Value Based Purchasing Reports

The MCO must develop an Annual Value Based Purchasing (VBP) Strategy that includes a detailed work plan outlining all of the interventions the MCO is implementing to reach VBP targets in each VBP component during the contract period. The VBP strategy for the contract period shall be submitted to HSD no later than the last business day of January in each contract period.

For each subsequent year the MCO must develop an Annual VBP Plan for achieving the requirements of Attachment 3, Delivery System Improvement Targets (DSIPT) and meeting the general expectation to reward Providers based on achieving quality and outcomes, initiatives, goals, targets, strategies, barriers and actions to overcome barriers experienced in the prior year. The MCOs Annual VBP Plan shall be submitted to HSD by April 1.

Additionally, the MCO is required to file Quarterly VBP Narrative reports, which are to inform HSD of the progress the MCO is making in achieving their stated VBP goals for the year. The quarterly narrative should include barriers, solutions, successes, status, supportive data, and other pertinent information to the DSIPT. The Quarterly VBP Narrative will be due forty-five (45) days after the end of each quarter.

Note that HSD will not provide the MCO a prescribed and preformatted template for the Annual VBP Strategy, Annual VBP Plan, or the Quarterly VBP Narratives. Given the nature of the information required to satisfy this reporting requirement, a preformatted template will not sufficiently accommodate the required information. For these reports, the MCO can use their preferred format so long as the report includes sufficient detail to satisfy the reporting requirement.

VBP Financial Report– Value Based Purchasing Report

This report is due quarterly.

The quarterly report will be due sixty (60) calendar days from the end of the first quarter, the remaining reports will be due forty-five (45) calendar days after the end of the respective quarter, with an Annual Supplemental report due on May 15th.

This report is an Excel-based standalone reporting template.

The purpose of this report is to collect expense and quality information that relates to the MCOs Value Based Purchasing. The information provided in this report is used to monitor the MCOs achievement of the DSIPT. The Annual Supplemental report will be used to calculate the DSIPT percentages.

The VBP reporting template contains an Information Input tab, QM Methodology, QM Detail, FIN Detail, Level 1 Detail, Level 2 Detail, Level 3 Detail, VBP Summary, Notes, and an Analysis tab. The VBP Summary tab is automatically populated using information from the FIN Detail, Level 1 Detail, Level 2 Detail and the Level 3 Detail tabs. The purpose of the VBP Summary tab is to inform the MCOs of the progress of achieving the DSIPT.

The MCO is to enter/select all information requested within the Information Input tab. This tab serves as a cover sheet for the information reported within the VBP reporting template. Note that the report period ending date and date of service range will automatically populate based on the MCOs selection of the calendar year reporting cycle and quarters included in the report. For items requiring selection(s) to be made by the MCO, the MCO is to use the drop-down boxes located on the right side of the table.

Where applicable, the MCO name, calendar year reporting cycle and report period ending selections will flow through to the other tabs within the VBP reporting template.

The MCO Notes and Analysis tabs located within the VBP reporting template are to be used to provide any necessary explanations or analyses that will help the reader understand the information.

QM Methodology

The purpose of this tab is to identify the quality and/or healthcare metrics associated with the VBP agreements and the methodology used to calculate each metric. It is possible that multiple VBP agreements among different providers would have the same quality and/or healthcare metrics. To reduce multiple entries this tab is not based on providers, but rather on the quality and/or healthcare metrics themselves. If a metric has multiple components, i.e. a PH and a BH metric or the payment is not tied to an individual quality measure, list each component on a separate line using the same Quality/Outcome Metric Short Name.

- Quality/Outcome Metric Short Name: Enter a short name description of the quality and/or healthcare metric. This name should be identical to the name used in column D of the QM Detail tab to tie the metric to the provider.
- Program: Select the applicable program.
- Description of Methodology: Describe in detail the methodology used to calculate the metric. This should include, but is not limited to, the measurement period, all applied exclusions to both the numerator and denominator, how the eligible population was identified (if applicable) and what rational was used to determine the required metric score. If the metric is based on survey results, please provide details regarding how the survey was conducted, including how the results were gathered and calculated. Enter additional rows if needed.
    - If the cell is unable to fit the required detail the MCO may either insert a file into the cell or send in an attachment with the VBP Report.

QM Detail Level 1

The purpose of this tab is to identify the quality and/or healthcare outcomes associated with the VBP Level 1 agreements. Each quality and/or healthcare outcome metric requirement will require a separate line and will be identified by the Quality/Outcome Metric Short Name that was given to it on the Quality Methodology tab. In the case of a provider having multiple quality and/or healthcare outcomes comingled with one payment, list all quality and/or healthcare outcomes on a separate line. List the Contract Rate, Payment Frequency, and Anticipated Provider VBP Payment on the providers first line and disclose in the Notes cell that the quality and/or healthcare outcomes are comingled into one payment.

- Provider Name: Input the name of the VBP provider
- Number of Attributed Members: Enter the unique number of Attributed Members for the quality and/or healthcare outcome metric.
- Quality/Outcome Metric Short Name: Select the quality and/or healthcare outcome metric short name that was given in the QM Methodology tab. VBP programs must be based upon improved quality and/or healthcare metric outcomes.
- Prior Year Metric Score: All included provider requirements must exceed the percentage required in the prior year. For contract years 2-4 enter the metric score that the provider achieved as stated in the prior year annual supplemental VBP report.
- Tier Required Metric Score (Column F-J): List the required score, for the Quality/Outcome Metric, that the provider must meet to receive the VBP payment. If the metric score has multiple tiers enter in the requirement for each tier. If the metric score is not tiered enter it into Tier 1 Required Metric Score (Column F).
- Metric Scores (Column K-N): List the current score that the provider has achieved in the respective quarter. Each quarter should be refreshed based on the claims lag information. The final report to refresh this data will be in the annual supplemental report.
- Contract Rate: Enter the contract rate found in the contract, if applicable.

  Examples:
  - If the contract is a Level 1 enter in the appropriate bonus payment, incentive payment, or withhold amounts.
  - If the contract is a Level 2 enter in the shared savings rate.
  - If the contract is a Level 3 having an upside sharing of 8% and a downside risk of 5% enter it as

    8% / (5%)
    - If the percentage of both upside and downside are the same enter it as ± 5%.
- Payment Frequency: Select the payment frequency of monthly, quarterly, semi-annual, or annual.
- Anticipated Provider VBP Payment: List the VBP payment to be made to the provider directly related to achieving the required quality and/or healthcare outcome.
- Notes: The MCO shall utilize the notes section to provide HSD with better understanding of the providers VBP agreement.

QM Detail Level 2

The purpose of this tab is to identify the quality and/or healthcare outcomes associated with the VBP Level 2 agreements. Each quality and/or healthcare outcome metric requirement will require a separate line and will be identified by the Quality/Outcome Metric Short Name that was given to it on the Quality Methodology tab. In the case of a provider having multiple quality and/or healthcare outcomes comingled with one payment, list all quality and/or healthcare outcomes on a separate line. List the Contract Rate, Payment Frequency, and Anticipated Provider VBP Payment on the providers first line and disclose in the Notes cell that the quality and/or healthcare outcomes are comingled into one payment.

- Provider Name: Input the name of the VBP provider
- Number of Attributed Members: Enter the unique number of Attributed Members for the quality and/or healthcare outcome metric.
- Quality/Outcome Metric Short Name: Select the quality and/or healthcare outcome metric short name that was given in the QM Methodology tab. VBP programs must be based upon improved quality and/or healthcare metric outcomes.
- Prior Year Metric Score: All included provider requirements must exceed the percentage required in the prior year. For contract years 2-4 enter the metric score that the provider achieved as stated in the prior year annual supplemental VBP report.
- Tier Required Metric Score (Column F-J): List the required score, for the Quality/Outcome Metric, that the provider must meet to receive the VBP payment. If the metric score has multiple tiers enter in the requirement for each tier. If the metric score is not tiered enter it into Tier 1 Required Metric Score (Column F).
- Metric Scores (Column K-N): List the current score that the provider has achieved in the respective quarter. Each quarter should be refreshed based on the claims lag information. The final report to refresh this data will be in the annual supplemental report.
- Contract Rate: Enter the contract rate found in the contract, if applicable.

  Examples:
  - If the contract is a Level 1 enter in the appropriate bonus payment, incentive payment, or withhold amounts.
  - If the contract is a Level 2 enter in the shared savings rate.
  - If the contract is a Level 3 having an upside sharing of 8% and a downside risk of 5% enter it as

    8% / (5%)
    - If the percentage of both upside and downside are the same enter it as ± 5%.
- Payment Frequency: Select the payment frequency of monthly, quarterly, semi-annual, or annual.
- Anticipated Provider VBP Payment: List the VBP payment to be made to the provider directly related to achieving the required quality and/or healthcare outcome.
- Notes: The MCO shall utilize the notes section to provide HSD with better understanding of the providers VBP agreement.

QM Detail Level 3

The purpose of this tab is to identify the quality and/or healthcare outcomes associated with the VBP Level 3 agreements. Each quality and/or healthcare outcome metric requirement will require a separate line and will be identified by the Quality/Outcome Metric Short Name that was given to it on the Quality Methodology tab. In the case of a provider having multiple quality and/or healthcare outcomes comingled with one payment, list all quality and/or healthcare outcomes on a separate line. List the Contract Rate, Payment Frequency, and Anticipated Provider VBP Payment on the providers first line and disclose in the Notes cell that the quality and/or healthcare outcomes are comingled into one payment.

- Provider Name: Input the name of the VBP provider
- Number of Attributed Members: Enter the unique number of Attributed Members for the quality and/or healthcare outcome metric.
- Quality/Outcome Metric Short Name: Select the quality and/or healthcare outcome metric short name that was given in the QM Methodology tab. VBP programs must be based upon improved quality and/or healthcare metric outcomes.
- Prior Year Metric Score: All included provider requirements must exceed the percentage required in the prior year. For contract years 2-4 enter the metric score that the provider achieved as stated in the prior year annual supplemental VBP report.
- Tier Required Metric Score (Column F-J): List the required score, for the Quality/Outcome Metric, that the provider must meet to receive the VBP payment. If the metric score has multiple tiers enter in the requirement for each tier. If the metric score is not tiered enter it into Tier 1 Required Metric Score (Column F).
- Metric Scores (Column K-N): List the current score that the provider has achieved in the respective quarter. Each quarter should be refreshed based on the claims lag information. The final report to refresh this data will be in the annual supplemental report.
- Contract Rate: Enter the contract rate found in the contract, if applicable.

  Examples:
  - If the contract is a Level 1 enter in the appropriate bonus payment, incentive payment, or withhold amounts.
  - If the contract is a Level 2 enter in the shared savings rate.
  - If the contract is a Level 3 having an upside sharing of 8% and a downside risk of 5% enter it as

    8% / (5%)
    - If the percentage of both upside and downside are the same enter it as ± 5%.
- Payment Frequency: Select the payment frequency of monthly, quarterly, semi-annual, or annual.
- Anticipated Provider VBP Payment: List the VBP payment to be made to the provider directly related to achieving the required quality and/or healthcare outcome.
- Notes: The MCO shall utilize the notes section to provide HSD with better understanding of the providers VBP agreement.

NF VBP

The purpose of this tab is to identify the MCOs NF VBP expenses and quality scores. The MCO must use the report from PointRight to populate this tab. The MCO must copy and paste values and formatting from the PointRight report.

FIN Detail

The purpose of this tab is to identify the MCOs medical expenses. The MCO must use paid claims data from Report 2 to accurately and appropriately report medical expenses, including those dual eligible expenses that the MCO would like to exclude from its overall medical expense. **Dual Eligible expenses to be excluded must be entered as a negative amoun**t. The amounts reported on this tab shall be

comprised of amounts from the MCOs Financial Package Report 2 Subtotal Health Care row, Paid Claims column for the respective quarter.

Level 1 Detail

The purpose of this tab is to identify the MCOs VBP spend in Level 1. The MCO must use paid claims data in their information systems to identify the VBP spend.

- Provider Name: Input the name of the VBP provider
- Level Structure: The drop-down menu includes the options of Bonus Payment, Incentive Payment, Withhold, and NF VBP. If the VBP agreement is structured as one of these select the appropriate one. If not leave the space blank and disclose the structure in the Notes tab.
- Program: Select the applicable program.
- Number of Attributed Members: Enter the number of unique Attributed Members for the provider in this VBP Level.
- Total Amount of Paid Claims: Enter the value of the claims that meet the VBP Claim definition as found in the Centennial Care Contract Attachment 3A(4).

Level 2 Detail

The purpose of this tab is to identify the MCOs VBP spend in Level 2. The MCO must use paid claims data in their information systems to identify the VBP spend.

- Provider Name: Input the name of the VBP provider
- Level Structure: The drop-down menu includes the options of Bundled Payments, Shared Savings, LTC/NF Readiness Build LTC, and NF. If the VBP agreement/workgroup is structured as one of these select the appropriate one. If not leave the space blank.
- Program: Select the applicable program.
- Number of Attributed Members: Enter the number of unique Attributed Members for the provider in this VBP Level.
- Total Amount of Paid Claims: Enter the value of the claims that meet the VBP Claim definition as found in the Centennial Care Contract Attachment 3A(4).
- High Volume Hospital: If the provider meets the definition of a High Volume Hospital, as found in the Centennial Care Contract Attachment 3A VBP Level 2 Definitions, select Yes from the drop-down menu. If the provider does not meet the definition of a High Volume Hospital select No from the drop-down menu.
- Readmission Baseline Rate: If the provider is a High Volume Hospital enter the readmission baseline rate utilizing the HEDIS “Plan All Cause Readmission” measure as prescribed in the contract.
- Current Year Readmission Rate: If the provider is a High Volume Hospital enter in the current year readmission rate utilizing the HEDIS “Plan All Cause Readmission” measure.
- Readmission Reduction: This field will automatically calculate the difference from the Readmission Baseline Rate and the Current Year Readmission Rate. If the Current Year Readmission Rate is left blank, and the Readmission Baseline Rate is greater than 0%, then this field will auto-populate to 0% until the Current Year Readmission Rate is filled out.

Level 3 Detail

The purpose of this tab is to identify the MCOs VBP spend in Level 3. The MCO must use paid claims data in their information systems to identify the VBP spend.

- Provider Name: Input the name of the VBP provider
- Level Structure: The drop-down menu includes the options of Risk Sharing, Full Risk, BH Workgroup, and LTC/NF Readiness Build. If the VBP agreement/workgroup is structured as one of these select the appropriate one. If not leave the space blank.
- Full Delegation of Care Coordination: Arrangements with full risk for Covered Services shall include Full Delegation of Care Coordination as detailed in the contract. Select "Yes" or "No". If the level structure is full risk but the column is left blank it will be counted as a No.
- Program: Select the applicable program.
- Number of Attributed Members: Enter the number of unique Attributed Members for the provider in this VBP Level.
- Total Amount of Paid Claims: Enter the value of the claims that meet the VBP Claim definition as found in the Centennial Care Contract Attachment 3A(4).
- High Volume Hospital: If the provider meets the definition of a High Volume Hospital, as found in the Centennial Care Contract Attachment 3A VBP Level 2 Definitions, select Yes from the drop-down menu. If the provider does not meet the definition of a High Volume Hospital select No from the drop-down menu.
- Readmission Baseline Rate: If the provider is a High Volume Hospital enter in the readmission baseline rate utilizing the HEDIS "Plan All Cause Readmission" measure as prescribed in the contract.
- Current Year Readmission Rate: If the provider is a High Volume Hospital, enter the current year readmission rate utilizing the HEDIS "Plan All Cause Readmission" measure.
- Readmission Reduction: This field will automatically calculate the difference from the Readmission Baseline Rate and the Current Year Readmission Rate. If the Current Year Readmission Rate is left blank, and the Readmission Baseline Rate is greater than 0%, then this field will auto-populate to 0% until the Current Year Readmission Rate is filled out.

VBP Summary

The purpose of this tab is to collect medical expense information and compare it to the MCOs VBP Spend. The information provided in this tab is used to monitor the MCOs achievement of the DSIPT. No final DSIPT score will be displayed on this tab, rather, this tab is to be used by the MCO to monitor their progress in reaching the DSIPT goals and requirements and identifying areas of deficiency.

- Line 1 Subtotal Health Care - Paid Claims: Amounts obtained from the FIN Detail Tab Lines 1-3, 5, and 6.
- Line 2 Excluded Dually Eligible: Amount obtained from the FIN Detail Tab Line 4.
- Line 3 Health Care Expenditures: Sum Line 1 and Line 2.
- Line 4 Level 1 Spend: Total Paid Claims amount from Level 1 Detail tab.
- Line 5 Level 2 Spend: Total Paid Claims amount from Level 2 Detail tab.

- Line 6 Level 3 Spend: Total Paid Claims amount from Level 3 Detail tab.
- Line 7 Total Value Based Purchasing Payments: Sum of Level 1, Level 2, and Level 3 VBP Spend.
- Line 8 Level Spend: Respective Level Spend divided by Line 3 Health Care Expenditures.
  Aggregate VBP Targets Met as required per Contract Year
  (Total Percentage Level of Spend Line 8)
    - Contract Year 3 - Total 33%
    - Contract Year 4 - Total 36%
- Line 9 Excess Allocation from other Levels: Excess Level 3 and Level 2 spend can cascade to the lower level to help reach that required level target.
- Line 10 Level Test Totals: Sum of Line 8 Level Spend and any applicable Line 9 Excess Allocation from other Levels.
- Line 11 DSIPT Level Requirement: VBP Level spend requirements based on the contract year
- Line 12 Level Excess: Amount of VBP Level spend above the required amount. This amount can be applied to lower levels on Line 9.
- Line 13 DSIPT Points Earned: Each VBP Level spend is allocated 10 points if the required level of VBP Spend is reached.

Additional Requirements Test

In accordance with the contract each level has additional requirements that the MCO must meet in order to be awarded the entirety of the points. Each additional requirement that is not met will result in a 2 point deduction from the DSIPT points earned for each Level of VBP spend. For each additional requirement not met the MCO is required to disclose why the requirement was not met in the Notes tab.

Level 1 Additional Requirements

- Line 14 Mix of Physical Health, Behavioral Health, Long Term Care and Nursing Facility Providers: The MCO is required to have a mix of Level 1 VBP programs. Column C through Column E count the number of providers listed, in the Level 1 Detail tab, which are PH, BH or LTSS providers. If a provider type count equals 0 then 2 points will be deducted.
- Line 15 Traditional PH Providers with at least 2 Small Providers: The contract defines a Small Provider as practices with 1,000 or less unique number of Attributed Members . Line 15 is a count of those providers that are listed in the Level 1 Detail tab as both PH and having Attributed Members of 1,000 or less. If the count is less than 2, than 2 points will be deducted.
- Line 16 Potential Level 1 Point Deductions: This line is the total of Level 1 Additional Requirements Point Deductions from Line 14 through Line 15.

Level 2 Additional Requirements

- Line 17 Mix of Physical Health, Behavioral Health, Long Term Care and Nursing Facility Providers: The MCO is required to have a mix of Level 2 VBP programs. Column C through Column E count the number of providers listed, in the Level 2 Detail tab, which are PH, BH or LTSS providers. If a provider type count equals 0 then 2 points will be deducted.

- Line 18 Traditional PH Providers with at least 2 Small Providers: The contract defines a Small Provider as practices with 1,000 or less Attributed Members. Line 18 is a count of those providers that are listed in the Level 2 Detail tab as both PH and having Attributed Members of 1,000 or less. If the count is less than 2, than 2 points will be deducted.
- Line 19 Level 2 BH VBP Program: The MCO is required to have a Level 2 VBP contract with a BH provider. If a Level 2 provider is identified as BH in the Level 2 Detail tab the requirement will be met.
- Line 20 Reserved/Development of LTC/NF Level 2 VBP Program/Level 2 LTC/NF VBP Program: The contract requires that the MCO develop Level 2 LTC/NF VBP Program during Contract Periods 1 and 2; and have a Level 2 LTC/NF VBP Program during Contract Periods 3 and 4.
    - For Contract Period 1 the line will be labeled "Reserved".
    - For Contract Period 2 the line will be labeled "Development of LTC/NF Level 2 VBP Program." If a provider is identified as LTSS in the Level 2 Detail tab the requirement will be met.
    - For Contract Periods 3 and 4 the line will be labeled "Level 2 LTC/NF VBP Program." If a provider is identified as an LTSS in the Level 2 Detail tab the requirement will be met.
- Line 21 Bundled Payments: Level 2 Additional Requirements requires the MCO to have VBP agreements with Bundled Payments. Line 21 is the count of those VBP providers which have been designated as Bundled Payments in the Level 2 Detail tab.
- Line 22 Potential Level 2 Point Deductions: This line is the total of Level 2 Additional Requirements Point Deductions from Line 17 through Line 21.

Level 2 and Level 3 Combined Additional Requirements

- Line 23 High Volume Hospital Spend: The MCO must have at least 5% of the overall total Contract Year percentages in Level 2 and Level 3 VBP contracting with High Volume Hospitals.
    - HVH Hospitals cell indicates how many High Volume Hospitals were identified in the Level 2 Detail and the Level 3 Detail tabs. If no High Volume Hospitals were identified, then the MCO did not meet the requirement of contracting with High Volume Hospitals.
    - Paid claims for those providers listed as High Volume Hospitals in Level 2 Detail and Level 3 Detail tabs are summed up in the HVH YTD Total cell. This amount is divided by the sum of Line 5 and Line 6 to arrive at the High Volume Hospital Spend.
- Line 24 Potential Level 2 and Level 3 Combined Point Deductions: This line is the total of Level 2 and Level 3 Combined Additional Requirements Point Deductions from Line 23.

Level 3 Additional Requirements

- Line 25 Mix of Physical Health, Behavioral Health, Long Term Care and Nursing Facility Providers: The MCO is required to have a mix of Level 3 VBP programs. Column C through Column E count the number of providers listed, in the Level 3 Detail tab, which are PH, BH or LTSS providers. If a provider type count equals 0 then 2 points will be deducted.
    - For Contract Period 1, the MCO is not required to have an LTC/NF provider in Level 3. For this period the cell will be blacked out.

- Line 26 Full Risk Arrangements require Full Delegation of Care Coordination: The contract requires that the MCO have Full Delegation of Care Coordination for all full risk contracts. If a Level 3 Full Risk VBP Program does not have a Full Delegation of Care Coordination in the Level 3 Detail tab then the requirement will not be met.
- Line 27 BH Provider Workgroup/Level 3 BH VBP Program: The contract requires that the MCO create a Level 3 BH Provider Workgroup for Contract Periods 1 and 2 and have a Level 3 BH VBP program during Contract Periods 3 and 4.
    - For Contract Periods 1 and 2 the line will be labeled "BH Provider Workgroup." If a Level 3 provider is identified as BH in the Level 3 Detail tab the requirement will be met.
    - For Contract Periods 3 and 4 the line will be labeled "Level 3 BH VBP Program." If a provider is identified as a BH provider in the Level 3 Detail tab the requirement will be met.
    - For Contract Period 4 the requirement is that at least 1% of the Level 3 spend be with a BH Provider. This is calculated as the paid claims for Level 3 BH Providers, identified as BH on the Level 3 Detail tab, divided by the total of Level 3 spend (Line 6).
- Line 28 Development of LTC/NF Level 3 VBP Programs/Level 3 LTC/NF VBP Programs:
    - This requirement is not required until Contract Period 2. For Contract Period 1 the line will be labeled as "Reserved" and the cells will be blacked out.
    - For Contract Periods 2 and 3 the line will be labeled "Development of LTC/NF Level 3 VBP Programs." If a Level 3 provider is identified as LTSS in the Level 3 Detail tab the requirement will be met.
    - For Contract Period 4 the line will be labeled as "Level 3 LTC/NF VBP Programs." If a Level 3 provider is identified as LTSS in the Level 3 Detail tab the requirement will be met.
- Line 29 Potential Level 3 Point Deductions: This line is the total of Level 3 Additional Requirements Point Deductions from Line 25 through Line 28.

Notes and Analysis

The MCO notes and analysis tabs located within the VBP Report are to be used to provide any necessary explanations or analyses that will help the reader understand the reported information.