NEW YORK STATE OF OPPORTUNITY. Department of Health

Total Care for the General Population Value Based Payment Arrangement

Measurement Year 2019 Fact Sheet

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NYS Medicaid Value Based Payment

Total Care for the General Population Value Based Payment Arrangement

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 to focus on the delivery of high-value, evidence-based care.[1]

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 ancillary 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.

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 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]

[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, A Path toward Value Based Payment: Annual Update, November 2017: Year 3, New York State Roadmap for Medicaid Payment Reform, November 2017, p. 30-31. (Link)

Constructing the TCGP Arrangement: Time Window and Services

To achieve improved clinical and financial outcomes under the TCGP arrangement, VBP Contractors must successfully manage patients at the population level, 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 and emergency medical care, as well as 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) patients **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. dual 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]

New York State's guidance for patient attribution in TCGP Arrangements is through the Medicaid MCO-assigned PCP.[4] 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

[3] Ibid, p.23.
[4] Ibid.

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.[5]

Section 2: VBP Quality Measure Set for the TCGP Arrangement

The 2019 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. The physical health measures were drawn from the measure sets developed by the Diabetes, Chronic Heart Disease and Pulmonary Clinical Advisory Groups (CAGs), and from the measures recommended for Advanced Primary Care (APC) by the Integrated Care Workgroup. Likewise, the behavioral health measures were drawn from the measure sets developed by the Behavioral Health CAG.

As the TCGP VBP Arrangement is a total cost of care arrangement, the State has recommended a full complement of physical and behavioral health measures to help ensure attributed patients receive high-quality physical and behavioral health care.

Measures recommended by the CAGs were submitted to NYS DOH, the Office of Mental Health (OMH), and the Office of Alcoholism and Substance Abuse Services (OASAS) for further feasibility review and, ultimately, to the VBP Workgroup responsible for overall VBP design and approval. During the final review process, the TCGP quality measure set was aligned with existing Delivery System Reform Incentive Payment (DSRIP) Program and Quality Assurance Reporting Requirements (QARR) measures and measures utilized by Medicare and commercial programs in NYS, where appropriate.

Historically, the VBP Quality Measure Sets for TCGP and Integrated Primary Care (IPC) Arrangements have been the same. During the 2018 Measure Review Cycle, the Children's Health CAG recommended adding several maternity-specific measures to the TCGP Quality Measure Set to better reflect the inclusion of maternity care in TCGP arrangements. These measures were not added to the IPC Quality Measure Set due to the focus on primary care in IPC arrangements. As a result, there are now separate VBP Quality Measure Sets for TCGP and IPC arrangements.

Measure Classification

Beginning in April 2016, the CAGs published their initial recommendations to the State on quality measures and support required for providers to be successful in the VBP arrangement. 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 inclusion during the 2017 VBP Measurement Year (MY). Each measure was 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. Some of these measures were further investigated during the 2017 & 2018 VBP Pilot programs; 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 P4R) in their specific contracts.

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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.[6]

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. 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.

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 few years. Please see the Value Based Payment Reporting Requirements Technical Specifications Manual for details as to which measures must be reported for the measurement year. [7] 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 included use in small sample sizes of attributed patients at a VBP Contractor level and limited potential for performance improvement in areas where statewide performance was already near maximum expected levels. These Category 3 measures will not be included in VBP arrangements in 2019.

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. During 2019, the CAGs and the VBP Workgroup will re-evaluate measures and provide recommendations for MY 2020. A full list of the 2019 TCGP measures is located in the NYS VBP Resource Library on the DOH website.[8]

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[6] 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)

[7] 2019 Value Based Payment Reporting Requirements; Technical Specifications Manual, November 2018, File is located in the Quality Measures tab of the VBP Resource Library (Link)

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