



**Department
of Health**

Total Care for the General Population Value Based Payment Arrangement

Measurement Year 2018 Fact Sheet



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 Total Care for the General Population Value Based Payment Arrangement is designed to incentivize primary care professionals, in cooperation 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 Contractors¹ to focus on the delivery of high-value, evidence-based care.²

The TCGP Arrangement provides the 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 of variation in unnecessary care (including ancillary and in-patient care) and improved adherence to guideline-driven, evidence-based care. This reduction in variation decreases downstream costs through initiatives that reduce the risk of acute medical events and the probability of inpatient hospitalizations.

This fact sheet provides an overview of New York State Medicaid's TCGP VBP Arrangement and is organized in 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 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 care for attributed members including primary care, specialty care, psychiatric rehabilitation services, emergency department visits, hospital admissions, and medication (with a cap for specialty, high-cost drugs).³

¹ A VBP Contractor is an entity – a provider or group of providers – engaged in a VBP contract.

² The TCGP Arrangement includes all services covered by mainstream managed care for the attributed population.

³ 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, June 2016: Year 2, New York State Roadmap for Medicaid Payment Reform, June 2016, p. 72. ([Link](#))



Constructing the TCGP Arrangement: Time Window and Services

Achieving improved clinical and financial outcomes under the TCGP arrangement requires that VBP Contractors 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 primary care providers, 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 member 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 Member Population

The eligible member population for the TCGP Arrangement includes all Medicaid Managed Care Organization (MCO) members **with the following exceptions:**

- **Medicaid members for whom Medicaid is not the sole payer:** Medicaid members with contract year services for which Medicaid is not the sole payer are excluded (e.g. dual eligible members and members with Medicaid as payer of last resort on a commercial premium).
- **Members eligible for inclusion under a VBP subpopulation arrangement:** Members eligible for inclusion under the HIV/AIDS, Health and Recovery Plan (HARP), Managed Long Term Care (MLTC), and Intellectually/Developmentally Disabled (I/DD) VBP Subpopulation Arrangements are excluded, although VBP Contractors and MCOs are free to add one or more subpopulations to their contract.

The TCGP Arrangement includes no additional requirements related to utilization of specific services or historical diagnostic information to be eligible for inclusion in the Arrangement. Members who are non-utilizers (those who do not seek services, including prescription drugs, during the year) are included in the eligible member population count and attributed to the primary care provider (PCP) as outlined below. These members will not contribute to the total cost calculation for the TCGP Arrangement but are included for tracking and quality purposes.

Member Attribution

The State guidance for member attribution in TCGP Arrangements is through the Medicaid MCO-assigned PCP. The VBP Contractor's total eligible population is defined by the group of PCPs contracted with the Medicaid MCO and the members assigned to each of the PCPs. VBP Contractors and the MCOs can adopt standards for attribution in their contracts not in alignment with the guidance above, so long as the contract receives State approval for meeting VBP contracting requirements.

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 members 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 a cap for specialty, high-cost drugs), laboratory, radiology, ancillary and behavioral health services aggregated to 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.⁴

Section 2: VBP Quality Measure Set for the TCGP Arrangement

The 2018 TCGP/IPC Quality Measure Set⁵ was developed drawing on the work of a number 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, or 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.

Because the TCGP VBP Arrangement is a total cost of care arrangement, the State is recommending a full complement of physical and behavioral health measures to help ensure attributed members receive high quality physical, as well as behavioral, health care.

Measures recommended by the CAGs were submitted to NYS DOH, the Office of Mental Health (OMH), and Office of Alcoholism and Substance Abuse Services (OASAS) for further feasibility review and, ultimately, to the VBP Workgroup, the group responsible for overall VBP design and final approval for NYS Medicaid. During the final review process, the TCGP/IPC 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. The measures were further categorized as Category 1, 2, or 3 based on reliability, validity, and feasibility, and by suggested use as either Pay-for-Reporting (P4R) or Pay-for-Performance (P4P).

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. Additionally, the reports addressed other implementation details related to VBP arrangements. Upon receiving the CAG recommendations, the State conducted additional feasibility review and analysis 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 felt to be both clinically relevant, reliable and valid, and feasible;
- **CATEGORY 2** – Measures that are clinically relevant, valid, and probably reliable, but where the feasibility could be problematic. These measures will be further investigated during the VBP Pilot program; 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.

⁴ Additional information on total cost of the arrangement and use in contracting will be made available through other DOH materials in the future.

⁵ The TCGP Arrangement measure set is the same set that will be used for the IPC Arrangement in MY 2018. Therefore, it is referred to as the TCGP/IPC quality measure set.

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 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 2018, 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 Manual⁷ 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 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. Some of these measures will be further investigated in the VBP pilots. The State requires that VBP Pilots select and report a minimum of one distinct Category 2 measure per VBP Arrangement for MY 2018 (or have a State and Plan approved alternative). VBP Pilot participants will be 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 identified as unfeasible at this time or as presenting additional concerns including validity or reliability when, for example, applied to an attributed member population of small sample size at a VBP contractor level or where there is already high performance at a statewide level, and, therefore, are no longer in the Category 1 or 2 measure list. These Category 3 measures will not be tested in pilots or included in VBP arrangements in 2018.

Annual Measure Review

Measure sets and classifications are considered dynamic and will be reviewed annually. Updates will include additions, deletions, change in categorization, and reclassification from P4R to P4P or P4P to P4R based on experience with measure implementation in the prior year. During 2018, the CAGs and the VBP Workgroup will reevaluate measures and provide recommendations for MY 2019. A full list of the 2018 TCGP/IPC measures is located in the NYS VBP Resource Library on the DOH website.⁸

⁶ New York State Department of Health, Medicaid Redesign Team, A Path toward Value Based Payment: Annual Update, June 2016: Year 2, New York State Roadmap for Medicaid Payment Reform, June 2016, p. 34. ([Link](#))

⁷ 2018 Value Based Payment Reporting Requirements; Technical Specifications Manual, Nov 2017, 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](#))