NEW YORK STATE Department of Health

Off-Menu Value Based Payment Contracting Checklist

January 19, 2018

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Off-Menu VBP Arrangement Tool: Supplemental Checklist

The Off-Menu Supplemental Checklist is intended to accompany Off-Menu VBP Arrangement ("OMA") submissions and to support the review conducted by the Department of Health ("DOH") Off-Menu Review Committee (the "Committee") in its contract approval process. The Checklist will be used by the contracting parties prior to submission, by the Committee during the review process, and during all follow-up communications between the Committee and the contracting parties.

Submission of Off-Menu VBP arrangements is intended to provide flexibility for entities who wish to address market specific needs. The Off-Menu option is *not* built to support changes to VBP arrangements defined in the NYS VBP Roadmap (the "Roadmap").

Prior to submitting an Off-Menu arrangement and this supplemental checklist, contracting parties must ensure alignment with the Roadmap on the following requirements:

I. The shared savings and losses outlined in the contract align with VBP level definitions *(See Appendix C)*:

1. Level 1: Minimum of 40% of shared savings must be allocated to the provider.
2. Level 2: Minimum of 20% of potential losses must be allocated to the provider, and a minimum cap of 3% of the target budget can be applied in Year 1 and 5% in Year 2.
   Below these levels, the VBP arrangement is counted as a Level 1 arrangement.
3. Level 3: N/A.

II. The arrangement meets **all** the four (4) criteria for Off-Menu arrangements as outlined in the Roadmap *(See Appendix D)*:

1. Off-Menu VBP arrangements that focus on conditions and subpopulations that address community needs but that are not otherwise addressed by VBP arrangement in the Roadmap;
2. Off-Menu VBP arrangements should be member centric;
3. Through sharing savings and/or losses, Off-Menu VBP arrangements should include a focus on both components of 'value': the quality and cost of the care delivered, and;
4. 'Off-Menu' VBP arrangements should utilize standard definitions and quality measures from the Roadmap where possible.

Specific details for each of the four criteria mentioned above are outlined in Appendix II of the Roadmap and included in Appendix D of this document. Please note that Off-Menu arrangements that are approved, will count toward the statewide VBP target goals.

In an effort to define the Off-Menu arrangement, please answer the flowing questions:

1. Off-Menu VBP Arrangement

a. Is the proposed contracted arrangement a modified version of one of the predefined arrangements in the Roadmap? Roadmap arrangements include: *Integrated Primary Care (IPC), Maternity, Total Care for the General Population (TCGP), Health and Recovery Program (HARP), HIV/AIDS, Managed Long Term Care (MLTC), Intellectually/Developmentally Disabled (I/DD).*

☐ **NO** ☐ **YES**

b. If **NO**, then what is the proposed VBP arrangement being contracted? Why was this VBP arrangement selected? Please remember that Off-Menu Arrangements are intended to serve populations and provide services that are not currently addressed by existing arrangements.

Please name and clarify:

c. Has this arrangement already been submitted in the past and approved by the Department of Health as an Off-Menu Arrangement?

☐ **YES** ☐ **NO**

If yes, please include the original DOH identification number for the contract approved by the Off-Menu Committee:

2. Scope of Services

a. If your proposed arrangement is a modified version of one of the predefined arrangements in the Roadmap (if **YES** was listed as the response to 1.a.), does the contract agree to cover all services and/or episodes for each arrangement as defined by the Roadmap? *(See Appendix A for Scope of Services)*

☐ **YES** ☐ **NO**

If **NO,** then **please document which services or conditions/episodes were carved out of the arrangement and why (per service)**:

b. If your proposed arrangement is *not* defined in the Roadmap (if **NO** was listed as the response to 1.a.) and an alternative VBP arrangement type is being proposed, then **please list the covered services below**:

(Note: As per the VBP Roadmap, the full continuum of care must be covered for any new arrangements.)

3. Quality Measures Reporting and Performance

a. If the proposed contracted arrangement is a modified version of one of the predefined arrangements in the Roadmap (if **YES** was listed as the response to 1.a.), does the contract commit to reporting on all Category 1 quality measures approved by the State for that respective arrangement? *(See Appendix B for 2017 Quality Measure Sets)*

☐ **YES** ☐ **NO**

If **NO**, then **please clarify which measures were not included and why** (please also note whether alternative measures were selected):

b. Does the proposed contract arrangement have at least one (1) Pay for Performance (P4P) measure tied to Shared Savings from the State approved Pay for Performance (P4P) list? *(See Appendix B for 2017 Quality Measure Sets)*

☐ **YES** ☐ **NO**

4. Shared Savings and Losses

While the State does not mandate a shared savings/losses distribution methodology, the following criteria must be met in order align with VBP Level definitions. If the proposed arrangement contains multiple levels over the course of the contract (e.g. Level 1 in year 1 and Level 2 in year 2), please check all appropriate boxes for the related contract year.

VBP Level Definitions (Please check box for appropriate level(s))			
	Year 1	**Year 2**	**Year 3**
Level 1: Minimum of 40% of shared savings must be allocated to the provider	☐	☐	☐
Level 2: Minimum of 20% of potential losses must be allocated to the provider, and a minimum cap of 3% of the target budget can be applied in Year 1 and 5% in Year 2? *If below these levels, the VBP arrangement is counted as a Level 1 arrangement.*	☐	☐	☐
Level 3: Payments being made through a capitated arrangement	☐	☐	☐

Off-Menu VBP Arrangement Supplemental Checklist: Appendix
Appendix A: Scope of Services

Arrangement Type	Definition and Scope of Services
Integrated Primary Care (IPC)	All Medicaid covered services included in preventive and routine sick care are included, as well as all services included in the Chronic Bundle: a. Hypertension b. Coronary Artery Disease (CAD) c. Arrhythmia d. Heart Block and Conductive Disorders e. Congestive Heart Failure (CHF) f. Asthma g. Chronic Obstructive Pulmonary Disease (COPD) h. Bipolar Disorder i. Depression & Anxiety j. Trauma & Stressor k. Substance Use Disorder (SUD) l. Diabetes m. Gastro-esophageal reflux disease n. Osteoarthritis o. Lower Back Pain
Total Care for the General Population (TCGP)	All Medicaid covered services for all members eligible for mainstream managed care and not eligible for one of the subpopulations (excluding duals).
Maternity Care	All Medicaid covered services included in the episodes for all pregnant women (and their newborns) eligible for mainstream managed care (excluding duals), including: 1. Pregnancy 2. Vaginal Delivery 3. C- Section 4. Newborn
Health and Recovery Program (HARP)	All Medicaid covered services for all members eligible for HARP (excluding duals).
HIV/AIDS	All Medicaid covered services for all members eligible for HIV/AIDS special needs population (excluding duals).
Managed Long Term Care (MLTC)	All Medicaid covered services for all members eligible for MLTC (including the Medicaid component of duals).
Intellectually/Developmentally Disabled (I/DD)	*In development.*

Appendix B: Quality Measures by Arrangement

Arrangement Type	Quality Measure Set – Measurement Year 2017
Integrated Primary Care (IPC)	https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/docs/tcgp_ipc.pdf
Total Care for the General Population (TCGP)	https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/docs/tcgp_ipc.pdf
Maternity Care	https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/docs/2017-03-21_maternity.pdf
Health and Recovery Program (HARP)	https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/docs/harp.pdf
HIV/AIDS	https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/docs/hiv_aids.pdf
Managed Long Term Care (MLTC)	https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/docs/2017-06-02_mltc.pdf
Intellectually/Developmentally Disabled (I/DD)	*In development*

Appendix C: VBP Roadmap Appendix X: Definitions of Level 1, 2 and 3 VBP Arrangements

Level 1: FFS with Retrospective Reconciliation - Upside Only

A Level 1 VBP arrangement continues the existing FFS payment[1] methodology from MCO to providers, but allows the VBP contractor to receive shared savings based on a 'target budget' set for the VBP arrangement. When the total spend on the services included in the VBP arrangement remain below the target budget, these savings are shared between MCO and VBP contractor. To be counted as a Level 1 VBP agreement, the minimum percentage of potential savings to be allocated to the VBP contractor with a high quality score is 40%.

Level 2: FFS with Retrospective Reconciliation – Up- and Downside

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. To be counted as a Level 2 VBP agreement, the minimum percentage of potential losses to be allocated to the provider with a low quality score is 20%, with a maximum cap of 3% of the target budget in the first year of the Level 2 contract and 5% from the second year on.[2][3]

Below these levels, the VBP arrangement is counted as a Level 1 arrangement.

Level 3: Prospective Payments (PMPM or Bundled Payments)

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.

The difference between Level 2 and Level 3 is the way the payment is effectuated: continuation of current payment mechanisms (with or without additional payments for e.g. coordination activities that do not currently have an existing billing code) versus prepaid payment arrangements. In terms of assuming risk by the VBP contractor, a Level 2 arrangement can be equal to a Level 3 arrangement.

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[1] For purposes of the NYS VBP program, the existing payment mechanisms referenced here include Diagnosis Related Groups and Enhanced Ambulatory Patient Groups

[2] 2 For Level 2, certain situations may warrant a lower cap, as in the case of an Integrated Primary Care arrangement or Chronic Care Bundles 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 they are held to account for. In those cases, the cap set should be proportional to the overall budget of the PCP / FQHC. Minimally, for PCPs or FQHCs engaged in Level 2 IPC or 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.

[3] 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. (I.e. 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 to be classified as Level 2.)

Appendix D: VBP Roadmap Appendix II: Criteria for 'Off-Menu' Options

'Off-Menu' options will have to be initiatives embraced by both the MCO and the involved providers. In addition, they have to fulfill certain criteria to be considered (at least) Level 1: they must reflect the underlying goals of payment reform as outlined in this Roadmap and sustain the transparency of costs versus outcomes. 'Off-Menu' approaches also, at a minimum, must meet DHHS' definitions of Alternative Payments Models (APMs). The following outlines the criteria the State will use when it assesses whether Off-Menu options reflect the goals of Medicaid VBP reform.

VBP models work only if the 'value' at heart of the model can be measured objectively and compared with other providers/MCOs. To allow transparency and proper benchmarking, then, calculations of 'costs' and 'outcomes' require a certain level of statewide standardization. If provider-MCO combinations define similar bundles or (sub)populations differently, the current inability to compare costs and outcomes across meaningful units of care would simply have been replaced by a similarly opaque situation, and the State would be hampered in its responsibility to monitor the value of care delivered to its most vulnerable populations.[4] In addition, standard VBP arrangement definitions significantly reduce the administrative burden for both MCOs and providers. Especially for smaller providers, varying definitions of a VBP arrangement between MCOs and/or differences in outcome measures to report would cripple their ability to fulfill their role.

This implies the following criteria:

1) **Off-Menu VBP arrangements that focus on conditions and subpopulations that address community needs but that are not otherwise addressed by VBP arrangement in the Roadmap**

   MCOs and VBP contractors are invited to focus on conditions and subpopulations that are locally highly 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 the State.

   Example of an acceptable 'Off-Menu' option:

   - An arrangement that focuses on a bundle or subpopulation that the Roadmap and the State are not supporting analytically, but that has significant local impact would satisfy this criteria. For example, a cancer treatment arrangement in an area with poor outcomes for cancer patients would constitute a potentially acceptable 'Off-Menu' arrangement.

2) **Off-Menu VBP arrangements should be member centric**

   The delivery of such care services will almost always require different provider types working together. All VBP arrangements should 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 that does include the continuum of covered services for all members eligible for mainstream managed care would satisfy this criteria, as dental services are outside of the set of covered services for these members.

[4] To maximize alignment across payers, the State will except certain alternative models such as Medicare ACOs and Medicare BCPI (Bundled Payments for Care Improvement) bundles; see further.

Examples of an unacceptable 'Off-Menu' option:

- A TCGP arrangement that excludes hospital costs would not satisfy this criteria. Urgent 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 Bundle arrangement that excluded obstetric services would fail this criteria. 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.

3) Through sharing savings and/or losses, Off-Menu VBP arrangements should include a focus on 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 APM. These total costs as well as the quality-based outcome measures need to be clearly defined; both the VBP arrangement definition as well as the outcomes need to be publically available so as to stimulate uptake by other providers and MCOs if desired. VBP contractors will need to publish their scores on the quality metrics as is the case for on-menu VBP arrangements.

Every VBP arrangement must satisfy this criteria through focusing on both cost and quality.

4) 'Off-Menu' VBP arrangements should utilize standard definitions and quality measures from the Roadmap where possible

The arrangement definitions and quality measures appearing in the Roadmap have been carefully developed by the CAGs and represent a highly collaborative and evidence-based approach to policy development. As such it is important for them to be implemented consistently across the state to enhance the ability for all stakeholders to monitor progress and success 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 a potentially acceptable 'Off-Menu' option:

- An arrangement that proposes carving out one or more conditions from the Chronic Bundle in the short term in order to expedite their ability to implement a VBP contract for IPC.

  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 a carve out for the IPC arrangement
- 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 state-wide 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 a potentially unacceptable 'Off-Menu' option:

- An IPC arrangement that carves out the depression and anxiety episode.
- An arrangement that omits CAG-recommended quality measures without approved rationale and/or inclusion of approved alternatives.