



Department  
of Health

Medicaid  
Redesign Team

# Value-Based Payments: Frequently Asked Questions

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# Value Based Payments (VBP) Frequently Asked Questions

The following questions have been selected based on their prevalence and pertinence to the overall VBP transformation, including the VBP Pilot Program. The list of questions will be updated on a periodic basis to continue to address questions in a uniform, succinct, and accurate manner. This document may be accessed at the following link: [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/vbp\\_library/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/index.htm).

If you would like to submit additional questions, please send them to [dsrip@health.ny.gov](mailto:dsrip@health.ny.gov) with “VBP FAQ” in the subject line.

The following questions are currently organized into six categories:

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## I. General Pilot / VBP Questions

1. **Q:** What is the role of the PPSs that are not contracting entities? How can they meet DSRIP milestones, if the relationship is directly between the providers and payers?

**A:** The previous PPS DSRIP milestones related to VBP were designed in anticipation of the PPSs becoming contracting entities. The State has recognized that this is not the case for the majority of the PPSs and has re-evaluated these milestones. New milestones and associated guidance on how PPSs can support the overall VBP effort have been drafted and are currently under review.

Examples of how a PPS can support the transition to VBP within their systems are provided below:

- Helping to ensure providers are aware of guidance being continuously rolled out on the NYS DSRIP / VBP website,
- Circulating VBP Bootcamp schedules and notices of State administered webinars,
- Coordinating VBP knowledge sharing sessions among PPS providers,
- Facilitating an understanding of what the PPS needs in order to more fluidly transition to VBP, and,
- Coordinating networking events to connect providers and payers interested in adopting VBP.

2. **Q:** Will pilots count toward Level 1 VBP (or Level 2 if applicable)?

**A:** If any contract – pilot inclusive – meets the criteria for Level 1 or Level 2, then that contract will count towards that payer’s achievement of VBP contract goals established by the State.

3. **Q:** What is the pilot “MCO incentive bonus” that MCOs participating in the pilot receive and when will that be paid out?

**A:** The MCO Incentive is a financial incentive administered to an MCO that agrees to pilot a VBP arrangement with a provider, consistent with the requirements of the VBP pilot program. MCOs will only receive the incentive after they have a VBP agreement or incentive in place with a provider network. Further guidance on the MCO incentive bonus and what will be available per plan and arrangement will be finalized once the final list of pilots is confirmed.

4. **Q:** What is the timeline for launching MLTC pilots? Are the October 31<sup>st</sup> and November 30<sup>th</sup> deadline applicable for MLTCs as well?

**A:** No, MLTCs will not follow the same timeline as the current pilot deadlines outlined for other VBP arrangements. There is no October 31<sup>st</sup> or November 30<sup>th</sup> deadline for MLTC pilots, but interested parties are encouraged to contact DOH and begin discussions as soon as possible.

## II. Data Related Questions

1. **Q:** Will 2015 data (or anything more recent than 2014) be distributed to pilots?

**A:** Access to an analytic environment to support pilots with relevant, up-to-date data is scheduled to be available in early 2017. Prior to that, more recent data may be made available where appropriate and when possible. Pilots are also encouraged to work with their plans to explore ways to access more recent data.

2. **Q:** When will pilot MCOs have access to the MAPP Dashboard?

**A:** Access to an analytic environment to support pilots with relevant, up-to-date data is scheduled to be available in 2017.

## III. Understanding Bundles and the Population

1. **Q:** The Maternity bundle appears to be triggered by the delivery – would the contracting entity be responsible for these delivery costs as part of the bundle?

**A:** The trigger for the bundle was chosen as the delivery to avoid triggering a bundle in the event of a miscarriage, early termination, or other scenario where there may be an incomplete bundle. However, it is important to keep in mind that the trigger of a bundle is not equivalent to the attribution. For maternity bundles, the attribution methodology utilizes a two-tiered approach. Maternity attribution is based first on the provider that administered a majority of the pregnancy care. If there was no pregnancy care, then attribution is determined by the OB providing the delivery care. The two tiered attribution methodology avoids having the provider that is responsible for the delivery be attributed costs for a bundle that he or she may have little control over.

2. **Q:** Is there a white paper or methodology paper regarding how 3M Treo CRG and HCI3 are used to calculate official risk scores?

**A:** The TCGP and Sub-Population-based VBP arrangement risk adjustments use standard 3M logic to assign Clinical Risk Groups (CRGs). An FAQ on this process is available here: [3M Risk Adjustment](#). The risk adjustment for HARP is under discussion and more information will be forthcoming.

For bundle VBP arrangements such as Maternity or IPC, standard PROMETHEUS episode risk adjustment is employed to adjust for episode severity and compute the expected cost values used in episode-based arrangement efficiency. A risk-adjustment methodology white paper describing this logic has been released by HCI3 and can be found here: [HCI3 PROMETHEUS Episode Risk Adjustment](#)

3. **Q:** What is the recommendation on calculating the most current risk scores for the current plan's specific population?

**A:** The State utilizes 3M's CRG risk-adjustment methodology to risk-adjust for populations and HCI3's PROMETHEUS methodology for risk-adjustment of episodes. The risk adjustment for HARP is under discussion and more information will be forthcoming.

4. **Q:** Payers and providers do not currently have the technology to support bundle arrangements (e.g. IPC), will the State be providing data for the baseline period, target budget, shared savings calculations, etc.?

**A:** Yes. The State will provide technical and analytical support during the first year of the VBP Pilot Program to ensure VBP contractors and MCOs have the necessary information to successfully implement bundle arrangements.

#### IV. Target Budget

1. **Q:** When will there be guidelines for the performance adjustments (efficiency and quality) that adjust the target budget by provider performance? As part of the pilot, the Roadmap states that the MCOs will receive these upward adjustment funds from the State (page 47).

**A:** The State has released the target budget setting methodology and reviewed the methodology in the State administered VBP Bootcamps. The target budget setting methodology, which includes calculation of performance adjustments, is outlined in the NYS VBP Roadmap, and may also be found in the VBP Bootcamp Session 2 presentation, which can be accessed here: [VBP Bootcamp Session 2](#)

The State will provide performance adjustments to providers and payers piloting VBP arrangements, when the provider and payer have a VBP agreement or contract in place.

Additionally, please see Section V, Question 1.1 below for more information regarding the timing of quality measure guidance.

2. **Q:** Are there any barriers or implications to MCOs and providers using Percent of Premium as basis for setting the target budget as opposed to the claims-based targets described in the Roadmap?

**A:** No. The baseline is negotiable and can use any agreed upon inputs for calculation. However, the performance adjustments administered by the State to the MCOs, which adopt VBP agreements, will utilize the State's target budget setting methodology as explained in the NYS VBP Roadmap (and the Session 2 presentation of the VBP Bootcamps).

## V. Quality Measures & Shared Savings

1. **Q:** Is there a listing of quality measures identified specifically for the total care for the general population arrangement to choose from?

**A:** The quality measures used for target budget setting and performance measurement are currently being finalized. Quality measures for Maternity and HIV/AIDS have recently been posted to the DSRIP / VBP Website. Additional guidance for the remaining VBP arrangements is forthcoming. Current quality measure guidance may be found at the following link: [Final CAG Reports](#)

2. **Q:** When will there be guidelines on the quality measures used to modify the potential earnings below target budget?

**A:** Refer to the answer to Question 1 above.

3. **Q:** How does the quality impact a potential savings or loss pool? If 50/50 is the starting point for shared savings, how would quality measures affect the 50% for a provider?

**A:** The NYS VBP Roadmap (Section titled “From Shared Savings towards Assuming Risk,”) provides guidelines for the distribution of shared savings or risk based on a provider meeting certain quality measures. A provider meeting greater than 50% of the quality measures in a Level 1 arrangement is eligible to receive 50% of the shared savings. In a Level 1 arrangement, the provider would not share in any risk.

In a Level 2 arrangement, a provider meeting greater than 50% of the quality measures is eligible for 90% of the shared savings. Since a provider is accountable for risk in a Level 2 arrangement, a provider meeting less than 50% of the quality measures is eligible for 10% to 90% of shared savings, subject to a sliding scale in proportion to the percent of quality targets met. As stated previously, the above is guidance provided in the [NYS VBP Roadmap](#); the impact of quality on shared savings/losses is negotiable between contracting parties.

4. **Q:** Does the state have any recommendations on the split for downside risk (50/50, 60/40, etc.) in order to qualify for Level 2? What is the minimum percentage of potential losses to be allocated to a provider?

**A:** Please refer to Question 3 above. Additionally, the VBP Roadmap prescribes minimum requirements for shared losses to constitute a Level 2 arrangement (refer to page 86, Appendix X). The minimum level of shared losses to qualify as a Level 2 arrangement is 20%. A maximum cap of 3% of the target budget can be applied in Year 1 and 5% in Year 2\*.

*\*Note: the language in the VBP Roadmap is being revised to appropriately reflect the above information*

5. **Q:** For the Pilot Program, how can we include quality measures in a contract if they have not been finalized from the CAG reports? How will the provider know which measures will be utilized toward their quality gate?

**A:** Until the quality metrics and the process for applying them is finalized, payers and providers are encouraged to utilize a “placeholder” provision in their contracts. This will enable providers and payers to adopt the quality metrics as prescribed by the State, once they are finalized. Finalization of the measures is occurring now and will mostly align with VBP agreement or contract commencement dates, leaving providers and payers the full performance period to meet quality targets.

## VI. Other Contracting Items

1. **Q:** Does the State have any recommendations on how the MCOs should recoup downside risk (i.e. recoup at end of performance year, recoup against future shared savings, recoup against future contracted rates, or another suggestion?)

**A:** The approach for recovering losses under VBP arrangement is negotiable. Options for consideration might include specific pay-back dates or to recoup via reduced prospective or concurrent payments.

2. **Q:** When will documentation be received that defines “requirements” vs “guidelines” and what is required to qualify for the pilot?

**A:** While all VBP agreements must be consistent with the NYS VBP Roadmap, in order to qualify as a VBP pilot, VBP contractors and MCOs must enter into agreements consistent with the following:

- Meet the volume threshold for each VBP arrangement being contracted;
- Agree on the VBP arrangement being contracted as it is defined in the VBP Roadmap (no off menu arrangements);
- Agree on the level of risk being contracted in Year 1 and 2;
- Utilize the attribution methodology for each VBP arrangement as outlined in the VBP Roadmap; and
- Transition to a Level 2 risk sharing agreement in Year 2

Additional guidance that defines guidelines and standards for VBP in general may be found here: [Subcommittee Recommendation Matrix](#)

3. **Q:** Are the NPIs submitted as part of the Pilot Program party to the Agreement and measured, even if the provider ends up leaving the group during the measurement period? Similarly, will additional NPIs be able to be added during the course of the pilot period and how might this affect the baseline?

**A:** Providers (represented by their NPIs) are only considered party to the Agreement directly or through the contracting entity if defined in the VBP agreement or contract

with the contracting MCO. Once defined, these providers will be included in measurements, up until the time they have formally been excluded from the group (regardless of who initiates their removal/exclusion).

4. **Q:** For the Pilot Program, what is the claims run out period before the final results of the measurement period are given to both MCO and VBP contractor in which the reconciliation will be based?

**A:** The State will be supplying data for the VBP arrangements as outlined in the NYS VBP Roadmap. For the IPC and Maternity VBP arrangement, the claims run-out period is six months. The claims run-out period for all other arrangements is subject to negotiation.

5. **Q:** Does the target budget / baseline need to be defined in the contract as an actual number, or just the methodology to develop the target budget?

**A:** For contracts involving downside risk (VBP Level 2 and Level 3 Contracts) the contract does need to specify the total dollar amount that is will be contracted at risk, and may be an estimate. This requirement can be found within the Contract Statement and Certification Form that needs to be completed and submitted to the State as a part of the contract submission process.

All contracts should include a detailed description of the methodology that will be used to calculate the target budget amount.

6. **Q:** For the Pilot Program, does the plan have to submit the VBP contract template to the state before working with providers? How quickly will the state approve templates?

**A:** The plan has to submit VBP contract templates before they can be approved as pilots. Approvals will be done on a rolling schedule, but in all cases must be in place before the pilot can begin operations.

Please keep in mind: As per the Provider Contract Guidelines, template contracts may not be used for contracts that involve providers taking on downside risk (VBP Level 2 and 3 contracts). For such contracts, specific contracts with defined parties must be submitted to the state prior to implementation. Approval of such contracts will be subject to the process defined within the Provider Contract Guidelines.

7. **Q:** Payers have a need for TINs associated with submitted NPIs, as NPIs can be associated with multiple entities. How can plans manage this from a contracting perspective?

**A:** Plans may require additional information beyond NPIs to help ensure appropriate identification of providers and their attributed population(s).