NEW YORK STATE OF OPPORTUNITY. Department of Health

Total Care for the General Population Value Based Payment Arrangement

Fact Sheet

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NYS Medicaid Value Based Payment

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This fact sheet has been prepared to assist payers and providers to more thoroughly understand New York State's Medicaid Total Care for the General Population (TCGP) Value Based Payment (VBP) Arrangement. It provides an overview of the Arrangement, including a summary of the components of care included and the categories of measures recommended for use in TCGP Arrangements.

Introduction

The TCGP VBP Arrangement is designed to incentivize Primary Care professionals (PCPs) to collaborate with behavioral health providers, community-based providers, medical specialists, and other health care professionals to improve the quality of care delivered to the New York State (NYS) Medicaid population. With a focus on outcomes and costs, the Arrangement contracts for all care provided to the attributed Medicaid population, thus encouraging VBP Contractors[1] to focus on the delivery of high-value, evidence-based care.

The TCGP Arrangement provides an impetus for significant investment in population management, including preventive care, care management for chronic conditions and care coordination. Savings in a TCGP contract are primarily achieved through improved outcomes, resulting from a reduction in unnecessary care (including outpatient ancillary, emergency department, and inpatient care) and improved adherence to guideline-driven, evidence-based care. Downstream costs are reduced through initiatives that lower the risk of acute medical events and the probability of inpatient hospitalizations. Social determinants of health, such as housing status and economic self-sufficiency, are also important variables for VBP Contractors to address with members.

This fact sheet provides an overview of NYS Medicaid's VBP TCGP Arrangement and is organized into two sections:

- Section 1 describes the care included in the TCGP Arrangement, the method used to define the attributed population, and the calculation of associated costs under the Arrangement;
- Section 2 describes the quality measure selection process and the categories of measures recommended for use in TCGP Arrangements.

Section 1: Defining the TCGP Population and Associated Costs

The TCGP Arrangement addresses the total care and associated costs of that care for the members/patients attributed under the Arrangement, regardless of where, how, or for what reason the care was delivered. VBP Contractors assume responsibility for the quality and costs for all care for attributed patients including: primary care; specialty care; psychiatric rehabilitation services; emergency department visits; hospital admissions; and, medication (with an exclusion option for specialty, high-cost drugs).[2]

Constructing the TCGP Arrangement: Time Window and Services

To achieve improved clinical and financial outcomes under the TCGP arrangement, VBP Contractors must

[1] A VBP Contractor is an entity a provider or group of providers – engaged in a VBP contract. The TCGP Arrangement includes all services covered by mainstream managed care for the attributed population.

[2] The VBP Roadmap includes categories of costs that may be excluded from VBP arrangements, where appropriate. For more information see New York State Department of Health, Medicaid Redesign Team, Value Based Payment (VBP), VBP Roadmap. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm

successfully manage patients at the population level. To complete this task, providers must build a network of provider partners consistent with the care management needs of the attributed population and work closely with teams across the continuum to efficiently coordinate care, identify improvement opportunities, and track planned improvements. This provider network would include PCPs, behavioral health providers, specialists, and others necessary to provide the comprehensive level of care needed for the population.

The TCGP Arrangement encompasses all services covered by mainstream Medicaid Managed Care provided to the attributed patient population during the contract year. This includes preventive care, sick care, the care for all acute and chronic conditions including but not limited to diabetes, asthma, hypertension, depression, anxiety, bipolar disorder, schizophrenia, as well as emergency medical care, procedures, or surgeries with a date of service or discharge date within the contract year.

Eligible Patient Population

The eligible patient population for the TCGP Arrangement includes all Medicaid Managed Care Organization (MCO) members with the following exceptions:

- **Medicaid patients for whom Medicaid is not the sole payer:** Medicaid patients with contract year services for which Medicaid is not the sole payer are excluded (e.g., dually eligible patients and patients with Medicaid as payer of last resort on a commercial premium).

The TCGP Arrangement has no additional requirements related to utilization of specific services or historical diagnostic information to be eligible for inclusion in the Arrangement. Patients who are non-utilizers (those who do not seek services, including prescription drugs, during the year) are included in the eligible patient population count and attributed to the PCP as outlined below. These patients will not contribute to the total cost calculation for the TCGP Arrangement but are included for tracking and quality purposes.

Patient Attribution

Medicaid patient attribution defines the group of patients for whom a VBP Contractor is responsible in terms of quality outcomes and costs. It becomes the basis for the aggregated total cost of care in a target budget for VBP. For patient attribution to occur in any arrangement, a Medicaid-covered recipient must be enrolled for three or more consecutive months with a managed care plan. The NYS Roadmap details attribution guidelines for VBP Contractors and Medicaid MCOs for each arrangement.[3]

The VBP Contractor's total eligible population is defined by the group of PCPs contracted with the Medicaid MCO and the patients assigned to each of the PCPs. However, an MCO and VBP Contractor may agree on a different type of provider to drive the attribution on the condition that the State is adequately notified.

Calculation of Total Cost for the Arrangement

The total cost for the population under the TCGP Arrangement is designed to account for all Medicaid-covered care provided to the attributed patients during the contract year. The total cost of the TCGP Arrangement is based on the cost of that care (defined as the total amount paid by the Medicaid MCO), including all costs associated with professional, inpatient, outpatient, pharmacy (with an exclusion option for high-cost, specialty drugs), laboratory, radiology, ancillary and behavioral health services aggregated to the attributed population level. The aggregate costs can be further analyzed to identify and understand sources of variation and opportunities for improvement in quality of care and resource use.

Section 2: VBP Quality Measure Requirements for the TCGP

[3] New York State Department of Health, Medicaid Redesign Team, Value Based Payment (VBP), VBP Roadmap. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm

Arrangement

The TCGP Quality Measure Set was developed drawing on the work of stakeholder groups convened by the Department of Health (DOH) to solicit input from expert clinicians around the state.

As the TCGP VBP Arrangement is a total cost of care arrangement, the State has recommended a full complement of physical and behavioral health, including Substance Use Disorder and Mental Health measures, to help ensure attributed patients receive high-quality physical and behavioral health care. The TCGP Measure Set includes 6 subset domains comprised of only pay-for-performance (P4P) measures. Managed Care Organizations (excluding Managed Long-Term Care) that execute a total cost of care for general population (TCGP) VBP arrangement must base shared savings and risk distribution on quality measures that include at least one, Category 1 P4P measure from each of the following domains:

I. Primary Care
II. Mental Health
III. Substance Use Disorder
IV. HIV/AIDS
V. Maternity
VI. Children's

Additionally, one of the domain measures must include at least one race and ethnicity stratified measure.[4]

Further, the State strongly encourages MCOs and VBP Contractors to select quality measures that are appropriate for the population being served within the contract. For example, MCOs and VBP Contractors should include asthma quality measures if there is a high prevalence of asthma-related illness in the attributed population of the VBP contract. For members who require behavioral health services, MCOs and providers should also look beyond purely medication maintenance/adherence quality measures.

Measure Classification

Each quality measure is designated by the State as Category 1, 2, or 3 according to the following criteria:

- **CATEGORY 1** – Approved quality measures that are deemed to be both clinically relevant, reliable, valid, and feasible;
- **CATEGORY 2** – Measures that are clinically relevant, valid, and reliable, but where the feasibility could be problematic and;
- **CATEGORY 3** – Measures that are insufficiently relevant, valid, reliable, and/or feasible.

Note that measure classification is a State recommendation. Although Category 1 Measures are required to be reported, Medicaid MCOs and VBP Contractors can choose the measures they want to link to payment and how they want to pay for them (P4P or pay-for-reporting (P4R)) in their specific contracts. The TCGP Arrangement does not include any Category 2 or 3 measures.

Category 1

Category 1 quality measures, as identified by the CAGs and accepted by the State, are to be reported by VBP Contractors. These measures are also intended to be used to determine the amount of shared savings for which VBP contractors would be eligible.

The State classifies each Category 1 measure as either P4P or P4R:

- **P4P** measures are intended to be used in the determination of shared savings amounts for which

[4] The quality measure set can be found under the VBP Quality Measures section for the respective measurement year and arrangement. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm

VBP Contractors are eligible. In other words, these are the measures on which payments in VBP contracts may be based. Measures can be included in both the determination of the target budget and in the calculation of shared savings for VBP Contractors; and,

- **P4R** measures are intended to be used by the MCOs to incentivize VBP Contractors for reporting data to monitor quality of care delivered to patients under the VBP contract. Incentives for reporting should be based on timeliness, accuracy, and completeness of data. Measures can be reclassified from P4R to P4P or P4P to P4R through annual CAG and State review or as determined by the MCO and VBP Contractor.

Please see the Value Based Payment Reporting Requirements Technical Specifications Manual[5] for details as to which measures must be reported for the measurement year. This manual will be updated annually in line with the release of the final VBP measure set for the subsequent Measurement Year.

Categories 2 and 3

Category 2 measures have been accepted by the State based on agreement of measure importance, validity, and reliability but flagged as presenting concerns regarding implementation feasibility.

Measures designated as Category 3 are deemed unfeasible. Reasons include use in small sample sizes of attributed patients at a VBP Contractor level or limited potential for performance improvement in areas where statewide performance was already near maximum expected levels.

Annual Measure Review

Measure sets and classifications are considered dynamic and will be reviewed annually. Updates will include additions, deletions, re-categorizations, and re-classification from P4R to P4P, or P4P to P4R, based on experience with measure implementation in the prior year.

[5] VBP Reporting Requirements Technical Specifications Manual can be found under the VBP Quality Measures section for the respective measurement year. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm