



Department  
of Health

Medicaid  
Redesign Team

# Value Based Payment: Update

*New York State Roadmap for  
Medicaid Payment Reform*

May 2022

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# 1. Introduction

Since approval by the Centers for Medicare and Medicaid Services (CMS) in July 2015 of the 1115 waiver demonstration to implement the Delivery System Reform Incentive Payment (DSRIP) program, New York State (NYS) has continued to work with CMS to align its efforts with the goals of the U.S. Department of Health and Human Services (HHS) on value-based purchasing and alternative payment models (APMs). The NYS Value Based Payment (VBP) Roadmap (Roadmap) was an integral part of the DSRIP Special Terms and Conditions (STCs), intended to move at least 80% of all Medicaid managed care payments, which were traditionally reimbursed through fee-for-service (FFS) arrangements, into VBP arrangements. With the expiration of DSRIP on March 31, 2020, and the success of NYS's transition to VBP, this Roadmap update carries the requirements and principles of payment reform from the DSRIP program through the current 1115 waiver and into ongoing contracting practice between plans and providers. The core principle of VBP is that payment should be concurrently tied to *both* the outcomes of care delivery *and* efficiency. The combination of these two principles is what drives the value for all Medicaid stakeholders. In this respect, arrangements captured under VBP differ from more traditional quality improvement programs or pay-for-performance (P4P) constructs where a bonus or penalty tends to be exclusively tied either to a cost result or a (set of) quality measure(s), but not both.

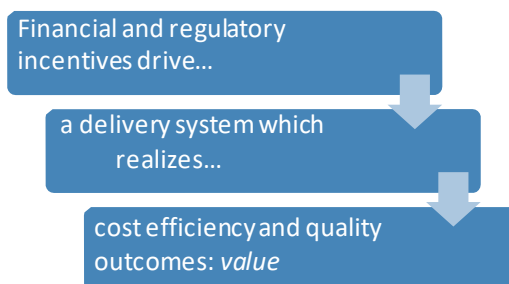
## Mission, Vision and Objective of VBP

As a matter of historical context, DSRIP was a major collective effort to transform NYS's Medicaid health care delivery system from a fragmented, inpatient care-focused system, to an integrated and community-based system focused on providing care in or close to the home.

Such a thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well. The NYS Medicaid payment reform goals focus on moving away from a FFS model, where increasing the value of the care delivered (preventing avoidable admissions, reducing administrative waste) has a *negative* impact on the financial sustainability of providers, towards a situation where the delivery of high value care can result in *higher* margins and a positive impact on financial sustainability.

Payment reform must maintain or improve funding and incentives for essential and mandatory costs within the system to sustain the provider/system for public goods, critical infrastructure support, and state/federal public health and compliance requirements. Examples of essential costs include: hospital/clinic/home care, indigent care, graduate medical education, federal conditions of participation, health information technology (HIT) capacity and interoperability, health care worker training and certification, quality assurance, emergency preparedness, community public health (e.g., immunization, disease response), and other vital needs.

This VBP Roadmap update represents the continuation of the progress made to date and reemphasizes the goals and importance of value-based healthcare. These values will be further represented in NYS's ongoing contracting process with the managed care organizations (MCOs) and reflected in the Medicaid Managed Care Model Contract.<sup>1</sup> The sections below detail the requirements that apply to NYS VBP arrangements ([General Arrangements section](#)), as well as specific requirements that apply only to



<sup>1</sup> NYS Department of Health, Medicaid Managed Care/Family Health Plans/ HIV Special Needs Plan/ Health and Recovery Plan Model Contract (March 1, 2019).

[https://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_care\\_fhp\\_hiv-snp\\_model\\_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf)

certain VBP arrangements ([Arrangement Specific section](#)). Where applicable, guidelines have also been included to illustrate additional options for arrangements between MCOs and VBP contractors.

NYS expects this update to be effective until such time as CMS is able to consider programmatic changes being proposed through a new 1115 waiver amendment focused on health equity and addressing the social care needs of Medicaid members. To this effect, NYS submitted a concept paper<sup>2</sup> in August 2021 to CMS highlighting the State's commitment to addressing these inequities further exacerbated by the COVID-19 pandemic. The concept paper outlines NYS's proposal to not only recover from the pandemic, but continue the advancements made in delivery system reform and VBP and outlines increased efforts in areas such as job creation and training, housing supports, and other social services. This waiver seeks to build upon the prior efforts and lessons learned from the DSRIP program and the move towards VBP to achieve a comprehensive, sustainable approach to achieving health equity across Medicaid populations.

## 2. VBP Contracting Requirements

The requirements in this section set forth NYS's expectations for MCOs regarding VBP contracting. Some requirements contained below may have an associated guideline. Guidelines are suggested methods or examples of current practices that may be useful for MCOs and VBP contractors to consider as they negotiate the specifics of a VBP arrangement. In addition to the requirements laid out in this document, VBP contractors and MCOs will continue to be subject to the following minimum VBP goals:

- 80% of total MCO expenditure (in terms of total dollars) will have to be captured in at least Level 1 VBP arrangements; and
- 35% of total payments contracted through Level 2 VBP arrangements or higher

MCOs that do not meet the minimum VBP goals or certain other regulatory requirements will be subject to penalties as outlined in the Medicaid Managed Care Model Contract.

### 2.1 General VBP Contracting Requirements

#### *Requirement 1: On-Menu Arrangements Shall Align to NYS VBP Arrangement Definitions*

The table below outlines the list of NYS-supported VBP arrangements that will be considered "on-menu" during the contract review process. Any arrangement that follows all the on-menu definitions will be eligible for approval by NYS. If the VBP arrangement includes carved-out services, has other changes that do not meet on-menu definitions, or has changes that are not among the allowed population exclusions, it is considered an "off-menu" arrangement and is subject to additional review by NYS, but may still be eligible for approval. For a list of criteria related to off-menu arrangements, see the [Off-Menu Arrangement Specific](#) section for more details. For a list of NYS-approved exclusions to the definitions in Table 1, please refer to [Appendix A-3](#). *Please note: Appendix A-3 does not represent an all-inclusive list of exclusions. Other exclusions or changes that do not meet on-menu definitions may be considered and are subject to review and approval by NYS.*

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<sup>2</sup> NYS Department of Health Office of Health Insurance Programs, New York 1115 Waiver Concept Paper, 1115 Waiver Demonstration: Conceptual Framework (August, 2021).  
[https://www.health.ny.gov/health\\_care/medicaid/redesign/2021/docs/2021-08\\_1115\\_waiver\\_concept\\_paper.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/2021/docs/2021-08_1115_waiver_concept_paper.pdf)

Table 1: Definitions of NYS On-Menu VBP arrangements

VBP Arrangement	Definition
<b>Total Care for General Population</b>	All Medicaid-covered services for all members eligible for Mainstream Managed Care. <b>TCGP arrangements can exclude dually eligible members (duals). Arrangement-specific requirements can be found in Section 2.2.</b>
<b>Total Care for HIV/AIDS Subpopulation</b>	All Medicaid-covered services for all members eligible for HIV/AIDS Special Needs Plan (SNP) (with the exception of duals).
<b>Total Care for HARP Subpopulation</b>	All Medicaid-covered services for all members eligible for a Health and Recovery Plan (HARP) (with the exception of duals).
<b>Total Care for MLTC Subpopulation</b>	<b>All Medicaid-covered services for all members enrolled in an integrated dual Managed Long-Term Care (MLTC) product.</b>
<b>Total Care for I/DD Subpopulation</b>	In development as of March 2022
<b>Total Care for Children Subpopulation</b>	All Medicaid-covered services for <b>all</b> children (ages 0-20), or for <b>children at or below 90th percentile of the MCO's overall cost/utilization distribution</b> enrolled in Medicaid Managed Care <b>(with the exception of duals)</b> .
<b>Maternity Care</b>	<p>All Medicaid-covered services included in the episodes for all pregnant individuals (+/- their newborns) eligible for Mainstream Managed Care (with the exception of duals). The services included in a Maternity arrangement shall be defined within each contract and include the related timeframes. State-suggested components and timeframes are included below.</p> <p>Maternity Care arrangement components:                      Prenatal (270 days prior to delivery)                      Delivery - Vaginal or Cesarean                      Hospital Neonatal Services                      Postpartum (84 days post discharge for pregnant individual)                      Newborn (30 days post discharge for the newborn)</p>

*Requirement 2: Level of Risk and Shared Savings/Losses for VBP Arrangements Must Match NYS Definitions*

NYS does not mandate a specific shared savings/losses distribution methodology, but the level of risk and potential shared savings, as well as potential shared losses, must be described in the contract and match the definitions for Contracting Levels 1 through 3 in [Appendix A-4](#).

Table 2: Summary of Minimum Risk for Contracting Levels

Contracting Level	Minimum Risk Requirement
<b>Level 1 - Upside Only Risk (Retrospective Reconciliation)</b>	The minimum percentage of potential savings to be allocated to the VBP contractor, if associated quality goals are met, is 40%. There are no shared losses in a Level 1 arrangement.
<b>Level 2 - Upside and Downside Risk (Retrospective Reconciliation)</b>	The minimum percentage of potential losses to be allocated to the VBP contractor is 20% if cost and quality targets are not met. There is a cap of 3% of the target budget on shared losses in the first year of the <b>Level 2 contract and 5% from the second year onward. Below these levels, the VBP arrangement is counted as a Level 1 arrangement.</b>  There are no state-mandated requirements for percent of shared savings. However, shared savings amounts should reflect the additional downside risk that VBP contractors include in these types of arrangements.
<b>Level 3 - Upside and Downside Risk (Prospective Payments)</b>	In a Level 3 arrangement, the VBP contractor assumes <b>full responsibility</b> for the shared savings as well as losses. The VBP contractor should strongly consider negotiating risk-mitigation strategies with the MCO, such as stop-loss arrangements, reinsurance, withholds, and risk-corridors. <sup>3</sup>

*Requirement 3: VBP Arrangements Must Detail the Attribution Methodology*

NYS does not mandate a specific methodology to be used to attribute members to a VBP arrangement for all on-menu VBP arrangements (except MLTC as detailed below). Such methodology shall describe:

- **Inclusion criteria:** Which members will be attributed to an arrangement, and thus included for the purposes of quality measurement and target budget setting; and
- **Exclusion criteria:** Which members will be excluded.

MLTC fully capitated arrangements shall attribute members to VBP contractors by following the Department's method provided in the VBP Technical Specifications Manual found in the VBP Resource Library.<sup>4</sup>

All contracts shall specify the attribution methodology. Refer to [Appendix A-5](#) for additional guidelines regarding assignment of members to VBP contractors and timing for attribution.

<sup>3</sup> NY Codes, Rules and Regulations, Section 98-1.11 - Operational and financial requirements for MCOs (July 3, 2019). <https://regs.health.ny.gov/volume-2-title-10/content/section-98-111-operational-and-financial-requirements-mcos>

<sup>4</sup> The VBP Reporting Requirements Technical Specifications Manual can be found under the VBP Quality Measures tab for the respective measurement year.

NYS Department of Health, Value Based Payment Reporting Requirements, Technical Specifications Manual. [https://www.health.ny.gov/health\\_care/medicaid/redesign/vbp/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm)

#### *Requirement 4: VBP Arrangements Must Detail the Target Budget Setting Methodology*

For all arrangements, NYS does not mandate a specific methodology to be used to calculate a target budget for an arrangement. However, the contracts shall specify that a target budget will be used and the method of calculation, including the frequency of target budget rebasing. MCOs and VBP contractors with more than one line of business covered by one contract shall establish target budgets separately for each line of business contained within a contract. [When calculating target budgets, providers and plans could consider both the provider's historical cost and the regional benchmark/MCO average during their negotiation process.](#) For additional guidelines and examples for the target budget setting process, please refer to [Appendix A-6](#).

#### *Requirement 5: VBP Arrangements Must Detail the Quality Measures and Include At Least One Pay-for-Performance Category 1 Measure*

The list of quality measures to be used for the calculation of shared savings and losses shall be included in the contract. In the quality measures to be included, at least one Category 1 P4P quality measure shall be selected from the NYS-approved Quality Measure Sets.<sup>5</sup> For arrangement-specific quality measure requirements please refer to the [Arrangement Specific](#) section. Additional information on the measure selection process carried out by the Clinical Advisory Groups (CAGs) can also be found in [Appendix A-8](#).

**Guideline:** NYS strongly encourages MCOs and VBP contractors to select quality measures that are appropriate for the population(s) 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 served. For members who require behavioral health services, MCOs and VBP contractors should consider quality measures beyond purely medication maintenance/adherence. Many members aspire to and require more than a bottom-line focus on taking medication and will benefit from additional evidence-based interventions to promote recovery.

#### *Requirement 6: Level 2 and 3 Agreements Shall Incorporate Interventions that Address Social Care Needs*

VBP contractors in Level 2 or Level 3 agreements are required to implement at least one intervention that addresses social care needs. VBP contractors shall select an intervention that aligns with at least one of the five (5) key domains of social care needs, as outlined in the Social Determinants of Health (SDH) Intervention Menu<sup>6</sup> and VBP Subcommittee Recommendation Report:<sup>7</sup> 1) Economic Stability, 2) Education, 3) Health and Healthcare, 4) Neighborhood and Environment, and 5) Social, Family, and Community Context. Interventions can focus on key areas such as:

1. Housing instability
2. Food insecurity
3. Transportation problems
4. Interpersonal safety and toxic stress
5. Health literacy and education

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<sup>5</sup> The Quality Measure sets can be found under the VBP Quality Measures tab for the respective measurement year. NYS Department of Health, Value Based Payment (VBP), VBP Quality Measures.

[https://www.health.ny.gov/health\\_care/medicaid/redesign/vbp/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm)

<sup>6</sup> NYS Department of Health, Value Based Payment (VBP) Resource Library, VBP Subcommittee Documents, SDH Intervention Menu. [https://www.health.ny.gov/health\\_care/medicaid/redesign/sdh/sdh-vbp\\_library.htm](https://www.health.ny.gov/health_care/medicaid/redesign/sdh/sdh-vbp_library.htm)

<sup>7</sup> NYS Department of Health, VBP Subcommittee Recommendation Report, Appendix C.

[https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/2016/docs/2016-feb\\_sub\\_comm\\_recommend\\_rpt\\_consol.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-feb_sub_comm_recommend_rpt_consol.pdf)

## 6. Economic instability

*Note: The intervention cannot be a Medicaid billable service.*

**Guideline:** NYS encourages providers in MCO networks to screen members as part of their intervention to address social care needs, using a validated social needs assessment, such as the core questions from the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool<sup>8</sup>, and to use corresponding z-codes.

MCOs contracting in a VBP Level 2 arrangement must share the costs and responsibilities associated with the investment, development, and implementation of the intervention(s) with the VBP contractor. For Level 3 arrangements, the VBP contractor is expected to solely take on the responsibilities and financial risk associated with the intervention(s) that address social care needs. *MCOs and providers that engage in VBP arrangements may collaborate with third party partners to identify and secure investment and support for these interventions, consistent with applicable law.*

Since service providers engaged in a VBP arrangement—such as Community Based Organizations (CBOs), who successfully address social care needs at both member and community levels—may not see savings in the short term, they shall be incentivized by MCOs upfront to identify one (or multiple) social care needs and be financially rewarded for addressing them. In the instance where a CBO is implementing these interventions, the CBO entity must receive start-up funds or seed money in addition to payment for services rendered. *The details for distribution of start-up funds/seed money should be part of the CBO contract, and the start-up funds/seed money should be used for the initial costs of the intervention outside of the service cost. Start-up funds/seed money must be reported to NYSDOH through the SDH Intervention Status Report.*

It is also recommended that VBP contractors incorporate the patient perspective in quality measurement and improvement (e.g., through Patient Reported Outcome Measures). Providers may utilize Patient Reported Outcome Measures (PROMs) in their practice, using tools to assess the member's symptoms, functional status, and quality of life. The selection can be based on information including, but not limited to: screening of individual members, member health goals, the impact of social care needs on their health outcomes, as well as an assessment of community needs and resources. The contractors should also create a report explaining why the social care need was selected and identify metrics that will be used to track its success, and report back to NYS. MCOs will continue to use the **SDH Intervention & CBO Contracting Template** to report this information to NYS.<sup>9</sup> MCOs are also encouraged to measure success of the programs implemented. Using the **Social Determinants of Health Intervention Status Report Template**,<sup>10</sup> MCOs contracting in Level 2 and 3 arrangements must report the following information to the State on an annual basis: intervention utilization, disbursed funds, evaluation, quality measurement outcomes, and success of the programs implemented. *If agreed upon by the contracting parties, the VBP contractor and CBO may complete the report and provide it to the MCO for their reporting submission.*

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<sup>8</sup> Centers for Medicare & Medicaid Services, The Accountable Health Communities Health-Related Social Needs Screening Tool. <https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>

<sup>9</sup> NYS Department of Health, SDH and CBO Contracting Documents for Managed Care Organizations (MCOs) and Providers. [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsr/vbp\\_library/docs/sdh\\_intervention\\_cbo\\_contract\\_temp.docx](https://www.health.ny.gov/health_care/medicaid/redesign/dsr/vbp_library/docs/sdh_intervention_cbo_contract_temp.docx)

<sup>10</sup> NYS Department of Health, Value Based Payment (VBP) Resource Library, SDH and CBO Contracting Documents for Managed Care Organizations (MCOs) and Providers, VBP - SDH Intervention Status Report Template. [https://www.health.ny.gov/health\\_care/medicaid/redesign/sdh/sdh-vbp\\_library.htm](https://www.health.ny.gov/health_care/medicaid/redesign/sdh/sdh-vbp_library.htm)



MCOs must also demonstrate use of the SDH intervention(s) and CBO contract through the report by reporting on the utilization to the State.

#### *Requirement 7: Level 2 and 3 VBP Arrangements Shall Include At Least One Not-for-Profit Organization / CBO*

All Level 2 and 3 VBP arrangements shall include a minimum of one not-for-profit Community Based Organization (CBO). This requirement does not preclude VBP contractors from including more than one CBO in an arrangement or a CBO network composed of not-for-profit organizations to address one or more social care needs. MCOs must provide a copy of the CBO or CBO network contract to the State that demonstrates funding to not-for-profit organization(s) for services.

A CBO is defined as a not-for-profit charitable organization that works at the local level to meet community needs. CBO is a social service organization or not-for-profit organization that is registered as a 501(c)(3).

## 2.2. Arrangement Specific Requirements: Total Cost of Care for General Population

### *Requirement 1: TCGP Arrangements Must Include At Least One Category 1 Measure for Each Applicable Domain*

MCOs (excluding MLTC plans) that execute a 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 in the TCGP Quality Measure Set:<sup>11</sup>

- Primary Care
- Mental Health
- Substance Use Disorder
- HIV/AIDS
- Maternity
- Children

TCGP VBP arrangements that exclude Maternity, Children, or HIV/AIDS are not required to include quality measures from the Maternity, Children, or HIV/AIDS quality measure set domains, respectfully. TCGP arrangements that exclude HARP members are still required to include quality measures from the Primary Care, Mental Health, and Substance Use Disorder quality measure domains, in addition to the Maternity, Children, and HIV/AIDS domains if these latter populations are included.

### *Requirement 2: For Professional-Led TCGP VBP Arrangements, Hospitals May Obtain Shared Savings by Satisfying Objectives Across Three Criteria*

To define the expected level of cooperation between professional-led VBP contractors and downstream hospitals, three main criteria (listed in Table 3) serve as a statewide standard in determining equitable shared savings in TCGP VBP arrangements. If the hospitals meet all three criteria and savings are generated in the VBP arrangements, the hospitals should receive an equitable portion of the savings depending on the arrangement's VBP Level.

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<sup>11</sup> The TCGP Quality Measure sets can be found under the VBP Quality Measures tab for the respective measurement year. NYS Department of Health, Value Based Payment (VBP), TCGP Quality Measure Set.  
[https://www.health.ny.gov/health\\_care/medicaid/redesign/vbp/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm)

Table 3: Criteria for determining Cooperation in Level 1 and 2 TCGP arrangements

Category	Detail
<b>Data Management and Data Sharing</b>	Provide real-time direct data feeds to professional-led VBP contractors for emergency room utilization, admissions, and discharges (including behavioral health and substance use).
<b>Innovation and Care Redesign</b>	<p>Fulfill at least one of the three following measures:</p> <p>Develop standardized care plans based on evidenced-based guidelines and practices to reduce inappropriate variation in the organization for at least one of the following service areas: high-cost imaging, emergency room care, oncology treatment, diagnostic testing, behavioral health treatment, or substance use treatment.</p> <p>Enhance care transitions to post-acute settings such as mental health treatment facilities, substance use disorder treatment facilities, Skilled Nursing Facilities, home, etc. to reduce readmission rates and potential complications.</p> <p>Implementation of palliative care and collaboration with hospice.</p>
<b>Quality and Engagement</b>	Collaborate with professional-led VBP contractors on CAG-approved measures.

### 2.3 Arrangement Specific Requirements: Fully Capitated MLTC

VBP goals and requirements for fully capitated plans in MLTC are the same as those that apply to fully capitated Medicaid Mainstream Managed Care, which include meeting requirements for inclusion of social care needs and CBO in Level 2 and 3 VBP arrangements, as outlined in [General Requirements 6 and 7](#).

*Requirement: MLTC Fully Capitated Arrangements Must Include At Least **Two** Category 1 P4P Quality Measures*

The contract must list quality measures agreed upon for calculating shared savings and losses. At least two (2) Category 1 P4P quality measures must be selected from the Medicaid Advantage Plus (MAP) or Program of All-Inclusive Care for the Elderly (PACE) measure set (based, respectively, on the line of business being contracted) located in the MAP or PACE Quality Measure Set.<sup>12</sup>

*Note: As of December 2021: Due to COVID-19 and the public health emergency, the calculation of the MLTC VBP Category 1 measures, except for the Potentially Avoidable Hospitalization (PAH) measure, is not currently possible. As a result, both parties, plan, and provider, should pre-plan how to evaluate VBP contracts with only PAH available. The other VBP Category 1 measures can be included once the Department resumes processing.*

<sup>12</sup> The MAP and PACE Quality Measure sets can be found under the VBP Quality Measures tab for the respective measurement year.

NYS Department of Health, Value Based Payment (VBP), MAP and PACE Quality Measure Set. [https://www.health.ny.gov/health\\_care/medicaid/redesign/vbp/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm)

### 2.3.1 Guidelines for Partially Capitated MLTC

Given the initiatives to promote integrated care for dual eligible populations and their impact on MLTC Partial Capitation (MLTCP) plans from the SFY 2020-21 Enacted Budget, NYS encourages MLTCP plans to examine the outcomes and impacts of their current VBP contracts upon expiration and to make an informed determination as to whether such arrangements should be renewed or expanded, or whether to enter new VBP arrangements. Beyond this encouragement, NYS is not imposing any broader expectations on MLTCP plans and understands that determinations will be made individually by MLTCP plans in collaboration with their providers.

*Definitions: Partially Capitated MLTC Arrangements Should Include Certain Measures for Level 1 or 2 VBP, if Pursued*

For partially capitated MLTC plans, a Level 1 VBP arrangement with a VBP contractor includes the following:

- Potentially Avoidable Hospitalization (PAH) measure, and
- Performance-based quality bonus between an MLTCP Plan and a VBP contractor that is based on meeting performance targets.

For partially capitated MLTC plans, a Level 2 VBP arrangement with a VBP contractor includes a:

- Potentially Avoidable Hospitalization measure and at least one other MLTC quality measure recommended by the MLTC CAG and approved by NYS,
- Minimum percentage of potential risk allocated to a provider is at least 1% of total annual expenditures in the contract between the plan and provider, and
- Social Care Needs and CBO requirements outlined in General Requirement 6 and 7.

### 2.4 Off-Menu VBP Arrangement Requirements

Off-menu VBP arrangements enable MCOs and the interested VBP contractors to flexibly define arrangements for specific market needs that are not covered by the on-menu definitions. An off-menu arrangement contract evaluation will be triggered if the proposed VBP contract:

- Is a modified version of one of the standard arrangements outlined in [2.1 General VBP Contracting Requirements](#); and/or
- Does not commit to reporting on all required quality measures for that respective arrangement.

Off-menu VBP arrangements will not require separate approval from NYS beyond the off-menu contract evaluation process.

While there is a large amount of flexibility for MCO and VBP contractors to design off-menu VBP arrangements, the following sections describe the requirements to which all off-menu arrangements must adhere.

*Requirement 1: Off-Menu VBP Arrangements Must Adhere to the Shared Savings and Losses Requirements for Standard VBP Arrangements*

All submitted off-menu VBP arrangements must align with the shared savings and losses outlined for each VBP level in [Appendix A-4](#).

## *Requirement 2: Off-Menu VBP Arrangements Must Support the Roadmap's Quality and Cost Goals Across Four Criteria*

Any off-menu arrangement will be submitted to a review across four criteria:

*Requirement 2.1: Off-menu VBP arrangements shall focus on conditions and subpopulations that address community needs but are not otherwise addressed by a VBP arrangement in the Roadmap.*

MCOs and VBP contractors are invited to focus on conditions and subpopulations that are locally relevant yet not identified as such by the VBP Roadmap. Off-menu arrangements are not intended to be used for making variations to the VBP arrangements that have been prioritized by NYS.

*Example of an acceptable off-menu option:*

- An arrangement that focuses on a bundle or subpopulation that has significant local impact would satisfy this requirement. For example, a cancer treatment arrangement in an area with poor outcomes for cancer patients would constitute a potentially acceptable off-menu arrangement.

*Requirement 2.2: Off-menu VBP arrangements shall be member-centric*

All VBP arrangements shall be member-centric and span the full continuum of care as appropriate for the target condition or subpopulation. The VBP arrangements outlined in the Roadmap offer clear examples. "Costs" and "outcomes" are measured across the entire spectrum of the care services.

*Example of an acceptable off-menu option:*

- A TCGP arrangement that excludes dental services but does include the continuum of covered services for all members eligible for Mainstream Managed Care would satisfy this criterion, as dental services are outside of the set of covered services for these members.

*Examples of unacceptable off-menu options:*

- A TCGP arrangement that excludes hospital costs would not satisfy this criterion. Emergent and tertiary care services are a necessary component of the continuum of care for the general Medicaid population due to the variability and unpredictability of medical needs.
- A Maternity Care arrangement that excluded obstetric services would fail this criterion. Obstetric services are a core component of the support provided to this cohort, and an arrangement that omitted these services would be unable to provide adequate care to its members.

*Requirement 2.3: Off-menu VBP arrangements must include payment tied to both components of "value": the quality and cost of the care delivered*

VBP contractors take responsibility for the total costs and quality delivered to the patient included in the arrangement. These total costs, as well as the quality-based process/outcome measures, need to be clearly defined. Both the VBP arrangement definition as well as the outcomes need to be available to stakeholders, to stimulate uptake by other providers and MCOs, if desired. MCOs will need to report their scores on the quality metrics to the Office of Quality and Patient Safety (OQPS), as is the case for on-menu VBP arrangements.

*Requirement 2.4: Off-menu VBP arrangements should utilize standard definitions and quality measures*

The arrangement definitions and quality measures appearing in the Roadmap and annual Quality Measure Sets<sup>13</sup>, respectively, should be implemented consistently across the state.

Variations on the defined arrangements may be allowable but will be reviewed and approved by the Department. These variations may include adjustments to target population parameters, covered services, or performance measures.

*Examples of potentially acceptable off-menu options:*

- An arrangement that proposes excluding one or more subpopulations from the Total Care for General Population arrangement in the short term to expedite their ability to implement a VBP contract.
- A HARP arrangement that includes new quality measures that have been developed after the HARP CAG report was published and that will assist the VBP contractor in monitoring outcomes in an enhanced manner.

*Note: the consistency of quality measures across similar arrangements statewide is an important aspect of monitoring the progress and results of the VBP program. VBP Arrangements should not omit quality measures recommended by the CAGs. Alternative quality measures outside of those recommended by the CAGs will be considered as long as they are consistent with the aims of the VBP program and are supported by a compelling argument for their use.*

*Examples of potentially unacceptable off-menu options:*

- An arrangement that omits CAG-recommended quality measures without approved rationale and/or inclusion of approved alternatives.

*Note: the integration of primary care and behavioral health care is core to the aims of enhanced patient-centered care and therefore the separation of primary care and behavioral health will not be an acceptable example of an exclusion for the TCGP arrangement.*

## 2.5 Reporting (Deliverable) Requirements

### *Requirement 1: MCO Shall Report All Required VBP Quality Measures to NYS*

The statewide VBP definitions and VBP quality measures have been set based on national standards and the recommendations from the Clinical Advisory Groups and the Technical Design Subcommittees. MCOs shall report these VBP measures to NYS and they will calculate claims-based measures as necessary. Where discrepancies exist between the Quality Assurance Reporting Requirement (QARR) measure set and the VBP arrangement-specific measures, NYS may modify the VBP measure set to optimally align how MCOs are scored.

For on-menu contracts, all agreed upon Category 1 quality measures (P4P as well as any applicable pay-for-reporting [P4R]) approved by NYS must be reported. If at least one (1) reportable Category 1 measure is missing, this arrangement will be considered off-menu and will be reviewed by the Off-Menu Committee.

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<sup>13</sup> The Quality Measure sets can be found under the VBP Quality Measures tab for the respective measurement year. NYS Department of Health, Value Based Payment (VBP), VBP Quality Measures [https://www.health.ny.gov/health\\_care/medicaid/redesign/vbp/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm)

For MLTC Fully Capitated arrangements, NYS mandates the reporting of all required P4R measures at the contract level, which can be found in the MAP and PACE quality measure set.<sup>14</sup> If at least one (1) required P4R measure is missing, this arrangement will be considered off-menu and will be reviewed by the Off-Menu Committee.

Inclusion of measure reporting requirements beyond Category 1 is optional. To assist in the reporting process, the VBP Technical Specifications Manual should be referenced as a guiding document.<sup>15</sup>

**Guideline:** MCOs are encouraged to standardize quality measure reporting with VBP contractors to enable provider and MCO partnerships to improve the quality of care. Such consistency enables transparency in performance between MCOs and VBP contractors, supports adequate monitoring of the quality and expenditures of the overall Medicaid system, and significantly reduces the administrative burden for both MCOs and VBP contractors. Especially for smaller VBP contractors, varying definitions of a VBP arrangement between MCOs and/or differences in reporting requirements could cripple their ability to fulfil their role.

*Requirement 2: Social Care Needs Investments Shall be Reported Through the Appropriate Template*  
All social care need-targeted funding shall be reported by the MCO to NYS using the Social Determinants of Health Intervention Status Report template.<sup>16,17</sup> Information requested in the template includes intervention utilization, disbursed funds, evaluation, quality measurement outcomes, and success of the programs implemented. The expenses for interventions that address social care needs being implemented within the VBP contract for which the MCO is making the investment shall be included in "Other Medical" on the Medicaid Managed Care Operating Report (MMCOR) and MLTC Reporting Requirements (MLTCRR).

## 3. Supporting Documents and Available Data Resources

### 3.1 Supporting Documents

NYS has created supporting documents to assist MCOs and VBP contractors in their VBP contracting process. These documents include:

- Contracting Checklists<sup>18</sup>

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<sup>14</sup> The MAP and PACE Quality Measure sets can be found under the VBP Quality Measures tab for the respective measurement year.

NYS Department of Health, Value Based Payment (VBP), MAP and PACE Quality Measure Set.  
[https://www.health.ny.gov/health\\_care/medicaid/redesign/vbp/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm)

<sup>15</sup> The VBP Reporting Requirements Technical Specifications Manual can be found under the VBP Quality Measures tab for the respective measurement year.

NYS Department of Health, Value Based Payment Reporting Requirements, Technical Specifications Manual (n.d.).  
[https://www.health.ny.gov/health\\_care/medicaid/redesign/vbp/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm)

<sup>16</sup> NYS Department of Health, Value Based Payment (VBP) Resource Library, SDH and CBO Contracting Documents for Managed Care Organizations (MCOs) and Providers, VBP - SDH Intervention Status Report Template.  
[https://www.health.ny.gov/health\\_care/medicaid/redesign/sdh/sdh-vbp\\_library.htm](https://www.health.ny.gov/health_care/medicaid/redesign/sdh/sdh-vbp_library.htm)

<sup>17</sup> Recipients of Accountable Health Communities awards will also be eligible to participate.

<sup>18</sup> NYS Department of Health, VBP On-Menu Checklist menu items (January 2020).  
[https://www.health.ny.gov/health\\_care/managed\\_care/hmoipa/hmo\\_ipa.htm](https://www.health.ny.gov/health_care/managed_care/hmoipa/hmo_ipa.htm)

- Model Contract Templates<sup>19</sup>
- Provider Contract Guidelines<sup>20</sup>

Once contracts are ready for submission, they can be submitted to NYS through the Division of Health Plan Contracting and Oversight as follows:

- Managed long term care plans: [MLTCcontract@health.ny.gov](mailto:MLTCcontract@health.ny.gov)
- All other MCOs: [contract@health.ny.gov](mailto:contract@health.ny.gov)

### 3.2 Data & Analytics Tools

NYS has a vested interest in making data more accessible to VBP contractors and MCOs alike. Towards that end, NYS has created analytic tools with the purpose of underscoring the importance of exchanging frequent, accurate, and timely data between stakeholders, as well as helping VBP contractors and MCOs get valuable information that could be useful before and during the contract negotiation process. Future efforts will continue to explore avenues toward achieving these factors to facilitate meaningful data sharing among its stakeholders. Below is a list of the data tools that are currently available:

- **Medicaid Analytics and Performance Portal (MAPP) Version 2:**
  - The MAPP tool allows users to review statewide and regional benchmarks for MCO performance across a variety of measures including efficiency (cost) and quality.
  - Additional information on the MAPP tool is available on the MAPP Access Process webpage.<sup>21</sup>
- **Coming Soon:**
  - NYS is developing public-facing dashboards that will allow users to look more closely at the cost and quality performance of the Medicaid membership. The tools will use State-defined attribution to link members, primary care physicians (PCPs), and MCOs, and allow for custom benchmarking by line of business, region, and VBP subpopulation type, among others. Release of these dashboards will be promoted through the Medicaid Redesign Team listserv.<sup>22</sup>

For additional questions about data availability and tools, please contact the NYS DOH VBP email at: [vbp@health.ny.gov](mailto:vbp@health.ny.gov). Additional tools may be developed by NYS to continue reporting on VBP performance and putting actionable data into the hands of MCOs and VBP contractors to support development of VBP arrangements. As the need for additional data sources arises, NYS will communicate this information to MCOs and/or VBP contractors.

Lastly, NYS will work with stakeholders to improve the quality of data provided by service providers to plans and from plans to NYS, as this data is foundational for the measurement of quality and costs. Poor quality data delivery may be financially penalized.

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<sup>19</sup> NYS Department of Health, Medicaid Managed Care/ Family Health Plans/ HIV Special Needs Plan/ Health and Recovery Plan Model Contract (March 1, 2019).

[https://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_care\\_fhp\\_hiv-snp\\_model\\_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf)

<sup>20</sup> NYS Department of Health, Provider Contract Guidelines for Article 44 MCOs, IPAs, and ACOs (April 1, 2017).

[https://www.health.ny.gov/health\\_care/managed\\_care/hmoipa/docs/guidelines.pdf](https://www.health.ny.gov/health_care/managed_care/hmoipa/docs/guidelines.pdf)

<sup>21</sup> NYS Department of Health, What do I need to do to get MAPP access? (February 2016)

[https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/2016/mapp\\_access\\_process.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/mapp_access_process.htm)

<sup>22</sup> NYS Department of Health, Medicaid Redesign Team (MRT) LISTSERV.

[https://www.health.ny.gov/health\\_care/medicaid/redesign/listserv.htm](https://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm)

## 4. Appendix

### A-1 Glossary of Terms

Attribution – Process used to determine which members a VBP contractor will be responsible for (in terms of quality outcomes and costs) under a VBP arrangement.

Clinical Advisory Groups – CAGs review the care bundle design and subpopulation definitions most relevant to NYS Medicaid. The CAGs make recommendations to NYS on quality measures, data, and support required for providers to be successful, and address other implementation details related to specific VBP arrangements, including bundles (episode-based) and subpopulations.

Episodic Care Services – Utilized for circumscribed periods of time when people require more specialized services for a specific health problem or condition. Within the Medicaid VBP arrangement types, maternity care may be the best example; for elderly members, hip and knee replacement episodes are the most prevalent examples. These services, which may involve a single service or combination of services across the continuum of care, should be tightly integrated with multidisciplinary teams working with evidence-based care pathways, organized around these members' specific needs, resources (including community resources), and cultural sensitivities.

Line of Business –The product offered by an MCO such as Medicaid (Mainstream), Commercial, HARP, and HIV/SNP.

Mainstream MCO – Refers to a health plan that offers the Mainstream Medicaid Managed Care line of business.

Managed Care Organization (MCO) – Refers to a health maintenance organization (“HMO”) or prepaid health service plan (“PHSP”) certified under Article 44 of the PHL.

Medicaid Managed Care (MMC) - Unless otherwise specified, includes Mainstream, HIV SNP, and HARPs.

Program of All-Inclusive Care for the Elderly (PACE) – A subset of the fully capitated products in MLTC, PACE provides comprehensive medical and social services to certain frail, community-dwelling individuals, ages 55 and older, and eligible for nursing home care, most of whom are dually eligible for Medicare and Medicaid benefits.

Specialized Continuous Care Services – Required for those individuals who require ongoing, dedicated, and specialized interdisciplinary services for their health problem(s) or condition(s). This type of care can involve both evidence-based specialty care for individual conditions (e.g., Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Serious Mental Illness (SMI) and/or Substance Use Disorders (SUD), as well as care for severely co-morbid and/or subpopulations (e.g., HARP and MLTC/Fully Integrated Duals Advantage (FIDA) populations, members with significant developmental disabilities, and members with HIV/AIDS). For the latter groups of members, personalized goal setting and intensive care coordination become more dominant than disease management. In both examples of care, a focus on maximizing a member's capability for self-management and personal autonomy in the most integrated settings (e.g., home and community) appropriate to a person's needs is central.



VBP Contractor – An entity that contracts VBP arrangements with an MCO. A VBP contractor can be an Accountable Care Organization (ACO), an Independent Practice Association (IPA), or an individual service provider (either assuming all responsibility and upside/downside risk or subcontracting with other service providers).

## A-2 Value Based Payment Reform Guiding Principles

The original NYS VBP Roadmap and the subsequent updates are guided by the following principles of payment reform:

- Be transparent and fair, increase access to high-quality health care services in the appropriate setting, and create opportunities for both payers and providers to share savings generated if agreed upon benchmarks are achieved.
- Be scalable and flexible to allow all providers and communities (regardless of size) to participate, reinforce health system planning, and preserve an efficient and essential community provider network.
- Allow for a flexible, multi-year phase-in to recognize administrative complexities, including system requirements (i.e., Information Technology).
- Align payment policy with quality goals.
- Reward improved performance as well as continued high performance.
- Incorporate a strong evaluation component and technical assistance to assure successful implementation.
- Engage in strategic planning to avoid the unintended consequences of price inflation, particularly in the commercial market.
- Financially reward, rather than penalize, providers and plans who deliver high-value care through emphasizing prevention, coordination, and optimal patient outcomes, including interventions that address underlying social care needs.

### **What New York State’s Medicaid VBP Roadmap is Not:**

**A new rate setting methodology:** NYS will show benchmarks and give guidance, but it will not set rates or dictate detailed terms for VBP arrangements.

**One size fits all:** There are a variety of options outlined in the Roadmap, and many details to negotiate between MCOs and VBP contractors. Also, MCOs and VBP contractors can jointly agree to pursue different or off-menu VBP arrangements, as long as those arrangements reflect the Medicaid VBP principles described herein. In addition, NYS’s VBP goals will be measured at the State level, not at the individual VBP contractor level, allowing for differences in adaptation between VBP contractors.

**NYS backing away from adequate reimbursement for Federally Qualified Health Centers (FQHCs) and other community-based providers:** NYS is committed to ensuring adequate reimbursement aligned with the value provided for the Medicaid population consistent with federal statute.

**An attempt to make providers do more for less:** In fact, the intent is the opposite. Under the NYS VBP approach, reducing lower value care and increasing higher value care in equal proportions should lead to higher margins rather than lower margins.

**An attempt to require MCOs to contract with certain providers for VBP**

**Arrangements:** MCOs are free to continue to build upon their existing direct provider contracts or IPA/ACO arrangements to achieve VBP goals.

**A Roadmap for all future payment reform:** This Roadmap pertains only to Medicaid payment reform and does not apply to payment reform in the commercial or Medicare marketplace, or payment reform that may occur as part of a new 1115 waiver demonstration.

### A-3 VBP Arrangement Exclusions

In principle, NYS does not want to wholly exclude any cost categories from the VBP arrangements. Generally speaking, excluding defined services and provider types undermines the principles of VBP as outlined here. NYS must, however, ensure that there are no structural barriers to achieving the statewide goals, and the following narrow list of services and providers either *are* excluded (i.e., they cannot be included) or *may be* excluded by MCOs and VBP contractors. Services not mentioned here or elsewhere in the VBP arrangement definitions, in other words, cannot be excluded. There may be special circumstances in VBP where these exclusions may be added into the arrangement, such as with FQHCs.

- **Services to Non-Attributed Members.** (Emergency) services performed by a provider for a Medicaid member who is not attributed to a VBP arrangement in which this provider participates will be excluded from the VBP arrangements and the target budget setting process.
- **High-Cost Specialty Drugs.** MCOs and providers may exclude high-cost specialty drugs from their VBP arrangements if they so choose, as including specialty drugs may shift too much insurance risk to the provider. CMS defines the threshold for specialty drugs based on their cost per month under Medicare Part D. This threshold will also be used for evaluating high-cost drugs in Medicaid VBP to align with existing CMS definitions.<sup>23</sup> Should plans and providers decide to include high-cost specialty drugs in their VBP arrangements, however, they are able to do so.
- **Transplant Services.** MCOs and contractors may choose to exclude the cost of organ transplant services (including organ acquisition) from their arrangements.
- **Dental Services.** MCOs and contractors may choose to exclude the cost of dental services from their arrangements.
- **Vision Coverage.** MCOs and contractors may choose to exclude the cost of vision services from their arrangements.
- **Federally Qualified Health Centers & Rural Health Clinics (RHC).** NYS encourages FQHCs and RHCs to adopt Level 1 (non-risk based) VBP arrangements with MCO partners and believes that where cost and quality outcomes are met, FQHCs and RHCs maintain the potential for increased financial incentive through shared savings. The NYS VBP model recognizes that FQHCs and RHCs have a statutorily mandated rate as prescribed in Federal law 42 USC 1396a (bb)(5)(A). The NYS VBP model will accommodate the current payment structure of FQHCs and RHCs in the following ways:
  - FQHCs & RHCs may continue to enter into Level 1 VBP arrangements as lead VBP Contractors.

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<sup>23</sup> With its stakeholders, NYS will monitor the pharmaceutical market to prevent an undue financial burden on VBP contractors.

- FQHCs & RHCs may not enter into Level 2 or Level 3 arrangements as lead VBP Contractors.
- FQHCs & RHCs may participate with a non-FQHC Lead VBP contractor in a Level 2 or 3 VBP arrangement. In these cases, all Medicaid members may be attributed to the lead VBP Contractor.

## A-4 Contracting Levels

When entering into VBP arrangements, organizations become “VBP contractors.”

### **Level 0: FFS only**

Level 0 is not considered to be a sufficient move away from traditional FFS incentives to be counted as VBP in the terms of this Roadmap.

### **Level 1: FFS with Retrospective Reconciliation, Upside Only Risk**

To be counted as a Level 1 VBP agreement, the minimum percentage of potential savings to be allocated to the VBP contractor, if associated quality goals are met, is 40%. A Level 1 VBP arrangement continues the existing FFS payment methodology from MCO to VBP contractors but allows the VBP contractor to receive shared savings based on a “target budget” set for the VBP arrangement and tied to selected quality outcomes. When the total spend on the services included in the VBP arrangement remains below the target budget and a minimum threshold on the quality outcomes is met, these savings are shared between MCO and VBP contractor. Potential losses are not shared and VBP contractors are not financially “at risk” in Level 1. The MCO and VBP contractor can agree on how to apportion shared savings based on meeting quality outcome targets as well. For example, if a VBP contractor meets most of its contracted quality outcomes, MCOs can return the savings. When fewer quality goals are met, the shared savings percentage returned to the VBP contractor is reduced. If quality outcomes decline over the course of the contracting period, no savings are shared.

### **Level 2: FFS with Retrospective Reconciliation, Upside and Downside Risk**

To be counted as a Level 2 VBP agreement, the minimum percentage of potential losses to be allocated to the VBP contractor is 20% in the event that cost and quality targets are not met. There are no state-mandated requirements for percent of shared savings to be allocated. However, shared savings amounts should reflect the additional downside risk that VBP contractors accept in these types of arrangements. A Level 2 VBP arrangement also continues the existing (usually FFS) payment methodology from MCO to providers but allows the VBP contractor to receive more shared savings than in a Level 1 arrangement, because the VBP contractor also shares in potential losses. If a VBP contractor meets the agreed upon percentage of its contracted quality outcomes, the MCOs can return most or all of the savings. Conversely, if a VBP contractor exceeds the virtual per member, per month (PMPM) capitation or bundle budget, and a smaller percentage of outcome goals are met, then these providers may be held responsible for an agreed upon percentage of the financial loss.

There is a cap of 3% of the target budget on shared losses in the first year of the Level 2 contract and 5% from the second year forward. Below these levels, the VBP arrangement is counted as a Level 1 arrangement. Certain situations may warrant a lower cap where the VBP contractor may be PCPs or FQHCs or other providers with an operating budget that may be significantly smaller than the total downstream costs to which they are held accountable. In those cases, the cap set should be proportional to the overall budget of the PCP / FQHC. PCPs or FQHCs engaged in Chronic Care arrangements that have received shared savings in year “t” should be able to lose the same amount of dollars in year “t+1.”

VBP contractors may re-insure against potential losses, which will not affect the categorization as Level 2 as long as the costs for that re-insurance are born by the VBP contractor (e.g., if the MCO pays for the re-insurance, that will be interpreted as reducing the risk born by the VBP contractor and may thus prevent the VBP arrangements from being classified as Level 2).

### **Level 3: Per Member Per Month or Bundled Payments**

In a Level 3 arrangement, the VBP contractor assumes full risk. The VBP contractor may negotiate various risk-mitigation strategies with the MCO, such as stop-loss arrangements and risk corridors. Level 3 arrangements are fully capitated PMPM arrangements or prospectively paid bundles. The presence of risk-mitigation strategies (stop-loss, risk corridors, etc.) does not affect the Level 3 classification.

## **A-5 Attribution Guidelines**

Medicaid member attribution determines which members a VBP contractor will be responsible for in terms of quality outcomes and costs. Attribution allows for the calculation of the total costs of care, patient-centered outcomes, and potential shared savings and losses per member or episode of care. The following paragraphs outline a series of guidelines for MCOs and VBP contractors to consider when outlining an attribution methodology. The guidelines are illustrative and do not present an exhaustive overview of potential approaches.

### **1. Member Assignment**

- The MCO-assigned Primary Care Physician drives attribution in Total Care for the General Population and the HIV/AIDs subpopulation.
- For episode-based arrangements the provider delivering the core services should drive attribution. In maternity care, that provider is the obstetric professional delivering the plurality of pregnancy care.
- The MCO-assigned Health Home or PCP can drive the attribution for the HARP subpopulation.
- The MLTC plan attribution should be to provider organizations of Certified Home Health Agency (CHHA), Licensed Home Care Services Agency (LHCSA), and Skilled Nursing Facility (SNF), which had the most frequent contact with the member and, therefore, could potentially impact quality measurement.

An MCO and VBP contractor may deviate from this guideline and agree on a different type of provider to drive the attribution on the condition that NYS is adequately notified within the contract terms. For example, a chronic care episode attribution may be determined via a specialist group rather than a PCP. In this case, cardiologists may be the point of attribution for an arrhythmia episode, or for the sickle cell population, the hematologist could be the attributable provider. The attribution entity does not need to be the same organization or even type of organization as the VBP contractor but must be part of the VBP arrangement (e.g., a hospital system could be the contractor for a TCGP population while its associated PCPs would drive the attribution). MCOs and VBP contractors can utilize multiple factors in establishing attribution.

### **2. Timing**

- Members are prospectively attributed to a provider through assignment (PCP, Health Home) or start of care (e.g., contract year).
- If the member switches their assigned PCP/Health Home within the first six months of the year, the member will be attributed to the VBP arrangement of the latter PCP/Health Home.

- To reduce complexity and assure predictability for the VBP contractor, it is not recommended to attempt retrospective reconciliation of members through an analysis of actual PCP or Health Home use.
- VBP contractors may use the same approach for downstream contractors joining or leaving at various points of the contract period (joining late or terminating early) as for Medicaid members joining or leaving the attribution pool.

## A-6 Target Budget Setting Guidelines

To determine whether savings or losses are made in Level 1 and 2 arrangements, a virtual “target budget” needs to be agreed upon for an episode-based arrangement or a (sub)population. A well-designed target budget, coupled with appropriate quality metrics, continuously incentivizes the improvement of quality and cost effectiveness for both historically high-performing and poorly performing VBP contractors.

The method outlined below is modeled on the Center for Medicare and Medicaid Innovation’s Next Generation ACO approach:<sup>24</sup>

- Starting from the VBP contractor’s own historical baseline.
- Including risk adjustment to account for differences in patient population between the baseline period and the contract period.
- Including “performance adjustments” which account for existing efficiency and quality (or lack thereof).

Realizing shared savings is difficult for those VBP contractors that are already highly efficient compared to the statewide average. Likewise, inefficient providers can realize savings relatively easily, and it would be unfair if a VBP methodology punished the former and rewarded the latter.

Performance adjustments reward VBP contractors that are highly efficient (and of high quality) by adjusting their target budget upwards, meaning more dollars in the overall pool, thus increasing their potential for shared savings. Vice versa, VBP contractors that deliver much lower value may see their target budgets adjusted downwards.

The method is *prospective*: the target budget is set based on historical performance. The expected PMPM or episode budget is determined at the start of the contract year or the episode – not reassessed during the year/episode. This ensures that an unforeseen shift in population characteristics does not unfairly (dis)advantage the VBP contractor while avoiding gaming and increasing predictability.

Using this methodology, the MCOs and VBP contractors can negotiate target budgets per arrangement to invest additionally in underserved areas of care or disincentivize above-average avoidable complication rates.

## A-7 Shared Savings Guidelines

Table 4 reflects the shared savings percentages that NYS established as a guideline to support VBP contractors and plans in their VBP contracting negotiations. Plans and VBP contractors may, however, decide on other percentages in their VBP agreements. For example, in a Level 2 VBP, when actual costs

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<sup>24</sup> Centers for Medicare & Medicaid Services, Center for Medicare and Medicaid Innovation, Next Generation ACO Model Request for Applications. <http://innovation.cms.gov/Files/x/nextgenacofa.pdf>

are greater than budgeted costs, the percentages of shared losses for the Level 2 arrangements will depend on, amongst other factors, the risk-mitigation strategies chosen. In many cases, especially when more “focused” VBP arrangements are contracted (e.g., an episode-based arrangement vs. a TCGP contract), actuarial analysis shows that the percentages of savings returned to providers can be higher than the percentages of losses shared with providers. There is currently no mechanism in place to determine whether VBP contractors enter into a “focused” versus “non-focused” VBP agreement. VBP contractors and plans are free to enter into the agreements that best serve their respective populations.

*Table 4: Shared Savings Guidelines*

Quality Targets % Met	Level 1 VBP Upside Only	Level 2 VBP Upside and Downside When Actual Costs < Budgeted Costs	Level 2 VBP Upside and Downside When Actual Costs > Budgeted Costs
<b>&gt; 50% of Quality Targets Met</b>	50% of savings returned to VBP contractors	Up to 90% of savings returned to VBP contractors	VBP contractors are responsible for up to 50% of losses
<b>&lt;50 % of Quality Targets Met</b>	Between 10 – 50% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)	Between 10 – 90% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)	VBP contractors responsible for 50-90 % of losses (sliding scale in proportion with % of Quality Targets met)
<b>Quality Worsens</b>	No savings returned to VBP contractors	No savings returned to VBP contractors	VBP contractors responsible for up to 90% of losses

The following general guiding principles for the distribution of shared savings amongst providers by the VBP contractor have been established:

- Funds are to be distributed according to provider effort, provider performance, and utilization patterns in realizing the overall efficiencies, outcomes, and savings.
- Required investments and losses of the involved providers can be taken into consideration in calculating and distributing available savings.
- The relative budgets of the providers involved should not be the default mechanism for making the distribution of savings/losses (i.e., distributing the savings among providers by the relative size of each provider’s budget).
- The distribution of shared savings should follow the same principles as the distribution of shared losses.

For shared losses, smaller providers, financially vulnerable providers, or providers with a regulatory limitation on accepting certain losses may be treated differently by the VBP contractor to protect these individual providers from financial harm. It is legitimate that this special consideration would weigh in as an additional factor in determining the amount of shared savings that these providers would receive.

## A-8 Clinical Advisory Groups

The task of the CAG is to review NYS's vision for the Roadmap to Value Based Payment, validate the proposed bundle (episode-based) or subpopulation definition and corresponding analysis, and decide upon a set of quality measures for each arrangement. Each CAG is comprised of clinicians and professionals with specific knowledge and industry experience with the condition and/or subpopulation. Members were nominated through recommendations from VBP Steering Committee members, other NY State agencies (such as the AIDS Institute and Office of Mental Health), and other professional groups and associations. Specific consideration was given to the composition of the CAG to ensure that it not only represented geographic diversity (both downstate and upstate), but also the total spectrum of care as it related to the specific condition/subpopulation discussed. For example, the Maternity CAG consists of stakeholders from obstetricians to neonatologists to health plans. CAG participation is dynamic and open to providers and MCOs.

For each prioritized VBP arrangement, the Clinical Advisory Groups originally began the quality measure selection process using the Domain 2 and 3 measures from the DSRIP program. They also considered applicable NYS Quality Assurance Reporting Requirements measures, relevant measures from CMS measure sets, the National Quality Forum (NQF) recommendations, the National Committee for Quality Assurance (NCQA) guidance, and CAG-specific measure sets (e.g., the American Thoracic Society for pulmonary measures and the NYS AIDS Institute's measures for HIV/AIDS).

Based on an analysis of clinical relevance, reliability and validity, and feasibility, each CAG ranks their respective measures into one of three categories:

- Category 1: Selected by the CAG as clinically relevant, reliable, valid, and feasible.
- Category 2: Seen as clinically relevant, valid, and likely reliable, but with problematic feasibility.
- Category 3: Rejected by the CAG on the basis of a lack of relevance, reliability and validity, and/or feasibility.

## A-9 Contract Risk Review Process

All VBP contracts submitted to NYS are subject to a contract review process, which assesses content and risk reserve requirements. This process is governed by the Provider Contract Guidelines for Article 44 MCOs, IPAs, and ACOs.<sup>25</sup>

## A-10 VBP Innovator Program

NYS implemented a VBP Innovator Program as a mechanism to allow experienced providers to continue to chart their path into VBP. The Innovator Program is a voluntary program for VBP contractors prepared for participation in Level 2 (full risk or near full risk) and Level 3 VBP arrangements for population-based arrangements. The Innovator Program does not apply to episode-based VBP arrangements because these arrangements cannot be translated into a percentage of premium nor would they involve any significant task shifting between the MCOs and the VBP contractors. As a result, participants in the Innovator Program enter into Total Care for General Population and/or Subpopulation arrangements and are eligible for up to 95% of the total dollars traditionally paid from NYS to the MCO. The Innovator Program is not intended to limit provider networks or member choice. The DOH administers the Innovator Program on an open enrollment basis.

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<sup>25</sup> NYS Department of Health, Provider Contract Guidelines for Article 44 MCOs, IPAs, and ACOs.  
[https://www.health.ny.gov/health\\_care/managed\\_care/hmoipa/hmo\\_ipa.htm](https://www.health.ny.gov/health_care/managed_care/hmoipa/hmo_ipa.htm)

