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

Partially Capitated Plans

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.

MLTC VBP General

1.) Where can additional MLTC VBP information be found?

a. The VBP Roadmap includes information relevant to MLTC plans and is the agreement between DOH and CMS as to how we will implement VBP for DSRIP funding. Everyone is encouraged to read the Roadmap.

b. The VBP Resource Library has a section for VBP Managed Long Term Care with additional resources.

2.) How do Level 1 and 2 VBP arrangements compare between partial capitated plans and Mainstream Managed Care and fully integrated products (MAP, PACE FIDA)?

	VBP Level 0	VBP Level 1	VBP Level 2
MLTC Partial Plans	Arrangements that go beyond strict FFS but do not meet the requirements of VBP Level 1. *Example: An arrangement including a quality performance bonus that does not include the Potentially Avoidable Hospitalization (PAH) measure.*	An arrangement that includes a performance bonus agreement between an MLTC Partial plan and a provider that is based on meeting performance targets for a set of specific quality measures agreed to in a VBP contract between an MLTC Partial Plan and provider. Such agreement must include the Potentially Avoidable Hospitalization (PAH) measure.	A pay-for-performance agreement between MLTC Partial plans and providers where incentive payments are based on meeting performance targets for quality measures agreed to in a VBP contract with the addition of a "downside" or quality withhold. To meet the Level 2 definition, plans and providers should establish a minimum downside of 1% of total annual expenditures in the contract between the plan and the provider.
Mainstream Managed Care and Fully Integrated Plans (FIDA, MAP and PACE)	Arrangements that go beyond strict FFS but do not meet the requirements of VBP Level 1. *Example: A shared savings arrangement that doesn't make shared saving contingent upon quality outcomes.*	These arrangements continue the existing FFS payment methodology from MCO to providers, but allows the VBP contractor to receive a percentage of the shared savings based on a 'target budget' set for the VBP arrangement.	These arrangements allow the VBP contractor to receive a higher percentage of shared savings than in Level 1 because the VBP contractor is also required to share a percentage of losses that result from spending more than the 'target budget'.

3.) What is the Potentially Avoidable Hospitalization (PAH) measure?

PAH is a measure used in the Managed Long-Term Care Quality Incentive. Value Based Payment will continue to use the PAH measure as a key indicator of quality. The New York State Department of Health (DOH) will calculate the PAH measure on a provider basis per each plan. The measure captures inpatient hospitalizations that might have been avoided if proper outpatient care was received in a timely manner. Six conditions are covered by the PAH measure: 1) anemia; 2) congestive heart failure; 3) electrolyte imbalance; 4) respiratory infection; 5) sepsis; and 6) urinary tract infection.

4.) Why are Licensed Home Care Service Agencies (LHCSAs), Certified Home Health Agencies (CHHAS), and Skilled Nursing Facilities (SNFs) designated as the primary VBP contractors for measurement year (MY) 2018? Are other entities allowed to engage in VBP contracts?

LHCSAs, CHHAs, and SNFs have been identified initially as primary VBP contractors for MLTC for MY 2018 VBP because they are typically responsible for a large proportion of the cost of care for MLTC members, and play a significant role in improving the overall quality of care and avoiding hospitalization. However, other entities may also engage in VBP either through partnership in networks of providers or directly in contracts with MLTC plans. A key factor to consider is whether the entity in question can influence the hospitalization of a member and more importantly, the overall health and quality of life of a member. The PAH measure is required in Level 1 and Level 2 VBP for partially capitated MLTC plans.

In light of the 2018-2019 budget actions that limited the SNF benefit in MLTC to 3 months, guidance will be forthcoming regarding the role of SNF in MLTC VBP arrangements for MY2019.

5.) You mentioned "lead" contractors. Our provider networks have not been formed. Are we supposed to be coming together to form networks?

The concept of "lead" agencies is introduced to make it clear that not all providers will be interested in or able to contract for VBP by themselves. Some may be too small to want to take on risk as VBP moves forward. Generally speaking, providers that come together to form robust networks that can address the needs of the member or population being served, will perform better in VBP arrangements.

6.) Is Level 1 a quality upside bonus? We haven't been hearing too much from Trade associations and questions remain about which goals are most important in the transition to VBP.

The VBP Roadmap is clear in establishing both the State's overarching goals that identify the total amount of MCO expenditure (Mainstream Managed Care and partial capitation) that must be transitioned to VBP, per the terms and conditions of the DSRIP waiver. The VBP Roadmap is also clear on the percent of MCO expenditure (Mainstream Managed Care and partial capitation) that must be transitioned to VBP for Levels 1 and 2, in order for MCOs (including partial capitated plans) to avoid penalties.

7.) Does Level 2 for MLTC partial plans require downside risk for VBP Contractors?

Yes, providers must adopt risk for a minimum of 1% of their total expenditures with the MLTC plan. Level 2 is a pay-for-performance agreement between MLTC Partial plans and providers where incentive payments are based on meeting performance targets for quality measures agreed to in a VBP contract with the addition of a "downside" or quality withhold.
It is important to recognize that not all providers must move to Level 2 arrangements. However, providers that do enter into Level 2 arrangements may realize increased portion of shared savings, depending on their negotiated arrangement with the plans.

8.) What does attribution mean in this context of Level 1 and 2 MLTC VBP?

Attribution in a Level 1 and 2 MLTC VBP context is simply a mechanism that established the covered or "attributed" population of members, that are included in the VBP arrangements. Providers are responsible for the total cost of care for that (attributed) population. This is likely to be the LHCSA, CHHA, or SNF for whom the PAH measure is applicable. VBP contracts may be pursued with other types of providers. Those contracts should specify the method for attributing the members covered by the arrangement to the particular VBP contractor that is party to the agreement.

9.) We have fully capitated MLTC product lines. Will there be additional guidance on VBP implementation for those product lines/providers soon?

Medicaid Advantage Plans (MAP), PACE and Fully Integrated Duals Advantage (FIDA) plans follow the same VBP model as Mainstream Managed Care per the VBP Roadmap. These are total cost of care population based arrangements which include primary, acute, and long-term services. PACE plans are very close to full compliance with Mainstream Managed Care since the PACE plans received a capitated payment from the State. In order for PACE plans to count their expenditure as VBP, they too must adhere to the

requirements of the Roadmap. In most cases, this requires PACE plans to adopts Social Determinants of Health interventions and include Tier 1 CBOs in their arrangement (to be deemed Level 3). Measure sets specific to MAP, FIDA, and PACE are available on the DOH website as are guidance documents.

10.) Are LHCSAs going to be penalized for not entering into a VBP arrangement?

All plans are subject to penalties as of 4/1/2018 as dictated in the Roadmap, if they do not transition a certain amount of MCO expenditure to VBP. These penalties will be assessed at the plan level. However, the successful transition of expenditure to VBP will take collaboration from both parties, plans and providers. Therefore, plans and providers should negotiate these aspects of their contracts and should consider how VBP stimulus funds are shared for those contracts that move to VBP, and how penalties are also shared.

11.) Do LHCSAs with fewer than 30 attributed members have to partner with other LHCSAs?

DOH cannot provide the PAH rate for providers/facilities with fewer than thirty (30) attributed members. We encourage identifying lead providers and/or collaboration amongst smaller LHCSAs.

12.) Are VBP requirements just for LHCSAs or CDPAS as well?

The Department encourages plans to involve whatever provider they prefer in their arrangements. However, due to the nature of MLTC, the Department is focusing on home care agencies (LHCSA and CHHA), skilled nursing facilities, and medical/dental IPAs, if appropriate. DOH encourages including contracts with entities best positioned to influence factors of the PAH measure.

Contracting Guidance

13.) Do agencies have to use the template DOH has posted? If we choose to modify a contract amendment template will you accept the amendment?

Agencies can enter into different types of arrangements, and are not required to use the templates. The templates have been made available as an optional tool for you to get started. They should be viewed as examples and may be modified to fit the requirements of the contracting parties.

VBP contracts must include the following elements: the specific VBP contractor/s and score of services to be covered in the agreement; the performance measures to be used including the PAH; a methodology and timeline for awarding performance bonuses; and the member population (number of members) to be attributed under the agreement and the method of attribution (e.g., LHCSA, CHHA, or SNFs for MY 2018). Level 2 arrangements must identify how risk (and the amount) is shared. Overall, contracts submitted with intent to "qualify" as VBP, must meet the requirements as outlined in the VBP Roadmap.

14.) 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.

15.) Can the PAH measure be calculated for Nursing Homes with fewer than 30 residents?

Nursing home PAH rates will be calculated at the Nursing Home facility level, not specific to just plan members in that facility. Nursing Homes with fewer than thirty (30) residents can aggregate with other Nursing Homes for the purpose of calculating the PAH rate.

Quality Measures/Data

16.) How were measures selected for use in VBP contracts?

The MLTC Clinical Advisory Group (CAG) recommends certain quality measures for use in VBP and submits those measure sets to the State for final approval. Recommended measures are categorized as Category 1 or 2 depending on feasibility constraints; measures designated Category 2 typically have some feasibility challenges to be addressed before widespread use is recommended. Measures are also classified as pay-for-performance or pay-for-reporting for the purposes of VBP contracting. Once the VBP measure set is finalized and becomes the recommended measure set for a given measurement year, MLTC plans and VBP contractors can employ measures contained in the measure set in VBP contracts. For MLTC currently, the PAH measure is a required pay-for-performance measure in VBP contracts. Other Category 1 and 2 measures can be selected and used at the discretion of the contracting parties. CAG recommendations for 2017 can be found here.

17.) Is the MLTC plan 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?

Plans may use whatever Category 1 or Category 2 measures they prefer in contracting with their providers for VBP. However, there is a minimum requirement for the inclusion of the Category 1 Potentially Avoidable Hospitalizations measure for Level 1. For Level 2, the PAH measure continues to be required in addition to at least one additional Category 1 VBP measure.

18.) When do the attributed enrollees get reported?

DOH aggregate provider performance across all submitted attribution files and that information is included when we release PAH results to the plans.

19.) Are there attribution thresholds to calculate PAH?

The Department of Health has a minimum threshold of thirty (30) members to calculate the PAH measure. Smaller LHCSAs or CHHAs can pool together to achieve increased volume.

20.) Will DOH be providing PAH data for the aggregated small providers per category (LCHSA, CHHA and for MY 2018 SNF)?

Yes.

21.) Who can we contact for specific data-related questions?

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

22.) Is DOH prepared to share provider PAH performance consolidated across multiple plans?

Plans should report to DOH their attributed enrollees on August 1, 2018. For more information please see the “2018 VBP Technical Specifications Manual”, page 14. The Direct link to the VBP Technical Specifications manual can be found here.

23.) Why must a provider have 30 or more attributed enrollees to participate in an individual MLTC Level 1 VBP Arrangement with a plan?

The Department has determined that a minimum of thirty (30) attributed enrollees are required for the measurement to be statistically significant.

24.) Can MLTCs and LHCSAs with fewer than 30 attributed enrollees use a different methodology from the "Aggregated Provider Program" example provided in the posted templates to satisfy Level 1 VBP?

Level 1 VBP arrangements require use of the PAH measurement. The State will only calculate the PAH measure when there are at least thirty (30) attributed enrollees. Therefore, VBP contracts for LHCSAs with fewer than thirty (30) attributed enrollees may need to include an arrangement that aggregates providers; the Department will review other arrangements and possibilities that satisfies the VBP Level 1 requirements.

25.) Will the MLTC attribution methodology be based upon plan enrollees that have more months of continuous enrollment?

Attribution methodology will be based on enrollees serviced by a provider for four (4) consecutive months or more.

26.) How is an enrollee attributed if a LHCSA provides services for 2 months and then the enrollee transfers to another LHCSA for 2 months?

This person would not be included in the attributed enrollee group as only individuals with four (4) continuous months of service with one provider are included in the attribution file.

27.) If a member was serviced by both a LHCSA and CHHA in each year, can they be attributed to both providers?

Yes. Members can be attributed to multiple providers in each year, if they received service for at least four (4) months under each provider. Both should be listed in the attribution file.

28.) Since PAH is measured over a 6-month period, how are plans expected to normalize PAH rates for providers that do not provide care on a long-term basis? For example, nursing home care that is skilled or sub-acute, LHCSA agencies that only service members for a period of time?

The PAH measures for CHHAs, LHCSAs and for MY 2018 Nursing Homes are for members enrolled for four (4) consecutive months with the provider. These measures are not for episodic or short stay members.

29.) With respect to the attribution file, what happens if a member changes providers multiple times in a given year?

As long as a provider provided service to a member for at least four (4) continuous months in the past year, the member will be attributed to that provider. Members can be attributed to multiple providers.

30.) I have heard from LHCSAs that MLTCs are stating that they will report the data but that there really won't be any bonus/incentive payment made if the LHCSA reaches the performance target. Is there any recourse on this?

The required VBP arrangements must include an upside bonus arrangement. The specifics are to be agreed upon between the plan and provider.

31.) Is there any difference in the member attribution between a nursing home and a LHCSA?

In the specifications for attribution, plans provided attribution files for CHHA, LHCSA & SNFs, which includes individuals who have been serviced for four consecutive months by that agency. OQPS will include all residents in a SNF regardless of plan membership to calculate PAH.

32.) Can you please confirm that the PAH for VBP is not risk adjusted as it is with the QI bonus?

That is correct, we will provide the unadjusted PAH so that you can compare an entity to itself over time. You cannot use the unadjusted PAH to compare entities to each other because they have not been case-mix adjusted.

33.) What progress has been made by the State regarding linkage to Medicare data?

The State recognizes the importance of linking Medicare and Medicaid data for members who are dually eligible for both programs. Efforts are underway to integrate Medicare claims data in order to support VBP.

34.) Why is PAH designated as the temporary proxy for Medicare costs?

The VBP Roadmap identifies the MLTC VBP Arrangement as a total cost of care arrangement. The goal is full integration of care across the spectrum of primary, acute, and long-term care. With much of Medicare remaining fee-for-service at this juncture, the costs of acute and primary care are not included in the premiums paid to the large majority of MLTC plans. Until the costs of Medicare are able to be included, the Roadmap allows for the use of the potentially avoidable hospitalization (PAH) measure as a temporary proxy for Medicare in pay-for-performance VBP agreements.

35.) When will the methodology for tracking progress on quality measures be disseminated by OQPS?

OQPS issued the quality measure calculation for the baseline year in late 2017. The MLTC VBP Quality Measure Data Reporting Timeline which includes PAH rate release dates for Measurement Year (MY) 2018 to 2020 was released in January 2018. Direct link to the timeline can be found here.

36.) What is the rationale for calculating the NCQI PAH measure at the facility level rather than the member level?

The Nursing Home Quality Initiative (NHQI), as well as CMS nursing quality metrics, compute measures to the facility level. The expectation is the care within a facility will not vary by payer and this will allow for a larger sample and a more stable metric.

37.) How does a MLTC plan gain access to SPARCS data?

Access to the SPARCS is not necessary, as DOH will calculate the PAH and all other quality measures for plans, based on their plan-provider attribution file. Information on accessing SPARCS can be found here.

38.) How current is SPARCS data?

SPARCS data has an approximate nine-month lag period.

39.) How are plans to know if a provider has met their targets?

The Department intends to provide the measure data at the provider level for plans to be able to monitor their providers. Once the measures have been delivered, it is incumbent on the plans to develop their methodology for assessing their providers.

40.) For measures that are non-UAS sourced, such as those that are collected by IPRO, will the plan be permitted to perform its own surveys which include the same Category measures on its own members?

Plans are encouraged to utilize whatever instrument, survey or otherwise, that they see fit to hold providers to their measure goals. However, the PAH measure is required for Level 1 contracts and the addition of a second Category 1 measures from the CAG-recommended VBP measure set is required for Level 2 contracts.

41.) Is MLTC data available only annually?

Plans will submit an attribution file in August 2018 to cover 15 months of plan/provider enrollment (April 2017 – June 2018).
Preliminary Community PAH Rates for January – June 2018 data will be released in March 2019.
Final rates that include data for the January – December 2018 PAH measurement period (for both Community and Nursing Home) and the July 2017 – June 2018 VBP QI will be released in October 2019.

42.) How can providers/plans collect data for CDPAS?

CDPAS may be excluded from partial capitation VBP arrangements (Level 1 and 2). As previously stated, CDPAS organizations are *not* prohibited from engaging in VBP.

43.) Will DOH be monitoring mortality?

No, mortality is not included in the PAH measure for 2018.

44.) Could the Department risk adjust the UAS-based measures so that provider performance could be compared to a benchmark or to peers?

There are over sixty MLTC plans and 11 quality measure in MLTC VBP, the Department does not have the resources to create over 600 risk-adjusted models. Risk adjusted performance would also limit provider comparison to within that measurement year and could not be used for

assessing performance over time. Using the data we have released, Provider performance can be benchmarked to the statewide average. Also, the expectation is high performing providers will maintain stability in their top performance, the Department recognizes improvement is not always possible for these providers. Plans and providers should keep the need to continue to incentivize high performing providers for stable, high quality service in mind as they design their VBP programs.

45.) Will the State continue to calculate the potentially avoidable hospitalization ("PAH") measure and begin to calculate the additional quality measures designated by the Clinical Advisory Group based upon the attribution files submitted by plans?

Yes, as in Level 1, the State will continue to calculate the PAH measure and will continue to calculate the quality measures recommended for VBP for MLTC plans for Level 2 based on attribution files submitted by plans.

46.) Some plans would like to use alternative quality measures (e.g., a measure of LHCSA communication to the plan regarding observations of changes in member condition). Can plans and providers use non-approved measures as a substitute for the 1 CAG-approved measure? Or in addition to the 1 CAG-approved measure and PAH?

Plans are required to use 1 CAG approved P4P measure and the PAH in Level 1 and 2 arrangements. Additional measures may be used at the discretion of the contracting parties.

Advancing in VBP to Level 2

47.) Are entities prohibited from pursuing Levels 2 and 3 VBP?

No, MLTC plans and providers are free to pursue more advanced VBP arrangements.

Provider Contracting

48.) Although the risk component of the Level 2 arrangement described in the webinar is characterized as a "withhold," will plans and providers be given the flexibility to structure the arrangements in many ways, including as a (i) prospective withhold to be paid or retained based on performance; or (ii) as a retrospective bonus/penalty arrangement; or (iii) a combination of the above?

Plans and providers have the flexibility to determine how they would like to structure the requirement of adopting risk for at least 1% of plan to provider expenditure, in Level 2 arrangements.

49.) Are plans responsible for paying out more VBP performance payments to providers than they receive from the $50 million VBP performance adjustment funds from DOH?

The determination of what to pay out is independent from the VBP performance payments from the State to the Plans. Plans and providers should determine what makes sense for them per the terms of their individual contracts while meeting the 1% minimum upside/downside requirement for Level 2 agreements. The VBP performance payments are not intended to be "pass-through dollars" as they are intended to incentivize plans to provide high quality service. Payment terms and timelines are established by plans and providers per the terms of their individual contracts.

50.) Is the amount "at risk" (minimum of 1%) calculated based on the revenue in the year prior to the contract year, the measurement year, or the payment year?

The 1% of expenditures may be calculated on the year prior to the contract year because that is a year for which there is available data to plan and provider for the purposes of contracting. Another responsible method may be used, as long as it is clearly defined within the contract submitted to DOH.

51.) To support the implementation of VBP arrangements, will DOH provide additional funding? If a plan has high performing providers from a quality perspective, but its spending overall is equivalent to, or exceeds, its capitated rate how will it fund VBP quality payments?

Plans will receive $50 million in VBP performance adjustments starting in 2020-21. Plans will also receive MLTC QI funds for quality results. In general, it is recommended that plans manage all costs, including VBP quality bonuses and downside penalties to providers, so as to not exceed their capitated rates.

52.) Is there a date requirement by which time all level 2 contracts need to be submitted and/or become effective, similar to the process for the level 1 contracts?

Plans and providers may execute Level 2 contracts at any time; however, it is likely that many will be reexamining Level 1 contracts to renew or change them in late 2018 with a start date of January 1, 2019. Plans are required to move 5% of total plan expenditures to Level 2 by April 1, 2019 and so should determine how best to proceed with their providers with whom they wish to advance to Level 2 to incorporate downside risk.

53.) Will the attribution and reporting timelines for Level 2 be the same as for Level 1?

The attribution and reporting timelines for Level 2 will be the same as for Level 1. Please refer the Quality Measure Reporting Timeline[1] for MLTC. It is the DOH's intention to adhere to the timeline and release PAH data to plans according. Plans are responsible for sharing performance data with their providers.

54.) Will the timeline for DOH's payment of the $50 million be the same with Level 2 as with Level 1?

Performance payments to the plans for VBP for the 2018 calendar year will be made in 2020-21. Payments will be made regardless of VBP contracting percentages engaged in by Plans. Plans are not tied to receiving these funds in order to make performance payments to providers and may negotiate alternative payment schedules.

The current rate adjustment schedule is in line with mainstream Medicaid plans and reflects the lag in collecting SPARCS data.

[1] The Managed Long Term Care Value Based Payment Quality Measure Data Reporting Timeline can be found in the VBP Resource Library here: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/

55.) Given the recently-enacted limits on the number of LHCSAs with which MLTCs may contract, will providers and plans have the flexibility to negotiate contract provisions that address the question of bonuses/withholds in the event of termination?

Yes, plans and providers have the flexibility to negotiate contract provisions that address the question of bonuses/withholds in the event of termination.

56.) On what basis are delegated care management providers excluded from plan VBP Level 2 contracting thresholds and assume risk? For example, care managers employed by plans, delegated care management providers can and do effectuate member outcomes and quality measures.

MLTC Partially Capitated plans will focus VBP contracting on LCHSA's, CHHA's and SNF's. Therefore, contracts involving pay for performance bonuses with delegated care management providers, while not explicitly prohibited, are not required for adequate progress in VBP contracting.

57.) Do recoupment dollars from provider withholds remain with the plan or are they returned to the Department?

Funding associated with downside performance penalties for VBP providers will not be directly recouped by the state. Such funds may be reinvested in quality bonuses for other providers.

58.) Are there shared savings and losses in a Level 2 VBP arrangement for partially capitated MLTC plans and their providers?

In Level 2 VBP arrangements for partially capitated plans and their providers, there is no requirement to set a target budget. Bonuses and withholds are paid to providers solely on the basis of quality performance and whether contractually established quality benchmarks were met. Shared savings and losses are typically associated with target budget setting for other types of VBP arrangements.

59.) Are plans able to submit a template for their Level 2 contracts for approval or are plans required to submit each Level 2 contract individually for approval?

Plans are required to submit each Level 2 contract to the State.

60.) Will there be a cap on the maximum amount of performance bonuses or withholds that a provider can negotiate in its VBP contracts with plans?

There is no maximum cap for performance bonuses or penalties outside of the standard requirements for provider risk sharing that apply in all downside payment arrangements regardless of VBP. There is a minimum of 1% of total provider expenditures with a plan for downside penalties in order to be considered an "on-menu" MLTC Partial VBP Level 2 arrangement.

Exclusions

61.) How will the 5% threshold for MLTC payments made via VBP arrangements be calculated (i.e., what will be included in the denominator?)? What time period will be used for measuring the MLTC payments made via VBP arrangements?

The required 5% threshold for MLTC VBP Level 2 contracts refers to the period 4/1/2018 to 3/31/2019. This amount increases for the following state fiscal year to a target of 15%. The denominator for both calculations is defined by the amount of Medicaid spending paid to LCHSAs, CHHAs, and SNFs by the Health Plan. Additional guidance is forthcoming that explicitly pertains to SNFs in light of the recently passed budget initiative related to permanently placed Nursing Home members.

62.) If Fiscal Intermediaries are excluded from MLTC VBP Level 2 agreements, are CDPAS expenditures also be excluded from total expenditure calculations (i.e., denominator) for MLTC VBP Level 2 arrangements?

MLTC Partially Capitated plans will focus VBP contracting on LCHSA's, CHHA's, and SNF's. Therefore, contracts involving pay for performance bonuses with delegated care management provides, while not explicitly prohibited, are not required for adequate progress in VBP contracting.

63.) If plans are to apply withholds to provider's claims payments, how should this be reflected on cost reports?

Additional guidance on cost reports is forthcoming.

Nursing Homes

64.) Given the limited nursing home benefit in MLTC, will MLTC payments to nursing homes be included in the denominator for purposes of calculating the 5% threshold for Level 2 VBP arrangements?

For 2018-2019 for the VBP Tracking Report SNFs will continue to be included. Measurement year 2018 contracts need not be re-opened. For measurement year 2019 additional guidance is forthcoming.

65.) Will the same parameters for Level 2 VBP arrangements apply to nursing homes as applied to home care agencies (i.e., pay-for-performance based on PAH and one CAG approved measure)?

Additional guidance on the SNFs and VBP for partial cap plans and providers is forthcoming.

Social Determinants of Health (SDH) and Community Based Organizations (CBOs)

66.) The SDH and CBO requirements of the Roadmap were designed with mainstream plans in mind. They assume that (i) plans are not already addressing social determinants of health through their care management activities and covered benefits; and (ii) significant savings will be generated through avoidance of hospital use that can then be reinvested in contracts with CBOs and SDH interventions. However, partially-capitated MLTC plans will not capture savings generated through avoidance of hospital use, and they are already engaged in many of the interventions listed in the Department's menu of options through benefits such as high-touch care management, home-delivered meals, and social day services. Their members generally don't need many of the other interventions listed in the menu, such as job training, child care, and home-based perinatal care. Will the Department re-think its approach to SDH for MLTC plans?

There are two separate Roadmap requirements in the VBP roadmap. The first is that all level 2 and 3 VBP contractors must have a minimum of at least one SDH intervention. If a MLTC plan is already engaged in SDH intervention activities, this requirement would be fulfilled once the Social Determinants of Health Template (SDHT) is submitted with the intervention(s) filled out.

The second requirement is for VBP contractors to contract with at least one tier 1 community based organization. This can be fulfilled through SDH activities or any other contracted activities that the MLTC sees fit. It may make sense to pair these requirements but it's not necessary and it is up to the discretion of the VBP Contractor. Also, if a VBP Contractor has a contract with a Tier 2 or 3 CBO and that CBO is sub-contracted with a Tier 1 CBO, that relationship would also fulfill the VBP CBO requirement.

Social determinants of health remain an important element of the NYS VBP model. While some interventions may not apply to the MLTC population, other interventions do and should be explored and implemented to improve overall quality of life.

67.) Will contracts and funding methodology be changed to reflect MLTC benefit expansion which states that plans cannot contract with a Tier 1 CBO that delivers an SDH intervention included in the benefit package?

A Tier 1 CBO that delivers a SDH included in the MLTC benefit package would fulfill the CBO requirement but not the SDH requirement. For MLTC programs, home delivered meals cannot be used to fulfill the SDH requirement because it can be billed to Medicaid however, if the CBO that is contracted to provide the service is a tier 1, they can be used to fulfill the CBO requirement. A different activity that is not billed to Medicaid can be used for the SDH requirement.

68.) Considering the current requirement that all providers billing MLTC plans must enroll in the State's Medicaid program and have an MMIS number, will CBOs be required to enroll or will they be excluded from this requirement?

A Tier 1 CBO is defined as non-profit, non-Medicaid billing entity. They are not required to have an MMIS number to be able to participate in a VBP arrangement.

69.) Is the requirement that plans or VBP contractors contract with a community-based organization (CBO) to determine the SDH intervention the same for Mainstream plans? Will the intervention be submitted with the contract?

Yes, please see page 41-43 of the VBP roadmap.

Finance

70.) How was the $10 million stimulus payment to partially capitated plans allocated?

It was allocated on a PMPM basis to MLTC partially capitated plans.

DOH will be recouping a portion of the stimulus funding based on the total dollar expenditure of a plan's LHCSA, CHHA and SNF contracted providers that did not have executed contracts or amendments with VBP arrangements by March 31, 2017. VBP dollars were reported to plans in the VBP Tracking Report, this data will be the basis for calculating any recoupment of stimulus funding.

71.) Are MLTCs required to use the stimulus funds for incentive payments?

No, plans can use the stimulus funding however they see fit. It is intended for the purpose of moving all of a plan's contracted LHCSA, CHHA and SNF providers into VBP arrangements by December 31, 2017. Certainly, a plan cannot transition its expenditure to VBP without the partnership of a provider. Both parties should work collaboratively to determine how the stimulus funds can be applied to establish a VBP arrangement that rewards improved quality and efficiency.

72.) Will VBP Quality Performance Adjustment Funds be available?

There is a $50 million VBP Quality Performance pool available to MLTC Partially Capitated plans for measurement periods beginning with CY 2018. The proportion of funding available to plans will be based on plan performance on the PAH measure.

73.) What is the revised timeline for MLTC?

The MLTC timeline for VBP is reflected in the VBP roadmap. Any updates to that schedule will be shared when needed.

74.) How are single case agreements handled regarding SNF/LHCSA/CHHA in regard to reporting in medical expense?

You should report a single case agreement for SNF/LHCSA/CHHA in the same manner that you report other medical expenses for those services. A single case agreement is just an agreement between a provider and a plan on a rate for a specific service/episode of care in the absence of a contracted rate.

75.) When you say that MLTC reported expenditures should not include services other than LHCSA, SNF and CHHA are you referring to responses on lines 21-23, 7 only or on the entire report? Should lines 9, 10 in columns 247 and 248 only include these disciplines too?

MLTC Partially Capitated arrangements includes only expenditure between plans and LHCSAs, CHHAs, and SNFs. MLTC Partially Capitated plans should only report on expenditures to LHCSAs, CHHAs, and SNFs, and input that expenditure into the appropriate level of VBP. Therefore, any fee-for-service dollars reported in the VBPTR should also only pertain to these provider types, if that expenditure is captured in a FFS only arrangement, and not a VBP Level 1 or 2 arrangement. Other provider types are not required to participate in MLTC Partially Capitated VBP arrangements and should not be included in the report as this would affect the VBP participation percentage and possible penalties or stimulus recoupment.