CRP Value Base Pilot: An Update

Presentation for CP Conference
John Ulberg

Meeting Date: October 17, 2016
CRP Value Based Payment (VBP) Pilot

• Goals/Objectives:
  • Capitalize on the Centers of Excellence (COE) expertise to explore VBP and other system reforms.
    • Centers of Excellence experience will be shared and adopted by non-COE providers once a framework is established.

• Today's Agenda:
  • Recap Progress to Date
  • Modify Fees/Corridor Approach
  • Attribution Analysis
  • VBP Overview
    • Measuring Total Cost of Care
    • Target Budget and Shared Savings
  • Next Steps
Recap

• Created CRP Fee effective 7/1/15, including 5% ATB increase.
• COEs compiled potential quality metrics.
• Performed first round attribution analysis for all CRPs.
• Evaluated Total Costs of Care and spending profiles by CRP based on first round attribution.
Modifying Current CRP Fees / Corridor Approach

• Current fees were based on historical rates, which exhibit significant variation amongst providers ($287 - $646 Per Diem).

• Concerns have been raised that adjustments are required to better balance resources with need.

• DOH/OPWDD have developed a corridor approach, consistent with VBP/MC, to redistribute CRP resources to mitigate financial impact.

• Under the approach, CRP resource utilization will be compared to the level of resources provided for under their current fees.

• Providers receiving resources in excess of their need will be caped at determined levels, with those excess resources being reallocated to providers receiving resources under their current need.

• The corridor is implemented by adjusting fees accordingly.
Example: A 3% corridor on net costs/(surplus) is used to redistribute dollars from providers with excess resources to those experiencing resource shortages.

CRP ABC

- Corridor Upper Bound: $103
- Current Fee: $100
- Corridor Lower Bound / New Fee: $97
- Cost: $95

CRP XYZ

- Cost: $105
- Corridor Upper Bound / New Fee: $103
- Current Fee: $100
- Corridor Lower Bound: $97
In order to evaluate VBP performance metrics, each CRP provider will have a cohort of individuals attributed to them. The attribution serves as the basis for development of the target metrics, as well as the subsequent performance metrics.

**Initial Draft Attribution Analysis**

- DOH performed an initial draft attribution analysis on 3 years of historical data (CYs 2013, 2014, and 2015).
- Attribution criteria required at least 350 days of ICF billing in that year.
- This analysis method attributed 80-87% of CRP capacity. The remaining 13-20% (50-70 ppl) either were not in a CRP the entire year, or switched CRPs midyear.
Attribution

Proposed Attribution Methodology

• Current CRP residents will be considered attributed to the CRP at which they reside, as long as a claims history of significant duration exists for that individual at that CRP (e.g., 6 months).

• Individuals residing in the CRP during the evaluation period, who were not initially attributed to the CRP, will not be considered “attributed” to the CRP for the purpose of performance measurements. Likewise, individuals who leave the CRP during the evaluation period will remain part of the measured cohort evaluated against VBP targets.
# Different Types of VBP Arrangements

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

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

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

*Level 0 is not considered to be a sufficient move away from traditional fee-for-service incentives to be counted as value based payment in the terms of the NYS VBP Roadmap.
General Population and Subpopulations

• VBP arrangement for I/DD is a subpopulation total cost of care arrangement

- The total population is divided into the general population and four specific subpopulations:
  1) HARP (Behavioral Health)
  2) HIV/AIDS
  3) I/DD
  4) MLTC

• Subpopulations are contracted for the total cost of care for their Medicaid members.

• Subpopulation design to incentivize care coordination across traditional “silos” of care.
Why Total Care for Subpopulations Can Be Attractive

• Dedicated focus on these subpopulations can get lost in larger Total Care for Total Population models (such as Medicare ACOs)
• Dedicated incentive to reduce the significant inefficiencies and potentially avoidable complications within these subpopulations creates maximum positive impact for these subpopulations
• The significant budgets of these subpopulations and the significant potential for shared savings become available for these groups of dedicated providers
• Rather than relying on separate and often small grants to improve housing and other social determinants of health, a large budget is now available to (re-)invest and restructure the delivery system and invest in Community Based Organizations & the social determinants of health
  • For these subpopulations (HARP, HIV/AIDS, MLTC, I/DD), these social determinants are especially important
Setting Target Budget is a Key Step in the Determination of Shared Savings/Losses

Defining the scope of services

Target Budget (3-Year Weighted Trend)

Determination of actual spend vs target budget

Calculation and Payment of Shared Savings / Losses

- Define Baseline Costs to be Included
- Key Questions:
  - Duals?
  - Private pay?

1. Baseline FFS Costs (3 years)
2. Trend (if update to current year is needed)
3. Other Adjustments
   - Partial year?
   - Corridors?

Upside gains: Actual spend < Target Budget Added to Next Year’s Fee

Retrospective Reconciliation
Financial Incentives for VBP Contractors and Other Providers: Shared Savings and More

- Potential for shared savings: incentives for a reduction in net spending for a defined patient population/bundle, and reinvestment of those savings back into the provider system
- Performance adjustments for those VBP contractors that are high value performers before the contract year starts
- Stimulus adjustments for those VBP contractors moving to Level 2 or higher
- All these incentives have their opposites: shared losses, downward performance adjustments, penalties for providers that could but are not moving to VBP
Average Total Spend = 186,679 Per Resident Per Year
Non-MA Spend on CRP Residents

- About 8% of CRP residents are also enrolled in Medicare, which is relatively low as compared to the overall OPWDD service population Medicare rate of about 50%.
- Based on a sample of the COE, about 47% of the CRP population has private third party insurance.
- Non-ICF MA spending on residents without private coverage is roughly 55% higher than that of privately insured residents.
- The majority of the difference between those with and without private insurance is the result of variations in spending on pharmaceuticals. Variations in inpatient and medical equipment spend also show significant differences between the populations.
Next Steps

• Modify CRP fees through implementation of the resource corridor. DOH will share results with the CRP providers.
• Agree upon quality metrics for use in VBP objective measurements.
• Perform updated attribution analysis.
• Establish Total Cost of Care target budgets, taking into account the 5% CRP investment as well as modifications resulting from the resource corridor.
• Begin pilot with Centers of Excellence.
• Expand pilot to include all CRPs.