

# Value Based Payment: Roadmap Update

An Updated Vision of Alternative  
Payment Models

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## | Introduction

The first iteration of the VBP Roadmap was released in July of 2015 as a compliment to the Delivery System Reform Incentive Payment (DSRIP) program. Since 2015, the State has released several Roadmap updates highlighting, among other things, New York's Value Based Payment (VBP) progress. During this time, New York successfully achieved the DSRIP goal of having 80% of managed care payments to providers using value-based payment methodologies.

Since the VBP Roadmap was originally designed, there have been significant changes to the VBP and healthcare landscape. The COVID-19 pandemic, new technologies, and additional New York State investments in transformation efforts have brought about rapid changes in all areas of healthcare, specifically in primary care, telehealth, maternity care, behavioral health, and access. The New York Health Equity Reform (NYHER) 1115 waiver amendment included sweeping Medicaid delivery system reform policies focused on coordination of social needs for Medicaid members, which are underway across the State. This updated VBP Roadmap redefines goals for VBP in NYS Medicaid to complement modern delivery system reform efforts and better address the needs of Medicaid members, providers, and other stakeholders.

## | VBP Vision and Guiding Principles

While New York celebrates the success in the adoption of VBP arrangements to date, the State has recognized that further guidance and parameters are needed to ensure that VBP arrangements continue to improve in efficacy. For example, VBP has not had a comprehensive and sustainable impact on improvement of health disparities across all Medicaid populations. NYS has also heard feedback that further transparency is needed in VBP contract negotiations. Therefore, **New York is establishing new Medicaid VBP principles and goals** to further the transformation of New York's Medicaid health care delivery system from a fragmented, inpatient care-focused system to an integrated and community-based system focused on providing equitable, whole person care.

To achieve New York's updated **vision** of making VBP's impact on quality outcomes and population health more comprehensive and sustainable across all NYS Medicaid populations, DOH is establishing three distinct **guiding principles**:

- VBP arrangements between plans and VBP contractors (providers) should foster integrated, whole person care (including behavioral health care and social care) by incentivizing wellness and preventive care in communities.
- Access to useful and current data that allows the State, payers, and providers to continuously improve their VBP arrangements, strengthen quality performance, and target the underlying drivers of poor health in underserved communities.
- VBP reform efforts must build on existing tools, programs, and data to reduce administrative burden and help VBP contracts target specific issues or incentives that are appropriate for the population served.

## | Goals for VBP

New York continues to maintain a high level of VBP participation and investments made to date have fostered

improved care coordination and care integration on a broad scale. However, DOH has conducted internal and external stakeholder engagement to identify opportunities for further refinement of the State's VBP approach to meet the evolving focus of VBP in New York. **This updated Roadmap identifies three key goals.**

NYS DOH will be focused on gathering refined metrics around VBP while also updating some guidelines and requirements in future iterations of the VBP Roadmap. This is all to support the forward progression to **more focused VBP models to address the needs of specific populations including historically underserved populations, improve data transparency, and create stronger MCO and provider collaboration.**

- **Goal 1:** Support payer-provider collaboration and transparency in VBP and assist providers in quality improvement efforts by refining arrangement guidelines/requirements
- **Goal 2:** Align VBP efforts with broader delivery system improvement opportunities such as the 1115 waiver demonstration
- **Goal 3:** Improve data collection processes for assessing VBP impacts and informing policies that focus on the needs of underserved populations and addressing health disparities.

## | Opportunities for Delivery System Reform Alignment

### NY Health Equity Reform 1115 Waiver Amendment

The most recent evolution of the NYS 1115 waiver program, the New York Health Equity Reform (NYHER) 1115 Waiver amendment was approved by CMS on January 9, 2024, and includes a focus on Health-Related Social Needs (HRSN), which includes screening, navigation services, housing supports, nutrition services, and medical respite. With the 1115 waiver amendment, Social Care Networks (SCN) have been established, which coordinate community-based organization (CBO) services in a specific region. MCOs are required to contract with SCNs for identified HRSN of their members.

Previous VBP Roadmaps required Level 2 and above VBP arrangements to implement at least one intervention that addresses social care needs and incorporate Community Based Organizations (CBOs) in contracting. Due to the MCO SCN contracting requirements **this VBP arrangement requirement is no longer mandatory. The future goal is for SCNs to enter value-based contracts with MCOs to support whole person, equitable care starting April 2027. More details will follow under the state's upcoming 1115 Waiver Amendment and in future updates to the VBP Roadmap.**

### New York Medicaid Patient-Centered Medical Home (PCMH) Model

[New York State PCMH](#) is a care delivery model where the primary care team, with the involvement of the patient (and family, when appropriate), is responsible for managing the full spectrum of health care needs, coordinating with clinicians in other settings when care cannot be provided in the primary care setting. The model emphasizes care coordination, population health, evidence-based guidelines, and effective use of Health Information Technology (HIT) to meet the patient's needs. NYS PCMH Recognition helps practices put in place the structure, systems, and processes to be effective in this model.

Beginning April 1, 2024, PCMH recognized primary care providers are entitled to an incentive payment of \$4 PMPM for enrollees under 21 years of age and \$2 for enrollees 21 and older in addition to the base \$6 PMPM payment. To continue receiving these enhanced dollars, providers must develop workflows to refer patients to

an SCN (described above) to help manage the social needs of these enrollees. **In the future, OHIP will continue to develop incentives for social care coordination and quality improvement within the NYS PCMH program. Quality measurement within the PCMH program will align with VBP quality measure lists.**

## | VBP Contract Requirements

The existing VBP arrangements included in OHIP’s historical design were to help guide the burgeoning market into focus areas and provide a measure of uniformity. As part of the next evolution of VBP in Medicaid, OHIP aims to assist payers and providers in developing more **targeted and population-specific** accountability mechanisms. **The State is requiring plans to progress past total cost of care-based arrangements towards implementation of VBP arrangements that address specific market needs to fill service gaps and improve access, improve regional outcomes, and address health disparities.**

See below for a list of *examples* of VBP arrangements defined by arrangement type (not exhaustive).

VBP Arrangement Type	Example Description
<b>Total Care</b>	An arrangement includes accountability for the cost and quality performance of all Medicaid-covered services. This does not necessarily mean the VBP contractor is at risk for all covered services. A portion of financial performance is tied to quality performance which is stratified by patient demographics. Total care arrangements can be applied to all Mainstream Managed Care members, a subset (e.g. Children, pregnant persons), or distinct lines of business (i.e. Health and Recovery Plan (HARP), Special Needs Plan (SNP)). Total Care arrangements can exclude dually eligible members (duals).
<b>Bundled Payment</b>	A practice contracts for a retrospective, bundled payment for attributed patients. A percentage of target is tied to quality performance which is stratified by patient demographics. The services included/excluded in a bundled arrangement shall be defined within each contract and include the related timeframes.
<b>Service Specific</b>	A provider located in an urban center with a large, homeless population receives a per member per month (PMPM) payment for agreed upon primary care services including care management and navigation services for its attributed members. A portion of the total PMPM is tied to quality performance.
<b>Condition Specific</b>	An MCO identifies a subset of members (stratified by race, ethnicity, language, etc.) where a medical condition (e.g. diabetes, asthma, HIV, Substance Use Disorder) is not as well managed when compared to other member cohorts. The MCO contracts with its providers to implement interventions and pays a PMPM for which a portion is tied to the identified cohort’s outcome improvements.

**Requirement 1: Each MCO participating in VBP must perform an analysis of health disparities within their Medicaid membership and offer a VBP arrangement informed by this analysis<sup>1</sup>.**

To continue advancing population health improvements in an efficient and targeted manner, MCOs participating in VBP must analyze their membership to determine where the largest disparities in health outcomes exist. From this analysis, the MCO is required to work with providers to develop a VBP arrangement addressing an identified health disparity (or multiple disparities). MCOs may utilize their existing arrangements and apply quality metrics stratified by demographics or create a new VBP arrangement to meet this requirement (see examples above). The arrangement(s) must be specific to the provider group or population in question and developed in collaboration with potential provider participants.

MCOs participating in VBP shall submit to [VBP@health.ny.gov](mailto:VBP@health.ny.gov) no later than August 31, 2026 the completed template including:

- The health disparities identified within their Medicaid population;
- A summarized analysis of how the health disparities were identified; and
- The planned approach to develop a VBP arrangement in collaboration with providers, targeting at least one of the identified health disparities.

MCOs must submit a proposed arrangement to OHIP by January 1, 2027 and offer a finalized arrangement for contracting no later than October 1, 2027.

This requirement does not lessen the importance of high-quality care for the entire Medicaid population. It is intended to improve outcomes for targeted populations **in addition** to broader care delivery improvement. Please note, OHIP will continue to develop reporting requirements for the totality of MCO VBP arrangements in addition to the above requirement.

**Requirement 2: Level of risk and shared savings/losses for VBP arrangements must match NYS definitions.<sup>2</sup>**

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 align with the definitions for Contracting Levels 1 through 3. Various risk arrangements may be applied across any of the examples in the table above.

Contracting Level	Minimum Risk Requirement
<b>Level 1 - Upside Only Risk</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.

<sup>1</sup> Available definitions of Health Disparities:

CDC: Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities. [Source: CDC, Health Disparities.](#)

NIH: Health disparities are largely preventable health differences that adversely affect populations who experience greater challenges to optimal health and are closely linked with intergenerational social, economic, and/or environmental factors—primarily observed among racial and/or ethnic minority populations and/or low socioeconomic status (SES) groups. [Source: NIH, What are Health Disparities? | NIMHD](#)

<sup>2</sup> VBP arrangements must also comply with data sharing requirements in Requirement 6 to meet NYS definitions for Contracting Levels.

<p><b>Level 2 - Upside and Downside Risk (Target Based)</b></p>	<p>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 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 maximums for percent of shared savings.</b></p>
<p><b>Level 3 – Maximum Risk Sharing</b></p>	<p>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. Such risk-mitigation strategies should be detailed in the contract, including details on how the provisions factor into financial calculations including premium risk.</p> <p>Two types of Level 3 arrangements are available:</p> <ul style="list-style-type: none"> <li>• <b>3A:</b> Financial target-based arrangement (ie. % MLR or claims-based target)</li> <li>• <b>3B:</b> the VBP contractor assumes responsibility <b>for a minimum of 90-95%</b> of plan premium, varied based on level of administrative responsibility as negotiated between parties.<sup>3</sup></li> </ul>

**Requirement 3: VBP arrangements must detail the attribution methodology.**

The methodology shall describe:

1. **Inclusion criteria:** Which members will be attributed to an arrangement and included for the purposes of financial and quality measurement, and target budget setting. This should include the methodology for either prospective or retrospective patient attribution.
2. **Exclusion criteria:** Which members will be excluded based on coverage, services, diagnosis or any other agreed upon criteria.

**Requirement 4: VBP arrangements must detail the target budget setting methodology.**

For all arrangements, NYS DOH 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 and/or trending.

NYS DOH does not support targets that would restrict care delivery to patients by creating unreasonable targets. MCOs should account for VBP contractors that are highly efficient (and of high quality) in their target setting. For example, if a provider already performs efficiently, the contract should not continue to reduce targets to an untenable level. The arrangement should support the provider in maintaining their efficiency and high quality and targets should stabilize at that level.

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.

**Requirement 5: Quality measures must be limited to no more than 10 measures including at least one pay-for-performance Category 1 Race and Ethnicity-Stratified measure.**

<sup>3</sup> Level 3B is inclusive of arrangements established under historical Innovator program.

To assist VBP contractors in navigating what can be a complex landscape of VBP design components, this VBP Roadmap **limits the total number of quality measures that can be included in existing and new VBP contracts to 10**. This requirement will create more succinct quality goals, maximize alignment potential across contracts, and simplify the negotiation process between plans and providers. Contractors and plans may agree to monitor additional measures on a Pay-for-Reporting basis if appropriate for the arrangement.

VBP contractors take responsibility for the costs and quality delivered to the patient included in the arrangement. These costs, as well as the quality-based process/outcome measures, need to be clearly defined. The list of quality measures to be used for the calculation of shared savings and losses shall be included in the contract. Lists of the NYS-approved Quality Measure Sets and any arrangement-specific quality requirements can be found on the NYS DOH Value Based Payment webpage, under the VBP Quality Measures tab<sup>4</sup>.

For the provider to receive payment under the arrangement, they must demonstrate they have met the mutually agreed-upon quality goals. Targets should be designed to support continual improvement by, for example, including a gap-to-goal methodology by incentivizing improvement over prior performance and rewarding high performance when attained. VBP contractors and MCOs must mutually agree on definitions of high performance (i.e. regional or state benchmarks). MCOs will need to report their scores on the quality metrics to the Office of Health Services Quality and Analytics.

MCOs are encouraged to work with VBP contractors to streamline quality measure selection as much as reasonable with each contractor. Especially for smaller VBP contractors, varying definitions of a VBP arrangement between MCOs and/or differences in reporting requirements could impede their ability to fulfil their role.

**Requirement 6: VBP arrangements must include data sharing between plans and contractors.**

For VBP contractors to have visibility into their financial performance and identify opportunities to improve care they need actionable data. This includes the data used to calculate targets such as baseline data, trend data, monthly performance data, and attribution data. Both parties should agree on specific data elements needed. The data sharing requirements for each Level must be met for a particular arrangement to meet the Level definitions above. **Minimum requirements are listed in Appendix A1 and A2.**

**Requirement 7: Federal Rule Requirements**

Under the new [Federal Rule sections 438.8\(i\)\(3\) and \(4\)](#), CMS requires States, through their contracts with MCOs, to require MCO incentive payment contracts with network providers to contain certain requirements, such as (non-exhaustive):

- (i) MCOs must have defined performance periods tied to the applicable MLR reporting period (BMCFO collects MLR for DFRS based on rate setting period, which is the SFY, not the Calendar Year),
- (ii) Contracts must be signed and dated by all parties before the measurement period,
- (iii) Contracts must include clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that the provider must meet to receive the incentive payment
- (iv) Contracts must contain a dollar amount or a percentage of verifiable dollar amount that can be clearly link to completion of the metrics, including the date of payment.

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<sup>4</sup> The Quality Measure sets 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](https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm)

Please note that plans will be expected to comply with and report on federal requirements as specified in upcoming revised Medicaid Managed Care contracts. The timeline and additional guidance will be forthcoming from the **Division of Health Plan Contracting and Oversight (DHPCO)**.

## | Reporting (Deliverable) Requirements

### **Requirement 1:** MCO shall report all required VBP Quality Measures to NYS DOH.

The statewide VBP definitions and VBP quality measures have been set based on national standards and the recommendations from the VBP Clinical Advisory Groups (CAGs) and the Technical Design Subcommittees. MCOs shall report these VBP measures, and NYS DOH 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 DOH may modify the VBP measure set to optimally align how MCOs are scored in overall quality.

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>5</sup>

NYS DOH is in the process of developing additional collection requirements for plans to report on their existing VBP arrangements to OHIP. NYS will be communicating those requirements separately to plans.

## | VBP Arrangement Aspects to Consider

### VBP Arrangement Exclusions

In principle, NYS DOH does not want to wholly exclude any cost categories from VBP arrangements. Excluding defined services and provider types undermines the principles of VBP as outlined here. NYS DOH 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 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.
- **Members Attributed to Another VBP Arrangement (Overlaps).** Medicaid members who are attributed to another provider can be excluded from VBP arrangements and the target and performance calculations. (i.e. Patients attributed to a Maternity Bundle can be excluded from a total cost of care arrangement).
- **Transplant Services.** MCOs and contractors may choose to exclude the cost of organ transplant services (including organ acquisition) from their arrangements.
- **Vision Coverage.** MCOs and contractors may choose to exclude the cost of vision services from their arrangements.
- **FQHCs & Rural Health Clinics (RHC).** NYS DOH 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

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<sup>5</sup> VBP Reporting Requirements Technical Specifications Manual can be found under the VBP Quality Measures tab for the respective measurement year. [https://www.health.ny.gov/health\\_care/medicaid/redesign/vbp/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm)

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.
- 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.

## Attribution

Medicaid member attribution determines which members a VBP contractor will be responsible for in terms of quality outcomes and cost. 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. MCOs and VBP contractors can utilize multiple factors in establishing attribution. 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 primary care physician (PCPs) would drive the attribution).

## Examples of Member Attribution

- The MCO-assigned Primary Care Physician drives attribution in total care arrangements.
- For an arrhythmia episode-based arrangement the cardiologist drives attribution.
- In maternity care, the obstetric professional delivering the plurality of pregnancy care drives attribution.
- The MCO-assigned Health Home could drive the attribution for the Health and Recovery Plan (HARP) population.
- Team based attribution for a pediatric practice offering integrated care delivery such as Healthy Steps

## Examples of Timing Considerations

- Members are prospectively attributed to a provider through MCO assignment logic (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, or the MCO assignment logic includes adjustments for actual utilization, the member will be attributed to the VBP arrangement of the latter PCP/Health Home.
- 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.

## Shared Savings

Plans and VBP contractors must agree upon shared savings percentages and be clearly stated within the contract. For example, in a Level 2 VBP arrangement, when actual costs 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.

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 should 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.

## | Appendix

### A1. Data Sharing Minimum Requirements for all VBP Arrangements

#### Requirements for Level 1 Arrangements:

##### Target Setting Data

Managed care organizations must provide VBP contractors with the information that is used to calculate their arrangement specific targets prior to finalization of the arrangement. This includes summaries of baseline claims costs by service category (e.g., inpatient, outpatient, pharmacy, dental, and professional), data supporting the adjustments made against the baseline, and anticipated trend factors. If the agreement includes rebasing targets, this data also needs to be shared prior to the associated performance period.

##### Performance Data

Summary data files are to be provided on a quarterly basis (at minimum) including aggregated VBP contractor level financial performance reports that aggregated claims cost including service category breakdowns (e.g., inpatient, outpatient, pharmacy, dental, and professional) specific to the arrangement.

##### Attribution Data

Attribution reporting must be provided to the VBP contractor minimally at the VBP contractor level. VBP contracts must include a process for correction of attribution discrepancies between MCOs and VBP Contractors. Prospective attribution lists should be provided by the contract performance start date and any adjustments to attributed patients should be shared monthly. Retrospective attribution lists should be provided on a monthly basis starting by the end of the first performance month. In both scenarios these reports should include member months at the individual member level, provided with 12-month retrospective look-back (monthly), including:

- a. Region and rate cell assignment (consistent with Schedule B naming conventions)
- b. Attributed Physician
- c. Demographic Information (e.g. address, phone numbers, email, CIN, family link ID)
- d. Recertification Date
- e. Aid Category Code (e.g. “H9” HARP eligible)

## Requirements for Level 2 Arrangements:

### Claims and Encounter Data

In addition to the requirements for Level 1 arrangements above, detailed claims and encounter data files are to be provided for **Level 2 and higher** arrangements and when requested by the VBP contractor. The data are to be provided in a relational format with consistent person identifiers across all files for members and providers. This data should include all claims and encounters included in the VBP arrangement and consist of:

- a. Member information consisting of patient identifiers, available demographic data, and eligibility data.
- b. Fully adjudicated medical claims data consisting of service-level claims and encounter data. This includes provider information, clinical diagnosis codes, procedure codes, service or admission/discharge dates, and place of service, for each billed service.
- c. Plan paid amount, co-pay amount, and allowed amounts should be included for VBP contractor owned providers.
- d. Provider information including provider identifiers and specialty codes with related definitions.

## A2. Data Sharing and Contractual Requirements Specific to Category 3B

Given the enhanced level of complexity and shared responsibility, OHIP is stipulating additional requirements for transparency between plans and contracted providers in level 3B. **In addition to the data sharing requirements listed in A1**, Category 3B arrangements must include the following elements:

### Risk Adjustment Data

If contracts are risk adjusted for Category 3B arrangements, the contract must stipulate the terms of risk methodology used including:

- a. Risk adjustment methodology and explanations for major changes made to risk scores (reviewed annually between plan and contractor)
- b. Acuity of the contractor's population
- c. Acuity of the rest of the health plan population used to calculate the contractor's relative risk position

### Revenue Data and Requirements

For Category 3B arrangements, contracts must stipulate that revenue data will be shared by the plan including:

- a. Schedule B, Schedule C data and associated addendums/documentation substantiating premium position as well as specifications around the handling of Schedule B and C premium determination
- b. Description of how carve-out and pass-through revenue are included and excluded from revenue and costs.
- c. File containing claim details for maternity and newborn kick payments

### Membership Information and Attribution

Contracts for 3B arrangements must also include processes for annual review of membership attribution logic. Review must include enough detail shared by the plan to ensure transparency regarding member selection, auto assignment processes, clinical appropriateness, and midyear adjustments to attribution methodology

### Claims and Utilization Data

For Category 3B arrangements, contracts must stipulate that the plan will provide the following using a 12-

month lookback period:

- a. Medical claims at the claim line level detail (including denied claims)
- b. Pharmacy claims (including for Medicaid/CHP/HARP patients)
- c. Any non-claim costs charge to full-risk provider at the member / PMPM / cost line level
- d. Coordination of benefit claims

### **Contract Management**

For Category 3B arrangements, contracts must stipulate that the plan will provide:

- a. Annual financial settlement reports completed within 12 months of performance period end.
- b. IBNR information at each settlement report, including methodology for deriving completion factors, claims triangles and completion factors by incurred/paid month, product, category of service, and final total amount reserved.

### **A3. 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>6</sup> Once contracts are ready for submission, they can be submitted to NYS through the Division of Health Plan Contracting and Oversight in the Office of Health Insurance Programs ([contract@health.ny.gov](mailto:contract@health.ny.gov)).

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<sup>6</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)