NY Medicaid Program Pushes Value-Based Purchasing Trend

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Law360, New York (July 7, 2015, 1:07 PM ET) -- New York has adopted an ambitious plan for value-based purchasing ("VBP") in its Medicaid program, placing the state at the forefront of the national movement to find new reimbursement models. As set forth in its plan currently under review by the Centers for Medicare & Medicaid Services, over the next five years New York aims to have 80 to 90 percent of Medicaid payments made through alternative payment models that entail shared risk tied to cost savings and quality measures.[1] New York's VBP plan is part of the roll out of the Delivery System Reform Incentive Payment program ("DSRIP") that will distribute $7.3 billion in Medicaid funds to 25 new organizations in the state, called performing provider systems ("PPS").[2]

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System Transformation in New York

Under DSRIP, each PPS will be funded for five years to build an integrated delivery system, reduce preventable hospital admissions and emergency department use by 25 percent, expand access to primary care and behavioral health services and manage population health. PPS entities have committed to carry out five to 11 projects from a CMS-approved list mapped out by the New York State Department of Health ("NYSDOH") that covers system transformation, clinical improvement and population health management. Comprised of providers from across the continuum of care, including hospitals and health systems, physicians, nursing homes, home care and behavioral health providers and federally qualified health centers, PPSs will be awarded payments based on performance of identified process and outcomes measures, focused in the first two years on tasks to build an integrated delivery system and in years three through five on reducing preventable hospital use.

Among many other requirements, PPS entities must work with providers in their networks to prepare and implement a VBP strategy and plan. NYSDOH, responsible for overseeing DSRIP, has urged each PPS to begin conversations with managed care organizations ("MCOs") to align goals, measures and incentives as a platform for VBP arrangements between PPSs and MCOs.

New York's VBP Plan

Implementation of the VBP plan and DSRIP are inextricably linked. The VBP plan is intended to enable providers to sustain the costs of care coordination, patient engagement initiatives, infrastructure, including information technology investments, and workforce training and redeployment that must accompany the shift of 25 percent of acute care utilization to community-based settings. DSRIP funds are targeted to pay for those costs during the planned five-year transition to VBP.[3]

The VBP plan discusses guiding principles for payment reform, including bonus payments to reward improved performance as well as high performance. The VBP plan lays out three different types of payment arrangements and goals to transition along the spectrum of those arrangements from fee-for-service to full capitation. Like the options under the Medicare Shared Savings Program for Accountable Care Organizations, providers and PPS entities can share only upside risk (i.e., shared savings but not shared losses), both upside and downside risk (i.e., shared savings and losses), and full capitation.

The VBP plan identifies four models for the arrangements, recognizing that providers and plans will be free to agree to other arrangements: (1) coverage of all care for the total population of Medicaid beneficiaries; (2) integrated primary care delivered through patient-centered medical homes and advanced primary care practices; (3) care bundles targeted to episodic care, such as maternity care and treatment for depression; and (4) total care for a subpopulation. NYSDOH will work with providers, plans and consumers to standardize key elements of each model: the services covered, eligible

beneficiaries, quality and outcome measures and methods for calculating the risk-adjusted cost of care for each model. NYSDOH will also seek alignment between the quality and outcome measures for VBP and for DSRIP.

Consistent with the significant role that NYSDOH played in bringing together the networks of providers that comprise the 25 PPS entities in DSRIP, the VBP plan envisions an active role for NYSDOH. The NYSDOH will convene an advisory panel of stakeholders, with subcommittees charged to develop recommendations for specific aspects of the VBP plan, including incentive design, regulatory relief and strategies to involve community-based organizations whose services could prevent hospital readmissions. MCOs will be required to increase VBP arrangements and will have financial incentives to engage in VBP, including higher capitation premiums based on the percentage of VBP arrangements, and reliance on a quality performance pool for MCOs targeted to VBP arrangements.

Conclusion

Spurred by the Affordable Care Act,[4] VBP arrangements by state governments and commercial insurers are on the rise. CMS recently announced its own plan to transition to VBP with a goal of attaining 85 percent of Medicare fee-for-service payments in VBP models based on quality and shared savings by 2016, and 90 percent by 2018.[5] Many other states have also launched VBP programs through Medicaid, expanding financial incentives initially focused on penalizing serious medical errors and preventable hospital admissions.

Tied to DSRIP, the VBP plan in New York faces clear hurdles. The scale of DSRIP and the transformation it seeks to achieve in the health care delivery system as a platform for VBP is unprecedented. Comprised in some cases of 1,500 or more providers, PPSs must build the capacity for data exchange, care coordination and data analytics to engage effectively in VBP. New York has provided the option for PPS entities to apply for state action immunity under federal antitrust laws and immunity from private claims under state law during the five-year period of DSRIP.[6] In an April 22, 2015, letter, the Federal Trade Commission[7] expressed strong reservations about the grant of antitrust immunity and the concentration of competing providers participating in each region in the PPSs that have applied for such immunity to date, stating that this may increase the risk of anti-competitive harm.[8]

The Federal Trade Commission letter highlights the unresolved tension between antitrust policy and health system redesign prompted by federal and state health reform. New York has linked VBP with far-reaching system transformation in its DSRIP program. By doing so, it is likely to test the willingness of both the federal and state governments to align their roles as payer and regulator in the national shift underway in reimbursement and care delivery models.

—By Tracy E. Miller, Bond Schoeneck & King PLLC

DISCLAIMER: The author currently represents three performing provider systems building integrated delivery systems under the Delivery System Reform Incentive Payment program.

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[1] New York State Department of Health. A Path Toward Value Based Payment: New York Roadmap for Medicaid Payment Reform. Albany, New York (April 2015). https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/revised_draft_vbp_roadmap.pdf.

[2] See DSRIP Overview at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/overview.htm.

[3] New York State Department of Health at 5.

[4] Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, amended by Health Care and Education Reconciliation Act ("HCERA"), Pub. L. No. 111-152 (2010); For discussion of the provisions of the ACA that require new payment arrangements linked to quality, see Tracy E. Miller, Policy Initiatives Drive Quality of Care to Center Stage for Payers and Providers, Bloomberg Law Reports, vol. 4, no. 4 (2011).

[5] CMS. Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume. CMS Fact Sheet (Jan. 25, 2015). http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-

26-3.html.

[6] 10 NYCRR Subpart 83-2.

[7] FTC, Letter to Center for Health Care Policy and Resource Development, New York State Department of Health (April 22, 2015).

[8] For an analysis of the issues raised by the FTC letter, see Dionne Lomax, Stephen Weiner, Nili Yolin, For NY Medicaid, It's Health Reform Vs. Antitrust Law. Law 360 (May 21, 2015).