



# VALUE-BASED PAYMENT FUNDAMENTALS

A Guide to New York State Medicaid Value-Based Payment

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# **VALUE-BASED PAYMENT FUNDAMENTALS**

A Guide to New York State Medicaid  
Value-Based Payment

Greater New York Hospital Association

# INTRODUCTION: THE SHIFT TO VALUE-BASED PAYMENT

Greater New York Hospital Association (GNYHA) is pleased to introduce this curriculum on the fundamentals of value-based payment (VBP). In New York, delivery system and payment reform are taking place in parallel through the 1115 Medicaid Waiver program, which funds the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP is largely focused on delivery system reform through the development of Performing Provider Systems (PPSs), which are implementing projects to promote provider collaboration and improve clinical quality and public health.

Under the premise that delivery system reform cannot succeed without payment reform, New York State has developed aggressive goals to funnel 80% of Medicaid managed care payments through VBP arrangements. Such arrangements must meet particular specifications that include quality improvement and efficiency standards. The New York State Department of Health (DOH) is relying on PPSs to further these VBP goals. As part of this effort to promote the shift to VBP, PPSs are expected to educate their network partners, which include hospitals; federally qualified health centers; primary care and specialty practices; individual practitioners providing primary care, specialty care, and behavioral health services; and community-based organizations (CBOs) that offer health and social services. With this wide range of partners, PPSs are well positioned to support New York's VBP rollout with training and technical assistance.

GNYHA has supported DSRIP implementation since its inception. GNYHA advocated with New York State and the Centers for Medicare & Medicaid Services (CMS) for 1115 Medicaid Waiver funding to support New York's critical infrastructure needs and to further transform the State's health care delivery system. In the time since the Waiver funding and New York's DSRIP program were approved, GNYHA has worked to ensure that PPSs can serve their network partners and work for communities in need. As PPSs support their partners through the impending shift to VBP, GNYHA will continue to support PPSs, hospitals, health systems, and their partners as they adopt payment models that reward the delivery of high-quality care.

## **ABOUT THE CURRICULUM**

GNYHA developed this curriculum to support PPSs in their efforts to facilitate the shift to VBP. DOH requires PPSs to provide VBP trainings specifically for primary care and behavioral health providers,

## INTRODUCTION (continued)

as well as CBO partners. The curriculum provides PPSs with content they can use to teach their partners the fundamentals of VBP, and to help them understand their role in VBP.

During the shift to VBP, many organizations, both clinical and non-clinical, will be affected by newly developed payment arrangements. This curriculum provides foundational information to be shared with partners as part of New York State's ongoing implementation of VBP, and can be used to facilitate population health activities by helping organizations understand their role in the evolving delivery system, particularly in the context of payment reform. The curriculum will also help individuals in various roles to better understand how to operate in a VBP environment. While those who negotiate and implement VBP contracts play a vital role in this environmental shift, this content is not intended for them. The curriculum provides fundamental information, rather than the technical guidance that contracting and finance departments may require.

This curriculum builds on concepts in GNYHA's Population Health Curriculum Guide, which was developed to support PPSs in implementing DSRIP deliverables and educating their partners about their roles in a population health-oriented delivery system.

## CURRICULUM DESIGN

The curriculum includes the following elements:

- **Learning Objectives:** what learners should know after the completion of each section
- **Learning Content:** information to support the learning objectives
- **VBP Resources:** references to already-developed content on VBP, including DOH-developed materials to support New York's VBP rollout, tools, articles, and other materials to support curriculum development
- **VBP Terms:** commonly used terms and acronyms that are highlighted throughout the curriculum
- **Appendix Items:** supplemental curriculum materials to support learners' understanding of VBP



A slide deck of the curriculum's content is also available for download on the GNYHA website ([www.gnyha.org](http://www.gnyha.org)). This content is publicly available.

## ACKNOWLEDGEMENTS

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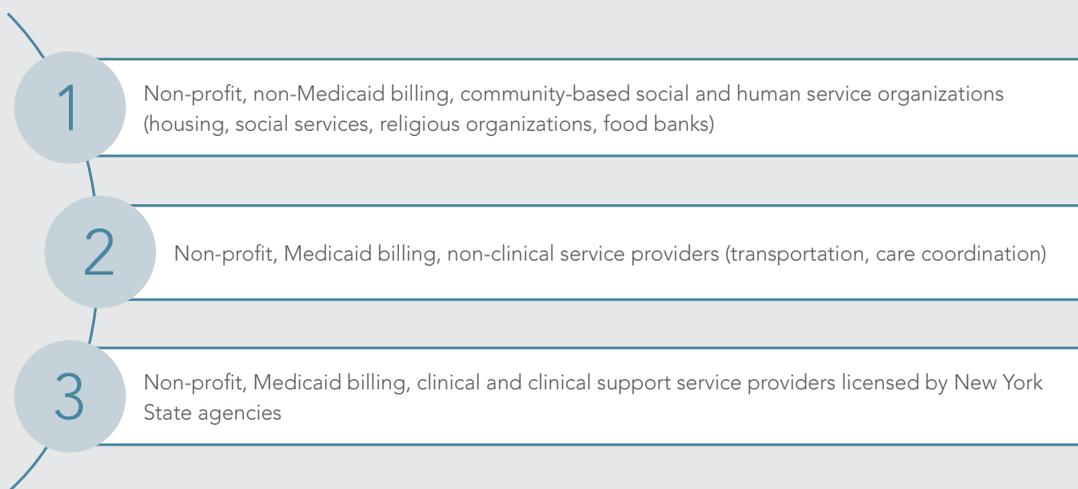
# COMMONLY USED TERMS

New York's DSRIP and VBP programs use specific terminology and certain terms with unique definitions in the context of these programs. To promote understanding and avoid confusion, the below list defines some commonly used terms in this curriculum. Terms are listed in alphabetical order.

## COMMUNITY-BASED ORGANIZATION (CBO)

CBO refers to organizations located in a community that provide primarily social services and potentially some health care or behavioral health services. The curriculum uses a general definition of CBO, accompanied by DOH's CBO Tiering methodology (Figure 1), which categorizes these organizations based on whether they provide Medicaid-billable services. In this curriculum, CBOs do not include federally qualified health centers or community-based physician practices.

**FIGURE 1: DOH CBO TIERS**



**MEDICAID MANAGED CARE ORGANIZATION (MCO)**

MCO refers New York State Medicaid managed care plans. Outside this curriculum, this term may be used more broadly to describe payers.

**NETWORK PARTNER**

Network partner refers to an organization, entity, or individual that has contracted with a VBP contractor (see definition below) to provide services to shared patients. Network partners can be providers or CBOs.

**PAYER**

Payer refers to the organizations that provide reimbursement for health care services. This includes commercial payers, managed care organizations, government-funded payers (Medicare and Medicaid), and self-funded payers (employers).

**PROVIDER**

Provider refers to organizations or individuals that deliver health care to patients. The definition includes a hospital, health system, or other institution; a practice; an individual practitioner; an organization contracting on behalf of one or more practitioners; or an entity contracting on behalf of one or more providers. CBOs that provide Medicaid-billable health care or care management services are also included.

**VBP CONTRACTOR**

VBP Contractor refers to the organization, individual, or entity entering into a VBP arrangement with an MCO. This is consistent with the definition provided by DOH.

## SECTION ONE

# VALUE-BASED PAYMENT AND THE POLICY CONTEXT

### LEARNING OBJECTIVES

- ✓ Define VBP and its fundamental variables
- ✓ Describe why population health concepts and techniques are important in the VBP environment
- ✓ Explain the policy impetus for moving payments from fee-for-service (FFS) to value-based
- ✓ Describe how DSRIP facilitates the shift to VBP

### DEFINING VBP

VBP arrangements are contractual agreements between health care providers and payers that incentivize performance around health care outcomes and costs related to health care utilization. VBP contracts set forth specific performance expectations for quality measures and health care costs. VBP arrangements are intended to make providers and systems more accountable for these factors for an identified patient population across the continuum of care. This change is a shift from the traditional FFS payment system that rewards volume to more performance-based payment models based on care for attributed patient populations. VBP arrangements incentivize performance by incorporating two fundamental variables:

- **Quality:** Some portion of the provider payment is tied to achieving or exceeding quality standards measures, which may vary depending on the individual arrangement
- **Efficiency:** Providers may earn shared savings or risk financial penalties based on the actual health care costs of assigned populations over time compared to the expected cost

The shift to VBP arrangements, both in practice and policy, facilitates the achievement of the Institute for Healthcare Improvement's Triple Aim framework (Figure 2)<sup>1</sup>, which aims to:

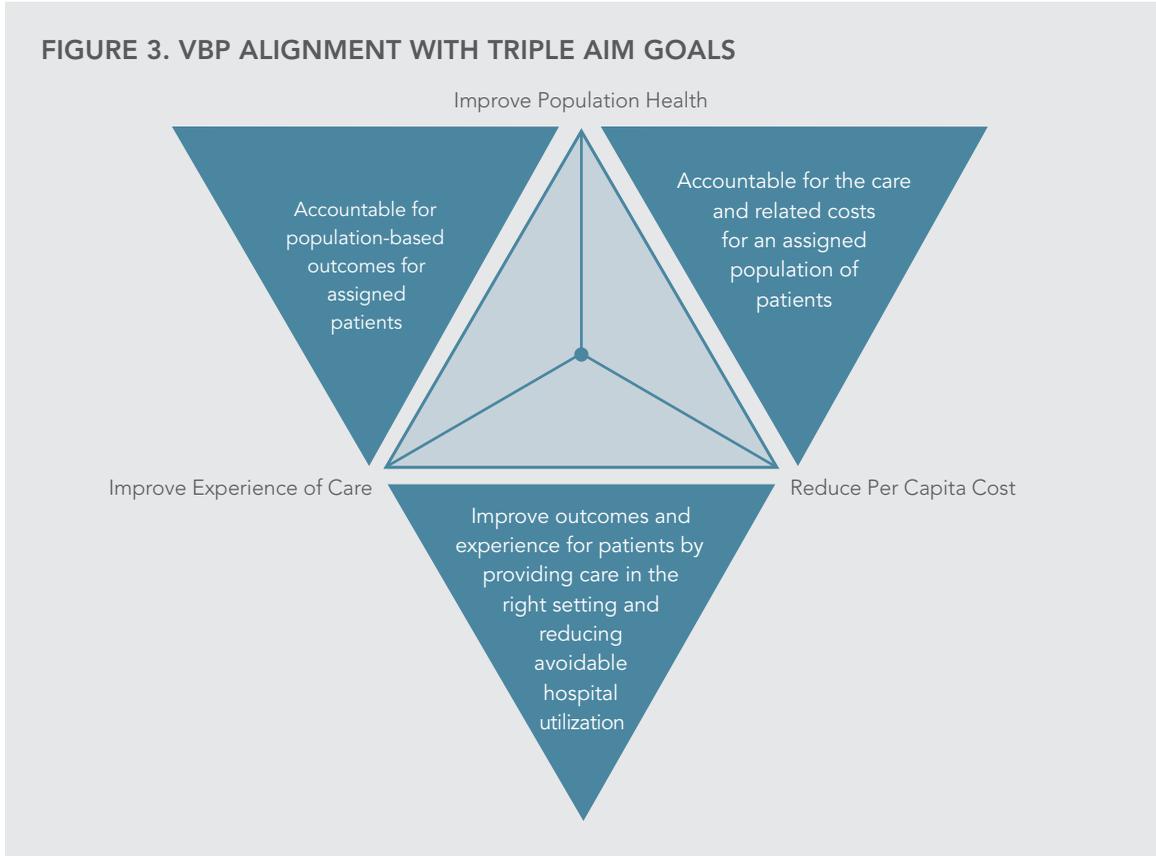
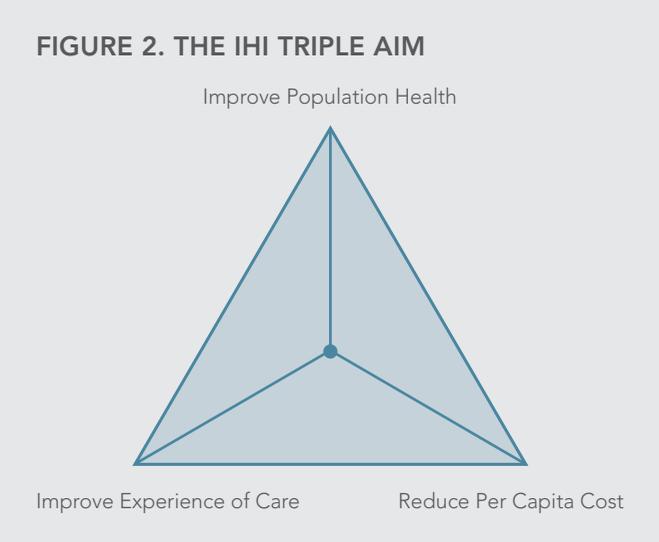
<sup>1</sup> Institute for Healthcare Improvement

**SECTION ONE** (continued)

- Improve the experience of care, including individual outcomes
- Improve population health
- Reduce the per capita cost of care

Figure 3 depicts concrete ways that VBP can help achieve Triple Aim goals.

While not every provider will enter into a VBP contract directly with a payer, there are opportunities for providers and CBOs to participate in VBP as network partners that contribute to the health and well-being of individual patients, broader populations, or communities. The concept of network partners, their roles in VBP, their relationships with payers, and potential payments from VBP contractors are described in Section 3.



## VBP AND POPULATION HEALTH

VBP aligns with the implementation of population health practices as a way to improve health care quality and decrease costs. To be successful in a VBP environment where providers are accountable for the health costs and outcomes of a defined population, consideration must be given to the many factors that affect those costs and outcomes, including social factors. Incorporating population health activities ensures that patient care is proactively managed, and that high-risk, high-cost patients get services and interventions that can reduce avoidable inpatient and emergency department (ED) admissions. Population health tools include:

- Registries that facilitate proactive tracking and management of individuals requiring specific services
- Electronic health records (EHRs) that sync with other tools and facilitate data tracking for performance and quality improvement, and share patient information when appropriate
- Care management tools and workflows that support care planning and coordination
- Referral management tools that track patient activity across providers in the care continuum
- Health information exchanges (HIEs) that allow access to up-to-date patient information
- Data analytics used to understand the outcomes and cost of care for a particular patient population and to set benchmarks for future maintenance or improvement



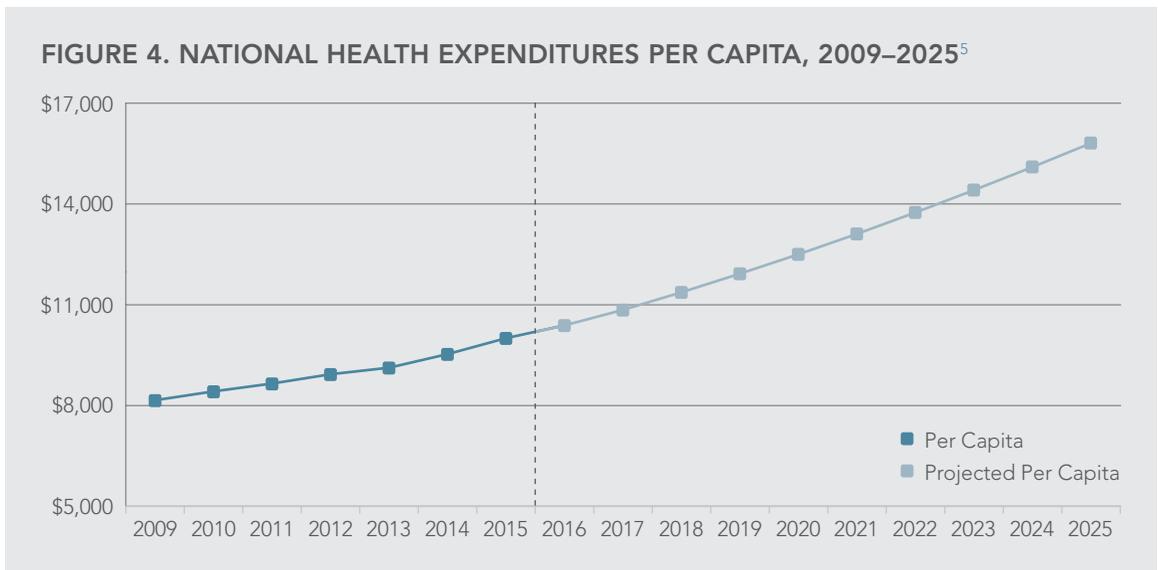
For more information on population health concepts, see GNYHA's *Population Health Curriculum Guide* (<https://www.gnyha.org/tool/population-health-curriculum-guide/>).

VBP arrangements can support investments in population health tools and activities through potential revenue streams related to achieving bonuses or shared savings. This is particularly helpful in supporting activities that are vital to whole-person care and improved health care outcomes, but for which providers cannot typically bill. Depending on the payer, such activities may include care management, care coordination, and assisting with social needs such as housing and food insecurity. This can include making housing referrals or working with housing agencies to prioritize high-risk patients and working with food pantries and Meals on Wheels programs to address nutritional needs.

## VBP IN POLICY

VBP arrangements are becoming more common nationally, in line with other health care reform initiatives that strive to improve health care outcomes and align provider quality of care with reimbursement. Many policymakers believe that the FFS payment model does not promote these goals. Additionally, policymakers have expressed concerns about the sustainability of publicly funded health care programs such as Medicaid and Medicare given the projected increase in health care spending over the next several years.

The Medicare Payment Advisory Commission reports that in 15 years, the Medicare program is projected to cover more than 80 million beneficiaries—up from 59 million today. Funding for these beneficiaries is threatened as the workforce, which pays for Medicare spending through payroll and income taxes, is projected to decline.<sup>2</sup> In addition, data shows that US health care is the costliest in the world, and costs are projected to rise through 2020.<sup>3</sup> The cost of care per individual is also rising, and is projected to exceed \$15,800 by year 2025 (Figure 4). This can be attributed to several factors, including higher prevalence of chronic diseases, behavioral health and substance use disorders, and certain risk factors such as tobacco use and physical inactivity. Other factors such as the aging population and increased life expectancy associated with advances in public health and clinical medicine also impact the projected costs.<sup>4</sup>



To address rising care costs, CMS developed several initiatives with VBP components to incentivize providers to achieve the Triple Aim, including DSRIP, State Innovation Model programs, and demonstration projects that promote advanced primary care delivery. CMS also announced the goal of having 85% of Medicare FFS payments flow through VBP arrangements that meet Categories 2 through 4 by 2016, and 90% by 2018. To facilitate this, CMS developed alternative payment models (APMs) such as bundled payment initiatives (e.g., the Comprehensive Care for Joint Replacement model, whereby hospitals are held financially accountable for hospital, physician,

<sup>2</sup> "A Data Book, Health Care Spending and the Medicare Program," Medicare Payment Advisory Commission, June 2017.

<sup>3</sup> "National Healthcare Expenditure Projections, 2010-2020," Centers for Medicare & Medicaid Services, Office of the Actuary.

<sup>4</sup> "Multiple Chronic Conditions Fact Sheet," Centers for Disease Control and Prevention, <https://www.cdc.gov/chronicdisease/about/multiple-chronic.htm> (accessed August 1, 2017).

<sup>5</sup> <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/national-healthaccountsprojected.html> (accessed October 24, 2017).

and post-acute care costs for hip and knee replacements) and the Accountable Care Organization (ACO) program, which was included in the Affordable Care Act to incentivize accountable care models for Medicare beneficiaries. CMS's VBP categories describe the extent to which payments are linked to quality and efficiency. CMS's payment taxonomy framework ([Appendix A](#)) defines the CMS categories and the CMS programs to which each is linked.

**VBP TERM: ALTERNATIVE PAYMENT MODEL (APM)**

CMS has defined APMs as payment approaches that give added incentive payments to provide high-quality and cost-efficient care. APMs can be built around specific clinical conditions, care episodes, or populations. APM is a specific term in CMS's Quality Payment Program (QPP), which is the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation. The two types of APMs are qualifying APMs and advanced APMs. CMS deems certain Medicare ACO models, for example, to be advanced APMs because of the degree to which they incentivize providers to achieve quality and cost outcomes. With the MACRA legislation, CMS set the stage for quality programs that will influence Medicaid and other payers throughout the US.



Additional information on MACRA and APMs is available here: <https://qpp.cms.gov/>.

**THE SHIFT TO VBP IN NEW YORK STATE**

DOH has aligned with Federal policy initiatives to move toward value-based care and payment reform. Payment reform in New York has largely been driven by the State's Medicaid waiver, the most recent version of which requires the State to transition Medicaid MCO payments to providers to VBP arrangements. A Medicaid waiver (also known as a Section 1115 waiver, which is received from CMS) waives certain Federal requirements for the State's Medicaid program to facilitate its health reform initiatives. Waivers must be budget neutral, and since they are expected to generate Federal savings, states typically seek a portion of available savings to reinvest in the state's health care system. The shift to VBP is woven into the DSRIP program, demonstrating CMS's and DOH's belief that new payment models are necessary to sustain activities associated with health care reform, including care coordination, patient engagement, CBO involvement, and information technology (IT) advancements. New York State has committed to shifting 80% of its MCO payments to VBP arrangements that incorporate both quality and efficiency by March 2020. This commitment is embedded in statewide DSRIP goals. It is worth noting that some providers have been participating in VBP contracts for many years. The State's most recent survey of MCOs on the extent of their VBP activity indicates that more than 38% of MCO payments to providers are currently under VBP arrangements.

New York’s waiver required DOH to develop a strategy document to support Medicaid’s shift to VBP. The document is titled *A Path to Value-Based Payment: New York State Roadmap for Medicaid Payment Reform*, and is commonly referred to as the “VBP Roadmap.” The VBP Roadmap guides the shift to VBP by detailing VBP models, contracting requirements, and guidelines for both providers and MCOs to ensure that contracts are consistent with State goals. The VBP Roadmap is updated annually based on guidance from DOH workgroups and the experiences of payers and providers as VBP is implemented. The Roadmap also describes DOH incentives for MCOs to incorporate VBP contracts into their portfolios.

### **ABOUT DSRIP**

New York’s DSRIP program is a five-year initiative funded by a \$6.8 billion Medicaid waiver from CMS. DOH was awarded the funding because it committed to implementing delivery system reform and demonstrated significant savings through its mandatory Medicaid managed care program and implementation of Governor Andrew Cuomo’s Medicaid Redesign Team initiative to reduce program costs and improve outcomes. DSRIP aims to reduce avoidable Medicaid hospital admissions, readmissions, and ED visits by 25% by March 2020.

DSRIP is being implemented across New York State by 25 PPSs, most of which are led by a hospital or health system and work in partnership with various health care stakeholders, including other hospitals, federally qualified health centers, community-based practices, behavioral health providers, long-term care providers, home health agencies, and CBOs. PPSs must implement between seven and 11 projects that focus on building integrated delivery systems and improving chronic disease management and public health. PPSs are awarded performance payments for achieving prescribed milestones and demonstrating improvement on more than 40 outcomes measures.

# VBP RESOURCES

## **DSRIP VBP Resource Library**

This online library from DOH provides resources to support New York State providers moving toward VBP. The library includes links to the VBP Roadmap, educational materials, fact sheets, and other resources developed by DOH.

[https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/vbp\\_library/](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/)

## **Delivery System and Payment Reform**

This section of the Center for Health Care Strategies (CHCS) website links to a library of resources, current projects, and blog posts related to delivery system transformation and the shift to VBP. Resources include technical assistance tools and briefs on various national reform efforts.

<https://www.chcs.org/topics/delivery-system-payment-reform/>

## **VBP in Medicaid Managed Care: An Overview of State Approaches**

This CHCS brief gives an overview of approaches to VBP arrangements between providers and MCOs across the country. It highlights different approaches and links to contract language, pertinent documents, and additional CHCS toolkits to support state purchasers.

<https://www.chcs.org/resource/value-based-payments-in-medicare-managed-care-an-overview-of-state-approaches/>

## SECTION TWO

# NEW YORK STATE'S VBP PROGRAM AND PARTNERS

### LEARNING OBJECTIVES

- ✔ Define the VBP Levels developed as part of the VBP Roadmap
- ✔ Recall and explain the VBP models developed as part of the VBP Roadmap
- ✔ Describe the roles of the various VBP stakeholders, including MCOs, the different provider types, and CBOs providing social services

DOH developed a VBP program, detailed in the VBP Roadmap, to support the changes to the health care system being implemented as part of DSRIP. The document defines levels of VBP, which are aligned with the CMS VBP categories (see crosswalk in [Appendix A](#)), as well as VBP models that can be adopted by payers and VBP contractors.<sup>6</sup>

### VBP LEVELS

DOH VBP Levels describe the extent to which VBP arrangements incorporate payments or rewards for good performance on quality measures and improved efficiency resulting in cost savings. The definitions of each level are as follows:

- **Level 0:** FFS payments with a bonus and/or withhold based on quality scores (these arrangements do not count toward the State's VBP goals because they do not incorporate accountability for efficiency)
- **Level 1:** FFS with upside-only shared savings when quality scores are sufficient. The amount of savings that can be shared with the VBP contractor increases as quality performance increases
- **Level 2:** FFS with risk sharing (the VBP contractor shares in losses as well as savings depending on quality performance. Shared savings increase as quality performance increases, and shared losses can increase as quality performance decreases)
- **Level 3:** Prepaid capitation with a quality-based component

<sup>6</sup> Content in this section references VBP Roadmap, annual update #2, June 2016.

The VBP Level also dictates how payments are dispersed to VBP contractors. Figure 5 below describes how reimbursements can flow from the MCO to the VBP contractor. How funds flow between the VBP contractor and other partners is described in Section 3.

VBP arrangements have a limited impact on how providers bill for services with the exception of Level 3 arrangements. Level 0, 1, and 2 arrangements still require billing and reimbursement on an FFS basis. The payment structure, availability of bonuses or shared savings, and impact on billing and payment are listed in Figure 5.

**FIGURE 5: PAYMENT STRUCTURE BY VBP LEVEL**

LEVEL	PAYMENT STRUCTURE	BONUS/SHARED SAVINGS	IMPACT ON BILLING AND PAYMENT
0	FFS	<ul style="list-style-type: none"> <li>Bonus or withhold based on quality scores</li> </ul>	<ul style="list-style-type: none"> <li>Provider bills FFS and is paid as agreed upon in contract</li> <li>Earned bonus payments calculated by MCO after all claims for the year have been processed and quality performance assessed</li> <li>Bonus, if earned, delivered as agreed upon in the contract</li> </ul>
1	FFS	<ul style="list-style-type: none"> <li>Shared savings available if quality scores are met</li> <li>Savings are determined based on actual costs during the contract year compared to expected costs</li> </ul>	<ul style="list-style-type: none"> <li>Provider bills FFS</li> <li>Savings calculated by MCO after all the year's claims have been processed and quality performance assessed</li> <li>Shared savings paid to provider as agreed upon in the contract</li> </ul>
2	FFS	<ul style="list-style-type: none"> <li>Shared savings or losses with level of shared savings or losses linked to quality performance</li> <li>Savings are determined based on actual costs during the contract year compared to expected costs</li> </ul>	<ul style="list-style-type: none"> <li>Provider bills FFS</li> <li>Savings or losses and quality performance calculated by MCO after all claims for the year have been processed</li> <li>Payments or penalties paid to or recovered from provider as agreed upon in the contract</li> </ul>
3	Prepaid capitation, PMPM, or prepaid bundle	<ul style="list-style-type: none"> <li>Payment is made to provider on a prospective basis ("up front") and all savings/losses accrue to the provider</li> </ul>	<ul style="list-style-type: none"> <li>Provider receives prospective payment for patients attributed to the population or episode of care. Penalties may result if quality metrics not achieved</li> </ul>

### VBP TERM: CAPITATION

Capitation is a payment arrangement in which a payer pays a set amount to a health care provider for each enrolled person assigned to the provider per period of time, regardless of whether that person seeks care. For example, a provider could receive a per member per month (PMPM) payment for an assigned person.

### VBP MODELS

DOH developed four VBP models. *Population-based arrangements* require VBP contractors to assume responsibility for outcomes and costs related to any care received by individuals who are members of the specified populations. Population-based models and their definitions are as follows:

- **Total Care for General Population (TCGP):** VBP contractors are responsible for all Medicaid-covered services related to the care for attributed individuals
- **Total Care for Special Needs Subpopulations:** VBP contractors are responsible for all Medicaid-covered services for populations that already have dedicated managed care arrangements, including HIV/AIDS, Health and Recovery Plans, Managed Long-Term Care, and Intellectual and Developmental Disabilities

*Episode-based arrangements* require providers to assume responsibility for specific care delivered for a particular disease or condition, regardless of the care setting. Episodes generally have specific start and end dates. Episode-based arrangement models and their definitions are as follows:

- **Integrated Primary Care (IPC) Bundle:** Contracted primary care providers (PCPs) are responsible for preventive and sick care, as well as care coordination activities. IPC includes a Chronic Bundle for 14 chronic diseases, including asthma, hypertension, diabetes, and certain behavioral health diagnoses. Serious acute care services such as cancer and trauma care are not included in the IPC bundle. Savings in the IPC generally result from reductions in hospital use and hospitals that cooperate with PCPs in these arrangements can share in the savings.
- **Maternity Bundle:** Contracted hospitals and/or providers that deliver maternity care are responsible for all care from the onset of pregnancy through the first month of a newborn's care

### DELEGATED ADMINISTRATIVE FUNCTIONS

VBP arrangements are often accompanied by an agreement in which the MCO delegates certain administrative functions to the VBP contractor, such as credentialing, preauthorization, and/or claims processing. This delegation is generally accomplished through a separate agreement known as a "management contract."

The VBP models can be implemented at any VBP Level (Figure 6). Additionally, providers can participate in multiple VBP arrangements with different MCOs at different levels.

**FIGURE 6: OPTIONS FOR COMBINING VBP ARRANGEMENTS AND LEVELS**

OPTIONS	LEVEL 0 VBP	LEVEL 1 VBP	LEVEL 2 VBP	LEVEL 3 VBP (Only feasible after experience with Level 2; requires mature VBP contractor)
Total Care for General Population	FFS with bonus and/or withhold based on outcome scores	FFS with upside-only shared savings when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside reduced when outcome scores are high)	Global capitation with outcome-based component
Integrated Primary Care	FFS (plus PMPM subsidy for care coordination) with bonus and/or withhold based on outcome scores	FFS (plus PMPM subsidy for care coordination) with upside-only shared savings (savings available when outcome scores are sufficient)	FFS (plus PMPM subsidy for care coordination) with risk sharing (upside available when outcome scores are sufficient; downside reduced when outcome scores are high)	PMPM Capitated Payment for Chronic Bundle with outcome-based component
Maternity Bundle	FFS with bonus and/or withhold based on outcome scores	FFS with upside-only shared savings based on bundle of care (savings available when outcome scores are sufficient)	FFS with risk sharing (upside available when outcomes scores are sufficient; downside reduced when outcome scores are high)	Prospective Bundled Payment with outcome-based component
Total Care for Subpopulation	FFS with bonus and/or withhold based on outcome scores	FFS with upside-only shared savings based on subpopulation total cost of care (savings available when outcome scores are sufficient)	FFS with risk sharing based on subpopulation total cost of care (upside available when outcome scores are sufficient; downside reduced when outcome scores are high)	PMPM Capitated Payment for total care for subpopulation with outcome-based component

**PARTICIPANTS IN NEW YORK’S VBP ARRANGEMENTS**

A VBP arrangement is, first and foremost, an agreement between an MCO and a VBP contractor; the VBP contractor can be a provider or a contracting entity established for one or more providers.

## SECTION TWO (continued)

However, providers and CBOs can also partner with VBP contractors to play unique roles in the success of the VBP arrangement even if the provider or CBO itself has not directly entered into its own VBP arrangement.

### MCO Role in VBP

MCOs have a key role in VBP because they contract with providers to deliver payments for services to the MCO's members. The MCOs will also implement the different VBP arrangements through their contracts. As a party to the contract, an MCO has a significant role in selecting VBP models, measures, quality and utilization targets, and reimbursement levels. Ultimately, these decisions are the result of negotiations between the MCO and the VBP contractor. In addition, MCOs have data and statistics based on their enrolled populations' claims history, including historical cost data, utilization patterns, and diagnostic information. This data is vitally important for VBP contractors to better manage their attributed populations. How and when this data is shared with the VBP contractor is an important consideration in contract negotiations.

DOH has developed incentives and penalties for MCOs to work with providers and shift contracts to VBP. MCOs have flexibility in how their incentives can be used, and may elect to use these to further incentivize providers to make the shift. They may also include penalties for providers that do not achieve targets or that are unwilling to move to a VBP arrangement. Whether incentives and/or penalties trickle down to providers is subject to contract negotiation.

### CONNECTING TO MCOS IN NEW YORK STATE

The Managed Care Technical Assistance Center has compiled a contact list of the MCOs that serve New York.



The database, found here <http://matrix.ctacny.org>, can be searched by region.

### Hospital Role in VBP

Hospitals can be VBP contractors or network partners. Because of their size and experience with quality programs, many hospitals and health systems have the financial resources and capabilities to enter into or facilitate shared-risk arrangements.

Hospitals provide care most often for emergent and acute episodes, settings in which care is costlier. Hospitals can have an important role in decreasing health care costs through effective care transitioning and discharge planning, which can mitigate issues that could otherwise cause a hospital readmission. Patients may be transitioned into another health care setting, such as long-term care or short-term rehabilitation services, or back into the community, often with the support of outpa-

tient primary care, behavioral health, or home care.

Many hospitals have large ambulatory care networks where patients can be seen post-discharge. Hospital capabilities such as HIEs, quality improvement programs, and population health tools can also be leveraged to achieve quality and efficiency targets.

### Primary Care Role in VBP

Primary care groups can be VBP contractors themselves or participants in VBP through a larger, comprehensive group of providers such as an Independent Practice Association (IPA) (see [Section 3](#)). Smaller primary care practices need to assess whether becoming a VBP contractor is prudent based on the size of their patient population, their payer mix, and the number of high-risk, high-cost patients being cared for. Primary care groups can also be network partners.

Due to their role in meeting quality benchmarks and as drivers of MCO attribution, PCPs are vitally important partners in VBP arrangements. Within VBP, MCO attribution is significant because having a large patient population is important to effectively spread risk and increase the likelihood of achieving shared savings.

PCPs have primary “ownership” of their attributed patients, from those with no chronic conditions who only come for annual preventive services to those requiring ongoing care for chronic diseases such as diabetes, asthma, or congestive heart failure. PCPs are often responsible for meeting quality targets for attributed patients and providing preventive care that could help avoid a future hospitalization or care that is more expensive. Examples of how PCPs accomplish this include:

- Pediatric, adolescent, and adult vaccines that prevent acute illnesses
- Cancer screenings that promote early detection of cancer and could result in a less-costly course of care
- Routine tests to assess how well a chronic disease is being managed, potentially preventing emergency exacerbation of diseases

### Role of Behavioral Health

Behavioral health providers can participate in VBP arrangements as VBP contractors or network partners. However, depending on practice size and volume, behavioral health providers may decide to participate in arrangements where they do not take on shared risk. Recommendations for VBP programs built around behavioral health chronic conditions were developed by DOH’s behavioral health Clinical Advisory Group (CAG). The recommendations are included in DOH’s VBP Resource Library.

Behavioral health providers are important VBP partners because behavioral health comorbidities are common in patients who use the most health care resources, including emergency and inpatient services. Studies have demonstrated that individuals with behavioral health diagnoses are

### VBP TERM: ATTRIBUTION

Attribution is the process of assigning patients to a provider or groups of providers to manage health outcomes and/or determine payment. Attribution is done for different purposes, and methodologies can vary depending on the program.

- **MCO Attribution:** An MCO attributes a member enrolled in its health plan to a PCP that participates in the plan network. This PCP attribution is generally intended to be the primary point of contact for the MCO member's care. While members can select or change their PCPs, MCO members are sometimes automatically assigned to a participating PCP if the member does not make a selection during the insurance enrollment process. An MCO may also attribute enrollees to a VBP contractor, which is frequently done based on the patient panel of the PCPs participating in the VBP arrangement.
- **Primary Care Practice Attribution:** A primary care practice with multiple providers will often attribute, or assign, a patient to a particular provider to ensure that each of the practice's patients has a single provider accountable for that patient's care. This attribution facilitates the patient developing a relationship with the PCP. In certain cases, such as primary care practices that also serve as training settings for medical residents, the patient could have a provider that is generally seen and an official provider (the supervising physician) who serves as the primary care provider "of record." While this primary care practice attribution is independent of MCO attribution, it is important for billing purposes that the official provider of record assignment match the MCO assignment.
- **DSRIP PPS Attribution:** In DSRIP, DOH attributes Medicaid members to PPSs to measure PPS progress on achievement of project goals. The methodology for assigning patients to a PPS is complex, and DSRIP's patient attribution changes as often as monthly depending on where patients receive care. Although MCO PCP assignment was a factor in determining PPS attribution, PPS attribution is performed solely for DSRIP program purposes and can vary from MCO or primary care practice attribution.

### TRAINING PROGRAMS TO PREPARE BEHAVIORAL HEALTH PROVIDERS FOR VBP

The Managed Care Technical Assistance Center (MCTAC) has developed a series of training programs specifically geared toward behavioral health providers to support their transition to VBP.



Free training materials are available on [www.mctac.org](http://www.mctac.org) and in-person trainings are also available.

more likely to need or use ED and inpatient services, particularly when compared to those with other medical conditions only.<sup>7,8,9</sup>

### Role of Post-Acute Care

Post-acute care providers, including skilled nursing, long-term care, and home health, are important partners to the success of VBP arrangements involving total cost of care or payment bundles where the post-discharge costs are monitored as part of the arrangement. Successful post-discharge handoffs and communication of key information can ensure both a smooth patient transition and that avoidable readmissions leading to unnecessary additional expenditures do not occur.

Skilled nursing facilities and home care providers to which patients can be assigned by Managed Long Term Care (MLTC) plans can be drivers of DSRIP PPS attribution. Additionally, the Total Care for Special Needs population model includes arrangements for individuals enrolled in MLTC plans. Models for this subpopulation are still under development through DOH's MLTC CAG. While details still need to be worked out, DOH also plans to coordinate with CMS on VBP initiatives for this population because many patients are dually insured under both Medicare and Medicaid.

### Role of CBOs

CBOs are unlikely to be VBP contractors themselves, as they have limited ability to be accountable for health care costs and performance across the entire continuum of care and are generally unable to receive patient attribution. This is particularly the case for Tier 1 CBOs that do not provide Medicaid-billable services (see [page 3](#) for DOH Tiering methodology). However, CBOs can be important partners in VBP arrangements and vital to achieving VBP success. Regardless of their tier "assignment," CBOs can partner or contract with MCOs and/or providers to provide unique services to patients, particularly those that address social needs. DOH requires VBP contractors in Level 2 and Level 3 arrangements to contract with one Tier 1 CBO for a social determinants of health intervention. Depending on the VBP contract level, the cost of the CBO and related intervention may be shared by the VBP contractor and the MCO. DOH's Social Determinants of Health CAG developed a menu of social interventions that could be conducted as part of a Level 2 or Level 3 arrangement. Menu excerpts are included in [Appendix B](#), and the full menu is available in the DOH VBP Resource Library.

Certain CBOs will demonstrate themselves to be important VBP partners because their services can help prevent avoidable admissions and unnecessary health care utilization. Such services include, but are not limited to, care management, housing placement, benefits enrollment, food and

<sup>7</sup> Jiang, H.J., et al. (23 February 2017). "Characteristics of Emergency Department Visits for Super-Utilizers by Payer, 2014." Agency for Health Care Research and Quality.

<sup>8</sup> *DSRIP-Medicaid Accelerated Exchange Series Final Report*. New York State Department of Health (January, 2017).

<sup>9</sup> Hayes, S.L., McCarthy, D., and Radley, D., "The Impact of a Behavioral Health Condition on High-Need Adults," *The Commonwealth Fund*, Nov. 22, 2016.

## SECTION TWO (continued)

meal assistance, employment and vocational training, and general social support. CBO services can be incorporated as part of care transitions, chronic disease management, and other preventive activities to promote the likelihood of cost savings and decreased utilization. To determine the roles that CBOs can play in the VBP environment, VBP contractors may consider how CBO services can directly translate to reduced overall health care costs or improved health care outcomes. [Appendix C](#) provides an example of how CBO services can impact specific health care outcomes.

[Appendix D](#) includes a series of case studies that demonstrate examples of provider and partner roles when included in various VBP arrangements.

# VBP RESOURCES

## **Hospital Value-Based Purchasing Fact Sheet**

This CMS fact sheet outlines the Hospital VBP Program's key points, including quality domains, measures, scoring, timelines, and funding mechanisms.

[https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/hospital\\_vbpurchasing\\_fact\\_sheet\\_icn907664.pdf](https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/hospital_vbpurchasing_fact_sheet_icn907664.pdf)

## **Healthcare Payment Reform and the Behavioral Health Safety Net: What's on the Horizon for the Community Behavioral Health System**

This National Council for Behavioral Health report provides an overview of the challenges behavioral health patients face within the health care delivery system and outlines the various reform activities underway to improve care delivery. It highlights opportunities to merge behavioral health reform activities with general delivery system reform efforts to better serve patients.

<https://www.thenationalcouncil.org/wp-content/uploads/2012/12/healthcare-payment-reform-full-report.pdf>

## **Incorporating Value in Behavioral Health**

This Healthcare Financial Management Association article highlights challenges and opportunities in the delivery of behavioral health care. It also provides an overview of government, health system, and private-sector efforts to promote integrated primary care and behavioral health services.

[http://www.hfma.org/leadership/archives/2017/july/incorporating\\_value\\_in\\_behavioral\\_health/](http://www.hfma.org/leadership/archives/2017/july/incorporating_value_in_behavioral_health/)

## **Demonstration Program for Certified Community Behavioral Health Clinics (CCBHC)**

This webpage, part of the Substance Abuse and Mental Health Services Administration website, provides information on the CCBHC demonstration program. The program, authorized by Section 223 of the Protecting Access to Medicare Act of 2014, was developed to support behavioral health practices entering into risk-based arrangements. New York is one of eight states participating. The site also includes contact information for the responsible parties at the New York State Office of Mental Health.

<https://www.samhsa.gov/section-223>

## **Linkage Lab Initiative**

This webpage, developed by the SCAN Foundation, contains materials from the organization's Linkage Lab initiative, which was developed to prepare California's CBOs to partner effectively with health care entities. Tools include case studies, webinars, and a list of the contracts into which the participating CBOs entered into.

<http://www.thescanfoundation.org/linkage-lab-initiative>

# SECTION THREE

# INTEGRATED DELIVERY SYSTEMS IN VBP

## LEARNING OBJECTIVES

- ✔ Define an integrated delivery system (IDS)
- ✔ Describe partnership elements that facilitate a higher level of integration
- ✔ Identify partnership models that meet the IDS definition
- ✔ Provide examples of how payment flows from MCOs to VBP contractors, and from VBP contractors to network partners

## PARTNERSHIPS FACILITATE VBP

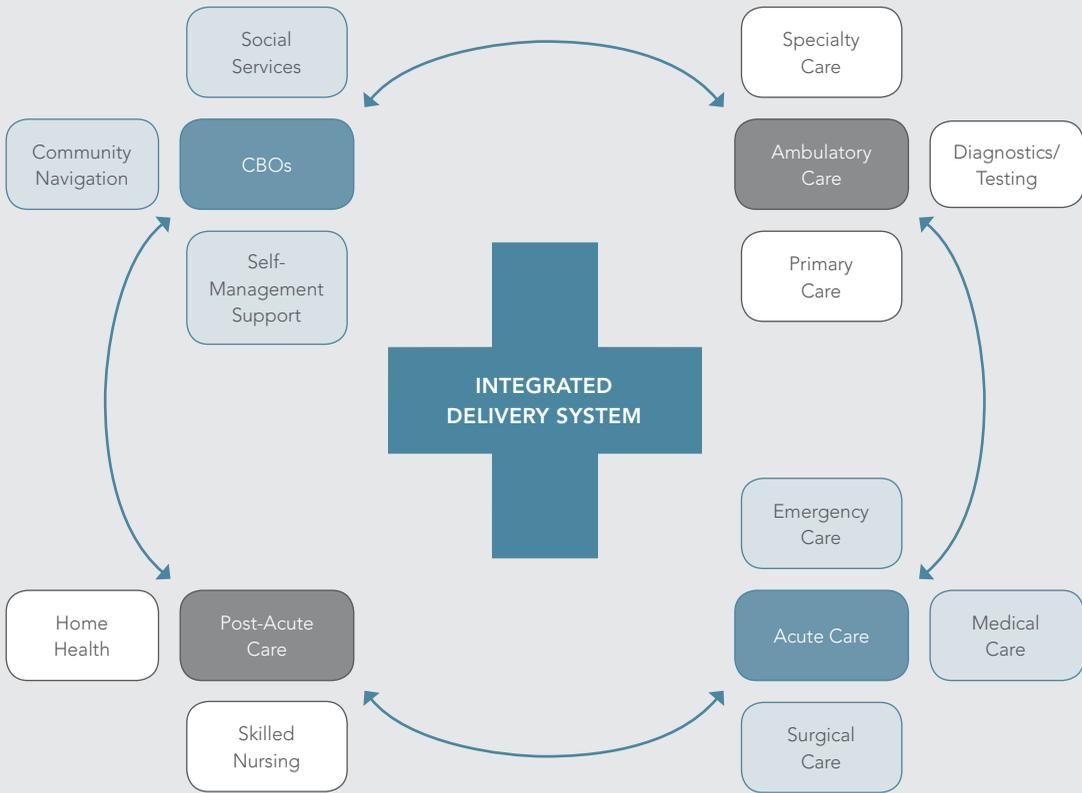
Because patients are often shared between providers and organizations across the care continuum, each of which can impact health care costs, successful VBP arrangements require partnerships, collaboration, data sharing, and in some cases risk sharing to impact the defined population. Interest in entering into a VBP arrangement incentivizes VBP contractors to create an IDS comprised of network partners with a shared motivation to build patient-centered systems in which the partners are accountable for quality outcomes and cost. An example of an IDS with network partners and types of provided services is in Figure 7.

## VBP TERM: INTEGRATED DELIVERY SYSTEM

An IDS is an organized, coordinated, and collaborative network that links various health care providers and stakeholders to provide a coordinated continuum of services to a particular patient population or community. Under a commonly used definition, a fully developed IDS is accountable, both clinically and fiscally, for the clinical outcomes and health status of the population or community served, and has systems in place to manage and improve them.<sup>10</sup>

<sup>10</sup> A.C. Enthoven, "Integrated Delivery Systems: the Cure for Fragmentation," *American Journal of Managed Care*. (December 2009).

FIGURE 7. EXAMPLE OF IDS PARTNERS AND SERVICES



**VBP TERM: INTEGRATED DELIVERY SYSTEM (continued)**

All 25 of New York State’s PPSs have been working toward developing IDSs as part of one or more selected DSRIP projects. IDS-related projects require PPSs to improve communication among partners, access HIEs, enhance primary care through adoption of the 2014 National Committee for Quality Assurance’s Patient-Centered Medical Home standards, and adopt care management capabilities. Although DSRIP requires the PPS lead entity to play a central role in the IDS’s formation, the PPS itself is not a contracting entity.

**PARTNERSHIP ELEMENTS**

Network partners in an IDS can adopt different partnership elements, with varying levels of formality. Elements such as partnership oversight, governance, information sharing, and interoperability are important to define, since they will guide the roles and requirements for network partners. Important partnership elements and examples of how they can be implemented are in [Figure 8](#).

**FIGURE 8: PARTNERSHIP ELEMENTS AND LEVEL OF FORMALITY**

PARTNERSHIP ELEMENT	LOW FORMALITY EXAMPLE	HIGH FORMALITY EXAMPLE
Defined Partner Roles and Processes	Verbal agreements or written processes that describe communication expectations such as information transferred and method of transmission	Formal contracts with defined roles, scopes of work, and payment terms
Governance	No centralized governance	Centralized governance structure
Outcomes Data Sharing	Limited sharing of data on patient outcomes	Regularly distributed reports on outcomes performance to network partners
Sharing Patient Information	Information sharing takes place as needed on an ad hoc basis	Signed agreements that meet Federal and State regulations allow partners to regularly share information on shared patients
Communication Strategy	Primarily through telephone, fax, and secure e-mail	Interoperable systems or processes to access an HIE
Payer Contracting	No central contracting entity, providers contract with payers on their own	Central contracting entity to contract with payers on behalf of all partners in the network
Funds Flow	No payment flows between partners	Central contracting entity flows payments to network partners for services provided OR for contributions to outcomes or shared savings

Note: Due to New York regulatory requirements, arrangements that seek to share items such as patient information or payment rates generally must establish a joint legal contracting entity such as an Independent Practice Association (IPA), ACO, or limited liability corporation (LLC).

Formal partnerships with centralized services, population health capabilities, and communication protocols can facilitate performance in VBP. IPAs and ACOs are examples of such partnerships.

### Independent Practice Association (IPA)

New York’s Public Health Law defines an IPA as a business entity (corporation, LLC, or professional services LLC) that contracts with providers in order to contract with MCOs. Unlike the often-used term “independent physician association,” in New York, an IPA is an organization that can contract jointly on behalf of physicians and/or other providers (e.g., a hospital). IPA composition can vary, but many have a centralized governance and contracting entity. Examples of IPA composition include:

- Physician practices only. In such cases, IPAs are organized and owned by a network of independent physicians for the purpose of reducing overhead or pursuing business ventures, including VBP contracts<sup>11</sup>

<sup>11</sup> “Independent Physician Association Definition.” American Academy of Family Physicians. <http://www.aafp.org/about/policies/all/independent-physicianassoc.html>.

## SECTION THREE (continued)

- Primary care providers only
- Combination of providers, including physician offices of varying specialties, as well as hospitals

New York's promotion of VBP is encouraging other types of providers such as nursing homes and behavioral health providers to explore the formation of IPAs for the purposes of VBP contracting.

### Accountable Care Organization (ACO)

An ACO is another legal entity that contracts with certain payers for participating providers. As with IPAs, ACO composition can include different provider types. The model allows providers to share in savings if spending and quality benchmarks are met.

The ACO model was initially developed for Medicare beneficiaries as a result of the Medicare Shared Savings Program in the ACA. Other payers, including certain Medicaid and commercial programs, have also developed ACO programs that provide shared savings for increased quality and decreased costs. In New York, Medicare ACOs generally cannot enter into Medicaid VBP arrangements without forming an IPA or obtaining New York State ACO certification.<sup>12</sup>

## FUNDS FLOW AMONG NETWORK PARTNERS

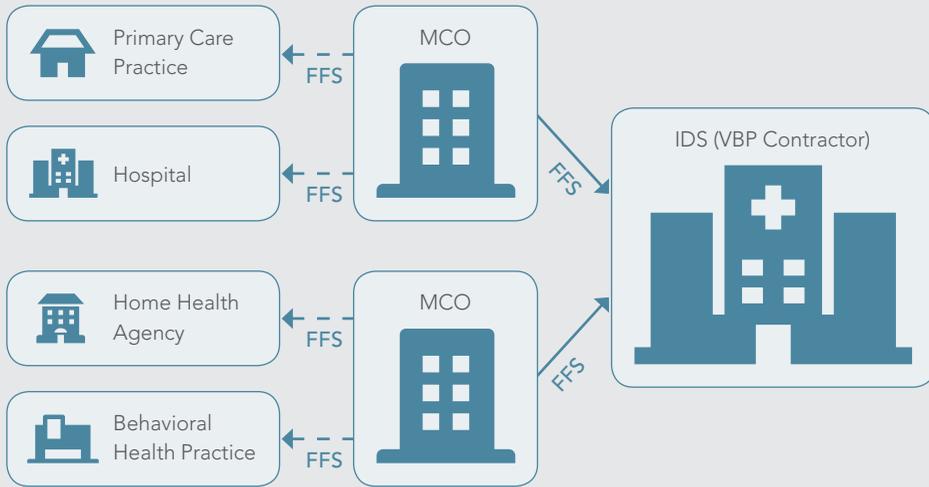
VBP arrangements may include a component whereby funds flow from the VBP contractor to network partners. However, as discussed in [Figure 5](#), depending on the VBP arrangement, reimbursement from MCOs to providers for health care services will most often be on an FFS basis, with VBP-related reconciliations occurring after adjudication and analysis of all claims in a specific period. In addition, funding can be provided from VBP contractors to their partners for particular services provided, to distribute shared savings, or to generally distribute funds from Level 3 bundled or capitated arrangements. Below are examples of funds flow processes from MCOs to VBP contractors and providers, and from VBP contractors to partners. Providers are included in the examples even if they are not VBP contractors because many providers will *not* be VBP contractors so they can continue to bill MCOs for services while potentially taking advantage of additional payments via participation as a VBP network partner. (Note: actual payments between MCOs and VBP contractors, MCOs and providers, and VBP contractors and network partners are all subject to negotiation between the relevant parties.)

### Scenario 1: IDS with Level 1 and Level 2 VBP Arrangements (Figure 9)

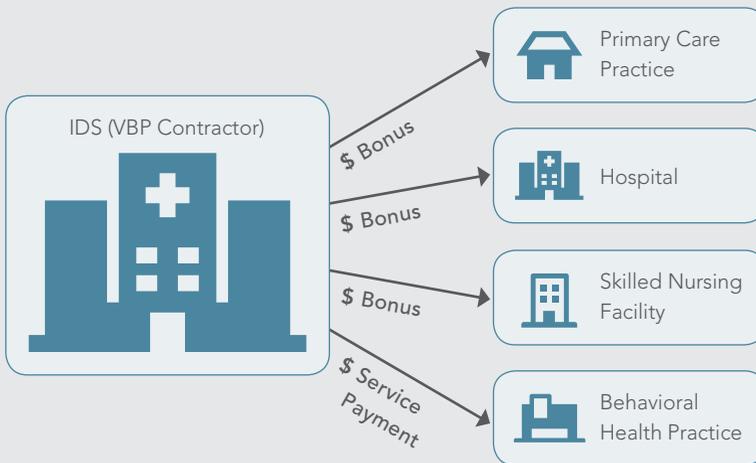
A group of partners, including a hospital, skilled nursing facility, primary care practices, behavioral health providers, and a home health agency have formed an IDS to allow for joint contracting. The IDS is the VBP contractor with multiple MCOs for VBP arrangements at Levels 1 and 2. Each MCO reimburses the VBP contractor as described in their contract. Separately, the MCOs have contracted with the network partners to make payments to those partners in accordance with their contracts.

<sup>12</sup> Accountable Care Organizations. CMS. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/>.

**FIGURE 9a. IDS WITH LEVEL 1 AND LEVEL 2 VBP ARRANGEMENTS**



**FIGURE 9b. IDS PAYMENTS TO NETWORK PARTNERS**



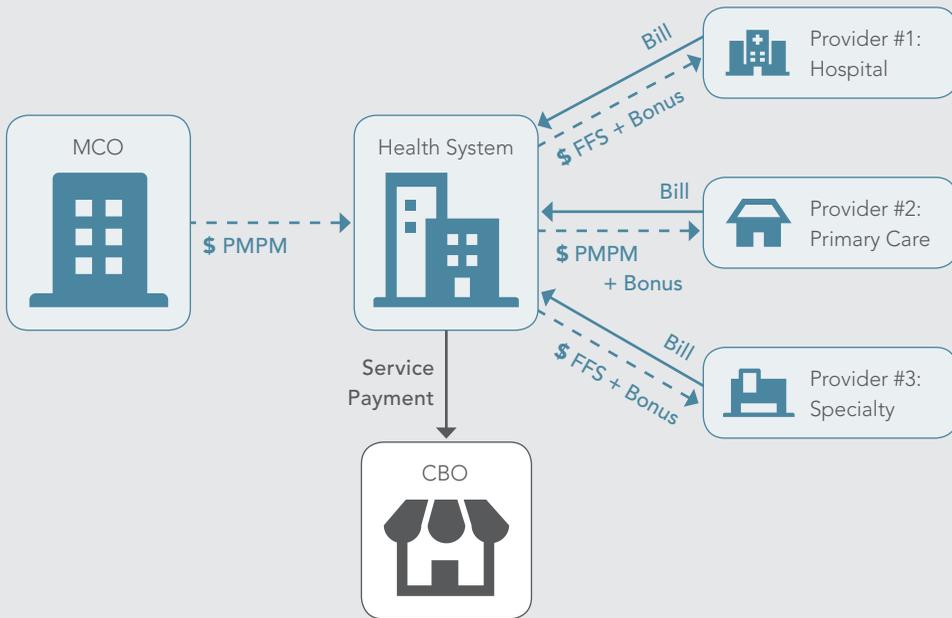
In addition to receiving MCO payments, most network partners each have an agreement with the VBP contractor describing their roles, performance expectations, and an incentive payment structure based on the VBP contract’s requirements. Certain network partners have fee-based agreements with VBP contractors to provide specific services, such as follow-up on behavioral health patients after discharge from a hospital to make sure the patient is accessing outpatient treatment.

Scenario 2: Health System with Level 3 Arrangement for Global Capitation (Total Cost of Care) (Figure 10)

A health system has a Level 3 global capitation arrangement with its largest MCO. The health system, as the VBP contractor, receives a prepaid, capitated payment for its attributed patients. In this case, these patients include those attributed to the health system-owned primary care practices, as well as community-based primary care practices with which the health system has partnered. Because the health system receives prepayment from the MCO, the health system must, in turn, pay the primary care practices for the services they provide to those attributed patients. Community-based specialty practices that treat those patients are also reimbursed by the health system.

These practices bill the health system, and the health system reimburses those practices on an FFS basis. One of the primary care practices negotiates a PMPM. All reimbursement is based on a contract between the health system and the practices. As part of their contract, the practices are eligible for bonus payments for meeting agreed-upon performance metrics. Providers in the health system-owned practices are also eligible for these bonuses. In the event of a loss, where expenses for the attributed patients exceed the global capitation amount, the contracted providers may not achieve their bonuses. The VBP contractor has purchased reinsurance, which helps to mitigate the impact of losses experienced under the global capitation arrangement.

FIGURE 10. HEALTH SYSTEM WITH LEVEL 3 ARRANGEMENTS



The health system also contracts with a local CBO to provide community health worker services for patients with chronic diseases. The service payments to the CBO are funded out of the negotiated MCO capitation.

## VBP RESOURCES

### **Accountable Care Organizations: General Information**

This section of the CMS website provides key definitions, an overview of the different ACO programs, and links to CMS-developed educational materials.

<https://innovation.cms.gov/initiatives/aco/>

### **Accountable Care Strategies: Lessons from the Premier Health Care Alliance's Accountable Care Collaborative**

This Premier Research Institute and Commonwealth Fund report shares national perspectives of ACOs that were part of a collaborative focused on accountable care implementation. The report includes feedback from health systems and hospitals, approaches to ACO organizational models, and best practices for implementing population health and performance assessments within ACOs.

[http://www.commonwealthfund.org/~media/files/publications/fund%20report/2012/aug/1618\\_forster\\_accountable\\_care\\_strategies\\_premier.pdf](http://www.commonwealthfund.org/~media/files/publications/fund%20report/2012/aug/1618_forster_accountable_care_strategies_premier.pdf)

### **IPAs for CBOs**

CBOs across the country have explored developing their own version of an IPA for contracting purposes. Community-based Integrated Care Networks (ICNs) have been developed by CBOs to serve as contracting vehicles between CBOs and payers. This concept was explored in Western New York through the region's participation in a local capacity-building initiative funded by the Health Foundation of Western and Central New York, as well as a national initiative funded by the Administration for Community Living, a special program of the US Department of Health and Human Services. A report on the experiences of participating organizations, *Community-Based Integrated Care Networks*, is available here: <http://www2.erie.gov/seniorservices/sites/www2.erie.gov/seniorservices/files/uploads/pdfs/wny%20integrated%20care%20collaborative%20community-based%20integrated%20care%20networks%20phase%202%20final%20report%202015.pdf>.

# SECTION FOUR

# CAPABILITIES, BENEFITS, AND CHALLENGES IN VBP

## LEARNING OBJECTIVES

- ✔ Describe the capabilities that partners should have to facilitate success in VBP arrangements
- ✔ List the common categories of health care measures
- ✔ Explain potential benefits and barriers for organizations when shifting to a VBP environment

## CAPABILITIES FOR SUCCESS IN VBP

Population health techniques and capabilities are important drivers of success in VBP. Specifically, care management and care coordination, referral management, technology, and quality and performance improvement can help VBP contractors and their partners achieve the quality outcomes and cost reductions that result in bonuses, incentives, and shared savings in VBP arrangements.

### Care Management and Care Coordination

Care management for high-risk individuals within a population applies interventions that address complex health care needs. While studies have shown mixed results as to the success of care management in driving down total health care costs, some evidence suggests that care management can lead to decreased high-cost services such as emergency room and inpatient admissions.<sup>13</sup>

Care coordination and patient navigation generally refer to non-clinical activities (e.g., making a follow-up call to ensure that a patient keeps an appointment with a specialist), but are important in ensuring that individuals are connected to the medical and social services needed to keep them healthy. This activity can result in patients receiving preventive services that can reduce the need for more acute interventions, or follow-up care that can prevent a readmission.

<sup>13</sup> J. Hsu, et al, "Bending the Spending Curve by Altering Care Delivery Patterns: The Role of Care Management within a Pioneer ACO," *Health Affairs* (2017).

## Referral Management

Managing resource utilization and health outcomes requires that referrals to specialists, diagnostic services (such as lab tests and imaging), and CBOs are made and that outcomes are reported back to the referring provider. Certain care team members may be tasked with tracking the progress and outcomes of referrals. This activity can be facilitated with technology that allows both health and social service organizations to send referrals and inform the referring provider when services have been delivered.

## Technology

EHRs and HIEs facilitate timely communication, information transfer, and data-sharing between network partners, which is critical to providing comprehensive care. Electronic care management tools and electronic patient registries can also help with promoting health outcomes. The collection and analysis of patient data using these tools helps identify trends and areas of opportunity to improve quality and reduce the cost of care.

## Quality Improvement and Performance Measurement

Improving health outcomes is at the core of VBP, and VBP contractors must be attuned to the outcomes and utilization patterns of their patients throughout the care continuum and continually find ways to improve. Most providers are familiar with quality improvement activities that focus on using data for continuous and systematic improvements, looking critically at workflows and processes, and working to identify areas for improvement. Quality improvement in the VBP context builds upon these efforts because VBP contractors are accountable for patient activity outside of their own organizations.

VBP arrangements include agreed-upon measures for which VBP contractors are accountable. Many of the measures come from claims submitted by providers and do not require separate reporting from the provider. However, some measures do require providers to collect and submit to the MCO data that is not available from administrative data sets such as claims. VBP measures can differ depending on the contracting parties and the patient populations served. DOH's CAGs developed measure sets for the VBP arrangements described in the VBP Roadmap. The measures generally align with national standards for measuring clinical processes, health outcomes, patient safety, patient experience, and cost of care.

Common categories of health care measures include:

- **Clinical Processes:** Measures that capture steps taken or interventions aimed at impacting clinical outcomes. Cancer screenings, immunizations, and initiation of specific treatments or interventions are all examples of clinical process measures.
- **Cost of Care:** Measures that capture the amount of money spent per patient or per episode of care.
- **Health Outcomes:** Measures that capture a change in health status that can be attributed to an intervention that an individual received. Mortality rate following a specific procedure or

## SECTION FOUR (continued)

rate of readmission following hospitalization are common outcome measures that may be tracked under certain VBP arrangements.

- **Patient Experience:** Measures that capture patient feedback on their satisfaction, engagement, and perception of the care delivered to them. The Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey is one common survey used nationwide to capture patient experience measures.
- **Patient Safety:** Measures used primarily in an inpatient setting to capture avoidable complications. These may be included in a VBP arrangement such as a bundled payment arrangement to ensure that providers continue to provide safe, high-quality care while controlling costs.

Pay-for-Reporting (P4R) measures mean that a VBP contractor is contractually obligated to submit timely, accurate, and complete data for the measure, but will not be judged on its performance for the measure. Pay-for-Performance (P4P) measures mean that a VBP contractor's performance is measured relative to a benchmark or target to determine whether or how much it is paid.

Network partners in a VBP arrangement may also be responsible for meeting a defined set of measures. These may replicate the measures that the VBP contractor is responsible for meeting. However, it may not always be appropriate or feasible for CBO partners that do not provide traditional health care services to be measured in the same way. These partners may be contracted to meet structural and process measures. The DOH-developed Social Determinants of Health Intervention Menu (referenced on [page 19](#)) is a helpful starting point for identifying measures that might be impacted by social interventions.

## BENEFITS OF VBP

The shift to VBP supports the Triple Aim of improving outcomes and population health while decreasing health care costs. In practice, this can translate into various benefits for VBP contractors and network partners.

### Patient Experience and Outcomes

Evidence suggests that the implementation of VBP models can positively impact both patient experience and quality outcomes. An evaluation of ACO initiatives showed improved performance over time on ACO quality measures and patient experience scores.<sup>14</sup> Another study that considered the implementation of the collaborative care model in primary care demonstrated that VBP has the potential to improve fidelity to evidence-based care and patient outcomes, particularly when the VBP arrangement is closely connected to quality targets and other key elements of evidence-based models.<sup>15</sup>

<sup>14</sup> Evaluation of CMMI Accountable Care Organization Initiatives. L&M Policy Research, LLC (December 2016).

<sup>15</sup> Y. Bao, et al. "Value-Based Payment in Implementing Evidence-Based Care: The Mental Health Integration Program in Washington State," *American Journal of Managed Care* (January 2017).

## SECTION FOUR (continued)

In general, activities that support VBP such as the incorporation of population health techniques, better use of data, and improved communication can help break down the siloes that patients sometimes encounter, thus ensuring a better health care experience. The direct link to health care providers when navigation and coordination activities are provided in the community setting can also help ensure that the providers are delivering proactive care that benefits their patients.

### Financial Incentives for VBP Contractors and Network Partners

As health care organizations and their partners strive to improve the health of their patients, clients, and communities, VBP arrangements can offer financial incentives that may help achieve those improvements. These incentives may be available at the provider level, where individual clinicians can receive additional payments for demonstrating high performance on defined metrics. Many providers are already engaged in activities to incentivize performance such as working within recognized patient-centered medical homes, where improving referral practices, reviewing data, and incorporating quality improvement initiatives into daily practice may lead to increased reimbursement. Any incentives for VBP contractors and network partners would be subject to negotiation between contracting parties.

For hospitals, there are specific considerations related to population-based arrangements in which a primary care group is the VBP contractor positioned to receive incentive payments resulting from decreasing avoidable hospital utilization. By partnering in these kinds of VBP arrangements, hospitals could benefit from incentive payments to cover related revenue loss. The hospitals also can participate in valuable care transitions activities.

### Operational Benefits and Sustaining Health Care Reform

Benefits related to operational performance and sustainability can vary depending on organization type. Hospitals, established IPAs and ACOs, and other providers that already engage in VBP could transition additional arrangements to VBP without requiring substantial changes to operations. These organizations likely have the organizational capacity and population health practices in place to work in this manner. Similarly, organizations with population health activities already underway to decrease avoidable admissions and ED visits can potentially leverage ongoing activities to achieve success in VBP.

As referenced in [Section 2](#), VBP contractors, particularly those in Level 2 and Level 3 arrangements, can take on certain MCO administrative functions such as utilization management, credentialing, and claims processing. The related challenges are discussed below, but organizations taking on these functions can establish their own protocols around utilization management and potentially decrease the administrative burden associated with denials for claims for services provided.

For CBOs, VBP can provide an opportunity to build business lines and demonstrate expertise in delivering services that are valuable to providers and the communities they serve. DOH is particu-

larly focused on Tier 1 CBOs and ensuring, through VBP Level 2 and 3 requirements, that there are opportunities for CBOs to partner with health care providers and institutions. To support CBOs in contracting with providers, DOH has funded a one-year planning grant in which participating CBOs have opportunities for capacity building, and technical assistance to prepare them to work more concretely in the health care space. DOH awarded three organizations in three regions (New York City, Long Island/Mid-Hudson, Rest of State) \$2.5 million each. Within their assigned region, each grantee is responsible for creating a consortium of Tier 1 CBOs with annual budgets of less than \$5 million, and working with a consultant to build an implementation plan for capacity building activities and partnering with health care providers.

A major impetus for VBP in New York State is to sustain the work that has taken place as part of the DSRIP program. PPSs and partners are currently using DSRIP performance payments to support population health activities such as care management and community navigation. DSRIP funding has also been used to help partners connect to HIEs, build quality improvement infrastructure, and fund trainings to prepare the workforce for the changing health care environment. State and Federal policymakers believe VBP arrangements can result in resources for providers that will enable them to sustain these activities into the future.

## **BARRIERS AND CHALLENGES TO VBP**

While there are myriad potential benefits to entering into VBP arrangements either as a VBP contractor or a network partner, there are potential operational and financial challenges.

### **Required Infrastructure and Capabilities**

VBP arrangements require substantial capabilities and infrastructure, including legal, IT, contracting, and administrative support. These capabilities are necessary to become a VBP contractor, but they are also important for network partners that may need to negotiate and enter into contracts with providers that are VBP contractors. As a result, VBP may be especially challenging for small clinical organizations and CBOs that do not already have this infrastructure.

VBP Level 2 and Level 3 arrangements—particularly total cost of care arrangements in which the VBP contractor agrees to take on utilization management, credentialing, and/or claims processing functions—may require even more resources. VBP contractors that negotiate to adopt these functions may require expertise that currently resides with MCOs, and there may be an associated learning curve.

VBP contractors require data capabilities and expertise, particularly in predictive analytics and reporting. Additionally, VBP contractors must have communication channels to provide timely reporting to network partners, and technical assistance capabilities to support partners who may be underperforming.

## SECTION FOUR (continued)

VBP may also require a major culture shift that transcends general infrastructure. Changing from a strictly FFS environment may be particularly challenging for health care organizations and providers that have built a culture around this reimbursement practice. Providers in a Level 3 arrangement may also need to consider billing and operating workflow changes.

This challenge may be mitigated by creating a planning team that includes clinical, business operations, quality, IT, contracting, and community outreach staff. Senior executives can ensure proper planning for workforce impact and strategies surrounding change management in order to achieve the organization's goals in participating in a VBP arrangement. Effective communication between the leadership team and local leadership is also important in managing significant cultural changes.

### Assumption of Risk

Level 2 and 3 VBP arrangements require VBP contractors to take on financial risk, and can result in a loss of revenue for the contractor as well as its network partners (depending on the contract) if performance targets are not met. Providers that enter into risk arrangements may also need to meet Department of Financial Services requirements for risk transfers.

Small organizations may also lack the scale, capacity, and payer mix that would facilitate success in a VBP arrangement. Large panels of patients across payers help spread the risk. Smaller practices or organizations with fewer attributed patients may do an assessment and decide that they are unable to take financial risk due to the number of high-risk patients they have or the unpredictability of their patient mix. Small practices may avoid entering into shared risk arrangements for these reasons or may opt to join a larger group of providers as members of an IPA or ACO.

VBP requires careful planning and strategy. Organizational leadership must assess the role they wish to play and the amount of risk, if any, they are willing to assume. These organizations must ensure that they can be successful under agreements that ultimately may affect financial performance.

### Partnerships

VBP arrangements require partnerships to be successful. Partnerships can take time to develop. Organizations must develop open lines of communication to discuss issues such as funds flow, performance, and operational challenges. Without effective partnerships with organizations across the care continuum, VBP may be a challenging undertaking.

Organizations planning to become VBP contractors may engage in a partner selection and vetting process to help ensure that potential partners can contribute to success.

# VBP RESOURCES

## **Overview of Preparing Community-Based Organizations for Successful Health Care Partnerships**

This article, published by the SCAN Foundation, describes the core competencies for CBOs to demonstrate their ability to contribute to improved health care outcomes and reduced utilization. The article provides specific steps and decision points for CBOs as they develop strategies for working with health care organizations.

[http://www.thescanfoundation.org/sites/default/files/tabbush-cbo\\_healthcare\\_prtnrshps-8-22-12.pdf](http://www.thescanfoundation.org/sites/default/files/tabbush-cbo_healthcare_prtnrshps-8-22-12.pdf)

## **Considerations for Pediatric Providers in Selecting Outcomes Measures**

This United Hospital Fund report focuses on the types of measures and outcomes that could be part of a pediatric VBP arrangement. The report includes case studies on innovative payer and provider partnerships and the measures that were incorporated into their payment arrangements.

<https://www.uhfnyc.org/publications/881134>

## **Facilitators and Barriers to Payment Reform**

This report, prepared by Bailit Health Purchasing, LLC, and funded by the Robert Wood Johnson Foundation, describes market-based, governmental, organizational, and design factors that can enable or impede payment reform. The report is intended for providers, employers, and other stakeholders interested in undertaking or supporting a payment reform effort. Report content was informed by interviews with RWJF grantees that implemented payment reform initiatives.

[https://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2013/rwjf407900](https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407900)

## **A Case Study in Payment Reform to Support Optimal Pediatric Asthma Care**

This Brookings Institution case study uses asthma care to illustrate how emerging payment models can influence care redesign and improve value in health care.

<https://www.brookings.edu/wp-content/uploads/2016/06/asthma-case-study.pdf>

# APPENDIX A

## COMPARING CMS VBP CATEGORIES<sup>16</sup> AND DOH VBP LEVELS

CMS developed a VBP taxonomy framework that defines the CMS VBP categories, the extent to which they impact quality and efficiency, and the CMS programs associated with each.

### CMS PAYMENT TAXONOMY FRAMEWORK

	CATEGORY 1: Fee-for-Service— No Link to Quality	CATEGORY 2: Fee-for-Service— Link to Quality	CATEGORY 3: Alternative Payment Models Built on Fee-for-Service Architecture	CATEGORY 4: Population-Based Payment
DESCRIPTION	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or two-sided risk	Payment is not directly triggered by service delivery, so volume is not linked by payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥ 1 yr)
MEDICARE FFS	<ul style="list-style-type: none"> <li>Limited in Medicare fee-for-service</li> <li>Majority of Medicare payments are now linked to quality</li> </ul>	<ul style="list-style-type: none"> <li>Hospital value-based purchasing</li> <li>Physician value-based modifier</li> <li>Readmissions/hospital-acquired condition reduction program</li> </ul>	<ul style="list-style-type: none"> <li>Accountable care organizations</li> <li>Medical homes</li> <li>Bundled payments</li> <li>Comprehensive primary care initiative</li> <li>Comprehensive ESRD</li> <li>Medicare-Medicaid financial alignment initiative fee-for-service model</li> </ul>	<ul style="list-style-type: none"> <li>Eligible pioneer accountable care organizations in years 3–5</li> </ul>

<sup>16</sup> <https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2015-fact-sheets-items/2015-01-26-3.html>

**APPENDIX A** (continued)

Although DOH’s and CMS’s overall goals are aligned, the VBP programs use slightly varying terms and descriptions. For Medicare purposes, CMS has developed VBP *categories* and their associated risk *levels*, while for Medicaid purposes, DOH has developed VBP levels. The below provides a side-by-side of the CMS and DOH VBP categories and descriptions.

CMS-MEDICARE VBP CATEGORIES		DOH-MEDICAID VBP LEVELS <sup>17</sup>	
Category Name	Description	Category Name	Description
Category 1	Fee-for-Service (FFS) with no link to quality	Level 0	FFS with bonus/withhold for quality outcomes (not VBP)
Category 2	FFS with a link to quality	Level 1	FFS with only upside risk
Category 3	Alternative payment models built on FFS methods	Level 2	FFS with risk sharing (upside and downside)
Category 4	Population health-based payments	Level 3	Global capitation

Both CMS and DOH developed VBP arrangements around clinical conditions, specific populations, and chronic disease care.

<sup>17</sup> DOH VBP Roadmap

## APPENDIX B

# DOH SDH INTERVENTION MENU EXCERPT

SOCIAL DETERMINANT	VBP-FUNDED INTERVENTION OPTION(S)	HEALTH OUTCOME(S)	RESOURCE(S) THAT CAN BE LEVERAGED	POPULATION HEALTH OBJECTIVE(S)
Economic instability, poverty, and lack of employment	Case management, entitlement assistance with disability benefits, public assistance, other subsistence benefits, referral to vocational rehabilitation services, referral to child care	Improved physical and mental health quality of life	Disability benefit programs, Temporary Assistance for Needy Families (TANF) and Safety Net Assistance, vocational rehabilitation programs, provision of child care	Improved disease management and prevention, reduction in chronic diseases associated with poverty, such as obesity, asthma, HIV, etc.
	Provision of child care	Greater economic well-being, leading to improved health	Means-based child care programs	
	Training and employment opportunities via the use of supportive employment or credentialing programs for peer-specialist community health workers in The New York State Office of Alcoholism and Substance Abuse, Office of Mental Health, DOH, and other Medicaid-funded programs to provide an avenue to return to work	Improved physical and mental health quality of life	Office of Temporary and Disability Assistance (OTDA) and local department of social services job training programs	Benefits to program participants include improved disease management and prevention; benefits to both program participants and patients served by community health workers include reduction in chronic diseases associated with poverty such as obesity, asthma, HIV, etc.

APPENDIX B (continued)

SOCIAL DETERMINANT	VBP-FUNDED INTERVENTION OPTION(S)	HEALTH OUTCOME(S)	RESOURCE(S) THAT CAN BE LEVERAGED	POPULATION HEALTH OBJECTIVE(S)
Homelessness, housing instability, and lack of access to affordable housing	Respite care	Reduced readmission/ER visits, more stable environment for delivery of health care services, reduction of stress and its adverse health outcomes, reduction in health problems associated with sub-standard housing	Homeless housing funding (capital and operating funding), PAM, Collage	Universal access to safe, appropriate and affordable housing
	Rental assistance	Increased health stability, reduction in avoidable inpatient and ER utilization, reduction of stress and its adverse health outcomes, reduction in health problems associated with sub-standard housing	TANF, New York City Housing Authority (NYCHA), Home Sharing Programs, Section 8, SCRIE, DRIE, NYS Housing & Community Renewal (HCR), NYC Housing Preservation & Development (HPD), PAM, Collage	
	Housing-related case management services	Increased health stability, reduction in avoidable inpatient and ER utilization, reduction of stress and its adverse health outcomes, reduction in health problems associated with sub-standard housing	Grant-funded case management programs, NYCHA, Home Sharing Programs, Section 8, SCRIE, DRIE, NYS Housing & Community Renewal (HCR), NYC Housing Preservation & Development (HPD), PAM, Collage	
	Legal services	Increased health stability, reduction in avoidable inpatient and ER utilization, reduction of stress and its adverse health outcomes, reduction in health problems associated with sub-standard housing	Legal services	

**APPENDIX B** (continued)

SOCIAL DETERMINANT	VBP-FUNDED INTERVENTION OPTION(S)	HEALTH OUTCOME(S)	RESOURCE(S) THAT CAN BE LEVERAGED	POPULATION HEALTH OBJECTIVE(S)
Food insecurity, lack of adequate nutrition, and lack of access to healthy foods	Community-based care coordination, nutritional case management, counseling and coaching (including client-centered technologies)	BMI/Chronic Disease Prevention, enhanced growth (during childhood and pregnancy); healing, maintenance, and development of healthy muscle mass, enhanced brain health	Supplemental Nutrition Assistance Program (SNAP), WIC, School Breakfast Program (SBP), Farmers Market, WIC Couponing, Summer Food Service Program, Child & Adult Food Care Program, Meals on Wheels, Senior Centers, Department for the Aging (DFTA), DOH, State Office for the Aging (SOFA), Human Resource Administration (HRA), Administration for Children's Services (ACS)	Access to high-quality nutritious foods for improved health; decreased incidence of costly chronic illnesses such as heart disease, diabetes, obesity, bone loss, osteoporosis, and Alzheimer's; enhanced growth (during childhood and pregnancy); healing, maintenance, and development of healthy muscle mass; nutrition to at-risk populations to increase overall population health
	Fruit and vegetable prescription	Decreased risk of heart disease, diabetes, obesity, bone loss, osteoporosis, and other chronic diseases		
Lack of education, educational disparities	Community-based case management	Chronic disease prevention, increased use of health care services	Existing programs such as the Community Health Advocates, HIV case management model, supportive services connected to education, funding for case management services (government and foundation)	Increased access to health care services

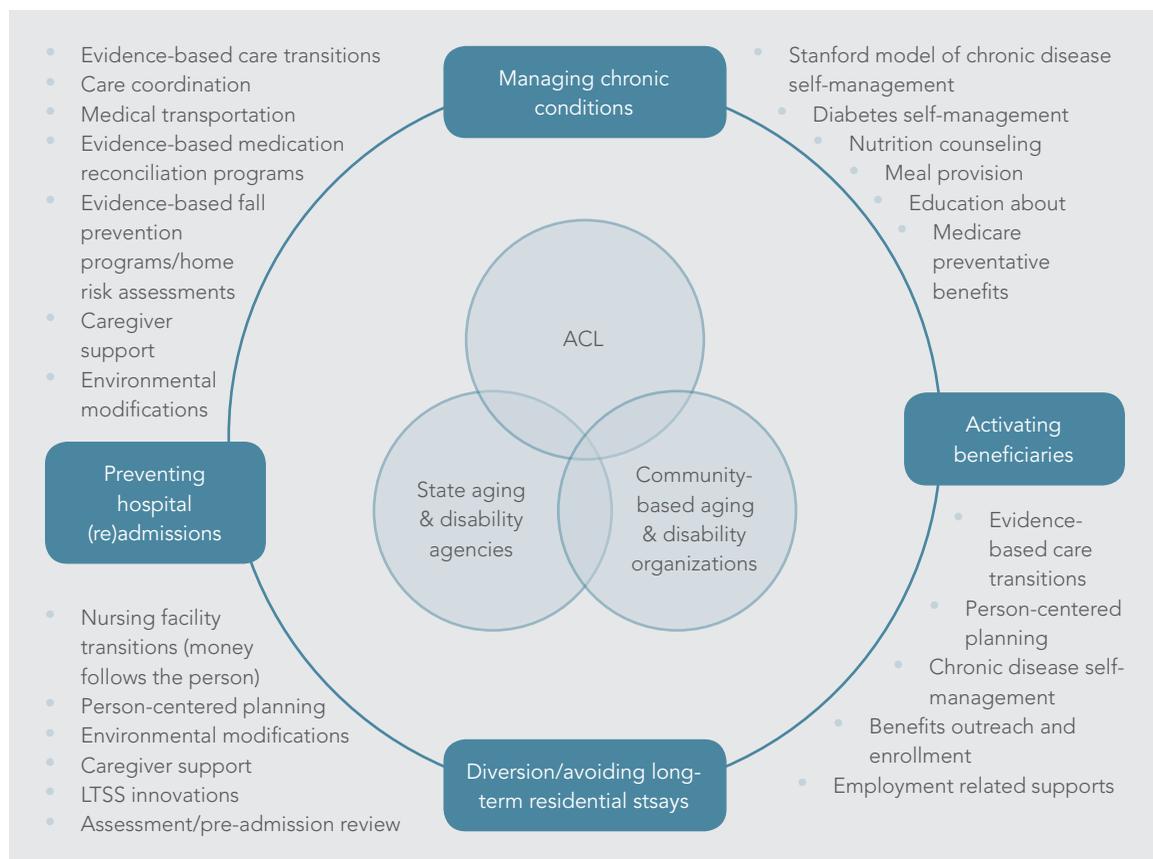
**APPENDIX B** (continued)

SOCIAL DETERMINANT	VBP-FUNDED INTERVENTION OPTION(S)	HEALTH OUTCOME(S)	RESOURCE(S) THAT CAN BE LEVERAGED	POPULATION HEALTH OBJECTIVE(S)
(continued)	Community health workers (CHWs)	Increased health stability (especially in high-risk/high-chronic illness/low health literacy communities), reduced use of hospital emergency rooms, trauma reduction, increased use of primary care, and improved treatment adherence	Existing CHW programs, existing CHW training programs (MRNY, CUNY, CHW Network of NYC), other state examples (Minnesota, Massachusetts, and Texas), CHW network/ NYSHF report/MRT work done, previous research such as the National Community Health Advisor Study and the Community Health Worker National Education Collaborative	Universal quality access to health care services, improved health outcomes (disease prevention and chronic disease management, such as control of asthma)
Criminal justice involvement	Ongoing support during incarceration that includes both pre and post re-entry services related to offender's health status	Successful offender re-entry into the community	DOJ, State, and local re-entry programs and funds	Decreased asthma, hypertension, substance use and other chronic conditions with a higher prevalence in prison population

# APPENDIX C

# OPPORTUNITIES FOR CBOs TO ADD VALUE<sup>19</sup>

The below figure was developed by the Administration for Community Living to demonstrate the ways in which CBOs serving seniors could impact specific health care outcomes. Providers and CBOs can use the image as a template to fill in specific outcomes and services of importance to the patient population.



<sup>19</sup> A. Parekh, Schreiber, R. "How Community-Based Organizations Can Support Value-Driven Health Care," (July 2015). <http://healthaffairs.org/blog/2015/07/10/how-community-based-organizations-can-support-value-driven-health-care/>.

## APPENDIX D

# CASE STUDIES: VBP IN ACTION

The following case studies provide concrete examples of how the implementation of VBP contracts may affect different kinds of providers.

### **TOTAL CARE GENERAL POPULATION (PRIMARY CARE PRACTICE EXAMPLE)**

Dr. Jones is a physician in a large, hospital-based primary care teaching practice. In addition to a panel of her own patients, Dr. Jones also supervises residents who each have their own patient panel. Most of their patients have traditional Medicaid or Medicaid managed care. The practice is an NCQA-recognized patient-centered medical home that has implemented population health capabilities such as registries to track patients with particular diagnoses, a referral management workflow to track specialist referrals, and EHR workflows to alert primary care providers when their patients are admitted to the ED or inpatient units. Practice staff include nurses, medical assistants, and front desk staff to provide support, education, registration, and referral assistance for the patients in the practice. The practice also includes social workers, care managers, and care coordinators to work with patients deemed high-risk.

#### **Current State**

Under the current FFS model, the practice's main emphasis is to ensure that it provides strong access and sees as many patients as possible. Dr. Jones' patients are scheduled for 10- to 15-minute visits each, and she is expected to see four–five patients per hour. This structure does not always allow her time to address her patients' various concerns. While under the FFS model, Dr. Jones bills for every visit, procedure, blood draw, and vaccine. Most of the care management and care coordination services provided by staff members are not billable services.

#### **VBP State: Various VBP Arrangements and Levels in a Practice**

The hospital that owns the practice is a VBP contractor with some MCOs, and the practice operates under a number of different arrangements for total care of the general population.

The practice has two arrangements that meet VBP Level 0 criteria, which is an FFS model with opportunities for bonus payments when quality measures are achieved. The arrangements do not count toward DOH VBP goals. The bonus payment, if achieved, could help cover the costs of care

management and coordination staff who help ensure patients receive certain preventative care services, the delivery of which contribute to better performance on the bonus-eligible measures monitored by the MCOs.

The practice also has one VBP Level 1 arrangement whereby it can share in savings generated within the contract year. Within this arrangement, the practice will continue billing the MCO for services provided, and will receive FFS payments as negotiated with the MCO. At the end of the contract year and after all claims have been processed, the MCO will calculate any savings achieved by the practice. The practice will only receive a payment if the cost of care for the attributed population was less than the expected cost calculated by the MCO. The practice also must achieve the agreed-upon quality measures to receive their shared savings payment. If the practice does not achieve savings or does not meet the quality measures, they are not at risk because the Level 1 arrangement includes upside risk only.

After two years of successful experience with its Level 1 shared savings arrangement, the hospital (as the VBP contractor) and the MCO agree to move to a Level 3 capitated arrangement. The hospital is now responsible for all costs of care for the attributed patients who are members of the MCO. Through this arrangement, the hospital receives a capitated PMPM for each patient attributed to the primary care practice who is a member of the MCO. This can be a profitable arrangement for the hospital if, in partnership with the primary care practice, it is able to keep total costs below the capitation amount. The Level 3 VBP arrangement includes an outcome-based component whereby the practice must demonstrate to the MCO that it has met the quality measures that are part of the agreement. The hospital is subject to financial penalties if quality benchmarks are not met.

### **INTEGRATED PRIMARY CARE WITH CHRONIC BUNDLE (SPECIALTY PROVIDER PARTICIPATION EXAMPLE)**

Dr. Lopez is a pulmonologist (lung doctor) working in a group practice with other providers in the same specialty. The practice includes one nurse and a few medical assistants. The practice accepts patients enrolled in certain MCOs.

#### **Current State**

Under the FFS model, Dr. Lopez focuses on ensuring strong access and sees as many patients as possible. Dr. Lopez and his colleagues receive annual bonuses as part of their contracts with the practice for meeting volume targets. Dr. Lopez's patients are scheduled for short visits, and there often is not enough time to provide them with as much education as may be needed to ensure they fully understand how to use their medications. The practice's medical assistants are busy with intake, rooming patients, and setting up for spirometries and other procedures.

#### **VBP State: Integrated Primary Care, Level 2**

The practice recently joined an IPA comprised of primary care and specialty providers. The IPA has entered into a Level 2 VBP integrated primary care arrangement. Within the chronic care bundle,

the pulmonary practice is an important partner because it provides specialty care for some high-risk patients with asthma. The pulmonary practice continues to bill the MCO on an FFS basis for the services it provides. The IPA has an opportunity to achieve shared savings at the end of the year if actual costs of the IPA patients are below the expected costs and if quality outcomes are met. The IPA has agreed to distribute a percentage of shared savings to the participating specialty practices that contribute to relevant outcomes—in this case, the asthma measures. To help the IPA achieve shared savings that can be distributed, the IPA has deployed care coordinators and care managers to partners to track and manage high-risk patients. Dr. Lopez and his colleagues collaborate with the care managers and care coordinators, who provide education, assist with medication adherence, and ensure effective handoffs between the practice and the other providers in the IPA. Though the IPA has taken positive steps to achieving savings, it is possible that savings will not be realized or that actual costs could exceed the expected costs. If this happens, the IPA is responsible for a share of the excess costs. The IPA will pay the MCO for its share of the losses by an assessment against physicians in the IPA.

### **TOTAL CARE FOR SPECIAL NEEDS SUBPOPULATIONS (BEHAVIORAL HEALTH EXAMPLE)**

Dr. Patel is a psychiatrist working in a community-based behavioral health practice. As an Article 31-designated clinic, the practice is licensed by the New York State Office of Mental Health and accepts Medicare and Medicaid plans. The practice provides mental health services, as well as care management, social work, and other navigation services for its patients. The practice is a health home partner with many patients eligible for and enrolled in the Health and Recovery Plan (HARP), a managed care product for adults who have significant behavioral health needs.

#### **Current State**

Under the FFS model, the practice is reimbursed for the billable services it provides. For patients enrolled in the HARP program, certain care management and navigation services are reimbursable. As a health home partner, the practice receives FFS payments for care management of health home patients, and it is funded to conduct outreach for health home-eligible patients. Outside the health home- and HARP-enrolled patients, care management and coordination services are not billable. Certain provided services are not billable at all, such as those that address patients' social needs. While the practice sometimes develops new programming with grant funding, it is difficult to sustain such services when the grant runs out.

#### **VBP State**

As a HARP provider, the practice has considered entering into a total care arrangement with its various MCOs for the HARP subpopulation. After an analysis, the practice discovers that it does not have sufficient volume with any single MCO to enter into a risk-based arrangement. A VBP Level 1 arrangement with upside shared savings may be a possibility, if the MCOs are willing to enter into the arrangement. The practice is also considering developing an IPA along with other community-based behavioral health practices. The IPA entity may permit this behavioral health practice to

join others to increase the total volume of patients, and may allow these individual practices to enter into higher-level VBP arrangements with payers and potentially take on risk.

### **CBO PARTICIPATION EXAMPLE**

Community Senior Center is a CBO that provides social services and support for individuals over age 65. The Center provides various services to the local community, including free and low-cost meals, meal delivery, social activities, and health care and nutrition education. The center also enrolls people in health insurance programs and the Supplemental Nutrition Assistance Program (SNAP, formerly known as “food stamps”). An anchor in the community, the center provides referrals for other social services and case management services for unmet social needs.

#### **Current State**

Community Senior Center does not provide services that are reimbursable by health care payers, making it a Tier 1 CBO, according to DOH’s tiering methodology. Certain activities are funded by the New York State Office for the Aging and the local government’s senior services division. The center seeks grant funding regularly to develop new programs, some of which are unsustainable when the grants end.

#### **VBP State: Network Partner**

Community Senior Center contracted with a local hospital to provide care transition services. The center works with hospital discharge planning staff to safely transition patients into the community and avoid costly readmissions.

The hospital refers high-risk patients over the age of 60, regardless of payer, to this newly established care transitions program. The senior center’s staff review the social needs of patients about to be discharged and provide referrals to organizations that can address them. The staff also conduct a home visit after the patient is discharged and provide intensive follow-up and case management for patients.

The hospital has VBP arrangements at different levels with multiple payers. The contract between the Community Senior Center and the hospital is separate from the hospital’s VBP contracts with its payers. The hospital pays the senior center a fixed amount per patient for care transition services. The hospital has built into its contract with the Center an additional incentive payment if the hospital meets cost and quality targets and receives shared savings. To receive the incentive payment, the Center must track the status of each referred patient and report agreed-upon process measures monthly to the hospital.

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