

Are you ready for New York State Medicaid value-based payment models?

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Background

The New York State Medicaid and Children's Health Insurance Plan (CHIP) programs insure about 4.7 million beneficiaries, providing healthcare coverage for about one quarter of New York State residents.¹ New York has had a long-standing commitment to the Centers for Medicare and Medicaid Services (CMS) to move its Medicaid-eligible populations into some form of care management and currently has over 80% of its Medicaid beneficiaries in managed care.² Lower payment rates tend to make Medicaid spending growth appear to be lower than what's seen in private health insurance, but on a national basis Medicaid accounts for one in every six dollars spent overall within the healthcare system.³ Medicaid payments in New York approached \$80 billion in fiscal year (FY) 2017.⁴

To ensure the long-term sustainability of its Medicaid program, New York State has launched an ambitious payment reform plan promoting use of value-based payment (VBP) models. According to the New York State Roadmap for Medicaid Payment Reform⁵ (Roadmap), New York has ambitious yearly VBP goals, with an ultimate target of 80% of Medicaid payments in VBP models (with at least 35% tied to downside risk) by the end of FY2020.

In this brief, we provide a high-level overview of the New York State VBP models, discuss the opportunities and challenges for providers considering participation in them, and highlight the needs for sophisticated actuarial, financial, and legal expertise to address the inherent business, legal, and operational risks.

¹ Kaiser Family Foundation (June 2017). Fact Sheet: Medicaid in New York. Retrieved September 12, 2018, from <http://files.kff.org/attachment/fact-sheet-medicaid-state-NY>.

² Kaiser Family Foundation. Share of Medicaid Population Covered Under Different Delivery Systems. Retrieved October 15, 2018 from <https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/>.

³ Kaiser Family Foundation (June 2017) Fact Sheet, op. cit., p. 2.

⁴ Kaiser Family Foundation. Total Medicaid Spending. Retrieved October 15, 2018 from <https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/>.

⁵ NYS Department of Health (November 2017). A Path Toward Value-Based Payment: Annual Update. New York State Roadmap for Medicaid Payment Reform. Retrieved September 12, 2018, from https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/docs/2017-11_final_vbp_roadmap.pdf.

Flexibility and options serve as foundation for New York State VBP reform

The Roadmap outlines several different options for implementing VBP reform, recognizing there may not be a single path forward to achieve sustainable change. We highlight key components of the VBP models below.

MODEL OPTIONS

The Roadmap provides a few different model options for managed care organizations (MCOs) and providers transitioning to VBP arrangements. Participating providers, or VBP contractors, choose from population-based models (e.g., total cost of care for the general Medicaid population or subpopulations like HIV or managed long-term care (MLTC) with upside/downside shared savings models against population-derived cost benchmarks) and bundle/episode models of care (integrated primary care, chronic care or maternity care).

CONTRACTING OPTIONS

New York offers a few different options around VBP contracting, defined as healthcare provider entities entering into arrangements with MCOs on terms of one of the VBP models. VBP contractors can be any of the following:

- **Independent practice association (IPA):** An association of independent physicians and other provider types, including other licensed professionals or licensed entities.
- **Accountable care organization (ACO):** A state-authorized and clinically integrated healthcare organization that ties provider payments to quality metrics and the cost of care.
- **Licensed entity:** A healthcare organization in a specific location with a specific owner, providing healthcare services in a setting that is not otherwise licensed by the state.

RISK LEVELS

The Roadmap provides four levels of risk, with increasing degrees of financial accountability from Level 0 (fee-for-service [FFS] only) to Level 3 (prospective capitation payment); all levels include a quality component. Level 1 is upside only and Level 2 is

a two-sided model with upside and downside risk. Level 0 is not considered sufficient for meeting New York's VBP targets.

QUALITY MEASURES

New York has established Clinical Advisory Groups (CAGs) to engage the professional clinical community in developing quality performance measurement systems designed to align health outcome goals with payment reform strategies. Several different CAGs were organized for various subpopulations with unique health needs, including HIV/AIDS, MLTC, and intellectually and developmentally disabled (I/DD), among others. Guidance is included in the Roadmap on integrating quality performance outcomes with financial accountability. Sliding scales may be used, for example, increasing percentages by levels of risk, to help determine the sharing of savings or losses with VBP contractors.

STATE TIMELINE AND MCO PENALTIES

The Roadmap has outlined an aggressive and expedited set of deadlines for achieving payment reform by increasing targets of VBP model contracting by the end of each fiscal year. By the end of FY2018, MCOs must have at least 10% of MCO expenditures in Level 1 VBPs or above. By the end of FY2020, the targets for Level 1 VBPs or above will increase to 80%, with at least 35% in Level 2 VBPs or above.⁶

MCOs that fall behind the VBP goals stated above may be subject to penalties applied to their managed care premium payments from the state. The penalty percentage will increase each year with a maximum penalty of up to 1.5% by 2020.⁷

STIMULUS ADJUSTMENT

To incentivize MCOs and providers to progress to Level 2 or Level 3 VBP models, VBP contractors can receive an upward adjustment to their target budget calculations: a 1% adjustment for episode-based models or 0.5% for total cost of care models.⁸ Stimulus adjustments are slated to cease in 2020.

SOCIAL DETERMINANTS OF HEALTH

New York has established a goal of addressing critical social factors that can contribute to overall health outcomes. Formal social determinants of health (SDHs) have been laid out, including (1) economic stability, (2) education, (3) health and healthcare, (4) neighborhood and environment, and (5) social, family, and community contexts. To stimulate innovation in these areas, VBP contractors in Level 2 or Level 3 VBP models will be required to address at least one SDH intervention.

Committed, innovative, and dynamic organizations most likely to succeed

New York has provided a template and guidance that enables organizations with varying structures and capabilities to work toward achieving the stated VBP goals. Below we highlight critical organizational attributes necessary to achieve sustainable VBP results and greater levels of VBP financial accountability over time. Seeking the needed expertise and gaining insight into how your organization measures against these attributes will be an important first step. These attributes include:

- **Governance:** Being flexible and innovative with access to integrated health services (and thus the ability to influence practice patterns), or an already vertically integrated health system entity.
- **Vision:** Gaining buy-in to VBP goals is vital to success and requires a leadership commitment from across the stakeholder spectrum within a VBP contractor organization. If not all stakeholders are “on board,” navigating organizational resistance could be time-consuming and costly. Ultimately, material financial consequences may occur if these issues cannot be resolved quickly and efficiently.
- **Data access and systems:** Supporting VBP arrangements with quantitative analytics and real-world business intelligence is critical to the success of VBP models. Examples include tracking emerging financial performance and delivering timely, relevant information to providers to optimize health outcomes. Providers should understand their historical and current costs of treatment and where inefficiencies may exist. Some VBP contractors may have these resources developed and readily available. Others may be willing to develop them from scratch or may need to engage third-party specialists to support their analytic and data warehousing needs.
- **Financial planning:** Having the ability to shift focus from revenue cycle cash view to population health budget view, while still balancing the economics of both, is critical.
- **Access to capital:** Having the ability to fund financial reserve requirements, or cross-guarantee financial risk obligations, to meet requirements regarding “risk bearing” for insurance contracts. For example, if a financial security deposit is required by the New York State Department of Health, the provider must establish and provide evidence of a financial security deposit (to be held by the MCO) in the amount of 7.25% of the estimated annual medical costs covered under the risk arrangement.⁹ These financial reserve requirements are often significant.

⁶ Roadmap, op. cit., p. 62.

⁷ Roadmap, op. cit., p. 48

⁸ Roadmap, op. cit., p. 28

⁹ New York State Department of Health (April 1, 2017). Provider Contract Guidelines for Article 44 MCOs, IPAs, and ACOs. Retrieved October 17, 2018, from https://www.health.ny.gov/health_care/managed_care/hmoipa/docs/guidelines.pdf

- **Model of care:** Identifying and deploying effectively shifting models of care to impact cost and quality is a virtual requirement.
- **Payments and distributions:** Designing thoughtful internal payment and distribution models (if applicable) to take advantage of opportunities to share in savings or to cover losses within the organization. Balancing incentives for hospitals, primary care providers (PCPs), specialists, and community-based providers to drive desired behaviors, while also equitably distributing shares of the risk, is an important feature of any sustainable VBP model.
- **VBP contract:** As referenced above, the design of the VBP model and the contractual provisions governing it go hand in hand. VBP compensation addenda to provider agreements tend to be detailed, complex, and arcane. Specifically, a VBP compensation addendum typically addresses the following key features that will affect a provider’s ability to succeed under the program: (1) the term of the VBP program and whether it aligns with the overall provider agreement; (2) the benchmark for measuring “success” under the VBP program (e.g., the “baseline”) and whether that benchmark adjusts year-to-year or cycle-to-cycle; (3) attribution mechanisms (see below); (4) quality reporting and measures (see below); (5) dispute resolution and audit rights of both payer and provider; (6) distribution between plan and provider if VBP bonuses are earned (or losses owed); and (7) “other” provisions, such as stop-loss mechanisms or material adverse change provisions.

Understanding the challenges and risks

Even the most capable, dynamic, and forward-thinking organizations will face challenges in this new Medicaid VBP world. While New York has provided guidance in its Roadmap, it has purposefully allowed flexibility to both providers and MCOs to optimize innovation and maximize the potential for achieving VBP goals. In this context, we discuss some key challenges and risks we expect VBP contractors will face.

- **Willing payer:** Just as providers will be working to navigate their VBP contracting strategies, so will MCOs. A key to VBP model success is a willing MCO with aligned goals in the VBP arrangement. VBP contractors should set clearly defined goals early in the contractual relationship and seek MCO partnerships that are a good fit. Without such alignment, providers may find it challenging to manage the VBP arrangement with the MCO, particularly when financial risk is at stake.
- **Design of VBP program:** This may seem obvious but, while New York has provided guidance, the devil is in the details when it comes to the actual nature and design of the VBP models. As discussed under the next bullet point, there are many possible variations of the VBP models. The work of clearly laying out the VBP model elements in the contract—shared savings/losses, funds flow, and target population(s)—can be surprisingly tedious and time-consuming. Having a preferred approach on these components sorted out before negotiating with MCOs, as well as knowing the touch points in negotiations, can help expedite this part of the development and design process.
- **Attribution:** New York recommends attribution based on the chosen primary care provider (PCP) (or core provider for episodes of care/bundles). However, this may result in a portion of attributed members falling into an “unknown” category when comparing PCP patient rosters (members the PCP already “knows”) to members assigned to these PCPs in the MCO system. Moreover, other types of VBP contracts, such as in behavioral health, may not lend themselves well to traditional attribution mechanisms that are based on the plurality of primary care services (e.g., the Medicare Shared Savings Program). VBP contractors must understand this dynamic and the degree to which they may be taking financial risk for members they do not “know” and may not be able to influence from a healthcare perspective.
- **Quality measures:** The VBP contractor will be accountable to performance on a comprehensive set of quality measures. The VBP contractor should understand their ability to influence outcomes for these quality measures included in the financial calculations. Data capture and timely measurement should also be considered.
- **Unknowns:** As with most reform efforts, there are always some unknowns and unanswered questions when it comes to guidance from the state with regard to actual implementation. We expect New York State to provide further guidance, for example, on the development of regional trends to use in the baseline, target budget calculations, and risk adjustment for subpopulations.

Taking the next step

Seeking actuarial, financial, and legal assistance is important as organizations navigate this complex and changing landscape. Whether VBP models are completely new to your organization or you have some experience, they pose unique challenges in Medicaid. The prospect of approaching Medicaid VBP arrangements can feel daunting and overwhelming. We offer the following options as a way to move forward in your VBP contractor life cycle:

1. Financial feasibility:
 - Understand your value proposition to payers
 - Complete a financial feasibility analysis for any VBP models under consideration
 - Consider risk capital requirements in the near term or long term
 - Include an opportunities analysis (e.g., can the organization capture additional revenue from redirecting leakage?)
 - Understand the impact to revenue and costs from expected managed models of care
2. Gap analysis:
 - Are you ready to be in a VBP contract?
 - Is your governance structure “right” for alternative payment models in terms of soliciting broad input while also being nimble to change?
 - Are you structured in a legally compliant manner regarding antitrust and healthcare fraud and abuse laws?
 - What are your organization’s strengths and weaknesses?
 - When considering data analytics and reporting capabilities, should you buy or build?

Conclusion

ACOs, IPAs, and MCOs managing Medicaid populations in New York State should be working to understand the complex and dynamic VBP model designs and seek guidance when needed from qualified experts to assist with their organizational readiness.



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