VBP Bootcamp Series
Session 2

Region 1: Capital Region, Mid-Hudson, Southern Tier

June 2016
Welcome

Jonathan Bick, Director
Division of Health Plan Contracting and Oversight
## Today’s Agenda:

<table>
<thead>
<tr>
<th>Agenda Items</th>
<th>Time</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Morning Session</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welcome</td>
<td>9:00 AM</td>
<td>5 mins</td>
</tr>
<tr>
<td>Summary of Session 1 and Overview of Upcoming Sessions</td>
<td>9:05 AM</td>
<td>15 mins</td>
</tr>
<tr>
<td>VBP Contracting Overview</td>
<td>9:20 AM</td>
<td>85 mins</td>
</tr>
<tr>
<td>Break</td>
<td>10:45 AM</td>
<td>15 mins</td>
</tr>
<tr>
<td>VBP Contracting Overview (Cont.)</td>
<td>11:00 AM</td>
<td>45 mins</td>
</tr>
<tr>
<td><strong>Break</strong></td>
<td>11:45 PM</td>
<td>60 mins</td>
</tr>
<tr>
<td><strong>Afternoon Session</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target Budget Setting</td>
<td>12:45 PM</td>
<td>75 mins</td>
</tr>
<tr>
<td>Financial Risk Management</td>
<td>2:00 PM</td>
<td>60 mins</td>
</tr>
<tr>
<td>Break</td>
<td>3:00 PM</td>
<td>15 mins</td>
</tr>
<tr>
<td>VBP Contracting Panel with Q&amp;A</td>
<td>3:15 PM</td>
<td>45 mins</td>
</tr>
<tr>
<td>Closing</td>
<td>4:00 PM</td>
<td>15 mins</td>
</tr>
</tbody>
</table>
VBP Bootcamp Session 1 Summary
What are VBP Bootcamps?

• This learning series will provide **foundational** knowledge about Value-Based Payment (VBP) structure and prepare you for VBP implementation

• Bootcamps will be held in 5 regions across NYS between June and October of 2016
  • Each Bootcamp will consist of 3 all-day sessions held approximately one month apart in a centralized location
  • You are highly encouraged to attend all 3 sessions
  • If unable to attend a session in your region, you may register for sessions in other regions. Also, webcast recordings are going to be available in the VBP Library
  • With the exception of the Regional data overview in Session 1, the content of sessions are applicable statewide

• There will be a networking event at every session, so please bring appropriate staff to extract the most value out of these sessions. These will include: business and clinical leadership, contracting staff, finance staff, IT staff, etc.
VBP Bootcamp Regions

Region 1: Capital Region, Southern Tier, Mid-Hudson

Region 2: Mohawk Valley, North Country, Tug Hill Seaway

Region 3: New York City (excluding Queens)

Region 4: Central NY, Finger Lakes, Western NY

Region 5: Long Island and Queens
Explore the VBP Bootcamp Website

The Website will provide access to the following:

- Bootcamp Schedules
- Bootcamp Registration
- Session Materials
- VBP Resource Library

Path: DSRIP Homepage → Value Based Payment Reform → VBP Bootcamps
Link: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_bootcamp/index.htm
Session 1 Summary

In Session 1 ‘Introduction to VBP’, the following was covered:

- Purpose of the Bootcamp series
- Introduction to Value-Based Payment Reform
- Overview of VBP Arrangement Types
- VBP Standards
- VBP Readiness Assessment

If you were unable to attend Session 1, you may attend in another region or watch the recorded session/go over the presentation posted in the VBP Library. Link: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/index.htm
## VBP Bootcamp Curriculum & Schedule

<table>
<thead>
<tr>
<th>Session</th>
<th>Topics covered</th>
<th>Date &amp; Time</th>
<th>Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>Introduction to VBP</td>
<td>Thursday, June 2, 2016</td>
<td>University at Albany: Performing Arts Center, Recital Hall</td>
</tr>
<tr>
<td></td>
<td>- VBP Design Overview</td>
<td>9AM - 4.30 PM</td>
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<tr>
<td></td>
<td>- High Level Readiness Assessment Considerations</td>
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<tr>
<td>Session 2</td>
<td>Contracting &amp; Risk Management</td>
<td>Wednesday, June 15, 2016</td>
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</tr>
<tr>
<td></td>
<td>- VBP Contracting Overview</td>
<td>9.00AM – 4 PM</td>
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<tr>
<td></td>
<td>- Target Budget Setting Guidance</td>
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<tr>
<td></td>
<td>- Financial Risk Management</td>
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<td></td>
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<tr>
<td>Session 3</td>
<td>Performance Measurement</td>
<td>Thursday, July 7, 2016</td>
<td></td>
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<tr>
<td></td>
<td>- Impact of Performance on Target Budget</td>
<td>10AM - 3PM</td>
<td></td>
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<tr>
<td></td>
<td>- Information Management Guidance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Network, network, network!
Networking Activity: Nametag “Families”

**Rules:** The word on your nametag belongs to a family listed below. Each family consists of at least 20 members. Throughout the day, please find at least 10 of your family members and write their names down. The first 5 people to present a list of 10 family members wins this networking challenge! *Hint: You may belong to more than one family.*

- NFL Football Team Names
- State Capital Cities
- Mammals
- Actors
- Car Models
- Sea Creatures
- Girls’ First Names
- Flower Varieties
- Boys’ First Names
- Countries
Session Logistics

• Remember to network
• For Q&A: please tweet your questions to @NYSMedicaidVBP
  • There will be multiple breaks for Q&A throughout the day
VBP Contracting Overview
Contracting Overview

The following topics will be covered in this section:

- Overview of Arrangement Types
- VBP Contracting Entities
- Key Components of a VBP Contract
- Contracting with Downstream Providers and CBOs
- Contract Review Process
Types of VBP Arrangements
## Different Types of VBP Arrangements

<table>
<thead>
<tr>
<th>Types</th>
<th>Total Care for General Population (TCGP)</th>
<th>Integrated Primary Care (IPC)</th>
<th>Care Bundles</th>
<th>Special Need Populations</th>
</tr>
</thead>
</table>
| Definition                   | Party(ies) contracted with the MCO assumes responsibility for the total care of its attributed population | Patient Centered Medical Home or Advanced Primary Care, includes:  
  • Care management  
  • Practice transformation  
  • Savings from downstream costs  
  • Chronic Bundle (includes 14 chronic conditions related to physical and behavioral health related) | Episodes in which all costs related to the episode across the care continuum are measured:  
  • Maternity Bundle | Total Care for the Total Sub-pop  
  • HIV/AIDS  
  • MLTC  
  • HARP                                                                                           |
| Contracting Parties          | IPA/ACO, Large Health Systems, FQHCs, and Physician Groups                                             | IPA/ACO, Large Health Systems, FQHCs, and Physician Groups                                      | IPA/ACO, FQHCs, Physician Groups and Hospitals                                | IPA/ACO, FQHCs and Physician Groups                                                      |
Contracting Entities/VBP Contractors
Contracting Entities/VBP Contractors

1. Independent Practice Associations (IPA)
2. Accountable Care Organizations (ACO)
3. Individual Providers
   - Hospital Systems
   - FQHCs and large medical groups
   - Smaller providers including community based organizations (CBOs)

1. Individual provider could either assume all responsibility and upside/downside risk or make arrangements with other providers; or
2. MCOs may want to create a VBP arrangement through individual contracts with these providers
VBP Contractors: Independent Practice Association

- An Independent Practice Association is a corporation (nonprofit or for-profit) and/or LLC that contracts directly with providers of medical or medically related services, or another IPA in order to contract with one or more MCOs to make the services of such providers available to the enrollees of an MCO.

- Who negotiates the IPA contract?
  - What is the governance of the IPA?
  - Who should the individual provider look to if there are questions and/or concerns?
VBP Contractors: Independent Practice Association

• IPAs facilitate network development and access
  • Single signature authority
    • Typically for a category of services amongst competing providers (could be with providers across the care continuum)
    • Allows providers to maintain independence regarding governance and clinical decision-making

• IPAs are not unions or guilds
  • Antitrust concerns related to collective negotiation
  • To avoid antitrust concerns, IPAs are usually entities that share risk or are clinically integrated

• IPAs can provide administrative services to providers who participate in the IPA and/or management services to MCOs
An Accountable Care Organization is an organization of clinically integrated health care providers that work together to provide, manage, and coordinate health care (including primary care) for a defined population; with a mechanism for shared governance; the ability to negotiate, receive, and distribute payments; and accountability for the quality, cost, and delivery of health care to the ACO’s patients.

- Medicare-only ACO (approved by CMS) for Medicare population
- Medicare ACO does not make you a Medicaid ACO and vice versa*
- IPAs may be certified by DOH as an ACO, but an ACO is not an IPA
- For Medicaid (and for commercial health insurance), an ACO must be approved as an IPA

*There is an expedited approval process for Medicare ACOs to become Medicaid ACOs.
Where Do You Fit in the Structure of a VBP Arrangement: Total Care for General Population

Flow of Funds

- DOH
- MCO
- IPA
- Hospitals
- Physicians
- FQHCs
- BH Providers
- Pharmacies
- CBOs
- Ancillary Providers
TCGP: Flow of Funds

IPA to IPA Contract

- DOH
- MCO
- IPA
  - Hospitals
  - Physicians
  - FQHCs
  - IPA
    - Provider
    - Provider
Where Do You Fit in the Structure of a VBP Arrangement: Total Care for a Subpopulation

Flow of Funds

- **DOH**
- **MCO**
  - **FQHC**
  - **IPA**
  - **Physician Group**
    - **BH Provider**
    - **Physicians**
    - **Hospitals**
    - **HCBS Provider**
    - **CBOs**
Where Do You Fit in the Structure of a VBP Arrangement: Integrated Primary Care (IPC)

Flow of Funds

- DOH
  - MCO
  - Physician Groups
- DOH
  - MCO
  - FQHCs
- DOH
  - MCO
  - Hospital
Where Do You Fit in the Structure of a VBP Arrangement: Maternity Care Bundle

Flow of Funds

- DOH
- MCO
- IPA
  - Hospital System
  - IPA
  - FQHCs
  - Physician Group
    - Physician
    - Hospital
    - Physician
    - Hospital
    - Hospital
Components of a VBP Contract
Components of VBP Contract

1. Measurement Period
2. Targeted Medical Budget
3. Services Included
4. Calculations
5. Savings and Losses
6. Reporting
7. Financial Protections
8. Quality Measures
Components of a VBP Contract

1. **Measurement Period**
   - Annual

2. **Targeted Medical Budget**
   - Percentage of Premium
   - Set dollar amount
   - Medical Loss Ratio
   - Risk Adjustment

3. **Services Included**
Components of a VBP Contract

4. Calculation Determination
   • Use of Incurred But Not Reported (IBNR) claims vs. Waiting for Expiration of Claims Run-Out

5. Savings and Losses
   • How much will the MCO and Contracting Provider share in savings and losses?
   • Risk and Savings is typically shared proportionally

6. Reporting
   • How often will reports be generated?
     • Final determination is typically 18 months after the measurement period
     • What reports will be generated so the VBP Contractor can ascertain its status and have time to make adjustments in service delivery patterns?
     • Will the Contracted Provider have an opportunity to object?

Risk adjustment methodology, services, and specifics on quality outcomes and measures are set by DOH and required for the Contracting Parties.
Components of a VBP Contract

7. **Financial Protections**
   - Letter of Credit
   - Reserve Fund
   - Stop Loss
   - Certified Financials

8. **Quality Measures**
   - Reports
   - Submission of data
   - Payment
Quality Measures*

VBP Arrangements are conditioned upon meeting certain quality outcomes or targets:

- **Outcome measures**
  - Reducing medically unnecessary services – e.g., inpatient hospitalizations and readmissions

- **Process measures**
  - Providing proper follow-up care with a Behavioral Health/Substance Use Disorder provider after inpatient hospitalization
  - Medication adherence
  - Reporting of data

*This topic will be covered in depth in Session 3 on Performance Measurement.*
Negotiable Items

- Attribution
- Target Budget
- Shared savings and losses
- Reconciliation Time Periods
- Financial Protections
Questions
Contracting with Downstream Providers
More on IPA-MCO Contracts

• The contract between the IPA and the IPA Participating Providers (“downstream entities”)  
  • Contain similar provisions as a provider agreement
• The contract between the MCO and IPA  
  • Key Issues:  
    • Governance of the IPA  
    • Payment of claims  
    • Exclusivity with the MCO and the MCO’s ability to exclude certain downstream providers  
    • Credentialing  
    • Risk sharing
Typical Provider Contract Terms

1. Parties and Definitions
2. Scope of Services and Access to Services
3. Payment Adjustments
4. MCO Administrative Requirements (i.e. timely filing)
5. Insurance
6. Indemnification and Liability
7. Compliance with all laws and Medicaid Model Contract
8. Term and Termination
9. Representations and Warranties
10. Amendment
11. Assignment
12. Notices to MCO
13. Dispute resolution or litigation
14. Audits, monitoring and oversight
Provider Contract Key Terms

Out of the entire list of terms these are the most important:

1. Payment Adjustments
   Need to understand how these activities will be handled (for example, the timeframe and notice requirements and payment implications)
   • Timely filing of claims
   • Adjustments to payments
   • Claim disputes and dispute resolution
   • Retroactive enrollments
   • Recoupments
Provider Contract Key Terms

2. Insurance
   • MCOs will require providers to have malpractice insurance and general liability insurance
   • Provider should understand its insurance limits and policy restrictions (Is contractual indemnification allowed?)

3. Indemnification and Liability
   • Contractual indemnification - mutuality
   • An MCO can’t transfer liability for its own acts onto a health care provider
   • Joint and several liability
Provider Contract Key Terms

4. **Term and Termination**
   - Automatic renewal or defined contract term
   - “For cause” versus “without cause” termination
     - Standard for material breach
   - Length of notice for termination and non-renewal
   - Due process rights

5. **Representations and Warranties**
   - Valid corporation and properly licensed, certified or designated by DOH, OMH or OASAS (licensure obligations can also apply to employees of the provider)
   - Legally binding and enforceable
   - Neither provider nor employees have been suspended or terminated from a federal health care program or convicted of a criminal offense related to Medicaid or Medicare
Provider Contract Key Terms

6. Amendment
   • Mutual agreement, automatic or upon 30 days’ notice without objection
   • Changes due to regulatory requirements

7. Assignment
   • On notice or with consent
   • Change of control

8. Notice to MCO in the event the provider has:
   • Any lapse, revocation, termination or suspension of license
   • Any lapse, revocation or cancellation of insurance
   • A disciplinary action initiated by a government agency
   • Excluded, suspended, debarred or sanctioned from a federal program
   • A grievance or legal action filed by an enrollee against the provider
   • An investigation, conviction or plea for fraud, a felony, or a misdemeanor
Provider Contract Key Terms

9. Dispute Resolution / Litigation
   • Claim disputes vs. other disputes
   • Venue and choice of law
   • Internal dispute resolution mechanism
     • Timeframe for resolution
     • Identify key management titles with the authority to resolve disputes
   • Alternative dispute resolution or mediation
     • Binding or non-binding
     • American Arbitration Association, American Health Lawyers Association, etc.

10. MCO’s right to monitor and audit its participating providers
Provider Contract Key Terms

Below are some of the key provisions covered by Law. Providers should expect their MCO to include these in the VBP Contracts.

- Provisional credentialing
- Medical necessity appeals
- External appeals
- Limits on prior authorization
- Prudent layperson
- Prompt pay – timeframes and interest
- Overpayments
- Claim submission timeframes and exceptions

- No balance billing of consumers
- Continuity of Care
- Term and Termination
- Sharing of enrollee medical records and other personal health information, including HIV, substance abuse, and mental health records
  - Consent obtained on Medicaid enrollment application
Reminder: Contracting with CBOs

Standard Summary*

Every Level 2 or 3 VBP arrangement will include a minimum of one Tier 1 CBO (non-profit, non-Medicaid billing, community-based social and human service organization) starting January 2018. The State will, however, make financial incentives available immediately for plans and providers who contract with Tier 1 CBOs.**

The SDH & CBO Subcommittee put forth several additional recommendations focusing on CBO involvement in VBP networks and the integration of SDH interventions into clinical care. While the recommendations are not requirements, contract language could include details on the intentions of the provider network and MCO regarding these initiatives.

*Please refer to the Master Subcommittee Recommendation Report to review the complete language of this Standard recommendation. Link: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-feb_sub_comm_recommend_rpt_consol.pdf

**Note: The State recognizes that CBOs may not exist within a reasonable distance to providers in some regions of New York. In such situations, providers/provider networks can apply to the State for a rural exemption.
Questions
Break – 15 mins
VBP Contract Review Process
Contract Review Process Moves from 5 to 3 Tiers

The existing five contract review levels per the existing Provider Contract Guidelines have been collapsed into three tiers.

**Tier 1**
- **The File and Use Tier** includes all VBP Level 1 arrangements (upside only arrangements) and all other arrangements that do not meet the minimum review thresholds for DOH Review (Tier 2) or Multi-Agency Review (Tier 3).

**Tier 2**
- **The DOH Review Tier** includes VBP Level 2, VBP Level 3, and all other arrangements that do not trigger Regulation 164, but contain over $1,000,000 of potential payments at risk AND ANY of the following factors listed on Slide 29.

**Tier 3**
- **The Multi-Agency Review Tier** includes all contractual arrangements which trigger Regulation 164.

*Note: Regardless of which Tier a particular agreement falls in, the financial and/or programmatic reviews referenced here only apply from the State’s perspective to assess financial and programmatic risks to the Medicaid program. The State is not providing legal advice to either plans or providers nor is the State determining whether the contractual arrangement is a fair business deal between the parties.*
Reminder: MCOs and Contractors can Choose Different Levels of Value Based Payments

There are different levels of risk that the providers and MCOs may choose to take on in their contracts:

<table>
<thead>
<tr>
<th>Level 0 VBP*</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/IPC, FFS may be complemented with PMPM subsidy)</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient)</td>
<td>Prospective capitation PMPM or Bundle (with outcome-based component)</td>
</tr>
<tr>
<td>FFS Payments</td>
<td>FFS Payments</td>
<td>FFS Payments</td>
<td>Prospective total budget payments</td>
</tr>
<tr>
<td>No Risk Sharing</td>
<td>↑ Upside Risk Only</td>
<td>↑↓ Upside &amp; Downside Risk</td>
<td>↑↓ Upside &amp; Downside Risk</td>
</tr>
</tbody>
</table>

*Level 0 is not considered to be a sufficient move away from traditional fee-for-service incentives to be counted as value based payment in the terms of the NYS VBP Roadmap.
DFS Regulation 164: Background

• An insurer or MCO has a contractual obligation to provide coverage to its subscribers.

• Regulation 164 allows (1) the insurer/MCO to transfer its financial risk (but not its contractual obligations) to a health care provider, and (2) the insurer/MCO to reduce its corresponding claims liabilities.

• Regulation 164 only applies to pre-paid, full capitation payments.

• The agreement must be approved by DFS.

• The insurer/MCO must demonstrate to DFS the “financial responsibility” of the health care provider.
Future Financial Review: Bucketing into Tiers

All contracts may be subject to Programmatic Review in addition to Financial Review.
Future Financial Review: Arrangements Included in Tier 1

Individual Contract Comes in for Review

More than $250,000 of annual payments to provider prepaid capitation (triggers Regulation 164)?

More than $1,000,000 of annual payments to provider at risk (shared losses, withhold)?

More than 25% of annual payments to provider at risk?

More than 15% provider’s Medicaid Revenue?

Off Menu VBP Arrangement?

No

Yes

No

No to All

Tier 1 DOH Review will include the following arrangements:

- VBP Level 1 Arrangements (upside only arrangements)
- All other arrangements that do not meet the minimum review thresholds for a Multi-Agency Review (Tier 3) or DOH Review (Tier 2).

All contracts may be subject to Programmatic Review in addition to Financial Review.
Future Financial Review: Arrangements Included in Tier 2

Tier 2 DOH Review will include the following arrangements:
- VBP Levels Two and Three Prepaid capitation arrangements that do not exceed the $250,000 threshold; OR
- VBP Level Two FFS arrangements (no prepaid capitation); OR
- Off-menu VBP arrangements that are either FFS or do not exceed the $250,000 prepaid capitation threshold; AND:
  - Exceed the $1,000,000 at risk payment threshold; AND
  - Meet one of more of the three highlighted criteria

All contracts may be subject to Programmatic Review in addition to Financial Review.
Future Financial Review for DOH Review Tier (Tier 2)

VBP Contracts which are determined to fall under DOH Review Tier 2 will undergo both programmatic and financial review prior to approval.

<table>
<thead>
<tr>
<th>Demonstration of Provider financial viability</th>
<th>Services provided directly by contracting provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>For all Contracts that fall under the DOH Review Tier, the financial viability of the contracting provider must be demonstrated.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Security Deposit (FSD)</th>
<th>Services paid through a participating provider network (IPA, ACO, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSD only required when providers in this column fail to demonstrate financial viability</td>
<td>FSD required for all arrangements involving participating provider networks</td>
</tr>
</tbody>
</table>
Financial Viability and Financial Security Deposits

- **Provider financial viability** will be determined by demonstrating a positive net worth. Accepted documentation includes but is not limited to:
  - Certified audited financial statements, or comparable means, such as an accountant’s compilation;
  - Positive net worth of the guaranteeing parents’ certified audited financial statements;
  - Other.

- **Financial Security Deposits (FSD) criteria**: the provider/IPA must establish and provide evidence of a FSD equal to 12.5% of the estimated annual medical costs for the medical services covered under the risk arrangement
  - The FSD is provider funded, must consist of cash and/or short-term marketable securities, and will be held “in escrow” by the plan
  - Under limited circumstances, a parental guarantee may be allowed
  - Out of network services already retained by the plan are not subject to the FSD
  - The above requirements may be mitigated to the extent that limits on the amount of financial risk are imposed

*This is not a new regulation.*
Future Financial Review: Arrangements Included in Tier 3

Individual Contract Comes in for Review

- More than $250,000 of annual payments to provider prepaid capitation (triggers Regulation 164)?
- More than $1,000,000 of annual payments to provider at risk (shared losses, withhold)?
- More than 25% of provider’s Medicaid Revenue?
- More than 15% provider’s Medicaid Revenue?
- Off Menu VBP Arrangement?
- Program Review will be completed in addition to Financial Review for all contracts

Tier 3 Multi-Agency Review will include the following arrangements that exceed the $250,000 prepaid capitation threshold:
- VBP Level Three arrangements; OR
- VBP Level Two partial capitation arrangements; OR
- Off-menu VBP options that include prepaid capitation
## Possible Risk Contract Review Tiers by VBP Arrangement Levels: Tier 3

<table>
<thead>
<tr>
<th>Tier 3: Multi-Agency Review (DOH, DFS)</th>
<th>Level 0 VBP*</th>
<th>Level 1 VBP**</th>
<th>Level 2 VBP**</th>
<th>Level 3 VBP**</th>
</tr>
</thead>
<tbody>
<tr>
<td>An arrangement that triggers Reg 164 but has NO quality component.</td>
<td>A risk arrangement that triggers Reg 164 but is NOT fully prepaid.</td>
<td>A fully prepaid arrangement that triggers Reg 164.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* = Level 0 VBP arrangements include a cost-savings component or a quality component, but not both.
** = Level 1, 2, and 3 VBP arrangements must include a quality component in addition to a cost-savings component.
*** = There are a few exceptions such as P4P where there is a FFS arrangement with a quality bonus, but no cost-savings component.
⛔ = This type of VBP arrangement will not be subject to this particular Tier of contract review.
### Possible Risk Contract Review Tiers by VBP Arrangement

#### Levels: Tier 2

<table>
<thead>
<tr>
<th>Tier 2: DOH Review</th>
<th>Level 0 VBP*</th>
<th>Level 1 VBP**</th>
<th>Level 2 VBP**</th>
<th>Level 3 VBP**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>An arrangement that does NOT trigger Reg 164, has NO quality component, and contains: 1) &gt;$1,000,000 of potential provider payments at risk; AND 2) At least one of the following: a) &gt;25% of annual Medicaid MC or MLTC payments at risk; OR b) &gt;15% of a provider's total Medicaid revenue; OR c) An Off-Menu arrangement.</td>
<td>A risk arrangement that does NOT trigger Reg 164 and contains: 1) &gt;$1,000,000 of potential provider payments at risk; AND 2) At least one of the following: a) &gt;25% of annual Medicaid MC or MLTC payments at risk; OR b) &gt;15% of a provider's total Medicaid revenue; OR c) An Off-Menu arrangement.</td>
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🚫 = This type of VBP arrangement will not be subject to this particular Tier of contract review.
### Possible Risk Contract Review Tiers by VBP Arrangement Levels: Tier 1

<table>
<thead>
<tr>
<th>Tier 1: File and Use</th>
<th>Level 0 VBP*</th>
<th>Level 1 VBP**</th>
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<tbody>
<tr>
<td>An arrangement that does NOT trigger Reg 164, has NO quality component***, and contains: 1A) ≤$1,000,000 of potential provider payments at risk; OR 1B) &gt;$1,000,000 of potential provider payments at risk; AND 2B) None of the following: a) &gt;25% of annual Medicaid MC or MLTC payments at risk; OR b) &gt;15% of a provider's total Medicaid revenue; OR c) An Off-Menu arrangement.</td>
<td>An upside-only shared savings arrangement (usually FFS) based on a target budget.</td>
<td>A risk-sharing arrangement that does NOT trigger Reg 164 and contains: 1A) ≤$1,000,000 of potential provider payments at risk; OR 1B) &gt;$1,000,000 of potential provider payments at risk; AND 2B) None of the following: a) &gt;25% of annual Medicaid MC or MLTC payments at risk; OR b) &gt;15% of a provider's total Medicaid revenue; OR c) An Off-Menu arrangement.</td>
<td>A fully prepaid payment arrangement that does not trigger Reg 164.</td>
<td></td>
</tr>
</tbody>
</table>

* = Level 0 VBP arrangements include a cost-savings component or a quality component, but not both.
** = Level 1, 2, and 3 VBP arrangements must include a quality component in addition to a cost-savings component.
*** = There are a few exceptions such as P4P where there is a FFS arrangement with a quality bonus, but no cost-savings component.
⚠️ = This type of VBP arrangement will not be subject to this particular Tier of contract review.
# VBP Arrangement Level Examples by Risk Contract Review Tiers

<table>
<thead>
<tr>
<th>Tier 3: Multi-Agency Review (DOH, DFS)</th>
<th>Tier 2: DOH Review</th>
<th>Tier 1: File and Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>An arrangement that triggers Reg 164 but has NO quality component.</td>
<td>A risk arrangement that triggers Reg 164 but is NOT fully prepaid.</td>
<td>An upside-only shared savings arrangement (usually FFS) based on a target budget.</td>
</tr>
<tr>
<td>A fully prepaid arrangement that triggers Reg 164.</td>
<td></td>
<td>A risk-sharing arrangement that does NOT trigger Reg 164 and contains: 1A) ≤$1,000,000 of potential provider payments at risk; OR 1B) &gt;$1,000,000 of potential provider payments at risk; AND 2B) None of the following: a) &gt;25% of annual Medicaid MC or MLTC payments at risk; OR b) &gt;15% of a provider’s total Medicaid revenue; OR c) An Off-Menu arrangement.</td>
</tr>
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<td>Tier 3: Multi-Agency Review (DOH, DFS)</td>
<td>Tier 2: DOH Review</td>
<td>Tier 1: File and Use</td>
</tr>
<tr>
<td>An arrangement that does NOT trigger Reg 164, has NO quality component, and contains: 1) &gt;$1,000,000 of potential provider payments at risk; AND 2) At least one of the following: a) &gt;25% of annual Medicaid MC or MLTC payments at risk; OR b) &gt;15% of a provider’s total Medicaid revenue; OR c) An Off-Menu arrangement.</td>
<td>A risk arrangement that does NOT trigger Reg 164 and contains: 1) &gt;$1,000,000 of potential provider payments at risk; AND 2) At least one of the following: a) &gt;25% of annual Medicaid MC or MLTC payments at risk; OR b) &gt;15% of a provider’s total Medicaid revenue; OR c) An Off-Menu arrangement.</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:**
- **Level 0 VBP**: NO quality component.
- **Level 1 VBP**: Fully prepaid arrangement that triggers Reg 164.
- **Level 2 VBP**: Risk arrangement that triggers Reg 164 but is NOT fully prepaid.
- **Level 3 VBP**: An arrangement that triggers Reg 164 but has NO quality component.
**Possible Risk Contract Review Tiers by VBP Arrangement Levels**

<table>
<thead>
<tr>
<th>Tier 3: (Multi-Agency Review)</th>
<th>Level 0 VBP</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible</td>
<td>Never</td>
<td>Possible</td>
<td>Likely</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 2 (DOH Review)</th>
<th>Level 0 VBP</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible</td>
<td>Never</td>
<td>Possible</td>
<td>Never</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 1 (File and Use)</th>
<th>Level 0 VBP</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible</td>
<td>Likely</td>
<td>Possible</td>
<td>Possible</td>
<td>Possible</td>
</tr>
</tbody>
</table>
Summary of DOH Review Tier Payment Thresholds

- **$1M**
  - Only the individual contract that is coming in for review
  - Medicaid Managed Care components of the contracts only

- **15%**
  - All MCOs that contract with the provider
  - All Medicaid (inclusive of Medicaid Managed Care and Medicaid FFS) contracts

  The ratio is expressed as:
  \[
  \frac{\text{Value of This Contract’s Projected Medicaid Revenue}}{\text{Total Projected Annual Medicaid Revenue for Provider}} \times 15\%
  \]

- **25%**
  - Only the individual contract that is coming in for review
  - Medicaid Managed Care components of the contracts only

  The ratio is expressed as:
  \[
  \frac{\text{Annual Medicaid Payments at Risk for this Contract}}{\text{Total Value of All Medicaid Contracts between this MCO and Provider}} \times 25\%
  \]

June 2016
DOH and DFS Will Sign a Memorandum of Understanding

- DOH and DFS are coming together to agree on a Memorandum of Understanding (MOU) to clarify and distinguish the responsibilities of both DOH and DFS related to Tier 3 Contract Review (Multi-Agency Review).

- Approval of this MOU is forthcoming and is expected this summer.
Questions
Lunch Break – 60 mins
Guidance on Setting Target Budget for a VBP Arrangement (between MCO and Provider)
Methodology
Setting Target Budget is a Key Step in the Determination of Shared Savings/Losses

Defining the scope of services
- Total Population
- Subpopulation
- Bundles

Target Budget
1. Baseline
2. Trend
3. Risk Adjustment
4. VBP Modifiers

Determination of actual spend vs target budget

Calculation and Payment of Shared Savings / Losses
Dependent on:
- Level of VBP Arrangement
- Stop Loss/ Risk Corridors
- Quality Performance
Target Budget Components

- 3 Years Weighted Baseline
  - Historic claims data
  - Growth Trend
  - Risk Adjustment

- Target Baseline Performance Adjustments
  - Efficiency Adjustment
  - Quality Adjustment

- Stimulus Adjustment (Through 2020)

= Target Budget

Note: The Target Budget Setting process outlined here is only a guideline. Plans and VBP Contractors are free to negotiate their own Target Budget Setting Methodology, provided it meets the State’s requirements.
## Baseline – Example

<table>
<thead>
<tr>
<th>Baseline Input</th>
<th>Year 3</th>
<th>Year 2</th>
<th>Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>$250</td>
<td>$750</td>
<td>$250</td>
</tr>
<tr>
<td>Sick Care</td>
<td>$1,000</td>
<td>$750</td>
<td>$500</td>
</tr>
<tr>
<td>Chronic Care (Diabetes)</td>
<td>$1,500</td>
<td>$1,000</td>
<td>$750</td>
</tr>
<tr>
<td><strong>IPC Total</strong></td>
<td><strong>$2,750</strong></td>
<td><strong>$2,500</strong></td>
<td><strong>$1,500</strong></td>
</tr>
<tr>
<td>Other Care</td>
<td>$1,500</td>
<td>$0</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$4,250</strong></td>
<td><strong>$2,500</strong></td>
<td><strong>$3,000</strong></td>
</tr>
</tbody>
</table>

Baseline Cost Weights: 15% 35% 50%

**Year 3:**

- $250 in Preventive Care
- $1,000 in Sick Care
- $1,500 in Diabetes-related Care
- $1,500 ER visit (accident at gym)
## Baseline – Example

### Baseline Input

<table>
<thead>
<tr>
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<td><strong>$2,500</strong></td>
<td><strong>$3,000</strong></td>
</tr>
<tr>
<td><strong>Baseline Cost Weights</strong></td>
<td>15%</td>
<td>35%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Year 2:

- $750 in Preventive Care
- $750 in Sick Care
- $1,000 in Diabetes-related Care

No other care provided
Baseline – Example

<table>
<thead>
<tr>
<th>Baseline Input</th>
<th>Year 3</th>
<th>Year 2</th>
<th>Year 1</th>
</tr>
</thead>
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<td>$750</td>
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<tr>
<td><strong>IPC Total</strong></td>
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<tr>
<td>Other Care</td>
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<td>$1,500</td>
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<td><strong>Total</strong></td>
<td><strong>$4,250</strong></td>
<td><strong>$2,500</strong></td>
<td><strong>$3,000</strong></td>
</tr>
<tr>
<td>Baseline Cost Weights</td>
<td>15%</td>
<td>35%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Year 1:
- $250 in Preventive Care
- $500 in Sick Care
- $750 in Diabetes-related Care
- $1,500 in IP for Migraines
Baseline – Formula

**Purpose:** to determine the weighted member-specific historical costs over a three year period.

<table>
<thead>
<tr>
<th>Formula</th>
<th>Year 3</th>
<th>Year 2</th>
<th>Year 1 (most recent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Cost</td>
<td>15%</td>
<td>35%</td>
<td>50%</td>
</tr>
<tr>
<td>Weights</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example Data</th>
<th>Year 3</th>
<th>Year 2</th>
<th>Year 1 (most recent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Cost: TCGP</td>
<td>$4,250</td>
<td>$2,500</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

**Formula:**

\[(\text{Year 3} \times 0.15) + (\text{Year 2} \times 0.35) + (\text{Year 1} \times 0.50)\]

**Formula: TCGP**

\[(4,250 \times 0.15) + (2,500 \times 0.35) + (3,000 \times 0.50) = 3,012\]

The baseline cost is a **weighted average** of actual per-member per-month (PMPM) or per-bundle payments **over 3 years** with the most recent year, “Year 1,” weighted the most.
Target Budget Components

3 Years Weighted Baseline

Target Baseline Performance Adjustments

Stimulus Adjustment (Through 2020)

= Target Budget

Historic claims data

Growth Trend

Risk Adjustment

Efficiency Adjustment

Quality Adjustment

Note: The Target Budget Setting process outlined here is only a guideline. Plans and VBP Contractors are free to negotiate their own Target Budget Setting Methodology, provided it meets the State’s
Note: The Downstate Region consists of the five counties comprising New York City, and the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The Upstate Region consists of all counties in the State other than those counties included in the Downstate Region. This aligns with NYS’ ambulatory patient groups definitions for up/down state.
Growth Trend – Example

VBP Contractor Growth Trend

<table>
<thead>
<tr>
<th>Example Data</th>
<th>Year 1 (most recent)</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Cost: TCGP</td>
<td>$ 4,100</td>
<td>$ 3,000</td>
<td>$ 4,500</td>
</tr>
</tbody>
</table>

Growth Trend = Year 1 / Year 3

VBP Contractor Growth Trend = $4,100 / $4,500 = 0.911

Regional Growth Trend

<table>
<thead>
<tr>
<th>Example Data</th>
<th>Year 1 (most recent)</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Cost: TCGP</td>
<td>$ 3,000</td>
<td>$ 2,900</td>
<td>$ 2,700</td>
</tr>
</tbody>
</table>

Growth Trend = Year 1 / Year 3

Regional Growth Trend = $3,000 / $2,700 = 1.111

Note: The Downstate Region consists of the five counties comprising New York City, and the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The Upstate Region consists of all counties in the State other than those counties included in the Downstate Region. This aligns with NYS' ambulatory patient groups definitions for up/down state.
Growth Trend – Formula

**Purpose:** to account for changes in cost of delivering care by applying a growth trend to the weighted baseline cost

**Formula:**

Weighted Baseline * (Regional Growth Trend + VBP Contractor Specific Growth Trend) * .5

**Example:**

\[
\begin{align*}
\text{Formula:} & \quad \text{Weighted Baseline} \times (\text{Regional Growth Trend} + \text{VBP Contractor Specific Growth Trend}) \times .5 \\
\text{Example:} & \quad \$3,012 \times (1.111 + 0.911) \times .5 \\
& \quad \$3,012 \times 1.011 \\
& \quad \$3,045.13
\end{align*}
\]

- The growth trend of costs during the performance period is calculated by averaging the regional growth trend (upstate or downstate) and a VBP contractor-specific growth trend.
- The trend is computed over the same three years as the baseline.

Note: The Downstate Region consists of the five counties comprising New York City, and the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The Upstate Region consists of all counties in the State other than those counties included in the Downstate Region. This aligns with NYS' ambulatory patient groups definitions for up/down state.
Target Budget Components

3 Years Weighted Baseline + Target Baseline Performance Adjustments + Stimulus Adjustment (Through 2020) = Target Budget

Historic claims data
Growth Trend
Risk Adjustment

Efficiency Adjustment
Quality Adjustment

Note: The Target Budget Setting process outlined here is only a guideline. Plans and VBP Contractors are free to negotiate their own Target Budget Setting Methodology, provided it meets the State’s
Purpose: At the start of the contract year the risk-profile of the population may be different from the historical baseline. The target budget may therefore need to be adjusted accordingly. This ensures that variance in the risk profile of member populations does not skew the target budget calculation.

Methods:

Comparing 3M CRG or HCI3 Risk Adjustment Coefficient of Baseline data to attributed population at start of contract.

- If the risk adjustment coefficient is different, the target budget is changed accordingly. This only happens at the start of the contract year.
Risk Adjustment

**Purpose:** At the start of the contract year the risk-profile of the population may be different from the historical baseline. The target budget may therefore need to be adjusted accordingly. This ensures that variance in the risk profile of member populations does not skew the target budget calculation.

**Method:**

Compare 3M CRG or HCI3 Risk Adjustment Coefficient of Baseline data to attributed population at start of contract.

Case Mix Factor x Target Budget = Risk-adjusted Target Budget

**Example:**

Case Mix Factor x Target Budget = Risk-adjusted Target Budget

\[ 1.025 \times \$3,045.13 = \$3,121.26 \]

*This only happens at the start of the contract year.*
Note: The Target Budget Setting process outlined here is only a guideline. Plans and VBP Contractors are free to negotiate their own Target Budget Setting Methodology, provided it meets the State’s...
Questions
Performance Adjustments
VBP Contracts Performance Adjustments - Efficiency

Efficiency

- **70th – 100th percentile**
  - ≥ 90th percentile = 3%
  - 80th – 89th percentile = 2%
  - 70th – 79th percentile = 1%

- **30th – 69th percentile**
  - 20th – 29th percentile = -1%
  - 10th – 19th percentile = -2%

- **< 30th percentile**
  - <10th percentile = -3%
VBP Contracts Performance Adjustments - Quality

Quality - Upward Adjustments

- 80th – 100th percentile
  - ≥ 90th percentile = 100% Upward Efficiency Multiplier

- 50th – 79th percentile
  - 80th – 89th percentile = 50% Upward Efficiency Multiplier

- 40th – 49th percentile
  - 40th – 49th percentile = 50% Downward Efficiency Multiplier

- < 40th percentile
  - < 40th percentile = No Upward Efficiency Awarded
VBP Contracts Performance Adjustments - Upwards Adjustment

**Efficiency**
- ≥ 90th percentile = 3%
- 80th – 89th percentile = 2%
- 70th – 79th percentile = 1%

**Quality**
- ≥ 90th percentile = 100% Upward Efficiency Multiplier
- 80th – 89th percentile = 50% Upward Efficiency Multiplier
- 50th – 79th percentile = No Multiplier
- 40th – 49th percentile = 50% Downward Eff. Multiplier
- < 40th percentile = No Upward Efficiency Awarded

**Output**
- 6% Upward Adjustment
- 4.5% Upward Adjustment
- 3% Upward Adjustment
- 1.5% Upward Adjustment
- No Upward Adjustment
VBP Contracts Performance Adjustments - Upwards Adjustment

### Efficiency
- ≥ 90th percentile = 3%
- 80th – 89th percentile = 2%
- 70th – 79th percentile = 1%

### Quality
- ≥ 90th percentile = 100% Upward Efficiency Multiplier
- 80th – 89th percentile = 50% Upward Efficiency Multiplier
- 50th – 79th percentile = No Multiplier
- 40th – 49th percentile = 50% Downward Eff. Multiplier
- < 40th percentile = No Upward Efficiency Awarded

### Output
- 4% Upward Adjustment
- 3% Upward Adjustment
- 2% Upward Adjustment
- 1% Upward Adjustment
- No Upward Adjustment
VBP Contracts Performance Adjustments - Upwards Adjustment

**Efficiency**

- ≥ 90th percentile = 3%
- 80th – 89th percentile = 2%
- 70th – 79th percentile = 1%

**Quality**

- ≥ 90th percentile = 100% Upward Efficiency Multiplier
- 80th – 89th percentile = 50% Upward Efficiency Multiplier
- 50th – 79th percentile = No Multiplier
- 40th – 49th percentile = 50% Downward Eff. Multiplier
- < 40th percentile = No Upward Efficiency Awarded

**Output**

- 2% Upward Adjustment
- 1.5% Upward Adjustment
- 1% Upward Adjustment
- .5% Upward Adjustment
- No Upward Adjustment
VBP Contracts Performance Adjustments - Efficiency

Efficiency

- 70th – 100th percentile
  - ≥ 90th percentile = 3%
  - 80th – 89th percentile = 2%
  - 70th – 79th percentile = 1%

- 30th – 69th percentile
  - 20th – 29th percentile = -1%
  - 10th – 19th percentile = -2%

- < 30th percentile
  - <10th percentile = -3%
VBP Contracts Performance Adjustments - Quality

**Quality - Downward Adjustments**

- **≥ 80th percentile**: 50% Upward Efficiency Multiplier
- **30th – 79th percentile**: 50% Downward Efficiency Multiplier
- **< 30th percentile**: 100% Downward Efficiency Multiplier
VBP Contracts Performance Adjustments - Upwards Adjustment

**Efficiency**
- 20th – 29th percentile = -1%
- 10th – 19th percentile = -2%
- <10th percentile = -3%

**Quality**
- ≥ 80th percentile = 50% Upward Efficiency Multiplier
- 30th – 79th percentile = No multiplier
- 15th – 29th percentile = 50% Downward Efficiency Multiplier
- < 15th percentile = 100% Downward Efficiency Multiplier

**Output**
- -0.5% Downward Adjustment
- -1% Downward Adjustment
- -1.5% Downward Adjustment
- -2% Downward Adjustment
**VBP Contracts Performance Adjustments - Upwards Adjustment**

**Efficiency**
- 20th – 29th percentile = -1%
- 10th – 19th percentile = -2%
- <10th percentile = -3%

**Quality**
- ≥ 80th percentile = 50% Upward Efficiency Multiplier
- 30th – 79th percentile = No multiplier
- 15th – 29th percentile = 50% Downward Efficiency Multiplier
- < 15th percentile = 100% Downward Efficiency Multiplier

**Output**
- -1% Downward Adjustment
- -2% Downward Adjustment
- -3% Downward Adjustment
- -4% Downward Adjustment
VBP Contracts Performance Adjustments - Upwards Adjustment

**Efficiency**

- 20th – 29th percentile = -1%
- 10th – 19th percentile = -2%
- <10th percentile = -3%

**Quality**

- ≥ 80th percentile = 50% Upward Efficiency Multiplier
- 30th – 79th percentile = No multiplier
- 15th – 29th percentile = 50% Downward Efficiency Multiplier
- < 15th percentile = 100% Downward Efficiency Multiplier

**Output**

- -1.5% Downward Adjustment
- -3% Downward Adjustment
- -4.5% Downward Adjustment
- -6% Downward Adjustment
First Target Budget Adjustment: Efficiency Ranking

**Purpose:** An efficiency ranking is applied to the baseline to reward providers that exhibit lower historic costs to keep them in VBP arrangements while bringing higher cost providers closer to the State average.

**Example:**

For this example, the VBP Contractor is in the **90th Percentile for Efficiency.** Thus there is a 3% efficiency adjustment.
First Target Budget Adjustment: Quality Ranking

**Purpose:** The quality ranking rewards historically high-quality providers but also discourages providers from reducing costs to the point where there is a deterioration of care.

**Example:**

For this example, assume the VBP Contractor is in the **70th Percentile for Quality.** Thus there is no quality multiplier.
First Target Budget Adjustment: Example Efficiency and Quality Calculation

**Efficiency**
- > 90th percentile = 3%

**Quality**
- 40th – 80th percentile = No Multiplier
- > 90th percentile = 3%

**Output**
- 3% Upward Adjustment

---

Example:

\[
\text{Performance Adjustment} = 3\% \times 3,121.26 = 93.64
\]

\[
\text{Target Budget (excluding Stimulus)} = 3,121.26 + 93.64 = 3214.90
\]
Target Budget Components

3 Years Weighted Baseline
- Historic claims data
- Growth Trend
- Risk Adjustment

Target Baseline Performance Adjustments
- Efficiency Adjustment
- Quality Adjustment

Stimulus Adjustment (Through 2020)

Target Budget

Note: The Target Budget Setting process outlined here is only a guideline. Plans and VBP Contractors are free to negotiate their own Target Budget Setting Methodology, provided it meets the State’s requirements.
Second Target Budget Adjustment: Stimulus Adjustment

Purpose: To incentive providers to undertake more risk and engage in high levels of risk, the stimulus adjustment rewards providers in Level 2 or Level 3 arrangements by creating greater potential for generating shared savings.

<table>
<thead>
<tr>
<th>VBP Arrangement</th>
<th>Stimulus Adjustment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Care for General Population</td>
<td>0.5%</td>
</tr>
<tr>
<td>Integrated Primary Care – Chronic Bundle</td>
<td>1.0%</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>1.0%</td>
</tr>
<tr>
<td>Total Care for HARP Subpopulation</td>
<td>0.5%</td>
</tr>
<tr>
<td>Total Care for HIV/AIDS Subpopulation</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

- Stimulus adjustments are computed using arrangement specific contracts.
- The stimulus adjustment will be paid as an adjustment to the target budget in level 2+ contracts (conditional on the VBP Contractor being > 50th percentile in efficiency and quality) to incentivize movement into higher levels.
- The duration of adjustment is two years.
Second Target Budget Adjustment: Example Stimulus Adjustment

<table>
<thead>
<tr>
<th>VBP Arrangement</th>
<th>Stimulus Adjustment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Care for General Population</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

**Formula:**

\[
\text{Stimulus Adjustment Amount} = \text{Stimulus Adjustment Percent} \times \text{3 Year Weighted Baseline}
\]

**Example:**

\[
\text{Stimulus Adjustment Amount} = (0.005 \times 3,121.26) = 15.61 \\
\text{Target Budget} = 3,121.26 + 93.64 + 15.61 = 3230.51
\]
Target Budget Components

3 Years Weighted Baseline
- Historic claims data
- Growth Trend
- Risk Adjustment

Target Baseline Performance Adjustments
- Efficiency Adjustment

Stimulus Adjustment (Through 2020)

= Target Budget

Note: The Target Budget Setting process outlined here is only a guideline. Plans and VBP Contractors are free to negotiate their own Target Budget Setting Methodology, provided it meets the State’s
Questions
## Setting Shared Savings/Losses Percentages

Below is a guideline for the distribution of the shared savings. This should be subject to contract negotiations.

<table>
<thead>
<tr>
<th>VBP Arrangement</th>
<th>Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td>• Starting point for shared savings percentage negotiations should be <strong>50%</strong> of savings to be retained by providers, other 50% - by MCO</td>
</tr>
</tbody>
</table>
| **Level 2**     | • Starting point for shared savings percentage negotiations should be **90%** of savings to be retained by providers, 10% by MCO  
• Shared savings and losses percentages may be modified dependent on the type of risk protection mechanisms (such as stop loss or risk corridors) that are implemented to limit total provider risk. |
Distribution of Shared Savings/Losses Amongst Providers

Guiding Principles:

• Funds are to be distributed according to provider effort and provider performance in realizing the overall efficiencies, outcomes, and savings.

• Required investments and losses are taken into consideration.

• The relative budget of the comparative providers should not be the default distribution mechanism.

• The distribution of shared savings should follow the same principles as the distribution of shared losses.

• For shared losses, smaller providers, financially vulnerable providers or providers with a regulatory limitation on accepting certain losses (e.g. FQHCs) may be treated differently to protect these individual providers from financial harm. It is legitimate that this ‘special treatment’ would weigh in as an additional factor in determining the amount of shared savings that these providers would receive.
**Performance Adjustment & Shared Savings**

In the first year (2017), only uptick adjustments will be available for VBP contractors entering into VBP contracts. The specific percentages and operational details mentioned below are directional. The State has the flexibility to adjust these in accordance with the integrity of the Medicaid Global Cap.

**Example:**

$\text{Shared Savings with out adjustments} = 3,121.26 - 3,100 = 21.26$

$\text{Shared Savings with adjustments} = 3,230.51 - 3,100 = 130.51$
Questions
Financial Risk Management
Financial Risk Management Overview

The following items will be reviewed in this section:

1. Understanding the financial risk curve
   - At the population level
   - At the episode/bundle level

2. Contracting considerations
   - Risk corridors – the “Donut Hole”
   - Pricing of stop loss
The Different Zones of Health Care Spending

Number of Plan Members

- Routine Sick and Preventive Care
- Chronic Illness, Acute Conditions, Procedures
- Uncommon Conditions & Procedures

Also known as ‘tail end’

Average Costs Per Member Per Year

Total Cumulative Costs

Costs:
- $: Routine Sick and Preventive Care
- $$: Chronic Illness, Acute Conditions, Procedures
- $$$$: Uncommon Conditions & Procedures
- $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ 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How it Plays Out in DSRIP and VBP Pilots

The table below contains a random sample of 50K plan members, 2014 Medicaid Claims (numbers rounded up):

<table>
<thead>
<tr>
<th>PMPY</th>
<th>TCGP</th>
<th>IPC-CB</th>
<th>Maternity</th>
<th>HIV/AIDS</th>
<th>HARP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>IPC</td>
<td>CB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volume</td>
<td>45,000</td>
<td>35,000</td>
<td>15,000</td>
<td>2,000</td>
<td>500</td>
</tr>
<tr>
<td>Average</td>
<td>$5,000</td>
<td>$700</td>
<td>$2,700</td>
<td>$10,500</td>
<td>$32,250</td>
</tr>
<tr>
<td>10th %ile</td>
<td>$200</td>
<td>$0</td>
<td>$0</td>
<td>$6,400</td>
<td>$6,300</td>
</tr>
<tr>
<td>25th %ile</td>
<td>$450</td>
<td>$60</td>
<td>$121</td>
<td>$7,500</td>
<td>$13,700</td>
</tr>
<tr>
<td>75th %ile</td>
<td>$3,750</td>
<td>$800</td>
<td>$2,500</td>
<td>$11,200</td>
<td>$41,000</td>
</tr>
<tr>
<td>90th %ile</td>
<td>$10,150</td>
<td>$1,500</td>
<td>$7,000</td>
<td>$15,300</td>
<td>$55,200</td>
</tr>
<tr>
<td>Coefficient of Variation</td>
<td>4.6</td>
<td>2.4</td>
<td>2.6</td>
<td>0.7</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Each cohort has its own distribution of costs and the coefficient of variation provides an indication of the length of the “tail” of the distribution. The longer the tail, the more variation and high cost cases. Small swings in high cost cases can impact the rest of the cohort.
The Effect of Small Samples on Financial Results

Sample Size: Number of Patients With Asthma

Cumulative Variance of Expected-to-Actual Costs of Asthma as a Percent of Actual

- Small population sample
- Large population sample
Population Size Considerations

• The size of your population matters – larger samples help better understand cost trends and population behaviors
• That said, more people doesn’t mean less individual case variation
• It is not recommended to contract VBP arrangements for small population groups
• Severity adjustment does work when applied properly (on larger population samples)
Cost Distribution of Episodes

Financial risk is asymmetrical:

- you can’t produce care for an episode for $0 (meaning there are limited savings)
- but you can potentially lose a lot on a single case.

The majority of high costs in an episode is driven by Potentially Avoidable Complications (PACs).
There are Significant Opportunities to Increase Value

- Reduce PACs to be a High Performer
- Reduce PACs & Episode Costs to be a High Performer
Questions
Understanding Asymmetrical Risk – Case Study

• We randomized 200 patients in 1000 physicians, created severity adjusted budgets and compared the budget to actual, and netted out the variance across all 200 patients to end up with a net saving or loss.

• We then simulated the effect on providers based on four different types of risk contracts – upside only, 100% upside/60% downside, 50/50 up/down, 100/100 up/down.

• We then simulated the effect when (a) patients are randomly distributed, (b) the provider has a moderately higher rate of severe patients, (c) a much higher rate of severe patients, and (d) a very high rate of severe patients.
Potential for Savings/Losses by Provider for Diabetes

This graph depicts a scenario with highly unlikely negative population health characteristics.

Almost impossible case scenario
Potential for Savings/Losses by Provider for Diabetes (cont.)

Gains/Losses Under Stop Loss (99th Pctile) - Expected Costs

<table>
<thead>
<tr>
<th>Risk Profile</th>
<th>Total Savings (&gt;0) or Losses (&lt;0) ($1,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% w Stop Loss</td>
<td></td>
</tr>
<tr>
<td>80% High Risk</td>
<td></td>
</tr>
<tr>
<td>50% Overweight</td>
<td></td>
</tr>
<tr>
<td>20% Overweight</td>
<td></td>
</tr>
<tr>
<td>Raw Overweight</td>
<td></td>
</tr>
</tbody>
</table>

June 2016
Implications for Equal Saving/Loss Sharing

• Even when adjusting for patient severity, a random assignment of patients yields a slightly greater potential for losses than savings because of the asymmetrical nature of savings/losses.

• A slight overweighting of greater than average severe patients can cause a greater imbalance in the potential for savings/losses by provider.

• A large overweighting of very severe patients will almost always result in provider losses. The opposite is also true.

• It’s possible to level the playing field up front, and then provider performance does the rest.
Cost Distribution of Episodes when Instituting a Stop-Loss

Opportunity for Provider Savings

Risk of Provider Loss

Payer Cost of Stop Loss

Stop Loss Limit

Average bundle price
The “Donut Hole”

Stop Loss

150%

100%

Payer Risk

Provider Risk – “Donut Hole”

Payer Risk

Episode Costs

Percent of Bundle Price
Managing Financial Risk in a Fixed Price Contract

• The provider is at risk for the excess costs over the prospective budget, up to the stop loss per episode
  • The budget is severity adjusted
  • The extent to which a provider is already highly efficient, a margin can be negotiated
  • The “Donut Hole” contains manageable risk
• There can be an aggregate stop loss in addition to a per episode stop-loss
• In the Level 1 “upside only risk” model, the stop loss = budget
  • But there is a cost to stop-loss for the payer
Considerations on Stop Loss

1. Payers and providers have to think thoroughly about the stop loss amount. Providers should be ready to pay stop loss premiums or reconsider their % of shared savings in order to stay protected.

2. It is important to remember that the lower the stop loss threshold, the higher the stop loss “premium” and vice versa.

3. Payers and providers can negotiate a “premium” for the stop loss, which would be equivalent to the payer’s estimated costs for instituting the stop loss, spread across all of a provider’s bundles and result in a budget reduction.
Considerations on Stop Loss (cont.)

4. The payer cost of stop-loss can be estimated by calculating the total costs in the tail of the episode cost distribution above the individual episode stop-loss.

5. The potential for provider loss (the “Donut Hole”) can be estimated by calculating the area of the episode cost distribution above the average bundle price and the stop loss limit.

6. The potential for provider savings can be estimated by calculating the area of the distribution above the actual and up to the average bundle price.
Effects of Stop Loss on Budget and Savings/Losses

Reducing the stop-loss has two effects:
1. Budgets are reduced because past high cost cases are trimmed
2. Budgets are further reduced by the “excess stop-loss” insurance

There is a point of diminishing returns in reducing stop-loss limits.
• The potential for savings decreases as the budget is lowered towards the minimum production costs of the arrangement, and
• The potential for losses increases to the point where all cases could generate a loss
Margins Could be Considered for Highly Efficient Providers

A margin is a percentage negotiated by the payer and provider, which is added to the expected or budgeted typical costs (not to costs of potentially avoidable complications).

You can’t produce a bundle for $0, and there is an absolute floor that could be calculated. Providers close to the floor need a margin to reinvest in continuous performance improvement.
General Risk Considerations

• Because of the asymmetrical distribution of savings and losses, you can’t produce good care management of a patient with a chronic disease for $0, but you can potentially end up with patients that have very high costs of PACs – consider asymmetrical risk-sharing contracts.

• Using a stop-loss mitigates the asymmetry by limiting the losses.

• The specific savings sharing formula can be informed by the shape of the episode cost distribution and the level of stop-loss.

• Once the up front odds have been leveled, the end result is a function of provider performance, not chance.
# Summary of Financial Risk Management Strategies

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>Upside/downside risk sharing arrangements don’t have to be symmetrical</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>Stop losses are for individual cases and can be in aggregate. There is a cost to a stop loss because the payer assumes the risk. “Excess” stop-loss insurance should come in reduction of the target budget/price</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>Defined margins are important to insulate providers from incurring losses because their potential for achieving further efficiencies is low</td>
</tr>
<tr>
<td><strong>4</strong></td>
<td>Quality scorecards can be used to encourage continued quality improvement even when providers have a bad financial year, and can be used to limit upside risk when quality doesn’t improve or fails to meet a certain threshold performance</td>
</tr>
</tbody>
</table>
Questions
Break – 15 mins
VBP Contracting Panel
Contracting Panel – Real Life Experience

Contracting and risk management through the eyes of VBP contractors.

Please listen to hear challenges, best practices and lessons learned from the VBP panelists on strategizing and implementing VBP arrangements.
<table>
<thead>
<tr>
<th>Panelist</th>
<th>Role</th>
<th>Organization</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patrick R Murphy, CPA</td>
<td>Chief Financial Officer</td>
<td>Cornerstone Family Healthcare</td>
<td>Non-profit, full-service, multi-specialty community healthcare provider</td>
</tr>
<tr>
<td>Dr. Amy Kohn</td>
<td>Chief Executive Officer</td>
<td>The Mental Health Association of Westchester County</td>
<td>CBO Mental Health Advocacy, Education and Direct Services</td>
</tr>
<tr>
<td>Pamela Mattel, LCSWR</td>
<td>Chief Operating Officer</td>
<td>Acacia Network</td>
<td>CBO Latino based not for profit; Integrated primary and behavioral health care, housing corporation</td>
</tr>
<tr>
<td>Heather Radliff</td>
<td>DSRIP Network Director</td>
<td>UnitedHealthcare Insurance Plans (UHC)</td>
<td>Health Insurance Company</td>
</tr>
</tbody>
</table>
Panel Questions

1. What has your organization done to get ready for VBP?

2. Can you please share a success story, challenge faced/overcome, and/or lessons learned from your organization’s current experience with VBP/ VBP-like contracts?

3. What is the best advice that you would give to entities that are beginning the VBP contracting process?

4. In your opinion, what made your organization most successful – any specific “Dos and Don’ts” that you would like share?
Questions
Do we have the Nametag “Families” winners?

If you found ten of the twenty possible members of your family, please come forward! Nametag families are:

<table>
<thead>
<tr>
<th>NFL Football Team Names</th>
<th>State Capital Cities</th>
<th>Mammals</th>
<th>Actors</th>
<th>Car Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sea Creatures</td>
<td>Girls’ First Names</td>
<td>Flower Varieties</td>
<td>Boys’ First Names</td>
<td>Countries</td>
</tr>
</tbody>
</table>
Recap & Closing: What Have We Learned?

Today, we have shared information on the following:

<table>
<thead>
<tr>
<th>VBP Contracting Overview</th>
<th>Guidance on Target Budget Setting</th>
<th>Financial Risk Management</th>
<th>VBP Contracting Panel</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Types of contracting entities</td>
<td></td>
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<tr>
<td>• Types of VBP arrangements</td>
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<tr>
<td>• Contract Key Components</td>
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<tr>
<td>• Contracting with CBOs</td>
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<tr>
<td>• New Contract review process</td>
<td>• Setting the Budget</td>
<td>• Understanding the financial risk curve</td>
<td></td>
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<tr>
<td></td>
<td>• Performance Adjustments</td>
<td>• Manageable Provider Risk</td>
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<td></td>
<td></td>
<td>• Stop Loss</td>
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<td>• Shared Lessons Learned</td>
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<tr>
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<td>• Key Considerations for Success</td>
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</tbody>
</table>
Next Session

Registration for Session 3 will open tomorrow June 16th and will close on June 30th.
Links to Registration – click here:

<table>
<thead>
<tr>
<th>Session</th>
<th>Topics covered</th>
<th>Date &amp; Time</th>
<th>Locations</th>
</tr>
</thead>
</table>
| Session 3 | Performance Measurement  
| | • Impact of Performance on Target Budget  
| | • Information Management Guidance | Thursday, July 7, 2016  
| | | 10:00AM – 3:00PM | University at Albany:  
| | | | Performing Arts Center, Recital Hall |
VBP Bootcamps Contact Info

Website:
www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_bootcamp

Twitter Account:
@NYSMedicaidVBP
Thank you