# Value Based Payment (VBP) Frequently Asked Questions (FAQs)

## Medicaid Advantage Plus (MAP) and Fully Integrated Duals Advantage (FIDA) Plans, and Programs of All-Inclusive Care for the Elderly (PACE)

**June 26, 2018**

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# Purpose

This FAQ document is designed to address questions related to the implementation of VBP within MAP, FIDA and PACE. Questions and answers will be updated or added to this document on a periodic basis to continue to address related stakeholder questions. The date at the bottom of the document will be updated to reflect periodic revisions.

The VBP Roadmap referenced in this document is reviewed annually and approved by the Centers for Medicare and Medicaid Services (CMS) and serves as the overarching guiding document for the implementation of VBP in New York State. The VBP Roadmap can be accessed at the VBP Resource Library in the *VBP Roadmap* folder.

Questions may be submitted to the MLTC VBP mailbox (MLTCVBP@health.ny.gov) with "MLTC FAQ" in the subject line.

# General

## *1.) What type of VBP arrangement should be pursued for MAP and FIDA Plans?*

Following the VBP Roadmap for fully capitated Managed Long-Term Care (MLTC), the VBP arrangement for MAP, FIDA, and PACE is a total cost of care subpopulation arrangement, inclusive of all services provided to the member. For MAP and FIDA, plans and providers ("VBP Contractors") should engage in the development of VBP contracts to cover the total cost of care using a target budget methodology that establishes a budget inclusive of all services. VBP Contractors could include Independent Practice Associations (IPAs), Accountable Care Organizations (ACOs), and/or single providers willing/able to take responsibility for the total cost and quality of all care provided to the member.

## *2.) What are the Levels of VBP Applicable to the MAP and FIDA Plans, and PACE?*

MAP and FIDA Plans and PACE Organizations are fully capitated plans and are treated similarly to mainstream Managed Care Organizations (MCOs) for VBP. Three levels, or types of contracts, are available depending on the preference and capacity of the contracting parties. Level 1 is a shared savings arrangement with no downside risk. Level 2 is a shared savings/shared losses arrangement with limited downside risk. Level 3 is a prospective global capitation payment. The VBP Roadmap contains additional information about Levels 1, 2, and 3.

## *3.) What type of VBP arrangement should be pursued for PACE?*

Because PACE provide services directly and are responsible for coordinating and delivering total care for participants under a global capitation payment, in many cases the PACE is fulfilling the role of the VBP Contractor in a traditional VBP arrangement. With the addition of a social determinants of health (SDH) intervention – as is required of Level 2 and 3 VBP Contractors in mainstream MCOs

– PACE can meet the definition of a Level 3 VBP arrangement. PACE may also pursue VBP arrangements with any independent providers under contract with them to deliver certain services. These arrangements should follow Levels 1, 2, and 3 for Mainstream MCOs as described in the VBP Roadmap.

### *4.) How can FIDA plans enter into VBP arrangements given their limited remaining duration under the demonstration, which expires in 2019?*

VBP contracts can be negotiated on an annual basis. FIDA plans can pursue VBP arrangements one year at a time, following an annual cycle for the remaining period of the demonstration. Beyond the demonstration period, New York State (NYS) is committed to the continuation and expansion of integrated care for MLTC members. Pioneering efforts to implement total cost of care subpopulation VBP arrangements for integrated MLTC product lines are likely to bear fruit under any scenario as these product lines are expanded. In addition, FIDA plans are offered as one product line for MLTC plans also offering a MAP or partially capitated plan option.

### *5.) What is the "attributed provider" for MAP and FIDA Plans and PACE?*

Attribution in a VBP arrangement applies to the quality and cost aspects of the arrangement. Attribution connects the member to the provider/VBP Contractor responsible for the VBP arrangement. The VBP Roadmap contains a recommended attribution for each arrangement. Because attribution is a recommendation and not a requirement, plans and providers/VBP Contractors can arrange for an alternative attribution per the terms of their specific VBP contract. For partially capitated MLTC plans, the recommended attribution in the Roadmap is to the long-term care provider. Because MAP and FIDA plans cover the continuum of care and include primary and acute care, attribution can be to the primary care physician (PCP) if that is what the contracting parties prefer. For PACE attribution will be to the PACE itself for the purposes of the NYS VBP quality calculation. A PACE may choose to pursue VBP with individual providers such as Licensed Home Care Service Agencies (LHCSAs), Certified Home Health Agencies (CHHAs), and Skilled Nursing Facilities (SNFs), and/or community PCPs not employed by the PACE.

## Contracting Guidance

### *6.) What is the Deadline for VBP Contracting for MAP and FIDA Plans and PACE?*

MAP and FIDA plans are required to submit VBP contracts to cover all provider types by March 31, 2018 and may retroactively cover the January 1 to March 31, 2018 period. PACE plans will be required to submit documentation regarding their compliance with SDH and "Tier 1" community based organization (CBO) contract requirements by March 31, 2018 to be considered VBP Level 3 (See question 18). Plans will be subject to penalties per the Roadmap if VBP arrangements are not in place. (See questions 22 and 23).

### *7.) How are performance targets within VBP contracts set? Who is responsible for setting them?*

Performance targets in VBP contracts are set by the contracting parties based on their own assessment of the potential for improvement. Plans and providers with high performance, where improvement is limited, are expected to maintain high performance. Plans are responsible for sharing Potentially Avoidable Hospitalization (PAH) and other quality rates included in their VBP arrangements with their providers.

### *8.) Are Pay-for-Performance Agreements Acceptable for Level 1 VBP for MAP, FIDA, and PACE?*

Pay-for-Performance (P4P) agreements, permitted to meet the Level 1 VBP definition for partially capitated MLTC plans, are not sufficient to meet the Level 1 VBP definition for MAP and FIDA plans, and PACE. Only VBP arrangements that meet the total cost of care subpopulation arrangement definition with shared savings opportunities against a target budget will be accepted as Level 1 arrangements. P4P contract templates with individual service providers such as LCHAs or CHHAs will not be used for MAP, FIDA, and PACE.

### *9.) How can MAP and FIDA plans and providers with small numbers of members engage in VBP?*

The VBP arrangement for MAP and FIDA is a total cost of care subpopulation arrangement. In this arrangement, the VBP Contractor is responsible for the total cost and quality of the VBP arrangement. Selection of the VBP level is up to the plan and the provider/VBP Contractor considering a VBP arrangement. Level 1 VBP arrangements are shared savings arrangements with no downside risk. At Level 2, plans and providers/VBP Contractors move forward with the addition of downside risk or shared losses in the arrangement.

VBP Contractors may be IPAs, ACOs, or a single provider taking responsibility for total costs and quality of the arrangement. In these types of arrangements, small volume providers may partner with other providers engaged as VBP Contractors or stay “downstream” and receive payment for services delivered to the VBP Contractor on a traditional fee-for-service model. The overarching total cost of care arrangement is accepted by the VBP Contractor per the terms of the VBP contract; VBP is not required for downstream providers who do not wish to engage in it.

## Quality Measures/Data

### *10.) What process was used to select quality measures for MAP, FIDA, and PACE VBP?*

DOH has vetted a list of additional quality measures for VBP for MAP, FIDA, and PACE with various stakeholders including plans and conducted an extensive feasibility review. Measures recommended for VBP for MAP and FIDA were selected to overlap with existing mainstream VBP arrangements including Integrated Primary Care (IPC) and Total Care for the General Population (TCGP) and from the list of measure currently collected using the Healthcare Effectiveness Data

and Information Set (HEDIS). Three PACE measures were selected from the current list of measures under development for PACE by CMS. In addition to these specific measures, the existing list of measures recommended for the 2018 VBP MLTC Quality Measure Sets are also available for use in VBP for MAP, FIDA, and PACE. Additional information on the quality measures recommended for VBP for MAP, FIDA, and PACE, including the measure lists, can be found in the VBP Resource Library in the *VBP Quality Measures* folder.

## *11.) Is the MAP or FIDA required to include all of the Category 1 quality measures in its VBP program with providers, or do plans have the option to select those measures that they deem most impactful to their members?*

MAP and FIDA plans are required to use at least one of the measures recommended by the State as a P4P measure in their VBP Contracts. The other Category 1 or 2 measures may be selected for use depending on the preference of the contracting parties.

## *12.) How were measures specific to MAP and FIDA selected and how will these be used?*

MAP and FIDA measures were selected from HEDIS measures currently in use by the CMS for MAP and FIDA, and from the measure sets currently recommended for use by NYS in mainstream VBP arrangements. Three measures relating to behavioral health – National Quality Forum (NQF) 0105, 0576, and 0004 – are in use for FIDA only. Although these measures are part of HEDIS, they will be newly collected for MAP plans. All measures will be required to be reported to NYS due to limited NYS access to Medicare data. These new measures are recommended as Pay-for-Reporting (P4R) measures until additional experience is gained.

For measures that are for P4P for VBP for MAP and FIDA including the PAH measure, DOH will calculate measure results for plan/Provider-VBP Contractor combinations submitted to the Office of Quality and Patient Safety (OQPS).

## *13.) How were measures specific to PACE selected and how will they be used?*

PACE measures were selected from the three “streams” of measures under consideration by CMS for PACE programs. CMS has issued detailed specifications for these measures and is nearing the end of a contract with Econometrica to complete measure development. Reporting will be newly required by NYS for the purposes of VBP and measures are recommended as P4R until additional experience is gained. These measures will be used in the NYS VBP performance calculation for PACE and may also be used by PACE in VBP contracts with VBP providers/VBP Contractors if appropriate.

The P4R measures should be reported for the PACE Organization itself.

### *14.) In what circumstances would a PACE use the quality measures recommended for VBP with an individual contract provider?*

PACE measures recommended for use in VBP will be used by the State to assess PACE performance. In some circumstances, it may be advantageous for PACE to enter VBP contracts with individual independent contractors within it network. For example, if the establishment or review of advance directives is dependent on the placement of a member in a nursing home, it would be appropriate to connect the "Percentage of Participants with an Annual Review of Their Advance Directive or Surrogate Decision-Maker, Percentage of Participants Not in Nursing Homes AND The PACE Participant Emergency Department Utilization Without Hospitalization" measures to a VBP contract with an individual SNF. In other cases, when the PACE provides the direct service, it will not be appropriate to do a VBP contract with an individual provider. For example, if the PACE has its own LHCSA, the "Percent of Participants Not in Nursing Homes" measure may not be appropriate for anything other than measuring the performance of the PACE itself.

### *15.) Can MAP, FIDA, and PACE select other measures from the MAP, FIDA, and PACE VBP measure sets for VBP contracts? If yes, how will these be calculated?*

Yes. Category 1 VBP measures recommended for P4P may be selected by MAP, FIDA, and PACE plans and their Providers/VBP Contractors from the MAP, FIDA, and PACE VBP measure sets. Results for these measures will be calculated by the State for Plan/Provider-VBP Contractor combinations submitted to the State in the plan-submitted attribution file. The Nursing Home PAH measure will be calculated annually at a facility level. All Category 2 VBP measures for MAP, FIDA, and PACE may be used at the discretion of the contractual parties.

### *16.) Who can we contact for specific data-related questions?*

Please direct data-related questions to nysqarr@health.ny.gov.

## Advancing in VBP (Levels 2 & 3)

### *17.) Are MAP and FIDA Plans and PACE Organizations required to implement social determinants of health (SDH) interventions?*

MAP and FIDA Plans and PACE Organizations are required to follow the SDH intervention requirements for Level 2 and 3 VBP arrangements. Level 2 and 3 contracts are required to include at least one Tier 1 CBO to implement a SDH intervention. Plans should consult the VBP Roadmap for additional information on VBP Levels and the menu of SDH implementations with Tier 1 CBOs. Additional information on SDH interventions and their contractual requirements can be found at the VBP Resource Library in the *Social Determinants of Health and Community Based Organizations (CBOs)* folder.

# Finance

## *18.) Are there dedicated stimulus funds to support VBP implementation for MAP, FIDA, and PACE? If so, how will these funds be distributed and are they subject to recoupment as they are for partially capitated MLTC plans?*

MAP, PACE, FIDA will have $1 million in stimulus funds available to them. The $1 million in stimulus will be distributed based on the number of attributed members with the potential to be recouped.

## *19.) Are MAP, FIDA, and PACE required to pass the stimulus funds along to providers?*

There is an expectation that the stimulus to plans will be used to also stimulate providers, but the allocation of stimulus funds to providers is to be determined by the plans.

## *20.) Partially capitated MLTC plans are eligible for $50 million in VBP performance funds to help them finance performance bonuses for providers. Are MAP, FIDA, and PACE also eligible for these funds? If not, what are the financial incentives for VBP implementation beyond the stimulus?*

The $50 million in VBP performance funds is only for partially capitated MLTC plans for the payment of performance bonuses to providers. It should also be noted that providers/VBP Contractors party to VBP agreements have the advantage of being able to gain from shared savings opportunities under a total cost of care arrangement if they perform well against a target budget. This provides a financial incentive to participate in VBP. “Bonus” payments as such are not necessary for the success of the model.

## *21.) Are MAP and FIDA Plans and PACE subject to penalties for not moving into VBP arrangements?*

Yes. The VBP Roadmap constitutes New York State’s agreement with CMS. Per the terms of the Roadmap the State agreed to certain penalties for failure to meet its VBP targets. Consistent with VBP Roadmap requirements, penalties applicable to mainstream MCOs will also apply to MAP and FIDA plans and PACE Organizations beginning in January 2018. The measurement will be based on responses to the VBP Survey in the Medicaid Managed Care Operating Reports (MMCORs).

## *22.) How would the calculations work for penalties for MAP, FIDA, and PACE?*

VBP targets for the percentage of managed care expenditures required to be in VBP established in the VBP Roadmap apply to MAP, FIDA, and PACE. These plan types are considered fully capitated managed care plans.

As a result of the fiscal year 2018-19 NYS budget, VBP penalties were increased. The changes apply to MLTC including MAP, FIDA, and PACE, as well as mainstream managed care plans. The following updates reflect changes in VBP penalties as of April 2018:

The Level 1 target in the VBP Roadmap for 2018 is 10%. If the target is not reached by April 1, 2018, a minimum penalty of 2% of the marginal difference between 10% and the reported percentage in Level 1 will be assessed. The 2019 Level 1 target is 50% and the Level 2 target is 15%. Penalties for failing to meet Level 1 targets remain a minimum of 2% of the marginal difference between the expenditure target and the actual. The penalty for failing to meet the Level 2 target is also a minimum of 2% of the marginal difference between the Level 2 target and the actual. Only the larger penalty will apply if both are incurred. The 2020 Level 1 target is 80% and the Level 2 target is 35%. Penalties for failing to meet Level 1 targets remain a minimum of 2% of the marginal difference between the expenditure target and the actual. The penalty for failing to meet the Level 2 target is also a minimum of 2% of the marginal difference between the Level 2 target and the actual. In 2020, both penalties will be applied if both are incurred.

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