MEDICAID INSTITUTE
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Navigating the New York State Value-Based Payment Roadmap

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Established in 2005, the Medicaid Institute at United Hospital Fund provides information and analysis explaining the Medicaid program of New York State. The Medicaid Institute also develops and tests innovative ideas for improving Medicaid's program administration and service delivery. While contributing to the national discussion, the Medicaid Institute aims primarily to help New York's legislators, policymakers, health care providers, researchers, and other stakeholders make informed decisions to redesign, restructure, and rebuild the program.

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Foreword

New York's health care system is currently undergoing an unprecedented amount of change, and nowhere is that more apparent than in its Medicaid program. The Medicaid Redesign Team, established by Governor Andrew Cuomo in 2011, set forth a vision for a transformed Medicaid program that is now taking shape—especially as implementation of the transformational Delivery System Reform Incentive Payment (DSRIP) program begins to hit full stride. Serving more than 6 million New Yorkers annually, Medicaid is a bedrock safety net for many of the state's most vulnerable residents, and sustaining the program for the long-term requires changes in both the way health care services are delivered and paid for.

Navigating the New York State Value-Based Payment Roadmap—prepared for the Medicaid Institute at United Hospital Fund by Rob Houston, Katherine J. Heflin, and Tricia McGinnis from the Center for Health Care Strategies—explains in simple terms how New York's Medicaid program plans to transform the way it finances health care services, moving from volume- to value-based payments (VBP). This transition is an essential one for reinforcing the broader goals of the Medicaid Redesign Team recommendations, and for sustaining the delivery system reforms that will emerge from DSRIP. Moving to VBP in this $60 billion per year program holds real promise for both improving the quality of care and reducing costs.

As New York State begins to more fully define and implement its approach to VBP in Medicaid, a number of policy and operational issues must be considered. This guide describes the vision presented in the State's VBP roadmap, giving providers and other stakeholders a list of open questions—many of which are in the process of being answered by the State's active stakeholder engagement process. We hope it helps Medicaid stakeholders keep track of the many moving parts involved in this considerable effort.

As always, we welcome your comments on our work.

James R. Tallon, Jr.
President
United Hospital Fund

Introduction

In June 2015, the New York State Department of Health (DOH) released *A Path toward Value Based Payment: New York State Roadmap for Medicaid Payment Reform* (the "Roadmap"), which laid out a vision for value-based payment (VBP) in Medicaid over the next four years.[1] The Roadmap, which was developed by the State and its VBP Workgroup, was written primarily for the Centers for Medicare & Medicaid Services (CMS) as a condition of the State's Delivery System Reform Incentive Payment (DSRIP) agreement. In addition to fulfilling this requirement, the Roadmap: (a) outlines the State's strategy to have 80-90 percent of Medicaid managed care payments (in dollars) to providers shifted from fee-for-service (FFS) payments to VBP by 2020; (b) describes the new payment approaches and the types of provider organizations that will be involved; and (c) answers key questions about potential VBP approaches. Achieving the State's ambitious VBP goal depends on reforming both the delivery system and payment methodologies. DOH intends to use DSRIP, the State Innovation Models (SIM) initiative, and related initiatives as catalysts for reforming how care is delivered, paving the way for Medicaid providers and managed care organizations (MCOs) to enter into new VBP arrangements that align with these new care models.

What is the Roadmap?

The New York State Roadmap for Medicaid Payment Reform is:

1. An overview of the State's Medicaid value-based payment strategy and how it aligns with other federal, commercial, and State initiatives.
2. A living document that will evolve with stakeholder input and DSRIP implementation experience.
3. A means to achieve the goal of 80-90 percent of Medicaid managed care payments to providers being VBP approaches by 2020.

Although the Roadmap provides an overview of many of the steps that the State intends to put in place over the next four years, it is not a complete blueprint for the transition to VBP. There are still many details to be developed by the VBP Workgroup, its subcommittees, and clinical advisory groups (CAGs).[2] These details will define the standards and guidelines for VBP, but the real transition will take place through negotiations between providers and MCOs. The State also emphasizes that the Roadmap is a "living document" that will be updated annually, which will allow the State to incorporate lessons from DSRIP implementation, continued stakeholder input, and multipayer alignment efforts with CMS into future versions of the Roadmap.

The change in payments outlined by the Roadmap will undoubtedly have a significant financial and organizational impact on providers, including hospitals, small and large primary care and multi-specialty practices, other specialty providers, federally qualified health centers (FQHCs), and community health centers (CHCs). Therefore, it is imperative that providers

1 Available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

2 More information on these groups can be found in the section "VBP Workgroup Subcommittees and Responsibilities."

and other stakeholders become familiar with the Roadmap and its potential impact on the health care delivery system. This guide describes the Roadmap and is intended to help providers and stakeholders prepare for the transition from FFS to VBP and be more informed participants in the ongoing implementation of the Roadmap's vision. In developing the Roadmap, the State is also very aware of VBP trends in the broader health care system. Commercial insurers and Medicare are making concerted efforts to drive the system away from the volume imperative in the FFS system toward various levels of VBP. Aligning Medicaid payments with these broader trends should also make life easier for the many Medicaid providers with Medicare and commercial beneficiaries among their patients.

Roadmap Goals and Background

VBP is a broad concept that involves paying providers for value in health care services. Examples of measurable values worth paying for include achieving improved health outcomes, choosing evidence-based processes, managing the costs of care, and implementing effective care coordination strategies. VBP is a significant change from FFS payments, which simply pay for a service to be performed regardless of the result. FFS payment arrangements unintentionally—but almost inevitably—reward providers financially for performing a high volume of services. The Roadmap describes the types of new payment arrangements between providers and MCOs that would count toward the 2020 VBP goal. While the Roadmap's VBP approach is heavily aligned with DSRIP, it is not exclusively a DSRIP document. Rather, it is intended for all provider organizations that contract with Medicaid MCOs, including accountable care organizations (ACOs), independent practice associations (IPAs), hospitals, clinics, and other providers.[3] Within the broad goal of 80-90 percent of total MCO payments to providers statewide in VBP arrangements, the State has set a goal that at least 35 percent of payments to providers by fully capitated MCOs be risk-based (Level 2 or 3) VBP arrangements.[4]

With the Roadmap's high-level goals in mind, providers can start by determining their current level of VBP activity and developing a strategy to shift toward VBP. The remainder of this guide focuses on what the Roadmap means for providers and what questions still need to be addressed by the State, the VBP Workgroup, subcommittees, and CAGs.

3 Performing Provider Systems are not legal entities that can contract directly with MCOs, but they may become ACOs or IPAs for purposes of VBP contracting. Financially challenged providers, such as those classified as Interim Access Assurance Fund (IAAF) providers and providers requiring Vital Access Provider (VAP) and/or Vital Access Provider Assurance Program (VAPAP) funding, are encouraged to join shared savings (Level 1) VBP agreements, but will not be allowed to share risk (Level 2 or higher).

4 VBP risk levels are discussed in more detail in the section "Transitioning to Greater Levels of Risk in VBP."

What the Roadmap Means for Providers

The Roadmap will undoubtedly change the way providers in the State of New York do business with Medicaid, and will influence not only payment methodologies, but also care delivery, data exchange, and their business models. To prepare for this new reality, providers will have to understand the contents of the Roadmap. Three main aspects of the Roadmap will affect providers over the next four years: (1) selecting VBP options; (2) transitioning to levels of risk-based VBP; and (3) implementing changes in managed care contracting. It is important to note that selecting a VBP option and a VBP risk level are separate decisions, but these two components will make up a single VBP "approach" (Figure 1) that will evolve over time.

Figure 1. Constructing a VBP Approach

These choices, and other related topics, are explored in detail below. The matrix in Figure 3 lays out descriptions of the resulting approaches.

Selecting VBP Options

The Roadmap lays out four specific VBP options that providers and MCOs might use to improve patient outcomes and reduce costs. These options, based on payment model and/or population served, include: (1) All Care for Total Population; (2) Integrated Primary Care; (3) Acute and Chronic Bundles; and (4) Total Care for Special Needs Subpopulations. The Roadmap does not express a preference for one option over others, allowing providers and MCOs to choose from the menu of options. All options include a quality component, in which a portion of payments is contingent on performance on quality metrics that measure patient outcomes.

- **All Care for Total Population.** Under this option, providers would be responsible for the total cost of care (TCOC) of services received by their attributed patients. It is possible that individual provider organizations (such as integrated delivery systems, hospital systems, or independent practice associations), as well as PPSs, could choose this VBP option.

- **Integrated Primary Care.** In this arrangement, patient-centered medical homes (PCMHs), advanced primary care (APC) practice providers, or other provider entities (e.g., PPSs, ACOs, or IPAs), would be responsible for the services, costs, and outcomes directly associated with good primary care (e.g., avoidable hospital admissions), but not for costs beyond the primary care practice's control (e.g., cancer care).

- **Acute and Chronic Bundles.** In acute care bundles, providers would be responsible for patient-focused bundles of care for a specific acute patient condition or episode of care (e.g., maternity care). Providers and MCOs can also form chronic care bundle arrangements, which manage all care involved for patients with a specific chronic condition, such as diabetes for a pre-determined amount of time (e.g., annually). Under both these bundled arrangements, providers receive a financial incentive if costs are reduced below a pre-established benchmark.

- **Total Care for Special Needs Subpopulations.** In this option, providers that focus on working with special needs subpopulations (e.g., people with severe comorbidities or disabilities) would be responsible for the specific care needs and TCOC for these individuals.

In addition to these four options, the Roadmap mentions the possibility of "off-menu" VBP options that could also count toward the 2020 goal. These options are not specified in the Roadmap, though loose criteria can be found in Appendix II of the Roadmap. These arrangements would be established by the providers and MCOs and would not need to be approved by the State, but must reflect the goals of the Roadmap and would be subject to periodic audits.

It is important to note that the State has also outlined the possibility of combining VBP approaches. For example, a provider and MCO may choose to create a chronic care bundle and a TCOC contract for the subpopulation of individuals with serious and persistent mental illness. In addition, contracts can also "carve out" specific services from a TCOC calculation.

Transitioning to Greater Levels of Risk in VBP

The Roadmap classifies VBP by levels of financial risk that a provider will assume, breaking it down into levels from 0 to 3; the levels are described in Figure 2. The levels are structured so that as providers move up a level, they will assume greater financial responsibilities for costs that exceed the benchmark and may be able to recoup a greater proportion of savings. While the State defines a Level 0 of VBP risk, it also emphasizes that it does not consider this level a VBP arrangement for purposes of meeting the 2020 goal. Only levels 1 through 3 are considered VBP contracts.

Figure 2. VBP Risk Levels

VBP Risk Level	Description
0	**Enhanced FFS.** Providers may receive a quality bonus, be subject to a quality withhold, or receive a payment for enhanced care coordination. There is no provider risk.
1	**Upside only shared savings without provider risk.** Providers still receive FFS payments, but have incentive to reduce costs and improve quality through a shared savings arrangement tied to cost benchmarks and quality metrics. There is no "downside" risk, so providers do not have to pay money to MCOs if they exceed cost benchmarks.
2	**Upside and downside risk-sharing arrangements.** As in Level 1, providers have a shared savings incentive, but are also accountable if costs exceed benchmarks and must reimburse MCOs a percentage of the excess amount if this is the case.
3	**Prospective payments that largely replace FFS.** MCOs pay providers on a per-member, per-month (PMPM) basis for a patient's TCOC. Providers may also be paid on a prospective basis for a bundled payment for a specific episode of care or for managing a specific chronic condition.

Source: *A Path toward Value Based Payment: New York State Roadmap For Medicaid Payment Reform,* available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

The Roadmap does not specify how quickly provider organizations must transition to higher-risk levels beyond the collective goals indicated for the State. It is assumed that providers and MCOs will enter higher-level VBP arrangements at their own pace based on the provider's size, capacity, prior experience with VBP, and other factors. However, while initial entry for many providers into VBP may begin at Level 1, providers are expected to progress toward arrangements with financial risk (Levels 2 and 3) over time.

The Roadmap also provides a helpful chart juxtaposing the four VBP options with the four VBP risk levels to show examples of how each level can be achieved for each option, thus mapping out potential VBP approaches. This chart has been reproduced in Figure 3.

Figure 3. Transitioning to Provider Risk: Determining VBP Approaches

VBP Risk Level → / VBP Options ↓	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP*
All Care for Total Population	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Global capitation (with outcome-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when outcome scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM capitated payment for primary care services (with outcome-based component)
Acute and Chronic Bundles	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when outcome scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Prospective bundled payment (with outcome-based component)
Total Care for Subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (savings available when outcome scores are sufficient)	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM capitated payment for total care for subpopulation (with outcome-based component)

* Requires experience with previous levels and mature provider organizations.

Source: *A Path toward Value Based Payment: New York State Roadmap For Medicaid Payment Reform*, page 15, available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

Payments under VBP arrangements are also dependent on quality of care and patient outcomes. While this exact mechanism is not specified, the Roadmap provides examples of how VBP arrangements can be constructed to reflect quality performance (Figure 4). More detail on this topic will be provided by the VBP Workgroup subcommittees and CAGs.

Figure 4. Potential Quality Incentives Based on VBP Level and Outcomes Achieved

Percentage of Outcome Targets Met	Level 1 VBP Upside only	Level 2 VBP Upside and Downside	
		When actual costs < budgeted costs	*When actual costs > budgeted costs*
≥ 50% of outcome targets met*	50-60% of savings returned to PPS/ providers	90% of savings returned to PPS/ providers	PPS/ providers responsible for 50% of losses.
< 50% of outcome targets met	Between 10% and 50%–60% of savings returned to PPS/ providers (sliding scale in proportion with % of outcome targets met)	Between 10% and 90% of savings returned to PPS/ providers (sliding scale in proportion with % of outcome targets met)	PPS/ providers responsible for 50%–90% of losses (sliding scale in proportion with % of outcome targets met)
Overall outcomes worsen	No savings returned to PPS/ providers	No savings returned to PPS/ providers	PPS/ providers responsible for 90% of losses

* Following the concept of rewarding "value," meeting targets would imply scoring higher than an absolute threshold, or a threshold set relative to other providers. MCOs and providers can opt to agree to (also) reward relative improvement over time.

Source: *A Path toward Value Based Payment: New York State Roadmap For Medicaid Payment Reform*, page 18, available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

Implementing Changes in Managed Care Contracting

For the State to move toward VBP arrangements, its contracts with Medicaid MCOs will need to be modified or restructured. The Roadmap does not give exclusive contracting responsibility to PPSs, nor does it require MCOs to form VBP contracts solely with PPSs. However, if providers choose to contract at the PPS level, or as a subset of the PPS, their contract terms would change. Before entering into a PPS-based contract, providers should consider the costs and benefits of entering into such an arrangement.

The State will submit modified MCO contract language to CMS, and has outlined a number of specific amendments it plans to include. Proposed amendments that will directly influence providers are listed below.

- To incentivize the adoption of VBP arrangements between providers and MCOs, the State will increase capitation rates for MCOs that have a higher percentage of VBP arrangements in place with providers. MCOs receiving this increase will be required to increase payments to providers engaged in higher-level VBP contracts.

- MCOs will be required to increase the percentage of provider payments in VBP arrangements each year, though a rate of increase or benchmark is not specified. MCOs will be required to submit an annual report outlining the percentage of providers under VBP arrangements and identifying these providers.

- MCO contracts may be risk-adjusted in new ways to accurately reflect patients' true TCOC and account for social determinants of health.

- The State may help ease the transfer of some risk from MCOs to providers by modifying some of its existing risk requirements, including regulations around reinsurance and reserves.

VBP Workgroup Subcommittees and Responsibilities

While the Roadmap establishes a vision for VBP in New York State, there are still many questions left to answer and parameters to define. This section describes the VBP Workgroup subcommittees that have been established by the State to fill in the details of the broad framework provided by the Roadmap.

The five subcommittees of the VBP Workgroup are made up of providers, MCOs, State officials, consumer groups, consultants, and other key stakeholders. The decisions made by the subcommittees and adopted by the Workgroup will increase clarity about how the State will implement VBP over the next four years. The subcommittees will also generate corresponding guidance and standards for providers and MCOs. The subcommittees and their responsibilities are listed below.

1. **VBP Technical Design (Group 1):** Determine technical details for VBP approaches, including shared savings, bundled payments, and capitated approaches, as well as standardization across PPSs and providers. Issues to address: cost benchmarking, patient attribution, stop-loss mechanisms, and shared savings percentages.

2. **VBP Technical Design (Group 2):** Discuss VBP design issues related to outcome measurement and implementation. Issues to address: technical definition of VBP for use in DSRIP measurement, inclusion and exclusion of specific health care services, quality and outcome metrics and benchmarks, and the design of the VBP Innovator Program (described below).

3. **Social Determinants and Community-Based Organizations:** Determine how to include social determinants of health in payment methodologies and outcomes measurement and how community-based organizations can be engaged to support VBP. Issues to

address: methods to capture savings across public spending, housing determinants, and training needs for community-based organizations.

4. **Regulatory Impact:** Identify and address regulatory and contractual barriers to VBP implementation. Issues to address: antitrust laws and regulations, anti-kickback measures, network adequacy, privacy and HIPAA concerns, contracting changes and approvals, certification, and dispute resolution.

5. **Advocacy and Engagement:** Focus on the best ways to communicate with all Medicaid stakeholders about VBP. Issues to address: upholding consumer "right to know" regulations, patient incentives, and informing patients of their eligibility for consumer incentives.

The State has also established CAGs, primarily made up of clinicians, to focus on a specific subpopulation or condition (e.g., defining an episode of care or bundled payment criteria). The CAGs will help define parameters and quality measures for VBP approaches targeted at these subpopulations and conditions, supporting the VBP Workgroup in its efforts to produce evidence-based and patient-centered methodologies.

Remaining Questions

Since many of the details for implementation of the Roadmap have yet to be worked out, it may be difficult for stakeholders to ready themselves completely for VBP based on the Roadmap alone. Therefore, it is important for providers and all stakeholders to understand these outstanding aspects and how the Roadmap may be affected once there is more detail. This section outlines issues that still need to be defined, and discusses the potential impacts of these decisions.

Which providers will enter into VBP contracts with MCOs?

The Roadmap does not dictate which providers will form VBP arrangements with MCOs. Instead, the Roadmap leaves this option flexible and offers a discussion of the different potential "levels." In many cases, providers themselves, not PPSs, will be the key negotiators, since providers and payers know each other already and will likely continue these relationships. However, as arrangements shift to risk-based Level 2 and 3 payments, PPSs may be better positioned to assume financial risk as they build up accountability and infrastructure. While some PPSs have already completed Certificate of Public Advantage (COPA) applications,[5] the State may still have to enact legislation or specifically define and regulate how such negotiations should take place, to avoid potential legal concerns.

5 https://www.health.ny.gov/health_care/medicaid/redesign/copa/index.htm

How will combined VBP approaches work?

Under the Roadmap, the State has laid out a number of payment reform options and made it possible for providers to combine methodologies when contracting with MCOs. However, how these mixed methods will work together is unclear. For example, a bundled payment for specific conditions such as an acute care episode (e.g., knee replacement) or management of a chronic condition (e.g., diabetes) might be difficult to integrate with a global payment or shared savings arrangement that uses a TCOC calculation, since the costs could potentially be included in both. The services and costs associated with a bundled payment would likely have to be excluded from the TCOC calculation, but this could create competing incentives among providers and make some services and procedures difficult to assign to a specific bundle or to TCOC. Greater clarity from the State on expectations for how these VBP structures could work together effectively would be useful.

How will patients be attributed to providers?

The number of "attributed lives," or patients assigned to a provider, is critical to ensuring appropriate accountability and the accurate measurement of quality and cost metrics. The ultimate decision on a preferred attribution method is assigned to the VBP Technical Design Subcommittee (Group 1). The Roadmap gives providers and MCOs the option to agree on alternate attribution methods, then provide their patient-level attribution data to the State.

How will costs be benchmarked?

To measure savings or losses relative to past performance or other standards, providers and MCOs must establish a benchmark with which to compare it. The Roadmap states that savings or losses incurred in Level 1 and 2 arrangements will require an agreed-upon 'virtual budget' that will be risk-adjusted based on historical costs and characteristics of the patient population. Providers and MCOs will use these risk-adjusted virtual budgets to negotiate "target budgets" for VBP arrangements. According to the Roadmap, the State will not directly influence these negotiations or set rates for these budgets; it will also not determine global payments or bundled rates. Rather, the State will use one standard methodology to calculate these target budgets, measure performance, and distribute this information to providers and MCOs. This methodology will be discussed and finalized by the VBP Technical Design Subcommittee (Group 1).

What quality measures will be used and how will they be tied to payments?

While the Roadmap states that all VBP approaches must link payments to quality in some way, it does not define what quality measures will be used and how payments will be specifically tied to quality. The State intends to empower VBP Technical Design Subcommittee (Group 2) and the CAGs to construct a set of VBP quality measures, building primarily on the current DSRIP and Quality Assurance Reporting Requirements (QARR) measures, which may include patient-reported outcome measures (including quality of life metrics). The State may also encourage or require MCOs to curtail shared savings and increase shared losses for providers if quality targets are not met. However, it seems unlikely

that the State will establish a specific method of doing so, given its position that it will not determine rates or influence negotiations between providers and MCOs.

How will the VBP approach interface with other State programs?

While the Roadmap mentions both the DSRIP program and New York's State Health Innovation Plan (SHIP), how exactly the VBP program will work alongside other existing and emerging programs remains undefined. To align these initiatives effectively around common goals and avoid duplicative or competing efforts, the State must address issues such as: (1) patient attribution; (2) duplication of care management and coordination efforts across MCOs, providers, and programs; (3) quality metric alignment; and (4) ensuring that patients are not confused by the multiple initiatives working together. The framework for how these initiatives and organizations will interact will likely be considered by the VBP Workgroup, as well as the SHIP Council.

How will smaller providers engage in VBP?

Smaller provider organizations (such as rural practices, and private practice physicians not connected with a PPS or hospital system), as well as CBOs, may experience more difficulty transitioning to VBP, especially if they do not benefit from the DSRIP payments. Though these organizations will likely be able to enter into Level 1 VBP arrangements with MCOs, many smaller providers may lack the necessary internal expertise and capacity to share risk at VBP levels 2 or 3. Further, some small and independent providers may worry that the sheer size of PPSs could create market power that may adversely affect their own contracting negotiations. As a result, these providers may benefit from tailored guidance from the State as to how to construct VBP approaches with MCOs.

How will the VBP Innovator Program work?

The Roadmap discusses the creation of a VBP Innovator Program that will support multi-year Level 2 or 3 VBP agreements between providers and MCOs that enter into these arrangements early in the process. The voluntary program will reward provider participants with an increased upside (up to 95 percent of shared savings). The criteria for this program will be decided by VBP Technical Design Subcommittee (Group 2) and must be approved by the VBP Workgroup.

Will patient wellness or lifestyle incentives be used?

The Roadmap mentions the State's intention for VBP approaches to also offer positive patient wellness and lifestyle incentives and encourage patients to make optimal health choices. While "positive incentives" that reward healthy lifestyle choices (e.g., entering a smoking cessation program) and provider choices (e.g., choosing to contact a PCP rather than going to the emergency department) may be used, "negative incentives" that add patient costs for health care service utilization (e.g., copayments or co-insurance) will not be permitted. Providers and MCOs may receive enhanced payments for offering positive incentives, and providers are expected to use community-based organizations to help address social

determinants of health. These issues will be discussed in the subcommittees on Advocacy and Engagement and Social Determinants and Community-Based Organizations.

Conclusion: Moving toward VBP

Through the Roadmap, the State of New York has designed an ambitious plan to move 80-90 percent of managed care payments to providers to VBP by 2020. The plan is quite flexible and allows providers and PPSs to define many aspects of their own approach to VBP to suit their capacity and current comfort and experience with VBP.

With that said, moving 80-90 percent of provider payments into VBP is a major undertaking. Over the next four years, providers will have to make a concerted effort to adapt their business models to maximize revenue under value-based—as opposed to volume-driven—payments, and build their capacity to accept risk. If leveraged fully, the DSRIP incentives and State Innovation Models investments can help providers build the necessary clinical and operational capacity to succeed under VBP arrangements. Many of the challenges providers will face in doing so have been outlined in this paper. A variety of issues, including attribution, benchmark setting, and the role of PPSs vs. other provider organizations in VBP, will need to be clarified to make this VBP goal a reality. The State has expressed a willingness to support providers in many ways to make these transitions, and to accomplish this goal. Even more importantly, to successfully transition to VBP, providers, MCOs, and the State must have shared objectives and mutually beneficial approaches that align their interests, as well as the interests and objectives of other VBP efforts in the Medicare and commercial sectors.

Appendix: Glossary of Terms

Term	Acronym	Brief Definition
Accountable Care Organization	**ACO**	A group of doctors, hospitals, and other health care providers, who provide coordinated high quality care to patients. ACOs are intended to tie provider reimbursements to quality metrics and reduce the total cost of care for attributed patients. When an ACO succeeds both in delivering high-quality care and reducing costs, it will receive a financial benefit, typically through a shared savings or shared savings/risk arrangement.
Advanced Primary Care	**APC**	New York's emerging model of primary care delivery—an augmented patient-centered medical home (PCMH) that provides patients with timely and integrated care. With enhanced access to teams of providers, the APC model aligns and leverages multiple ongoing initiatives and emphasizes prevention, health information technology, care coordination, and shared decision-making among patients and providers.
Alternative Payment Model	**APM**	A payment model that incentivizes providers to improve quality and outcomes, and to contain costs. APMs help to promote patient value and efficiency by shifting some financial risk to providers. APMs are a broad term for the variety of risk-based or budget-based payment models in use today such as accountable care organizations.
Attribution		The process of assigning individuals to a provider or group of providers (e.g., PPSs, ACOs, or IPAs). That group of providers is then responsible for the care of these individuals.
Avoidable Hospital Use		A term used to indicate hospital service use that could have been avoided or was unnecessary, such as non-emergency use of the emergency department.
Bundled Payment		An initiative that links multiple services beneficiaries receive during an episode of care into a single payment. This system holds providers responsible for both cost and performance, usually with the goal of encouraging care coordination. Bundled payments may lead to improved care transitions, fewer rehospitalizations, and better delivery of appropriate care following discharge—potentially at a lower cost.
Capitation		Payment methodology wherein an organization is paid standard fee per covered patient (often per member per month), to reimburse all services rendered (the total cost of care).
Centers for Medicare & Medicaid Services	**CMS**	The federal agency, part of the U.S. Department of Health and Human Services, responsible for overseeing state administration of Medicaid as well as administering Medicare and coordinating some services for Medicare-Medicaid enrollees.
Community-Based Organization	**CBO**	Public or private organization that is representative of a community or a significant segment of a community, and is engaged in meeting health, human services, educational, spiritual, or public safety needs of the community.

Term	Acronym	Brief Definition
Delivery System Reform Incentive Payment	**DSRIP**	Resulting from the Section 1115 waiver program, a federally funded initiative that provides states with funding to support hospitals and other provider organizations that commit to changing how care is provided to Medicaid beneficiaries. In 2014, New York became the seventh state to have a DSRIP program approved; it began implementation in 2015. Its primary goals are to stabilize the safety-net system and reduce avoidable hospital use by 25 percent over five years. DSRIP is the largest piece of the MRT waiver amendment, with a total allocation of $6.9 billion.
DSRIP Eligible Providers		DSRIP definition of providers—such as hospitals, safety net providers, and CBOs—that are able to participate in the program and be part of PPSs. Detailed lists of qualifying institutions are available at the NY DSRIP Program Project Design Grant Application Instructions (http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_design_grant_application_instructions.pdf).
DSRIP Year	**DY**	The year of the DSRIP project (0-5) in which a project or goal is planned.
Electronic Medical Record	**EMR**	A patient record that contains clinical data. An electronic medical record is a digital version of a paper chart that contains all of a patient's medical history from one practice. An EMR is mostly used by providers for diagnosis and treatment.
Emergency Department	**ED**	Medical treatment facilities specializing in emergency medicine, the acute care of patients who present without prior appointment either by their own means or by that of an ambulance.
Episode of Care		Methodology that includes all services provided to a patient with a medical problem, usually within a specific period of time, across a continuum of care in an integrated delivery system. Each episode of care includes a defined set of services delivered by designated providers in specified health care settings related to treating a patient's medical condition or performing a major surgical procedure.
Fee-for-Service	**FFS**	Payment to medical providers for the number of hours, visits, or services rendered. Payment is based on the volume of services provided rather than process, quality, or outcomes involved.
Health and Recovery Plan	**HARP**	Managed care plans for adults with significant behavioral health needs, facilitating the integration of physical health, mental health, and substance use services for individuals requiring specialized expertise, tools, and protocols.
Health Information Exchange	**HIE**	Infrastructure that enables the electronic transmission of health care data among providers, facilities, organizations, and government agencies.
Health Information Technology	**HIT**	Information technology infrastructure, hardware, and software applied to health care, which provides a secure exchange of data between consumers, providers, government and quality entities, and insurers.
Independent Practice Association	**IPA**	An association of independent physicians that provides services to managed care organizations on a negotiated per capita rate, flat retainer fee, or negotiated fee-for-service basis. IPAs are legal vehicles developed to primarily contract with third-party payers.

Term	Acronym	Brief Definition
Integrated Delivery System	**IDS**	Organized, coordinated, and collaborative networks of health care providers that offer a continuum of services to a particular patient population or community. A goal of an efficient IDS is to be accountable, both clinically and fiscally, for the clinical outcomes and health status of the population or community served, and have systems in place to manage and improve them.
Long-Term Care	**LTC**	Services and care that help meet high-need individuals' medical and non-medical needs for long periods of time. Such services can include traditional medical services, social services, housing, and activities of daily living. Those receiving this care are usually living with a chronic illness or disability and cannot care for themselves.
Managed Care Organization	**MCO**	Health care organizations that administer medical benefits and absorb financial risk in exchange for a predetermined monthly fee. MCOs combine the functions of health insurance administration, utilization management, and care coordination, and contract with a network of hospitals, physicians, and other providers to provide health care services.
Medicaid Redesign Team	**MRT**	An entity established by Governor Cuomo in January 2011 as a means of finding new ways to lower Medicaid spending in New York State during the 2011-12 fiscal year. The MRT is made up of stakeholders and health care experts from throughout the state, and has continued its work in the form of 10 work groups, convened to address more complex issues and cooperatively create a multi-year roadmap for state health care reform.
Medical Loss Ratio	**MLR**	The percentage of premium an insurer spends on administration, marketing, and profits, rather than on claims and expenses that improve health care quality.
MRT Waiver Amendment		A program that allows New York to reinvest $8 billion in Medicaid Redesign Team generated federal savings back into the state's health care delivery system over five years. The waiver amendment contains three parts: (1) Interim Access Assurance Fund—temporary, time-limited funding to ensure current trusted and viable Medicaid safety net providers can fully participate in the DSRIP transformation without unproductive disruption ($500 million); (2) DSRIP—including Planning Grants, Provider Incentive Payments, and administrative costs ($6.42 billion); and (3) other MRT purposes—to support health home development through a State Plan Amendment, and investments in long-term care workforce and enhanced behavioral health services through managed care contract payments ($1.08 billion).
New York State Department of Health	**DOH or NYSDOH**	The department of New York State government responsible for improving and promoting the health, productivity and well-being New Yorkers.
Off-Menu options		Value-based payment (VBP) arrangements that MCOs and providers can jointly agree to pursue outside of those outlined in the Value-Based Purchasing Roadmap. Such arrangements must reflect the Medicaid VBP principles described in the Roadmap and must be considered Level 1 or higher.
Patient-Centered Medical Home	**PCMH**	Method of organizing primary care that emphasizes care coordination and communication to provide patients with timely, well-organized, and integrated care. The PCMH model also seeks to enhance access to teams of providers within a health care organization.

Term	Acronym	Brief Definition
Per Member Per Month	**PMPM**	A total cost of care payment that refers to the dollar amount paid to a provider each month for each person for whom the provider is responsible for providing services.
Performing Provider System	**PPS**	Partnerships formed between providers responsible for performing a DSRIP project. Under this arrangement, PPSs include DSRIP-eligible providers, with a designated lead provider for the group that will be held responsible for ensuring that the PPS meets DSRIP program requirements.
Primary Care Provider	**PCP**	Health care practitioners who are responsible for monitoring an individual's overall health care needs. A PCP is often a physician, but could also be a physician assistant or a nurse practitioner.
Project Advisory Committee	**PAC**	State-mandated, internal advisory entities within every performing provider system (PPS) that offer recommendations and feedback on PPS initiatives. The PAC should be involved in the various facets of developing a PPS's DSRIP Project Plan and then engaged in the implementation and oversight of the Project Plan.
Quality Assurance Reporting Requirements	**QARR**	A set of clinical and administrative performance measures required to be reported by the NYSDOH. The State publishes the QARR results for public consumption and uses the results in decisions affecting health plan operations. The State has incorporated national Health Plan Employer Data and Information Set (HEDIS) as well as other state-specific measures within QARR. These measures are required to be reported annually by health plans for their commercial, Medicaid, and Child Health Plus programs (as well as Family Health Plus, eventually); data must be audited by certified auditors from National Committee on Quality Assurance (NCQA) Licensed Organizations. The QARR is posted on the Department of Health's website (www.health.state.ny.us/nysdoh/mancare/mcmain.htm).
Risk-Based Arrangement		Sometimes called "budget-based contracting," risk-based arrangements are payments predicated on an estimate of what the expected costs to treat a particular condition or patient population should be. Managed care organizations or other payers usually base expected costs on sophisticated and actuarially sound models.
Safety Net Provider		An entity that provides care to underserved and vulnerable populations whose lack of health coverage or other social and economic vulnerabilities limits their ability to access mainstream medical care. Such programs often have very specific definitions for which providers fall into the category. Safety net definition details are posted on the Department of Health's Website (www.health.ny.gov/health_care/medicaid/redesign/dsrip/safety_net_definition.htm).
Shared Savings or Shared Savings/Risk		These payment models can be either one-sided (upside—just shared savings without risk) or two-sided (upside-downside—shared savings/risk). In both, the providers receive a percentage of savings relative and benchmarked costs. Two-sided (shared savings/risks) models require providers to share in the financial risk by accepting some accountability for costs that exceed the benchmarks.
State Health Innovation Plan	**SHIP**	Roadmap to achieve the "Triple Aim" for New Yorkers: improved health, better health care quality and better consumer experience, and lower costs. The intent and goal of the SHIP is to identify and stimulate the spread of promising innovations in health care delivery and finance that result in optimal health outcomes. The plan was established in April 2013 as a result of a State Innovation Models (SIM) grant.

Term	Acronym	Brief Definition
State Innovation Models	**SIM**	Initiative funded by the by the Centers for Medicare and Medicaid Innovation, part of CMS, which provides financial and technical support to states for the development and testing of state-led, multipayer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs.
Total Cost of Care	**TCOC**	Calculation that includes the complete range of health care services for patients typically used in population-based or shared savings payment methodologies.
Vital Access Provider Program	**VAP**	Program that makes funding available to providers who are qualified based on the high need and poverty rates of the populations they serve to improve community care and financial stability for these safety-net providers.
Value-Based Payment	**VBP**	A strategy used to promote quality and value of health care services. The goal of VBP is to shift from volume-based payment, such as fee-for-service, to payments that are linked in some way to evidence-based processes or patient outcomes.
Waiver Program		Authorization used to provide flexibility in addressing their populations' particular needs with the resources available. On the federal level, the Social Security Act allows states to waive certain federal Medicaid requirements in order to establish programs for specific populations or purposes.

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