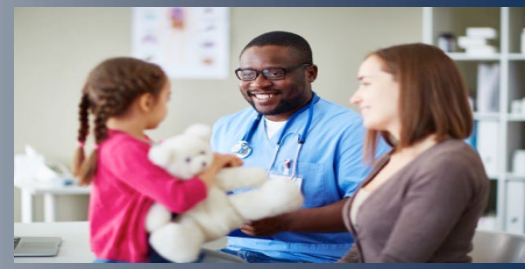






Guide for Completing the NC Medicaid Standard Plan VBP Reporting Deliverables QAV03 and QAV04

August 6, 2024

Background

Standard Plan VBP Reporting Deliverables

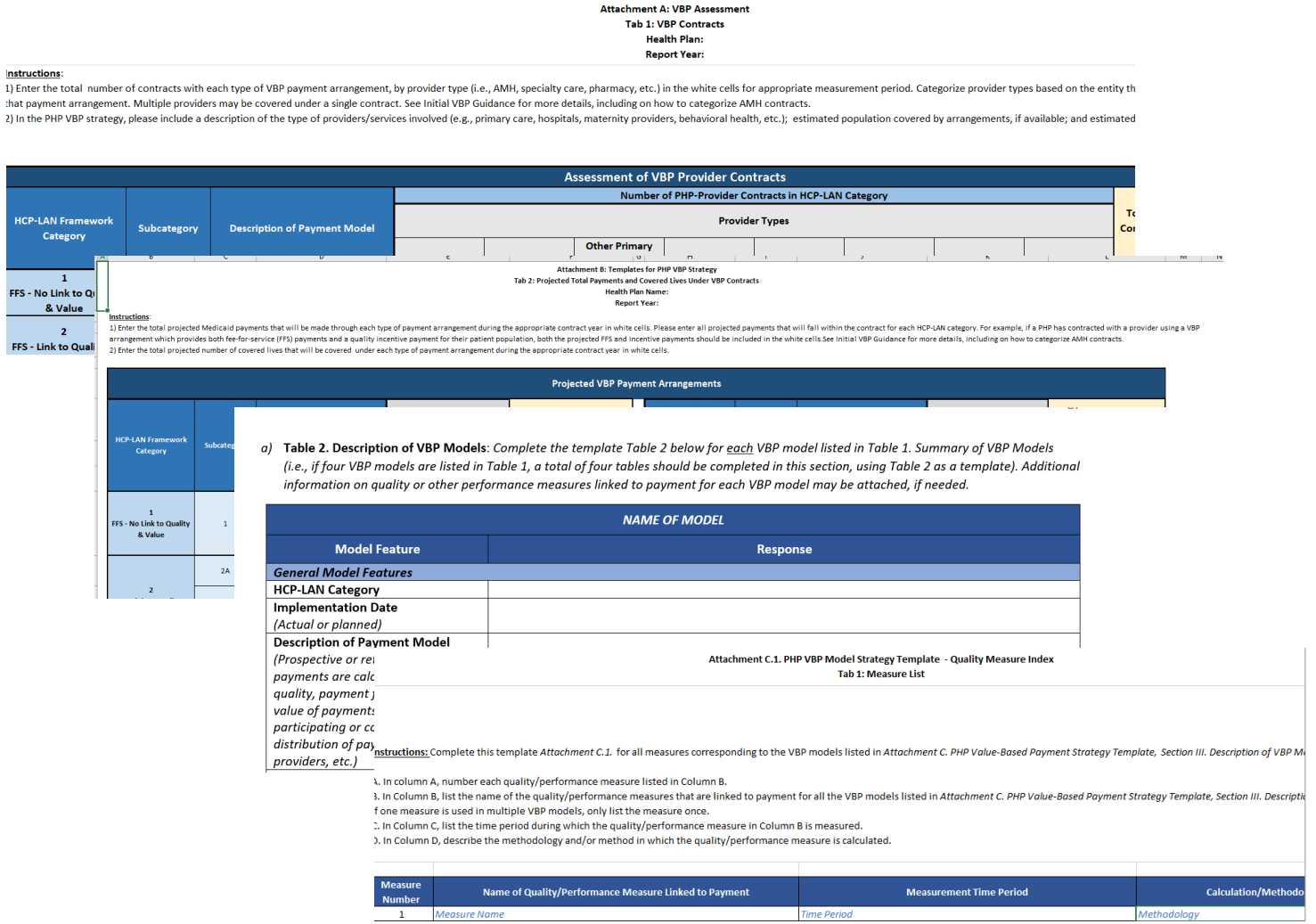
Standard Plans are required to submit annual reports on their VBP arrangements and strategies by September 30th:

QAV03 (VBP Assessment):

1. **Attachment A:** Provides information on VBP contracts by provider type and total payments and covered lives under VBP contracts for the **previous** SFY (July 1st – June 30th)

QAV04 (VBP Strategy):

1. **Attachment B:** Provides **projected** information on VBP contracts by provider type and total payments and covered lives under VBP contracts for the **current** SFY (July 1st – June 30th)
2. **VBP Narrative Attachment C:** Provides summary information on current and future VBP models, including model results, participating providers, performance measures used in each model, and IT capabilities
3. **Quality Measure Index Attachment C.1:** Provides information on quality measures linked to payment in each VBP model a Standard Plan offers, including information on measure calculation and methodology



Attachment A: VBP Assessment
Tab 1: VBP Contracts
Health Plan:
Report Year:

Instructions:
1) Enter the total number of contracts with each type of VBP payment arrangement, by provider type (i.e., AMH, specialty care, pharmacy, etc.) in the white cells for appropriate measurement period. Categorize provider types based on the entity th
that payment arrangement. Multiple providers may be covered under a single contract. See Initial VBP Guidance for more details, including on how to categorize AMH contracts.
2) In the PHP VBP strategy, please include a description of the type of providers/services involved (e.g., primary care, hospitals, maternity providers, behavioral health, etc.); estimated population covered by arrangements, if available; and estimated

Assessment of VBP Provider Contracts				
HCP-LAN Framework Category	Subcategory	Description of Payment Model	Number of PHP-Provider Contracts in HCP-LAN Category	
			Provider Types	
			Other Primary	
1 FFS - No Link to Qu & Value				
2 FFS - Link to Quali				

Attachment B: Templates for PHP VBP Strategy
Tab 2: Projected Total Payments and Covered Lives Under VBP Contracts
Health Plan Name:
Report Year:

Instructions:
1) Enter the total projected Medicaid payments that will be made through each type of payment arrangement during the appropriate contract year in white cells. Please enter all projected payments that will fall within the contract for each HCP-LAN category. For example, if a PHP has contracted with a provider using a VBP arrangement which provides both fee-for-service (FFS) payments and a quality incentive payment for their patient population, both the projected FFS and incentive payments should be included in the white cells.See Initial VBP Guidance for more details, including on how to categorize AMH contracts.
2) Enter the total projected number of covered lives that will be covered under each type of payment arrangement during the appropriate contract year in white cells.

Projected VBP Payment Arrangements		
HCP-LAN Framework Category	Subcateg	
1 FFS - No Link to Quality & Value	1	
2	2A	

a) **Table 2. Description of VBP Models**: *Complete the template Table 2 below for each VBP model listed in Table 1. Summary of VBP Models (i.e., if four VBP models are listed in Table 1, a total of four tables should be completed in this section, using Table 2 as a template). Additional information on quality or other performance measures linked to payment for each VBP model may be attached, if needed.*

NAME OF MODEL	
Model Feature	**Response**
General Model Features	
HCP-LAN Category	
Implementation Date *(Actual or planned)*	
Description of Payment Model *(Prospective or re payments are calc quality, payment value of payment participating or cc distribution of pa providers, etc.)*	

Attachment C.1. PHP VBP Model Strategy Template - Quality Measure Index
Tab 1: Measure List

Instructions: Complete this template *Attachment C.1.* for all measures corresponding to the VBP models listed in *Attachment C. PHP Value-Based Payment Strategy Template, Section III. Description of VBP M*

. In column A, number each quality/performance measure listed in Column B.
. In Column B, list the name of the quality/performance measures that are linked to payment for all the VBP models listed in *Attachment C. PHP Value-Based Payment Strategy Template, Section III. Descriptio*
f one measure is used in multiple VBP models, only list the measure once.
. In Column C, list the time period during which the quality/performance measure in Column B is measured.
. In Column D, describe the methodology and/or method in which the quality/performance measure is calculated.

Measure Number	Name of Quality/Performance Measure Linked to Payment	Measurement Time Period	Calculation/Methodo
1	*Measure Name*	*Time Period*	*Methodology*

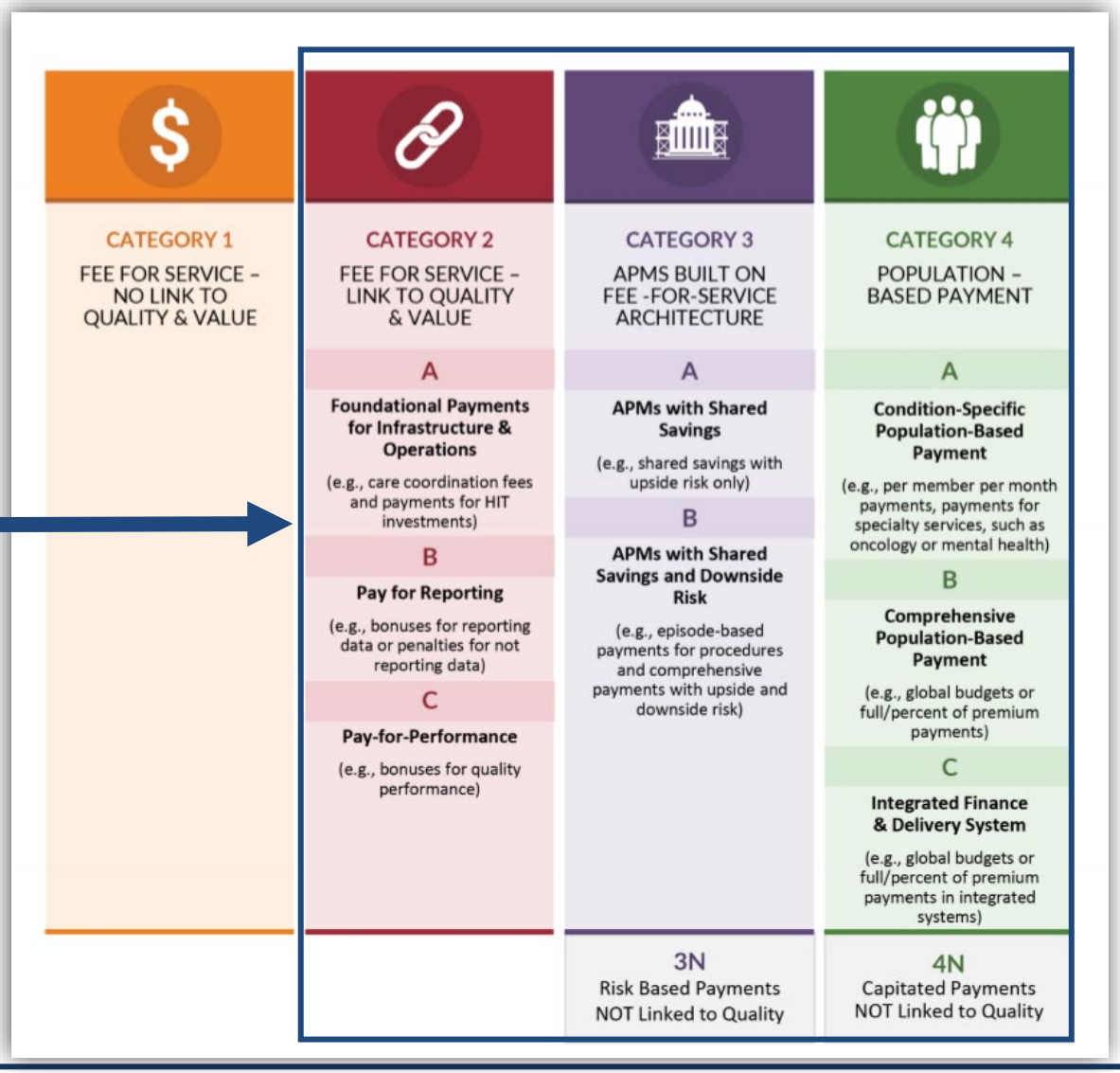
Value-Based Payment Defined

VBP Defined:

Value-based payments are payments from health plans to providers that are tied to quality or value (not simply fee-for-service).

For example: bonus payments made to providers for quality performance

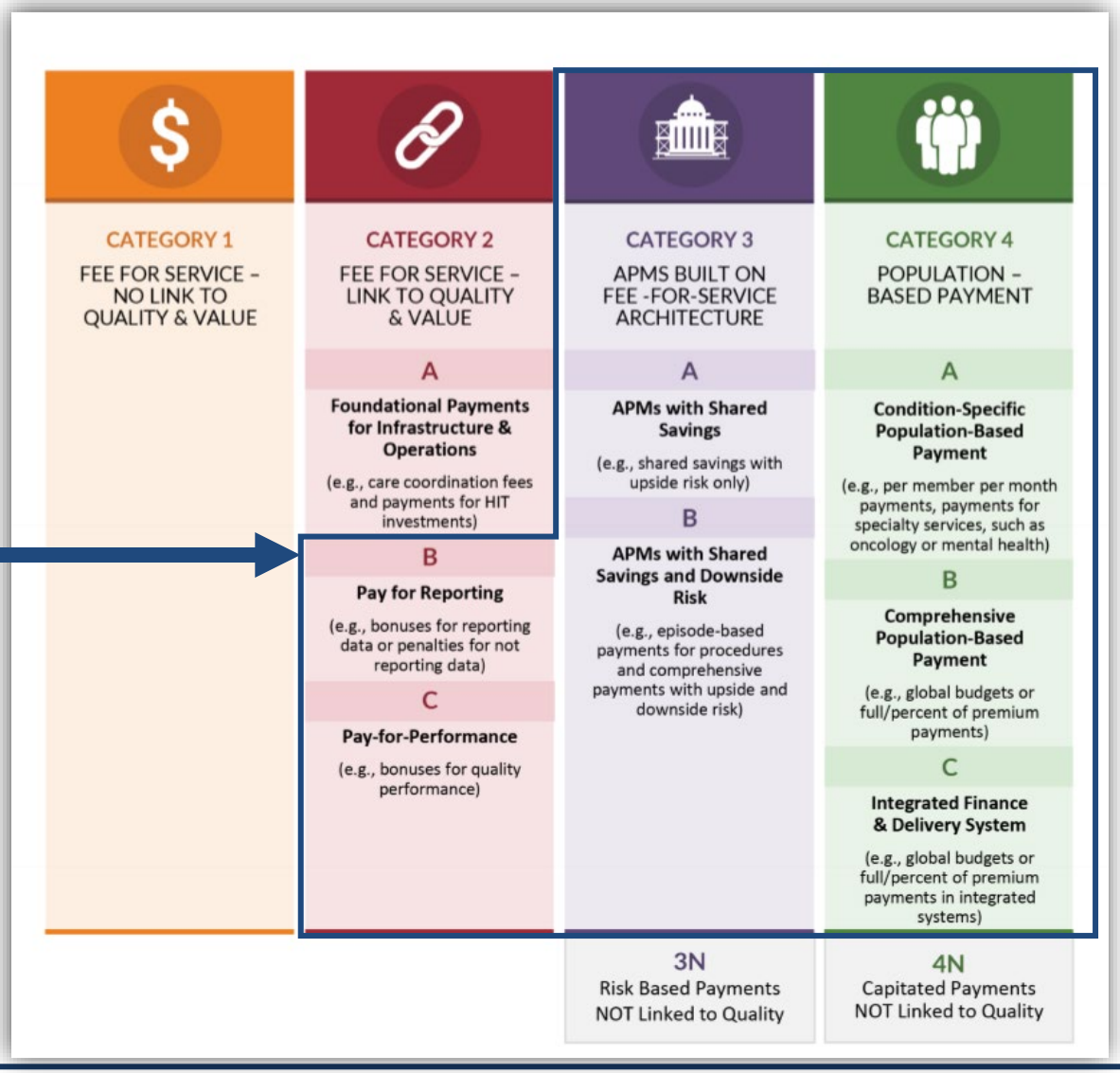
The Department defines VBP arrangements as those that fall within Categories 2 through 4 of the multi-payer Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM) framework.*



*Beginning with reports submitted in 2024, the Department is updating how it calculates VBP totals to focus on arrangements in category 2B or higher. **See slide 17 for more details.**

Focus on HCP-LAN Category 2B or Higher

Beginning with reports submitted in 2024, the Department is updating how it calculates VBP totals to focus on arrangements in category 2B or higher.



Standard Plan Year 2 Contract Requirement

Year 2 (July 1, 2022 – June 30, 2023) Contract Requirement:

According to the contract, "The Department requires that by the end of Year 2 of SP operations, the portion of each SP's medical expenditures governed under VBP arrangements will either:

- Increase by twenty (20) percentage points **OR**
- Represent at least fifty percent (50%) of total medical expenditures."

Standard Plans reported their VBP expenditures via an annual PCDU deliverable, QAV03-SP.

The Department has not implemented any additional VBP targets for Year 3 (July 1, 2023 – June 30, 2024) in the Standard Plan Contract

Standard Plan VBP Reporting Summary

Reporting Element	VBP Assessment QAV03	VBP Strategy QAV04
VBP contracts	The total number of contracts that include a type of VBP payment arrangement	The total number of projected contracts that will include a type of VBP payment arrangement
VBP payments	The total Medicaid payments made through contracts that include a type of VBP payment arrangement	The total projected Medicaid payments that will be made through contracts that include a type of VBP payment arrangement
Payments tied to value under VBP contracts	The total payments to providers that are tied to value under VBP contracts (excluding fee-for-service payments)	The total projected payments to providers that are expected to be tied to value under VBP contracts (excluding fee-for-service payments)
AMH payments tied to value under VBP contracts	The total payments to AMH providers that are tied to value under VBP contracts (excluding fee-for-service payments)	The total projected payments to AMH providers that are expected to be tied to value under VBP contracts (excluding fee-for-service payments)

Refer to the next slide for the reporting periods covered for each deliverable

Standard Plan VBP Reporting Periods

Contract Year	Attachment A Reporting Period (VBP Assessment QAV03)	Attachment B Reporting Period (VBP Strategy QAV04)	Due Date to be Uploaded into PCDU
Year 2	July 1, 2022 – June 30, 2023	July 1, 2023 – June 30, 2024	September 30, 2023
Year 3	July 1, 2023 – June 30, 2024	July 1, 2024 – June 30, 2025	October 31, 2024 (Extension Granted)
Year 4	July 1, 2024 – June 30, 2025	July 1, 2025 – June 30, 2026	September 30, 2025
Year 5	July 1, 2025 – June 30, 2026	July 1, 2026 – June 30, 2027	September 30, 2026

VBP Deliverable Enhancements as of 2024

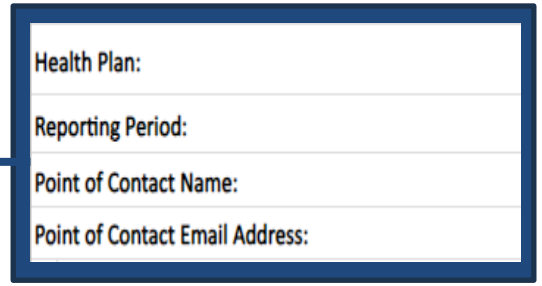
All Attachments: Additional Information Fields

Beginning Year 3 (July 1, 2023 – June 30, 2024), across all VBP reporting attachments, DHHS has created additional information fields to streamline data comparison across reporting years and support Standard Plans in completing reports fully and accurately.

Additional Fields Include:

1. **Reporting period:** Indicate the period of time for which the reported data applies
   - Reporting Periods For Deliverables Due by September 30, 2024:
     - **Attachment A:** Reporting period for Year 3 will be **July 1, 2023 – June 30, 2024**
     - **Attachment B:** Reporting period for *projected* Year 4 will be **July 1, 2024 – June 30, 2025**

2. **Point of contact at the Standard Plan for DHHS questions about the deliverable submission**
   - Please include the name and email address of who DHHS should contact for questions and clarifications regarding the Standard Plan's deliverable



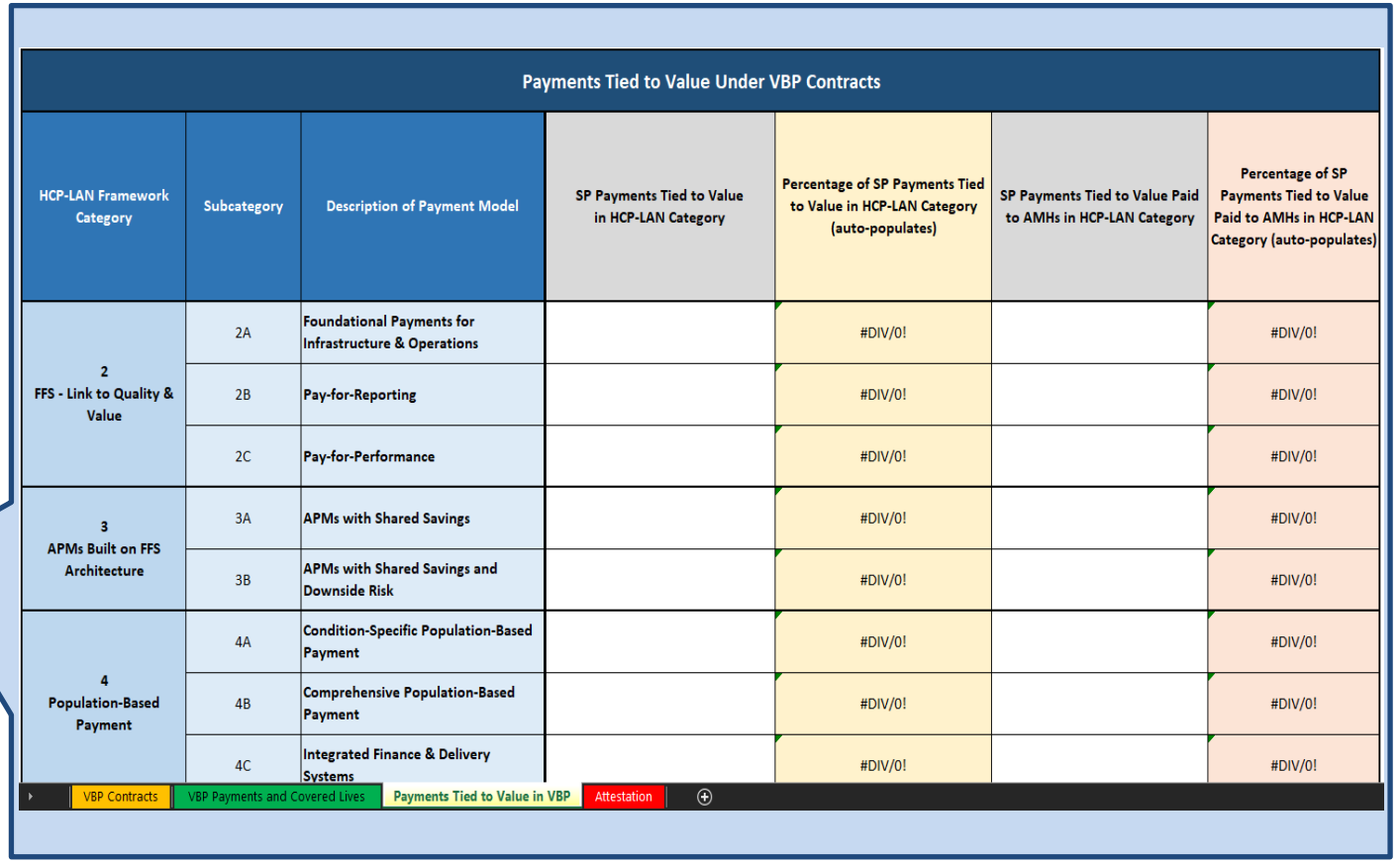
If you have any questions about how to complete Attachment A, please email Medicaid.Quality@dhhs.nc.gov and include "VBP Report Submission Support" in the subject line of the email.

Attachments A & B Enhancement: Projected Payments Tied to Value

In Year 3, Standard Plans will be required to report the total payments to providers that are **tied to value** under VBP contracts, by HCP-LAN category (excluding FFS). Standard Plans will also be required to report the amount of payments tied to value paid to AMH practices (within the overall payments tied to value)

Attachment A & B Enhancement

1. There is an additional tab in Attachment A of the QAV03 report and Attachment B of the QAV04 report, which requests information on payments (or projected payments) tied to value under VBP contracts.
2. Payments tied to value should exclude fee-for-service payments and include, for example, the value of reporting or performance incentive bonuses (Category 2B and 2C), shared savings payments (Category 3A), and prospective payments (Category 4A-C).



Payments Tied to Value Under VBP Contracts

HCP-LAN Framework Category	Subcategory	Description of Payment Model	SP Payments Tied to Value in HCP-LAN Category	Percentage of SP Payments Tied to Value in HCP-LAN Category (auto-populates)	SP Payments Tied to Value Paid to AMHs in HCP-LAN Category	Percentage of SP Payments Tied to Value Paid to AMHs in HCP-LAN Category (auto-populates)
2 FFS - Link to Quality & Value	2A	Foundational Payments for Infrastructure & Operations		#DIV/0!		#DIV/0!
	2B	Pay-for-Reporting		#DIV/0!		#DIV/0!
	2C	Pay-for-Performance		#DIV/0!		#DIV/0!
3 APMs Built on FFS Architecture	3A	APMs with Shared Savings		#DIV/0!		#DIV/0!
	3B	APMs with Shared Savings and Downside Risk		#DIV/0!		#DIV/0!
4 Population-Based Payment	4A	Condition-Specific Population-Based Payment		#DIV/0!		#DIV/0!
	4B	Comprehensive Population-Based Payment		#DIV/0!		#DIV/0!
	4C	Integrated Finance & Delivery Systems		#DIV/0!		#DIV/0!

VBP Contracts | VBP Payments and Covered Lives | Payments Tied to Value in VBP | Attestation

QAV04 Attachment C Enhancements: VBP Narrative and Strategy

Attachment C Enhancement #1:

New requirement to report average PMPM incentive payments paid to providers for contracts that were linked to performance on AMH quality measures, or a subset of AMH quality measures. This requirement is only for performance incentive models that Standard Plans are using to meet AMH VBP requirements currently.

Rationale for Enhancement:

Allows DHHS to learn, on average, how meaningful the AMH Performance Incentive Payment contracts are to practices and better understand funding available to practices to support care delivery reforms

AMH Performance Incentive Model Name	Average PMPM Incentive Payment in Contract Year Reporting Period	Estimated PMPM Incentive Payment for Current Contract Period (Next Year Reporting Period)
Name	$	$

QAV04 Attachment C Enhancements: VBP Narrative and Strategy

Attachment C Enhancement #2:

New requirement to include provider narrative on their contracts with "Other" Primary Care Providers, including the average panel size of the practices.

Rationale for Enhancement:

Allows DHHS to learn about PCPs that are not participating in the AMH Program to better understand barriers to participation and engagement in VBP contracts

V. "Other" Primary Care Providers

a) Description of "Other" Primary Care Providers: *In the tabs "VBP Contracts" and "Projected VBP Contracts" in Attachments A. and B., respectively, there is a provider type listed as "Other Primary Care" (column G), which should exclude AMH providers. Please provide narrative information on these providers, including whether they are enrolled in VBP models, average panel size, and geography.*

QAV04 Attachment C Enhancements: VBP Narrative and Strategy

Attachment C Enhancement #3:

Clarification of Standard Plan requirement to report on number of Historically Underutilized Providers (HUPs) that are participating in VBP arrangements

Rationale for Enhancement:

Allows DHHS to better understand how VBP arrangements may support delivery system transformation for historically marginalized groups

Number and Percent of Participating Historically Underutilized Providers (HUPs)[1] & Estimated Number of Beneficiaries Served *(Completion of this field is strongly encouraged; if there are no HUPs participating in the model, please report as such)*	

QAV04 Attachment C Enhancements: VBP Narrative and Strategy

Attachment C Enhancement #4:

Requesting additional information in Table 1. Summary of VBP Models, including the types of providers eligible to participate in the model and whether the VBP model fulfills the AMH performance incentive requirements.

Rationale for Enhancement:

Streamline analysis of reporting through high-level classification of VBP models by eligible providers and clarify which models fulfill Standard Plan requirements to offer AMH Tier 3 practices performance incentives.

VBP Model Name	HCP-LAN Category	Row for Corresponding Entry in Attachment A and/or B	Eligible Provider Types (AMH, Behavioral Health, Hospital, etc.)	Fulfills AMH Performance Incentive Requirement? (Y/N)

QAV04 Attachment C Enhancements: VBP Narrative and Strategy

Attachment C Enhancement #5:

New requirement to report any updates made to VBP contracts due to the Standard Plan Withhold Program, including contract changes and updates to measures included in models due to the withholds.

Rationale for Enhancement:

Allows DHHS to learn about how plan-level performance priorities impact provider-level performance priorities through VBP contracts and measure selection.

III. VBP Model Results

a) **Approach to Assessing VBP Model Results**: *Describe the PHP's approach to evaluating the impacts of its VBP contracting, including assessing changes in quality, utilization, or costs associated with the Model. Describe the specific approach to assessing impacts of models on equity and health disparities.*

b) **Table 3. VBP Model Results:** *Using Table 3 below, summarize and give examples of any observed outcomes or results to date (e.g., on cost savings, quality improvements, health disparity improvements) for each VBP model listed in Table 1. Summary of VBP Models,* ***if such results are available****. Include additional rows if needed.*

QAV03 & QAV04 Contracts Reporting Instructions

QAV03 & QAV04: "VBP Contracts" Tab

Guidance on Counting Contracts in Attachments A & B	
#1	Count contracts, not addendums or number of providers covered by each contract
#2	Count each contract only once, in highest applicable HCP-LAN category
#3	Count all contracts, including Category 1 (FFS)
#4	Contracts with practices that include Performance Incentive Payments (including all contracts with providers in AMH Tier 3) should count as VBP in HCP-LAN Categories 2B or above
#5	AMH Tiers 1 and 2 AMH contracts should be counted as VBP only if they include a performance-based incentive program
#6	Beginning with reports submitted in 2024, the Department is updating how it calculates VBP totals to focus on arrangements in HCP-LAN Category 2B or higher. PHPs should continue reporting on 2A contracts, but they will not be included in measures of total VBP arrangements.

QAV03 & QAV04: "VBP Contracts" Tab

Guidance on Counting Contracts in Attachments A & B

#7	**Handling Multiple VBP Arrangements at the Same HCP-LAN Category**: • If a contract includes multiple VBP arrangements at the same HCP-LAN category, count that as 1 contract under the highest category and for the provider or service type that the SP considers the primary contract holder or service type.
#8	**Reflecting Contracts with Multiple VBP Components**: • If a provider entity has a contract that includes multiple VBP components and/or multiple service types, report the contract in the row of the highest HCP-LAN category applicable and under the column for the provider type that most closely correlates with the VBP arrangement in that category.

QAV03 & QAV04 Payment Reporting Instructions

QAV03 & QAV04: VBP Assessment "Payments & Lives Under VBP" Tab

On the QAV03 & QAV04: VBP Assessment "Payments & Lives Under VBP" Tab

#1	SPs should report **all payments** made: • During the applicable contract year/reporting period • Under finalized provider contracts that include a VBP payment arrangement
#2	Include all payments made under such contracts, including FFS payments
#3	**Exclusions from Reporting**: • Payments not made under contracts that include a VBP component • Payments not made in the reporting period/contract year in question
#4	**Extended Timeframe for VBP Payments**: • VBP payments (e.g., performance incentives) are often paid on an extended timeframe. • Report VBP payments in the contract year/reporting period in which they are made

QAV03 & QAV04: VBP Assessment "Payments & Lives Under VBP" Tab

Payments & Lives Under VBP

Definition:
All payments made under contracts with a VBP component, as well as the lives covered under those contracts.

SP Total Medical Expenditures

Definition:
Includes all payments that flow from SPs to providers, excluding only the following payment types:

- Directed payments to hospitals associated with UNC and Vidant medical schools
- Additional utilization-based payments to certain providers, as described in Amendment #14 of Standard Plan contract Section D. Providers, Subsection 4. Provider Payments.

QAV03 & QAV04: VBP Assessment "Payments & Lives Under VBP" Tab

Guidance on How AMH Tier 3 Payments Count in Terms of VBP

Numerator Counting:	
#1	Count all payments that flow from SPs to AMHs contracted at a Tier 3 level as VBP in the "Payments & Lives Under VBP" tab. This includes: • FFS Payments • Medical Home Fees • Care Management Fees • Performance Incentive Payments
#2	AMH Tiers 1 & 2 in performance-based incentive programs should be treated the same as AMH Tier 3s for reporting purposes in the "Payments & Lives Under VBP" tab.

QAV03 & QAV04: VBP Assessment "Payments & Lives Under VBP" Tab

Guidance on How CMARC & CMHRP Payments to LHDs Count in Terms of VBP

Numerator Counting:	
#1	Payments to LHDs for care management under these programs (CMARC & CMHRP) will only count in the numerator as VBP if the SPs contract with the LHD includes Performance Incentive Payments

QAV03 & QAV04: VBP Assessment "Payments Tied to Value in VBP" Tab

Guidance on the QAV03 & QAV04: VBP Assessment "Payments Tied to Value in VBP" Tab	
#1	**HCP-LAN category 2A payments**, which include foundational payments for infrastructure and operations such as care management payments and medical home fees, should be reported, but will not count towards total payments tied to value starting in 2024.
#2	Include only the value of performance incentive payments and any other payments to providers that are linked to value that are categorized within HCP-LAN categories 2 through 4. This should **exclude** fee-for-service payments.
#3	The "Total SP Payments Tied to Value Under VBP" calculation is auto-populated to only include HCP-LAN category 2B payments and above. Beginning with reports submitted in 2024, the Department is updating how it calculates VBP totals to focus on arrangements in category 2B or higher.

QAV03 & QAV04: VBP Assessment "Payments Tied to Value in VBP" Tab

Reporting Example on the QAV03 & QAV04: VBP Assessment "Payments Tied to Value in VBP" Tab	
#1	Ensure accurate reporting by categorizing each payment according to the HCP-LAN contract type associated with it.
#2	For example, if a Health Plan has a 2B contract and a 3A contract with the same provider, they should report: • The pay-for-reporting payments made to the provider in the 2B row and • The shared savings payments (if any) made to the provider in the 3A row

QAV03 Attestation Instructions

QAV03: VBP Assessment "Attestation" Tab

Attestation Guidance	
#1	**Purpose of Attestation:** • To certify the accuracy and completeness of the data provided by the Health Plan in Attachment A of the VBP Assessment
#2	**Key Considerations:** • Ensure all information provided is accurate and up-to-date • Review all elements of the assessment thoroughly to ensure it is complete before attesting
#3	**Attestation Statement:** • The undersigned attests that the content of this assessment is accurate and complete to the best of their knowledge

The Attestation must be completed by the Health Plan's Medicaid business line leadership

QAV04 Attachment C Instructions

QAV04: Attachment C

Instructions	
#1	Complete Sections 1 through 4 in their entirety
#2	Follow the italicized instructions for each Section
#3	All fields are mandatory and must include a response (if the question is not applicable, please respond “N/A”. Do not leave fields blank.
#4	Health Plans are strongly encouraged to provide information on the number and percentage of **Historically Underutilized Providers (HUPs)** participating in their VBP arrangements. If these data are not available, please report “N/A” in the corresponding HUP field.

QAV04 Attachment C.1 Instructions

QAV04: Attachment C.1

"Measure List" Tab Instructions	
#1	**Column A: Numbering Measures** • Assign a unique number to each quality/performance measure listed in Column B. Ensure that each measure is numbered sequentially.
#2	**Column B: Quality/Performance Measure Names** • List the name of each quality/performance measure that is tied to payment in the VBP models as outlined in *Attachment C. PHP Value-Based Payment Strategy Template, Section III. Description of VBP Models*. • If a measure applies to multiple VBP models, list it only once.
#3	**Column C: Measurement Time Period** • Specify the time-period during which the quality/performance measure is measured • This should indicate the start and end dates or relevant reporting period
#4	**Column D: Measure Calculation/Methodology** • Provide a description of the methodology and/or method used to calculate the quality/performance measure listed in *Column B*

QAV04: Attachment C.1

Measures by VBP Model Tab Instructions	
#1	**Column A: List VBP Models** • Enter the name of each VBP model as specified in *Attachment C. PHP Value-Based Payment Strategy Template, Section III. Description of VBP Models*
#2	**Column B: Measure Numbers** • For each VBP model listed in Column A, provide the measure numbers from *Tab 1, Column A* of this template that correspond to the quality/performance measures linked to payment for that specific VBP model
#3	**Column C: Additional Notes/Comments** • Include any relevant additional notes or comments in Column C. This may include clarifications, exceptions, or supplementary information that supports the data provided in Columns A and B
#4	Ensure that all information is accurate and complete before finalizing the template