



**Department
of Health**

Health and Recovery Plan Value Based Payment Arrangement

Fact Sheet



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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 distinct populations 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 Contractors¹ 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.

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

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, Value Based Payment (VBP), VBP Roadmap. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm



support services; 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 Addiction Services and Supports (OASAS). Eligibility criteria include a diagnosis of a serious mental illness and/or substance use disorder, among other factors. 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.

Patient Attribution

Medicaid patient attribution defines the group of patients 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 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 MCO for each arrangement.⁴

New York State's guideline for member attribution in HARP VBP Arrangements is based on the Medicaid MCO-assigned Health Home. 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.

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 an exclusion option for specialty, high-cost drugs); laboratory; radiology; ancillary; and behavioral health services aggregated to the attributed population

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. [New York Request for Qualifications for Adult Behavioral Health Benefit Administration \(ny.gov\)](https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm)

⁴ New York State Department of Health, Medicaid Redesign Team, Value Based Payment (VBP), VBP Roadmap. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm

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.

Section 2: VBP Quality Measure Set for the HARP Arrangement

The HARP Quality Measure Set is developed drawing on the work of 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 population arrangement, the CAG recommends 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 initially recommended by the CAGs were submitted to NYS DOH, OMH, and OASAS for further feasibility review and, ultimately, to the VBP Workgroup, which was responsible for overall VBP design for NYS Medicaid and provided 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 Classification

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; 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 on them (P4P or P4R) in their specific contracts. At least one Category 1 P4P race and ethnicity stratified measure must be included in any HARP-specific VBP contract.⁵

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.

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

⁵ The quality measure set can be found under the VBP Quality Measures section for the respective measurement year and arrangement. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm



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

- **P4R** measures are intended to be used by the 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 or vice versa through annual CAG and State review or as determined by the MCO and VBP Contractor.

Please see the Value Based Payment Reporting Requirements Technical Specifications Manual⁶ for details as to which measures must be reported for the measurement year. This manual will be updated annually, in line with the release of the final VBP measure set for the subsequent measurement year.

Categories 2 and 3

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

Measures designated as Category 3 are deemed unfeasible. Reasons include concerns about valid use in small sample sizes of attributed members at a VBP contractor level or limited potential for performance improvement in areas where statewide performance is already near maximum, expected levels.

Annual Measure Review

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

⁶ VBP Reporting Requirements Technical Specifications Manual can be found under the VBP Quality Measures section for the respective measurement year. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm