NEW YORK STATE | Department of Health | Medicaid Redesign Team

HIV Quality Advisory Committee Meeting

VBP Arrangements and Quality Measurement

March 15, 2018

Agenda

VBP Arrangement Exploration & What it Means for a Provider
- Core Components
- Quality Measurement
- Target Budget Adjustments and Distribution of Shared Savings

VBP Measure Set Development & Implementation
- Intro to VBP Quality Measure Set Development and Implementation: Approach and Timeline
- Measure Set Development and Maintenance

AIDS Institute's Quality Advisory Committee and HIV VBP Clinical Advisory Group

Top 10 Provider Considerations

Top 10 Provider Considerations

1. **Each VBP Arrangement has an associated VBP Measure Set** identified by the Clinical Advisory Groups and accepted by the State; these measures include those to be reported to the State and are those intended to be used in the determination of shared savings for which VBP contractors are eligible.

2. **VBP Contractors** should **tailor the arrangement** they contract **based on** the **services** they provide and can impact. E.g. the Total Care for the General Population (TCGP) arrangement may be more suited for larger providers, the Integrated Primary Care (IPC) arrangement for smaller providers.

3. **Quality outcomes are measured on the members/patients who are attributed to an arrangement** (in most cases via a primary care practitioner); for this **reason care coordination amongst providers is key**.

4. **VBP Contractors must decide** if they want to **contract for** arrangements that cover the **total cost of a person** (population-based agreements) **or** total cost of **clinical events** (episodic-based agreements (IPC and Maternity)); this decision may largely be informed by the arrangement type by which providers are most able to impact the generation of shared savings.

5. Quality is given a strong emphasis in VBP; even if a provider is efficient, **no savings will be earned without meeting minimum quality thresholds**.*

* This is a VBP Roadmap guideline that ultimately is subject to negotiation between Plans and Providers. Plans rates will be adjusted based on this guideline, so it anticipated that these incentives will trickle down to Plan-to-Provider contracts.

Top 10 Provider Considerations (continued)

6. **Most** of the Category 1 **quality measures** are measures **already reported by providers and MCOs** for other quality improvement initiatives.

7. The entirety of Measurement Year 2017 VBP Measure Sets contain **5** Category 1 P4P **measures** that are **currently not in QARR**.** This potentially means less of an administrative burden for providers.

8. **Quality performance adjusts the target budget** set by the MCO and VBP Contractor at the **beginning of the contracting period**: High/low quality = higher/lower target budget*

9. **Quality performance is a factor in determining percentages of savings / losses** shared with the VBP contractor at the end of the contracting period.*

10. **Providers should look at the quality measure sets** and make sure their networks are designed to address them.

* This is a VBP Roadmap guideline that ultimately is subject to negotiation between Plans and Providers. Plans rates will be adjusted based on this guideline, so it anticipated that these incentives will trickle down to Plan-to-Provider contracts.

* * New York's Quality Assurance Reporting Requirements (QARR) measures are part of the quality component of QI Program. QARR includes National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS®), and NYS-specific measures.

VBP Arrangement Exploration & What it Means for a Provider

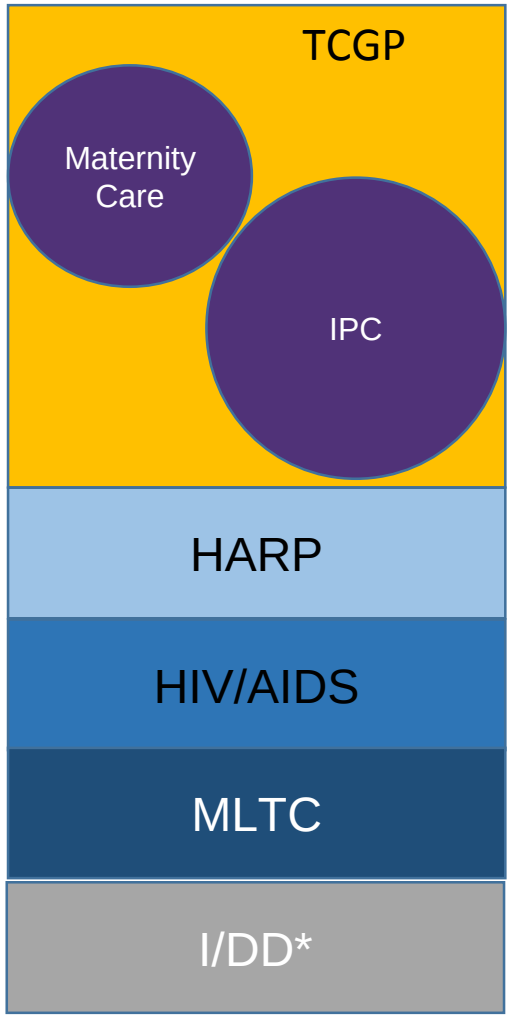
Core Components

VBP Arrangements

There is no single path towards Value Based Payments. Rather, there are a variety of options from which MCOs and providers can jointly choose:

Arrangement Types

- **Total Care for the General Population (TCGP):** All costs and outcomes for care, excluding MLTC, HARP, HIV/AIDS, and I/DD* subpopulations.
- Total Care for Special Needs Subpopulations: Costs and outcomes of total care for all members within a subpopulation exclusive of TCGP.
  - **HARP:** For those with Serious Mental Illness or Substance Use Disorders
  - **HIV/AIDS**
  - **Managed Long Term Care (MLTC)**
  - **I/DD***
- Episodic Care
  - **IPC:** All costs and outcomes associated with primary care, sick care, and a set of chronic conditions selected due to high volume and/or costs.
  - **Maternity Care:** Episodes associated with pregnancies, including delivery and first month of life of newborn and up to 60 days post-discharge for mother.



VBP Contractors can contract TCGP as well as Subpopulations as appropriate; nothing mandates that the Roadmap-defined arrangement types must be handled in standalone contracts.

*Total Care for the I/DD Subpopulation will be available as an arrangement when the population is moved to managed care.
Acronyms: MLTC = Managed Long Term Care; HARP = Health and Recovery Plans; I/DD = Intellectually/Developmentally Disabled

Total Care for Special Needs Subpopulations

Goal: Improve population health through enhancing the quality care for specific subpopulations that often require highly specific and costly care needs.

- Subpopulations include:
  - **HIV/AIDS**
  - Health and Recovery Plans (HARP)
  - Managed Long Term Care (MLTC)*
  - Intellectual and Developmental Disabilities (I/DD)*
- All services covered by the associated managed care plans are included, and all members fulfilling the criteria for eligibility to such plans are included.
- Quality measures include both HIV-specific measures, as well as general health measures.

In this arrangement the VBP Contractor assumes responsibility for the care of the specific population, where co-morbidity or disability may require specific and costly care needs, so that the majority (or all) of the care is determined by the specific characteristic of these members.

Total Population

– TCGP

Subpopulations*

* Arrangements are still being developed as of 4/6/17.

VBP Arrangement Exploration & What it Means for a Provider

Quality measurement & the role of measures

VBP Refresher: VBP Levels

In addition to choosing which integrated services to focus on, the MCOs and contractors can choose different levels of Value Based Payments:

Level 0 VBP	Level 1 VBP Retrospective reconciliation against a target budget	Level 2 VBP Retrospective reconciliation against a target budget	Level 3 VBP Prospective
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available **when outcome scores are sufficient**	FFS with risk sharing (upside available **when outcome scores are sufficien**t)	Prospective capitation PMPM or Bundle (**with outcome-based component**)
FFS Payments	FFS Payments	FFS Payments	Prospective total budget payments
No Risk Sharing	↑ Upside Only	↑ Upside & ↓ Downside Risk	↑ Upside & ↓ Downside Risk

Target Budget Setting Components are Flexible

The VBP Roadmap outlines a recommended, but not required, method to establish a target budget.

The State does not mandate a specific methodology to be used to calculate a target budget for an arrangement. However, contracts should specify that a target budget will be used.

Baseline Setting

Guideline: Historic claims data

3 year look back. Recent years are weighted more.

Trend Determination

Guideline: Growth Trend

1 year look back weighted evenly by two factors:

- *VBP contractor specific growth trend (50%)*
- *regional growth rate (50%)*

Risk Adjustment

Guideline: Risk Adjustment Factor

- *TCGP = 3M CRG methodology*
- *Subpopulations = risk adjustment methodology used for Plan rate setting*
- *Bundles of Care (IPC, Maternity) = Altarum's episode severity adjustment*

Performance Adjustment

Guideline: Performance Adjustments (Efficiency / Quality)

Adjustment to target budget with combined range of -6% to 6% for quality and efficiency.

Level 1 Agreement

50% Shared Savings (Upside Only)
If Quality Metrics Met

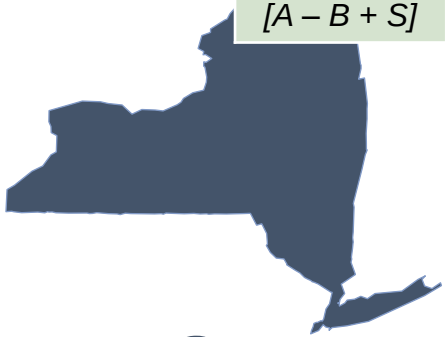
Coordinated care among team members

Payer	Forestland Care
Payer Premium	$ 6,000 ($ 500 PMPM)
Provider	New York Medical Group *(contracts a VBP arrangement)*
2014 Claims	Primary Care: $ 2,000 ER (Opioid overdose): $ 2,600 **Total: $ 4,600**
Provider Cost	$ 4,000
VBP Budget	$ 5,500

MCO Profit & Loss		
[A]	Revenue *(Premium)*	$ 6,000
[B]	Cost *(Claims)*	$ 4,600
[A-B]	*Profit*	$ 950 + $ 450 = $1400
[S]	Shared Savings (50%)	$ 450
[A – B + S]	**Total Profit / (Loss)**	**$ 950**

Provider Profit & Loss		
[B]	Revenue *(Claims)*	$ 4,600
[C]	Provider Cost	$ 4,000
[B-C]	Profit	$ 600
[S]	Shared Savings (50%)	$ 450
[B – C + S]	**Total Profit / (Loss)**	**$ 1,050**

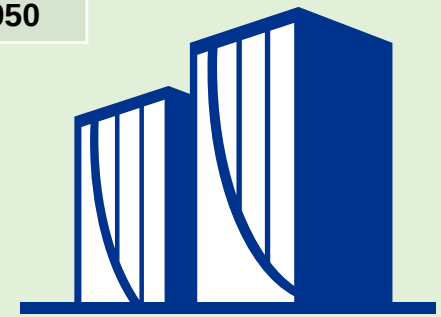
Shared Savings Calculation		
[TB]	Target Budget	$ 5,500
[B]	Claims	$ 4,600
[TB - B]	Shared Savings	$ 900



State

$6,000

Premium



Payer/MCO

$4,600

MC FFS

Provider

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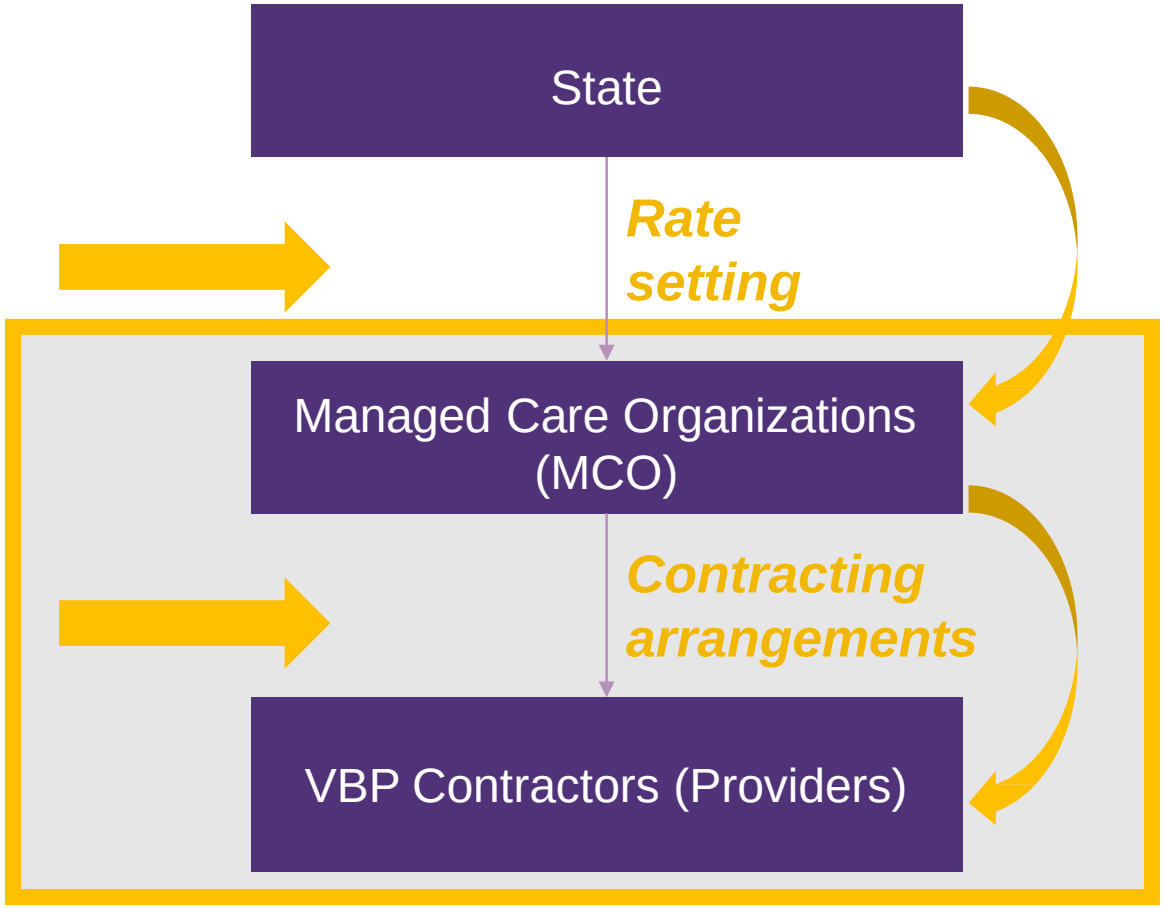
Role of Quality in VBP

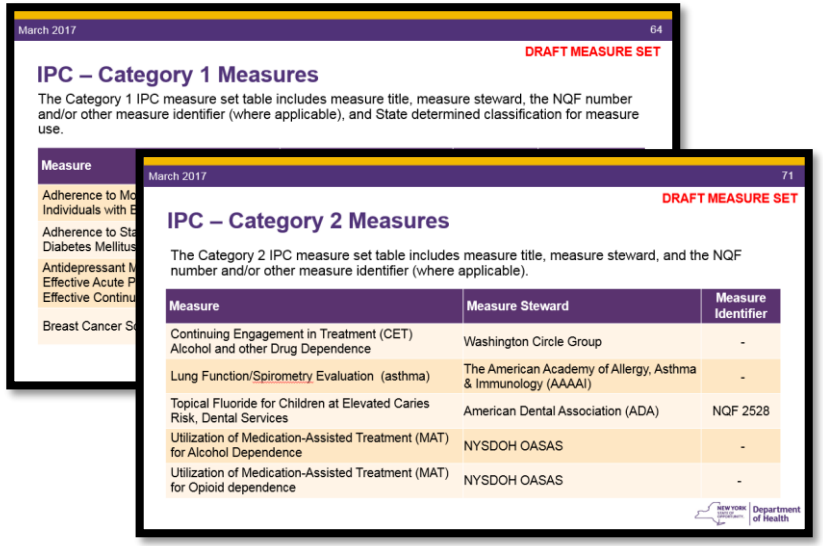
- Quality of **all** contracted care (whether VBP or not) is rewarded through up- and downward adjustments of premiums received by the MCO from the State *following the same guidelines as have been created by the VBP Subcommittees.*
- According to VBP Contracting Guidelines, quality performance impacts the target budget set by the MCO for the VBP Contractor.
    - High/low quality = higher/lower target budget
- Quality Performance also determines percentages of savings / losses shared with VBP contractor.



Quality Plays an Important Role in VBP Arrangements

1. MCOs and VBP Contractors select arrangements.

- Total Care for the General Population (TCGP)
- Total Care for the HARP Subpopulation
- Total Care for the HIV/AIDS Subpopulation
- Total Care for the MLTC Subpopulation
- Total Care for the I/DD Subpopulation
- Integrated Primary Care (IPC)
- Maternity Care



2. Per the NYS VBP Roadmap, MCOs and VBP Contractors must report on quality measures associated with their selected arrangement(s).

3. The quality measure results are intended to be used to determine the amount of shared savings for which VBP contractors are eligible. Adjustments to the target budget are based on quality measure performance.

(June 2016 NYS VBP Roadmap, p. 12)

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Upside and Down Side Risk Sharing Arrangements (Guideline)

- While VBP encourages efficiency, **quality** is paramount!
- No savings will be earned without meeting minimum quality thresholds.

Quality Targets % Met goal	Level 1 VBP Upside Only	Level 2 VBP	
		Upside when actual costs < budgeted costs	Downside when actual costs > budgeted costs
> 50% of Quality Targets Met	50% of savings returned to VBP contractors	Up to 90% of savings returned to VBP contractors	VBP contractors are responsible for up to 50% losses
<50 % of Quality Targets Met	Between 10 – 50% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)	Between 10 – 90% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)	VBP contractors responsible for 50-90 % of losses (sliding scale in proportion with % of Quality Targets met)
Quality does not Improve or Worsens	No savings returned to VBP contractors	No savings returned to VBP contractors	VBP contractors responsible for up to 90% of losses

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYS DOH VBP website (Link) *June 2016 updated version approved by CMS March 2017.*

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Measure Set Development and Maintenance

HIV/AIDS Complete Measure Set

- Measures recommended by the HIV/AIDS CAG were aligned with measures included in the NYS DOH portfolio of programs including the Delivery System Reform Incentive Payment (DSRIP) Program, the Quality Improvement Program (QIP), Quality Assurance Reporting Requirements (QARR), and the State's HIV/AIDS care measures.

- The final HIV/AIDS Category 1 measure set includes a subset of the Total Care General Population (TCGP)/Integrated Primary Care (IPC) Arrangement.

Categorizing and Prioritizing Quality Measures

CATEGORY 1
Approved quality measures that are felt to be both clinically relevant, reliable and valid, and feasible.

CATEGORY 2
Measures that are clinically relevant, valid, and probably reliable, but where the feasibility could be problematic. These measures should be investigated during the 2016/2017 pilot program.

CATEGORY 3
Measures that are insufficiently relevant, valid, reliable and/or feasible.

Category 1 Measures

- Category 1 quality measures as identified by the CAGs and accepted by the State are to be reported by VBP Contractors.

The State classified each Category 1 measure as P4P or P4R:

Pay for Performance (P4P)

- Measures designated as P4P are intended to be used in the determination of shared savings amounts for which VBP Contractors are eligible.
- Performance on the measures can be included in both the determination of the target budget and in the calculation of shared savings for VBP Contractors.

Pay for Reporting (P4R)

- Measures designated as P4R are intended to be used by MCOs to incentivize VBP Contractors for reporting data to monitor quality of care delivered to members under the VBP contract.
- MCOs and VBP Contractors will be incentivized based on timeliness, accuracy & completeness of data reporting.

- Measures can move from P4R to P4P or vice versa through the annual CAG and State review process or as determined by the MCO and VBP Contractor.

HIV/AIDS – Specific Measures
2018 Value Based Payment Quality Measure Set
Category 1

Measure Name	Description	Steward	VBP Category
HIV Viral Load Suppression	The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	HRSA	**Cat 1 P4P**
Substance Abuse Screening	Percentage of new patients with a diagnosis of HIV who have been screened for substance use (alcohol & drugs) in the measurement year	HRSA	**Cat 1 P4R**
Proportion of Patients with HIV/AIDS that have a Potentially Avoidable Complication during a Calendar Year	Proportion of Patients with HIV/AIDS that have a Potentially Avoidable Complication during a Calendar Year	Altarum	**Cat 1 P4R**

Acronyms: HRSA - Health Resources and Services Administration, NCQA - National Committee for Quality Assurance

HIV/AIDS – Specific Measures
2018 Value Based Payment Quality Measure Set
Category 2

Measure Name	Description	Steward	VBP Category
Linkage to HIV Medical Care	Percentage of patients who attended a routine HIV medical care visit within 3 months of HIV diagnosis	HRSA	**Cat 2 ***
Sexually Transmitted Diseases: Screening for Chlamydia, Gonorrhea, and Syphilis	Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea and syphilis screenings were performed at least once since the diagnosis of HIV infection	NCQA	**Cat 2 ***
Sexual History Taking: Anal, Oral, and Genital (HIV/AIDS)	Percentage of patients who were asked about sexual activity (3 sub-measures)	NYSDOH AIDS Institute	**Cat 2**

* Recommended by HIV Quality Advisory Committee of the AIDS Institute to align with ETE

Acronyms: HRSA - Health Resources and Services Administration, NCQA - National Committee for Quality Assurance

Annual Measure Review Cycle

VBP Arrangement Quality Measure Set Development and Maintenance

Quality Measure Set Development and Maintenance

2017-2018 Measure Review Process

Purpose: Review feedback from VBP Pilot Contractors and Managed Care Organizations (MCOs) as it relates to feasibility of data collection and reporting at a VBP Contractor unit of analysis.

- **Cadence**: General Committee: Bi-monthly; Sub-teams: Monthly
- **Stakeholders**: Quality Measurement Professionals, VBP Pilots (Plans and Contractors)

Sub-teams:
- Behavioral Health (BH) / Health and Recovery Plan (HARP)
- Health Information Technology (HIT)-Enabled Quality Measurement
- HIV/AIDS
- Maternity
- Total Care for the General Population (TCGP) / Integrated Primary Care (IPC)

Monthly: Measure Support Task Force and Sub-teams*

As Needed: Clinical Validation Groups (CVGs)*

June – September: Clinical Advisory Groups (CAGs)

October: Release Annual VBP Quality Measure Reporting Manual

Early October: VBP Workgroup

Purpose: Define and refine the episodes of care for each VBP Arrangement as well as for each Potentially Avoidable Complication (PAC) measure.

- **Cadence**: As necessary
- **Stakeholders**: New York State (NYS) Agencies** (OHIP, OQPS, OMH, OASAS, AI, etc.) and Altarum

Purpose: Identify and fill critical gaps in the clinical and care delivery goals to strengthen Statewide quality measurement program.

- **Cadence**: Annual (or bi-annual) meeting
- **Stakeholders**: NYS Agencies, CAG Members (Clinicians/ Medical Professionals from across the State)

Clinical Advisory Groups (CAGs):
- BH/HARP
- Children's Health
- Chronic Conditions/ Primary Care
- HIV/AIDS
- Managed Long Term Care (MLTC)
- Maternity

** Initially for 2017-2018, the Measure Support Task Force and CVGs require a more intensive effort. The workload for these groups is expected to taper off after the VBP Pilot program ends after 2018.*

*** OHIP: Office of Health Insurance Programs, OQPS: Office of Quality and Patient Safety, OMH: Office of Mental Health, OASAS: Office of Alcoholism and Substance Abuse Services.*

HIV CAG

- Proposing a change in CAG process
- Eliminate additional HIV Medicaid specific CAG and instead leverage QAC
- Proposed role of QAC members in VBP quality measurement annual review cycle
  - Review and provide recommendations on clinical quality measures in light of any significant changes in the evidence base and clinical guidelines
  - Provide insight into opportunities for improvement identified through experience in clinical practice
  - Identify any gaps in the clinical and care delivery goals
  - Ensure alignment with other HIV-specific initiatives (e.g. ETE)
- We welcome your comments!

Annual Update Cycle

Final VBP Arrangement Measure Sets and Reporting Guidance

- The VBP Quality Measure Sets for each arrangement will be finalized and posted to the NYS DOH VBP website by the end of October of the year preceding the measurement year and has been published for Measurement Year 2018. (Link)

- The VBP Measure Specification and Reporting Manual will be released alongside the QARR reporting manual in October of the measurement year and has been published for Measurement Year 2017. (Link)

Thank you!
Questions?

Additional Information:

DOH Website:

http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/index.htm

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/providers_professionals.htm

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