VBP Partially Capitated Plans FAQs

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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.) What is an MLTC Level 1 VBP Arrangement, and how does it differ from mainstream?

For partially capitated MLTC plans (not covering Medicare benefits), the Roadmap allows for a more introductory form of VBP. An acceptable Level 1 for MLTC is pay-for-performance VBP where plans and providers can agree to quality measures and performance payments for meeting them. The Potentially Avoidable Hospitalization (PAH) measure is required to be included in the contract. In contrast, Level 1 VBP for mainstream managed care is shared savings with no risk and requires target budget setting.

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

PAH is a measure used in the Managed Long Term Care Quality Incentive, calculated by the New York State Department of Health (DOH) on a provider basis by plan, or facility basis by plan for nursing homes. The measure is an inpatient hospitalization 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? Are other entities allowed to engage in VBP contracts?

LHCSAs, CHHAs, and SNFs have been identified initially as primary VBP contractors for MLTC 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. The PAH measure is required in Level 1 VBP for partially capitated MLTC plans.

5.) You mentioned "lead" contractors. Our provider networks have not yet 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 themselves. Some may be too small to want to take on risk as VBP moves forward in the MLTC sector or may not have a significant enough role in care to prevent the hospitalization of a member and improvement on the PAH measure.

6.) Is Level 1 a quality upside bonus? Trade associations haven't been promoting VBP, and actually said we don't need to worry about the 12/31/17 deadline.
The 12/31/17 deadline stands. Providers need to improve or maintain benchmarks to receive bonuses. MLTC VBP Level 1 requires use of the PAH measure with Fee for Service (FFS) and an upside performance bonus.

7.) What does attribution mean in this context of Level I MLTC VBP?
Attribution in a Level 1 MLTC VBP context is simply the main provider taking responsibility for the members covered under the arrangement. 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, however, and those contracts should specify the method for attributing the members covered by the agreement to the particular VBP contractor that is party to the agreement. This could be as simple as indicating that a list covering a specific number of members has been agreed to between the plan and the VBP contractor.

8.) We have fully capitated MLTC product lines. Will there be additional guidance on VBP implementation for those product lines/providers soon?
All fully integrated MLTC plans will be required to be in VBP arrangements by 4/1/2018. Guidance will be forthcoming.

9.) If LHCSAs haven't heard from MLTC plans, who should reach out? In other words, 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. Additional guidance will be forthcoming.

10.) Is there a minimum number of members that a provider must have in order for there to be a required VBP arrangement? Are plans allowed to limit participation in VBP to only those providers who meet minimum thresholds?

a. The Department has a target number of thirty (30) members for statistical significance.
b. The Department does not wish to see providers who are willing or desire to participate in VBP to be excluded because of volume-related issues. We encourage alternative contracting mechanisms to make contracting with those providers a possibility.

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 in 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. At this time, the Department is not including Consumer Directed Personal Assistant Service (CDPAS) in its VBP MLTC goal.

Contracting Guidance

13.) Are plans required to submit VBP contract amendments to DOH for review?
Yes, plans will be required to submit VBP contract amendments to DOH in accordance with the Provider Contracting Guidelines. The contracts should be sent to MLTCcontract@health.ny.gov.

The State will need to approve a contract template or contract amendment template for CHHAs/LHCSAs and a template for SNFs. Contracts that vary from the template will need to be approved separately.

14.) 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 particular 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 SNF).

15.) Due to the short timeframe, will providers and plans be able to execute contracts after January 1, 2018 if they are retroactively effective January 1, 2018?
All contract templates and amendment templates must be submitted to DOH by 12/31/2017. To meet VBP goals, plans must have contracts signed and enforced by 1/1/18.

16.) 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.

17.) What years should be covered in our contracts? Is it okay if we look ahead to put agreements in place for 2018 as we are almost at the end of 2017?
Yes, in order to complete a VBP agreement, MLTC plans and providers will need to agree on a baseline year and a target year for performance and payment. Contracts can designate 2018 as the measurement year.

18.) 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

19.) How were measures selected for use in VBP contracts?
Measures recommended for use in VBP are put forward by the MLTC Clinical Advisory Group (CAG) and reviewed by the State. 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.

20.) Is the MLTC 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.

21.) When do the attributed enrollees get reported?
2016 PAH rates were sent back to plans at the end of October 2017 based on attribution files sent to DOH at the beginning of October 2017. Additional guidance regarding future attribution file requests and PAH calculation is forthcoming.

22.) Are there attribution thresholds to calculate PAH?
Yes and no. Yes, in that OQPS considers only plans serving at least thirty (30) members. No, in that smaller LHCSAs or CHHAs can pool members and determine the lead provider for attribution.

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

24.) Who can we contact for specific data-related questions?
Please direct data-related questions to nysqarr@health.ny.gov.

25.) Is DOH prepared to share provider PAH performance consolidated across multiple plans?
DOH has already provided this data to plans on 11/1/17 and 11/20/17 via email.

26.) 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 in order for the measurement to be statistically significant.

27.) 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 which requires 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.

28.) Will the MLTC attribution methodology be based upon plan enrollees that have 4 or more months of continuous enrollment from April 2017 to June 2018?
Attribution methodology will be based on enrollees serviced by a provider for four (4) consecutive months or more. Additional guidance regarding the attribution process will be forthcoming.

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

30.) 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.

31.) 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 Nursing Homes are for members enrolled for four (4) consecutive months with the provider. These measures are not for episodic or short stay members.

32.) 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.

33.) 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.

34.) 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.

35.) 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.

36.) 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 and other analytic platforms, and this data will be made available as soon as possible.

37.) 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 the 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.

38.) 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 October 2017. Additional information for future PAH rate release dates will be forthcoming.

39.) 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.

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

Plans will likely not have easy access to SPARCS data, so OQPS has decided to send out data semi-annually on a non-risk-adjusted basis at the provider level, since most of care is still Fee for Service (FFS).

41.) How current is SPARCS data?

SPARCS data has an approximate nine-month lag period.

42.) 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.

43.) 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.

44.) Is MLTC data available only annually?
MLTC plans have always received annual data. For VBP, we rely on SPARCS data, which is sent to us annually. DOH has access to interim data; however, that data could change before it is finalized. Additional guidance regarding the attribution process of schedule to share provider PAH rates will be forthcoming.

45.) How can providers/plans collect data for CDPAS?
CDPAS is not included in the 12/31/17 deadline. As previously stated, CDPAS organizations are *not* prohibited from engaging in VBP.

46.) Will DOH be monitoring mortality?
No, mortality is not included in the PAH measure for 2018.

Advancing in VBP (Levels II & III)

47.) Are entities prohibited from pursuing Levels 2 and 3 VBP?
No, MLTC plans and providers are free to pursue VBP arrangements that incorporate shared savings opportunities and shared risk.

48.) Will the State be providing additional guidance on Level 2 and 3 for MLTC?
The final 2017 recommendations of the MLTC CAG are posted in the MLTC folder of the VBP Resource Library. These recommendations include the development of more advanced VBP for MLTC. The State will provide updated guidance as is necessary.

49.) If we're entering VBP MLTC Level 2 & Level 3 contracts will we be required to have to adhere to the Social Determinants of Health requirements?
Yes. Please review Social Determinants of Health (SDH) & Community Based Organizations (CBOs) Informational Webinar.

FINANCE

50.) How will the $10 million stimulus payment to partially capitated plans be allocated?
It will be 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 do not have executed contracts or amendments with VBP arrangements by December 31, 2017.

51.) 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.

52.) Are there any funds to be allocated for 2019 or 2020?
These questions will be addressed in the forthcoming MLTC VBP webinar slated for 12/15/2017.

53.) Are plans going to be paid additional funds for these "bonus" arrangements? Are there guidelines on the levels of financial payments that would be required to meet any required thresholds?

a. The Division of Finance and Rate Setting will be providing more information on the creation of an incentive pool for performance payments to plans.
b. Once guidance is released on the incentive payment component, the Department will defer to that document on threshold payments to providers. However, the prevailing thought on VBP arrangements urges plans to use the incentive payments to their providers as they see fit.

54.) 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.