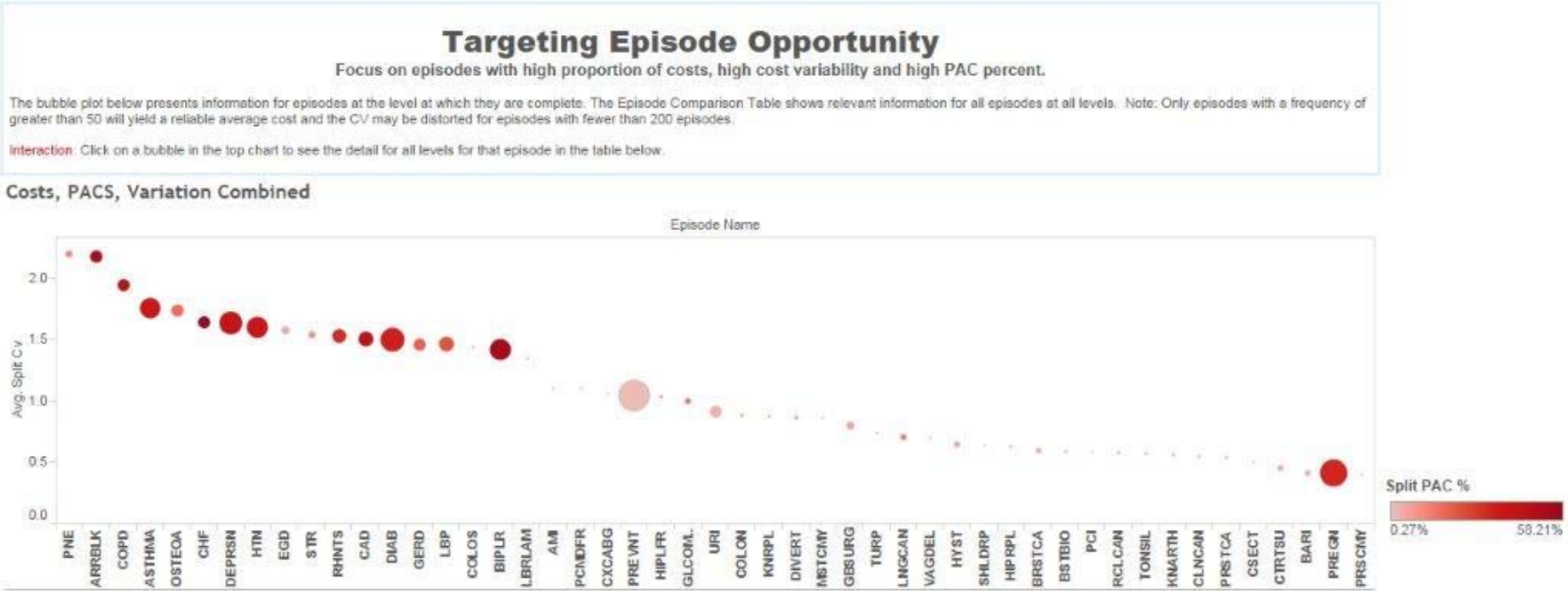
The savings resulting from fewer such potentially avoidable complications were significant. Following the State's guidelines, they had agreed to split these savings 50/50 with the hospitals within their PPS, helping them further reduce inpatient capacity to the newly modeled demand. For the Health Home and the Advanced Primary Care practices, even 50% of 50% of savings amounted to a significant increase in revenue. They used this to fulfill some long-standing desires: increase payment levels for the primary care docs and the home care organizations; expand their use of visiting nurses to further prevent hospitalizations in at-risk individuals; invest in new staff across all levels (some of which were transferred from inpatient care organizations through the DSRIP workforce retraining programs they had put in place). Building upon the DSRIP programs, they paid much attention to ensuring cultural competency within their staff, adequately reflecting the cultural and ethnic diversity of the populations they served.

They moved to Level 2 in 2018 for Integrated Primary Care, with an increased stop-loss provision just to 'get used to the risk', as they called it. They moved to Level 1 for the MLTC/FIDA/MLTC population that year, and remained in Level 1 for the HARP population. When their interventions for the HARP populations seemed to bear fruit throughout 2018, they shifted to Level 2 for that population as well. For the remainder of the care within the PPS, a Level 1 Total Cost for the Total Population arrangement was agreed upon in 2018 that would suffice until further notice. There was no risk involved in such an arrangement, and the MCOs had agreed to simply distribute potential savings (according to overall involved Medicaid dollars) amongst the East Forestland PPS providers, with the option to negotiate different arrangements in the future.

In West Forestland, the Forestland Hospital Center and its neurologists had realized its potential to be an early adopter of integrated Stroke care. It had long been a center of excellence for stroke care, and its own analyses showed that optimizing the acute phase of stroke care, starting rehabilitation during day one, and working with a select group of specialized post-acute rehabilitation and home care providers would yield significant improvements in mortality and long term outcomes. They were aware that the bulk of costs of stroke care, when seen across the total cycle of care, were long term care costs. Improving quality of acute stroke care, they were convinced, would improve the number of stroke patients recovering fully and thus reduce the number of patients left with impairments and corresponding life-long care dependency. Their own analyses had shown them that much of these potentially avoidable 'downstream costs' were incurred outside of their PPS: nursing homes, other post-acute care providers and hospitals that were not part of their PPS.

They decided to opt in the VBP Innovator program, moving immediately to a fully-fledged Level 2 model. The incentive associated with this Innovator program was significant, but – as they had predicted – the savings that they were able to realize, largely without impacting any of their PPS provider colleagues, were greater. The public attention their work received led to an increase of patients being brought to them for acute stroke care, including Medicare and commercial patients. In 2018, Forestland Hospital Center was the first organization in the State to enroll in the aligned Medicaid-Medicare stroke bundle, which extended the 'rules of engagement' of the Medicaid bundle to the duals and the Medicare FFS population. This was part of a broader alignment between CMS and New York State on the Medicaid and Medicare payment reform, which allowed for adaptation of New York State's Medicaid VBP models in Medicare, and selected Medicare Innovation Models within Medicaid.

Contrary to East Forestland, there initially was not much focus on value-based payment arrangements in the remainder of the West Forestland provider community. Triggered by the success of the Stroke Program, and the bristling of activities in their sibling 'hub' within the PPS, they decided to 'try out' a Level 1 Total Care for the Total Population program in 2018 (which excluded only stroke care). Because they were successful in meeting most of their DSRIP goals, overall costs of care dropped somewhat, which became an unexpected source of additional revenue (they had booked a significant sum of 'lost revenue compensation' within the DSRIP funds for 2018). Emboldened by that result, and perhaps also somewhat driven by competition with the West Forestlanders, they moved to Level 2 in 2019, while planning to realize an integrated Medicaid-Medicare ACO in 2020.

Appendix III: Quantitative Analysis per Integrated Care Service

Summary analysis showing per integrated care service the total costs associated with that care, the # of Medicaid patients, cost variation and potentially avoidable complications.