NEW YORK STATE OF OPPORTUNITY. Department of Health

Health and Recovery Plan Value Based Payment Arrangement

Measurement Year 2019 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 Health and Recovery Plan (HARP) Value Based Payment (VBP) Arrangement. It provides an overview of the Arrangement, including a summary of the types of care covered by the Arrangement and the categories of measures recommended for use in HARP VBP Arrangements.

Introduction

New York State (NYS) has identified certain subpopulations within the Medicaid population for whom highly specialized intensive care is required. The goal for these populations is to improve care coordination across traditional provider silos, ensuring all healthcare providers work together to meet the needs of their patients. HARP VBP Arrangements include the total cost of care for the members to incentivize all care professionals, including behavioral health providers, community-based providers, medical specialists, and other health care professionals, to provide high-quality care. By rewarding VBP Contractors based on quality and cost-effectiveness within a total cost of care budget, VBP Contractors are encouraged to focus on care coordination and high-value, evidence-based practice across the care delivery spectrum.[1]

Savings in a HARP contract can be primarily achieved by providing appropriate interventions for chronic behavioral health conditions that are often comorbid with other chronic physical health conditions, such as diabetes or heart disease. As members are connected to Health Homes, behavioral and physical health care providers, and Behavioral Health Home and Community Based Services (BH HCBS), their health and well-being are expected to improve, leading to a reduction in acute medical events and a lower total annual cost of care. Social determinants of health, such as housing status and economic self-sufficiency, are also important variables for VBP Contractors to address with HARP members.

This fact sheet provides an overview of New York State's HARP VBP Arrangement and is organized in two sections:

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

Section 1: Defining the HARP VBP Arrangement and Associated Costs

The HARP VBP Arrangement addresses the total care and the associated costs of that care for the members 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 conditions and types of care for attributed members, including: primary care; specialty care; psychiatric rehabilitation services; emergency department visits; hospital admissions; and, medications (with an exclusion option for specialty, high-cost drugs).[2] The following specialized BH HCBS benefits are available to HARP members and must be included in HARP VBP arrangements: psychosocial rehabilitation; community support and treatment; habilitation services; family support and training; respite; education support services; peer support services;

[1] A VBP Contractor is an entity – a provider or group of providers – engaged in a VBP contract.
[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, A Path toward Value, November 2017, p. 31 (Link)

pre-vocational services; and, employment supports. HARP members must also receive enhanced care management as outlined in the NYS Office of Mental Health's Medicaid Managed Care Request for Qualifications document, to help them coordinate care for physical and behavioral health and to help meet non-Medicaid support needs such as housing.[3] Only Medicaid Managed Care Organizations (MCOs) that offer the HARP product line can provide BH HCBS services.

Constructing the HARP Arrangement: Time Window and Services

The HARP VBP Arrangement encompasses all services provided to the attributed HARP member population during the contract year. This includes primary care for all acute and chronic conditions, including procedures and surgeries with a date of service or discharge date within the contract year. All specialized behavioral health services covered by Medicaid, including BH HCBS, must also be included.

Eligible Patient Population

Patients can be covered under a HARP VBP Arrangement if they are eligible for HARP and participate in a Medicaid MCO that offers a HARP product.

To be eligible for HARP, a member must be 21 or older, be insured only by Medicaid and be eligible for Medicaid Managed Care. Patients must also meet further criteria established by the New York State Department of Health (DOH), the Office of Mental Health (OMH), and the Office of Alcoholism and Substance Abuse Services (OASAS). Eligibility criteria include a diagnosis of a serious mental illness and/or substance use disorder, among other factors.[4] All HARP eligible members receive notifications from NYS regarding their HARP eligibility at which point two different eligibility assessments must be performed by a local Health Home, including the general eligibility assessment and the community mental health assessment tool, which determines eligibility for HCBS services available to the member.

Member Attribution

Medicaid member attribution defines the group of members for which 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 member 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 MCO for each arrangement.[5]

New York State's guideline for member attribution in HARP VBP Arrangements is based on the Medicaid MCO-assigned Health Home.[6] The Health Home is the primary point of intervention with the HARP member. Health Homes can also help members coordinate care across the physical and behavioral health domains, and address social determinants of health such as housing, social supports, and economic self-sufficiency. 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.

[3] New York State Department of Health, Office of Mental Health, and Office of Alcoholism and Substance Abuse Services, New York Request for Qualifications for Behavioral Health Benefit Administration**:** Managed Care Organizations and Health and Recovery Plans, March 21, 2014, p. 26. (Link).
[4] Ibid. p. 16.
[5] New York State Department of Health, Medicaid Redesign Team, A Path toward Value Based Payment: Annual Update, November 2017: Year 3, New York State Roadmap for Medicaid Payment Reform, November 2017, p. 23. (Link).
[6] Ibid.

Calculation of Total Cost for the Arrangement

The total cost for the attributed membership in HARP VBP Arrangements includes all Medicaid-covered services provided during the contract year. The total cost of the HARP VBP 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 a cap or exception for specialty, high-cost drugs); laboratory; radiology; ancillary; and, behavioral health services aggregated to the attributed population level. Any additional BH HCBS services covered by HARPs must also be included. 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.[7]

Section 2: VBP Quality Measure Set for the HARP Arrangement

The 2019 HARP Quality Measure Set was developed drawing on the work of stakeholder groups convened by DOH to solicit input from expert clinicians around the state. The Behavioral Health Clinical Advisory Group (CAG) convened specifically to make HARP and behavioral health measure recommendations.

Because the HARP VBP Arrangement is a total cost of care subpopulation arrangement, the CAG recommended a full complement of physical health measures in addition to behavioral health measures to ensure HARP members receive high quality physical, as well as behavioral, health care. Measures derived from the BH HCBS eligibility screening tool were also recommended to address key functional outcomes. The physical health measures were drawn from the measure sets developed by the Diabetes, Chronic Heart Disease and Pulmonary CAGs, and from the measures recommended for Advanced Primary Care (APC) by the Integrated Care Workgroup.

Measures recommended by the CAGs were submitted to NYS DOH, OMH and OASAS for further feasibility review and, ultimately, to the VBP Workgroup, who are responsible for overall VBP design for NYS Medicaid and provide final approval. During the final review process, the HARP VBP measure set was aligned with existing Delivery System Reform Incentive Payment (DSRIP) Program and Quality Assurance Reporting Requirements (QARR) measures, as well as measures utilized by Medicare and Commercial programs in NYS, where appropriate. The measures were further categorized as Category 1, 2, or 3 based on their reliability, validity, and feasibility, and by suggested use as either Pay-for-Reporting (P4R) or Pay-for-Performance (P4P).

Measure Categorization

In April 2016, NYS published the initial recommendations of the Behavioral Health CAG regarding quality measures for use in HARP VBP Arrangements and included a review of the types of data needed for the recommended measures. These reports also addressed other implementation details related to VBP arrangements. Upon receiving the CAG recommendations, the State conducted a further review of measure feasibility to define a final list of measures for use during the 2017 VBP Measurement Year (MY). Each measure has been 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 clinically relevant, reliable and valid, and feasible;
- **CATEGORY 2** – Measures that are clinically relevant, valid, and reliable, but where the feasibility could be problematic. These measures were investigated during the 2017 & 2018 VBP Pilot programs; and,

[7] Additional information on total cost of the arrangement and use in contracting will be made available through other DOH materials in the future.

- **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 on them (P4P or P4R) in their specific contracts.

Category 1

Category 1 quality measures as identified by the CAGs and accepted by the State are to be reported by VBP Contractors. A subset of these measures is also intended to be used to determine the amount of shared savings for which VBP contractors would be eligible.[8]

The State classified 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 VBP Contractors are eligible.[9] 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 Medicaid MCOs to incentivize VBP Contractors for reporting data to monitor quality of care delivered to members 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 through annual CAG and State review or as determined by the MCO and VBP Contractor.

Not all Category 1 measures will be reportable for Measurement Year 2019, as reporting on some of these measures will be phased in over the next 2 years. Please see the Value Based Payment Reporting Requirements Technical Specifications Manual[10] for details as to which measures must be reported for the measurement year. This manual will be updated annually each Fall, 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. The State required VBP Pilots to select and report a minimum of one Category 2 measure per VBP Arrangement for MY 2018 (or have a State and Plan approved alternative). VBP Pilot participants are expected to share meaningful feedback on the feasibility of Category 2 measures when the CAGs reconvene during the Annual Measure Review.

Measures designated as Category 3 were deemed unfeasible. Reasons include concerns about valid use in small sample sizes of attributed members at a VBP contractor level and limited potential for performance improvement in areas where statewide performance is already near maximum, expected levels. These Category 3 measures will not be tested in pilots or included in VBP arrangements in 2019.

Annual Measure Review

[8] New York State Department of Health, Medicaid Redesign Team, A Path toward Value Based Payment: Annual. Update, November 2017: Year 3, New York State Roadmap for Medicaid Payment Reform, November 2017, p. 34. (Link).
[9] Ibid.
[10] 2019 Value Based Payment Reporting Requirements; Technical Specifications Manual, Nov 2018. File is located o the Quality Measures section of the VBP Resource Library (Link).

Measure sets, and classifications are considered dynamic and will be reviewed annually. Updates will include additions, deletions, re-categorizations and re-classifications from P4R to P4P, or P4P to P4R, based on experience with measure implementation in the prior year. The complete Category 1 and 2 VBP HARP measure set includes a subset of the IPC Measure Set determined to be relevant to the HARP VBP Arrangement by the State. During 2019, the CAGs and the VBP Workgroup will re-evaluate measures and provide recommendations for MY 2020. A full list of the MY 2019 HARP VBP measures is included in the NYS VBP Resource Library on the DOH website.[11]

[11] NYS Delivery System Reform Incentive Payment (DSRIP) - VBP Resource Library (Link).