Value Based Payment Quality Improvement Program (VBP QIP)

Facility Plan Guidance Document – Frequently Asked Questions

Last Edited:
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Value Based Payment Quality Improvement Program

Facility Plan Guidance Document Frequently Asked Questions

Purpose

The purpose of this document is to provide Value Based Payment Quality Improvement Program (VBP QIP) participants with responses to frequently asked questions (FAQs) on the VBP QIP Facility Plan Guidance Document. Questions were gathered from webinars, correspondence with DOH, and other forums. Questions are sorted by category and include the date in which they were added to the document.

Facility Plan Guidance Document FAQs

Ref	Area	Question	Response	Date Added
1	General	Does the Facility Plan guidance document govern the actual contract with Managed Care Organizations (MCOs) or is it more comprehensive guidance on the VBP QIP contract?	There are a couple of documents that are important to the VBP QIP. All VBP QIP partners have a VBP contract and a separate governance document. These are the documents that really govern the partnership. A number of recommendations contained in the VBP QIP Facility Guidance Document reflect some of the best practices found in the submitted Facility Plans. These recommendations provide partners with an opportunity to see what other VBP QIP participants submitted and the State highly recommends reviewing and potentially adopting some of the structure and best practices provided in the VBP QIP Facility Plan Guidance Document. That said, VBP QIP is an MCO driven program, and it's up to the Facility's paired MCO to specify what requirements will govern the actual contract in terms of complying with the program.	January 27, 2017
2	General	Who will incur financial penalties?	The Facility will incur the penalties if it fails to meet the VBP QIP requirements. This is a managed care program that is overseen by the Facility's VBP QIP paired MCO, but it is ultimately the Facility that must comply with the program's requirements in return for receiving funding. MCOs are expected to hold the Facilities accountable for the deliverables in the Facility Plans.	January 27, 2017
3	General	With facility penalties, will funding levels be changed or will the adjustment be followed/recouped by the Performing Provider Systems (PPS) or Facility?	The Department of Health (DOH) is going to distribute money to the MCO for the respective year. If the Facility meets measures outlined in the Facility Plan, it will get paid. If not, then the money will be held by the MCO and a "true-up"/ "reconciliation" will be performed at the end of the year and the State will recoup any undistributed VBP QIP funds. The MCOs do not get to keep undistributed VBP QIP funds.	January 27, 2017
4	Application	Do the MCOs need to resubmit an application every year?	No. Participating MCOs do not need to re-submit an application each year of the program.	August 4, 2017

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5	Application	Can any Facility apply to be in VBP QIP?	Facilities do not need to apply to participate in VBP QIP. DOH selected qualified Facilities to participate in the program.	August 4, 2017
6	MCO-PPS-Facility Assignment	Will the Department approve programs or transformation plans associated with VBP QIP?	DOH only reviewed and provided feedback on Governance Plans. Paired MCOs were responsible for approving the Facility Transformation Plans. DOH provided a Facility Plan Guidance Document in March 2017 that outlined programmatic guidance. Additionally, although the MCO has ultimate approval authority, DOH expects the partners to collaborate, meaning the MCO should reach out to the PPS for its input.	August 4, 2017
7	MCO-PPS-Facility Assignment	If more than one MCO is working with the same PPS, to what degree can the MCOs collaborate on milestones and metrics?	In the rare case that a single Facility is working with more than one MCO through its PPS for VBP QIP, DOH expects the MCOs to collaborate with each other. The Facility should not be made to create more than one separate Facility Plan, so milestones and metrics should align between the MCOs. In general, the MCOs can collaborate to the extent that their collaboration ensures that the Facility is not put under undue pressure because it is working with more than one MCO.	August 4, 2017
8	Measure Credits	If a Facility can attest to being in a Level 2 VBP contract throughout Demonstration Year (DY) 4 and DY5, does it get one (1) measure credit per year?	Quarterly measure credits will be credited in the quarter the requirement is met and is applicable to the three (3) subsequent quarters. If the Level 2 VBP contract extends through later years, the Facility should recertify that a contract is in place to earn a measure credit for each quarter in the next year.	March 28, 2017

Ref	Area	Question	Response	Date Added
			If a Facility has an executed Level 2 or higher VBP contract during DY3, the Facility can earn an additional measure credit applied to the DY4 Annual Improvement Target (AIT) measures. If the Facility has an executed Level 2 or higher VBP contract in DY4 or DY5, the Facility can earn an additional measure credit applied to the DY5 AIT measures.	
9	Structure and Timeline	How long will VBP QIP run for?	VBP QIP is a 5-year program that runs in line with DSRIP.	August 4, 2017
10	Structure and Timeline	When will VBP QIP payments begin?	Payments should have already began for both Group 1 and Group 2 Facilities.	August 4, 2017
11	Structure and Timeline	What are the MCOs specifically administering in VBP QIP?	The MCOs will be overseeing the transformation of the Facility as outlined in its Facility Plan. Specifically, the MCO will monitor the Facility's progress to ensure that it meets program objectives and milestones, and will forward payment based on the achievement thereof.	August 4, 2017
12	Structure and Timeline	What is the purpose of the VBP QIP MCO Governance Plan?	The purpose of the Governance Plan is to document a detailed outline of the MCOs plan for governance over the 5 years of the program. The administration of the program and evaluation of the Facility's progress is the main role of participating MCOs, so the Governance Plan must be a thorough plan that supports a smooth transition to VBP.	August 4, 2017
13	Structure and Timeline	What is the role of the MCOs throughout VBP QIP?	As described in the VBP QIP DY2 Guidance Webinar held on June 8, 2016, the role of the MCO is as follows:	August 4, 2017

Ref	Area	Question	Response	Date Added
			• Develop the Governance Plan • Develop the template for the Facility Transformation Plan in accordance with DOH-provided criteria • Review and approve Facility Plans (in collaboration with the PPS) • Oversee the program milestone achievement; perform and report on program funding distribution • Review and approve programmatic deliverables outlined in the Facility Plan. • *Note: The MCO is not responsible for ensuring that the Facilities achieve the goals of VBP QIP.*	
14	Structure and Timeline	What is the role of the PPSs throughout VBP QIP?	The role of the PPS in VBP QIP is as follows: • Consult with Facilities and MCOs to ensure Facility Transformation Plan aligns with DSRIP and VBP goals • Provide support (non-financial) and guidance to the participating Facilities • Flow funds from MCO to Facility	August 4, 2017
15	Structure and Timeline	What is the difference between Pay for Reporting (P4R) and Pay for Performance (P4P)?	The purpose of VBP QIP is to transition financially distressed Facilities to VBP, improve their quality of care, and as a result, achieve financial sustainability over the duration of the Program. The	August 4, 2017

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			measures established in the Facility Transformation Plan should reflect the purpose of VBP and align to the metrics in the VBP Roadmap provided by DOH. DOH issued the Facility Plan Guidance Document prior to April 2017. In it, P4P refers to the quality measures the Facility selects to perform on for the duration of VBP QIP, and P4R refers to VBP contracting milestones	
16	Contracts and Plans	Are the dollar amounts being contracted for known? Is there a set amount that would flow through one of these contracts?	An amount will be built into the MCO's premium annually based on the estimated need of the VBP QIP Facilities.	August 4, 2017
17	Contracts and Plans	Will DOH consider deeper involvement or an escalation process for Facilities that do not make progress toward the agreed upon goals set forth in their Facility Plans?	It is first and foremost the responsibility of the MCO to oversee the implementation of VBP QIP milestones by its paired Facilities. DOH should be notified in the case that any party is not meeting their responsibilities. This includes Facilities not meeting their goals set forth in the Facility Plans, and also MCOs and PPS that fail to provide oversight and guidance to the Facilities.	August 4, 2017
18	Contracts and Plans	Will contracting be for a specific sub population?	No. The singular VBP QIP contract between the Facility, its PPS, and its MCO (or, in special cases, multiple MCOs) will cover the entire program, inclusive of all of the Facility's operations, and inclusive of all of the patient populations it serves.	August 4, 2017

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19	Contracts and Plans	What happens if a contract between an MCO and PPS expires within the 5 years of VBP QIP and is not renewed?	The State expects MCOs, PPS, and Facilities to either renew contracts over the course of the Program or create a contract that lasts for the Program's duration. Ultimately, it is the responsibility of the participants to negotiate contracts that are acceptable to all parties, so that all aspects of the Program can progress uninterrupted.	August 4, 2017
20	Contracts and Plans	Do Facilities need to move to VBP contracting with all of their MCOs or just their paired VBP QIP MCO?	Facilities need to take steps towards transitioning to VBP contracting with its contracting MCOs that account for 80% of the Facility's Medicaid Managed Care revenue based on calendar year 2016 data. That may include paired MCOs and other MCOs that are not participating in this program. The paired MCO is not responsible for making sure the contracts occur or for approving VBP contracts, but is responsible for holding the Facility accountable and providing support in guidance in VBP contracting.	August 4, 2017
21	Contracts and Plans	What information should a Facility share with its paired MCO regarding other MCO contracts?	Facilities are expected to provide paired MCOs with attestations stating that they already have VBP contracts per the programmatic milestones outlined in the Facility Plan Guidance Document. The Facility should submit MCO Contract Lists directly to the VBP QIP mailbox at vbp_qip@health.ny.gov. The contracting MCO should submit the VBP contract with required documentation to contracts@health.ny.gov.	August 4, 2017
22	Contracts and Plans	When are Facilities expected to enter Level 1 contracting?	Facilities were required to submit one Level 1 VBP contract that meets NYS Roadmap requirements by June 30, 2017. Facilities must submit Level 1	August 4, 2017

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			VBP contracts that account for 80% of the Facility's Medicaid Managed Care revenue based on calendar year 2016 by April 1, 2018.	
23	Contracts and Plans	According to DOH, what will constitute a "small" patient population for which a Facility would not need to enter in a Level 1 VBP contract with an MCO?	As per the program requirements, Facilities must submit Level 1 VBP contracts that account for 80% of the Facility's Medicaid Managed Care revenue based on calendar year 2016 data by April 1, 2018. Reaching the 80% VBP contracting target may mean having more than one VBP contract, with more than one MCO. Facilities and potential MCO partners together should analyze their patient population to understand whether there are significant opportunities to improve care and reduce cost (e.g., through addressing potentially avoidable complications (PACs)). The decision to enter into a VBP contract should be determined based on the analysis of the population as well as financial interest and viability of the contracting parties.	August 4, 2017
24	P4P Measures	Are quality measures different for VBP QIP vs. the actual contracts with MCO partners?	Yes. While the measures do relate, there is a specified menu of measures DOH has suggested for VBP QIP, and there are suggested measures for each of the different types of VBP arrangements. VBP QIP measures are Facility specific, but we expect significant alignment between facility measures for VBP QIP, PPS measures for DSRIP and VBP contract measures.	January 27, 2017
25	VBP QIP Disbursement	Should MCOs prepare to provide funding for VBP QIP before payment from DOH?	It is the State's commitment to ensure that MCOs have adequate resources to administrate the Program without having MCOs advance funds prior to receiving programmatic funds from the State. This includes the State releasing funds early,	August 4, 2017

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			initiating rate adjustments, expediting reconciliations for prior-year payments, and the development of a set funds flow schedule so that all parties can anticipate and plan for payment.	
26	VBP QIP Disbursement	How should funds be accounted for when they are flowed down to the Facilities? Are MCOs expected to monitor the funds moving to the Facility?	MCOs must report on VBP QIP funds distribution in the Medicaid Managed Care Operating Report (MMCOR). There is also accountability via cost reports and in that manner the funds will be reconciled and validated. It is important to have a complete tracking system of the funds being distributed from the MCO to the PPS, and ultimately to the Facility.	August 4, 2017
27	VBP QIP Disbursement	Will the distribution and proportion of funds change as other Facilities enter the program?	Yes. Both the distribution and proportion of funds can change as other Facilities enter the VBP QIP, and as Facilities transform and gain financial stability through VBP. DOH will provide updated figures for VBP QIP Facilities annually.	August 4, 2017
28	VBP QIP Disbursement	How will the money be distributed over the 5 years of the program?	Each year will have its own distribution. It is expected that each year of the program will have an amount allocated for distribution. DOH expects to develop a set funds flow schedule so all parties can better anticipate and plan for receipt of payment.	August 4, 2017
29	VBP QIP Disbursement	Will the proposed 5% administrative fee be offered to the MCOs? Do you see the 5% administrative fee increasing with time since the MCOs see that there will be more work as they move from just paying for reporting to being more involved in the program?	The MCO's administrative fee is 5% of the total payment.	August 4, 2017

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30	VBP QIP Disbursement	Will program payments be segregated for cost reporting and other purposes?	Payments for this program are segregated on the MCOs' Premium Schedule B's, addendum schedules for cost reporting, and other purposes within the cost reports (MMCOR). For those MCOs participating in the program, the cost report reporting directions can be found in the MMCOR Instructions located in the Healthcare Financial Data Gateway (HFDG) within the Health Commerce System (HCS).	August 4, 2017
31	VBP QIP Disbursement	Are VBP QIP budget amounts determined on a hospital-by-hospital basis?	Yes, VBP QIP allocations are determined by reviewing each Facility and working with the Health Economics Team at OPCHSM to understand the level of financial distress that the Facility is in. Then, calculations are done to determine the amount of money needed to sustain the Facility and aid them in moving towards VBP contracting. For these calculations, DOH uses historical data, audits, budgets, and other sets of financial information to determine the VBP QIP funding amount.	August 4, 2017
32	P4P Measures	What if a Facility wants to choose an alternative performance measure that is not nationally recognized but is specific to the Facility?	While this is not recommended by DOH, a Facility can elect to use an alternative performance measure that is specific to that Facility, but they must be prepared to justify their selection and fully document the measurements specification. It will be up to the Facility's VBP QIP paired MCO to accept the criteria for any alternative measures, as well as, to approve the specifications for that measure.	January 27, 2017

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33	P4P Measures	Do all six (6) performance measures have to be finalized before submitting final Facility Plan updates?	Yes. A Facility must have all six (6) performance measures finalized before submitting the final Facility Plan updates.	January 27, 2017
34	P4P Measures	Are the measures All-Payer or Medicaid / Medicare only populations?	All-Payer measures are recommended over Hospital/ MCO-specific measures or Medicaid only populations because there would be the possibility of running into “small cell size/denominator” issues.	March 28, 2017
35	P4P Measures	How should facilities select measures if means for AIT measurement in DY4 will not be released until June 2017?	The Centers for Medicare and Medicaid Services (CMS) does not release updated mean information until April 2017. DOH does not anticipate significant changes in the measures’ means from the means reported in the Facility Plan Guidance Document released in March 2017.	March 28, 2017
36	P4P Measures	What version of the 3M Solutions are Facilities expected to report the PPV and PPA measures for the VBP QIP?	PFP v132. Population-focused Preventables (PFP) Software	March 28, 2017
37	P4P Measures	Within the measures menu, two measures are derived from 3M. Are there any proxies that may be replaced for these, as many Facilities aren’t able to report on 3M measures?	There are no specific proxies for these measures, which is why they are asterisked in the Facility Plan Guidance Document as it is up to the Facility to determine whether it is able to report those measures if selected. These measures were included in lieu of some others previously in consideration such as PPR measures, which lagged by over a year. The 3M measures can be reported on within a 6 month time frame if the Facility has access to a vendor with the necessary data. Facilities are not required to select 3M measures as there are eleven (11) other measures in the VBP QIP measure menu, and Facilities also have the option to select up to two (2) alternative measures.	March 28, 2017
38	P4P Measures	Are Facilities required to determine measure improvement is statistically significant?	No. For the Quarterly Improvement Target (QIT), the Facility is required to maintain or improve performance for the measure to be considered	March 28, 2017

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			achieved. For AIT, the Facility is required to improve performance and exceed the mean New York State (NYS) results for the specific for the measure to be considered achieved. It is advised that facilities select measures where they can improve because it will become progressively harder to achieve performance as outcomes improve.	
39	P4P Measures	Why was the Venous Thromboembolism (VTE) measure removed from the original menu of measures?	Upon further review of the measure, DOH discovered that the measure has topped out and been removed by CMS as of January 1, 2016. Therefore, there is not a national data source to benchmark the mean for AIT.	March 28, 2017
40	P4P Measures	What happens if a Facility is part of a reorganization or consolidation that impacts its ability to meet minimum denominator requirements in the future?	Facilities that anticipate a reorganization should select measures based on their current state as this is how they will currently be assessed. However, if a Facility undergoes a reorganization, it should contact DOH to reassess their Facility Plan and needs to focus on Facility outcomes.	March 28, 2017
41	P4P Measures	If a denominator falls below 30 in a given quarter, will it affect all of the 12 month rolling annual results until the invalid quarter is out of the calculation?	DOH elected a rolling annual calculation for baseline and measurement periods to help alleviate low denominator issues. Facilities should select measures that consistently impact more than 30 patients over the course of a year.	March 28, 2017
42	P4P Measures	Why are pay for performance (P4P) measures valid based on a minimum of 30 denominator size if the Delivery System Reform Incentive Payment (DSRIP) program goals seek to decrease hospital use and hence may decrease denominator size for some measures?	P4P measures must have a valid denominator with a significant population to assess performance to help promote the acceptance of the program to governing bodies. Facilities are also encouraged to select measures that have true, meaningful opportunity for improvement.	March 28, 2017

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43	P4P Measures	When Critical Access Hospitals (CAHs) establish baselines for measures with inpatient days, should swing bed units also be included?	The baselines for inpatient days should be established based on how the hospital submits the data.	March 28, 2017
44	P4P Measures	Will DOH allow denominators less than 30 if a Facility can demonstrate a proportional/significant decrease in hospitalizations or length of stay?	DOH will only allow a decrease in denominators to 15 for facilities with less than 100 licensed medical / surgical beds. Additionally, there are currently two (2) measures from the menu that are related to avoidable emergency department (ED) use and avoidable admissions.	March 28, 2017
45	P4P Measures	What if a Facility only has valid denominators for less than four (4) measures?	Facilities have the option to choose at a maximum two (2) alternative measures. Additionally DOH created an addendum for facilities with less than 100 licensed medical / surgical beds that decreases denominator thresholds to 15 and provides four (4) additional measures for facilities who meet the criteria. If a Facility still fails to meet quarterly performance for four (4) measures, the quarterly award amount will be decreased 25% for each measure under four (4) that is not met. Facilities will have the opportunity to earn these funds back through the AIT. If AIT is not met, the amounts will not be awarded to the Facility.	March 28, 2017
46	P4P Measures	Where can a Facility obtain information on the sepsis measure?	The Facility should obtain sepsis data from the hospital infection preventionist at the Facility. Additionally, the NYS Sepsis Report Calendar Year (CY) 2015 was released in mid-March 2017 and can be found here https://www.health.ny.gov/press/reports/docs/2015_sepsis_care_improvement_initiative.pdf	March 28, 2017
47	P4P Measures	What is the definition of “population” for the P4P measures?	The population refers to all payers for the Facility.	March 28, 2017

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48	P4P Measures	How is the 50% of P4P amounts distributed if performance is only measured in one-quarter in DY3?	P4P award amounts make up 50% of the program payments in DY3. This portion of payments is split evenly between DY3 Q3 and DY3 Q4. The Facility will be paid in DY3 Q3 for collecting and reporting on the baseline period for DY2 Q4 (April 2016 – March 2017). The Facility will be paid for DY3 Q4 based on performance measured in DY3 Q1 compared to its baseline.	March 28, 2017
49	P4P Measures	Can you provide an example of a rolling annual calculation?	DOH included an example the rolling annual calculation for two quarters in the Facility Plan Guidance Document. The rolling annual calculation includes the current quarter's measurement period plus the nine (9) preceding months.	March 28, 2017
50	P4P Measures	Can the MCO veto an alternate measure selected by the Facility?	Yes. The Facility's paired MCO has to review and accept the alternate measures chosen by the Facility and PPS. However, DOH advises MCOs to be as flexible as possible if the Facility's proposed measure is relevant, valid, and feasible.	March 28, 2017
51	P4P Measures	Can P4P quality measures be changed at any time? Is it advantageous to select more than six (6) P4P quality measures?	The MCO, Facility, and PPS ultimately decide if more than six (6) measures can be selected. However, DOH advises that Facility selects no more than six (6) measures, as there should be a focus on improving in targeted areas over the course of the program. Barring corporate restructuring/reorganization, the selected measures must be used for the remainder of VBP QIP.	March 28, 2017

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52	P4P Measures	Are AIT benchmarks for alternative measures required to be established prior to the submission of the Facility Plan?	No. However, Facilities should document the reason for using an alternate measure and explain how data will be collected and reported to its MCO, including the mean used in AIT measurement. AIT baselines should be in place by June of each year so that the Facility knows its AIT target before the start of the AIT measurement period.	March 28, 2017
53	P4P Measures	Are VBP QIP facilities required to improve performance for an alternate measure to be considered achieved?	For QIT, the Facility must **either maintain or improve** performance compared to the preceding quarter's rolling annual results. For AIT, the result of the Annual Measurement Period must **be better than** (i.e. improve) the Annual Baseline Period and the mean NYS results for the specific measure as the most recently published report by the designated data source.	March 28, 2017
54	P4P Measures	If an MCO agrees, can a Facility select more than 2 alternative measures?	No. The maximum number of alternative measures a Facility may select is two (2).	March 28, 2017
55	P4P Measures	Is a Facility measured against its own performance on a quarterly basis or an annual basis?	The QIT is based on a rolling annual calculation. If a Facility meets its QIT for four (4) out of six (6) measures for each quarterly measurement period throughout the year, it will not need to report on AIT since all available P4P funds were earned. If there are unearned quarterly funds throughout the year, the Facility has the ability to earn these funds by achieving both requirements set forth in the Facility Plan Guidance Document for AIT.	March 28, 2017
56	P4R VBP Contracting	Will DOH release a contracting template?	No. DOH is not releasing a VBP contract template.	March 28, 2017
57	P4R VBP Contracting	If a Facility's initial VBP contract included information on the performance of PPS projects, is the requirement still applicable and tied to payment?	The Facility Plan Guidance Document and other materials released by DOH are guidance. It is ultimately up to the paired MCO and Facility to adopt the guidance. DOH feels the guidance	March 28, 2017

Ref	Area	Question	Response	Date Added
			provided will help promote the purpose and validity of the program.	
58	P4R VBP Contracting	When will Total Care for General Population (TCGP) measures for VBP contracts get approved by the Clinical Advisory Groups (CAGs)?	TCGP measures were approved in March 2017. Information on TCGP measure approved by the CAGs can be found at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/vbp_final_cag_reports.htm.	March 28, 2017
59	P4R VBP Contracting	Is the June 2016 VBP Roadmap the version partners should reference for guidance on VBP Contracting?	Yes. The VBP Roadmap published in June 2016 is the most recent version partners should reference for VBP contracting guidance.	March 28, 2017
60	P4R VBP Contracting	Why are contracting requirements stringent for VBP QIP than what applies for PPS in general?	PPS are not able to contract VBP arrangements because they are not legal entities. A PPS will only be able to contract VBP if it forms an Independent Practice Association (IPA) or Accountable Care Organization (ACO). Milestones were removed for this reason.	March 28, 2017
61	P4R VBP Contracting	Will a Facility that is part of an IPA that holds VBP contracts be sufficient to meet requirements or is the individual Facility required to hold the actual contract?	A VBP QIP Facility may enter a VBP contract as a primary VBP Contractor or as a member/partner of a larger VBP contracting entity (such as a qualified IPA contractor). The VBP Roadmap encourages providers to enter into VBP arrangements and form networks that will be able to provide continuity of care based on the type of arrangement chosen. Networks have to be adequate to deliver services within the scope of the arrangement, In most cases, an individual provider or a small group of providers are not able to form adequate networks. Thus, VBP QIP Facilities are encouraged to review the menu of arrangement option within the Roadmap and assess their ability (or lack thereof) to provide services under a specific VBP arrangement.	March 28, 2017

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62	P4R VBP Contracting	How should Facilities contract with MCOs that are out of network?	Facilities should focus on contracting with MCOs with whom they already have Medicaid Managed Care Contracts in order to provide improved services to the Medicaid population they cover under those contracts.	March 28, 2017
63	P4R VBP Contracting	Could program requirements further weaken already distressed hospitals' ability to earn its VBP QIP payment?	VBP QIP payments are based on the overall performance of the Facility in the Program (P4P) as well as its ability to enter into VBP contracts (P4R). Entering into VBP contract will strengthen the Facility's ability to meet the P4R requirements and potentially, earn measure credits to account for the inability to meet the P4P goals.	March 28, 2017
64	P4R VBP Contracting	Can a Facility use an existing Level 1 VBP contract instead of a Letter of Intent (LOI) for the April 1, 2017, pay for reporting (P4R) requirement?	Yes. If the Facility has an existing contract that is Level 1 or higher, a Contract Attestation can be submitted instead of an LOI. The Facility will still need to provide an MCO Contract List.	March 28, 2017
65	P4R VBP Contracting	How can a Facility confirm it is meeting the required VBP contracting thresholds?	DOH released an MCO Contract List for Facilities to populate and submit for one of the April 1, 2017, requirements. DOH is developing an MCO Contract List that due on July 1, 2017, that will be populated based on calendar year 2016 Medicaid Managed care revenue. These spreadsheets should be used as tools for the facilities to see VBP contracts needed to meet their 80% requirement. A VBP QIP Facility must have Medicaid MCO contracts where at least 80% of Medicaid MCO contracted payments (based on CY2016 data) to the Facility are tied to at least Level 1 VBP components by April 1, 2018.	March 28, 2017
66	P4R VBP Contracting	How should smaller safety net providers unable to enter into contracts proceed?	While Facilities may not be able to contract with an MCO as a primary VBP Contractor, it is suggested that they join VBP arrangements negotiated under a larger umbrella (e.g. an IPA is the VBP Contactor	March 28, 2017

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			in a TCGP arrangement, and the Facility joins as a provider with general inpatient and outpatient hospital services). Facilities should be working on developing their value proposition to the VBP Contractor and highlight their ability to contribute to the overall success of the arrangement. Facilities should notify DOH as soon as possible if they encounter difficulties engaging MCOs in VBP contracting, but it is the Facility's responsibility to enter into VBP contracts by April 1, 2018.	
67	P4R VBP Contracting	Should the MCO Contract List due on April 1, 2017, include 2015 cost data or 2015 Medicaid Managed Care revenue?	The MCO Contract List should be populated using Medicaid Managed Care revenue.	March 28, 2017
68	P4R VBP Contracting	If a Facility already has a VBP contract in place by April 1, 2017, and submits the Contract Attestation, is the Facility exempt from reporting on the milestone for July 1, 2017 to have one executed Level 1 VBP contract?	Yes, if a Facility already has a VBP contract in place by April 1, 2017 the Facility can submit a Contract Attestation in lieu of the LOI on April 1, 2017 and this will also be considered sufficient for meeting the July 1, 2017 milestone of one executed Level 1 VBP contract.	March 28, 2017
69	P4R VBP Contracting	How should a Facility and MCO populate section 6 of the LOI template if they have not decided an arrangement type?	DOH expects partners to determine expected arrangements when LOIs are signed.	March 28, 2017
70	P4R VBP Contracting	How should the Facility handle a situation where an MCO refuses to enter into a VBP contract?	While Facilities may not be able to contract with an MCO as a primary VBP Contractor, it is suggested that they join VBP arrangements negotiated under a larger umbrella (e.g. an IPA is the VBP Contactor in a TCGP arrangement, and the Facility joins as a provider with general inpatient and outpatient hospital services). Facilities should be working on developing their value proposition to the VBP Contractor and	March 28, 2017

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			highlight their ability to contribute to the overall success of the arrangement. Facilities should notify DOH as soon as possible if they encounter difficulties engaging MCOs in VBP contracting.	
71	P4R VBP Contracting	Where can partners access LOI templates for VBP QIP?	The April 2017 LOI template for VBP QIP is located on the program home page at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_initiatives/	March 28, 2017
72	P4R VBP Contracting	Are IPA contracts considered Medicaid Managed Care contracts?	Yes. If the IPA is a VBP contracting entity, the contracts would be considered Medicaid Managed Care.	March 28, 2017
73	P4R VBP Contracting	Where can parties find information on quality measures used for TCGP VBP arrangements?	Information on TCGP quality measures can be found in the VBP Resource Library at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library under the "VBP Clinical Advisory Groups" section.	March 28, 2017
74	P4R VBP Contracting	How should smaller facilities pursue TCGP contracts for MCOs that require a minimum threshold of 1,000 members?	If there is a minimum threshold established by an MCO and the Facility in unable to meet the requirement, the Facility could try to become part of a larger contracting entity. DOH suggests that the Facility reaches out to with the contracting entities in the Facility's area. Additionally, the Facility should reach out to its MCO partners and hospital associations for assistance. DOH anticipates that MCO partners will work with the VBP QIP facilities as they are held to the 80% VBP requirement.	March 28, 2017
75	P4R VBP Contracting	How will a Facility that does not have primary care providers employed (to attribute population through) have the ability for 80% of Medicaid	Although attribution is typically based on Primary Care Physician (PCP) assignment, it is not required. Lives can also be attributed through physicians that you have VBP participation	March 28, 2017

Ref	Area	Question	Response	Date Added
		Managed Care amounts through a TCGP arrangement?	agreements with but don't employ. The method to capture attribution is left to the discretion of the contracting partner and MCO. The partners will need to be able to demonstrate how this contract meets the requirements of the roadmap with quality measures, target budget, and shared savings. The State will review VBP contracts to make sure required elements are included.	
76	P4R VBP Contracting	Are facilities required to use a certain amount of TCGP measures?	Yes. VBP contractors must report on all finalized Category 1 measures. They are free to add more measures in their VBP contracts if they so choose with their MCO.	March 28, 2017
77	P4R VBP Contracting	For facilities that already have level 1 contracts in place with their respective MCO, what needs to be documented to demonstrate the requirement is met?	The Facility should submit a Contract Attestation that was distributed to participants and is posted on the VBP QIP website at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_initiatives/	March 28, 2017
78	P4R VBP Reporting	Why does the MCO Contract List for April 1, 2017 only contain fields for TCGP agreements?	The MCO Contract List for April 1, 2017 focuses on TCGP arrangements because DOH anticipates that the most straightforward way to achieve the 80% VBP threshold will be through contracting TCGP arrangements as they capture most of the attributed population. However, the MCO Contract List for July 1, 2017 will include space for non – TCGP arrangement types.	March 28, 2017
79	Reporting and Payment	Is DOH confident that the facilities are capable of producing data on performance measures within 120 days of the end of the performance period?	DOH believes that many facilities can abstract data from their own databases to comply within 120 days for all of the proposed menu of VBP QIP quality measures suggested by the State. However, each facility's collection and reporting process may differ, so facilities need to assess the ability to collect performance data on each of the quality measures it selects for VBP QIP.	January 27, 2017

Value Based Payment Quality Improvement Program

Facility Plan Guidance Document Frequently Asked Questions

Ref	Area	Question	Response	Date Added
80	Reporting and Payment	Can DOH provide an example of a timeline for P4P data submission?	DOH provided a visual example of two (2) quarters in the Facility Plan Guidance Document. For example, the data submission deadline for DY3 Q1 is October 28, 2017. Additionally, the measurement period covers July 1, 2016 through June 30, 2017.	March 28, 2017
81	Reporting and Payment	Why is DOH recommending P4P and P4R payments be paid in distinctly separate quarters of the third performance year (DY3)?	DOH is recommending that all P4R payments in DY3 be paid in the first two quarters of DY3, so there is more predictable cash flow for the facilities during the first half of DY3. This structure also provides the facilities with more time to implement and fully operationalize their performance measurement systems	January 27, 2017
82	Reporting and Payment	If MCOs only access measurements from a given period after the period has ended, how will the MCO plan on making monthly payments?	MCOs do not make prospective payments. Payments for P4P are lagged so that MCOs should have the data to evaluate measure achievement by the time the quarterly payment occurs. It is the MCO's responsibility to review the measurement data and report any deficiencies to the Facility.	March 28, 2017
83	Reporting and Payment	What happens to funds unearned for P4R amounts that are linked to contracting targets that have been previously effectuated to the MCO?	DOH will perform a reconciliation at the end of each year to recoup unearned funds from MCOs. Facilities should remember the unearned P4R amounts cannot be earned through meeting the AIT.	March 28, 2017
84	Reporting and Payment	What is the first measurement period for Group 2 participants?	Beginning in DY3, Groups 1 and 2 will be on the same timeline. The first P4R reporting period begins on April 1, 2017. The first P4P reporting period begins in DY3 Q3 where the Facility is required to report their initial baseline. The baseline reported in DY3 Q3 should include DY2 Q4 plus nine preceding months (or April 2016 – March 2017).	March 28, 2017

Ref	Area	Question	Response	Date Added
85	Reporting and Payment	Will DOH provide a template for the Facility to attest to quarterly report submissions?	DOH is currently working on a P4P reporting template and expects to release it in April 2017.	March 28, 2017
86	Reporting and Payment	Can you describe the expected process and timeline for Facility reporting and MCO payment? Specifically, based on the current process defined in the guidance document, it looks like funding should be dispersed to facilities immediately, and adjustments following the 120 day period would apply to the subsequent period.	DOH recommends a timeline for P4P measure collection, reporting, review, and payment preparation of 180 days after the measurement quarter's close. Specifically, DOH recommends 120 days for the Facility to collect and report to their paired MCO, 45 days for the MCO to review the Facility's report, and 15 days for the MCO to prepare payment. DOH is confident this should be ample time for the MCO to make a decision and distribute the earned amount to the Facility over the following quarter.	March 28, 2017
87	RH/CA Addendum	Can small Rural Health (RH) and Critical Access (CA) facilities who only meet the denominator for four (4) measures from the menu use statistical significance to accommodate for small volumes?	DOH has decided to remain using an "average" rather than a "standard deviation" calculation to assess performance achievement for RH and CA hospitals in its VBP QIP Facility Plan guidance. DOH developed an addendum for facilities with less than 100 licensed medical / surgical beds. This addendum allows facilities meeting the criteria listed above four (4) additional measures and lowers the valid denominator threshold from 30 to 15. These new measures specifically geared toward RHs and CAHs (along with the ability for the Facility to select alternative measures) should provide a Facility the flexibility to find measures where it has meaningful volume relative to its size.	March 28, 2017
88	RH/CA Addendum	Will the Office of Quality and Patient Safety (OQPS) release the standard deviations for measures along with the mean for AIT?	No. OQPS will only release the means for the menu of measures annually for AIT since standard	March 28, 2017

Ref	Area	Question	Response	Date Added
			deviations are not needed for measurement in the program.	
89	RH/CA Addendum	Which facilities are able to utilize the sepsis measure?	Every Facility should be able to identify the sepsis case if their measure is valid.	March 28, 2017
90	RH/CA Addendum	Are RH / CA facilities required to select measures from the four (4) additional measures included in the addendum?	No. The Facility can select measures off of the menu in the main Facility Plan Guidance Document.	March 28, 2017
91	RH/CA Addendum	If an RH / CA Facility selects a measure from the main Facility Plan Guidance Document, is the minimum required denominator threshold 15 or 30?	Facilities that meet the requirements to be considered an RH / CA Facility outlined in the Facility Plan Guidance document have a minimum required denominator of 15.	March 28, 2017
92	RH/CA Addendum	Are there any changes to P4R requirements for RH / CA facilities?	The only changes for RH / CA facilities are for P4P and are the addition of four (4) measures and decrease minimum denominators from 30 to 15.	March 28, 2017
93	Other	Will there be a specific line item where VBP QIP funds can be tracked?	Yes. There is a specific line item to identify the VBP QIP funds within the MMCOR. There are segregated adjustments in the MCOs' Schedule B's and addendum schedules so that MCOs can see the funds that are associated with surplus, taxes, additional administration, and what is distributed to the Facilities.	August 4, 2017
94	Other	Will the rates be sent to CMS for approval?	Yes. The rates will be sent to CMS for approval.	August 4, 2017
95	Other	Will payments pursuant to this program not be counted toward minimum loss ratio (MLR) calculation?	VBP QIP funds will count towards the MLR calculation. Should this change, DOH will provide guidance to the MCOs.	August 4, 2017
96	Other	Will the payments pursuant to this program affect total funding otherwise planned for the Medicaid quality incentive?	The payments under VBP QIP will not affect total funding planned for the existing Medicaid quality incentive program premium add-on.	August 4, 2017

Ref	Area	Question	Response	Date Added
97	Other	Is the program going to be based on shared savings, shared risk, or both?	It could be either, or both, depending on the MCO/Facility contract. See the VBP Roadmap for more detail on menu of VBP contracts available for MCOs and Facilities to enter into as the Facility transitions to VBP.	August 4, 2017
98	Other	Does this program affect the upper payment limit?	No. VBP QIP payments do not affect the upper payment limit.	August 4, 2017
99	Other	Are Facilities required to submit monthly financial reports to MCOs?	DOH expects Facilities to report on VBP QIP contractual obligations to their paired MCOs.	August 4, 2017
100	Other	Is VBP QIP in compliance with State and Federal regulations?	Yes. VBP QIP is in compliance with State and Federal regulations. The NYS Medicaid Director issued a formal letter to Program participants at the initiation of VBP QIP, which stated that the Program is in compliance with State and Federal Regulations. The State stands by this letter and affirms that the design of the program and the payments that have been made for the prior years are in compliance as implemented. The State will monitor the program to ensure its continued compliance with State and Federal law.	August 4, 2017